GRIEF REACTIONS EXPERIENCED BY WIDOWS COMPARED TO PERCEPTIONS OF WIDOWS' GRIEF REACTIONS BY SELECTED PROFESSIONS

A THESIS

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BY

SHOSHANNA E. WILLIAMS CONWAY, B.S.N.

DENTON, TEXAS

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TEXAS WOMAN'S UNIVERSITY
DENTON, TEXAS

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Date

To the Provost of the Graduate School:

I am submitting herewith a thesis written by Shoshanna E. Williams Conway, entitled "Grief Reactions Experienced by Widows Compared to Perceptions of Widows' Grief Reactions by Selected Professions". I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Community Health Education.

Ruth E. Tandy
Dr. Ruth Tandy, Major Professor

Roger Shipley — Dr. Roger Shipley

Marie M. Fuller — Dr. Marie Fuller

Bert Hayslip Jr. — Dr. Bert Hayslip, Jr.
University of North Texas

Roger Shipley — Chair, Department of Health Education

J Ann Keller — Dean, College of Health, Physical Education, Recreation, and Dance

Accepted
Leslie M. Thompson
Provost of the Graduate School

DEDICATION

JOHN ESTES CONWAY

JUNE 14, 1950 -- NOVEMBER 9, 1977

TO JOHN, WHOSE DEATH BECAME THE PRIMARY MOTIVATION FOR THIS STUDY, AND WHOSE LIFE AND LOVE ENRICHED MINE BEYOND MEASURE.

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COMPLETED RESEARCH IN HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE Texas Woman's University, Denton, TX

A. Uhlir
Institutional Representative

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A study was conducted to determine whether or not differences existed between widows' experiences in conjugal bereavement and selected professionals' perceptions of widows' experiences in conjugal bereavement. The selected professionals were clergy, counselors, funeral directors, and physicians. 300 widows from Widowed Persons Service in Ft. Worth, TX were randomly selected and sent a demographic questionnaire, the Bereavement Experience Questionnaire (BEQ), the Impact of Event Scale (IES), and the Coping Inventory (CI). 100 professionals from each of the 4 professions were also randomly selected and sent a demographic questionnaire specific to their profession, a BEQ, an IES, and a CI. The professionals were instructed to answer so as to reflect their perceptions of widows' grief reactions. Of the 5 null hypotheses which dealt with widows and professionals, 4 were rejected ($p < .05$) and 1 was partially rejected.

The 6th hypothesis, which compared mean scores of professionals who had and had not dealt with the problems of widows, was accepted. The 7th and final hypothesis was partially rejected when mean scores of long-term widows (widowed $>$ 3 years) were compared to mean scores of short-term widows (widowed $\leq$ 3 years).

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INTRODUCTION

Rationale

An individual who has lost a spouse through death embarks upon a tortuous journey of adjustments. That person may turn to a professional for ventilation, insight, and support. Most logically, that professional would be a counselor, physician, funeral director, or member of the clergy. These professionals can help significantly if they are educated, empathetic, and realistic about the needs and experiences of the widowed, acknowledging that, "...widowhood continues to be stressful long after the death of a spouse" (Barrett and Schneweis, 1980-81, p. 103).

Clergy, counselors, and physicians in particular have potential for long-term relationships with the widowed. It is projected that these three groups of professionals, as well as the funeral director, are in positions to provide important and critical support at times of intense need. If the clergy, counselors, and physicians have a realistic and thorough intellectual understanding of widowhood, they are better equipped to

empathize and provide support, as well as to be able to detect potential for pathology. However, in reference to health related professionals, Weizman and Kamm (1985) further emphasize the importance of education and training:

> Although most professionals--psychiatrists, psychologists, social workers, doctors, nurses, and clergypersons--do encounter loss and death in their practices, they are not necessarily prepared to work with bereaved persons. They may not have an understanding of the process of mourning and could aggravate the problem by mishandling. (p. 109)

Assessing for potential pathology would logically lead to intervention, thus possibly preventing some of the devastations of unresolved grief. "Grief has been studied by numerous thanatologists who agree that postponement of grieving may lead to a maladaptive, pathological response" (Cherry, 1977, p. 88). Further, it has been noted that "Grief swallowed or denied does not go away. It builds inside until it becomes unbearable. When it becomes unbearable, it either surfaces in illness, neurosis, or must be drowned in sedatives" (Manning, 1978, p.6).

While clergy, counselors, and physicians may have contact with the widow initially and/or on a long-term basis, the funeral directors are among the first professionals to be aware of a death or an impending death. They too can function in ways which are either supportive or nonsupportive to the bereaved. Frequently the widow's encounters with the funeral director will affect how the bereaved feels in the immediate post-death period. A funeral director perceived as being impersonal and manipulative will add to the anguish already present. On the other hand, a caring, understanding, supportive funeral director can aid the widow through a difficult period of decision-making.

In that grief is a normal response to loss, it behooves the professional who counsels to distinguish between "normal" grief reactions and grief gone awry. John Bowlby (1980), a psychiatrist and prolific pioneer in the fields of attachment and loss believes that:

> ... clinical experience and a reading of the evidence leave little doubt that much psychiatric illness is an expression of pathological mourning--or that such illness includes many cases

> of anxiety state, depressive illness, and hysteria, and also more than one kind of character disorder. (p. 23)

This line of reasoning also implies that the patient may not be cognizant of the source of the disturbance. William Worden (1982) a noted researcher on death awareness, waves a red flag for physicians as well as for counselors. He stated that, "People seek physical and mental health care without necessarily recognizing that there may be a grief issue underlying their particular physical or mental condition" (p. 1). Hence, the effects of bereavement can be multi-dimensional and enduring.

Further investigation into the components of widowhood can provide needed information to clergy, counselors, funeral directors, and physicians who desire to help the bereaved. These professionals can play important roles in the adjustments of the widow to her new life situation.

Purpose

The primary purpose of this study was to compare the grief reactions of widows to the grief reactions thought to occur in widowhood by clergy, counselors, funeral directors, and physicians.

Statement of the Problem

The problem of the study was to determine the grief reactions of short-term and long-term widows by use of questionnaires and to collectively compare these grief reactions to selected professionals' understanding of the widows' grief reactions. Clergy, counselors, funeral directors, and physicians comprised the professional group.

Subproblems

1. Is there a significant difference between the grief reactions of widows and the clergy's understanding of widows' grief reactions?
2. Is there a significant difference between the grief reactions of widows and counselors' understanding of widows' grief reactions?
3. Is there a significant difference between the grief reactions of widows and funeral directors' understanding of widows' grief reactions?
4. Is there a significant difference between the grief reactions of widows and the physicians' understanding of widows' grief reactions?
5. Is there a significant difference between the grief reactions of widows and the professionals' collective understanding of widows' grief reactions?

6. Is there a significant difference between the professionals who have and have not dealt with the problems of the widowed in regard to the widows' grief reactions?

7. Is there a significant difference between the grief reactions experienced by short-term and long-term widows?

Hypotheses

Seven major null hypotheses were tested at the .05 level for mean scores which represented conjugal bereavement experiences and professionals' perceptions of widows' grief experiences.

1. There is no significant difference between the scores made by widows and the scores made by clergy on the Bereavement Experience Questionnaire (BEQ), the Impact of Event Scale (IES), and the Coping Inventory (CI).

2. There is no significant difference between the scores made by widows and the scores made by counselors on the BEQ, the IES, and the CI.

3. There is no significant difference between the scores made by widows and the scores made by funeral directors on the BEQ, the IES, and the CI.

4. There is no significant difference between the scores made by widows and the scores made by physicians on the BEQ, the IES, and the CI.

5. There is no significant difference between the scores made by widows and the combined scores made by the professionals on the BEQ, the IES, and the CI.

6. There is no significant difference between the scores of the professionals who have and have not dealt with the problems of the widowed on the BEQ, the IES, and the CI.

7. There is no significant difference between the scores of the short-term and long-term widows on the BEQ, the IES, and the CI.

Assumptions

1. An individual will experience grief at the death of a spouse.

2. The loss of a spouse through death is one of the most stressful life change events.

3. Resolution of the grief process will be accomplished through the successful adjustment of the bereaved.

4. Supportive measures are available to aid the loss resolution.

5. The widow is more likely to recover better and in a more timely fashion if she perceives her support system to be strong.

6. Widows sometimes seek assistance from clergy, counselors, funeral directors, and/or physicians for physical, psychological, and/or theological problems.

7. Clergy, counselors, funeral directors, and physicians have areas of deficiency in the understanding of the widow's grief reactions.

Limitations

This study was limited by the following factors:

1. the number of responses from the designated subjects,

2. the researcher's access to the names and addresses of the widowed population in Tarrant County, and

3. the interest in and the amount of work with widows which the clergy, counselors, funeral directors, and physicians have had.

Delimitations

The researcher chose to restrict this study to:

1. the female widowed person,

2. the widow living in Tarrant County,

3. the widow who has had some type of contact and/or involvement with the Widowed Persons Service,

4. the woman widowed five years or less,

5. marriage and family counselors practicing in Tarrant County,

6. clergy employed in Tarrant County,

7. funeral directors in Tarrant County, and

8. family and general practitioners, internists, gastroenterologists, neurologists, cardiologists, obstetricians and gynecologists, and psychiatrists practicing in Tarrant County.

Definition of Terms

1. Bereavement--signifies the state of loss; ". . . the event in personal history which triggers the emotion of grief" (Grollman, 1974, p. 3).

2. Grief--a response to bereavement; ". . . the intense emotion that floods life when a person's inner security system is shattered by acute loss. . ." (Grollman, 1974, p. 2).

3. Grief work, process, or reactions--painful work involving suffering and tension resulting from the physical absence and the very real memories of the presence of the deceased; a suffering which promotes healing (Freud, 1917).

4. Long-term widow--a woman who has experienced conjugal bereavement for more than three years.

5. Mourning--". . . the process by which the powerful emotion of grief is slowly and painfully brought under control" (Grollman, 1974, p. 3). In addition, "...mourning refers to the culturally patterned expressions of the bereaved person's thoughts and feelings" (Kastenbaum, 1977, pp. 243-244).

6. Short-term widow--a woman who has experienced conjugal bereavement for three years or less.

7. Sudden death--death as a result of illness or injury of less than one week's duration.

8. Support systems--comprised of those persons, places, organizations, habits, experiences, and/or attitudes which confirm, augment, and give life credence, purpose, and a basic sustaining endorsement.

9. Therapeutic measures or postvention--those steps taken to help prevent pathology or minimize its effects, resulting in successful completion of the grief process.

10. Unresolved, incomplete, or inadequate grief--that mourning which leaves the survivor unable to cope properly with life.

CHAPTER II

REVIEW OF THE LITERATURE

Due to the fact that there is a vast amount of literature concerned with dying, death, grief, and widowhood, the review of literature reflected a sampling of several areas. For this paper, those areas included: characterizations of the widow, widowhood as a stressful life event, overview of death attitudes, grief dynamics, and involvement of professionals.

Characterizations of the Widow

According to the U.S. Bureau of the Census, there were 13,473,592 widowed persons in 1980. Of this number 11,317,896 (84%) were widows. Furthermore, the number of widows has been on the increase over the past several decades (Kastenbaum, 1977). In addition there is the disconcerting and more personal realization that three out of every four married American women will become widows (Brite, 1979; Lewis & Berns, 1975; Shipley, 1982).

Since 75% of married women in this country can anticipate conjugal bereavement, into what kinds of experiences and what sort of atmosphere will they be thrust? From whom should they try and seek counsel and

from what resources should they expect realistic and empathetic insight? How many will be painfully surprised when they feel like a momento mori, wearing an obvious and indelible black "w"? Lewis and Berns (1975) report that widows have used terms such as "hot potato," "fifth wheel," "third eye," "hole-in-the-head," "sinking ship," "ice-in-water," and "broken arm" to describe how married "friends" have made them feel. The picture appears to be even more bleak when considered in the light of a statement by Parkes and Weiss (1983):

> In most "developed" countries the widow is often roleless, an object of pity, a fifth wheel, a living reminder of the now dead spouse. Widows who pursue active civic lives often do so primarily as "representatives" of their husbands . . . . Many widows, lacking a social system that welcomes them, roles to occupy them, status to preserve their self-esteem, or beliefs to give them hope, are often lonely, adrift, self-doubting, and hopeless. (p. 253)

As unsettling as the above may be, the ominous clouds become even more black in Barrett's (1977) portrayal of the widows' plight.

> As a minority group they suffer from sexism, ageism, and in some cases racism. All of them suffer because they are perceived to be carriers and transmitters of the reality of death. They may be abused by bureaucracies and insensitive professionals, shunned by relatives and former friends, exploited by racketeers and Don Juans, discriminated against by employers, and berated by others in similar circumstances. They belong to a subculture whose members live in relative oblivion, submerged in the despair of loneliness, chiding each other for self-pity, advising each other to keep busy, individually hoping for an avenue of escape, and collectively succumbing to an attitude of hopelessness. (p. 856)

How very different from the popularly conceived "merry" widow or the aberrant "black" widow!

Widowhood as a Stressful Life Event

With such representations of life as a widow, it becomes easier to appreciate why Holmes and Rahe (1967) and Horowitz and Wilner, as cited in Poon (1980), listed conjugal bereavement as the most or one of the two most stressful life events. Thus, there are many

considerations to apprehend in the extensive effects of stressful life events. From the biological and epidemiological points of view, there is a complexity of system interplay which can lead to a biophysiologically and/or psychosocioculturally compromised individual. From the clinical laboratory to the laboratory of life, evidence has accumulated to support the idea that grief can have negative consequences for the immune system, the respiratory system, the cardiovascular system, the endocrine system, the autonomic system, and the gastrointestinal system (Dohrenwend & Dohrenwend, 1984; Elliott & Eisdorfer, 1982; Kraus & Lilienfeld, 1959; Osterweis, Solomon, & Green, 1984; and Weizman & Kamm, 1985). It has even been suggested that the ramifications of grief could result in death due to a "broken heart" (Stroebe, Stroebe, Gergen, & Gergen, 1981).

Although it is beyond the purpose of this paper to explore all variables within the context of conjugal bereavement, it is pertinent to make some token recognition that the status of today's American widow is the product of many factors. That is, the historical, anthropological, ethno-cultural, psychological, sociological, and biophysiological

perspectives all act in the evolution and adaptation of a woman to widowhood. Each of these areas is important and would warrant study in and of itself. Out of each could be distilled a theoretical paradigm for the bereavement of widowhood.

Overview of Death Attitudes

Attitudes and philosophies about death within a given culture are never static for long. The continuing technological improvements have served to prolong death--as well as life--and have served to remove death from the home. The ramifications of this have been numerous and far-reaching. Fulton, a contributor in Hickey (1973), noted that in 1972 only six percent of all deaths were children under 15 years old. This was in comparison to the same age group having accounted for over half of all deaths just several decades previously. R. V. Nichols in Margolis et al. (1975) pointed out that, "America now has the world's first death free generation. . ." (p. 24). This is a stark contrast to many parts of the world where, he continues, ". . . illness and death are daily experiences of living which are shared by all members of the family and the community, from the very young to the very old" (p. 24).

Ariès (1974) observed that non-preoccupation with death in the 1100's changed in the late Middle Ages to an attitude of life being a "stay of execution." This was compared to the 18th century when death became more dramatic and romantic and was accompanied by a new interpretation of cemeteries and tombs. The period of time between 1930 and 1950 is credited with the beginning of death avoidance and denial. Choron (1963) cited Fournier D'Albe's observation that:

> The twentieth century is too busy to occupy itself much with the problems presented by death and what follows it. The man of the world makes his will, insures his life, and dismisses his own death with the scantiest forms of politeness. . . . Death is all but dead as an overshadowing doom and an all-absorbing subject of controversy. (p. 269)

In Hickey (1973), Feifel acknowledged that Americans' attempts at coping with death have been by ". . . disguising it and pretending that it is not a basic condition of all life. We tend to seek refuge in euphemistic language: we pass on, join our forefathers, cease to exist. . . but rarely do we die" (p. 38). As evidence for further confusion of the issue, Schneidman as found in Corr, Stillion, & Ribar

(1983) states, "Death is oxymoronic, a paradox made up of contrasting values, opposite trends, and even contradictory facts" (p. 27).

