THESIS

This is to certify that the

dissertation entitled

THE EFFECT OF A LIFE MANAGEMENT SKILLS PROGRAM ON DEPRESSION AND GRIEF IN WIDOWS

presented by

JOYCE A. THOMAS

has been accepted towards fulfillment of the requirements for

Ph.D. degree in Curriculum and Instruction

Major professor

Date May 18, 1982

MSU is an Affirmative Action/Equal Opportunity Institution

O-12771

MICHIGAN STATE UNIVERSITY LIBRARY
3 1293 10591 9397

L

5

MSU LIBRARIES

RETURNING MATERIALS:
Place in book drop to remove this checkout from your record. FINES will be charged if book is returned after the date stamped below.

JAN 24 '86
OCT 0 8 '86
NOV 0 6 '86
NOV 2 6 '86
SEP 2 5 1997
JAN 26 '86
IL:60427O1

THE EFFECT OF A LIFE MANAGEMENT SKILLS PROGRAM ON DEPRESSION AND GRIEF IN WIDOWS

By

Joyce Ann Thomas

6117269

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Curriculum and Instruction

1982

ABSTRACT

THE EFFECT OF A LIFE MANAGEMENT SKILLS PROGRAM ON DEPRESSION AND GRIEF IN WIDOWS

By

Joyce Ann Thomas

The primary purpose of this study was to determine the effect of a Life Management Skills Program on depression and grief in recent widows.

The approach of the investigation involved administering a pre- and post-test of The Texas Revised Inventory of Grief and The Measurement of Depression scale to all of the participants.

The subjects were divided into two groups: Participants (those who were involved in the six weeks Life Management Skills Program) and Non-Participants (those who were involved only in normal, social activities). There were nine and eighteen widows in each group respectively.

The Life Management Skills Program included those skills and information that would assist the widow in dealing with and adjusting to the legal, financial and psychological changes which had occurred as the result of the death of her spouse.

Two research questions were formulated:

1. Are depression scores of widows who participated in a Life Management Skills Program reduced more than those

who are non-participants in such a program?

2. Are grief scores of widows who participated in a Life Management Skills Program reduced more than those who are non-participants in such a program?

The statistical technique used for all tests of significance was the t-test.

It was concluded that:

1. There was a significant difference in the decline of depression in the participant group at the .05 level when comparing the pre- and post-test scores of the two groups.

2. There was no significant change in the level of grief when comparing the pre- and post-test grief scores of the two groups.

Dedicated to

The loving memory of my grandmother

ALICE ELLIOTT

ACKNOWLEDGMENTS

The successful completion of this dissertation is the cooperative efforts of many people. To some I want to give special recognition.

Dr. Cas Heilman, Committee Chairman and friend without whose guidance and encouragement, this project would not have been completed.

Dr. Jane Oyer, Dr. Norman Kagan and Dr. Richard Gardner, Committee Members, who each in their own way were a source of motivation.

Mrs. Garnet Hauger, and Mr. Paul Bufkin, statisticians, whose assistance was an absolute necessity.

Miss Kathy Hiler, typist, whose good humor and long hours met the pressing deadlines.

Special thanks to Il Sung Chung for his editorial assistance, and Kelly for her contribution.

There were so many friends and colleagues who seemed to know just when their love and friendship were needed.

My children, Teresa, Sheryl and Steven, my mother, Jennie, and my sister, Jackie, for always believing in me.

TABLE OF CONTENTS

TABLE OF CONTENTS--Continued

LIST OF TABLES

CHAPTER I

INTRODUCTION

Death has made millions of Americans single again. The number of widows in the United States reached 10.7 million in 1976, an increase of more than one million since 1970. Currently one of every eight women fourteen years or older is widowed. (Metropolitan Life Insurance Company, 1977).

The economic, social, intellectual, psychological and physiological profile of the American widow indicates that the newly widowed have: more physical illness, more mental illness, more hospitalization, and more chances of dying than their married, female counterpart.

They feel lonely, frightened, isolated and alienated. They have problems with children, jobs, finances, housing and socializing. The loss of a spouse through death constitutes one of the most traumatic of human experiences.

The initial days of widowhood are rough, but bearable. There are memories to share, decisions to make, and most important, people to be with. But after the first few weeks of the loss, the minister pays the final visit, relatives and friends resume their normal routines, and the widow is left alone to learn a different way of life, a new and unwanted role, to adjust to changed economic circumstances, and to

cope with a maze of feelings: loneliness, anger, relief, guilt, hopelessness, panic, self-pity and depression; feelings that family and friends--however loving--cannot fully understand.

Widowhood is a demanding, transitional role. A study of 1,744 widows, done in 1969 by the Life Insurance Agency Management Associations, revealed that widows whose husbands died before their 65th birthday need:

a. help to acclimate to their new status;

b. help to deal with legal, financial, economic and employment adjustments and,

c. family, friends and clergy, even though these persons are not the primary source of help in long-term adjustment.

The average period of widowhood is 13.5 years (Carter and Glick, 1970) but the average widow whose husband dies of natural causes will spend eighteen and one-half years as a widow (Lopata, 1973).

Maintaining a separate household is a financial hardship for most widows but to think of living any other way for many entails a loss of privacy as well as a loss of independence (Chevan and Korson, 1972).

In 1976 there were 1.3 million children under eighteen in families headed by a widowed mother. One-sixth of these children were less than six years old (Metropolitan Life Insurance Company, 1977).

Virtually every study of widows reports the difficult financial situation of the woman as a result of her husband's

death. The median income of widowed heads of households in the United States in 1975 was $4,312.00 (Metropolitan Life Insurance Company, 1977).

The most frequently reported problem of the widow is loneliness (Barrett, 1974).

Maddison (1968) says the period of widowhood requires a reorganization and reintegration of social roles suitable to a totally new status.

In a study of 375 widows done by Maddison, (1968) in Boston, one-fourth of the young widows reported a significant deterioration in health in the first thirteen months.

In a study done by Glick, Weiss and Parkes, (1974) they found that the widows had three times as many hospitalizations and spent considerable more time sick in bed than the control group.

Cox and Ford (1964) studied 60,000 widows under 70 years of age and found mortality in widows was higher than usual in the second year after widowhood and Rees and Lutkins (1967) followed all the close relatives of all members of a small community in Wales who died in a six year period. During this time 4.8 percent of them died within one year of bereavement compared with only 0.7 percent of a comparable group of non-bereaved people of the same age, living in the same area.

Parkes (1964) compared the medical records of forty-five London widows for two years before and eighteen months after bereavement and found that for widows under the age

of sixty-five a consultation rate for psychiatric symptoms more than tripled during the first six months after bereavement, and the amount of sedation prescribed to widows was seven times greater during the eighteen month period after the bereavement.

In subsequent studies (1964, 1975), Parkes found that of 3,245 patients admitted to psychiatric units in a two year period, 94 developed their illness within six months of the death of a spouse or parent. This number was six times greater than the expected rate of bereavement in the general population.

From various samples of psychiatric hospital admissions, the percentage whose primary difficulty was diagnosed as unresolved grief was: 9 percent (Jackson, 1957), 10 percent (Bachmann, 1964), and 15 percent (Lazare, 1976).

The high rate of suicide among the widowed has also been well documented. Sainsbury (1955) showed that suicides were more common among the widowed than the single, and that the rate was lowest among the married. Segal (1969) confirmed the suicide rates of the divorced, separated and widowed to be regularly higher than the married. Bunch (1972) studied suicide mortality and found that in a five year period preceding the suicide, 36 percent of the sample had been bereaved of a parent or spouse and that more widows than widowers killed themselves.

Additional studies showing the relationship between suicide and widowhood have been conducted by Durkheim (1951),

Rushing (1968) , Resnik and Cantor (1970), Marris (1969) and others.

There has been a growth recently in programs concerned with assistance for the widowed. The purpose of these programs is to provide assistance in the form of listening, to help with adjustments that follow death and to provide friendships and companionship.

Since funeral directors are now receiving an increasing number of requests to perform bereavement services, "The National Funeral Directors' Association was pressed to make available a manual that would assist in the establishment of such programs." The product developed by a committee, headed by Dr. Donald Steele, was The Funeral Director's Guide to Designing and Implementing Programs for the Widowed (1975).

Many intervention models have been implemented, with the most well-known being the Widow to Widow programs of Phyllis Silverman. This organization received a developmental grant from the National Funeral Directors Association for the initial research and implementation. Basically, it provided a systematic effort of re-engaging the newly bereaved individual with the widow as the primary caregiver (1970).

Barrett (1974) also developed a very significant group intervention program for widows using three distinct formats including: self-help groups, women's consciousness raising groups and "confidant" groups based on the model

of Lowenthal and Haven's research (1968) on the relationship

post-test, sub-

y higher self

ed widowed to

have been success-

inctly social

at they provide

through a variety

at for helping

ts of her loss and

re experiences and

cial matters, etc.

s" have been used

h the bereaved.

helpful in pro-

NAIM and Post-Cana,

a non-demoninational

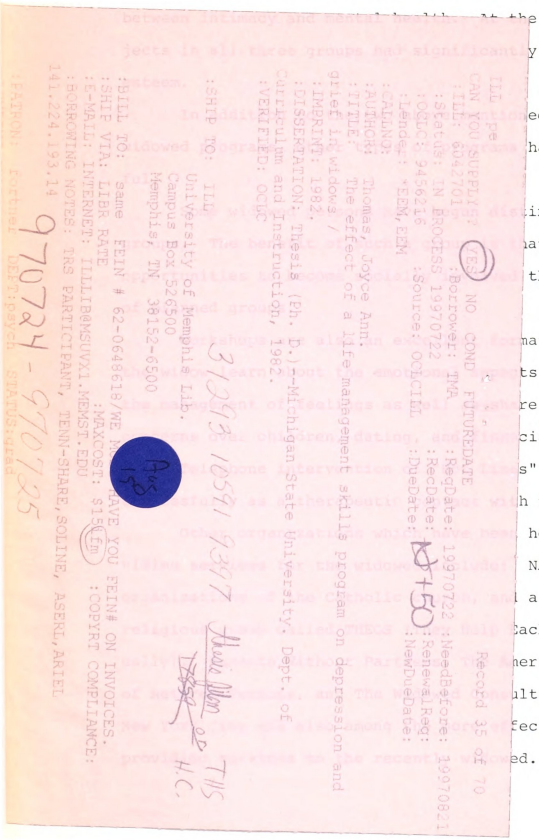
ach Other Spirit-

erican Association

ltation Center in

fective agencies

ed.



of Lowenthal and Haven's research (1968) on the relationship between intimacy and mental health. At the post-test, subjects in all three groups had significantly higher self esteem.

In addition to the two above mentioned widowed to widowed programs, other types of programs have been successful.

Some widowed persons have begun distinctly social groups. The benefit of such a group is that they provide opportunities to become socially involved through a variety of planned groups.

Workshops are also an excellent format for helping the widow learn about the emotional aspects of her loss and the management of feelings as well as share experiences and concerns over children, dating, and financial matters, etc.

Telephone intervention of "Hot Lines" have been used successfully as a therapeutic contact with the bereaved.

Other organizations which have been helpful in providing services for the widowed include: NAIM and Post-Cana, organizations of the Catholic church, and a non-demoninational religious group called THEOS (They Help Each Other Spiritually). Parents Without Partners, The American Association of Retired Persons, and The Widowed Consultation Center in New York City are also among the more effective agencies providing services to the recently widowed.

Statement of the Problem

This research was an exploratory study attempting to determine the influence of a Life Management Skills Program on the levels of depression and grief in recent widows. It was entered into as a pilot study.

Purpose of the Study

Specifically, this study sought to test the effects of a Life Management Skills Program of systematic intervention on depression and grief in recent widows.

The organization of such a group was based on the principle that people communicate most sensitively with others who share their experiences, through exchanging ideas, sharing feelings and emotions, and given the opportunity to gain information and make new friends, progress more easily throughout the grieving process with less depression.

More specifically, the content of this Life Management Skills Program of intervention included:

1. Assisting recent widows in understanding the nature and process of grief.
2. Giving practical financial and legal information and skills needed in making adjustments and transitions in their lifestyle.
3. Giving information and skill acquisition opportunities in:
   values clarification, decision making, goal setting, budgeting, and coping with stress.

The first goal of this exploration would be to create an environment where participants would feel comfortable

learning these skills.

The intent of the group process was to offer systematic intervention in the form of practical information and acquisition of skills that would assist the widow in handling her depression and grief.

It was assumed that it would be "safer" for the grieving widow to deal with these feelings in a structured environment where the primary focus was on the acquisition of skills and adjustment information of a concrete nature.

It was further felt that the participants would serve as a support group to the others in similar circumstances.

The context in which self help groups have experienced a current surge of growth is given the following perspective by Sidel and Sidel (1976).

> "The self help and mutual aid movement is a response to a number of different factors in our society which made human services unavailable or unresponsive to those who need them: the complexity and size of institutions and communities, with their accompanying depersonalization and dehumanization, the alienation of people from one another, from their communities and institutions and even from themselves; and the professionalism of much which in the past was done by individuals for themselves or for one another. Self help groups have made major contributions toward dealing with problems which cannot be dealt with by other institutions in the society, and at the same time have provided people with opportunities for helping roles, roles which have become increasingly difficult to find in our society as more and more helping has been taken over by professionals. Self help or mutual aid groups provide a mechanism whereby individuals, in a collective setting with others who face similar life situations, can assume responsibility for their own bodies, psyches, and behavior and can help others do the same. They are the grass roots answer to our hierarchical, professionalized society--to a society which attempts, in so many ways, to render impotent the individual, the family, the neighbor. Not only are self help

> groups providing desperately needed services, but they are returning to the individual a feeling of competence and self respect and they are forging new lines, new connections among people."

The overriding purpose of this group was to provide life management skills in a therapeutic environment.

Research Questions

Question 1: Are depression scores of widows who participated in a Life Management Skills Program reduced more than those who are non-participants in such a program?

Question 2: Are grief scores of widows who participated in a Life Management Skills Program reduced more than those who are non-participants in such a program?

Delimitations

This study is of twenty-seven widows living in Shiawassee County, between the ages of 31 and 73, who participated in a series of six weekly sessions of three hours per session. A Life Management Skills Program was presented with the outcomes of such a program reported on the selected tests.

Definition of Terms

Depression: Depression is defined operationally as a "syndrome comprised of co-existing signs and symptoms which signify the presence of pathological disturbances or changes in four areas: somatic, psychological, psychomotor and mood" (Zung, 1974).

The model of depression which most closely fits the subjects in this study is the learned helplessness theory

as proposed by Seligman (1975). Briefly, the theory holds that depression results from the perception that one has little power to change aversive situations, thus producing an apathetic and negative outlook.

Grief: As with depression, there are a variety of definitions for grief. The most pertinent for this study is by Doss who describes it as an experience which is a result of deprivation: "Grief, an important, normal response to death, is essentially a deprivation experience manifesting itself physically and emotionally" (1974).

