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Cognitive Changes During the Grief Process

Barbara J. Benner

COGNITIVE CHANGES DURING THE GRIEF PROCESS

by
Barbara J. Benner

Bachelor of Arts, State University of New York at Stony Brook, 1974
Master of Arts, University of North Dakota, 1976

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ABSTRACT

Although many authors have used the term "grief work" since Lindemann (1944) first coined it, there has been no systematic investigation of the nature of this phenomenon. This study sought to delineate the cognitive and interpersonal events that occur during grief events and grief resolution. It was hypothesized that grief work involves the creation of a new relationship with the deceased, and that this would be manifested in a variety of styles of grief.

Men and women who had been widowed within the previous two years were identified through newspaper obituaries and recruited as subjects. Sixty subjects completed two process measures. The Grief Work Survey measured recent behaviors and thoughts concerning the loss. The Attitude Toward Grief Survey measured attitudes toward loss and grief. Subjects also completed forms designed to measure a number of prebereavement variables and to assess the degree of grief resolution. In addition an unstructured interview was conducted.

On the Grief Work Survey, subjects reported that they thought about their loss quite frequently. However, the loss was only rarely mentioned by other people and subjects stated that they only rarely discussed the loss with others. This pattern of behavior contrasted sharply with subjects' attitudes toward grief. Subjects reported on the Attitudes Toward Grief Survey that under optimal conditions grief is shared with other people.

In order to determine styles of grieving, a hierarchical clustering of subjects was conducted based on responses to the Grief Work Survey. When clusters were based on the entire form, four clusters emerged. These were labeled "nongrievers," "overwhelmed grievers," "stiff upper lip grievers" and "emotionally expressive grievers." The overwhelmed and stiff upper lip clusters stood out as showing significantly poorer outcomes. There were few differences among groups on pre-bereavement variables.

In a second attempt to determine styles of grief responses to the Grief Work Survey were factor analyzed. Four factors emerged. These appeared to lie along two dimensions: public-private and pain-comfort. Factor scores for each subject on each factor were calculated and these were correlated with the various pre-bereavement and outcome measures. The pain factors were found to be correlated with bad outcome. A long terminal illness was correlated with a private pattern of grief work. Finally, older women who reported high marital satisfaction were found to engage most frequently in behaviors which loaded highly on the comfort factors.

Behavior during the unstructured interview was reported. Implications concerning a cognitive theory of grief and concerning appropriate therapeutic interventions for the bereaved were discussed.

CHAPTER I

LITERATURE REVIEW

Ever since human beings reached a point in the evolutionary process where the species became capable of observing itself, there has been awareness that a period of intense pain and suffering follows the death of a loved individual. This pain appears to be the cost of a close relationship. Artists of all kinds as early as the ancient Greek playwrights have been intrigued by the grief process and have discussed it in their work. Their contributions to the understanding of grief have been eloquent and poignant. Social scientists, on the other hand, have largely ignored the grief process until recent years. Their attempts to understand the grief process have been hesitant and fumbling. The techniques of social science are only now beginning to add to the understanding of the artist.

Much of the literature on grief is purely theoretical. The authors sought to describe and explain the grief process, but made no attempt to use research methods to support their theoretical conceptions. Freud (1917/1963), Bowlby (1961, Bowlby & Parkes, 1970) and Averill (1968) provide unsupported theoretical statements of the grief process.

Other social scientists have attempted to study the natural process of grief by interviewing the recently bereaved. These researchers, typified by Marris (1958) and Gorer (1965), conducted

long, unstructured interviews. They provide a great deal of information about what happens to the bereaved individual, but very little about how it happens.

Most recently there have been systematic studies of the cognitive and interpersonal behavior of the recently bereaved. Few studies of this sort have been conducted. Maddison and Walker (1967) conducted a systematic study of the support systems of recent widows. Metzger (1978) investigated the role of emotional expression in grief resolution. Many facets of the grief experience have not yet been systematically studied.

The present work seeks to build on this most recent tradition. It attempts to investigate in a systematic fashion the cognitive variables involved in grieving and to determine the relationship of these variables to the grievers' background and future outcome.

Theoretical Conceptions of Grief

Analytic Conceptions of Grief

Freud's (1917) article "Mourning and melancholia" is usually seen as the first scholarly examination of the grief process. Unfortunately the purpose of the article was not to study grief as such, but to use the normal grief process as a comparison for the pathological condition of depression. Freud defines grief as the psychological reaction to the loss of a loved object and describes it as a painful condition characterized by dejection, loss of the capacity to love, loss of interest in the outside world, and a lowered activity level. He notes that such a syndrome would be considered pathological were it not universal and that grief differs from the pathological state

of depression only in that a lower level of self-esteem is present in depression.

Freud saw grief resolution as an uncomplicated process in which the ego constantly collides with an unpleasant reality it seeks to ignore. Gradually this confrontation with reality forces the breaking of ties with the deceased. Libido (or psychic energy) is withdrawn from the lost object and reinvested in new relationships. Freud does not attempt to explain why this process is so painful.

A more recent psychodynamic approach to the understanding of the grief phenomenon is that of John Bowlby (1961, Bowlby and Parkes, 1970) who bases his theory on the concepts of attachment and separation. According to Bowlby, grief is an instinctive response to separation. The pain of grief serves as a motivation for reunion with the lost object and as a punishment for separation. In most cases, this is an adaptive response which serves to keep the individual united with his social unit. Only in the statistically rare case of the death of the lost object does the pain of the grief experience cease to be functional.

Bowlby sees the grief process as divided into four distinct stages. The first stage is an initial feeling of shock or numbness which may last as long as a week. In the second stage there are persistent strenuous efforts to recover the lost object. These are usually involuntary and frequently unconscious, but can be observed in the hopes, fantasies, dreams and actions of the griever. Anger and weeping are common features. As the patterns of stage 2 gradually drop away or become extinguished, stage 3 develops. Stage 3

is a period of despair, depression and behavioral disorganization. It is marked by extreme restlessness and mental anguish. Despite its pain, Bowlby sees this stage, like the others, as normal and healthy; the avoidance of pain is pathological for the griever. The fourth and final stage consists of a reorganization process. The griever's outlook changes as behaviors which are no longer appropriate toward the deceased drop out and other behaviors, such as pursuing goals which have been developed in association with the deceased, remain. The griever continues to relate to the deceased, but in a new manner which does not preclude his forming intense new relationships.

Psychiatric Concepts of Grief

Lindemann (1944) interviewed 101 bereaved people including the survivors of the Cocoanut Grove Nightclub fire in Boston and developed a theory of the grief process. He described what he called "acute" (normal) and "morbid" (pathological) grief reactions. Lindemann saw acute grief as a distinct syndrome with a predictable sequence of psychological and somatic symptoms. The successful recovery from grief depends on the griever's ability to complete his "grief work." To do this:

> He has to accept the pain of bereavement. He has to review his relationship with the deceased and has to become acquainted with the alterations in his own modes of emotional reaction. His fear of insanity, his fear of accepting the surprising changes in his feelings, especially the overflow of hostility, have to be worked through. He will have to express his sorrow and sense of loss. He will have to find an acceptable formulation of his future relationship to the deceased. He will have to verbalize his feeling of guilt and he will have to find persons around him whom he can use as "primers" for the acquisition of new patterns of conduct (Lindemann 1944, p. 147).

All this, Lindemann feels, can be completed in eight to ten psychiatric sessions.

Biological Conceptions of Grief

Averill (1968) agrees with Bowlby that grief is a natural, instinctive process. However, he feels that while grief is evolutionarily functional for the species, it may harm the individual by separating him from the larger group and hindering the formation of new relationships that may aid survival. Averill sees three stages of grief which are roughly equivalent to Bowlby's first, third and fourth stages. He sees anger, anxiety and guilt as less central to the grief process and generally sees grieving as a less active process than Bowlby does.

Behavioral Conceptions of Grief

Gauthier and Marshall (1977) provide a cognitive behavioral conception of the grief process. While they believe that grief is "a common reaction to loss" (p. 40), they feel that the intensity and duration of the grief reaction are controlled by the environmental events which follow it. In the case of normal grief, family and friends of the bereaved initially show sympathy and support for grief behaviors, but withdraw this support as time passes. This withdrawal of support together with the encouraging of behaviors alternative to grief leads to grief resolution.

Pathological grief, according to Gauthier and Marshall, can occur in two ways. First, sympathy may not be withdrawn or the bereaved individual may seek out new sources of support as the old ones are withdrawn. Secondly, the bereaved individual and those close to him may attempt to avoid a grief reaction altogether by avoiding contact with reminders of the deceased. This fails, say the authors, because it is difficult to

control one's thoughts. Thus, thoughts about the deceased will occur with high frequency, but the bereaved will attempt to avoid them. Such a strategy leads to incubation rather than resolution of grief.

Thus, a variety of theoretical conceptions of the grief process have been offered. With the exception of Lindemann, who conducted unstructured interviews with a self-referred population, none of the theories have been tied to data collection. Likewise, research studies of the grief process have usually been only loosely guided by a given theory. Cognitive issues in the grief process have been largely ignored. Research on the grief process can be described as focures around three basic questions: (a) What relationship does grief have to behavior pathology and physical illness? (b) What are the experiences of the normal griever and how does he achieve grief resolution? (c) What variables predict a negative outcome? The research in each of these areas will be reviewed.

The Relationship Between Grief and Pathology

Lindemann (1944) was the first to discuss the relationship between grief and pathology. He developed an initial approach to studying the relationship between these two conditions and identified what he called "morbid grief reactions." These he divided into two categories: delayed grief and distroted grief. Delayed grief is characterized by an absence of distress. Distorted grief is indicated by the presence of overactivity without a sense of loss; symptoms of the deceased's last illness; medical disease (e.g. ulcers); alteration in relationship to friends and relatives; extreme hostility against specific persons; affect and behavior resembling

schizophrenia; lasting loss of patterns of social interactions; and agitated depression. All of these patterns are, according to Lindemann, linked to severe psychopathology.

Cobb and Lindemann (1943) described grief as a distinct syndrome with clear physical components which included "a feeling of tightness in the throat, choking with shortness of breath, need for sighing, an empty feeling in the abdomen, and a lack of power in the muscles" (p. 814). Later, Engel (1961) suggested conceiving of grief as a disease. Among other benefits, said Engel, this conception would force physicians to examine the effects of grief on other diseases, and especially to examine grief as a cause of other diseases.

Following this line of reasoning, a number of studies have shown that the bereaved have illness and mortality rates that far exceed those of the normal population. Cox and Ford (1964) found, for example, that the death rate among a group of widows receiving pensions was much higher than the death rate among married women of the same age. Krause and Lilienfeld (1959), using data from the National Office of Vital Statistics, showed that the death rate for single, divorced and widowed people in every age group was higher than that of their married counterparts. This was particularly true for the young widowed who in some cases showed a death rate that was ten times that of married people of similar ages. Rees and Lutkins (1967) followed relatives of people who had died in a rural area of Great Britain. Death rates of the bereaved were compared with those of a matched control group over a six year period. The bereaved showed a sevenfold increase in risk during the first year of bereavement. The effect was greater for males than females and was greatest among the

widowed.

Young, Benjamin and Wallis (1963) followed 4486 widowers of 55 years of age and older for the first five years after their wives' deaths. They found an excessively high death rate within the first six months, but none thereafter. In a followup of this study, Parkes, Benjamin and Fitzgerald (1969) investigated the causes of these early deaths. It was found that the effect cut across social class lines and that the greatest increase in the death rate came in deaths from heart disease.

Another approach to investigating the relationship between grief and physical illness has been to assess the number of grievers in a physically ill population. Schmale (1958), for example, reported that 29 of 42 medical patients and/or their family members reported that they had experienced object loss immediately prior to disease onset. In 41 of the 42 cases, the investigator felt that there was "verbal and/or nonverbal evidence of actual, threatened or symbolic object loss" (p. 270). Greene and Miller (1958) reported that 31 of 33 childhood leukemia sufferers experienced separation or loss during the two years prior to disease onset. Parkes (1970a) states that studies have demonstrated links between object loss and a wide variety of physical diseases including reticuloses, cervical cancer, ulcerative colitis, and asthma. However, most of these studies have been methodologically weak, lacking both control groups and adequate definitions of object loss.

A third approach to investigating the relationship between bereavement and physical illness has included more direct measurement of health deterioration. Parkes (1964a) discovered a marked rise in the number of

consultations British widows had with their physicians. This increase was especially great during the first six months of bereavement. Younger widows were more likely to complain of psychiatric symptoms while older widows were more likely to present somatic complaints. However, psychiatric problems accounted for only half of the extra consultations.

Parkes and Brown (1972) studied 68 Boston widows under age 45 and an equal number of matched controls. Within the first 14 months after bereavement, the widows reported having spent more days sick in bed and having had a greater number of hospital admissions than the non-bereaved. Furthermore, the bereaved showed more disturbance of sleep, appetite and weight; more evidence of depression, restlessness and difficulty in making decisions; and a greater number of symptoms of autonomic disturbance. However, there was no difference between the two groups in number of consultations with a physician. The authors speculate that this may be a result of the high cost of medical care for American widows, while the British widows studied earlier had access to free medical care.

Some studies which have investigated health deterioration in the widowed have failed to find changes in physical health, but have found deterioration in psychological functioning and the occurrence of psychosomatic symptoms. Maddison and Viola (1968), for example, compared widows in Boston, Massachusetts and Sydney, Australia with a control group of married subjects. Twenty-one percent of Boston widows and 32 percent of Sydney widows showed marked health deterioration as compared to 7.2 percent and 2.0 percent of the respective control groups.

However, further investigation of the complaints of the widows revealed that this deterioration was caused by psychological and psychosomatic symptoms. Forty-seven percent of the widows, for example, reported a reduced capacity to work and 13 percent had sought treatment for depression.

As noted above, Parkes (1964a) had also discovered a large number of psychiatric symptoms among the widowed, particularly among younger widows. In a related study, Parkes (1964b) investigated the number of bereaved among a hospitalized mentally ill population. He found there to be six times as many of the recently widowed in the hospitalized population as would be expected by their presence in the general population. Many more of the bereaved than nonbereaved hospitalized patients were classified as suffering from affective disorders, particularly reactive and neurotic depressions. However, these categories accounted for only 28 percent of the bereaved patients, with the rest being classified as suffering from a wide variety of disorders. Parkes concludes that loss of a spouse can be considered a cause of mental illness, but does not speculate as to the mechanism by which this happens.

Clayton and her colleagues at Washington University in St. Louis have conducted a series of studies comparing the grief process in normal uncomplicated bereavement with clinical depression. In the first of these studies (Clayton, Desmarais & Winokur 1968) 40 relatives of 30 patients who died in a St. Louis hospital were interviewed within the first few days following the death and again at a three month followup. Subjects were asked to identify symptoms and feelings they had experienced during three different time periods: "ever before (excluding

terminal illness)," "during the terminal illness," and "since the death."

It was found that symptoms such as depressed mood, sleep disturbance, crying, difficulty in concentrating, loss of interest in previously pleasurable activities, and anxiety attacks were likely to occur for the first time during bereavement. Only the first three of these occurred in more than half of the subjects. Other symptoms such as self-condemnation, suicidal thoughts, feeling tired, diurnal variation, hallucinations, depersonalization, derealization, multiple somatic complaints, use of medicines, loss of interest in church or job, and fear of losing one's mind were unlikely to appear during bereavement. Only heavy drinkers and alcoholics were likely to increase their alcohol consumption during the bereavement period. In general, symptoms were more likely to occur in women than in men. In contrast to other researchers, Clayton et al. found few differences between subjects whose relatives had experienced long terminal illnesses and those whose relatives had died suddenly. There were also no significant differences between spouses of the deceased and other relatives of the deceased.

At followup the three most common symptoms had significantly improved and most symptoms were less frequent. Subjects who had not reported a symptom during the first interview had only rarely experienced that symptom during the intervening months. Eight-one percent of the subjects reported feeling better and those few who attempted to date their improvement felt that it began from six to ten weeks after the death.

The authors concluded that bereavement in an unselected population "is a relatively mild reaction for most subjects" (p. 176) and

criticized previous researchers who, they said, biased their results by selecting subjects who had already come to medical attention.

In a later study by the St. Louis Group (Clayton, Halikas, & Maurice 1972), 109 recent widows and widowers who had been recruited through obituaries and death certificate records were interviewed. Of these, the 38 whom the authors classified as depressed were compared with the 71 non-depressed subjects on 53 demographic, social and physical variables. Few differences were found. Most notably the subject's sex, age, previous psychiatric history and length of marriage were unrelated to membership in the depressed group, as was the length of the deceased's terminal illness.

Most of the differences that were found between the depressed and non-depressed groups seemed to simply be symptoms of the depression. These included, for example, the depressed group's greater tendency toward diurnal variation in mood. The only clearly environmental difference was that the depressed group had fewer children in the local area whom they considered close. In addition, the depressed group reported more frequently wishing to have done the things surrounding the terminal illness or death in a different way and they were more bothered by loneliness and by the suffering of the deceased. The authors chose to see these latter variables as examples of depressive thinking. However, the method of data collection does not allow the ruling out of the possibility that these might be more reflective of the circumstances of the death and the post-bereavement support system.

Bornstein, Clayton, Halikas, Maurice and Robins (1973) reported a followup study of this same group of subjects at 13 months post-

bereavement. They found that, while a large percentage of each group became or remained "non-depressed," those who were depressed one month after the death were more likely to be depressed at followup. Again, age, sex, religion, length of marriage, length of terminal illness, and previous psychiatric history failed to differentiate between groups. However, a number of variables related to mourning behaviors and environmental support did predict depression. Depressed subjects were less likely to live with their families or be members of churches. They had greater financial difficulties and were less likely to have had previous experience with bereavement. The authors conclude that grief is a separate entity from psychotic depression and should be studied separately from the affective disorders.

Following this advice, Clayton, Herjanic, Murphy and Woodruff (1974) compared the bereaved sample with hospitalized patients who carried a diagnosis of primary affective disorder. Results showed tremendous overlap of symptoms. However, the hospitalized subjects tended to have more symptoms than the bereaved and only one symptom (crying easily) was more common among the bereaved. The authors point out that, for the bereaved, both they and their environment experience their symptoms as "normal." In contrast, patients with affective disorder experience their behavior as an inappropriate change which leads them to seek help and define themselves as patients.

Thus, although there are many suggestions that grievers are at risk for both physical and mental illness, the relationship between grief and pathology remains unclear. The St. Louis research points out that while grievers possess many symptoms of depression, they can be

clearly differentiated from the depressed by the smaller number of their symptoms and by the reaction of their environment to their symptoms. Those grievers who do develop mental and physical illnesses seem to have much in common with those who do not. The authors share only the conclusion that grief is an important area for future psychological and medical investigation.

Interview Studies with Normal Grievers

A number of researchers have attempted to investigate the nature of normal bereavement and to describe the experience of the ordinary griever. They have made more or less rigorous attempts to select representative samples of bereaved individuals and by interviewing these people, have begun to shed light on the subjective grief experience.

Marris (1958) interviewed 72 working class widows in London whose husbands had died in youth or middle age. These women had been bereaved an average of two years at the time of the study. Subjects were questioned about their social and financial problems as well as about their emotional reactions to bereavement.

Marris identified four components of a grief syndrome. These were quite similar to those identified by Lindemann and included somatic distress, loss of contact with reality (inability to comprehend the loss), tendency to withdraw, and hostility. He saw his subjects as plagued by ambivalence, as, for example, when they tried to both cultivate and avoid memories of the deceased. Their task, he said, was "to abandon the dead without rejecting him."

Marris stressed the importance of mourning ritual in helping the bereaved to express emotion and work towards grief resolution. This

research seemed to have occurred during a transitional stage of mourning customs. Ninety percent of widows over 40 wore mourning clothes for more than three months while only 64 percent of widows under 40 did so. He noted that those widows who did not have the support of well defined mourning customs seemed to require greater reassurance that they had "grieved enough" before being able to resume their normal living patterns.

Finally, Marris noted that the nature of the grief syndrome makes it most difficult for the bereaved to accept support from family and friends even though this is the time in their lives when the need for support is greatest. The feelings of ambivalence and withdrawal made the bereaved feel as if the acceptance of support represented a devaluing of the relationship with the deceased and a betrayal of the previous relationship. Furthermore new responsibilities and financial hardships suffered by the widows put practical difficulties in the way of forming and maintaining relationships.

Bereavement, said Marris, causes emotional turmoil that frequently takes two or more years to resolve. The support of others, particularly the reassurance that one has mourned enough, may be the best aid to grief resolution.

Hobson (1964) interviewed 40 widows under age 60 in a small rural town in Great Britain. This area had a vastly different social system from the London area where Marris had conducted his research and Hobson found her widows to be in much more uncomfortable situations. Hobson portrayed a picture of grief which included multiple somatic symptoms lasting an average of 15 months, a feeling of remoteness from and indifference toward the outside world, painful contradictory feelings

of wanting to both cherish and escape from past memories, and anger toward God and "fate." Although her subjects had been widowed for as long as four years, social activity was "almost nonexistent" except for daytime visits with relatives. Most continued to suffer extreme financial hardship. Hobson attributes the poorer situation of these widows as compared to those studied by Marris to a more loosely knit kinship network which failed to provide the emotional, social and financial support that the London widows had received.

