ASSERTIVENESS AND POSTBEREAVEMENT ADJUSTMENT IN WIDOWS

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SCIENCE

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

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DECEMBER 1981

ACKNOWLEDGEMENTS

I am deeply grateful to the widows who were willing to share their experiences with me and without whom this study could not have been done.

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CHAPTER 1

INTRODUCTION

Studies on bereavement have identified the widowed as a high risk group for both somatic and emotional illnesses (Brown & Parkes, 1972; Clayton, Halikes, & Maurice, 1971, 1972; Dorpat & Ripley, 1977; Maddison, 1968; Shneidman, 1976). Identification of the needs of this high risk group has implication for nursing, particularly since the nurse's role has expanded to include primary intervention in the community.

A widow may experience symptoms of physical and psychological distress a year or longer after the death of her husband. In addition to evidence of the increased vulnerability to illness, studies also reveal an increase in mortality and suicide rates among the bereaved. The duration of the bereavement period and its healthy resolution depend on the ability of the survivor to become less emotionally preoccupied with the deceased and adjusted to the environment in which the deceased no longer exists.

Bereavement is a condition generally described as consisting of three phases which may vary in intensity

and duration. The first phase is marked by denial and disbelief. Survivors often experience an alteration in sensorium and feel stunned or numb. The numbness is thought to be an adaptive mechanism which consciously or unconsciously serves to soften the impact of the loss, permitting the bereaved to accept the loss gradually.

In the second phase awareness develops and the loss is felt most acutely. Anorexia and insomnia are common, as well as somatic symptoms typical of anxiety. Depression and apathy are predominant although extreme restlessness and aggressive feelings are also reported. The bereaved may experience anger toward the deceased which is inexplicable to them and which contributes to guilt feelings. Disturbing dreams, suicidal thoughts, and hallucinatory experiences may occur and may be interpreted by the bereaved as signs of approaching insanity.

Reorganization takes place in the final, or recovery, period and is contingent upon the acceptance of the finality of the loss. Only then can the bereaved begin to restructure life without the deceased. For some survivors such acceptance may take years, and in cases of pathological grief it may never be realized. There

are also survivors who emerge from bereavement with strengthened or newly developed methods of coping which assist them in problem solving and more independent functioning in the future.

The task of adjustment to widowhood may be complicated by a reduction in income, lack of educational preparation for employment, responsibility for dependent children, and social isolation. Loneliness is the most frequently reported problem in the bereavement period. Often the widow perceives herself as being stigmatized by virtue of her husband's death and feels shunned by the friends she had previously. The widow may equate the loss of her husband with the loss of social status. In a couple-oriented society it is not unusual for a married woman to take her role as a wife as her primary identification.

According to historical statistics of the United States Bureau of the Census (1975), there were 4,000,000 widows in the United States in 1930 and in 1970 that number had increased to over 9,500,000. Thus, the number of widows is increasing continuously and substantially. The multiplicity and complexity of the problems widows experience make this expanding segment of the population a highly vulnerable group.

In the 40 year interim between 1930 and 1970, the number of widowers in the United States remained relatively constant at 2,000,000. The present ratio of widows to widowers is more than 4 to 1 (United States Bureau of the Census, 1978), indicating that bereavement is a problem particularly affecting women.

Women often feel they must make the role transition from wife to widow without the support of others. Many widows report they do not perceive physicians, clergymen, or family members as being particularly helpful during bereavement. While there is little evidence of purposeful intervention to assist widows, many do adjust to their new roles and develop a satisfying, productive, personal existence on their own.

External factors that influence adjustment have been identified. However, it appears there have been few attempts to determine what intrinsic factors might affect resolution of bereavement. Having certain psychological characteristics may enable a woman to adjust better to the death of her husband.

A variable that may influence a woman's ability to adjust is her level of assertiveness. Inherent in assertive behavior is the ability to act in one's own

best interest and to do things on one's own initiative, thus exercising responsibility. The assertive woman is more likely to be independent and feel strong and confident (Bloom, Coburn, & Pearlman, 1975). Feelings of adequacy and of being a worthwhile individual, whether married or unmarried, may facilitate mastery of the painful problems associated with death, loss, and adjustment to a new role.

The present study was done to determine if there was a relationship between the personality variable, assertiveness, and the adjustment of two groups of widows to bereavement. The process of bereavement, its phases, and the characteristics of each phase were described in general and then more specifically as they relate to widows. An exploration of the problems associated with widowhood was made to provide rationale for research to identify factors that may assist widows in the adjustment process. In this study, assertiveness was examined as a variable that may influence the ability of a woman to adjust to her husband's death and to her role transition from wife to widow.

Statement of Problem

The problem of this study was to determine the relationship between levels of assertiveness and adjustment in widows, and to examine these variables in relation to length of widowhood.

Justification of Problem

Many women can be expected to become widows. Their bereavement will generally proceed through three phases which may entail severe problems of social readjustment complicated by financial insecurity, dependent children, and lack of support. While research has indicated some of the external factors which limit length of bereavement, there is little evidence of the impact of psychological factors on bereavement; hence, this study focused upon the degree of assertiveness as a possible factor in alleviating bereavement. Awareness of any alleviating factors should guide nurses in their interactions with widows and in assisting widows to adjust to widowhood.

Ball (1977) described widowhood as a rapidly developing phenomenon of American society. According to a 1978 United States Bureau of the Census, one of every six women over 21 years of age is a widow. These

10,000,000 widows represent a significant proportion of this country's population.

In that death always involves two parties, the person who dies and the survivor who experiences the loss, Toynbee (1969) stated that death is a dyadic event. This event is rated by Holmes and Rahe (1967) as the most stressful event possible because of the degree of social readjustment required. Degree of adaptation to the loss of her husband is dependent upon a widow's resolution of bereavement.

Bereavement has been most consistently described as consisting of three phases of varying length. Although called by various names, these phases are similarly described. Bowlby (1961b) divided the three phases into periods of protest and denial, of despair and disorganization, and of a final recovery period, during which adjustment and reorganization take place.

The period of initial impact is characterized by shock and disbelief. Any thoughts acknowledging the reality of the death may be partially or totally blocked. Engel (1964) suggested this defense mechanism serves to mute temporarily the painful feeling, allowing the full reality of the loss to develop gradually.

Realization of the loss and its implications occurs in the second phase and may have pronounced effect on the survivor. During the first year of widowhood, an estimated one out of five persons will suffer substantial health deterioration (Greenblatt, 1978), and an increase in mortality has been documented (Brown & Parkes, 1972). In an investigation of 114 suicides, Dorpat and Ripley (1977) discovered that 40% had been unable to resolve the loss of a loved one. The painful physical and psychological symptoms associated with the grieving process are most prominent in the second phase.

The psychological distress experienced by widows includes symptoms characteristic of depression such as feelings of helplessness and hopelessness. Circumstances of the death may arouse feelings of guilt and self-blame. Hallucinatory phenomena, including seeing, hearing, or sensing the presence of the dead husband, are not uncommon. These sensory experiences may not be reported by widows for fear others will think they are developing psychological problems due to their grief (Rees, 1971). This uncertainty may be partly the reason that widows do report experiencing feelings of distance by relatives and friends even to the extent that they

feel shunned or stigmatized by their husband's deaths. Such estrangement may require the widow to develop a new social matrix, thus adding stressful change to her life.

Another serious loss experienced by widows is that of economic security. Fewer than 3 out of 10 husbands leave wills, thus complicating the settlement of estates. Also, the average widow is inadequately provided for by her spouse; in 1977 the average death benefits received by widows was reported to be $12,000 while death expenses averaged $4,000 (Conroy, 1977). In a study of socio-economic adjustment to widowhood, Adams, Pihlblad, and Rosencranz (1972) found all subjects, 698 widows over 65 years of age, subsisting on incomes below the poverty level. The lower income may necessitate a residence change--an additional stressor during bereavement.

Assuming total responsibility for the economic support and the single parenting of dependent children proves very problematic for some women. Englander and Silverman (1975) cited a study which revealed 627,000 widow-child families in the United States with a total of 2,200,000 paternal orphans under the age of 18 years.

The widow's difficult situation may be further compounded by her perceived lack of support in coping

with these new problems. Studies indicated that many widows do not consider clergymen, friends, or extended family helpful or supportive during bereavement (Formo, Freeman, Freedman, Lyall, Rogers, & Vachon, 1977). Thus, the widow faced with probably the greatest stressor she will experience may have little, if any, intervention or assistance.

With or without help during bereavement, the widow's grief and mourning behavior typically modifies as time passes and she enters the third phase of bereavement--the period of reorganization or recovery. Most widows report a reduction in depressive symptomatology after a few months or at least by the end of a year; however, it is not unusual for them to experience a resurgence of grief feelings periodically (Buxbaum, 1974; Carey, 1977; Glick, Parkes, & Weiss, 1974). Lindemann (1944) observed a phenomenon that may also occur, a delayed grief reaction. The survivor may show little or no reaction for weeks, or even years, and then suffer a depression precipitated by the unresolved grief. Grief that extends over a prolonged period may become pathological, necessitating psychiatric treatment.

Since some widows experience recovery from grief by the end of a year while others report depressive

symptomatology years later, comparison of widows in two time periods appears indicated. Such comparisons may reveal factors that may assist widows in the resolution of grief and the reorganization of their lives.

Studies have indicated some external variables which influence adjustment to widowhood: age, presence of dependent children, economic security, level of education, anticipation of the husband's death, and social isolation (Atchley, 1975; Carey, 1977; Morgan, 1976). There is very little evidence of investigation, however, or psychological factors that may have significant bearing on widowhood.

A psychological variable that could affect adjustment is the level of assertiveness because assertiveness is characteristic of an active and independent approach to life rather than a passive, dependent one (Alberti & Emmons, 1978). Engel (1964) hypothesized that the more dependent the relationship between deceased and mourner, the more difficult the task of resolving the loss. If this is true, the more independent woman might logically be a stronger, more stable survivor with a more positive adjustment.

In view of the rapidly expanding number of widows in this country and the threats bereavement poses to

physical and psychological health, the study of adjustment to widowhood appears relevant to nursing. Determination of personality factors associated with positive adjustment may contribute to the identification of those at higher risk of poor adjustment.

In the practice of nursing there are many opportunities to provide support for those facing or experiencing bereavement. Nurses possess clinical and interpersonal skills which may be practiced in a variety of settings. Rogers and Vachon (1975) reasoned that this makes nurses uniquely suited to provide preventive and therapeutic intervention in the promotion of healthier adjustment to widowhood.

Theoretical Framework

The theoretical framework of this study was based on concepts derived from the theory of bereavement and mourning. In addition, the concept of assertiveness, which exists within the general framework of behavior theory, provided further structure for this study.

Bereavement and Mourning

The theory of bereavement and mourning is useful in understanding both normal and pathological responses

of survivors to the deaths of loved ones. Bowlby's (1961a) theory of mourning and bereavement is an expansion of his earlier studies (Bowlby, 1958, 1960) of maternal-child attachment and loss. In comparing separation anxiety in infants and children with bereavement, similar processes and characteristics were recognized. Both, Bowlby (1961a) contended, require a period of mourning in which the subjective experience is grief.

Bereavement is divided into three phases--protest and denial, despair and disorganization, and reorganization and recovery. Reactions in these periods vary according to the individual but are to a certain degree predictable. Progression through the sequence of phases depends upon the resolution of each successive one. The three features specific to the processes of bereavement were identified by Bowlby (1961b) as the persistence of behavior oriented toward the lost object, hostility directed toward others or the self, and a tendency to identify with the lost object.

In phase one of the mourning process the survivor experiences shock and disbelief. A state of disequilibrium exists. Permanency of the loss has not yet been accepted and the bereaved tend to resent those who

encourage them to accept reality. Freud (1917/1959) described reality as being accepted in piecemeal fashion during this period. This gradual acceptance of reality was believed by Engel (1964) to be a defensive mechanism by which the bereaved raises the threshold against the painful feelings produced by recognition.

As reality returns in the second phase the bereaved fully realizes the lost love object is irretrievable. Depression is the primary feature of this period and is usually accompanied by a loss of self-esteem. The survivor lacks the ability to respond to stimuli in an effective, organized way. Bowlby (1961b) concluded that the acute pain experienced in this phase is related to the fear of becoming disorganized to the point of losing control.

The behavior of the bereaved modifies with the passing of time and the process of adjustment to life without the deceased begins. The bereaved individual, moving into a state of reorganization, begins to discriminate in patterns of behavior and rejects those that are no longer appropriate or effective. Recovery usually follows for the majority of individuals, who are considered to have had "healthy" mourning.

Pathological mourning is differentiated from normal mourning by degree, rather than by kind. The bereaved is thought to become fixated in a phase of mourning, resulting in an exaggeration of the processes of that phase. In the healthy resolution of the bereavement process the individual ultimately adjusts to life without the lost object, relates to new objects, and finds satisfaction.

Assertiveness

Contrary to the psychoanalytical view that emotional and behavioral problems are intrapsychic or interpersonal in origin, a basic belief of behavior theory is that all behavior is learned. Behavior theory is formulated on Skinner's (1953) learning model which rejects cognitive explanations of behavior. Behaviorists believe that individuals acquire conditioned reactions and reflexes as a result of early experiences. These reactions become habit patterns which not only influence but actually control the individual's behavior.

Reyna, Salter, and Wolpe (1964) agreed that the learning of unadaptive habits creates anxiety, inhibits interpersonal relationships, and may lead to neurosis formation. In order to eliminate such behaviors and

replace them with more satisfying ones, the behavior therapist applies the learning process in reverse, assisting the individual to unlearn undesirable behavior. Through such conditioning or modification, behavioral and emotional states that are unadaptive may be reduced and eliminated (Wolpe, 1973).

