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THE SURVIVORS:
A COMPARISON OF BEREALEMENT EXPERIENCES FOLLOWING THE
SUICIDE, ACCIDENTAL, OR NATURAL DEATH OF A SPOUSE

by
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Bachelor of Arts, Wooster College, 1971
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A Dissertation
Submitted to the Graduate Faculty
of the
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy
Grand Forks, North Dakota

May
1989
This Dissertation submitted by Terence W. Barrett in partial fulfillment of the requirements for the degree of Doctor of Philosophy from the University of North Dakota has been read by the Faculty Advisory Committee under whom the work has been done, and is hereby approved.

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Title: The Survivors: A Comparison of Bereavement Experiences Following the Suicide, Accidental, or Natural Death of a Spouse

Department: Counseling

Degree: Doctor of Philosophy

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Date

February 20, 1987
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ABSTRACT

The purpose of this study was to compare bereavement experiences of suicide survivors with those of other survivors. The primary focus of investigation was upon grief reactions suggested to be unique to suicide bereavement and upon quality of grief resolution two to four years after death. Fifty-seven women and men, between ages 24 and 48, who had experienced the death of a marital partner were interviewed. Subjects were assigned to one of four groups by cause of death (Suicide, Accident, Unanticipated Natural, and Expected Natural). The categories of death served as the independent variable. Dependent variables were total grief reactions, defined grief reactions, and quality of grief resolution.

ANOVA's and Scheffe Procedures were performed to test for the presence and location of significant differences among the four groups. No significant differences were indicated among survivors on frequencies of grief reactions considered common to all bereavements. Suicide survivors were significantly different from all others on certain grief measures, including rejection and unique grief reactions, from Unanticipated and Expected Natural Death survivors on total grief reactions, stigmatization, and shame variables, and from only Expected Natural Death survivors on search for explanation and responsibility variables. No significant differences were indicated among the four groups on measures
Primary conclusions based on these findings included: 1) suicide survivors consistently experience greater number of grief reactions when compared with other survivors; 2) suicide bereavement is an accretion of different forms of grief reactions including those common to all bereavements, those concomitant with unexpected death, those concomitant with other-than-natural death, and those rare to bereavements other than suicide; 3) suicide survivors do not recover from grief in any manner significantly different from other survivors; 4) accident bereavement is closer in impact to suicide bereavement, whereas unexpected natural death is closer to natural death; 5) course of bereavement and recovery is influenced by factors more critical than cause of death; and 6) complications previously reported among suicide survivors result from factors needing further delineation. Suggestions regarding bereavement studies, methodological limitations of this study, and comments regarding grief experiences of young adults were discussed.
Suicide is one of the four ways that life can end officially in the United States. The other three ways are by accident, homicide, and natural cause. Today, in our nation, suicide is considered to be one of the ten leading causes of death (Wekstein, 1979). It does not discriminate among sex, race, creed, nationality, intelligence, health, social status, marital status, nor age.

Statistics regarding suicide are somewhat troublesome. Depending on the author's perspective, suicide may be considered relatively rare or frighteningly common (Maris, 1981; Wallace, 1977; Wekstein, 1979). Menninger (1957) at one time proclaimed that once every minute, or even more frequently, someone intentionally tries or succeeds in suicide. Each day, 60 to 70 of these attempts are completed successfully. Wekstein (1979), concluded that suicide is both prevalent and insidious in our culture. He maintained that the scale of its frequency is both alarming and difficult to comprehend.

The actual number of completed suicides that occur in one year is difficult to ascertain. Estimates may range between approximately 20,000 to 50,000 annually (Shneidman 1976a; Kiev, 1976). Shneidman (1976a) stated that about 25,000 suicides are reported each year in the United States. He suggested that, because of religious and bureaucratic prejudices, family sensitivity, differences in coroners'
proceedings and post mortem examinations, and the vague
distinctions between suicides and accidents (equivocal
deaths such as auto accidents, industrial accidents, and
various addictions) suicide is underrecorded.

The number of people who attempt suicide has been pro­
posed to be anywhere from 350,000 into the millions annually
(Cantor, 1975; Wekstein, 1979). Shneidman (1976a) reported
that suicide attempts occur about eight times more often
than do the reported successful suicides. Ginsburg (1971)
estimated that about four per cent of the population at­
ttempts suicide annually. The prevalence of suicide attempts
can distort the reality of suicidal death. In fact, Maris
(1981) and others suggested that people who attempt suicide
and fail and those who succeed in completing suicide actu­
al­ly belong to two distinct groups. In evidence of this
theory, Maris reported that 80% to 90% of those who attempt
suicide sometime during their lives ultimately die nonsui­
cidal deaths. On the other hand, as many as 75% of those
who complete suicide do so successfully on their first
attempt.

In terms of who chooses suicide as a way of dying,
Maris (1981) stated that the greatest number of suicides
occur among older males who are physically ill, disabled or
retired, and rather socially isolated. Considering the
combined population of men and women, suicide seems most
likely to occur between the ages of thirty-five and sixty,
with a steady increase in number as age advances. According
to Wekstein (1979) the overall rate for males within our population is 18 per 100,000. The ratio of completed suicides is three males to every one female. The overall rate for females is 6.6 per 100,000 persons. Three times as many women attempt suicide and fail as do men. Wekstein (1979) suggested that the evidence indicates that the ratio of female suicides in comparison to males is on the rise.

Although some researchers view suicide to be a rare event in terms of total lives lost (Wallace, 1977; Maris, 1981), Wekstein stated that among our adolescents aged 15 to 19, suicide is the second most common mode of death, ranking lower only to automobile accidents. Significantly, white males between 10 and 15 years of age rank fifth among groups of individuals who die from suicide. Cantor (1975) estimated the number of suicides occurring among those between the ages of 15 to 24 to approximate 4000 annually. Although the U.S. Division of Vital Statistics does not list deaths of children under the age of eight as suicide, regardless of the information provided about the death, Tallmer (1977) reported that early attempts between the ages of 5 to 14 are increasing and that the actual rates for this age group are higher than shown by records. Incredibly, the only age group that appears to be exempt from suicidal death includes children under the age of five, although suicidal death has been officially reported among children as young as three.

The preponderance of research and literature on the subject of suicide indicates a prodigious effort to under-
stand, predict, identify, deter, and prevent this self-destructive event. There has been much focus on personality traits that may predispose a person to suicide. The lives of those who complete suicide have been subjected to psychological autopsies. Differences between those who complete and those who merely attempt suicide have been studied. The hidden motives for self-destruction have been postulated, and the external factors that may precede it have been illuminated. Even the many ways suicide is successfully completed have been catalogued. It does appear that a better comprehension of the self-destructive human tendency has resulted from this research. However, there has been little success in predicting, preventing, reducing, or eliminating suicide in the human experience. Maris (1981), along with various other reviewers, went so far as to conclude that few major theoretical or methodological breakthroughs have been made in the study of suicide in the last several decades.

The Survivors

Completed suicide is usually conceived as an intensely private and personal act; that is, it is considered a choice by a single individual to end his/her own life. Such a conception springs from the fact that the motivation for taking one's own life seems so unfathomable to most people. Commenting on the motivation for self-destruction, Alvarez (1972), for example, stated that the motives which impel a man to complete suicide belong to his internal world, which is devious, contradictory, labyrinthine, and, for the most
part, out of sight. While such a belief might certainly be valid on one hand, on the other it tends to obscure both the fact that suicide is typically an interpersonal event and that the devastating consequences of the act are usually encountered by someone other than the decedent. Toynbee (1976) stated there are always at least two parties to a death, the person who dies and the survivor who is bereaved. In the apportionment of suffering, the sting of death is always less sharp for the person who dies than it is for the survivor.

In the study of suicide, several researchers have emphasized that most suicidal events are dyadic, that is, two-person events (Maris, 1981; Shneidman, 1976b; Wekstein, 1979; Whitis, 1968). Suicidal tensions are typically between two people who are keenly known to each other; e.g., spouse and spouse, parent and child, lover and lover.

That suicide is a dyadic event is not always clearly evident from the circumstances surrounding some deaths, especially in cases in which the decedent was apparently isolated from social contact. Maris (1981) stated that even the most isolated suicides do not take place in interpersonal or social vacuums. Each suicide can be considered the product of human association or interaction. While suicide is an activity that usually involves relatives and friends, even those acts which appear to occur in isolation include individuals other than the deceased. Someone must discover the suicide's body. Sometimes paramedics or physicians be-
come involved in futile life-saving efforts. Someone must notify officials about the suicidal nature of the death. Officials must file reports. There is involvement of the coroner, mortician, cemetery personnel, and often times the media. If the media bring attention to the suicide, then many people without knowledge, contact, or emotional investment in the deceased must deal with the suicide.

In order to comprehend how widespread the impact of suicide is in our society, a study by Ginsburg (1971) produced some interesting findings. Of 208 randomly selected people interviewed in the Reno, Nevada area, 74% of the sample knew one or more persons who had either completed suicide, attempted suicide, or probably attempted suicide. Fifty-three percent personally knew at least one person who had completed suicide. Of these, 21% were family members, 37% knew the decedent very well, and another 29% knew the decedent at least fairly well. Of course, there are limits to results gathered from one study carried out in a single location, especially in one which may attract a special kind of individual. There are other studies, however, which indicate the enormity of suicide's influence. Shneidman (1976a) estimated that the number of surviving family members to suicide to be between 250,000 and 300,000 annually in the U.S.. According to Wekstein (1979), the number of people intimately associated with suicide, including family, friends, relatives, and associates, may be as high as
750,000 a year. Over a period of years, the number of suicide survivors reaches into the millions.

The impact which suicidal death has upon individuals who were intimately involved with the deceased represents a neglected area of suicide research. Previous studies have been directed toward investigating the event that brought an ending to life, and little attention has been focused upon the experience of those whose lives continue in the aftermath of suicide. This has been a myopic perspective which, to a great extent, has resulted in missing sight of the larger problem associated with suicide. As Wekstein (1979) maintained, the prevalence of suicidal death and its concomitant great number of survivors within our culture represent a large public health problem. Shneidman (1973) proposed that, in the case of suicide, the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered. The risk to health derives from the fact that the bereaved survivors, who far outnumber the individuals who have completed suicide, bear some terrible consequences in the aftermath of someone else's self-destruction.

Although the serious consequences of grief resulting from suicidal death have been variously suggested and described, the implication that suicide exacts a more terrible vengence upon the survivors than experienced in other forms of bereavement has long been in need of research. It was
upon the suggested profound effects of suicide survivorship in comparison to other forms of grieving that the present study was focused.

The Grief Process

Suicide is, as Alvarez (1972) stated, an extreme and brutal way for an individual to ensure that he will not readily be forgotten. How a person is remembered after any form of death is common and consistent among all humans. It is a process called grieving or, sometimes, mourning or bereaving. Though this process has many different components in various cultures, it is an experience that is shared by all people who have suffered the loss of someone intimately known to them. Thus Hajal (1977) described grief not as a cluster of symptoms, but as a normal process having as its outcome the recovery of the survivor from his/her loss and the readjustment to life as indicated in the development of new relationships and interests. In another description of grief Shneidman (1981) stated that the bereaved survivor is likely to be affected as if he were suffering from a disease of known course. The recently bereaved person is typically disorganized. Long-standing patterns of intimate interpersonal responses have been irreversibly severed. There is a concomitant experience of strong feelings that usually include abandonment, despair, guilt, and anger, and, in addition, a sense of crushing emptiness and loss. Shneidman suggested also that serious physical and psychological con-
comitants are normal as reflected in heightened morbidity and even greater risk of death.

The literature abounds with descriptions of the process, course, and patterns of normal grief. Lindemann (1944) was among the first to suggest that persons in acute grief show remarkably uniform reactions. He indicated that there are five primary reactions in grief, namely, 1) somatic distress of a limited duration, 2) alteration of the sensorium resulting in a preoccupation with the image of the deceased, 3) guilt, 4) hostile reactions, and 5) loss of patterns of conduct. Other authors whose descriptions of grief are often cited include Bowlby (1961), Hinton (1972), and Parkes (1970).

Typically grief is described as a discernable sequence of events which can be divided into three or four distinct stages that are common to most bereaved survivors. Parkes (1970), who identified grief as a process rather than either a static state of being or a disease with specific symptoms, distinguished four phases in the bereavement process. These were, 1) numbness, 2) yearning/protest, 3) disorganization, and 4) reorganization.

Parkes (1970) described numbness as the immediate reaction to death which might be likened to a state of shock. It is a transient reaction which typically dissipates in a few days or, in most cases, lasts no longer than a month or so. It features denial, outbursts of extreme behavior (cry-
ing, aggression, elation), panic attacks, restless busyness, and suppression of feelings.

Yearning/protest is similar to separation anxiety. It includes such reactions as intense pining for and a strong urge to recover the dead person, preoccupation with thoughts of the deceased, irrational anger, aggressive behavior, guilt, restlessness and tensions, identification with the deceased, and inhibition of normal appetites and activities. These are the principle features of the grieving process. They are typically present a year after the death, but are either in abeyance or past their peaks. Though grief after one year can in no sense be said to be finished, as time goes by, one after another of these principle features will become less frequently aroused and less intense.

Disorganization includes apathy and aimlessness, a disinclination to look to the future, and the slow return of appetites and interests. This phase usually continues throughout the first year of bereavement and well into the second year.

Reorganization marks the survivor's recovery from the bereavement and return to a healthy and socially rewarding existence. There is less thought of the deceased, an ability to plan for the future, a more confident outlook, and increased striving for social interaction.

A number of factors have been suggested to influence the course of bereavement. Among these are the nature and quality of the relationship between the survivor and the
decendent, the suddenness of the death, the previous experience with loss and the manner and degree of recovery from that, the sex, age, personality, and physical health of the survivor, plus social class, cultural factors, and the nature of the death (Achte, 1977; Osterweis, Solomon, & Green, 1984; Parkes & Weiss, 1983; Saunders, 1981).

Obviously, the course that grief takes is not the same in all instances of death. In regard to the nature of the relationship with the deceased, for example, it has been suggested that the death of a spouse is a particularly stressful event (Lindemann & Greer, 1953). In fact, much of the research regarding grief has been focused on the impact of death within a marital relationship. Similarly, the present study investigated only the bereavement experiences of husbands and wives whose spouses had died.

Another factor which has received much attention has been the influence of anticipation of death upon the course of bereavement. The work of Kubler-Ross (1970) suggested that patients suffering terminal illness experience a grief process that can be described in stages. This implied that spouses of terminally ill patients would themselves experience a process of grieving that prepared them for the eventual death. Other research supports the contention that response to grief is different between individuals who have had an opportunity to prepare for the death and those for whom the death has come unexpectedly; the consequences of unanticipated death generally being more severe (Parkes &
Weiss, 1983; Schultz, 1978; Worden, 1982). Studying widows and widowers, Parkes and Weiss (1983) reported that, in the event of unanticipated death, bereavement and recovery involve different emotional implications than those encountered with anticipated death. Unanticipated death was more likely to result in an inability to accept the reality of the death, self-punitive tendencies, social withdrawal and alienation, chronic anxiety, loneliness, depression, and complicated recovery. In fact, Parkes and Weiss included these reactions in a constellation of symptoms which they termed "Unexpected Loss Syndrome." While they emphasized that it may not be possible to assign greater pain to one or another kind of grief, Parkes and Weiss concluded that the trauma of unanticipated death is clearly the more disabling for the bereaved survivor. Summarizing their findings, they stated that unanticipated death injures functioning so severely that uncomplicated recovery can not be expected.

**Complicated Grief**

Our society sets certain limits on what might be accepted as normal bereavement. While the intensity, duration, and form of grieving may vary greatly from one survivor to another, most grief variations are accepted to be within the range of normal bereavement (Parkes & Weiss, 1983). Grief reactions which are not included within the normal boundaries, however, are typically considered pathological in some sense and have acquired various labels such as pathological grief, morbid grief, unresolved grief, ab-...
sent, abbreviated, delayed, chronic, or exaggerated grief, conflicted grief, or, most commonly, complicated grief (Rando, 1984; Worden, 1982).

Lindemann (1944) was one of the first to categorize morbid grief reactions. He stated that such reactions represented distortions of normal grief and fell into the categories of either delayed grief or distorted reactions. Bowlby (1961) maintained that pathological expressions of grief were merely exaggerations and caricatures of normal grief reactions. Both Lindemann and Bowlby viewed distorted grief reactions as surface manifestations of an unresolved grief reaction. Parkes & Weiss (1983) suggested that pathological reactions to bereavement outside of typical grief could be classified as, 1) chronic grief, an indefinite prolongation of grief which is the most common pathological reaction encountered, 2) inhibited grief, with some partial or distorted expression of grief, and 3) delayed grief, in which the survivor shows little of the normal initial grief reactions following the death.

