BABY BOOMERS AND HOSPICE USE: A QUANTITATIVE LOOK AT GRIEF

A DISSERTATION

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To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a dissertation written by Ann Rathbun entitled "Baby Boomers and Hospice Use: A Quantitative Look at Grief." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Health Education.

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We have read the dissertation
and recommend its acceptance:

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Associate Vice President
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ABSTRACT

COMPLETED RESEARCH IN HEALTH SCIENCES
Texas Woman's University, Denton, Texas

Rathbun, A. Baby Boomers and Hospice Use: A Quantitative Look at Grief. Ph.D. in Health Education, 1999, 70 pp. (E. Doyle)

This purpose of this study was to determine if hospice influences the level of grief in Baby Boomers. The individuals (n=157) surveyed were categorized as "Hospice Users" and "Non-Hospice Users." Participants were asked to respond to the 26-item Texas Revised Inventory of Grief (Faschingbauer, 1979) for measuring grief. Each respondent was given two grief scores (Past Behavior and Present Feelings). Demographic information (age of respondent, age of deceased, time since the death occurred, and cause of death) was collected to delimit factors possibly influencing grief scores. Data were interpreted using both one-way and two-way analysis of variance.

It was discovered that, in the population surveyed, hospice did not make a significant difference in the level of grief for participants. Findings also included no significant difference in grief scores based on age of deceased, age of respondent, or cause of death. The time since death occurred was found to be significant ($p<.05$) in the present

feelings of participants whose loved one died more than 60 months prior to the survey.

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CHAPTER I

INTRODUCTION

When preparing for death, one has a chance to pay attention to one's psychosocial health needs. One way in which psychosocial aspects of health may be addressed is to employ a hospice agency to be a part of the care for the dying patient. According to Smith (1984), hospice as an intervention was shown to make a difference in the way the bereaved adjusted to the death of a loved one. Ransford and Smith (1991) interviewed bereaved individuals whose loved ones had died in both hospice and non-hospice settings. Trends in their qualitative study indicated that, over time, users of hospice services were better adjusted than non-hospice users.

Bass, Bowman, and Noelker (1991) indicated that the support received during the "predeath situation" is more likely to affect the adjustment of spouses (and other relatives) than specific support given during bereavement. Hospice can be one factor in supporting the family during the period that Bass (et.al.) define as "predeath." A more quantitative study will provide the researcher with definite answers to the questions regarding how well hospice

users adjusted to the death as opposed to those who did not use hospice.

Baby Boomers, individuals aged 34-52, were the specific group that was used for this study, as 28% of Americans fall into the "group" known as Baby Boomers (BBHQ, 1999). Kalish and Reynolds (1977) indicated that middle-aged adults were less accepting of death (in general) than older persons.

Purpose of the Study

The purpose of this study was to determine if hospice use influences the level of grief in Baby Boomers. The individuals being surveyed were categorized as "Hospice Users" and "Non-Hospice Users." Several demographic variables were used to identify potential biases that may have occurred in the population studied.

Hypotheses

H1: There will be no significant difference in grief scores of respondents based on their age.

H2: There will be no significant difference in grief scores of respondents based on age of the deceased.

H3: There will be no significant difference in grief scores of respondents based on length of time since death has occurred.

H4: There will be no significant difference in grief scores of respondents based on cause of death.

H5: There will be no significant difference of grief scores of respondents based on hospice use.

H6: There will be no significant interaction between age of respondent, age of deceased, length of time since death, cause of death or hospice use.

Definition of Terms

1. Baby Boomers were defined as those individuals born between 1946 and 1964 Boomers (BBHQ ,1999).
2. Hospice was defined (for the purpose of this study) as a concept of humane and compassionate care for the dying with the benefit of trained hospice staff.
3. Hospice User was defined as an individual who had experienced the death of a loved one with the benefit of support by trained hospice staff.
4. Non-Hospice User was defined as an individual who had experienced the death of a loved one without the benefit of support by trained hospice staff.
5. Grief was defined as "deep and poignant distress caused by or as if by bereavement" or "the loss of something[one] loved" (Merriam-Webster, 1973).
6. Loved One was defined as any person who had major significance in the life of the bereaved. This

relationship (may have) included any individual who was related to the bereaved by blood or by marriage. This definition was also extended to same sex partners and extended family that were the result of: 1)choosing to gain support from one's community, or 2)disengagement or estrangement of/from the family of origin.

Limitations

The study was limited by the following:

1. Convenience sampling. The sample was self-selected, thus the results will not be generalizable.
2. The sample was drawn from largely gay and lesbian churches in metropolitan areas (Dallas-Ft. Worth, Texas, and Columbia, South Carolina).

Delimitations

The following were delimitations for the study:

1. Participants must have experienced the death of a loved one.
2. Participants must have been English speaking.
3. Participants must have been born between January 1, 1946 and December 31, 1964 (to be defined as Baby Boomers).

Background and Significance

Death is beautiful. If one is to look into the literature, the mass media, and 20th century popular culture, one might get the impression that death is, indeed,

beautiful. There is a recurring trend in the media (especially in books, films, and television) that allows America to put a pretty face on death. This trend is disturbing because it allows for a romanticism of death that will ultimately, for the bereaved, be far from reality. Fry (1986) states that a "romantic view of death and dying is a more or less permanently available way of responding to a permanent evil." The current trend to romanticize death (Sneed, 1998) could make for a generation of individuals who are not ready for death, and who may have an expectation that death has a beautiful face. Will everyone experiencing death live "happily ever after?" The unrealistic picture of death is potentially dangerous to the mental health and well-being of bereaved individuals.

CHAPTER II

REVIEW OF LITERATURE

This literature review covers areas related in a variety of ways to the subject of Baby Boomers and hospice use. The general topics to be examined are: Baby Boomers (their characteristics, their commonalties, the impact of grief and loss on this population), arts and media and the depiction of death, hospice care (a history of hospice, and program characteristics), and general characteristics of grief (the stages of grief, anticipatory grief, type of death and it's relation to grief).

Because Americans have different views about many things, Americans' perspectives of death also vary. Mullen, McDermott, Gold, and Belcastro (1996) outlined five different perspectives on death. The authors wrote that humanistic, ecological, religious, life-after-life, and reincarnation perspectives are emergent views in the U.S. The ecological perspective includes a "survival of the fittest" attitude and a cyclical perspective of all life (not just human life). Those accepting the humanistic perspective believe that human life is more valuable than other forms of life (plant life, animal life). Valuing of human life leads to an attitude that leaving one's mark in the world (immortality) is important.

Mullen et al. defined the religious perspective as being, somewhat, a Christian attitude in that those who accept this perspective believe in a higher being (God) and that there is life everlasting through a savior (Jesus Christ). A good versus evil mentality is also pervasive in the perspective. The religious perspective differs from the life-after-life perspective. The difference between the two perspectives is largely due to the view of the dying person who, in the life-after-life perspective, sees a "light, a tunnel, a flashing past of one's previous life." The near death experiences of many individuals have helped form the life-after-life perspective.

The reincarnation perspective has been accepted by some Westerners although it was borne out of Eastern philosophies. Believers in this perspective choose to live their life achieving a state of enlightenment (while in the earth plane) and then entering an astral plane. Upon living a selfless life, the dead person is not afraid of death, but sees death as another experience where she/he can be selfless or not (Mullen et al., 1996).

