The Effect of Attending a Bereavement Support Seminar on the Level of Depression of Bereaved Spouses within the First Year after the Spouses' Deaths; An Experimental Study

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

by

Carole Jeanne Weidaw

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
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The effect of attending a bereavement support seminar on the level of depression of bereaved spouses within the first year after the spouses' deaths: An experimental study

Weidaw, Carole Jeanne, Ed.D.
Western Michigan University, 1988
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THE EFFECT OF ATTENDING A BEREAVEMENT SUPPORT SEMINAR
ON THE LEVEL OF DEPRESSION OF BEREAVED SPOUSES
WITHIN THE FIRST YEAR AFTER THE SPOUSES' DEATHS: AN EXPERIMENTAL STUDY

Carole Jeanne Weidaw, Ed.D.
Western Michigan University, 1988

The primary purpose of this study was to determine the effect of providing information about the grief process and a supportive environment of peers on depression in recently bereaved spouses.

The treatment intervention consisted of the Bereavement Support Seminar, which provided didactic material relating to the normal aspects of the grief process with emphasis on dealing with anger, guilt and progressive growth while allowing for feelings and memories to be vented and supported.

The subjects were divided into two groups: experimental (those who were involved in the 4-week Bereavement Support Seminar) and control (those who received no intervention). The experimental group contained 25 persons and the control contained 37 persons, which represented subjects studied in Michigan and Pennsylvania and then combined for hypothesis testing.

The approach of the investigation involved administering a pre- and posttest of Kincannon's Mini-Mult Short Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Form of the Minnesota Multiphasic Personality Inventory to all study participants with evaluation of Scale 2 (Depression).

Data were analyzed by use of a nondirectional two-tailed \( t \) test for independent means between the experimental control groups, and pretest-posttest comparisons were analyzed by means of a correlated sample \( t \) test, both at the .05 alpha level.

It was concluded that there was not a significant difference in the depression level of the experimental group as compared with the control group.
DEDICATION

I dedicate this dissertation to my parents. My mother, Madeline Manders Heston, is a bereaved spouse who has been grieving since 1979, and inspired the development of this study. While my father, Russell Eugene Heston, Sr. did not live to see this achievement, I know it would please him because he placed such a high value on education. My thanks for giving that value to me and heading me in the right direction.
ACKNOWLEDGEMENTS

First, I acknowledge the help of Dr. Robert Oswald, my committee chairperson, who has been very supportive throughout my doctoral program. He has given me worthwhile advice on more than this dissertation. I want to thank also my entire committee, John Geisler, Ed.D., Robert M. Brashear, Ph.D., and David J. Cowden, Ed.D. for their help with this dissertation.

I want to thank my family for their support. My husband, Kenneth M. Weidaw III, and my children, Katharine and Kenneth IV, have encouraged me to complete my doctoral work and have made sacrifices to ensure it. My husband's parents, Mr. and Mrs. Kenneth M. Weidaw, Jr., must be remembered for the hours they cared for my family while I attended school. Their contribution has been invaluable.

Last, but definitely not least, my heartfelt thanks to my colleague and friend, Susan Jean Zonnebelt-Smeenge. As we worked together, her commitment was an inspiration to me. Her contribution to this study is greatly appreciated, but her friendship means even more.

Carole Jeanne Weidaw
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CHAPTER I

INTRODUCTION

Statement of the Problem

Grief, the emotional reaction to a loss, is a very individual matter, but usually follows a relatively predictable course. Stages of grief have been described and a normal pattern identified that occurs before the reality of loss is accepted. During this grief process, each person experiences the devastating emotional impact of loss in a unique way. Previous research has documented physical and emotional symptoms that occur among bereaved persons often enough to be considered normal reactions to loss.

One of the most common emotional symptoms to occur during normal grief is depression. Common depressive symptoms, such as crying, fatigue, appetite and weight loss, sleep disturbance and difficulty concentrating, are seen early in bereavement and in grief associated with loss of spouse, depression is known to persist in varying degrees. When the attachment has been a high level of attachment, it is thought the loss is more devastating, affecting adjustment for recovery.

A growing proportion of the population is becoming
widowed, but even as more people are affected, death remains a subject that many people resist discussing and fear experiencing in their families. The United States has ambiguous mourning rites, and in a society based on couples, the surviving spouse, who has a need to talk about death and the person who has died, finds that those around the mourner only support getting on with living. The widow(er) gets the message that this is his/her cross to bear and "time heals," making grieving a lonely, isolated time to be endured.

It has been realized that education is good preventative medicine. Learning what is normal, understanding the grief process and the changing identity that evolves as progress toward recovery is made can reduce the anxiety and stress associated with loss of spouse. The research that has been done to learn more about conjugal bereavement and what promotes recovery suggests the importance of perceived supportiveness of environment interactions and permission to ventilate thoughts and feelings (Maddison, 1968). Even Shakespeare realized the importance of talking when he wrote, "Give sorrow words. The grief that does not speak whispers the o'er-fraught heart and bids it break" (Macbeth, Act IV, Scene iii).

However, finding a receptive environment for grieving is not easy. Widows/widowers, through the interview method, have reported a lack of satisfaction with their
own adjustment and recovery, suggesting they have grown used to a bereavement state, rather than feeling recovered. This study questioned if professional intervention that supplied both education and a supportive environment of peers, when provided early in the conjugal bereavement, could effect the depression level experienced following the loss of spouse.

**Operational Definition of Terms**

**Bereavement**: The process of grieving experienced by a person following a significant loss.

**Bereaved spouse**: A person who has lost his/her marriage partner through death, and who is now in the process of grieving, which is experienced by a person following significant loss.

**Bereavement Information Sheet**: A self-report form developed by the researchers for study participants to give information about themselves and the deceased spouse in relation to age, education and years married, physical health prior to and following the death, cause of death, and depression history.

**Bereavement Questionnaire**: A retyped and labeled copy of Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory (MMPI), which covers 9 of the 10 scales of the MMPI, with a reduced number of items (71 rather than 566).
Bereavement Support Seminars: A group session lasting one and one-half hours per week and ongoing for four weeks, during which time didactic information regarding the grief process was disseminated, and support, through mutual sharing, was given.

Scale 2 (Depression): A scale which measures a person's mood in relation to sadness or degree of pessimism at the time of administration. Usually, the mood indicated is in relation to pressing current events and not an indicator of chronic depression.

Sudden death: Death that occurs not more than two days after notice is given that all is not well or without notice that all is not well and a problem may ensue that is life-threatening.

Anticipatory grief: That process of grieving that begins prior to the actual death as a reaction to the anticipation of impending loss, often with diagnosis of a life-threatening illness.

Blue days: An affective feeling-tone of mild downheartedness, sadness, or dispirited attitude toward one's environment that can occur as a part of everyday life exclusive of grieving.

Statement of Hypothesis

Research Hypothesis

There is a significant difference in the level of
depression 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 2 (Depression) 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 2 (Depression) 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 2 (Depression) 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 2 (Depression) 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

\[ \text{Ho: } \bar{X}_I \neq \bar{X}_{NS} \]

\[ \text{Ha: } \bar{X}_I \neq \bar{X}_{NS} \]

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
Man is a social being, attaching himself to men, things, and places during his lifetime. Bowlby (1980) first postulated the attachment theory in his work with infants and children, but it seems to be a normal part of adult development as well (Belitsky & Jacobs, 1986). The Anglican cleric, John Donne (as cited in Rome, 1986), observed "that the bell that tolls is for each of us" (p. 268). When loss of one of these attachments occurs, man suffers to a greater or lesser degree in relation to the degree of involvement based on the unique quality of the relationship and the resultant feelings of deprivation. The social isolation of never forming attachments has been demonstrated to have very negative consequences, but when normal, secure attachments are made and then lost, the result "invariably leads to the development of grief reactions" (McKinney, 1986, p. 281).

When there is attachment, then loss results in grieving. "Grief has been described as a normal emotional and physical process that accompanies the crisis of loss" (Richter, 1984, p. 46). Individuals experiencing grief do so at various levels for various lengths of time. Its "manifestations vary widely," but the adaptive function
seems to have a biological base (Hauser, 1983, p. 23). "Bereavement is perceived as extremely stressful across many cultures, and is a life change" (Raphael, 1977, p. 1450). However, a process of grief and a pattern of stages seems to be followed by most persons. Kubler-Ross (1969) has documented her work in relation to death and dying. The denial, anger, bargaining, depressions and on to acceptance are anticipated stages to grief closure.

Other researchers describe grief reactions as proceeding "through various phases from shock to repatterning, but not usually in an orderly nor completely predictable manner" (Hauser, 1983, p. 23). Lindemann (1944) is well known for his description of acute grief as "a normal reaction to a distressing situation" (p. 141) and demonstrated grieving persons to be "remarkably uniform" (Lindemann, 1944, p. 141) in the symptoms displayed, naming five main points: (1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reactions, and (5) loss of patterns of conduct. A sixth point, or assuming traits of the deceased has also been noted (Lindemann, 1944, p. 142).

Grief work is a painful process of emotionally detaching oneself from the deceased or lost object, and has been noted to be accompanied by functional impairment that is predictable. The term "disease model" and likening bereavement to a wound and the grief process as healing
allows for expected symptoms to be experienced by the survivor (Brown & Stoudemire, 1983).

Research has been conducted to validate the stages of grief and to distinguish normal grief from pathological grief. What can be normal symptoms may become distorted, exaggerated, delayed, and classified as pathological. Grief can affect the person's physical and emotional health. Wide individual variations in specific symptoms and in their intensity and duration have been demonstrated (Zisook, Devaul, & Click, 1982).

However, a timetable for normal grief has not been determined. For some, "grieving begins at diagnosis. Anticipatory grief is conceptually defined as a process characterized by cyclical periods of mental anguish and feelings of loss that begin . . . in expectation of the deprivation of a significant relationship and social role through the expected death of a loved one" (Welch, 1982, p. 150). Lindemann first used the term "anticipatory grief" (1944, p. 147) in relation to separations that carried a threat of loss. He observed that grief work can be quite effectively carried out in such anticipated situations, such as a husband marching off to war.

