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I am submitting herewith a dissertation written by Judy Bryant Keith entitled "The Relationships Between the Adjustment of the Widowed and Social Support, Self-Esteem, Grief Experience, and Selected Demographic Variables." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Health Education.

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THE RELATIONSHIPS BETWEEN THE ADJUSTMENT OF THE
WIDOWED AND SOCIAL SUPPORT, SELF-ESTEEM,
GRIEF EXPERIENCE, AND SELECTED
DEMOGRAPHIC VARIABLES

A Dissertation
Presented for the
Doctor of Education
Degree
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Judy Bryant Keith
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DEDICATION

In Memory of
LEONARD JOE KEITH

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ABSTRACT

The purpose of this study was to determine the relationship between adjustment of widowed persons and self-esteem, social support, the grief experience, and specific demographic variables. The sample consisted of persons widowed in 1979 or the first six months of 1980 who resided in Anderson County, Tennessee. Mailed questionnaires collected data from 58 persons on adjustment, self-esteem, social support, organizational involvement, the grief experience, and demographic variables.

The data were analyzed using chi-square, gamma, lambda, and frequencies and percentages. Gamma and lambda were important for their predictive properties.

Relationships were found between adjustment and nine scales on the Grief Experience Inventory and personal self-esteem. In addition, relationships were found between sex and eight of the social support questions, with males indicating less interpersonal support than females. A relationship was also found between sex and remarriage with males remarrying more frequently than females.

From these findings, the following conclusions were drawn:

1. Adjustment to widowhood is a lengthy process, and widowed persons may continue to experience adjustment problems for more than one year.
2. While research cited in the review of literature

indicated variables (age, sex, parental status, education, income, anticipatory grief, social support, and length of bereavement) which were related to adjustment 13 months after the death of a spouse, these variables do not appear to be related to adjustment over longer periods of time.

3. However, certain grief experiences do appear to be related to adjustment, and these are reflected in the physical, emotional, and social realms of the widowed person's life.

4. Males appear to have less interpersonal support than females.

5. Personal self-esteem appears to be more important to adjustment than general or social self-esteem.

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CHAPTER I

INTRODUCTION

An individual in American society has little experience with death, grief, and subsequent adjustment following the loss of a loved one.

As a matter of fact, contemporary American youth could be called the first "death free" generation in the history of the world. That is, it is now one generation or twenty years that a family in the United States can expect, statistically, not to have a death occur among its immediate members (Fulton, 1970).

In addition, due to advances in medical technology, death is becoming an event primarily of the aged with over 61 percent of these people dying in nursing homes or hospitals (Fulton, 1970). When death becomes such an isolated event, what effect does it have on the individual who must confront this experience? Although the status of the widow and widower are different in several respects, Ball's (1976-1977) description is applicable.

A widow's grief is especially difficult as she is generally an older person in our youth dominated society; she is single in a couple-oriented society; she is female in a male dominated society; she is often poor in an affluent society. With one out of every six women over twenty-one a widow, there is a need to study all aspects of her life and particularly her grief process.

A review of the literature revealed that the bulk of the research to date has focused on defining normal and abnormal grief reactions. Less has been written regarding the process and problems associated with redefining the

life of the individual who has suddenly moved from the status of married to that of widowed. Silverman (1972) described the impact of this sudden change when she said:

Widowhood does not just happen when a spouse dies. A woman may legally become a widow at this point; however, the legal fact does not always coincide with her social and emotional acceptance of the role.

The widowed encounter numerous problems, literally touching on every aspect of their lives. Physical and mental health problems have been documented by a number of researchers including Clayton et al. (1972), Maddison (1968), Maddison and Viola (1968), Maddison and Walker (1967), and Parkes (1964, 1975). In addition, Rees et al. (1967) found a much higher rate of mortality among the bereaved. Social isolation and loneliness are serious social problems also documented by several researchers (Clayton et al., 1972; Kivett, 1978; Lopata, 1969-1970, 1970-1971, 1978a, 1978b; Silverman, 1969; Vinick, 1978).

If the effects of the death of a spouse are so broad in their impact on the bereaved's life, what variables can and do mediate this impact? Education, income, forewarning of death, time, and social support have been suggested as beneficial in the research literature (Ball, 1976-1977; Bornstein et al., 1973; Carey, 1977, 1979-1980; Clayton et al., 1972; Parkes, 1975; Lopata, 1969-1970, 1970-1971, 1978; and Silverman, 1969).

With an increasing elderly population, it follows that the number of widowed is also increasing (Havinghurst,

1969). If health is viewed in terms of physical, mental, social, and spiritual well-being; serious efforts must be made to understand how grief can affect each of these areas. This knowledge can then be transferred through health education and counseling, thereby preventing some problems and aiding a large segment of the population in achieving a more positive adjustment to life.

I. NEED FOR THE STUDY

Research into bereavement and adjustment after the death of a spouse has been limited. The majority of studies to date have been conducted in large urban areas with little emphasis on adjustment in rural communities. These studies have also been limited primarily to grief reactions with some attention given to social support and other variables which could predict adjustment (Carey, 1977, 1979-1980; Clayton et al., 1972; Parkes, 1975; Lopata, 1969-1970, 1971, 1978; and Silverman, 1969). Although self-esteem is referred to in a few studies (Barrett, 1978; Hirsch, 1980; Sheskin and Wallace, 1976; and Silverman, 1967), no research has been conducted that actually measures the relationship of self-esteem, social support, the grief experience, and specific demographic variables to adjustment. Since the literature revealed that no research has been conducted that actually measures the relationship of self-esteem, social support, the grief experience, and specific demographic variables to

adjustment, it was felt that research addressing these areas was indicated. The link between health problems and bereavement has been established. Among these problems were early death, greater risk of depression, insomnia, loss of appetite, use of drugs, head aches, chest pains, etc. Further research into variables capable of mediating these problems, and perhaps breaking the chain of events, was warranted.

II. PURPOSE OF THE STUDY

The purpose of this study was to determine the relationship between the adjustment of widowed individuals and self-esteem, social support, the grief experience, and specific demographic variables.

III. STATEMENT OF THE PROBLEM

The research problem for this study was to analyze the adjustment behavior of persons widowed in 1979 or the first six months of 1980 who resided in Anderson County, Tennessee. In order to study adjustment of the widowed, it was necessary to determine the relationship between adjustment and each of the following: 1) age, 2) sex, 3) parental status, 4) education, 5) organizational involvement, 6) income, 7) anticipatory grief, 8) length of bereavement, 9) grief experience, 10) social support, and 11) self-esteem.

IV. RESEARCH HYPOTHESES

Eleven research hypotheses were developed as follows. There is a significant relationship between adjustment and the following variables: 1) age, 2) sex, 3) parental status, 4) education, 5) organizational involvement, 6) income, 7) anticipatory grief, 8) length of bereavement, 9) grief experience, 10) social support, 11) self-esteem.

V. BASIC ASSUMPTIONS

1. The widowed person's perceptions of one's social support, self-esteem, and grief experience were valid.

2. The adjustment of the widowed could best be described by the widowed themselves.

3. The demographic questionnaire, organizational list, Social Support Index, Self-Esteem Inventory, Adjustment/Depression Inventory, and Grief Experience Inventories were appropriate instruments for collecting data for this study.

4. Responses to the instruments were honest and accurate.

VI. DELIMITATIONS

This study involved persons aged 18 to 65 years, who resided in Anderson County, Tennessee, whose spouses died between January 1, 1979, and June 30, 1980.

VII. DEFINITION OF TERMS

Adjustment. Indicated by a score on Carey's Adjustment/Depression Scale for Widowed Persons (Carey, 1977, 1979-1980).

Anticipatory Grief. Experiencing grief prior to the death and some degree of acceptance of the loss before it actually occurs.

Bereavement. "The state of feeling, thought, and activity, which is the consequence of the loss of a loved or valued person" (Parkes, 1965).

Depressed. Indicated by a score of 8-15 on Carey's Adjustment/Depression Scale for Widowed Persons (Carey, 1977, 1979-1980).

Grief Experience. "The sequence of subjective states that follow loss and accompanies mourning" (Bowlby, 1961).

Moderate Adjustment. Indicated by a score of 16-20 on Carey's Adjustment/Depression Scale for Widowed Persons (Carey, 1977, 1979-1980).

Mourning. A psychological process that begins with the loss of a loved object and ends with relinquishing of the object (Bowlby, 1961).

Self-Esteem. The perception the individual has of his/her own worth (Battle, 1981).

Social Support. "A set of actions or objects which the giver, receiver, or both define as necessary or helpful in maintaining a style of life." Support may be economic,

service, social, and emotional (Lopata, 1978).

Well-Adjusted. Indicated by a score of 21-24 on Carey's Adjustment/Depression Scale for Widowed Persons (Carey, 1977, 1979-1980).

CHAPTER II

REVIEW OF RELATED LITERATURE

I. STUDIES RELATED IN CONTENT

To have some basis for understanding the relationships of social support, self-esteem, and the grief experience to adjustment, the literature was reviewed in the following areas: 1) Bereavement, Grief, Mourning Defined, 2) Normal Grief Reactions, 3) Abnormal Grief Reactions, 4) Grief as a Process, 5) Duration of Grief Process, 6) Problems Associated with Widowhood, 7) Positive Effects of Being Widowed, 8) Adjustment to Widowhood, 9) Social Support and the Widowed, and 10) Self-Esteem and the Widowed.

Bereavement, Grief, Mourning Defined

The terms bereavement, grief, and mourning are often used interchangeably. Freud (1929) was one of the earliest to attempt to define bereavement and provide insight into the adjustment required of the bereaved individual.

Although we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it is filled completely, it nevertheless remains something else. And actually that is how it should be. It is the only way of perpetuating that love which we do not want to relinquish.

Peretz (1969) also defined bereavement in terms of those thoughts, feelings, and actions that result from the ". . . loss of a loved or valued person." The individual

who has experienced such a loss is described as bereaved.

Bowlby (1961) viewed mourning in terms of a psychological process that begins with the loss of a loved object and commonly leads to the ". . . relinquishing of the object." He described grief as the ". . . sequence of subjective states that follow loss and accompany mourning."

Krupp (1972) provided a rather comprehensive definition of all three terms.

Mourning, therefore, is not simply reaction to the loss of a loved person, but a process of extricating interest from that person and transferring it elsewhere. It is a painful and difficult task to carry out the "work of mourning." Whereas the term bereavement implies the external appearance and behavior, as well as attitudes and feelings, of someone who is engaged in the severance of ties necessitated by death, the word grief, although not entirely exclusive of inner emotions, appearance and behavior, basically refers to the inner emotions, attitudes, and thoughts of the mourner. Mourning also often tends to be applied to the external rites, customs, and conventions.

Normal Grief Reactions

Researchers attempting to classify grief reactions have most often done so by first describing atypical reactions, primarily because patients suffering from severe grief reactions availed themselves of treatment services and were more readily available for research. Atypical reactions, because of their intensity, were also more easily recognized. Grief reactions were quite varied and would be affected by many variables.

Clayton (1969) used several descriptors for normal grief reactions: feeling sad, difficulty in sleeping,

crying, loss of appetite and weight, loss of interest in current events and friends, difficulty in concentration, irritability, and attacks of anxiety accompanied by shortness of breath, palpitation, weakness and trembling, apprehension, and fearfulness.

Bowlby (1961) described "healthy mourning" as occurring in three overlapping phases involving withdrawal of emotional concern from the deceased and preparing for new relationships. Phase one revolves around the ". . . urge to recover the lost object." The main features of this phase are crying and expressions of anger. Phase two involves disappointment at not being able to recover the lost object: ". . . hopes fade, despair sets in and behavior becomes disorganized." He described depression in this phase as:

. . . nothing more than the subjective aspect of this state of disorganization. The depressed individual of any age and species is the one whose behavior is no longer organized and self-sustaining.

Bowlby suggested that because the individual believes he can no longer function effectively in the world, he views himself as empty which accounts for much of the loss of self-esteem, so characteristic of depression. Many widows report a feeling of loss of self when the spouse dies. They may, in fact, be referring to a loss of identity as a married person, since identity is often tied to that of the husband. Bowlby stated that when the bereaved relinquishes a loved object, he must ". . . accept the destruction of part of his personality before he can organize it afresh toward a new

object or goal." Phase three is described by reorganization of the individual's life as it relates both to the image of the lost object and emerging new objects.

Dr. Erich Lindermann's (1965) classic research of the relatives and survivors of the Coconut Grove fire in Boston has provided a more detailed view of responses to grief. Five main points are listed in his description:

1. Somatic distress characterized by a ". . . marked tendency to sighing respiration, . . ." lack of strength, a feeling of exhaustion, and loss of appetite.
2. Preoccupation with remembering the deceased.
3. Preoccupation with feelings of guilt involving searching the past for any failure on their part in the relationship with the deceased.
4. Hostile reactions described as a ". . . loss of warmth in relationship to other people, a tendency to respond with irritability and anger, and a wish not to be bothered by others . . ." when friends and relatives are making every effort to be helpful.
5. Changes in patterns of behavior described as "the disorganized response":

The bereaved activity throughout the day of the severely bereaved person shows remarkable changes. There is no retardation of action or speech; quite to the contrary, there is a push of speech, especially when talking about the deceased. There is restlessness, inability to sit still, moving about in an aimless fashion, continually searching for something to do. There is, however, at the same time, a painful lack of capacity to initiate and maintain organized patterns of activity. What is done is done with lack of zest, as though one were

going through the motions. The bereaved clings to the daily routine of prescribed activities; but these activities do not proceed in the automatic, self-sustaining fashion which characterizes normal work but have to be carried out with effort, as though each fragment of the activity is a special task. The bereaved is surprised to find how large a part of his customary activity is done in some meaningful relationship to the deceased and has now lost its significance. Especially the habits of social interaction--meeting friends, making conversation, sharing enterprises with others--seem to have been lost. This loss leads to a strong dependency on anyone who will stimulate the bereaved to activity and serve as the initiating agent.

Hardt (1978-1979) attempted to classify grief reactions by stages with the use of an attitude scale. His research indicated five stages rather than three as suggested by Bowlby. While Stage I is characterized by shock and denial, Stage II is characterized by false acceptance. In Stage III the mourner appears to have reorganized his life, however, this is only pseudoreorganization. Stage IV tends to be the longest with the bereaved depressed and suffering from fluctuations in attitudes. Stage V involves final reorganization and acceptance.

Parkes (1965) clearly defined grief reactions as a functional mental disorder

. . . whose cause is known, whose symptomatology is stereotyped and whose outcome is predictable. That grief is a mental disorder there can be no doubt, since it is associated with all the discomfort and loss of function which characterized such disorders.

Parkes gave the most descriptive details of responses to grief to date. He separated grief into four different forms: 1) typical, 2) chronic, 3) inhibited, and 4) delayed. Typical reactions to bereavement can vary in intensity and

duration depending on the closeness of the relationship with the deceased. The first response is usually one of numbness lasting from a few hours to a few days. Bowlby and Hardt also included the reaction of numbness in their description. However, long delays of grief response leads to what Parkes described as delayed grief reactions. After the numbness phase ends, attacks of yearning for the deceased occur which are aggravated by reminders of the deceased. There is a loss of appetite, difficulty in sleeping, feeling of exhaustion, restlessness, and irritability with occasional outbursts of anger directed at others or at themselves. The bereaved is preoccupied with thoughts of the dead person and tends to idealize his memory. He described these responses as decreasing in intensity within 1 to 6 weeks, reaching a minimal level within 6 months. However, these feelings can and do return when reminders (anniversaries, holidays) of the deceased precipitate them.

Abnormal Grief Reactions

Parkes (1965) offered several descriptions of abnormal grief reactions.

Chronic grief. An abnormal prolongation and intensification of the typical form, frequently associated with ideas of guilt and self-blame, identification symptoms, and/or aggressive or delinquent behavior.

Inhibited grief. A large part of the total picture is lastingly inhibited but certain other symptoms, some of which resemble aspects of grief, occur in its place. This type seems to be most common in the very young and the old.

Delayed grief. This is a mixed form in which a typical or chronic reaction takes place after a period

of delay which may range from weeks to years in duration. As with inhibited grief distorted forms may occur during the period of delay but there is no reason to regard them as peculiar to this form of grief.

Linderman (1965) also listed nine morbid grief reactions which represent distortions in normal grief reactions and are more serious in nature: 1) overactivity without a sense of loss, 2) the acquisition of symptoms belonging to the last illness of the deceased, 3) a recognized medical disease such as ulcerative colitis, 4) alterations in relationships to friends and relatives, 5) intense hostility against specific persons (blaming the doctor), 6) woodenlike behavior patterns exemplified by living without emotions, and 7) a prolonged loss of patterns of social interaction. The person is described as being restless but unable to initiate any activity without the aid of someone else. He will appreciate sharing activities with others but cannot initiate activity alone. The person may take actions that are detrimental such as giving away belongings or making poor economic decisions. The most extreme reaction described by Lindermann was that

. . . of a straight agitated depression with tension, agitation, insomnia, feelings of worthlessness, bitter self-accusation, and obvious need for punishment. Such patients may be dangerously suicidal.