The perspective of death that the bereaved takes may play a part in the adjustment of grief over time. In the Mu Ghayeb belief in traditional Omani society, a prolonged denial of death actually helps the bereaved. In Westernized

Muslim bereaved subjects, the denial of death resulted in clinical depression and other psychiatric disorders (Al-Adawi, Burjorjee, & Al-Issa, 1997).

Baby Boomers

As previously defined, Baby Boomers are those individuals who were born between 1946 and 1964 (BBHQ, 1999). An historical view of the events in the life of "Boomers" in the U.S. reveals a sordid tale of death that may effect death-related outlooks, attitudes, and characteristics of Baby Boomers. Several political leaders including John F. Kennedy and Bobby Kennedy were assassinated. Social change agents, Malcolm X and Martin Luther King, Jr. were also murdered during the 1960's. The death of pop icon Marilyn Monroe filled the news during the 60's. The Vietnam war raged out of control and there were nightly news casts that spilled death into American households. The American people saw three astronauts die on the launching pad as fire consumed a yet-to-be-launched space capsule (BBHQ, 1998). The impact of historical events on Baby Boomers is yet unknown, but must certainly play a part in the way that they view life, culture, and death.

Another critical component of Baby Boomer characteristics is that of consumerism and the desire for convenience (BBHQ, 1999). Media markets are filling the

convenience-driven niche by offering talk radio shows and features on news programs that satisfy the desire for convenient health information. The Wall Street Journal Interactive (1998) recently featured an article on "media doctors" who influence societal healthcare views. These media doctors are featured on national and local newscasts and on talk radio. The consumers (viewers and callers) of the media doctoring are hungry for convenient, consistent, caring medical attention. The era of managed care, where a visit to the doctor can often be characterized by "five-minute blurs" and restricted access to specialists, has many Boomers frustrated and turning to alternative sources for health information (A. Petersen, 1998). The media solutions often are concentrated on the caller presenting symptoms and the media doctor making a diagnosis over the phone with little attention to psychosocial aspects of health. A. Petersen's interview with Dr. Richard DeSilva focused on seeking healthcare, but fell short on end-of-life issues.

Adults and Grief

In relation to how Baby Boomers actually handle death, Bower (1997)indicates the need to ask adult children (40-65) whether (or why) they have accepted the death of a parent. In a study involving adult children, Bower asked questions regarding what accepting the death of the parent meant to

the bereaved adult child. Her qualitative study found that adult children felt compelled to talk about the death of their parent. Findings concluded that assertion of acceptance of the parents' death were contingent upon values and beliefs (relating to death), the power of feelings, and on the strength of memory regarding the parent.

S. Petersen and Rafuls (1998) used grounded theory to examine the process of adult grief after the loss of a parent. The interviewees (aged 22-55) were asked to report on generational transitions. Three phases were identified that emphasized the familial nature of the grief in adult children. One finding of the study was that the spouse of the bereaved played a pivotal role in grief recovery and bereavement.

As America ages, the numbers of individuals utilizing health services will increase. The need for acute care will decrease and the need for long term care will increase (Burton, 1982) by 1.5 times by the year 2040 (Russell, 1982). Burton (1982) further states that current medical models need to be revised to include a continuum of care that deals with aging populations and their needs. The medical model that takes the view of "body as machine" (Radley, 1995) may be unacceptable to Baby Boomers as they

progress through differing stages of (both) the experience of loss of loved ones and their own mortality.

Television, Film, and other Media

Television, films, and pop culture depict a variety of situations, dilemmas, and life events. Among the life events depicted in the media are death and dying. According to Winter (1999) movies and television are responsible for plunging the American population into a sort of virtual reality that immerses "our senses in 'experiences' that are not actually happening." Sprengle and Skeels(1998) agree with Winter, as they contend that when "people in your own family die, it is nothing like the movies. It is usually exhaustion, rather than drama that is felt." Movies teach Americans what birth, relationships, and death are "supposed" to look like. As human beings, everyday reality is much different than in the movies. One may only have one experience of a broken family relationship, one may only have one "true love," one may have very limited experience with death and dying (Winter, 1999).

Television is guilty of many of the same kind of depictions of death as film. In an article that appeared in USA Today (Brezing, 1998), readers were responding to the question of whether the lead character in the television program NYPD Blue (played by Jimmy Smits) should be "killed

off." Reader reactions were varied, and more than one said that the "hunk" should live ("He's too much of a hunk for anything bad to happen to him") (p. 2E). Other readers indicated that it would be "boring" to witness the grief of the T.V. widow ("Who wants five more episodes watching Russell [the widow of Smits] agonize and cry? We already had enough of that…")(p. 2E).

One example of a true reality in the arts is the play Angels in America Part I (Millennium Approaches). Angels in America "makes the ravages of AIDS seem appallingly real, according to Doll (1997). The play also provides the message that hope can come out of loneliness, fear, guilt, suffering, and denial, and that "though life is painful we must move forward" (Kennair, 1997). Although film and television have always dealt with and continue to deal with real life issues like death and dying, one's outlook on the topic may be formed by what is presented in these mediums.

History of Hospice Care

A historical look at the concept of hospice begins in the 11th century in the time of the Crusaders (Hockley, 1997). Until the 11th century, the dying were not admitted into places where healing could take place. The first real hospices were located in the Holy Land and were places where travelers could stop, and the sick and the dying could find

care. Hockley (1997) compared the evolution of the hospice movement to that of the early concepts of providing care to travelers on the move in that the movement did not remain static. Lack & Buckingham (1979) also used the metaphor of travel in describing the mission of hospice. The "road" is the course of terminal illness and the travelers are the patients and their families. The spiritual component of hospice was first recognized as "work" by the Pope in 1309 when the Hospitallers were recognized as a military order whose purpose it was to care for the sick and the dying.

By the 17th century, St. Vincent de Paul opened a number of houses for orphans, the poor, the sick, and the dying. Our Lady's Hospice was opened in Dublin in the 17th century. In 1902, the Irish Sisters of Charity opened a hospice in London (St. Joseph's Hospice) for the dying poor.

Hospice concepts of pain management and holistic treatment of the patient were eventually discovered at St. Joseph's by Dr. Cicely Sanders. The philosophy for keeping a patient comfortable and as pain-free as possible with the use of narcotics began with Dr. Sanders' work at St. Joseph's and was continued as she opened St. Christopher's Hospice in London in 1967. Dr. Sanders' interdisciplinary treatment (physical, emotional, spiritual, and

psychological) was further developed in her work at St. Christopher's (Connor, 1998).

Hospice made its way to America in the early 1970's in New Haven, Connecticut. Hospice, Inc. was started as an in-home care service. By the mid-70's facilities were opening throughout the United States. Conner (1998) states that the movement at that time was "a small but committed...movement" (p. 6). A variety of models (free standing, home care, hospital based, and mixed community) were being tested at that time (Cohen, 1979).

The National Hospice Organization (N.H.O.) was founded in the United States in 1978. The organization was responsible for publishing the first comprehensive list of hospices in the U.S. Americans had added their own flair for volunteerism and psychosocial aspects of care as the movement continued to take shape in this country. Medicare began paying for hospice care in 1982. The addition of hospice to the list of reimbursable services allowed the movement to flourish. By 1996, the list of hospices in the U.S. had grown from 1,200 to 2,900 (Connor, 1998).