This definition includes the important components of grief: (1) normalcy, (2) deprivation as its cause, (3) physical manifestations, and (4) emotional manifestations.

Life Management Skills: Life management skills are those skills and information designed to assist the widow in dealing with and adjusting to the legal, financial and psychological changes which have occurred as a result of the death of her spouse.

CHAPTER II

REVIEW OF THE LITERATURE

PROFILE OF THE AMERICAN WIDOW

The profile of the American widow that follows is taken predominantly from the U.S. Census Reports, a comprehensive study done by Robert C. Nuckols for the Life Insurance Agency Management Association of Hartford, Connecticut (1973), and a similar study done by the Metropolitan Life Insurance Company (1977).

FREQUENCY

The number of widows in the United States reached 10.7 million in 1976 (Metropolitan Life Insurance Company, 1977), an increase of more than one million since 1970. The rising number of widows is accounted for mainly by the increase in the number of women at the older ages and to a lesser degree by the likelihood that a wife will outlive her spouse.

The increase in the number of widows in the 1966-76 period resulted almost entirely from an increase in the number of widows over age 55. In 1976, nine out of every ten widows were at least 55 years old and almost four out of every ten were at least 75 years old. The median age of widows rose to 71.1 years, an increase of 1.8 years between 1970 and 1976, compared with a decrease of 1.1 years in the median age of all

women aged 14 and over to 39.3 years. During the same period, the number of younger widows decreased substantially; by 1976 less than four percent of all widows were under 45 years of age and only one percent were under 35.

AGE

Widows now outnumber widowers by more than 5 to 1 and at ages under 45 by more than 7 to 1. This margin reflects the lower mortality among women than among men, as well as the fact that a wife is generally younger than her husband at the time of marriage.

Currently one out of every eight women 14 years or older is widowed. The proportion at the younger ages is low, but increases sharply with advance in age. Widows constituted only three percent of the female population under age 35 in 1976, but represented one-fifth of all women at ages 55-64. The proportion doubled at ages 65-74, and at ages 75 and over nearly three-fourth of all women were widowed (See Table I) (Metropolitan Life Insurance Company, 1977).

RACE

Widowhood is less frequent among white women than among the non-white at every age, but the widest variance is at the younger ages. Under age 35 and at ages 45-54 the proportion of widows among non-whites was about twice that among white women. In the 35-44 age group, the ratio was as much as 4 to 1. At the older ages the proportion ranged from 6 to 9 percentage points higher for non-white women than for white women. (Bureau of the Census, 1970)

TABLE I

CHARACTERISTICS OF WIDOWS
United States, March 1976

Characteristics	14 and over	14-34	35-44	45-54	55-64	65-74	75 and over
Number in thousands	10,727	127	295	883	2,017	3,374	4,030
Percent distribution	100.0	1.2	2.7	8.2	18.8	31.5	37.6
Widows per 100 widowers	540	750	760	510	570	600	490
Percent of all women	12.5	.3	2.5	7.2	19.1	42.4	71.3
White	12.5	.3	1.8	6.5	18.3	41.8	70.6
Nonwhite	12.2	.7	7.3	12.7	26.6	48.0	79.3
Living arrangement-%	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Head of household	77.2	87.4	91.5	88.3	87.1	83.7	63.2
Head of primary family	22.0	68.5	82.0	54.8	30.4	16.0	9.9
Primary individual	55.2	18.9	9.5	33.5	56.7	67.7	53.3
Not head of household	16.2	11.8	8.1	10.9	11.7	13.1	22.8
In families	14.9	10.2	7.1	9.2	9.4	12.2	21.9
Inmates of institutions	6.6	.8	.4	.8	1.2	3.2	14.0
Family heads by number of own children under age 18 - percent	100.0	100.0	100.0	100.0		100.0	
No children	71.4	2.2	11.5	66.8		98.6	
One child	14.1	29.2	28.0	21.1		.9	
Two children	7.4	28.1	25.5	7.8		.3	
Three children or more	7.1	40.5	35.0	4.3		.2	
Labor force participation - percent	100.0*	100.0*	100.0	100.0	100.0	100.0	
In labor force	22.3	55.6	58.8	61.8	46.7	7.7	
Percent employed	93.9	91.4	92.5	94.6	95.4	91.1	
Not in labor force	77.7	44.4	41.2	38.2	53.3	92.3	

Occupation group of employed in 1970-%	100.0	100.0	100.0	100.0	100.0	100.0
Professional, technical and kindred workers	11.9	14.7	12.8	11.0	12.0	11.5
Managers and administrators	6.0	6.2	6.2	5.7	5.8	6.7
Sales workers	8.6	5.6	6.0	7.5	8.8	11.5
Clerical and kindred workers	24.7	24.7	26.3	27.9	24.9	20.0
Operatives	14.9	17.6	16.6	16.6	15.1	10.8
Private household workers	10.0	3.9	6.7	7.4	9.6	16.7
Other service workers	19.7	15.3	19.0	19.6	20.5	19.7
Other+	4.2	12.0	6.4	4.3	3.3	3.1

* Excludes ages 14 and 15.

+ Consists of craftswomen and laborers.

Source of basic data: Reports of the Bureau of the Census and the Bureau of Labor Statistics.

LIFE EXPECTATION

The gain in life expectancy for women since the turn of the century has been greater than for men at nearly all ages. Since 1900, female life expectancy at birth has increased by 28.4 years, while male life expectancy has increased by 22.7 years. The difference in the average length of life between men and women has also increased. Life expectancy at age 40 was about 1.4 years longer for a woman than for a man at the turn of the century; it is now 6.3 years longer. (See Table II)

In contrast, the difference in life expectancy between white and non-white Americans has been greatly reduced in this century. Generally, the gain for non-white males has exceeded that for white males at all ages. Non-white females showed the greatest gains at the younger and older ages. For white females, life expectancy increased most between the ages of about 45 and 65.

In 1976, the difference in life expectancy between white and non-white persons at birth was 4.7 years for females and 5.6 years for males, and this difference decreased with age. (See Table III)

LENGTH OF WIDOWHOOD

The average period of widowhood is 13.5 years (Carter and Glick, 1970) but the average widow whose husband died of natural causes will spend eighteen and one-half years as a widow (Lopata, 1973). 68 percent of Lopata's Chicago sample of widows over age 50 were widowed five or more years ago.

TABLE II

EXPECTATION OF LIFE AT BIRTH IN THE UNITED STATES (YEARS)

Year	White			All Other			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1900	46.6	48.7	47.6	32.5	33.5	33.0	46.3	48.3	47.3
1910	48.6	52.0	50.3	33.8	37.5	35.6	48.4	51.8	50.0
1920	54.4	55.6	54.9	45.5	45.2	45.3	53.6	54.6	54.1
1930	59.7	63.5	61.4	47.3	49.2	48.1	58.1	61.6	59.7
1940	62.1	66.6	64.2	51.5	54.9	53.1	60.8	65.2	62.9
1950	66.5	72.2	69.1	59.1	62.9	60.8	65.6	71.1	68.2
1960	67.4	74.1	70.6	61.1	66.3	63.6	66.6	73.1	69.7
1961	67.8	74.5	71.0	61.9	67.0	64.4	67.0	73.6	70.2
1962	67.6	74.4	70.9	61.5	66.8	64.1	66.8	73.4	70.0
1963	67.5	74.4	70.8	60.9	66.5	63.6	66.6	73.4	69.9
1964	67.7	74.6	71.0	61.1	67.2	64.1	66.9	73.7	70.2
1965	67.6	74.7	71.0	61.1	67.4	64.1	66.8	73.7	70.2
1966	67.6	74.7	71.0	60.7	67.4	64.0	66.7	73.8	70.1
1967	67.8	75.1	71.3	61.1	68.2	64.6	67.0	74.2	70.5
1968	67.5	74.9	71.1	60.1	67.5	63.7	66.6	74.0	70.2
1969	67.8	75.1	71.3	60.5	68.4	64.3	66.8	74.3	70.4
1970	68.0	75.6	71.7	61.3	69.4	65.3	67.1	74.8	70.9
1971	68.3	75.8	72.0	61.6	69.7	65.6	67.4	75.0	71.1
1972	68.3	75.9	72.0	61.5	69.9	65.6	67.4	75.1	71.1
1973	68.4	76.1	72.2	61.9	70.1	65.9	67.6	75.3	71.3
1974	68.9	76.6	72.7	62.9	71.2	67.0	68.2	75.9	71.9
1975	69.4	77.2	73.2	63.6	72.3	67.9	68.7	76.5	72.5
1976	69.7	77.3	73.5	64.1	72.6	68.3	69.0	76.7	72.8

SOURCE: National Center for Health Statistics, U.S. Department of Health, Education, and Welfare, 1976.

TABLE III

EXPECTATION OF LIFE AT VARIOUS STAGES
IN THE UNITED STATES 1976

Age	White		All Other		Total	
	Male	Female	Male	Female	Male	Female
0- 1	69.7	77.3	64.1	72.6	69.0	76.7
1- 5	69.8	77.2	64.9	73.3	69.2	76.7
5-10	66.0	73.4	61.1	69.5	65.4	72.9
10-15	61.1	68.5	56.3	64.6	60.5	68.0
15-20	56.2	63.6	51.4	59.7	55.7	63.1
20-25	56.1	58.7	46.8	54.9	51.0	58.2
25-30	47.1	53.9	42.5	50.2	46.5	53.4
30-35	42.4	49.1	38.2	45.5	41.9	48.6
35-40	37.7	44.2	34.0	40.9	37.3	43.8
40-45	33.1	39.5	30.0	36.4	32.8	39.1
45-50	28.7	34.9	26.1	32.1	28.4	34.5
50-55	24.4	30.4	22.5	29.0	24.2	30.1
55-60	20.5	26.1	19.2	24.3	20.4	25.8
60-65	16.9	22.0	16.3	20.7	16.8	21.8
65-70	13.7	18.1	13.8	17.6	13.7	18.0
70-75	10.9	14.4	11.3	14.3	10.9	14.4
75-80	8.5	11.2	9.7	12.3	8.6	11.2
80-85	6.6	8.5	8.6	10.9	6.8	8.7
85 and over	5.1	6.4	7.2	9.1	5.3	6.6

SOURCE: National Center for Health Statistics, U.S. Department of Health, Education, and Welfare, 1976.

REMARRIAGE

Marriage may be seen as a solution to the loneliness of widowhood. However, the widowed remarry less often than the divorced. While 75 percent of all divorcees will be married within five years, only 25 percent of widows remarry in that length of time. The likelihood of remarriage decreases sharply with increasing age (Bernard, 1956).

Remarriage rates are also substantially lower among women than among men (Metropolitan Life Insurance, 1977). One-fourth of the widows remarry within five years compared to one-half of the widowers and three-fourths of all divorced. The likelihood of remarriage decreases with age more sharply for the widow than for the widower (Bernard, 1956).

Several studies show that many widows do not want to remarry (Cosneck, 1966). In this connection, Marris (1958) has pointed out that there is guilt associated with the grief and a sense of loyalty to the deceased spouse as an obstacle to remarriage, while Marsden (1969) observes that remarriage may be a financial risk for the widow who might lose her government benefits. The widow's seeming lack of interest in marrying may not be a true indication of her desires, however, it may be lack of opportunity; men die seven to eight years sooner than women and grooms are usually older than the women they marry.

HOUSING

Many surveys have shown that older people prefer to live apart from their children, preferably in their own homes

and the tendency for widows to maintain their own households seems to be growing. In 1976 more than 87 percent of all widows under age 65 headed households, while 84 percent of those aged 65-74 and 63 percent of those aged 75 and over did so. Four-fifths of all widows at age 35-44 headed a family unit and for those under age 55 as a group the proportion was more than three-fifths.

Maintaining an independent household is more prevalent among older widows with about three-fifths of all widows at these ages living alone or with non-relatives. Most other widows live in the homes of relatives. Relatively few widows reside in institutions; of those who do, 80 percent are 75 years of age or older (Metropolitan Life, 1977).

> "In a Chicago sample, 49 percent of widows over 50 years of age live alone (Lopata, 1971): 29 percent share their residence with one other person; 12 percent with two others; and 10 percent with more than two. Most (69%) of the widows who share their households are the heads of the household; unmarried children are still there. Only 10 percent of the total sample live in a household headed by their children or children's spouse.
>
> Half the widows living alone and two-thirds of widows who head larger households in Chicago are still living in the same house where they lived prior to becoming a widow.
>
> Five percent live in institutions. About 75,000 persons or 15 percent of the institutionalized group reside in mental hospitals." (Barrett, 1974)

Lopata (1973) observes that older widows expect problems in living with married children or are enjoying the ease and independence of living alone sufficiently to offset its disadvantages. Widows sharing a residence tend to be with unmarried children or those undergoing a disorganization of their marriage and many times the widow emerges as the head

of such a household.

Maintenance of an independent household is for many of the widowed the symbolic bastion within which they define their roles. To think of living any other way entails a loss of privacy as well as independence (Chevan and Korson, 1972). However, the research data obtained so far dispels any sense of uniformity in the type of housing of the widowed.

> "No single representation can suffice for all segments of the widowed population. Characterizing the widowed population as isolated and alone is as unjustified as picturing the widowed surrounded by kin in three-generation households." (Chevan & Korson, 1972).

CHILDREN

Many younger widows have the responsibility of supporting children. In 1976 there were 1.3 million children under 18 in families headed by a widowed mother. Almost all families with a widow, under age 35 as head of the household included at least one child; in two-fifths of the families, there were three or more children. Half of these families included children under six years of age. At ages 35-44 the proportion of widowed mothers with dependent children was still fairly high - almost 90 percent had children under 18 years of age and one-sixth of the families included children less than six years old. Among widows at ages 45 and over, however, the proportion dropped sharply; there were children under 18 in only one-third of the families headed by a widow aged 45-64 and in fewer than two percent of the families headed by a widow aged 65 or over (Metropolitan Life Insurance Company, 1977).

EMPLOYMENT

Many more widows are to be found in the work force than their married counterparts of the same age. Carter and Glick (1970) reported that 26.9% of white widows and 35.5% of non-white widows were employed.

In 1976, more than half of the widows who were less than 65 years of age were in the labor force, although the proportion of all ages combined who were employed or seeking work was only 22 percent. The great preponderance of widows at ages 65 and over, less than 8 percent of whom were in the labor force, accounted for the low participation rate at all ages combined. Widows under age 65 were found to have a higher labor force participation rate than married women and the lowest unemployment rate of all women. Unemployment averaged about 6 percent for all widows and about 5 percent for widows under age 65 (Nuckols, 1973).