Krupp (1972), as did Bowlby (1961), spoke of grief as being healthy when it decreases in intensity, when the finality of separation is accepted, and when there is a commitment once again to life. Unhealthy grief becomes an

illness when it becomes fixed in despair and apathy. He stressed the importance of helping the bereaved survive the ". . . ordeal with an increased awareness of his own capacities for living." When the bereaved becomes fixed in despair and apathy, pathological responses may take several forms. One of the most common forms is described as "exaggerated" when the grief reactions are prolonged and intense, leading to a true depression. The depression may be accompanied by nightmares, outbursts of fear and anger, and strong feelings that the mourner has no right to live. Another form described as a "complete ego breakdown" involves intense rage projected outward, possibly leading to paranoia and delusions of persecution. Krupp also described as pathological the assumption of disease symptoms of the deceased as an attempt by the bereaved to retain the deceased in fantasy. Another pathological form which may occur is neurotic mourning which prevents the individual from maturing. The psychosocial development of the bereaved becomes fixed at an immature level. Total absence of mourning is still another form which, according to Krupp, is pathological and involves denial or postponement of emotion as a defense against the psychic pain felt during grief. While it is classified as the first stage in healthy bereavement, if it is not overcome, the reaction must be described as pathological. Parkes (1965) probably described these last two reactions but classified them as "inhibited" or "delayed."

Eliot as early as 1932 listed individual effects of bereavement. The list is self-explanatory.

- A. Total failure to readjust
 - 1. Suicide
 - 2. Early death
 - 3. Insanity
 - 4. Moral disintegration
 - 5. Obsession
- B. Partial failure
 - 1. Eccentricities
 - 2. Physical illness or prostration
 - 3. Aboulia, purposelessness
 - 4. Isolation
 - 5. Embitterment, misanthropy, cynicism
 - 6. Reversion to or recurrence of griefs
 - 7. Self-blame or personal hates
 - 8. Fears
 - 9. Loneliness
- C. Partial success
 - 1. Resignation, "God's will," etc.
 - 2. Stoicism
 - 3. Stereotyped formulae of immortality, misery escaped, etc.
 - 4. Sentimental memorials
 - 5. Effective repression of memories
 - 6. Intensification of affections
 - 7. Extension of affections
 - 8. Deliberate absorption in distractions or duties
 - 9. New or fantasized love objects
- D. Conspicuous success
 - 1. New love object
 - 2. Thoroughgoing religious rationalization
 - 3. Spontaneous forgetting, relaxation of tensions
 - 4. Devotion to life work
 - 5. Identification with role of deceased
 - 6. Creation of constructive memorials
 - 7. Transmutation of the experience into a productive reintegration of the personality

The researchers cited used a variety of descriptors to identify grief reactions. Differences in terminology should not be interpreted as one researcher contradicting the work of another. The grief reactions described are separated more by intensity or duration of response rather than by definition. The work of one researcher builds on

another providing further confirmation and clarification. For example, Bowlby, who developed the concept of three phases of mourning, later revised his concept to include Parkes' theory of an initial reaction of numbness. Each of these researchers indicated that reactions may be overlapping and recurring depending on the individual and his/her relationship to the deceased.

Grief as a Process

Parkes (1974) suggested that the work of earlier research by Eliot (1932) and David M. Fulconer (1942) is important for

. . . the recognition that grieving was not a single emotional state that appeared at the time of loss and then disappeared abruptly when mourning had been accomplished, but rather a process with successive phases leading from emotional devastation to eventual readjustment.

Duration of the Grief Process

The duration of typical grief reactions is in question. Lindermann (1965) suggested that these lasted four to eight weeks. Hardt (1978-1979) suggested eight months before all five stages were completed. Parkes (1970) suggested that after 13 months the intense grief responses had passed their peak, but that the grief work had not been completed. Ball (1976-1977) studied a group of widows six to nine months after the death of their spouses. When asked to rate their adjustment, 54 percent rated themselves somewhat recovered, 11 percent not at all recovered, and

34 percent almost or completely recovered. Silverman (1970) reported that the widow seldom recovered from her bereavement within a year. While ". . . she may be over the acute stage of her grief, she is not recovered, and may even be depressed by her growing awareness of what the loss means." She stated that the widow never recovers but rather learns to adjust to the situation. This process takes about two years to accomplish and involves ". . . an ability to repattern her life without a husband, to find new friends, new interests, and sometimes a new career. It also means learning to live with loneliness." Silverman, therefore, chose to define the length of bereavement as including some measure of adjustment.

The length of bereavement and even the intensity of grief can be affected by several factors. Anticipatory grief was first presented as a concept by Lindermann (1965). Anticipatory grief occurs prior to the loss, allowing the bereaved to begin dealing with their feelings prior to the actual death. Long illnesses, therefore, have the advantage of allowing the bereaved to address some of their feelings prior to the loss, if they accept the death as inevitable. This does not mean that the death is any less painful or the feelings any less intense than those felt when a death occurs unexpectedly. It merely means that more time has been available to deal with them.

According to Carey (1979-1980), forewarning of the

death of a spouse is an asset leading to adjustment for women only. He suggested that this difference may be attributed to a greater emotional need for women to talk through their anxieties and grief.

Ball (1976-1977) found age to be a more significant factor than anticipatory grief in the intensity of grief reactions. She reported that restlessness and irritability symptoms were significantly higher in young widows whose husbands had died after a prolonged illness.

Goldberg (1973) described mourning to be of longer duration but lesser intensity when anticipatory grief has occurred. Sanders (1979-1980) found no support for the belief that the grief response is more intense in sudden deaths versus anticipated deaths. Her study (1980-1981) indicated that younger spouses demonstrated a greater intensity of grief during the first two months but that 18 months later a reverse trend was evident. Older spouses in her study had an initially diminished grief response.

Smith (1975) in his five year, quasi-longitudinal study found anticipatory grief to be significantly related to adjustment. Williams (1976) agreed with Smith's findings, stating that ". . . the more sudden, tragic, violent, or unexpected the death is, the greater the chance the bereaved relative has for poor outcome." Sheskin and Wallace (1976) argued that anticipation does not lessen the person's grief but that the knowledge of the impending death forces the

surviving spouse to begin redefining roles. Even if the person refuses to accept the death, the redefinition of roles and acceptance of responsibilities during the illness forces that person into a process of decision making which assists them in recovery after the death. Sheskin and Wallace found that:

Unanticipated death occasions the most severe bereavement reactions. With no anticipation of death there had been no role preparation for independence. Thus the grief these women experienced was compounded by their lack of preparation for the future.

Maddison and Walker (1967), using health as a measure of outcome of bereavement, found no relationship between the widow's illness score and anticipatory grief. They found, however, that younger widows experienced more health problems than older widows. Gerber et al. (1975) also used health as a measure of outcome. They found that the male survivor's health is poorer than that of the female survivor's; and, rather than a long anticipatory grief period being helpful to the adjustment of the survivor, the opposite is true. They suggested that the surviving spouse's health may be negatively affected because he or she has neglected himself/herself to care for the ailing individual or that the emotional pressures of watching the spouse die could aggravate an existing chronic illness.

Mourners in our society are often told that "time will help," as if the mourner only needed to entrust himself passively to a guardian angel, called Time, and then wait patiently for the eventual return of his peace of mind. Few people other than those who have themselves

experienced deep mourning will show an understanding that the mourner may have the hardest task of his life ahead of him and that his labors will require a great deal of effort and concentration in order to succeed (Gut, 1974).

The effects of anticipatory grief are obviously not fully resolved. Interpretations are difficult because of lack of similarity in studies, with bereavement responses and outcomes being measured differently which make comparisons almost impossible.

Problems Associated with Widowhood

The problems encountered by widowed individuals are many, touching on every aspect of their lives. Because of the tremendous changes in living circumstances and the interaction of these variables, it is difficult to state without reservation that these problems are solely related to the state of bereavement. Many of the problems lead to further problems; for example, less income may relate to poorer diet, which could relate to poorer health, which could also relate to inadequate health care due to financial restrictions.

Health problems have been associated with bereavement via differences in mortality and morbidity rates. Rees and Lutkins (1967) studied bereaved relatives over a six year period. They noted a significant difference between the bereaved and control groups at the .001 level, with the bereaved group at greater risk of dying. Their study also indicated a greater risk for males than for females, with widowed spouses achieving a .01 significance level. In

addition, their study indicated that people who die following the death of a family member are generally younger than that person, with the second death occurring at an earlier age than is usual for the community in which they live.

Parkes (1964) examined the incidence of recent bereavement in the pre-illness histories of patients admitted to a psychiatric clinic to determine whether, and among which patients, illness exceeds the incidence which could have occurred by chance. He found that:

The number of patients whose illness followed the loss of a spouse was six times greater than expected and suggests that the bereavement was a causative factor in the development of the illness.

His study indicated that women were more "inclined" to mental illness following bereavement than men, with the incidence of affective disorders, particularly reactive and neurotic depressions, more significant in the bereaved group.

Maddison and Walker (1968) conducted two studies, one in Boston in 1964-1965 and one in Sydney, Australia, in 1966. They selected widows between the ages of 45-60 and collected their data 13 months after the death. The two study samples were matched. In Boston, younger women of deceased younger husbands showed a significant decline in physical and psychological health. Age was not significant with the Australian group. However, the bereaved groups, when compared to the control groups, recorded more health complaints. Psychological symptoms rather than physiological

symptoms most clearly differentiated the bereaved and control groups. Symptoms mentioned were insomnia, nervousness, loss of appetite, weight loss, reduced work capacity, and an increase in smoking. The Boston widows also mentioned an increase in the use of alcohol, while the Sydney widows relied more on drugs. Maddison and Walker (1967) found that the widow's health correlated with her perceptions of the supportiveness of her environment. In addition to the increase in health complaints among the younger widowed, they also found that the widows who were in good health viewed their environment as supportive. Those widows in poor health felt that individuals in their environment had actually blocked their feelings of grief expressed through crying or anger, had shown hostility toward them, and had discouraged communications about the deceased. They also found that anticipatory grief had no effect on the health status of these widows.

Raphael (1977) used the same instrument as Maddison and Walker to determine groups at greater risk for increased health problems as a result of bereavement. These high risk individuals were then randomly assigned to control and experimental groups. The experimental group was given supportive intervention during the first three months following the death. This intervention involved encouragement of expression of grief, such as sadness, anger, anxiety, hopelessness, helplessness, and despair.

The bereaved were also encouraged to review both the positive and negative aspects of the lost relationship. The variable lack of supportiveness was significant at the .001 level as a predictor of poor health between the experimental and control groups.

Clayton (1972) studied depression in a sample of white widows and widowers. The specific problems expressed most often by the depressed group were loneliness and concern with the suffering of the deceased. When the depressed and non-depressed widowed were compared, lack of support (especially from family), was significant. In assessment of the helpfulness of the support available to them, more of the depressed group reported their interactions with others as not helpful or disappointing than the non-depressed group. She did not find depression to be more common in women than in men, nor was it associated with a family history of psychiatric illness. Age and previous treatment for depression were two other variables which were not predictive of outcome.

Bornstein et al. (1973) followed Clayton's (1972) study by following the sample through the 12 months of bereavement. They found depression diagnosed at one month to be a predictor of depression at one year. Once again depression occurred in similar percentages in women and men. The depressed group suffered significantly from insomnia, fatigue, restlessness, the wish to be dead,

decreased interest, weight loss, and anorexia. The depressed described themselves as being in poor health, suffering from such symptoms as blurred vision, dizziness, and chest pains. Previous experience with death appeared to be helpful in decreasing the level of depression. Twenty-five percent of the depressed and only 4 percent of the non-depressed had had no previous death experience. This findings was significant at the .02 level. In addition, the depressed had lower incomes indicating that financial support was lacking. Income was significantly associated with depression at the .05 level.

Silverman (1969) suggested that depression and loneliness became more serious problems for the widow six months to one year after the spouse's death. Vinick (1978) found that the number of friends a widowed person had correlated with loneliness. These findings were significant for men at the .05 level and for women at the .01 level. Kivett (1978), in her study of rural widows, measured loneliness against 16 physical, social, and psychological variables. Her study indicated that ". . . loneliness was related to frequency of telephoning, the presence of a confidant, morale, self-rated health, and problems with transportation." Two linear combinations of variables separated widows according to levels of loneliness.

Emotional isolation was observed through the importance of visiting with friends and neighbors, the presence or absence of a confidant, and life satisfaction.

Physical isolation was determined in the main by self-rated health and adequacy of transportation.

Friends and neighbors appeared to have a greater impact on preventing loneliness than relatives. Widows in poor health and with transportation problems were at greater risk of loneliness. The study did not find a significant relationship among loneliness and number of children, club or church participation, vision and/or hearing impairments, income, or living arrangements.

Arling (1976) conducted his research in the Piedmont region of South Carolina. He compared family involvement with friendships and neighboring relationships to determine the greatest impact on morale of the widowed. Again, neighboring and friendships were more significant (at the .01 level) than family members, especially children, in higher morale in widows. Arling believed that neighboring and friendships were more significant because they offered more companionship, a confidant, the feeling of usefulness, and community respect. These relationships, as compared to the family relationships, required more initiative on the part of the widowed to keep contacts active. Family interactions were viewed as more often evolving out of a sense of obligation.

Silverman (1969), in her widow-to-widow program conducted in Boston, found that a widow could offer positive support to another widow because she could relate to the feelings and problems encountered by the newly widowed. She

questioned whether or not this outreach fellowship program in a large city simply formalized what would naturally occur in a rural community.

Lopata (1969-1970) also studied widows in a large urban area, namely Chicago. In her study, 48 percent listed loneliness as the major problem of widowhood, and another 22 percent referred to it in conjunction with other problems. She defined loneliness as:

. . . a sentiment felt by a person when he defines his experienced level or form of interaction as inadequate. Such feelings are likely to arise when the habitual or expected depth of relations with other people is judged as temporarily or permanently unavailable, broken, or under-developed.

Lopata suggested that social isolation is a major problem for widowed persons, and that it occurs because society does:

. . . little to facilitate the re-engagement of persons whose life patterns is [sic] broken or who for other reasons for involving people is rationalized by the assumption that those who become socially isolated do so voluntarily.

She further suggested that the widows themselves:

. . . have not been socialized to analyze logically the resources of their environment, to choose desired social roles, to prepare themselves for entrance into interaction scenes, to be willing to be tested by secondary criteria, and generally to rebuild their lives.

Ball (1976-1977) also researched problems encountered by the widowed. She studied widows, bereaved for six to nine months, in the age categories young, middle, old. She was primarily concerned with age, mode of death, and whether anticipatory grief was a mediating factor. Age was more

significant than anticipatory grief in intensity of grief reactions. The widows reported their biggest problems as: 1) loneliness--44 percent, 2) learning to take responsibility and make decisions--36 percent, 3) economic and financial problems--18 percent, 4) children--6 percent, 5) getting settled, not being able to drive, illness, sex, going out alone, and being depressed--15 percent.

Several researchers have found financial resources to be an important variable associated with grief reactions and consequent adjustment. Pihlblad et al. (1972) found that most elderly widowed subsist on incomes below poverty level. Widowers' incomes were about one-half that of married persons incomes, with widows having incomes only three-fourths that of widowers. Two-thirds of the widows studied by Lopata (1978) in Chicago were living on incomes below the poverty level as established by the Social Security Administration and the U.S. Department of Labor. While Pihlblad (1972) found that widows with financial problems compensate by getting a job, Lopata (1978) found that many of the Chicago widows were unskilled for employment. Bornstein et al. (1973) found that depression was significantly related to lower incomes at the .05 level. Parkes (1975) found low socioeconomic status to be a predictor variable in outcome of bereavement. Bahr (1979) also found income to be the second best predictor of adjustment.

Parental responsibilities also presented problems

for the widowed. Maddison (1968) suggested that younger widows (under 45 years of age) with a number of dependent children were at high risk of having difficulty resolving the bereavement crisis. Parkes (1975) indicated that behavior problems with a child were associated with poor outcome of parental bereavement. Silverman (1975) reported that the widow with dependent children at home is more acutely aware of her widowed status. She suggested that these widows often repressed their feelings, did not cry or talk about dad in front of the children for fear that it would upset them. Some widows indicated a deep preoccupation with themselves, almost to the point of neglecting their children. However, some widows in Silverman's sample indicated that their children gave meaning to their lives when they felt all else was hopeless. For some it meant that they had to stay alert and reorganize their lives for the sake of the children. Others used the children as a source of support, actually getting more from their children than they gave.

Another important problem area is that of social and interpersonal interaction between the widowed and others in their environment. Communication is often suppressed because society offers few rituals or opportunities for expression of grief. This is particularly true for males. People are expected to be rather quiet about the grief. Frequently friends and relatives withdraw from the bereaved

person because they do not know how to relate to or handle these expressions of grief (Peretz, 1969). Parkes (1965) described the world's picture of the widow as an individual treated with sympathy, but also with a measure of fear.

People are often tense and nervous in their contact with newly bereaved people and it takes some time for this embarrassment to wear off. When it does, the status of the bereaved is not quite the same.

Role change after the loss of a spouse is a particular problem for the woman, especially, because much of her identity had been derived from that of the husband.

Socially, she and her husband had been regarded as a unit, although appreciated individually up to a point. Without his presence, the unit is dissolved and friends are perplexed as to what to do.