Hospice Care Today

Hospice as a concept has standard characteristics and meanings. Lack & Buckingham (1979), Connor (1998), Hockley (1997), and Soltys, Brookins & Seney (1998) all outline

characteristics of the hospice experience. According to Lack & Buckingham (1979), who worked to open the first American hospice in Connecticut, "hospice is a health care program that offers the kind of continuing care that enables the (dying) patient and family to live out their lives together as fully and comfortably as possible" (p. 3). Further, Lack and Buckingham point out that the hospice program aims to satisfy a variety of needs of the patient and their family. These needs consist of psychological, physiological, spiritual, and social needs. Soltys, Brookings & Seney (1998) define and describe hospice as "a coordinated program that addresses the physical, emotional, social, and spiritual needs of the terminally ill individual and their families." Soltys (et al.) continues by outlining a humane return to a family oriented philosophy aimed at improving the quality of life for all involved.

A list of universally developed (necessary) characteristics (Connor, 1998) of a hospice program is readily available when one looks into the literature regarding hospice. These characteristics are: (a) both the patient and the family are the unit of care, (b) care is provided at different venues (in-home or in-patient facilities), (c) management of symptoms is the focus of treatment, (d) the hospice approach is a holistic approach

(treating the whole person), (e) services are available 24 hours a day, 7 days a week, (f) the hospice approach is an interdisciplinary approach, (g) each hospice experience is directed by a physician, (h) volunteers play an integral part of the experience, (i) no one is denied services based on ability-to-pay, and (j) need-based bereavement services are provided to families (Connor, 1998).

Hospice is a concept of care within a program, not usually a place (Soltys, et al., 1998). Travelers (both patients and families) on the end-of-life journey can find comfort, care, and support to ease that journey.

Grief

Grief has been extensively studied and researched, particularly in relation to the stages of grief. Seminal works on the stages of grief were completed by Lindemann (1944), Bowlby (1974), and Parkes (1975). All of these researchers found that grief does, indeed, develop in stages.

Lindemann was the first to conduct a systematic study of grief. In his 1944 work, Lindeman concluded that uncomplicated grief was marked by a "predictable course with identifiable symptoms" (Burnett, et al. 1994, p. 123). The symptoms marking the stages of grief are: somatic distress, preoccupation with the image of the deceased,

guilt, hostility, loss of usual patterns of conduct, and (in some) imitation of behaviors that were purveyed by the deceased (Burnett, et al., 1994).

Bowlby (1974) found that there were four identifiable stages of grief: numbness, yearning, disorganization and despair, and reorganization. Parkes' identified stages were substantially more complex by name, but have similar undertones with Bowlby's findings. Parkes identified the stages of grief as: shock, surprise, numbness, denial, suppression of affect, crying (and other emotional outbursts) anxiety, guilt, and depression. S. Petersen & Rafuls indicate that the relationships studied in both cases (Bowlby and Parkes) could possibly have influenced the findings. Both Bowlby and Parkes studied "intense, dependent relationships" that occurred as they studied spouses and parents with young children.

Kubler-Ross and Worden (1978) found that there were "tasks" that were necessary to resolve grief (rather than a "stages" approach taken by Bowlby and Parkes). They found that the tasks of grief resolution include accepting the reality of the death, allowing the experience of the pain of the loss, adjusting to changes, and making a determination of the emotional perspective of the deceased individual.

S. Petersen and Rafuls (1998) conducted a study of adults receiving familial authority (after the death of a parent). Their study concludes by saying that, rather than experiencing the death as an "anticipated tumult and anguish" (p. 521) (as presented by seminal works in the field), families experience "an orderly, deeply meaningful passage from one generation to another" (p. 521).

Huber and Gibson (1990) indicate that grieving prior to the death of a loved one, referred to as anticipatory grief, can increase the speed at which the bereaved recover from loss. The notion of anticipatory grief has been given mixed reviews in the literature. Lindemann(1944), Blank (1969), Goldberg (1973), and Morris & Murrell (1987) (as cited in Huber & Gibson, 1990) all agree that there is some preparation for loss that allows for pre-death grieving. On the other hand, Kutscher (1969), Parkes & Weiss (1983), and Silverman (1974) (as cited in Huber & Gibson, 1990) tend to disagree with the former authors. Kutscher, Parkes, Weiss, and Silverman contend that preparing for death does not equate to grief work and that some disloyalty was felt by family members who were planning for their "spouses' demise."

In their study of anticipatory grief, Huber & Gibson (1990) found that hospice care enhanced the bereaved family

members' ability to do "anticipatory griefwork." The study revealed that family members felt the hospice care received on a routine basis actually acted as a bereavement intervention and that it had a "strong, positive impact on survivors' bereavement" (p.65).

Anticipatory grief can be an opportunity for patients to receive interventions to assist them in dealing with a terminal diagnosis. Counselors and other healthcare providers can work with ill individuals to give the patient a chance to focus on immediate psychosocial and physical needs. These needs may range from pain management to who will care for a pet that is in the home. "Resolution of the individual's issues invariably bring feelings of accomplishment and relief and the ability to continue living with a huge decrease in anxiety" (O'Donnell, 1996, p.134). According to O'Donnell (1996), anticipatory grief manifests the expectation of loss before it actually occurs.

Anticipatory grief in individuals with HIV/AIDS may begin at diagnosis. There may be loss issues surrounding fear of the loss of a job, health status, family, healthcare, or monetary issues. The ill person is not the only person affected by anticipatory grief; the family and friends of the ill individual may also experience feelings of grief and loss. Anticipatory grief may come in different

stages; first at initial diagnosis, then later as an asymptomatic individual becomes symptomatic (O'Donnell, 1996).

Stroebe and Stroebe (1993) state that individual feelings of internal control will predict the degree to which he or she will become depressed following the death. Further, Stroebe and Stroebe indicate that "expectedness" of having at least one day's notice of the death did not have any lasting effects on adjustment to death four to seven months after the death. This finding differs in young versus elderly widows. In her study of the correlation between age, psychosocial maturity and death anxiety, Rasmussen (1996) indicated that age alone cannot account for the decrease in death anxiety in the elderly; rather, that psychosocial maturity plays a large role. Stroebe and Stroebe close by saying that elderly widows were found to have a built-in expectation regarding death and, therefore; "expectedness" did not play a role in adjustment.

Sudden loss (death without warning) presents special problems for survivors. Doka (1996) indicates that there are three particular problems that the bereaved must face when dealing with sudden loss. The three problems are intensified grief (because there is little or no opportunity to say 'good-bye'), the shattering of the person's normal

world (things like driving a car may become a perilous trip in a 'death machine'), and the experience of secondary losses (the bereaved may lose income or even material possessions).

Doka lists six factors affecting the nature of the sudden loss:

1. Natural-human made. Was the death due to natural versus human causes?

2. The degree of intentionality. Was the victim murdered, or was there a random act of violence?

3. The degree of preventability. The "what if's" normally crop up as the bereaved examine this questions like "What if we had not stopped at that convenience store?"

4. Suffering. Did the deceased suffer or was death instantaneous?

5. Scope. How many others suffered the same fate (were there others killed at the same time in the same way?)

6. The degree of expectedness. Some chronic illness (i.e. cardiovascular disease) carries with it the expectation that one might eventually die. Other types of sudden death have no basis for expectation, and have no forewarning at all.