Gorer (1965) interviewed a British sample of bereaved individuals and identified eight mourning styles. "Denial of mourning" is the attitude that death is not important. The bereaved individual might say, for example, that there is little difference between the deceased being dead and his living in a distant country. In a few cases, Gorer noted an "absence of mourning." This usually occurred when the deceased was a parent or sibling of the bereaved and the relationship had been a relatively casual one. "Mourning before the death" sometimes occurred when terminal, illnesses were especially long or painful. In these cases, the death itself was experienced as a release.

Widows trying to shield young children from the pain of grief were particularly likely to "hide their grief." These women seemed to feel that giving way to their grief would be morbid and unhealthy. Instead they chose to maintain a schedule that was so busy they had no time to grieve. Gorer felt that "by denying expression to their grief [these people] had reduced their lives to triviality, even though their purposeful busy-ness warded off any overt symptoms of depression" (p. 75).

"Time limited mourning," which Gorer felt to be the most psychologically healthy mourning style, is characterized by a period of intense grief (including such symptoms as weeping, loss of weight, sleeplessness, and withdrawal from social activities) followed by a return, in stages, to normal activity. The period of intense grief was seen as lasting from six to twelve weeks.

Finally, Gorer identified three forms of "unlimited mourning." The first of these, the "never let go" style was seen as relatively benign. While these people overtly deny the healing effect of time, they seemed to resolve their intense grief. Gorer speculated that the statements that recovery is impossible are proclamations of the continued affection for the deceased. A second form of unlimited mourning was labeled "mummification." These grievers attempt to preserve their relationship with the deceased by maintaining themselves and their homes exactly as they had been when the dead person was alive. Lastly, and most pathologically, some unlimited mourners suffer "despair." These people exhibit severe depression which they seem unable to resolve.

Gorer sought to relate the opportunity to participate in cultural mourning rituals to styles of grief and success in grief resolution. He noted that those subjects who had participated in structured mourning rituals seemed to have less difficulty resolving their grief. Ritual, he said, gives the bereaved individual a safe, accepable method to express grief and gives the community a structure for providing support for the bereaved. The majority of Gorer's subjects had not participated in ritual and had made little progress towards grief

resolution. He concluded that the declining role of ritual in our society is detrimental to psychological well-being and proposed the development of secular mourning rituals for those who have abandoned religious ritual.

Parkes (1970b) conducted a lontigudinal study of 22 London widows under the age of 65. Interviews were conducted at 1, 3, 6, 9 and 13 months post-bereavement. The first interview was designed to elicit information about reactions to the final illness and the death and to obtain background information about life situation and family history. The second, third and fourth interviews covered events and reactions since the previous interviews. The interviewer also elicited information to complete checklists of psychological features. During the final interview ratings of psychological, social and physical adjustment were completed.

In general, Parkes saw his results as supporting Bowlby's theory that grief is a phasic process, although Parkes saw the phases as less distinct than Bowlby did. Parkes' subjects experienced an initial period of "Numbness" usually lasting from one to seven days. Many subjects reported continuing to experience brief periods of numbness or disbelief as long as a year after the death. Numbness was followed by a period of "Yearning" or "Protest" characterized by pangs of intense pining for the deceased interspersed with thoughts and behaviors which mitigated feelings of grief. These feelings peaked during the second through fourth weeks of bereavement and were followed by the apathy and aimlessness characteristic of Bowlby's "disorganization" phase. Parkes felt that about two-thirds of his subjects continued in

this phase at the end of the study. He stressed that grieving was continuing and that this should not be considered as the long term outcome of widowhood. At the close of the study Parkes described 3 of his 22 subjects as poorly adjusted, 9 as intermittently disturbed and depressed, 6 as tenuously adjusted and 4 as well adjusted. Unfortunately the criteria by which he made these ratings are unspecified.

The Harvard Bereavement Study (Glick, Weiss & Parkes 1974) is one of the few studies to examine the grief experiences of a non-clinical widowed population over an extended period of time. Subjects were Boston widows and widowers under age 45 whose spouses had died from natural causes or from accidents. They were identified from city death records and asked to volunteer. In all, 49 widows and 19 widowers participated; this represented approximately one-fifth of the eligible population. Subjects were interviewed three weeks, eight weeks and thirteen months after the loss. Follow-up interviews were conducted between two and four years after the death. The study attempted to answer three broad questions.

> First, what are the experiences through which young widows and widowers move from the time of their loss to the time of its resolution? Second, what are the emotional and psychological phenomena associated with bereavement? Finally, what seems to help, or to hinder, recovery? (pp. 15-16).

The report of the Harvard Bereavement Study concentrated on the experience of the widows because of their prevalence in the sample. Glick, Weiss and Parkes found that their subjects underwent a grief process not unlike the theoretical model of grief stages that Bowlby had earlier proposed. Following death, there was an initial period of shock and disbelief. Although this reaction was less intense for those women who

had anticipated their husbands' deaths and was particularly tempered in those few cases where husband and wife had discussed the approaching death, it seemed to be present in all new widows. The shock period was characterized by a feeling of unreality. Widows stated that they "couldn't believe" that their husbands had died or that "the impossible had happened." At the same time, there was an obsessional review of the events leading up to the death, particularly of the widow's final communication with her husband.

The period of shock was followed by a period of intense sadness, characterized by weeping and crying. During this period, guilt, anger and anxiety were common complicating emotions. At first, widows seemed to see this display of emotion as healthy and many cried freely in the company of others. Quite quickly, however, this was replaced by a desire for self-control; crying became a solitary activity.

Disorganization was also common in early grief. Some widows became passive and apathetic, as if the disruption in their physical, social and emotional lives had left them unable to function. Many feared nervous breakdowns, and, while none contemplated active suicide, the feeling that death would be a welcome escape was common.

The Harvard Bereavement Study showed that throughout the grief process and even when grief had been successfully resolved, widows continued to feel a close tie to their dead husbands. Throughout the process they immersed themselves in memories of their lives together, and seemed to find comfort and refuge in these memories. Many widows reported a comforting sense of the husbands' presence which sometimes bordered on hallucination. They retained memorabilia of their marriage

and sometimes displayed these "linking objects" prominently in their homes. When decisions were made, the widow was actively aware of what her husband's opinion would have been. As time passed and she became more independent in her judgment, she might make decisions with which he would have disagreed, but never without being aware of what his wishes would have been.

Widows reported three themes when discussing the process of their recoveries. These were keeping themselves occupied, learning new skills, and returning to active social participation. Recovery patterns were divided by the researchers into two types: toward remarriage (and integration into a lifestyle similar to the former one), and away from remarriage. This latter pattern was further subdivided into intimate nonmarital relationships, close relationships with kin, and independence of close relationships. A final group of widows appeared unable to recover at all; these women continued to lead chactic, unfulfilled lives even several years after the death had occurred.

The only variable which predicted recovery patterns was the ability to anticipate the husband's death. Those widows who had anticipated the death were more likely to remarry. Those whose husbands had died suddenly expressed fears of losing another spouse and tended to live independently or organize their lives around nonmarital relationships. Those who did not recover could be identified as early as the second interview. They had not anticipated the death, tended not to express their grief, and tended to increase their alcohol consumption shortly after bereavement. Ambivalent marriage

relationships were more common in this group and many of these widows had shown signs of emotional instability earlier in their lives.

Widowers' reactions to their losses were seen as similar to that of the widows insofar as they were reacting to the loss of a loved one, but different insofar as they were reacting to a traumatic disruption of their lives. In contrast to widows, widowers were more likely to have difficulty concentrating on their jobs, and were less likely to express their grief. They were quicker to reorganize their lives but did not seem to move more quickly toward emotional recovery than did widows. Widowers were more likely to remarry than were widows and the tendency to remarry was not as closely correlated to anticipation of the death. However, among the remarried widowers who had not anticipated the death there were several who were seen as not having satisfactorily resolved their grief. This was rare among remarried widows.

As the only studies to study the grief process longitudinally, the London and Harvard studies have added much to the understanding of the bereavement experience. In his foreword to the Harvard study project report, Gerald Caplan (1974) points out two changes in the conception of the grief process that are, perhaps, most significant. First we now realize that the grief process is not a short crisis to be resolved, as Lindemann had said, in four to six weeks. Rather, it is a long term process. Most people make significant progress within the first year of bereavement, but the grief process continues for a much longer period. In fact, Caplan speculates that "most widows continue the psychological work of mourning for their dead husbands for the rest of their lives" (p. viii).

Secondly, Caplan feels the projects have demonstrated that many of the behaviors previously considered pathological are, in fact, well within the bounds of "normality" and are not predictive of future maladjustment. He suggests that the assurance of normality and the understanding of the wide range of emotional responses to grief may be therapeutic for the widowed.

Prediction of Outcome

While many of the interview studies identified groups of grievers who failed to resolve their grief and made some guesses as to the cause of this failure, little substantive research on the causes of poor grief resolution was done until recently.

Parkes (1975) reported a more thorough examination of the variables that distinguished the good and poor outcome groups in the Harvard Bereavement Study. By means of a "complex" but unreported series of outcome measures, extreme groups with good and poor outcomes at 13 months post-bereavement were identified. A discriminant function analysis identified seven variables which predicted poor outcome. These were (1) a prediction of negative outcome by data coders, (2) the presence of intense and continuous pining at one month, (3) an attitude of welcoming one's own death, (4) the spouse having had a brief terminal illness, (5) low socioeconomic class, (6) the presence of high levels of anger at one month, and (7) the presence of high levels of guilt at one month. Further analysis of the good outcome subgroup indicated that the amount of time the bereaved person had had to prepare for the death was a better indicator of good outcome than any behavior that had occurred during the terminal illness. Thus, the presence of the spouse at the death,

and various forms of communication with the terminally ill individual showed no relationship with outcome. Parkes concludes that both the length of the illness and the length of the termination need to be taken into account in identifying a short preparation, high risk group.

Accordingly, a Short Preparation subgroup of 24 survivors who had had less than two weeks warning that the spouses' condition was likely to be fatal and/or less than three days' warning that death was imminent was compared to a Long Preparation subgroup which consisted of the remaining 46 subjects. At 13 months post-bereavement, 60 percent of the Long Preparation group and only 13 percent of the Short Preparation group were rated as having achieved a good outcome.

Follow-up interviews were conducted at two to four years post-bereavement. At that poing the Long Preparation group was rated as having 65 percent good outcomes whereas the comparable figure for the Short Preparation group had fallen to only 6 percent. Short Preparation subjects were less likely to remarry or to possess a good attitude toward the future. They were more likely to have difficulty performing their jobs and to have continuing financial problems.

In searching for the cause of these remarkable differences, Parkes noticed that the grief process had been quite different for the two groups. The Short Preparation group had experienced persistent feelings of disbelief, emotional disturbance, anxiety and guilt; these emotions were fleeting or not present in the Long Preparation group. Furthermore, the members of the Short Preparation group were more likely to experience confusing feelings of anger toward the

deceased who, it seemed, had abandoned them. Parkes speculated that two factors may be responsible for the more healthy grief process of the Long Preparation group. First, the Long Preparation group may have made use of the opportunity to deal with any ambiguities in the relationship and make restitution for any of their own contributions to an ambivalent relationship. Thus, at the time of death, a clear, positive relationship had existed between the deceased and the survivor, and the survivor did not experience feelings of anger or guilt. Secondly, Parkes noted the sheer magnitude of the change with which the Short Preparation subject was suddenly confronted. Whereas the Long Preparation subject could confront the painful reality of death in small, gradual steps, the Short Preparation individual was faced suddenly with an overwhelming situation. Under such circumstances, Parkes hypothesized, the Short Preparation bereaved erect strong defenses which prevent the confrontation with reality. The survivor persists in feeling that the death is unreal and, thus, the painful searching never undergoes extinction. Grief becomes part of the subject's normal life pattern.

Parkes noted the contradiction between his results and those of Bornstein et al. (1973) who found that a sudden bereavement showed no relationship with the presence of a "depressive symptom complex" a year after the death. Reanalysis of the Parkes' data in terms of the Bornstein et al. variables led to no change in the results. Parkes cited two factors as possibly responsible for these differences. First, Parkes included spouses of those who had experienced a short terminal illness and those who had experienced a brief termination after a long

illness whereas the Bornstein et al. study had included only those who had been ill for fewer than five days in its Short Preparation group. Second, the Parkes' study included only those under age 45 whereas the Bornstein et al. study included a much broader age range. Parkes concluded that the poor outcomes of the Short Preparation group were caused by deaths that were untimely as well as unexpected.

Maddison and Raphael (1975) shed more light on the prediction of poor outcome in the bereaved. They reported four factors which when measured in recently bereaved widows by reliable raters and combined in a weighted actuarial prediction format have identified a group of whom 80 percent will have a bad outcome. These factors are the presence of a non-supportive or actively hostile social network (as identified by Maddison & Walker 1967), the presence of additional concurrent crisis situations, a mode of death which maximizes guilt or anger, and a pre-existing pathological marital relationship, especially one characterized by extreme dependence or ambivalence. The authors noted that three of these four predictive factors are "past history" at the time at which possible intervention could occur. Therefore, possible intervention strategies are limited to changing the character of the social network and/or providing therapy to help the widow to learn to cope with the latter three factors. Maddison and Raphael supported the use of both intervention strategies. Programs which strengthen the social network, such as the "widow to widow" program (Silverman 1976) would be helpful to many widows. However, those who show many of the risk factors, may be too disturbed to be able to accept or profit from such casual interventions. These high risk widows are seen by the authors as

being in need of more intense professional assistance.

Maddison and Walker (1967) investigated widows' perception of their support systems. One hundred thirty-two widows of Boston men who had been between 45 and 60 years of age at the time of death completed a self-report measure of the degree to which their physical and/or mental health had deteriorated during the first thirteen months of bereavement. On the basis of this measure 28 of the women (21%) were classified as having had clear "bad outcomes" and 57 (43%) were classified as clear "good outcome" widows.

Twenty good outcome widows and twenty bad outcome widows, matched for religious affiliation, socioeconomic status, and duration of warning of death, were selected for more extensive interviews. Interviews were designed to determine specific persons and forms of interaction that the widow had felt to be available to her during early bereavement. In order to insure comparable data from all 40 subjects, a list of 59 items focusing on expression of affect, review of the past, orientation towards the present and future, and provision of concomitant needs was discussed at the close of the interview. Subjects indicated whether or not each of the 59 types of interaction had been present or absent in their environment. If absent, the subject further indicated whether or not she had felt in need of such an interaction. If present, she indicated whether the interaction had been helpful, unhelpful or indifferent.

Data regarding specific persons available to the widow could not be statistically analyzed due to the small number of subjects. It was interesting to note, however, that almost half of the subjects rated their clergyman as "indifferent," while the majority of widows rated the funeral

director as "helpful" to them.

The specific forms of interaction data were able to be analyzed and result showed that the bad outcome widows perceived of themselves as having many more unmet needs than did the good outcome widows. These unmet needs were quite broad and included needs for permission to more freely express affect, needs to discuss the past, and needs for practical help and general support. While good outcome widows were more likely to see a quiet permission to talk as helpful, bad outcome widows were more likely to appreciate those in their environment who actively encouraged emotional expression. Bad outcome widows stated that there were people in their environments who actively opposed the expression of affect by minimizing the loss, or telling them to 'pull themselves together." They tended to actively focus the widow's attention on the present and future and discourage exploration of the past.

The authors acknowledged that they have measured only the widow's perception of her environment and that there were no objective measures of environmental support. Furthermore, it is quite possible that the bad outcome widows' long standing patterns of maladaptive social interaction may have made her more needy or less able to benefit from environmental support. Indeed, the fact that bad outcome widows felt a need for active encouragement to express emotion rather than simple permission to do so suggests that they possessed a more rigid defensive structure. However, the differences between groups are quite striking and it does not seem likely that they can be explained on the basis of personality characteristics alone.

Metzger (1978) attempted to measure the effects of the open expression of emotion ("discharge") on the resolution of grief. Recently bereaved individuals who had been referred to the study by their clergyman were asked to record discharge behaviors on forms which differentiated between situations in which the subject was alone thinking about the death and situations in which the grief was shared with other people. In addition, subjects completed several measures which were designed to measure the degree to which grief had been resolved. Subjects were seen weekly for the first four months of bereavement.

In a second portion of her study, Metzger conducted retrospective interviews with individuals who had been bereaved within the past year. Subjects were asked to rate the degree to which they had engaged in discharge, both alone and in interpersonal situations, during several time periods after the death. These subjects completed the same outcome measures as had the longitudinal subjects.

Metzger's results need to be viewed with caution due to the small size of her sample and the wide variety of types of bereavement they had experienced. Ten subjects participated in the longitudinal portion of the study and eight in the retrospective portion. Some had been widowed, some lost parents, and others had experienced the death of their children. Causes of death and lengths of awareness of terminality were also highly variable.

Despite the fact that most subjects subjectively reported that sharing their grief with others "was helpful and made them feel better" (p. 89), results failed to confirm a positive relationship between high

levels of discharge behaviors and positive resolution of grief. In fact, a negative, although statistically nonsignificant, correlation was found. Emotional discharge which occurred in isolation was seen as especially likely to be a detrimental behavior.

Metzger divided her subjects into good and poor outcome groups on the basis of health, social participation and life satisfaction. It was noted that poor outcome subjects tended to have experienced a more difficult grief(to have lost spouses and children rather than parents), to have felt less prepared for the loss, to have had no other adults living in their household, and to indicate a greater need for an opportunity to express their feelings. This final variable was also identified by Maddison and Raphael (1975) as a predictor of poor outcome.

Thus, while Metzger's study failed to confirm emotional discharge as an important variable in grief resolution, there were indications that the chance to talk about the loss with others is important. Perhaps this sharing of feelings is important for reasons other than catharsis.

The Role of Cognitive Factors

Grief resolution is frequently seen as a highly cathartic process. Throughout the grief literature there runs a thread of belief that grief must be expressed in order to be resolved. Whole therapies have been developed to teach people to cry, sob, tremble and otherwise express their emotions. Indeed many studies reported that grievers themselves feel the need to "get it all out" by crying or by some other form of emotional catharsis.

Another, less noticed and not necessarily contradictory, thread runs through the grief literature. This concerns the need of the griever

to cognitively rearrange his world. The bereaved individual has lost a person around whom revolved a large part of his physical, social and emotional world. He needs to develop a style of dealing with a world that does not contain this individual. He also needs to find a place for the lost individual or the memory of him in the new world.

Although they have not emphasized it, most writers have noted this as part of a griever's task. In the long list of grief work tasks cited above, Lindemann (1944) said that the griever "will have to find an acceptable formulation of his future relationship to the deceased" (p. 147). Bowlby (1961) while saying that grief resolution involves "a withdrawal of emotional concern from the lost object" (p. 319), in the same article stated that many ties to the deceased remain after grief resolution and that, indeed, the grief process is one by which "an effective loving relationship with the lost person can be built afresh" (p. 337). Glick, Weiss and Parkes (1974) in their report on the Harvard Bereavement Study, noted that successful grievers seem to maintain a continued tie with the deceased and that, paradoxically, this continued tie does not seem to interfere with independence of judgment or with future intimate relationships.

This feeling of a continued but restructured tie is also evident in the autobiographical accounts of the grief process. C. S. Lewis in A Grief Observed reported his feeling of a continued contact with his deceased wife as he resolved his grief:

> It's the quality of last night's experience--not what it proves but what it was--that makes it worth putting down. It was incredibly unemotional. Just the impression of her mind momentarily facing my own. Mind, not "soul" as we tend to think of soul. . . . Not at all like the rapturous reunion

> of lovers. Much more like getting a telephone call or a wire from her about some practical arrangement. Not that there was any "message"--just intelligence and attention. No sense of joy or sorrow. No love even, in our ordinary sense. No unlove. . . . Yet there was an extreme and cheerful intimacy. . . . Wherever it came from, it has made a sort of spring cleaning in my mind. . . . One didn't need emotion. The intimacy was complete--sharply bracing and restorative too--without it (pp. 85-87).

Catherine Marshall, the widow of spiritual leader Peter Marshall, in To Live Again recounted the comfort she received from editing a book of her husband's sermons and from writing his biography. She noted that it was particularly important to her to convey the essence of her husand's life and accomplishments to others. It is clear that this is not a description of breaking ties, but of changing their nature.

Finally, in a particularly poignant passage of Widow, Lynn Caine noted that she has become "someone else" as a result of her grief experience. She wondered if this new woman would fall in love with the same man. She says:

> But today I am someone else. I am stronger, more independent. I have more understanding, more sympathy. A different perspective. I have a quiet love for Martin. I have passionate, poignant memories of him. He will always be part of me. But--
>
> If I were to meet Martin today . . . ?
>
> Would I love him?
>
> I ask myself. Startled. What brought the question to mind? I know. I ask it became I am a different woman.
>
> Yes. Of course I would. I love him now. But Martin is dead. And I am a different woman. And the next time I love, if I ever do, it will be a different man, a different love (p. 182, emphasis added).

These statements by people who have through their books shared their progression through the grief process, point out that grief resolution is not simply a matter of "letting go of the dead" or of "extinguishing emotional ties." People who have successfully resolved their

grief continue to have strong ties to the deceased, but these are very different from the ties that existed when the dead person was alive. The new ties are quieter, less emotional, more abstract. They are of a type that would be appropriate for a person to feel toward a memory or an ideal, for that is what the deceased has become.