Usually, she is deluged with social invitations, sometimes before she is prepared to venture into the world again. If she does, she may find that friends are too cordial, oversolicitous but obviously cautious about saying the wrong thing. She has enough of her own anxiety without being subjected to that of others. After the too early flurry of invitations, to which she has not responded very graciously, she may find herself tacitly abandoned because, as less than a unit, she no longer fits into the social scene. If she is relatively young and attractive, her female friends may be threatened by her presence in their social circles. When she is ready to find new social contacts, she may discover that the opportunities have disappeared and that her contacts are limited to spinsters and widows. Social affairs are

usually couple-oriented, and single men and women available at couple affairs are definitely shunned. If the widow has a career, daily contact with men would continue as before, but again her role in their eyes may gradually change. However much they may have respected her as a married woman, she may come to be seen as hungry for love and sex on any basis and fair game for them. These factors provide a further disruption in her already convulsed world and undermine her self-esteem and identity. She may begin to question her own behavior, assuming that she must now have some defect in her character and worth (Cattell, 1969).

Silverman (1970) also suggested that widowhood is viewed with social stigma, even to the point where some view that status as defective.

If society has a difficult time with the identity of the widow and her status, the widow has even greater identity problems. She is the recipient of the projections of the individuals within their social environment, and at the same time must deal with her own feelings, questions, and insecurities.

Widowhood does not just happen when a spouse dies. A woman may legally become a widow at this point; however, the legal fact does not always coincide with her social and emotional acceptance of the role (Silverman, 1972).

Golan (1975) referred to the transition the widowed must make as a progression of three self-concepts: wife, widow, and single woman. Role change and acceptance of new and different responsibilities in all aspects of the widowed

person's life is required before adjustment can be achieved (Goldberg, 1973 and Lopata, 1970-1971).

Positive Effects of Being Widowed

To consider only the problems associated with being widowed would be a biased approach, because despite the pain and hardships associated with widowhood, personal growth also occurs. The roles and responsibilities formerly filled by the spouse must now be assumed by someone else. The widowed learn new skills, of necessity, which allow them to function without the deceased. Women learn to drive, balance a checkbook, mow the grass, etc., and men learn about child care, cooking, and home management. While somewhat skeptical about their abilities to manage these unfamiliar tasks, they must be managed in some way. The mastering of one unfamiliar skill soon leads to another which coincides with an increase in self-confidence and further personal growth.

Adjustment to Widowhood

Several researchers have attempted to quantify adjustment and to identify variables that can predict a positive adjustment (Bahr, 1979; Bornstein et al., 1973; Carey, 1979-1980; Demi, 1978; Maddison, 1967, 1968; Parkes, 1975; Silverman, 1967; and Williams et al., 1976).

Bahr (1979) developed a step-ladder questionnaire which allowed widows to indicate perceptions of their

adjustment level. This procedure was used to describe (retrospectively) their adjustment prior to and following the death. He found that the experimental group of widows tended to view the past in a more positive way than did the control group of married women, indicating that the former group tended to idealize the past. Variables he found to be predictors of positive adjustment were: 1) education (73 percent with high school education achieved a satisfactory level of adjustment as compared to 38 percent without a high school education), 2) income, 3) and others such as age, church membership and attendance, perception of self as a religious person, activity in voluntary associations, and having a new group of friends.

Bornstein et al. (1973) found depression at one month to be a predictor of depression at one year. The depressed saw themselves in poorer health, had had no previous experience with death, attended church less frequently, and had lower incomes than the non-depressed.

Carey (1979-1980) developed an eight item, self-report measure of adjustment for the widowed which measured depression. He found widowers to be significantly better adjusted than widows. None of the widows had remarried 13-16 months after the death while 20 percent of the widowers had done so. Widows who had forewarning of the death adjusted better than widows without forewarning. Widowers, however, were not affected by forewarning of the death. Age was a more important factor for women than for men. Those

over age 57 were better adjusted than those under 57 years. Education was another variable which was more important for women than for men. Those with college degrees were better adjusted than those with high school degrees or less. Men tended to have higher incomes than women, and persons of either sex who had incomes over \$10,000 were better adjusted than those with incomes under \$10,000. Those individuals living alone were better adjusted than the widowed living with dependent children. Those living with independent children were the least adjusted. He also studied those individuals who, in the widowed person's opinion, were most helpful during the bereavement crisis. Eighty percent of the widowed indicated that the family was most helpful, 76 percent indicated funeral directors, 56 percent of the widowers and 68 percent of the widows indicated neighbors.

Demi (1978) suggested that the three factors having the greatest influence on adjustment were: having suspected the spouse's death, fewer role changes after the death, and the recognition and expression of ambivalence by widows toward their spouses. Smith (1975) found a significant positive relationship between earlier experiences with death, anticipatory grief, childless widows, and adjustment.

Sixty-five percent of those indicating they had happy marriages in Clayton's et al. sample (1972) suffered minimal depressive symptoms the first month of bereavement.

Maddison and Walker (1967) used health as reported by the widow to determine outcome or adjustment. The sample of widows were separated into three categories:

1. Those well-adjusted with minimal problems were described as "good outcomes."

2. Those poorly-adjusted with mental and physical health problems were described as "bad outcomes."

3. The intermediate group was not included in the statistical analysis.

They suggested that those who resolved the bereavement crisis in a healthy manner perceived their interpersonal relationships as more supportive. They found age to be significantly related to outcome, with younger widows of younger spouses faring worst. They found no relationship between anticipatory grief and bereavement outcome. Their study was particularly interesting because of the emphasis given to interpersonal interactions. They explored four areas of interaction:

1. Expression of affect: interchanges which permitted or promoted this, or which showed sensitivity to the subject's unique feelings or which, conversely, blocked or discouraged affect expression or minimized its significance.

2. Review of the past and an attempt to find some meaning and purpose in the bereavement: interchanges which encouraged or permitted the widow to engage in this activity or which, conversely, were felt to be unsympathetic or actively opposed to such behavior.

3. Orientation towards the present and the future: interchanges which attempted to direct the subject towards an active, detailed consideration of future interests and activities.

4. Provision of concomitant needs: interchanges which were perceived by the widow as relating either

to (a) her practical needs at the time or (b) her needs for non-specific support and the maintenance of her self-esteem.

Widows with "bad outcome" felt they needed more encouragement, support, and understanding to allow a freer expression of feelings, to review the past, and to talk about their husbands. These widows felt that their environment failed to provide an opportunity to express feelings or to offer sufficient general and practical support. Some even indicated that persons in their environment had not only failed to provide the opportunity to express feelings but had overtly or covertly opposed this expression. The widow was encouraged to be strong, to suppress feelings, and to focus on the present and future rather than being allowed and encouraged to review the past. Younger widows were often confronted with discussion of remarriage early in the bereavement period. The researchers suggested that some "bad outcome" widows ". . . by virtue of their own rigid defensive structure, had felt inhibited in the expression of emotion. . . ." The researcher further suggested that ". . . much, and perhaps, all of the unhelpfulness and hostility perceived in the environment is caused by the projection of the widow's own hostile feelings."

Maddison (1968) suggested that the following features might indicate a "bad outcome":

1. A young widow (less than 45 years old) with a number of dependent children;
2. Evidence of a pre-existing pathological marital relationship;

3. Pre-existing overt neurosis;
4. A protracted death, particularly if associated with severe suffering and/or disfigurement;
5. A pathological reaction to the death in another family member;
6. Additional crises in close temporal relationship to the bereavement;
7. A disturbed relationship with her own mother or with the husband's family;
8. Long-continued reaction formations against dependence;
9. Deliberate avoidance of affect expression.

Parkes (1975) suggested that factors which predict "poor outcome" are:

. . . low socio-economic status, short terminal illness with little warning of impending death, multiple life crisis (particularly if they involved disturbances of the marital relationship), and reactions to bereavement including severe distress, yearning, anger, or self reproach.

Behavior problems with a child were associated with "poor outcome" of parent, although which caused which could not be determined. Persons whose spouses had died suddenly tended to be more socially withdrawn throughout the year following the death. Parkes clarified this by saying that:

. . . the more sudden, tragic, violent, or unexpected the death is, the greater the chance the bereaved relative has for poor outcome. In addition, the more maladjusted the family system or members are, the greater the potential chance for poor outcome; that is, such environmental and family system forces, as well as their interaction, may be such complex and powerful determinants of outcome that present-day conceptual frameworks and intervention strategies may be inadequate to make a significant impact on acute bereavement.

Goldberg (1973) discussed individual adjustment in relationship to family adjustment, indicating that one facilitates the other. Redistribution of roles must occur

and the family must give permission for expressions of grief. He indicated that those families with good communication systems as well as a prior equitable allocation of roles respond more adaptively to the crisis of death.

Silverman (1976) talked about the recovery period as involving ". . . learning to be alone, finding meaningful social and emotional life, in addition to being head of a household, breadwinner, and both mother and father to the children." She viewed adjustment as the hardest period to describe and believed that "Whatever adjustment an individual makes will depend on his life style, education, personality, and so forth." She said that the widowed must be encouraged to use their own resources in coping with adjustment.

Social Support and the Widowed

Several researchers have studied the relationship of social support and the grief experience. Lopata (1978) defined support as ". . . a set of actions or objects which the giver, receiver, or both define as necessary or helpful in maintaining a style of life." She said support may be economic, service, social, or emotional. Economic support can include gifts of money and/or payment or help with payment of rent, food, clothing, medical bills, vacation bills, etc. Service support can include transportation, household repairs, housekeeping, shopping, yard work, child care, care of the car, care during illness, decision making, and legal

aid. Social support includes companionship in going to public places, visiting, entertaining, engaging in sports, group activities, or celebrating holidays. Emotional support can be of two types, "rational sentiments" and "feeling states." Those people providing emotional support can be persons that the widowed: 1) feel closest to, 2) enjoy being with, 3) tell problems to, 4) find comforting when depressed, 5) feel important to as a person, 6) are angered by, or 7) turn to in a crisis.

Hirsch (1980) studied support systems in terms of density and multidimensionality of friendships. He stated that density is the most important feature of a social support system and defined it ". . . as the number of relationships that exist among the members of an individual's natural support system as a proportion of the total possible number of such relationships." He defined a relationship as multidimensional ". . . if and only if it involves engaging in at least two different kinds of activities or behaviors important to that individual." He was concerned with the relationship between natural support systems and mental health, specifically, symptomatology, mood, and self-esteem. His sample consisted of 20 recent widows and 14 mature women returning to college as full-time students. He studied five forms of interaction which might positively or negatively affect the success of one's coping efforts: 1) cognitive guidance, such as provision of information or advice,

2) social reinforcement, such as provision of either praise or criticism regarding specific actions, 3) tangible assistance, such as helping or declining help with chores or child-care, 4) socializing, such as going somewhere with others, and 5) emotional support, such as interaction which made one feel better or worse when one was already upset or under pressure. His data indicated that:

. . . satisfaction with support variables are significantly associated with all three measures of mental health. Greater satisfaction with cognitive guidance is related very strongly to both less symptomatology and better mood. Higher self-esteem . . . is most strongly associated with greater satisfaction with socializing experiences.

Density of social support systems was ". . . associated with significantly less satisfaction with socializing, social reinforcement, emotional support, and cognitive guidance." Moreover, though only approaching significance, denser social support systems were also associated with poorer mood and self-esteem. Denser social support systems were related to significantly less multidimensional relationships, an overall smaller support system, and fewer friends. Denser nuclear family-friendship relationships were ". . . significantly related to greater symptomatology, poorer mood, and lower self-esteem." Friendships that were more multidimensional was significantly related to higher self-esteem, more satisfying social experiences, and helpful tangible assistance. Multidimensional relationships were not associated with larger social support systems or larger

families. He suggested that helpful guidance from the social support system may help to separate necessary from unnecessary tasks, encourage alternative coping behaviors through utilization of environmental resources, and increase effectiveness of one's coping efforts.

Lopata (1979-1981) discussed the social effects of the death of the husband on the wife in terms of her roles and readjustment.

In general, the more functional the husband-wife relation is to the wife's role, and the more multi-dimensional the involvement of her husband in a woman's life, the more disorganized become her other social relations with her husband's death. . . . Thus, the major factor in the amount of the disengagement experienced by a woman upon the death of her husband is the degree to which her various social roles were dependent upon him.

She believed there are three levels of re-engagement by the widow.

The first is re-engagement at medium or high levels of interaction in social roles and relations similar to those in her life prior to the death of her husband. Such involvement is dependent upon the availability of social groups which do not require the husband's presence. Such groups tend to be kin, long-time friends, neighbors, work associates, and voluntary associations. The second type of social re-engagement on the part of widows involves entrance into new social roles and less organized social relations. The third type of re-engagement is one of relative social isolation.

In summation, Lopata found an overall absence of secondary social resources and, in lieu of these, a dependency on personal resources. She felt that personal social support is needed to make widows feel like important persons, to prevent them from becoming disengaged or socially isolated. Emotional support is needed to encourage accomplishment of

grief work and to promote relationships with confidants, companions, and other people who will make widows feel competent, adequate, self-sufficient, basically well-adjusted and reasonably content as human beings.

Hirsch (1980) criticized Maddison and Walker's (1967) study of the effects of interpersonal interactions upon adjustment because the latter researchers were aware of the adjustment outcome (illness scores) prior to collecting the interview data on the widow's perceptions of interpersonal interactions. Despite his criticism, which is certainly valid, their study determined a significant relationship between adjustment outcome and widows perceived social support.

Hays (1978) described the perceptions of support between widows whose husbands died suddenly and those whose husbands died after extended illnesses. Widows whose husbands died suddenly perceived a greater need for emotional support, especially during the first three months after the death. While there was no difference in perceived need between the two groups of widows in later months, both experienced increased emotional needs. Suddenly bereaved women needed more help with business affairs and more material support. Women with young children needed more material assistance than women without children.

Clayton et al. (1972) found depression and lack of support to be significantly related. The depressed group

reported more unhelpful or disappointing responses than the non-depressed group.

Rosen (1973) suggested that intimate relationships are important for maintenance of morale and that voluntary forms, such as having a confidant, are preferred over kinship relationships.

Brown (1973) studied the patterns of social participation and disengagement of the elderly widowed. He suggested that the loss of a spouse is a major cause of disengagement and that those disengaged tended to have lower morale. He suggested that disengagement does not occur as a result of age but from disruptive events such as the death of a spouse. Along these same lines, Wilcox (1979) assessed the impact of the recency of a life event and social support or stressful life events and psychological adjustment. He found a significant positive correlation between social support and stressful events.

Several researchers have presented intervention strategies for encouraging positive adjustment to widowhood. Williams et al. (1972) provided intervention for the family the first three months following death. The clinician providing counseling intervention was viewed as a resource support for the family. They found that:

. . . survivors who have received intervention at the time of death are more expressive of feelings of guilt, anger, and anxiety. In addition, they do not find it necessary to keep busier following the death as compared to the intervention control group.

Although the study has not been completed, the preliminary results indicated no difference in physical and emotional health between treatment and non-treatment groups.

Cohen et al. (1977) studied the utilization of internal (family) and external (friends, neighbors, professional agencies, and caretakers) for social support. She found a significant relationship ". . . between the free flow of information and utilization of internal support systems."

. . . . The more family members were able to communicate with one another, to share information, and to share in decision making, the greater the likelihood of an effective adjustment during the postdeath period.

Goldberg (1973) and Slivkin (1977) drew the same conclusion. Cohen et al. (1977) also studied the utilization of external support by characterizing the family as centripetal (inwardly centered) or centrifugal (outwardly centered). "The findings showed that the more inwardly directed the family, the more likely it was to make effective use of external support systems." Centripetal families were significantly better adjusted than centrifugal.

Arling (1976) and Lopata (1978) found that friends and neighbors provided more helpful social support than family, especially children.

Vachon et al. (1980) found that a perceived lack of social support accounted for up to 35 percent of the variance in distress levels of the widows in her sample. She stated that the social network could either 1) provide support for

transition into the traditional widow role, 2) support and facilitate the development of a new identity, or 3) reject the widow, leaving her locked into the past or reaching out alone to develop her own identity.

Self-Esteem and the Widowed

This is an area of research that has been referred to by several researchers already quoted in this review, but neglected in terms of empirical study. The changing identity, feelings of worth or worthlessness, and concept of self are mentioned frequently. Only one research study was found that actually measured self-esteem in relation to widowhood. Barrett (1978) experimented with self-help groups and their effects on adjustment. She used two therapist-led groups, one which focused on the use of a confidant and one which focused on consciousness-raising, plus a control group. All three groups were tested with a pre-test, post-test, and at a 14 week follow-up. Both experimental groups had significantly higher self-esteem, experienced an increase in intensity of grief, and had a more negative attitude toward remarriage. She suggested that the increase in self-esteem can be accounted for because the widows in the experimental groups had people interested in and listening to their problems.

The association between depression and adjustment has already been discussed. Battle (1978), who developed self-esteem instruments for both adults and children, has

demonstrated a significant relationship between depression and low self-esteem. He defined self esteem as a ". . . subjective and multifaceted evaluation of an individual's perception of self-worth." Depression is defined by Battle as ". . . a mood disturbance which typically includes feelings of apprehension, gloom, helplessness, and worthlessness."

Summary

The earlier research into bereavement centered around the definition of bereavement as a crisis, including normal and abnormal responses. More recent research has focused on the variables which affect the bereavement crisis and subsequent adjustment by the widowed. More research is needed in all these areas to clarify the relationship among these variables, bereavement, and adjustment.