OCCUPATIONS

The occupations of employed widows under age 65 vary only slightly with age. According to the 1970 census, about one-fourth were employed as clerical workers, one-fourth as service workers, one-sixth as operatives, and one-eighth as professional and technical workers. Among young widows relatively more were employed as craftswomen and laborers, as professionals and technical workers and as operatives (semi-skilled workers). On the other hand, private household and other service workers constituted a relatively smaller proportion of employed young widows.

An occupational analysis of women ages 45-54 (Carter and Glick, 1970) concurred that there was a preponderance of widows in professional jobs. One-half of the employed non-white widows ages 45-54 were employed for private household work and one-half the employed white widows were in white-collar jobs.

INCOME

Virtually every study of widows reports the difficult financial situation of the woman as a result of her husband's death.

In his study on 1,774 women who had been widowed nearly two years and whose husbands died before 65 years of age, Nuckols (1973) found that family incomes were significantly decreased. The change showed a four percent increase for families formerly receiving less than $3,000.00 to a 57 percent decrease among families with incomes formerly over $15,000.00

There is a loss of income from the husband's job, possible freeze on bank accounts, large bills from prolonged illnesses and high funeral costs. According to Nuckol's Study (1973):

> "The median or 'typical' widow was faced with final expenses amounting to $2,860.00. The average (mean) final expense was $3,900.00, of which $1,740.00 represented medical bills, $1,510.00 funeral expenses, and $650.00 for taxes, estate administration, and miscellaneous items."

Ninety-two percent of the widows said that their husbands had had some form of life insurance, and ninety-one percent

received monthly benefit payments from income options or annuities.

The most common manifestation of a lowered standard of living was a pervasive sense of concern about money, e.g. of the need to cut back all unnecessary spending for fear of acquiring debts. Clothing, social and recreational activities, and food were the specific areas in which cutbacks were most often reported (Nuckols, 1973).

The median income of widowed heads-of-households in the United States in 1975 was $4,312.00 (Metropolitan Life, 1977). Almost one-half of the widows heading households had incomes of less than $4,000.00 and one-fifth had incomes between $4,000.00 and $7,000.00 and one-eighth had incomes between $7,000.00 and $10,000.00. An additional one-sixth received more than $10,000.00.

In 1963 Palmore discovered that the average earnings of employed widows were only about three-fourths the average earned by all female workers. Twenty-five percent of these families had income below the Social Security Administration poverty level. The highest source of income was the widow's own earnings (40 percent). Forty-seven percent of these widows were working prior to death and 56 percent after the death.

In a study of 849 widowed compared to 702 married persons in small towns of Missouri in 1966, Pihlblad, Adams and Rosencranz concluded: 1. Widowers' incomes are about half the incomes of their married counterparts and widows' incomes

are about three-fourths the widowers' incomes. 2. There is a tendency for widows to adjust to lower incomes by seeking employment, whereas widowers tend to reduce expenditures. 3. Residence with and dependence upon children tends to be the last resort to socio-economic adjustment. 4. Almost never do friends become a source of dependence.

BENEFITS

Currently, widows without dependent children are not aided by the Federal Government before age 62 and then only if the widow or her husband were insured under Social Security. There are approximately 2 million such underage widows without dependents (Barrett, 1974).

In 1962 (Palmore, et. al.) made a study of widows and children who met eligibility requirements for survivor benefits. The median total income of eligible families was $3,570.00. Old age, Survivors, Disability and Health Insurance were the major sources of income for nearly two-thirds of the families. Other assistance included investment returns, help from friends and relatives, employment, Veteran's benefits, insurance and federal employee survivor benefits.

The average per capita monthly income payment from all sources was $155.00. Seventy-one percent of the husbands did not have a will and 25 percent had programmed life insurance (Nuckols, 1973).

THE ELDERLY WIDOW

Elderly widows (65+) comprise a group of special interest because their low financial status and high rate of residential

isolation expose them to greater social and economic risks than other segments of the elderly population. Also, because they have many problems unique to them, the following profile is presented separately.

According to the Bureau of Census (1970), there were 6.5 million elderly (65+) widows residing in U.S. households in March 1975. These 6.5 millions widows, reports G. Fowles in his "Data Analysis and Dissemination on Division of the Department of Health, Education and Welfare", constituted nearly one-third (31 percent) of all persons 65+ years old and over one-half (53 percent) of all elderly women.

The principal reason for such a large number of elderly widows is higher mortality rates for males at all ages resulting in an estimated average life expectancy of 68.2 years in 1974, about eight years less than for females. If these mortality rates were held constant in the future, only two-thirds of all males born in 1974 would survive to age 65, compared to over four-fifths for females. Mortality rates for females rise more rapidly after age 65 than for males, but the average life expectancy for 65 year old females is four years greater than for males (17.5, compared to 13.4). This mortality differential is a major contributor to the number of widows in America.

Another major factor contributing to widowhood is the average disparity in ages between husbands and wives. According to the 1970 Census, three-fourths of all husbands were older than their wives. The median difference in ages

was 2.4 years. For older husbands (65+), the disparity was even more striking. About 81 percent were older than their spouses and the average age difference was over four years. Even if there were no difference in life expectancy between the sexes, the fact that men generally marry younger women would insure a larger number of widows.

Remarriage for the elderly widow is quite limited, due to the small number of eligible males in this age group. Elderly females who are eligible for marriage outnumber eligible males by a ratio of 4 to 1. In addition, males who marry after the age of 65 tend to marry women from younger age groups. Data for 1974 show that the number of men 65 years and over who married during the year was twice as high as the number of elderly brides. Even though most of the elderly brides probably married men over 65, over half of the elderly grooms married females under 65.

Age and Race

The proportion of elderly women who are widowed increases with age because of the cumulative effect of the above mentioned factors. About four of every ten women, according to Fowles (1976) 65 to 74 years are widows, but seven out of every ten women 75 years and older are widows.

TABLE IV
PERCENT OF WOMEN 65+ WHO ARE WIDOWS
Bureau of Census

AGE	ALL RACES	WHITE	BLACK
65+.....	52.5	51.8	60.2
65 to 74.....	41.9	40.8	52.6
75+.....	69.4	68.9	73.9

Elderly black women are more likely to be widowed than their white counterparts, because of higher mortality rates for blacks and the age differences between black husbands and their wives is greater than for whites, particularly in the 65+ age groups. About three of every four black females 75 years old and over are widows (Fowles, 1976).

Living Arrangements

Data from the 1960 and 1970 decennial censuses show that the number of three and four generation families decreased by ten percent during the 1960's while the total number of families grew by 13 percent. The multi-generation families represented only four percent of all families in 1970.

Elderly married couples tend to live by themselves. For most widows, the choice is to continue residing in a separate household when the spouse dies. About 62 percent of all widows who were 69 years and older were living alone in 1975. This proportion was slightly higher for widows 65 to 74 and slightly lower for the 75 and older group. This group often has more physical difficulties that necessitate moving to a nursing home or the home of a relative. Among all elderly women, about 59 percent reside with their husbands or other family members, but only 35 percent of elderly live with relatives (Bureau of Census, 1970).

Employment

A somewhat different occupational distribution existed among widows over age 65. Fewer were employed as clerical

workers and operatives while a greater proportion worked in private households and as sales personnel. On the whole, widows comprised a relatively larger proportion of those employed in management and service occupations and a smaller proportion of those in professional and clerical positions than was true for the total female work force.

Income

The information from the Bureau of Census data on cash income in 1974 show that the median income for all elderly women (65+) was $2,375.00.

Black females 65+ reported incomes 25 percent lower than their white counterparts. Among those without husbands, blacks received a median income of only $1,838.00, about 30 percent less than whites.

According to the federal government's official statistical measure of poverty, the "poverty index", about 18 percent of all elderly women were below the poverty level in 1974. Only eight percent of those elderly women who were living with their husbands reported joint incomes below this level, as compared to 24 percent for widows. There were about 1.6 million widows who fell in this category. Among all elderly women who live alone about one out of every three was poor.

The rate of poverty for black women was about twice as high than for whites. More than four of every ten elderly black widows were below the poverty level.

Housing

Housing characteristics taken from the 1970 Census are published for all elderly women who lived alone, of which 85 percent were widows.

Over three-fourths of all elderly couples (husband-wife families with a husband 65+ years old) resided in a home they owned compared to slightly over one-half for elderly women living alone. However, some of this is done by choice. Many elderly persons choose to move to apartments.

The housing of elderly women living alone tended to be older and of lower market value than that of elderly couples. The median value of homes owned by elderly females was $11,000 in 1970 and 63 percent were built before World War II. For women 75 years old and over, an even higher proportion (68 percent) of their homes were built during this pre-war period. The homes owned by elderly couples were valued about 26 percent higher than those of elderly females and about half were built prior to 1940.

The median rent paid by elderly couples was $20.00 higher than for females living alone ($102 vs. $82), but the units occupied by couples was one room larger. Over two-thirds (69 percent) of the female individuals paid 35 percent or more of their annual income for housing costs, compared to 30 percent for elderly couples.

Elderly females living alone are more likely to live in units lacking complete plumbing than elderly couples. Complete plumbing defined by the Bureau of the Census, consists of hot

and cold piped water, flush toilets, and tub or shower.

Availability of Services to the Elderly Widowed

The higher frequency of illness and disability, decreased financial resources and increased social isolation of the elderly often require a wide variety of supportive services. Some of these services are provided in the home, but many services in the medical, educational, recreational and nutritional centers are provided outside the home, often at some distance. Therefore, the availability of an automobile or transportation services can be a crucial factor in access to these services.

The 1970 Census data indicate that most elderly females living alone do not own or have regular use of a private automobile. Only two of every five females 65 to 74 years of age had use of an automobile, and this dropped to one of every five women for women 75+. By contrast, over 80 percent of all elderly couples owned or had regular use of an automobile.

Many elderly widows chose not to own or drive a car because of the financial expenses in maintaining and operating a vehicle and because of physical disabilities such as failing eyesight. Many elderly married women never learned to drive and are unwilling to assume this role when their husband dies.

Summary

Current data on various characteristics of the nation's 6.5 million elderly widows not living in institutions indicate that the conditions of their existence are considerably different from the elderly population in general. Most widows live

alone on relatively low incomes. One-fourth rely on cash incomes below the federal government's poverty index. Many have given up their homes and moved to smaller apartments, but housing costs consume a large share of their income. Most do not have automobiles and must rely on other sources of transportation.

These data do not measure the quality of the total life situation of the elderly widow. The extent to which the widow's kinship and friendship networks provide emotional, physical, and economic support is not measured. The benefits from many of the existing public and private programs designed to assist the elderly is also a positive input into the elderly widow. Also, direct financial assistance, such as supplemental security income payments and subsidized housing, are of great benefit. Still, however, there is a very prominent need for supportive services among the nation's elderly widow.

OVERVIEW OF BEREAVEMENT

Our society, in general, encourages the repression of grief. But often it is the case that the "strong, silent ones" are far more likely to get into serious emotional problems than the seemingly "weak" grievers who express openly all their feelings. Because the grief situation does not readily lend itself to experimental and quantitative manipulation of the usual forms of controlled observation, the subject of grief has been ignored by academic psychologists.

Grief is a universal deprivation experience which causes emotional and psychological reactions in the griever. As Bowlby (1961) points out, the loss of a loved object often leads to behavioral sequences, which, varied as they might be, are in some degree predictable. These behavioral sequences are associated with subjective experiences which begin with anxiety and anger, and proceed to pain and despair and, if all goes well, end with hope. Both the behavior and subjective experiences oscillate turbulently with yearning, protest, rage, alternating with blank, mute despair. This entire experience is referred to as "grief" by Bowlby. Many authors have made attempts at charting the normal process of grief (See Table V).

Grief is not particularly a negative reaction, and this

TABLE V

STAGES OF GRIEF

Kubler-Ross (1969)	Parkes (1972)	Hodge (1972)	Bonnell (1971)	Hecht (1971)	Westberg (1962)
1. Denial & isolation	1. Numbness	1. Shock & surprise	1. Numbness or shock	1. Shock	1. Shock
		5. Panic	2. Fantasy or denial		5. Panic
		2. Emotional release			2. Emotion
		4. Anxiety & physical distress		2. Somatic symptoms	4. Physical distress
2. Anger		7. Hostility & projection			
3. Bargaining	2. Pining	6. Guilt	3. Guilt recrimination	4. Guilt	6. Guilt
4. Depression	3. Depression	3. Loneliness			
		8. Suffering in silence	4. Whole-hearted grief	5. Despair	3. Depressed & lonely
		9. Gradual overcoming		6. Withdrawal	8. Unable to return to usual activities
5. Acceptance	4. Recovery	10. readjustment	5. Adjustment	7. Prolonged reconstitution	9. Gradual hope
			6. Acceptance		10. Struggle to affirm reality

Karen Peterson (1971)

is well explained when Peter Marris (1958) describes it as:

> "the expression of a profound conflict between contradictory impulses--to consolidate all that is still valuable and important in the past, and preserve it from loss; and at the same time, to re-establish a meaningful pattern of relationships, in which the loss is accepted."

According to Freud, who was one of the first to explore this process, the grief reaction in victims of bereavement is something normal, not to be treated medically, but simply allowed to run its natural course. In his famous article, "Mourning and Melancholia", he writes:

> "Although grief involves grave departures from the normal attitude to life, it never occurs to us to regard it as a morbid condition and hand the mourner over to medical treatment. We rest assured that after a lapse of time it will be overcome, and we look upon any interference with it as inadvisable or even harmful." (1917)

Grief is not a disease to be treated, but a process to be experienced, according to Freud.

GRIEF PROCESS

At the moment of his death (1949), the Prince Andrei Bolkonsky of War and Peace, reflects: "When it is a beloved and intimate human being that is dying, besides the horror at the extinction of life there is a severance, a spiritual wound, which like a physical wound is sometimes fatal and sometimes heals..." (Book XV, Chapter I). The process of grief ideally protects this open wound from rough and painful contact and leads at last to healing (Siggens, 1967).

The normal grief process is a multi-faced experience:

> "Grief work", explained by Freud (1917) is the task of mourning. And it is work--hard, long, painful, slow, repetitive, a suffering through of the same effort over and over. It's a matter of re-thinking, re-feeling, re-working the same longpast fields, the same old emotional material, over and over breaking through the denial and disbelief that the past and the deceased are both dead; re-examining one's past life repeatedly and seeing each through, each intimate experience, with and without the deceased, looking at everything that has gone before from a thousand or more points of view until finally the past, like the deceased, is ready to be buried."

Also, grief varies widely from one person to another.

Elizabeth Kubler-Ross (1969) suggests the following stages of grief.

1. denial and isolation
2. anger
3. bargaining
4. depression
5. acceptance

Other normal traits in the grief process include: denial, obsessional review, identification with the deceased, idealization, rationalization, substitution, alter perceptions, and physical manifestations, (crying, sleep disturbances, restlessness, appetite changes, change in sexual desires, emotional manifestations, fear, anger, depression, guilt). Physical distress and worsened health, an inability to surrender the past, brooding over memories, sensing the presence of the dead, clinging to possessions, being unable to comprehend the loss, feelings of the unreality, and withdrawal into apathy and hostility against others, against fate or turned upon onself are also common reactions.