Four methods are employed in behavior therapy: assertive behavior, systematic desensitization, evocation of strong anxiety, and operant conditioning (Haber, Leach, Schudy, & Sideleau, 1978). Salter (1961) was credited by Wolpe (1973) with pioneering techniques for teaching assertive behavior. Salter (1961) described the "inhibitory personality" (p. 47) as a person who either knowingly or unknowingly conceals true emotional impulses, is discontent with relations with others, and is low in self-sufficiency. Inhibited individuals are afraid of responsibility and of making decisions, but can be taught, however, to acquire more control of themselves and their environment by learning assertive behavior.

Alberti and Emmons (1978) described assertive behavior as the ability of an individual to act in one's best interest, to stand up for oneself without undue

anxiety, to express one's feelings honestly and comfortably, or to exercise one's own rights without denying the rights of others. In order to behave according to these criteria, one must first love and respect one's own self (Cotler & Guerra, 1976). Being assertive also involves not only respecting oneself, but also developing a deeper awareness of self.

An individual who is assertive can guard against being taken advantage of by others; can make decisions and free choices in life; and can recognize and express wants, values, needs, expectations, dislikes, and desires. The assertive individual can also express a wide range of feelings, both positive and negative. Wolpe (1973) believed avoidance of open expression of feelings results in inner conflict which may produce psychosomatic symptoms and may result in failure to satisfy needs.

Assertive behavior denotes an active approach to life, rather than a passive one. Traditionally, women have assumed a more passive role, particularly in the male-dominated Western culture. Contemporary women were described by Austin and Phelps (1975) as being caught between conforming to existing standards and stereotyped roles and exploring new alternatives.

As women adopt more assertive behaviors, they will become able to function more independently, thus acquiring more control over their lives. This control should be reflected in the ability of women to cope with stressful life events and to adjust to role transition.

According to literature and research, the death of a spouse is a stressor that may require more adjustment than any other life event. Successful resolution of bereavement appears to involve the dual tasks of being able to function independently, yet asking for assistance of others if it is needed. Since these two tasks are inherent in assertive behavior, it appeared reasonable to determine the relationship between the level of assertiveness and the level of adjustment to bereavement. If being assertive does influence adjustment positively, an implication of the findings could be to offer widows the opportunity to learn assertive behavior.

Assumptions

This study was based upon the following assumptions:

1. Women whose husbands die experience bereavement.

2. Personal adjustment of the bereaved is necessary for the resolution of bereavement.

Hypotheses

For this study, the following null hypotheses were developed:

1. There are not significantly more assertive widows than nonassertive widows as measured by the Rathus Assertiveness Schedule.

2. There are not significantly more widows adjusted to bereavement than widows not adjusted to bereavement as measured by the Adjustment Scale.

3. There is no relationship between levels of assertiveness of widows and their levels of adjustment to widowhood.

4. There is no significant difference between widows of 3-12 months and those 3-5 years in levels of assertiveness and levels of adjustment to widowhood.

Definition of Terms

For the purposes of this study, the following terms were defined:

1. Widow--a woman who has experienced the death of her spouse and has not remarried.

2. Length of widowhood--the length of time that has elapsed since the death of a woman's spouse.

3. Adjustment--the process of adaptation to bereavement as measured by the Adjustment Scale (Carey, 1977).

4. Assertiveness--the ability to act in one's best interest, to stand up for oneself without undue anxiety, to express one's feelings honestly and comfortably, or to exercise one's own rights without denying the rights of others (Alberti & Emmons, 1978). For this study, assertiveness is measured by the Rathus Assertiveness Schedule (Rathus, 1973).

Limitations

The uncontrolled intervening variables that might have influenced the validity of this study were:

1. Demographic variables of age, socioeconomic status, number of years married, number of dependent childern, and level of education.

2. Marital satisfaction of subjects prior to deaths of spouses.

3. Anticipated or nonanticipated deaths of the spouses.

4. Degree of dependency of the subjects on the spouses.

5. Stage of bereavement in each subject.

6. Individuals' response to test items in accordance with social desirability.

7. Effect of prebereavement psychological adjustment on postbereavement adjustment.

Summary

The purpose of this study was to determine the relationship between the levels of assertiveness in widows and their levels of adjustment to widowhood. The scope and complexity of the problems confronting women who become widowed was the focus of the study. Also addressed was the lack of purposeful intervention by others to assist the woman who experiences the dual loss of her husband as well as her role as a wife. Lack of investigation of personality factors that might influence the favorable adjustment to widowhood was noted. Relevance of the study of the problem for nursing research was proposed.

The theoretical framework for this study was based on the following concepts: bereavement is a process consisting of stages characterized by physical and

psychological symptomatology, the resolution of bereavement requires adjustment to the death of a loved one, external and intrinsic factors may influence the adjustment process, and adaptive behavior may be taught. Assertiveness, as a construct, was viewed as an intrinsic factor that could be taught to widows if a relationship could be established between assertiveness and adjustment to widowhood. The study was based on the assumption that personal adjustment is necessary for a woman to resolve the bereavement experienced when her husband dies.

The problem of the study and the justification for researching the problem have been presented in this chapter. Also included in this first chapter were the hypotheses, limitations, and conceptual definitions of terms relevant to the study.

CHAPTER 2

REVIEW OF LITERATURE

Literature related to bereavement and assertiveness, the concepts comprising the theoretical framework of this study, was reviewed to support this study. In the theoretical framework bereavement was described as consisting of phases, with particular physical and psychological effects being evidenced in each phase. The literature review focused on the bereavement of widows and the social and external variables affecting their adjustment process. Assertiveness was viewed as an internal, or personality, variable that may have positive effect on the adjustment process of widows.

Widowhood as a Social Problem

Widowhood has been established as a social phenomenon shared by many women. In the female population over 18 years of age in the United States, 13% have been identified as widows. United States Bureau of the Census (1978) figures revealed that the number of widows in the United States has been increasing by approximately 100,000 annually. Jeter (1978) identified

three factors contributing to the increasing numbers of widows: (a) the tendency of women to marry men older than themselves, (b) the statistical evidence that the life expectancy of women today exceeds that of men by approximately 7 years, and (c) the fact that widows are less likely to remarry than widowers.

Projections of the United States Bureau of the Census (1978) predicted an increase of 43% in the size of the total population over 65 years of age by the year 2000. A logical accompanying prediction would be an increase in the number of widows paralleling the increasing older population. The development of widowhood as a social problem, however, has not been one restricted to old age. In 1977 the median age for the onset of widowhood was 56 years of age and, according to life expectancy rates for that year (Statistical Bulletin, 1977), such a widow could expect to live another 20 years. Over one-half of the women widowed at the older age of 65 were predicted to live another 15 years. Thus, widowhood has been identified as a status not occupied exclusively by elderly women or by those living their final years of life.

The status of widowhood has been described not only as one the average woman may occupy for 20 years, but

also as one for which the average woman has little, if any, preparation. Lopata (1973) observed that in Western culture a woman is socialized all through her early life for her roles of wife and mother, but typically has no preparation for the status she will occupy for possibly the last 15-20 years of her life.

According to Z. S. Blau (1973), role exit occurs whenever any stable pattern of interaction and shared activities between two or more persons ceases. Widowhood was viewed as a terminal role exit from marriage and as a probable permanent detachment from that particular institutionalized form of family life since the majority of widows do not remarry. Role exit threatened self-identity, an important factor in a widow's adjustment to bereavement and adaptation to her new role (Z. S. Blau, 1973).

Adaptation to the widow's role has been compared by Yates (1976) to the roles of single women and divorcees. Yates explained that the roles differed because the single woman may have occupied her role by choice and the divorcee, even if not divorced by choice, had some period of time to weigh the matter and make an adjustment to the idea of being single again. A unique

difference for the widow could have been the total unexpectedness of her role change, a role change that was initiated by death and experienced concurrently with bereavement.

Bereavement

Bereavement, or the process of mourning a lost love object, has been described consistently as having three phases, each of which is characterized by specific behaviors and/or physical symptoms. A uniform picture of bereavement emerged in the 101 grieving subjects observed by Lindemann (1944). As a result of the study, Lindemann defined grief as a definite syndrome with psychological and somatic symptomatology. Commonalities identified in all subjects were: (a) somatic disease, (b) intense preoccupation with the image of the deceased, (c) guilt feelings, (d) hostile feelings, and (e) lack of capacity to initiate and maintain activity.

Lindemann (1944) termed the resolution of bereavement "grief work" and believed the duration of grief work depended upon three factors: (a) emancipation from bondage to the deceased, (b) adjustment to an environment where the deceased no longer existed, and

(c) formation of new relationships. Two types of pathological grief reactions were also described. In one type little reaction was exhibited by the bereaved initially, however, grief feelings surfaced months or even years later. Another type of grief reaction was termed distorted. Such reactions were characterized by a variety of behaviors including: (a) overactivity without a sense of loss, (b) the acquisition of physical symptoms associated with the last illness of the deceased, (c) intense hostility toward others connected with the death, (d) psychosomatic illness, (e) social isolation, (f) altered affective states resembling schizophrenia, and (g) severe depression with suicidal ideation (Lindemann, 1944).

Hodge (1971) agreed that grief was a definite syndrome, which he further defined as having characteristic onset, course, duration, and termination. Hodge suggested that the bereavement process might be better understood by examining it in the same general framework long found useful in studying mental illness. According to Hodge, both bereavement and mental illness were influenced by the predisposing personality and by external precipitating factors, and both involved the

transformation of anxiety, helplessness, and depression into physical symptoms.

The belief that grief follows certain, rather predictable phases was supported by Engel (1964), who defined the phases in terms of the psychological defense mechanisms operating in each one. The stunned and numbed feelings reported in the first phase temporarily prevented access to consciousness of the full impact of the loss. Crying in the second phase was not only indicative of the anguish and despair felt but also to the regression to a more helpless and child-like state. Restitution, the work of the third phase, included identification with and idealization of the deceased. These mechanisms were viewed as being manifested by behaviors such as erecting external memorials, reliving gratifications associated in the past with the deceased, and attempting to carry on the deceased's ideals and wishes. Factors thought to affect the duration of the three phases were the existence of other meaningful relationships in the life of the bereaved, the nature and number of previous losses, and the physical and psychological health of the mourner (Engel, 1964).

Bowlby (1961b) divided the phases of mourning behaviorally. Early bereavement behaviors began with

craving, angry efforts at recovery, and accusations against the self. These behaviors proceeded through apathy, depression, and disorganization. Mourning reached a healthy resolution if the individual developed a more or less stable reorganization, related to new objects, and found satisfaction. Bowlby reasoned that the intense pain and the inability to respond in an affective, organized way were due to the fear of becoming disorganized to the point of lowing control. Successful resolution of bereavement depended upon the ability to retain the behaviors that were reasonable, maintaining values and goals previously shared with the deceased, without compromising reality. Pathological grief, Bowlby proposed, resulted when the bereaved continued to live as though the deceased were present.

As a result of work with bereaved individuals in the United States and in Britain, Parkes (1972) outlined the seven features most common in the grief reactions which he observed. These main features were:

1. A process of realization in which the bereaved moved from denial and avoidance to recognition and acceptance of the loss.

2. Physiological responses such as anxiety and restlessness.

3. An urge to search for and find the lost person in some form.

4. Anger and guilt manifested in outbursts directed toward those who urged the bereaved toward a premature acceptance of the loss.

5. Feelings of internal loss or mutilation.

6. Adoption of traits, mannerisms, or symptoms of the lost person.

7. Pathological variants of grief in which the reaction was excessive, prolonged, or inhibited.

The phases of bereavement were more specifically related to widows by Golan (1975) in a study of women widowed in the 1973 Yom Kippur War in Israel. The start of the bereavement process was delayed for many of the widows due to difficulties in recovering and identifying bodies of slain soldiers. Israeli widows who observed shiva, a prescribed week of mourning for Orthodox Jews, found their acceptance of the death easier, leading Golan to conclude that a particular need of the women in the first phase was a benign, permissive atmosphere in which the overt expression of grief was encouraged.

The second phase was marked by attendance to duties and problems of a more material nature: the unfamiliar matters of taxes, insurance, probate, estate settlement, and survivor's benefits. The widows were faced simultaneously with issues such as adequacy of income, single parenting, return to the labor market, and household management. Widows were described in the third phase as being more confident and functioning more competently. Golan (1975) expressed the belief that the widow's primary psychological task of the entire bereavement period was to loosen the ties with the deceased husband, transforming experiences with him into memories.

Freud (1917/1959) hypothesized that the primary work of the mourning period was the freeing of the libido from the lost object. Freud described this process as "painful unpleasure," a natural consequence of an individual's reluctance to willingly abandon a cathected object. This opposition to relinquishing investment in the deceased might be of such intensity that the bereaved would cling to the lost object through halluncinatory phenomena. In healthy grief resolution, Freud believed reality testing would prevail and the work of mourning would be completed, thus freeing and uninhibiting the ego again.

Physical and Psychological Effects of Bereavement

Regardless of the names given to the phases of mourning and the psychosocial tasks thought inherent in the bereavement process, theorists have agreed that it is in the second phase that the most acute psychological and physical distress is experienced. Depressive symptomatology has been most often reported, and in some grief reactions has been exhibited, a year or more later (Clayton, 1979).

In an attempt to examine morbidity and mortality in the first year of bereavement, Clayton (1974) conducted a prospective study of 109 widows and widowers. These widows and widowers were age-matched and sex-matched with married control subjects. In the bereaved subjects, 35% met the criteria for a diagnosis of depression at 1 month, 25% at 4 months, 17% at 12 months, and 45% at some point during the year. Depression was reported in 13% for the entire first year of bereavement. The bereaved experienced significantly more psychological and physical depressive symptoms than the nonbereaved controls. There was no significant difference in the 1-year mortality rates of the two groups.

Clayton's (1974) views were not consistent with those of Parkes (1972) who studied 22 London widows at multiple points in their first year of bereavement. Parkes' principal finding was that a woman who had become widowed recently was more likely than a non-widowed woman to die from alcoholism, malnutrition, and disorders typically related to the neglect of self.