Grief may be perceived as complicated in either the type of grief reactions expressed or in the length of time that the bereavement endures. For example, Parkes & Weiss (1983) stated that many pathological reactions to bereavement are characterized by excessive guilt and self-reproach. In regard to the duration of grief reactions, they noted two major groups of factors which may complicate the course of grief, namely, those which discourage the expression of
grief and those which discourage the ending of grief. Either of these groups of factors may result in a course of chronic grieving.

There remains some question about how long normal grief lasts. Jensen & Wallace (1967) stated that most normal grief reactions are self-limited to a period of about one year. The inference is that grief lasting longer than this time is complicated in some manner. Rogers, Sheldon, Barwick, Letofsky, & Lancee (1982) suggested that survivors who were bereaved longer than two years have difficulties so severe that professional treatment is indicated. Parkes (1970), however, maintained that, although the principle features of grief are normally beyond their peak after thirteen months, there is no sense in which grief can be said to be finished in that time. Grief remains ongoing although one after the other of the grief reactions becomes less frequently aroused and less intensely experienced. Schulz (1978) suggested that within three to four years after the death, survivors are satisfactorily engaged in life and can look upon their lives to be at least as rich and fulfilling as they were before their bereavement.

**Recovery**

Bereavement is a purposeful process, allowing the spouse to experience a significant loss, enabling him/her to separate from the deceased, and facilitating the rebuilding of a new life in which the deceased is no longer a signifi-
can part. The final aim, that of building a new life, is sometimes called reinvolvement, reconstruction, or recovery. According to Parkes & Weiss (1983), after a period of time has passed, a spouse begins to recover in the sense that he/she replans his/her life and achieves a new and independent level of functioning. The survivor does not, however, return to being the same person nor living the same life as had been experienced before the death of the spouse. Parkes & Weiss suggested that the survivor does not just forget the past and start a new life. Instead, the survivor must recognize that a life change has occurred and it must be accepted if satisfaction is to be attained in the new life.

The quality of reinvolvement in life, or recovery, depends entirely on various complex factors involved in the bereavement process (Parkes & Weiss, 1983). Lindemann (1944), for example, insisted that adequate recovery depended upon the success with which the survivor freed him/herself from the bond with the deceased, readjusted to the environment in which the deceased was missing, and formed new relationships. Cantor (1975) stated that a mourning process which is to culminate with any sense of growth for the survivor had to begin with a sense of honesty regarding the circumstances of the death and of the reactions that come in its aftermath. Yufit (1977) stated that, for recovery from bereavement to occur, the survivor must be encouraged to dwell in the past, to work through all good and bad
memories, and to literally surround him/herself in the stream of recalled events which filter through to consciousness.

In their description of the process of recovery from bereavement, Parkes & Weiss (1983) identified three tasks that must occur in the course of bereavement in order for a normal, adequate recovery to take place. These were: 1) the loss must be accepted intellectually, requiring the development of an explanation of how the death occurred; 2) the death must be accepted emotionally, requiring the repeated confrontation with every element of the loss until the intensity of distress is diminished to the point where it becomes tolerable and the pleasure of recollection begins to outweigh the pain; and, 3) a change of self-identity to match the reality of the new life's circumstances must occur, requiring the survivor to acknowledge that a permanent loss and change of circumstances has been experienced. Parkes & Weiss concluded that when it appeared that recovery was going well, these three tasks had been accomplished by the end of the first year of bereavement.

Considering the variations and the complications which might arise in the expression of grief, plus the various ways in which recovery might be described or measured, it is difficult to determine the degree of recovery achieved. However, recovery from bereavement is typically marked by the absence of grief reactions, by the establishment, maintenance, and involvement in helpful and gratifying relation-
ships, and by the achievement of a new quality of satisfac-
tion in life. As Parkes & Weiss (1983) concluded, good re-
covery outcomes are characterized not only by adequate func-
tioning in social roles, and freedom from physical and emo-
tional symptoms traceable to the bereavement, but also by
emotional investment in the present life, by hope regarding
the future, and by a return to a genuine capacity for exper-
iencing gratification.

Impact of Suicide on the Survivor

There is a small but provocative body of research sug-
gest ing that suicide has a devastating impact upon the be-
reaved. Cain & Fast (1966a) discovered that the implicit
interpersonal tugs and pulls of the suicidal person's gen-
eral presuicidal behavior and ultimate suicidal act have
profound effects upon surviving intimates which may last
long after the suicidal act. Shneidman (1971) stated that
suicide survivors are saddled with an unhealthy complex of
disturbing emotions, including shame, guilt, hatred, and
perplexity. They are obsessed with thoughts about the
death, seeking reasons, casting blame, and often punishing
themselves, as if the person who completes suicide puts his
social skeleton in their psychological closet. Wekstein
(1979) added that suicide survivors are tortured by self-
blame, confusion, ambivalence, shame, loss, and hatred.
Many brood and spend years searching for reasons for the act
which might serve to absolve them of responsibility for the
death. Overwhelmed by guilt recrimination, rumination, loss
of self-esteem, dysphoria, condemnation, and delayed grief, their depression and emotional states make them candidates for a suicidal course themselves.

Though it may be true, as Maris (1981) inferred, that our entire population must deal with each individual report of suicide on some emotional level and that millions of people must cope with self-destructive events on an intimate basis, the impact of suicide on the survivor depends partially on the closeness of the relationship which had been developed with the deceased. Therefore, while there may be similarities in the grief reactions experienced by children, brothers or sisters, parents, spouses, relatives, or friends of the suicide, there will also be enough differences in the experiences to create unique difficulties for each of the survivors.

Several sources describe the profound psychological impact of parent suicide upon a child (Cain & Fast, 1966b; Hajal, 1977; Shepherd & Barraclough, 1976). Most significant among the psychological stresses and burdens reported consequent to suicide of a parent include anger, guilt, distortions of communication, personality malformations, increased risk to suicide, and behavioral disruptions. Pfeffer (1981) added that, besides the disturbing effects upon childhood development, parental suicide increases the possibility of suicide and depression when the child reaches adulthood.
Both Whitis (1968) and Cantor (1975) stated that suicide among young people and children can be especially demoralizing, and even catastrophic, for the bereaved family. The reactions include exorbitant shame, irrational guilt, disturbed communication processes, strong denial, idealization of the victim, social estrangement, and a sense of stigmatization. Hatton & Valente (1981) reported that the major difficulties experienced by parents after the suicide of a child included guilt, fear and self-doubt, obsession to understand, unresolved grief, loss of parenting roles, feelings of rejection, and burdensome responsibility for the death.

Foglia (1977), reviewing a study of the impact of adolescent suicides upon parents, reported that the responses include overwhelming hostility and denial, long-lasting guilt and depression, and frequent signs of family disruption. Resnik (1972) suggested that siblings are equally at a loss in coping with the suicidal death of an adolescent and are probably less psychologically able to deal with it than their more mature parents.

There are many researchers who have proposed that the death of a spouse, especially in the event of suicide, is a particularly traumatizing experience (Lindemann & Greer, 1953; Shepherd & Barracloough, 1974; Sheskin & Wallace, 1967). According to Cain & Fast (1966a), suicide has a pathogenic potential upon a spouse that is distinct from and well beyond the disruptive factors generally surrounding and
following a death. Wallace (1973), added that the suicide of a spouse produces the most intense grieving of any type of death. Whether it be labeled complicated, acute, or any other term, its intensity is searing.

That suicide can have an impact on others outside of the immediate family constellation is indicated in studies by Ballenger (1978), Kolodny, Binder, Bronstein, & Friend (1979), Rounsaville & Weissman (1980), and Solomon (1982). Focusing on the suicide of a relative, friend, patient, or therapist, these authors reported the presence of such reactions as sensations of being lost, angry, demoralized, and to some degree, responsible for the death. Typical initial reactions to the suicide might be feelings of shock, loss, abandonment, loss of trust, and isolation. Later reactions may include depression, recurrent suicidal ideation, self-destructive behavior, anger, helplessness, anxiety attacks, guilt, and terrible sorrow.

For many years, clinical opinion has been that the experience of grief and the subsequent resolution in cases of suicide are something other than that experienced in normal grief. Common suggestions are that those intimately associated with a person who completes suicide suffer bereavement that is both qualitatively and quantitatively different from that resulting from other forms of death (Calhoun, Selby, & Selby 1982; Cantor, 1975; Neuringer, 1977; Saunders, 1981; Shneidman, 1971; Solomon, 1981; Stone, 1972; Raphael, 1983; Wallace, 1973). Hajal (1977), for example, stated that the
normal processes of grief and mourning are greatly interfered with for survivors of suicide. These survivors are likely to get stuck in their grieving and to go on for years in a state of close isolation.

Both Schuyler (1973) and Shneidman (1977) proposed that the survivor of a suicidal death must recover on a different psychological level than individuals who experience natural, accidental, or homicidal death. Reactions that are normal in other forms of death are intensified and aggravated in suicide bereavement, sometimes to unbearable proportions, by the searing additions of shame, guilt, self-blame, and hostility reactions. In fact, suicide bereavement is considered to be so different, that it has sometimes been suggested that it does not entail the same grief process that has been observed in other, more normal forms of survivorship (Fisher, Barnett, & Collins, 1976; Shneidman, 1972; Stone, 1972). Perhaps Wekstein's (1979) depiction of suicidal bereavement best describes the differences suggested to be inherent in this form of grieving. He stated that suicide casts a pall upon the survivors that far exceeds that from any other type of death. Long after the death, the presence of the decedent lingers on, festering, and hounding the lives of both the family and other people associated with him. The survivors abruptly left behind must endure emotions that may never be eradicated or resolved. It is the survivors who become the real victims of suicide. Their lives are damned and devastated forever.
The opinion that bereavement and its resolution in the event of suicide is different than that in other forms of death is based, in large part, on clinical observation, intellectual conjecture, and theoretical speculation. The few empirical attempts to compare suicide survivorship with other types of bereavement include studies by Sheskin & Wallace (1967), a retrospective comparison of suicide and natural death bereavements based on the reports of widows interviewed in two different earlier studies; Flesch (1977), who compared psychological difficulties in the aftermath of accidental and suicidal death; Demi (1984), who compared the adjustments to widowhood after the sudden death of a husband by suicide, accident, and natural cause; and Saunders (1981), who compared the resolution of grief among widows who had experienced the suicidal, accidental, homicidal, or natural death of their husbands. Calhoun et al., (1982) criticized the few existing investigations on a number of traditional methodological criteria, for example, the retrospective nature of the investigations, the lack of control groups, the use of specialized and nonstandardized instruments, and the lack of operational definitions for the measured reactions.

Although the conclusions of Sheskin & Wallace (1967) are open to question in regard to how they may be applied to common grief experiences, they provided a useful framework in which to consider the many differences that have been suggested for the experience of suicide survivorship. Com-
paring aspects of bereavement as experienced by widows of suicidal, natural, and accidental deaths, they identified four important areas that are critical to the bereavement process among surviving spouses. These are 1) anticipation, 2) personal reactions, 3) reactions of others, and 4) adjustment and reinvolvement.

Anticipation is one of the most important determinants of the survivor's ability to accept the death of a spouse and of the adequacy of recovery, even in the case of suicide. Though death is still traumatic when anticipated, it can be better understood when expected and, under such conditions, time might be allowed for the bereaved to redefine their role. Consistent with Parkes & Weiss (1983), Sheskin & Wallace maintained that unanticipated death, regardless of its cause, occasions the most severe bereavement reactions. Denial of the death is a prominent feature in all cases. The survivor often dwells on what happened and searches for the cause of the events.

While suicide may certainly be unanticipated in the majority of cases, there is evidence that it includes significant elements which detrimentally influence grief and recovery, beyond the mere lack of preparation for death. Sheskin & Wallace (1967) suggested that there is a significant feature in the case of suicides wherein the suicide survivors must not only deny to themselves that the death has occurred but must deny also the cause of death. Wallace (1977) stated that to anticipate death is to prepare for it, and to
be even somewhat prepared for even the most tragic loss helps the survivor to cope with the traumatic loss. In the case of suicide, however, even if the death had been anticipated to occur by some other means, a pattern of responses is elicited that is different from other bereavements. Anticipating death does not appear to facilitate grieving when the death is a suicide (Maris, 1981; Sheskin & Wallace, 1967; Ross, 1979). Survivors who have experienced previous suicide attempts or ideation on the part of the decedent are not resigned to the eventual suicidal death.

In the second critical area of the bereavement process outlined by Sheskin and Wallace (1967), they observed that there were similar immediate and long-term personal reactions to death common to all types of death. These include periods of shock, physical distress, deep despair, bewilderment, loneliness, depression, intense grief, and personal disorganization. In suicide, assuming responsibility for the death becomes a primary issue, and there is a greater tendency for the bereaved to feel blameworthy. This occasions an obsessional review of the prior relationship that is more intense and longer lasting than in deaths when the survivor does not feel responsible. With suicide it is difficult not to see the death as an attack upon one's self as well as upon the past relationship. For spouses, the sense of copartnership in the death is especially apparent. The search for explanations is more intense, more solitary, and less amenable to resolution than in other forms of
death. Suicide may be more likely to occasion self-destructive acts by survivors. Finally, disclosing the death and sharing its cause carry more risks for suicide survivors including fear of incrimination, repugnance, blame, discomfort, and denial, all of which become barriers to successful, healthy interaction and communication with others. These barriers are less likely to develop in other modes of death.

In their description of the third area of critical bereavement factors, reactions of others, Sheskin & Wallace (1967) indicated that bereavement is a lonely and isolating experience for the surviving spouse regardless of cause of death, and support typically diminishes after the official period of mourning. In suicide, however, finding social support seems to be a greater problem. Friends may insist upon working out their own explanations and rationale for the suicide which collide with the survivor's needs, and they may insist that the survivor not talk about the event. There is a greater tendency for the suicide survivor to feel exploited in their moment of grief by the funeral director; they are more likely to direct their anger at officials and professionals than upon the suicide victim.

In the fourth area, adjustment and reinvolvement, Sheskin and Wallace (1967) stated that recovery patterns of the suicide survivor are not as likely to be complete nor to take place as quickly. In fact, incomplete mourning is often reported as a common sequelae to suicide bereavement.
(Charmaz, 1980; Lindemann & Greer, 1953; Osterweis et al., 1984; Rudestam, 1977; Schuyler, 1973). Parkes & Weiss (1983) stated that the capacity to establish helpful and gratifying social ties and movement toward remarriage are indications that recovery is progressing. In the case of suicide survivors, there is evidence that they experience difficulty in establishing close relationships with others, are less likely to remarry in the years subsequent to the death, and often view their current life as worse or no better than that which they had with the decedent (Hajal, 1977; Rudestam, 1977; Schuyler, 1973; Wallace; 1973). Sheskin & Wallace (1967) concluded that, not only does re-involvement in social activities come more slowly for suicide survivors, but also that these survivors continue to deny suicide and death itself for longer periods of time.

**Unique Aspects of Suicide Survivorship**

Some have suggested that, not only is suicide bereavement different from other forms of grieving, it is also a unique form of bereavement, either in part or as a total experience (Battle, 1984; Cain, 1972; Foglia, 1977; Hatton & Valente, 1981; Neuringer, 1977; Osterweis et al., 1984; Whitis, 1968). In their examination of available studies concerned with the psychological aftermath of suicide, Calhoun et al., (1982) stated that the consequences of suicidal death are seen to be unique in some aspect. Though they suggested caution in drawing conclusions from these studies, Calhoun et al. summarized these unique aspects
attributed to suicide survivorship, which included search for explanation, guilt, responsibility, shame, stigmatization, loss of social support, rejection, and self-destructive behavior. The descriptions of these eight unique reactions to death as experienced by the survivors of suicide follow.

1) Search for Explanation. Seeking an understanding for why the death occurred appears to be a significant component of suicide. Menninger (1938) observed that suicide is a very complex act, not a simple, incidental, isolated act of impulse. It is neither logical nor inexplicable. Analysis of the motives for suicide is difficult not only because of the untrustworthiness of conscious and obvious motives but particularly by reason of the fact that a completed suicide is beyond study.

There is a suggestion that the search for an explanation of a suicide occurs because the causal explanations which society generally offers the bereaved are not available to suicide survivors and because the explanations which are offered are not emotionally acceptable to them. Kalish, Reynolds, & Farberow (1974), for example, described the norms that our society has established regarding the meaning and causes of suicide. They reported that the most common reason people give for self-destructive behavior is that the person suffers an enduring mental illness or a temporary psychological state of stress, guilt, or frustration. Causes that are considered most likely usually focus on the
inner-personal realm, whereas more concrete factors like financial difficulties, work problems, and the like are typically perceived as secondary causal components. Lindemann and Greer (1953) stated that suicide is so unacceptable that the obvious tendency is to ascribe some form of insanity, or mental problem, to the decedent in order to explain the act. However, to tell a grieving person that his loved one was psychologically unbalanced does nothing to ease his burden. The existence of personal problems in the life of the deceased is also a common cause attributed to suicide (Buksbazen, 1976). This places the survivor into the position of having to determine whether or not this was true in the case of the suicide known by him, and if it appears to be so, whether or not he contributed to the personal problems of the deceased.