One of the foundational works on the process of grief is Lindemann's study on acute grief (1944), which, interviewing

101 grieving persons, describes symptoms and behavior patterns of normal grief and also "morbid grief reactions" and develops a system for the management of grief. He gave three tasks to be accomplished as a part of grief work:

1. emancipation from the bondage to the deceased;
2. readjustment to the environment in which the deceased is missing; and
3. the formulation of new relationships.

Lindemann observed from this study that the characteristic signs of grief were somatic distress, pre-occupation with the image of the dead, guilt, hostile reactions and loss of patterns of conduct.

Most human behavior occurs on a normal-abnormal continuum, and it is difficult to separate normal and pathological grief. This is particularly true because many of the components of normal grief (intense anger, somatic distress and denial) would be viewed as abnormal under most other circumstances. Nevertheless, there is the basic difference between normal and inadequate grief. The latter is the mourning that leaves the survivor unable to cope properly with ordinary life.

> "A turning-point comes when the pathological processes of the illness can be seen as intensifications, deviations, or prolongations of processes that occur in health." (Bowlby, 1961)

Recently, the medical profession is beginning to pay serious attention to pathological, or morbid grief, and the physical and psychological implication of ignoring "grief work".

"Pathological grief" is, according to Freese (1977),

> ". . . the inadequate or uncompleted mourning. Here the bereaved goes on living in the old emotional bondage which like all forms of peonage keeps its vassals in perpetual slavery . . . one loses the opportunity to mature and change, is left to go through life permanently shackled to the long age."

Pathological grief represents the nonconclusion of the grief work.

Parkes (1972) gives the following picture of a "typical" pathological griever:

> "From the evidence available, which comes mostly from studies of bereaved women rather than bereaved men, our high-risk case would be a young widow with children living at home and no close relatives nearby. She would be a timid, clinging person who had reacted badly to separation in the past and had a previous history of depressive illness. Closely bound up with her husband in an over-reliant or ambivalent relationship, she would not have prepared herself for his unexpected and untimely death. Cultural and familial tradition would prevent her from expressing the feelings that then threatened to emerge. Other stresses occuring before or after the bereavement such as loss of income, changes of home, and difficulties with children would increase her burden. Although she may at first appear to be coping well, intense pining would subsequently emerge, together with evidence of pronounced self-reproach and/or anger. These feelings, instead of declining as one might expect, would tend to persist."

Thus, we term "pathological" the griever that does not successfully complete the tasks of grief work: release of grief, structuring, acceptance of reality, making the decision for life, expressing socially unacceptable emotions and experiences, evaluation of the loss, incorporation of the dead, and a new-life orientation.

Lindemann (1944) determined that the following were the forms of pathological grief:

1. Distorted reaction where there are major changes in the behavior pattern such as:
   a. Overactivity with no sense of loss.
   b. Major alterations in the social life, especially isolation.
   c. Acquisition of symptoms belonging to the deceased or that caused the death.
   d. A physiological disease such as ulcerative colitis, rheumatoid arthritis or asthma.
   e. Blatant states of agitated depression.
   f. Activities which are detrimental and self-punitive without awareness of guilt.
   g. Lasting loss of patterns of interactions with others.
   h. Hiding of feelings by becoming "wooden", or schizophrenic-like.
   i. Furious hostility against specific persons.
2. Delay of a grief reaction where the grief may be unresolved for many years. The grief may finally be activated by a less significant event.

According to Parkes (1964), there are three types of morbid grief:

1. Inhibited type of grief--where the bereaved feels nothing and does not express the feelings of loss. It may take the form of neurotic or psychomatic disorders. Symptoms are often present. Some say that most cases of depression are due to unexpressed

grief. This inhibited grief is often found in children and in the old.

2. Chronic types of grief--where there is a prolongation of grief with intense anxiety attacks, depression and searching behavior.
3. The delayed type of grief--the expression of grief is put off for weeks, months or years. Some day the major loss will be felt, perhaps when a person finds himself grieving for a minor loss.

Parkes (1972) states:

> "Although there is no clear ending to grief, it is common for widows to describe one or several "turning points: that is, events associated with a major revision of their feelings, attitudes, and behavior. Such turning points may occur, for instance, when a widow goes away on a holiday, takes a job, goes out with a man for the first time since her bereavement, or redecorates her house. They both reflect and engender an abandonment of the old modes of thinking and living."

Relating normal and pathological grief to the widowed population, Glick et. al (1974) have conducted a study of bereaved widows who were having adjustment difficulties after one year. Twenty-eight percent agreed at the end of the first year with the statement, "I would not care if I died tomorrow." A few reported that their grief had continued unabated and was as intense at the end of the year as it has been at the beginning. Still other widows, though they claimed partial recovery, seemed compelled to dissipate in frenetic activity feelings that might otherwise have been expressed as fear, anxiety or intense sorrow.

Glick et. al (1974) felt that disposing of the personal belongings of the deceased may demonstrate a critical turning point in the grief process.

> "The first determined movement of a widow toward acceptance of her separation often was going through her husband's belongings, putting aside what was to be kept and giving away or throwing away the remainder. . . Most widows waited several weeks or even months before moving their husband's belongings from their bureaus and closets. Often this was a painful task, accompanied by reminiscence and tears. But when it was completed it became a statement that one era of the widow's life had ended and that another was beginning."

The ultimate goal of grief work is to be able to remember without pain, and to be able to reinvest the emotional surplus. Volkan (1972) summarizes five factors which will affect the success of the grief process:

"1. Whether or not the death had been anticipated.

2. The mourner's rapport with the one who had died.

3. The mourner's emotional make-up.

4. Whether death was caused by self-destruction or violence, or came about through illness.

5. Whether or not the death has brought about changes in the real world for those left behind."

PREDICTORS OF UNFAVORABLE BEREAVEMENT OUTCOME

Maddison (1968) attempted to determine parameters predictive of an unfavorable resolution (defined by the presence of physical and emotional difficulties that precipitate a deterioration in health) of the bereavement crisis. The evidence available thus far comes predominantly from studies of bereaved women, rather than bereaved men.

The widow who turned out to be a "bad-outcome" subject was dissatisfied with the help available to her during the crisis. She perceived a high frequence of unhelpful interactions with persons within her social network during the first three months following the death of her spouse. She considered persons around her to be actively or passively opposing her wish to review past memories and be experienced with the deceased spouse. Not only were significant others (including family, friends, clergy and physicians) minimally helpful in assisting the widow in ventilating her feelings, but the people often encouraged development of new activities and new romantic relationships at times when the widow was not prepared emotionally for such suggestions. Such attempts were met with great anger and bitterness.

According to Maddison the best single predictor of physical and psychological symptoms was the widow's perceptions of her environment as failing to meet her needs during the crisis. "Good-outcome" widows reported that they received permissive support from the environment and that was seen as helpful.

Parkes also did a study on determinants of outcome following bereavement (1975) with sixty-eight widows and widowers which were interviewed shortly after bereavement and again a year later. Factors which at the early interviews predicted poor outcome included: "low socio-economic status, short terminal illness with little warning of impending death, multiple life crises (particularly those involving disturbance

of marital relationship) and reactions to bereavement of severe distress, yearning, anger or self-reproach."

Lindemann (1944) stated that ambivalent relationships of the deceased and survivor often lead to severe grief reactions.

Also, Lopata (1972) found that disorganization suffered by widows depended on the wife's role, the psychological and social dependencies of the woman upon being the wife of that specific man, and the extent to which the couple operated as a team.

Other significant facts (other than inadequate and ineffectual environmental support) contributing to bad outcome were: (1) age of widow less than 45 with dependent children; (2) evidence of pre-existing marital difficulties; (3) protracted death (associated with severe suffering and disfigurement) maximizing pre-existing ambivalence, leading to feelings of guilt and inadequacy; (4) prior history of severe reaction to death of another family member; (5) additional stresses or crises in close temporal relationship to bereavement; (6) deliberate avoidance of affective expression, especially controlling hostile and angry feelings; (8) continued reaction formation against dependence; (8) poor interpersonal relationship with own mother or husband's family.

Epstein et. al (1975) agrees very closely with Parkes (1972) that a high risk case tends to be a young widow with children living at home and no close relatives living nearby. Cultural and familial norms prevent her from expressing feelings

of anger, ambivalence, and guilt. Other stresses occurring before or after the bereavement, such as a loss of income, change in residence, and difficulties with children also increase the widow's burden.

PROBLEMS OF THE WIDOWED

Transition

Loss of a spouse requires the widow to change roles. She is no longer wife, but widow. This involves a search for a new definition of self as a single person. Without the benefit of a marital relationship which once framed and focused her daily life, the widowed person must learn to live with loneliness and still find new purpose. This transition may turn out to be most difficult.

Also, the loss of a spouse involves significant changes in the "every-dayness" of the person's remaining. A widow may need to learn to drive, fill out tax forms, do minor household repairs and make decisions never asked of her previously. This happens when her friends and family are also struggling with their own grief after the loss, thus making them less able to be supportive of her.

Despite her grief, her sense of loss, and the lack of preparation for her new role, the widow must attend to many practical matters in the hours and weeks following her husband's death. The funeral must be arranged, death certificates obtained, insurance claims filed, social security benefits applied for, and many other legal and financial matters attended to. In this context, Nuckol's study (1973) with widows has estimated the helpfulness of the persons

they encounter. According to the study, widows reported family and close relatives as most helpful with attorney following. When reporting the most helpful persons among those they contacted, they reported again family and close relatives, followed by attorney.

It is impossible for a wife of any age to be completely prepared for the grief and loneliness that will follow the loss of her husband. However, there are steps that can be taken, either in direct anticipation of death or in the course of daily living, to make it easier for her to adjust to her new responsibilities as head of the household. Income needs may be anticipated and a program of life insurance developed; a will can be prepared; social security and employee benefits can be discussed; papers can be put in order and their locations made known; and she may gain experience in money management by handling the day to day finances of the household (Nuckols, 1973). If she is in good health, the widow may be able to earn an income. She will have the proceeds from her husband's life insurance; she will also have social security while the children are growing up and after she reaches retirement age. But these resources are probably not enough to maintain a semblance of her former standard of living.

The most frequently reported problem of the widow is loneliness (Barrett, 1974). The more recent the death of a spouse, the greater the likelihood of reported loneliness (Townsend, 1957). Lopata (1969) examined the forms and

and components of the sentiment of loneliness as experienced by 300 Chicago area widows. The forms include: loneliness for the deceased husband as an individual, an object of love, the person making the woman an object of love, a companion, someone whose presence organizes time and work, a partner in the division of labor, a source of status, and a source of life style. Loneliness is also experienced by widows because of strains in relations with married friends and an inability to convert secondary relations into ones of greater depth. The very lonely are women who were socialized into passive membership in automatically encompassing groups, who now lack such relations. In general, however, most widows continue some close relations or build new life styles solving many of the problems of loneliness. Next to loneliness, widows list finance and rearing children as the most serious problems (Nuckols, 1973).

Lopata (1973) holds that participation and adjustment following widowhood is primarily a function of personality, attitudinal, and ethnic factors. Until recently, however, the status of widowhood has largely been colored by economic considerations. Pressing material needs in homes broken through the death of the breadwinner have assumed a paramount position and have overshadowed real understanding of the social and psychological problems the widow must face.

Single Parenthood

While the big problem facing divorced or separated parents is how to get along with an ex-spouse, the chief

concerns of widows and widowers is how to get along without one. This is the main difference that distinguishes almost all the special problems of single parents who have been widowed.

Some feel widows with children are fortunate because the children's needs may help the widow achieve perspective on her own grief, and because children provide an antidote to the awful silence that widows without children experience. But as mothers, among other things, they worry about psychological problems for kids raised without a father. The bereaved child has a higher than chance risk of developing serious problems as an adult and, especially, Brown (1966) and Birtchnell (1970) found a clear relationship between adult depression and early childhood bereavement.

In fact, several studies have noted that the high rate of parental loss experienced by delinquent populations (Gleuck and Gleuck, (1950), Gregory (1965), found that although delinquence was more a consequence of divorce than death, both boys and girls that had lost a parent by death dropped out of high school prematurely. And, Bonnard (1961) claimed that much anti-social or delinquent behavior is a consequence of bereavement.

According to Newman and Denman (1971), white males who had lost their fathers prior to age 18 are more likely to be involved in criminal behavior. Greer (1964) has also shown that individuals with sociopathic symptoms had experienced greater paternal death.

It is an interesting sideline to note Woodward's (1974) finding that scientific genuis is positively associated with parental loss to death in childhood. Amongst eminent scientists, two out of five have lost a parent during their childhood.

Without question, however, the widow with young children faces a task with many inherent psychological risks.

Social Adjustments

Widowhood is a major crisis in a women's life which requires new social adjustments for the family, as well as for herself. It requires the development of alternative patterns of behavior if the individual is to maintain satisfactory relations with the family, the kin group, and the community and if she is to sustain a minimum level of personal equilibrium.

As Madison (1968) says, the period of widowhood requires a reorganization and reintegration of social roles suitable to a new status. Suddenly a women is no longer a wife, she is a widow, "We" becomes "I", "ours" becomes "mine". She sees far less of her husband's relatives than before his death (Lopata, 1970; Marris 1958), while contact with widows' own relatives is basically unchanged (Marris, 1958). Family and friends are quite tolerant to the initial bereavement response, but if prolonged, they quickly tire of it and may isolate the individual.

The single world is a difficult place for the typical widow to adapt. She finds it hard to accept sexual

changes in recent years. Also, the widow often finds herself ostracized by her female friends. Much to her surprise, she may be seen as a rival for a husband. Thus, she has to develop a new social matrix which may be difficult during the period of bereavement.

Widows are often approached by friends of her husbands, but sexual complications hinder relationships and conflicts may arise because they feel still married to their husbands. In the present couple-oriented society, further, a widow is no longer socially desirable as before and this leads her to feel angry and isolated. Also, she may be unable to form new relationships because she has previously assumed a passive role in making new contacts.

In general, the bereaved tend to devalue all relationships except the one that has been lost. This makes it difficult for others to help the widow. Maddison (1968) suggests two tasks: to detach herself from the lost spouse in order to permit the continuance of other relationships and the development of new ones, and to develop a new role conception as an adult woman without a partner.

In spite of the many social problems, most widows do adjust to the change in status and some enjoy their new life. In a study of 300 widows in Chicago, Lopata (1972) found that many believed themselves to be more independent, competent, active and freer than when their husbands were living.

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

The impact of adjustment of a decrease in social interaction, or a loss of social roles, is considerably softened if the individual has a close personal relationship (Lowenthal and Haven, 1968). Also, religion plays an important role in the process of adapting to widowhood, especially in the case of females. Whereas widowers were the least likely to attend religious services, widows were the most likely to attend (Berando, 1967).