Clayton, Halikes, and Maurice (1971) compared the depression of bereaved subjects with that of depressed hospitalized patients in an effort to distinguish various populations with depression. A difference noted in the two groups was the quality of guilt feelings experienced. The guilt expressed by widows concerned their worry over perceived negligence of their husbands and/or minor omissions related to the final illnesses or their marriages. Crying, depressed mood, and sleep disturbances were described as the cardinal symptoms of the bereavement period (Clayton et al., 1971).

The long accepted relationship between object loss and depression has raised the question of whether bereavement might be associated not only with morbidity and mortality, but also with suicidal behavior. Bunch (1972) studied the relationship between recent

bereavement and suicide. Retrospectively, 75 suicides that occurred over a 14-month period were examined. A comparison group of 150 living subjects was equivalent to the suicide victims in sex, age, marital status, and area of residence. In the 5-year period preceding the suicides, 36% of those taking their own lives had experienced the loss of a parent or spouse, compared with 13% of the control subjects. Bunch (1972) examined the availability of relatives as social support. There was no significant difference found in the geographical distribution of relatives; however, those who committed suicide had been having much less contact with relatives. The bereaved who had suicided had experienced more social disruption in the 5-year period than the control group and were more likely to have been living alone.

Object loss was identified by Dorpat and Ripley (1977) as a predominating factor in 114 suicides. Over 40% had been unable to resolve the loss of a loved one. The majority of the losses had occurred in the year preceding the suicide, however, in some cases the pathological grief reaction had continued for 5 years. The bereaved who suicided had demonstrated an excessive dependency on the deceased and loss of the loved one

had been coupled with loss of meaning and purpose in life.

The findings of the Harvard Study (Brown & Parkes, 1972) supported the theory that health deterioration does occur in the first year of widowhood and that it is more prominent in younger widows. During the first 14 months following the deaths of their spouses, 49 widows under 45 years of age were interviewed 4 times. A final interview was conducted 2 to 4 years following the deaths of the subjects' husbands. The widows were matched with a control group of married subjects. Compared to the control subjects, the widowed at the 13 to 14 month interview reported more disturbances of sleep, appetite, and weight. Increased consumption of tranquilizers, tobacco, and alcohol was noted. More days spent in bed due to physical complaints and more hospital admissions were also documented in the widowed group. Brown and Parkes (1972) concluded that 2 to 4 years after bereavement there was no significant difference in depressive symptomatology in the widowed group and the control group. However, there was evidence of persistent disengagement among the bereaved who reported continuing to feel "apart" from others,

remote even among friends, and unconcerned about world affairs and/or the opinions of others. The widows expressed a tendency to avoid new relationships, believing it "safer" not to get involved (Brown & Parkes, 1972).

Becker, Blanchard, and Blanchard (1976) agreed that depressive symptomatology was more pronounced in younger widows. Becker et al. examined the patterns of abatement of depression in a group of widows under 45 years and measured 20 symptoms of depression. By the end of the first year of bereavement 16 of the symptoms had abated significantly. Symptoms of restlessness, worthlessness, hopelessness, and dreams of the spouse persisted. The investigators concluded that at different points in bereavement widows experienced certain symptoms more often than at other points, and that those symptoms indicative of a widow's concern for her future were of more impact later in the grief process.

In a study by Maddison (1968), 312 young and middle-aged widows were divided into separate groups according to satisfactory or unsatisfactory resolution of bereavement. Widows described as having "bad outcomes" were those who had experienced physical and/or mental

deterioration, who reported a high frequency of perceived unhelpful interactions with others, and who experienced a large number of unmet needs during the bereavement. The relationships between "bad outcomes" and age of the widow were significant for younger widows ($p < 0.05$).

Maddison (1968) also attributed the following factors to the development of a "bad outcome" for a widow:

1. Being less than 45 years of age and having dependent children.

2. Having had a pathological marital relationship.

3. Having exhibited evidence of a pre-existing overt neurosis.

4. Observing a husband's protracted illness and death, particularly if illness was associated with severe suffering and/or disfigurement.

5. Being aware of a pathological reaction to the death by another family member.

6. Experiencing disturbed relationship with the widow's mother or with her late husband's family.

7. Experiencing additional crises in the bereavement period.

8. Avoiding affect expression deliberately.

9. Having a long-continued reaction formation against dependence.

Maddison (1968) proposed that the younger widow's difficulty in resolving grief might be correlated with a more intense sexual involvement with her husband than an older widow might have been experiencing. The more intense sexual relationship, Maddison reasoned, would have contributed to a more intense cathexis of the husband's person which would necessitate a more painful decathexis, thus complicating the grief reaction.

Michels (1974), describing the relationship between husband and wife as the most intimate and all encompassing one in Western society, agreed that the loss of the sexual partner might have direct and dramatic effect on grief. Death and sex both involve strong emotions which Michels noted were grounded essentially in very private areas of an individual's life. Michels reasoned that the simultaneous experience of grief and loss of sexual partner could produce an exaggerated form of behavior and an intensified grief reaction.

Toth and Toth (1980) concurred that sexual identity became problematic for widows. In group therapy sessions conducted by these authors, widows expressed

surprise over this unexpected need for sexual release. For many widows there were no acceptable alternatives to marital relations, thus satisfaction of sexual needs was denied.

The intensity of grief reactions was assessed by Sanders (1979-1980) in 102 bereaved subjects, employing 107 control subjects who had not experienced bereavement in the 5-year period preceding the study. The two groups were matched in age, religion, church attendance, country of birth, and ethnic background. In the group of bereaved subjects, 78 had experienced the death of a spouse, 53 had experienced the death of a parent, and 14 had experienced the death of a child. More intense grief reactions, greater depression, anger, and guilt were reported by those who had experienced the death of a child. In a comparison of the widows and widowers in the study, two scales (somatization and death anxiety) yielded higher scores for the widows with the results being statistically significant at the .05 level. Widows also had higher scores than widowers on the scales for anger, social isolation, depersonalization, sleep disturbance, and loss of appetite; however, these were not significantly different. The

findings, Sanders (1979-1980) claimed, supported the belief that widows display greater overt reactions than do widowers. According to Sanders, there appeared to be no single indicator of grief, but rather a constellation of physical and psychological symptoms.

Psychological symptoms reported during the bereavement period have included hallucinations. This psychological phenomenon was described by 45.8% of the 227 widows interviewed by Rees (1971). The sensory modalities most often involved, in order of frequency reported, were visual and auditory. Tactile experiences were the least common. Widows also reported "sensing" the presence of the dead husband, without seeing or hearing him. Rees determined that there was a positive correlation among the incidence of hallucinatory experiences, the age of the widow, and the length of widowhood. Older widows and those more recently bereaved reported more hallucinatory phenomena. Hallucinatory occurrences were not affected by race, creed, cultural group, site of residence, or degree of social isolation. Frequency of occurrence, however, corresponded positively with length of time married.

Ball (1977) described the psychological symptomatology experienced by 80 women who had been widowed

for 6 to 9 months. Hallucinatory experiences involving the deceased husbands were reported by 48% of all subjects. Sensing the husband's presence was the most frequently reported type, with auditory and visual experiences being less frequently claimed.

In a study by Iwasaki, Ohonogi, Yamamoto, and Yoshimura (1969), the process of mourning in widows in Japan was examined. These authors found that 90% of those interviewed had experienced sensing the presence of the deceased husband.

Hallucinatory phenomena were also described as part of the bereavement process by 60% of the 37 widows interviewed by Kalish and Reynolds (1974). Kalish and Reynolds suggested that such an experience was a normal outgrowth of a severe sense of loss. The widows stated that the occurrences did not cause them discomfort or concern for their sanity, however, they refrained from telling others of the experiences for fear the occurrence might be perceived as becoming mentally unbalanced.

External Variables Influencing Adjustment to Widowhood

Studies have indicated that while the widow is experiencing the physical and psychological distress of

bereavement, her grief is being impacted by demographic and social variables. A demographic variable which has been thought to interact with bereavement intensities has been that of socioeconomic status. According to Adams, Pihlblad, and Rosencranz (1972), widowhood necessitated frequent change in socioeconomic status and lifestyle. A companion study was conducted of 702 married men and women and 849 widowed men and women. Income levels for widowed females were lower than income levels of widowers and married subjects. Due to their decreased incomes, more widows had been forced to move to smaller quarters, to have fewer household facilities, and to have reduced mobility. Widows were more capable of maintaining self-dependence; however, with widowers demonstrating more dependency on children and other relatives.

The morale of 232 widows was compared with the morale of 363 married women by Morgan (1976). The subjects ranged in age from 45 to 74 years and comprised three ethnic groups. Morgan found morale significantly lower in younger widows than in their married age-peers. Lower morale among widows correlated with lower income, less involvement with work, and less family interaction.

Morgan (1976) proposed that lower morale was more directly attributable to those social and demographic factors co-occurring with widowhood than to the actual state of being widowed.

In a similar study, Atchley (1975) interviewed 902 men and women aged 70-79 years in an effort to describe differences between elderly widowed subjects and elderly married subjects and differences between widows and widowers. Widowers were found significantly more likely to have higher incomes and more social participation than widows. As a result Atchley described income adequacy as an essential component of adjustment to widowhood.

Conroy (1977) hypothesized that the widowed are a high risk population for mental illness due not only to the stress of their loss, but also to the changes in their roles and lives associated with widowhood. The plight of the widow was described in terms of what she was required to give up--her husband, her status, and her expectations. Conroy concluded that material sacrifices were necessitated often by the loss of financial status. Changes in personal habits, in social activities, and even in residence were defined as stressors further complicating the grief work of widows.

Income did not contribute negatively to the grief experiences of widows observed by Sanders (1979-1980). In an examination of the factors correlating with a more severe grief reaction in 38 widows, Sanders concluded that the low socioeconomic status of the subjects was not attributable to their widowed status, but rather was a pre-existing condition which contributed negatively to the stressful situation.

For the older widow the reduced income has been considered more problematic than for the widow who was young enough to be employed or who might receive financial assistance and/or benefits for herself and her dependent children. Arling (1976) described widowhood as the event which constituted the greatest change in the status of older people. Arling's study of 409 widows revealed that their median income was $100 to $150 per month, leading the author to conclude that the older widows had the lowest income of any segment of the elderly population.

Lopata (1973) poignantly described the plight of older widows:

> They are women in a male dominated society. They are old in a society that venerates youth. Many are grieving and lonely in a country that would

> deny and ignore such unhappy emotions. They are without mates in a social network of couples . . . they are poor in a wealthy land. (p. 92)

The variables of income and educational level of widows have been examined jointly in studies as factors affecting bereavement. A paradox was evident in the findings of Lopata's (1973) research on widowhood which involved 300 widows. The more highly educated woman found her life more disrupted initially by her husband's death, however, education provided her with more skills for re-entering society and reconstructing her life. Lopata believed that the greater disruption in the more highly educated widow's life was the result of such a woman's belief that her performance as a wife had a direct impact on her husband, his health, and his career. Widows with higher levels of education had socialized more and shared more activities with their husbands. Thus, the loss of their husbands constituted for these widows a loss of identity. Lopata identified education and social class as major determinants of the way a woman views herself and in the way she restructures her life after her husband's death.

Carey (1977) attempted to identify correlates of adjustment to widowhood. Widows and widowers were

interviewed 13 to 16 months after being widowed. Age was positively related to the adjustment of widows, lending further support to the hypothesis that younger widows experience more adverse reactions to widowhood. Education was a stronger factor in the adjustment of widows than widowers. Income was positively related to adjustment in all widowed persons ($p < .055$).

Carey's (1977) study was replicated in part and expanded upon by Bahr and Harvey (1980) who determined correlates of adjustment in a group of 44 women widowed by the same accident. The median age of the subjects was 37 years. Comparison samples of nonwidowed controls were employed. The findings were congruent with Carey's (1977) findings in that higher education and higher income were determined to be predictors of higher morale and better adjustment in widows. Bahr and Harvey (1980) labeled these two variables "buffers" in the adjustment process.

Anticipatory Grief

Having forewarning of a death has been considered as an external variable that might reduce the intensity of grief in the mourning period, thus enabling the mourner to cope more adequately with grief. The grieving

process that is initiated as a terminal patient's family and friends are involved in the final illness and death has been conceptualized as anticipatory grief. The process also has been called preparatory grief or premourning behavior. Goldberg (1977) described two aspects of anticipatory grief that might influence the grief potential after death. With forewarning, much of the grief work will have occurred by the time of the death. The second factor noted was that forewarning of the death permitted the dying person to share in death preparations, and to even facilitate them through advice and consultation. Goldberg projected that this could be a "powerful family affective experience."

Anticipatory grief could be considered the first stage of bereavement for mourners with forewarning of death, Weisman (1974) proposed. Weisman expressed the belief that anticipatory grief could be used constructively by both the dying and the survivor as a time of mutual reality and by the mourner as a time of compassionate survival. Weisman stated, "practically enough, compassion can generate a fusion of love and death which is the basis for finding a death we can live with" (p. 18).

A depressive symptom complex was measured and correlated with anticipatory grief by Clayton et al. (1973). In a study of 109 widows and widowers, a positive correlation was found at 1 month and at 4 months after the death. At the end of 1 year of bereavement there was no significant difference in the depressive symptomatology of subjects who had forewarning of their spouses' deaths and subjects who had none.

Arkin, Battin, Gerber, Hannon, and Rusalem (1975) examined the relationship between anticipatory grief and adjustment to widowhood in 47 widows. There was no significant difference in the level of adjustment in widows whose husbands had died of chronic illness and widows whose husbands had died of short-term acute illness. A significant finding in the study was that widows whose husbands' final illnesses had lasted 6 months or longer exhibited poor adjustment. Arkin et al. (1975) concluded that an extended "death watch" had negative, rather than positive, impact on the intensity of grief experienced after death.