Cain (1972) suggested that society's preferred explanations of suicide tend to be, at best, ambiguous and fertile with the seeds of blame. Additionally, not only are there virtually no institutions nor mechanisms for relieving the survivor of his unique burdens, but also, attitudes toward the suicide are basically punitive. Wallace (1977) added that, without socially acceptable reasons for the death, suicidal loss can not be socially acceptable. The survivor has no available rationale to ease ultimate acceptance of the death. Friends have no socially acceptable words of comfort. There are no special rituals or ceremonies to be invoked for support, and no tradition exists to
help filter the remembrance of the death. Therefore, in this virtually normless atmosphere, the survivor must search independently for an understanding of the death. Both Rogers et al. (1982) and Henslin (1972) maintained that, because society offers only ambiguous or conflicting explanations for suicide, the survivor is left to himself to determine the reason for the death. The survivors scrutinize the interactions they had with the decedent, especially the recent ones which might be viewed as antecedents and possibly precipitants of the suicide, in an attempt to track down clues and analyze their own role in the self-destructive act. Henslin added that, since there is no clear explanation for the death, the survivor can go on indefinitely looking for one. Calhoun et al. (1982) concluded that the many and complex factors involved in suicide make the search for explanation more intense, more solitary, and less easily resolved for suicide survivors than it is in any other form of bereavement.

2) Guilt. The experience of self-reproach is a common element of most bereavements (Parkes, 1970). Such guilt might be the result of the perception of some act or omission which diminished the decedent's former peace of mind. It might be a form of survivor's guilt, a recrimination for living on without the deceased. Finally, guilt might also result from behavior that followed in the aftermath of the death. It is not that guilt experienced during suicide bereavement is unique, but the fact that such guilt is so
frequent and intense. In fact, severe guilt is one of the most commonly reported reactions concomitant to suicidal grief. Unlike that which is experienced in other forms of grief, guilt is more frequent, more intense, and of longer duration in suicide (Battle, 1984; Buksbazen, 1976; Cain & Fast, 1966a; Danto, 1977; Maris, 1981; Neuringer, 1977; Rando, 1984; Solomon, 1981; Worden, 1982). As Silverman (1972) reported, guilt (or even anger) is a fleeting issue for most survivors of other deaths, but in suicide it is a primary concern.

3) Responsibility. Various ways in which a suicide survivor might be burdened with an overwhelming sense of responsibility in the death of a spouse have been described (Battle, 1984; Charmaz, 1980; Fliegel, 1977; Henslin, 1972). Probably the most troubling way a survivor experiences responsibility for the death is through perceiving that somehow she directly caused the suicide. Similarly, there may be the perception that the survivor could have or should have prevented the death. There may also be a sense that the survivor should have been aware of the suicidal intent of the decedent or, if the intent had been communicated, should have informed others of such intent. It is not likely that such perceptions are experienced by survivors of other bereavements. If they should be, it might well be expected that they would be of lesser intensity and duration in comparison to suicide survivorship.
The perception of survivor responsibility in suicidal death is rooted in social attitudes. As noted above, our culture does not offer adequate nor acceptable explanations for death by suicide. The survivor must, therefore, find the reasons for the death on her own and, as Henslin (1972) stated, because of the ambivalent feelings present in all people, she is likely to discover some reason for having been responsible herself. The survivor might focus on personal actions or minor omissions which may appear to have served as motivation for the decedent to end his life. Or, as Buksbazen (1976) described, the survivor may obsessively analyze the days before the death for clues of his responsibility in not saving the person's life. Goldberg and Mudd (1968) stated that the suicide act itself is hostile and loaded with the implication that the survivor is somehow at fault. The survivor, after the fact, finds it almost impossible to ignore this accusation.

Backer, Hannon, & Russell (1982) and Buksbazen (1976) highlighted the importance of another, deeper social perception that generates difficulties for the survivor. They observed that our society stresses the belief that, if a suicide could have been prevented, it should have been. In this pervasive social attitude the responsibility of suicide prevention is placed outside the decedent. It must rest upon someone else, and, as Ginsburg (1971) stated, many people believe that the family has a special responsibility to see that suicide attempts do not occur or recur.
The outgrowth of these generally-accepted social perceptions may be that a survivor can never, with great assurance, conclude whether his actions could have made a difference in the completion of the suicide. Therefore, there is a tendency for him to take a far greater share of responsibility for either causing or not preventing the death than is common in other bereavements.

4) **Shame.** Worden (1982) stated that, of all the specific feelings suicide survivors experience, shame is one of the most predominant. Unlike other bereavements, survivors of suicide are likely to experience a sense of shame and embarrassment about the nature of the death and report feelings of shame at having to tell others that a family member died by suicide (Buksbazen, 1976; Cain & Fast, 1966b; Fisher et al., 1976; Hajal, 1977; Hewett, 1980). Ginsburg (1971) reported that suicide is perceived by many people as a shameful event. The experience of shame may result in a frequent denial of the cause of the death and in an inability to talk openly and honestly about the death. Calhoun et al. (1982) added that this sense of shame may generally lead survivors to experience discomfort in social interactions.

5) **Stigmatization.** Solomon (1982) described stigma as a mark upon the survivor which potentially detracts from his character or reputation. Hewett (1980), explaining the Greek derivation of the word, stated that stigma results from disgrace and reproach expressed by others.
A natural death does not typically stigmatize the survivor to any degree. Suicide, not only stigmatizes the survivor, but results in more negative views of the family than other types of death (Calhoun, Selby, & Abernathy, 1984; Charmaz, 1980; Hewett, 1980; Rando, 1984; Rudestam, 1977; Shneidman, 1969; Shneidman, 1976b; Worden, 1982). Maris (1981) reported that suicidal death has been routinely stigmatized in our society as cowardly, irresponsible, or narcissistic. The suicide survivor is likely to feel stigmatized by the death because he encounters gossip, negative attitudes, social avoidance, the hint of family discord or mental illness, and overt blame for the death.

This generally negative attitude toward suicide may not be as pervasive as once believed. Shepherd & Barraclough (1974) reported that only 41% of the suicide survivors that they interviewed had actually encountered critical, unsympathetic, shocked, or frightened attitudes in others. Solomon (1982) also reported that a minority of suicide survivors were effected by stigma and that, for those so effected, it was not particularly burdensome. More recently, Calhoun et al. (1984) noted that individuals who actually knew survivors who had experienced either suicidal, accidental, or naturally caused bereavements did not differ significantly in their descriptions of the bereaved nor in the way they perceived the survivors to have been impacted by the death. The authors concluded that the degree to which suicide sur-
vivors were perceived in a negative manner by others was more limited than previously suggested.

Suicide survivors may feel themselves to be stigmatized by the death, even in the absence of negative encounters. Shepherd & Barraclough (1974) reported that potentially stigmatizing experiences were neither necessary nor sufficient in themselves to produce self-reported stigma. Some who felt stigmatized did not actually have stigmatizing experiences, whereas some who did experience them did not report feeling stigmatized by the suicide. Shepherd & Barraclough (1974) and Solomon (1982) both concluded that there is a low incidence of suicide survivors who actually feel the sting of stigmatization and encounter negative or critical attitudes from others. However, they failed to make comparisons with survivors of other deaths. It may be that the numbers that they interpret as low, are indicative of a significant experience that is not encountered in bereavements other than suicide. As Solomon stated, in the case of suicide and homicide, stigma does become a real possibility with potential personal and social consequences for the survivor.

6) Loss of social support. Although it is not unusual in any type of bereavement for the survivor to sense some loss of support from friends and family, several authors have reported that a family grieving over a suicide is given even less overt social support than is normal in other
bereavements (Cain & Fast, 1966b; Calhoun, Selby, & Faulstich, 1980; Hatton & Valente, 1981; Osterweis, et al., 1984; Sheskin & Wallace, 1967). Hewett (1980) stated that, in the most extreme situation, the suicide survivors find themselves without any support. Their feelings of shame intensify, their grief becomes hopelessly stuck, and they retreat into their homes, change their phone numbers, and eventually move away. Danto (1977) specifically noted that two sources of support which are offered under normal death circumstances, i.e., support from neighbors and in-laws, is conspicuously absent in most instances of suicide. Wallace (1977) added that, just at the time when a survivor needs interpersonal support, friends often leave, neither the survivor nor the comforter knowing what to do in the normless situation of suicide. He suggested that social support for the survivor is lessened because suicide is unacceptable. Family and friends do not know what to expect. Thus, they are less likely to encourage expressions of grief and probably are more likely to encourage the survivor to forget the decedent as quickly as possible instead of cherishing positive memories. Calhoun et al. (1984) proposed that the lower levels of social support reported among suicide survivors might be connected with the general negative social interpretations ascribed to suicide. In a comparison of reactions of others to survivors of suicide, accident, and natural death, they reported that individuals had greater difficulty expressing sympathy to the family of a suicide at
the funeral and that they rated talking to the suicide sur-
vivors as more uncomfortable when compared to other bereave-
ments. As Silverman (1972) suggested, many survivors become
even more uncomfortable over the awkward sympathy extended
to them and find themselves having to reassure others in-
stead of being supported by them. More significant than the
anxiety of others, suicide survivors are likely to experi-
ence negative encounters with others. Wallace (1973) stated
that, while the loss of social support may result from the
survivor's discomfort in social settings, it is just as
likely to result from the anxiety of others in resolving
their own discomfort with the suicidal nature of the death.
Comforters are at a loss for the "right thing" to say to the
bereaved and may tend to avoid encounters with the survivor.

The increased social isolation and alienation of the
suicide survivor has often been noted (Rando, 1984;
(1973), for example, reported that suicide survivors did not
talk very much about their spouses. Typically they withdrew
into themselves, felt outcast, rejected, alone, and hurt.
They perceived that there were few who would listen to them,
few who were able to respond to their grief, and while some
family members and friends did listen to them, most did not.
Increased isolation and alienation, and the concomitant loss
of social support, also results if the suicide survivor
moves from her community. Lindemann & Greer (1953) indicat-
ed that the fears of what others might think or say can re-
sult in a move to a new community where the circumstances of the death could be kept secret. The motive for moving may be unique to suicide, but whether the actual tendency to move is greater for one bereavement or another is difficult to determine. Other authors have suggested that there may be an increased tendency among suicide survivors to make an early or unnecessary move from their communities (Cain & Fast, 1966a; Shepherd & Barraclough, 1974; Whitis, 1968), but there is little empirical basis to allow comparisons with other forms of bereavement.

7) Rejection. It is not uncommon in bereavement for the survivor to experience a sense of having been deserted by the deceased. Typically this is no more than a fleeting sensation which includes little sense of intentionality on the part of the deceased. Feeling deserted is usually overcome by the realities surrounding the death. As Schuyler (1973) explained, the survivor rationally understands that the deceased did not leave him behind intentionally.

In the case of suicide, the sensation of having been deserted is a serious and enduring concern. The suicide survivor may often experience the death as an outright and intentional rejection on the part of the deceased (Saunders, 1981; Osterweis et al., 1984; Rando, 1984). As Yufit (1977) stated, while the feelings associated with implied rejection may be present in other forms of death, they are not usually as intense or severe as in the case of suicide. In suicide, the resultant rejection is determined by a very specific act
of the decedent. This alone may account for the perception that suicide is the most hostile type of transaction that any spouse could complete (Goldberg & Mudd, 1968).

Neuringer (1977) concluded that suicide is unique among the ways of dying because of the strong message that it carries to the survivor. The suicide makes a statement about the feelings that were shared between the decedent and the survivor, and the conscious deliberateness of purpose in the act intensifies the impression that the survivor has been deserted because of the inadequacy of those feelings. Maris (1981) observed that in our society suicide is very often perceived as a form of revenge. It seems that it is the survivor at whom this hostile act is most often directed. Menninger (1938) suggested that in many cases, the decedent kills himself for the express purpose of taking revenge upon the survivors. The resultant abandonment and rejection experienced by the survivor are almost always inherent in the self-destructive act itself. This may explain the real wound and deep affront that Lindemann & Greer (1953) suggested is experienced by suicide survivors.

The communicative aspect of suicide may carry beyond the immediate environs of the close survivor. As Kastenbaum (1976) suggested, the person who completes suicide seems to flaunt society, hinting that the kind of lives we have built for ourselves is not worth keeping. That person rejects the sanctions against suicide, and thereby assaults the social fabric that ties humans to all others. Kastenbaum concluded
that even more than this, the decedent rejects the option to share in the love and the life offered by the survivor.

8) Self-destructive behavior. Arnold Toynbee (1976) coined the phrase "peril of survivorship" to describe the observation that a bereaved survivor's life is actually in jeopardy. For at least a year after a death, regardless of the type of bereavement, the survivor is more at risk to take less adequate care of herself, to become ill, to be hospitalized, to be involved in accidents, to die, or to be killed. The suicide survivor is in even greater peril than is normally expected of those suffering bereavement, for there is a far greater risk of repeating the suicide experience (Cain & Fast, 1966b; Lindemann & Greer, 1953; Schulz, 1978). That the suicide survivor is at a greater risk than other survivors to undertake her own self-destructive course is indicated by the number of times that identical suicides occur within the same family and by the incidence of repetitious self-destructive acts from one generation to the next. Rounsaville & Weissman (1980) presented four cases in which a relative or intimate friend made a suicide attempt within one month of the significant other's suicide, typically using either the exact or a very similar method.

There are other features of grieving which have been proposed to be somewhat unique in the experience of suicide survivorship. These include a feeling of relief, disturbed communications regarding the death, denial of the death, more prevalent depression, increased incidence of physical
ailments, and increased dependence on drinking and prescription medications. However, these features are not consistently nor commonly reported and, as Calhoun et al. (1982) indicated, are tentative as unique aspects of suicide bereavement.

The Study of Suicide Bereavement

Although many of the researchers in the field of suicidology have suggested that suicide bereavement is unique (distinct from other kinds of bereavement), there have been few serious attempts to empirically evaluate the suspected differences. While the paucity and limitations of the literature regarding survivors of suicide has been recognized (Calhoun et al., 1982; Foglia, 1977; Hatton & Valente, 1981; Henley, 1984; Henslin, 1971; McIntosh, 1985; Schuyler, 1973) the amount has remained small. However, some recent evidence suggests that the study of suicide survivorship has gained momentum. McIntosh (1985) noted that a comprehensive bibliography of suicide covering the years 1897 to 1970 listed only fifteen references related to suicide survivors. In his own bibliography, McIntosh included sixty recent titles regarding family survivors and fourteen regarding non-family survivors which have been printed since 1980.

Although survivors have received increased attention, practical and ethical considerations involved in research on the psychological aftermath of suicide continue to make it difficult to employ stringent methodological approaches to
its study (Cain, 1972; Calhoun et al., 1982; Osterweis et al., 1984; Rudestam, 1977). For the most part, the difficulties encountered in the study of suicide bereavement can be divided into two categories, methodological design and survivor contact.

Beyond the fact that most of the research consists of case studies and clinical observations, Calhoun et al. (1982) faulted survivor studies on a variety of traditional methodological criteria. These included the lack of control groups, the almost exclusive study of clinical or patient samples, the lack of operational definitions for such clinical constructs as depression, guilt, and anxiety, the retrospective nature of the investigations, and the use of specialized and nonstandardized questionnaires. Osterweis et al. (1984) suggested that the unusual methodological problems inherent in the study of suicide bereavement might be circumvented by including comparisons to bereavements following deaths which share some of the characteristics of suicide. These characteristics include suddenness of death (accident), volitional completion of death (smoking with diagnosed heart disease or drinking with cirrhosis), social unacceptability of the mode of death (Acquired Immune Deficiency Syndrome), and the type of relationship the survivor lost (child, parent, spouse).

Bereavement is a personal, sensitive, and painful experience and, as a result, its investigation is made more complicated. As Saunders (1981) warned, early bereavement
is a sensitive time to ask anyone to participate in research and care must be taken in the methods of inviting participation. This would seem to be particularly evident in the study of suicide bereavement. Wekstein (1979) reported that some suicide survivors refused to interact, found it too painful to bring up matters pertaining to their own feelings of guilt and shame, and considered intervention an intrusion that opened old wounds. Resnick (1972) discovered that some suicide survivors would become anxious and angry and might express displeasure or hostility toward anyone who would refer to the death as a suicide.