The important factor seems to be that "grief work, namely emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships
(Lindemann, 1944, p. 143) needs to occur. Delaying or avoiding the bereavement experience is not helpful. In fact, Parkes (1970) states that "grief cannot be permanently postponed and that the longer and more complete the inhibition of feelings the more severe they will be when they finally emerge" (p. 143). Long after the immediate grief period, many bereaved individuals continue to report physical and emotional symptoms. Some research has indicated that symptoms are still present between one and two years after the death, although the intensity seems to decline while some feelings continue indefinitely sparked by anniversary memories (Zisook et al., 1982; Bornstein & Clayton, 1972).

Grief is not a static time of existence, but a process that is part of living. Research done by Parkes confirmed "Bowlby's belief that grief is a phasic process although the transitions from one phase to another are seldom distinct and features from one phase of grief often persist into the next" (Parkes, 1970, p. 465). During this complex process of grief work that has physical and emotional implications, the survivor must reorient himself to living in a world that is forever altered. The one who grieves must accept an external event that was undesired and has changed the way he views the world and relates to it. The griever goes from an anxiety state of crisis that uses denial and sensation of numbness to blunt reality to
aimlessness, protests, and hostility toward the new reality. Researchers have related bereavement to a transition state where the griever must restructure his plans for living in a world that has altered (Vachon, 1976).

Using attachment theory, bereavement resulting from a loss of spouse can be a devastating experience. "The death of a spouse is consistently seen as a major life stressor requiring more readjustment than any other life event" (Gallagher, Thompson, & Peterson, 1981-1982, p. 79). Even if the relationship was unsatisfactory in some respects, marriage is significant and thus the loss is significant, and "has been shown to be associated with increased rates of physical and mental illness and even an increase in the mortality rate" (Parkes, 1970, p. 444).

In the elderly, there may have been other losses, such as health, career, or friends to compound the experience with less resources, opportunity and time to find satisfaction in substituted or altered relationships.

An increasing proportion of the population is experiencing widowhood. "In 1960, there were 9 million widowed persons in this country; this number had increased to 12 million by 1975--and of these 11 million were women" (Balkwell, 1981, p. 177). Canada reports "10% of adult Canadian women are widowed at any one time" (Greenblatt, 1978, p. 43) and a ratio of four widows to every widower (Vachon, 1976, p. 35). In the United States, women are
more likely to be the surviving spouses. Some reasons given include: (a) lower mortality among women who are usually younger than their husband, and (b) the woman is less likely to remarry than a man who is a surviving spouse (Vachon, 1976, p. 35) or a divorced person of the same age (Balkwell, 1981, p. 118).

In addition to normal grief risks, the widowed must develop a life as one without a partner. Grollman (1974) has worked extensively with grieving persons and he comments, "usually we do not grieve for the person who had died, but rather for ourselves and our own sense of loss . . . it is usually a conflicted feeling" (Grollman, 1974, p. 3). On this same theme of feeling personally deprived and reduced because of the lost relationship, Decker writes, "But for the widowed, fear of death often plays second role to the fear of continued living . . . how fearful the future seems for the lonely partner left behind" (Decker, 1973, pp. 56-57). Decker started THEOS (They Help Each Other Spiritually), a support group for the widowed, in Pittsburgh on February 25, 1962, in response to her own loneliness as a new widow without a support network.

Loneliness is considered one of the greatest problems (Vachon, 1976). In a culture that is couple oriented, the aloneness of widowhood brings about feelings of isolation and the griever is often without a support system. Death
is a subject that makes many people uncomfortable to discuss and withdrawal from the circumstances seems easier. Death is a certainty in this life, but association with someone who has experienced loss of spouse is a reminder of one's own vulnerability. Greenblatt (1978) studied the grieving spouse and recognized the need of the surviving spouse to vent feelings within a supportive environment, but that those who are "well-meaning friends or relatives may have their own ideas of how grieving should proceed and sometimes become impatient and even irritated when the process proceeds slowly" (Greenblatt, 1978, p. 45). In addition, the current lifestyle of the newly bereaved spouse may be further altered by financial changes that result in reduced available income. This places an additional stress on an already stressful situation.

Richter (1984) has developed a "crisis theory" for mate loss and quoted a widow as saying, "To lose a mate is like losing the trunk of a tree" (Richter, 1984, p. 45). Richter has determined that as the crisis proceeds, the surviving spouse begins to use the resources that are available and those who are more successful in their grief work report "access to adequate and appropriate resources" (Richter, 1984, p. 47).

Carey (1979) examined the adjustment to being widowed during the first year and found that those over the median
age of 57, with a college degree and an annual income over $10,000 made a better adjustment to the loss of spouse. Anticipatory grief seemed to only be a factor for widows (women). The grieving persons in this study rated that they received support from various sources, including hospital personnel, neighbors, friends, and family, but the important element was to not feel alone at this time.

Maddison (1968) reported on "good outcome widows" who seemed to be dependent on the "degree and quality of support which is available to the widow during crisis" (Maddison, 1968, p. 223). A study done by Kalish (1982) determined "the subsequent adjustment of widows and widowers appears to be related to the extent to which there had been the opportunity for open communication" (p. 163). This communication needs to begin with an honest discussion regarding diagnosis/prognosis that leads to an opportunity for anticipatory grieving and a venting of feelings during subsequent grief.

Depression is a common experience within the grief process and may be "viewed as a normal reaction to the loss of one's spouse" (Balkwell, 1981, p. 119). Many symptoms of depression that are seen in studies "during the first year of bereavement reveal that crying, fatigue, appetite and weight loss, sleep disturbance, irritability, anhedonia, difficulty concentrating, guilt, self-reproach and somatic symptoms are all common" (Belitsky & Jacobs,
1986, p. 278), but do not last as long as the later appearing "psychological symptoms of depression" such as "depressed mood, restlessness, hopelessness, worthlessness, and suicidal thoughts" (Belitsky & Jacobs, 1986, p. 278).

Depression has been seen to be "frequently masked" (Smith, 1978, p. 81) in the elderly population, but in a study done by Blazer and Williams (1980), a prevalence of 14.7% of elderly persons were found with depressive symptoms. The researchers identified that this may "actually represent decreased life satisfaction and periodic episodes of grief secondary to the physical, social, and economic difficulties encountered by aging individuals in the community" (Blazer & Williams, 1980, p. 442).

Goidel's (1985) study demonstrated recent life events to have a significant positive relationship to depression. Adding a condition of conjugal bereavement can only enhance the likelihood of depressive symptoms. In a study done by Gallagher, Breckenridge, and Thompson (1983) "the odds of depression were 1.56 times higher for the bereaved than for the comparison controls. In addition, the odds for depression were 1.47 times higher for women than for men" (Gallagher et al., 1983, p. 569) and Blanchard, Blanchard, and Becker (1976) found "younger widows showing more depressive symptomatology than older widows" ( Blanchard et al., 1976, p. 394). Smith (1975) found
higher mean depression scores were found for childless widows, widows whose husband died without warning, and for widows who perceived their own health as poor. A study by Blanchard et al. (1976) demonstrated younger widows displayed more depressive symptoms than older widows, but there was no significant difference in depression as related to the number of years of marriage. When introducing the variable of lack of warning of impending death, those widows who had been married for shorter lengths of time initially were more depressed.

Depression has been seen to persist as the grieving process continues. Belitsky and Jacobs (1986) report "approximately 15% of patients are still clinically depressed greater than a year after their loss (p. 278)." Bornstein and Clayton (1972) have studied 92 bereaved spouses one month after the loss and then again approximately 12 months later. At the initial interview, by specific criteria, 16 were put in a "depressed" group and 76 in a "non-depressed" group. At the later interview, symptoms were identified that would be indicative of an "anniversary reaction." Those who experienced the most severe reaction were significantly more often in the depressed group. Thirty percent had a mild reaction, but none of these were in the depressed group. However, 67% of the 92 persons had a reaction of some type indicating that depression was still present a year later. Kalish
(1982) reports episodes of a second depressive reaction that occurs much later and may be more intense. Decker (1973) referred to grief as "a festering boil which must come to a head before healing begins" (p. 66). Grollman (1977) frequently extols those he works with that there is no way around dealing with bereavement and while those around the bereaved are quick to say "time heals," Grollman (1977) insists that it isn't time itself, but how it is spent. Peterson (1977) wrote, "We believe that it is possible to wash depression away with tears . . . (but) grief work is inescapable" (p. 35).

Zisook and Shuchter (1986) also studied grief reactions in newly bereaved spouses over time. Initially, an interview was conducted three to five weeks after the death and were repeated at intervals up to 49 months following the death. The researchers found "bereaved spouses were most affectively distressed at one month with gradual reductions over the next four years . . . however, several widows still felt tearful and depressed" (Zisook & Shuchter, 1986, p. 291).

Bornstein, Clayton, Halikas, Maurice, and Robins (1973) continued to study bereaved spouses one month after death and then at 13 months. This study reported that "seventy-five percent of the subjects who were depressed at 13 months had already been depressed at one month" (Bornstein et al., 1973, p. 562), with a similar breakdown
of percentage for men and women. It was concluded that "lack of support could be a contributing factor to the depression of widowhood" (Bornstein et al., 1973, p. 565). Paul (1982) investigated adaptation in widowhood, "the length of widowhood, (in the period) between 13 and 29 months, made no difference in the levels of morale and depression" (p. 387).

It seems well accepted that grieving comes with loss and depression comes with grieving and is not easily abated. Shuchter and Zisook (1986) have suggested that "depression distorts grieving and increased maladaptation, while treatment of the depression facilitates the adaptive processes" (p. 304). Grollman (1977) agrees when he says, "grief shared is grief diminished" (p. 95). Studies that have investigated intervention programs range from treatment with antidepressants (Shuchter & Zisook, 1986), widow-to-widow programs (Vachon, Lyall, & Rogers, 1980), bereavement support groups (Lund, Demond, & Juretich, 1985), and groups that provided education of coping skills (Ray, 1983) and life management skills (Thomas, 1982).