Ball (1977) hypothesized that widows who experienced anticipatory grief would resolve the bereavement crisis with less intense grief than widows who had

experienced the sudden deaths of their mates. A further hypothesis was that younger widows would have a more intense grief reaction. Ball divided 80 women widowed 6 to 9 months into three age groups and further into two categories according to the mode of the husbands' death. Young widows (18-46 years of age) were more affected with grief symptoms ($p < .10$) and with symptoms higher ranking in severity ($p < .05$) than middle-aged (47-59 years of age) or older widows (60-75 years of age).

The grief intensity of younger widows was significantly affected by anticipatory grief ($p < .05$); however, this correlation was not established for the other two age groups. As a result of the study, widows under 46 years of age, with minimal or no forewarning of their husbands' deaths, were described as the most vulnerable of all widows to intense grief reactions (Ball, 1977).

Parkes (1973) proposed that conjugal bereavement could never be as unexpected for the older widow as for the younger widow. Therefore, a more traumatic reaction to the loss of a spouse should be expected in younger widows. A further suggestion advanced by Parkes was that the process of disengagement might have already

started in older widows, thus they might react to the object loss with less intense grief.

Gerber (1974) identified the social component involved in anticipatory grief as a positive aspect in grief intensity reduction. When a death has been anticipated the survivor has had time for deliberation about role functioning after the death. Gerber acknowledged that planning for role changes before a death might be considered improper by society, but stated that for future survivors such plans were realistic considerations. The author cautioned that the relationship between anticipatory grief and postmortem bereavement should not be considered a mutually exclusive one, but one that was also contingent on other factors such as the expectations of the survivor, the degree of emotional attachment to the object, and the ability of the survivor to accept the inevitable.

Lebow (1976) stressed that the survivor has not been spared grief when there is a forewarning of death, but has been faced with the task of moving through a series of emotional reactions over a period of time with increasing awareness and acceptance of the death of a loved one. Increasing anxiety, inadequate defense

mechanisms, and unresolved ambivalence were viewed as potential stressors in the predeath period. Lebow (1976) described the period of anticipatory grief as an acutely painful and critical experience for the survivor who was having to react to daily gradual losses while experiencing separation anxiety over the approaching final loss.

Dependent Children

The question has been raised regarding the effect the presence of dependent children had on adjustment to widowhood. In the results of a study of conjugal bereavement and the factors affecting a "good outcome" or "bad outcome" for 40 widows, Maddison (1968) described the ambivalent situation that existed for subjects with dependent children. Widows with dependent children expressed the belief that the very existence of their children gave purpose to life at a time of profound sorrow. In an effort to protect children, however, some mothers reported deliberately masking, or even denying, their grief. Suppression of affect was thought to impede the resolution of grief in these widowed mothers. Other problems noted by mothers were those

involving support of the family and assumption of the single parent role.

Conroy (1977) contended that ambivalence existed in another form for widows with dependent children. The author claimed that although children represented a purpose in life, they prevented the mother's resumption of a typical single role and could be a factor in preventing remarriage. Conroy concurred with Maddison (1968) that keeping up appearances for the children's sake could prevent the necessary grief work and resolution of bereavement for the mother.

Realignment of intrafamilial roles was viewed by Goldberg (1977) as one of the major tasks confronting widows. Basic concerns facing widows with dependent children were: (a) providing continuing financial support for the family, and (b) providing the children with love and nurturance previously given by two persons, while concurrently satisfying her own emotional needs without a spouse. According to Goldberg, increased family solidarity and support could be the favorable outcome of the healthy resolution of grief of a widowed mother and her children.

As part of the interview process with 52 widows with children under 16 years of age, Englander and

Silverman (1975) investigated the following areas: (a) the reaction of the children to their father's deaths, (b) problems experienced in rearing the children that mothers deemed bereavement-related, and (c) what help, if any, was available to widowed mothers. All subjects reported having children gave meaning to their lives at a time when they were experiencing despair and hopelessness; however, they also believed the presence of children made them more acutely aware of their widowed state. The subjects found the children's questions about death and its meaning the most painful issue. In order to make their children feel more secure, some mothers deliberately refrained from crying in the presence of the children, only to learn that this behavior had been interpreted as unfeeling and uncaring by the children.

Mothers of younger children reported experiencing loneliness more acutely due to the longer sleeping periods of their children. Another concern expressed was that more physical care was required for younger children and these mothers had total responsibility for child care. Enuresis and sleeplessness occurred among younger children.

In older children three reactions were described: (a) fear of losing the surviving parent; (b) assumption of special responsibilities in the family, particularly increased involvement in the care of younger siblings; and (c) social withdrawal, decline in school performance, and apathetic behavior. The most extreme reactions were found in boys between 11 and 14 years of age. The widowed mothers stated that relatives offered little assistance during the bereavement period.

The chronological age and developmental stage of the child whose father has died have been identified as determinants of the child's reaction to the loss and as influencing factors in behavioral problems exhibited by the child. Behavioral problems of children, in turn, have influenced the adjustment period of the widowed mothers. Furman (1974) developed case histories of 23 children who had experienced the death of a parent and who were followed in therapy. A referral for one of the children for psychological counseling was for specific assistance in grief work. The remaining 22 subjects were referred for learning problems, self-hurting tendencies, difficulties in social relationships, inhibition of speech and mobility, sleep disturbances,

and disciplinary problems. Histories of the children revealed various precipitating factors thought to have contributed to deviant behavior, however, the therapists agreed the parents' deaths were of significance in the development of pathology in the subjects (Furman, 1974).

In a study by Glick et al. (1974), widowed mothers stated that one of their primary concerns was that fatherlessness might have deleterious effects on their children's development. The mothers expressed concern that their sons were lacking a male role model and their daughters were receiving a distorted view of the role of an adult women. The 40 mothers believed that they had two conflicting tasks--positively influencing the morale of their children while at the same time being honest, straightforward, and helping them face reality.

In describing how bereavement had affected their parenting, some mothers reported they had become more authoritarian, believing that having total responsibility for children demanded increased firmness. Other mothers reported they had adopted a more permissive approach with their children, had become more indulgent, and found themselves treating their children more like equals. The rationale offered for permissive behavior

was twofold: mothers hesitated to be "hard" on bereaved children and in their loneliness were fostering more companionable behavior from their children. Mothers of older children reported more difficulty maintaining parental control of their children and believed their authority became questionable without a father's support and reinforcement.

Glick et al. (1974) extended their investigation to include interviews with the children of the widowed subjects. The children expressed concern that they themselves might die, a fear attributed to the recent personal reminder of mortality. Older children viewed themselves as having increased standing in the family due to the loss of the father.

Rosenblatt (1967) stressed the importance of the correlation of a child's stage of development with the reaction to the loss of the father. Rosenblatt observed that children tended to ask age-relevant questions regarding their deceased fathers, a reaction mothers found disturbing. The author advised mothers to remember the directness and inquisitiveness of children and to refrain from judging them as insensitive or uncaring.

Rosenblatt (1967) also described the oedipal stage of development as a potential time for pathological grief

reaction. A child in the oedipal stage might have been experiencing ambivalence, love yet hate, toward the father whom the child saw as a rival and for whom he/she may have harbored death wishes. If a father died at this particular time, the child, lacking the abstract thinking ability to differentiate the causal effects of wishes from the causal effects of actions, could feel such guilt that psychopathology might develop. Rosenblatt projected another factor contributing to the development of psychopathology in that the child who has lost a father by death might lose his/her mother in an emotional sense. A mother's reaction to her own grief could be so intense that she would inadequately meet her child's emotional needs.

According to Furman (1974), the surviving parent's major task is not simply to mourn in unison with a child. In actuality, this would be an impossible task since parent and child might be at different points in grief work at different times (Furman, 1974). Furman (1974) stated:

> Rather, the adult, through his own mourning and through his support of the child's, conveys that mourning is an appropriate and masterable response to one of life's great hardships. (p. 116)

Furman (1974) defined the following specific tasks for the mother who must help her child through mourning: (a) fulfilling the child's physical and psychological needs; (b) helping the child understand the concrete aspects of death, the specific circumstances and cause of death; (c) helping the child master his anxiety concerning the death; and (d) helping the child differentiate himself appropriately from the deceased parent.

In examining families in crisis, Glasser and Glasser (1970) identified three variables in the histories of mothers and children who had been able to cope effectively with the loss of their husbands and fathers. Families that had adjusted well exhibited involvement with each other, with extended family, and with societal groups. The second variable was integration of the loss into the lives of the survivors in such a manner that their individual growth and development was not hindered, but allowed to follow natural progression. The third variable, adaptation, was demonstrated in the ability of the survivors to be flexible in their individual behavior, their role changes, and as members of a family group (Glasser & Glasser, 1970).

Intervention

Widowhood has been established as a social phenomenon having significant physical and psychological affect on the lives of millions of women of all ages, and being impacted by age, educational level, income, presence of dependent children, and unexpectedness of the husband's death. Thus, questions have been raised concerning which persons or groups, if any, might intervene in the bereavement process and assist widows in their adjustment.

Since physicians and ministers have represented "helping" professions and traditionally have been involved with deaths, Maddison (1968) asked widows in a study of conjugal bereavement if they had found their ministers and physicians helpful in the time of bereavement. In the group of 40 subjects, 19 considered their ministers of no help whatsoever while 3 viewed their ministers as "actively unhelpful." Fewer than 19 of the widows reported their physicians as helpful in any way during the bereavement. Maddison suggested working with widows in the immediate postmortem period in discussion periods in which affect expression was encouraged and opportunity to review the past was provided. The author

further proposed that preventive intervention would promote better physical and mental health for widows.

Widows in a study conducted by Glick et al. (1974) reported they found the funeral directors more helpful than either the physician or minister. The funeral director was viewed as the one person who was able to give concrete, specific directions and advice at a time of disorganization. The widows described the loss of help and support encountered when left "on their own" after the funeral as family and friends withdrew.

Formo et al. (1977) interviewed 162 widows 5 times during a 2-year period following the deaths of their husbands. The interviews were conducted at 1, 3, 6, 12, and 24 months following bereavement. Death was due to cancer in 73 of the cases; 51 deaths were due to cardiovascular diseases; and 38 deaths were due to other causes. Widows in the three groups reported a lack of perceived support from physicians and clergymen. Women whose husbands had died of cancer expressed more anger toward physicians and the medical care system than widows whose husbands died of other causes. The major areas of dissatisfaction were: (a) quality of nursing care, (b) accessibility of physicians, and (c) inadequacy and

inaccuracy of information given. The widows of cancer victims complained that as their husbands' deaths approached nurses and doctors became increasingly less available, tending to leave the wives alone to care for their husbands.

In a self-report measure of adjustment to bereavement 1 to 2 months after the deaths, 38% of women widowed due to cancer were experiencing grief intensely as compared with 23% of widows whose husbands died of other causes. Widows of cancer victims reported persistent nightmares about their husbands' final illnesses. Formo et al. (1977) concluded that the more intense distress of these widows was due to a summation effect of the stress of bereavement and the debilitating effect of the husband's terminal illness. Women widowed due to cancer stated they would have benefitted from counseling and intervention from a caregiver more during the husband's terminal illness than after his death.

Silverman (1967) offered three reasons for the failure of clergymen to be more involved with bereaved widows: (a) lack of time to spend with bereaved subjects individually, (b) failure of the bereaved to make direct requests known, and (c) uncertainty as to type

of support the widow would find most helpful. Silverman (1967) noted that the minister's role has been well defined for the funeral but not for the bereavement period which follows.

Silverman (1967) conducted a study to determine what needed to be done to develop a program of preventive intervention for the widowed under 60 years of age, a group considered at high risk for the development of mental illness. A conclusion of the study was that the most effective caregiver to the bereaved widow was another widow who had resolved grief and adjusted to widowhood.

MacKenzie, Pettipas, and Silverman (1974) described an experimental program begun in response to Silverman's (1967) earlier investigation. Every newly-widowed woman under the age of 60 years in a community was contacted by another widow. The volunteer widows, called "widow-aides," were women who believed they had made a satisfactory adjustment to widowhood and could offer friendship and emotional support, as well as practical advice, to the more recently widowed.

Over a 2 1/2 year period, 430 women were contacted and 286 became involved in the widow-to-widow program.

The two most frequently identified needs of the recently widowed were to ventilate and to ask advice in matters related to helping their children cope with the deaths of their fathers. Every widow who accepted the offer of assistance from a widow-aide reported finding the assistance helpful. The widow-aide was viewed as someone with whom the widow did not have to present an appearance of strength, but in whom she could confide feelings of hopelessness and despair. Another benefit cited by the widows was learning from the widow-aide that feelings being experienced in bereavement were normal. Recent widows expressed the belief that observing the state of adjustment in the widow-aides gave them expectation that their own grief would be time-limited.

D. Blau (1975) disagreed with Silverman's (1974) approach and was critical of the widow-to-widow program. D. Blau expressed concern that a non-professional caregiver might be unable to recognize symptoms of pathology in the bereaved. According to D. Blau, a widowed caregiver might also be inclined to use the relationship for her own purposes, not appreciating the extent to which her own needs might intrude on the situation. This author recommended that community mental health

nurses visit all bereaved persons to assist with the normal work of mourning and to recognize any emotional difficulties that might be developing. D. Blau further proposed that widows have often needed more concrete assistance, particularly with financial and legal matters.

A program of preventive intervention consisting of four basic elements was developed by Barnett, Becker, Brenner, and McCourt (1976). A "widowed line" was made available which allowed individuals to call a counselor whenever advice or an opportunity to ventilate was needed. Home visits were made to widows weekly for a 2 month period following the deaths of their spouses. Social gatherings were held every 2 weeks to provide widows with opportunities to re-enter society by first interacting with those who had resolved successfully their own feelings of loss. Community seminars were conducted, exploring issues of relevance to the widowed in their adjustment process. Since its inception, the program has received an average of 1,200 calls from widows annually. In a program evaluation, 85% of the participating widows described the program as very helpful in their grief resolution and role transition.