Wortman, Silver, and Kessler (1993) found contrary evidence to much of the literature regarding sudden death

and it's impact on the bereaved. In a study that combined the bereaved parents of SIDS babies, persons who were paralyzed by traumatic accidents, and bereaved spouses and children of motor vehicle accident victims, Wortman et al. expressed that there were a substantial percentage of bereaved individuals who did not show evidence of intense grief reactions following sudden loss. Further they concluded that the participants in their study did not strive to find meaning in what had happened. Previous studies had shown that the opposite was true of survivors of sudden loss; the survivors DID seek to find meaning in the situation to make sense of the loss. Wortman et al. did indicate that if one were to find meaning in sudden loss, one would set about doing so shortly after the loss occurred. Finally, the study revealed that the relationship of the bereaved person to the deceased had an impact on the adjustment to the loss. The study suggests that it may "take far longer than we have previously expected for people to recover from the loss of a spouse or child" (p.361).

The review of the literature shows that there are many differing opinions regarding grief reactions, although there may be (according to the literature) stages or commonalties in those who have experienced the loss of a loved one.

CHAPTER III

DESIGN AND METHODOLOGY

The purpose of this study was to determine the effect of hospice on grief of bereaved individuals. This chapter describes the sample population and sampling procedure, how subjects were protected, procedures for the study, instrumentation, and treatment of data; including a description of the statistical method used.

Population and Sample Selection

The population used for this study was a sample of males and females aged 34-52. As discussed in Chapter I, participants in the age group utilized for the purpose of this study were considered Baby Boomers. The convenience sample was drawn from the members and visitors at Metropolitan Community Churches (MCCs) in Dallas/Fort Worth Texas, and Columbia, South Carolina. The members and visitors at Metropolitan Community Churches were largely gay and lesbian individuals. A power analysis (Ginch, Hinson, & Butcher, 1994) was performed to determine the appropriate number of subjects needed for the study. Based on the number of variables being examined in the study, it was determined that the sample size should be 128. There were actually 157 participants in the study.

Protection of Human Subjects

The study was presented to the Human Subjects Review Committee at Texas Woman's University. In the application for permission, it was outlined that the subjects would be given a cover sheet with each survey. The cover sheet (Appendix B) explained the purpose of the study to participants. Participants were assured that the study was completely voluntary, that the survey was anonymous and that the researcher would make the results of the study available to the members and guests of the churches. The phrase "I understand that the return of my completed questionnaire constitutes my informed consent to act as a subject in this research" was added to the top of the survey to further protect and inform participants.

Procedures

The study progressed in an appropriate and logical sequence of events that was straightforward and simple. The steps involved gaining permission from the churches to collect data, and administering the survey at the churches.

Step One: Gaining Permission from Cathedral of Hope, MCC

After work on the prospectus, a member of the clergy at Cathedral of Hope, MCC, was contacted regarding administration of the survey at the church. The clergy member requested more information regarding the study design

and protection of human subjects. Once further information had been supplied to the contact at the church, permission was granted to conduct a data collection session on a specific Sunday morning.

Step Two: Administration of the Survey at Cathedral of Hope, MCC

Data collection was planned for a Sunday morning in January 1999. The researcher had sent information to the church prior to the data collection date so that an announcement would appear in the church bulletin regarding the administration of the survey. The researcher also asked that the senior pastor make an announcement from the pulpit regarding the survey. Both the printed and spoken announcement were utilized to recruit subjects on the designated date pre-set by the church staff. Part of the human subjects protection protocol involved giving the participants alternative ways to participate in the study without identifying themselves in public. To facilitate this, the announcement that appeared in the church bulletin included an option for the participant to pick up a card containing the name and telephone number of the researcher so that the researcher could confidentially mail a survey to the participant.

Data were collected immediately following a Sunday morning worship service. The researcher selected a corner of the fellowship hall in which to set up two stations so that participants could fill out the survey. A copy of the cover sheet was attached to each survey. Pens and pencils were made available to participants. Participants were asked to note that there were two sides to the survey, and were also asked to put their completed surveys in large envelopes that were labeled "Completed Surveys." The researcher was close at hand to answer any questions that arose while participants were filling out the survey. All protection of human subjects guidelines were strictly followed. Eighty-three surveys were collected at this site.

Step Three: Additional requests for permission to collect data at other MCCs

The researcher followed the initial data collection with phone calls to MCCs in Fort Worth, Arlington, and Denton Texas, and in Columbia, South Carolina. The researcher had access to the congregation in Columbia, South Carolina through a personal relationship with the pastor at that location. Cathedral of Hope, MCC was also contacted for another data collection session to take place after a Wednesday evening service. Permission was requested and received via telephone from each of the churches. A date

was set with each pastor for data collection at the various locations.

The same protocol was used at for all four churches. Because three of the churches are located in the Dallas/Fort Worth area, the researcher was present during data collection. A total of fifty-seven surveys were collected from other MCCs in the Dallas/Fort Worth metroplex area. The researcher sent approximately 30 surveys to the clergy member at the Columbia, South Carolina MCC. The clergy member was asked to follow all protocols for the study including subject selection criteria and human subject protection protocol. A self-addressed stamped envelope was included in the packet of surveys so that the clergy member could return the completed surveys to the researcher. Seventeen surveys were collected at this site.

Instrumentation

The Texas Revised Inventory of Grief (T.R.I.G., Appendix C) measures grief as a present emotion (longing) and as an adjustment to a past life event with several stages (stages of grief)(Faschingbauer, 1981). Both medical and personal experiences can be measured with this instrument. The author of the instrument indicates that the instrument can be administered "with a minimum of intrusion into the bereaved person's already disrupted life"

(Faschingbauer, p. 1). The TRIG is a two-part Likert scale that measures grief following bereavement.

The instrument, developed in 1978, has two parts. Part I measures Past Behaviors of the bereaved. Part I has an internal consistency of +.67, with an alpha coefficient of +.77. The split half reliability for Part I is +.74. Part II measures grief as Present Feelings. Part II has an internal consistency of +.69. The alpha coefficient is +.86, and the split half reliability is +.88.

Total possible scores on the Past Behavior scale ranged from 8-40. Total possible scores on the Present Feelings scale ranged from 13-65. For each scale, the higher an individual's score, the higher the grief level for that individual.

In a comparison of scales assessing grief among the elderly, Gabriel & Kirschling (1989) site the TRIG as the best (out of 9 scales) on the basis of validity. On measures of reliability, Gabriel and Kirschling gave the TRIG one of the highest ratings as well.

The survey includes a set of demographic questions that includes a request for the participant's name and/or social security number. Because the survey was to be anonymous, the researcher sought permission from the author to replace this lead question on the survey with the question "Did your

loved one die under the care of hospice?". Permission was gained from the author of the instrument to change the demographic information in any way that was appropriate to fit with the study design. Permission was also requested (and gained) to add "Partner/Significant Other" to the section that asks respondents to give their relation to the deceased. "Cause of Death" was also be added to the instrument and was categorized and coded for the purpose of data entry.

Treatment of Data

The statistical techniques used encompassed a series of One-Way and Two-Way Analyses of Variance. One-Way ANOVA tests were performed on each of the following independent variables: a) Age of the deceased, b) age of the respondent, c) cause of death, d) time since the death occurred, and e) hospice use. Two-Way ANOVAS were also performed on the independent variables of age of deceased, age of respondent, and time since death occurred with hospice use being held constant. The dependent variables for all analyses were the participants' TRIG scores (past behavior and present feelings).