Research is still seeking an intervention that is most helpful, but generally Hauser (1983) states that education is the best prevention, "providing information about bereavement in general and widowhood specifically would enable women to know what to expect and how to help themselves" (Hauser, 1983, p. 30). Wambach (1985-1986)
urges that information about the grief process be used by the bereaved as a guide to gauge progress and provide reassurance that all is proceeding normally. Raphael (1978) urges support be provided early at the time of crisis as a preventative tool. In her study (1977) where preventative intervention in the form of "specific support for grief and encouragement of mourning" (p. 1450) was supplied to the experimental group for the first three months to test lowering postbereavement morbidity, there was significant lowering of morbidity, but it was seen to be most helpful for those persons who perceived their environment as non-supportive. This same phenomenon had been reported earlier by Maddison (1968). The study of widow-to-widow help by Vachon et al. (1980) noted that when the early support that had been given to the bereaved withdraws, the loss becomes more real and more depressive symptoms are manifested. The widow-to-widow program provided "emotional, cognitive, and practical support to the individual" (Vachon et al., 1980, p. 1384) and progress was seen, but the surprising factor was that it took two years before "a difference in overall disturbance between intervention and control groups became apparent" (Vachon et al., 1980, p. 1384).

Maddison's study (1968) that demonstrated the importance of a supportive environment also discovered the importance of perceived permission to openly express
feelings and "review the past and talk at length about their husbands" (Maddison, 1968, p. 224). The bereaved felt pushed into new relationships and/or activities to encourage them to move on with their lives and this was found to arouse anger.

Thomas (1982) used a life management skills program lasting six weeks as an intervention and examined the effect on depression. This group aided the bereaved spouse in legal, financial and psychological changes that had occurred and found a significant lowering of depression in the experimental group. The Ray (1983) study used a 16-hour program over four weeks that focused on coping skills for the bereaved spouses. Although depression was not significantly reduced, the group treatment approach seemed to be a significant intervention. This study had groups being conducted in four different churches concurrently without the location being a significant variable.

There is some resistance to attending support groups for help with bereavement. Culturally, death is a taboo topic for open discussion and professional help with bereavement is not common at this point unless grief has become pathological. To avoid the social stigma, bereaved spouses tend to suffer their pain alone. Lund et al. (1985) studied the characteristics of persons who would attend a bereavement support group. Using persons over 50 years of age who had recently lost a spouse to death as
reported in the obituary column, interviews were conducted every six months over two years. While not statistically significant, percentages lend clues that persons who are "female, younger, more educated, employed, been married for fewer years, and living in higher income areas" (Lund et al., 1985, p. 313) are more likely to agree to participation in a group of this type. These persons reported that they had a support network or confidant, but help was not always readily available. A small difference was noted in the two groups in relation to emotional coping with bereavement. Those who desired help from a group rated "their coping abilities less positively, had higher levels of depression, and lower levels of life satisfaction" (Lund et al., 1985, p. 317). It would seem that there are bereaved spouses in the community who recognize a benefit can be realized from support group intervention and are willing to share their grief.

Augspurger (1978) found that "active griever resolved grief regardless of treatment" (p. 5534) while those who were resisting grief work needed a personal intervention given in the form of pastoral visitation to move towards acceptance and restructuring. When no visit was given, the nonactive grievers became significantly worse. This reinforces Parkes (1970) and Peterson (1977) that grief work must be done and symptoms that are inhibited tend to eventually surface and in a more severe
The literature supports a grief process in reaction to loss, with loss of spouse one of the more devastating losses to endure. The grief process has physical and emotional manifestations that are evident to different degrees in stages that can be labeled and defined, but seem to be overlapping. Depression is a symptom so commonly seen as to be expected and one that seems to persist over time, usually in decreasing intensity, but noted anniversary reactions cause reoccurrence. The ultimate aim is progression toward resolution and formation of a new identity that is no longer wife/husband or widow(er), but single person with new goals and recognized abilities within a life that remembers the spousal relationship that was lost, but no longer depends on it. This does not always happen.

Death and mourning in this country are not topics for easy discussion. One's friends and relatives are often supportive for the initial period, but then in a coupled society the bereaved spouse is alone. Having a need to talk and remember and talk some more, it is difficult to find a good listener. People trying to be helpful want the bereaved to meet new people, keep busy and get on with living, while the one who is grieving as significant a loss as that of a marriage partner of many years wants to cry and curse and vent anger at being deserted.
There has been some current research that attempts to determine intervention techniques that not only meet the needs of the bereaved, but will be attended. When contacted early in bereavement, the grieving spouse is resistant to interference and because of depressive symptoms, has low energy for activity commitment. However, the literature suggests that treatment early in the crisis may encourage the grief work and diminish latent symptoms that are more pathological.

Groups have been shown to be helpful, even widow-to-widow intervention, when the bereaved person perceives the environment to be permissive of venting feelings and remains supportive. Education has been mentioned, with knowledge of the grief process used as a ruler to test progress on an individual basis and provide reassurance that the progress being made is positive. As the population becomes increasingly older and more likely to contain a larger proportion of bereaved spouses, professions would benefit from research that specifically offers intervention strategies that have been proven to reduce symptoms and promote resolution of the grief process.

The Bereavement Support Seminar being offered as the intervention in this study combines education of the grief process and support for mutual sharing by group members over a 4-week period. It is being offered early in the bereavement period and the study tested the effect the
intervention had on depression levels. Combining all these aspects made this study interesting and hopefully beneficial to professionals who work with the bereaved.
CHAPTER III

METHODS AND PROCEDURES

Subjects

The sample for this researcher's contribution to the study was bereaved persons in Pittsburgh, Pennsylvania, and the surrounding suburban areas included in Allegheny County, Pennsylvania, known as the Pittsburgh Metropolitan Area. Pittsburgh is a major metropolitan region with this country's only inland seaport as the Monagahela and Allegheny rivers join to form the Ohio River. Allegheny county is nestled in the Allegheny Mountains, with each valley identified as an independent community that is suburban to Pittsburgh proper. The population of Pittsburgh proper is close to a half-million people, but including the surrounding communities that comprise the Pittsburgh Metropolitan Area, the population is slightly more than 2 million people, with cross-sections of race, culture and economic levels. Once known exclusively for steel production, this has now declined leaving many workers unemployed and/or with changed careers, and the area now supports a wide diversity of industry and employment opportunities with many corporate headquarters and new high-tech businesses locating here.

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Concurrently, Zonnebelt-Smeenge (1988) was contributing a sample to the study in Grand Rapids, Michigan. This city is primarily an urban area with surrounding suburbs and a small percentage of rural area. The greater Grand Rapids, Michigan area has a population of approximately 650,000 people with cross-sections of race, culture and economic levels.

The two locales allow the study to include subjects from a Midwest area that is not as heavily populated or as industrialized, representing "Middle America," and a more cosmopolitan urban region that represents the eastern, mid-Atlantic region of the United States. As this study was enlarged by combining subjects from two different areas of the country, the broader scope of representation also enhances the generalizability of the study results.

Using the Pittsburgh Press and Grand Rapids Press obituary columns on successive days from December 8, 1986 to March 2, 1987, collecting only names who were identified as the surviving spouse until 60 names from each source were collected for formation of Group 1 in Pittsburgh and Grand Rapids, and the process repeated for Group 2 in Pittsburgh and Grand Rapids, making the initial sample for the study 240 people recently bereaved because of the loss of a spouse.

To form Group 1 (Pittsburgh), 60 bereaved persons (25 males and 35 females) residing in the Pittsburgh
Metropolitan Area were contacted by letter on January 19, 1987 (see Appendix D for letters) asking each to complete the Bereavement Information Sheet and the testing instrument labeled Bereavement Questionnaire (see Instruments for explanation; see Appendix A & B for samples). After a follow-up mailing, a total of 29 instruments or 48% had been returned, constituting six (10%) who refused to participate, two (3%) who had moved and not left a forwarding address, and 21 (35%) with valid data for the study. These individuals were randomly divided into a control group of 10 persons and an experimental group of 11 persons. The control group received only a posttest Bereavement Questionnaire sent on April 6, 1987, of which eight (80%) were returned. The experimental group was invited to attend the Bereavement Support Seminar, of which 4 persons definitely agreed to attend and two more were hopeful to be in town for most of the sessions. Only three (27%) completed all four sessions and the posttest. The three completing were one male and two females. The reasons given by those who did not complete the series were medical problems at the beginning of the series. One woman required elective surgery on her foot and a man experienced a mild myocardial infarction, which was not life-threatening, but required their activity level to be medically restricted to staying home. The third person was not present due to travel involving a family wedding.
In consideration of the small numbers, the process was repeated to form Group 2 (Pittsburgh) in a like manner that was used to form Group 1 (Pittsburgh). On March 2, 1987, 60 more bereaved persons (17 males and 43 females) were contacted by letter and asked to complete the Bereavement Information Sheet and the testing instrument. After a follow-up reminder mailing, a total of 26 instruments or 43% had been returned, constituting seven (12%) who refused to participate, two (3%) who had moved and not left a forwarding address and 17 (28%) with valid data for the study. These individuals were randomly divided into a control group of eight persons and an experimental group of nine persons. The control group received only a posttest Bereavement Questionnaire sent on May 18, 1987, of which seven (88%) were returned. The experimental group was invited to attend the Bereavement Support Seminar and with follow-up phone calls, eight persons (88%) agreed to attend and all eight completed the four sessions and the posttest assessment. This experimental group consisted of two males and six females. The data collected from the two groups in Pittsburgh was combined to form the Pittsburgh study sample as illustrated in Table 1.
Table 1

Pittsburgh Study Sample

<table>
<thead>
<tr>
<th>Sex</th>
<th>Control Group n = 15</th>
<th>Experimental Group n = 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Females</td>
<td>13</td>
<td>8</td>
</tr>
</tbody>
</table>

Comparative data of the Pittsburgh control and experimental groups is shown in Tables 2, 3, and 4. It can be noted that the control group in Pittsburgh was composed of 87% female and 13% male with a mean age of 65.7 years. The mean years married was 39 years. The majority of the participants had prior warning of their spouse's death with a mean spouse's illness of 24.7 months. The educational background of the control group had seven persons (46.7%) with a high school diploma and four persons (26.7%) with educational beyond high school. In addition, this group also contained four persons (26.7%) with less education than high school completion.
Table 2
Comparison of Pittsburgh Control and Experimental Groups

<table>
<thead>
<tr>
<th></th>
<th>Mean Age</th>
<th>Mean Yrs. Married</th>
<th>Female n</th>
<th>Female %</th>
<th>Male n</th>
<th>Male %</th>
<th>Mean Months of Spouse's Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>66</td>
<td>39</td>
<td>13</td>
<td>87</td>
<td>2</td>
<td>87</td>
<td>24.7</td>
</tr>
<tr>
<td>Experimental</td>
<td>59</td>
<td>34</td>
<td>8</td>
<td>73</td>
<td>3</td>
<td>27</td>
<td>15.1</td>
</tr>
</tbody>
</table>