Of the professional writers who discussed this formation of new ties, Marris (1958, 1974) did so most directly. He stated that ". . . grief is mastered, not by ceasing to care for the dead, but by abstracting what was fundamentally important in the relationship and rehabilitating it" (1974, p. 34). This little noticed statement contains the seed of a cognitive model of the grief process. Such a model would predict a number of grief behaviors which, while not contradicted by a cathartic model, would make more sense when viewed in a cognitive framework. Some evidence currently exists to support a cognitive model of grief but this evidence has never been viewed as a coherent picture.

First, a cognitive model would predict that the griever would go through a period of intense preoccupation with the relationship. He would review past memories, seeking to simplify and make sense of years of experience. He would be trying to know the deceased person better and would welcome additional information that could be added to the synthesis. Because the griever was so intensely involved with his memories, he would show little interest in the outside world and would appear apathetic and indecisive to an outside observer. Such a process could occur in association with a great deal of cathartic discharge, but it could also occur quietly. The nature of the grief work would be determined by an interaction of the character of the deceased, the

cognitive style of the survivor and the nature of the relationship between the two.

The process would have a great deal in common with Bowlby's hypothesized searching process. Parkes (1970) described the Bowlby process as having four behavioral components: pining and preoccupation with thoughts of the deceased; direction of attention toward places and objects in the environment which are associated with the lost person; development of a perceptual "set" for the deceased, and crying. The cognitive process would, however, be a more active one; the griever would be incorporating new information and abstracting meanings rather than simply obsessing over a loss until it begins to feel real. Furthermore, while Bowlby's process is doomed to failure because the griever will never be reunited with his lost love, the cognitive griever is on some level able to succeed.

Many authors have reported data which is relevant to the above prediction. Without exception, researchers have noted that grievers are preoccupied with the deceased and that they show little interest in the world around them. Parkes (1970), however, provided one of the few discussions of the phenomenon. He noted that at first there is usually a concentration on the painful memories of the final illness and death, but this is replaced later in the grief process by a preoccupation with events earlier in the relationship. As time passed, preoccupation declined, but memories remained as clear and as important as they ever had been.

Maddison and Walker (1967) noted that poor outcome widows felt they had been discouraged from reviewing the past and encouraged to

deal only with the present and the future. It is easy to see how such an attitude would make it impossible to form the necessary new relationship with the deceased and thus contribute to a bad outcome.

Metzger (1978) reported that her subjects felt a strong need to discuss their loss with others, but she found no relationship between catharsis and outcome. A cognitive approach to grief work would explain that this need to share the loss was a need to explore and abstract the relationship rather than a simple need to release pain.

A second prediction of a cognitive model of grief might be that, during this period of intense preoccupation, the griever might feel a special closeness to the deceased. This, too, has been observed. Parkes (1970) noted that many of his subjects reported an attraction toward places they associated with their dead husbands. They stated that they received comfort from being in those places and from viewing and handling objects which they associated with their husbands. Furthermore, nearly half of his subjects thought that they saw or heard their husband at some time during the grief process. Many others felt a "sense of presence" of the deceased. Unfortunately for the purpose of this discussion, there was no investigation of the relationship between this phenomenon and the degree of preoccupation.

Rees (1975) presented a more systematic investigation of the phenomenon of hallucinations among the bereaved. He expanded the term to include "a sense of the presence of the dead person" as well as seeing or hearing the deceased. Two hundred ninety-three widowed individuals in mid-Wales were interviewed. This group represented 80.7 percent of the widowed population in the area. Forty seven percent of those

interviewed reported having experienced hallucinations of the deceased at some time during their bereavement. The most common form of these hallucinations was the feeling of a sense of the deceased's presence. However, visual, auditory and tactile hallucinations were also common and a substantial number of subjects stated that they had spoken to the deceased.

The majority of those who reported hallucinations found the experiences to be pleasant and helpful to them. Only a few reported fear or other unpleasant emotions. The benign nature of these events was further underlined by the fact that they were more likely to occur in those who had experienced longer marriages and happier marriages. Moreover, there was no difference in suddenness of death, cultural background, religious affiliation, social isolation, and occurrence of depressive symptoms between the hallucinating and non-hallucinating groups.

Yamamoto, Okonogi, Iwasaki and Yoshimura (1969) also reported the occurrence of hallucinations among the bereaved. They interviewed 55 widows of Tokyo traffic accident victims very shortly after the death had occurred. In contrast to the bereaved in Western countries, the Japanese bereaved have a culturally approved method of maintaining contact with the deceased. This is done by means of the family altar. Yamamoto et al. reported that Japanese widows experienced this ritual communication as very real and as an important source of comfort during early widowhood. However, it was also the authors' impression that the Japanese widows showed less early acceptance of their loss than do Western widows. Unfortunately, the study did not include a follow-up interview so it is impossible to estimate the long range effects of these hallucinations.

A third prediction of a cognitive interpretation of the grief process would be that a griever who had shared an ambivalent relationship with the deceased would have more difficulty resolving grief. An ambivalent relationship would be a more painful one to think about, making many grievers avoid the process entirely. Furthermore, once faced, an ambivalent relationship would be, by its very nature, a more difficult one to abstract. Again, there are data to support this prediction. Parkes (1970, 1972) has noted, that the guilt and anger, which frequently are expressed by grievers of ambivalent relationships are closely associated with poor outcome. Guilt is particularly common among women who develop mental illness following bereavement.

A fourth prediction phenomenon which might be expected to occur during an active preoccupying search for the essence of a deceased person would be some kind of identification with the deceased. Parkes (1970) reported four kinds of identification behavior among his subjects. These were a tendency to behave or think more like the spouse, the occurrence of symptoms resembling those of the spouse's final illness, the feeling that the spouse was "inside" the griever, and the location of the dead spouse within the couple's children. Parkes noted that these behaviors are more common among grievers who express grief and self-reproach and saw them as ways in which the widow punishes herself. He did note, however, that self-punitive identification and "the forms of identification which seem to reflect attempts at finding the lost spouse" (p. 459) may reflect different phenomena.

Thus, there is some evidence that grievers' thoughts, images, and memories may play an important part in grief resolution. Indeed,

it may be that when the cathartic process is effective, it is largely because, as Nichols and Zax (1977) suggest, it allows the individual to examine and restructure cognitions. Grief may be a more active cognitive process than it is usually considered. Although Lindemann coined the term "grief work" in the 1940s, there has as yet been no structured investigation of the nature of this process. The present study seeks to determine what cognitive activities are involved in the grief process. Also, it seeks to discover the relationship between these activities and both the variables in the subject's pre-bereavement history and the degree of success in resolving the grief.

CHAPTER II

METHOD

The present study sought to investigate the nature of "grief work" and its relationship to pre-bereavement experience and to grief resolution. Sixty recently bereaved people were interviewed in a structured fashion to determine the nature and frequency of their grief work. In addition, a wide range of other variables regarding the subjects' background, attitude and degree of grief resolution was measured. The relationship between these variables and grief work was investigated through the statistical procedures of cluster analysis and factor analysis.

Subjects: Recruitment

The subject population was obtained from among the surviving spouses of people whose obituaries appeared in the Grand Forks Herald from May 1, 1976 through April 30, 1978. This was approximately the two year period prior to the time interviews were conducted. The spouse was considered a potential subject if the deceased had been 65 years of age or younger at the time of death and had lived within a 50 mile radius of Grand Forks, North Dakota. Two hundred twenty-six people were included in this group.

A second subject pool was added to ensure an adequate number of volunteers. This consisted of spouses of deceased individuals

65 years of age or younger who had died in the Fargo, North Dakota/ Moorhead, Minnesota area and whose obituaries were listed in the Fargo Forum between September 1, 1977 and March 31, 1978. This was a pool of more recently bereaved people which was selected because it appeared this group would be under-represented among the sample obtained via the Grand Forks Herald. Those widowed between April 1, 1978 and April 30, 1978 were excluded only because those obituaries were not yet available on microfilm. Forty-eight people were included in the Fargo/Moorhead group. Thus, there were 334 individuals in the full subject pool.

A letter was sent to each member of the subject pool explaining the nature of the research and requesting the widowed person's participation in the study (appendix A). A stamped self-addressed postcard on which the potential subject could express his/her willingness or unwillingness to participate was enclosed in the letter (appendix B).

In order to avoid being overly intrusive, no attempt was made to personally contact those who did not return the postcard. However, the research project was featured in a popular local newspaper column approximately three weeks after the first group of letters was mailed (appendix C). This article included the researcher's name and telephone number; it was intended to be a non-intrusive reminder to those who had not responded to the letter.

Of the 334 letters sent to potential subjects, 24 were forwarded long distances or were returned because the widowed person had moved and left no forwarding address. Twenty letters were forwarded to individuals who had moved, but continued to live within the Grand Forks or Fargo/ Moorhead areas. Thus, it is assumed that 290 letters were delivered

to widowed individuals who continued to live in the home shared with the spouse. However, the lack of personal contact with those who failed to respond makes this figure uncertain.

Of the 310 letters assumed to be received by individuals who were still living in the area, 84 responses were received. These included the 60 people who eventually became subjects, 13 people who refused to participate, 10 people who volunteered to participate but for whom business and/or vacation schedules made it impossible to schedule an appointment, and one intellectually limited woman who volunteered to participate, but found the experience beyond her intellectual abilities. Thus, of those who responded most (84.5%) agreed to participate and 71.4 percent eventually became subjects. The huge majority of the subject pool (76.7%), however, never responded to the letter at all and it is impossible to determine their reaction to the letter or, in fact, to be certain that the letter was received. Most of those who volunteered did so within a few days of the time the letter was received. There were no additional volunteers following the publication of the newspaper article. This lends support to the idea that most of those who did not respond simply chose not to participate or no longer lived in the area.

Subjects: Description

The 60 subjects who participated in the study included 49 widows and 11 widowers. At the time they were interviewed they ranged in age from 21 years to 71 years, with a mean age of 50.9 years. Their deceased spouses had, at the time of death, ranged in age from 26 years to 65 years, with a mean age of 52.4 years. At the time of interview the

subjects had been widowed for a mean of 11.0 months. Of the 60, six of the spouses had died in accidents, 28 had died suddenly of natural causes (usually heart attacks), 23 had died following long illnesses (usually cancer), and 3 had committed suicide.

Subjects: Comparison Between Subjects and Population

Recruitment through newspaper obituaries made available a variety of information about those who did not volunteer to participate in the study. Since it was felt that the obituaries listed virtually every death in the area, it was possible to compare participating subjects with the entire widowed population on a number of variables. The newspaper provided information about the sex and age of the deceased, the date of death, and the town in which the deceased had lived. In addition, Department of Health death certificate statistics were available for Grand Forks County for 1977. This made it possible to compare cause of death for a subgroup of subjects (i.e., those who lived in Grand Forks County) with that population.

In the newspaper obituaries, 69.8 percent of the surviving spouses were female whereas 81.7 percent of the subjects were widows. A binomial test was performed showing a significant difference between the sample and the population, $z = 2.01$; $p < .025$.

The mean age of the deceased in the obituaries was 54.5 years. The mean age of the deceased for participating subjects was 52.4 years. A z-test showed no significant difference between these two means, $z = 0.27$; $p = .79$.

At the time they received the letters inviting them to participate in the study, the population had been widowed for a mean of 10.4

months. Subjects had been widowed for a mean of 10.9 months. No significant difference was found between these means, $z = .35$; $p = .73$.

It was also possible to compare the two groups on the basis of the size of the towns in which they resided. Towns were divided into five groups: those with populations greater than 10,000; those with populations between 5,000 and 10,000; those with populations between 1,000 and 5,000, those with populations between 500 and 1,000, and those with populations less than 500. A Kolgomorov-Smirnov test (Siegel 1956) was performed comparing number of subjects who fell into each of these five categories to the number who would be expected to fall into these categories if the proportions were the same as in the obituary population. No significant differences were found, $p = .73$ $.066$; $p > .20$.

Finally, the cause of spouses' death for the 21 subjects who were residents of Grand Forks County was compared with county health statistics for 1977. Four categories were used: cancer, heart disease, accident, and other. In a chi square test, the number of subjects who fell into each of these four categories was found not to be significantly different from the number who would be expected in these categories if the subjects were perfectly representative of the obituary population $\chi^2(3) = 4.21$; $.20 < p < .30$.

Thus, on the variables examined the subjects appear to be highly representative of the population. There are no significant differences in age of the deceased, time since death, the size of the town in which the deceased had lived, and the cause of death. The sample differed from the population only in the over-representation of women in the

sample. However, it must be acknowledged that there are many variables which might affect the results of the study for which the population and the sample could not be compared. In addition, there is no way of determining what differences, if any, may exist between this subject group and those who did not volunteer by virtue of the fact that these people were the volunteers. Neither is it possible to determine how this fact affected the results of the study.

Measures

Three types of measures were included in the study: (1) Background measures were used to assess the subject's situation at the time of bereavement and the nature of the death. (2) Process measures investigated the subject's attitude toward grief and the cognitive activities which he/she used to cope with grief. (3) Outcome measures were intended to assess the degree of success the subject had had in grief resolution.

Background Measures

The Background Information Survey asked 14 questions about the nature of the death, the subject's condition at the time of bereavement, and the stability of other conditions in the subject's life since the death (appendix D).

The Social Readjustment Rating Scale (Holmes & Rahe 1967) measured the amount of stress the bereaved person had experienced in the five years prior to the death. The 43 items on the scale were rated as having been present or absent in the subject's past. The items which had occurred were then weighted and summed to yield a single life stress score (appendix E).

The Locke-Wallace Marital Adjustment Survey (Locke 1968) was adapted by changing the present tense items to past tense. The survey asked 25 questions designed to measure the quality of the subject's marriage to the deceased. The items are weighted differentially and summed to yield a single estimate of marital adjustment. The maximum score is 157 for males and 154 for females (appendix F).

Process Measures

The Grief Work Survey was designed to measure the frequency with which the subject engaged in 51 cognitive and emotional activities typical of grievers. It also asked the subject to rate the relative helpfulness or harmfulness of these activities. The grief work activities were divided into three types: subject's behavior when alone, subject's behavior when with others, and other people's behavior toward the subject (appendix G).

The Attitude Toward Grief Survey asked five questions designed to measure the subject's attitude toward the grieving and mourning processes. It was phrased in general terms, asking what optimal behavior would be, as opposed to the Grief Work Survey which asked in which behaviors the subject had actually engaged. Items were constructed based on attitudes suggested in the literature and by specific attitudinal issues mentioned by grievers in the Metzger (1978) study (appendix H).

Outcome Measures

The Health Questionnaire used by Maddison and Walker (1967) measured deterioration since the death on a variety of health indices.

Responses were weighted according to the seriousness of the symptomatology experienced and summed to yield a single deterioration score. For the purposes of this study, subjects were asked to additionally note which symptoms had continued to persist into the present. Maddison and Walker had simply asked subjects to note health problems that had occurred at any time during bereavement (appendix I).

The Outcome Self-Report form is an 18 item multiple choice scale constructed by Metzger (1978) to obtain a combined estimate of psychological and social adjustment. The items were based on information used to determine outcome in the Harvard Bereavement Study (Glick et al. 1974; Parkes 1970; Parkes & Brown 1972). The form yields a summary score which can range from 15 to 60 (appendix J).

The Havinghurst-Neugarten Life Satisfaction Index (Adams 1969; Neugarten, Havinghurst & Tobin 1961) was used in the form revised by Metzger (Note 1) for use with a bereaved population. The scale was originally designed for use with a geriatric population. The 18 questions are intended to measure the optimism and pessimism of the subject's future expectations. The index yields a summary score which can range from 18 to 90 (appendix K).

The first two of the three questions on the Outlook Survey asked the subject to rate his/her ability to look back at the past with pleasure and forward to the future with optimism. The final question asked the subject to rate the amount of personal growth he/she had experienced during the grieving process. All three questions were rated on a nine point scale (appendix L).

Procedure

After volunteers returned the postcard stating their willingness to participate, an interviewer telephoned to schedule an appointment and answer any questions about the study. Interviews were conducted by one of four female graduate students in clinical psychology. Widowed individuals were assured that complete confidentiality would be maintained.

During the first part of the interview itself, the widowed person was given the opportunity to describe the events surrounding the death and mourning periods. This was done prior to the data collection because previous researchers (e.g., Metzger, 1978) had found subjects reluctant to participate in more structured data collection until they had discussed their loss with the interviewer. Usually an hour or more was spent in such discussion.

Throughout this portion of the interview, the interviewer listened attentively, reflected feelings and attempted to communicate acceptance of the subject's emotions. Interviewers did not try to guide the discussion nor did they attempt to provide therapy.

The second portion of the interview consisted of the subject completing the nine measures described above. The interviewer was available to answer questions about the forms. In addition, interviewers sometimes found it necessary to deal with emotional reactions triggered by specific questions. This usually consisted of allowing or facilitating emotional expression. Subjects spent an hour or more completing the forms. Subjects tended to have many questions about the research. These were answered following the data collection.

CHAPTER III

RESULTS

Table 1 shows mean frequency scores for each of the 51 items on the Grief Work Survey. The grand mean of scores for the 20 items which concerned what the subject thought about was 3.88. Mean scores on this subset of items ranged from 2.17 (close to "several times per day") for item 20 (remind myself of how much I value the time we did have together) to 5.47 (approximately once per month) for item 4 (review unpleasant memories from our past together and/or remember my spouse's bad qualities).

The grand mean of scores for the 13 items which concerned what other people told the subject was 5.03. Mean scores for this subset of items ranged from 3.88 (approximately once per week) for item 22 (tell me about pleasant memories they have about my spouse and/or tell me about my spouse's good qualities) to 5.90 (rarely or never) for item 23 (tell me about unpleasant memories they have about my spouse and/or tell me about my spouse's bad qualities).

The grand mean of scores for the 18 items which concerned the subject's behavior during discussions about the loss was 4.95. Mean scores for this subset of items ranged from 3.38 (approximately once per day) for item 36 (talk about good memories of my spouse) to 5.85 (rarely or never) for item 45 (try to figure out some of the confusing and/or troubling things that happened between us when we were married).

Thus, it appears that for the average subject solitary grief work was common, with some types of cognitions occurring as frequently as several times per day. Grief work with other people was more rare. The most frequent item in these subsets occurred daily, but most items occurred weekly or less frequently.

TABLE 1

MEAN FREQUENCY SCORES FOR ITEMS ON GRIEF WORK SURVEY

Behavior While Alone		Other's Behavior		Subject's Behavior	
Item	Mean Score	Item	Mean Score	Item	Mean Score
1	3.4	21	4.0	34	4.7
2	4.7	22	3.9	35	5.3
3	2.4	23	6.0	36	3.4
4	5.5	24	5.0	37	5.7
5	4.6	25	4.8	38	5.4
6	4.1	26	5.2	39	5.7
7	4.4	27	5.7	40	5.1
8	3.8	28	5.8	41	4.9
9	3.2	29	5.1	42	4.8
10	4.5	30	5.5	43	4.0
11	3.3	31	4.2	44	4.8
12	3.0	32	5.0	45	5.9
13	5.3	33	5.3	46	5.6
14	4.9			47	4.7
15	3.8			48	4.6
16	2.8			49	4.8
17	2.9			50	5.5
18	4.4			51	4.4
19	4.4				
20	2.2				

Subjects showed a great deal of consistency in their responses to the Attitude Questionnaire. Questions 1, 2, and 3 which asked subjects to rank groups of statements in order of importance were scaled using the normalized rank method (Guilford, 1954). Using this technique, random responding would result in the items clustering tightly around the zero point on the scale whereas perfect agreement

would result in the items being widely spaced across the scale. Figure 1 shows the scale resulting from Question 1 which asked which of a series of behaviors are most important for a bereaved person. Subjects saw "allowing himself/herself to express emotion" as most important for a bereaved individual and "forgetting" as least important. The index of reproducibility ($\underline{r}_r$), a measure of consistency in responding, was .66.

Figure 2 shows the scale resulting from Question 2 which asked how close friends and relatives can best help a bereaved person. "Showing they care" and "listening" were seen as the most helpful activities whereas "avoiding the mention of the deceased" was seen as the least helpful thing a close friend or relative could do. The index of reproducibility for this scale was .76.

Much less consistency was seen in responses to Question 3 which asked about situations that make bereavement harder than it need be. Subjects identified having to deal with "other people's embarrassment about talking about death" as a significant problem, but otherwise did not seem to respond to this question in any consistent fashion. Figure 3 shows the scale resulting from Question 3. The index of reproducibility for this scale was .25, noticeably lower than for the previous scales.

Table 2 shows the number and percentage of subjects choosing each alternative in Question 4. This question asked which alternative a bereaved person should choose if circumstances were optimal for dealing with their grief. Binomial tests were performed to determine the probabilities that distributions as deviant as these from an equal division would occur by chance. In six of the eight pairs of alternatives differences achieved high statistical significance ($\underline{p}<.001$). Subjects showed clear preference for active grief work rather than passive

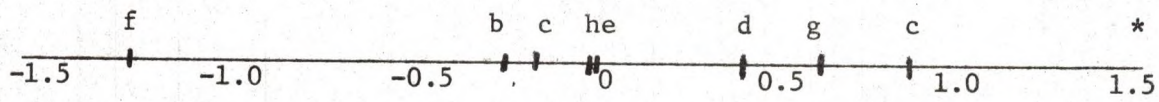

Fig. 1. Scaled rankings of grief tasks.