II. STUDIES RELATED IN METHODOLOGY

Sanders (1979-1980, 1980-1981), who developed the Grief Experience Inventory, reported on a comparison of grief experiences of spouse, child, and parent deaths. She used the obituary section of the newspaper to locate her sample. In addition to the Grief Experience Inventory, she also used a demographic questionnaire, conducted a personal interview, and left the Minnesota Multiphasic Personality Inventory for the sample to complete and return later. The first contact with the sample was 1-1/2 months after the

death, by letter, followed by a telephone call requesting an appointment. Her sample consisted of 76 women, 26 men, and 107 individuals in a control group. She found a significantly higher intensity of grief in parents who survived their child's death. There were definite physiological symptoms in the bereaved sample as compared to the controls. Frequent church goers exhibited more optimism and social desirability but repressed their grief more than those who attended church less frequently. Widows in her sample displayed greater overt grief reactions than did widowers, with age having no effect on bereavement response. Individuals who attended church less frequently, and who have no close alliances with family, had more intense grief reactions, exhibited more anger, and less optimism. She found no support for a more intense grief reaction for those associated with a sudden death situation. Widows showed a significant degree of death anxiety. Older widows exhibited more denial than younger widows, who indicated more feelings of isolation. In the second study reported by Sanders (1980-1981) the same instrument was used to compare younger and older spouses in their bereavement reactions. The sample consisted of people 65 years and older ($N = 21$) and 63 years and younger ($N = 24$), with a non-bereaved matched control group ($N = 52$). The results indicated a trend toward greater intensity of grief for younger spouses initially at two months, however, 18 months later a reverse trend was

evident. The older spouses had an initially diminished grief response. In comparing adjustment between the younger and older groups, the results were: younger group-- 70 percent good adjustment, 29 percent poor adjustment; older group--52 percent good adjustment, 47 percent poor adjustment.

Carey (1977, 1979-1980) developed the Adjustment/Depression Scale for Widows. He interviewed 119 widowed persons 13 to 16 months after the spouse's death. He acquired his sample from the hospital's records where he was employed as Director of Research. Those persons over 70 years of age were excluded from the study so that effects of advanced age would not be confused with bereavement. The age range was 28 years of age to 70 years of age, with a median age of 57. None of the widows had remarried at the time of the interview, however, 20 percent of the widowers had. In addition, he administered the instrument to 86 married people who served as control group. The Adjustment/Depression Scale for Widows is an eight item, self-report measure of adjustment and depression. The married persons in his control group were significantly better adjusted than widowed persons according to the scale. Widowers were significantly better adjusted than widows. Widows who had forewarning of the death were better adjusted than widows without forewarning. Widowers were not affected by forewarning. With regard to age, the widowers over 57 years of

age were better adjusted than those under 57, with age being more important for women than for men. Education was positively related to adjustment for those with a college degree as compared to those with high school or less. Education was a stronger indicator of adjustment for women than for men. Those having incomes over \$10,000 were better adjusted than those having incomes under \$10,000. However, men tended to have higher incomes so adjustment may have been related more to sex than income. Those individuals living alone were better adjusted than those living with dependent children who were in turn better adjusted than the widowed living with independent children. Carey's study, reported in 1977, indicated that at one year following the death, 25 percent of the widowed were still depressed.

Wilcox (1979) studied the impact of life event recency and social support on the relationship between stressful life events and psychological distress. He also explored the relationships between life stress, social support, and perceived quality of life. In this dissertation research, he developed the Social Support Index and list of clubs and organizations which will be utilized in the present research. His sample consisted of 500 adults, 18 years of age and older, who responded to a hand-delivered questionnaire. One of his hypotheses was that there would be a significant correlation between the Social

Support Index and the number of supporters the person reported. This hypothesis was substantiated at the .001 level. He also hypothesized that social support as measured by the Social Support Index ". . . would account for a significant proportion of the variance in explaining Mental Health Index score." This hypothesis was supported at the .001 level. He indicated that the relationship between stressful life events and psychological distress is dependent on the level of social support.

Battle (1980) developed the Culture-Free Self-Esteem Inventory for Adults. The standardized instrument, when used in research, has indicated that depressed individuals almost always possess low self-esteem. When those depressed individuals enter therapy, their self-esteem generally improves as measured by the same instrument. "Moreover, subscale scores enable psychologists, psychiatrists, counselors, and social workers readily to identify the areas of difficulty the child or adult may be experiencing." The adult inventory offers subscale scores in the areas of general, social, and personal self-esteem (Battle, 1980).

A number of researchers used death certificates as a source for their sample (Ball, 1976-1977; Maddison and Viola, 1968; Sheskin and Wallace, 1976; and Silverman, 1969).

Two examples of research that separated the sample by outcome (depression and illness scores) and then attempted

to find associations with predictor or relationship variables were Clayton et al., 1972; and Maddison and Walker, 1967. The Maddison and Walker research can be criticized because the researchers who conducted and scored the interview data were aware of the illness outcome scores and were, therefore, open to bias.

Summary

The studies related in methodology have identified some of the measurable reactions to grief, levels of adjustment, and important variables relating to each. The use of death certificates insures avoidance of bias in sample selection. Further, the acquisition and blind scoring of all data is important in preventing researcher bias.

CHAPTER III

METHODOLOGY

This chapter encompasses a description of sample selection, instrumentation, procedure for collection of data, and statistical design.

I. SAMPLE SELECTION

Age and length of bereavement were the criteria used to establish sample boundaries similar to previous research cited (Carey, 1977, 1979-1980; Madison and Viola, 1968; and Parkes, 1965). The State Office of Vital Records, Nashville, Tennessee, provided a list of married persons who died between January 1, 1979, and June 30, 1980, who were between the ages of 18 and 65 at the time of death. (See Appendix A for letters requesting assistance and an explanation of how the list was obtained.) Since the list contained only the names and addresses of the deceased, a search was made of the obituary column for the names of the surviving spouses. Twelve husbands' names could not be located and, therefore, were eliminated from the sample. The final sample consisted of 242 persons, 174 females and 68 males. The State Office of Vital Statistics cooperated by providing a list of deceased with the understanding that confidentiality would be maintained as provided by the Tennessee Code, Section 53. To assure confidentiality the

following precautions were taken:

1. Only the researcher had access to the list of names.
2. Letters and data collecting instruments were mailed to the sample requesting their anonymous participation and assuring them of confidentiality.
3. Return of the completed instruments implied a willingness to participate in the study.
4. Reports of the results of this study will at no point identify the participating subjects.
5. All data pertinent to this study was stored in a locked file cabinet for the duration of the project. The file cabinet was located in the researcher's home and only the researcher had access to the key.

II. INSTRUMENTATION

The following instruments were used to collect data:

1. A demographic questionnaire developed by the researcher.
2. The Adjustment/Depression Scale for Widowed Persons by Raymond G. Carey, Ph.D.
3. The Culture-Free Self-Esteem Inventory for Adults by James Battle, Ph.D.
4. The Grief Experience Inventory by Drs. Catherine M. Sanders, Paul A. Mauger, and Paschal N. Strong, Jr.
5. The Social Support Index and a list of clubs and

community organizations by Brian Leroy Wilcox, Ph.D.

Copies of all instruments are in Appendix C. A brief description of each instrument follows:

1. A demographic questionnaire was developed for this research to collect data in the following areas: age, sex, length of bereavement, anticipatory grief, education, parental status, living arrangements, and income.

2. The Adjustment/Depression Scale for Widowed Persons is an eight-item questionnaire which can be answered by yes, uncertain, or no. The answers are weighted which allows the individual's score to be described as depressed (8-15), having a moderate adjustment (16-20), or well adjusted (21-24). The Scale was developed by Dr. Raymond G. Carey, Director of Research for Parkside Medical Corporation, Park Ridge, Illinois. Dr. Carey (1977, 1979-1980) gave his permission for the use of this instrument in the research. (See Appendix B.) The Scale was developed from a 40-item questionnaire which was subjected to factor analysis. Eleven of the 40 items qualified for the Adjustment Scale. Three items were eliminated because they were inappropriate questions for the married controls and because one had religious connotations not appropriate for all samples. The Adjustment Scale was in strong agreement when compared to the measure of depression used by Bornstein et al. (1975) but was much simpler to administer and to score (Carey, 1976). The instrument was designed to be

completed in approximately four minutes.

3. The Culture-Free Self-Esteem Inventory for Adults (SEI) by Dr. James Battle has been standardized and can be completed in 15 to 20 minutes. This 40-item instrument is answered by a simple yes or no, offers two scoring options of high and low self-esteem as well as four sub-scales: a) general self-esteem, b) social self-esteem, c) personal self-esteem, and d) lie items which indicate defensiveness. The test-retest reliability for the SEI is .79 for males and .82 for females. A factor analysis indicated the following scores for the four sub-scales: General = .72, Social = .57, Personal = .72, and Lie Scale = .54. Content validity was built in by ". . . developing a construct definition of self-esteem, and . . . by writing items intended to cover all areas of construct." Concurrent validity was accomplished through a favorable comparison of this instrument to that of A.T. Beck's Depression Inventory and the Minnesota Multiphasic Personality Inventory. The SEI is scored by separation of self-esteem scores (32) from lie scores (8). One may also compute separate scores for each of the sub-scales (Battle, 1962). This instrument is covered by a copyright and must be purchased.

4. The Grief Experience Inventory (GEI) was developed by Drs. Catherine M. Sanders, Paul A. Mauger, and Paschal N. Strong, Jr. Permission to use this copyrighted instrument is in Appendix B. The instrument consists of 135

true-false statements. The content areas covered in the Inventory are: Denial, Atypical Responses, Despair, Anger/Hostility, Guilt, Social Isolation, Loss of Control, Rumination, Depersonalization, Somatization, Death Anxiety, Sleep Disturbance, Loss of Appetite, Loss of Vigor, Physical Symptoms, Optimism, Despair, Dependency, and Social Desirability. A literature search was utilized to develop typical responses of bereaved individuals which formed the basis of this instrument. The instrument was then given to 135 volunteers. Further refinement based on their responses was made to clarify the wording of each statement. A multi-stage internal consistency item analysis was performed and the items were grouped into scales according to their content. The Denial Scale is modeled after the Lie Scale in the Minnesota Multiphasic Personality Inventory.

The reliability of the Grief Experience Inventory scales has been studied in several samples. . . . The test-retest reliability coefficients from the two samples . . . show the stability of the scales over a moderate length of time. These correlations are also of comparable size to those reported for the Minnesota Multiphasic Personality Inventory. . . .

In establishing validity for the Inventory, the authors correlated it with other inventories measuring similar constructs by comparison of bereaved and non-bereaved individuals, as well as comparing different types of bereavement, for example, loss of spouse, child, or parent. The instrument takes approximately 20 minutes to administer.

5. The Social Support Index and list of clubs and community organizations was developed by Dr. Brian Leroy

Wilcox as part of his dissertation research. The Social Support Index consists of 18 yes-no items. The instrument takes approximately eight minutes to administer and is scored by ". . . summing the number of items responded to in the 'support present' direction." Test-retest reliability coefficient for the Social Support Index was .89 with a split-half reliability coefficient of .92. The list of clubs and community organizations is just that, a list allowing the individual to indicate the number of organizations in which participants are involved.

III. PROCEDURES FOR COLLECTION OF DATA

A letter explaining the study and assuring confidentiality was mailed along with all instruments for data collection to 242 widowed persons in Anderson County, Tennessee. The sample was requested to return the anonymously completed instruments in a self-addressed, stamped envelope within two weeks. A follow-up post card was mailed immediately following the two week deadline.

IV. ANALYSIS OF DATA

Since the Self-Esteem and Grief Experience Inventories offered several pertinent sub-scales, it was necessary to hand score the instruments. The data were then analyzed using various computer programs available through The University of Tennessee.

The scores from the Adjustment/Depression Inventory,

which allowed the sample to be separated into levels of "well adjusted," "moderately adjusted," and "depressed," were used as the dependent variables. The remaining data from all other instruments were used as independent variables.

Because the data were both ordinal and nominal, gamma and lambda were utilized to determine the relationship. These two techniques were also utilized because they offer PRE (proportional reduction in error) interpretations. Lambda was employed when one variable was ordinal and one was nominal. Gamma was employed when both variables were ordinal (Champion, 1981). Chi-square was utilized when it was necessary to determine significance between variables.

All demographic data were presented in descriptive form using frequencies and percentages. For interpretation of the significance of chi-square and the level of association, Champion (1981) was utilized as a reference.

V. SUMMARY

This chapter has contained a description of sample selection which included measures taken to protect the confidentiality of participants. A description of the instrument and the procedure for data collection was also included. Finally, the procedure for analysis of the data was presented.

CHAPTER IV

ANALYSIS OF THE DATA

I. INTRODUCTION

The purpose of this study was to determine the relationship between the adjustment of widowed individuals and self-esteem, social support, the grief experience, and specific demographic variables. Since the literature revealed no research had been conducted that actually measures these relationships, it was felt that research addressing these areas was indicated.

This chapter contains the results of the data analysis. An explanation of the sample response, a description of the data on demographic characteristics, the statistical analysis, and the results from the statistical analysis is presented.

II. SAMPLE RESPONSE

According to a list provided by the Office of Vital Statistics, the population for this research consisted of 242 persons, 174 females and 68 males. Since the research involved individuals who were widowed between January 1, 1979, and June 30, 1980, it was not surprising that 32, or 13 percent, of the original sample had moved with no forwarding address available. In addition, two individuals returned the survey indicating that their spouses had not

died! One man was listed twice, and four widowed persons were now deceased. Therefore, 39 persons, or 16 percent of the 242 individuals were not available to participate in the study. Five individuals returned the survey by mail indicating they did not wish to participate, and two responded by phone. Fifty-nine survey forms were returned, with one only partially completed. The incomplete survey had to be eliminated from the statistical analysis. Two persons were apparently given the forms by individuals who did not wish to participate in the study. They (a widow of 12 years, and the mother of a deceased son) graciously completed the forms, but their data was also eliminated from the statistical analysis. Those individuals who had moved, were now deceased, or indicated an unwillingness to participate accounted for a total of 47 persons, or 19 percent of the original sample. The 58 individuals participating in this study represented 30 percent of those available to participate. All responses combined accounted for 49 percent of the original sample. Although the response rate was lower than expected by the researcher, Black and Champion (1976) indicate that it is normal to expect ". . . nearly 70 percent of the questionnaires mailed will not be returned." Van Coevering's (1973) research with widows which involved a mailed questionnaire resulted in a 29 percent response rate. Considering the sensitive nature of the study and the problems inherent in mailed

questionnaire research, the response rate was considered typical (Black and Champion, 1976).

III. METHODS OF STATISTICAL ANALYSIS

This study was concerned with the relationship between the dependent variable, adjustment, which is considered ordinal level, and the independent variables of age, sex, parental status, education, organizational involvement, income, anticipatory grief, length of bereavement, grief experience, social support, and self-esteem. Variables considered ordinal level were age, length of bereavement, income, grief experience, and self-esteem. Variables considered nominal level were sex, parental status, education, organizational involvement, anticipatory grief, and social support. To determine the association between the dependent and independent variables, lambda was used with nominal level variables and gamma was used with ordinal level variables. Not only do these measures indicate whether an association is positive or negative and the strength of the association, they also offer a proportional reduction in error measure which permits prediction of one variable based on a knowledge of the other (Champion, 1981).

After the individual questionnaires were hand scored, the data were transferred to green sheets for keypunching. The SAS Program was used for statistical analysis. Analysis of the data follows.

IV. DEMOGRAPHIC CHARACTERISTICS

The population for this research consisted of 242 persons, 174 females, or 71.90 percent, and 68 males, or 28.10 percent, who resided in Anderson County, Tennessee, and were widowed between January 1, 1979, and June 30, 1980. Of the valid responses 15, or 25.86 percent, were male and 43, or 74.14 percent, were female. Considering the difference in the original population, it is interesting that the percentage of actual responses are so similar. The population of males and females being widowed is quite similar to that indicated by previous research with a much larger proportion of females to males. The sex distribution is presented in Table 1.

TABLE 1
SEX DISTRIBUTION OF RESPONDENTS

	Original Sample		Valid Response	
	Total	Percentage	Total	Percentage
Males	68	28.10	15	25.86
Females	<u>174</u>	<u>71.90</u>	<u>43</u>	<u>74.14</u>
Totals	242	100.00	58	100.00

The age range of the respondents was represented by 38 as the youngest and 69 as the oldest, with a mean age of 54.24. The age for the deceased spouse ranged from 38 to 65, with a mean age of 55.78. The youngest female in the widowed sample was 38 while the youngest male was 42. The oldest widowed female was 64, while the oldest widowed male was 69. The age and sex differences for this sample compared to that reported in previous research, indicating that the largest proportion of widowed persons are older, with males dying younger than their female counterparts. Table 2 contains the age distribution by sex of the widowed persons.

Statistical analysis of sex and the variables of income, education, living arrangements, parental status and degree of emotional pain indicated a lambda of .000 which is interpreted as no relationship was present. Tables 3, 4, 5, and 6 contain these distributions.

Since only two respondents indicated their race to be black, one male and one female, and the female's survey was incomplete, no computations were made regarding race.