In very early literature writers described the need to express feelings of grief. An admonition was given in a Shakespearean play, "to give sorrow words. The grief that does not speak knits up the o'erwrought heart and bids it break" (Shakespeare, 1623/1975, p. 1065). In studies of intervention in the bereavement process of widows and their particular needs in that period, a frequent finding has been the widow's perceived lack of permission to discuss her feelings. Widows have also reported encountering resistance in their efforts to discuss their marriages and their husbands' deaths (Buxbaum, 1974; Golan, 1975; Maddison, 1968; Shneidman, 1976; Silverman, 1967; Toth & Toth, 1980).

Toth and Toth (1980) described the "conspiracy of silence" widows encountered among friends and relatives. Widows interviewed expressed resentment toward others who indicated, either overtly or covertly, that discussions regarding death and grief were not acceptable. Toth and Toth stated that many widows felt a sense of abandonment by their husbands even though cognitively they realized the husband's death was not willful.

Widows also reported feeling guilty about what they might have done differently and were concerned

that they might have failed to treat their husbands as well as they should have. Toth and Toth (1980) claimed that ventilation of such doubts and concerns was essential in grief resolution.

Shneidman (1976) stressed the importance of letting the bereaved express any affective state, even those considered "negative" such as anger, shame, and/or guilt. Shneidman (1973) termed intervention in bereavement postvention, which he further defined as "those appropriate and helpful acts that come after the dire event itself" (p. 192). The purpose of postvention was to assist the survivor to live longer and to live more productively and less stressfully. Shneidman believed the survivor needed abreaction, interpretation, reassurance, direction, and perhaps gentle confrontation. The individual doing postvention assumed the role of "reality tester," becoming for the breaved "the quiet voice of reason."

Lack of encouragement of a widow's expression of affect was attributed by Albrecht (1979) to a cultural reluctance to discuss death and to exhibit openly anger, guilt, or sorrow. Albrecht claimed that emotions such guilt and hostility were normal reactions to the loss of

a loved object and the resulting urge to recover the lost object.

Glick et al. (1974) questioned 49 widows in various stages in their first year of bereavement, regarding which actions by others were found helpful. A frequent finding was that widows had been discouraged from displaying emotions by physicians, relatives, and friends who advised the bereaved to "control themselves." Other widows reported being encouraged to cry at first, then control themselves and display no further emotion. These injunctions were perceived as very unhelpful. Glick et al. expressed belief that a common societal opinion is that grief exists in a certain quantity which if expelled at once exists no more. Noting that bereavement had become a "solitary activity" for many of the widows involved in the study, Glick et al. stressed the widow's need to engage in obsessional review, to relive the events surrounding her husband's death over and over. A further suggestion was that the review was therapeutic in that it gave the widow an opportunity to integrate the emotional and cognitive realities of her loss into her ongoing life. Obsessional review allowed the widow to engage in a search for meaning and make some sense of the death.

Golan (1975) contended the mourning rituals of Orthodox Jewish widows and widows with Eastern backgrounds encouraged overt expression of grief, enabling women to begin more easily the transition from wife to widow. In comparison, widows with Western backgrounds admitted they would like to have grieved more openly but felt restricted by well-meaning relatives. In the study of Isreali women widowed in the Yom Kippur War, Golan concluded that the widow who was unable to find a socially sanctioned outlet for her grief repressed emotions, adopted a facade, and found the transition to widowhood more painful and prolonged.

Clayton et al. (1971) conducted interviews with 76 widows, all of whom reported that they derived benefit from reviewing the terminal illness and death. Benefits cited were the opportunity to express emotions, to confirm the reality of the husband's death, and to reassure themselves that they had done everything possible for their husbands.

Nurse's Role in Intervention

According to Rogers and Vachon (1975), nurses tended to refer bereaved individuals to physicians who medicated them and to clergymen who urged them to have faith and

to pray, thus none of the three caregivers takes ongoing responsibility for the service that is required to meet the needs of the bereaved. Rogers and Vachon (1975) suggested that nurses practice preventive health care by meeting the needs of bereaved individuals. The unique suitability of nurses for intervention in bereavement was attributed to the communications skills which nurses possess and the variety of settings in which nursing is practiced.

The following therapeutic tasks were proposed by Rogers and Vachon (1975) for nurses intervening in the bereavement process:

1. Giving ongoing social and emotional support.

2. Allowing grief to proceed and be expressed without censure.

3. Realizing there may be repressed anger and permitting its expression.

4. Mobilizing family, friends, and professionals to maintain support systems.

5. Encouraging reassessment of the current reality situation.

6. Making suggestions about coping with practical matters.

7. Using termination of the nurse's relationship as another loss and assisting the bereaved to acquire further coping skills in resolving loss.

Buxbaum (1974), agreeing that the expression of emotions was essential for healthier resolution of grief, stressed that the involvement of doctors and nurses in the care of terminally ill patients gave opportunity for the practice of primary health care with the survivors. Buxbaum (1974) outlined six ways in which medical personnel could practice effective intervention in the bereavement process:

1. Helping survivors accept their feelings as natural and normal.

2. Utilizing a vocabulary that clearly establishes and confirms reality.

3. Limiting explanations of death to those that are medical and refraining from theological explanations.

4. Suggesting that grief resolution may take months and that resurgences of grief are to be expected.

5. Realizing that children in a family have grief work to do.

6. Informing survivors of help available to them.

Group therapy for widows has been conducted by Toth and Toth (1980), who projected that nurses are in a position to be involved in the special problems and needs of widows because nursing is still predominantly a female profession and many nurses can expect to become widows.

In group sessions conducted jointly by a nurse and a social worker, widows explored their mutual problems and offered support to each other. Toth and Toth (1980) concluded that the insight developed in group therapy and the understanding gained of normal grief reactions contributed to a healthier resolution of grief in the widowed subjects.

Assertiveness

Assertiveness, as a construct, was founded on the humanistic philosophy which recognizes the unique nature and worth of each human being. The assertive individual believes himself to be an important living being entitled to his thoughts, emotions, and feelings. According to Wolpe (1973), an individual who is assertive can establish close, interpersonal relationships; can guard

against being taken advantage of by others; can make decisions and free choices in life; can recognize interpersonal needs and have them met; and can verbally and nonverbally express a wide range of feelings and thoughts, both positive and negative.

Bloom et al. (1975) described assertive behavior as the "golden mean" between aggressiveness and non-assertiveness. The non-assertive woman was viewed as one who allows others to choose for her and who feels anxious and disappointed. In contrast, a self-enhancing woman was described as confident and direct in expressing herself.

Jakubowski (1973) defined assertive behavior as interpersonal behavior characterized by standing up for personal rights without violating the rights of others. Inherent in assertive behavior was the expression of personal feelings, opinions, and beliefs. In non-assertive behavior personal feelings, opinions, and beliefs were either not expressed or expressed in such an anxious manner that others disregarded them. The assertive individual has been described not only as one who is able to express feelings but who is also self-assured and independent.

Galassi, Gay, and Hollandsworth (1977) related assertiveness to the constant social dominance, which involved influencing and controlling one's interpersonal environment. Galassi, Gay, and Hollandsworth (1975) developed an assertiveness inventory which was administered to 464 subjects. Subjects were also asked to describe themselves using an adjective checklist. Higher scores on the assertiveness inventory correlated with higher ratings of self-confidence and independence.

Alberti and Emmons (1978) defined assertive behavior as

> behavior which enables a person to act in his or her own best interests, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, or to exercise personal rights without denying the rights of others. (p. 2)

Exercising assertive behavior was viewed as a method of developing a more enhancing personal existence on one's own and facilitating personal growth. Three barriers to self-assertiveness were described: (a) many individuals do not believe they have the right to be assertive, (b) many individuals are highly anxious and/or fearful about being assertive, and (c) many individuals lack the social skills necessary for effective self-expression. Alberti and Emmons (1978) proposed that

behavior was learned and that assertiveness was a combination of learned skills and not an inborn trait; therefore, individuals could overcome the barriers and learn self-assertiveness.

Assertiveness Behavior Training

Assertive training, existing within the general framework of behavior therapy, has been based on social learning theory, the basic premise of which is that behavior is learned, hence it can be unlearned and replaced by new, more effective, and more rewarding behavior. Salter (1961), considered the pioneer of assertive techniques, first described them as a treatment modality for individuals who experienced anxiety in interpersonal relationships. The "inhibitory personality" was viewed by Salter as a person trained in habit systems of inadequacy. The inhibited personality was preoccupied with self, being afraid of responsibility, and afraid to make decisions.

Salter (1961) recommended conditioned reflex therapy to help the inhibited personality overcome low self-sufficiency and become more self-reliant. Treatment was based on reconditioning or learning more effective interpersonal behaviors to replace the

unsatisfying and ineffective habits to which the inhibited personality had become conditioned.

Reyna et al. (1964) claimed that persistent unadaptive habits that have been conditioned or learned developed into neuroses. The unadaptive behavior was described as ineffective, useless, and incapacitating. The most characteristic and common feature of neurotic habits was thought to be anxiety. Wolpe (1973) further suggested that such anxiety was accompanied by repression of feelings which would result in inner conflict. Conflict, in turn, might produce psychosomatic symptoms and pathological body changes.

Reyna et al. (1964) reasoned that if a response inhibitory of anxiety could be made to occur in the presence of an anxiety-evoking stimulus, it would weaken the bond between the stimulus and anxiety. Assertive responses could be taught to an individual with a need to overcome neurotic anxiety. Each act of assertion would, to some extent, reciprocally inhibit the anxiety, thus weakening the anxiety response habit.

Austin and Phelps (1975) contended that learning assertive skills would complement a woman's heightened

awareness of changing values and roles. The assertive woman would learn to overcome, or at least reduce, the anxiety that accompanied significant changes in her life.

Austin and Phelps (1975) outlined three steps in learning new behavior: (a) description or modeling of the behavior, (b) reinforcing the desirable behavior, and (c) receiving accurate and rapid feedback. The authors stated that women traditionally have been expected to "react to situations rather than act to change them" (p. 121). By learning assertive behavior, women could promote personal freedom and power, functioning more autonomously and independently. A consciousness-raising group was proposed as a logical setting in which women could be motivated to learn assertive behavior.

According to Bloom et al. (1975), women have begun to question not only their legacy of passivity and self-effacement, but also the social structure in which it has been perpetuated. Difficulty was expected in teaching women more self-enhancing behavior because the admonition to place the welfare of others first would have become "second nature" to many women. Boom et al.

(1975) claimed assertive training could help bridge the gap between old patterns of behavior and new opportunities. These authors cautioned that learning assertive behavior was not an end in itself, but an ongoing process built on awareness of one's rights and developed with practice. Bloom et al. emphasized that assertive behavior should not be considered a panacea, but as a means by which women could communicate better, improve relationships, satisfy their needs, and like themselves more. Bloom et al. (1975) stated that:

> Once women learn to be assertive, they have a skill that will give them more choices, more independence, more strength, and more control over their own lives. (p. 218)

Hooker (1976) stated that an individual's ability to resolve a crisis depended upon the individual's belief in the contingent relationship between an individual's actions and outcome. A state of learned helplessness existed when one failed to learn the conjunction between action and outcome. Hooker further defined learned helplessness as the ineffective functioning or major disorganization that resulted from unsatisfactory resolution of a crisis. Reactive depression was identified as the emotional manifestation of learned helplessness. A therapeutic strategy suggested by Hooker

was to modify behavior, engaging an individual in a program of behavioral change in which the relationship between behavior and outcome could be experienced and learned.

Rathus (1973) measured assertiveness in a group of 127 females who were outpatients, inpatients, and partial hospital patients in a community mental health center. Rathus Assertiveness Schedule scores were positively related to therapists' descriptions of their patients on scales indicative of activity, happiness, and strength of will. The positive correlation led Rathus to conclude that the greater happiness and activity found in more assertive patients suggested that assertive training might be a useful treatment modality for depression.

In a study of grief reactions in 50 widows, Pomeroy (1975) attempted to measure variables related to a more positive adjustment to widowhood. Two variables determined to be significantly correlated to better adjustment were: (a) the presence of an intimate other, and (b) the widow's independence in her former marital relationship. Pomeroy suggested further research was needed to determine how independence might be learned and how it

might be taught specifically to enable a widow to cope with grief.

Ferguson (1972) hypothesized that marital interaction patterns determined adjustment to widowhood and that more specifically, the pattern of decision-making between husband and wife determined her success at decision-making as a widow. Eighty-six widows were divided into three groups, according to the decision-making patterns established in their marriages. Dominant widows had made more marital decisions than their husbands; the husbands of dependent women had made most of the marital decisions; and equalitarian couples had made an equal number of decisions, often independently. The extent of tranquilizer use was determined in the widows and correlated with their self-assessment of their adjustment to widowhood. Use of tranquilizers was reported by 75% of the dependent widows, 68.4% of dominant widows, and 42.9% of equalitarian widows. Widows who had been equalitarian wives viewed themselves as successfully reorganizing their lives while subjects in the other groups did not. Ferguson concluded that a wife who made decisions independently in her marriage would experience less

difficulty in accepting the reality of her changed circumstances and reorganizing her life.

Barrett (1975) divided 70 widows, aged 32-74 years, into three groups for 7 weeks of group intervention. One group considered a self-help group, had neither facilitator nor specific treatment applied. In the second group each widow was paired with a "confidant," another widow from whom she could draw support. A third group was designated as a consciousness raising group. Psychological functioning, reactions to widowhood, life-style, and attitudes toward women were assessed in a pretest, at the final group session, and again at 3 1/2 months after the termination of the group sessions.

Widows in the consciousness-raising group gave the program the highest ratings of helpfulness and reported the most positive life changes during a 5 to 6 month evaluation period. Barrett (1975) suggested that women who benefitted most from the program were younger widows, the more recently widowed, and those with least forewarning of their husbands' deaths.

Summary

The incidence of widowhood has been shown to be increasing significantly. Inherent in the process of adjustment to widowhood are potential physical, psychological, and sociological problems. Identification of factors affecting postbereavement adjustment is a prerequisite to preventive intervention with this population.