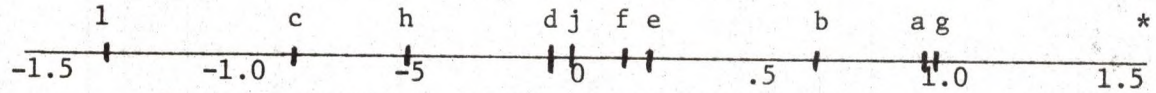

Fig. 2. Scaled rankings of griever's needs.

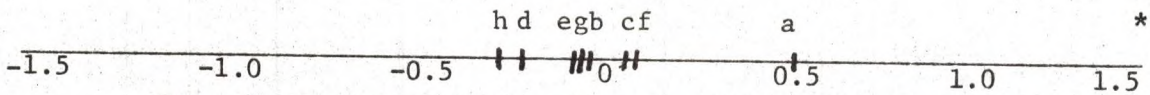

Fig. 3. Scaled rankings of events which make grief more difficult.

*See appendix H for explanation of small letters.

TABLE 2

NUMBER AND PERCENTAGE OF SUBJECTS CHOOSING EACH ALTERNATIVE FOR QUESTION 4 ON THE ATTITUDE TOWARD GRIEF SURVEY

Question	Number	Percentage	p
Live alone	24	40%	
Live with others	36	60	
	60		p=.1212
Continue to live in same place	54	90	
Move	6	10	
	60		p<.001
Use tranquilizers	14	23	
Avoid tranquilizers	46	77	
	60		p<.001
Spend time with close friends	49	83	
Spend time alone	10	17	
	59		p<.001
Participate in funeral	46	78	
Avoid participation	13	22	
	59		p<.001
Visit cemetery	41	69	
Avoid cemetery	18	31	
	59		p≤.003
Continue social activities	49	82	
Withdraw from social activities	11	18	
	60		p<.001
Interact with many acquaintances at funeral	47	80	
Interact with only close friends	12	20	
	59		p<.001

acceptance and for sharing their grief with others rather than grieving alone.

Question 5 of the Attitude Survey asked about subjects conception of the societal support available to the widowed. Table 3 shows the number and percentage of subjects agreeing with each statement presented.

Except in regard to the item regarding the expectation of "eventually" returning to a full social life, significant minorities of subjects seemed to fault their support systems on each of the issues raised. Indeed, less than half of the subjects felt that their pain could be understood by people who had not experienced it.

TABLE 3

NUMBER AND PERCENTAGE OF SUBJECTS AGREEING WITH STATEMENTS ON QUESTION 5 OF THE ATTITUDE TOWARDS GRIEF SURVEY

	Number Agreeing	Percentage Agreeing
The widowed person tends to be abandoned by his /her former friends	11	18%
Clergy tend to provide good support for widowed people	39	65
People understand the emotions that a bereaved person is experiencing	27	45
It is reasonable for a widowed person to expect to return to an interesting social life	55	92
Many married people see the widow or widower as a threat	16	27

Changes in Grief Work Over Time

In order to assess changes in the nature of grief work over time, subjects were divided into four groups on the basis of the length of time they had been bereaved. Group 1 consisted of 19 subjects who had been bereaved for six months or fewer. Group 2 had been bereaved between seven and twelve months. Group 3 had been bereaved between 13 and 18 months and Group 4 for 19 months or more. The mean number of months of bereavement for the four groups was 4.42, 9.68, 15.00, and 21.75 respectively.

Table 4 shows the mean frequency score on each item of the Grief Work Survey for each of the four groups. For each item, the group with the lowest average score (i.e., the group that is engaging in that activity most frequently) is circled. The group with the highest average score (i.e., the group that is engaging in that activity least frequently) is boxed.

TABLE 4

MEAN FREQUENCY SCORES FOR EACH GROUP ON ITEMS OF THE GRIEF WORK SURVEY

Item Number	1 (6 Months or less)	2 (7-12 Months)	3 (13-18 Months)	4(19 Months or more)
1	(2.9)	3.5	[3.7]	[3.7]
2	(4.4)	4.8	4.6	[5.0]
3	(2.1)	[2.7]	2.6	2.3
4	(5.2)	5.4	[5.9]	5.8
5	(4.3)	4.7	[4.9]	4.8
6	(3.7)	4.3	[4.4]	4.3
7	(3.5)	[4.8]	4.7	5.1
8	3.8	[4.0]	3.9	(3.5)
9	3.3	(3.0)	[3.4]	3.2
10	[5.0]	(4.1)	4.6	4.4
11	3.4	(3.0)	[3.7]	3.4
12	(2.5)	[3.3]	2.7	3.2
13	(5.1)	5.2	[5.9]	5.8
14	(4.7)	4.8	4.9	[5.5]
15	(3.3)	3.9	[4.4]	3.8
16	(2.3)	[3.2]	2.7	2.9
17	2.9	(2.8)	[3.0]	[3.0]
18	[4.6]	4.5	(4.0)	4.2
19	(3.8)	4.5	[5.1]	4.5
20	(1.9)	2.0	[2.7]	2.6
21	(3.4)	4.4	[4.7]	4.1
22	(3.5)	4.0	[4.3]	3.9
23	6.0	(5.8)	6.0	6.0
24	(4.8)	5.1	[5.3]	5.0
25	(4.7)	4.8	[4.7]	[5.0]
26	(4.9)	5.1	[5.6]	5.3
27	5.8	5.6	[5.9]	(5.5)
28	(5.5)	5.9	[6.0]	5.8
29	5.0	5.2	[5.4]	(4.8)
30	(5.4)	5.5	[6.0]	5.5
31	(3.7)	4.5	[4.9]	4.0
32	(4.8)	5.2	[5.3]	(4.8)

TABLE 4--continued

Item Number	1 (6 Months or less)	2 (7-12 Months)	3 (13-18 Months)	4 (19 Months or more)
33	5.2	5.5	4.7	5.5
34	3.9	5.0	5.4	5.1
35	4.9	5.5	5.6	5.6
36	3.2	3.4	3.9	3.3
37	5.7	5.5	6.0	5.7
38	5.2	5.4	5.7	5.6
39	5.3	5.9	5.9	5.6
40	5.2	4.8	5.6	5.1
41	4.6	5.0	5.3	4.8
42	4.6	5.0	4.9	4.6
43	4.0	4.5	3.0	3.7
44	4.7	5.0	4.7	4.6
45	5.8	5.9	5.7	6.0
46	5.4	5.6	5.6	5.8
47	4.7	4.5	5.0	4.8
48	3.9	4.7	5.4	4.7
49	4.4	4.9	5.0	5.1
50	5.4	5.5	5.4	5.6
51	4.5	4.2	4.6	4.5

Group 1, the most recently bereaved, shows a pattern of being more frequently engaged in most forms of grief work. They are least commonly engaged only in worrying about the problems of being single and trying to distract themselves from thinking about the grief. Otherwise, there appear to be few differences among groups.

Analyses of variance were conducted for each to determine whether or not differences among groups were significant. Only three of the 51 items achieved statistical significance. These were item #7 (feeling that the loss is unreal), #34 (tell others about my emotions) and #35 (cry). Tables 5 - 10 show the results of the analyses of variance and Duncan's multiple range tests for these items. For item 7, Group 1,

(the most recently bereaved) engaged in the behavior significantly more often than intermediate Groups 2 and 3. For item 34, Group 1 engaged in the behavior significantly more frequently than all other groups. For item 35, Group 1 engaged in the behavior significantly more frequently than Group 4. Thus, all three of the significant results were in the direction indicating that the newly bereaved were more frequently involved in grief work.

Analyses of variance were also conducted to determine the relationship between recency of bereavement and the various outcome measures. No significant differences between groups were found. Results of all the nonsignificant tests are found in appendix M.

TABLE 5

ANALYSIS OF VARIANCE - ITEM 7

Source	df	Ms	F	P
Model	3	7.93	3.15	.03
Error	56	2.52		
Total	59			

TABLE 6

DUNCAN TEST - ITEM 7

Grouping	Mean	N	Group
A	5.08	12	4
A	4.77	22	2
B A	4.71	7	3
B	3.53	19	1

TABLE 7

ANALYSIS OF VARIANCE - ITEM 34

Source	df	MS	F	P
Model	3	6.59	3.91	.01
Error	56	1.69		
Total	59			

TABLE 8

DUNCAN TEST - ITEM 34

Grouping	Mean	N	Group
A	5.43	7	3
A	5.08	12	4
A	5.00	22	2
B	3.89	19	1

TABLE 9

ANALYSIS OF VARIANCE - ITEM 35

Source	df	MS	F	P
Model	3	1.80	2.66	.06
Error	56	0.68		
Total	59			

TABLE 10

DUNCAN TEST - ITEM 35

Grouping		Mean	N	Group
	A	5.58	12	4
B	A	5.57	7	3
B	A	5.50	22	2
B		4.89	19	1

Cluster Analysis

In order to differentiate styles of grieving, subjects were clustered based on their answers to the Grief Work Survey. A hierarchical technique (McQuitty, 1957; McQuitty and Clark, 1968) was used. Basically, this technique pictures each subject as occupying a unique point in multi-dimensional space as determined by the answers to the items on the survey. The two subjects closest to each other are then fused at a point midway between them forming the first cluster. This process is continued until all subjects are fused at a point that reflects average answers for the entire group of subjects. This technique produces a hierarchical structure which can be diagrammed. Division into clusters can occur at any point along the hierarchy, creating clusters which vary in their degree of consistency.

Four separate cluster analyses were performed. The first was based on all 51 items on the Grief Work Survey. The latter three were conducted on each of the three subsets of items: (1) behavior while alone, (2) other people's behavior when with the subject, and (3) the subject's behavior when with other people.

In the hierarchical classification of subjects based on all 51 items, a line was drawn dividing subjects into four major clusters and four individual or small groups which seemed to be rather unique in their thinking and behavior. Table 11 shows cluster membership.

Table 12 shows mean scores of each cluster on critical items of the Grief Work Survey. These items were chosen because they had a greater variance than other items and therefore differences between clusters were more likely to be meaningful ones. For each item, the cluster with the lowest average score (i.e., the cluster that is engaging in that activity most frequently) is circled. The cluster with the highest average score (i.e., the cluster that is engaging in that activity least frequently) is boxed.

TABLE 11

CLUSTER MEMBERSHIP FOR FIRST CLUSTER ANALYSIS

Cluster 1		
Subjects #:	2,3,6,9,10,12,15,17,19,20, 23,24,26,28,30,36,37,39,45, 47,48,50,52,54,55,59,60	N = 27
Cluster 2		
Subjects #:	7,11,21,25,27,33, 34,35,38,40,43,57	N = 12
Cluster 5		
Subjects #:	1,5,13,18,31,32,49,51	N = 8
Cluster 7		
Subjects #:	14,29,41,44,46,53,58	N = 7
	TOTAL IN CLUSTERS: =	54

TABLE 12

MEAN SCORES OF CRITICAL ITEMS ON THE
GRIEF WORK SURVEY FOR THE FIRST CLUSTER ANALYSIS

Item # *	Cluster #			
Behavior while alone	1	5	2	7
6	4.9	4.4	4.1	2.6
7	5.4	3.5	4.8	2.7
8	4.4	4.0	3.7	3.1
9	3.7	1.8	3.3	2.0
10	5.3	4.9	4.1	2.6
11	4.3	3.3	3.0	1.9
12	3.5	2.5	2.3	2.1
15	4.4	3.8	4.3	2.0
16	3.2	1.1	2.8	2.4
17	3.6	2.1	2.7	2.0
18	4.8	5.1	4.3	4.1
19	5.3	4.6	3.4	2.9
Others behavior toward subject				
21	4.7	1.6	4.1	4.3
22	4.6	1.6	3.9	3.9
31	4.7	3.1	3.9	3.7
32	5.4	4.5	4.7	4.1
Subjects behavior with others				
34	5.1	4.3	4.5	3.3
36	4.0	2.0	3.3	3.1
42	5.7	3.8	3.7	5.0
43	4.7	3.6	2.8	4.0
44	5.4	4.5	3.8	3.9
47	5.2	4.8	4.7	3.3
48	5.3	3.1	4.7	3.0
49	5.2	4.3	4.6	3.6
50	5.8	5.9	5.3	5.7
51	4.8	4.3	4.2	3.9

*See appendix G for explanation of items.

Cluster 1 appears to be a group of people who are not actively involved in the grief process. They are the group which is least likely to engage in the greatest number of grief behaviors. Perhaps this is a group which has resolved their grief. On the other hand, it is possible

that these people are simply denying their grief.

In contrast to Cluster 1, Cluster 7 appears to be the group that is most acutely grieving. They are most likely to engage in the greatest number of grief behaviors. They are the group which most frequently expresses emotion, and engages in active grief work such as discussing linking objects or their spouse's values and interests. However, they also seem to feel that the loss is unreal, to think about the suffering involved in the death, and to remind themselves of the need to continue living despite the loss. Perhaps this group could best be described as overwhelmed.

Cluster 5 appears to contain a group of people who, while not grieving as acutely as those in Cluster 7, are also doing a great deal of grief work. These people seem to share their feelings and memories with others more than members of the other clusters do and they appear to have better support systems. They are the most likely to be told that others miss their spouse and that others are concerned about them. They are also most likely to share positive memories with others. Perhaps this group could best be described as emotionally expressive active grievers.

Cluster 2 is distinguished from the others as being highly likely to attempt to distract themselves from thinking about their loss and most likely to change the subject when another person mentioned the deceased. They were also likely to remind themselves of their need to continue living despite the loss. When discussing the loss with others, they were the most likely group to reaffirm their religious beliefs and to discuss their need to learn new independent living skills. Cluster 2 is a more difficult cluster to label than the others,

but perhaps they could best be described as attempting to "maintain a stiff upper lip" in the face of their loss. The interviewers felt that members of this group showed hysteroid features. Unfortunately, the collected data does not contain the information that would be necessary to support or refute this observation.

One way analyses of variance were conducted to determine the relationship between cluster membership and a number of other variables. Separate analyses were performed for each of the following variables: age of subject, length of marriage, number of previous losses, time since the death, use of tranquilizers in early bereavement, stress prior to bereavement as measured by the Holmes Rahe Survey, present score on the Health Questionnaire, total score on the Health Questionnaire, scores on each of the three items on the Outlook Survey, score on the Life Satisfaction Survey, score on the Outcome Self-Report, and marital quality as measured by the Locke-Wallace Survey. Five of the analyses of variance were found to be significant at the p .05 level or better. Duncan Multiple Range tests were performed to determine which pairs of means were significantly different from each other. Tables 13-22 show the results of the analyses of variance and Duncan multiple range tests for each of the significant analyses. Results of the nonsignificant tests are found in appendix M.

TABLE 13

ANALYSIS OF VARIANCE FOR MONTHS SINCE DEATH ON FIRST CLUSTER ANALYSIS

Source	df	MS	F	p
Model	3	131.32	3.43	.02
Error	49	38.33		
Total	52			

TABLE 14

DUNCAN TEST FOR MONTHS SINCE DEATH ON FIRST CLUSTER ANALYSIS

Grouping		Mean	N	Cluster
	A	15.50	12	2
B	A	11.41	27	1
B		8.17	6	7
B		7.38	8	5

TABLE 15

ANALYSIS OF VARIANCE FOR HEALTH QUESTIONNAIRE-TOTAL SCORE ON FIRST CLUSTER ANALYSIS

Source	df	MS	F	p
Model	3	357.04	5.83	.002
Error	49	61.28		
Total	52			

TABLE 16

DUNCAN TEST FOR HEALTH QUESTIONNAIRE-
TOTAL SCORE ON FIRST CLUSTER ANALYSIS

Grouping		Mean	N	Cluster
	A	16.08	12	2
B	A	12.83	6	7
B	C	8.38	8	5
	C	5.26	27	1

TABLE 17

ANALYSIS OF VARIANCE FOR HEALTH
QUESTIONNAIRE-PRESENT SCORE ON FIRST CLUSTER ANALYSIS

Source	df	MS	F	p
Model	3	287.53	6.39	.001
Error	49	44.98		
Total	52			

TABLE 18

DUNCAN TEST FOR HEALTH QUESTIONNAIRE-
PRESENT SCORE ON FIRST CLUSTER ANALYSIS

Grouping		Mean	N	Cluster
	A	11.83	12	2
B	A	5.33	6	7
B		2.13	8	5
B		2.00	27	1

TABLE 19

ANALYSIS OF VARIANCE FOR OUTCOME SELF-REPORT FORM ON FIRST CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	61.41	3.75	.02
Error	49	16.36		
Total	52			

TABLE 20

DUNCAN TEST FOR OUTCOME SELF-REPORT FORM ON FIRST CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	35.00	6	7
B	29.92	12	2
B	29.63	8	5
B	28.89	27	1

TABLE 21

ANALYSIS OF VARIANCE ON LOCKE-WALLACE MARITAL SATISFACTION SURVEY ON FIRST CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	891.54	3.71	.02
Error	48	240.40		
Total	51			

TABLE 22

DUNCAN TEST ON LOCKE-WALLACE MARITAL SATISFACTION SURVEY ON FIRST CLUSTER ANALYSIS

Grouping		Mean	N	Cluster
	A	141.25	12	2
B	A	137.88	8	5
B	A	125.67	6	7
B		125.23	26	1

According to test results, members of Cluster 2 (those with a "stiff upper lip") had been widowed for a significantly longer period of time than members of Clusters 5 and 7 (the emotionally expressive and acute grievers). Cluster 2 also showed significantly greater health deterioration both throughout the bereavement and at the time of the interview than Cluster 5 (the emotionally expressive grievers) and Cluster 1 (the non-grievers). Cluster 2 was also distinguished as reporting significantly greater marital satisfaction than Cluster 1.

Cluster 7 (the acute grievers) was distinguished as showing significantly greater health deterioration throughout the bereavement than Cluster 1 and significantly greater health deterioration persisting to the time of the interview than both Clusters 5 and 1. Cluster 7 also showed significantly poorer levels of social functioning (as measured by the Outcome Self-Report form) than any other cluster. No other differences between groups were significant.

Cluster Analysis: Cognitive Behavior While Alone

The first 20 items of the Grief Work Survey concern the subjects behavior when alone and thinking about the loss. Subjects were hierarchically clustered based on their responses to these items and a line was drawn dividing subjects into four major clusters and one isolated pair that seemed to be rather unique in their thinking. Table 23 shows cluster membership.

Table 24 shows mean scores of each cluster on each of the 20 items. For each item the cluster with the lowest average score (i.e., the cluster that is engaging in that activity most frequently) is circled. The cluster with the highest average score (i.e., the cluster that is engaging in that activity least frequently) is boxed.

TABLE 23

CLUSTER MEMBERSHIP FOR THE SECOND CLUSTER ANALYSIS

Cluster 1		
Subjects #:	2,3,5,6,9 11,12,13,17,19 20,24,26,28 30,32,36,37,38 39,47,52,55,59 60	N=26
Cluster 3		
Subjects #:	1,7,10,21,23 25,27,31,33,34 35,40,42,45,46 48,51,54,57	N=19
Cluster 4		
Subjects#:	4,16,22,43,44 53	N=6
Cluster 5		
Subjects #:	14,18,29,41,49 56,58	N=7
	TOTAL IN CLUSTER =	58

Cluster 1 appears to be a group of people who are not actively involved in the grief process. In that regard they are similar to the first cluster identified when the entire form was clustered. Cluster 1 was the least likely of the four clusters to engage in 15 of the 20 items listed. They were most likely to engage in only one activity: reviewing negative memories. However, this was an activity that was extremely rare in all clusters. As when the clusters were based on the entire form, this cluster may represent people who have resolved their grief or who are denying their grief. Of the 26 members of Cluster 1, 21 are also members of the first cluster of the total survey clustering.

TABLE 24

MEAN SCORE OF ITEMS ON THE GRIEF WORK SURVEY FOR THE SECOND CLUSTER ANALYSIS

ITEM *	CLUSTER			
	1	3	4	5
1	3.8	3.9	2.5	1.9
2	5.1	4.9	3.7	4.0
3	3.0	2.2	1.8	1.3
4	5.4	5.7	5.7	5.6
5	5.3	4.5	5.2	2.8
6	5.0	4.5	1.8	2.6
7	5.4	4.8	2.3	2.0
8	4.5	3.7	2.5	3.0
9	3.9	2.5	2.2	2.3
10	5.5	4.2	2.0	3.7
11	4.9	2.1	1.7	2.0
12	3.8	2.3	2.5	2.3
13	5.6	5.7	4.8	4.3
14	5.5	5.0	4.5	2.4
15	4.7	3.8	2.5	1.7
16	3.2	2.5	3.3	1.7
17	3.8	2.2	1.7	1.9
18	4.6	4.9	2.2	5.3
19	5.0	4.1	3.2	3.4
20	2.9	1.7	1.3	1.0

*See appendix G for explanation of items.