While selecting samples of adequate numbers is always a concern, it is a particularly important consideration in suicide bereavement studies. Although both Henslin (1971) and Shneidman (1971) reported that most suicide survivors were willing and eager to talk to a professional and showed little resistance when approached, other researchers have indicated a reluctance on their part to be involved in bereavement studies (Resnik, 1972; Rogers et al., 1982; Whitis, 1968). In comparison to a response rate of 82% reported by Henslin (1971), Saunders (1981), for example, reported that only 24% of the survivors she contacted agreed to participate in her study. She reported that suicide survivors surprisingly showed a greater willingness to be involved than other survivors. Of survivors contacted, 40% of suicide, 38% of natural death, 20% of accident, and 3% of homicide survivors agreed to participate. Rudestam (1977)
reported that 56% of the suicide survivors who were asked were willing to discuss the death and that 31% sometimes hedged or described the death as accidental or natural.

Finally, the study of suicide bereavement is made difficult by the lack of standardized instruments with which the impact of suicidal death could be compared with other forms of survivorship (Spence, Goldney, & Moffitt, 1984). Few instruments are available to empirically investigate the various forms of bereavement. Parkes & Weiss (1983) described the design of The Health Questionnaire, a measurement of bereavement outcome regarding health and personality factors. Calhoun, Selby, Tedeschi, & Davis (1981) designed the Aftermath of Suicide Instrument, a measurement of social reactions to families who have experienced a suicidal death. It was structured specifically to assess the way in which a survivor is likely to be viewed by others and as a reflection of the overall social climate, or social sympathy, toward survivors. Battle (1984) described a Survivor of Suicide Questionnaire which was employed in the collection of information for group therapy. Although these instruments may have utility for the special purposes for which they were designed, they are of limited utility for empirical comparisons among various groups of survivors in regard to the grief reactions typically reported to be different or unique to suicide.
Summary of the Literature

The preponderance of research and literature on the subject of suicide is evidence of a prodigious effort to understand, predict, identify, deter, and prevent self-destructive behaviors. Historically the focus of attention has been upon the person who engages in suicidal behavior, and little attention has been directed toward the experience of those whose lives continue in the aftermath of someone else's suicide. While the paucity of literature regarding survivors of suicide has been recognized, consideration of the impact that suicidal death has upon the individuals who were intimately involved with the deceased remains a neglected area of suicide research.

For many years clinical opinion has been that grief in cases of suicide is something other than normal grief and is uniquely different from that experienced in cases of death from other causes. Observations suggest that the experience of suicide survivorship is an especially severe form of bereavement, and that the surviving family members are the most directly implicated in the terrible aftermath of suicidal death. A small but provocative number of research studies offer some evidence of the particularly devastating impact of suicide upon the survivors. A compilation of clinical observations and the research efforts available suggests that there are features of grieving which are somewhat unique to suicide survivorship, namely, the experience of various reactions not concomitant with other forms of be-
reavement and the enduring difficulty in achieving resolu-
tion of the grief.

The literature includes cautions in regard to inferen-
ces regarding suicide bereavement and suggestions for more
methodologically-sound research. It is an accepted percep-
tion that methodological criteria, the lack of useful com-
parative instruments, and the sensitive nature of suicidal
bereavement make the study of suicide and its concomitant
aftermath a difficult endeavor to undertake.

The present study addressed certain specific questions
regarding suicide survivorship's uniqueness. These included
1) whether or not suicide survivors experience a different
frequency of grief reactions than other survivors, 2) wheth-
er or not grief reactions experienced by suicide survivors
are common among other survivors, 3) whether or not suicide
survivors experience any unique grief reactions not common
among other survivors, and 4) whether or not suicide survi-
vors' recovering from bereavement experience is different
than that of other survivors.
CHAPTER 2

METHOD

Purpose of Study

The purpose of this study was to compare the bereavement experience of suicide survivors with that of natural death and accidental death survivors. The primary focus of investigation was upon the presence or absence of certain factors believed to be unique to suicide bereavement and upon the quality of grief resolution two to four years after the death.

Four nonclinical groups of survivors who had experienced either suicide, accident, unanticipated natural death, or expected natural death bereavements were assessed. The accident and unanticipated natural death groups were included to control for the effects of unexpected death. Historically the unanticipated/anticipated factor in bereavement has presented difficulties in comparing suicide bereavement with natural death bereavement when the unique aspects of suicide are attributed to the unexpected nature of the death. However, the available literature indicates that the surprise factor in suicide does not, by itself, predict the grief reactions that are experienced by the survivor. Although bereavement resulting from accidental and unanticipated natural death may be expected to differ in some ways from expected natural death bereavements, all these other bereavements should be different from suicide bereavement in many important ways. Features reported to be typical of
suicide bereavement were not expected to be a part of the bereavement experience of other survivors.

It is difficult to compare bereavement experiences based primarily on cause of death if the relationship of the survivor to the decedent varies. It is accepted that the bereavement experience is different for a spouse, a parent, a child, a sibling, a lover, a friend, or an associate. As Wallace (1977) suggested, the loss a survivor experiences is roughly proportional to the level of involvement developed with the decedent. Achte (1977) added that the impact of bereavement upon the survivor is different dependent upon both the age of the decedent and of the survivor. It may be intuitively obvious that bereavement should be particularly stressful for the decedent's family members. Yet, the differences in grief reactions even among family members presents problems when investigating the impact of the cause of death. Rogers et al. (1982), suggested that the concerns and needs of children and siblings differ from those of parents and spouses and require special approaches of study. Therefore, the focus of this study was on the experiences of survivors who have suffered the loss of a husband or a wife. Additionally, the age of the survivors was limited among the four study groups.

Many of the studies evaluating the impact of suicide upon the survivors have described only the experiences of widows and, therefore, do not account for differences which might occur between the sexes (Sheskin & Wallace, 1967;
Wallace, 1973). This may be explained, in part, by the fact that a greater number of men complete suicide, resulting in greater numbers of women survivors. Also, there may be a greater reticence on the part of men to be open about their emotional experiences, especially in the case of suicide grief (Rudestam, 1977). This study included comparable numbers of men in the four study groups.

In summary, this study investigated differences in suicide, accident, unanticipated natural, and expected natural death bereavements as experienced by the male and female spouses of the decedents. The primary foci of this study were upon:

1) various demographic factors,
2) various aspects of grief often reported to be unique to suicide; and
3) the quality of reinvolvement and readjustment in life two to four years after the experience of a spouse's death.

**Hypotheses**

This study investigated the following four hypotheses:

1) The mean frequency of total grief reactions for the suicide group will be significantly different from the other three study groups, among whom there will be no significant differences.

2) On scales measuring features reported to be common to all bereavements, the mean frequency of reactions will not be significantly different among the four groups of sur-
vivors. These scales include somatic reactions and general grief reactions.

3a) On scales measuring various "unique" aspects of suicide bereavement, mean frequencies among suicide survivors will be significantly different from those of all other survivors. These scales include search for explanation, loss of social support, stigmatization, guilt, responsibility, shame, rejection, self-destructive behavior, and unique reactions.

3b) On these scales measuring various "unique" aspects of suicide bereavement, the mean frequency of reactions will not be significantly different among accidental death, unanticipated natural death, and natural death survivors.

4) On measures of levels of reinvolve and readjustment to life, suicide survivors will be significantly different from the other survivors, among whom there will be no significant differences.

Subjects

Subjects were 57 individuals who had experienced the death of a marital partner. Forty-five of the survivors were women and 12 were men. Men were included, not for purposes of sex comparisons, but in response to methodological concerns indicating that men have generally been excluded from grief studies. It has been suggested that the reported impact of suicide has been biased by studying primarily the reactions of women. Including similar numbers of males in each of the study groups was meant to balance any
sex factors across groups. The ages of the survivors at the
time they experienced the death of their spouses ranged from
24 to 48 years. The ages of the decedents ranged from 23 to
53. The amount of time which had passed since the death had
occurred was between two to four years. The length of their
marriages ranged from 16 to 349 months. The number of chil­
dren that the couples had had together ranged from none to
five (see Table 1).

Names of survivors were collected from articles and
obituaries in the Fargo Forum newspaper between the period
of February, 1982 and March, 1984. The survivors were resi­
dents of North Dakota and Minnesota who lived in communities
within a 150 mile radius of Fargo and Grand Forks. This
search identified 143 survivors meeting age, time since
death, and community proximity criteria. Two lists of sur­
vivors were compiled according to the cause of death listed
in the newspaper, namely natural death by illness (27 survi­
vors) and accidental death (38 survivors). A third list in­
cluded those for whom no cause of death was given (78 sur­
vivors). Addresses and telephone numbers of 84 survivors
(18 natural death, 22 accident, and 44 unknown cause) were
obtained from listings in their local telephone directories.
It had been anticipated that obtaining addresses from tele­
phone directories would exclude survivors who had either
moved, remarried, or were not included within the listings.
This exclusion was not entirely realized. Seven survivors
who had moved to new communities and 15 who had remarried
were contacted by forwarding mail and by locating their names in their new community directories.

Of 82 contact letters mailed, 12 were returned with no forwarding address available (3 accident, 3 natural cause, 6 unknown cause). One accident survivor's telephone had been disconnected, precluding personal contact. Contact was made with a total of 69 survivors; 57 (83%) of these survivors agreed to participate. Of the twelve who declined, four had experienced the accidental death of their spouse, one a natural illness, and seven a death by unlisted cause.

The survivors were assigned to one of four groups, determined at the time of the interview by the type of death which each survived and the concomitant form of bereavement experienced. The four groups were Suicide (SU), Accident (AC), Unanticipated Natural (UN), and Natural (NA). There were three males in the SU and AC groups, two in the UN, and four in the NA group. The SU group included 14 survivors, all but one from the no-cause-listed obituaries. The name of one of the survivors was provided by an associate of the investigator who knew the circumstances of the death. The SU group included one survivor whose spouse had been terminally ill for fourteen months, but who ultimately died of suicide. The AC group included 15 survivors who had experienced the sudden, unexpected accidental death of their spouses, including homicide but not sudden illness. The UN group included 15 survivors who had experienced the sudden, unexpected natural death of their spouses by such cause as
### Table 1
Summary of means of the four groups on subject variables.

<table>
<thead>
<tr>
<th></th>
<th>Suicide (n=14)</th>
<th>Accident (n=15)</th>
<th>Unanticipated (n=15)</th>
<th>Natural (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decedent age</td>
<td>36.00</td>
<td>35.20</td>
<td>37.80</td>
<td>40.23</td>
</tr>
<tr>
<td>Survivor age at death</td>
<td>34.35</td>
<td>34.20</td>
<td>34.33</td>
<td>39.38</td>
</tr>
<tr>
<td>Months since death</td>
<td>35.93</td>
<td>34.07</td>
<td>37.00</td>
<td>36.77</td>
</tr>
<tr>
<td>Months married</td>
<td>145</td>
<td>166</td>
<td>177</td>
<td>230</td>
</tr>
<tr>
<td>Number of children</td>
<td>2.14</td>
<td>2.80</td>
<td>2.27</td>
<td>2.92</td>
</tr>
</tbody>
</table>

Heart attack, kidney failure, and brain hemorrhage. The NA group included 13 survivors whose spouses had died of an expected, terminal illness and who had some time to prepare themselves for the eventual death. The average time between discovery of the terminal nature of the illness and the actual death was 13 months, with a range from two to forty-eight months of anticipation time.

**Procedure**

The contact of subjects included those within all three lists simultaneously. Contact was first directed toward subjects who lived within the limits of Fargo and Grand Forks. The distance from these communities was gradually increased until the 150 mile limit was reached, at which
time the accident and unknown cause lists were exhausted. In order to keep the male/female ratio balanced among the study groups, contact was ended though two males remained in the natural death list.

Contact with each survivor was accomplished in three steps. A letter of introduction and explanation of the study was mailed (see Appendix A). Within one week of the mailing, contact was made by telephone. The purpose of the call was to answer any questions the survivor might have regarding the research, to solicit participation, and to arrange a private interview. Finally, the survivor was interviewed, in private, by the investigator.

So that time between the initial contact and the interview could be kept to a minimum, only a few introductory letters were mailed, across groups, at any one time. Fourteen mailings were spaced approximately five to seven days apart.

Fifty-three of the interviews were conducted in the homes of the survivors. Several of the survivors indicated that they would rather be interviewed elsewhere. Three of these were interviewed in the author's office, and three others were interviewed in quiet, local restaurants. The average duration of the interviews was 108 minutes, with a range of 45 to 202 minutes.

The interview followed a structured format (see Appendix B). The survivor was first asked a series of background questions. These questions were intended to gather informa-
tion about the pre-bereavement circumstances of the survivor. They were considered pertinent to the possible outcome of grief, without being intrusive, overly sensitive, or too personal. They were also meant to provide the survivor time to become comfortable with the investigator. After completion of the background questions, the survivor was given the Grief Experience Questionnaire (described below). To reduce possible response demand characteristics, anonymity was emphasized. The survivor was asked not to put his/her name on the questionnaire and was assured that absolutely no personal identification would be assigned to the GEQ. After the survivor completed each of the first four pages, he/she was asked to stop and address any thoughts, feelings, or reactions that might have been generated by that page of questions. The short break provided an opportunity for the survivor to elaborate freely and more fully on any of the questions and to describe any general impressions that may have resulted from the questionnaire. When the questionnaire was completed, the survivor was asked to fold it and seal it in an envelope. Finally, the survivor was asked to respond to five more questions regarding personal experiences both with the spouse and subsequent to the death (see Appendix B). A scoring key was utilized later to facilitate comparisons of responses to the various background, demographic, and personal experience questions (see Appendix C). The values assigned to the various responses were arbitrary
and were not intended to reflect judgement of the intrinsic worth of any of the particular categories of replies.

The interviewer did not probe nor ask for elaboration beyond the survivor's spontaneous response to each question. The portions of the interview in which the survivor described reactions to the questionnaire pages and responded to the last five questions were tape recorded. This permitted the interviewer to give his full attention to the survivor and freed him from having to make notes during the meeting. Following the structured interview, the author explained the purpose of the study, answered any questions the survivor might have, and typically engaged in an extended conversation regarding the grief experiences of young adults.

A few weeks after the interview, the survivor was contacted again by telephone. The purpose of the follow-up call was to thank the survivor for participating in this research, to discuss any feelings that might have surfaced following the interview, and to facilitate possible referral for professional assistance or support. In no case did the investigator believe referral necessary.

Statistical Analyses

ANOVA's were performed to determine if there were statistically significant differences in the mean scores of the four study groups on various demographic factors, total grief reactions, eleven defined grief reactions, the first fifty-five individual questionnaire items, and on the
quality of reinvolved. The four categories of death served as the independent variable and total grief reactions, defined grief reactions, questionnaire items, and quality of reinvolved were the dependent variables.

Scheffe Procedures were performed to determine where among the four groups significant differences were located on each of the measured variables.

Supplemental ANOVA's and Scheffe Procedures were performed on Items 1-55 of the GEQ to determine which of the individual items differentiated the groups. The questionnaire items are comprised of survivor statements suggested to be common to all bereavements or to be unique to suicide. Therefore, apart from inclusion in the theoretical grief reaction subscales, each individual item may itself be considered a specific grief reaction. Although differences in grief reactions between females and males were not under investigation, supplemental T-tests were performed to indicate whether sex differences were present.

Instrumentation

Two instruments were used in this study, one incorporated into the other as a subscale (see Appendix D).

The Grief Experience Questionnaire (GEQ), developed especially for this study, consists of 76 items designed to assess 1) reactions generally regarded as common to grief, 2) various aspects considered to be unique to the suicide grief experience, and 3) the level of recovery from bereavement. The items were derived from two existing instruments
(noted below) and from suicide survivors' statements described in the literature. Initially a list of 100 possible grief reactions was compiled. In concern for asking survivors too many sensitive questions or for unnecessarily prolonging a potentially emotional interview, that number was reduced to 45 items whose content best described nine particular grief reactions common among suicide survivors. Added to these 45 suicide grief reactions were 10 items reflecting common grief reactions and 20 items measuring recovery from bereavement. The GEQ was divided into the twelve subscales listed below with name, items, description, and alpha as derived from this study.

1) Somatic Reactions (Items 1-5). This subscale is comprised of grief experiences common to all bereaved individuals. The questions were derived from the Autonomic Reaction Cluster (ARC) of the Health Questionnaire (Parkes & Weiss, 1983). The ARC is comprised of twelve questions which represent somatic symptoms likely to be affected by bereavement, including running or clogged nose, lump in the throat, chest pain, palpitations, sick feeling, frequent urination, itching, dizziness or fainting, nervousness, trembling or twitching, hot flashes, and inappropriate sweating. Parkes & Weiss reported that percentages of bereaved individuals responding to these questions were clearly differentiated from a matched comparison group of non-bereaved individuals one year after the death. No reliability or validity data was provided. (Alpha derived from this study = .79)
Item 1 of this subscale was intended to measure the survivor's general perception of his/her physical condition during the first two years of bereavement. The remaining four items were based on ARC questions which, according to Parkes & Weiss (1983), indicated the largest significant differences between bereaved and non-bereaved individuals.