A review of the literature has been presented regarding the concepts of mourning, postbereavement adjustment, and assertiveness. Bereavement, which was analyzed from different theoretical points of view, was reviewed as it is experienced generally by individuals and more specifically by widows. Studies were reviewed which described the problems encountered in adjustment to widowhood and the lack of assistance reported by widows in coping with their problems. Literature reviewed supported the view that nurses are in a unique position to offer assistance to widows. Numerous variables, reported to be associated with adjustment to widowhood, have been explored.

Assertiveness was proposed as a personality variable affecting adjustment to widowhood. Literature was

researched defining assertiveness. A review was presented of studies relating postbereavement adjustment of widows to independent functioning, an essential component of assertiveness.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The problem of this ex post facto study was to determine the relationship between assertiveness and postbereavement adjustment of widows, and to examine these variables in relation to length of widowhood. An assessment of assertiveness and identification of a personality trait that might influence women's adjustment to their husbands' deaths and to the role transition from wife to widow were the major aims of this study. In this chapter, the setting of the research project, the population, ethical consideration for protection of human subjects, tools used for data collection, demographic data, and the procedure for data collection and treatment are discussed.

Setting

The study was conducted in a three-county area of a Southeastern state. The three counties are combined into a regional district for many state and national programs and for health care delivery purposes.

Total population of the three counties was approximately 239,555 persons. The majority of the population is employed in either textile-related industries or agriculture. Data were collected in the homes of the individual subjects.

Population and Sample

The population consisted of women living in a three-county area of a Southeastern state, who had been widowed either for 3 to 12 months or from 3 to 5 years. Names of women widowed in the two time periods chosen for the study were obtained from the obituary columns of a newspaper through a file search. The newspaper used reports all deaths occurring in the three-county area. The obituary listed the widow by name as a survivor.

Plans for the study were made known to 10 area ministers chosen at random. The assumption was made that ministers, having conducted funeral services for deceased husbands, would be able to identify the widows with whom they had been in contact. Only one minister contacted referred a widow for consideration. Women's clubs and a Parents Without Partners organization were also contacted. One self-referral came from a Parents

Without Partners member. There were no referrals from women's clubs.

The sample included 36 women who ranged in age from 27 to 76 years. Educational backgrounds of the subjects ranged from high school incompletion to completion of Master's degree. Fourteen subjects had dependent children. Annual incomes of the subjects ranged from under $10,000 to over $20,000.

Subjects were divided into two groups. Group 1 consisted of 20 women widowed for 3 to 12 months. Group 2 consisted of 16 women widowed for 3 to 5 years. In addition, both groups of widows met the following criteria:

1. First widowhood experience
2. Living with spouse at the time of his death
3. Consent to participate in the study
4. Able to read and write English
5. Residing in one of the three counties comprising the setting of this study.

Protection of Human Subjects

After approval of the research proposal was obtained from the thesis committee and the Human Research Review Committee of Texas Woman's University (Appendix A) and

the graduate school (Appendix B), names of widows were sought from newspaper obituary columns and through ministers. Prospective subjects were sought through notices sent to women's clubs in the three counties and a Parents Without Partners organization. Widows were then contacted by phone to ask if a home visit might be made to discuss the study. The interviews took place in the subjects' homes for the convenience and comfort of the subjects.

The subjects were informed regarding the nature of the study, the purposes of the study, and the time and activity their participation would entail (Appendix C). Subjects were assured of anonymity and confidentiality and were requested to give written, as well as verbal, consent to participate in the study.

The researcher waited for the subjects to complete the instruments and a self-report of demographic data. Data were collected only on those subjects signing the Consent to Act as a Subject for Research and Investigation (Appendix D).

Instruments

Adjustment Scale

Levels of adjustment were measured by administration of the Adjustment Scale (Appendix E) (Carey, 1977) which was designed to measure the degree of adjustment to bereavement. Permission for use of this instrument was obtained (Appendix F). An 8-item Adjustment Scale was developed by Carey from questions widowed men and women were asked regarding their attitudes and feelings. Their responses were scored on a 3-point scale with higher scores indicating a more positive response. A factor analysis indicated that a 1-factor solution was appropriate and a factor loading of .5 was used as a cutoff point.

The Adjustment Scale shows a high degree of internal consistency using the Kuder-Richardson Formula 20 Test for reliability. The scale, which can locate a person on a continuum between adjustment and depression, shows strong agreement with the Bornstein and Clayton (1972) measure of depression. Applying the Bornstein and Clayton measure of depression to Carey's (1977) sample, 26% of the sample was depressed. Using the Carey Adjustment Scale, 25% of the sample was depressed.

Rathus Assertiveness Schedule

Assertiveness levels were measured by administration of the Rathus Assertiveness Schedule (Appendix G) (Rathus, 1973), a self-report inventory that permits reliable and valid assessment of assertiveness or social boldness. Permission for use of this instrument was obtained (Appendix H). Each of the 30 items on the test is rated on a 6-point scale ranging from -3 (very uncharacteristic) to +3 (very characteristic) with a range of possible total scores from -90 to +90.

The test-retest reliability of the Rathus Assertiveness Schedule (RAS) was established by administering the instrument to 68 college undergraduate students. A Pearson product moment correlation coefficient between respondents' pretest and posttest scores yielded an r of .7782, indicating moderate to high stability of test scores ($p < .01$). The Pearson product moment correlation coefficient expresses in numerical terms the direction and magnitude of a relationship, with the values ranging from -1.00 for a perfect negative correlation to +1.00 for a perfect positive correlation (Polit & Hungler, 1978).

Internal consistency of the RAS was determined by having 18 college students administer the test to 67

nonstudent adults (Rathus, 1973). A Pearson product moment correlation coefficient was run between total odd and total even item scores, with the results suggesting that the qualities measured by the RAS possess moderate to high homogeneity ($p < .01$).

In the first validation study conducted by Rathus (1973), again involving college students, Pearson product moment correlation coefficients were run between 67 RAS scores and the scores of a personality trait rating scale administered to raters who knew the 67 subjects well and were willing to rate their impressions of the personality traits of the subjects. Rathus Assertiveness Schedule scores correlated significantly ($p < .01$) with each of the five scale comprising the assertiveness factor of the rating schedule (r = .6124, .6163, .3424, .5374, and .3294, respectively).

A more recent study (Besing, Dinning, & Quillen, 1977) attempted to further standardize the RAS. The scale was administered to 133 college students. A correlated split-half reliability coefficient of .76 and a Kuder-Richardson coefficient of .73 were obtained. In this study, percentile norms were established for the RAS. The individual scoring above 0 in the total

score may be considered assertive and a total score of 0 or below indicates nonassertiveness.

Nevid and Rathus (1977) administered the RAS to 191 psychiatric patients, including neurotics, schizophrenics, and personality disorders. This was done to determine if the instrument, which had concurrent validity established in college and general adult populations, had validity for persons manifesting behavioral disorders. Concurrent validity was established by comparison of RAS scores with therapists' ratings of patients' assertiveness on semantic differential scales defining a general assertiveness factor. A split-half reliability coefficient, corrected for length by the Spearman-Brown formula, of .95 was found. In this procedure the test items are divided into two groups, according to odd and even questions. A correlation between the two half-tests was obtained to determine whether the halves are measuring the same characteristic, thus estimating the internal consistency of the scale (Polit & Hungler, 1978).

Demographic Data

A demographic data form (Appendix I) was used to collect information to describe the sample. The data

which were collected included age, length of time widowed, cause of husband's death, number and ages of children under 18 years, educational background, and annual family income at the present time.

Data Collection

Names of women widowed for 3 to 12 months and names of women widowed 3 to 5 years were obtained from the obituary columns of a newspaper through a file search. Widows whose names were obtained were contacted by telephone and asked if a home visit could be made. In the home visit the purposes of the study were explained using a standardized explanation form. After written consent was obtained the instruments were administered to those widows who were willing to participate.

A total of 40 home visits was made. Four willing participants could not be used as subjects after it was determined in the course of the visit that delimitations of the study prohibited their participation. One of the women who volunteered to participate had been widowed twice and three volunteers had been widowed for time periods inappropriate for inclusion in the study. The home visits required approximately 1 to 3 hours.

Time required to complete the instruments used in the study was approximately 30 minutes; however, visits were extended necessarily to meet the needs of those subjects desiring to discuss further their widowhood experiences.

Treatment of Data

For each subject two scores were calculated. The Rathus Assertiveness Schedule score was the total score obtained by adding the numerical responses to each of the items on the Rathus Assertiveness Schedule, after changing the signs of reversed items. High Rathus Assertiveness Schedule scores (1-90) correspond to assertive responses while low scores (0 to -90) correspond to nonassertive responses.

The Adjustment Scale score was the total of the numerical responses to the eight items. High Adjustment Scale scores (16-24) corresponded to moderately or well adjusted responses while low Adjustment Scale scores (0-15) corresponded to depressed responses.

The chi-square test was used to determine if there were significantly more adjusted widows than nonadjusted and more assertive widows than nonassertive. Mann-Whitney's U Test was used to compare the Adjustment

Scale scores of the two groups. The U Test was also used to compare the Rathus Assertiveness Schedule scores.

Pearson's correlational coefficient was used to correlate adjustment and assertiveness scores for both groups. The Pearson correlational coefficients of the two groups were statistically compared using Fisher's test to determine if the strength of the relationship between adjustment and assertiveness scores was different due to the variation in length of widowhood in the two groups. Descriptive statistics were presented for the two groups for both scores.

Demographic data, including the variables length of time widowed, forewarning of spouse's death, presence and number of dependent children, educational background, socioeconomic status, and age were presented for both groups. A regression analysis was done to determine if there was a relationship between the demographic, or independent, variables and the Adjustment Scale scores. A .05 level of significance was used as a basis for the rejection or acceptance of the hypotheses.

CHAPTER 4

ANALYSIS OF DATA

In this chapter the data collected will be analyzed in two parts. First the research sample will be described according to the demographic variables examined in the study. Analysis of the four hypotheses of the study will follow. Data collected regarding demographic variables and the two instruments administered will be presented in tabular form, along with appropriate statistical analyses. Lastly, the findings of the study will be summarized.

Description of Sample

The frequency distribution of length of time widowed is shown in Table 1. Twenty subjects, or 55.5%, of the sample had been widowed 3-12 months and 16 subjects, of 44.4%, had been widowed 3-5 years.

The frequency of anticipated and nonanticipated deaths of spouses is presented in Table 2. Nine subjects, or 25%, had forewarning of their husbands' deaths. Twenty-seven subjects, or 75%, had no forewarning of their husbands' deaths.

Table 1

Frequency Distribution of Responses Regarding Length of Widowhood

Length of Widowhood	Frequency Distribution	Percentage
3-12 months	20	55.5
3-5 years	16	44.4

n = 36.

Table 2

Frequency Distribution of Responses Regarding Anticipation of Spouses' Deaths

Anticipation of Spouses' Deaths	Frequency Distribution	Percentage
Anticipated deaths	9	25
Nonanticipated deaths	27	75

n = 36.

The frequency distribution of dependent children under 18 years of age is presented in Table 3. Twenty-two subjects, or 61.1%, had no dependent children under 18 years of age and 38.3%, or 14 subjects, had dependent

children under 18 years of age. Ages of dependent children ranged from 17 months to 18 years. Of the 14 subjects having children under 18 years of age, 50% had 1 child, 14.2% had 2 children, and 35.7% had 3 children.

Table 3

Frequency Distribution of Dependent Children

Dependent Children	Frequency Distribution	Percentage
Dependent children under 18 years of age	14	38.3
No dependent children under 18 years of age	22	61.1

$\underline{n}$ = 36.

The frequency distribution of the educational levels of the subjects is given in Table 4. High school graduates and technical school graduates numbered 10 respectively, thus each of these groups accounted for 27.7% of the total distribution. There were 8 college graduates among the subjects, comprising 22.2%, and 8 subjects who were in a group categorized as "other,"

accounted for the remaining 22.2% of the distribution. In the group designated "other" were 3 subjects who had never graduated from high school, 3 subjects who had completed 1-3 years of college, and 2 subjects with Master's degrees.

Table 4

Frequency Distribution of Levels of Education

Level of Education	Frequency Distribution	Percentage
High school graduate	10	27.7
Technical school graduate	10	27.7
College graduate	8	22.2
Other	8	22.2

$n = 36$.

Table 5 presents the frequency distribution of annual income of the subjects. Twelve, or 33.3% of the subjects, had an annual income of less than $10,000. Fourteen subjects, or 38.8%, reported an annual income between $10,000 and $20,000. Ten subjects, or 27.7%, had an annual income above $20,000.

Table 5

Frequency Distribution of
Annual Income

Annual Family Income	Frequency Distribution	Percentage
Under $10,000	12	33.3
$10,000-$20,000	14	38.8
Over $20,000	10	27.7

n = 36.

Descriptive statistics for the ages of subjects in the two groups are depicted in Table 6. Ages of subjects ranged from 27 years to 76 years.

Findings

An analysis of the four null hypotheses posed for this study are as follows:

Hypothesis 1 stated: There are not significantly more assertive widows than nonassertive widows as measured by the Rathus Assertiveness Schedule. The Rathus Assertiveness Schedule is a self-report inventory containing 30 items. Each item is rated on a 6-point scale that ranges from -3 (very uncharacteristic) to +3 (very characteristic), with a range of possible

Table 6

Frequency Distribution, Means, and Standard Deviations of Subjects by Age

Subject Groups	Frequency Distribution	Mean Age	Standard Deviation
Subjects widowed 3-12 months	20	50.40	12.898
Subjects widowed 3-5 years	16	52.88	13.798

$\underline{n}$ = 36.

total scores from -90 to +90. Using previously established scoring norms (Besing et al., 1977), a score above 0 was considered indicative of behavior as assertive in the majority of respondents and a score of 0 or below indicated nonassertive behavior. Table 7 presents the Rathus Assertiveness Schedule results.