Grief Dynamics

Although there appears to have been an explosion of information about dying, death, and bereavement in the past 25 to 30 years, this movement was obscure and painstakingly slow. Sigmund Freud fathered a remarkable contribution in his work Mourning and Melancholia (1917). In Hickey (1973), Fulton tracked some studies of loss, referring to Eric Lindemann's "classic" publication in 1944 on the symptoms and management of grief. Around the same time, Anna Freud studied the effects of parental separation and loss on English school children. However, Fulton points to Feifel as having provided the watershed literature for grief.

> Systematic research into grief and bereavement began to burgeon, however, after the appearance in 1959 of Dr. Herman Feifel's book, The Meaning of Death. Illustrative of the impact of his book on the scientific community is the fact that in the five years following its publication, professional researchers contributed more material in the

> social and medical literature on death, grief, and bereavement than had appeared in the previous 100 years. (p. 18)

Then in 1969 Kubler-Ross' book On Death and Dying seemed to have the effect of sanctioning the layperson's pursuit of a previously taboo topic. As a result there were a number of theorists who scrutinized bereavement reactions in order to elucidate the emotions, dynamics, stages, phases, and/or tasks of grief.

Kubler-Ross' (1969) five stages in the confrontation of dying were: denial, anger, bargaining, depression, and acceptance. They were also viewed as being applicable to the grief of the bereaved. Kavanaugh (1972) defined seven grief dynamics: shock, disorganization, volatile emotions, guilt, sense of loss and loneliness, feelings of grief, and re-establishment. Brown (1980) outlined the emotions of grief and placed them within the stages of: living through death, living with the dead, living without the dead, living for the dead, and living beyond death. Bowlby (1980) traced grief through shock/protest, disorganization, and reorganization. Worden (1982) defined four tasks as: accepting the

reality of loss, experiencing the pain of grief, adjusting to an environment in which the deceased is missing, and withdrawing emotional energy for reinvestment in another relationship. Silverman (1986) postulated three phases based on the work of Tyhurst in 1958 and an earlier work of Bowlby in 1961. The descriptive terms applied to these phases were impact, recoil, and accomodation.

The above citations by no means constitute an exhaustive list of possibilities for the quantification of grief reactions. However, it does portray the fact that grief and its resolution can be viewed in diverse ways.

Stages, phases, and/or tasks provide the framework for grief process. Within this structure there are very wide-ranging grief reactions. The grief experienced in conjugal bereavement has both unique elements and elements which overlap with bereavement due to other types of loss. One concern is the duration of grief. Silverman (1986) reported that, ". . .current psychiatric thought pictures grief as having an end, usually in six months" (p. 5). The other end of the spectrum depicts attachment to a dead relative as potentially being timeless (Goin, Burgoyne,

& Goin, 1979). In any case, the consensus is that grief work is necessary (Aries, 1974; Bachmann, 1964; Barrett, 1977; Bowlby, 1980; Clayton, Desmaris, & Winokur, 1968; Corr et al., 1983; Hickey, 1973; Margolis, et al., 1975; Oates, 1976; Osterweis et al., 1984; Parkes & Weiss, 1983; Peterson & Briley, 1977; Shneidman, 1976; Simos, 1979; Weizman & Kamm, 1985; Worden, 1982; Yeagley, 1981).

There have been a variety of models constructed and applied to the grieving widow. Silverman (1986) cited Engel's "grief as illness" model as one of these. Silverman took exception to this theory which would logically demand a cure.

> To seek a cure for one's responses to an irretrievable and real loss--the end of life for a person one has loved and still loves--seems inconsistent with the nature of the event. Whether the cure is called decathecting or letting go, it would seem to deny the meaning that the deceased person has had in one's inner and outer life. (p. 7)

The question of quantity and duration of grief is associated with a variety of factors. Worden (1982) cites six determinants of grief: who the deceased

person was, the nature of the attachment (i.e. strength, security, and relationship ambivalence), mode of death, historical antecedents (how previous losses were grieved), personality variables, and social variables. Several researchers have further defined social variables in terms of support systems, and have found these to be very important (Borman & Lieberman, 1981; Lopata, 1979; Parkes & Weiss, 1983; Raphael, 1983; Silverman, 1986). Green et al., as found in Osterweis et al.(1984), state that, "Studies indicate that recovery from bereavement may be enhanced when health professionals at a hospital encourage the use of informal and formal support available through family, friends, and the community" (p. 221). However, Kutscher (1969) interjects a note of caution, ". . . the fact that relatives and friends, although personally involved, are not in as unbiased and detached a position to give constructive advice to the bereaved as are the professional experts in the many and diverse fields of human care and relations. . ." (p. 21). If all professionals having contact with the bereaved were well prepared to counsel, this might be true. As illustrated in the following information, such is not the case.

Involvement of Professionals

Several authors of note have long been recognized as reliable sources of information about the widowed. Their studies and resultant information have contributed much to the understanding of the widow's grief process and ramifications.

In spite of the available resources, professionals who would logically be expected to have the best information have not necessarily offered much help to the widowed. Robert Fulton, cited in Silverman (1974), and his staff at the Minnesota Center at the University of Minnesota have become increasingly aware that where death is concerned there not only ". . . is a glaring lack of information and of basic social skills," but also that ". . . doctors, nurses, the clergy and other members of service professions . . . know next to nothing about grief or bereavement" (p. 149). Fulton, a contributing author, comments further, "One of the major problems that all of us face when we lose someone we love through death, is the hostility of our society toward the fact. Clergymen and doctors . . . are oftentimes the worst offenders" (p. 153).

Unfortunately Fulton's conclusions are not isolated and unique. They are supported by Shuchter (1983), director of the San Diego Gifford Mental Health Clinic at the University of California. He states, "Physicians frequently have contact with bereaved patients who have lost a spouse and all too frequently are at a loss to communicate helpfully about how to deal with this traumatic, stressful experience" (p. 10). Heinemann (1982) continues with a similar type of commentary. She observed that the clergy and physicians are no longer the emotional resources that they once were, and although medical care is better from a technical perspective, it is also somewhat sterile and estranging to many patients.

Justice (1982) further defines the negligence of the pastoring community.

> Bachmann's national survey and Harris's [sic] in a large Southern US city seem to arrive at the same conclusion. Few people receive any grief ministry after the day of the funeral. . . .
>
> Harris's . . . findings tell us that during the three years of his study, only 15 families of each 100 had even one pastoral visit following the funeral of a loved one. (pp.67-68)

Carey (1979-80) noted factors related to the adjustments in widowhood. One factor addressed was that of clergy visitation. He stated that the widowed really appreciated visits from the clergy, but that these visits were unusual. In so stating, a large area of deficiency in ministering is implied. Justice (1982) took it one step further. "We might also wonder if our neglect of a follow-up ministry may be one of the primary reasons many people leave the church within six months after the death of a close family member" (p. 60).

Funeral directors also have their share of accusers. They have been cited by the bereaved as being opportunistic, cold, and manipulative. Instead of being sensitive and helpful, funeral directors have at times been known to make a painful situation worse. "People feel that the funeral director has a great deal of power over them, and, like a car salesman, is in a position to manipulate and take advantage of them" (Marks & Calder, 1982, p. 87).

Counselors become involved with the conjugally bereaved both on primary and secondary levels. Often when a counselor has a client obviously dealing with bereavement, there is a focus of speedy recovery

(Bowlby, 1980; Silverman, 1986). In the search for professional mental health services for the grieving, Silverman (1986) obtained a representative sample of social and psychiatric agencies in Boston. Her interviews with the director and facility staff members revealed that the widowed made very little use of their services. Beyond that, records showed that when therapists did counsel widows, the ". . . therapists could not deal with the widow's intense pain and, unaware of this reaction, they would often change the subject" (p. 61).

Although the preceding statement was specifically about therapists, from the widowed purview it could have been applicable to most professionals with whom widows may be involved. For this research undertaking, the four professions with whom the widow was deemed most likely to have contact were the clergy, counselors, funeral directors, and physicians.

Of the four professions listed, the clergy hold a distinct dissimilarity to the other three. Not only does there exist a community expectation of support during bereavement, but there is also a professional obligation which is Biblically mandated: James 1:27, Acts 6:1-7, Deuteronomy 24:19-22 & 26:12-14, Isaiah

1:17, Zechariah 7:9-10, Psalms 68:5 & 146:9, and Proverbs 15:25. The rabbi, parish pastor, or priest may be sought out for spiritual ministrations as a recognized representative of God. Bachmann (1964) characterized the situation in this way:

> The pastor, of all the helping specialists stands in a unique relationship to the grief sufferer. He still has uninvited access and entree to the homes of his parishioners and is expected to call. His handling of grief situations can prove decisive in the recovery of equilibrium and the return of the sufferer to pneumo-psycho-somatic balance . . . . The image of the pastor is one that exemplifies, among other symbolizations the spirit of Him who came to comfort and heal the broken relationships . . . and . . . that profound hope . . . that God does not forsake His children in the most critical periods of their existence. (p. 25)

It is generally agreed that the spiritual delegate could be a positive influence in a situation of bereavement if this person were an accessible and willing participant (Doka & Jendreski, 1986-87; Jackson, 1963; Hickey, 1973; Margolis et al., 1975;

Oates, 1976; D. Switzer, personal communication, October 18, 1984; Wiersbe & Wiersbe, 1985).

As earlier implied in this chapter, religious leaders are often perceived and experienced to be non-involved on a meaningful and personal level (Barrett, 1977; Heinemann, 1982; Silverman, 1986). Kavanaugh (1972), a former priest, noted that:

> Professionals, like doctors, nurses, clergy, and funeral directors tend to don masks, pretending their experience has made them more skilled near death than factual studies reveal. . . . Ritual sacraments, Bible readings, silent prayers and hospital rules can rescue uneasy clergymen from any but casual involvement. (pp. 8 & 24)

However important a pastor, priest, or rabbi may be to some people, there are others for whom this type of individual is unnecessary. In this instance a bereaved individual could seek to utilize the services of a counselor. Silverman (1986) cited: ". . . studies (Meyers & Timms, 1969; Silverman, 1969a) had found discrepancies between the way a mental health or family agency client characterized his or her problems and the way the professional saw the difficulty" (p. 61). Silverman also noted that the atmosphere this

variance fostered, often led clients to drop out after only one visit.

Professional counseling has not frequently been mentioned in the literature from the widows' point of view. However, there has been more bereavement counseling and/or therapy work published in the recent past. Several of these include: Doyle, 1980; Margolis et al., 1975; ; Weizman & Kamm, 1985; Worden, 1982.

It is most likely that a widow will have been in contact with a funeral director even if she did not request or employ the services of a clergyperson or counselor. The various responsibilities a funeral director undertakes have met with a number of changes and philosophical differences throughout the years. Kavanaugh (1972) made an historical note:

> Funeral directors began in America as a combination of three professions needed at the time of death: cabinetmaker, livery stable men and sextons. Now they are nudging out other professions often by default, becoming cosmeticians, psychological therapists, part lawyer and insurance advisor, part clergyman and businessman. (p. 10)

It quickly becomes evident that the diversity and its interpretation within the funeral home industry could lead to confusion among consumers. Whatever the situation, there appears to be increasing expectations from consumers and intersecting professions alike, that some degree of grief counseling and/or referral service should be offered by the funeral director (Aries, 1974; Borman & Lieberman, 1981; Corr et al., 1983; Hickey, 1973; Kavanaugh, 1972; Margolis et al., 1975; Pine, 1975; Worden, 1982).

Of all the four professions, the physicians have the most frequent contact with dying and the event of death. Because of their in-depth knowledge of the biological processes involved and because of their encounters with death and dying, it would seem safe to assume that physicians would be empathetic and supportive during bereavement. In general this is not true. Not only are physicians not well educated in grief dynamics, they also harbor a high degree of death anxiety (Caldwell & Mishara, 1972; Campbell, Abernathy & Waterhouse, 1983; Lattanner & Hayslip, 1984; Shipley, 1982). This, taken together with the "healing" or improvement of "quality of life" aspect of their profession, could provide a situation where the

practitioner is more likely to offer a hurried platitude, a prescription (for Valium, most likely), and a gentle but firm push out the door. However, patients and some members of their own profession are appealing to physicians for a responsive re-evaluation of their obligations to patients' families. Some professionals have even advocated a proactive role for physicians, especially those in primary care (Bachmann, 1964; Clouse, 1966; Editorial, 1984; Osterweis et al., 1984; Parkes, 1980).

Whether examined by profession or as a group, it would appear that clergy, counselors, funeral directors, and physicians are not frequently "helping professions" in the experience of the bereaved. In reporting results from a study of Chicago widows, Lopata (1979) revealed that:

> One of the more dramatic findings . . . is the absence of the "helping professions and groups" during the period of the husband's illness, immediately after his death, when the widow was trying to establish a new life, and now. Even ministers, priests or rabbis are mentioned rarely; if they appear at all, it is often as persons who

failed to provide expected and needed help. (pp. 357-358)

In a charge to the helping professionals not to abdicate their responsibilities to the bereaved, Parkes and Weiss (1983) comment:

> It is futile for doctors to say that it is not their job to treat grief if the bereaved and their relatives continue to see grief as an illness. It is pointless for social workers to suggest that the elderly widowed live with their children if there is no place for them in the children's homes or lives. And it is fruitless for clergy to throw up their hands and blame our problems on the current decline in religious faith if churches remain empty and the faith they proclaim is unbelieved. Social problems require social solutions. (pp. 253-254)

Death is omnipresent and inevitable. However, in our fast-paced society, death is often ignored until it detonates in our path. Hence, many people--including health care and ministering professionals--neither confront nor understand conjugal bereavement and its sequelae. Sanders (1982) concludes:

Bereavement is multidimensional and the ripple effect extends beyond the emotional and physical factors. Churches and community organizations could also take a more active role in the provision of support systems. It is not enough that bereaved individuals are supported through the funeral; they need to be helped back into the social milieu best suited for their needs and over a much longer period of time than has heretofore seemed appropriate. (p. 240)

CHAPTER III

METHODOLOGY

Introduction

The purpose of this chapter was to explain the procedures necessary to adequately investigate the stated problem. Chapter subdivisions include: (1) design, (2) preliminary procedures, (3) selection of subjects, (4) selection of instruments, (5) data collection, and (6) treatment of the data.

Design

A descriptive study was deemed appropriate for the selected subject matter. Additionally, the study was defined as ex post facto and cross-sectional in nature.

Preliminary Procedures

After having formulated an idea at a rudimentary level, it was presented to an health education faculty member. This was followed by a partial review of pertinent literature and a search for relevant instruments. A written proposal was submitted to a thesis committee. Designated changes were made and a committee approved proposal was submitted in prospectus form to the Dean of the College of Health, Physical

Education, Recreation, and Dance. The Dean approved the prospectus as well (Appendix A).

Selection of Subjects

Widows

In order to obtain a broad spectrum of widows, the Bureau of Vital Statistics in Fort Worth, Texas was contacted. The Bureau refused access to their records, hence another source of widows was sought. The Widowed Persons Service (WPS) of Tarrant County was called. After careful deliberation, the president of the WPS granted permission for usage of names on their mailing list. This list included names of individuals who had attended at least one meeting or whose name had been contributed by someone else.

After the WPS mailing list was secured, the first task was to delete men's names. This left a pool of 372 widows from the original 439. Next, the names of the widows were numbered. These numbers were written on separate pieces of paper, and were placed in a box for thorough tossing. Three hundred widows were selected at random by independent sampling--the lottery method. This was accomplished in a reverse manner so that the names not to be used were drawn. After a number was drawn from the pool, the number was noted

and then returned to the pool. The numbers were remixed and another number drawn and returned until 72 different numbers were obtained.