Statistical analysis of the remarriage of widowed persons by sex indicated a chi-square of 22.071 with 1 degree of freedom which was significant at the .0001 level. A critical value of 3.841 was necessary for significance at the .05 level. Table 7 contains the remarriage rate by sex of the respondents, indicating that widowers do

TABLE 2
AGE DISTRIBUTION BY SEX OF THE RESPONDENTS

	38	40	41	42	43	46	48	49	52	54	55	56	57	58	59	60	61	62	63	64	69
Male				2		1						2	1	1	1		2		1	2	2
Female	1	4	3	1	1	2	1	1	2	3	4	2	2	1	1	8	2	2	1		2

TABLE 3
INCOME DISTRIBUTION BY THE SEX OF THE RESPONDENT

	Less Than \$4,999	Between \$5,000- \$9,999	Between \$10,000- \$14,999	Over \$15,000	Would Not Report
Male	1	3	2	9	
Female	<u>3</u>	<u>8</u>	<u>14</u>	<u>17</u>	<u>1</u>
Totals	4	11	16	26	1

TABLE 4
EDUCATION DISTRIBUTION BY THE SEX OF THE RESPONDENT

	Less Than High School	High School	College	Technical School
Male	4	5	5	1
Female	<u>12</u>	<u>17</u>	<u>11</u>	<u>3</u>
Totals	16	22	16	4

TABLE 5
LIVING ARRANGEMENTS BY SEX OF THE RESPONDENTS

	Living Alone	Living With Dependent Children	Living With Independent Children	Living With Others
Male	7	4	0	4
Female	<u>23</u>	<u>10</u>	<u>7</u>	<u>3</u>
Totals	30	14	7	7

TABLE 6
EMOTIONAL PAIN BY SEX OF THE RESPONDENTS

	Mild	Moderate	Severe	Do Not Recall
Male	0	3	12	0
Female	<u>1</u>	<u>11</u>	<u>29</u>	<u>2</u>
Totals	1	14	41	2

TABLE 7
REMARRIAGE RATE BY SEX OF THE RESPONDENTS

	Yes	No
Male	8	7
Female	<u>1</u>	<u>42</u>
Totals	9	49

Chi-square = 22.071

Critical value = 3.841

Significant at .0001

remarry more frequently than do widows. This finding corresponds to previous research regarding remarriage.

It should be noted also that all males who indicated they were living with others were living with a new spouse. All females who were living with others were caring for elderly relatives or grandchildren.

Statistical analysis of the parental status of widowed persons by sex indicated no relationship was present. Only two females and one male indicated they did not have children. The youngest child was 10 years of age and the oldest was 42.

V. STATISTICAL ANALYSIS OF THE HYPOTHESES

Null Hypothesis 1

There is no relationship between adjustment and age at the .05 level.

Table 8 presents the levels of adjustment to the widowed person's age. Because interpretation of a table with 22 columns was cumbersome, the mean age was used to construct a three by two table. Age was categorized as either below the mean or above the mean which was 54.24. Statistical analysis indicated a chi-square value of 2.665 with 2 degrees of freedom which was not significant at the .05 level. A critical value of 5.991 or above was necessary for rejection of the hypothesis. Therefore, Hypothesis 1 could not be rejected. However, a positive gamma of .35 was found. This association represents a moderately low association which accounted for 35 percent of the error in predicting adjustment. The positive gamma was interpreted as a higher level of adjustment with older persons.

Null Hypothesis 2

There is no relationship between adjustment and sex at the .05 level.

Table 9 presents the levels of adjustment to the widowed person's sex. Statistical analysis of the data indicated a chi-square of 3.440 with 2 degrees of freedom

TABLE 8
LEVELS OF ADJUSTMENT TO RESPONDENTS' AGE

	Below Mean Age of 54.24	Mean Mean Age of 54.24
Depressed	10	10
Moderately Adjusted	7	11
Well Adjusted	<u>5</u>	<u>15</u>
Totals	22	36

TABLE 9
LEVELS OF ADJUSTMENT TO RESPONDENTS' SEX

	Male	Female
Depressed	3	17
Moderately Adjusted	4	14
Well Adjusted	<u>8</u>	<u>12</u>
Totals	15	43

Total N = 58

which was not significant at the .05 level. A critical value of 5.991 was necessary for rejection of the hypothesis. Therefore, Hypothesis 2 could not be rejected. However, a positive lambda of .09 was found. This association represented no or very low association and accounted for only 9 percent of the error in predicting adjustment.

Null Hypothesis 3

There is no relationship between adjustment and parental status at the .05 level.

Table 10 presents the levels of adjustment to the widowed person's parental status. Statistical analysis of the data indicated a chi-square of 1.933 with 2 degrees of freedom which was not significant at the .05 level. A critical value of 5.991 was necessary for rejection of the hypothesis. Therefore, Hypothesis 3 could not be rejected. A lambda of only .02 was found which was interpreted as no or low association and accounted for only 2 percent of the error in predicting adjustment.

Null Hypothesis 4

There is no relationship between adjustment and educational level at the .05 level.

Table 11 presents the levels of adjustment to the widowed person's educational level. Statistical analysis of the data indicated a chi-square value of 9.463 with 6 degrees of freedom which was not significant at the .05

TABLE 10
LEVELS OF ADJUSTMENT TO PARENTAL STATUS

	Yes	No
Depressed	18	2
Moderately Adjusted	18	0
Well Adjusted	<u>19</u>	<u>1</u>
Totals	55	3

TABLE 11
LEVELS OF ADJUSTMENT TO EDUCATIONAL LEVEL

	Less Than High School	High School	College	Technical School
Depressed	8	9	2	1
Moderately Adjusted	6	5	5	2
Well Adjusted	<u>2</u>	<u>8</u>	<u>9</u>	<u>1</u>
Totals	16	22	16	4

level. A critical value of 12.592 was necessary for rejection of the hypothesis. Therefore Hypothesis 4 could not be rejected. A lambda of .13 was found which was interpreted as no or low association and accounted for 13 percent of the error in predicting adjustment.

Null Hypothesis 5

There is no relationship between adjustment and organizational involvement at the .05 level.

Table 12 presents the frequency of organizational involvement to sex of the widowed persons.

Simple visual analysis of Table 12 indicated that the organization this group participated in most frequently was church or church-related. It should also be noted that 83 percent of the females were active in church while only 66 percent of the males were. One could also assume that as a group these individuals are socially active with organizational involvement since only 6 of the 58 persons, or 10 percent, were involved in no clubs or organizations.

Table 13 presents the levels of adjustment to the widowed person's organizational involvement.

Simple visual analysis of Table 13 indicated that the depressed group, with a total of 43 club involvements, is as active as the moderately adjusted group, which also had a total of 43, and nearly as active as the well-adjusted group with 58 club associations. It should also be noted that those who were active in no clubs or organizations

TABLE 12
FREQUENCY OF ORGANIZATIONAL INVOLVEMENT TO SEX

	Male	Female
1. Church or Synagogue	10	36
2. Church-Connected Groups	1	18
3. Labor Unions		3
4. Fraternal Lodges/Veterans' Organizations	3	3
5. Business or Civil Groups	2	7
6. Professional Groups	2	5
7. Parent-Teacher Organizations	1	4
8. Youth Groups		1
9. Community Centers	4	7
10. Neighborhood Improvement Associations		
11. Social or Card-Playing Groups	2	10
12. Sport Teams	1	2
13. Country Clubs		2
14. Political Clubs or Organizations	1	1
15. Issue or Action Groups		1
16. Others	2	7
17. None	<u>2</u>	<u>4</u>
Totals	31	111
Number of Organizations Per Sex	2.06	2.58

TABLE 13
LEVELS OF ADJUSTMENT TO ORGANIZATIONAL INVOLVEMENT

	Organizations																
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Depressed	15	7	2	2	1	2	1	1	3		2				3	4	4
Moderately Adjusted	13	6	1	1	3	2	1		4		3	1		1	2		2
Well Adjusted	18	6		3	5	3	3		4		7	2	2	1	3		1

were either depressed or moderately adjusted.

A chi-square of 20.944 with 28 degrees of freedom was found which was not significant at the .05 level. A critical value of 41.337 was necessary for rejection of the hypothesis. Therefore, Hypothesis 5 could not be rejected.

Statistical analysis indicated a lambda of only .04 which was interpreted as no or low association and accounted for only 4 percent of the error in predicting adjustment.

Null Hypothesis 6

There is no relationship between adjustment and income level at the .05 level.

Table 14 presents the levels of adjustment to the widowed person's income level. Statistical analysis of the data indicated a chi-square value of 3.320 with 2 degrees of freedom which was not significant at the .05 level. A critical value of 5.991 was necessary for rejection of the hypothesis. Therefore, Hypothesis 6 could not be rejected. A gamma of .43 was found which was interpreted as a moderately low association and accounted for 43 percent of the error in predicting adjustment.

Null Hypothesis 7

There is no relationship between adjustment and anticipatory grief at the .05 level.

Since Carey (1979-1980) found forewarning of death to be an asset leading to adjustment for women only, that

TABLE 14
LEVELS OF ADJUSTMENT TO INCOME LEVEL

	Less Than \$4,999	Between \$5,000- \$9,999	Between \$10,000- \$14,999	Over \$15,000
Depressed	3	5	6	6
Moderately Adjusted	1	3	6	7
Well Adjusted	<u>0</u>	<u>3</u>	<u>4</u>	<u>13</u>
Totals	4	11	16	26

relationship was explored as well. Table 15 presents the frequency of awareness of death by sex. This relationship was not statistically significant at the .05 level. A chi-square value of .049 with 1 degree of freedom was found while a critical value of 3.841 was necessary for significance.

TABLE 15
FREQUENCY OF AWARENESS BY SEX

	Yes	No	No Response
Male	8	7	
Female	<u>21</u>	<u>21</u>	<u>1</u>
Totals	29	28	1

Table 16 presents the frequency of awareness of death by adjustment level.

Statistical analysis indicated a chi-square of 3.836 with 2 degrees of freedom which was not significant at the .05 level. A critical value of 5.991 was necessary for rejection of the hypothesis. Therefore, Hypothesis 7 could not be rejected. A lambda of .17 was found which was interpreted as no to low association and accounted for only 17 percent of the error in predicting adjustment.

TABLE 16
FREQUENCY OF AWARENESS BY ADJUSTMENT LEVEL

	Yes	No	No Response
Depressed	10	9	1
Moderately Adjusted	12	6	
Well Adjusted	<u>7</u>	<u>13</u>	—
Totals	29	28	1

Null Hypothesis 8

There is no relationship between adjustment and length of bereavement at the .05 level.

The range time since death of the spouse was from a minimum value of 15 months to a maximum value of 42 months with a mean time of 26.96 months. To simplify the statistical analysis the mean time was used, with number one

representing all those persons below the mean and number two representing all those persons above the mean. Table 17 presents the levels of adjustment to the time since death of a spouse.

Statistical analysis of the data indicated a chi-square of 2.734 with 2 degrees of freedom which was not significant at the .05 level. A critical value of 5.991 was necessary for rejection of the hypothesis. Therefore, Hypothesis 8 could not be rejected. A gamma of .13 was found which was interpreted as no to low association and accounted for only 13 percent of the error in predicting adjustment.

TABLE 17
LEVELS OF ADJUSTMENT TO TIME SINCE DEATH

	1	2
Depressed	12	8
Moderately Adjusted	6	12
Well Adjusted	<u>10</u>	<u>10</u>
Totals	28	30

Null Hypothesis 9

There is no relationship between adjustment and the grief experience at the .05 level.

Since the Grief Experience Inventory consists of 18 subscales, each is discussed separately. Tables are presented for those scales where statistical significance was found.

The relationship of Denial to adjustment was not statistically related at the .05 level. However, a gamma of .40 was found which was interpreted as a moderately low association and accounts for 40 percent of the error in predicting adjustment.

The relationship of Atypical Response to adjustment was statistically significant at the .004 level with a chi-square value of 10.844 with 2 degrees of freedom. A negative gamma of .71 was also found which was interpreted as a moderately high association and accounted for 71 percent of the error in predicting adjustment. Of importance was the direction of the relationship, indicating that the depressed scored higher on the Atypical Response Scale. Table 18 presents levels of adjustment to scores on the Atypical Response Scale.

The relationship of Despair to adjustment was statistically significant at the .001 level, with a chi-square value of 22.349 with 2 degrees of freedom. Critical value for 2 degrees of freedom was 5.991. A negative gamma of .87 was also found which was interpreted as a high association and accounted for 87 percent of the error in predicting adjustment. Also of importance was the

TABLE 18
LEVELS OF ADJUSTMENT TO ATYPICAL RESPONSE

	Scores							
	9	10	11	12	13	15	16	18
Depressed	1	2		2	1	1	1	1
Moderately Adjusted	1	1	3	2				
Well Adjusted	<u>2</u>	—	—	—	<u>1</u>	—	—	—
Totals	4	3	3	4	2	1	1	1

Chi-square = 10.844

Critical value = 5.991

Significant at .004

direction of the relationship, indicating that once again the depressed scored higher on this subscale, and well-adjusted scored lowest. Table 19 presents the levels of adjustment to scores on the Despair Scale.

The relationship of Anger/Hostility to adjustment was not statistically significant at the .05 level. A negative gamma of .46 was found, indicating a moderately low association and accounting for 46 percent of the error in predicting adjustment. Again, the negative gamma indicated that the depressed persons scored higher on the Anger/Hostility Scale, while the well-adjusted scored lower.

TABLE 19
LEVELS OF ADJUSTMENT TO DESPAIR

	1	2	3	4	5	6	8	9	10	11	12	14	16	18
Depressed				2		1		1	4	1	4	4	2	1
Moderately Adjusted	1	1	4		1	3	1	1	2	2	1			
Well Adjusted	<u>6</u>	<u>4</u>	<u>2</u>	<u>3</u>	<u>2</u>	<u>4</u>	<u>1</u>	<u>1</u>	—	—	—	<u>1</u>	—	—
Totals	7	5	6	5	3	8	2	3	6	3	5	5	2	1

Chi-square = 22.309

Critical value = 5.991

Significant at .001

The relationship of Guilt to adjustment was not statistically significant at the .05 level. A negative gamma of .12 was found which was interpreted as a no or low association and accounted for only 12 percent of the error in predicting adjustment. Again, the negative gamma indicated that the depressed scored higher on the Guilt Scale, while the well-adjusted scored lower.

The relationship of Social Isolation to adjustment was statistically significant at the .009 level with a chi-square value of 9.479 and 2 degrees of freedom. A critical value of 4.991 was necessary for significance at the .05 level. In addition a negative gamma of .29 was found which

was interpreted as moderately low association and accounted for 29 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the Social Isolation Scale for the depressed and a lower score on the Scale for the well-adjusted. Table 20 presents the levels of adjustment to scores on the Social Isolation Scale.

TABLE 20
LEVELS OF ADJUSTMENT TO SOCIAL ISOLATION

	1	2	3	4	5	6	7
Depressed	3	1	3	4	6	2	1
Moderately Adjusted	3	5	7	2	1		
Well Adjusted	<u>3</u>	<u>1</u>	<u>1</u>	<u>4</u>	<u>2</u>	—	—
Totals	9	7	11	10	9	2	1

Chi-square = 9.479

Critical value = 5.991

Significant at .009

The relationship of Loss of Control to adjustment was statistically significant at the .009 level with a chi-square of 15.299 and 2 degrees of freedom. A critical value of 5.991 was necessary for significance at the .05 level. A negative gamma of .67 was found which was interpreted as a moderately high association and accounted

for 67 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the Loss of Control Scale for the depressed and a lower score on the Scale for the well-adjusted. Table 21 presents the levels of adjustment to scores on the Loss of Control Scale.

TABLE 21
LEVELS OF ADJUSTMENT TO LOSS OF CONTROL

	1	2	3	4	5	6	7	8	9
Depressed		1	3	1	2	4	6	2	1
Moderately Adjusted	1	2		2	6	4		2	1
Well Adjusted	<u>3</u>	<u>2</u>	<u>7</u>	<u>4</u>	<u>2</u>	<u>1</u>	—	<u>1</u>	—
Totals	4	5	10	7	10	9	6	5	2

Chi-square = 15.299

Critical value = 5.991

Significant at .009

The relationship of Rumination to adjustment was statistically significant at the .01 level with a chi-square of 9.087 and 2 degrees of freedom. A critical value of 5.991 was necessary for significance at the .05 level. A negative gamma of .60 was found which was interpreted as a moderately high association and accounted for 60 percent of the error in predicting adjustment. The negative gamma

indicated the depressed scored higher on the Rumination Scale, while the well-adjusted scored lower. Table 22 presents the levels of adjustment to scores on the Rumination Scale.

TABLE 22
LEVELS OF ADJUSTMENT TO RUMINATION

	1	2	3	4	5	6	7	8	9	10	11	12
Depressed			1	2	3	2	2	3	3	1	2	1
Moderately Adjusted		2	4	3	3	2	2	1			1	
Well Adjusted	<u>2</u>	<u>2</u>	<u>3</u>	<u>—</u>	<u>4</u>	<u>3</u>	<u>1</u>	<u>2</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
Totals	2	4	8	5	10	7	5	6	3	1	3	1

Chi-square = 9.087

Critical value = 5.991

Significant at .01

The relationship of Depersonalization to adjustment was statistically significant at the .005 level with a chi-square value of 15.261 and 2 degrees of freedom. A critical value of 5.991 was necessary for significance at the .05 level. A negative gamma of .73 was found which was interpreted as a moderately high association and accounted for 73 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the

Depersonalization Scale for the depressed and a lower score on the Scale for the well-adjusted. Table 23 presents the levels of adjustment to scores on the Depersonalization Scale.