The experimental group in Pittsburgh had a composition of 73% female and 27% male with a mean age slightly younger than the control group at 58.7 years. The mean years married was 33.6 years, which was also less than the control group. This was the only marriage for all but two women for which it was a second marriage, but the first widowhood in each case as divorce had ended the first marriage. The majority of participants in this group also had prior warning of their spouse's death, but less time, with a mean spouse's illness of 15.1 months. The educational level was slightly higher than the control group with no one having less education than a high school diploma. Six persons (55%) had completed a high school education and five persons (45%) had some education beyond the high school diploma.
Table 3
Comparison of Education Level Achieved for Pittsburgh Control and Experimental Groups

<table>
<thead>
<tr>
<th>Pittsburgh</th>
<th>Less than H.S. Diploma</th>
<th>H.S. Diploma</th>
<th>More Than H.S. Diploma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 15</td>
<td>4  26.7</td>
<td>7  46.7</td>
<td>4  26.7</td>
</tr>
<tr>
<td>Experimental</td>
<td>6  55</td>
<td>5  45</td>
<td></td>
</tr>
<tr>
<td>n = 11</td>
<td>4  26.7</td>
<td>7  46.7</td>
<td>4  26.7</td>
</tr>
</tbody>
</table>

Table 4
Length of Deceased Spouse's Illness Comparisons of Michigan vs. Pennsylvania, Experimental and Control Groups

<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>n  %</td>
<td>n  %</td>
</tr>
<tr>
<td>Experimental Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
</tbody>
</table>

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Table 4—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>25+ mo.</td>
<td>5</td>
<td>36</td>
<td>4</td>
</tr>
<tr>
<td>Control Group</td>
<td></td>
<td></td>
<td></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>

In Grand Rapids, Michigan, Zonnebelt-Smeenge (1988) was collecting data in an identical manner using the Grand Rapids Press obituary column. It was intended that the subjects from the Michigan study were exposed to the same Bereavement Support Seminar information (see Appendix E for course materials) and tested with the same instrument to enable the data collected to be combined for analysis, thus enlarging the population of the study.

The researcher in Michigan reports that after sending 60 initial letters and testing packets consisting of 44
females and 16 males, and after a follow-up letter, an overall return rate for Group 1 in Grand Rapids was 34 instruments or 57%, with 31 (52%) with valid data for the study. This group consisted of 11 males and 20 females. Three (5%) refused to participate with no one reported to have moved without a forwarding address.

Group 1 (Grand Rapids) returns were randomly divided into a control group of 16 persons and an experimental group of 15 persons. The control group in Grand Rapids, Michigan also received only a posttest Bereavement Questionnaire sent on April 6, 1987, of which 12 (75%) were returned. The experimental group was invited to attend the Bereavement Support Seminar held in Grand Rapids, Michigan. Six persons (40%) composed of three males and three females agreed to come and all persons completed the series of four sessions and the posttest assessment.

The researcher in Michigan also repeated the process to form Group 2 (Grand Rapids) and provide for a larger sample overall. On March 2, 1987, 60 more bereaved persons (16 males and 44 females) were contacted by letter and asked to complete the Bereavement Information Sheet and the testing instrument. After a follow-up reminder mailing, a total of 32 instruments (53%) had been returned, constituting 2 (3%) who refused to participate. No one who had moved and not left a forwarding address. Thirty (50%) were returned with valid data for the study.
These persons (10 males and 20 females) were randomly divided into a control group of 15 persons and an experimental group of 15 persons. The control group received only a posttest Bereavement Questionnaire, as was done in Pittsburgh, on May 18, 1987, of which 10 (67%) were returned. The experimental group was invited to attend the Bereavement Support Seminar and eight persons (53%) agreed to attend. The group, consisting of five females and three males, all completed the four sessions and posttest assessment. The data collected from the two groups formed in Grand Rapids was combined to form the Grand Rapids study sample as illustrated in Table 5.

Table 5
Grand Rapids Study Sample

<table>
<thead>
<tr>
<th>Sex</th>
<th>Control Group n = 22</th>
<th>Experimental Group n = 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Females</td>
<td>16</td>
<td>8</td>
</tr>
</tbody>
</table>

Comparitive data of the Grand Rapids control and experimental groups is shown in Tables 4, 6, and 7. It can be noted that the control group in Grand Rapids was composed of 73% female and 27% male with a mean age of 63.7 years. The mean years married was 37.2. The Grand Rapids control group had more males, was slightly younger.
and married fewer years than the control group in Pittsburgh.

The educational background of the Grand Rapids control group shown in Table 7 had 10 persons (45.5%) with a high school diploma and 9 persons (40.9%) with education beyond high school. In addition, this group also contained three persons (13.6%) with less education than high school completion. This represented a similar percentage of high school graduates as in the Pittsburgh control group, but a larger percentage of persons with higher education than in Pittsburgh. The majority of the participants had prior warning of their spouse's death with a mean spouse's illness of 24.5 months.

The experimental group in Grand Rapids also had more females with a composition of 57% female and 43% male. The mean age was 62.2 years, which was older than the Pittsburgh experimental group, but younger than the Grand Rapids control group. The mean years married was 29.6 years, which was the lowest of all the groups. The educational level was slightly higher than the control and similar to the Pittsburgh experimental group with no persons having less education than a high school diploma. Seven persons (50%) had completed a high school education and seven persons (50%) had some education beyond the high school diploma. The majority also had prior warning of their spouse's death with a mean spouse's illness of 38.4
months.

Table 6
Comparison of Grand Rapids Control and Experimental Groups

<table>
<thead>
<tr>
<th></th>
<th>Mean Age Yrs.</th>
<th>Mean Yrs. Married</th>
<th>Female n %</th>
<th>Male n %</th>
<th>Mean Mos. of Spouse's Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control n = 22</td>
<td>63.7</td>
<td>37.2</td>
<td>16 73</td>
<td>6 27</td>
<td>24.5</td>
</tr>
<tr>
<td>Experimental n = 14</td>
<td>62.2</td>
<td>29.6</td>
<td>8 57</td>
<td>6 43</td>
<td>38.4</td>
</tr>
</tbody>
</table>

Table 7
Comparison of Education Level Achieved for Grand Rapids Control and Experimental Groups

<table>
<thead>
<tr>
<th></th>
<th>Less than H.S. Diploma n %</th>
<th>H.S. Diploma n %</th>
<th>More Than H.S. Diploma n %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control n = 22</td>
<td>3 13.6</td>
<td>10 45.5</td>
<td>9 40.9</td>
</tr>
<tr>
<td>Experimental n = 14</td>
<td>- -</td>
<td>7 50</td>
<td>7 50</td>
</tr>
</tbody>
</table>

Some comparative statistics were calculated on the separated groups of Michigan participants and the Pennsylvania participants, but in testing the research hypothesis the control and experimental groups consisted of combining the Michigan and Pennsylvania participants to form the combined study sample illustrated in Table 8.
Table 8
Combined Study Sample

<table>
<thead>
<tr>
<th>Control Group</th>
<th>Experimental Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 15 Pittsburgh</td>
<td>n = 11 Pittsburgh</td>
</tr>
<tr>
<td>n = 22 Grand Rapids</td>
<td>n = 14 Grand Rapids</td>
</tr>
<tr>
<td>Total n = 37</td>
<td>Total n = 25</td>
</tr>
<tr>
<td>Males = 8</td>
<td>Males = 9</td>
</tr>
<tr>
<td>Females = 29</td>
<td>Females = 16</td>
</tr>
</tbody>
</table>

The comparative data of the combined total control and experimental groups is shown in Tables 4, 8, 9, and 10. As can be noted, the combined total control group was composed of 78% female and 22% male with a mean age of 64.7 years and having been married a mean of 38.1 years. The majority of the participants had prior warning of their spouse's death with a mean spouse's illness of 24.6 months. However, within that group, four persons reported no warning of impending spousal death and four persons reported extended illness of 216, 96, 72, and 60 months duration for their spouse. Eliminating these extremes and calculating a mean with an n = 29, the mean spouse's illness becomes 16.1 months.

The educational background of the combined total control group had 17 persons (45.9%) with a high school diploma. Only seven persons representing 18.9% of the
The total combined experimental group was composed of 64% female and 36% male with a mean age that was slightly younger than the control group with a mean of 60.5 years, and having been married fewer years with a mean of 31.6 years. The majority also had prior warning regarding the spouse's death with a mean spouse's illness of 28.2 months. However, within that group two persons reported
no warning of impending spousal death and two persons reported extended illness of 204 and 181 months duration for their spouse. Eliminating these extremes and calculating a mean with an $n = 21$, the mean spouse's illness becomes 15.2 months. The educational level was slightly higher than the control group with no persons having less education than a high school diploma. The group was almost evenly divided between 12 persons or 48% who had done study beyond the high school diploma and 13 persons or 52% who were high school graduates.

Table 10

<table>
<thead>
<tr>
<th></th>
<th>Less than H.S. Diploma</th>
<th>H.S. Diploma</th>
<th>More than H.S. Diploma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
<td>$n$</td>
</tr>
<tr>
<td>Control</td>
<td>37</td>
<td>18.9</td>
<td>45.9</td>
</tr>
<tr>
<td>Experimental</td>
<td>25</td>
<td>-</td>
<td>52</td>
</tr>
</tbody>
</table>

The total combined experimental group and the Pittsburgh experimental group were also similar in all respects except composition by sex, with the combined group populated with a larger percentage of males. The ratio of men to women in Pittsburgh was 1:3, while the combined total group showed a ratio closer to 1:2. This represents a
higher concentration of males proportionately than the control group or the population at large.

Instruments

Bereavement Information Sheet

The study required each surviving spouse to complete a Bereavement Information Sheet (see Appendix A) devised by the researchers to gain demographic information about the bereaved spouse, the deceased, and the manner of death. This self-report form recorded physical and emotional health of both partners prior to the death and following the death, and any professional help that had been required. This information was used to describe the experimental and control groups, and for comparisons between the Michigan and Pennsylvania participants.