Professionals

One hundred subjects from each of the four professions--clergy, counselors, funeral directors, and physicians--were chosen by a combination of two methods. The first method was designated as "matching". When a responding widow listed a member of the clergy, a counselor, a funeral director, and/or a physician with whom she had consulted, that professional's name was placed on a list. In this way 22 clergy, 11 counselors, 17 funeral directors, and 24 physicians were identified as "matching" professionals. This then left 78 clergy, 89 counselors, 83 funeral directors, and 76 physicians to be chosen in the same way as the widows--randomly by the lottery method.

The yellow pages of the Fort Worth telephone book were the source for the pool of physicians. Physicians in the previously named specialties--family and general practice, internal medicine, gastroenterology, neurology, cardiology, obstetrics and gynecology, and psychiatry--were potential subjects. This yielded a

pool of 441 physicians from which to randomly select 76.

Names of unmatched counselors were chosen from the same source as were the physicians--the Fort Worth telephone book. These names came from the yellow page headings of family and marriage counselors, psychologists, and psychotherapists. A pool of 204 counselors was obtained. Eighty-eight counselors were randomly selected from this pool.

The yellow pages of the Fort Worth telephone book had a listing for funeral homes. This listing and the funeral home advertisements provided only a few names of funeral directors. There was not a separate, yellow page designation for funeral directors. An inquiry at a local funeral home led to the address and phone number of the State Board of Morticians in Austin, Texas. Upon receipt of the required fee, the State Board sent a directory of all funeral homes and directors in Texas. All certified embalmers and/or morticians in Tarrant County were isolated and numbered. The random selection of 83 from a population of 195 funeral directors was made by the same procedure used for the selection of the counselors and physicians.

Names of clergy in Tarrant County were obtained from yet another source. As was the case with the funeral directors, churches were listed in the yellow pages and only a few clergy were also identified. There was not a separate listing for clergy. A local church was contacted to determine if a complete listing of clergy of all faiths in Tarrant County existed. The researcher was directed to the Office for the Tarrant County Area Community of Churches (TCACC) in Fort Worth. An employee of the TCACC indicated that a nearly complete list of Tarrant County clergy--inclusive of all faiths--could be obtained. The roster of 532 clergy was subsequently purchased. Selection of the 78 clergy was accomplished in the previously defined manner.

Selection of Instruments

A variety of instruments was reviewed for possible inclusion in this study. The topics of these instruments ranged from questions about health status to questions about death anxiety. Since the problem of this study revolved primarily around grief reactions due to conjugal bereavement, an instrument was deleted because of its peripheral association with the main topic. Of the two instruments which best represented

feelings of grief, the Bereavement Experience Questionnaire (BEQ) was selected. This questionnaire appeared to cover a broader scope of feelings in a more in depth manner than the other instruments examined. Permission to use the BEQ in this study was requested and granted (see Appendix B).

The BEQ is a Likert-type scale containing 67 items with accepted validity and reliability. It has eight defined subscales: guilt (17 items), anger (nine items), yearning (10 items), depersonalization (five items), stigma (six items), morbid fears (six items), meaninglessness (eight items), and isolation (four items). Scoring for each item was one through four: never, sometimes, often, and almost always. The BEQ's author, Dr. Alice Demi, described the instrument's validity and reliability in an explanation of the BEQ's development (personal communication, October 4, 1984):

> The reliability and validity coefficients of the revised form of the BEQ met the preset criteria in most instances. The internal consistency reliability of the Stigma subscale was .70 (.65) and the correlation of the Isolation subscale (corrected) with the BEQ scale was .65 (.48). Subscale to subscale correlation coefficients were

> computed to assess convergent construct validity. All coefficients met the established criteria (.30 to .70) . . ., thus supporting convergent construct validity of the subscales.

The second instrument chosen for this study was the Impact of Event Scale (IES). This instrument was constructed and then revised by Horowitz, Wilner, and Alvarez (Zilberg, Weiss, & Horowitz, 1982). The intent of Horowitz and Wilner for the instrument as cited in Poon was ". . . to assure the current degree of self-reported distress related to a specific event" (1980, p. 366). Hence, the purpose of the IES appeared to be relevant to the study at hand. At the same time its subscales were different from the BEQ as was the reference time-frame (one week versus one month). Thus it was determined that the IES in addition to the BEQ would further expand the information obtained about grief experiences.

With regard to the background, validity, and reliability, two of the IES authors, Horowitz and Wilner, were cited in Poon (1980):

> Items for this measure were derived from statements most frequently made by distressed persons who had experienced recent serious life

> events. The scale focuses on the form and quality of conscious experiences during the previous 7 [sic] days, and the event for the individual serves as a written referent on the scale itself. The 7-day time limit was found to be best for clinically valid reports of current subjective distress and states of mind related to a particular life event. Studies of reliability and validity led to reducing these items from 30 to 16, with two subscales that were both logically and empirically consistent. These subscales yield intrusion and avoidance subscores (Cronbach's alpha was .78 and .82 for these subscales, respectively test-retest reliability for the instrument was .87). (p. 366)

Cross-validation was reported by Zilberg et al. (1982):

> The measure has again been found to have highly relevant item content and to be composed of subscales related to intrusion and avoidance experiences. These subscales have high internal consistency (.79 to .92 using Cronbach's alpha) across repeated measurement in time, in both patient and field subject samples and at varying average levels of subscale scores. (p. 411)

Horowitz and Wilner, as cited in Poon (1980), at the Center for the Study of Neuroses, University of California, developed the Coping Inventory (CI). This instrument was designed as a method of measuring the utility of a variety of strategies in the adjustment to a serious life event. The CI contains three subject areas: turning to other attitudes and activities, working through the event, and socialization. The CI has 33 items each having three different responses from which to choose: does not apply, does apply, and does apply and was very helpful.

Even though the CI does not yet have established validity and reliability, it was selected as the third instrument. Neither the BEQ nor the IES measures specific, positive adjustment activities. Therefore, still another angle of grief reactions could be viewed by the use of the CI. It was hoped that the data resulting from the usage of this instrument would not only supplement and enhance the meaning of the BEQ and IES, but also provide data which could be utilized in determining validity and reliability of the CI. Permission for use of the CI and the IES was given by Dr. Wilner (see Appendix C).

Data Collection

During the fall of 1985 questionnaire packets were sent to the randomly selected 300 widows. These packets included eight items: (1) a letter which explained the purpose of the study, (2) a permission request, (3) a demographic information questionnaire, (4) a confidential request for involved clergy, counselors, funeral directors, and physicians, (5) the BEQ, (6) the IES, (7) the CI, and (8) a self-addressed, stamped envelope (see Appendix D for printed contents of packet).

A procedural note of interest is appropriate at this point. Two bulk mailing permits were used for the 700 mailed packets--one for sending and one for receiving. Even with the expense of the permits ($50 each) and the envelope printing as required by the post office, approximately one-half the cost was saved over mailing the packets (and return envelopes) by use of stamps.

A deadline of two weeks was given for the return of requested information. At the end of two weeks, a reminder card was sent to all widows. Most of the questionnaires which were returned, came after the

initial mailing. However, there were also a few responses as a result of the reminder cards.

From the widow's responses to the confidential request of involved professionals, a list of matched professionals was compiled. The list included 22 clergy, 11 counselors, 17 funeral directors, and 24 physicians.

As explained in the section on selection of subjects, the "matched" and randomly selected professionals were sent questionnaire packets. These packets included six items: (1) a letter of the study's purpose, (2) a demographic information questionnaire, (3) the BEQ, (4) the IES, (5) the CI, and (6) a self-addressed, stamped envelope (see Appendix E for printed contents of professionals' packets). The follow-up procedure used for the widows was used for the professionals as well.

When sufficient time had elapsed for the return of questionnaires from all groups, the demographic information and instrument items were coded. This coding facilitated the transference of the subjects' responses to computer sheets. The sheets were then used to enter the numbers into the computer system for analysis.

Treatment of the Data

Measures of central tendency such as the ranges, standard deviations, and means were used for the demographic data. The means of the three instruments and means of designated demographics were used in a parametric test, the one-way ANOVA, to compare the widows to the professionals.

Another parametric analysis, the "t" test, was used when the comparison between "matched" widows and professionals was made. The nonparametric chi-square was used in cross tabulation calculations by status. Pearson correlation coefficients were used for comparison of some of the demographic variables. Most other comparisons utilized the one-way ANOVA.

CHAPTER IV

ANALYSIS OF THE DATA

A cross-sectional, descriptive, ex post facto study was conducted to ascertain if members of four professional groups perceived the grief reactions in widowhood to be different than the self-reported grief reactions of widows. This chapter consists of the subjects' demographic information, subjects' responses to questionnaires, statistical analyses of the data as related to the hypotheses, and additional findings.

Demographics of the Widows

From the randomly selected sample of 300 widows, 92 (30.7%) widows returned their questionnaires. Of the 92, 88 women listed their ages which ranged from 24 years old to 80 years old. The mean age was 58.4 years old with a standard deviation of 11.3. Only one subject (1%) was younger than 30, eight (9.1%) were between 30 and 39, nine (10.2%) were 40 to 49, 21 (23.9%) were 50 to 59, 37 (42.1%) were 60 to 69, 11 (12.5%) were 60 to 69, and one (1%) was 80 years old. However, since these women could have been widowed any length of time when they answered the questionnaires, a more pertinent age grouping was sought. The woman's

age at the time of her husband's death was calculated by subtracting the length of widowhood (item #9 on the questionnaire) from the widow's current age (item #1). For the women who were widowed more than once, the age at the time of the most recent bereavement was used. As would be expected, the ages at the time of the husbands' death were skewed to the left of the women's current ages.

Eighty-six of the 88 women who listed their ages also listed when their husbands died. Women's ages at the time of their husbands' death ranged from 23 years old to 79 years old. Two women (2.3%) were in their twenties, eight (9.3%) were 30 to 39, 12 (14%) were 40 to 49, 40 (46.5%) were 50 to 59, 21 (24.4%) were 60 to 69, and three (3.5%) were 70 to 79 years old. The mean age of this group was 53.9 years old with a standard deviation of 10.5.

The second demographic question dealt with employment and 90 women responded to this item. Thirty-five (38.9%) were employed outside the home, seven (7.8%) were employed at home, while 48 (53.3.%) were not currently employed.

Ninety subjects also responded to the items on race and amount of formal education. Two women (2.2%)

were American Indian, 83 (92.2%) were Caucasian, one (1.1%) was Hispanic, one (1.1%) was Oriental, and three (3.3%) were "other," and no respondent was Black. Two women (2.2%) had less than an eighth grade education and 31 women (34.4%) went to school through twelve grades. Six women (6.7%) had completed technical school and 33 (36.7%) had spent some time in college. Two women (2.2%) had associate degrees, 11 (12.2%) had bachelor's degrees, and five (5.6%) had completed master's degrees.

All of the 92 subjects answered the question about religious affiliation. Eighty women (87%) were Protestant, eight (8.7%) were Catholic, two (2.2%) were Jewish, and two (2.2%) were none of the three religions listed.

Ninety-one women responded to the question about attendance at religious services. Forty-nine widows (53.8%) attended services at least once a week. Twelve (13.2%) attended services less than weekly but more than monthly. Fifteen widows (16.5%) attended services more than once every six months but less than monthly. Eight (8.8%) attended services once or twice yearly, while seven (7.7%) went to services less than once a year.

Eighty-seven women answered the question about belief in life after death. Seven women (8%) indicated that they did not believe in life after death. On the other hand, 80 (92%) believed in life after death.

Of the 90 widows who listed how long ago their husbands had died, 13 (14.4%) had been widowed for one year ± six months. Twenty-three (25.6%) were widowed two years ± six months, 18 (20%) for three years ± six months, five (5.6%) for four years ± six months, five (5.6%) for five years ± six months, one (1.1%) for six years ± six months, six (6.7%) for seven years ± six months, eight (8.9%) for eight years ± six months, three (3.3%) for nine years ± six months, and three (3.3%) for ten years ± six months. Two women (2.2%) were widowed for 13 years ± six months, while one woman was widowed for each of the following: 18, 20, and 24 years ± six months (3.3%).

Fifty-four (59.3%) of 91 widows expected the deaths of their husbands. But 37 (40.7%) husbands died unexpectedly. One widow did not indicate if her spouse's death were expected.

Eighty-one (95.3%) of the responding 85 subjects indicated that their husbands' deaths were due to illness. These illnesses ranged from chronic cancer to

sudden death by heart attack. The deaths of four men (4.7%) were attributed to accidents. No respondent was widowed due to suicide or homicide. However, there were seven widows who did not answer this question.

Length of marriage varied from one year to 53 years for the 90 respondents to this question. Ten women (11.1%) were married 10 years or less. Sixteen women (17.8%) had been married 10 to 19 years, 13 (14.4%) had been married 20 to 29 years, 30 (33.3%) from 30 to 39 years, 20 (22.2%) from 40 to 49 years, and one woman (1.1%) was married for 50 to 59 years. The mean length of marriage was 29 years with a standard deviation of 13.3.

One of the cognitive variables was the widow's knowledge of death, bereavement, grief process, and widowhood as a result of reading. Seventy-nine (86.8%) of 91 respondents had done topical reading. Twelve women (13.2%) had not read about any of the topics listed above.

All women answered the question of whether or not they had taken death education classes or courses either before or after their husbands' deaths. Thirty-one (33.7%) indicated that they had taken classes, while 61 (66.3%) had not. Of the 31 who had taken a

class or course, three (14.3%) had taken it before the deaths, 18 (85.7%) had taken it after the deaths, while ten widows did not indicate which was their circumstance.

The women were questioned about how often they had attended support group meetings for the widowed. Everyone answered this question with 29 (31.5%) having responded "frequently," 37 (40.2%) responded "occasionally," eight (8.7%) responded "rarely," and 18 (19.6%) responded "never."

Attendance at grief seminars was also questioned. Ninety women responded with 55 (61.1%) never having attended any grief seminar, whereas 35 (38.9%) had attended grief seminars of some kind.

Fifty widows (54.9%) indicated that they had not been contacted by the clergyperson who performed their husband's funeral, after the funeral. Forty-one widows (45.1%) had been contacted by their respective clergyperson after the funeral, while one widow did not respond to this question.

Of the 84 women who answered the question about whether or not they had sought counseling after their conjugal bereavement, 38 (45.2%) had not sought counseling, but 46 widows (54.8%) had sought

counseling. From the group of 46 who had sought counseling, 37 indicated the type of professional from whom they sought counseling. Six (16.2%) had been counseled by their pastors, five (13.5%) had been counseled by their physicians, four (10.8%) had been counseled by psychiatrists, 11 (29.7%) had their counseling experiences with professional counselors, and two (5.4%) had had some counseling from their funeral directors. Nine widows (24.3%) had sought counseling from someone other than the aforementioned professionals. Forty of the 46 women who had had counseling indicated the quality of these experiences. Fifteen (37.5%) reported "excellent" counseling experiences, 12 (30%) felt that their experiences had been "above average," 11 (27.5%) reported "average" experiences, and two (5%) reported "poor" counseling experiences. No one indicated a "below average" type of experience.

The final experiential variable involved evaluation of the funeral home experiences associated with their husbands' deaths. Eighty-eight of the 92 widows responded to this question. Thirty-nine widows (44.3%) felt that they had had "excellent" funeral home experiences, 16 (18.2%) classified their experiences as

"above average," while 28 (31.8%) indicated "average" experiences, two (2.3%) had "below average" experiences, and three (3.4%) had "poor" funeral home experiences.

Demographics of the Clergy

One hundred clergy who had been randomly selected or matched were sent questionnaires. From this number, 33 (33%) returned the questionnaires.

In terms of age, one (3%) was 20 to 29 years old, 11 (33%) were 30 to 39, 10 (30%) were 40 to 49, six (18%) were 50 to 59, and three (9%) were 60 to 69 years old. The remaining two clerics (6%) were in their seventies. This resulted in a mean age of 46.4 with a standard deviation of 11.66.

Nearly all of the 33 clergy respondents were men: 31 (93.9%). The other two respondents (6.1%) were women. One clergyperson (3.1%) had never been married, one (3.1%) was divorced, 30 (93.8%) were married, and one did not indicate a marital status. In terms of race, 31 (94%) were Caucasian, one (3%) was Black, and one (3%) indicated "other" for race.