Cluster 5 is a group of seven individuals, four of whom had been in the seventh (overwhelmed) cluster when clusters had been based on the entire form. The other three subjects had been in the fifth (emotionally expressive) cluster or had been isolated in the former analysis. Cluster 5 appears to be a group of people who are grieving quite acutely. They are the individuals least likely to attempt to distract themselves from thinking about their loss. They were most likely to be engaging in a variety of active grieving behaviors such as reviewing positive memories, attempting to make sense of the relationship, dealing with unfinished business, thinking about how the spouse would have reacted to current situations, and consciously continuing shared values and interests. Perhaps this group could best be labeled as active grievers.

Cluster 4, like Cluster 5, also seems to represent a group of individuals who are in the midst of acute grief. In contrast to Cluster 5 members, however, members of Cluster 4 are more oriented toward their need to continue than toward dealing with their loss or with relationship issues. This group reports crying more frequently than any of the other groups. However, they are also most likely to remind themselves of their need to continue despite their loss, to try to plan their future, to worry about the social problems involved in being single again, to try to develop new skills for independent living and to try to distract themselves from thinking about the loss. Most members of Cluster 4 had been isolates on the earlier cluster analysis. Perhaps they could best be labeled as struggling to continue.

Cluster 3 consists of 19 individuals who fell into a number of different clusters in the prior analysis. They are a rather nondescript group which seems to be grieving less acutely than members of Cluster 4

and Cluster 5, but are more involved in their grief than members of Cluster 1.

One-way analyses of variance were conducted to determine the relationship between cluster membership and a number of other variables. Separate analyses were performed for each of the following variables: age of subject, length of marriage, number of previous losses, time since death, use of tranquilizers in early grief, stress prior to bereavement as measured by the Holmes Rahe Survey, present score on the Health Questionnaire, total score on the Health Questionnaire, scores on each of the three items on the Outlook Survey, score on the Life Satisfaction Survey, score on the Outcome Self-Report, and marital quality as measured by the Locke-Wallace Survey. Six of the analyses of variance were found to be significant at the $p<.05$ level or better. Duncan's Multiple Range tests were performed to determine which pairs of means were significantly different from each other. Tables 25-36 show the results of these statistical tests. Results of the non-significant tests are summarized in appendix M.

It can be seen that those in Cluster 4 (those struggling to continue) report on the Life Satisfaction Survey that they are significantly less satisfied with their lives than those in any of the other three clusters. Cluster 4 members also report a significantly poorer social functioning level (as measured by the Outcome Self-Report) than any of the other three groups. Finally, Cluster 4 members report having experienced a greater number of previous losses than members of any of the other three groups.

Cluster 3 (the rather nondescript group of intermediate grievers) was distinguished as showing significantly greater health deterioration both at the time of the interview and throughout the bereavement period

TABLE 25

ANALYSIS OF VARIANCE FOR NUMBER OF PREVIOUS LOSSES ON SECOND CLUSTER ANALYSIS

Source	df	MS	F	p
Model	3	12.64	2.95	.04
Error	54	4.28		
Total	57			

TABLE 26

DUNCAN TEST FOR NUMBER OF PREVIOUS LOSSES ON SECOND CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	5.00	6	4
B	2.58	19	3
B	2.29	7	5
B	2.27	26	1

TABLE 27

ANALYSIS OF VARIANCE FOR MONTHS SINCE DEATH ON SECOND CLUSTER ANALYSIS

Source	df	MS	F	p
Model	3	106.50	2.76	.05
Error	54	38.59		
Total	57			

TABLE 28

DUNCAN TEST FOR MONTHS SINCE DEATH ON SECOND CLUSTER ANALYSIS

Grouping		Mean	N	Cluster
	A	13.63	19	3
B	A	11.38	26	1
B	A	9.50	6	4
B		6.00	7	5

TABLE 29

ANALYSIS OF VARIANCE FOR HEALTH
QUESTIONNAIRE PRESENT SCORE ON SECOND CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	190.61	3.93	.01
Error	54	48.61		
Total	57			

TABLE 30

DUNCAN TEST FOR HEALTH QUESTIONNAIRE-
PRESENT SCORE ON SECOND CLUSTER ANALYSIS

Grouping		Mean	N	Cluster
	A	8.47	19	3
B	A	8.17	6	4
B	A	4.14	7	5
B		1.73	26	1

TABLE 31

ANALYSIS OF VARIANCE FOR HEALTH QUESTIONNAIRE - TOTAL SCORE ON SECOND CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	295.39	3.86	.01
Error	54	76.50		
Total	57			

TABLE 32

DUNCAN TEST FOR HEALTH QUESTIONNAIRE - TOTAL SCORE ON SECOND CLUSTER ANALYSIS

Grouping		Mean	N	Cluster
	A	14.58	19	3
B	A	11.33	6	4
B	A	9.43	7	5
B		5.69	26	1

TABLE 33

ANALYSIS OF VARIANCE FOR LIFE SATISFACTION INDEX ON SECOND CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	194.10	2.68	.06
Error	54	72.47		
Total	57			

TABLE 34

DUNCAN TEST FOR LIFE SATISFACTION INDEX ON SECOND CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	56.50	6	4
B	46.43	7	5
B	46.42	19	3
B	45.85	26	1

TABLE 35

ANALYSIS OF VARIANCE FOR OUTCOME SELF-REPORT FORM ON SECOND CLUSTER

Source	df	MS	F	P
Model	3	67.91	3.50	.02
Error	54	19.40		
Total	57			

TABLE 36

DUNCAN TEST FOR OUTCOME SELF-REPORT FORM ON SECOND CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	35.50	6	4
B	30.43	7	5
B	30.26	19	3
B	29.03	26	1

than the nongrievers in Cluster 1. Cluster 3 members had been widowed for a significantly shorter period of time than the active grievers of Cluster 5. No other differences between groups were significant.

Cluster Analysis: Behavior With Others

Behavior of others and behavior of the subjects when with others showed much less variability than did the behavior of the subjects when they were alone and thinking about their loss. All interpersonal grief activities were much less frequent than were the solitary grief activities. Consequently, clustering and examination of differences among clusters must be undertaken with caution.

A hierarchical classification of subjects based on the thirteen items that asked how other people behaved toward the subject when the loss was discussed was determined and a line was drawn dividing subjects into three clusters and four isolated subjects. Table 37 shows cluster membership. Reflecting the lack of variability in this area, Cluster 1 includes more than half of the subjects.

Table 38 shows mean scores of each cluster on the thirteen items. For each item, the cluster with the lowest average score (i.e., the cluster engaging in that activity most frequently) is circled. The cluster with the highest average score (i.e., the cluster engaging in that activity least frequently) is boxed. The scores for Cluster 5 on items 21 and 22 appear to reflect a misunderstanding of the question, since "1" was defined as "almost all the time" (which was implicitly more than "2," "several times a day").

TABLE 37

CLUSTER MEMBERSHIP FOR THE THIRD CLUSTER ANALYSIS

Cluster 1		
Subjects #:	2,3,7,8,9 10,12,14,15,16 17,19,22,23,24 25,26,28,29,30 35,36,37,40,41 45,47,48,50,51 52,54,55,56,57 59	N=36
Cluster 2		
Subjects #:	4,11,20,21,27 34,38,39,43,44 46,49,53,58,60	N=15
Cluster 5		
Subjects #:	5,6,31,32,33	N=5
	TOTAL IN CLUSTERS =	56

TABLE 38

MEAN FREQUENCY SCORE OF ITEMS ON THE GRIEF WORK SURVEY FOR THE THIRD CLUSTER ANALYSIS

Item #*	CLUSTER 1	2	5
21	4.7	4.2	1.0
22	4.5	4.1	1.0
23	5.9	6.0	5.6
24	5.4	4.3	5.4
25	5.1	4.3	4.8
26	5.2	5.2	5.2
27	5.6	5.7	6.0
28	5.9	5.7	5.6
29	5.3	4.5	5.0
30	5.8	5.3	5.8
31	4.7	3.4	3.6
32	5.5	3.9	5.8
33	5.5	4.8	5.8

*See appendix G for explanation of items.

Stylistic differences among the three clusters do not seem apparent. Rather, these clusters seemed to be based on the amount of interaction subjects were having with others regarding the loss. Cluster 2 seems to be the group having the most interaction with others regarding the loss and Cluster 1 seems to have the least. Cluster 5 falls between Cluster 1 and Cluster 2.

One way analyses of variance were conducted to determine the relationship between cluster membership and a number of other variables. Separate analyses were performed for each of the following variables: age of subject, length of marriage, number of previous losses, time since the death, use of tranquilizers in early bereavement, stress prior to bereavement as measured by the Holmes Rahe Survey, present score on the Health Questionnaire, total score on the Health Questionnaire, score on each of the three items on the Outlook Survey, score on the Life Satisfaction Index, score on the Outcome Self-Report form, and marital quality as measured by the Locke Wallace Survey. Only one of these analyses was significant. Table 39 shows the results of the analysis of variance for scores on the Locke Wallace Survey. Results of the non-significant tests are summarized in appendix M. The Duncan Multiple Range test, as shown in Table 40, showed no significant differences between individual pairs of means. A Scheffé test revealed that Clusters 2 and 5 combined stated significantly more satisfaction with their marriages than those in Cluster 1 ($p<.05$).

TABLE 39

ANALYSIS OF VARIANCE FOR LOCKE-WALLACE MARITAL SATISFACTION SURVEY ON THE THIRD CLUSTER ANALYSIS

Source	df	MS	F	p
Model	2	1294.87	5.27	.0008
Error	52	245.92		
Total	54			

TABLE 40

DUNCAN TEST FOR LOCKE-WALLACE MARITAL SATISFACTION SURVEY ON THE THIRD CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	141.00	5	5
A	139.13	15	2
A	125.37	35	1

On the hierarchical classification of subjects based on the 18 items which concerned how subjects behaved when discussing their loss with other people a line was drawn dividing subjects into four clusters. As seen on Table 41, Clusters 1 and 2 contained the majority of subjects. Eight individuals whose behavior was relatively unique were not included in any of the four clusters.

Table 42 shows mean scores of each cluster on each of the 18 items. Again, for each item, the cluster with the lowest average score (i.e., the cluster engaging in that activity most frequently) is circled. The cluster with the highest average score (i.e., the cluster engaging in that activity least frequently) is boxed.

Cluster 1, the largest group, appears to be composed of people who do not discuss their grief. They report that they tell someone about a positive memory of their spouse approximately once per week. However, they report engaging in all other interpersonal grief behavior less frequently than once per month. This group shows significant overlap in membership with the first cluster found in the total survey cluster analysis. Of the 23 members of Cluster 1, 18 were members of the first cluster in the previous analysis.

TABLE 41

CLUSTER MEMBERSHIP FOR THE FOURTH CLUSTER ANALYSIS

Cluster 1		
Subjects #:	6,8,9,10,12 15,16,17,20,23 24,26,28,32,36 37,47,50,54,55 56,57,59	N=23
Cluster 2		
Subjects #:	2,3,5,11,13 21,25,27,29,30 33,35,38,39,40 48,53,58,60	N=19
Cluster 4		
Subjects #:	1,7,19,49,51 52	N=6
Cluster 7		
Subjects #:	18,41,44,46	N=4
		TOTAL IN CLUSTERS =52

At the other extreme, Cluster 7 appears to be composed of acute grievers. Three of the four members of Cluster 7 had been in the seventh (overwhelmed) cluster found in the total survey cluster analysis.

TABLE 42

MEAN FREQUENCY SCORES FOR ITEMS ON
THE GRIEF WORK SURVEY FOR THE FOURTH CLUSTER ANALYSIS

Item #*	1	2	4	7
34	5.3	5.1	3.0	2.3
35	5.7	5.3	4.3	4.8
36	4.0	3.5	3.3	2.0
37	5.4	5.7	5.8	6.0
38	5.7	5.3	5.5	5.3
39	5.9	5.7	5.5	5.5
40	5.6	4.7	6.0	3.8
41	5.3	4.6	5.0	3.0
42	5.3	5.1	4.3	4.3
43	5.3	3.1	3.3	4.0
44	5.4	4.3	5.7	3.0
45	6.0	5.8	5.5	5.5
46	6.0	6.0	4.8	4.0
47	5.3	4.8	5.0	3.8
48	5.3	4.5	4.7	3.0
49	5.5	4.7	4.5	3.8
50	5.6	5.5	5.7	6.0
51	5.2	4.4	3.8	3.5

*See appendix G for item explanation.

Members of Cluster 7 were most likely to engage in 14 of the 18 listed grief activities.

Clusters 2 and 4 are difficult ones to label. They both appear to fall into an intermediate range between Clusters 1 and 7. However, it is difficult to differentiate between them on a qualitative basis. It does appear that the individuals in Cluster 4 are more acutely grieving than are those in Cluster 2. In addition, members of Cluster 4 seem much more likely to share their emotions with others.

One way analyses of variance were conducted to determine the relationship between cluster membership and a number of other variables. Separate analyses were performed for each of the following variables: age of subject, length of marriage, number of previous losses, time since death, use of tranquilizers in early grief, stress prior to bereavement as measured by the Holmes-Rahe, present score on the Health Questionnaire, total score on the Health Questionnaire, scores on each of the three items on the Outlook survey, score on the Life Satisfaction Index, score on the Outcome Self-Report, and marital satisfaction as measured by the Locke-Wallace. Three of the analyses were found to be significant at the $p<.05$ level or greater. Duncan's Multiple Range tests were performed to determine which pairs of means were significantly different from each other. Tables 43-48 show the results of these tests. Results of the nonsignificant tests are summarized in appendix M.

TABLE 43

ANALYSIS OF VARIANCE FOR MONTHS SINCE DEATH ON THE FOURTH CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	120.34	3.35	.03
Error	47	35.91		
Total	50			

TABLE 44

DUNCAN TEST FOR MONTHS SINCE DEATH ON THE FOURTH CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	13.05	19	2
B A	11.00	23	1
B	6.00	6	4
B	4.33	3	7

TABLE 45

ANALYSIS OF VARIANCE ON HEALTH QUESTIONNAIRE-TOTAL SCORE ON FOURTH CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	251.13	3.48	.02
Error	47	72.21		
Total	50			

TABLE 46

DUNCAN TEST ON HEALTH QUESTIONNAIRE-
TOTAL SCORE ON FOURTH CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	14.66	3	7
A	13.58	19	2
A	6.17	23	1
A	5.33	6	4

TABLE 47

ANALYSIS OF VARIANCE FOR LOCKE-WALLACE MARITAL
SATISFACTION SURVEY ON FOURTH CLUSTER ANALYSIS

Source	df	MS	F	P
Model	3	1972.41	9.91	.0001
Error	46	199.11		
Total	49			

TABLE 48

DUNCAN TEST FOR LOCKE-WALLACE MARITAL
SATISFACTION SURVEY ON FOURTH CLUSTER ANALYSIS

Grouping	Mean	N	Cluster
A	140.79	19	2
A	137.50	6	4
B	120.23	22	1
B	109.33	3	7

Members of Cluster 7 (the acute grievers) had been widowed for a significantly shorter period of time than members of Cluster 2 (one of the intermediate groups). On the Locke-Wallace survey of marital adjustment members of both Cluster 2 and Cluster 4 (the other intermediate group) reported being significantly more satisfied with their marriage than members of either Cluster 1 (the nongrievers) or Cluster seven. While the analysis of variance for total bereavement score on the Health Questionnaire showed significance, the Duncan Multiple Range test showed no two groups to be significantly different from each other. This probably indicates that some combination of groups contained the significant difference. Since such a combination would be impossible to interpret from a real-world perspective, no further statistical tests were performed.

Factor Analysis

In another attempt to isolate styles of grief, the 51 items from the Grief Work Survey were factor analyzed. The principal axes method of factor analysis (Nunnally, 1967), a method which tends to maximize the amount of variance explained by the factors was used. A four factor solution was chosen as most meaningful. The factors were rotated using the varimax rotation system (Kaiser, 1958) which produces orthogonal (i.e. non-related) factors. Together the four factors accounted for 41 percent of the variance. Table 49 lists the item number and factor loading for the items on the Grief Work Survey that loaded highest on each of the four factors.

TABLE 49

FACTOR LOADINGS

Factor 1		Factor 2		Factor 3		Factor 4	
Item*	Loading	Item*	Loading	Item*	Loading	Item*	Loading
38	.81	6	.75	20	.68	31	.73
24	.81	7	.75	4	-.61	34	.71
30	.72	15	.69	37	-.55	32	.63
40	.70	50	.60	9	.55	48	.60
46	.66	1	.60	17	.49	12	.59
25	.64	2	.58	27	-.49	16	.53
19	.60	10	.56			35	.52
51	.54	14	.54			41	.48
42	.51	5	.49			21	.44
36	.46	11	.47			29	.44
5	.45	13	.45			44	.43
49	.44	8	.43			43	.42
47	.42	47	.42			22	.42
21	.41					36	.41

*See appendix G for item explanation.

Factor 1 appears to relate to the public recognition by both the griever and those around him of the immensity of the loss. It appears to focus largely on the griever's pain but does not relate to the emotional expression of that pain. Factor 2 appears to be a private factor relating to feelings of pain and suffering which are not shared with others. It appears to be affective in nature. Factor 3 also appears to be a private factor. In contrast to Factor 2, however, Factor 3 relates to positive thoughts of continuing links to the deceased and of gratitude for the time together. Factor 4 appears to relate to the receiving of comfort by sharing emotions with others and by remembering religious teachings about life after death. It is highly affective in nature. Thus, of the four factors, two (factors 1 and 4) are public and two (factors 2 and 3) are private. In addition, two factors (factors 1 and 2) seem to relate to the pain of bereavement and two (factors 3 and 4) relate to the comfort received.

Factor scores were calculated for each of the 60 subjects on each of the four factors. These factor scores were then correlated with scores on a number of other variables to determine whether specific cognitive patterns were related to specific background or outcome variables. The correlation between factor scores and each of the following background variables was determined: subject's sex, subject's age, subject's pre-bereavement health status, the length of the marriage, the number of previous losses, the time since the death had occurred, the length of the final illness, whether or not the subject had changed residences since the death, whether or not the subject had used tranquilizers during the early bereavement period, pre-bereavement stress

level, and marital satisfaction. Scores on the following outcome measures were also included: the Outlook Survey, the Life Satisfaction Index, the Outcome Self-Report and the two forms of the Health Questionnaire.

Two background measures, religious affiliation and type of death experienced, were nominal in nature and, thus, could not be examined using the standard correlation technique. The relationships with these two variables were analyzed by multiple regression in which dummy codings of the variables were used.

Factor 1, which related to public recognition of the immensity of the loss, correlated significantly with three variables. There was a significant relationship between Factor 1 and health deterioration during the entire bereavement period as measured by the Health Questionnaire (r=+0.44; p<.0002). This indicates that people who experienced frequent public recognition of their loss also experienced greater numbers of physical complaints. Factor 1 was also related to the Life Satisfaction Index (r=+0.28; p<.03), although this variable is more closely related to Factor 2. Subjects who experienced frequent recognition of their loss also stated more dissatisfaction with their current lives. Finally, Factor 1 was correlated with the use of tranquilizers in early grief (r=+0.27;p<.04). Those whose loss was recognized were more likely to have taken tranquilizers.

Factor 2, privately dwelling on one's pain, was significantly correlated with four other variables. People whose spouses had experienced longer final illnesses were more likely to dwell privately on their pain (r=+0.29);p<.02). As might be expected, high frequency of thinking about one's own current pain was also associated with a low

ability to view the past with pleasure as measured by the Outlook Survey (r=-0.25);p<.05), high dissatisfaction with one's current life as measured by the Life Satisfaction Index (r=+0.39; p<.002), and poor social functioning as measured by the Outcome Self-Report (r=+0.32; p<.01).

Factor 3, privately dealing with positive aspects of the relationship to the deceased, was significantly correlated with five other variables. Older people tended to engage in more positive reminiscing (r=+0.29; p<.02) as did people who had remained in the home they had shared with the deceased spouse (r=+0.37;p<.003). People who scored high on Factor 3 were also more likely to have been married to people who experienced long terminal illnesses (r=+0.26;p<.04) and to report that they had been highly satisfied with their marriages (r=+0.27;p<.04). Finally, Factor 3 showed a significant relationship to type of death experienced as determined by the multiple regression analysis ($F_{3,56}$= 7.65;p<.0003). Scheffé tests, performed to determine which groups or combination of groups differed significantly from each other, showed that those who had been able to anticipate their spouse's death (i.e., deaths from long illnesses) were much more likely to engage Factor 3 activities than those whose spouses had died suddenly in accidents, suicides or as a result of sudden illnesses. Furthermore, those whose spouses had died of natural causes (both short and long illnesses) were more likely to engage in these activities than those whose spouse had died in accidents or committed suicide. There was no significant difference between short and long illness. No other pairs of means were tested.

Factor 4, public expression of affect and receiving of comfort, was significantly correlated with two other variables. Women were

more likely to engage in this behavior than men were (r=+0.28;p<.03). In addition, people who were likely to engage in this behavior were also more likely to state that they had grown emotionally as a result of their grief experiences (r=+0.37;p<.003).