Kincannon's Mini-Mult

Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory (MMPI) was retyped and labeled Bereavement Questionnaire (see Appendix B). This assessment instrument was administered as a pre- and posttest, scoring scales 1, 2, and 3 on all study participants. This researcher used the scores obtained on Scale 2 to evaluate the depression level of each individual, and Zonnebelt-Smeenge (1988), the researcher in Michigan, used the scores from Scale 1 with reference to Scale 3 to
examine physical health levels of the participants.

Kincannon's Mini-Mult was developed in 1968, using cluster analysis and proportionately selecting those items from each cluster with the greatest scale overlap, thus reducing the test to 71 items. The long form of the MMPI was not considered feasible because the recently bereaved population would most likely be resistant to the test length of 566 items and the need to take the test twice while grieving would promote noncompliance. However, it was necessary to select an instrument that was reliable and valid on both physical-somatic manifestations and depression level scales so the samples from Grand Rapids and Pittsburgh could be combined to enlarge the study. Kincannon's Mini-Mult was selected on this basis.

Kincannon's Mini-Mult Short Form has been reported useful for outpatient populations and group studies. While the long form is preferred on an individual basis, in research with groups, the time involved is lengthy. Kincannon's Short Form has been used as a substitute previously and reports median reliability at .76 and median predictive validity at .79, including the scales required for this research (Fauschingbauer, 1974). Kincannon, who developed the instrument, has reported comparing the Mini-Mult to the standard MMPI on a sample of 50 men and 50 women who had been admitted to the psychiatric service of a city-county 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).

After testing a group that represented inpatient status, he repeated the study with a sample of 25 men and 25 women associated with a community mental health center to increase the data to include outpatient representation. In this case, the results were "essentially identical to those of the inpatient . . . (with) correlations (that) ranged from .70 to .96 with a median of .87" (Kincannon, 1968, p. 320).

This researcher examined only Scale 2 (Depression). This is primarily a mood scale which "measures the degree of pessimism and sadness the person feels at the time of administration" (Duckworth, 1979, p. 67). Therefore, the scale is raised or lowered depending on the degree of depression at the time. Scale 2 has been noted to indicate a "reaction to problems that are pressing on the person" (Duckworth, 1979, p. 68) as opposed to being a measure of chronic depression. Therefore, this scale could give an index of depression level at the different times tested.

Kincannon also compared means of the individual scaled scores for the standard MMPI and the Mini-Mult on two administrations. The results for Scale 2
(Depression), used in this study, has been extracted and presented in Table 11.

Table 11
Comparison of Means for Scale 2 Scores for Standard MMPI and Mini-Mult on Two Administrations

<table>
<thead>
<tr>
<th></th>
<th>First Administration</th>
<th>Second Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Standard MMPI</td>
<td>28.60</td>
<td>8.10</td>
</tr>
<tr>
<td>Mini-Mult</td>
<td>28.75</td>
<td>7.22</td>
</tr>
</tbody>
</table>


Notice that the standard deviation is smaller for the Mini-Mult than the standard form in both administrations. In determining the reliability of the Mini-Mult scales, Kincannon found Scale 2 to have a correlation of .83 with a retest of the Mini-Mult (Kincannon, 1968). In correlating Scale 2 of the Mini-Mult with Scale 2 of the standard form of the MMPI, the standard form had a retest reliability coefficient of .86 and the comparison of standard form Scale 2 results with an independent administration of the Mini-Mult, resulted in a reliability coefficient of .79 (Kincannon, 1968, p. 321). If the Mini-Mult score for Scale 2 is obtained by drawing the appropriate items off
an answered standard form of the MMPI, then the correlation is .91 (Kincannon, 1968, p. 321).

One complaint with using a short form arises when 2- or 3-point codes are interpreted. This does not apply in this study as a single scale score was isolated for hypothesis testing.

Design

By the random sampling method without replacement, one-half of the sample who returned the Bereavement Information Sheet and the pretest assessment instrument titled Bereavement Questionnaire (see Subjects) were classified as the experimental sample and were invited to attend a 4-week Bereavement Support Seminar (see Appendix E for course materials) and those who participate by attending four sessions and completing the posttest assessment instrument (see Instrument) given in Michigan and Pennsylvania were the experimental group. The remaining one-half of the sample who returned the Bereavement Information Sheet and the pretest assessment instrument titled Bereavement Questionnaire were designated as the control group and only completed a posttest assessment at the same time interval as it was administered to the experimental group without benefit of professional intervention in the interim.

The professional intervention of the Bereavement
Support Seminar provided to the experimental group and not
the control group represented the independent variable.
The dependent variable was the level of depression experi­
enced by the participants of each group as determined by
the pre- and posttest assessment, using the Scale 2 score
on Kincannon's Mini-Mult Short Form of the Minnesota
Multiphasic Personality Inventory. The differences in the
pre- and posttest scores between the experimental and
control groups were compared for a difference at the .05
level of significance using a nondirectional two-tailed t


test for independent means. The causal-comparative method
is utilized when two groups are selected which differ on
an independent variable with comparison of the groups on a
dependent variable. The rationale for selecting this
method was that all variables cannot be controlled or
manipulated and only a relationship can be established,
not necessarily a causal one.

The experimental design employed in the study then,
represented a two group pretest-posttest experimental and
control group design, graphically represented in Figure 2.
R₁ X 0₁
R₂ 0₂

R₁ indicates random assignment to experimental group
R₂ indicates random assignment to control group
X indicates treatment
0₁ indicates outcome of experimental group
0₂ indicates outcome of control group

Figure 2. Experimental Design of Study

Procedure

The sample for this study was collected in Pittsburgh, Pennsylvania and Grand Rapids, Michigan (see Subjects). Every effort was made during this process to control possible uncontrolled extraneous variables by rigid procedures to promote consistency in each locale.

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

Using the obituary column beginning December 8, 1986, 60 names who were identified as the surviving spouse, were collected and each was sent on January 19, 1987, a letter explaining the proposed research (see Appendix D for
letters), a Bereavement Information Sheet (see Appendix A), and the testing instrument labeled Bereavement Questionnaire (see Appendix B). The persons who received this initial mailing were all recently bereaved spouses, the death having occurred not more than two months previously. Included was a self-addressed, stamped return envelope to aid in compliance with returning the requested data.

After two weeks, on February 2, 1987, those persons who had not responded were sent a follow-up letter and another copy of the Bereavement Information Sheet, the Bereavement Questionnaire and another self-addressed, stamped envelope. This letter again requested help with the research and urged the bereaved spouse to complete the information. Three weeks subsequent to the second mailing, the returned instruments were considered by the researchers to be the sample of bereaved spouses to be utilized in the study.

On February 23, 1987, by the random sampling method without replacement, one-half of the sample was classified as the experimental group (see Subjects) and a letter was sent inviting these subjects to attend the 4-week Bereavement Support Seminar. A stamped, self-addressed postcard was included to return to indicate a willingness to attend the seminar, to indicate any problems with the scheduled time of the seminar, transportation difficulties, or any additional questions, in which case the subject was given a return phone call by the researcher.
The researchers wanted participants to all be in early grief with group members having lost their spouse at approximately the same time. Collecting names from the obituary column on successive days in both Pittsburgh and Grand Rapids beginning on December 8, 1986, provided for homogeneity. Table 12 illustrates the days elapsed since the death of spouse to the initial contact, the start of the Bereavement Support Seminar, and the posttest administration in Pittsburgh. The data collection schedule provided for the Grand Rapids sample to be similar.

Table 12
Grieving Time for Pittsburgh Experimental and Control Groups

<table>
<thead>
<tr>
<th></th>
<th>Mean Days From DOS to Initial Contact</th>
<th>Mean Days From DOS to Start BSS</th>
<th>Mean Days From DOS to Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>n = 11 58.7</td>
<td>114.7</td>
<td>135.7</td>
</tr>
<tr>
<td>Control</td>
<td>n = 15 52.9</td>
<td></td>
<td>129.5</td>
</tr>
</tbody>
</table>

DOS = Death of Spouse; BSS = Bereavement Support Seminar

It was intended that the Bereavement Support Seminar given in Pittsburgh with this researcher as group facilitator, and the Bereavement Support Seminar given in Grand Rapids with Zonnebelt-Smeenge (1988), as group facilitator be identically organized and the presentation be as
consistent in each locale as possible to prevent the site of the seminar from becoming an uncontrolled extraneous variable. Each seminar was given in a centrally located church meeting room that had comfortable furnishings.

The seminars were set up for a 4-week period, meeting once per week for one and one-half hours and included didactic information and allowed that support for group members be a key ingredient and include mutual sharing. The course syllabus (see Appendix E) was prepared jointly by both researchers in a detailed manner and followed closely. The material was broken down into specific segments to be covered at each group session and handed to the participants in an outline form (see Appendix F) that allowed space for notes to be taken and the sheet could be taken home for later reference.

During Week 1, the content of the seminar was the grief process and discussed the stages that could be expected and provided information that could be helpful in understanding the pain associated with their bereavement along with the cultural aspects that were associated with the loss of his/her spouse. The issue of confidentiality was discussed at this first session and that along with mutual sharing and expression of private grief came mutual support. It was stressed that in helping each other much could be learned about the work that was to come as each progressed in an individual way and at an individual rate.
from new widow/widower to a person progressively reaching toward grief resolution and a new identity of single person.

During Week 2, the seminar investigated how the week had passed for each group member and how each participant spent his/her days. Interest was shown if plans regarding clothes and possessions of the deceased had been made and when the plan would be executed. The didactic material dealt with anger and guilt in relation to grief and information on how to distinguish characteristics of normal and abnormal grief. All group members were urged to keep a journal, to vent feelings in writing, as an immediate outlet and to be saved and reread later as a self-assessment of the grief work being accomplished.

The seminar content for Week 3 focused on reconstruction and growth toward a new identity. No one was at this point, but the session was intended as a reassurance that life would get better. The material provided information for the future, suggesting that as hard as it was to believe, life could be good again, not forgetting the lost relationship, but building on it and stretching to achieve potential that has been dormant.

As with every session, each member was given the opportunity to share where he/she was in the grief process at the present time and to seek support for problem areas. Reflections, memories, stories about the relationship that
was now lost were always encouraged. The state of current relationships with friends, co-workers, and family members with the identification of how feelings and behaviors had changed since the spouse's death. This type of discussion, once again, brought forward the realization that death is not easily discussed and many find the subject uncomfortable. However, the bereaved spouse wants to talk, and talk, and during the group session an environment for supportive ventilation was present.