2) General Grief Reactions (Items 6-10). These are questions regarded to be common to most grief experiences. (Alpha = .68)

3) Search for Explanation (Items 11-15). Death is most easily accepted when the survivor can intellectually formulate an acceptable reason for it, therefore, survivors commonly search for reasons to explain the occurrence of a death. These items reflect the suggestion that suicide survivors engage in a more difficult and more enduring search for acceptable reasons in the experience of suicidal death. (Alpha = .69)

4) Loss of Social Support (Items 16-20). Bereaved individuals often report that friends and family do not seem to be supportive enough during a period of grief. This may take the form of avoidance, abandonment of friendship, an unwillingness to listen, lack of concern and understanding, or isolation. Although the real or perceived loss of support from family and friends is commonly considered concomitant with grief, these items reflect the suggestion that generally negative social perceptions of suicide result in
more frequent and severe isolation and alienation of the suicide survivor. (Alpha = .86)

5) Stigmatization (Items 21-25). These items reflect the suggestion that suicide is perceived to reflect negatively upon and permanently mark the survivor as different than other survivors. Such stigma may result from the actual encounter of blame or gossip regarding the death or from perceptions, opinions, and prejudices that the survivor him/herself has regarding suicide. (Alpha = .88)

6) Guilt (Items 26-30). All survivors are likely to experience a sense of guilt regarding features of their marriage to the decedent. Such guilt derives from things said or done and from things failed to be said or done during the period of the marriage before the death occurred. This subscale reflects the suggestion that guilt is more frequent and severe among suicide survivors. (Alpha = .89)

7) Responsibility (Items 31-35). These items reflect the suggestion that complicity in the cause of death is often experienced by the suicide survivor. In part, this may result because of the belief that suicide can and should be prevented, or because of the perception that interactions with the decedent either led up to or actually caused the self-inflicted death. (Alpha = .88)

8) Shame (Items 36-40). These items reflect the suggestion that the experience of embarrassment regarding the cause, nature, or circumstances surrounding the death is regarded as common to suicide bereavement. (Alpha = .83)
9) Rejection (Items 41-45). While most survivors report that they sometimes sense that their spouse deserted them by dying, there is little implication that death or desertion were intentional acts on the part of the decedent. This subscale reflects the suggestion that suicide, however, often implies a deliberate abandonment and rejection of life, the spouse, and the marital relationship. (Alpha = .87)

10) Self-Destructive Behavior (46-50). Survivors are reported to be at risk of life-threatening behaviors during bereavement. Such behaviors include obvious features like suicide attempts, self-inflicted physical injuries, and driving while under the influence of alcohol or narcotics. They also include more subtle components like loss of appropriate hygiene, food, drug and alcohol abuse, and loss of concern for health. This subscale reflects the suggestion that suicide survivors are at greater risk for involvement in these behaviors. (Alpha = .76)

11) Unique Reactions (51-55). Some experiences would seem to be intuitively and inherently unique to survivorship of a suicidal death and the items on this subscale were expected to be logically outside the experience of other survivors. (Alpha = .76)

12) Quality of Reinvolve (56-75). A dependent variable like reinvolve and readjustment to life after a death is difficult to operationally define, partly because there are several ways from which it might be approached. For the purpose of this study, reinvolve and adjustment
to life was considered to be a reflection of the survivor's ability to discover satisfaction in a life changed by the death of the spouse. Furthermore, this sense of satisfaction was considered to be an expression of the degree to which the survivor perceived his/her life to have purpose and meaning. The quality of reinvolvment was measured by Crumbaugh's (1968) Purpose-In-Life Test (PIL).

The PIL was designed to assess the degree to which a person experiences a sense of meaning and purpose in life. More specifically, the scale was devised to test the thesis that lack of meaning in life results in existential frustration. Total scores on the scale range from 20 (indicating low purpose and probable dissatisfaction in life) to 140 (high purpose and probable satisfaction). Crumbaugh reported that average scores tend to skew toward the purposeful end of the scale. Examples provided of average scores among various groups include successful businessmen and professionals (Mean = 118.9, SD = 11.3) and hospitalized alcoholics (Mean = 85.4, SD = 19.4).

Crumbaugh reported a split-half reliability correlation of .85 for the PIL. Kvernen (1983) reported an alpha of .89, a one-week test-retest r of .83, and a four-week test-retest r of .86 when deriving reliability figures for the PIL. This study yielded an alpha of .95.

As a measure of recovery from grief, the PIL was incorporated into the GEQ with three changes. An item regarding suicidal thoughts was deleted because it was redun-
dant with an item on the self-destructive behavior subscale. Item 75 was added to assess the survivor's satisfaction with his/her present life compared to the life that had been shared with the deceased spouse. To maintain consistency with the other GEQ subscales, the scoring of the PIL scale was reversed so that lower range scores would indicate probable satisfaction and greater recovery. Scores in the higher ranges were suspected to indicate continuing grief reactions and lack of recovery from grief.

The internal consistency reliabilities of the total GEQ scale (alpha = .97) and the 12 GEQ subscales, being moderately high to high, indicate that the design and use of the GEQ in this study was appropriate for its intended purpose.

Question 76 concerns the survivor's frequency of contact with a counselor, psychologist, minister, priest, or other professional helper after the death of the spouse.

The 76 GEQ items are answered on Likert scales. The 55 grief reaction items have scores of 1=never, 2=rarely, 3=sometimes, 4=often, and 5=almost always. The 20 recovery items of the PIL have scores ranging between 1 and 7, one being the most positive response and seven being the most negative. The questionnaire yields a total grief reactions score and twelve subscale scores. The total grief reactions score is a summation of the Likert answers from items 1 to 55. The subscale scores are obtained by summing the individual items in each of the particular subsections, as described above. The higher the scale score, the greater is
the likelihood that a particular survivor reaction is indicated.
CHAPTER 3

RESULTS

ANOVA$s and Scheffe Procedures were performed to determine whether or not significant differences exist among the four study groups on various background, demographic, and personal experience factors, to test the four hypotheses, and to determine if significant differences exist among the four groups on each of the fifty-five GEQ grief reaction items (Item 1-55).

Demographic and Background Factors

The means, SD$s, and the results of the ANOVA$s of the four groups on decedent's age, survivor's age at the time of death, time since the death in months, length of marriage in months, and number of children, are summarized in Table 2. The ANOVA results on other background factors are as follows: the survivor's history of work during the last five years of the marriage, $F(3,53)= 0.493$; the survivor's type of work, $F(3,53)= 1.531$; the deceased spouse's work history during the last five years of the marriage, $F(3,53)= 1.430$; the spouse's type of work, $F(3,53)= 0.037$; the survivor's verbal description of the marriage, $F(3,53)= 1.893$; and the survivor's verbal description of the spouse, $F(3,53)= 2.746$. None of the differences among the groups on these factors reached statistical significance ($p > .05$).
Summary of means, standard deviations, and ANOVA results for the four groups on background and demographic factors.

<table>
<thead>
<tr>
<th>Factor</th>
<th>SUICIDE (n=14)</th>
<th>ACCIDENT (n=15)</th>
<th>UNANTIC. (n=15)</th>
<th>NATURAL (n=13)</th>
<th>F(3,53)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deced. age</td>
<td>36.00 8.28</td>
<td>35.20 7.69</td>
<td>37.80 5.37</td>
<td>40.23 5.75</td>
<td>1.436</td>
<td>NS</td>
</tr>
<tr>
<td>Surv. age at death</td>
<td>34.35 7.57</td>
<td>34.20 6.90</td>
<td>34.33 5.08</td>
<td>39.38 5.66</td>
<td>2.130</td>
<td>NS</td>
</tr>
<tr>
<td>Months since death</td>
<td>35.93 9.64</td>
<td>34.07 7.12</td>
<td>37.00 8.12</td>
<td>36.77 7.37</td>
<td>0.396</td>
<td>NS</td>
</tr>
<tr>
<td>Months married</td>
<td>145 98</td>
<td>166 75</td>
<td>177 69</td>
<td>230 72</td>
<td>2.779</td>
<td>NS</td>
</tr>
<tr>
<td>No. of child.</td>
<td>2.14 1.51</td>
<td>2.80 1.61</td>
<td>2.27 1.33</td>
<td>2.92 1.04</td>
<td>1.060</td>
<td>NS</td>
</tr>
</tbody>
</table>

* NS = p > .05

**The Hypotheses**

Hypothesis 1. The mean frequencies of the suicide survivors on Total Grief Reactions will be significantly different from those of the accident, unanticipated, and natural death survivors. The differences among the non-suicide survivors on this measure will not be statistically significant.

Hypothesis 2. The mean frequencies of common grief reactions among the four groups of survivors (as measured by the Somatic Symptoms and General Grief Reactions subscales) will not be significantly different.
Hypothesis 3-a. The mean frequencies of suicide survivors on the nine suicide grief reaction subscales (Search For Explanation, Loss Of Social Support, Stigmatization, Guilt, Responsibility, Shame, Rejection, Self-Destructive Behavior, Unique Reactions subscales) will be significantly different from those of other survivors.

Hypothesis 3-b. The mean frequencies of the accident, unanticipated, and natural death survivors on these same measures will not be significantly different.

Hypothesis 4. The mean scores of suicide survivors on measures of recovery from grief (GEQ Recovery subscale, Employment Status, Description Of Recovery, Description Of Present Life, New Relationship Involvement, Need For Counseling) will be significantly different from those of other survivors, among whom there will be no significant differences.

**Grief Reactions**

The means, SDs, and results of ANOVAs performed on the Total Grief Reactions factor and on the eleven GEQ grief reaction subscales are summarized in Table 3. The means on the eleven GEQ subscales represent the frequency of occurrence of grief reactions which the survivor reported to have experienced in the first two years after the death (5 = Never, 10 = Rarely, 15 = Sometimes, 20 = Often, 25 = Almost Always). Scheffe Procedures were performed to determine where among the four groups the significant differences were located. The results of these analyses are summarized in Table 4.
### Table 3

Summary of means, standard deviations, and ANOVA results of the four groups on total grief reactions and on the eleven GEQ grief reaction subscales.

<table>
<thead>
<tr>
<th>Scale</th>
<th>SUICIDE (n=14)</th>
<th>ACCIDENT (n=15)</th>
<th>UNANTIC. (n=15)</th>
<th>NATURAL (n=13)</th>
<th>F(3,53)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Grief React</td>
<td>164.1 48.9</td>
<td>134.4 31.6</td>
<td>123.8 31.5</td>
<td>109.9 19.9</td>
<td>6.048</td>
<td>*</td>
</tr>
<tr>
<td>Soma. Sympt</td>
<td>12.86 4.57</td>
<td>12.40 4.01</td>
<td>12.67 3.27</td>
<td>11.08 3.01</td>
<td>0.606</td>
<td>NS</td>
</tr>
<tr>
<td>Search for Explan</td>
<td>18.36 4.45</td>
<td>17.00 3.84</td>
<td>15.53 3.07</td>
<td>13.08 3.09</td>
<td>5.151</td>
<td>*</td>
</tr>
<tr>
<td>Sup. Loss</td>
<td>14.36 5.64</td>
<td>14.20 4.72</td>
<td>11.20 5.27</td>
<td>12.23 4.28</td>
<td>1.373</td>
<td>NS</td>
</tr>
<tr>
<td>Stigma</td>
<td>15.28 5.58</td>
<td>11.80 4.86</td>
<td>10.13 5.10</td>
<td>7.85 1.77</td>
<td>6.242</td>
<td>*</td>
</tr>
<tr>
<td>Guilt</td>
<td>16.50 5.36</td>
<td>14.87 4.85</td>
<td>14.60 4.94</td>
<td>12.23 4.15</td>
<td>1.759</td>
<td>NS</td>
</tr>
<tr>
<td>Respon</td>
<td>14.50 6.58</td>
<td>10.07 4.71</td>
<td>9.73 3.90</td>
<td>6.69 2.36</td>
<td>6.457</td>
<td>*</td>
</tr>
<tr>
<td>Shame</td>
<td>13.07 5.46</td>
<td>10.27 4.42</td>
<td>7.87 3.27</td>
<td>8.23 2.95</td>
<td>4.658</td>
<td>*</td>
</tr>
<tr>
<td>Reject</td>
<td>15.79 6.15</td>
<td>9.20 3.57</td>
<td>8.67 3.31</td>
<td>7.46 1.98</td>
<td>11.845</td>
<td>*</td>
</tr>
<tr>
<td>Self-Destru</td>
<td>12.00 5.22</td>
<td>9.27 2.94</td>
<td>9.80 3.32</td>
<td>9.54 2.11</td>
<td>1.716</td>
<td>NS</td>
</tr>
<tr>
<td>Unique React</td>
<td>15.00 5.19</td>
<td>10.40 3.14</td>
<td>9.20 1.78</td>
<td>8.23 1.88</td>
<td>11.480</td>
<td>*</td>
</tr>
</tbody>
</table>

NS = p > .05
* = p < .01
Summary of variables wherein suicide survivors were significantly different ($p < .05$) from non-suicide survivors. (X denotes which groups were different from suicide survivors)

<table>
<thead>
<tr>
<th></th>
<th>ACCIDENT</th>
<th>UNANTICIPATED</th>
<th>NATURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Grief Reactions</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Search for Explanation</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Stigmatization</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Responsibility</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Shame</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Rejection</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Unique Reactions</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Consistent with Hypothesis 1, significant differences were indicated between the mean frequencies of Total Grief Reactions of the suicide survivors and those of unanticipated natural, and natural death survivors. The differences between the suicide and accident survivors did not reach statistical significance. The differences among the non-suicide survivors on this measure did not reach statistical significance ($p > .05$). Hypothesis 1 is not rejected for differences among the suicide, unanticipated, and natural death survivors nor for differences among the non-suicide survivors. Hypothesis 1 is rejected for differences between suicide and accident survivors.

The relationship of the differences among the four groups of survivors on each of the eleven grief subscales is depicted in Fig. 1. Consistent with Hypothesis 2, differ-
Fig. 1. Means of the Suicide (S), Accident (A), Unanticipated Natural (U), and Natural Death (N) groups on the eleven GEQ grief reaction subscales.

(SOM=SOMATIC SYMPTOMS, GEN=GENERAL GRIEF REACTIONS, EXP=SEARCH FOR EXPLANATION, SUP=LOSS OF SOCIAL SUPPORT, STI=STIGMATIZATION, GUI=GUILT, RES=RESPONSIBILITY, SHA=SHAME, REJ=REJECTION, DES=SELF-DESTRUCTIVE BEHAVIORS, UNQ=UNIQUE GRIEF REACTIONS)

ences among the four groups on the Somatic Symptoms and the General Grief Reactions subscales did not reach statistical significance. Since the mean frequencies of common grief reactions among the survivors were similar, Hypothesis 2 is not rejected.

Consistent with Hypothesis 3-a, significant differences between the suicide survivors and the other survivors were indicated on six of the nine suicide grief reaction sub-
scales. As shown in Table 5, suicide survivors were clearly differentiated from all the other survivors on the Rejection and Unique Grief Reaction subscales, from the unanticipated and natural death survivors on the Stigmatization and Shame subscales, and from only the natural death survivors on the Search For Explanation and Responsibility subscales. The differences among the survivors on the Loss Of Social Support, Guilt, and Self-Destructive Behavior subscales did not reach statistical significance (p > .05). Hypothesis 3-a is not rejected for the Rejection and Unique Grief Reactions scales, is rejected in part for Stigmatization, Shame, Search For Explanation, and Responsibility scales, and is rejected in total for the Loss Of Social Support, Guilt, and Self-Destructive Behavior scales.

Without exception, the differences among the accident, unanticipated, and natural death survivors on the nine suicide grief reaction subscales did not reach statistical significance (p > .05). Hypothesis 3-b is not rejected.

**Recovery from Grief**

ANOVA s were performed to determine whether or not significant differences existed among the four groups on the recovery from grief measures. The means, SDs, and ANOVA results on the GEQ RECOVERY subscale (PIL) are summarized in Table 5. The results of the statistical analyses on the GEQ items relating to recovery from grief are as follows: whether or not the survivor is currently employed, $F(3,53)=0.568$; verbal description of how the survivor feels he/she
Summary of means, standard deviations, and ANOVA results of the four groups on the GEQ recovery subscale.