Using the chi-square test to compare the non-assertive subjects to the assertive, a chi-square value of 7.11 was determined. The results are significant at less than .01, therefore Hypothesis 1 was rejected. Thus, more subjects reported being assertive than non-assertive.

Hypothesis 2 stated: There are not significantly more widows adjusted to bereavement than widows not adjusted to bereavement as measured by the Adjustment Scale. The Adjustment Scale (Carey, 1977) is an 8-item adjustment to bereavement and depression or poor adjustment. A maximum score of 24 is possible, with a score of 21-24 signifying a well adjusted individual, 16-20 a moderately adjusted individual, and 8-15 a poorly adjusted individual. For the purposes of this study, moderately or well adjusted subjects were categorized adjusted and poorly adjusted subjects were categorized

Table 7

Frequency Distribution and Percentages of Assertive and Nonassertive Subjects According to Length of Widowhood

Subject Groups	Assertive		Nonassertive	
	n	Percentage	n	Percentage
Subjects widowed 3-12 months	14	53.8	6	60.0
Subjects widowed 3-5 years	12	46.1	4	40.0
Totals	26		10	

n = 36.

as nonadjusted. The results of the Adjustment Scale are presented in Table 8.

Using the chi-square test to compare the poorly adjusted subjects to the moderately and well adjusted subjects, a chi-square value of 4 was determined. The results are significant at less than the .05 level. Therefore Hypothesis 2 was rejected. Thus, in the sample there were significantly more adjusted widows than nonadjusted widows.

Hypothesis 3 stated: There is no relationship between levels of assertiveness of widows and their levels of adjustment to widowhood. Pearson's correlational coefficient was used to correlate adjustment and assertiveness scores for widows of 3-12 months and those of 3-5 years. Pearson's correlation measures the amount of association between two factors, with the coefficient always being between -1 and +1. Coefficients equal to 1 or -1 show a perfect linear relation. When the coefficient is negative, the relationship is inverse. Coefficients between 0 and $\pm$.4 indicate a low degree of association, those between $\pm$.4 and $\pm$.7 indicate a moderate degree of association, and those between $\pm$.7 and $\pm$1 indicate a high degree of

Table 8

Levels of Adjustment Among Subjects According to Length of Widowhood

Subject Groups	Poorly Adjusted		Moderately Adjusted		Well Adjusted	
	n	Percentage	n	Percentage	n	Percentage
Subjects widowed 3-12 months	7	58.3	9	64.2	4	40
Subjects widowed 3-5 years	5	41.7	5	35.7	6	60
Total	12		14		10	

n = 36.

association. Table 9 presents the Pearson's correlational coefficients between Rathus Assertive Schedule scores and Adjustment Scale scores for the two groups. Associated with the Pearson coefficient is the significance level or p value. If the p value is less than .05, then the level of association indicated by Pearson's coefficient is not attributable to chance. It is indicative of a nonrandom relationship between the two factors.

The correlation for subjects widowed 3-12 months was .6138 and p = .002, a significant degree of association. In the group widowed 3-5 years the coefficient was .5620 and the p value .012. Thus, there was a moderate amount of association between the Rathus Assertiveness Schedule scores and Adjustment Scale scores for both groups. This implies that widows in both groups with high Adjustment Scale scores had correspondingly high Rathus Assertiveness Schedule scores. Those with low Adjustment Scale scores had correspondingly low Rathus Assertiveness Schedule scores.

The coefficients of the two sets of Adjustment Scale scores were further subjected to regression analysis, along with the coefficients of the independent

Table 9

Pearson Correlational Coefficients for Assertiveness and Adjustment of Subjects According to Length of Widowhood

Subject Groups	n	Correlational Coefficient between Rathus Assertiveness Schedule and Adjustment Scales	p value
Subjects widowed 3-12 months	20	.6138	.002
Subjects widowed 3-5 years	16	.5620	.012
Total	36		

variables. Regression analysis models the relationship between one dependent variable, in this study the Adjustment Scale scores, and a set of independent variables. The analysis produces a coefficient or weight for each of the independent variables which indicates the contribution of that factor in the model. The independent variables, their coefficients, and corresponding significance levels are listed in Table 10.

Two conclusions were drawn from the regression analysis:

1. The coefficient for the two subject groups (-1.956) with $p = .6161$, indicated that after adjusting for all of the other factors there was no significant difference in the Adjustment Scale scores between the two groups.

2. The coefficient for the Rathus Assertiveness Schedule scores (.071) with $p = .0184$, indicated there was a significant amount of association between the Rathus Assertiveness Schedule scores and Adjustment Scale scores. This is consistent with the conclusion based upon the Pearson correlation coefficients. The two statistical analyses support a relationship between the assertiveness of widows and their adjustment to widowhood. Therefore, Hypothesis 3 was rejected.

Table 10

Coefficients from Regression Analysis between Adjustment Scale Scores and Independent Variables

Independent Variables	Coefficients/ Weights	Significance Level (p)
Age	.051	.5106
Length of time widowed	.050	.6287
Anticipated or nonanticipated deaths	-.975	.5739
Dependent children	1.007	.3512
Income level	1.395	.1800
Rathus Assertiveness Schedule scores	.071	.0184
Subject Group (3-12 months widowed) (3-5 years widowed)	-1.956	.6161
Educational Level:		
High school graduate	-2.164	.3200
Technical school	- .939	.6400
College (removed)	--	--
Other	2.629	.3951

n = 36.

Fisher's test was used to determine if the strength of the relationship between adjustment and assertiveness scores was different due to the variation in length of widowhood in the two groups. The results are shown in Table 11.

The conclusion of this analysis was that there was no significant difference between the amount of association as measured by Pearson's coefficient between Adjustment Scale scores and Rathus Assertiveness Schedule scores for the two subject groups.

Hypothesis 4 stated: There is no significant difference between widows of 3-12 months and those 3-5 years in levels of assertiveness and levels of adjustment to widowhood. The statistical analysis of the Rathus Assertiveness Schedule scores is shown in Table 12. Rathus Assertiveness Schedule scores were determined after reversing the indicated 16 of the 30 items.

The Mann-Whitney U Test, a nonparametric procedure for testing the difference between two independent samples, was used to compare the Rathus Assertiveness Schedule scores of the two groups. The test resulted in a calculated U value (182.50) and a corresponding p value (.430). The p is the probability of observing

Table 11

Fisher's z of Adjustment and Assertiveness of Subjects According to Length of Widowhood

Subject Group	n	Pearson's Coefficient	Fisher's z	p
Subjects widowed 3-12 months	20	.6138		
			0.323	.749
Subjects widowed 3-5 years	16	.5620		
Total	36			

Table 12

Means and Standard Deviations of Rathus Assertiveness Schedule Scores According to Length of Widowhood

Subject Group	Frequency Distribution	Mean Score	Standard Deviation
Subjects widowed 3-12 months	20	6.55	30.060
Subjects widowed 3-5 years	16	13.938	29.816

$\underline{n}$ = 36.

a sample that would show more of a difference. Since the p value was large (> .05) the difference in the ranking of the Rathus Assertiveness Schedule scores for the two groups was negligible and attributable to chance. A conclusion of the findings was there was no significant difference in the Rathus Assertiveness Schedule scores for the two groups.

Adjustment scale scores were obtained by affixing the designated numerical value to the responses of subjects and then adding the numerical values. In Table 13 statistical analysis of the Adjustment Scale scores of the subjects is presented.

The Mann-Whitney U Test was used to compare the rankings of the Adjustment Scale scores for the two groups. The test resulted in a calculated U value (180.50) and a corresponding p value (.436). Since the p value is large (> .05), the difference in the ranking of the Adjustment Scale scores for the two groups was negligible and attributable to chance.

The results of the Mann-Whitney U tests indicated an absence of relationship between widows of 3-12 months and those widowed 3-5 years in assertiveness and adjustment. Therefore, Hypothesis 4 was not rejected.

Table 13

Means and Standard Deviations of Adjustment Scale According to Length of Widowhood

Subject Group	Frequency Distribution	Mean Score	Standard Deviation
Subjects widowed 3-12 months	20	17.20	3.722
Subjects widowed 3-5 years	16	17.56	5.202

n = 36.

Summary of Findings

The research sample was described in terms of the following demographic variables: length of time widowed, forewarning of spouse's death, presence of dependent children, educational background, annual income, and age. A regression analysis failed to establish a significant relationship between the adjustment of widows and the demographic variables.

Data collected indicated there were significantly more assertive than nonassertive widows. Hypothesis 1, which predicted no significant difference, was rejected. In analyzing the results of the study it was determined that there were significantly more adjusted widows than nonadjusted widows. Thus, Hypothesis 2, which predicted no significant difference, was rejected.

Scores of the two instruments administered to subjects in this study were compared through statistical analysis. Correlational coefficients were provided for the two rankings of scores. The statistical analysis revealed a significant relationship between the Rathus Assertiveness Schedule scores and the Adjustment Scale scores for subjects widowed 3-12 months and for those widowed 3-5 years. The degree of significance led to

the rejection of Hypothesis 3, which predicted the absence of a relationship between the two factors. Widows of 3-12 months did not differ significantly from widows of 3-5 years in either adjustment to widowhood or assertiveness. Therefore, Hypothesis 4 was not rejected.

CHAPTER 5

SUMMARY OF THE STUDY

The problem of this study was to determine the relationship between levels of assertiveness and adjustment in widows and their length of widowhood. The sample was composed of one group of subjects who had been widowed 3-12 months and one group of subjects who had been widowed 3-5 years.

This chapter includes a summary of the study, discussion of findings, and conclusions and implications drawn in regard to widows and the effects of assertiveness or adjustment to widowhood. Lastly, recommendations for further study are made as the result of the findings.

Summary

The data for this study were collected in a three-county area of a Southeastern state. The sample consisted of 20 women widowed 3-12 months and 16 women widowed 3-5 years. Plans for the study were made known to ministers who were requested to refer widows of their acquaintance. No referral came from this source.

Women's clubs in the area and a Parents Without Partners organization were contacted and information concerning the study was made available. One self-referral resulted from this contact. The remaining subjects' names were obtained from the obituary column of a daily newspaper published in one of the counties. Written permission was obtained from the Human Research Review Committee of Texas Woman's University before contacting subjects. Widows were contacted and asked to participate in the study. A standardized oral presentation was made to each subject, explaining the purpose of the study and any risks involved. A written consent form was obtained from each subject. Data were collected in the homes of subjects. An offer was made to make available the results of the study to each subject.

Subjects were described in terms of demographic variables. No significant correlation was established between these demographic variables and adjustment to widowhood.

The Adjustment Scale (Carey, 1977) was used to determine the level of adjustment to widowhood in subjects. The instrument consisted of 8 items and was scored on a 3-point scale with higher scores indicating

a more positive adjustment. The Rathus Assertiveness Schedule (Rathus, 1973) was administered to determine the assertiveness levels of the subjects. The schedule consisted of 30 items rated on a 6-point scale that ranged from -3 to +3 with a range of possible total scores from -90 to +90.

The chi-square test was performed to determine if there were more adjusted than nonadjusted widows and more assertive than nonassertive widows. Mann-Whitney's U test was used to compare the Adjustment Scale scores and the Rathus Assertiveness Schedule scores of the two groups. Pearson's correlational coefficient was used to correlate adjustment and assertiveness scores for the two groups. The Pearson correlational coefficients were compared using Fisher's Test to determine if the strength of the relationship between adjustment and assertiveness scores was different due to the length of widowhood. The results revealed a significant relationship between the assertiveness of widows and their adjustment to widowhood. This relationship was not significantly affected by length of widowhood. A regression analysis was done to determine if demographic variables affected adjustment and to further support the

relationship identified between assertiveness and adjustment.

Discussion of Findings

Subjects in this study were significantly more assertive than nonassertive. Similarly, there were significantly more adjusted than nonadjusted widowed subjects. A significant finding was that there was a relationship between the personality variable assertiveness and adjustment to widowhood.

In comparing a group of subjects widowed 3-12 months with a group of subjects widowed 3-5 years, it was determined that there was no significant difference in the two groups in assertiveness and adjustment to widowhood. No relationship was established between adjustment to widowhood and any of the demographic variables identified in the literature review as having impact on resolution of bereavement and adjustment to widowhood. These factors were: length of widowhood, anticipation or nonanticipation of the spouse's death, presence of dependent children, educational level, socioeconomic status, and age.

There are several possible interpretations for the non-significant findings regarding the demographic

variables examined in the study. Lack of significance in research findings implies a lack of evidence, rather than an absence of correlation or relationship. Lack of evidence in this study could be the result of the limited sample size. Another possible factor could be the extensive number of variables being examined. Complexity of the interrelatedness of variables such as behaviors, states, attitudes, and characteristics was thought by Polit and Hungler (1978) to contribute to faulty interpretation, a weakness these authors identified in correlational research. Restriction of the number of variables in this study might have produced more significant data.

According to statistical evidence in literature reviewed, the median age of widows in the United States in a recent year was 56 years of age. While the ages of subjects in this study ranged from 27 to 76 years, the median age was 51.64, somewhat younger than the statistical median. Failure of age to relate to adjustment might have been due to the wide range of ages of subjects. A more positive relationship might have been determined if subjects had been controlled for age.

Socioeconomic status, which has been thought to have impact on adjustment to widowhood, did not

positively relate to adjustment in this study. Figures for 1977 (Statistical Bulletin, 1977) issued by the Metropolitan Life Insurance Company, gave the average death benefits received by widows as $8,000 after death expenses. Studies by Arling (1976) and Lopata (1973) have cited elderly widows as the poorest members of society with as many as 100% of the elderly widows in these respective studies existing on income levels below poverty levels. Although one-third of the subjects in the present study had an annual income of less then $10,000, 10 of the subjects had annual incomes over $20,000. Broad income categories were chosen for this study out of consideration for the subjects. More accurate data could be obtained if exact income had been determined and compared to adjustment.