Five (16.7%) of the 30 clerics who responded to the question about the number of years in the ministry, indicated that they had been in their profession for

less than 10 years. Ten (33.3%) had been in the ministry for 10 to 19 years, 10 (33.3%) for 20 to 29 years, three (10%) for 30 to 39 years, and two (6.7%) had been in the ministry for 40 to 49 years. Thirty-one (93.9%) of the clergy were Protestant and two (6.1%) were Catholic. Of the 33 clergypeople, 28 (87.5%) responded that they believed in life after death, four (12.5%) did not hold this belief, and one did not respond.

When questioned in regard to reading about death and related topics, six (18.2%) responded that they read "frequently," 26 (78.8%) read "occasionally," and one (3%) "rarely" read about this topic. One (3%) clergyperson was a member of the Forum for Death Education and Counseling and 32 (97%) were not members of this organization.

The clergy were asked if they had experienced the death of a spouse, child, or other close relative or friend within the past five years. Nineteen (57.6%) had not had a bereavement experience while 14 (42.4%) had had a bereavement experience.

Sixteen of the clergy (53.3%) indicated that they "frequently" had taken the opportunity of talking with widows about their conjugal bereavement after the

funeral. Thirteen (43.3%) "occasionally" had taken this opportunity, one (3.3%) "rarely" did, and three did not respond to this question.

Demographics of the Counselors

For this study, 100 randomly selected or matched counselors were mailed the demographic questionnaire, the BEQ, IES, and CI. Of these, 35 (35%) returned the information. The respondents were almost evenly divided by sex with 19 men (54.3%) and 16 women (45.7%). The ages of the counselors ranged from 29 years old to 66 years old with a mean age of 44 and a standard deviation of 8.45. There was one counselor (2.9%) who was in the twenties, 10 (29.4%) were 30 to 39, 13 (38.2%) were 40 to 49, nine (26.5%) were 50 to 59, one (2.9%) was in the sixties, and one did not indicate age. This distribution of age represents an almost perfect Bell curve.

Most of the counselors were married at the time of answering the questionnaire: 31 (88.6%). Two counselors (5.7%) were divorced, one (2.9%) was living with someone, and another (2.9%) was widowed. All 35 counselors were Caucasian.

Twenty-nine of the 35 counselors indicated their lengths of time in professional practice. A majority of

18 (62%) had been in practice for less than 10 years. Ten (34.5%) had been in practice for 10 to 19 years, and one (3.5%) had been counseling for 43 years.

In regard to religion, 24 (75%) of the 32 counselors who responded to this question were Protestant. Two counselors (6.3%) were Catholic, one (3.1%) was Jewish, and five (15.6%) were of some other religious affiliation.

Thirteen counselors (38.2%) indicated that they attended religious services at least once a week. Seven counselors (20.6%) attended services more than monthly, but less than weekly, and three (8.8%) attended more than once every six months, but less than monthly. Five (14.7%) attended services once or twice yearly, six (17.6%) attended less than yearly, and one did not answer this question.

Thirty of the 35 counselors answered the question about belief in life after death. Of the 30, 24 (80%) indicated a belief in life after death while the remaining six (20%) did not believe in life after death.

A majority of the counselors, 27 (79.4%) had taken a course or seminar concerned with death. Seven counselors (20.6%) had not taken this type of class or

seminar and one did not respond. Five counselors (14.3%) answered that they "frequently" read about death related topics, 25 (71.4%) "occasionally" did this sort of reading, and five (14.3%) "rarely" read this kind of material. None of the 35 counselors belonged to the Forum for Death Education and Counseling.

Of this group of counselors, 21 (60%) responded that they had experienced the death of a spouse, child, or other close relative or friend in the past five years. The remaining 14 (40%) had not experienced this type of death.

In regard to their counseling practices, four (11.4%) had "frequently" counseled widows in relationship to conjugal bereavement, 23 (65.7%) had "occasionally" done this type of counseling, seven (20%) had "rarely" counseled widows for bereavement, and one (2.9%) had never done counseling of this type.

Demographics of the Funeral Directors

The funeral directors who were sent questionnaires had been chosen in the same manner as the other professionals: random selection and matching. Twenty-six funeral directors (26%) returned usable questionnaires. In the group of 26, one declined to

list age. Four (16%) were from 20 years old to 29 years old, 11 (44%) were 30 to 39, five (20%) were 40 to 49, one (4%) was 50 to 59, and four (16%) were 60 to 69. The mean age was 40.8 years old with a standard deviation of 12.45. Twenty-two funeral directors (84.6%) were males and four (15.4%) were females.

Responses to the marital status variable showed that four funeral directors (15.4%) had never been married and 17 (65.4%) were married. Three funeral directors (11.5%) were divorced and two (7.7%) were widowed. All 26 were Caucasian.

Two funeral directors (9.1%) had been in their profession for less than ten years, ten (45.5%) for 10 to 19 years, six (27.3%) for 20 to 29 years, two (9.1%) for 30 to 39 years, and two (9.1%) for 40 to 49 years. Four funeral directors did not respond to this question.

Most funeral directors, 24 (92.3%) indicated that they were Protestant and two (7.7%) were Catholic. Eleven (42.3%) attended religious services at least once a week and eight (30.8%) attended more than monthly, but less than weekly. Four funeral directors (15.4%) attended services more than once every six months, but less than monthly, two (7.7%) attended once

or twice yearly, and one (3.8%) attended less than yearly. Of these 26 funeral directors, 21 (80.8%) responded that they believed in life after death and five (19.2%) did not believe that there is life after death.

Because of the nature of the funeral director's work, it was assumed that all would have taken a course or seminar having to do with death, therefore no data were collected on this item. It was also similarly assumed that funeral directors had read about death and related topics in the course of their preparatory work.

One funeral director (4%) was a member of the Forum for Death Education and Counseling, while 24 (96%) were not members. One person did not respond to this question.

In regard to having experienced the death of a spouse, child, or other close relative or friend in the past five years, 10 (38.5%) had not had this experience. Sixteen funeral directors (61.5%) had experienced this type of death in the past five years.

Four funeral directors (15.4%) indicated that they "frequently" had had the opportunity of talking with widows about their conjugal bereavement. Fifteen (57.5%) indicated having had an "occasional"

opportunity for this kind of counseling, five (19.2%) "rarely" had this kind of opportunity, and two (7.7%) had "never" helped the conjugally bereaved in this way.

Demographics for the Physicians

As with the other three groups of professionals, the physicians were chosen by random selection and matching. The response rate from this population was 16 (16%), the lowest of the four professional groups. Ages of the responding physicans ranged from 29 years old to 66 years old. Their mean age was 49 with a standard deviation of 11.37. Of these 16 doctors, one (6.7%) was between 20 and 29 years of age, two (13.3%) were 30 to 39, four (26.7%) were 40 to 49, five (33.3%) were 50 to 59, three (20%) were 60 to 69, and one doctor did not list an age.

All 16 physicians (100%) were males. Of these 16 men, 12 (80%) were married, three (20%) were widowed, and one doctor did not give a marital status.

Four races were represented by the physicians. The majority, 12 (75%) were Caucasian, two (12.5%) were Latin American, one (6.3%) was Black, and one (6.3%) was from a race not listed.

There was a diversity in the number of years in practice by these doctors. The range was from one to

32 years in practice. Four doctors (26.7%) had been in practice for less than 10 years, three (20%) had been in practice for 10 to 19 years, four (26.7%) had practiced for 20 to 29 years, four (26.7%) from 30 to 39 years, and one person did not state the length of time in practice.

When questioned about religious affiliation, three physicians did not respond. However, nine (69.2%) were Protestant, one (7.7%) was Catholic, one (7.7%) was Jewish, and two (15.4%) were from religions not listed in the questionnaire. Of these physicians, five (35.7%) attended services at least weekly and six (42.9%) attended services more than monthly but less than weekly. Two doctors (14.3%) attended once or twice yearly, one (7.1%) attended less than yearly, and two did not answer this question. All but one doctor answered the question about belief in life after death. The majority, 11 (73.3%) believed in life after death while four (26.7%) did not believe in life after death.

Ten physicians (71.4%) had never taken a course or seminar related to death. Four (28.6%) had taken a course or seminar and two physicians did not respond.

While none of the physicians read "frequently" about death and related topics, five (33.3%)

"occasionally" read this type of material, eight (53.3%) "rarely" did this kind of reading, and two (13.3%) never read about death related topics. Again there was one doctor who did not answer this question. None of the physician respondents belonged to the Forum for Death Education and Counseling.

In the past five years, 13 (92.9%) of the 16 physicians had experienced the death of a spouse, child, or other close relative or friend. One (7.1%) had not had this type of experience and two physicians did not respond.

During office visits, six physicians (40%) had had frequent opportunities to talk with widows about their health in relationship to their experiences of conjugal bereavement. Seven (46.7%) "occasionally" took the opportunity, one (6.7%) "rarely" did, and one (6.7%) "never" talked with widows about their health in view of the grief process. One physician did not answer this question.

Analysis of the Data from the Instruments

In the following report of the data, the reader will note that the numbers associated with the instruments may vary from comparison to comparison.

The variance was due to the computer purging an instrument if the instrument were incomplete.

Table 1

Comparison of Widows vs. Clergy and Counselors

	Instrument		
Group	BEQ	IES	CI
Widows			
M	129.88	35.19	33.85
SD	18.86	11.85	11.12
Clergy			
M	147.08	42.55	41.69
SD	15.58	7.06	8.78
Significance of *F*	.000*	.002*	.001*
Counselors			
M	154.14	44.00	45.24
SD	15.57	7.98	9.00
Significance of *F*	.000*	.000*	.000*

*$p < .01$

Widows and Clergy

On the BEQ there were 60 usable instruments from widows and 25 from the clergy. Table 1 depicts some relevant statistics for widows, clergy, and counselors. The mean score for the widows was 129.88 while the mean score for the clergy was significantly higher at 147.08 ($F_{1,83} = 16.16$, $p < .01$).

On the CI, widows ($n = 69$) had a mean score of 33.85. The clergy's ($n = 29$) mean score was significantly higher at 41.69 ($F_{1,96} = 11.29$, $p < .01$).

IES results closely replicated those of the BEQ and CI. Widows ($n = 78$) had a mean score of 35.19. Clergy ($n = 29$) had a significantly higher mean score (Table 1) of 42.55 ($F_{1,105} = 9.87$, $p < .01$).

There was also a significant difference in age between the two groups, but in the opposite direction. For the widows ($n = 87$) the mean age was 58.3 years and the mean age for the clergy ($N = 33$) was 43.4 years ($F_{1,118} = 25.94$, $p < .01$).

Widows and Counselors

On the IES, the mean score for the counselors was significantly higher than the mean score for the widows (see Table 1). The mean score for the widows ($n = 78$)

was 35.19 while the mean score for the counselors (n = 32) was 44.00 ($F_{1,108} = 14.91$, $p < .01$).

BEQ results showed the widows (n = 60) with a mean score of 129.88. The counselors (n = 29) had a significantly higher mean score of (Table 1) 154.14 ($F_{1,87} = 36.05$, $p < .01$).

Results from the CI closely replicated those of the IES and BEQ (Table 1). The mean score of the widows (n = 69) was 33.85, while the counselors (n = 33) mean score of 45.24 was significantly higher ($F_{1,100} = 26.08$, $p < .01$).

There was also a significant difference between the mean ages of the two groups. The mean age for the widows (n = 87) was 58.3 years, and the mean age for the counselors (n = 34) was 44.2 years ($F_{1,119} = 43.07$, $p < .01$).

Widows and Funeral Directors

When the cases were processed using the analysis of variance for the BEQ, the mean score for the widows (n = 60) was 129.88. Table 2 depicts some relevant statistics for widows, funeral directors, and physicians. The mean score for the funeral directors (n = 20) was significantly higher at 147.15 ($F_{1,78} = 13.98$, $p < .01$).

Table 2

Comparison of Widows vs. Funeral Directors and Physicians

	Instrument		
Group	BEQ	IES	CI
Widows			
M	129.88	35.19	33.85
SD	18.86	11.85	11.12
Funeral Directors			
M	147.15	44.12	39.00
SD	14.45	7.82	8.10
Significance of *F*	.000*	.001*	.049**
Physicians			
M	151.18	45.57	36.86
SD	20.36	11.89	9.81
Significance of *F*	.001*	.003*	.352***

*$p < .01$ **$p < .05$ ***$p > .05$

In the cell means for the IES, the widows' (n = 78) score was 35.19. The funeral directors (n = 25)

again were significantly higher with a mean score of 44.12 ($F_{1,101} = 12.41$, $p < .01$).

Whereas the differences between widows and funeral directors for the BEQ and IES were significant at the .01 level, such differences for the CI were significant at the .05 level (Table 2). For this instrument, the widows ($n = 69$) had a mean score of 33.85. The mean score of the funeral directors ($n = 22$) was 39.00 ($F_{1,89} = 3.99$, $p < .05$).

The ages of the two groups were also significantly different. The mean age for the widows ($n = 87$) was 58.3 years, while the funeral directors ($n = 25$) had a mean age of 40.8 years ($F_{1,110} = 44.07$, $p < .01$).

Widows and Physicians

On the IES, the mean score for the physicians was significantly higher than the mean score for the widows. The physicians ($n = 14$) mean score was 45.57 (see Table 2) and the widows ($n = 78$) mean score was 35.19 ($F_{1,90} = 9.12$, $p < .01$).

BEQ results showed the widows ($n = 60$) to have a significantly lower mean score of 129.88. The physicians ($n = 11$) mean score (Table 2) was 151.18 ($F_{1,69} = 11.58$, $p < .01$).

Table 3

Comparison of Widows vs. Professionals

	Instrument		
Group	BEQ	IES	CI
Widows			
M	129.88	35.19	33.85
SD	18.86	11.85	11.12
All Professionals			
M	150.04	43.83	41.65
SD	16.04	8.23	9.21
Significance of *F*	.000*	.000*	.000*

*$p < .01$

The physicians were the only professionals who did not differ significantly from the widows on the CI. Physicians (n = 14) had a mean score of 36.86 (Table 2) and the widows (n = 69) mean score was 33.85 ($F_{1,81}$ = 0.88, $p > .05$).

The mean ages of the two groups were significantly different ($F_{1,100}$ = 8.22, $p < .01$). The widows (n = 87)

mean age was 58.3 years and the physicians (n = 15) mean age was 49.2 years.

Widows and Professionals as a Group

The analyses of the data for the widows versus the professionals as a group, nearly replicated the comparisons of the widows versus the four professions singly. Table 3 depicts some statistics relevant to this comparison.

On the BEQ, the widows (n = 60) mean score was 129.88. The professionals (n = 85) as a group (N = 110) had a mean score of 150.04 ($F_{1,143} = 47.97$, $p < .01$).

The results from the CI showed that the widows (n = 69) had a mean score of 33.85 (Table 3). Significantly higher were the mean scores of the professional group (n = 98) at 41.65 ($F_{1,165} = 23.87$, $p < .01$).

As with the BEQ and CI, the results for the IES showed a significant difference (Table 3). The widows (n = 78) had a mean score of 35.19, while the professionals (n = 100) mean score was 43.83 ($F_{1,176} = 32.79$, $p < .01$).

In terms of age comparison, there was a significant difference as one would suspect. Widows (n

= 87) had a mean age of 58.3 years, while the professionals (n = 107) as a group had a mean age of 44.8 years ($F_{1,192}$ = 69.67, $p < .01$).

Table 4

Comparison of Counseling vs. Noncounseling Professionals

	Instrument		
Professional	BEQ	IES	CI
Counseling			
M	155.57	47.06	40.60
SD	9.71	7.32	8.12
Noncounseling			
M	149.59	43.48	42.10
SD	16.54	8.06	8.59
Significance of F	1.70***	2.73***	.392***

***$p > .05$

Counseling and Non-counseling Professionals

A one-way analysis of variance revealed no significant difference on the three instruments between the professionals who had and had not counseled widows.

Table 4 depicts some statistics relevant to this comparison. The mean score on the BEQ for the professionals (n = 14) who had counseled widows was 155.57. The mean score for the professionals (n = 69) who had not counseled widows was 149.59 ($F_{1,81}$ = 1.70, $p > .05$).