<table>
<thead>
<tr>
<th>Scale</th>
<th>SUICIDE (n=14)</th>
<th>ACCIDENT (n=15)</th>
<th>UNANTIC. (n=15)</th>
<th>NATURAL (n=13)</th>
<th>F(3,53)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery scale</td>
<td>X  SD</td>
<td>X  SD</td>
<td>X  SD</td>
<td>X  SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60.14 26.8</td>
<td>54.20 20.1</td>
<td>51.00 16.4</td>
<td>51.62 12.4</td>
<td>0.629</td>
<td>NS</td>
</tr>
</tbody>
</table>

NS = p > .05

has been doing since the death of the spouse, \( F(3,53)=0.675 \); the survivor's perception of the quality of life now compared to his/her prior life with the spouse (GEQ Item 75), \( F(3,53)=0.676 \); whether or not the survivor has been or is currently involved in a relationship described to be close and satisfying, \( F(3,53)=0.491 \); and how frequently the survivor engaged in professional counseling (Item 76), \( F(3,53)=0.891 \). None of the differences among the groups on these recovery measures reached statistical significance (p > .05). Hypothesis 4 can not be accepted; the Suicide group was not significantly different from the other groups on any of the recovery measures.

Supplementary Analyses

ANOVA were performed to determine if significant differences existed among the four groups on the fifty-five GEQ grief reaction items (Item 1-55). Significant differences
were indicated on eighteen of the items. The means, SDs, and ANOVA results for the items reaching statistical significance are summarized in Table 6. The means on the GEQ items represent the frequency of occurrence of a grief reaction which the survivor reported to have experienced in the first two years after the death (1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Almost Always). Scheffe Procedures were performed to determine where among the four groups the significant differences were located. The results of these analyses are summarized in the last column of Table 6.

The Suicide group was clearly differentiated from the three other groups on eight items: feeling uncomfortable revealing the cause of death (37), feeling embarrassed about the death (38), feeling like the spouse chose to leave the survivor (41), feeling like the spouse never considered what the death might do to the survivor (44), feeling that the spouse's death was a rejection (45), wondering about the spouse's motivation for not living longer (51), feeling that the spouse was somehow getting even by dying (52), and telling someone that the cause of death was something other than what it was (54).

The Suicide group was differentiated from the Accident and Natural Death groups on one item; feeling that an early sign of the impending death was missed (34). The Unanticipated Natural Death group was also significantly different from the Natural Death group on this item.
Table 6

Summary of means, standard deviations, ANOVA and Scheffe results of the four groups on the eighteen GEQ grief items which reached significant differences levels.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>SUICIDE (S=14)</th>
<th>ACCIDENT (A=15)</th>
<th>UNANTIC. (U=15)</th>
<th>NATURAL (N=13)</th>
<th>F(3,53)</th>
<th>p</th>
<th>Scheff</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>4.00 1.18</td>
<td>3.87 0.83</td>
<td>3.53 1.30</td>
<td>2.62 0.96</td>
<td>4.425</td>
<td>**</td>
<td>S/N</td>
</tr>
<tr>
<td>22</td>
<td>3.36 1.22</td>
<td>2.60 1.45</td>
<td>2.33 1.23</td>
<td>1.62 0.96</td>
<td>4.572</td>
<td>**</td>
<td>A/N</td>
</tr>
<tr>
<td>23</td>
<td>2.86 1.41</td>
<td>1.80 1.26</td>
<td>1.87 1.06</td>
<td>1.08 0.28</td>
<td>5.944</td>
<td>**</td>
<td>S/N</td>
</tr>
<tr>
<td>24</td>
<td>3.07 1.21</td>
<td>2.27 1.22</td>
<td>1.80 1.08</td>
<td>1.31 0.63</td>
<td>6.689</td>
<td>**</td>
<td>U/N</td>
</tr>
<tr>
<td>27</td>
<td>3.93 0.92</td>
<td>3.33 0.82</td>
<td>3.47 1.13</td>
<td>2.77 1.17</td>
<td>2.995</td>
<td>*</td>
<td>S/N</td>
</tr>
<tr>
<td>32</td>
<td>2.93 1.59</td>
<td>2.07 1.33</td>
<td>1.73 1.10</td>
<td>1.15 0.55</td>
<td>5.063</td>
<td>**</td>
<td>S/N</td>
</tr>
<tr>
<td>34</td>
<td>3.64 1.34</td>
<td>1.73 1.03</td>
<td>2.60 1.45</td>
<td>1.23 0.43</td>
<td>11.666</td>
<td>**</td>
<td>S/AN</td>
</tr>
<tr>
<td>35</td>
<td>2.50 1.61</td>
<td>1.93 1.03</td>
<td>1.67 0.90</td>
<td>1.15 0.55</td>
<td>3.560</td>
<td>*</td>
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</tr>
<tr>
<td>37</td>
<td>3.29 1.44</td>
<td>1.87 0.92</td>
<td>1.47 0.83</td>
<td>1.15 0.38</td>
<td>13.008</td>
<td>**</td>
<td>S/N</td>
</tr>
<tr>
<td>38</td>
<td>2.64 1.34</td>
<td>1.53 0.83</td>
<td>1.13 0.35</td>
<td>1.00 0.00</td>
<td>11.825</td>
<td>**</td>
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</tr>
<tr>
<td>41</td>
<td>3.00 1.52</td>
<td>1.40 0.83</td>
<td>1.40 0.74</td>
<td>1.23 0.60</td>
<td>9.965</td>
<td>**</td>
<td>S/AUN</td>
</tr>
<tr>
<td>43</td>
<td>2.79 1.58</td>
<td>1.87 1.13</td>
<td>1.40 0.83</td>
<td>1.38 0.65</td>
<td>4.940</td>
<td>**</td>
<td>S/UN</td>
</tr>
<tr>
<td>44</td>
<td>3.29 1.59</td>
<td>1.87 1.30</td>
<td>1.53 0.83</td>
<td>1.31 0.63</td>
<td>8.177</td>
<td>**</td>
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</tr>
<tr>
<td>45</td>
<td>3.29 1.44</td>
<td>1.47 0.83</td>
<td>1.47 0.83</td>
<td>1.39 0.51</td>
<td>12.863</td>
<td>**</td>
<td>S/AUN</td>
</tr>
<tr>
<td>51</td>
<td>3.50 1.35</td>
<td>1.33 0.90</td>
<td>1.33 0.62</td>
<td>1.31 0.86</td>
<td>18.030</td>
<td>**</td>
<td>S/AUN</td>
</tr>
<tr>
<td>52</td>
<td>2.21 1.53</td>
<td>1.13 0.52</td>
<td>1.07 0.26</td>
<td>1.00 0.00</td>
<td>7.041</td>
<td>**</td>
<td>S/AUN</td>
</tr>
<tr>
<td>53</td>
<td>3.36 1.55</td>
<td>2.67 1.54</td>
<td>2.00 0.85</td>
<td>1.54 0.78</td>
<td>5.604</td>
<td>**</td>
<td>S/UN</td>
</tr>
<tr>
<td>54</td>
<td>1.79 1.19</td>
<td>1.01 0.26</td>
<td>1.13 0.52</td>
<td>1.00 0.00</td>
<td>4.249</td>
<td>**</td>
<td>S/AUN</td>
</tr>
</tbody>
</table>

* = p < .05  ** = p < .01

Note: Location of differences among the Suicide (S), Accident (A), Unanticipated Natural (U), and Natural Death (N) survivors is indicated in the Scheffe column by a "/".
The Suicide group was differentiated from the Unanticipated and Natural Death groups on three items: feeling that the death was a negative reflection upon the survivor or family (24), feeling that the death was a deliberate abandonment (43), and feeling that the survivor could have prevented the death (53).

The Suicide group was differentiated from only the Natural Death group on six items: questioning why the spouse had to die (11), feeling like others were wondering about the couple's personal problems (22), feeling like others blamed the survivor for the death (23), wishing that certain things had not been done or spoken during the marriage (27), feeling that being a different person would have prevented the spouse's death (32), and feeling that marital problems contributed to the death (35). The Accident group was also significantly different than the Natural Death group on questioning why the spouse had to die (11).

On the remaining 37 items the differences among the four groups did not reach statistical significance (p > .05). Except for Items 11 and 34, the differences among the Accident, Unanticipated, and Natural Death groups on the fifty-five GEQ grief items did not reach statistical significance (p > .05).

To determine if male and female survivors were significantly different, t-tests were run on Total Grief Reactions, on the eleven grief reaction subscales, and on the Recovery subscale. No sex differences were indicated on any of these
variables ($p > .05$). The results of the t-tests are summarized in Table 7, Appendix E. Differences between male and female survivors on the need for counseling (Item 76) did not reach statistical significance ($p > .05$).
CHAPTER 4
SUMMARY AND DISCUSSION

Recapitulation of Findings

It is usually reported that bereavement resulting from suicidal death is a particularly devastating experience and that its impact is distinct from bereavements following other forms of death (Osterweis et al., 1984; Shneidman, 1971; Wekstein, 1979). However, it has also been suggested that bereavement features reported to be unique to suicide are not actually a result of the suicidal nature (or cause) of the death but reflect the influence of other factors present in varying degrees in all bereavements (Achte, 1977). Factors proposed to influence the expression of grief include the age of the survivor; the type, length, and quality of the relationship lost; the presence of support networks; amount of unfinished business with the deceased; the immediate circumstances of the death; the timeliness of the death; anticipation of the death; educational, economic and occupational status of the survivor (Rando, 1984).

The original purpose of this study was to compare the bereavement experience of suicide survivors with that of natural death survivors, while implementing various methodological recommendations (Cain, 1972; Calhoun et al., 1982; Osterweis et al., 1984). The survivors were a nonclinical sample, all of whom shared similar proclivities toward seeking professional counseling support consequent to bereave-
ment. Both men and women were included in this study with the relationship between survivor and deceased being marital. To account for the unexpected characteristic of sudden death, survivors who had experienced accidental and unanticipated natural death were included in the comparisons. The survivors were all young adults at the time of death. The time since the death was between two and four years. Additionally, the survivors were remarkably similar on various background factors. These included the length of marriage, the perceived quality of the marriage, the number of children surviving, economic and occupational status of the survivor, and the work histories of both the survivor and the deceased.

The present findings provide support for suggestions that bereavement in the case of suicide is different from bereavement experienced in the event of natural death (e.g., Cantor, 1975). If just the suicide and natural death survivors were compared they would differ significantly on Total Grief Reactions and on six of the nine individual grief subscales (Search for Explanation, Stigmatization, Responsibility, Shame, Rejection, Unique Reactions). However, the findings add little credence to the proposition that these differences between the two forms of bereavement are essentially a reflection of different influences resulting from the cause of death. In fact, based on the present findings, it does not seem appropriate to refer to specific grief reactions as unique to suicide bereavement. Of the reactions
examined, none were reported exclusively among suicide survivors. Each of the reactions was experienced in some degree by survivors of other forms of death. As Rando (1984) suggested, it may be the intensity of the grief reactions experienced by suicide survivors that sets their bereavement apart from normal bereavement.

Unlike Shneidman's (1972) assertion that essentially only two kinds of bereavement and recovery patterns exist; i.e., those experienced in accidental, homicidal, disaster, and naturally-caused death and those resulting from suicide; it seems more likely that the experience of reactions which occur in suicide bereavement are an accretion of reactions experienced to some degree in the other forms of survivorship. Suicide bereavement is not unique in terms of the types of reactions that comprise it. However, in terms of the consistency with which both the highest frequencies of individual grief reactions and the greatest number of total grief reactions are experienced within it, suicide survivorship may be perceived as a unique form of bereavement.

According to Hewett (1980), bereavement following in the aftermath of suicide is actually the result of the confluence of three different grief features which impact upon the survivor. First of all, there is the normal amount of grief involved in the loss of a family member. Second, there is the shock and pain of experiencing a sudden death. Third, there is the additional trauma of dealing with the unique aspects of suicide. Similar to this model of suicide
bereavement, the present findings suggest that suicide sur-
vivors experience the influence of at least four distinct
types of grief reactions. First, grief reactions which are
the normal result of losing a family member include somatic
symptoms, hopelessness, anger, guilt, loss of social sup-
port, and self-destructive behavior. Second, reactions that
result from experiencing a death that is by any means other
than natural causes and can, therefore, be perceived as hav­
ing been somehow avoidable include feeling stigmatized and
shamed by the death, feeling abandoned by the spouse, and
the perception that the death may have been preventable.
Third, grief reactions that result from the shock and pain
of experiencing a sudden death, regardless of its cause, in­
clude searching for an acceptable explanation for the death,
taking responsibility for the death, and feeling blamed for
the death. Finally, reactions that result from the addi­
tional trauma of dealing with the suicidal nature of the
death include feeling rejected by the deceased, feeling em­
barrassment over the cause of the death, wondering about the
spouse's motivation for not living longer, feeling like the
deceased was somehow getting even with the survivor by dy­
ing, and concealing the cause of death by saying that it was
something other than what it was.

Regarding recovery from bereavement, Wallace (1977)
concluded that suicide bereavement is different than others,
but its atypicality is not necessarily pathological (es­
pecially in terms of Bowlby's, 1961, description of patho­
logical). The present findings offer support for this view. The fact that suicide bereavement reflects the accumulation of different types of grief reactions and that it consistently includes greater frequencies of reactions than do other forms of bereavement does not automatically result in a poor, or complicated, outcome for the survivors. It is encouraging to note that suicide survivors indicated a capacity to recover from bereavement and to discover renewed satisfactions in life that were similar to survivors of other forms of death. The present findings suggest that the poor recovery outcomes often reported to be experienced by suicide survivors result from factors other than the cause of death, factors that are in need of further delineation.

**Grief Reactions**

Consistent with Hypothesis 1, suicide survivors reported a greater frequency of total grief reactions than any of the other survivors. Without exception, suicide survivors reported the highest frequencies on each of the eleven grief reactions. These findings indicate that, especially in regard to the frequency of total grief reactions, the bereavement experience of suicide survivors is different from that of other survivors. The findings suggest that this difference may result from an accumulative effect such as that described by Hewett (1980) in which the suicide survivor experiences grief reactions resulting from general grief, unexpected grief, and unique grief factors. The inconsistent pattern of progression among the other three groups of sur-
vivors on four of the individual grief subscales makes the influence of this accumulative effect less clear. The implications of this inconsistency is discussed below.

In support of Hypothesis 2, the present findings indicate that suicide bereavement is partly comprised of grief reactions reported to be common features of "grieving". For example, the survivors did not differ in their reports of experiencing such grief reactions as increased physical concerns; general grief experiences like feeling discomfort upon receiving condolences, difficulty in getting through each day, and initial hopelessness regarding recovery from the death; feeling anger towards the spouse; feeling somehow guilty after the death; and feeling deserted by the spouse. As implied in hypothesis two, there are grief reactions which might be described as normal concomitants to grieving the loss of a spouse, regardless of the cause of death, and which would, therefore, be expected to be experienced by most survivors. These reactions, then, might be considered among those Hewett (1980) described as aspects of normal grief.

The two elements of Hypothesis 3 were intended to confirm the presence of unique factors within the experience of suicide bereavement. Hypothesis 3-a suggests that certain features of suicide survivorship differentiate this bereavement from other forms of grieving. Hypothesis 3-b infers that grief reactions reported to be somehow unique only to suicide survivorship would not be an important aspect of the
bereavement experience of accident, unanticipated natural death, and natural death survivors. The findings offer some support to Hypothesis 3-a, but not to the extent expected. Consistent with Hypothesis 3-b, the accident, unanticipated natural death, and natural death survivors did not differ significantly on the grief subscales investigated in this study. However, this finding can not be interpreted clearly without further explanation of Hypothesis 3-a.

According to Hypothesis 3-a, suicide survivors were expected to experience the nine "unique" aspects of bereavement in significantly higher frequencies than the survivors of other types of death. Reactions that clearly differentiated the suicide survivor from the other survivors included feeling uncomfortable about revealing the cause of death, feeling embarrassed about the death, feeling like the spouse had made a choice to leave the survivor, feeling like the spouse had rejected the survivor by dying, questioning the motives of the spouse for not living longer, feeling that the spouse was somehow trying to get even with the survivor by dying, and telling others that the cause of death was something different from what it really was.

That several of the reactions typically described to be unique to suicide bereavement did not clearly differentiate suicide survivors from other survivors suggests that these reactions are also common to other bereavements. That suicide survivors reported significantly higher frequencies of certain reactions when compared to the unanticipated natural
and natural death survivors, but not from the accidental death survivors, suggests that these reactions are common to both suicide and accidental death bereavements and not to natural death bereavements whether expected or not. That suicide survivors reported significantly higher frequencies on other reactions only when compared to natural death survivors and not to accident or unanticipated natural death survivors, suggests that such reactions are common features of all but expected natural death bereavements.

Contrary to much of the earlier suicide research, the findings from this study indicate that some of the grief reactions which have been suggested to differentiate suicide bereavement from other forms of bereavement do not, in fact, do so. Included among these reactions are guilt, loss of interpersonal support, and self-destructive behavior. Returning to Hewett's (1980) cumulative description of suicide bereavement, these reactions are more appropriately included among normal grief reactions. The fact that these reactions are not unique to suicide but are common to all bereavements may explain the inconsistency in the findings regarding Hypothesis 1 noted above. The frequencies of non-suicide survivors on measures of common grief reactions would be expected to be similar enough to render the pattern of their differences inconsequential.