CHAPTER IV

DISCUSSION

Behavior and Attitudes

The bereaved individuals studied here stated that they thought about their loss frequently. Many of the grief work thoughts were reported to occur on a daily basis or more frequently. The most common of these activities were ones which demonstrate the continuing tie to the deceased, a central feature of the cognitive theory of grief resolution. Grievers tended to dwell on the cognitions and activities through which they could continue to relate to a beloved human being who had become only an abstract thought. Thus, they reviewed positive memories of time spent together, they sought to continue the values and activities that were important to the relationship, they treasured objects that reminded them of the lost individual and they reminded themselves of the value of the time they had been able to share. At the same time, they recognized that while some ties to the deceased continued, the relationship with the deceased and the daily life of the survivor must change radically. Thus, grievers became preoccupied with their present loneliness, and their future plans. They sought comfort for the present in their religious faith and they sought security for the future by developing the new skills necessary for independent living.

Grief work was much less common when the bereaved individual was with other people. In sharp contrast to their own daily

preoccupation with the loss, the bereaved reported that a friend or acquaintance would mention the loss to them only rarely. A mention that someone else missed the deceased, a recollection of a positive memory or an expression of concern for the survivor might occur weekly, far less frequently than the corresponding thought. Other types of references to the loss occurred monthly or even less frequently.

The bereaved shared their thoughts and feelings with others almost as infrequently as others mentioned the loss to them. The sharing of the emotional pain of the loss and of the continuing tie to the deceased occurred only monthly or less frequently. Sharing of the comfort found in religious faith and sharing of the learning and personal growth that had occurred through grief might occur weekly. Only the sharing of positive memories occurred commonly, although this too was far less frequently than the thoughts occurred.

The behavior of the bereaved described above was far different from the behavior pattern they described as optimal on the Attitude Toward Grief Survey. In contrast to the relatively solitary grief work patterns they demonstrated, subjects described optimal grief work as being actively shared with other people. The most helpful funeral, for example, was believed to be a large one, actively planned and participated in by the family. The griever should interact not only with close friends and relatives, but also with casual acquaintances. Subjects described receiving a great deal of comfort and support from stories recounted by business associates of the deceased whom the survivor knew only casually if at all. Tranquilizers were to be avoided during early grief since the grievers saw these as reducing the individual's ability to experience and express feelings. After

the funeral, the bereaved would continue to grieve actively. They would visit the cemetery frequently, continue to interact with a variety of people and live in the home that reminded them of the deceased spouse.

The Attitude Toward Grief Survey further revealed that the bereaved saw their most important tasks as "expressing emotion", "keeping busy", and "talking about the loss with others". Again, these choices reflect a belief that active grieving shared with others is most helpful. "Reviewing memories" and "moving forward and developing a new life" were seen as less important activities followed by "being brave" and "being independent". "Forgetting" was almost universally placed last on the list and was frequently angrily rejected by the subject. Yet, by their behavior, this was frequently what those in the environment encouraged the griever to try to do.

Subjects also showed agreement when asked how close friends and relatives could help them with their grief. Behaviors which quietly gave grievers permission to do their grief work were seen as most helpful. These included "showing they care", "listening", and "allowing the expression of emotion". Behaviors in which the other person expressed his own grief or helped the griever with the practical tasks necessary to continuing life without the deceased were also valued. These included "giving practical help", "expressing sympathy", "sharing good memories", and "giving advice about practical and legal matters". The least helpful behaviors were seen as "providing distractions from feelings of loss", "giving advice about emotions" and "avoiding the mention of the deceased". These items seem to share the common trait of denying the reality and/or importance of the bereaved's feelings.

Anger was expressed toward those who did not mention the deceased in an effort to avoid rekindling old pain. The assumption that the bereaved thought about the loss only when reminded of it was seen as the ultimate denial of their pain. This anger is seen as well in the bereaved's statement that "other people's embarrassment about talking about death" made bereavement harder than it would have to be. There was little consensus as to other situations that increased the difficulty of bereavement.

Thus, the contrast between the bereaved's attitudes and their behavior seems to indicate a deficit in the ability of their environment to provide the support needed during this difficult period.

Changes Over Time

When grievers were divided into groups based on the length of their bereavement, few differences among groups were found. Early grievers (those widowed for six months or fewer) showed a tendency to be somewhat more actively involved in grief work than those who had been bereaved for a longer period of time. There were no differences among those who had been widowed for more than six months.

In addition to the general tendency of the newly bereaved to be more actively involved in grief work, three items on the Grief Work Survey stood out as being particularly more likely among this group. First, two items indicated that they were more likely to share emotions with others than the later bereaved. In view of the attitudes presented earlier, it is likely that this reflects the permission the bereaved received to express themselves. Early grievers feel that they have at least some permission to cry in public and to admit that they feel

terrible. Later grievers do not feel this permission.

The third item that appeared particularly different for early grievers concerned the tendency of the loss to seem unreal. Early grievers showed a much greater tendency to "feel that my loss is unreal, feel like my spouse is present or imagine that I see him/her in a familiar situation". Since this event occurs when the subject is alone and would, thus, tend to be relatively unaffected by environmental attitudes, this finding provides the only evidence for qualitative changes in the grief process over time. It appears that the acceptance of the reality of the loss is a problem which is central during early grief.

It is also interesting that time since the death showed no relationship with any of the outcome measures. The high degree of distortion observed in this study makes all of these measures somewhat circumspect. However, results appear to indicate that the simple passage of time has little relationship with grief resolution.

Clusters

One of the goals of this project was to identify styles of grief. This was attempted through the technique of cluster analysis. The four analyses performed were only partially successful in identifying distinct groups. As stated above, subjects reported that they rarely interacted with others regarding their loss. There was, thus, little variability within the two sections of the survey which discussed behavior when the subject was with other people. Furthermore, the paucity of subjects in the earliest stages of grief (zero to three months post-bereavement) probably depressed the amount of variability

in all three sections of the survey. This relative homogeneity seems to have led to cluster formation based largely on quantitative rather than qualitative variables. That is, clusters were based on the amount of grief work rather than the type of grief work that was done. The fact that differences in thoughts accounted for a large proportion of the variance whereas differences in interpersonal grief work accounted for very little may explain the lack of correspondence in membership of the clusters formed by the four different analyses.

The cluster analysis performed using all 51 items of the Grief Work Survey is probably most meaningful since it included all of the variance. This analysis came closest to identifying specific styles of grieving. Four clusters were identified.

Cluster 1 was labeled "nongrievers". This was a group of people who reported doing very little grief work. They stated that they only rarely thought about or discussed either the pain of their loss or the time before the death. It seems likely that this group was composed of a number of types of people. First, some members of Cluster 1 seem to be people who have been widowed for a year or more and are no longer intensely involved in grief work. A second subset of Cluster 1 appears to be people who have been widowed more recently and are using a neurotic denial system to cope with their pain. These people seem to be operating on the principle that not dealing with their pain will lead to its disappearance. A final subset could be distinguished from the second only by their interview behavior. These appeared to be people who, although they were actively involved in grief work, were motivated for some reason to appear otherwise. These were people who, for example, would state that they shared a good memory

about their spouse only monthly, but during the course of the interview revealed several instances of that behavior within the last week.

Cluster 7, in direct contrast to Cluster 1, was composed of individuals who appeared to be grieving quite actively and intensely. Cluster 7 members reported spending a great deal of time in grief work activities of all types. That is, while they reported frequently engaging in grief work activities of the type necessary to abstract the relationship, they also reported frequently dwelling on their pain in rather nonconstructive ways. It may be significant that the degree of difference between Cluster 7 and the other clusters was greater for thoughts than for interpersonal behavior. That is, while members of Cluster 7 were much more likely to be actively grieving while alone, they were only slightly more likely to share their grief with others.

Cluster 5 consisted of a group of people who, like the members of Cluster 7, were actively involved in their grief work. However, they seemed less overwhelmed by their grief than did members of Cluster 7. Cluster 5 members concentrated their grief work in the area of emotional expression. When alone they were less likely to dwell on the pain of grief or their struggle to continue living than were the members of Cluster 7, but they were as likely as Cluster 7 members to deal with the cognitive issues such as thinking about shared values and activities. Cluster 5 members were most likely to share pleasant memories about their deceased spouses. Furthermore, Cluster 5 members seemed to have the best support systems in that they were most likely to hear others express concern for them and they were most

likely to have other people share good memories of the deceased with them.

Cluster 2 was the final cluster identified in the analysis using all 51 items. It seemed to be a group of people who, though they thought about their grief more often than the non-grievers of Cluster 1, seemed to be rather uncomfortable with their grief. This group was most likely to try to distract itself from feelings of loss and most likely to change the subject when other people mentioned the deceased. When dealing with the loss, these people concentrated more than other groups on their need to continue and on the comfort of religious belief. They were relatively unlikely to hear or discuss pleasant memories. Members of Cluster 2 were identified by the interviewers as being rather hysteroid in their approach to grieving.

Thus, although four clusters were identified, only Clusters 2 and 5 appeared to be distinct styles. These appeared to represent hysteroid, denying grievers and emotionally expressive, active grievers respectively. Clusters 1 and 7 appear to have been differentiated based on quantitative issues rather than on any specific pattern of grief work activities. Cluster 1 reported being rarely involved in any of the grief work activities and Cluster 7 reported being frequently involved in all of them.

When viewed in terms of the outcome measures, the deniers and the acute grievers stood out as having had significantly poorer outcomes. Both groups reported significantly greater amounts of health deterioration than other subjects. Only the acute grievers reported significantly poorer social functioning. The fact that the deniers did not report difficulty in social functioning seems to be representative of their

style. Indeed, that style may be the cause of the indicated health problems.

There was little among the background measures that differentiated the four clusters. The deniers had been widowed for a significantly longer period of time than the expressive grievers and the acute grievers. They also reported significantly higher levels of marital satisfaction than the nongrievers. These results do not appear to fall into any meaningful pattern. In view of the large number of statistical tests performed on background measures, it seems best not to over-interpret the significance of these few findings.

The results of the other three cluster analyses added little to the information obtained when the analysis was based on the entire Grief Work Survey. The analysis based on items which concerned the subjects' behavior while alone yielded four clusters, two of which corresponded quite closely to the original clusters. These were a nongrieving cluster and an acutely grieving cluster. A third cluster shared some characteristics with the "stiff upper lip" cluster on the original analysis. These were people whose thinking concentrated on their pain and on their struggle to continue without the deceased rather than on dealing with issues regarding the relationship. The fourth cluster was a rather nondescript group of people for whom no specific label could be determined.

When comparisons were made among the clusters the strugglers to continue stood out as having the poorest outcome. They scored significantly poorer than any of the other clusters in terms of life satisfaction and social functioning. These people also reported a higher number of previous losses than any of the other clusters. Since

all of these variables are based on self-report, they are probably best interpretted as indicating the world view of cluster members rather than as a more objective measure of outcome. (As will be discussed later, distortion of self-report data appeared to be particular problem in this study.) Thus, the picture of the members of this cluster is one of them seeing themselves in much the same manner that the cluster analysis has labeled them. They see themselves as having been dealt more than their share of bad experiences and as having survived despite that fact. However, they are unhappy with their lives, and see themselves as not functioning as well as they might have been.

Two other significant results were obtained from comparisons among these clusters. Acute grievers, as expected, had been widowed for the shortest period of time, although this difference achieved significance only when compared to one other cluster. Secondly, the unlabeled cluster showed the greatest amount of health deterioration. Again this achieved statistical significance only when compared with one other cluster.

The two cluster analyses which were based on events that occurred when the loss was discussed with others did not seem to yield styles of grief at all. Clusters appeared to be based only on the quantity of interaction that occureed in all areas rather than on any specific interaction patterns. In view of the high degree of agreement on the attitude measures that grief should be shared with others, it appears likely that these clusters are based more on the subjects' support systems than on the subjects' own willingness to discuss their grief. Comparisons among groups in one of the cluster analyses

revealed those widowed for the shortest period of time to be the most active grievers. Scores on the marital adjustment survey showed a significant relationship to cluster membership on both of these analyses. However, this was not a simple linear relationship. Again, there was a problem of gross distortion on this self-report measure and it appears to measure only the way in which the subject portrayed the marriage to others and not its actual quality. Thus, it appears that the way in which the griever discussed the marriage affected the willingness of those in the environment to discuss the loss.

When viewed together, the results of the four cluster analyses present a vague picture of several different ways to approach grief cognitively. One may become overwhelmed by it, thinking quite frequently about both the pain of the loss and about the relationship with the deceased. This approach appeared to be associated with poor outcome.

A second approach to grief is to maintain a "stiff upper lip" and struggle to continue despite the loss. Such an approach may involve discharge of emotion when alone, but largely it involves attempting to distract oneself, struggling (perhaps prematurely) to achieve an independent lifestyle and keeping one's pain secret. In some people who use this approach, the defense mechanism of denial appears to be quite dominant. This approach also appears to be associated with a poor outcome, manifested in health deterioration when denial is prevalent and lower life satisfaction and social functioning when it is not.

A third way to approach grief appeared to be to share the pain with others. When done, these people were more likely to concentrate

on the time before the terminal illness and death than were others. This approach shows no clear relationship with outcome.

The largest number of subjects fell into the cluster labeled "nongrievers". Some of these people appeared to have completed the most active portion of their grief. Many, however, simply appeared to lack either the ability to observe their own behavior or the willingness to share their grief work patterns. Thus, their style of grieving remains a mystery.

Factor Analysis

The factor analysis was more successful in relating styles of grief to other variables than was the cluster analysis. Four factors were identified. These appeared to fall along two dimensions. First, there was a public-private dimension which appeared to measure the extent to which the grief work was done alone or shared with others. Secondly, a pain-comfort dimension concerned the degree to which the griever concentrated his thinking and behavior on the pain of the loss as opposed to the comfort received. Of the four factors, the two which related to comfort are closest to measuring the cognitive processes necessary to abstract and continue the relationship. However, other variables such as receiving comfort from religious beliefs and from the expression of emotion in a supportive environment were also included in these factors.

Three patterns of results are of interest in interpreting the factor analysis. First, the two pain factors show a significant correlation with bad outcome as measured several different ways. However, there is no significant relationship between good outcome and

any of the four factors. This may indicate that dwelling on pain is causally linked to bad outcome. On the other hand, it might simply be a reflection of the pain oriented response set. That is, those who concentrate on their pain might also tend to distort the outcome measures in a negative direction. The fact that the Outcome Self-Report, the most objective of the outcome measures, correlated less highly with the pain factors speaks in favor of this idea.

The second interesting pattern of results is that a long terminal illness is closely related to a private pattern of grief work. Since length of terminal illness is only minimally susceptible to bias through response set, this result is likely to be indicative of a true relationship. Such a pattern is likely to occur because those who have gone through long terminal illnesses with their spouse may feel that they have "used up" the resources that friends and neighbors have to offer. In a long illness family members need to depend on physical help from others. After the death occurs, it may seem to both the bereaved and the friends of the bereaved that the need for support has lessened. Thus, environmental support is not sought or is not available at a time when it is sorely needed.

Finally, the correlations provided some information about those most commonly engaging in behaviors which loaded on the two comfort factors. These people were likely to be older women who reported having been quite satisfied with their marriages. It is interesting that older women are those most likely to be widowed. Thus, these may be people whose widowhood was least shocking both to themselves and of their community. This may have provided some degree of preparation for the loss and some framework in which to deal with it. It is also

interesting that the public comfort factor was highly correlated with the statement that bereavement had led to personal growth.

Methodological Issues

This study illustrates once again the difficulty of attempting to study grievers cross-sectionally rather than logitudinally. The present study was much like trying to judge a motion picture using only isolated photographs of the actors. No matter how clear the focus, a single shot cannot explain the process which the individual has undergone. Grievers would be more appropriately studied over a period of time so that the changes in their thinking and behavior could be observed.

The recruitment method proved to provide an adequate number of subjects. However, few subjects were willing to participate during the first three months of their bereavement. Even those who volunteered at this time tended to postpone the actual interview until a much later date. Thus, the early period of bereavement, in which the greatest amount of change is likely to occur, was not represented.

It is difficult to know how this problem could have been corrected. Previous researchers (e.g. Metzger, 1978) have attempted to recruit grievers through their clergymen and found few subjects were referred. In addition a strong selection factor seemed to exist. Clergy were reluctant to invite extremely distressed individuals to participate. However, this procedure did allow the researcher to make contact with the bereaved at an earlier point in the grief process. Perhaps then, a combination of these two approaches might be most fruitful. For example, the clergy might be included as

members of the research team. As such, clergy and psychologists might approach potential subjects together.

Problems in measurement of psychological variables have always been myriad and this study was not expected to prove exceptional in this regard. Even with this expectation in mind, however, the problems in measuring grief work and grief resolution were remarkable. The picture obtained from the paper-and-pencil measures was quite different from the way subjects appeared to be relating during the interview.

Two basic processes seem to have been involved in the shortcomings of the measurement instruments. First, subjects seemed to have difficulty making the transition between the general (and sometimes abstract) questions asked and the very concrete experience of their own lives. Thus, for example, a widow might report that she "never" engaged in a behavior that was quite common during the interview. Or she might state that she had never experienced someone else behaving towards her in a manner that she had clearly described earlier as having occurred. This phenomenon occurred most frequently with the more abstract of the process measures. It seemed to reflect partly an inability to arrive at a shared definition of the behavior involved and partly an inability of the subject to achieve enough psychological distance from his own behavior to be able to form abstractions about it.

The second cause for measurement shortcomings seemed to be specifically related to the area being studied. Grievers were observed to be especially prone to use repression and denial as defense mechanisms. This tended to distort reported outcome and pre-bereavement data. Marital satisfaction, for example, was reported as exceptionally

high and there was clear evidence during the interview that a great deal of distortion was occurring. One woman's marriage, for example, had been marred by her husband's criminal behavior, bankruptcy, and frequent infidelity. She had been in the process of divorce when her husband committed suicide in a manner that was clearly intended as a punishment to her. Despite all this, she rated her degree of marital satisfaction as only slightly below average.

Some subjects seemed to view the outcome measures as their chance to prove to themselves how far they had come in resolving their grief. They seemed to have a strong need to view their current functioning in as favorable a light as possible. Again, this tended to result in distortion of the data. The clearest example of this behavior occurred in a widower who, although he was clearly uncomfortable showing emotion, burst into tears when the interviewer arrived. He stated that his life was over, that his pain was overwhelming, and that he was certain that he would never feel any better. He paced nervously for the entire three hours of the interview and was so agitated that it was necessary for him to dictate his responses to the structured questions. Yet he placed himself at the midpoint of a scale asking his degree of optimism in facing the future. In justification for this response, he stated only that he no longer had a mortgage on his home.

In view of these problems, it seems that this study's total reliance on self-report data was a mistake. In future research, self-report data might be supplemented with the observations of significant others and/or with systematic analysis of the behavior during the interview.

Interview Impressions

Much was learned in the course of this project that was not reflected in statistical data. Each subject spent an hour or more in an unstructured interview before the formal data was collection. Because the content of these interviews was largely determined by the interviewee, they were as different as the bereaved themselves. However, there were also some striking similarities in what occurred.

Perhaps most surprising was the warm welcome which the interviewer received in each home visited. Despite the fact that the interviewer was a complete stranger, introduced only by a letter, she was almost always treated as an honored guest. Refreshments were almost always served and on a few occasions the interviewer was invited to dinner. Subjects usually expressed gratitude for the opportunity to participate in the research. Some subjects clearly labeled this as an opportunity to help themselves; others expressed happiness at being able, through the research, to help others who would undergo the pain of bereavement in the future. This is clearly a very different reaction than researchers in other areas usually receive.

The interview itself, although begun by a single vague question, almost always consisted of three stories. First the story of the death was told. This began with a healthy individual (or in one case with an invalid whose disease was not life threatening and who ultimately died of a very different illness) and proceeded through the first disease symptoms (which were usually ignored), to the painful dawning realization that death would occur. The deceased's final time

was dealt with in detail and his thoughts during that time period were deemed especially important. The story of the death proceeded in detail through the funeral and ended with a brief statement as to how the widowed person had been treated since that time. There was usually a feeling that "everyone has been wonderful to me", but that this had not affected the degree of pain experienced.

The story of the death usually included some search for a meaning to the death. These searches varied greatly in their framework depending upon the background and personality of the survivor. Frequently, they were religious in nature; the subject would see God as having allowed the death and ask why. Others sought meaning in more secular terms. The central questions seemed to be "Why me?" and "Why now?". As part of this search for meaning, those whose spouses had experienced unexpected deaths, sometimes placed special hidden meanings on a statement the spouse had made shortly before the death. They believed that their spouse had on some level been aware of impending doom and was preparing the survivors to live alone.

It was interesting that the structure and length of time spent telling the story varied little, although the types of death were quite varied and the length of the dying period ranged from only a few minutes to almost 13 years. It seemed that there were certain issues that were intrinsically important to every griever and that these had to be covered. The structure of the stories varied only when the spouse was not present at an unexpected death. This was usually the case in accidents and suicides and sometimes the case in heart attacks. In these stories much more attention was paid to the survivor's feelings and behavior when notified of the death. The

deceased's final behaviors and thoughts could only be speculated upon.

The second story told during the interview was the story of the life. It seemed very important to the griever that the interviewer understand that the departed spouse had been a special and unique individual whose death had been noticed beyond the family. The story of the life usually began with the couple's courtship, although sometimes earlier if childhood events were believed to have had special influence on the adult personality. Few of the deceased had been highly successful as that word is usually defined. Nevertheless, the story was usually one of triumph. These were people who had built small businesses, raised healthy families, maintained life-long friendships, braved North Dakota winters, and earned the respect of their small communities. Most of all, these were people who had cared deeply for their families and who had earned their love and respect in return. To their survivors, this was triumph enough. Weaknesses, even those which had seemed particularly difficult in life, were documented but seen as small in the context of the entire life. Frequently, they were exaggerated and laughed about.