Week 4 allowed for review, questions, more talk and the posttest was administered. Termination was needed, but each was encouraged to use what had been learned as the grief process continued. Handouts were given (see Appendix F) that provided a list of community resources available locally to help and a suggested reading list that listed books available in the local library. Some printed literature by agencies was made available. Another resource was the other group members who were willing to be called by other members and some made plans to meet for lunch or other social outlets. Terminating the group was done, but not without other means of support for them during bereavement.

At the same time, the Bereavement Questionnaire was mailed to the control group, with a letter explaining the need to examine again and a stamped, self-addressed envelope for return.
It was necessary to repeat the process and run another 4-week Bereavement Support Seminar to secure sufficient data (see Appendix C for schedule and Time Table for Data Collection).

The profiles were held until all the seminars had been completed and the control group's mailed responses received. In August, 1987, the Grand Rapids and Pittsburgh profiles for both experimental and control groups were combined and mean scores computed. Some comparative data was obtained by computing means for Michigan and Pennsylvania groups separately, but the study hypothesis used the combined groups. A t-test for independent means was done to test for a difference on Scale 2 (Depression) on Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory.

In September, 1987, letters were sent to all participants, thanking them for their contribution to the study. The results of the study were briefly outlined for the control group members, with more specific data regarding the Bereavement Support Seminar attendees given in the letter sent to the experimental group (see Appendix D).

Communication between the researchers was continual from joint planning for the study and as the data collection process progressed to ensure as much consistency as possible. By combining subjects and testing for each other's variable, the study was enlarged. The researchers
have worked together professionally in the past by co-facilitating groups and co-therapy for private clients. Therefore, it was hoped that facilitator style for the group sessions would not be different enough to be considered an uncontrolled extraneous variable.
CHAPTER IV

RESULTS OF THE STUDY

With the initial contact by letter, the Bereavement Information Sheet was enclosed to obtain information about the person's experience with "blue days" and past history of depression along with any needed treatment. This was a self-report form (see Appendix A) that required a response of "yes" or "no" and if treatment had been received to check the following choices: (a) inpatient hospitalization, (b) outpatient therapy, and/or (c) medication.

This information was compiled as comparative data for the total experimental and control groups and the Michigan and Pennsylvania experimental and control groups. It was also necessary to consider the responses made in relation to the possibility of a subject being treated for chronic depression previous to the loss of spouse that could skew the study results, suggesting that the subject was not an appropriate candidate for this study. No subject was eliminated because of his/her responses on this Bereavement Information Sheet.

Table 13 depicts the number of subjects in each group and the percentage so represented who reported having had experienced "blue days" and those who did not.
It can be noted from Table 13 that the majority of subjects in every grouping (Michigan, Pennsylvania, and total combined) of experimental and control groups reported to having experienced "blue days" before the death of their spouse. The experimental and control groups were very similar on this issue with 72% of the combined experimental group and 76% of the combined control group admitting to "blue days."

The expression "blue days" is commonly used and is acceptable to most people as a happening in everyday life exclusive of grieving. As this was asked of a grieving population, the majority of whom had had advanced knowledge of impending death, it is somewhat surprising that the data does not more closely approach 100%
reporting to some feeling of "blueness" or mild sadness and depression. It is also surprising that 36%—more than one-third of those subjects who agreed to attend the Bereavement Support Seminar in Pittsburgh and 21% in Grand Rapids do not report having "blue days." When considering the combined experimental group, more than one-fourth (28%) were unable to see themselves as having had some down or sad days.

The next question asked about previous history of treatment for depression.

Table 14

<table>
<thead>
<tr>
<th>Depression Treatment</th>
<th>Pennsylvania</th>
<th>Michigan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Experimental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>91</td>
<td>13</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>87</td>
<td>21</td>
</tr>
</tbody>
</table>

The results seen in Table 14 demonstrate a study sample largely composed of persons who have not previously experienced depression that required treatment. In both
the combined experimental and control group, 92% had never been treated for depression. This makes the groups very similar on this point.

When considering Pennsylvania, only one experimental group member reported previous treatment (9%) and that was with prescription medication. In the control group in Pennsylvania, two persons reported previous treatment (13%), one with medication and one person did not specify. For Michigan, the experimental group had one person (7%) and the control group also had one person (5%) who reported having received outpatient treatment for depression.

This allows for the assumption that by self-report the majority of the sample in this study do not perceive depression to have been a problem in their lives. This then, allows that the depression items endorsed on the pre- and posttest instrument used to test the hypothesis of this study are more likely to be a result of the current problems now present in relation to the loss of spouse and the bereavement process. It could be said from Table 14 that the majority of the study sample did not report previous treatment. As seen in Table 13, this sample has some reluctance on self-report in relation to "blue days." This reluctance may be intensified when asked about help from mental health professionals. It may be that the subjects want to present the best possible image of themselves, but for the results of this study,
the self-report was not discounted and the combined experimental and control groups were seen as similar on this issue.

The primary statistical tool for outcome measures was the t test for independent means. The conventional .05 alpha level was used as a nondirectional, two-tailed test done. It was used because the results were expected to lie on each end of the distribution. The degrees of freedom for the t test were 1 between groups (the number of groups minus one) and 60 within groups (the number of subjects minus the number of groups). The dependent variable, the reported depression level, was measured by Scale 2 (Depression) on Kincannon's Mini-Mult Short Form of the Minnesota Multiphasic Personality Inventory which was retyped and labeled Bereavement Questionnaire (see Instrument). The experimental and control groups were given a pretest as a baseline, and a posttest following the professional intervention.

Group means for pretest and posttest for experimental and control groups were computed for the score on Scale 2 (Depression). Since this scale score is raised or lowered depending on the degree of depression at the time of administration of the test and seems to be most reflective of pressing current issues, the score for each subject will reflect his/her current level of depression. By comparing these means, it can be determined if there was a
significant difference in the experimental group's level of depression following the treatment intervention, compared to the mean score of Scale 2 (Depression) reflecting depression level in the control group who were left to their own devices without the benefit of the bereavement support seminar to affect their grief process.

Table 15
Mean Pretest Scores on Scale 2 (Depression)

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>11</td>
<td>65.6</td>
<td>12.3</td>
</tr>
<tr>
<td>Michigan</td>
<td>14</td>
<td>55.5</td>
<td>9.21</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>60.0</td>
<td>11.6</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>15</td>
<td>61.6</td>
<td>13.0</td>
</tr>
<tr>
<td>Michigan</td>
<td>22</td>
<td>61.7</td>
<td>11.3</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>61.7</td>
<td>11.8</td>
</tr>
</tbody>
</table>

The pretest was mailed out with the initial contact letter and returned prior to random sampling division of subjects into experimental and control groups. Participants at the time they returned the completed pretest were not aware that future contact was anticipated. Some required a second urging to comply, but those profiles have not been isolated.
Table 15 delineates the mean pretest scores on Scale 2 (Depression) for all groups. It can be seen how almost identical the mean scores of the control groups are from Michigan and Pennsylvania. The Pennsylvania experimental group had the highest mean score, 10 points above the score for Michigan's experimental group and four points above the control group. This is interesting in that the Pennsylvania experimental group also represented the largest proportion to deny experiencing blue days. However, when an instrument was used that disguised what was being asked, this group endorsed more items indicating sadness and pessimism than the other groups. This reinforces the premise that the group was attempting to appear in the best light possible on the self-report form.

In comparing the pretest mean scores for experimental and control groups, the control group has a slightly higher mean, (a $t = -0.57$ and $p = 0.57$), making the difference not significant. However, the difference seen in the mean scores for Pennsylvania and Michigan experimental groups had a $t = 2.28$ and a $p = 0.035$, making the Pennsylvania group who elected to attend the Bereavement Support Seminar significantly more depressed at the outset than the Michigan group who elected to attend the Bereavement Support Seminar.

Tables 16 and 17 examine the mean scores for the posttest and a comparison of pretest and posttest means.
In observing the mean scores, all groupings of the control group elevated their depression level score from pretest to posttest. The difference in the mean scores for Pennsylvania and Michigan posttest is close, although not as exact as in the pretest, with Michigan receiving the higher mean on the posttest. However, the difference between Pennsylvania and Michigan control group means was not significant with $t = -0.10$, and $p = 0.92$. The Pennsylvania control group increased their posttest mean, but the difference between the Pennsylvania control group's pretest mean and posttest mean, analyzed by means of a correlated sample $t$ test, was not a significant difference with $t = -0.46$, and $p = 0.65$. The Michigan
control group's posttest mean score was also increased over the pretest mean, but this difference was not significant either, with $t = -0.69$, and $p = 0.49$. The combined control group pretest and posttest means showed an increase in mean depression level over time without any intervention that was not significant, with $t = -0.84$, and $p = 0.40$. Therefore, the control group demonstrated that as time passed, their depression level seemed to rise, but not significantly.

The data reflects a small rise in depression level from pretest to posttest mean scores for the experimental group. The Pennsylvania experimental group, who had the highest mean score on the pretest, did lower their mean score, but the difference was not statistically significant with $t = 0.14$, and $p = 0.89$. The Michigan experimental group, who had endorsed fewer depression items on the pretest, when taking the posttest endorsed more items causing the mean to elevate, but the elevation in depression level was not a significant difference with $t = -0.55$, and $p = 0.58$. The combined experimental groups saw almost no change in the mean pretest and posttest scores, with a slight elevation of 0.7 points which was not significant with $t = 0.21$, and $p = 0.83$. 

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Table 17
Pretest-Posttest Scale 2 (Depression) 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 2 Pretest</td>
<td>55.5</td>
<td>65.6</td>
<td>60.0</td>
</tr>
<tr>
<td>Scale 2 Posttest</td>
<td>57.4</td>
<td>64.8</td>
<td>60.7</td>
</tr>
<tr>
<td>Scale 2 Pretest/Posttest</td>
<td>$t = -0.55$</td>
<td>$t = 0.14$</td>
<td>$t = 0.21$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.58$</td>
<td>$p = 0.89$</td>
<td>$p = 0.83$</td>
</tr>
<tr>
<td><strong>Control Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale 2 Pretest</td>
<td>61.7</td>
<td>61.6</td>
<td>61.7</td>
</tr>
<tr>
<td>Scale 2 Posttest</td>
<td>64.3</td>
<td>63.9</td>
<td>64.1</td>
</tr>
<tr>
<td>Scale 2 Pretest/Posttest</td>
<td>$t = -0.69$</td>
<td>$t = -0.46$</td>
<td>$t = -0.84$</td>
</tr>
<tr>
<td></td>
<td>$p = 0.49$</td>
<td>$p = 0.65$</td>
<td>$p = 0.40$</td>
</tr>
</tbody>
</table>

In comparing the posttest means for the combined experimental group and combined control group, the control group had a higher level of depression. Those persons who attended the Bereavement Support Seminars endorsed fewer items indicating sadness and pessimism than those persons who did not experience the intervention. However, the control group was not significantly more depressed with $t = -1.05$, and $p = 0.30$ than the experimental group at the
time the posttest was administered.