The second influence described by Hewett (1980) to be inherent within suicide bereavement is the impact of sudden and unexpected death. If the unexpected nature of a death
is suggested to have an additional impact upon the survivor, then it would be expected that survivors who experience an unexpected death, regardless of its nature, would suffer grief reactions not common to anticipated death. In the context of the present study, it is suggested that suicide survivors would be different from anticipated natural death survivors in some way, but not from other survivors who experienced an unexpected death. The findings do, in fact, offer strong evidence for this suggestion. Reactions which differentiated suicide survivorship from only the expected natural death survivors but not from any other survivor included searching for an acceptable explanation for the death, taking responsibility for the death, and feeling blamed for the death. There were no significant differences among the suicide, accident, and unanticipated natural death survivors on these reactions. Therefore, it is more likely that the protracted search for an acceptable explanation for the death, the tendency to somehow feel personally responsible for the death, and the experience of encountering or feeling blamed for the death are more the effects of the unexpected nature of suicidal death than than they are unique features of suicide bereavement itself as previously suggested (Wallace, 1977; Battle, 1984).

There is some indication from these findings that certain grief reactions are not consistently experienced among sudden and unexpected death survivors. Bereavement following sudden and unexpected death is also influenced by the
specific cause of death. This is reflected in the fact that the frequency of many of the reactions consistently differentiated the suicide survivors from the expected natural death survivors, but these same reactions varied in frequency among the suicide, accident, and unanticipated natural death survivors. In comparison to natural death, whether it be expected or unanticipated, suicide results in the survivor's feeling stigmatized and shamed by the death, feeling deliberately abandoned by the deceased, and feeling like the death was personally preventable by the survivor. Accidental death survivors also experienced the feelings of being stigmatized and shamed by the death, of being abandoned by the deceased, and of failure to personally prevent the death. Reactions suicide survivors reported significantly more frequently than anticipated and unanticipated natural death survivors but not significantly more frequently than accident survivors can not be considered truly unique to suicide.

The present findings also provide some evidence that suicide survivorship does include grief factors not common in other bereavements and may be considered unique to suicide bereavement. For example, the suicide survivor is more likely than other survivors to feel rejected by the deceased, to feel embarrassment over the cause of the death, to wonder about the spouse's motivation for not living longer, to feel like the deceased was somehow getting even with the survivor by dying, and to conceal the cause of death by
saying that it was something other than what it was. These reactions, then, would reflect the third impact experienced by suicide survivors as described by Hewett (1980).

That suicide and accident survivors were not significantly different in regard to feeling stigmatized, shamed, abandoned, and unable to prevent the death of a spouse leads to the conclusion that some of the features suggested to be unique to suicide are not necessarily related to either the suicidal or the unexpected nature of the death, but are more likely the result of the death occurring by means other than natural causes. Therefore, a fourth factor might be added to Hewett's (1980) hierarchy of grief reactions within suicide bereavement. That is, suicide bereavement includes features that are common to death that occurs by any means other than natural cause.

Recovery From Grief

The second focus of this investigation was upon the quality of grief resolution two to four years after the experience of the death of a spouse. Hypothesis 4 proposed that levels of reinvolvement and readjustment to life would be reported to be significantly different among suicide survivors when compared with other survivors. No significant differences on recovery subscales were expected to be reported among the other survivors.

In the present study, levels of recovery were measured by the survivor's reported capacity to find meaning and satisfaction in his/her present life, the achievement of some
level of independence as indicated by the survivor's current employment, the survivor's description of both how he/she perceives him/herself to be doing since the death and how he/she perceives the current life to be in comparison to the one shared with the spouse, the continued need for some professional counseling; and finally, whether or not there is involvement in a new, satisfying relationship.

This study included the broad variety of recovery from bereavement measures in an attempt to recognize and acknowledge the difficulties encountered in determining the resolution of grief. Recovery from, or resolution of, grief is a difficult factor to measure. For one thing, there has been some suggestion that grief does not ever completely end. There are some aspects of grief which can be said to continue for the remainder of the survivor's life, e.g., sad memories, longing or loneliness, and tearfulness at anniversaries. Although the occurrence of such experiences may become less frequent, less enduring, and less emotionally-laden with the passage of time, they do not end. Therefore, recovery-from-grief measures are more assessments of the degree to which resolution has occurred than they are measures of whether or nor not grief has been resolved.

Another difficulty in bereavement studies is the selection of specific aspects of the experience which might reflect the degree of grief resolution. Many variables have been proposed to indicate the abeyance of grief and the return to a "normal" life. Parkes & Weiss (1983) suggested
that it is normal for survivors to recover from grief in the sense that they replan their lives and achieve a new and independent level of functioning. Recovery from bereavement, then, is typically marked by the decreased presence of grief reactions, by the establishment, maintenance, and involvement in helpful and gratifying relationships, and by the achievement of a new quality of satisfaction in life. Good recovery outcomes are also characterized by emotional investment in the present life, by hope regarding the future, and by a return to a genuine capacity for experiencing gratification. Movement toward remarriage is also used as an indication of recovery from grief (Sheskin & Wallace, 1967; Schuyler, 1973; Parkes & Weiss, 1983).

There were no significant differences among the survivors on any of these measures of recovery, and therefore, no evidence to support Hypothesis 4. Suicide survivors reported no greater difficulty in recovering from bereavement than did other survivors. They were similar to all other survivors in their capacity to discover satisfaction in life, in their descriptions of how they are presently getting along after the death of the spouse and of how they view their present lives compared with life as it was shared with their spouses, in their present employment status, in the development of new satisfying relationships, and in the level of need for continuing professional counseling. The suicide survivors did not appear to be "stuck" in their
grieving, nor to be in the state of cold isolation that Lindemann & Greer (1953) described.

Although the majority of research has indicated that recovery from suicide bereavement follows a different course than that experienced in other bereavements, these findings support a viewpoint that has been expressed by few researchers. Shepherd & Barraclough (1974) stated that rather than there existing great differences between suicide and other survivors and rather than suicide being especially damaging to the survivor, the spouses of suicides resembled the survivors from all causes. Demi (1978) also reported that suicide survivors did not differ significantly from accident or unanticipated natural death survivors in regard to overall satisfactory adjustment up to two years after the death. The present findings suggest that suicide survivors do not differ from other survivors in their reported capacity to find meaning and satisfaction in their present lives, in their ability to achieve some level of independence, in their descriptions both of how their lives have been since the death and of how they perceive their current lives to be in comparison to the ones shared with their spouses, in any continuing need for professional counseling, nor, finally, in whether or not there is involvement in new, satisfying relationships.

Conclusions & Discussion

Conclusions regarding the experience of suicide bereavement derived from the present data include:
1. Suicide survivors consistently experience more grief reactions than other survivors.

2. Suicide bereavement is comprised of four distinct types of grief reactions, i.e., common grief reactions, other-than-natural death reactions, unexpected death reactions, and suicidal death reactions which are rarely experienced in other bereavements.

3. Accidental death is more similar to suicide in its effect, whereas unexpected natural death is more similar to natural death in its impact.

4. Among suicide survivors, the course and quality of recovery from grief is not different from that of other survivors.

5. Recovery from grief is not determined by the type of death experienced nor by the grief reactions occasioned by the death. Instead, factors more critical than cause of death and concomitant grief reactions influence both the course of bereavement and the quality of resolution.

6. Complications reported regarding bereavement concomitant to suicide reflect the influence of factors other than cause of death and are in need of further research attention.

The description of suicide bereavement has primarily been based on small-n or single-n case studies, clinical observations, or theoretical conjecture and speculation. The result has been a pervasive impression that suicide bereavement is more intense, more severe, and fraught with complications and myriad unique grief reactions when com-
pared to other forms of bereavement. There have been few empirical comparisons of different bereavements to test this impression, and those studies which have been reported have been criticized for various methodological weaknesses. The question has remained whether the differences suggested to be unique to suicide bereavement truly reflect the impact that cause of death has on survivors or whether they reflect imperfections and artifacts of the research itself.

The findings of this study, employing recommended methodological constraints, indicate that the depiction of suicide bereavement in much of the literature is questionable. Many of the grief reactions reported to be unique to suicide seem unlikely to result from that cause of death, per se. Previous conclusions have been distorted by lack of control groups, age disparities among survivors, differences in the type, duration, and quality of the relationship lost, and differences in the psychological, economic, and occupational status of the survivors.

Suicide bereavement is not unique in composition or in course. It is comprised primarily of grief reactions common to other forms of bereavements, including natural death, both expected and unanticipated, and accidental death. There seem to be no reactions truly unique to suicide bereavement insofar as reactions, infrequent to other forms of grieving, are reported by survivors who have experienced non-suicidal death. The unique aspect of bereavement following self-inflicted death is not in the reactions themselves, but in
the consistency with which rare reactions (e.g., feeling rejected by the deceased, sensing a motive of revenge in the death, and denying the cause of death) are experienced.

The preponderance of literature on suicide bereavement suggests also that these survivors take longer in their recovery from grief and typically do not achieve the same quality of resolution as other survivors. That the present findings regarding recovery from suicide bereavement are inconsistent with these conclusions is both intriguing and encouraging. Certainly, that suicide survivors consistently experience more grief reactions throughout their bereavement than do other survivors yet display the same level and quality of resolution two to four years after the death merits further consideration.

The inconsistency between the present findings and previous findings might be explained in several ways. First, as mentioned above, the present study incorporated a number of methodological constraints that previous studies have lacked. Second, this study included an entirely nonclinical sample. Most research has been conducted exclusively with survivors actively engaged in some form of counseling or psychotherapy. The influence various pathologies of these survivors might have upon findings complicate conclusions regarding the impact of suicidal death. As Foglia (1977) stated, studying a clinical sample affords little insight into the dynamics of successful modes of bereavement. She concluded that using nonpatient survivors would contribute
to a more complete and accurate understanding of the suicide survivor experience. Rudestam (1977) included nonclinical respondents and reported grief reactions among suicide survivors similar to those of accident and natural death survivors. Like those of the present study, such results lend credence to Foglia's assertion.

A third factor contributing to the inconsistency of the present findings with previous findings regarding recovery is related also to the use of clinical or nonclinical survivors. Calhoun et al. (1982), Parkes & Weiss (1983), and Shepherd & Barraclough (1974, 1976) suggested that the intensity, duration, and general outcome of bereavement following suicide is influenced by the quality of the marriage which preceded the death. Many reports of complicated recovery from suicide bereavement have been based on clinical samples in which previous marital discord had been prevalent. Therefore, the reported poor outcomes of suicide bereavement may reflect the quality of disrupted marriages moreso than the effects of suicidal death, per se. This study addressed the issue of the status of the pre-death relationship between the survivor and the deceased. Investigating a nonclinical sample does not ensure that dysfunctional or troubled marriages are excluded from study. In this study, some survivors reported alcoholic or abusive marriages, previous separations with the deceased, and impending divorces. Though decidedly in the minority, these descriptions were provided by suicide, natural death, and
accident survivors alike. Positive or neutral descriptions of the marriage were more frequent among the survivors. In fact, the descriptions of both the prior marriage and of the deceased spouse as a person reported in the course of the present study were remarkably similar across the four study groups. The similarity of marital relationships among the survivors is believed to have contributed significantly to the findings regarding grief resolution.

A fourth factor influencing the present recovery findings is that there appear to be other important differences among the survivors interviewed for this study when compared to those included in previous research efforts. For example, the present survivors all had educations of at least high school level. They were either already employed during the marriage, were able to find work after the death, or were financially stable enough to remain at home after the death without overwhelming economic concerns. Although many of the survivors experienced some loss of social support after the death, few reported being socially isolated or alienated from family, friends, or society in general. None of the survivors displayed overt or remarkable psychological, emotional, or intellectual instability nor was there indication of any severe impairment of interpersonal functioning. As was suggested above, the interaction of such factors is believed to influence the course of bereavement and recovery moreso than actual cause of death.
Bereavement Studies

Suggestions have been made that the study of grief is a difficult task to undertake because of the survivor's sensitivity to discussing the details of the death and their experiences afterwards (Saunders, 1981) and that suicide survivors might be hesitant or hostile if approached about their grief experiences (Resnick, 1972; Wekstein, 1979). No such difficulties were encountered when conducting this study. The majority of survivors who were contacted displayed a great willingness to meet and discuss their experiences with the author. Each was cordial, pleasant, and open. The reasons that the survivors gave for their participation were varied. Some said that they agreed to be interviewed because they thought it would be nice if their experiences might be helpful to others. Some survivors hoped they would learn more about grief, while others hoped to find out how they were doing in comparison with other survivors. Finally, some survivors reported that they were simply curious to find out more about the research that was being conducted. The twelve survivors who declined to be in this study consistently gave the same reasons for not doing so. These reasons included the feeling that the survivor was over the death and did not care to bring it back up, the feeling that the survivor was not yet over the death and that talking about it would be too traumatic, and the feeling, given by three survivors who had remarried, that discussing the death of their former spouse might be somehow
disruptive to their present marriage. None of the survivors who declined were adamant about doing so, and although there was no attempt beyond the content of the initial contact letter to further persuade the survivor to participate, the author felt that it would have required no more than another letter and telephone call to these survivors to elicit their response. Upon follow-up contact, the survivors indicated that they had enjoyed the opportunity to talk openly about their experiences and felt that they had benefitted from doing so.

**Limitations of the Study**

Calhoun et al. (1982) included the retrospective nature of suicide bereavement studies among methodological flaws which weakened conclusions regarding suicide survivorship. Considering the retrospective nature of this study, many of the survivors stated that, had they been contacted any sooner, especially in the first two years of bereavement, they would have been more reluctant to participate in any grief research. This attitude was particularly apparent among the survivors who were just two years or so beyond the experience of the death. Several survivors stated that, had they been contacted between one month to six months earlier, they would not have wanted to discuss their experiences with the author. This may indicate that some previous difficulties with survivor participation may have resulted from contacting the survivors too soon in the grief process. It may suggest that, in the case of grief studies, it is both nec-
necessary and ethically sensitive to conduct retrospective re-
search.

A primary limitation of the present study is the utili-
zation of a nonstandardized questionnaire. Although using a
valid, standardized questionnaire would have been empirically
ideal, there is currently no instrument that has been
widely used in the study of grief in general. Additionally,
there is no single instrument specifically constructed to
measure individual grief elements suggested to be unique to
suicide. For purposes of this study, there was no instru-
ment designed to measure the grief reactions reported to be
inherent to suicide bereavement. Statistical analysis and
standardization of the Grief Experience Questionnaire could
be beneficial for use in similar empirical studies of sui-
cide bereavement and for the clinical identification of sur-
vivors experiencing severe or complicated bereavement reac-
tions. The internal consistency reliabilities that were
obtained in the analyses of the questionnaire suggest its
research practicality. Apart from these reliability esti-
mates of the Grief Experience Questionnaire, there is evi-
dence in support of the content and face validity of this
instrument. As the survivors answered the items of the
questionnaire, their remarks indicated an ability to iden-
tify the intent of the subscales. Such remarks included:
"these seem normal"; "I guess everyone goes through this";
"these seem to be about guilt"; "these questions seemed to
be about feeling responsible"; "I guess everyone feels like
their spouse deserted them"; "everyone who loses a spouse feels like they lose other friends and family, too"; "these questions aren't like the other ones"; "I don't think anyone whose spouse died from an illness would feel like these questions say".

Additional Comments

The present findings and the conversations that took place with the survivors during the interviews suggest several general comments regarding bereavement. First of all, the loss of a spouse to a young adult is, in most cases, a traumatic and devastating experience, regardless of the cause of death. Typically the death is immediately followed by a period of shock or numbness in which the survivor is little aware of anything beyond the loss. This state may continue anywhere from a few weeks to several months after the death. Gradually there follows a long period of time in which the survivor deals with the reality of the death and the reactions which arise consequent to it. The survivors reported that the most troubling and intense of the emotional reactions began to subside in the time between the first and second years after the death. During the third and fourth years after the death, the survivors reported that they felt more emotionally removed from the death, were more actively engaged in building new lives, and were more able to find new satisfactions. However, few survivors, including those who had remarried after the death, believed that their
grief was finished or that they had recovered completely from the death.

Bereavement research has been conducted predominantly with female survivors. Though males were included in this study for methodological concerns and comparisons of sex differences among grief experiences exceeds expressed purposes of study, the present findings do suggest that sex differences may not significantly influence the course of bereavement.