TABLE 23
LEVELS OF ADJUSTMENT TO DEPERSONALIZATION

	1	2	3	4	5	6	7	8
Depressed			1	1	4	2	6	6
Moderately Adjusted	2		6	2	2	3	2	1
Well Adjusted	<u>5</u>	<u>2</u>	<u>2</u>	<u>3</u>	<u>3</u>	<u>1</u>	—	<u>1</u>
Totals	7	2	9	6	9	6	8	8

Chi-square = 15.261

Critical value = 5.991

Significant at .005

The relationship of Somatization to adjustment was not statistically significant at the .05 level. However, a negative gamma of .43 was found which was interpreted as a moderately low association and accounted for 43 percent of the error in predicting adjustment. The negative gamma indicated a higher score on Somatization by the depressed and a lower score on the Scale by the well-adjusted.

The relationship of Death Anxiety to adjustment was

not significant at the .05 level. However, a negative gamma of .50 was found which was interpreted as a moderately low association and accounted for 50 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the Death Anxiety Scale by the depressed and a lower score on the Scale by the well-adjusted.

The relationship of Sleep Disturbance to adjustment was statistically significant at the .001 level with a chi-square value of 13.885 and 2 degrees of freedom. A negative gamma of .78 was also found which was interpreted as a high association and accounted for 78 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the Sleep Disturbance Scale for the depressed and a lower score on the Scale by the well-adjusted. Table 24 presents the levels of adjustment to scores on the Sleep Disturbance Scale.

The relationship of Loss of Appetite to adjustment was not significant at the .05 level. A negative gamma of .29 was found which was interpreted as moderately low association and accounted for 29 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the Loss of Appetite Scale by the depressed and a lower score on the Scale by the well-adjusted.

The relationship of Loss of Vigor to adjustment was significant at the .009 level with a chi-square value of

TABLE 24
LEVELS OF ADJUSTMENT TO SLEEP DISTURBANCE

	1	2	3	4	5	6	7	8	9
Depressed	1	3	2	1	1	3	2	6	1
Moderately Adjusted	3	1	1	5	2	3	1	1	
Well Adjusted	<u>7</u>	<u>4</u>	<u>2</u>	—	—	—	—	—	—
Totals	11	8	5	6	3	6	3	7	1

Chi-square = 13.885

Critical value = 5.991

Significant at .001

9.418 with 2 degrees of freedom. A negative gamma of .63 was also found which was interpreted as a moderately high association and accounted for 63 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the Loss of Vigor Scale by the depressed and a lower score on the Scale by the well-adjusted. Table 25 presents the levels of adjustment to scores on the Loss of Vigor Scale.

The relationship of Physical Symptoms to adjustment was significant at the .02 level with a chi-square value of 8.209 with 2 degrees of freedom. A negative gamma of .64 was found which was interpreted as a moderately high association and accounted for 64 percent of the error in

TABLE 25
LEVELS OF ADJUSTMENT TO LOSS OF VIGOR

	1	2	3	4	5	6
Depressed	1	2	2	3	5	6
Moderately Adjusted	3	2	5	3	4	
Well Adjusted	<u>5</u>	<u>4</u>	<u>4</u>	<u>4</u>	—	—
Totals	9	8	11	10	9	6

Chi-square = 9.418

Critical value = 5.991

Significant at .009

predicting adjustment. The negative gamma indicated a higher score on the Physical Symptoms Scale by the depressed and lower score on the Scale by the well-adjusted. Table 26 presents the levels of adjustment to scores on the Physical Symptoms Scale.

The relationship of Optimism/Despair to adjustment was not significant at the .05 level. A negative gamma of .53 was found which was interpreted as a moderately high association which accounted for 53 percent of the error in predicting adjustment. The negative gamma indicated a higher score on the Optimism/Despair Scale by the depressed and a lower score on the Scale by the well-adjusted.

The relationship of Social Desirability to

TABLE 26
LEVELS OF ADJUSTMENT TO PHYSICAL SYMPTOMS

	1	2	3	4	5	6	7	8	9
Depressed		1	3	5	3	1	4	2	1
Moderately Adjusted	2	3	3	2	2	1	2	1	
Well Adjusted	<u>5</u>	<u>4</u>	<u>3</u>	<u>1</u>	—	<u>1</u>	—	—	—
Totals	7	8	9	8	5	3	6	3	1

Chi-square = 8.209

Critical value = 5.991

Significant at .02

adjustment was not significant at the .05 level. A gamma of .04 was found which was interpreted as no or low association and accounted for only 4 percent of the error in predicting adjustment.

Nine of the 18 scales of the Grief Experience Inventory were found to be significantly related to adjustment at the .05 level. These were Atypical Response, Despair, Social Isolation, Loss of Control, Rumination, Depersonalization, Sleep Disturbance, Loss of Vigor, and Physical Symptoms.

Null Hypothesis 10

There is no relationship between adjustment and social support.

The relationship of social support to adjustment was not significant at the .05 level for any of the 18 questions. There was only slight variation in the lambda scores with the highest being .07. None, therefore, offered any substantial predictive value.

When the relationship of sex to social support was examined there were some interesting significant relationships found.

Question 1 was related to sex at the .02 level. Males answered false more frequently to the question: I have someone who will listen to me and talk things over with me when I need understanding.

Question 2 was not related to sex at the .05 level.

Question 3 was related to sex at the .02 level. Males once again answered false more frequently to the question: There is at least one person I know whose advice I really trust.

Question 4 was related to sex at the .04 level. A higher percentage of females indicated lack of support by answering true to the question: I feel that none of my friends or relatives really understand my problems.

Questions 5 and 6 were not related to sex at the .05 level.

Question 7 was related to sex at the .001 level. A percentage of males indicated lack of support by answering the question false: I have at least one person I can share my most private thoughts and problems with.

Question 8 was not related to sex at the .05 level.

Question 9 was related to sex at the .004 level. A higher percentage of males indicated lack of support by answering the question false: When I need suggestions for how to deal with a personal problem, I know someone I can turn to.

Question 10 was related to sex at the .004 level. A higher percentage of males indicated a lack of support by answering the question false. When I need someone to give support and encouragement, I have someone who will be with me all the way.

Question 11 was not related to sex at the .05 level.

Question 12 was related to sex at the .04 level. A higher percentage of males indicated lack of support by answering the question false: If I need some straight talk about how to deal with a family problem, there is someone I could turn to.

Questions 13, 14, 15, 16, and 17 were not related to sex at the .05 level.

Question 18 was related to sex at the .02 level. A higher percentage of males indicated lack of support by answering false to the question: If I felt a need for

someone to tell me what to do about a personal problem, there is someone I could talk with.

Most striking about the questions that were related to sex is that males reported less social support on a level that involved communication and assistance with personal problems. Those questions that were not related to sex dealt with the completion of a physical task such as borrowing money, moving, assistance in getting to the doctor, etc., and males and females alike reported support.

Null Hypothesis 11

There is no relationship between adjustment and self-esteem at the .05 level.

Since the Self-Esteem Inventory consisted of three scales, each was analyzed separately. General self-esteem related to the individual's feelings toward the value of life as a whole. Social self-esteem related to the individual's feelings toward their social worth, and personal self-esteem related to feelings of personal worth. General self-esteem was not related to adjustment at the .05 level. A negative gamma of only .10 was found which was interpreted as no or low association and accounted for only 10 percent of the error in predicting adjustment. The direction was important since it indicated that the depressed scored lowest on the scale for general self-esteem.

Social self-esteem was not related to adjustment at

the .05 level. However, a positive gamma of .41 was found which was interpreted as a moderately low association and accounted for 41 percent of the error in predicting adjustment. The direction was important here because it indicated that the well-adjusted scored higher on the scale for social self-esteem.

Personal self-esteem was related to adjustment at the .0001 level with a chi-square value of 36.578 and 8 degrees of freedom. A critical value of 15.507 was necessary for significance at the .05 level. In addition, a positive gamma of .70 was found which was interpreted as a moderately high association and accounted for 70 percent of the error in predicting adjustment. The positive direction indicated that the well-adjusted scored higher on the scale for personal self-esteem. Table 27 presents the levels of adjustment to personal self-esteem.

VI. SUMMARY

This chapter described the analysis and interpretation of the data. Statistical analysis utilizing chi-square found no significant relationship between adjustment and age, sex, parental status, education, organizational involvement, income, anticipatory grief, or length of bereavement. However, 9 of the 10 scales of the Grief Experience Inventory were significant at the .05 level. Eight of the 18 questions on the social support inventory

TABLE 27
LEVELS OF ADJUSTMENT TO PERSONAL SELF-ESTEEM

	1	2	3	4	5
Depressed	8	3	5	2	0
Moderately Adjusted	1	9	2	4	2
Well Adjusted	<u>0</u>	<u>0</u>	<u>5</u>	<u>9</u>	<u>6</u>
Totals	9	12	12	15	8

Chi-square = 36.579

Critical value = 15.507

Significant at .0001

were found to be related to sex, but social support overall was not significantly related to adjustment. Personal self-esteem was found to be related to adjustment, but social and general self-esteem were not. In addition, several of the variables demonstrated moderately low to high associations which are directly interpretable as proportional reduction in error values useful in predicting adjustment.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

The research problem was to analyze the adjustment of persons widowed in 1979 or the first six months of 1980 who resided in Anderson County, Tennessee. In order to study the adjustment of the widowed it was necessary to determine the relationship between adjustment and each of the following: 1) age, 2) sex, 3) parental status, 4) organizational involvement, 5) education, 6) income, 7) anticipatory grief, 8) length of bereavement, 9) grief experience, 10) social support, and 11) self-esteem.

Data were collected through the use of a mailed questionnaire. A total of 58 usable instruments were returned from the original list of 242 names. Data from the completed questionnaires were analyzed using chi-square, gamma, lambda, frequency, and percentages.

II. FINDINGS

Statistical analysis of the data produced the following findings:

1. There was no relationship between adjustment and

age at the .05 level. A positive gamma of .35 was found.

2. There was no relationship between adjustment and sex at the .05 level. A positive lambda of .09 was found.

3. There was no relationship between adjustment and parental status at the .05 level. A positive lambda of .02 was found.

4. There was no relationship between adjustment and education at the .05 level. A positive lambda of .13 was found.

5. There was no relationship between adjustment and organizational involvement at the .05 level. A lambda of .04 was found. Church-related activities were the most frequent for this population.

6. There was no relationship between adjustment and income at the .05 level. A positive gamma of .43 was found.

7. There was no relationship between adjustment and anticipatory grief at the .05 level. A lambda of .17 was found.

8. There was no relationship between adjustment and length of bereavement at the .05 level. A positive gamma of .13 was found.

9. Relationships at the .05 level were found between adjustment and the following scales on the Grief Experience Inventory. Gamma scores for each are listed:

Atypical Response	-.71
Despair	-.87
Social Isolation	-.29
Depersonalization	-.73
Sleep Disturbance	-.78
Loss of Vigor	-.25
Physical Symptoms	-.64
Loss of Control	-.67
Rumination	-.60

There was no relationship at the .05 level between adjustment and the following scales on the Grief Experience Inventory. Gamma scores for each are listed:

Denial	.40
Anger/Hostility	-.46
Guilt	-.12
Somatization	-.43
Death Anxiety	-.50
Loss of Appetite	-.29
Optimism/Despair	-.53
Dependency	-.33
Social Desirability	-.04

10. Relationships at the .05 level were found between sex and the following questions on the social support scale: questions 1, 3, 4, 7, 9, 10, 12, and 18.

There was no relationships at the .05 level between sex and the following questions on the social support

scale: questions 2, 5, 6, 8, 11, 13, 14, 15, 16, and 17.

Of importance is that the responses indicated a lack of support that involved interpersonal communications and assistance with personal problems.

There was no relationship between adjustment and social support at the .05 level.

11. There was no relationship at the .05 level between adjustment and general self-esteem and social self-esteem. Gammas of $+.41$ and $-.10$, respectively, were found for each of the scales.

There was a relationship at the .05 level between adjustment and personal self-esteem. A positive gamma of $.70$ was found.

The only significant demographic variable was between sex and remarriage, which was significant at the .0001 level. Males remarried more frequently than did females.

III. CONCLUSIONS

Based on the findings, the following conclusions were drawn concerning adjustment of the widowed:

1. Adjustment to widowhood is a lengthy process, and widowed persons may continue to experience adjustment problems for more than one year.

2. While research cited in the review of literature indicated variables (age, sex, parental status,

education, income, anticipatory grief, social support, and length of bereavement) which were related to adjustment 13 months after the death of a spouse (Bornstein et al., 1975; Carey, 1976, 1977, 1979-1980), these variables do not appear to be related to adjustment over longer periods of time.

3. However, certain grief experiences do appear to be related to adjustment, and these are reflected in the physical, emotional, and social realms of the widowed person's life.

4. Males appear to have less interpersonal support than females.

5. Personal self-esteem appears to be more important to adjustment than general or social self-esteem.

IV. RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made for further research:

1. A similar study based on a longitudinal design should be conducted to determine over time what specific variables are significantly related to adjustment.

2. Continued research into the interpersonal support available to widowed persons is needed.

3. Further research into the total support system of the widowed is needed based on a longitudinal design to determine how the support system changes in relation to

the widowed person's personal growth process.

4. Because of the changes occurring in the family relationships due to the increasing number of women employed outside the home, studies that compare generational differences could be important in determining the adjustment in the future.

5. Since Atypical Response was found to be related to adjustment, studies that clarify the circumstances which lead to an atypical response could be valuable in promoting a more positive adjustment.

6. Further investigation into additional personal crises that occur in close proximity to a death could prove beneficial in understanding why some individuals fail to make a positive adjustment.

7. Long-range studies related to death education and adjustment to widowhood should be conducted to determine if educational and emotional preparation for death can reduce some of the difficulties associated with bereavement and adjustment.

8. And finally, a study of death education courses should be conducted to determine if and to what extent the adjustment process is included in the curriculum.

CHAPTER VI

EPILOGUE

To end this project without addressing the intensely emotional impact that death can bring would be a disservice to those persons who so generously shared their experiences with me. Completing the questions asked in this study was a painful experience because each individual had to review the past, call forth their feelings, and examine them once again. Two days before the defense of this research, a completed questionnaire was received. It came from a lady who apologized for its lateness, explaining that her daughter had kept it from her. Her daughter did in fact call me to express her concern, that to participate in the study would cause her mother great pain, which she wished her not to endure. I expressed my concern for her and for her mother but indicated that I hoped she would allow her mother to make the decision. As another example, a son called me on his mother's behalf. She was so distressed upon receipt of the questionnaire that she had talked with a lawyer about invasion of her privacy. I assured him, and subsequently assured her through a personal letter, that I did not wish her harm and that her name would be removed from the research project. My own interest in this research stems from the loss of my husband and the realization that the process of recovery is so difficult. The

probing questions for me were "How could that process be made easier?" "What could I learn that could be helpful to others?"

The American culture with its multitude of differences in customs and religious affiliations offers little positive support for the status of widowhood. Concern is shown for the bereaved during the funeral and for a short period of time thereafter. Somehow the magical first year has become a milestone, after which the widowed are expected to have recovered from their grief and adjusted to the loss of the spouse. However, a review of the literature indicates limited research in the adjustment process of the widowed. The information that is available, as well as this research study, indicates that adjustment does not always occur within a year and that the process can be long, slow, and painful.

This study was concerned with persons who had been widowed for more than a year and attempted to identify variables that were related to adjustment. These variables might be described as resources utilized to cope with the crisis of adjustment after the death of a spouse.

Since health does involve an emotional component, then this study indicates that we must learn more about the emotional needs in recovery from crisis events. We apparently need to teach communication skills, especially to males, which can serve as a resource in personal

interactions. Long-range studies coupled with death education need to be conducted to determine if educational and emotional preparation for death can mediate and facilitate the readjustment process. In addition, more emphasis should be given in health education to the effects of the emotions on the total health of the person.

And finally, we need to recognize that as people differ, so do experiences with widowhood. While each person has resources which can be called forth to aid in coping with a crisis, we, as helping professionals and as human beings, can and have an obligation to offer assistance with strengthening these resources. Our assistance should be based on individual need because the individual in crisis knows best when the crisis is over.

Our emotional health is vulnerable and appears more difficult to support. Offering assistance with a physical chore is easier. Fixing a leaking roof can be supportive assistance. On the other hand, it can be interpreted as "let me do this for you because you are incapable" if the recipient of your aid is suffering from a loss of identity or a loss of confidence. When a spouse dies, the loss is more than someone who fixed the roof or cooked the meals. The loss is a significant relationship which gave each individual a feeling of worth because each was valued by the other. These needs remain after a death. A widowed person needs to hear things like, "I know you can," "I

like you as a human being," "I value you," "You have worth." With this kind of support, the individual can learn to do many of the tasks necessary for adjustment, and along with the completion of a new task comes confidence, identity, and a feeling of meaningful existence.