Educational Level

Cosneck (1966) has shown that the widow's educational level is related to her subsequent adjustment to her new social roles; the greatest social isolation occurs among women with the least education. According to Lopata's (1973) survey, the lower a woman's education, the less likely she is to rank the role of wife in first place in the hierarchy of roles for women. Instead, she places the role of mother first. The less-educated woman feels that she has no share in her husband's world. This is especially true of black women. They were twice as likely as white widows to say that they shared only a few activities with their husbands and they were more used to making decisions on their own.

Physical Health

The grief precipitated by the death is almost certainly associated with changes in the function of the endocrine and central nervous system. In turn the effects of this have secondary consequences for resistance to various illnesses.

The health of 375 widows, thirteen months after their bereavement, was evaluated in Boston, Massachusetts and Sydney, Australia (Maddison, 1968). The reported health of matched, non-bereaved controls was evaluated over the same period.

In Boston, 21.2 percent of the widows sustained a marked health deterioration, with the control group being at 7.2 percent. In Sydney, the figures were 32.1 percent for widows and 2.0 percent for the controls. In the Boston widows, Maddison found that young age was associated more frequently with higher illness scores than older age, but this was not replicated in the Australian sample. One-fourth of the young widows reported a significant deterioration in health in the first thirteen months.

TABLE VI
PREVALENCE OF HEALTH DETERIORATION

	No. of Subjects	Degree of Deterioration-%		
		Marked	Moderate	Nil
Boston widows	132	21.2	35.6	43.2
Sydney widows	243	32.1	36.2	31.7
Boston controls	98	7.2	31.6	61.2
Sydney controls	101	2.0	28.7	69.3
Total widows	375	28.0	36.3	35.7
Total controls	199	4.5	30.2	65.3

A score of 16 or above represented a marked deterioration

in health and a score of four or less did not seem to involve any significant health deterioration.

In 1968 and 1969, 109 white widows and widowers were interviewed (Clayton et. al, 1971) about the physical and mental health of the survivor as well as questions attempting to assess the marriage and the social network of the survivor.

Among other results, they discovered that crying, depressed mood and sleep disturbance are the cardinal symptoms of the bereavement reaction. Fifty-two percent of these persons took sleep or nerve medicines.

Parkes (1970) also published a report of 22 London widows under the age of 65 who were seen at one, three, six, nine and thirteen months after the deaths of their husbands. At 13 months there were six widows (27 percent) whose health was definitely worse.

Further, in a sample of 49 widows under 45, Glick, Weiss and Parkes (1974) found that within eight weeks after the death of their husbands, 40 percent of the widows had consulted their physicians because of headaches, dizziness, muscular aches, menstrual irregularities, loss of appetite and sleeplessness. In the year following bereavement, they had three times as many hospitalizations and spend considerably more time sick in bed than did a control group.

There is a higher rate of disabling illness among unmarried females (primarily widows) than among married females (Woolsey, 1952). Also, a greater number of disability days

per person and a higher frequency and duration of hospitalization shows up in widowed, divorced or separated women than married women.

In one of the latest investigations, new widows report significantly more physical symptoms and psychological stress as measured by the Goldberg General Health Questionnaire . . . than did a comparable group of women with newly diagnosed breast cancer (Vachon, 1975).

Mortality

In the final analysis, mortality is due to a physical phenomenon. However, the social processes play a significant role in the etiology of many disorders that lead to death and frequently determine how promptly and persistently one seeks treatment. And, of course, with some types of mortality, such as suicide, the role of social factors is obvious.

> With regard to the relationship between marital status and mortality for men and women, the married have lower mortality rates than the unmarried and the differences between being married and being single, widowed, or divorced are greater for men than for women. These differences are particularly marked among these types of mortality where one's psychological state would appear to affect one's life chances." (Gove, 1979).

Using mortality statistics, Kraus and Lilienfield (1959) found an increase in mortality rates of forty percent for widowers in the first six months following bereavement. The greatest increase was found in those dying from coronary thrombosis and other arteriosclerotic and degenerative heart diseases and vascular lesions of the central nervous system.

Cox and Ford (1964) studied durational mortality statistics of 60,000 widows under 70 years of age and found the mortality in widows was higher than usual in the second year after widowhood and Rees and Lutkins (1967) followed all the close relatives of all members of a small community in Wales who died in a six year period. Nine hundred and three close relatives of 371 residents who died during 1960-65 showed that a 4.8 percent of them died within one year of bereavement compared with only 0.7 percent of a comparable group of non-bereaved people of the same age, living in the same area. The mortality rate was particularly high for widows and widowers, twelve percent of whom died during the same period.

Psychological Adjustments

Numerous researchers have attempted to measure bereavement reactions by using indicators such as rates of physical and mental illness and mortality statistics. Parkes has probably done more in this field than any other single author. In his initial study (1964) he compared the medical records of forty-five London widows for two years before and eighteen months after bereavement.

He found that: (1) for widows under the age of 65 a consultation rate of psychiatric symptoms (anxiety, depression, insomnia, tiredness, run down, attendance for tonics and sedation) more than tripled during the first six months after the bereavement. The amount of sedation prescribed to widows under the age of 65 was seven times

greater during the 18 month period after the bereavement than it has been in the control period; (2) no such changes for psychiatric symptoms and sedatives were found among widows over 65; and (3) the consultation rate for non-psychiatric symptoms was not significantly increased in the younger group. (4) There was a significant increase in this rate for older women.

In the subsequent studies, (1964, 1975) Parkes found that of 3,245 patients admitted to psychiatric units in a two year period, 94 developed their illness within six months of the death of a spouse or parent. This number was six times greater than the expected rate of bereavement in the general population. In another study, Parkes compared a group of bereaved patients with a group of non-patient widows. He found that in the bereaved group, there was greater difficulty in accepting the loss, and feelings of self-blame were more intense.

A group of thirty-five grievers were studied by Parkes (1972) that were referred to professionals for help.

> "Twenty-six were referred for depression, six for alcoholism, five for hypochondrical symptoms, and four for phobic symptoms and there were smaller numbers with panic attacks, asthma, loss of hair, depersonalization, insomnia, fainting, or headaches. In addition, there were two cases of frank psychosis with hallucinations peculiar to bereavement."

In a study by Parkes and Brown (1972) of 40 widows and 19 widowers under 45 who had been bereaved 14 months, the bereaved sample showed greater evidence of depression and general emotional difficulty, as reflected by recent

disturbances, sleep, appetite and weight fluctuation, loneliness, restlessness, indecisiveness, poor memory, and an increased consumption of tranquilizers, alcohol and tobacco. Survivors were four times as likely as controls to have been hospitalized in the preceding year (general medical and psychiatric). Members of the widowed group more often than controls sought advice for emotional problems from physicians and clergy.

From various samples of psychiatric hospital admissions, the percentage whose primary difficulty was unresolved grief was: nine percent (Jackson, 1957), ten percent (Bachmann, 1964), and fifteen percent (Lazare, 1976).

Stein and Susser (1968) concluded in their study of mental illness and widowhood that recent widowhood precipitates the seeking of psychiatric care and, presumptively, the inception of mental illness. Widowhood is not associated with chronic disablement arising from mental illness, however. These actions follow closely on the event of bereavement more often than expected by chance.

In a study of 109 widows and widowers, Bornstein, et. al (1973) found that the best single predictor of depression at thirteen months after the loss was depression at one month. These depressed subjects differed from other bereaved in that they had fewer children living nearby, did not live with other family members and had less financial and religious support. The depressed subjects also had few, if any, previous bereavement experiences; thus it

would seem that coping with a prior bereavement experience facilitates adjustment to the death of a spouse, as confirmed by Huston (1971).

Clayton et. al (1972) evaluated a group of widows, average age 61, one month after the death of their spouses. Thirty-five percent of them had a collection of depressive symptoms similar to those common in psychiatric depressed patients.

One social variable was significant and showed that fewer of the group with reactive depression had children in the area they considered close. Thus one means of support emotional, physical or financial was not available to them.

Those at greatest risk following death of spouse include widows:

1. with poor social support;
2. under 45, whose spouse died suddenly or over 65 whose spouse had an illness of six months or more;
3. who had experienced an ambivalent marital relationship;
4. who had a minimal funeral ceremony associated with denial; or
5. with previous psychiatric history (Vachon, 1976).

Marital status and mental disorders among aged were studied by Bellin and Hardt (1958) with 1803 persons aged 65 and over residing in six census tracts in an upstate New York urban community.

The ordering of mental disorder rates among the married,

widowed, separated, or divorced and single is identical for each sex: the separated-divorced have the highest rates, followed in order by the widowed, single and married. On a gross basis, mental disorder rates for the widowed are significantly higher than those of the married (Bellen and Hardt, 1958).

Suicide

The loss of a marital partner, which causes the disruption of social relationships on the part of the victim, has been seen as one of the most significant factors precipitating self-destruction, and the high rate of suicide among the widowed has been well-documented.

Durkheim (1951) states:

> "The suicides, occurring at the crisis of widowhood. . . are really due to domestic amomaly, resulting from the death of a husband. A family catastrophe occurs which affects the survivor. He has not adapted to the new situation in which he finds himself and accordingly offers less resistance to suicide."

Many studies confirm that suicide, attempted or actual, is often preceded by the disruption of significant social interaction and reciprocal role relationships through the loss of a mate (Rushing, 1968). Sainsbury (1955) showed that suicides (causing over 5,000 deaths a year, not far off the number who die in road accidents) were more common among the widowed than the single, and that the rate was lowest among the married. Between 1955 and 1967 Segal (1969) studied the New Hampshire suicide rates by age, sex and

marital status. He discovered the suicide rates of the divorced, separated and widowed to be regularly higher than the married.

TABLE VII
RATIO'S OF MEN'S TO WOMEN'S FREQUENCIES OF SUICIDE
BY AGE & MARITAL STATUS

By Age		By Marital Status	
Age Group	Ratio	Status Group	Ratio
0 - 24	5:1	Married	2.9:1
25 - 44	2.4:1	Never Married	4.1:1
45 - 64	2.4:1	Widowed	2.5:1
65 & More	4.8:1	Separated-Divorced	2.6:1

In regard to the mortality risk of the bereaved, Bunch (1972) studied suicide mortality and found that in the five year period preceding the suicide, 36 percent of the sample had been bereaved of a parent or spouse and that more widows than widowers killed themselves. She suggests that the risk to the widowed is of longer duration than is usually believed.

Berardo (1967) depicted widowhood among the aged as a critical situation involving social and personal disorganization. Old statuses and roles are lost and new relationships must be made for a satisfactory adjustment. However, nebulous and contradictory expectations become the social context of the new status confronting the aged survivor. The relationship between suicide and widowhood has been documented by Durkheim (1951), Rushing (1968), Resnik and Cantor (1970), Marris (1969), and others.

INTERVENTION AND SUPPORT FOR THE WIDOW

Widowhood emerges as a rather dismal picture. Clearly, the majority of women survivors generally have to face many personal and family adjustment problems while concurrently attempting to establish a satisfactory adaptation to a new and relatively undefined social role. Their economic situation is likely to be unstable; more often than not they will need to get a job. Moreover, as already pointed out, in comparison to the still married, they face the possibility of an early mortality, and have more than an average probability that they will develop some mental disorder or commit suicide.

As Lowenthal and Haven (1968) reported, the presence of an intimate relationship serves as a buffer both against gradual social losses in role and interaction and against the more traumatic losses accompanying widowhood and retirement. This is confirmed by Barrett and Becker's study (1978): those widows who, as wives, had friends who were widows scored higher in preparation for widowhood. The best prepared were the widows of men who died of long illnesses. Those living alone reported better preparation than those living with children or others. Age, long marriages and marital happiness had no bearing on preparation.

TABLE VIII
FREQUENCY OF DEPRESSION AMONG 280 AGED, WIDOWED AND MARRIED PERSONS WITH AND WITHOUT A CONFIDANT

	Percent Satisfied	Percent Depressed
Widowed within 7 years		
Has confidant	55	45
No confidant	27	73
Married		
Has confidant	65	35
No confidant	47	53

Lowenthal and Haven (1968)

RELIGIOUS FAITH

Very often people turn to religious beliefs to give support in the transition from wife to widow. However, studies done by various researchers have provided little in way of conclusive evidence on the role of faith in the widowed.

In the 1974 Boston widows' study done by Glick, Weiss and Parkes, the role of the clergy is seen as limited.

> "In truth, few widows seemed to want closer contact with clergy than they had. They had little enough energy for anyone outside their intimate family and friends, and they might have felt especially reluctant to play hostess for a courtesy call from a priest or minister they previously had met only on Sunday mornings."

According to their study, experiencing widowhood may be destructive to one's faith.

> "The death of their husband damaged the religious faith of some widows. Although seventy-three percent of our sample said that the death had not affected their religious beliefs, a significant minority said in an early interview that their faith had been shaken, and one in eight said she

> was angry with God or fate for having permitted her loss."

Parkes (1972) offers the following on the ambivalent role of one's faith in relationship to bereavement:

> "A month after bereavement thirteen widows out of eighteen in the London Study who expressed belief in God said that their faith had helped them. The relationship between religion and adjustment, however, is not simple. There was some evidence that those whose religious beliefs helped them to place the bereavement in a meaningful perspective coped better with bereavement than those who had no such faith, but it was also true that several of the regular church-attenders did not make out well. The view of God as a protecting, loving father was hard to maintain in the face of untimely bereavement, and the possibility of reunion in days to come did not help the widow to tolerate the absence of her husband now."

For some widows religious beliefs has the possibility of giving meaning to their grief and loss. However, as Glick, Weiss and Parkes (1974) observed,

> "It seems to make little difference whether a widow held a fatalistic view of death, believed in predesination, or held that life, and death were in the hands of God. Whatever her beliefs, the review process, the exploration of alternative outcomes, and the fleeting fantasies of undoing the fatal outcome were pursued."

SUPPORT SYSTEMS

Lopata (1970) points to the lack of facilities for helping people who are socially disengaged to find new ways of re-engaging in society. She also notes that if people need assistance with this they are often viewed as different or defective. It is reported that mental health agencies in the United States are underutilized by widows. Their services are not oriented to the needs of this group (Silverman, 1970).

However, there are some organizations that have been helpful, including:

1. A Catholic Church organization called NAIM and another, Post-Cana. Also, a non-demonination religious group THEOS (They Help Each Other Spiritually) (Decker and Kooman, 1973).

2. Parents Without Partners started in 1957, is a group for widowed, separated and divorced persons with dependent children (Eagleson & Eagleson, 1961).

3. The American Association of Retired Persons offers services for the widowed (Loewinsohn, 1977).

4. The Widowed Consultation Center in New York City, staffed by professionals, including social workers, psychiatrists and legal and financial advisors, has served thousands of widows.