For the CI, 15 of the professionals indicated that they had counseled widows and they had a mean score of 40.60. Eighty professionals had not counseled widows and had a mean score of 42.10 ($F_{1,93}$ = 0.39, $p > .05$).

As with the BEQ and the CI, the IES was not sensitive to death-related counseling experience. The professionals (n = 16) who had counseled widows had a mean score of 47.06. Eighty-two professionals indicated that they had not counseled widows and had a mean score of 43.48 ($F_{1,96}$ = 2.73, $p > .05$).

Short-Term and Long-Term Widows

Forty-three widows (n = 70) had been widowed for three years or less, while 27 had been widowed for more than three years. Table 5 depicts some statistical differences between the two groups. On the CI, the short-term group had a mean score of 32.09 (See Table 5) and the long-term group had a mean score of 36.67

resulting in no significant difference ($F_{1,68}$ = 2.88, $p > .05$).

Table 5

Comparison of Short-Term vs. Long-Term Widows

	Instrument		
Widow	BEQ	IES	CI
Short-term			
M	133.87	36.35	32.09
SD	20.97	12.28	11.60
Long-term			
M	122.48	32.97	36.67
SD	12.11	11.03	9.88
Significance of *F*	.03**	.22***	.09***

**$p < .05$ ***$p > .05$

For the IES, 48 widows out of 79 widows were short-term widows and had a mean score of 36.35. The long-term widows (n = 31) had a significantly lower mean score of 32.97 ($F_{1,77}$ = 1.55, $p > .05$).

In contrast to the two previous instruments, the results from the BEQ showed a significant difference between the two groups (Table 5). The short-term widows (n = 38) had a mean score of 133.87. On the other hand, the long-term widows (n = 21) had a mean score of 122.48 ($F_{1,57} = 5.21$, $p < .05$).

Additional Findings

When the statistical analyses were reviewed, questions were generated with regard to whether or not relationships existed other than those hypothesized. The following is a synopsis of findings related to the hypotheses as well as the nonhypothesized relationship of the widows matched to professionals versus unmatched widows and professionals.

It should be noted at this point that high scores on the CI meant something different than high scores on the BEQ and the IES. High scores on the CI indicated that coping interventions were used by the widows (or perceived to have been used by the widows) more frequently and more successfully than did low scores. High scores on the BEQ and the IES however, signified that the death had been (or was perceived to have been) more negatively impactful in terms of thoughts and feelings in the past one to four weeks.

In reference to hypotheses one through five, the question of whether or not the professional groups would differ from one another in their responses to the instruments arose. The mean scores of the clergy plus the mean scores of the physicians (group #2) were compared as a whole to the mean scores of the counselors in addition to the mean scores of the funeral directors (group #1) as a whole. No significant differences were demonstrated with the ANOVA between the groups. On the CI, the mean score for group #1 (n = 18) was 33.44 and the mean score for group #2 (n = 52) was 34.00 ($F_{1,68}$ = .03, $p > .05$). For the BEQ, the mean score for group #1 (n = 14) was 132.00 and the mean score for group #2 (n = 46) was 129.24 ($F_{1,58}$ = .23, $p > .05$). And, on the IES the mean score for group #1 (n = 24) was 37.17 and the mean score for group #2 (n = 55) was 34.09 ($F_{1,77}$ = 1.13, $p > .05$).

In the analyses for hypothesis #7 the mean scores of women widowed $\leq$ three years were compared with women widowed $>$ three years. It had been observed that the more usual definitions in the literature of "short-term" included women widowed $\leq$ six months or $\leq$ one year. So, analyses were run for two other short-term

time-frames: $\leq$ two years and $\leq$ one year. As opposed to the three year time-frame used for this study, analyses for the other two short-term time spans did not show any significant differences.

Another question which evolved from this study was whether other selected variable(s) singly or in combination with the variable of length of widowhood would elicit results different than those found in the analysis of hypothesis #7. Therefore, length of widowhood was conjoined with length of marriage, age at bereavement, support group attendance, grief seminar attendance, age at marriage, if the death were expected, mode of death, whether or not death-related material had been read, and whether or not help for coping with grief had been sought.

When length of widowhood, age at bereavement, and if the death were expected were analyzed by use of an ANOVA for the BEQ, a significant main effect for length of widowhood was found for $\leq$ three years ($F_{1,47} = 4.06$, $p \leq .05$). The mean score for the short-term widows ($n = 35$) was 132.66 and the mean score for the long-term ($>$ three years) widows ($n = 20$) was 122.80. The IES scores showed effects due to age of bereavement for those who were $\leq$ 55 years old at the time of

conjugal bereavement ($F_{1,66} = 4.18$, $p < .05$). The mean score for the younger widows ($n = 39$) was 37.92 and the mean score for the older ($\geq$56 years old) widows ($n = 35$) was 32.43. No effects for expectation of death were found.

A 4-way ANOVA was used to determine if there were significant differences on the BEQ, the IES, and the CI with the combination of length of widowhood, age at bereavement, if the death were expected, and the mode of death. The main effect of age at bereavement on the IES was marginally significant ($F_{1,65} = 3.82$, $p = .06$). The mean score for the younger widows ($n = 36$) was 38.00 while the mean score for the older widows ($n = 34$) was 31.91. Marginal significance was also demonstrated for length of widowhood on the BEQ ($F_{1,46} = 3.54$, $p = .07$). The mean score for the short-term widows ($n = 33$) was 132.36 and the mean score for the long-term widows ($n = 18$) was 123.67.

In another analysis, age at marriage and if the death were expected were checked for main effects and/or interactions on the three instruments. Significance was demonstrated on the BEQ for the main effect of age at marriage ($F_{1,51} = 6.62$, $p < .05$). The mean score of the widows who married at $\leq$ 25 years of

age (n = 27) was 135.41 and the mean score of the widows who married at $\geq$ 26 years of age (n = 28) was 123.61.

There were significant differences on the BEQ and borderline significance on the CI for length of widowhood. On both instruments the significance was for the main effect of widowhood $\leq$ three years. The mean score for the short-term widows (n = 37) was 133.62 and the mean score for the long-term widows (n = 21) was 122.48 on the BEQ ($F_{1,54} = 5.32$, $p < .05$). On the CI, the mean score for the long-term widows (n = 27) was 36.67 ($F_{1,65} = 3.28$, $p = .08$).

The variables of age at bereavement and if the death were expected were also analyzed. The women who were $\leq$ 55 years old (n = 39) at bereavement scored significantly higher on the IES than did those who were $\geq$ 56 years old (n = 35) at bereavement. The mean score for the younger group was 37.92 and the mean score for the older group was 32.43 ($F_{1,70} = 4.32$, $p < .05$).

When age at bereavement was analyzed alone a significant difference was noted only on the IES. The women who were widowed at $\leq$55 years old (n = 40) had a mean score of 38.23 while those widowed at $\geq$56 years

old (n = 35) had a mean score of 32.43 ($F_{1,74}$ = 5.19, $p < .05$).

When the variable of age at marriage was analyzed, a significant difference was demonstrated only on the BEQ ($F_{1,54}$ = 6.16, $p < .05$). The mean score for those who were $\leq$ 25 years old at marriage (n = 27) was 135.41 and the mean score for those $\geq$ 26 years old at marriage (n = 29) was 124.26.

In another but more complex situation, the data for the widows and for all professionals were merged to examine the impact of bereavement education and clinical contact (N = 143). In one group were the professionals who had had clinical contact with widows and widows who had sought help from professionals versus professionals who did not have clinical contact with widows and widows who had not sought help from professionals for their grief reactions. The second variable included professionals and widows who had had a seminar(s) and/or class(es) on death-related material versus professionals and widows who had taken neither a seminar nor a class. The main effect of "professional-contact and widow-help" was significant on all instruments. On the BEQ, the mean score (147.16) for "professional-contact and widow-help" (n = 90) was

significantly higher than the mean score (121.96) for the "professional-no contact and widow-no help" (n = 24), ($F_{1,110}$ = 32.31, $p<.001$). Likewise on the IES, the mean score of 41.09 for "professional-contact and widow-help" (n = 110) was significantly higher than the mean score of 34.61 for the "professional-no contact and widow-no help" (n = 33) ($F_{1,139}=6.56$, $p < .05$).

Significant differences were demonstrated for both main effects on the CI. The mean score of 39.96 for the "professional-contact and widow-help" (n = 110) was significantly higher than the mean score of 32.54 for the "professional-no contact and widow-no help" (n = 24) ($F_{1,130}$ = 6.94, $p<.01$). And, the mean score of 41.24 for the professional and/or widow with class or seminar (n = 74) was significantly higher than the mean score of 35.42 for the professional and/or widow without class or seminar (n = 60) ($F_{1,130}$ = 7.32, $p < .01$).

Previous references were made to "matched" widows and professionals. All widows were asked to cite any clergyperson, counselor, funeral director, and/or physician whom they had seen about experiences and feelings in conjugal bereavement. Of the 74 professionals who were identified and sent instruments,

27 returned information and were matched to 29 widows (each of two counselors was cited by two widows). This matching was done in order to better control for experience. The 27 professionals included nine members of the clergy, five counselors, nine funeral directors, and four physicians. Since the numbers were small when the professions were viewed individually, it was decided to combine the four professions into one, larger, professional group. As such, two areas of significant differences were revealed in analysis by a 2-tailed t-test. The mean age of 45 for the professionals was significantly lower than the mean age of 54 for the widows ($\underline{t}_{28} = -2.67$, $\underline{p} < .05$). The other significant difference was for the impact of perceived grieving from the IES. The mean score of 44.34 for the professionals was significantly higher than the mean score of 35.52 for the widows ($\underline{t}_{28} = 3.38$, $\underline{p} < .01$).

Certain patterns emerged in the additional findings. These showed that the professionals did not differ significantly from one another in their responses regarding perceptions of widowhood.

In two of three cases, the length of widowhood was used as a variable. Scores for short-term widows $\leq$ (three years) were significantly higher or marginally

higher (once) than the long-term (>three years) widows on the BEQ. The two times age at marriage was used, significant differences were higher on the BEQ for those married at a younger age ($\leq$25 years old) than those married at an older age ($\geq$26 years old). Significant differences were also apparent on the BEQ for the analysis comparing "professional-contact and widow-help" to "professional-no contact and widow-no help".

The same strength of relationship existed between the IES and widows' ages at bereavement. All four times this variable was used, significant differences (three times) or a marginally significant difference (once) were demonstrated in the direction of the younger widows ($\leq$55 years old) as opposed to the older widows ($\geq$56 years old). On the IES the matched professionals differed significantly from the matched widows. And, "professional-contact and widow-help" differed significantly from the "professional-no contact and widow-no help" on the IES.

Professionals and widows who had had a class and/or seminar in a death-related area, differed significantly on the CI from professionals and widows who had had neither a class nor a seminar. And in one

instance, length of widowhood was noted to be marginally significant on the CI.

Another finding was that the redefined short-term widows did not differ significantly from the redefined long-term widows. Short-term had been redefined as either $\leq$ two years or $\leq$ one year bereavement; and long-term widow had been redefined as either $>$ two years or $>$ one year.

A final finding related to the use of the Pearson correlation coefficient in the comparisons of the three instruments to each other with regard to the widows and also to the professionals. For the widows there was a significant correlation with only one comparison: the BEQ with the IES (r = .30, $p < .05$). The other two comparisons were not significant: the BEQ with the CI (r = -.01, $p > .05$) and the IES with the CI (r = -.001, $p > .05$). On the other hand, the comparisons of the professionals' mean scores showed significant differences for all three instances: the BEQ with the IES (r = .49, $p < .001$), the BEQ with the CI (r = .27, $p < .01$), and the IES with the CI (r = .31, p = .001).

CHAPTER V

SUMMARY OF THE STUDY

Introduction

The purpose of this chapter was twofold. First, there is a recapitulation of the information presented in the previous chapters. And second, there is a presentation of probable and possible meanings of that information as it relates to this study and potentially for other studies. There are six chapter subdivisions: summary, tests of the hypotheses, discussion, implications, conclusions, and recommendations.

Summary

This investigation was designed to determine if significant differences existed between the grief reactions experienced by widows and the grief reactions expected of widows by clergy, counselors, funeral directors, and physicians. Additionally, significant differences in grief reactions were determined between: (1) short-term and long-term widows, (2) professionals who had and had not counseled widows, and (3) between widows who had been matched to the professionals with whom they had been in contact and unmatched widows and professionals.

The data collection involved sending demographic questionnaires and three instruments--the Bereavement

Experience Questionnaire (A. Demi, personal communication, October 4, 1984), the Impact of Event Scale (Poon, 1980), and the Coping Inventory (Poon, 1980) to the samples of widows and professionals randomly selected from the specified reference groups. These groups consisted of 300 widows, 100 clergy, 100 counselors, 100 funeral directors, and 100 physicians. Usable questionnaires were returned by 92 widows, 33 clergy, 35 counselors, 26 funeral directors, and 16 physicians. The procedure for data collection also included sending reminders to all groups two weeks after having sent the questionnaires.

Data collected were subjected to statistical analysis by use of measures of central tendency. Computed means from the scores of the widows and professionals were then compared primarily by use of the one-way ANOVA. Other comparisons were made by use of the chi-square and t-tests.

Tests of the Hypotheses

The following seven null hypotheses were tested for significance at the .05 level:

Hypothesis #1--There is no significant difference between the scores made by the widows and the scores made by the clergy on the Bereavement Experience Questionnaire (BEQ), the Impact of Event Scale (IES), and the Coping Inventory (CI). Rejected.

Hypothesis #2--There is no significant difference between the scores made by the widows and the scores made by the counselors on the BEQ, the IES, and the CI. Rejected.

Hypothesis #3--There is no significant difference between the scores made by the widows and the scores made by the funeral directors on the BEQ, the IES, and the CI. Rejected.

Hypothesis #4--There is no significant difference between the scores made by the widows and the scores made by the physicians on the BEQ, the IES, and the CI. Partially rejected.

Hypothesis #5--There is no significant difference between the scores made by the widows and the combined scores made by the professionals on the BEQ, the IES, and the CI. Rejected.

Hypothesis #6--There is no significant difference between the scores made by the professionals on the BEQ, the IES, and the CI who have and have not dealt with the problems of widows. Accepted.

Hypothesis #7--There is no significant difference between the scores made by the short-term and the long-term widows on the BEQ, the IES, and the CI. Partially rejected.

Discussion

Tests of hypotheses one through five showed widows' grief reactions to be significantly different from the professionals' perceptions of widows' grief reactions for 14 out of 15 comparisons. That is, each of the four professions compared to widows on three instruments and the professions together compared to the widows on the three instruments combined for a total of 15 comparisons (hypotheses one through five).

It should be noted again that high scores on the CI meant something different than high scores on the BEQ and the IES. High scores on the CI indicated that coping interventions were used by the widows (or perceived to be used by the widows) more frequently and more successfully than low scores. High scores on the BEQ and the IES however, signified that the death had been (or was perceived to have been) more negatively impactful in terms of thoughts and feelings in the past one to four weeks. Hence, the results would suggest that the professionals thought that the widows were impacted more negatively than the widows reported themselves to be and that the professionals thought that widows were coping better than the widows' self-report indicated. This was true except for one instance. That instance involved the physicians where

there were no significant differences with the widows on the CI. (Refer to tables 1 and 2 in Chapter IV.)

Prior to the data collection, the researcher predicted that hypotheses one through five would be rejected; and they were. However the direction of the significant differences was exactly the inverse of the researcher's prediction! As a general rule, it was thought that the professionals would significantly underestimate the degree of impact. In this case, empirical evidence seemed to confound theory.

The acceptance of the sixth hypothesis would indicate that having been in professional contact with widows made no difference in the professionals' perceptions of grief reactions in widowhood. All professionals, regardless of whether or not they had dealt with the problems of widows, seemed to view grief reactions in much the same way.