BIBLIOGRAPHY

BIBLIOGRAPHY

- Arling, Greg. "The Elderly Widow and Her Family, Neighbors, and Friends." Journal of Marriage and the Family 38 (November 1976):757-768.
- Bahr, Howard, and Harvey, Carol D. "Widowhood and Perceptions of Change in Quality of Life: Evidence from the Sunshine Mine Widows." Journal of Comparative Family Studies 10 (Autumn 1979):411-428.
- Ball, Justine F. "Widow's Grief: The Impact of Age and Mode of Death." OMEGA Journal of Death and Dying 7 (1976-1977):307-355.
- Barrett, Carol J. "Effectiveness of Widows' Groups in Facilitating Change." Journal of Consulting and Clinical Psychology 46 (1978):20-31.
- Battle, James. "Relationships Between Self-Esteem and Depression." Psychological Reports 42 (1978):745-746.
- _____. Culture-Free SEI: Self-Esteem Inventories for Children and Adults. Seattle: Special Child Publications, 1981.
- Black, James A., and Champion, Dean J. Methods and Issues in Social Research. New York: John Wiley & Sons, Inc., 1976.
- Bornstein, Phillipp E.; Clayton, Paula J.; Halikas, James A.; Maurice, William L.; and Robins, Eli. "The Depression of Widowhood After Thirteen Months." British Journal of Psychiatry 122 (1973):561-566.
- Bowlby, John. "Processes of Mourning." The International Journal of Psycho-Analysis 42 (1961):517-540.
- Brown, Arnold Smith. "The Elderly Widowed and Their Patterns of Social Participation and Disengagement." Dissertation Abstracts International 34 (1973):422-A.
- Carey, Raymond G. "The Widowed: A Year Later." Journal of Counseling Psychology 24 (1977):125-131.
- _____. "Weathering Widowhood: Problems and Adjustment of the Widowed During the First Year." OMEGA Journal of Death and Dying 10 (1979-1980):163-174.

- . "The Widowed After One Year." Summary Report, Office of Evaluation and Research Services, Lutheran General Hospital, Park Ridge, Illinois, 1976. (Mimeographed.)
- Cattell, James P. "Psychiatric Implications in Bereavement." In Death and Bereavement, pp. 153-162. Edited by Austin H. Kutscher. Springfield: Charles C. Thomas, 1969.
- Champion, Dean J. Basic Statistics for Social Research. New York: Macmillan Publishing Co., Inc., 1981.
- Clayton, Paula J.; Halikas, James A.; and Maurice, William L. "The Depression of the Widowhood." British Journal of Psychiatry 120 (1972):71-78.
- Cohen, Pauline; Dizenhuz, Israel M.; and Winget, Carolyn. "Family Adaptation to Terminal Illness and Death of a Parent." Social Casework 58 (April 1977):223-228.
- Demi, Alice Mae. "Adjustment to Widowhood After a Sudden Death: Suicide and Non-Suicide Survivors Compared." Dissertation International Abstracts 38 (1978):5847-5849.
- Eliot, Thomas D. "The Bereaved Family." The Annals of the American Academy of Political and Social Science 160 (March 1932):184-190.
- Fulconer, David M. The Adjustive Behavior of Some Recently Bereaved Spouses: A Psycho-Sociological Study. Unpublished doctoral dissertation, Northwestern University, 1942.
- Fulton, Robert. "Death, Grief, and Social Recuperation." OMEGA Journal of Death and Dying 1 (1970):23-28.
- Freud, Sigmund. (1929) Letter to Binswanger. In Letters of Sigmund Freud, p. 386. Edited by E.L. Freud. London: Hogarth, 1961. Cited by Bowlby, John. "Processes of Mourning." The International Journal of Psycho-Analysis 42 (1961):317-340.
- Gerber, Irwin; Rusalem, Roslyn; Hannon, Natalie; Battin, Delia; and Arkin, Arthur. "Anticipatory Grief and Aged Widows and Widowers." Journal of Gerontology 30 (1975):225-229.
- Glick, Ira O.; Weiss, Robert S.; and Parkes, C. Murray. The First Year of Bereavement. New York: John Wiley & Sons, Inc., 1974.

- Golan, Naomi. "Wife to Widow to Woman." Social Work (September 1975):369-374.
- Goldberg, Stanley B. "Family Tasks and Reactions in the Crisis of Death." Social Casework (July 1973):398-405.
- Gut, Emmy. "Some Aspects of Adult Mourning." OMEGA Journal of Death and Dying 5 (1974):323-342.
- Hardt, Dale Vincent. "An Investigation of the Stages of Bereavement." OMEGA Journal of Death and Dying 9 (1978-1979):279-285.
- Havinghurst, Robert J. "Research and Development Goals in Social Gerontology." The Gerontologist 9 (Winter 1969):5.
- Hirsch, Barton J. "Natural Support Systems and Coping with Major Life Changes." American Journal of Community Psychology 8 (1980):159-172.
- Kivett, Vira R. "Loneliness and the Rural Widow." The Family Coordinator 27 (October 1978):389-394.
- Krupp, George. "Maladaptive Reactions to the Death of a Family Member." Social Casework 53 (July 1972):425-434.
- Lindermann, Erich. "Symptomatology and Management of Acute Grief." In Death and Identity, pp. 186-201. Edited by Robert Fulton. New York: John Wiley & Sons, Inc., 1965.
- Lopata, Helena Znaniecki. "Loneliness: Forms and Components." Social Problems 17 (1969-1970):248-262.
- _____. "The Social Involvement of American Widows." American Behavioral Scientist 4 (1970-1971):41-57.
- _____. "Contributions of Extended Families to the Support Systems of Metropolitan Area Widows: Limitations of the Modified Kin Network." Journal of Marriage and the Family 40 (May 1978):355-363.
- _____. "The Absence of Community Resources in Support Systems of Urban Widows." The Family Coordinator 27 (October 1978):383-388.
- Maddison, David. "The Relevance of Conjugal Bereavement for Preventive Psychiatry." British Journal of Medical Psychology 41 (1968):223-233.

Maddison, David, and Walker, Wendy L. "Factors Affecting the Outcome of Conjugal Bereavement." British Journal of Psychiatry 113 (1967):1057-1067.

Parkes, Colin Murray. "Recent Bereavement as a Cause of Mental Illness." British Journal of Psychiatry 110 (1964):198-204.

_____. "Bereavement and Mental Illness: Part 1. A Clinical Study of the Grief of Bereaved Psychiatric Patients." British Journal of Medical Psychology 38 (1965):1-12.

_____. "Bereavement and Mental Illness: Part 2. A Classification of Bereavement Reactions." British Journal of Medical Psychology 38 (1965):13-26.

_____. "The First Year of Bereavement: A Longitudinal Study of the Reactions of London Widows to the Death of Their Husbands." Psychiatry 33 (November 1970): 444-467.

_____. "Determinants of Outcome Following Bereavement." OMEGA Journal of Death and Dying 6 (1975):303-323.

Peretz, David. "Understanding Your Mourning: A Psychiatrist's View." In But Not to Lose, pp. 137-151. Edited by Austin H. Kutscher. New York: Frederick Fell, Inc., 1969.

Pihlblad, C.T.; Adams, David L.; and Rosencranz, Howard A. "Socio-Economic Adjustment in Widowhood." OMEGA Journal of Death and Dying 3 (November 1972):295-305.

Raphael, Beverly. "Preventive Intervention With the Recently Bereaved." Archives of General Psychiatry 34 (December 1977):1450-1454.

Rees, W. Dewi, and Lutkins, Sylvia G. "Mortality of Bereavement." British Medical Journal 4 (October 1967):13-16.

Rosen, David Hyman. "Social Relationships and Successful Aging Among the Widowed Aged." Dissertation Abstracts International 34 (1973):2029-A.

Sanders, Catherine M.; Mauger, Paul A.; and Strong, Paschal N., Jr. "A Manual for the Grief Experience Inventory." University of South Florida, Department of Psychology, 1979. (Mimeographed.)

- _____. "Comparison of Younger and Older Spouses in Bereavement Outcome." OMEGA Journal of Death and Dying 11 (1980-1981):217-236.
- Sheskin, Arlene, and Wallace, Samuel E. "Differing Bereavements: Suicide, Natural, and Accidental Death." OMEGA Journal of Death and Dying 7 (1976): 229-232.
- Silverman, Phyllis Rolfe. "Services to the Widowed: First Steps in a Program of Preventive Intervention." Community Mental Health Journal 3 (Spring (1967):37-45.
- _____. "The Widow-to-Widow Program: An Experiment in Preventive Intervention." Mental Hygiene 53 (July 1969):333-337.
- _____. "The Widow as a Casegiver in a Program of Preventive Intervention With Other Widows." Mental Hygiene 54 (October 1970):540-547.
- _____. "Widowhood and Preventive Intervention." The Family Coordinator (January 1972:95-102.
- Silverman, Phyllis, Rolfe, and Englander, Sue. "The Widow's View of Her Dependent Children." OMEGA Journal of Death and Dying 6 (1975):3-19.
- Smith, Walter John. "The Desolation of Dido: Patterns of Depression and Death Anxiety in the Adjustment and Adaptation Behaviors of a Sample of Variably-Aged Widows." Dissertation Abstracts International 36 (1975):1933-B.
- Vachon, M.L.S.; Lyall, W.A.L.; Rogers, J.; Freidman-Letofsky, K.; and Freeman, S.J.J. "A Controlled Study of Self-Help Intervention for Widows." American Journal of Psychiatry 137 (November 1980):1380-1384.
- Vinich, Barbara H. "Remarriage in Old Age." The Family Coordinator (October 1978):359-363.
- Wilcox, Brian Leroy. "Life Event Recency and Social Support as Mediators of the Relationship Between Stressful Life Events and Psychological Adjustment." Ph.D. Dissertation, University of Texas at Austin, 1979.
- Williams, W. Vail; Polak, Paul; and Vallman, Rita R. "Crisis Intervention in Acute Grief." OMEGA Journal of Death and Dying 3 (1972):67-70.

APPENDICES

APPENDIX A

LETTERS OF REQUEST FOR SAMPLE NAMES

PROCEDURE FOLLOWED FOR OBTAINING SAMPLE

After the decision was made to obtain a sample from death certificates, the researcher phoned the local Office of Vital Records to inquire about procedure for obtaining permission. The local office refused permission. However, since review of the literature had revealed this method as frequently utilized, the researcher phoned a friend, Dr. A.S. Holmes, who is Health Officer of the Kentucky River District Health Department, Hazard, Kentucky. Dr. Holmes indicated that such information could be legally made available and offered to make further inquiries on the researcher's behalf. He phoned the Director of Vital Statistics in the State of Kentucky and was assured of cooperation if the researcher wished to conduct the study in that State. Dr. Holmes then wrote Mr. Wendell Spurgeon, Director of Vital Statistics in Nashville, requesting access to the records on the researcher's behalf. Mr. Spurgeon directed his staff member, Ms. Bonnie Hurt, to provide the researcher with a computer printout of the names requested.

April 24, 1981

Mr. Wendell Spurgeon
Director of Vital Records
Room C3-323
Cordell Hull Building
Nashville, Tennessee 37219

RE: Judy Keith
University of Tennessee
Knoxville

Dear Mr. Spurgeon:

I have talked with Omar L. Greeman, your counterpart in the Kentucky Bureau for Health Services, and would like your advice on the following.

A friend who is studying for her Ph.D. at Knoxville, is in need of help toward getting certain information from death certificates at Clinton, Blount County. This material would be used to search out a number of widows in certain age groups, who in turn would be asked if they would participate in a study. Confidentiality would be observed strictly, of course.

Omar told me that this would not be any special problem in Kentucky, but we were not certain how the rules go in Tennessee. Would you be kind enough to let me know if there is any special procedure we should follow in approaching Blount County about this.

Your cooperation is much appreciated.

Sincerely,

A.S. Holmes, M.D.
Health Officer

May 1, 1981

Mr. Wendell Spurgeon
Director of Vital Records
Room C3-323
Cordell Hull Building
Nashville, Tennessee 37219

Dear Mr. Spurgeon:

I know by way of a carbon copy of a letter from my friend, Dr. A.S. Holmes, that you are already aware of my need for access to death certificates here in Tennessee.

Please allow me to elaborate. I am working on my dissertation toward a doctorate in Health Education. Previous research in other states have utilized death certificates to obtain a random sample. I had considered conducting my research in Kentucky but since this would require relocating my family twice in 1 year, my preference would be a rural county near Knoxville, perhaps Anderson/Blount.

Specifically, I will be studying the relationship of social support systems and the adjustment outcome of the widowed. Procedures for selecting the sample would be to canvass the death certificates for a period of 2 years (1979-1980) to delineate those people who were married at the time of death of the spouse and who are between the ages of 18 and 65. Each person meeting those criteria would be mailed a letter explaining the study and a demographic questionnaire. Return of the completed questionnaire would indicate their willingness to participate in the study. An appointment would then be made with each individual at a time and place convenient to him/her to collect data on their adjustment level (Bell Adjustment Inventory) and social support system (instrument not confirmed). All information obtained would, of course, be held in strictest confidence. There will be no publication of names of individuals participating in the study.

If there are specific procedures required to obtain permission to use the death certificates, please advise. If you have any questions or need further information, please contact me. I am a graduate teaching assistant at The University of Tennessee, Division of Health and Safety, 1914 Andy Holt Avenue, Knoxville, Tennessee 37916, phone number (615) 974-5041. I greatly appreciate your assistance.

Sincerely,

Judy Keith

May 22, 1981

Kentucky River District
Health Department
825 High Street
Hazard, Kentucky 41701
Attention: Mrs. Holmes

RE: Data from Death
Certificates

Dear Mrs. Holmes:

Thank you for your letter of April 24, 1981.

For research purposes, we will furnish the data pertaining to the deaths which occurred in Clinton, Tennessee, without charge to your agency and you may then designate it to the graduate student on your official letterhead indicating that the information is for research purposes and will be confidential. Please submit the following: full name of deceased, date of death, place of death, and the data that you desire for research purposes.

Please return this letter with your reply to expedite handling and to insure that no fee will be charged to your client.

Sincerely yours,

Wendell Spurgeon
State Registrar

May 29, 1981

Ms. Judy Keith
University of Tennessee
Division of Health and Safety
1914 Andy Holt Avenue
Knoxville, Tennessee 37916

Dear Ms. Keith:

As requested in your letter of May 1, 1981, attached please find death listing of residents of Anderson County that were married and between the ages of 18 and 65. We can only supply you with 1979 final and 1980 provisional death data as our 1981 death data are not on tape as yet.

I want to be sure you are aware of the confidential nature of this information. Section 53 of the Tennessee Code Annotated (relevant parts of which are enclosed) contains a clause stating that it is unlawful to disclose information contained in vital records.

If you have any questions regarding the confidentiality of these records, please contact me. If I do not hear from you, I will assume you agree to abide by the restrictions while using the death data for your research.

Sincerely,

Bonnie Harrah Hurt
Manager, Information and
Referral Unit
Division of Health Statistics

APPENDIX B

LETTERS OF REQUEST AND PERMISSION
TO USE INSTRUMENTS

July 16, 1981

Judy Keith
Division of Health and Safety
1914 Andy Holt Avenue
The University of Tennessee
Knoxville, Tennessee 37916

Dear Ms. Keith:

Please forgive the long delay in sending the GEI Manual to you. Unfortunately, my mail was held up at the University of South Florida and I received your request only recently.

Enclosed is a copy of the Manual as well as an extra copy of the instrument, scoring sheet, and profile sheet. Please feel free to reproduce what you need for your own work. We are charging a fee of \$8.00 to cover the costs of reproduction and mailing.

If I can answer any questions or be of any help, please contact me at (704) 825-1911 or at the above address.

Sincerely,

Catherine M. Sanders, Ph.D.

May 11, 1981

Raymond G. Carey, Director
Evaluation and Research
Lutheran General Hospital
Park Ridge, Illinois 60068

Dear Dr. Carey:

While reviewing the literature for my dissertation, I read your article in OMEGA, "Weathering Widowhood: Problems and Adjustment of the Widowed During the First Year." I would be most interested in seeing copies of the instruments you used in conducting your study. Would you be kind enough to share those with me?

I would, of course, be happy to cover any costs. If you would bill me when you send the instruments, prompt payment will follow.

I am most grateful to you for your assistance.

Sincerely,

Judy Keith

Judy Keith
Division of Health and Safety
1914 Andy Holt Avenue
The University of Tennessee
Knoxville, Tennessee 37916

Dear Judy:

Enclosed is a copy of the seven page questionnaire and also a separate sheet showing the scoring of the eight questions used for the Adjustment/Depression Scale.

No charge to you. Good luck in your work.

Sincerely,

Ray Carey
Director
Health Care Evaluation Division
Parkside Medical Services

Enclosures

The List of Clubs and Organizations and Social Support Index were developed by Dr. Brian Leroy Wilcox as part of his dissertation at the University of Texas. Even though not protected by a copyright, a courtesy letter was sent requesting permission to use the instruments. The letter was mailed to the address in California listed in his dissertation. After several weeks without a reply, this researcher phoned the University of Texas to request a more current address. Dr. Wilcox was at that time a professor at the University of Virginia. When phoned in Virginia, he graciously consented to the use of the aforementioned instruments.

APPENDIX C

COPIES OF INSTRUMENTS

DEMOGRAPHIC QUESTIONNAIRE

Directions: Please answer the following questions by placing an X in the space that applies to you, or by filling in the blanks.