SELF HELP GROUPS

Most often groupings develop around "critical transitions" in a person's life, when other solutions are unavailable or ineffective. In mutual help groups the individual is not defined as a deviant or a patient, but as someone undergoing a natural and normal experience, such as bereavement, childbirth or divorce.

Mutual help groups are defined as those organizations that limit their membership to individuals with common problems. The purpose of such organizations is to help the members and others with the same difficulties solve their mutual problems. In time, recipients of help will move to become helpers.

Several conditions give rise to such organizations; they develop when the professional caregiver fails to deal successfully with the problem, when this caregiver solves a

problem, but does not understand or attend to the problems that are created by the solutions. At times of rapid social change, mutual help groups develop when there is a lacuna between existing social patterns and the requirements of new situations.

Programs for the widowed grew out of the latter situation. Social mobility, changing death rates, changing patterns of behavior and role sets in the family, as well as enormous changes in religious behavior, left a vacuum, so that patterns for grieving were not passed on by one member of the family to another. Communities are more homogeneous so that the new widow, for example, might be unique in her community. Families move around so that their support and guidance are not readily available, nor do the patterns of previous times always seem relevant to the present situation. In a mutual help program, help can be offered spontaneously as neighbor reaches out to neighbor, thus expanding the helping network in which a person participates.

The purpose of any program of preventive intervention is to prevent emotional breakdown in a vulnerable population. Caplan (1964) describes the characteristics of an effective preventive intervention program: the service should be available immediately or soon after the critical event occurs. It should be able to reach every exposed person, that is, each individual in the population at risk. It must have a legitimate access to the population, that is, some mandate from the community. Finally, it must be able to provide a

maximum benefit with minimal cost.

The Widow to Widow program provides a systematic effort at re-engaging the bereaved individual in a new but acceptable role. The primary caregiver is a widow. A widow caregiver bears no stigma of illness, or disability. To take help from such a person does not reflect negatively on the individual's own competence. As a teacher, a role model, as a bridge person, she helps make order out of the chaos of grief and provides the widow direction in the role transition. This is the essence of prevention.

The social situation is different. The woman is no longer a wife. She must search for a new definition of self as a single person. She must learn to live with loneliness and yet find new purpose. The transition of learning to be a widow is difficult and many need help to be successful.

If she finds help only from a mental health specialist she becomes a deviant, her problem is pathological. The newly bereaved are not able to ask for help; they do not know what they need. Neither are they well organized enough to seek out anyone.

Also, the widows served can move into the role of caregiver. This is then one of the new roles available to them as they move to redefine their lives without a spouse. The caregiver in turn is helped. This is another aspect of self help efforts that the person helping is also being helped by the activity.

These widow-caregivers are a very specialized group

of "experts". They have lived through the crises, they have recovered, and they teach others that it can be done and how to do it.

Carol Barrett (1974) developed a group intervention program for widows using three distinct formats, including: self-help groups, women's consciousness-raising groups for widows, and "confidant" groups based on the model of Lowenthal and Haven's research of the relationship between intimacy and mental health in old age (1968). At post-test, subjects in all three groups had significantly higher self-esteem. The women's consciousness-raising participants gave the program the highest helpfulness ratings. They also reported the most positive life changes during the six month follow-up period.

Parkes (1972) cautions that groups of the bereaved can become self-defeating and ingrown at times. Social activities with other widows should be seen as steps towards other forms of activity, rather than as ends in themselves. Otherwise there is a danger that inward-looking cliques will develop, whose members succeed only in reinforcing one another's fears of the outside world as hostile and dangerous.

However, the extensive work of Silverman (1970, 1972, 1974 and 1975), Barrett (1973, 1974, 1977, 1978), and Lopata (1969, 1970, 1971, 1972, 1973, 1975) clearly demonstrates the value of such structures for recent widows.

In asking widows what kind of help they needed (Barrett 1977, 1978), two suggestions were paramount: one was related

to financial preparation and the other emotional preparation for widowhood. They urged all women to learn financial management and become familiar with all financial documents and transactions, to give attention to life insurance, making of wills and savings of money, and to develop a marketable skill.

In the second area, they suggest developing independent interests and resources. Barrett cites Lopata's prediction: "the more areas of one's life which are dependent on the spouse's participation, the greater the role discontinuity at widowhood." Their roles as wives shape the boundaries of their roles as widowed women (Lopata 1971, 1973).

An additional theme was specific planning for widowhood. Talking with their husbands ahead of time and finding an advisor from among family associates or relatives. Finally, explicit emotional preparation: know and understand all the possible emotional reactions to bereavement; appreciate your husband and live to the fullest while your husbands are alive.

Advice given by widows, reported by Nuckols (1973) encouraged the potential widow to: "be active, have faith", be open with relatives and friends, take advantage of special support services and make necessary preparations to ensure the transition with as much ease as possible.

From interviewing 150 persons, Clayton et. al (1971) confirmed that the bereaved have difficulty making decisions. Perhaps this is why the lawyer and undertaker are viewed as helpful and aid the widow in making immediate decisions. Without exception, professionals encouraged life-planning

behavior.

The purpose of talking about feelings should be to free the person to act. Offering help with feelings alone when a person does not know how to act does not in fact move the situation ahead. In helping the widowed, this is especially true, since a role lacuna often exists and the new widow needs a role model from whom to learn how to be a widow. Some widows do need a place or relationship in which they can express their feelings, but most need help with concrete, specific difficulties.

Two basic problems facing a widow need to be examined: the first is that of facing the fact of widowhood; that is, accepting their changed marital status and all this involves. The second is to learn to manage their own lives, and to demonstrate to themselves and others that they can be and are independent (Silverman, 1972).

Self help has a peer status to achieve therapeutic goals. Peers must and do reveal themselves to each other. All have experienced the problem or behavior which defines them as peers. They are totally involved in a fellowship and each experience is part of therapy (Hurvitz, 1970). They are therapists because of their ability to disclose themselves, create empathy and encourage and support others' efforts to change.

CHAPTER III

RESEARCH METHODOLOGY

The purpose of this study was to test the effects of a Life Management Skills Program of systematic intervention on depression and grief in widows.

In order to test the following research questions, a participant group of widows that were involved in a six week Life Management Skills Program was compared to a non-participant group of widows on pre- and post-, self-reporting scales of depression and grief.

Research Questions

Question 1: Are depression scores of widows who participate in a Life Management Skills Program reduced more than those who are non-participants in such a program?

Question 2: Are grief scores of widows who participate in a Life Management Skills Program reduced more than those who are non-participants in such a program?

Selecting the Population

The population of this study were widows predominantly from Shiawassee County, Michigan.

The population was divided into two groups (referred to as participants and non-participants). Both groups consisted of volunteers from an on-going county Widow to

Widow program that was meeting on a monthly basis.

The participant group consisted of nine widows who volunteered to participate in a weekly Life Management Skills Program for six consecutive weeks.

The non-participant group consisted of eighteen widows who volunteered to be part of the study.

The participant group consisted of nine participants yielding the demographic data shown in Appendix F.

The non-participant group consisted of eighteen participants with demographic data also displayed in Appendix F.

Demographic variables included: age, months widowed, income level, number of children, children at home, personal health, level of education, and intensity of religious belief.

There were certain uncontrolled variables that might have affected the grief and depression levels of the widows, including: the passage of time, participation in other social activities and other outside support systems.

There was no formal attempt made to control the impact of these variables.

Data Collection

All members of the participant and non-participant groups completed the Confidential Information Sheet, The Texas Revised Inventory of Grief and The Measurement of Depression scale at the onset of the program. The non-participant group was given these pieces with an accompanying letter of instructions at the monthly widow to widow

meeting and the participant group completed the forms at the first meeting.

At the end of the six weeks The Texas Revised Inventory of Grief and The Measurement of Depression scale were administered. The participant group completed the two scales at the last group meeting and the non-participant group were sent the scales in the mail with instructions for completing and returning them to the group leader.

Pre- and post- test scores for both tests on populations in the participant and non-participant groups were compiled and contrasted. The t-test was used for all tests of significance. The .05 level of significance was determined to be the level for rejection of the null hypothesis.

Description of the Instruments

The Confidential Information Sheet

A short questionnaire was designed to gather basic, demographic information regarding the subjects. This included: income, number and ages of children, age widowed, length of illness, living conditions, health, church affiliation, employment history, current problems and support systems (See Appendix A).

Summary tables of this information are included for both the participant and non-participant groups (See Appendix F).

The Measurement of Depression

This is a self-rating depression scale (SDS) developed

by William WLK. Zung, M.D. for the quantitative measurement of depression as an emotional disorder based upon the operational definition, "depression is a syndrome comprised of co-existing signs and symptoms which signify the presence of pathological disturbances or changes in four areas: somatic, psychological, psychomotor and mood."

The test contains twenty items each with a "depression" value of 1 to 4 with 1 indicating little or no depression and four indicating much depression. A respondent with a score of 20 displays no measurable amount of depression, while a respondent with a score of 80 displays a considerable amount of depression. The total score is scaled so that a score of 20 matches an SDS (Self-rating Depression Scale) Index of 25, while a score of 80 is associated with an SDS index of 100.

Individual item scores tell what specific sign or symptom the individual is manifesting, while aggregate scores of several items tell what area(s) the individual is having the most difficulty with.

The SDS is intended to rate depression as a disorder. However, it is not intended to differentiate the different types of depression. It serves rather to quantitatively measure the intensity of depression regardless of the diagnostic label used.

Certain safeguards are incorporated in the construction of this rating scale. An individual is unable to discern a trend in their answers because half of the statements are

worded symptomatically positively and half are worded symptomatically negative. Additionally, an even rather than an odd number of columns is used to offset any possibility of an individual checking middle colums in order to look average.

The SDS Index can be interpreted as follows:

Below 50	Within normal range, no psychopathology
50 - 59	Presence of minimal to mild depression
60 - 60	Presence of moderate to marked depression
70 7 over	Presence of severe to most extremely depressed

The above interpretations are based upon data which compares depressed versus non-depressed individuals, and depressed versus normal subjects in the 20 - 64 year old range. High scores are not in themselves diagnostic, but indicate the presence of symptoms which may be of clinical significance.

The SDS instrument, the Diagnostic Criteria for Depressive Disorders, and the Table for Converting Raw Scores to the SDS Index can be found in Appendixes B, C, and D respectively.

The Texas Revised Inventory of Grief

The Texas Revised Inventory of Grief, (1978) is a self report measure composed of three parts developed by Thomas Faschingbauer, Richard DeVaul, and Sidney Zisook.

The TRIG is a two scale Likert-type measure of grief

following bereavement. It was developed using factor analysis.

Demographic/Psychographic Data

The TRIG answer sheet begins by inquiring about the bereaved person (name, age, sex, race, education, and religion). Next is a series of questions about the deceased person's age, duration since they died, their relationship to the bereaved, how close that relationship was, and how suddenly and unexpectedly they died.

Part I consists of eight items which have a median correlation with their total score minus each particular item of +.67. The alpha coefficient of reliability is +.81.

Construct validity was assessed for Part I by hypothesizing that the deaths of persons active and important in the daily life affairs of the bereaved would produce greater levels of life disruption than those less actively involved.

These items all attempt to measure the amount of life disruption incurred consequent to bereavement. Completely true answers are scored 5, completely false items 1, and those between 4, 3, and 2.

Part II consists of thirteen items which have a median correlation with their total score minus each particular item of +.69. The alpha coefficient of reliability is +.86, and the split half reliability was .88. These items are also scored from 5 to 1 in the same direction as those in Part I. The total score here reflects the present level of unresolved grief.

These two parts contain a total of 21 items with a

"grief" value of 1 to 5 with 1 indicating little or no grief and 5 indicating much grief. A respondent with a score of 21 has no measurable grief, while a respondent with a score of 105 displays a considerable amount of grief.

Combining Parts I and II

In addition to measuring both past adjustments and present feelings, the TRIG appears to provide information regarding a person's progress through the various stages of grief by combining Parts I and II. It was hoped that two orthogonal measures of grief might function much as do the measure of barometric pressure and temperature in delineating seasonal weather changes.

Part III consists of five items, true and false, of related facts that might be important clinically. However, these items did not load highly enough to be included in Part I or II (See Appendix E).

Program Description

The Life Management Skills Program was a six week program that took place in one of the family rooms at the Knapp and Smith Funeral Home on a weekly basis from 7:00-9:00 P.M. weekly.

The program was content specific and product oriented. The technique used was a dialogue-interactive mode with every meeting having some "hands-on", substantive material to deal with. It was felt that the participants would be more comfortable if they could externalize the grief on some concrete issue.

This group was begun on March 29th and continued for six consecutive Monday evenings.

Following is a schedule of events for each session:

Session I

1. Consent Form
2. Confidential Data Sheet
3. Texas Revised Inventory of Grief
4. Depression Scale
5. Key Differences Between Grieving and Depression

In addition to completing the above instruments and forms the researcher gave a short lecture on, "The Normal Process of Grief". Then, each of the participants were invited to share whatever they felt comfortable with about their own particular loss.

Session II

1. Self Assessment Inventory
2. Living Your Loneliness
3. Check sheet for financial, legal, mental, physical, psychological, social and philosophical well being.
4. What Do I Value in Life?

A short lecture was presented on "Managing Our Loneliness" and also on "Values Development and Clarification" by the group leader. In each session the participants were free to ask questions and contribute in any way.

Session III

1. Time Diary
2. Record of Important Family Papers
3. Documents You Will Need to Handle Business Matters
4. Let's Talk About Money
5. The Money Manager

In this session the focus was on the good management of our time and financial resources. Each participant was given the assignment of keeping track of how they spent their time

and were asked to make out a budget of how they spent their money. In addition, the discussion covered the many documents that a widow would need to have in order to efficiently manage their legal and financial matters.

Session IV

1. Holmes-Rahe Stress Test
2. Personality and Disease Predisposition
3. Stress and the Family

This session was given entirely to stress management. The stress instrument was administered and a discussion followed. Next, we discussed the relationship between individual personalities and their predisposition to certain illnesses; more generally referred to as type A and type B personalities. Then several articles were distributed for home reading from the Family Living Series on Stress and the Family which was developed by the Michigan State University Cooperative Extension Service.

Session V

1. Decision Making
2. Nutrition
3. Exercise

Session V dealt with the ability and components of good decision making skills. Each participant was asked to share a decision she was trying to make at that time.

A short lecture was given on the value of good nutrition and exercise in order to feel more physically fit. Also, the effects of poor diet on depression. Participants shared the problems of cooking for one person and were asked to each bring a recipe for one that they especially enjoyed.

Session VI

1. General Goal Setting
2. Short Term Goal Setting
3. Long Range Goal Setting
4. Competency Assessment
5. Texas Revised Inventory of Grief
6. Depression Scale

This final session was given to setting personal goals for each individual and making a personal assessment of where they felt they were with their own life management skills. The two research instruments were given to all the participants.