CHAPTER IV

FINDINGS

In this chapter, the researcher presents descriptive characteristics of the study participants, descriptive analyses of the data regarding the independent variables of age of the deceased, age of the respondent, cause of death, time since death occurred, and hospice use. An analysis of the five ANOVA tests that were run follow.

Descriptive Characteristics of the Sample

The sample (n=157) consisted of both female (n=80) and male (n=77) respondents. The race of participants was mostly white (n=144) although there were a small number of other races represented. One participant listed his race as African American, one listed Asian, four of the participants listed themselves as Latino, and there were two who listed themselves as American Indian. Five individuals did not list a specific race on their survey.

Most of the individuals in the sample were Protestant (n=117), while there were twenty who considered themselves to be Catholic. One person specifically listed Latter Day Saints for their religious affiliation. Four persons self-identified as non-denominational, and fifteen participants did not list a response for the religion demographic question.

Other demographics included the age range of participants and the time since the death of their loved one. Because current age was a qualifier for participation in the study, ages or respondents were limited to the range of 34-55 years of age. The time since the death of a loved one ranged from one month to more than twenty years.

The number of participants whose loved one died under the care of hospice was thirty-nine. The number of participants who did not use hospice was 118.

Tests of the Hypotheses

Grief scores were recorded and analyzed as two separate scores; past behavior and present feelings. The possible range of scores for Past Behavior was 8-40. The possible range of scores for Present Feelings was 13-65.

H1: There will be no significant difference in grief scores of respondents based on their age.

Ages of respondents in the study were grouped in six year increments. As previously stated, the researcher made the decision to include individuals up to age 55 in the sample. Table 1 shows descriptive statistics for each grief score by age of respondent.

Table 1

Descriptive Statistics for Age of Respondent

Classification	n	M	SD
Past Behavior			
Hospice Users			
34-40	17	21.77	6.69
41-47	15	22.93	6.17
48-55	7	19.57	7.37
Hospice Non-Users			
34-40	55	23.40	7.01
41-47	43	21.23	7.97
48-55	20	21.90	7.20
Present Feelings			
Hospice Users			
34-40	17	41.29	8.18
41-47	15	39.87	9.05
48-55	7	38.71	12.54
Hospice Non-Users			
34-40	55	39.67	10.16
41-47	43	38.02	9.21
48-55	20	35.55	11.87

Note. The higher the grief score, the higher the grief level for an individual.

Tables 2 and 3 reveal that there was no significant difference found for this hypothesis. This would indicate that age of the respondent does not make a difference in either grief score.

Table 2

ANOVA Summary Table for Age of Respondent-Past Behavior

Source of Variance	df	SS	MS	F	p
Between	2	85.81	42.90	.8198	.44
Within	154	8,059.39	52.33		
Total	156				

Table 3

ANOVA Summary Table for Age of Respondent-Present Feelings

Source of Variance	df	SS	MS	F	p
Between	2	277.76	138.88	1.42	.25
Within	154	15,094.57	98.02		
Total	156				

H2: There will be no significant difference in grief scores of respondents based on age of the deceased.

Grief scores categorized by age of the deceased are represented in Table 4. Since there was only one hospice user in the 1-35 year old category, there was no standard deviation reported for either grief score.

After testing the second hypothesis via one-way ANOVA, it was found there was no significant difference for this variable (Tables 5 and 6). The second hypothesis was not rejected; indicating that age of the deceased did not make a significant difference in either grief score for individuals in the study.

Table 4

Descriptive Statistics for Age of Deceased

Classification	n	M	SD
Past Behavior			
Hospice Users			
1-35	1	19.00	0.00
36-71	23	23.22	6.82
≥ 72	15	19.87	6.40
Hospice Non-Users			
1-35	21	22.81	7.60
36-71	58	23.33	7.59
≥ 72	39	20.82	6.98
Present Feelings			
Hospice Users			
1-35	1	43.00	0.00
36-71	23	39.70	8.43
≥ 72	15	41.00	10.73
Hospice Non-Users			
1-35	21	41.10	11.12
36-71	58	23.33	10.17
≥ 72	39	20.82	8.76

Note. The higher the grief score, the higher the grief level for an individual.

Table 5

ANOVA Summary Table for Age of Deceased-Past Behavior

Source of Variance	df	SS	MS	F	p
Between	2	234.77	117.39	2.26	.11
Within	154	7,910.42	51.37		
Total	156				

Table 6

ANOVA Summary Table for Age of Deceased-Present Feelings

Source of Variance	df	SS	MS	F	p
Between	2	487.56	243.78	2.52	.08
Within	154	14,488.77	96.65		
Total	156				

H3: There will be no significant difference in grief scores of respondents based on length of time since death has occurred.

The descriptive statistics for grief scores based on time since death occurred are represented in Table 7. Time since death categories were coded according to the way the instrument read. This method was decided upon by the researcher to ease coding.

The ANOVA for this independent variable did show a significant difference (Tables 8 and 9). A Scheffé post hoc test was run to discover where the differences resided in the one-way ANOVA (Table 10). The decision was made to reject this hypothesis. There is an inference that time since death makes a difference in the Present Feelings grief level of certain bereaved individuals.

Table 7

Descriptive Statistics for Time Since Death Occurred

Classification	n	M	SD
Past Behavior			
Hospice Users			
1-9 months	9	22.22	6.22
10-60 months	23	21.61	7.33
>60 months	7	22.00	5.97
Hospice Non-Users			
1-9 months	21	20.33	8.64
10-60 months	57	22.81	7.08
>60 months	40	22.78	7.21
Present Feelings			
Hospice Users			
1-9 months	9	44.33	10.30
10-60 months	23	39.04	8.89
>60 months	7	39.14	8.38
Hospice Non-Users			
1-9 months	21	39.57	11.08
10-60 months	57	22.81	10.10
>60 months	40	22.78	9.17

Note. The higher the grief score, the higher the grief level for an individual.

Table 8

ANOVA Summary Table for Time Since Death-Past Behavior

Source of Variance	df	SS	MS	F	p
Between	2	66.06	33.02	.6296	.53
Within	154	8,079.14	52.46		
Total	156				

Table 9

ANOVA Summary Table for Time Since Death-Present Feelings

Source of Variance	df	SS	MS	F	p
Between	2	665.71	332.85	3.49	.03*
Within	154	14,706.63	95.50		
Total	156				

*p <.05.

Table 10

Scheffe Post Hoc Test for Unequal Sample Sizes- Present Feelings by Time

Means Compared	Means Difference	Significant?
1-9 mo. Vs. 10-60 mo.	1.15	Yes
1-9 mo. Vs. >60 mo.	5.23	Yes
10-60 mo. Vs. >60 mo.	4.08	Yes

H4: There will be no significant difference in grief scores of respondents based on cause of death.

The descriptive statistics for causes of death appear in Table 11. The blanks in the table represent data that is missing. The missing values are due to the fact that those whose death was categorized as "Accident" or "Other" were not able to plan for the death; therefore, hospice care was not available to them.

Table 11

Descriptive Statistics for Cause of Death

Classification	n	M	SD
Past Behavior			
Hospice Users			
Illness	39	21.82	6.70
Accident			
Other			
Hospice Non-Users			
Illness	98	21.93	7.45
Accident	13	22.23	6.78
Other	7	28.57	7.23
Present Feelings			
Hospice Users			
Hospice Users			
Illness	39	40.28	9.17
Accident			
Other			
Hospice Non-Users			
Illness	98	37.65	9.57
Accident	13	40.08	12.37
Other	7	45.29	12.46

Note. The higher the grief score, the higher the grief level for an individual.