Hypothesis seven was rejected only in the case of the BEQ. Here the short-term widows had significantly higher scores than the long-term widows. This implied that the short-term widows had experienced more thoughts and feelings related to the death in the four weeks prior to filling out the BEQ than did the long-term widows. On the other hand, both short-term and long-term widows were coping similarly within the past week in regard to the impact of spousal death and in

regard to the helpful, positive coping methods being used.

When the findings for the hypotheses were combined with subsequent additional findings, the outcome included reinforcement of some results and the introduction of new information not stated in the study's purpose. In examination of the data, questions surfaced as to why, in hypotheses one through five, the professionals' perceptions were significantly different from the widows' reported experiences for 14 of 15 comparisons. Several possibilities emerged. The first possibility was in reference to age. All professionals had mean ages that were significantly younger than the mean age of the widows. This could indicate that the professionals in general were operating with more limited, personal life-experiences. Therefore, the professionals' perceptions could have been more narrow and shallow, thereby in part, accounting for the significant differences. This is supported by the analysis with the physicians. They were the only group which showed no significant differences versus the widows on an instrument (the CI). The mean age of the physicians was the closest of the professional groups to the mean age of the widows although still significantly different. The physicians' perceptions

of the widows' coping skills were closer to what the widows reported as determined by analysis of the CI. Parenthetically, the physicians who responded had the highest mean age of all the professionals. It is thought that death anxiety is inversely related to age (Pinder & Hayslip, 1981). Therefore, one might conclude that the physician by virtue of age would be less death anxious, but by virtue of occupation would be more death anxious. A greater percent of the physicians had experienced a significant-other death (93% as compared to 62%, 60% and 42% of the other professional groups). This may underlie the findings on the CI in that their experience with death gave them greater insight into the problems widows may experience at bereavement.

Another variable which could have been responsible for some of the differences, was that of sex. By the delimitations set for this study, all widowed persons were women. However, only 20% of the responding professionals were women. If the men operated from a presumed traditional, stereotypical male perspective, then it could be logically ventured that the professionals in part overestimated the degree to which the women reacted to their conjugal bereavement. Possibly in an attempt to accurately answer the instruments, the male professionals tried to imagine

themselves as widowers. Although there is a modicum of research related to widowers, that which exists seems to indicate that there are remarkable differences between the two sexes in their grief reactions (Bowlby, 1980; Doyle, 1980; Glick, Weiss, & Parkes, 1974; Kohn & Kohn, 1978; Shipley, 1982).

There are other plausible explanations. Perhaps the professionals perceived that the widows were more negatively impacted than they were due to how the widows presented themselves, in contrast to the professionals' preconceived ideas. Either they overinterpreted distress or they only saw widows in the most distress. It is also possible that the professionals more narrowly defined adjustment to widowhood when responding to the instruments. For example, they could have viewed the critical period of adjustment to widowhood as between six months and one year. (See hypothesis #7.) It should be noted that the professionals' mean scores were closer to the mean scores of the short-term widows on the BEQ and the IES (significance not determined).

If hypothesis #6 were assessed by itself, it would seem that the professionals' preconception of grief in conjugal bereavement was well established and not subject to alteration by counseling with widows.

However, it could be that the widows with whom some of the professionals dealt did actually fit into the professionals' theoretical, grief framework. Further, the results from the comparison of two professional groups against each other implies that the professional groups do not differ from one another and hence perceive widows' grief reactions similarly.

The exception to the aforementioned situation seems to be in the cases of professionals matched to the widows with whom they had contact. Despite the significant difference in mean age, the matched professionals did not differ significantly from the widows on the BEQ or the CI. It could be that these matched professionals were different from unmatched professionals because they had more frequent contact, more recent contact, and/or more lengthy contact with their matched widows. It is also possible that in general these matching professionals counseled more widows and/or were more interested in the dynamics of conjugal bereavement than the unmatched professionals.

As represented in the additional findings, a different aspect was presented when professionals and widows were grouped together in "having" versus "not having" contact with each other pertaining to conjugal bereavement. Considering that (1) there were no significant differences between the professionals

themselves who had and had not counseled widows, and that (2) there was no significant difference in two instruments with matched widows and professionals, it is of interest that (3) there was significant difference on all instruments when all professionals were combined with widows for similarity of contact in having dealt with the problems of widows. One could extrapolate from the preceding that if widows who had sought counseling were compared to widows who had not sought counseling, the difference might be strongly significant.

The second part of the former comparison had to do with the knowledge base of death/grief-related material. This knowledge base included the variables of having read material related to death/grief, having attended a seminar, or having attended a class related to death/grief. The results would seem to denote that an increased knowledge base made a significant difference when professionals were grouped together with widows where more long-term positive coping behaviors (CI) were concerned, but not in terms of more recent thoughts and feelings experienced (BEQ and IES) relevant to bereavement. This disparity could also be a consequence of the presumed male/female differences in definitions of adjustment to widowhood.

Results of hypothesis seven could lead to the conclusion that women widowed $\leq$ three years had more difficulty than women widowed $>$ three years, over the four weeks prior to answering the instruments as determined by the BEQ. But, this was not true on the IES for the prior week or for coping behaviors (CI). At this point, the additional findings for short-term/long-term widows should be interjected. Inasmuch as the $\leq$ one year and $\leq$ two years short-term widows did not significantly differ from the $>$ one year and $>$ two years long-term widows, respectively, it might be deduced that some problematic issues emerged or re-emerged around the three year time period. And, that when the issue(s) was/were confronted that they were more impactful in view of the long-term, recent past (four weeks - BEQ) as opposed to the short-term, recent past (one week - IES), or as opposed to the widows' coping ability in general (CI).

The final additional findings relate to the calculated variables of age at marriage and age at bereavement. The significant findings in both situations are indicative of greater impact for the younger age groups. A reason for this could be that the concept of death was less contemplated, and therefore less anticipated at a younger age, though present exploratory analyses of this factor do not

support this conclusion. As with the younger professionals, the younger widows may also have fewer life experiences and consequently fewer coping skills in reference to major loss. Perhaps the women married at a younger age took being married more for granted than the women married at an older age, and were thus more vulnerable to the negative effects caused by the intrusion of spousal death. There could also be a generation of difference between the younger and older groups of widows, representing different outlooks on life, modes of thought, social mores, and exposure to death.

Other questions surface in regard to the written instrument method of data collection. Were the widows and professionals convinced of the importance and gravity of the study? Were the instruments geared more toward a particular level of education or personality construct? Were three instruments too many, especially given the length of the BEQ? Would another ordering of the instruments have made a difference? Could fatigue have been a problem in answering questions about a sensitive, emotion-laden topic? Did sending the questionnaire in the early fall, as compared to another time of year (not close to a holiday), make any difference?

A note of caution is warranted at this point regarding comparisons of the instruments. The professionals were instructed to answer all three instruments as they perceived women widowed less than five years would. However, superimposed on the five years was the parameter of the prior four weeks for the BEQ and the parameter of the prior week for the IES.

Mailed questionnaires are susceptible to biases associated with a small percentage of returns. Seasoned researchers recommend at least one or two, if not three follow-up reminders (Drew & Hardman, 1985) to insure adequate returns. One reminder was used in this study. The response rates of usable material were: widows--30.7%, clergy--33%, counselors--35%, funeral directors--26%, and physicians had an abysmal 16%.

Two and three reminders were ruled out for a combination of reasons. First, the Widowed Persons Service (WPS) office received several calls of protest within two days of the packets having been mailed. This was perceived to be disconcerting to the faithful volunteer at the WPS office who had subsequently called the researcher. Calls to the WPS were unanticipated because WPS was never mentioned in the packet information and because the researcher's phone number had been listed in the cover letter attendant to an invitation for anyone with questions to call. In

addition, the WPS volunteer's anxiety seemed to be heightened when informed of the established procedure of sending reminders.

The second reason for not sending more reminders was due to the desire not to unduly push or corner subjects on such an emotionally heavy topic. Thirdly, the response rate to the first reminder was small. And fourthly, the researcher would tend to question the validity of the responses if those responses were thought to be the products of perceived goading or coercion.

This then leads to the question of what, if anything, may have been different about the sample of widows who did not respond to the questionnaires in this study? It could be that the nonrespondents were having a more difficult time of adjustment and did not want to face the pain which could likely be evoked as a result of the material covered in the instruments. Support for this could come from the fact that only one woman widowed $\leq$ eight months returned a usable instrument. And, only four respondents were widowed $<$ one year. (However, it was not known how many of the widows who were sent packets had been bereaved for $\leq$ one year.) This would suggest an even more severe professional bias.

Another reason for widows' nonresponse could be that of denial. Being unwilling to admit to the status of "widow," could have led to not confronting the questions contained in the BEQ, the IES, and the CI. On the other hand, nonresponding widows could have been made up of women who were adjusting well or who were very, long-term widows and did not see the need for participating in this study. (Several widows returned their unanswered questionnaires with notes attached. These notes in effect said that the nonrespondents had been widowed for so long-13 and 18 years-that they felt their information would not be useful.)

And lastly, there were two relevant but miscellaneous items. First, for the widows who responded, there could have been a degree to which the Hawthorne effect was present within their answers. And second, it should also be appreciated that this widowed sample was experimentally accessible and not necessarily representative of the broader, target population.

Now to the issue of what may have been different about the professionals--especially the physicians--who did not respond. Five possibilities were proposed. (1) It could be that the professionals felt threatened by a death-related issue. This would parallel the supposition that our American culture is largely death-

denying. (2) The professionals may have been unwilling to recognize conjugal bereavement as a potentially long-term problem, lasting more than three, six, or twelve months. This could be a component of our "instant everything" society. (3) Perhaps these professionals were simply uninterested and/or uneducated about widows and conjugal grief reactions. (4) Maybe the professionals--especially the physicians--perceived themselves as being too busy to spend the time necessary to respond. And, (5) it is also possible that the physicans, who are construed to be "healers," and whose work it is to thwart death, may be more firmly entrenched in a death-denying stance than other professionals. Hence, the physicians who responded may in effect represent the antithesis assumed of physicians, and may be death-confronting. The fact that 93% of the responding physicians had experienced the death of a significant other in the past five years, could be interpreted as evidence for this speculation.

It was most disappointing to have a response rate of 16% from the physicians. However, this abated somewhat upon reading an overview of the results of a survey sent out by the Religion Committee of the Tarrant County Medical Society's (TCMS) auxiliary. All

members of the TCMS (nearly 1200) were sent the survey. Only 17% of the physicians responded to a survey sanctioned by their own county medical society (Tow, 1983). Follow-up procedures, if any, were unreported.

In a review of the material generated from this study, the challenge and responsibility to answer questions and to make those elusive "intuitive leaps" was intimidating. As soon as initial questions were answered, a second generation and in some instances, a third generation of questions was propagated. Consequently, it appears plausible that an investigation can become more than a theoretical exercise. Thus, it is encouraging to believe that an embryonic piece of work may contain elements which can be honed and fine-tuned in the ever-expanding, antipodean horizons of research.

Implications

In view of this study, the overwhelming indications of misperception would lead to the assumption that alterations need to be made in regard to death/grief education for professionals. Either content and/or quality of existing courses needs to be amended, or the courses need to be established and required.

Additionally, the question is raised as to whether or not there should be a continuing institutional

obligation to the bereaved, especially by hospitals, funeral homes, and churches. Although this is controversial, suggestions by some physicians, administrators, and funeral directors indicate that this is a professional responsibility (Ariès, 1974; Borman & Lieberman, 1981; Hickey, 1973; Kavanaugh, 1972; Osterweis et al., 1984; Worden, 1982).

There is another more broadly based implication. Formalized death/grief education in general is lacking (Shipley, 1982). It is an example of the situation where a decision not to educate is a decision to educate with opinions and hearsay. That is, not offering death education can serve to reduce the issues of dying, death, and bereavement to the "pornographic" level (Gorer, 1965).

Conclusions

The significant differences repeatedly found between the widows and professionals suggest that the clergy, counselors, funeral directors, and physicians do not perceive the grief reactions similarly to the widows' experiences of grief reactions. Moreover, previous professional contact with widows resulted in little or no improved comprehension of what widows

reported experiencing in conjugal bereavement. In fact, controlling for experience seemed to lessen such misperceptions.

Another significant difference was that on the IES, women widowed two to three years experienced more difficulty in their adjustment to conjugal bereavement than did women widowed less than two years but more than eight months.

Recommendations

It is suggested that further investigation of this topic include replication of this study with the following changes:

1) use of control groups matching widows to non-widows to control for dynamics in conjugal bereavement,

2) use of a time-series design,

3) use of other types of professionals, i.e., hospital chaplains, lawyers, interns and residents, and/or medical students,

4) include demographic questions which would be indicators of poor bereavement outcomes, e.g., questions about illnesses, visits to doctors, and/or hospitalizations since spouse's death,

5) use of other variables and/or a redefinition of time-frames such as younger/older or short-term/long-term,

6) use of a population of widows which offers greater diversity,

7) increase number of times reminders are sent or set a specific number of subjects to obtain,

8) define length of widowhood more narrowly for the professionals,

9) use of other instruments or development of one's own instrument,

10) use of an interview instead of mailed, written instruments,

11) include in the investigation a follow-up of the non-respondents using only the demographic data to assist in the identification of variables related uniquely to nonrespondents, and/or

12) send designated instruments to widows; then from their responses formulate more narrow conjugal bereavement guidelines to which the professionals could respond.

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Appendix A

Graduate School Approval of Prospectus

TWU Texas Woman's University
P.O. Box 22479, Denton, Texas 76204; (817) 383-2302, Metro 434-1757, Tex-An 834-2133
THE GRADUATE SCHOOL

September 5, 1985

Ms. Shoshanna Conway
3968 Windhaven Rd.
Fort Worth, TX 76133

Dear Ms. Conway:

Thank you for providing the materials necessary for the final approval of your prospectus in the Graduate Office. I am pleased to approve the prospectus, and I look forward to seeing the results of your study.

If I can be of further assistance, please let me know.

Sincerely yours,

Leslie M Thompson

Leslie M. Thompson
Provost

tb

cc Dr. Ruth Tandy
Dr. Roger Shipley
Dr. Ann Uhlir ✓

Appendix B

Permission for Use of the Bereavement Experience Questionnaire

MCG

Medical College of Georgia
Augusta, Georgia 30912
School of Nursing
Department of Community Health Nursing

October 4, 1984

Ms. Shoshanna Conway
3968 Windhaven Road
Fort Worth, Texas 76133

Ms. ~~Conway~~ Shoshanna:

I enjoyed talking with you at the Forum Conference in Arkadelphia. As you requested, I am sending you information on the research instrument I am developing, the Bereavement Experience Questionnaire (BEQ). Enclosed are the instrument, a description of the process of development of the instrument, and preliminary reports on reliability and validity of the instrument.

If you choose to use the instrument on bereaved subjects, I would require that you provide me with a copy of your raw data so that I can continue development of the instrument.

I wish you success in your research endeavors.

Sincerely,

Alice S. Demi, R.N., D.N.Sc.
Professor and Chair
Department of Community Nursing

ASD/dr

Enclosure

Appendix C

Permission for Use of the Impact of Event Scale and the Coping Inventory

Department of Psychiatry &
Langley Porter Psychiatric Institute
401 Parnassus Avenue
San Francisco, California 94143

University of California, San Francisco . . . A Health Sciences Campus

UCSF

September 4, 1985

Shashanna E. Conway
3968 Windhaven Road
Ft. Worth, TX 76133

Dear Ms. Conway:

Thank you for your letter which arrived today.

You may use the Coping Inventory and the Impact of Event Scale* in your research on widows. We would appreciate seeing the data analysis (not necessarily the raw data), and wish you luck with your project.

Sincerely,

Nancy Wilner

Nancy Wilner
Research Specialist

* The IES is designed to be completed "for the past seven days." For long-term widows, this may be complicated.

Appendix D

Contents of Packets to Widows

TWU Texas Woman's University
P.O. Box 23717, Denton, Texas 76204 (817) 383-3569

DEPARTMENT OF HEALTH EDUCATION
COLLEGE OF HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE

3968 Windhaven Rd.
Ft. Worth, TX 76133
5 September 85

Dear Widow,

As a student at Texas Woman's University-Denton, part of my graduate work involves a study about widowhood and grief reactions. Your responses to the enclosed questionnaires are vital to the conduct of this study.