In computing the $t$ test for independent means at the 0.5 alpha level there is no basis to reject the null hypothesis. The null hypothesis is retained.
CHAPTER V

SUMMARY, CONCLUSIONS, DISCUSSION, AND IMPLICATIONS

Summary

This study investigated the effectiveness of attending a Bereavement Support Seminar on the level of depression 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 in each locale 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 postspousal loss to explain the research; a questionnaire, devised by the researchers to gain demographic information; and Kincannon's Mini-Mult 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 one-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 where group members were allowed to vent feelings and memories were shared.

In addition, the intervention was provided early in the bereavement process in an attempt to test if depression level commonly seen in grief would be altered with the Bereavement Support Seminar which would provide the bereaved spouse with coping skills and the previously studied perceived supportive environment that could aid the bereaved individual in his/her attempt to keep the depression level under control as the grief process proceeded.

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 2, Depression, of the Kincannon's Mini-Mult was the measure employed to compare experimental and control groups' depression level. The depression level was not significantly altered at the .05 alpha level for either group.

Conclusions

At this early stage of grief, the depression level was not significantly altered at the .05 alpha level for either group. Therefore, the null hypothesis was retained.

Discussion

The sample for this study was collected in two states in different sections of the United States and then combined for an experimental group sample of 25 subjects. This was considered a minimum goal by the researchers at the outset. The control group sample was 37 subjects, making it larger than the experimental group, but adequate in relation to a concern for comparable samples.

Collecting newly bereaved subjects was difficult. In
early grief, it is unlikely a person desires to be a part of a study, take tests, answer questions on a form or even be cooperative. The initial contact was made by mail from the obituary column. The researchers were unknown to the prospective subjects and it was difficult to be sure the bereaved spouse was opening and reading any mail. The researchers tried typing envelope addresses and writing out names in ink on different mailings to see if one approach was better received than another, but the return rate was not altered.

In addition, in some cases, the researchers did not even communicate with the bereaved spouse because irate adult children tried to protect their parent from this intrusion, returning the material unanswered and often accompanied with a brief note asking that the bereaved spouse not be bothered again. The theme seemed to be that if the grieving person were just left alone, all would be well. Such misinformation hindered the collection of samples.

Those persons who responded and accepted the invitation to the Bereavement Support Seminar were attending something new in relation to dealing with death within a culture that finds a person unusual who seeks help with grief. Some persons stated that they were doing just fine themselves, but they had attended to help others who were not doing so well and really needed the help.
The persons constituting the experimental group of this study supported the characteristics reported in the literature in areas that were examined with the exception of depression level of the Michigan experimental group who had a lower mean depression score than the control group. Otherwise, those attending the bereavement support seminar tended to be female, younger, married fewer years, better educated, and in the Pennsylvania experimental group, more depressed.

Perhaps contacting people so soon after the death hindered compliance and made subject collection more difficult, but the researchers wanted to study early bereavement. Also, contacting the bereaved by phone or in person may have brought a larger success rate, but would have been difficult with time constraints without research assistants. The researchers considered using agency contacts, such as funeral homes and hospice programs, for names of possible subjects instead of the more random collecting using the obituary column, but a more representative sample was thought to be obtained by using the newspaper.

Implications

This study used persons from Michigan and Pennsylvania, living in both a smaller city and a large metropolitan area, assessed early in their bereavement, and
although the study was broad in its approach, consistency was a constant concern. This enhances the generalizability of the results. The sample was randomly chosen from newspapers without consideration for race, creed or economic level.

This sample was studied early in their bereavement and present an excellent opportunity for future study to follow this one to see if the results are altered at later time intervals. Studies have not determined a time span for grief, except that symptoms persist probably longer than has been previously studied.

It may have been too early in the bereavement process to expect a significant lessening of depression. However, the Bereavement Support Seminar may have provided information and coping skills to the participants that as grief progressed, the depression experienced would be considered manageable and not overwhelming or debilitating. Future study could examine the depression level of Bereavement Support Seminar participants at intervals to see if the intervention was beneficial in reducing depression as time progressed and to what degree it was reduced. Another aspect would be to examine if this type of intervention which was studied was helpful in maintaining a depression level that did not worsen over time.

This study gives evidence that leaving grieving persons alone does not significantly lower their level of
depression in the early phases of grief. Future study could examine if this changes as time passes and how long it takes for depression to be reduced by time alone.

Another test question could examine if an early intervention such as this affected an earlier resolution of depression associated with grief, than is seen in persons not accepting intervention. It would also be interesting to extend the Bereavement Support Seminar to see if a longer exposure to the supportive environment made a significant difference in the participant's depression level.

Each study that addresses death and helping persons to cope with the subject matter, in addition to the emotional reactions to loss, are making a contribution that brings an inevitable life event, but taboo subject to the forefront. There is a need for grief therapists, who must first face their own feelings about death, and then be ready to provide an environment where the person grieving is not alone. There is a need to educate the public about the grief process and provide understanding that seeking professional help during bereavement is an appropriate behavior. More studies of this type can provide helpful clues of how best to help those who have loved and lost.
APPENDICES
Appendix A

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 spouse's 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 spouse's 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 spouse's 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 spouse'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. ____________

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Appendix B

Bereavement Questionnaire
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 thievery?
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 you 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?
---

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 C

Data Collection Schedule
<table>
<thead>
<tr>
<th>Date</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 December 1986</td>
<td>Begin to collect names of bereaved spouses from the obituary column to form Group I</td>
</tr>
<tr>
<td>19 January 1987</td>
<td>Send out letter and initial assessment packet to 60 participants of Group I. Begin to collect names of bereaved spouses from the obituary column to form Group II</td>
</tr>
<tr>
<td>2 February 1987</td>
<td>Send out follow-up letter and initial assessment packet to participants of Group I who have not responded</td>
</tr>
<tr>
<td>23 February 1987</td>
<td>Send out letter inviting Experimental Group I participants to attend the Bereavement Support Seminar</td>
</tr>
<tr>
<td>2 March 1987</td>
<td>Send out letter and initial assessment packet to 60 participants of Group II. Send out follow-up letter and initial assessment packet to participants of Group II who have not responded</td>
</tr>
<tr>
<td>16 March 1987</td>
<td>Begin Bereavement Support Seminar for Experimental Group I to continue for four weeks</td>
</tr>
<tr>
<td>6 April 1987</td>
<td>Send out letter inviting Experimental Group II participants to attend the Bereavement Support Seminar. This week administer post-test assessment and terminate Bereavement Support Seminar for Group I</td>
</tr>
<tr>
<td>27 April 1987</td>
<td>Begin Bereavement Support Seminar for Experimental Group II to continue for four weeks</td>
</tr>
<tr>
<td>18 May 1987</td>
<td>This week administer post-test assessment and terminate Bereavement Support Seminar for Group II. Send out letter and post-test assessment to Control Group II</td>
</tr>
<tr>
<td>September 1987</td>
<td>Send out letter of thanks and results of study</td>
</tr>
</tbody>
</table>
Appendix D

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

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

Approved By:
Dr. Robert Oswald, Professor
Doctoral Committee Chairperson
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
Doctoral Candidate

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

Approved By:

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson
Dear

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

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

Approved By:

[Signature]

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson
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.

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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:

Dr. Robert Oswald, Professor
Doctoral Committee Chairperson

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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
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
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
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 Questionaire, 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 E

Bereavement Support Seminar
Course Materials
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:

Loss

Recovery

Rather, it is like this:

Loss

Recovery

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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?
Workshop #2

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 sensing. 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).
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

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 F

Hand-Outs for Seminar Participants
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
BEREAVEMENT SUPPORT SEMINAR
Presented By: Susan J. Smeenge, R.N., M.A.
Carole Jeanne Weidaw, R.N., M.A.
Doctoral Candidates

WEEK II

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.
      5. Allow yourself to forgive yourself.
      6. Let go of the person who is gone, the incident, and your involvement.
      7. Determine that some good is going to come out of this terrible experience.
      8. If necessary, seek professional help in a counselor/therapist to help you with this process.

III. What's Normal and Abnormal in Grief?

   Distinguishing 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?
BEREAVEMENT RESOURCE GROUPS

PITTSBURGH AREA

South Hills Family Hospice Bereavement Support Group
Meets monthly on first Tuesday of the month
For information call 561-4900, ext. 6712

Young Widowed Parents
Meets monthly on first Sunday of Month at 7:30 P.M.
Wallace Memorial Presbyterian Church
Greentree, Pa.
Mrs. Elaine Kray 885-1486
Mr. Vince DeGeorge 653-1822

Parents Without Partners
National HQ: 8807 Colesville Road
Silver Spring, Maryland 20910
South Hills Chapter No. 278
Meets twice a month on 1st and 3rd Monday
P. B. Box 14654
Pittsburg, PA. 15234-0654
884-0718

Pittsburgh Chapter No. 15
P.O. Box 1574
Pittsburgh, Pa. 15230
561-6827

Widowed Persons Service
121 Race Street
Pittsburgh, Pa. 15218
Pat Byers 371-6733

THEOS (To Help Each Other Spiritually)
Several chapters in the Pittsburgh area
HQ: Penn Hills Shopping Center
471-7779
FROM THE LIBRARY


Because Grief
Can Be So Painful...

Because grief can be so painful and because it seems overwhelming, it frightens us. It is important to cry and talk with people about your feelings. Many people worry if they are grieving in the "right" way and they wonder if the feelings they have are normal. People who suffer a loss may experience several reactions. The bereaved person might:

• Feel tightness in the throat or heaviness in the chest.
• Have an empty feeling in his/her stomach with a loss or an increase of appetite.
• Feel guilty at times; angry at others.
• Feel restless and look for activity but find it difficult to concentrate.
• Feel as though the loss isn't real; that it didn't actually happen.