Similarly, more significant data likely would have been obtained if the variable of education had been controlled. Educational levels of the subjects ranged from the extremes of high school incompletion to Master's degrees.

The finding in the present study that the presence of dependent children was not significantly related to adjustment could be viewed as support for the ambivalence

that is reported to exist regarding that variable. For some widows the presence of children constitutes a purpose in life in a time of great sorrow. For others total responsibility for the economic support and parenting of children complicates the adjustment process.

In the present study, there was no significant relationship between forewarning of the husband's death and adjustment to widowhood. An influencing factor may have been the disproportionate number of subjects in each category. In order to determine if anticipation of the spouse's death facilitated adjustment, a larger sample who had forewarning would need to have been studied.

The mean scores on adjustment of the women widowed 3-12 months and those widowed 3-5 years showed little difference. Literature reviewed (Clayton, 1974; Clayton et al., 1971) supported the view that grief resolution may take longer than 1 year and that even after a healthy resolution has been reached, resurgences of grief may still occur. In evaluating the lack of significance in adjustment in the two groups of subjects in the present study, two possible factors are considered. Grief resolution may indeed take longer than 1 year. Another

possibility is that by the time 3 months have passed, a widow, having already experienced the most intense feelings of grief, may have arrived at a level of adjustment that will remain relatively constant.

The relationship between assertiveness and adjustment to widowhood was found to be significant in the present study. Widows have reported receiving little, if any, support in their adjustment to their loss and to their role change. The woman who is more assertive might adjust more easily to widowhood for two reasons. An assertive widow might be able to take control of her life and function more independently than a nonassertive widow. At the same time an assertive widow would be more likely to acknowledge her needs and ask for the support she desires from others.

A factor that must be considered is the decision made voluntarily by the subjects to participate in the study. This could be indicative to a more assertive approach to life in that the widow made a choice and was willing to engage in an interview with the unknown investigator.

Consideration must also be given to the possibility that a reversed relationship exists between the

two factors examined in the present study. The independent functioning required in adjusting to widowhood may increase the assertiveness of women. Assertive behavior may become a coping mechanism for the widow who faces the often solitary tasks of working through grief, adjusting to role change, and assuming increased responsibility.

Conclusions and Implications

The following conclusions were drawn with regard to widows and the effects of assertiveness or adjustment to widowhood:

1. There are significantly more assertive widows than nonassertive widows.

2. There are significantly more adjusted widows than nonadjusted widows.

3. There is no significant difference in adjustment to widowhood and assertiveness of women widowed 3-12 months and women widowed 3-5 years.

4. There is no significant relationship between adjustment to widowhood and any of the following demographic variables: length of widowhood, anticipation or nonanticipation of the spouse's death, presence of

dependent children, educational level, socioeconomic status, and age.

5. There is a significant relationship between assertiveness of widows and their adjustment to widowhood.

The conclusion drawn regarding the relationship between assertiveness and adjustment to widowhood has several implications. The 10,000,000 widows in the United States today represent a significant portion of the total population. According to statistical evidence there will continue to be an increase in the number of widows in the United States. Widows have been identified as a group at risk of deterioration in physical and mental health due to the extreme level of stress encountered in the deaths of their spouses. The transition from wife to widow involves role change for which a woman is not typically prepared. The transition may be further complicated by the stressors of reduced income and total responsibility of dependent children. Compounding the problematic role change is the widow's perceived lack of support in the adjustment to widowhood.

If widows are going to become an even more sizeable portion of the population and ever increasing

numbers of women are going to be faced with adjustment to widowhood, it is important to define factors that might influence the adjustment process. Similarly, if widows do find little, if any, purposeful intervention in their bereavement and adjustment to widowhood, it is important to identify potential caregivers.

A particularly significant factor in the conclusion regarding assertiveness and adjustment to widowhood is that assertiveness is a personality variable that can be fostered and developed. Since behavior is modifiable, nonassertive behavior can be changed. As part of the women's movement of recent years, assertive training has been offered to women. This training could be offered to widows who experience difficulty in the adjustment to widowhood. An even more effective situation would be to expand the development of assertiveness in women in general so they would be better prepared to encounter stressors and experience role change.

From the literature review it is obvious that a particular need of the widow in bereavement is that of ventilation, to express whatever affective state she is experiencing, and to review her marriage and her

husband's death (Clayton et al., 1971; Toth & Toth, 1980). Another identified need is to know the normal course of bereavement. Group therapy would appear to be a logical and appropriate modality for meeting both these needs (Toth & Toth, 1980). In group therapy widows could learn more of what to expect in the bereavement period and in the adjustment to widowhood. Sharing experiences with other widows could reduce the feelings of being different and alone reported by many widows.

Group therapy could be didactic in nature, with assertiveness being taught. The group setting would provide opportunity for behavior rehearsal, feedback, and validation. The assertive individual has been described as one who can make decisions and choices, who can guard against being taken advantage of, and who can recognize interpersonal needs and have them met. The assertive individual is more self-assured and independent. Thus, becoming more assertive should facilitate the transition a woman must make from wife to widow.

As members of a profession that currently is almost exclusively female, nurses should be particularly

sensitive to the needs of the widowed population. A development of recent years has been to include theories of death and dying in nursing curricula so that nurses could meet more effectively the needs of dying patients. Attention should also be focused on the needs of bereaved families. Nurses in hospital settings could assist widows by helping them recognize what is expected in a normal course of bereavement. The communication skills of nurses would facilitate the development of a relationship that would permit the widow expression of feelings.

A further reason for nurses to be concerned with meeting the needs of this population is the preventive aspect. Primary nursing intervention, or the prevention of the development of mental and/or physical illness, is a current nursing trend. Psychiatric-mental health nurses appear to be uniquely suited to offer a preventive health measure to widows. Not only are these nurses prepared to conduct group therapy, but numbers of psychiatric-mental health nurses are acquiring skills in teaching assertive behavior as part of their clinical expertise. The combination of group therapy and assertive training could be effective

in assisting a woman to cope with the death of her husband and to be able to function in her new role more independently and effectively.

Recommendations for Further Study

As a result of this study, the following recommendations for further research are made:

1. A similar study using a larger sample would provide more significant data.

2. Replication of the study with delimitation of the demographic variables examined might produce more significant data.

3. Measurement of adjustment in a group of widows before and after they are given assertive training is recommended.

4. Provision of assertive training to a group of widows and comparison of their adjustment to widowhood with control subjects not offered assertive training would provide a more complete and significant data base.

5. Replication of the study, using an instrument that would measure factors significant in adjustment other than depressive symptomatology, is recommended.

APPENDIX A

TEXAS WOMAN'S UNIVERSITY

Human Research Committee

Name of Investigator: Juanita Patrick Center: Dallas

Address: 107 Manchester Drive Date: 11/26/79

Spartanburg, S. Carolina 29301

Dear Ms. Patrick:

Your study entitled Relationship Between Levels of Assertiveness and Levels of Adjustment in Widows has been reviewed by a committee of the Human Research Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education and Welfare regulations require that written consents must be obtained from all human subjects in your studies. These forms must be kept on file by you.

Furthermore, should your project change, another review by the Committee is required, according to DHEW regulations.

Sincerely,

Estelle D. Kurtz

Chairman, Human Research Review Committee

at Dallas

APPENDIX B

TEXAS WOMAN'S UNIVERSITY

DENTON, TEXAS 76204

THE GRADUATE SCHOOL

February 27, 1981

Mrs. Joyce Juanita Wilson Patrick
107 Manchester Drive
Spartanburg, SC 29301

Dear Mrs. Patrick:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Robert S. Pawlowski
Provost

RP:dl

cc Ms. Estelle Kurtz
Dr. Anne Gudmundsen
Graduate Office

APPENDIX C

Oral Presentation to Subjects

I am a student of Texas Woman's University, completing requirements for a Master of Science degree in Nursing. I am carrying out a study of widows in order to determine which factors might influence a woman's adjustment to widowhood. If these factors are identified and understood, hopefully, nurses in their practice may be able to assist widows in this adjustment process.

To obtain information for my study, I am asking widows to answer three questionnaires. One asks seven questions seeking basic demographic data: age, level of education, cause of husband's death, number and ages of dependent children, length of time widowed, and socioeconomic status. The other two questionnaires ask about your feelings and how you express yourself. There are no right or wrong answers. The estimated time for completion is 30 minutes.

Participation in this study is voluntary and a signed consent form will be requested. If you experience any discomfort in answering the questionnaires or for any reason desire to withdraw from participation, please feel free to do so.

The forms upon which you answer the questions and any information you may give me will be kept confidential. Your name will not be written on any of the forms and will remain unknown.

In you are interested, I will be glad to share with you, by mail, the results of the study when it is completed. Thank you very much for your willingness to participate in this study.

Juanita Patrick

APPENDIX D

TEXAS WOMAN'S UNIVERSITY

(Form B--Oral presentation to subject)

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time.

_____ _____
Signature Date

_____ _____
Witness Date

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

_____ _____
Signature Date

_____
Position

_____ _____
Witness Date

APPENDIX E

ADJUSTMENT SCALE

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

Please answer according to the following key:
1--Yes
2--Uncertain (to some extent)
3--No

1.	Is loneliness a serious problem for you?	1	2	3
2.	Do you feel you are about to go to pieces once a month or more?	1	2	3
3.	Are you sometimes so unhappy that you would not care if you died tomorrow?	1	2	3
4.	Are you at peace and content most of the time?	1	2	3
5.	Do you often feel depressed (sad, low, blue, despondent)?	1	2	3
6.	Is depression a serious problem?	1	2	3
7.	Do you cry frequently?	1	2	3
8.	Do you sometimes feel your life is futile and empty?	1	2	3

Total Score:
8-15 = Depressed
16-20 = Moderately Adjusted
21-24 = Well Adjusted

APPENDIX F

LUTHERAN GENERAL HOSPITAL

Human Society is the understanding and treatment of the human being and the personal right of his relationship to God himself, his family, and the society in which he lives

August 1, 1976

Ms. Juanita Patrick
107 Manchester Drive
Spartanburg, SC 29301

Dear Ms. Patrick:

Enclosed is a copy of the adjustment scale that you requested. For your use I would suggest retyping the directions to meet your needs, drop the 1, 2, and 3 in the response columns, and omit the scoring code.

Sincerely,

Raymond G. Carey

Raymond G. Carey, Ph.D.
Director
Evaluation and Research Services

RGC/c
Encl.

APPENDIX G

RATHUS ASSERTIVENESS SCHEDULE

Directions: Indicate how characteristic or descriptive each of the following statements is of you by using the code given below.

+3 = very characteristic of me, extremely descriptive
+2 = rather characteristic of me, quite descriptive
+1 = somewhat characteristic of me, slightly descriptive
-1 = somewhat uncharacteristic of me, slightly nondescriptive
-2 = rather uncharacteristic of me, quite non-descriptive
-3 = very uncharacteristic of me, extremely non-descriptive

_____1. Most people seem to be more aggressive and assertive than I am.*

_____2. I have hesitated to make or accept dates because of "shyness."*

_____3. When the food served at a restaurant is not done to my satisfaction, I complain about it to the waiter or waitress.

_____4. I am careful to avoid hurting other people's feelings, even when I feel that I have been injured.*

_____5. If a salesman has gone to considerable trouble to show me merchandise which is not quite suitable, I have a difficult time saying, "no."*

_____6. When I am asked to do something, I insist upon knowing why.

_____7. There are times when I look for a good, vigorous argument.

_____8. I strive to get ahead as well as most people in my position.

_____9. To be honest, people often take advantage of me.*

____10. I enjoy starting conversations with new acquaintances and strangers.

____11. I often don't know what to say to attractive persons of the opposite sex.*

____12. I will hesitate to make phone calls to business establishments and institutions.*

____13. I would rather apply for a job or for admission to a college by writing letters than by going through with personal interviews.*

____14. I find it embarrassing to return merchandise.*

____15. If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance.*

____16. I have avoided asking questions for fear of sounding stupid.*

____17. During an argument I am sometimes afraid that I will get so upset that I will shake all over.*

____18. If a famed and respected lecturer makes a statement which I think is incorrect, I will have the audience hear my point of view as well.

____19. I avoid arguing over prices with clerks and salesmen.*

____20. When I have done something important or worthwhile, I manage to let others know about it.

____21. I am open and frank about my feelings.

____22. If someone has been spreading false and bad stories about me, I see him/her as soon as possible to "have a talk" about it.

____23. I often have a hard time saying, "no."*

____24. I tend to bottle up my emotions rather than make a scene.*

____25. I complain about poor service in a restaurant and elsewhere.

____26. When I am given a compliment, I sometimes just don't know what to say.*

____27. If a couple near me in a theatre or at a lecture were conversing rather loudly, I would ask them to be quiet or to take their conversation elsewhere.

____28. Anyone attempting to push ahead of me in a line is in for a good battle.

____29. I am quick to express an opinion.

____30. There are times when I just can't say anything.*

Note: Total score obtained by adding numerical responses to each item, after changing the signs of reversed items.

* Reversed item.

APPENDIX H

COLLEGE OF EDUCATION

DEPARTMENT OF COUNSELING AND EDUCATIONAL PSYCHOLOGY
Box 3AC/Las Cruces, New Mexico 88003
Telephone (505) 646-2121

NEW MEXICO STATE UNIVERSITY

1/14/81

Dear Juanita,

You have my permission to use the RAS in your master's thesis.

D. A. Lathen

APPENDIX I

DEMOGRAPHIC DATA

Age: _____

Length of time widowed: _____

Cause of husband's death: _____

Number of children under 18 years of age: _____

Ages of children under 18 years of age: _____

Educational background:

High school graduate: Yes_____ No_____

Technical school graduate: Yes_____ No_____

College graduate: Yes_____ No_____

Other: _____

Annual family income at present:

Under $10,000 _____

$10,000 - $20,000 _____

Over $20,000 _____

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