These stories deviated from the tale of triumph only when the deceased had died at an especially young age or when the cause of death had been suicide. When a young person had died the theme was usually one of aborted triumph and of marveling at the impact that had been made in so short a time. The life stories of the three suicide victims sounded like a classic tragedy: these were good men who had been destroyed by a fatal flaw.

The "data" for the life stories consisted of two types. First, the interviewer was told of specific incidents in the past that were seen as particularly revealing of the deceased. Secondly, the tangible mementoes of the marriage were displayed. These included photographs, letters, jewelry, furniture, books, crafts objects and even a bathroom that had been remodeled shortly before the death.

The chance to share these two stories seemed quite valuable to the survivor. This was as true for the widowed person who seemed to have an active support network as for the subject who appeared to be isolated. While those with good support systems seemed to have had the opportunity to discuss their feelings and to share numerous isolated memories from the past, it did not appear that they had had the chance to tell the "whole story". This seemed to be useful because it helped place the life in perspective. It seemed an essential component of "abstracting and rehabilitating" the essense of the relationship.

The third story related during the interview was that of the grief. Usually the first feeling was one of disbelief if the death had been an unexpected one or relief if the death had followed a painful or debilitating illness. After this initial feeling faded, usually within a few days, the griever tended to experience a confusing jumble of emotions. These feelings included most of those listed in stage theories of grief: anxiety, anger, guilt, depression, fear, pain, loneliness and others. However, rather than the neat sequence of predominant feelings described by the theorists, the grievers described a dizzying whirlwind of emotional changes that sometimes led them to fear that they might be "going crazy".

The anger and guilt of grief were particularly interesting in that they were rarely identified as such by the grievers themselves. Subjects would, for example, angrily detail their complaints about physician's distance, hospital's inflexibility, clergymen's apathy, friend's lack of understanding, relative's betrayal, and/or society's poor treatment of the widowed, then state that they had not experienced anger during their bereavement.

Few subjects were able to articulate their anger at "fate" or at the deceased for having "abandoned" them. Most, however, seemed to have experienced such feelings and discussed them in ways that avoided the term "anger". They might, for example, discuss their envy of the spouse, who, by dying first, had avoided the pain of widowhood. A few insightful individuals were able to directly relate instances of anger towards the spouse. One woman, for example, mentioned a flash of rage she had experienced when she discovered that her husband had not "had the courtesy to clean up the basement" before having his heart attack. The people who were able to express these incidents seemed to derive support from the interviewer's acceptance of their feelings.

The bereaved stressed that they did not want to "forget", "break ties with", or "learn to stop missing" their loved one. The deceased had been a central part of their life and, even in death, they wanted that person to continue to be important to them. Indeed many grievers seemed interested in getting to know the spouse better. They sought out information about the years before they had known the spouse or they tried to speak to workmates and other people who had shared aspects of the spouse's life that they themselves had not. This need to continue involvement and to search for the full picture of the

spouse's life is perhaps best illustrated by a widow who was not part of this study. Mrs. Muriel Humphrey, upon leaving the Senate, stated in a television interview that she was grateful for that opportunity because "I would not know Hubert Humphrey as well as I do now if I had not spent time in the United States Senate." Though not stated as articulately, these sentiments were shared by the widowed people in this study.

The continuing involvement with the dead spouse seemed to be true in fact as well as desire. As subjects described their post-bereavement decision making processes, for example, it was clear that the spouses' opinions continued to be considered. Early grievers tended to give the dead spouse an equal vote. Later in grief, the surviving spouse was more likely to go against the deceased wishes, but always with full awareness that they were doing so and with full documentation as to the reason for the decision. This could be done comfortably and without guilt, but it was as if the deceased was owed an explanation.

Survivors also continued to imagine the spouse's reaction to both important and unimportant life events. These tended to be pleasant thoughts, usually of how proud, happy or interested the spouse would have been in some friend or family member's experience or accomplishment. Grievers expressed the hope and conviction that these thoughts would continue throughout their lives.

A final example of this continued involvement was found in tasks the survivor voluntarily assumed in the spouse's memory. Some of these were "memorials" in the traditional sense. Others were much more creative. One woman became interested in gardening because her

husband had always been proud of the landscaping on their farm. Another, who lived alone, put a second bathroom in her house because her husband had always wanted one. Activities which had been enjoyed together in life became even more special after the death. The widowed explained that they "felt closer" to the spouse during those times and, again, they expected to continue these feelings and activities throughout their lives.

Conclusions: Nature of the Grief Process

Although this study has not provided a clear picture of the grief process, it does add some new information to the current literature and allow speculation as to the nature of the grief process. Data collected here also raise some questions regarding previously accepted theories of grief.

Bowlby and many others have, for example, viewed grief as a process which occurs in distinct stages. Each stage is said to be characterized by a preponderance of one emotion, a specific problem to be resolved, and a preponderance of a particular type of grief work. The current study provided only limited support for this idea. There was some evidence that for approximately the first six months grievers need to deal with the issue of making the loss seem real. However, there is no evidence that they do this to the exclusion of other types of grief work. Indeed, the similarities between the grief styles of those at various time periods are far more remarkable than the differences. Furhtermore, subjects subjectively report that they experience a confusing array of constantly changing feelings rather than a neat progression of stages.

Bowlby's theory seems to be much more appropriate in terms of the tasks he sees the griever as dealing with and the types of emotional reactions he sees the griever as experiencing. Bowlby's first stage involves coming to terms with the reality of the loss. His second stage centers around searching for the lost relationship. Stage 3 involves coming to terms with the pain of grief and state 4's task is to develop a satisfying lifestyle that does not include the physical participation of the lost loved one. Subjects in this study reported both in the interview and in the structured data that they were actively involved in all of these tasks. However, instead of solving the tasks in the neat progression that Bowlby describes, it appears that the griever bounces from one task to another.

Thus, the concept of stages of grief might be replaced by a concept which highlights the repetetive changes that occur in emotion and task. The metaphor of a pendulum, which stabilizes itself by moving to extremes, comes to mind. The griever looks confused and disoriented while swinging from one grief task to another, but it is this process which eventually allows the achievement of a new equilibrium.

This study also speaks to the question of anticipatory grief. There is no evidence that the type of death that occurred has any effect on ultimate grief resolution. Moreover there is little indication that the type of death bears any relationship to the style of grief. Of the four styles identified in the various cluster analyses none was associated with a particular type of death. Only the factor analysis showed a tendency for those who anticipated the death to engage in more solitary grief work. This finding merits further investigation.

However, the study as a whole provides little support for the notion that anticipatory grief occurs or that it results in a qualitatively different and/or less difficult post-bereavement period.

In general, the results of this study provide some support for the proposed cognitive theory of grief. This is seen most clearly in the attitude measures and in behavior during the unstructured interview. As predicted, subjects angrily rejected the idea of "breaking ties" with or "forgetting" the deceased. Indeed they seemed to be searching to know the lost person better. They sought quiet permission to grieve as they chose and their choices of grief behavior were closely related to the lifestyle they had shared with the deceased. Those who had successfully established new lifestyles seemed to have found "a place" in their lives for the deceased spouse and continued to cherish their memories.

The results of the cluster and factor analyses do not provide as clear support for a cognitive model of grief. None of the cluster analyses yielded a cluster that could be labeled as "cognitive grievers". These behaviors seemed to be occurring to some degree in all of the clusters. Neither did a clear "cognitive factor" emerge from the factor analysis. As stated above, the two comfort factors contained many of the behaviors seen as important in the cognitive model. However, these were contaminated by behaviors involving catharsis and religious preoccupation. Thus, the cluster and factor analyses did not allow a direct examination of the cognitive model. While they did not support the theory, neither did they contradict it. The cognitive model of grief remains a viable theory for future investigation.

Conclusions: Implications for Grief Therapy

According to the cognitive model, the bereaved have a clear task before them. They must change an intense relationship with a living human being into a relationship of a very different kind. They must create a relationship with a memory or an abstraction. At times, grievers seek professional help to achieve this goal. Several points seem important in creating therapeutic support for the grief process.

First, the therapist can provide the bereaved with some understanding as to the nature of the grief process. Universally, the bereaved reported being confused by their thoughts and feelings. Some seemed to feel guilty regarding feelings which they saw as disloyal or illogical. Lack of information about these feelings can only compound the pain of grief.

Secondly, the therapist can help the griever discover and assess his needs. The general task of abstracting and rehabilitating the relationship seems to be handled in a multitude of different ways. Those in this study ranged from dancing to wallpapering, from raising children to raising vegetables. They shared only the characteristic that while they were being done, thoughts centered on the deceased individual. People needed to grieve for the lost spouses in a manner that was closely related to the way they had lived with them.

To determine their best mode of expressing grief, therefore, the griever needs to gain a broad perspective on his life with deceased. Here again, the therapist can be of help. Subjects in this study seemed to derive therapeutic benefit from the chance to tell their whole story. Listening to this story does not require great professional skill, but it does provide a service that the majority of grievers in this study did not seem to find in their environment.

As the griever becomes more aware of his own needs, the therapist might help him determine how these needs might best be met in the community. Too often the bereaved are surrounded by concerned friends who lack only the knowledge of how to be helpful. A griever who is aware of his needs and able to make them explicit to others might find himself surrounded by a vastly improved support network.

Finally, the grief therapist needs to be aware of the pitfalls associated with various forms of grief and to be able to help the griever avoid them. Foremost among these is the problem of the griever who had an ambivalent relationship with the deceased. Such a relationship would be quite difficult to restructure. In this case the therapist's marriage counseling skills might prove useful.

Throughout grief therapy, the therapist needs to avoid the goal of removing pain. The pain of bereavement can be viewed as the cost of the relationship. To many of the bereaved, it is itself a source of comfort, informing them of the high value of the years together. The goal of therapy is instead the placing of the pain in its proper perspective so that it does not interfere with future life satisfaction or with the formation of new relationships. Grievers will continue to miss the deceased throughout their lives, but after grief is resolved they will also have a highly valued continuing relationship with the deceased from which they can derive a great deal of comfort.

APPENDICES

APPENDIX A

Letter to Potential Subjects

The University of North Dakota
GRAND FORKS 58201

DEPARTMENT OF PSYCHOLOGY TELEPHONE: (701) 777-3451

Dear

For the past two years we have been studying bereavement and grief. We would like to help counselors, ministers, and others who work with people who have lost a loved one. Our eventual goal is to achieve an understanding of normal grief so that we can be of more help to those who seem to be unable to recover from grief. The only way we can learn more about how to help people to deal with grief is to learn from those who are actually grieving themselves.

This means we must ask for the help of people who have recently experienced a loss, so that they can tell us what the experience is like. With this information, we can develop better methods of counseling the bereaved. According to the obituary section of the Grand Forks Herald, you have been widowed within the last two years. Therefore, if you are willing, we would like you to help us with our studies. Participation would require spending two or three hours with one of our interviewers. We can arrange the time of the interview to fit your schedule and can arrange to do it in your home if that is more convenient.

We have enclosed a self-addressed postcard on which you can indicate your willingness or unwillingness to participate. We recognize that a few people may be upset by receiving this letter. If you feel that way, we apologize for the intrusion. Please simply discard the letter. Do not return the postcard and no further attempt will be made to contact you.

If you have any questions, feel free to contact us at the UND Psychology Department (701)-777-3451. We look forward to hearing from you.

Sincerely,

Barbara J. Benner, M.A.

J. Dennis Murray, Ph.D.
Assistant Professor

APPENDIX B

Postcard

NAME_____

TELEPHONE NUMBER_____

___Yes, I am willing to participate

___No, I am not willing to participate. Do not contact me.

___Please contact me. I would like more information before making my decision.

APPENDIX C

Newspaper Article

Obituaries key to death, grief study

Those who are willing, will be interviewed in a summer project.

"We feel we need to know more about what the normal person has been through," says Ms. Benner.

"We don't mean to intrude," she says, "But we would like people to know about the research and have a chance to volunteer."

(The phone number at the psychology department is 777-3451.)

Already several interviews have been conducted for the sudy with surviving spouses.

"We usually end up thanking them for their cooperation," says Ms. Benner. "Many people have told us they want to thank us. They say nobody has ever listened to them talk about their bereavement."

APPENDIX D

Background Information Survey

Subject #_____

Date_____

INFORMATION ABOUT YOU:

your age _____

your health status prior to bereavement
excellent _____ good _____ fair _____ poor _____

your religious affiliation _____

length of your marriage _____

number of major losses experienced prior to spouse's death _____

number of other people currently living in your household _____

INFORMATION ABOUT YOUR BEREAVEMENT:

cause of spouse's death _____

date of death _____

spouse's age at death _____

length of terminal illness _____

length of time you knew your spouse's death was immanent _____

A FEW ADDITIONAL QUESTIONS:

Do you still live in the same house or apartment you shared with your spouse? Yes _____ No _____
If not, how long after death did you move?_____

(Choose the most appropriate.)

Since the death, my financial status has:
a. improved significantly
b. remained about the same
c. worsened significantly

APPENDIX E

The Social Readjustment Rating Scale by Holmes and Rahe

Subject #_____

INSTRUCTIONS: Next to each of the 42 events listed below, circle "Yes" if the event occurred to you within the five years prior to your spouse's death. Circle "No" if the event did not occur within that time period.

1. A lot more or a lot less trouble with your boss: Yes No
2. A major change in your sleeping habits: Yes No
3. A major change in your eating habits: Yes No
4. Revision of your personal habits (dress, manner, etc.): Yes No
5. Major change in your recreation (type or amount): Yes No
6. Major change in your social activities: Yes No
7. Major change in church activities: Yes No
8. Major change in number of family get-togethers: Yes No
9. Major change in your financial status: Yes No
10. Major trouble with in-laws: Yes No
11. Major change in the number of arguments with your spouse: Yes No
12. Sexual difficulties: Yes No
13. Experienced personal illness or injury: Yes No
14. Lost a close family member (other than spouse) by death: Yes No
15. Experienced the death of a spouse: Yes No
16. Experienced the death of a close friend: Yes No
17. Gained a new family member (birth, oldster moving in, etc.): Yes No
18. Major change in the health of behavior of a family member: Yes No
19. Change in residence: Yes No
20. Experienced detention in jail or other institution: Yes No
21. Had been found guilty of minor violations of the law: Yes No
22. Underwent a major business readjustment (merger, bankruptcy, major reorganization, etc.): Yes No
23. Got married: Yes No

24. Got divorced: Yes No

25. Marital separation from your spouse: Yes No

26. Had an outstanding personal achievement: Yes No

27. Had son or daughter leave home (marriage, college, etc.): Yes No

28. Retired from work: Yes No

29. Major change in your working hours or conditions: Yes No

30. Major change in your responsibilities at work: Yes No

31. Got fired from work: Yes No

32. Major change in living conditions (building a new home, remodeling, deterioration of home or neighborhood, etc.): Yes No

33. Spouse began or ceased working outside the home: Yes No

34. Took out a mortgage greater than $10,000 (purchasing a home, buying into a business, etc.): Yes No

35. Took a mortgage or loan of less than $10,000 (purchasing a car, TV, sending a child through school, etc.): Yes No

36. Experienced foreclosure on a mortgage or loan: Yes No

37. Went on vacation: Yes No

38. Change to a new school: Yes No

39. Changed to a different line of work: Yes No

40. Began or ceased formal schooling: Yes No

41. Had a marital reconcilation with your spouse: Yes No

42. Had a pregnancy or fathered a pregnancy: Yes No

APPENDIX F

The Locke-Wallace Marital Adjustment Survey

Subject #_____

Listed below are 25 questions about different aspects of your marriage. Place a check mark on the line to indicate your answer.

1. Before your spouse's final accident or illness, did you ever wish you had not married?
   a. Frequently ____
   b. Occasionally ____
   c. Rarely ____

2. Before your spouse's death, you felt that if you had your life to live over again you would:
   a. Marry the same person ____
   b. Marry a different person ____
   c. Not marry at all ____

3. Did you and your spouse engage in outside activities together?
   a. All of them ____
   b. Some of them ____
   c. Few of them ____
   d. None of them ____

4. In leisure time, which did you prefer?
   a. Both husband and wife to stay home ____
   b. Both to be on the go ____
   c. One to be on the go and the other to stay at home ____

5. Did you and your spouse generally talk things over together?
   a. Never ____
   b. Now and then ____
   c. Almost always ____
   d. Always ____

6. How often did you kiss your spouse?
   a. Everyday ____
   b. Now and then ____
   c. Almost never ____

7. How happy would you have rated your marriage?
   a. Very happy ____
   b. Happy ____
   c. Average ____
   d. Unhappy ____
   e. Very unhappy ____

8. How happy would your spouse have rated your marriage?
   a. Very happy ____
   b. Happy ____
   c. Average ____
   d. Unhappy ____
   e. Very unhappy ____

9. Check any of the following items which you think caused serious difficulties in your marriage. Check all that apply.

Spouse attempted to control my spending money ____
Other difficulties over money ____
Religious differences ____
Different amusement interests ____
Lack of mutual friends ____
Constant bickering ____
Interference of in-laws ____
Lack of mutual affection (no longer in love) ____
Unsatisfying sex relations ____
Selfishness and lack of cooperation ____
Little or no help with the children ____
Adultery ____
Desire to have children ____
Sterility of husband or wife ____
Veneral diseases ____
Spouse paid more attention to another person ____
Desertion ____
Non-support ____
Drunkenness ____
Gambling ____
Ill health ____
Mate sent to jail ____
Other reasons ____

10. How many things satisfied you about your marriage?
a. Nothing ____
b. One thing ____
c. Two things ____
d. Three or more ____

11. When disagreements arose they generally resulted in:
a. Husband giving in ____
b. Wife giving in ____
c. Neither giving in ____
d. Agreement by mutual give and take ____

12. What is the total number of times you left mate or mate left you because of conflict?
a. No times ____
b. One or more times ____

13. How frequently did you and your spouse get on each other's nerves around the house?
a. Never ____
b. Almost never ____
c. Occasionally ____
d. Frequently ____
e. Almost always ____
f. Always ____

14. What were your feelings on sex relations between you and your spouse?
    a. Very enjoyable ____
    b. Enjoyable ____
    c. Tolerable ____
    d. Disgusting ____
    e. Very disgusting ____

15. What were your mate's feelings on sex relations with you?
    a. Very enjoyable ____
    b. Enjoyable ____
    c. Tolerable ____
    d. Disgusting ____
    e. Very disgusting ____

Check the amount of agreement or disagreement for the following questions:

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
16. Handling family finances						
17. Matters of Recreation						
18. Demonstration of affection						
19. Friends						
20. Intimate relations (sex)						
21. Ways of dealing with In-laws						
22. The amount of time that should be spent together						
23. Conventionality (good, right, and proper conduct)						
24. Aims, Goals, and things believed to be important in life						

25. On the line below, check the dot which best describes the degree of happiness, everything considered, of your marriage. The middle point, "happy," represents the degree of happiness which most people get from marriage, and the scale gradually ranges on one side to those few who experience extreme joy in marriage and on the other to those who are very unhappy in marriage.

. . . . . .

Very unhappy Happy Perfectly Happy

APPENDIX G

Grief Work Survey

Subject #_____

The following 48 statements are activities bereaved people engage in when thinking or talking about their grief. We realize that feelings and activities change over time. Please indicate the way you have acted and felt during the last month. We are interested in two issues:

- the frequency with which you have engaged in this activity
- how helpful or harmful you feel this activity to be

For frequency, please use the following six point scale. This happens:

1. almost all the time
2. several times a day
3. about once a day
4. about once a week
5. about once a month
6. rarely or never

For helpfulness, please use this five point scale. I find this activity to be:

++very helpful
+ somewhat helpful
N neither helpful nor harmful
- somewhat harmful
--very harmful

Remember, we need two ratings for each item.

frequency	helpfulness	
		I. When I'm alone and thinking about my loss, I:
___	___	1. **think about how guilty, angry or lonely I am.**
___	___	2. **cry, sob, shake or tremble**
___	___	3. **review pleasant memories from our past together and/or remember my spouse's good qualities.**
___	___	4. **review unpleasant memories from our past together and/or remember my spouse's bad qualities.**
___	___	5. **think about the terrible experience of my spouse's final accident or illness and about how hard that was for me.**
___	___	6. **think about how much my spouse suffered during his/her final accident or illness.**

frequency	helpfulness		
___	___	7.	feel that my loss is unreal, feel like my spouse is present or imagine that I see him/her in a familiar situation.
___	___	8.	tell myself that I have suffered enough and that I need to continue my life despite my loss.
___	___	9.	try to plan my future.
___	___	10.	worry about my place in the world as a single person.
___	___	11.	think about my need to develop new independent living skills and try to develop these skills.
___	___	12.	think about my religious faith and my belief in what the Bible says about life after death.
___	___	13.	try to figure out some of the confusing and/or troubling things that happened between us when we were married.
___	___	14.	think about things that I wanted to tell my spouse before he/she died and/or I imagine what his/her reaction would have been.
___	___	15.	think about things that my spouse would have been interested in knowing had he/she lived and imagine how he/she would have felt about this information.
___	___	16.	continue values and activities that were important to both of us.
___	___	17.	look at or use possessions that were important to my spouse or look at pictures of my spouse.
___	___	18.	try to distract myself and stop thinking about it.
___	___	19.	tell myself how far I've come in my grief and how proud my spouse would have been of the way I've handled difficult situations.
___	___	20.	remind myself of how much I value the time we did have together.