According to several California researchers, widowhood is one of the two most stressful life change events. As such, widowhood can cause many painful changes. A purpose of this study is to determine how a woman reacts to the death of her spouse. The enclosed questionnaires include statements about your thoughts, feelings, and experiences as a widow.

In completing the questionnaires, you will help provide valuable information to professionals interested in understanding, and emotionally, physically, and spiritually supporting the widow. In so doing, you will also run the risk of evoking painful thoughts and feelings.

As a fellow widow, I appreciate the need for privacy, as well as the need for others to be more knowledgeable about the intense emotions and experiences of widowhood. All information will be held in the strictest confidence.

Please complete and return the enclosures by the 23rd of September. If you have any questions, feel free to call me at 294-0155. (An answering machine will pick-up if no one is available.)

Your assistance in this study is greatly appreciated. Thank you for your time and effort.

Sincerely,

Shoshanna E. Conway, RN

Shoshanna E. Conway, R.N.

Dr. Ruth E. Tandy /sc

Dr. Ruth E. Tandy,
Professor of Health Education

TWU Texas Woman's University
P.O. Box 23717, Denton, Texas 76204 (817) 383-3569
DEPARTMENT OF HEALTH EDUCATION
COLLEGE OF HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE

RELEASE OF PROFESSIONAL INFORMATION

There are times during widowhood when an individual seeks the counsel of a professional about problems that are encountered. This need for counsel can include anything from funeral related decisions to difficulty in coping with the emotional, physical, and/or spiritual realities of spousal death.

In order to assist in the collection of accurate information, it will be helpful to know the names of clergy, counselors, funeral directors, and/or physicians with whom you have consulted. If you choose to list one or more of these professionals, you will not be identified to them either by name, specific experience, or by other personal data. At the same time, neither will the professionals be informed that they have have been named by a widow with whom they have consulted.

Clergyperson_____

Counselor_____

Funeral Director_____

Physician_____

TWU Texas Woman's University
P.O. Box 23717, Denton, Texas 76204 (817) 383-3569

DEPARTMENT OF HEALTH EDUCATION
COLLEGE OF HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE

CONSENT FORM

I the undersigned, do hereby consent to participate in the following study: "Grief reactions experienced by short-term and long-term widows as compared to the grief reactions expected of widows by clergy, counselors, funeral directors, and physicians". My participation is voluntary and includes completing and returning the following: this consent form, demographic information questionnaire, Bereavement Experience Questionnaire, Impact of Event Scale, Coping Inventory, and if I choose, the list of professionals consulted.

I realize that answering the questions could produce painful memories, and strong feelings in connection to these memories. Further, I will not hold the researcher, professors, and/or university responsible for the possible distress caused by the evocation of these memories and feelings.

I also understand that all information will be treated confidentially. That is, my name will not be used at any time to any other widows, to professionals, and/or in the write-up of the research.

Signature_____Date_____

Witness_____Date_____

Demographic Information (Widows)

Please either fill-in-the-blank or place a check by your selected response(s) as indicated.

1. Age_____
2. Occupation
   _____employed outside the home _____not employed
   _____employed at home
3. Race
   _____American Indian _____Caucasian _____Oriental
   _____Black American _____Hispanic _____Other
4. Number of children 18 years old or younger_____
5. Last year of formal schooling completed:
   _____8th grade or less _____some college_____master's
   _____9th-12th grade _____assoc. deg. _____doctor
   _____technical school _____bach. deg. _____other
6. Religious affiliation:
   _____Protestant; indicate denomination_____
   _____Catholic Other, indicate_____
   _____Jewish
7. How often do you attend religious services?
   _____at least once a week
   _____more than once a month, but less than weekly
   _____more than once each six months, but less than monthly
   _____once or twice yearly
   _____less than yearly
8. Do you believe there is life after death?
   _____yes _____no
9. When did your husband die?_____
10. Was his death_____expected or _____unexpected?
11. Mode of death: _____illness _____homocide
    _____accident _____suicide
12. How long had you been married?_____
13. Have you read about death, bereavement, grief process and/or widowhood since your husband's death?
    _____yes _____no
14. Have you ever taken a class or course in death education either before or after your husband's death?
    _____yes: _____before_____after
    _____no
15. Have you attended any widow's support group meetings? _____frequently _____rarely
    _____occasionally _____never
16. Have you attended a grief seminar? _____yes_____no
17. Did the clergyman who performed your husband's funeral initiate contact with you after the funeral in regard to how you were coping? _____yes_____no

Demographic Information (Widows)
page two

18. Did you seek counseling after your husband's death?
_____yes: _____pastor _____professional counselor
_____physician _____funeral director
_____psychiatrist _____other
(indicate)_____

19. Was this experience (Were these experiences)
_____excellent _____below average
_____above average _____poor
_____average

20. How would you evaluate the funeral home experience associated with your husband's death?
_____excellent _____below average
_____above average _____poor
_____average

21. Of all the experiences in your grief process, which experience do you think is least understood by nonwidows?

BEREAVEMENT EXPERIENCE QUESTIONNAIRE

BEQ instructions for widows:

On the left side of the page are thoughts and feelings that bereaved people sometimes have. Read the item on the left, then in the right column circle how often you have experienced the stated thought or feeling in the past month, including today.

Thoughts and Feelings I've Had in the Past Month (4 weeks) N = Never S = Sometimes O = Often A = Almost Always	N	S	O	A
1. Felt angry at friends.	1	2	3	4
2. Felt that life has no meaning.	1	2	3	4
3. Found myself searching for the person who died.	1	2	3	4
4. Thought I saw the deceased person.	1	2	3	4
5. Felt guilty when I enjoyed myself.	1	2	3	4
6. Felt I had a poor relationship with the deceased person.	1	2	3	4
7. Felt fearful that something else bad might happen.	1	2	3	4
8. Lost interest in people that I formerly cared about.	1	2	3	4
9. Thought that I contributed to the death.	1	2	3	4
10. Yearned for the deceased person.	1	2	3	4
11. Lost my religious faith.	1	2	3	4
12. Felt fearful that I might die.	1	2	3	4
13. Lost interest in my work.	1	2	3	4
14. Thought I was losing my mind.	1	2	3	4
15. Felt a need for physical intimacy.	1	2	3	4
16. Lost interest in activities that I formerly cared about.	1	2	3	4
17. Felt blamed by others for the death.	1	2	3	4
18. Felt fearful that another of my loved ones might die.	1	2	3	4
19. Felt ashamed of the way he/she died.	1	2	3	4

Thoughts and Feelings I've Had in the Past Month (4 weeks)	Never	Sometimes	Often	Almost Always
20. Felt like a part of me was/is dead.	1	2	3	4
21. Felt that he/she contributed to his/her own death.	1	2	3	4
22. Felt like I was watching myself go through the motions of living.	1	2	3	4
23. Felt I should have done more for him/her during his/her life.	1	2	3	4
24. Felt that the deceased person was/is guiding me.	1	2	3	4
25. Heard the deceased person's voice, cry, cough, etc.	1	2	3	4
26. Thought that the death was a punishment for things I did in the past.	1	2	3	4
27. Sensed the deceased person's persence.	1	2	3	4
28. Felt a need to be emotionally close to someone.	1	2	3	4
29. Felt angry at strangers.	1	2	3	4
30. Felt that some person was responsible for the death.	1	2	3	4
31. Felt guilty about my sexual needs.	1	2	3	4
32. Was preoccupied with thoughts of death.	1	2	3	4
33. Felt angry over local, national, or world events.	1	2	3	4
34. Felt guilty about some things I said or did since the death.	1	2	3	4
35. Spent time looking at the deceased person's pictures, clothing, or belongings.	1	2	3	4
36. Felt angry at relatives.	1	2	3	4
37. Felt that I have nothing to live for.	1	2	3	4
38. Felt that the deceased person is located within me.	1	2	3	4
39. Felt guilty because I'm doing so well since the death.	1	2	3	4
40. Felt compelled to change my residence because of what some people thought about the death.	1	2	3	4
41. Felt emotionally distant from people.	1	2	3	4
42. Thought that there are some very real reasons why I have felt guilty.	1	2	3	4

Thoughts and Feelings I've Had in the Past Month (4 weeks)	Never	Sometimes	Often	Almost Always
43. Felt angry at God.	1	2	3	4
44. Felt that I caused the death.	1	2	3	4
45. Felt guilty about some things I said and did before the death.	1	2	3	4
46. Felt angry at myself.	1	2	3	4
47. Thought that there isn't any real reason for me to feel guilty, yet I do.	1	2	3	4
48. Felt relieved that he/she died.	1	2	3	4
49. Felt I could have done something to prevent the death.	1	2	3	4
50. Felt guilty about little, unimportant things.	1	2	3	4
51. Felt angry at the deceased person.	1	2	3	4
52. Felt I had a very good relationship with the deceased person.	1	2	3	4
53. Felt guilty because I have lived longer than he/she did.	1	2	3	4
54. Felt that I did not grieve correctly.	1	2	3	4
55. Felt angry at people who provided care to the deceased person (doctors, nurses, therapists, etc.).	1	2	3	4
56. Was preoccupied with thoughts about the deceased person.	1	2	3	4
57. Felt guilty about my sexual behavior.	1	2	3	4
58. Felt afraid to be alone.	1	2	3	4
59. Felt empty.	1	2	3	4
60. Felt my life has no purpose.	1	2	3	4
61. Felt a need to be touched or held.	1	2	3	4
62. Felt that my presence makes people uncomfortable.	1	2	3	4
63. Was unable to reach out to others for help.	1	2	3	4
64. Could not bear to sort or part with the deceased person's belongings.	1	2	3	4
65. Felt unable to recall the deceased person's image.	1	2	3	4
66. Felt I would welcome death.	1	2	3	4
67. Felt afraid of losing control of my emotions.	1	2	3	4

Impact of Event Scale (Center for the Study of Neuroses, U. of California, San Francisco)

INSTRUCTIONS

Below is a list of comments made by people after stressful life events. Please fill in the box for each item, indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please fill in the NOT AT ALL box. Please answer EACH item by filling in ONE OF THE BOXES.

	NOT AT ALL	RARELY	SOME-TIMES	OFTEN
1. I thought about it when I didn't mean to.	1	2	3	4
2. I had trouble doing other things because the event kept coming into my mind.	1	2	3	4
3. I avoided letting myself get upset when I thought about it or was reminded of it.	1	2	3	4
4. I tried to remove it from memory.	1	2	3	4
5. I had trouble falling asleep or staying asleep because of pictures or thoughts about it that came into my mind.	1	2	3	4
6. I had waves of strong feelings about it.	1	2	3	4
7. I had dreams about it.	1	2	3	4
8. I stayed away from reminders of it.	1	2	3	4
9. I felt as if it hadn't happened or it wasn't real.	1	2	3	4
10. I tried not to talk about it.	1	2	3	4
11. Pictures about it popped into my mind.	1	2	3	4
12. Other things kept making me think about it.	1	2	3	4
13. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	1	2	3	4
14. I tried not to think about it.	1	2	3	4
15. Any reminder brought back feelings about it.	1	2	3	4
16. My feelings about it were kind of numb.	1	2	3	4

APPENDIX E

Contents of Packets to Clergy, Counselors, Funeral Directors, and Physicians

TWU Texas Woman's University
P.O. Box 23717, Denton, Texas 76204 (817) 383-3569

DEPARTMENT OF HEALTH EDUCATION
COLLEGE OF HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE

3968 Windhaven Rd.
Ft. Worth, TX 76133
11 November 85

Dear Clergyperson,

As a graduate student at Texas Woman's University in Denton, I am conducting thesis research on the grief reactions in widowhood. I am also interested in professional perceptions of this process. Your responses to the enclosed questionnaires are vital to the conduct of this study.

Widowhood is one of the most stressful life change events, and there are over 12,000,000 widowed persons in the United States today. Chances are that you have worked with and will continue to work with many widowed persons. Increased understanding of the ramifications of widowhood will be beneficial to you the practitioner, as well as to your widowed clients.

All information you provide will of course be held in strict confidence. Please complete and return the questionnaires by 25 November. If you have any questions, please feel free to call me at 294-0155. (Answering machine will pick up if no one is available.)

Your assistance in this study is greatly appreciated. Thank you for your time and effort.

Sincerely,

Shoshanna E. Conway, R.N.

Shoshanna E. Conway, R.N.

Dr. Ruth E. Tandy

Dr. Ruth E. Tandy,
Professor of Health Education

Demographic Information (Clergy)

Please either fill-in-the-blank or place a check by your selected response(s) as indicated.

1. Age_____
2. Sex _____Male _____Female
3. Marital Status:
   _____Never married _____separated _____widowed
   _____living together _____married _____divorced
4. Race:
   _____American Indian _____Caucasian _____Oriental
   _____Black American _____Latin-Amer. _____Other
5. Level of education
   College: ___Bachelor Seminary: ___Bachelor
   ___Master ___Master
   ___Doctorate ___Doctorate
   ___attended;non-graduate ___attended;non-graduate
   _____Other(indicate)_____
6. Number of years in the ministry_____
7. Religious affiliation:
   _____Protestant(indicate denomination)_____
   _____Catholic _____Other(indicate)_____
   _____Jewish
8. Do you believe in life after death?___yes___no
9. Have you ever taken a course or seminar having to do with death? _____yes_____no
10. Do you read about death and related topics?
    _____frequently _____rarely
    _____occasionally _____never
11. Do you read articles from any of the following?
    Journal of Pastoral Care ___yes___no
    Journal of Religion and Health ___yes___no
    Omega ___yes___no
    Pastoral Psychology ___yes___no
12. Have you taken a Clinical Pastoral Education (CPE) program? _____yes_____no
13. Do you belong to:
    The American Association of Pastoral Counselors
    _____yes_____no
    The Forum for Death Education and Counseling
    _____yes_____no
14. Do you have the opportunity of talking to the widow about the conjugal bereavement after the funeral?
    _____frequently _____rarely
    _____occasionally _____never
15. Does your church offer any programs, support groups, or classes for the widowed? _____yes_____no
16. Have you experienced the death of a spouse, child, or other close relative or friend in the past five years? _____yes; relation to the deceased_____
    _____no

TWU Texas Woman's University
P.O. Box 23717, Denton, Texas 76204 (817) 383-3569

DEPARTMENT OF HEALTH EDUCATION
COLLEGE OF HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE

3968 Windhaven Rd.
Ft. Worth, TX 76133
11 November 85

Dear Counselor,

As a graduate student at Texas Woman's University in Denton, I am conducting thesis research on the grief reactions in widowhood. I am also interested in professional perceptions of this process. Your responses to the enclosed questionnaires are vital to the conduct of this study.

Widowhood is one of the most stressful life change events, and there are over 12,000,000 widowed persons in the United States today. Chances are that you have worked with and will continue to work with many widowed persons. Increased understanding of the ramifications of widowhood will be beneficial to you the practitioner, as well as to your widowed clients.

All information you provide will of course be held in strict confidence. Please complete and return the questionnaires by 25 November. If you have any questions, please feel free to call me at 294-0155. (Answering machine will pick up if no one is available.)

Your assistance in this study is greatly appreciated. Thank you for your time and effort.

Sincerely,

Shoshanna E. Conway, R.N.

Shoshanna E. Conway, R.N.

Dr. Ruth E. Tandy /sc

Dr. Ruth E. Tandy,
Professor of Health Education

Demographic Information (Counselors)

Please either fill-in-the-blank or place a check by your selected response(s) as indicated.