Phone numbers were given for support systems if they felt they needed additional assistance. Only one of the group members kept in touch by telephone and that on an infrequent basis.

CHAPTER IV

RESULTS

Sample Descriptions

The purpose of this chapter is to give a detailed description of the samples and present the results of the statistical treatment of the data.

The population of this study were widows predominantly from Shiawassee County, Michigan. The population was divided into two groups referred to as participants and non-participants with nine and eighteen members respectively.

Participants

The sample of the participant group ranged in age from 31 to 64, with a mean age of 50.9 and a standard deviation of 14.3 years.

TABLE IX
AGE DISTRIBUTION OF PARTICIPANT AND NON-PARTICIPANT GROUPS

Age Range	Participant Frequency	Non-Participant Frequency
31-40	3	1
41-50	0	3
51-60	3	7
61-70	3	6
71-73	0	1
	$n = 9$ $\bar{x} = 50.9$ SD = 14.3	$n = 18$ $\bar{x} = 56.6$ SD = 10.2

The duration of widowhood among the subjects ranged from three months to four years and one month, with a mean duration of eighteen months and a standard deviation of sixteen months.

TABLE X
DURATION OF WIDOWHOOD OF THE PARTICIPANT AND NON-PARTICIPANT GROUPS

Number of Months Widowed	Participant Frequency	Non-Participant Frequency
1-12	4	5
13-24	2	7
25-36	2	1
37-60	1	2
61-84	0	2
85-101	0	1
	$n = 9$	$n = 18$
	$\bar{x} = 18.9$	$\bar{x} = 30.7$
	SD = 14.7	SD = 28.8

The educational level of the participants ranged from five completing high school to two completing two years of college. The mean years of education was 13.3 with a standard deviation of 1.7 years.

TABLE XI
EDUCATIONAL LEVEL OF THE PARTICIPANT AND NON-PARTICIPANT GROUPS

Years Completed	Participant Frequency	Non-Participant Frequency
8-11	0	5
12	5	10
13-17	4	2
	$n = 9$	$n = 17$*
	$\bar{x} = 13.3$	$\bar{x} = 11.5$
	SD = 1.7	SD = 2.1

*one non-participant did not respond

The mean monthly income of the participant group prior to the death of the spouse was $1,000 and following

the death $853, the range prior to the spouse's death was $600 to $1600 and 0 to $1667 after. Approximately fifty percent of the sample worked prior to and following the death. Table XII compares the current and marital incomes.

TABLE XII

MONTHLY INCOME BEFORE AND AFTER WIDOWHOOD OF PARTICIPANT AND NON-PARTICIPANT GROUPS

Monthly Income Range	Participant Frequency		Non-Participant Frequency	
	Before	After	Before	After
0-$500	0	2	2	6
600-1000	4	2	3	3
1100-1500	1	1	4	0
1600-2000	1	1	0	0
	n=6*	n=6	n=9	n=9**
	$\bar{x}$=$1000	$\bar{x}$=$853	$\bar{x}$=$854	$\bar{x}$=$470
	SD=$365	SD=$589	SD=$443	SD=$261
* 3 participants did not respond **9 non-participants did not respond				

The participant sample had a mean of 2.25 children with the range from 1 to 4. Only four of the subjects had children living at home after the death of the spouse.

TABLE XIII

NUMBER OF CHILDREN IN THE PARTICIPANT AND NON-PARTICIPANT GROUPS

Number of Children	Participant Frequency	Non-Participant Frequency
0-1	1	4
2-3	7	8
4-5	0	5
6-7	0	1
	n=8*	n=18
	$\bar{x}$=2¼	$\bar{x}$=2.9
	SD=1	SD=1.6
* one participant did not respond		

On a scale ranging from 1 to 6 measuring religious intensity (one being low intensity and six high intensity) the self-reported mean was 5. Of the sample only one was Catholic with the remainder being Protestant.

Participants reported their physical condition on a four point scale: poor, fair, good and excellent, the mean prior to and following the death was good to fair physical health. Appendix F.

Non-Participants

Analysis of the non-participant group yielded the following demographic details. The age range of this group was 33 to 71 years with the mean age 56.6 and the standard deviation 10.2 years.

The mean number of years widowed was 2 years and 6.7 months with the range of 0 (less than one year) to 8 years with a standard deviation of 28.8 months.

The non-participant range of education was 8 to 17 years with the mean level at 11½ years and a standard deviation of 2.1 years.

This group had a lower mean monthly income before and after the death than the participant group. Prior to widowhood the range was $69.00 to $1400 per month with a mean of $470 per month. The standard deviation was $443 and $261 respectively. Approximately one third of these widows worked before and after the death of their spouse. The issue of money appeared to be a very sensitive one.

Both the participant and non-participant groups were reluctant to report their financial condition.

The non-participant sample had a mean of 2.9 children with a range from 0 to 8 children and five of these had children currently living at home.

To the question of religious intensity the mean response of this group was 5.24 on a six point scale with a distribution between Catholic and Protestant being 12 and 6 respectively.

Responses regarding physical health for this group yielded a mean response of "good" prior to widowhood and "fair to good" following widowhood.

Individual scores and responses for each participant are recorded in Appendix F.

Research Questions

The data were collected and treated as outlined in Chapter III.

Two research questions were explored. The first related to changes in depression scores and the second related to changes in grief scores.

Question 1

Are depression scores of widows who participate in a Life Management Skills Program reduced more than those who are non-participants in such a program?

Question 1 was tested using change scores from the depression scale, The Measurement of Depression Scale (Zung, 1975).

All nine respondents in the participant group completed the pre and post depression inventories. The results are shown in Table XIV.

Seventeen respondents in the non-participant group completed the pre and post depression inventories (there was one non-usable pre-test). See Table XV for the results.

Question 2

Are grief scores of widows who participate in a Life Management Skills Program reduced more than those who are non-participants in such a program?

Question 2 was tested using change scores from the grief scale, The Texas Revised Inventory of Grief (Fasching-bauer, 1978).

Six respondents in the participant group completed pre and post grief inventories (there were two non-usable pre-tests and one non-usable post-test). The results are shown in Table XVI.

Sixteen respondents in the non-participant group completed the pre and post grief inventories (there were two non-usable pre and post-tests). The results are shown in Table XVII.

In every case the scores of persons were not used unless they completed both pre and post-tests on the individual instrument.

TABLE XIV

SELF RATING DEPRESSION SCALE
PARTICIPANT GROUP

POPULATION PARTICIPANT	PRE-TEST RAW SCORE	PRE-TEST SDS INDEX	POST-TEST RAW SCORE	POST-TEST SDS INDEX	DIFF.** (PRE-POST)
1	47	59	40	50	9
2	48	60	49	61	-1
3	45	56	40	50	6
4	44	55	45	56	-1
5	37	46	36	45	1
6	55	69	52	65	4
7	44	55	44	55	0
8	55	69	36	45	24
9	45	56	24	30	26

$n = 9$ $\bar{x}_1 = 58.33$ $\bar{x}_2 = 50.78$ $\bar{y}_1 = 7.56$

$s_1 = 7.21$ $s_2 = 10.32$ $s_{y_1} = 10.45$

**A positive value here indicates a lower score on the post-test than on the pre-test and represents a decline in depression. A negative value here indicates a larger score on the post-test than on the pre-test and represents an increase in depression. $\bar{y}_1$ indicates an average decline in depression of 7.56 S.D.S. units.

TABLE XV

SELF RATING DEPRESSION SCALE
NON-PARTICIPANT GROUP

NON-PARTICIPANT	PRE-TEST RAW SCORE	PRE-TEST SDS INDEX	POST-TEST RAW SCORE	POST-TEST SDS INDEX	DIFF.** (PRE-POST)
1	32	40	32	40	0
2	34	43	26	33	10
3	48	60	43	54	6
4	48	60	38	48	12
5	36	45	28	35	10
6	26	33	35	44	-11
7	42	53	37	46	7
8	48	60	31	39	21
9	28	35	41	51	-16
10	26	33	27	34	-1
11	38	48	45	56	-8
12	33	41	28	35	6
13	40	50	48	60	-10
14	30	38	37	46	-8
15	32	40	39	49	-9
16	41	51	40	50	1
17	29	36	33	41	-5

$n = 17 \quad \bar{x}_3 = 45.05 \quad \bar{x}_4 = 44.76 \quad \bar{y}_2 = .29$

$s_3 = 9.43 \quad s_4 = 8.13 \quad s_{y_2} = 10.05$

*FORMULA: $\text{Index} = \frac{\text{Raw Score Total}}{\text{Max.Score of 80}} \times 100 = \text{Self-Reporting Depression Scale Index}$

**A positive value here indicates a lower score on the post-test than on the pre-test and represents a decline in depression. A negative value here indicates a larger score on the post-test than on the pre-test and represents an increase in depression. $\bar{y}_2$ indicates an average decline in depression of .29 S.D.S. units.

TABLE XVI

PARTICIPANT GROUP
PRE AND POST TEST GRIEF SCORES

POPULATION PARTICIPANT	PRE-TEST			POST-TEST		
	PART I	PART II	PART III	PART I	PART II	PART III
1	26	44	1	26	43	1
2	16	51	2	21	48	3
3	31	56	3	34	50	5
4	24	45	1	23	42	1
5	25	47	2	36	49	2
6	32	23	2	32	23	2

PART I = Amount of life disruption incurred consequent to bereavement. 5 = completely true; 1 = completely false.
PART II = Present level of unresolved grief.
PART III = Related Clinical Facts, T = 1, F = 1.

PRE-TEST		POST-TEST	
PARTICIPANT	TOTAL SCORE	TOTAL SCORE	DIFFERENCE
1	70	69	1
2	67	69	-2
3	87	84	3
4	69	65	4
5	72	75	-3
6	55	55	0

$\bar{x}_1 = 70.00$ $\bar{x}_2 = 69.50$ $\bar{y}_1 = .5$

$s_1 = 10.28$ $s_2 = 9.71$ $s_{y_1} = 2.74$

$n = 6$ $n = 6$ $n = 6$

**A positive value here indicates a lower score on the post-test than on the pre-test and represents a decline in grief. A negative score here indicates a higher score on the post-test than on the pre-test and represents an increase in grief. $\bar{y}_1$ indicates an average decline in grief of .5 units.

TABLE XVII

NON-PARTICIPANT GROUP
PRE AND POST TEST GRIEF SCORES

POPULATION PARTICIPANT	PRE-TEST			POST-TEST		
	PART I	PART II	PART III	PART I	PART II	PART III
1	18	30	3	17	34	2
2	24	24	1	20	25	3
3	22	44	1	24	41	3
4	26	47	1	19	42	1
5	24	37	1	29	33	3
6	22	35	2	23	44	3
7	24	46	3	23	40	2
8	16	38	2	13	25	3
9	21	27	3	18	26	3
10	15	43	3	13	41	3
11	24	57	1	17	58	1
12	29	35	3	23	30	3
13	17	30	1	23	32	1
14	21	48	1	23	49	1
15	17	33	3	12	39	1
16	13	43	1	13	37	1

PRE-TEST		POST-TEST	
PARTICIPANT	TOTAL SCORE	TOTAL SCORE	DIFFERENCE*
1	48	51	-3
2	48	45	3
3	66	65	1
4	73	61	13
5	61	62	-1
6	57	67	-10
7	70	63	7
8	54	38	16
9	48	44	4
10	58	54	4
11	81	75	6
12	64	53	11
13	47	55	-8
14	69	72	-3
15	50	51	-1
16	56	50	6

$n = 16$ $\quad \bar{x}_3 = 59.38$ $\quad \bar{x}_4 = 56.63$ $\quad \bar{y}_2 = 2.75$

$s_3 = 10.34$ $\quad s_4 = 10.37$ $\quad s_{y_2} = 7.06$

*A positive value here indicates a lower score on the post-test than on the pre-test and represents a decline in grief. A negative value here indicates a higher score on the post-test than on the pre-test and represents an increase in grief. $\bar{y}_2$ indicates an average decline in grief of 2.75 units.

Treatment of Data

The t-test was used for all tests of significance. This test is especially designed for small sample sizes and was appropriate for this study.

The following tests of significance were run:

1. Non-participant group pre-test vs. non-participant group post-test scores on
    a. depression
    b. grief
2. Participant group pre-test vs. participant group post-test scores on
    a. depression
    b. grief
3. Non-participant group vs. participant group pre and post-test scores on
    a. depression
    b. grief

Depression Scale Results

When comparing the pre and post-test scores of the participant group on the depression scale, the results indicated a significant difference (α =.05) between the pre-test and post-test reporting of depression in the participant group. See Table XIV.

When comparing the pre and post-test scores of the non-participant group on the depression scale, the results were not significant at the .05 level. See Table XV.

When testing the differences in decline of depression between the participant and non-participant groups, the difference was significant at the .05 level.

Therefore it can be stated that the participants in the six weeks Life Management Skills Program for widows did have a decrease in depression.

TABLE XVIII

SELF RATING DEPRESSION SCALE (SDS)

Participant Group	Non-Participant Group	
$n = 9$	$n = 17$	
$\bar{x}_1 = 58.33$	$\bar{x}_3 = 45.05$	Average Pre-Test Score
$(s_1 = 7.21)$	$(s_3 = 9.43)$	
$\bar{x}_2 = 50.78$	$\bar{x}_4 = 44.76$	Average Post-Test Score
$(s_2 = 10.32$	$(s_4 = 8.13)$	
$\bar{y}_1 = 7.56$	$\bar{y}_2 = .29$	Average Diff. Between Pre-Test & Post-Test Scores
$(s_{y_1} = 10.45)$	$(s_{y_2} = 10.05)$	

Grief Scale Results

The results comparing the participants pre- and post-test scores on the grief inventory were not significant at the .05 level. Thus, the treatment program was not effective in reducing the level of grief. See Table XVI.

When comparing the non-participants pre- and post-test scores on the grief inventory there was no significant difference at the .05 level. See Table XVII.

T-tests run on the comparative grief scores of the participants and non-participants demonstrated no

significant differences in the decline of grief between the participants and non-participants.

TABLE XIX

TEXAS INVENTORY OF GRIEF

Participant Group	Non-Participant Group	
$n = 6$	$n = 16$	
$\bar{x}_1 = 70.00$	$\bar{x}_3 = 59.38$	Average Pre-Test Score
$(s_1 = 10.28)$	$(s_3 = 10.34)$	
$\bar{x}_2 = 69.50$	$\bar{x}_4 = 56.63$	Average Post-Test Score
$(s_2 = 9.71)$	$(s_4 = 10.37)$	
$\bar{y}_1 = .5$	$\bar{y}_2 = 2.75$	Average Diff. Between Pre- and Post-Test Scores
$(s_{y_1} = 2.74)$	$(s_{y_2} = 7.06)$	

Therefore it can be concluded that the treatment program was not effective in reducing the levels of grief.