The one-way ANOVA (Tables 12 and 13) did not reveal a significant difference based on cause of death. This hypothesis was not rejected. Because there was no significant difference found in either grief score of individuals based on cause of death, one can infer that cause of death does not play a role in the grief of bereaved individuals.

Table 12

ANOVA Summary Table for Cause of Death-Past Behavior

Source of Variance	df	SS	MS	F	p
Between	2	296.60	148.30	2.91	.06
Within	154	7,848.59	50.96		
Total	156				

Table 13

ANOVA Summary Table for Cause of Death-Present Feelings

Source of Variance	df	SS	MS	F	p
Between	2	237.06	168.53	1.73	.18
Within	154	15,035.27	97.63		
Total	156				

H5: There will be no significant difference of grief scores of respondents based on hospice use.

Descriptive statistics for the grief scores of hospice users versus non-hospice users are represented in Table 14. The researcher ran a one-way ANOVA test on hospice use to see if hospice use made a difference in either grief score of individuals in the study. Tables 15 and 16 show that there is no significant difference for the either score of individuals based on hospice participation.

Table 14

Descriptive Statistics for Hospice Users and Hospice Non-Users

Classification	n	M	SD
Past Behavior			
Hospice Users	39	21.82	6.70
Hospice Non-Users	118	22.36	7.23
Present Feelings			
Hospice Users	39	40.28	9.17
Hospice Non-Users	118	38.37	10.16

Note. The higher the grief score, the higher the grief level for an individual.

Table 15

ANOVA Summary Table for Hospice-Past Behavior

Source of Variance	df	SS	MS	F	p
Between	1	8.40	8.40	.1691	.69
Within	155	8,136.79	52.50		
Total	156				

Table 16

ANOVA Summary Table for Hospice-Present Feelings

Source of Variance	df	SS	MS	F	p
Between	1	106.84	106.84	1.08	.30
Within	155	15,265.49	98.49		
Total	156				

As a precautionary measure the researcher manipulated the data set to make certain that the number of hospice non-users (n=118) was not creating bias in this independent variable. The researcher randomly selected 79 hospice non-user cases to remove from the data set and then re-ran the one-way ANOVA test using equal sample sizes. Table 17 shows

descriptive statistics for hospice users (n=39) and hospice non-users (n=39). Tables 18 and 19 reveal that even after the samples sizes were equal, there was still no significant difference in either grief score based on hospice use.

Table 17

Descriptive Statistics for Hospice Users and Hospice Non-Users - Equal Sample Sizes

Classification	n	M	SD
Past Behavior			
Hospice Users	39	21.82	6.70
Hospice Non-Users	39	22.64	7.31
Present Feelings			
Hospice Users	39	40.28	9.17
Hospice Non-Users	39	38.23	11.03

Table 18

ANOVA Summary Table for Hospice Use- Equal Sample Sizes- Past Behavior

Source of Variance	df	SS	MS	F	p
Between	1	13.13	13.13	.2669	.61
Within	76	3,738.72	49.19		
Total	77				

Table 19

ANOVA Summary Table for Hospice Use- Equal Sample Sizes- Present Feelings

Source of Variance	df	SS	MS	F	p
Between	1	21.55	21.55	.2095	.65
Within	76	7,838.37	102.85		
Total	77				

H6: There will be no significant interaction between age of respondent, age of deceased, length of time since death, cause of death or hospice use.

Based on 2-Way ANOVA tests that were performed, there were no interactions between any of the variables. This hypothesis was not rejected.

CHAPTER V

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

As America ages, so should America prepare to die. The numbers of potential hospice users in this country will increase in the coming years. Baby Boomers will begin to experience the death of their parents and siblings in the coming years. Baby Boomers' grief responses could set the stage for a healthy cohort who continues to contribute to society or an unhealthy cohort who is burdensome to the healthcare systems of the next millennium.

Discussion

The literature bears out the fact that, in many cases, hospice use makes a difference in the grief level of the bereaved. Studies were presented that documented the use of hospice as a tool in preparing for the death of a loved one. The variables used in this study were selected to discover if hospice did make a difference in the population selected. The relationship of each to measures of grief are addressed here.

Of concern was the issue of geographic differences and their impact on the grief scores of respondents in the study. A separate ANOVA was run to ensure that neither

score was impacted by location of the respondent. It was found that there was no significant difference in either grief score for individuals in the study based on geographic location.

Age of the Deceased

It was discovered that the age of the deceased made no significant difference in the grief score of the bereaved individuals in the study. There have been several studies represented in the literature that relate to the age of the deceased. Much of the work has been on the elderly widowed (Wegmann, 1987) and on children. Some of the seminal works in grief (Bowlby, 1974 and Parkes, 1975) were implemented with parents who had experienced the loss of children.

Wegmann (1987) and Stroebe and Stroebe (1993) both found that the elderly study participants adjusted to grief more quickly and saw the death of their elderly spouse as a part of the end of life cycle. Bowlby (1974) and Parkes (1975) found that their grief reactions were strong and complicated when the deceased was a child. The deceased in this study ranged in age from infant to 100+ years of age. The wide range of ages of deceased loved ones in this study could have affected the findings.

Age of the Respondent

It was suggested by grief expert, Judith Stillion, Ph.D. (personal communication, March 14, 1999) that the years of the cohort be limited to those born 1960-1952. Dr. Stillion felt that to be a "true" cohort, those born 1961-1964 should be excluded. A cohort group is defined by the length of the generation and by it's peer personality (Strauss & Howe, 1991).

In this study, the age of the respondent made no significant difference in the grief scores of the participants. Rasmussen (1996) indicated that psychosocial maturity rather than age alone accounts for the decrease in death anxiety in the elderly respondents in her study.

Bower (1997) did research on a group similar in age to the participants in this study. She found evidence that accepting a parent's death was contingent upon values and beliefs relating to death. The depth or power of feelings, and the strength of memory regarding the parent were also found to affect acceptance of the death. Acceptance of the death could lead to a lower level of grief in these individuals. Her findings regarding values and beliefs about death support the findings of this study. The population in this study may have fewer grief related issues based on the fact that they were all church-goers. Although

the results in this study are inconclusive, evidence of reasons for the differences might include religion and it's role in supporting Mullen et al. (1996). As previously cited, the religious perspective is the belief in a higher being (God) and that there is life everlasting through a savior (Jesus Christ). The value or belief about death, and the resolution of grief for baby boomers in this study may be based on religion and the philosophy of death and dying.

Cause of Death

Because of the amount of data and the different levels of cause of death in the respondents, cause of death was coded as "illness", "accident", and "other." Illnesses listed by respondents were: cancers of all kinds, heart disease, kidney disease, diabetes, cardiovascular accident (stroke), AIDS, and old age/natural. Accidents listed by respondents were: car accident, lightening strike, murder, and falls. Other causes of death (as coded by the researcher) were: suicide, carbon monoxide poisoning, drug interaction, doctor's mistake, and starvation. The cause of death was not found to be significant in the scores of the respondents.

A more thorough look at cause of death where type of illness acts as the independent variable will be of interest. The researcher will attempt to discover if type

of illness (i.e. cancer, AIDS, cardiovascular disease, cerebrovascular disease) has an impact on either grief score of the individuals in this particular population.