1. Age_____
2. Sex: _____Male _____Female
3. Marital status:
   _____never married _____separated _____widowed
   _____living together _____married _____divorced
4. Race:
   _____American Indian _____Caucasian _____Oriental
   _____Black American _____Latin Amer. _____Other
5. Type of counseling practice_____
6. Number of years in practice_____
7. What degree(s) and/or certifications do you hold in psychology and/or counseling?_____
   _____
   _____
   _____
   _____
8. Religious affiliation:
   _____Protestant(indicate denomination)_____
   _____Catholic _____Other
   _____Jewish
9. How often do you attend religious services?
   _____at least once a week
   _____more than monthly, but less than weekly
   _____more than once each six months, but less than monthly
   _____once or twice yearly
   _____less than yearly
10. Do you believe in life after death? ___yes___no
11. Have you ever taken a course or seminar having to do with death? _____yes_____no
12. Do you read about death and related topics?
    _____frequently _____rarely
    _____occasionally _____never
13. Do you belong to the Forum for Death Education and Counseling? _____yes_____no
14. Have you experienced the death of a spouse, child, or other close relative or friend in the past five years?
    _____yes; relation to the deceased_____
    _____no
15. Have you counseled widows in relation to their conjugal bereavement?
    _____frequently _____rarely
    _____occasionally _____never

TWU Texas Woman's University
P.O. Box 23717, Denton, Texas 76204 (817) 383-3569

DEPARTMENT OF HEALTH EDUCATION
COLLEGE OF HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE

3968 Windhaven Rd.
Ft. Worth, TX 76133
11 November 85

Dear Funeral Director,

As a graduate student at Texas Woman's University in Denton, I am conducting thesis research on the grief reactions in widowhood. I am also interested in professional perceptions of this process. Your responses to the enclosed questionnaires are vital to the conduct of this study.

Widowhood is one of the most stressful life change events, and there are over 12,000,000 widowed persons in the United States today. Chances are that you have worked with and will continue to work with many widowed persons. Increased understanding of the ramifications of widowhood will be beneficial to you the practitioner, as well as to your widowed clients.

All information you provide will of course be held in strict confidence. Please complete and return the questionnaires by 25 November. If you have any questions, please feel free to call me at 294-0155. (Answering machine will pick up if no one is available.)

Your assistance in this study is greatly appreciated. Thank you for your time and effort.

Sincerely,

Shoshanna E. Conway, R.N.

Shoshanna E. Conway, R.N.

Dr. Ruth E. Tandy /sc

Dr. Ruth E. Tandy,
Professor of Health Education

Demographic Information (Funeral Directors)

Please either fill-in-the-blank or place a check by your selected response(s) as indicated.

1. Age_____
2. Sex: _____Male _____Female
3. Marital status:
   _____never married _____separated _____widowed
   _____living together _____married _____divorced
4. Race:
   _____American Indian _____Caucasian _____Oriental
   _____Black American _____Latin Am. _____Other
5. What is the highest educational level you have completed?_____
6. Degree(s), certification, and/or licensure obtained related to your funeral home occupation._____
_____
_____
_____
7. How many years have you been in the funeral home business?_____
8. Religious affiliation:
   _____Protestant(indicate denomination)_____
   _____Catholic _____Other(indicate)_____
   _____Jewish
9. How often do you attend religious services?
   _____at least once a week
   _____more than monthly, but less than weekly
   _____more than once every six months, but less than monthly
   _____once or twice yearly
   _____less than yearly
10. Do you believe in life after death? ___yes___no
11. Do you belong to the Forum for Death Education and Counseling? ___yes___no
12. After the funeral, do you have the opportunity of talking with widows about their conjugal bereavement?
   _____frequently _____rarely
   _____occasionally _____never
13. Have you experienced the death of a spouse, child, or other close friend or relative in the past five years?
   _____yes; relation to the deceased_____
   _____no

TWU Texas Woman's University
P.O. Box 23717, Denton, Texas 76204 (817) 383-3569

DEPARTMENT OF HEALTH EDUCATION
COLLEGE OF HEALTH, PHYSICAL EDUCATION, RECREATION, AND DANCE

3968 Windhaven Rd.
Ft. Worth, TX 76133
11 November 85

Dear Physician,

As a graduate student at Texas Woman's University in Denton, I am conducting thesis research on the grief reactions in widowhood. I am also interested in professional perceptions of this process. Your responses to the enclosed questionnaires are vital to the conduct of this study.

Widowhood is one of the most stressful life change events and there are over 12,000,000 widowed persons in the United States today. Chances are that you have worked with and will continue to work with many widowed persons. Increased understanding of the ramifications of widowhood will be beneficial to you the practitioner, as well as to your widowed patients.

All information you provide will of course be held in strict confidence. Please complete and return by 25 November. If you have any questions, please feel free to call me at 294-0155. (Answering machine will pick up if no one is available.)

Your assistance in this study is greatly appreciated. Thank you for your time and effort.

Sincerely,

Shoshanna E. Conway, R.N.

Shoshanna E. Conway, R.N.

Dr. Ruth E. Tandy

Dr. Ruth E. Tandy,
Professor of Health Education

Demographic Information (Physicians)

Please either fill-in-the-blank or place a check by your selected response(s) as indicated.

1. Age_____
2. Sex: _____Male _____Female
3. Marital status:
   _____never married _____separated _____widowed
   _____living together _____married _____divorced
4. Race:
   _____American Indian _____Caucasian _____Oriental
   _____Black American _____Latin Amer. _____Other
5. Type of practice_____
6. Number of years in practice_____
7. Religious affiliation:
   _____Protestant (indicate denomination)_____
   _____Catholic _____Other (indicate)_____
   _____Jewish
8. How often do you attend religious services?
   _____at least weekly
   _____more than monthly, but less than weekly
   _____more than once each six months, but less than monthly
   _____once or twice yearly
   _____less than yearly
9. Do you believe in life after death? ___yes___no
10. Have you ever taken a course or seminar having to do with death? ___yes___no
11. Do you read about death and related topics?
    _____frequently _____rarely
    _____occasionally _____never
12. Do you belong to the Forum for Death Education and Counseling? ___yes___no
13. Have you experienced the death of a spouse, child, or other close relative or friend in the past five years?
    _____yes; relation to the deceased_____
    _____no
14. During office visits, have you had occasion to talk to the widow(s) about their health in relationship to their experiences of conjugal bereavement?
    _____frequently _____rarely
    _____occasionally _____never

BEREAVEMENT EXPERIENCE QUESTIONNAIRE

BEQ instructions for professionals:

On the left side of the page are thoughts and feelings that bereaved people sometimes have. Read the item on the left, then in the right column circle how often you would expect a woman widowed five years or less to have experienced the stated thought or feeling in the past month, including today.

Thoughts and Feelings a widow has Had in the Past Month (4 weeks) N = Never S = Sometimes O = Often A = Almost Always	N	S	O	A
1. Felt angry at friends.	1	2	3	4
2. Felt that life has no meaning.	1	2	3	4
3. Found myself searching for the person who died.	1	2	3	4
4. Thought I saw the deceased person.	1	2	3	4
5. Felt guilty when I enjoyed myself.	1	2	3	4
6. Felt I had a poor relationship with the deceased person.	1	2	3	4
7. Felt fearful that something else bad might happen.	1	2	3	4
8. Lost interest in people that I formerly cared about.	1	2	3	4
9. Thought that I contributed to the death.	1	2	3	4
10. Yearned for the deceased person.	1	2	3	4
11. Lost my religious faith.	1	2	3	4
12. Felt fearful that I might die.	1	2	3	4
13. Lost interest in my work.	1	2	3	4
14. Thought I was losing my mind.	1	2	3	4
15. Felt a need for physical intimacy.	1	2	3	4
16. Lost interest in activities that I formerly cared about.	1	2	3	4
17. Felt blamed by others for the death.	1	2	3	4
18. Felt fearful that another of my loved ones might die.	1	2	3	4.
19. Felt ashamed of the way he/she died.	1	2	3	4

Thoughts and feelings a widow has had in the past four weeks.	Never	Sometimes	Often	Almost Always
20. Felt like a part of me was/is dead.	1	2	3	4
21. Felt that he/she contributed to his/her own death.	1	2	3	4
22. Felt like I was watching myself go through the motions of living.	1	2	3	4
23. Felt I should have done more for him/her during his/her life.	1	2	3	4
24. Felt that the deceased person was/is guiding me.	1	2	3	4
25. Heard the deceased person's voice, cry, cough, etc.	1	2	3	4
26. Thought that the death was a punishment for things I did in the past.	1	2	3	4
27. Sensed the deceased person's persence.	1	2	3	4
28. Felt a need to be emotionally close to someone.	1	2	3	4
29. Felt angry at strangers.	1	2	3	4
30. Felt that some person was responsible for the death.	1	2	3	4
31. Felt guilty about my sexual needs.	1	2	3	4
32. Was preoccupied with thoughts of death.	1	2	3	4
33. Felt angry over local, national, or world events.	1	2	3	4
34. Felt guilty about some things I said or did since the death.	1	2	3	4
35. Spent time looking at the deceased person's pictures, clothing, or belongings.	1	2	3	4
36. Felt angry at relatives.	1	2	3	4
37. Felt that I have nothing to live for.	1	2	3	4
38. Felt that the deceased person is located within me.	1	2	3	4
39. Felt guilty because I'm doing so well since the death.	1	2	3	4
40. Felt compelled to change my residence because of what some people thought about the death.	1	2	3	4
41. Felt emotionally distant from people.	1	2	3	4
42. Thought that there are some very real reasons why I have felt guilty.	1	2	3	4

Thoughts and feelings a widow has had in the past four weeks.	Never	Sometimes	Often	Almost Always
43. Felt angry at God.	1	2	3	4
44. Felt that I caused the death.	1	2	3	4
45. Felt guilty about some things I said and did before the death.	1	2	3	4
46. Felt angry at myself.	1	2	3	4
47. Thought that there isn't any real reason for me to feel guilty, yet I do.	1	2	3	4
48. Felt relieved that he/she died.	1	2	3	4
49. Felt I could have done something to prevent the death.	1	2	3	4
50. Felt guilty about little, unimportant things.	1	2	3	4
51. Felt angry at the deceased person.	1	2	3	4
52. Felt I had a very good relationship with the deceased person.	1	2	3	4
53. Felt guilty because I have lived longer than he/she did.	1	2	3	4
54. Felt that I did not grieve correctly.	1	2	3	4
55. Felt angry at people who provided care to the deceased person (doctors, nurses, therapists, etc.).	1	2	3	4
56. Was preoccupied with thoughts about the deceased person.	1	2	3	4
57. Felt guilty about my sexual behavior.	1	2	3	4
58. Felt afraid to be alone.	1	2	3	4
59. Felt empty.	1	2	3	4
60. Felt my life has no purpose.	1	2	3	4
61. Felt a need to be touched or held.	1	2	3	4
62. Felt that my presence makes people uncomfortable.	1	2	3	4
63. Was unable to reach out to others for help.	1	2	3	4
64. Could not bear to sort or part with the deceased person's belongings.	1	2	3	4
65. Felt unable to recall the deceased person's image.	1	2	3	4
66. Felt I would welcome death.	1	2	3	4
67. Felt afraid of losing control of my emotions.	1	2	3	4

Impact of Event Scale (Center for the Study of Neuroses, U. of California, San Francisco).

INSTRUCTIONS

Below is a list of comments made by people after stressful life events. Please fill in the box for each item, indicating how frequently you feel these comments would be true for a widow, of five years or less, DURING THE PAST SEVEN DAYS. If you feel they would not occur during that time, please fill in the NOT AT ALL box. Please answer EACH item by filling in ONE of the boxes.

	NOT AT ALL	RARELY	SOME-TIMES	OFTEN
1. I thought about it when I didn't mean to.	1	2	3	4
2. I had trouble doing other things because the event kept coming into my mind.	1	2	3	4
3. I avoided letting myself get upset when I thought about it or was reminded of it.	1	2	3	4
4. I tried to remove it from memory.	1	2	3	4
5. I had trouble falling asleep or staying asleep because of pictures or thoughts about it that came into my mind.	1	2	3	4
6. I had waves of strong feelings about it.	1	2	3	4
7. I had dreams about it.	1	2	3	4
8. I stayed away from reminders of it.	1	2	3	4
9. I felt as if it hadn't happened or it wasn't real.	1	2	3	4
10. I tried not to talk about it.	1	2	3	4
11. Pictures about it popped into my mind.	1	2	3	4
12. Other things kept making me think about it.	1	2	3	4
13. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	1	2	3	4
14. I tried not to think about it.	1	2	3	4
15. Any reminder brought back feelings about it.	1	2	3	4
16. My feelings about it were kind of numb.	1	2	3	4

Coping Inventory (Center for the Study of Neuroses, U. of California, San Francisco)

INSTRUCTIONS

Below is a list of ways that other people sometimes use to cope with stressful life events. Please read each item and decide whether you believe it applies to a widow of five years or less. If it does not, fill in the box under the DOES NOT APPLY column. If the statement does sound at least a little like a widow would feel, then fill in the box in the DOES APPLY column. If you believe it would apply and be VERY HELPFUL, fill in the box in that column. Please answer EACH item by filling in ONE of the boxes.

	DOES NOT APPLY	DOES APPLY	DOES APPLY AND WAS VERY HELPFUL
1. I tried to concentrate on other things in my life.	0	1	2
2. I tried to think through the meanings of the event for my life at present.	0	1	2
3. I tried to work out how the event related to things in my past.	0	1	2
4. I worked to revise my expectations of the future.	0	1	2
5. I tried to find a humorous or even tragi-comic element in the event or in life in general.	0	1	2
6. I tried to separate the rational from the irrational in my responses.	0	1	2
7. I tried to separate the possible from the unlikely consequences that occurred to me.	0	1	2
8. I sought increased emotional support from others.	0	1	2
9. I tried to find new interests.	0	1	2
10. I tried to experience all my feelings and work them through.	0	1	2
11. I tried to dose myself, to experience feelings sometimes, but put them out of mind at other times.	0	1	2
12. I tried to put the event out of mind and just go on with my life.	0	1	2
13. I sought consolation in philosophy or religion.	0	1	2
14. I spent more time in nature, listening to music, with art or writing.	0	1	2
15. I tried to devote myself to my work.	0	1	2
16. I tried to talk about the event with others.	0	1	2
17. I tried to find people who had experienced the same kind of event to see how they dealt with it.	0	1	2
18. I tried to figure out why the event evoked the feelings it did.	0	1	2
19. I tried not to be bothered by conflicting feelings in my reactions to the event.	0	1	2
20. I tried to develop an attitude toward the event which would help me to deal with it.	0	1	2
21. I tried to clarify the choices I have in adjusting my present life to the effects of the event.	0	1	2
22. I tried not to withdraw from other people.	0	1	2
23. I welcomed some time alone to think about what had happened.	0	1	2
24. I tried to figure out what would happen in the future if I behaved one way, and what would happen if I behaved another way.	0	1	2
25. I tried not to make any decisions about the future until I was sure I was seeing things more clearly.	0	1	2
26. I tried to look at my present situation as realistically as possible.	0	1	2
27. I thought about events in my past life which might help me to deal better with the present.	0	1	2
28. I tried to find some other outlets, like sports, cooking, or gardening, to relieve some of the feelings I had	0	1	2
29. I tried doing things impulsively, that I might have thought about before, if they made me feel better and didn't bother anyone else.	0	1	2
30. I tried to think about the good things that had happened in my life and weigh what had happened against them, for a better perspective.	0	1	2
31. I tried to be more useful to others.	0	1	2
32. I looked for a person who could provide direction for me.	0	1	2
33. I tried to remind myself that what has happened could have been worse.	0	1	2

Appendix F

Reminder Card

Sent to the Widows

9-23-85

REMINDER

Several weeks ago, you received information and questionnaires relating to my research project on the grief reactions of widowhood. If you have already returned the questionnaires, thank you very much!

If you have not yet filled those out, you still have time to do so. Your input is important to the successful conduct of this study.

Sincerely,

Shoshanna E. Conway, R.N.

Shoshanna E. Conway, R.N.
graduate student,
Texas Woman's University

Sent to the Professionals

11-25-85

REMINDER

Several weeks ago, you received information and questionnaires relating to my research project on the grief reactions of widowhood. If you have already returned the questionnaires, thank you very much!

If you have not yet filled those out, you still have time to do so. Your input is important to the successful conduct of this study.

Sincerely,

Shoshanna E. Conway, R.N.

Shoshanna E. Conway, R.N.
graduate student,
Texas Woman's University