• Sense the loved one's presence, like finding her/himself expecting the person to walk in the room at the usual time, hearing his/her voice, or seeing his/her face.
• Wander aimlessly and forget to finish things she/he started doing around the house.
• Have difficulty sleeping, and dream of his/her loved one frequently.
• Experience an intense preoccupation with the life of the deceased.
• Assume mannerisms or traits of her/his loved one.
• Feel guilty or angry over things that happened or didn't happen in the relationship with the deceased.
• Feel intensely angry at the loved one for leaving them.
• Feel as though they need to protect others who seem uncomfortable around them by not talking about the feelings of loss.
• Need to tell and re-tell and remember things about the loved one and the experience of his/her death.
• Have unexpected mood changes.
• Cry at unexpected times.

These are all normal and natural grief responses.

The Forbes Hospice
Bereavement Program
665-3304
WIDOWED PERSONS SERVICE

FACT SHEET

The Widowed Persons Service (WPS) identifies community resources and helps newly widowed persons not only to recover from the trauma of a spouse's death, but also to rebuild their lives. Adjusting to the shock of being alone after years of marriage can seem overwhelming to the surviving spouse. The sense of loneliness can be heightened by the loss of a spouse, especially if there is no one else to provide comfort and support. The Widowed Persons Service offers a helping hand to those who need it most.

Widowed Persons Service helps newly widowed persons not only to recover from the trauma of a spouse’s death, but also to rebuild their lives.

Outreach is the backbone of WPS. In each community where WPS is at work, volunteers widowed 10 months or more, are trained to reach out and offer support to the newly widowed. Other volunteers, widowed and non-widowed, contribute their skills to WPS through such activities as fundraising, board participation, and other management.

A special effort is being made to involve widowers in WPS. Statistics paint a grim picture of the stress experienced by a man who survives his wife. Widowers die four times as often from smoke and six times as often from heart disease as married men of the same ages do. Thus high death rates among widowed men justify concern as does the high divorce rate among widowers who remarry.

WPS is trying to counteract some of these statistics by offering widowers innovative ways to become involved in WPS. Other groups who have been less active in WPS are also being contacted.

The recommendations of the WPS Minority Task Force, which met in 1984, are being implemented and expanded by WPS.

A single copy of On Being Alive, a booklet written for recently bereaved men and women, is available at no cost from AARP but your free copy, write to:
AARP Fulfillment, On Being Alive,
P.O. Box 2000, Long Beach, CA 90801

AARP is the nation’s largest and oldest organization of Americans age 50 and over, retired and working. A nonprofit, nonpartisan organization with more than 1.5 million members, AARP serves its members through legislative representation, educational and community service programs and direct membership benefits.

For more information about Widowed Persons Service, contact
Marjorie G. Maxwel
WIDOWED PERSONS SERVICE
AARP
1201 15th Street NW
Washington, D.C. 20051-0345
(202) 786-6370

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Appendix H

Human Subjects Approval Form
TO: Carole Jeanne Weidaw
Robert Oswald

FROM: Ellen Page-Robin, Chair

RE: Research Protocol

DATE: December 2, 1986

This letter will serve as confirmation that your research protocol, "The Effect of Attending a Bereavement Support Seminar on the Level of Depression of Bereaved Spouses Within the First Year After the Spouses' Death," has been approved as exempt by the HSIRB.

If you have any questions, please contact me at 383-4917.
RESEARCH SHOULD NOT BEGIN UNTIL THE PROTOCOL HAS BEEN REVIEWED AND APPROVED BY THE HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD, WHICH MEETS ON A REGULAR MONTHLY BASIS. PROTOCOLS MUST BE RECEIVED BY THE HSIRB CHAIR AT LEAST SEVEN DAYS PRIOR TO A REGULARLY SCHEDULED MEETING IN ORDER TO BE ACTED ON AT THAT MEETING. PLEASE TYPE EACH RESPONSE—EXCEPT SIGNATURES. REFER TO THE WESTERN MICHIGAN UNIVERSITY POLICY FOR THE PROTECTION OF HUMAN SUBJECTS TO DETERMINE THE APPROPRIATE LEVEL OF REVIEW.

PRINCIPAL INVESTIGATOR Carole Jeanne Weidaw DEPARTMENT CECP

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Ann Arbor, Michigan 48103

PROJECT TITLE: The Effect of Attending A Bereavement Support Seminar on the Level of Depression of Bereaved Spouses Within the First Year After the Spouses' Death

SUBMISSION DATE: 26 Nov 86 PROPOSED PROJECT DATES Jan 87 TO May 37

APPLICATION IS: X New Renewal Continuation Supplement

SOURCE OF FUNDING: NA

Signature of Investigator

STUDENT RESEARCH (Fill out if applicable)

Name of Student Carole Jeanne Weidaw Phone (313) 668-0269

Address 2526 Lone Oak Drive, Ann Arbor, Michigan, 48103

The Research is: X Undergraduate Level

Faculty Advisor Dr. Robert Oswald Department CECP

Signature of Faculty Advisor
VULNERABLE SUBJECT INVOLVEMENT (Fill out if applicable)

Research involves subjects who are: (check as many as apply)

1. __children
   approximate age ___
2. __mentally retarded persons
   check if institutionalized
3. __mental health patients
   check if institutionalized
4. __prisoners
5. __pregnant women
6. __Other subjects whose life circumstances may interfere with their ability to make free choices in consenting to take part in research
7. __Subjects are newly bereaved but have free choice as to involvement
   (Describe please)

LEVEL OF REVIEW: Please indicate here if you think that the research project is exempt from review, subject to expedited review, or subject to full review.

   X Exempt (Forward 1 application to IRB Chair)
Which category of exemption applies? #
   ___ Expedited (Forward 4 applications to IRB Chair)
   ___ Subject to Full IRB review (Forward 9 applications to IRB Chair)

Comments:

HSIRB ACTION

1. __Exempt
   Signature HSIRB Chair  Date

2. __Expedited ___ Full

Your application was reviewed and the Human Subject Institutional Review Board (HSIRB) has determined that:

___1. The proposed activities, subject to any conditions and/or restrictions indicated in Remarks below, have (a) provided adequate safeguards to protect the rights and welfare of human subjects involved, (b) established appropriate procedures and/or documents to obtain informed consent, and (c) demonstrated that the potential benefits of the research substantially out-weigh the risks.

___2. The proposed activities, for reasons indicated in Remarks below do not provide adequate protection for the rights and welfare of the human subjects.

At its meeting on _____, the HSIRB (approved) (provisionally approved - see remarks) this application with regard to the treatment of human subjects. The HSIRB categorized this application as:

___1. Involving subjects at no more than minimal risk.
___2. Involving subjects at more than minimal risk.

REMARKS:

Signature HSIRB Chair  Date
PRINCIPAL INVESTIGATOR: Carole Jeanne Weidaw  Date: 12 Nov 86

TITLE OF PROJECT: The Effect of Attending a Bereavement Support Seminar on the Level of Depression of Bereaved Spouses Within the First Year After the Spouses' Death

ABSTRACT: Briefly describe the purpose, research design, and site of the proposed research activity.

Research data relating to the grief process indicates depression to be a significant part of grieving with individual differences as to degree and length. This study plans to evaluate the effect of professional support by means of a bereavement seminar early in the grief process on the level of depression experienced. Subjects will be selected by random sampling without replacement using the obituary column in the local newspaper. Half of the sample will be invited to the bereavement seminar and the other half will act as control. The seminar will run four weeks and the process repeated until a minimum of 25 subjects have been secured. (Please see attached proposal)

I had originally planned to data collect in Ann Arbor, Michigan, but it now appears I will be spending the winter in the Pittsburgh, Penn., area and will data collect in that area.

CHARACTERISTICS OF SUBJECTS: Briefly describe the subject population (e.g., age, sex, prisoners, people in mental institutions, etc.). Also indicate the source of subjects.

The subjects are newly bereaved persons who have lost a spouse to death within the past year, obtained from the local newspaper obituary column. Information sheets will be mailed and randomly half the subjects invited to a seminar. The subjects become part of the study by returning the information sheets and attending the seminar of their own free will.

SUBJECT SELECTION: How will the subjects be selected? Approximately how many subjects will be involved in the research?

A minimum of 25 subjects for each control and experimental groups, selected from the obituary column of the local newspaper that a spouse had died within the year.
CONFIDENTIALITY OF DATA: Briefly describe the precautions that will be taken to ensure the privacy of subjects and confidentiality of information. Be explicit if data is sensitive.

A number will be placed in the right-hand corner of the information sheets to identify which forms have been returned and which individuals need a second reminder. However, only group data will be reported.

BENEFITS OF RESEARCH: Briefly describe the expected benefits of the research.

Individually, those attending the seminar will be receiving professional support and direction to further deal with the loss of their spouse at no charge. In contributing to the project, more information will be learned that may benefit others in the future.

RISKS TO SUBJECTS: Briefly describe the nature and likelihood of possible risks (e.g., physical, psychological, social) as a result of participation in the research.

Participants are attending the seminar and contributing to the data sheets of their own free will and will complete the project because the subject finds value in it. There does not seem to be a risk to the subject.

PROTECTION FOR SUBJECTS: Briefly describe measures taken to protect subjects from possible risks, if any.

Their identity is protected and no one will be coerced into participating or continuing to participate if the subject does not wish to do so.

INFORMED CONSENT: Please attach a copy of the informed consent form. If oral consent will be obtained, describe procedures for obtaining and documenting such consent. (Subject should be given a copy of the consent form).

As the subject completes the information sheets and attends the seminar he has given his consent. No formal consent form will be used.

QUESTIONNAIRES OR INTERVIEW SCHEDULES: If questionnaires, interview schedules or data collection instruments are used, please identify them and attach a copy of what will be used in the project.

All instruments are attached with the exception of the Information Sheet which will include age, sex, date when spouse died, was the death preceded by illness?, was the death sudden and without warning?, religious background and cultural background (optional), and history of previous depression to distinguish "blue days" from pathology.
BIBLIOGRAPHY


Morse, T. A. (1973). *Life is for living.* New York:


Wambach, J. A. (1985-1986). The grief process as a

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social construct. Omega: Journal of Death and Dying, 16(3), 201-211.