Comparing the bereavement experiences of young spouses with those of older individuals also goes beyond the empirical limits of this study. However, the interviews suggest several differences which seem intuitively supportable. The first is that young adults who experience the death of a spouse are typically unprepared for the occurrence of such an event. Even when a terminal diagnosis has been made, a young spouse seems to hold on to the belief that a young person will not soon die. Second, these young spouses are often the only person in their social age group who have experienced a marital death, and they find that none of their friends can understand their experiences. They are likely to have fewer peers to turn to for advice and support, and may find it more necessary to seek out new social groups than do older survivors. Third, a young person whose spouse dies not only loses all that is concomitant to a marital relationship, but also loses a great portion of what was expected of the future. Typically, survivors talked of
missing the decedent at future graduations, weddings, anniversaries, vacations, retirements, etc. It seems that young couples may focus more of their attention on the future together, whereas older couples spend more of their attention looking back upon their lives together. Therefore, a younger spouse might experience more of a loss, at least in regard to the shared life in which the spouse was a part. Finally, the experience of a younger spouse is typically different because of the presence of children still living in the home. The most consistent concern voiced among the survivors was for their children and the effects that the loss of the spouse might have upon them. Having sole responsibility for children while experiencing the trauma of bereavement goes well beyond the grief experienced by individuals without children in the home.

Another observation resulting from the interviews is that, while there are certainly elements which are common to grief regardless of its cause, and while there are elements which might be considered to be common only to certain types of death, it seems evident that the manner in which a person grieves is unique to that individual. As others have indicated, the cause of death does not necessarily determine the course of bereavement independently of other variables. For example, among the suicide survivors were spouses who reported few enduring negative reactions as a result of the nature of the death and who indicated extraordinary recovery from the loss of the spouse. On the other hand, there were
among the natural death survivors those who experienced high levels of negative experiences and indicated that recovery from grief was an ongoing and difficult process. It is likely that the ultimate expression of any grief reaction and the course which bereavement and recovery from it follow are determined by a host of factors which go beyond the influence of the cause of death. Among the factors which these survivors credited for helping them through their grief were the presence of children in the home for whom they felt a responsibility to be strong, supportive and understanding family and friends, strong religious beliefs, confidence that satisfaction could be found in the future, and having been employed during their marriage.
APPENDIX A

LETTER OF INTRODUCTION

Dear ________,

I would like to ask for your help in research that would be of benefit to me, to others, and possibly to yourself. I am presently completing my last year of Doctoral course work in Counseling Psychology at the University of North Dakota and am contacting people in both North Dakota and Minnesota who have shared a similar experience. In a review of obituaries, it was noted that you have suffered the death of your spouse within the last several years. It is widely accepted that the loss of a spouse through death is one of the most traumatic and stressful events that a person can experience. The turmoil that we face at such a moment can often be overwhelming, and time must pass for us to resolve the grief we experience. It is likely that many of your reactions to the death are shared by others. At the same time, some of your experiences may have been unique.

I am hoping to obtain information about some of the kinds of experiences one might face after the death of a spouse. The information that you provide about your own experiences could be very worthwhile not only in helping others, like myself, to understand the grief experience, but could also be useful in identifying the special needs of adults when they lose a spouse. I hope that information you provide will lead to the development of more effective ways of meeting the special needs of those who experience this singularly stressful event.

Within the next couple of days, I will call you to see if you would be willing to provide information for this study and to answer any questions you might have about the research I am conducting. If you do care to help me, I would like to set up a time when we could meet privately for an interview. In addition to answering some questions, I will ask you to complete a questionnaire which asks that you circle choices to various items. It is my estimate that we would need about an hour of time together. You may find that many of the questions are of a personal nature. I would like to assure you that all the information that you provide will be received in a sensitive manner and will be kept in strictest confidence. Your name will not be identified with the questionnaire nor with any of your other responses. It is hoped that this will allow you to be as open as possible in your responses, but it will also protect your privacy. After you have completed the questionnaire, I will have you seal it in an envelope. The envelopes of all those
who meet with me will be collected together so that it will not be possible to determine the identity of anyone who completes them. There will be absolutely no connection between your name and your questionnaire.

After a few weeks have passed, I will call you once again. You may find that talking about your grief experiences will revive memories of the death. The purpose of my follow-up telephone call will be to ask you about further reactions you may have had to meeting with me and to discuss with you any feelings that might have surfaced afterwards. You may find that completing the questionnaire and discussing your reactions with me may help you clarify and better understand the experiences you had when your spouse died. It is likely that there will be no need for further contact between us after my follow-up call.

Thank you in advance for any help you might be able to give me. I will talk with you soon. If you should like to contact me prior to hearing from me, you may call and leave a message at the University of North Dakota Counseling Department, (701) 777-2729.

Sincerely,

Terence W. Barrett
APPENDIX B

INTERVIEW FORMAT

1. Introduction and explanation of interview and questionnaire.

2. Background information:
   - Your age at the time of ______'s death ______
   - Years/Months married ________________
   - Years/Months since death ______________
   - Children? YES NO # _______
   - Employed in last 5 years of your marriage? YES NO
      Full-time? Part-Time? Off-On?
   - What kind of work? __________________________
   - Employed now? YES NO
   - Spouse employed during last 5 years of marriage? YES NO
      Full-Time? Part-Time? Off-On?
   - What kind of work? __________________________
   - Was there any time before the death for you to prepare for it? NO YES How much? __________________________

3. Questionnaire:
   - Do you have any thoughts, feelings, or reactions to those questions (Page 1)?
   - Do you have any reactions to those questions (Page 2)?
   - Do you have any reactions to those questions (Page 3)?
   - Do you have any reactions to those questions (Page 4)?

4. How do you feel you have been doing since _____'s death?

5. How would you describe your life with _______ prior to his/her death?

6. Have you been involved in a satisfying, close relationship since _______'s death?

7. How would you describe _______ as a person?

8. Looking back, is there anything you can think of which would have made your period of grief to this time any easier?

9. Explanation of study, interviewer's remarks and impressions, discussion of grief, and conclusion of interview.
APPENDIX C

SCORING KEY

Work History

0 = Unemployed
1 = Intermitent
2 = Part-time
3 = Full-time (at least 9 months per year)

Work Type

0 = Unemployed
1 = In home (Babysitting, Crafts, Avon)
2 = Unskilled (Clerk, Cashier, Postal)
3 = Manual labor/Construction
4 = Farming/Own business
5 = Office work/Secretarial
6 = Managerial/Skilled trade/Salesperson
7 = Professional/Executive (any vocation requiring at least a college degree)

Description of Marriage/Spouse/How doing since/Life now

1 = Predominantly negative
2 = Negative with some positive
3 = Neutral; neither predominantly positive nor negative
4 = Positive with some negative
5 = Predominantly positive

Employed now/New relationship

0 = No
1 = Yes
APPENDIX D

GRIEF EXPERIENCE QUESTIONNAIRE

Please do not put your name on this questionnaire.
Please circle your sex.  F  M

What was the cause of your spouse's death (circle one)?
Suicide  Accident  Homicide  Natural (please specify)

In completing the items of this questionnaire, please think back upon your experiences since the death of your spouse. You may find that some of the questions asked do not apply to you. For these, you should circle "never". For those experiences that you do remember, please try to determine how long they lasted. You may find that some were brief, while others lasted a long time before they finally stopped. Other of the items you may find that you are still experiencing. After considering if an item applies to you, try to judge, as best you can, how frequently you experienced it in the first two years after your spouse's death.

Use these answers unless otherwise indicated:

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Almost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Since the death of your spouse, how often did you:

1. Think that you should go see a doctor?
   1  2  3  4  5

2. Experience feeling sick?
   1  2  3  4  5

3. Experience trembling, shaking, or twitching?
   1  2  3  4  5

4. Experience light-headedness, dizziness, or fainting?
   1  2  3  4  5

5. Experience nervousness?
   1  2  3  4  5

6. Think that people were uncomfortable offering their condolences to you?
   1  2  3  4  5
7. Avoid talking about the negative or unpleasant parts of your marriage?
   1  2  3  4  5

8. Feel like you just could not make it through another day?
   1  2  3  4  5

9. Feel like you would never be able to get over the death?
   1  2  3  4  5

10. Feel anger or resentment towards your spouse after the death?
    1  2  3  4  5

PLEASE STOP

11. Question why your spouse had to die?
    1  2  3  4  5

12. Find you couldn't stop thinking about how the death occurred?
    1  2  3  4  5

13. Think that your spouse's time to die had not yet come?
    1  2  3  4  5

14. Find yourself not accepting the fact that the death happened?
    1  2  3  4  5

15. Try to find a good reason for the death?
    1  2  3  4  5

16. Feel avoided by friends?
    1  2  3  4  5

17. Think that others didn't want you to talk about the death?
    1  2  3  4  5

18. Feel like no one cared to listen to you?
    1  2  3  4  5

19. Feel that neighbors & inlaws did not offer enough concern?
    1  2  3  4  5

20. Feel like a social outcast?
    1  2  3  4  5

21. Think people were gossiping about you or your spouse?
    1  2  3  4  5
22. Feel like people were probably wondering about what kind of personal problems you and your spouse had experienced
   1 2 3 4 5

23. Feel like others may have blamed you for the death?
   1 2 3 4 5

24. Feel like the death somehow reflected negatively on you or your family?
   1 2 3 4 5

25. Feel somehow stigmatized by the death?
   1 2 3 4 5

PLEASE STOP

26. Think of times before the death when you could have made your spouse's life more pleasant?
   1 2 3 4 5

27. Wished that you hadn't said or done certain things during your marriage?
   1 2 3 4 5

28. Feel like there was something very important you wanted to make up to your spouse?
   1 2 3 4 5

29. Feel like maybe you didn't care enough about your spouse?
   1 2 3 4 5

30. Feel somehow guilty after the death of your spouse?
   1 2 3 4 5

31. Feel like your spouse had some kind of complaint against you at the time of the death?
   1 2 3 4 5

32. Feel that, had you somehow been a different person, your spouse would not have died?
   1 2 3 4 5

33. Feel like you had made your spouse unhappy long before the death?
   1 2 3 4 5

34. Feel like you missed an early sign which may have indicated to you that your spouse was not going to be alive much longer?
   1 2 3 4 5
35. Feel like problems you and your spouse had together contributed to an untimely death?
   1 2 3 4 5

36. Avoid talking about the death of your spouse?
   1 2 3 4 5

37. Feel uncomfortable revealing the cause of the death?
   1 2 3 4 5

38. Feel embarrassed about the death?
   1 2 3 4 5

39. Feel uncomfortable about meeting someone who knew you and your spouse?
   1 2 3 4 5

40. Not mention the death to people you met casually?
   1 2 3 4 5

   PLEASE STOP

41. Feel like your spouse chose to leave you?
   1 2 3 4 5

42. Feel deserted by your spouse?
   1 2 3 4 5

43. Feel that the death was somehow a deliberate abandonment of you?
   1 2 3 4 5

44. Feel that your spouse never considered what the death might do to you?
   1 2 3 4 5

45. Sense some feeling that your spouse had rejected you by dying?
   1 2 3 4 5

46. Feel like you just didn't care enough to take better care of yourself?
   1 2 3 4 5

47. Find yourself totally preoccupied while you were driving?
   1 2 3 4 5

48. Worry that you might harm yourself?
   1 2 3 4 5

49. Think of ending your own life?
   1 2 3 4 5
50. Intentionally try to hurt yourself?  
1  2  3  4  5

51. Wonder about your spouse's motivation for not living longer?  
1  2  3  4  5

52. Feel like your spouse was somehow getting even with you by dying?  
1  2  3  4  5

53. Feel that you should have somehow prevented the death?  
1  2  3  4  5

54. Tell someone that the cause of death was something different than what it really was?  
1  2  3  4  5

55. Feel that the death was a senseless and wasteful loss of life?  
1  2  3  4  5

PLEAS STOP

For each of the remaining items, circle the number that would be most nearly true of you, now, at the present time. Note that the numbers always extend from one extreme feeling to its opposite kind of feeling. "Neutral" implies no judgement either way. Try to respond in the neutral as little as possible.

56. I am usually:

1  2  3  4  5  6  7
Exuberant/Enthusiastic
Neutral
Completely bored

57. Life to me seems:

1  2  3  4  5  6  7
Always exciting
Neutral
Very routine

58. In life I have:

1  2  3  4  5  6  7
Clear goals & aims
Neutral
No goals at all

59. My personal existence is:

1  2  3  4  5  6  7
Purposeful & Meaningful
Neutral
Utterly meaningless, without purpose

60. Every day is:

1  2  3  4  5  6  7
Constantly new & different
Neutral
Exactly the same
61. If I could choose, I would:
   1 2 3 4 5 6 7
   Like another life just Neutral Prefer never to
   like the one I have now have been born

62. After retiring, I would:
   1 2 3 4 5 6 7
   Do some of the exciting Neutral Completely loaf the
   things I have always wanted rest of my life

63. In achieving life goals, I have:
   1 2 3 4 5 6 7
   Reached fulfillment Neutral Made no progress
   at all

64. My life is:
   1 2 3 4 5 6 7
   Full of exciting Neutral Empty, filled with
good things despair

65. If I should die today, I would feel that my life has been:
   1 2 3 4 5 6 7
   Very worthwhile Neutral Completely
   worthless

66. In thinking of my life, I:
   1 2 3 4 5 6 7
   Always see a Neutral Often wonder
   reason for being why I exist

67. As I view the world in relation to my life, the world:
   1 2 3 4 5 6 7
   Is fully Neutral Completely
   meaningful confuses me

68. I feel like I am:
   1 2 3 4 5 6 7
   Very responsible Neutral Very irresponsible

69. Concerning man's freedom to make his own choices, I believe we:
   1 2 3 4 5 6 7
   Are free to make Neutral Are bound by
   all our choices many limitations

70. With regard to death, I am:
   1 2 3 4 5 6 7
   Prepared & unafraid Neutral Afraid & unprepared
71. I regard my ability to find a meaning, purpose, or mission in life as:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very great</td>
<td>Neutral</td>
<td>Practically none</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

72. My life is:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my control</td>
<td>Neutral</td>
<td>Controlled by external factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

73. Facing my daily tasks is:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleasurable &amp; satisfying</td>
<td>Neutral</td>
<td>Painful &amp; boring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

74. I have discovered:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear goals &amp; a satisfying life</td>
<td>Neutral</td>
<td>No mission or purpose in life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

75. Compared to what it was with my spouse, my life now is:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better in many ways</td>
<td>Better in some ways</td>
<td>Exactly the same</td>
<td>Worse than before</td>
<td>Far worse in every way</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

76. In the time since my spouse's death, I sought the help of a counselor, psychologist, minister, priest, or other professional helper:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Once</td>
<td>Twice</td>
<td>Sometimes</td>
<td>Regularly</td>
<td>Often</td>
<td>Always</td>
</tr>
</tbody>
</table>
### APPENDIX E

**Table 7**

Summary of means, standard deviations, and t-test results comparing male with female survivors on total grief reactions, the eleven GEQ grief reaction subscales, and the recovery subscale.

<table>
<thead>
<tr>
<th>Scale</th>
<th>FEMALE SURVIVORS (n=45)</th>
<th>MALE SURVIVORS (n=12)</th>
<th>F(1,53)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Total Grief React</td>
<td>132.29</td>
<td>40.63</td>
<td>137.25</td>
<td>33.83</td>
</tr>
<tr>
<td>Soma. Sympt</td>
<td>12.31</td>
<td>3.97</td>
<td>12.17</td>
<td>2.86</td>
</tr>
<tr>
<td>Gen. React</td>
<td>14.84</td>
<td>4.14</td>
<td>14.58</td>
<td>3.53</td>
</tr>
<tr>
<td>Search for Explan</td>
<td>16.16</td>
<td>4.22</td>
<td>15.67</td>
<td>3.45</td>
</tr>
<tr>
<td>Sup. Loss</td>
<td>13.18</td>
<td>5.11</td>
<td>12.33</td>
<td>5.07</td>
</tr>
<tr>
<td>Stigma</td>
<td>11.51</td>
<td>5.47</td>
<td>10.58</td>
<td>4.42</td>
</tr>
<tr>
<td>Guilt</td>
<td>14.22</td>
<td>5.01</td>
<td>16.00</td>
<td>4.67</td>
</tr>
<tr>
<td>Respon</td>
<td>9.82</td>
<td>5.33</td>
<td>12.08</td>
<td>5.02</td>
</tr>
<tr>
<td>Shame</td>
<td>9.71</td>
<td>4.79</td>
<td>10.42</td>
<td>3.55</td>
</tr>
<tr>
<td>Reject</td>
<td>9.96</td>
<td>5.10</td>
<td>11.50</td>
<td>5.13</td>
</tr>
<tr>
<td>Self-Destru</td>
<td>9.84</td>
<td>3.90</td>
<td>11.25</td>
<td>2.34</td>
</tr>
<tr>
<td>Unique React</td>
<td>10.73</td>
<td>4.30</td>
<td>10.67</td>
<td>3.47</td>
</tr>
<tr>
<td>Recovery</td>
<td>53.84</td>
<td>20.17</td>
<td>55.67</td>
<td>17.70</td>
</tr>
</tbody>
</table>
REFERENCES