There could be potential bias created in the study due to the numbers of deaths from illness (n=137) versus deaths from accident (n=13) or other causes (n=7). The researcher attempted to discover whether or not the expectedness of the death and the speed at which the death occurred made a difference in the grief scores, however; problems with responses on the instrument precluded testing this hypothesis.

Wortman, Silver, & Kessler (1993) had similar findings in their three tier study of bereaved who experienced sudden loss. There was no significant grief reaction in those whose loved ones died suddenly versus those who did not. Stroebe and Stroebe (1993) indicated that "expectedness" did not play a role in adjustment. Doka (1996) finds to the contrary and insists that there is a significantly more intense grief reaction that accompanies sudden loss.

Time Since Death Occurred

There was no significant difference detected for time since death upon past behavior. However, a significant difference was found for time since death upon present feelings. The longer the time since death, the lower the

grief score on present feelings was. Specific differences were found to reside in individuals whose loved one had died less than nine months previous to completing the survey. There was a significantly higher grief score reported by this group as compared to those whose loved one had died more than five years ago. There was also a significant difference in the grief score between those whose loved one had died nine to sixty months previous to the survey when compared to those in the sixty months or more group. This difference was reflected as the way the bereaved presently feel versus the past behavior of the bereaved. This finding is supported by the literature.

Silverman, Nickman, & Worden (1993) found that time since death does make a difference in the adjustment of the bereaved. The authors write that an emphasis, over time, should be placed on renegotiating the relationship with the deceased rather than letting go of the memories of the deceased. Silverman (as cited in Connor, 1998) states that grief is a lifelong process and that one never really "finishes" grieving.

Hospice Use

It was found that, for this sample, hospice use did not make a significant difference in the grief scores of bereaved individuals. This finding differs from those found

by Smith (1984) who detected that bereaved individuals utilizing hospice were better adjusted than those whose loved one died in a hospital. A possible explanation for this difference may be related to differing research techniques. Smith utilized qualitative research in her study.

There may be other explanations for the disparity in findings related to instrumentation. According to Robert Neimeyer, Ph.D. (personal communication, March 13, 1999), problems with the general nature of the Texas Revised Inventory of Grief may have caused the results of this study to be contrary to findings represented in the literature. Neimeyer stated that there are more appropriate, specific instruments to use in measuring grief in bereaved individuals. Specifically, Dr. Neimeyer mentioned Raphael's Core Bereavement Inventory and Prigerson's Traumatic Grief Inventory. More research is needed to further investigate differences based on research technique and instrumentation.

Conclusions

All alpha levels for the tests of significance were set at the .05 level. For both the one-way and two-way analyses of variance, the following hypotheses were not rejected:

H1: There will be no significant difference in grief scores of respondents based on their age.

H2: There will be no significant difference in grief scores of respondents based on age of the deceased.

H3: There will be no significant difference in grief scores of respondents based on length of time since death has occurred.

H4: There will be no significant difference in grief scores of respondents based on cause of death.

H5: There will be no significant difference of grief scores of respondents based on hospice use.

H6: There will be no significant interaction between age of respondent, age of deceased, length of time since death, cause of death, or hospice use.

The third hypothesis in the study, H3: There will be no significant difference in grief scores of respondents based on length of time since death has occurred, was rejected based on the one-way ANOVA test. A Scheffé Post-Hoc test (for unequal sized groups) was performed to discover where the significant differences lay.

Recommendations

Future Research

Future research should focus on finding specific instrumentation related to specific types of grief. The focus could either be on uncomplicated grief or on complicated grief. Uncomplicated grief would be considered

as grief without extraordinary circumstances. Complicated grief is experienced by those who have multiple psychosocial issues to deal with simultaneously. With either instrument, the specific focus could support the literature that states that hospice use makes a difference in the grief of bereaved, for, perhaps, particular types of grief.

Other needed research areas might include discovering differences in grief scores as influenced by the type of relationship to the deceased as an independent variable. The researcher did not delimit the study based on relationship to the deceased, and there were a variety of relationships listed in the demographic section of the instrument utilized. Even more poignant may be the "closeness" of the relationship to the deceased.

As previously mentioned, examining type of illness and its relationship to grief may be a key in discovering the variable that may affect grief scores in this population.

Further exploration of the delimitation of year of birth will be of interest to the researcher. The cultural experiences for 34 year olds may be so different from that of 52 year olds in the study that this, may have effected the findings of the study.

Implications for Health Educators

To circumvent the media blitz on the sense of "beauty" surrounding the topic of death, health educators must be willing to talk openly about death and dying issues. This talk may occur in community organizations, college and public school classrooms, and in healthcare institutions. Health education curricula should include a section on death and dying. Curriculum issues should include choices in caring for the dying, advanced directives, grief and preparation for grief, concepts of normal grief, and complicated grief. There are cultural implications that are in place with death and dying. It is the responsibility of the health educator to be aware of cultural practices and beliefs of individuals of different cultures.

As previously stated, the health educator has the important job of opening dialogue regarding issues about death, dying, and bereavement. It will be an important point to remember that there are ways to deal with the death of a loved one in a proactive way; which may include the holistic approach presented by hospice care for the dying.

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Appendices

Appendix A

Permission Letter from TWU Human Subjects Review Committee

TEXAS WOMAN'S
UNIVERSITY
DENTON / DALLAS / HOUSTON

HUMAN SUBJECTS
REVIEW COMMITTEE
P.O. Box 425619
Denton, TX 76204-5619
Phone: 940/898-3377
Fax: 940/898-3416

January 4, 1999

Ms. Ann Rathbun
P.O. Box 425742
Denton, TX 76204

Dear Ms. Rathbun:

Your study entitled "Baby Boomers and Hospice Use: A Quantitative Look" has been reviewed by a committee of the Human Subjects Review Committee and appears to meet our requirements in regard to protection of individuals' rights.

Be reminded that both the University and the Department of Health and Human Services (HHS) regulations typically require that agency approval letters and signatures indicating informed consent be obtained from all human subjects in your study. **These consent forms and agency approval letters are to be filed with the Human Subjects Review Committee at the completion of the study. However, because you do not utilize a signed consent form for your study, the filing of signatures of subjects with the Human Subjects Review Committee is not required.**

Your study was determined to be exempt from further TWU HSRC review. However, another review by the Committee is required if your project changes. If you have any questions, please feel free to call the Human Subjects Review Committee at the phone number listed above.

Sincerely,

Jerry D. Wilkinson

Chair
Human Subjects Review Committee

cc. Graduate School
Dr. Eva Doyle, Department of Health Studies
Dr. Susan Ward, Department of Health Studies

Appendix B

Cover Letter to Study Participants

Thank you for volunteering to participate in this research study. The study is designed to better understand the grief process. Specifically, the study will be looking at how use of hospice may/may not assist in processing grief more effectively.

The purpose of this study is to determine if hospice influences the level of grief in Baby Boomers. You will be asked to respond to the 26-item Texas Revised Inventory of Grief (Faschingbauer, 1979) for measuring grief. You will also fill out some demographic information to help further understand other possible influences on the level of grief.

It is important that you feel comfortable in completing the survey. If at ANY time, you become uncomfortable or ill at ease, please stop and turn in your incomplete survey.

If you have experienced multiple losses (i.e. more than one loved one has died), please answer the survey in relation to your most recent experience.

In case you wish to contact the researcher please feel free to call: Ann Rathbun (940-898-2862) or Dr. Eva Doyle (940-898-2860) at Texas Woman's University.