II. When I am <u>with</u> <u>others</u> and discussing my loss, <u>I</u> <u>allow people</u> to:

___	___	21.	tell me how much my spouse is missed by others.
___	___	22.	tell me about pleasant memories they have about my spouse and/or tell me about my spouse's good qualities.

frequency	helpfulness		
___	___	23.	tell me about unpleasant memories they have about my spouse and/or tell me about my spouse's bad qualities.
___	___	24.	offer their sympathy.
___	___	25.	tell me about their own grief experiences.
___	___	26.	help me plan my future.
___	___	27.	tell me that I have grieved enough and that I need to face the future.
___	___	28.	help me realize that my loss is very real and that denying it is not helping me.
___	___	29.	comfort me by reminding me of my religious beliefs.
___	___	30.	tell me to be brave and face the future.
___	___	31.	express their concern for me and their willingness to help me.
___	___	32.	encourage me to express my emotions.
___	___	33.	distract me from thinking about my loss.

III. When I'm <u>with</u> <u>other</u> <u>people</u> and discussing my loss, I:

___	___	34.	tell them about my emotions.
___	___	35.	allow myself to cry, sob, shake or tremble.
___	___	36.	talk about good memories of my spouse.
___	___	37.	talk about bad memories of my spouse.
___	___	38.	tell them about the terrible experience of my spouse's final accident or illness and about how hard that was for me.
___	___	39.	tell them about how much my spouse suffered during his/her final accident or illness.
___	___	40.	discuss what place there is in the world for me as a single person.
___	___	41.	discuss my future plans.

frequency	helpfulness		
___	___	42.	try to realize that I need to stop mourning and face the future.
___	___	43.	reaffirm my religious beliefs.
___	___	44.	discuss my need to be independent and to develop new independent skills.
___	___	45.	try to figure out some of the confusing and/or troubling things that happened between us when we were married.
___	___	46.	talk about things that I wanted to tell my spouse before he/she died and/or imagine what his/her reaction would have been.
___	___	47.	talk about things that my spouse would have been interested in had he/she lived and imagine or discuss how he/she would have felt about this information.
___	___	48.	talk about how I'm continuing the values and activities that were important to both of us.
___	___	49.	show pictures of my spouse or show possessions that were important to my spouse.
___	___	50.	change the subject and talk about more pleasant things.
___	___	51.	share what I've learned about loss and grief.

APPENDIX H

Attitude Toward Grief Survey

Subject #_____

Please rank each of the following groups of statements in order of importance.

I. It is important for a bereaved person to:

A. be brave
B. be independent
C. allow himself/herself to express emotion
D. talk about the loss with others
E. review memories
F. forget
G. keep busy
H. move forward and develop a new life

II. Close friends and relatives can best help a bereaved person by:

A. listening
B. allowing the expression of emotion
C. giving advice in how to handle emotions
D. giving advice in practical and legal matters
E. giving practical help (e.g. babysitting)
F. expressing sympathy
G. showing they care
H. providing distractions from feelings of loss
I. avoiding the mention of the deceased
J. telling the bereaved about their good memories of the decased

III. What makes bereavement harder than it would otherwise have to be?

A. other people's embarrassment about talking about death
B. other people losing control of their emotions
C. having to worry about legal and financial problems
D. social problems; being single in a married society
E. having to go through funeral and mourning rituals
F. isolation
G. being with people who try to stop you from feeling your grief
H. knowing that your grief reminds other people about losses that they have not yet adequately dealt with

For each pair below, chose either a or b.

IV. If circumstances were optimal, the bereaved person would:

a. live alone
b. live with others

a. continue to live in same place
b. move to a new house or apartment

a. use tranquilizers to help get through the pain of early grief
b. use no medication during this period

a. spend most of their time with close friends
b. spend most of their time alone

a. participate as much as possible in funeral and burial rituals
b. participate as little as possible in these activities

a. visit the cemetery frequently
b. avoid visiting the cemetery

a. continue to participate in social activities during the initial period of mourning
b. withdraw from social activities during this period

a. interact with many acquaintances at the funeral
b. interact only with close friends and relatives during the funeral

V. Check all that you believe to be true.

1. The widowed person tends to be abandoned by his/her former friends.

2. Clergymen tend to provide good support for widowed people.

3. People understand the emotions that a bereaved person is experiencing.

4. It is reasonable for a widowed person to expect to eventually return to an interesting social life.

5. Many married people see the widow or widower as a threat.

APPENDIX I

Health Questionnaire

HEALTH QUESTIONNAIRE

We are interested to learn as much as we can about your state of health since the death. In particular, we wish to know whether you have developed any new complaints or whether any old complaints have been bothering you more than usual during this time. On the next page you will see a list of complaints and symptoms, and we would like you to underline any item in this list ONLY IF

_____ this is a new complaint, which you have never had before, which has caused you considerable concern since the death;

OR IF

_____ this is an old complaint, but it has been much more troublesome since the death.

You will see from the above statements that we DO NOT want you to underline an item if it refers only to a minor complaint which did not last very long and did not concern you very much, OR if the complaint is an old one which has not bothered you any more than usual since the death.

Complaints and Symptoms

(Remember to underline an item ONLY IF it is a new complaint which has caused you considerable concern since the death, OR IF it is an old complaint which has been much more troublesome since the death.)

1. Constipation
2. Sleeplessness
3. Asthma
4. Pains in the back
5. General nervousness
6. Swollen or painful joints
7. High blood pressure
8. Difficulty in swallowing
9. Persistent fears
10. Marked loss of hair
11. Cold sores
12. Migraine
13. Headaches
14. Severe itching
15. Fainting spells
16. Palpitations
17. Shortness of breath
18. Stomach ulcers
19. Nightmares
20. Hay fever
21. Pains in the face
22. Frequency of urination
23. Convulsions (fits)
24. Heart failure
25. Hives
26. Indigestion

27. Diarrhea
28. Rheumatism
29. Repeated peculiar thoughts
30. Pains in the chest
31. Trembling
32. Excessive tiredness
33. Twitching
34. Dizziness
35. Blurred eyesight
36. Diabetes (increased blood sugar)
37. Skin rashes
38. Excessive appetite
39. Painful monthly periods
40. Goiter (swelling in the neck)
41. Feelings of panic
42. Colitis
43. Vomiting
44. Excessive sweating
45. Fear of nervous breakdown
46. General aching
47. Poor appetite
48. Frequent infections
49. Very heavy monthly periods
50. Cancerous growth

Before you leave these pages, please look again at any items you have underlined, and mark the item with a capital D if since the death you saw a doctor about this complaint for the first time.

Look once more at any underlined items, and mark the item with a capital H if since the death you had to spend time in a hospital because of this complaint for the first time.

Finally, mark with an asterisk (*) any item that remains a serious problem for you.

[ ] Please place an X here if you read these pages and found nothing that applies to you.

SOME FINAL QUESTIONS ABOUT YOUR HEALTH

The next pages contain statements which can be completed in several possible ways. Please read carefully the first part of each statement, and then look at each of the endings which we have suggested and decide which one is most true for you. Mark with a cross (X) the ending which you select.

1. Since the death my weight:
   _____ has increased enough to concern me.
   _____ has not changed enough to concern me.
   _____ has decreased enough to concern me.

2. (DO NOT answer this question if you have always been and still are a non-smoker.) Since the death, I have been smoking:
   _____ much less than before.
   _____ a little less than before.
   _____ about the same amount as before.
   _____ a little more than before.
   _____ much more than before.

3. Before the illness and death I had depressed moods:
   _____ hardly ever.
   _____ from time to time, but never enough to concern me seriously.
   _____ so frequent or so severe that I was seriously concerned.
   _____ severe enough for me to see a doctor.
   _____ severe enough for me to be admitted to a hospital.

4. After the first 2 or 3 months following the death my mood has been:
   _____ about the same as before the death.
   _____ depressed to an extent I thought was reasonable under the circumstances.
   _____ more depressed than I thought was reasonable.
   _____ depressed enough to concern me.
   _____ bad enough for me to see a doctor about it.
   _____ bad enough for me to be admitted to a hospital.

5. Before the death I took sleeping pills, tranquillizers, or nerve pills:
   _____ not at all.
   _____ occasionally.
   _____ regularly, but not enough to concern me.
   _____ so much that I was concerned about it.

6. During my first week of bereavement I took sleeping pills, tranquillizers, or nerve pills:
   _____ not at all
   _____ once or twice
   _____ all week long

7. Since the first week of bereavement I have taken sleeping pills, tranquillizers or nerve pills:
   _____ not at all.
   _____ less than before the death.
   _____ about the same as before the death.
   _____ more than before the death, but not enough to concern me.
   _____ so much that I have been concerned about it.

8. Before the death I drank alcoholic beverages:
   _____ not at all.
   _____ occasionally.
   _____ fairly regularly, but not enough to concern me.
   _____ so heavily that I was concerned about it.
   _____ so heavily that I needed special treatment.

9. Since the death I have drunk alcoholic beverages:
   _____ not at all.
   _____ less than before.
   _____ about the same as before.
   _____ more than before, but not enough to concern me.
   _____ so heavily that I have been concerned about it.
   _____ so heavily that I have needed special treatment.

10. Since the death my ability to do my work has been:
   _____ much better than before.
   _____ a little better than before.
   _____ the same as before.
   _____ a little less than before.
   _____ much less than before.

Are there any general comments you would like to make about your health during the past four months?

Would you like to make any comments about the questions we have asked you? Was there anything you did not understand?

Thank you for your co-operation.

APPENDIX J

Outcome Self-Report Form

In each set, mark the single statement which best describes you at the present time.

1. ___I participate more than I used to in church activities.
___My relationship to my church has not changed recently.
___I participate less than I used to in church activities.
___I cannot make myself participate in church activities anymore.

2. ___I have joined new clubs or accepted new responsibilities for club activities.
___I have not changed my participation in clubs or organized groups.
___I have let my attendance drop or have taken less responsibility for club activities.
___I have let my membership lapse in clubs or organized groups.

3. ___I don't feel as though I have many friends.
___I don't see much of my old friends, but I have made some new friends.
___My friendships are very stable.
___I still see a lot of my old friends, but I've also made some new friends.

4. ___I spend almost all my time by myself.
___I spend about 75% of my time by myself.
___I spend about 50% of my time by myself.
___I spend about 25% or less of my time by myself.

5. ___I have recently learned some new skills.
___I am planning to learn some new skills.
___I continue to do the things I've always done.
___I have recently felt as though I can't do things I used to do.

6. ___My performance at work has improved.
___My performance at work hasn't changed.
___My performance at work has declined somewhat.
___My performance at work has declined a lot.
___I am not employed.

7. ___My work is the only thing that keeps me going.
___My work is one of the few important things in my life.
___My work is one of the many important things in my life.
___My work is no more important than other parts of my life.
___I am not employed.

8. ___I work more than 40 hours a week.
___I work between 30 and 40 hours a week.
___I work between 20 and 30 hours a week.
___I work less than 20 hours a week.
___I am not employed

9. ___I have no financial problems.
___I have to be careful, but my financial situation is satisfactory.
___I often worry about my financial situation.
___I am in serious financial difficulty.

10. ___It is too painful to think of the past.
___It hurts some to think of the past.
___Thinking of the past is more pleasant than unpleasant.
___It feels good to think of the past.

11. ___I definitely feel pessimistic about the future.
___I prefer not to think about the future.
___I think the future will be OK.
___I enjoy making plans for the future.

12. ___Most of the time I feel very happy.
___Most of the time I feel rather happy.
___Most of the time I feel rather sad.
___Most of the time I feel very sad.

13. I feel depressed:
___always
___sometimes
___seldom
___never

14. I feel lonely:
___always
___sometimes
___seldom
___never

15. ___I feel much worse than I ever did before.
___I feel somewhat worse than I did before.
___I feel no differently than I did before.
___I feel better than I did before.

16. ___I have not changed anything that was theirs since the death.
___I have disposed of everything that was theirs since the death.
___I can't bear to look at anything of theirs since the death.
___I kept some things that I enjoy seeing in my house.

17. ___There are a lot of places and people I avoid because of the memories.
___There are a few places and people I avoid because of the memories.
___Sometimes I find myself suprised by the memories some places and people hold.
___I enjoy reminiscing around familiar places and people.

18. ___I feel I am adjusting well to my loss.
___I am adjusting better than I expected to my loss.
___I am adjusting less than I expected to my loss.
___I feel I am adjusting poorly to my loss.

APPENDIX K

Life Satisfaction Index

Here are some statements about life in general that people feel different ways about. Would you read each statement on the list and decide if you strongly agree, agree, disagree, or strongly disagree with it. Then put a check mark under the heading that describes your response. If you are not sure one way or the other, put a check mark in the space under "?". PLEASE BE SURE TO ANSWER EVERY QUESTION ON THE LIST.

	strongly agree	agree	?	disagree	strongly disagree
.As time passes, things seem better than I thought they would be.	____	____	____	____	____
.I have gotten more of the breaks in life than most of the people I know.	____	____	____	____	____
.This is the dreariest time of my life.	____	____	____	____	____
.I am just as happy as I was earlier in my life.	____	____	____	____	____
.My life could be happier than it is now.	____	____	____	____	____
.These are the best years of my life.	____	____	____	____	____
.Most of the things I do are boring or monotonous.	____	____	____	____	____
.I expect some interesting and pleasant things to happen to me in the future.	____	____	____	____	____
.The things I do are as interesting to me as they ever were.	____	____	____	____	____
10.I feel old and somewhat tired.	____	____	____	____	____
11.As I look back on my life, I am fairly well satisfied.	____	____	____	____	____
12.I would not change my past life even if I could.	____	____	____	____	____
13.Compared to other people my age, I make a good appearance.	____	____	____	____	____
14.I have made plans for things I'll be doing a month or a year from now.	____	____	____	____	____
15.When I think back over my life, I didn't get most of the important things I wanted.	____	____	____	____	____
16. Compared to other people, I get down in the dumps too often.	____	____	____	____	____

	strongly agree	agree	?	disagree	strongly disagree
7. I've gotten pretty much what I expected out of life.	_____	_____	_____	_____	_____
8. In spite of what some people say, the lot of the average man is getting worse, not better.	_____	_____	_____	_____	_____

APPENDIX L

Outlook Survey

Subject #_____

When I look back at the past I feel:

1	2	3	4	5	6	7	8	9
only pain				pain and pleasure equally				only pleasure

When I look toward the future I feel:

1	2	3	4	5	6	7	8	9
only pessimism				optimism and pessimism equally				only optimism

Despite the pain I've suffered, I have grown a great deal because of this experience.

1	2	3	4	5	6	7	8	9
agree strongly								disagree strongly

APPENDIX M

Summary of Non-significant Statistical Tests

TABLE 50

NONSIGNIFICANT TEST RESULTS: TIME SINCE DEATH

Variable	df	F	p
Background measures			
Sex	3,56	0.06	.98
Age	3,56	0.32	.81
Pre-bereavement			
Health	3,56	0.18	.91
Years of marriage	3,56	0.43	.73
Number of previous losses	3,56	0.65	.59
Time since death	3,56	0.44	.73
Months of illness	3,56	0.87	.46
Moved?	3,56	0.39	.76
Use of tranquilizers	3,56	0.25	.86
Holmes-Rahe	3,56	0.30	.83
Locke-Wallace	3,55	0.43	.74
Grief Work Survey			
1	3,56	1.00	.40
2	3,56	0.82	.49
3	3,56	0.99	.41
4	3,56	1.82	.15
5	3,56	0.52	.67
6	3,56	0.52	.67
8	3,56	0.14	.93
9	3,56	0.09	.96
10	3,56	0.87	.47
11	3,56	0.31	.82
12	3,56	0.88	.46
13	3,56	1.72	.17
14	3,56	0.87	.47
15	3,56	0.79	.51
16	3,56	0.98	.41
17	3,56	0.07	.97
18	3,56	0.28	.84
19	3,56	1.22	.31
20	3,56	1.03	.39
21	3,56	2.06	.12
22	3,56	0.64	.59
23	3,56	0.72	.54
24	3,56	0.50	.69
25	3,56	0.26	.86
26	3,56	0.70	.56
27	3,56	0.68	.57
28	3,56	1.14	.34
29	3,56	0.64	.60

TABLE 50--continued

Variable	df	F	p
30	3,56	0.68	.57
31	3,56	1.68	.18
32	3,56	0.64	.60
33	3,56	0.96	.42
36	3,56	0.38	.77
37	3,56	0.98	.41
38	3,56	0.65	.59
39	3,56	1.96	.13
40	3,56	0.98	.41
41	3,56	0.76	.52
42	3,56	0.32	.81
43	3,56	2.47	.07
44	3,56	0.43	.74
45	3,56	0.79	.51
46	3,56	0.46	.72
47	3,56	0.34	.80
48	3,56	2.20	.10
49	3,56	1.05	.38
50	3,56	0.06	.98
51	3,56	0.22	.88
Past	3,56	0.91	.44
Future	3,56	0.36	.78
Grow	3,56	0.44	.73
Life Satisfaction Index	3,56	0.85	.47
Outcome Self-Report	3,56	0.10	.95
Health - Total	3,56	0.82	.49
Health - Present	3,56	1.50	.22

TABLE 51

NONSIGNIFICANT TEST RESULTS: FIRST CLUSTER ANALYSIS

Variable	df	F	p
Age	3,49	1.08	.37
Years of marriage	3,49	1.00	.40
Number of previous losses	3,49	0.72	.54
Use of tranquilizers	3,49	0.74	.53
Holmes Rahe	3,49	0.58	.63
Past	3,49	0.24	.87
Future	3,49	0.52	.67
Growth	3,49	1.65	.19
Life Satisfaction Index	3,49	0.77	.52

TABLE 52

NONSIGNIFICANT TEST RESULTS: SECOND CLUSTER ANALYSIS

Variable	df	F	p
Age	3,54	0.01	.99
Years of marriage	3,54	0.36	.79
Use of tranquilizers	3,54	1.10	.36
Holmes Rahe	3,54	0.59	.63
Locke Wallace	3,53	1.34	.27

TABLE 53

NONSIGNIFICANT TEST RESULTS: THIRD CLUSTER ANALYSIS

Variable	df	F	p
Age	2,53	0.63	.54
Years of marriage	2,53	0.80	.45
Number of previous losses	2,53	2.73	.07
Months since death	2,53	0.39	.68
Use of tranquilizers	2,53	0.32	.73
Holmes Rahe	2,53	2.17	.12
Health - Present	2,53	0.92	.40
Health - Total	2,53	1.05	.36
Life Satisfaction Index	2,53	0.18	.83
Outcome Self-report	2,53	0.21	.80

TABLE 54

NONSIGNIFICANT TEST RESULTS: FOURTH CLUSTER ANALYSIS

Variable	df	F	p
Age	3,47	1.44	.24
Years of marriage	3,47	0.56	.64
Number of previous losses	3,47	0.04	.99
Use of tranquilizers	3,47	0.86	.47
Holmes Rahe	3,47	0.90	.45
Past	3,47	2.17	.10
Future	3,47	0.81	.50
Growth	3,47	0.94	.43
Health - present	3,47	1.96	.13
Life Satisfaction Index	3,47	1.10	.36
Outcome Self-report	3,47	0.03	.99

TABLE 55

NONSIGNIFICANT TEST RESULTS: CORRELATIONS WITH FACTORS

Variable	Correlation with factors							
	Factor 1		Factor 2		Factor 3		Factor 4	
	r_1	p_1	r_2	p_2	r_3	p_3	r_4	p_4
Sex	-.14	.30	-.15	.26	-.02	.90	Significant	
Age	.21	.12	-.05	.70	Signif.		.14	.29
Health	-.05	.71	-.19	.14	-.24	.06	.10	.44
Years of marriage	.06	.67	-.09	.47	-.15	.26	.12	.38
Number of previous losses	.12	.37	-.15	.24	.06	.62	-.17	.18
Months since death	.08	.56	.15	.24	-.17	.19	.17	.21
Months of illness	.18	.17	Signif.		Signif.		.08	.54
Moved?	.19	.15	-.01	.95	Signif.		.10	.44
Use of tranquilizers	Signif.		-.22	.10	.08	.57	.09	.52
Past	-.17	.21	Signif.		-.15	.25	-.16	.21
Future	.08	.55	.05	.68	-.04	.73	-.17	.20
Growth	-.02	.90	-.16	.24	.04	.77	Significant	
Health-total	Signif.		-.14	.30	.01	.93	-.03	.81
Health-present	-.24	.07	-.22	.10	.00	.97	-.01	.94
Life Satisfaction Index	Signif.		Signif.		.05	.69	.12	.36
Outcome Self-Report	.09	.50	Signif.		.07	.62	.16	.24
Holmes Rahe	-.07	.60	.08	.53	.12	.37	.18	.17
Locke Wallace	-.10	.46	.09	.50	Signif.		-.22	.10

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