1. Your age at the time of your spouse's death _____
2. Your spouse's age at the time of death _____
3. Your sex _____
4. Your race _____
5. Time since death of spouse _____ (years, months)
6. Were you aware that your spouse was about to die? Yes _____ No _____
7. Number of years you completed in school?
 - _____ 1. less than a high school diploma
 - _____ 2. high school diploma
 - _____ 3. college degree
 - _____ 4. technical school degree
 - _____ 5. graduate degree
8. Parental status at the time of spouse's death:
 - _____ Yes, I had children
 - _____ No, I did not have children
9. If you had children, how many children did you have? Circle the number you had.
 1 2 3 4 5 6 7 8 9 10+
10. Age and sex of your children at time of spouse's death beginning with the oldest:

_____ age _____ sex	_____ age _____ sex	_____ age _____ sex
_____ age _____ sex	_____ age _____ sex	_____ age _____ sex
_____ age _____ sex	_____ age _____ sex	_____ age _____ sex
11. At present are you living: alone? Yes _____ No _____
 - with dependent children? Yes _____ No _____
 - with independent (married and/or self-supporting) children? Yes _____ No _____
 - with others? Yes _____ No _____
12. Have you remarried since spouse's death? Yes _____ No _____
13. Is your yearly income from all sources:
 - _____ less than \$4,999
 - _____ between \$5,000 and \$9,999
 - _____ between \$10,000 and \$14,999
 - _____ over \$15,000
14. Please rate the level of emotional pain you felt in response to the death of your spouse.
 - _____ mild
 - _____ moderate
 - _____ severe
 - _____ do not recall
15. Yes, I would like to receive a summary of this study. My name and address is:

Directions: Here is a list of clubs and organizations that many people belong to. Please look at this list and place an X next to any of the organizations that you belong to and participate in.

- a. ☐ Church or synagogue
- b. ☐ Church connected groups
- c. ☐ Labor unions
- d. ☐ Fraternal lodges or veterans' organizations
- e. ☐ Business or civic groups
- f. ☐ Professional groups
- g. ☐ Parent-teacher organizations
- h. ☐ Youth groups
- i. ☐ Community centers
- j. ☐ Neighborhood improvement associations
- k. ☐ Social or card playing groups
- l. ☐ Sport teams
- m. ☐ Country clubs
- n. ☐ Political clubs or organizations
- o. ☐ Issue or action groups
- p. ☐ Other (which? _____)
- q. ☐ Other (which? _____)

If you aren't actively involved in any such clubs or organizations, place an X next to the word "none" below.

- r. ☐ None

Directions: Please answer these questions as accurately as you can. Circle the answer that best represents your feelings.

	<u>Yes</u>	<u>Uncertain</u> (to some extent)	<u>No</u>
1. Is <u>loneliness</u> a serious problem for you?	Yes	Uncertain	No
2. Do you feel you are about <u>to go to pieces</u> once a month or more?	Yes	Uncertain	No
3. Are you sometimes so unhappy that you would not care if you <u>died tomorrow</u> ?	Yes	Uncertain	No
4. Are you at <u>peace</u> and <u>content</u> most of the time?	Yes	Uncertain	No
5. Do you often feel <u>depressed</u> (sad, low, blue, despondent)?	Yes	Uncertain	No
6. Is <u>depression</u> a serious problem?	Yes	Uncertain	No
7. Do you <u>cry</u> frequently?	Yes	Uncertain	No
8. Do you sometimes feel your life is <u>futile</u> and <u>empty</u> ?	Yes	Uncertain	No

GRIEF EXPERIENCE INVENTORY

Catherine M. Sanders, Paul A. Mauger, and Paschal N. Strong, Jr.

Instructions: Read each statement and then try to determine how well it describes you during your period of bereavement. If you are still experiencing some of these thoughts or feelings, please respond in the same manner as you would a past experience. If the statement is true or mostly true as applied to you, check "true." If the statement is mostly false, check the space for "false." If a statement does not apply to you leave it blank.

	TRUE	FALSE
1. Immediately after the death I felt exhausted	___	___
2. I tend to be more irritable with others	___	___
3. I am strongly preoccupied with the image of the deceased	___	___
4. I frequently experience angry feelings	___	___
5. It is not difficult to maintain social relationships with friends	___	___
6. My arms and legs feel very heavy	___	___
7. I am unusually aware of things related to death	___	___
8. It seems to me that more could have been done for the deceased	___	___
9. I showed little emotion at the funeral	___	___
10. I felt a strong necessity for maintaining the morale of others after the death	___	___
11. I feel cut-off and isolated	___	___
12. I rarely take aspirins	___	___
13. I feel reluctant to attend social gatherings	___	___
14. I was unable to cry at the announcement of the death	___	___
15. I have feelings of guilt because I was spared and the deceased was taken.	___	___
16. I have a special need to be near others	___	___
17. I often experience confusion	___	___
18. I feel lost and helpless	___	___
19. I am comforted by believing that the deceased is in heaven	___	___
20. I have had frequent headaches since the death	___	___
21. It was difficult to part with the clothing and personal articles of the deceased	___	___
22. It was necessary to take sleeping pills after the death	___	___
23. The yearning for the deceased is so intense that I sometimes feel physical pain in my chest	___	___
24. I cry easily	___	___
25. I have taken tranquilizers since the death	___	___
26. I experience dryness of the mouth and throat	___	___
27. I feel restless	___	___
28. Upon first learning of the death I had a dazed feeling	___	___
29. Concentrating upon things is difficult	___	___
30. I have feelings of apathy	___	___
31. I experienced a feeling when the death occurred that "something died within me"	___	___
32. Aches and pains seldom bother me	___	___
33. I find I am often irritated with others	___	___
34. I could not cry until after the funeral	___	___
35. I feel that I may in some way have contributed to the death	___	___
36. I find myself performing certain acts which are similar to ones performed by the deceased	___	___
37. I made the funeral arrangements	___	___
38. I lack the energy to enjoy physical exercise	___	___
39. I rarely feel enthusiastic about anything	___	___
40. I feel that grief has aged me	___	___
41. I have never dreamed of the deceased as still being alive	___	___
42. I find myself frequently asking "why did the death have to happen in this way?"	___	___
43. I sometimes have difficulty believing the death has actually occurred .	___	___
44. I feel a strong desire to complete certain unfinished tasks the deceased had begun	___	___
45. I have often dreamed of times when the deceased was living	___	___

	TRUE	FALSE
46. I am often irritable	_____	_____
47. I have dreamed of the deceased as being dead	_____	_____
48. I feel extremely anxious and unsettled	_____	_____
49. I feel tenseness in my neck and shoulders	_____	_____
50. Sometimes I have a strong desire to scream	_____	_____
51. I am so busy that I hardly have time to mourn	_____	_____
52. I feel anger toward God	_____	_____
53. I have the urge to curl up in a small ball when I have attacks of crying.	_____	_____
54. I feel the need to be alone a great deal	_____	_____
55. I rarely think of my own death	_____	_____
56. I find it difficult to cry	_____	_____
57. Looking at photographs of the deceased is too painful	_____	_____
58. Life has lost its meaning for me	_____	_____
59. I have no difficulty with digestion	_____	_____
60. I have had brief moments when I actually felt anger at having been left .	_____	_____
61. I have no trouble sleeping since the death	_____	_____
62. I have a hearty appetite	_____	_____
63. I feel healthy	_____	_____
64. It comforts me to talk with others who have had a similar loss	_____	_____
65. I yearn for the deceased	_____	_____
66. I seldom feel depressed	_____	_____
67. I have the feeling that I am watching myself go through the motions of living	_____	_____
68. Life seems empty and barren	_____	_____
69. There are times when I have the feeling that the deceased is present . .	_____	_____
70. I often take sedatives	_____	_____
71. I have frequent mood changes	_____	_____
72. The actions of some people make me resentful	_____	_____
73. My feelings are not easily hurt	_____	_____
74. I am losing weight	_____	_____
75. Small problems seem overwhelming	_____	_____
76. I sometimes feel guilty at being able to enjoy myself	_____	_____
77. I frequently have diarrhea	_____	_____
78. I often wish that I could have been the one to die instead	_____	_____
79. I have lost my appetite	_____	_____
80. I sometimes talk with the picture of the deceased	_____	_____
81. I am not interested in sexual activities	_____	_____
82. At times I wish I were dead	_____	_____
83. It is hard to maintain my religious faith in light of all the pain and suffering caused by the death	_____	_____
84. I seem to have lost my energy	_____	_____
85. I dread viewing a body at the funeral home	_____	_____
86. I find myself idealizing the deceased	_____	_____
87. I have problems with constipation	_____	_____
88. I frequently take long walks by myself	_____	_____
89. I avoid meeting old friends	_____	_____
90. I have a special need for someone to talk to	_____	_____
91. It often feels like I have a lump in my throat	_____	_____
92. I sometimes find myself unconsciously looking for the deceased in a crowd	_____	_____
93. I seem to have lost my self-confidence	_____	_____
94. I drink more alcohol now than before the death	_____	_____
95. After the announcement of the death I thought, "this could not be happening to me"	_____	_____
96. I have nightmares	_____	_____
97. The thought of death seldom enters my mind	_____	_____
98. I have never worried about having a painful disease	_____	_____
99. Funerals sometimes upset me	_____	_____
100. I would not feel uneasy visiting someone who is dying	_____	_____
101. I often worry over the way time flies by so rapidly	_____	_____
102. I have no fear of failure	_____	_____

I would now like you to think about the people you feel close to and the people you feel you can depend on for help, advice, assistance, etc. These people might be family members, other relatives, co-workers, friends, or clergy.

Below are 18 true-false statements which deal with the types of things people feel they can ask of their friends, and the types of relationships people might have with one another.

For each statement, check "true" if the statement is true for you, or check "false" if the statement is not true for you.

	TRUE	FALSE
1. I have someone who will listen to me and talk things over with me when I need understanding	___	___
2. If for some reason I were put in jail, there is someone I could call who would come bail me out	___	___
3. There is at least one person I know whose advice I really trust	___	___
4. I feel that none of my friends or relatives really understands my problems	___	___
5. If I had to go out of town for a few weeks, someone I know would look after my house (the plants, pets, yard, etc.)	___	___
6. I would not know who to ask for advice about hiring a lawyer or finding a good surgeon	___	___
7. I have at least one person I can share my most private thoughts and problems with	___	___
8. If I were sick and needed someone to drive me to the doctor, I would have trouble finding someone	___	___
9. When I need suggestions for how to deal with a personal problem, I know someone I can turn to	___	___
10. When I need someone to give support and encouragement, I have someone who will be with me all the way	___	___
11. There is no one I would call on if I needed to borrow a car for a few hours	___	___
12. If I needed some straight talk about how to deal with a family problem, there is someone I could turn to	___	___
13. There is no one I know who seems to have much confidence in me	___	___
14. If I needed a quick emergency loan of \$100, there is someone I could get it from	___	___
15. There is no one I feel comfortable going to for advice about personal or family problems	___	___
16. I have someone who will do all they can for me when I need help	___	___
17. If I needed some help in moving to a new home, there is someone I could depend on for help	___	___
18. If I felt a need for someone to tell me what to do about a personal problem, there is someone I could talk with	___	___

	TRUE	FALSE
103. I am close with only a few persons	_____	_____
104. The sight of a dead person is horrifying to me	_____	_____
105. I always know what to say to a grieving person	_____	_____
106. I often seek advice from others	_____	_____
107. It does not bother me when people talk about death	_____	_____
108. I cannot remember a time when my parents were angry with me	_____	_____
109. I do not think people in today's society know how to react to a person who is grieving	_____	_____
110. I never have an emotional reaction at funerals	_____	_____
111. I often think about how short life is	_____	_____
112. I am not afraid of dying from cancer	_____	_____
113. I do not mind going to the doctor for check-ups	_____	_____
114. I shudder at the thought of nuclear war	_____	_____
115. The idea of dying holds no fears for me	_____	_____
116. I never lose my temper	_____	_____
117. I have always been completely sure I would be successful when I tried something for the first time	_____	_____
118. I am not usually happy	_____	_____
119. I feel that the future holds little for me to fear	_____	_____
120. I cannot ever remember feeling ill at ease in a social situation	_____	_____
121. I find myself sighing more now than before the death	_____	_____
122. I spent a great deal of time with the deceased before the death	_____	_____
123. It helps me to comfort others	_____	_____
124. My family seems close to me	_____	_____
125. I feel that I did all that could have been done for the deceased	_____	_____
126. My religious faith is a source of inner strength and comfort	_____	_____
127. I am smoking more these days	_____	_____
128. I am not a realistic person	_____	_____
129. I am awake most of the night	_____	_____
130. I feel exhausted when I go to bed but lie awake for several hours	_____	_____
131. I lose sleep over worry	_____	_____
132. I often wake in the middle of the night and cannot get back to sleep	_____	_____
133. I sleep well most nights	_____	_____
134. Things seem blackest when I am awake in the middle of the night	_____	_____
135. I can sleep during the day but not at night	_____	_____

CULTURE-FREE SEI, FORM AD

Name_____Age_____Date of Birth_____

Examiner_____Today's Date_____Total___G___S___P___L___

Directions

Please mark each question in the following way: If the question describes how you usually feel, make a check mark (✓) in the "yes" column. If the question does not describe how you usually feel, make a check mark (✓) in the "no" column. Please check only one column (either "yes" or "no") for each of the 40 questions. This is *not* a test, and there are no "right" or "wrong" answers.

	Yes	No
1. Do you have only a few friends?	☐	☐
2. Are you happy most of the time?	☐	☐
3. Can you do most things as well as others?	☐	☐
4. Do you like everyone you know?	☐	☐
5. Do you spend most of your free time alone?	☐	☐
6. Do you like being a male? / Do you like being a female? . .	☐	☐
7. Do most people you know like you?	☐	☐
8. Are you usually successful when you attempt important tasks or assignments?	☐	☐
9. Have you ever taken anything that did not belong to you? .	☐	☐
10. Are you as intelligent as most people?	☐	☐
11. Do you feel you are as important as most people?	☐	☐
12. Are you easily depressed?	☐	☐
13. Would you change many things about yourself if you could?	☐	☐
14. Do you always tell the truth?	☐	☐
15. Are you as nice looking as most people?	☐	☐
16. Do many people dislike you?	☐	☐
17. Are you usually tense or anxious?	☐	☐
18. Are you lacking in self-confidence?	☐	☐
19. Do you gossip at times?	☐	☐
20. Do you often feel that you are no good at all?	☐	☐
21. Are you as strong and healthy as most people?	☐	☐
22. Are your feelings easily hurt?	☐	☐
23. Is it difficult for you to express your views or feelings? . .	☐	☐
24. Do you ever get angry?	☐	☐
25. Do you often feel ashamed of yourself?	☐	☐
26. Are other people generally more successful than you are? .	☐	☐
27. Do you feel uneasy much of the time without knowing why?	☐	☐
28. Would you like to be as happy as others appear to be? . .	☐	☐
29. Are you ever shy?	☐	☐
30. Are you a failure?	☐	☐
31. Do people like your ideas?	☐	☐
32. Is it hard for you to meet new people?	☐	☐
33. Do you ever lie?	☐	☐
34. Are you often upset about something?	☐	☐
35. Do most people respect your views?	☐	☐
36. Are you more sensitive than most people?	☐	☐
37. Are you as happy as most people?	☐	☐
38. Are you ever sad?	☐	☐
39. Are you definitely lacking in initiative?	☐	☐
40. Do you worry a lot?	☐	☐

APPENDIX D

CORRESPONDENCE WITH SAMPLE POPULATION

1325 Burton Road
Knoxville, Tennessee 37919
(615) 584-9289

Dear

I am a doctoral student at The University of Tennessee. I am also a widow. As part of the requirements for completion of my degree, I am conducting a major research project. My own personal experience as a widow has made me aware of how difficult it is for an individual to readjust to life without a spouse. I am interested in learning more about the problems encountered and the kind of assistance needed by the widowed in making a successful readjustment.

You can help by completing the enclosed forms and returning them to me in the self-addressed, stamped envelope. It is most important that every question is answered. Please return the completed forms to me by

If you have any difficulty completing the forms, I would be happy to come to your residence to assist. Simply mail the envelope back to me with your name, address, and phone number. I will telephone to arrange a convenient time.

Please be assured that any information you share with me will be held in strictest confidence. No names will be revealed to anyone other than myself.

I hope that through this study, more can be learned about how to help others deal with the pain of grief. Your participation is voluntary and may be withdrawn at any time you desire. Once you have mailed the forms to me, you have completed all that is necessary. I would be happy to share a summary of the results of this study with you.

I look forward to hearing from you and deeply appreciate your assistance.

Very sincerely yours,

Judy Keith

Enclosures

POST CARD FOLLOW-UP

You received a letter recently asking for your participation in a research study of the widowed. If you have already returned your anonymous forms, please disregard this reminder. If not, you can still be included if the forms are received by _____.

VITA

Judy Bryant Keith was born in Clintwood, Virginia, August 3, 1947. She graduated from Clintwood High School in 1965, enrolled in Berea College that same year, and graduated with a Bachelor of Arts degree in Sociology in 1970.

She married Leonard Joe Keith in July 1969. In 1974 she earned a Master's degree in Health Education from Eastern Kentucky University.

Following graduation from Berea College, she was employed with Mountain Maternal Health League, Inc., an affiliate of Planned Parenthood-World Population, Inc. She continued her employment with that agency as Executive Secretary, Program Developer, Outreach Supervisor, Equal Opportunity Officer, Education Director, and Executive Director for a period of eight years. After her husband's death in 1977, she resigned from the position of Executive Director to return to school.

In 1979 she entered the doctoral program at The University of Tennessee, where she served as a Graduate Teaching Assistant. She received a Doctor of Education degree with a major in Health Education and a collateral in Public Health in August 1982.