Please note that your participation in this study is completely voluntary and that your answers are completely confidential (all surveys will remain confidential). Please do not put your name on the survey.

Thank you again for your participation in this important study,
Ann Rathbun
COH Member

Appendix C

Texas Revised Inventory of Grief

I understand that the return of my completed questionnaire constitutes my informed consent to act as a subject in this research.

TEXAS REVISED INVENTORY OF GRIEF

Did your loved one die under the care of hospice? ☐ YES ☐ NO Your Age: ___ Sex: ___ Race: ☐ White ☐ African Am. ☐ Latinino ☐ Asian Am. ☐ Other (list)

Circle Last Year of Formal Schooling Completed: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 or More

Religion: ☐ Protestant ☐ Catholic ☐ Jewish ☐ Muslem ☐ Hindu ☐ Budhist ☐ Other (list)

The person who died was my (check one only): ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Husband ☐ Wife ☐ Son

☐ Daughter ☐ Friend ☐ Grandparent ☐ Uncle ☐ Aunt ☐ Partner/Significant Other ☐ Other (list)

Looking back, I would guess that my relationship with this person was (check one only):

☐ Closer than any relationship I've had before or since. ☐ Closer than most relationships I've had with other people.

☐ About as close as most relationships with others. ☐ Not as close as most relationships. ☐ Not very close at all.

PLEASE COMPLETE A SEPARATE FORM FOR EACH PERSON WHO HAS DIED.

How old was this person when they died? _____ What was the cause of the person's death? _____

This person died (check only one box):

☐ Within the past 3 months ☐ 9-12 months ago ☐ 5-10 years ago

☐ 3-6 months ago ☐ 1-2 years ago ☐ 10-20 years ago

☐ 6-9 months ago ☐ 2-5 years ago ☐ More than 20 years ago

This person's death was (check all that apply): ☐ Expected ☐ Unexpected ☐ Slow ☐ Sudden

Put Score In Box

PART I: PAST BEHAVIOR

Think back to the time this person died and answer all of these items about your feelings and actions at that time by indicating whether each item is Completely True, Mostly True, Both True and False, Mostly False, or Completely False as it applied to you after this person died. Check the best answer.

	COMPL. TRUE	MOSTLY TRUE	TRUE & FALSE	MOSTLY FALSE	COMPL. FALSE
1. After this person died, I found it hard to get along with certain people.....					
2. I found it hard to work well after this person died.....					
3. After this person's death I lost interest in my family, friends, and outside activities.....					
4. I felt a need to do things that the deceased had wanted to do.....					
5. I was unusually irritable after this person died.....					
6. I couldn't keep up with my normal activities for the first 3 months after this person died.					
7. I was angry that the person who died had left me.....					
8. I found it hard to sleep after this person died.....					

OVER

PART II: PRESENT FEELINGS

Put Score In Box

Now answer all of the following items by checking how you presently feel about this person's death.
Do not look back at Part I.

	COMPL. TRUE	MOSTLY TRUE	TRUE & FALSE	MOSTLY FALSE	COMPL. FALSE
1. I still want to cry when I think of the person who died.....					
2. I still get upset when I think about the person who died.....					
3. I cannot accept this person's death.....					
4. Sometimes I very much miss the person who died.....					
5. Even now it's still painful to recall memories of the person who died.....					
6. I am preoccupied with thoughts (often think) about the person who has died.....					
7. I hide my tears when I think about the person who has died.....					
8. No one will ever take the place in my life of the person who died.....					
9. I can't avoid thinking about the person who has died.....					
10. I feel it's unfair that this person died.....					
11. Things and people around me still remind me of the person who died.....					
12. I am unable to accept the death of the person who died.....					
13. At times I feel the need to cry for the person who has died.....					

PART III: RELATED FACTS

Answer the following items by circling either True or False.

1. I attended the funeral of the person who died.....	True	False
2. I feel that I have really grieved for the person who died.....	True	False
3. I feel that I am now functioning about as well as I was before the death.....	True	False
4. I seem to get upset each year at about the same time as the person died.....	True	False
5. Sometimes I feel that I have the same illness as the person who died.....	True	False

THANK YOU FOR ANSWERING ALL OF THESE QUESTIONS. WE ARE ALSO VERY INTERESTED IN YOUR SPECIAL THOUGHTS AND COMMENTS.
USE THE REST OF THIS SIDE (AND ANY ADDITIONAL SHEETS YOU WISH TO ADD) TO TELL US ABOUT ANY THOUGHTS AND FEELINGS YOU HAVE.

OVER

Appendix D

Letter of Permission from Author of Texas Revised Inventory of Grief

THOMAS R. FASCHINGBAUER, Ph.D.
Psychologist

P. O. Box 542150
Houston, TX 77254
(713) 523-3419 / - 7718
E-Mail: SIMONSAYS @ aol.com

January 20, 1999

Ann Rathbun
P. O. Box 425742
Denton, TX 76204

Re: Use of TRIG in your research

Dear Ms. Rathbun,

In consideration of your return of 49 TRIG test forms and payment of $75. licensing fee, you may modify and reproduce the TRIG for your research (up to 250 copies) provided you make no infringement on our copyright and provide me with a copy of your results and permission to include them in any future TRIG manuals.

I understand that you are working on a dissertation project and are being supervised through Texas Woman's University. As I understand it, your project involves giving the test to primary care givers to study their attitudes toward grieving as well as their recovery from it.

Call if I can help in any way.

Yours truly,

Thomas R. Faschingbauer, Ph.D.
Honeycomb Publishing Co.

Appendix E

Sample of Publicity from Data Collection Site

Ministry News

Grief Survey after Worship

One of our members, Ann Rathbun, is conducting research for her Ph.D. and would like to survey members of our congregation on the topic of grief in Baby Boomers. She will be in the Fellowship Hall today after both morning services and would like for qualified individuals to fill out a 10-minute survey. To qualify, you need to be 34-52 years old and have experienced the loss of a family member, partner, or significant other. You may pick up a card with her name and office number at the front desk if you do not wish to participate here at the church.

Lay Minister Of Worship Training

Lay Ministers of Worship are the dedicated folks you see dressed in red and black each Sunday. They prepare communion for worship, light candles, lead the processional and help serve communion. We will be training new people interested in being LMOW's TODAY at 2:30 p.m. We need both Acolytes and Communion Servers for all services. Please call Dewayne at 214-351-1901, ext. 260 to reserve your place.

Flowers 1999 - Chancel and Communion

There are a lot of dates left. It's time again to begin taking orders for Chancel flowers (2 arrangements in urns) and Communion Table flowers (1 arrangement in front of the Communion Table) for 1999. The flowers can be given "in honor of" or "in memory of" your loved ones or for a special occasion in your life. Please call 214.351.1901, ext. 264.

Single Men's Pot Luck Dinner

Beginning in February, the First Friday, Single Men's Fellowship dinner format will change to a pot luck dinner. Food assignments will be made according to last name, and will rotate each month. For example, for February: A-G=Entree, H-M= Salad, N-S=Desert, T-Z=Beverages. There will be a $1.00 donation for paper and plastic products. For more information about the Single Men's Pot Luck Dinner, contact John at 214.946.3365.

Wednesday Night Supper Is Served!

When: 5:30-6:30, Wed., Jan27
Where: Fellowship Hall
What: Meat loaf, macaroni and cheese, broccoli, tossed salad, dinner rolls, cherry pie
How Much: Only $5!