To summarize, the following table of tests of significance was constructed.

TABLE XX

TESTS OF SIGNIFICANCE

	Depression	Grief
Non-participant pre-test average vs. Non-participant post-test average	Test not significant at .05 level	Test not significant at .05 level
Participant pre-test average vs. Participant post-test average	Significant at .05 level	Test not significant at .05 level
Non-participant vs. Participant	Significant at .05 level	Test not significant at .05 level

It appears that without any deliberate attempt to deal with depression and grief in the non-participant group, there was no significant changes in the levels of these two factors during the six weeks period of testing.

However, the test results demonstrate that within the participant group involved in the six weeks Life Management Skills Program, there was no significant decline in grief, but a significant decline in depression at the .05 level.

Therefore, it can be concluded that participants in the Life Management Skills Program for widows did show a decrease in depression.

CHAPTER V

DISCUSSION

Summary

The primary purpose of this study was to test the effects of a Life Management Skills Program of systematic intervention on the levels of depression and grief in widows.

This was an exploratory study to determine if a full scale study was warranted.

The approach of the investigation involved administering pre and post-test self-reporting depression and grief instruments to all the persons involved in the study.

The population of this study were volunteers who were widows, predominantly from Shiawassee County, Michigan. The population was divided into groups of their choosing referred to as participants and non-participants. There were nine and eighteen widows in each group respectively. The non-participants did not receive any specialized treatment.

The instruments that were used in the study were The Texas Revised Inventory of Grief and The Measurement of Depression scale. In addition, all of the population filled out the Confidential Information Sheet.

To achieve the purpose of the study, two research questions were formulated:

The results indicated that the participant group began with significantly higher depression and grief levels than the non-participant group, but that the participant group made larger gains in recovering from depression. Although it is true that the two groups started at different places with respect to both depression and grief, the tests of significance still validate that the participant group made the greatest positive change with respect to depression. Tables XIV, XV, and XVIII.

One additional observation was explored in relation to the stability in the level of grief in the participant and non-participant groups as measured by the grief inventory.

The change in grief for the participant group ($\bar{y}_1$ = .5; s_{y_1} = 2.74) does appear to be less than the change in grief for the non-participant group ($\bar{y}_2$ = 2.75; s_{y_2} = 7.06). ($\bar{y}_2$ and $\bar{y}_1$ represent average changes in grief). It appears that the non-participant group experienced a larger change in grief than the participant group. This would lead one to suspect that the grief of the participant group was more stable than that of the non-participant group. In testing the difference in variation (variance) between the change in grief of the non-participant group and the change of the participant group, the results indicated that the non-participants group experienced significantly (α = .05) more variation in grief than the participant group. This

Question 1: Are depression scores of widows who participated in a Life Management Skills Program reduced more than those who are non-participants in such a program?

Question 2: Are grief scores of widows who participated in a Life Management Skills Program reduced more than those who are non-participants in such a program?

The statistical technique used for all tests of significance was the t-test. The findings of the investigation were presented statistically in Chapter IV.

Findings

In testing Question 1, it was found that there was a significant difference in the decline of depression in the participant group at the α .05 level when comparing the pre and post-test scores of the participant and non-participant groups.

The results of testing Question 2 showed that there was no significant change in the level of grief when comparing the pre and post-test grief scores of the participant and non-participant groups.

Other Findings

The data were exploited for information other than that directly related to the research questions.

T-tests were run on the sample means of the participant group pre-tests compared to the sample means of the non-participant group pre-tests to determine if the two groups started at different grief and depression levels.

would lead one to conclude that the grief of the participant group was more stable than the grief of the non-participant group.

Conclusions

On the basis of the findings of this study the following conclusions can be drawn:

A Life Management Skills Program of systematic intervention for recent widows does not have a reduction effect on the grief level of the widow involved. However, the grief of the participant group remained more stable than that of the non-participant group. This appears to imply that the effect of a support group kept the participants from the radical fluctuations in their grief levels. The fact that the program did not reduce grief also seems to confirm the classical research of Freud (1917) when he stated in his famous article, "Mourning and Melancholia",

> "Although grief involves grave departures from the normal attitude to life, it never occurs to us to regard it as a morbid condition and hand the mourner over to medical treatment. We rest assured that after a lapse of time it will be overcome, and we look upon any interference with it as inadvisable or even harmful."

He further stated that grief is not a disease to be healed, but a process to be experienced.

An additional observation can be made that if the person has an understanding of the "normal" parameters of this experience, it will make the process less painful.

The second major conclusion drawn is that a Life

Management Skills Program of systematic intervention was effective in reducing the levels of depression for participants in such a program.

Delimitations

The sample allowed for certain uncontrolled variables that may have had some effect on the outcomes including: the passage of time, participation in other social activities and the impact of other family and community support systems. Two additional limitations may have been the small number of subjects and the length of the program period.

There is also the possibility that the effect of simply being in a group in a therapeutic environment with others who face a similar painful life situation had as much to do with their decrease in depression as did the content of the Life Management Skills Program. This type of positive group effect is validated in the research findings of Sidel, Silverman, and Barrett as described in Chapter II.

More specifically the results can be applied to widows living in Shiawassee County, between the ages of 31 and 73, who participated in a six weeks Life Management Skills Program, with the outcomes reported on the selected tests of measurement.

Implications for Further Research

The suggestions for future research closely parallel the limitations of this study. There is a clear need to

repeat this program with a larger population. The sample should be randomized and the program expanded for a longer period of time than six weeks. A statistical analysis should also be done to determine a carefully controlled study with matched pairs and more elaborate statistical procedures.

Additional variables to be given specific attention would be the impact of educational level, income, age, number of children, social class and length of widowhood on the levels of depression.

A similar study should also be conducted on widowers.

It would be appropriate for these groups to be offered in a variety of community agencies including mental health centers, churches, colleges and universities and funeral homes.

The researcher suggests that additional Life Management Skills Programs make no overt attempt to address grief but rather only assess the pre-post levels of this process.

The results of this study give strong support that the program of intervention is worthwhile, and that widows who are competent in managing their lives have less depression when they lose their spouse. A feeling of mastery of these skills may then lead to an attitudinal change that may generalize to other areas of their lives.

The findings of this study warrant a full scale study. This statistical analysis gives a guide for a

future, controlled study.

An additional task is the structuring of the training procedure so it could be replicated by others.

APPENDICES

APPENDIX A

THE CONFIDENTIAL INFORMATION SHEET

APPENDIX A

INFORMATION SHEET

CONFIDENTIAL

All information which you fill in is strictly confidential.

NAME _____ AGE _____

ADDRESS _____ TELEPHONE _____

1. How long have you been widowed: _____ years _____ months.

2. At at which you were widowed _____. Race _____.

3. Length of illness of spouse _____. Cause of death _____.

4. Number of children _____ Ages _____ Children at home _____

5. Do you live alone _____ With someone _____ With whom _____

6. Highest grade completed ___1-12 grades ___ 2 yrs. college ___ B.A. Degree
___ M.A. Degree ___ Ph.D./M.D. Degree
___ Other: specify

7. What was the state of your health prior to the death of your spouse:
_____ Excellent _____ Good _____ Fair _____ Poor

8. What is the state of your health now?
_____ Excellent _____ Good _____ Fair _____ Poor

9. Family, monthly income before widowed _____. After widowed _____.

10. Previously employed _____ Currently employed _____ Hours per week ____.
Occupation _____

11. Religious Affiliation _____ How important is religion in your life?
Not at all _____ Extremely
1 2 3 4 5 6

12. What are your most pressing problems/concerns?

13. What other major life stresses have occured during the last year?

14. From what person, group or organization do you receive the most emotional support?

Joyce A. Thomas, Director
KNAPP AND SMITH FUNERAL HOMES
Bereavement Outreach Program

APPENDIX B

THE MEASUREMENT OF DEPRESSION

APPENDIX B

THE MEASUREMENT OF DEPRESSION

Self-rating Depression Scale

Name_____

Age____Sex_____Date_____

	None OR a little of the Time	Some of the Time	Good Part of the Time	Most Or All of the Time
1. I feel down-hearted, blue and sad				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping through the night				
5. I eat as much as I used to				
6. I enjoy looking at, talking to and being with attractive women/men				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to do				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

APPENDIX C

DIAGNOSTIC CRITERIA FOR DEPRESSIVE DISORDERS AND RELATION TO SDS ITEMS

APPENDIX C

DIAGNOSTIC CRITERIA FOR DEPRESSIVE DISORDERS & RELATION TO SDS ITEMS

The SDS statements in Table 2 are not in the same order as in the Scale, but are listed opposite correspondong symptoms of depression organized into: I. pervasive affective, II. physiological, III. psychomotor and IV. psychological disturbances.

Words in the items appearing in italics are the reverse of what patients complain of. As stated earlier, these words have been converted from symptomatically positive to symptomatically negative to prevent the patient from discerning the pattern of his answers.

TABLE 2

Symptoms of Depressive Disorder	SDS ITEMS	ITEM NUMBER
I. PERVASIVE AFFECTIVE DISTURBANCE		
1. Depressed, sad, down-hearted, low, and blue	I feel down-hearted, blue and sad	(1)
2. Tearful	I have crying spells, or feel like it	(3)
II. PHYSIOLOGICAL DISTURBANCES		
1. Diurnal variation: exaggeration of symptoms in the AM and some relief as the day goes on	Morning is when I feel the best	(2)
2. Sleep: characteristically early or frequent waking	I have trouble sleeping through the night	(4)
3. Appetite: decreased food intake	I eat as much as I used to	(5)
4. Weight loss: associated with decreased food intake, or increased metabolism and decreased rest	I notice that I am losing weight	(7)
5. Sex: decreased libido	I enjoy looking at, talking to, and being with attractive women/men	(6)
6. Gastrointestinal: constipation	I have trouble with constipation	(8)
7. Cardiovascular: tachycardia	My heart beats faster than usual	(9)
8. Musculoskeletal: increased and unexplainable fatigue	I get tired for no reason	(10)
III. PSYCHOMOTOR DISTURBANCES		
1. Agitation	I am restless and can't keep still	(13)
2. Retardation	I find it easy to do the things I used to	(12)
IV. PSYCHOLOGICAL DISTURBANCES		
1. Confusion	My mind is as clear as it used to be	(11)
2. Emptiness	My life is pretty full	(18)
3. Hopelessness	I feel hopeful about the future	(14)
4. Indecisiveness	I find it easy to make decisions	(16)
5. Irritability	I am more irritable than usual	(15)
6. Dissatisfaction	I still enjoy the things I used to	(20)
7. Personal devaluation	I feel that I am useful and needed	(17)
8. Suicidal rumination	I feel that others would be better off if I were dead	(19)

APPENDIX D

CONVERSION OF RAW SCORES TO THE SDS INDEX

APPENDIX D

Conversion of Raw Scores to the SDS Index

$$\left(\text{Index} = \frac{\text{Raw Score Total}}{\text{Maximum Score of 80}} \times 100\right)$$

Raw Score	SDS Score	Raw Score	SDS Score	Raw Score	SDS Score
20	25	40	50	60	75
21	26	41	51	61	76
22	28	42	53	62	78
23	29	43	54	63	79
24	30	44	55	64	80
25	31	45	56	65	81
26	33	46	58	66	83
27	34	47	59	67	84
28	35	48	60	68	85
29	36	49	61	69	86
30	38	50	63	70	88
31	39	51	64	71	89
32	40	52	65	72	90
33	41	53	66	73	91
34	43	54	68	74	92
35	44	55	69	75	94
36	45	56	70	76	95
37	46	57	71	77	96
38	48	58	73	78	98
39	49	59	74	79	99

APPENDIX E

TEXAS REVISED

INVENTORY OF GRIEF

APPENDIX E

TEXAS REVISED INVENTORY OF GRIEF

Name or #: _____ Age: ____ Sex: ____ Race: ____ White ____ Black ____ Lat. Am. ____ Oriental

Circle Last Year of Formal School Completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 or more ____ Other

Religion: ____ Protestant ____ Catholic ____ Jewish ____ Other (List)

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

___ Son ___ Daughter ___ Friend ___ Other (List)

LOOKING BACK I WOULD GUESS THAT MY RELATIONSHIP WITH THIS PERSON WAS (check only one):

____ Closer than any relationship I've ever had before or since.

____ Closer than most relationships I've had with other people.

____ About as close as most of my relationships with others.

____ Not as close as most of my relationships.

____ Not very close at all.

PLEASE COMPLETE A SEPARATE FORM FOR EACH PERSON WHO DIED.

HOW OLD WAS THIS PERSON WHEN THEY DIED? _____

THIS PERSON DIED (check only one):

___ Within the past 3 months ___ 6-9 months ago ___ 1-2 years ago ___ 5-10 years ago ___ More than 20 years ago

___ 3-6 months ago ___ 9-12 months ago ___ 2-5 years ago ___ 10-20 years ago

THIS PERSON'S DEATH WAS: ___ Expected ___ Unexpected ___ Slow ___ Sudden

PART I: PAST BEHAVIOR

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

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

PART II: PRESENT FEELINGS

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

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

PART III: RELATED FACTS

Now please answer the following items by circling either True or False.

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

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

APPENDIX F

COMPOSITE OF STATISTICAL AND DEMOGRAPHIC PROFILE DATA

APPENDIX F

COMPOSITE OF STATISTICAL AND DEMOGRAPHIC PROFILE DATA

	Person Identity	Age Widowed	Age Tested	Months Widowed	Months Ill	Health Before	Health After	Number of Children	Children at Home	Living Alone ?	Years of Education	Income Before	Income After	Employment History	Religious Intensity	Depression SDS Before	Depression SDS After	Depression Difference	Grief Before	Grief After	Grief Difference	Depression Raw Before	Depression Raw After	Part 1 Pre Grief	Part 1 Post Grief	Part 2 Pre Grief	Part 2 Post Grief	Part 3 Pre Grief	Part 3 Post Grief	
PARTICIPANTS	P1	33	35	29	0	E	G/F	3	3	NO	14	900	1200	P/	P/5	59	50	9	70	69	1	47	40	26	26	44	43	1	1	
	P2	31	32	11	36	P/M	G	2	2	NO	14	600	850	P/C	P/5	55	55	0	72	75	-3	44	44	25	26	47	49	2	2	
	P3	61	63	31	3	E	E	3	0	YES	12	-	-	P/	/6	46	45	1	69	65	4	37	36	24	23	45	42	1	1	
	P4	57	58	14	-	F	F	1	1	NO	12	1600	0	/	P/6	55	56	-1	87	84	3	44	45	31	34	56	50	3	5	
	P5	32	32	7	0	G	G	2	2	NO	16	900	1000	P/C	P/6	56	30	26	55	55	0	45	24	32	32	23	23	2	2	
	P6	60	60	3		F	F	3	0	YES	12	-	-	P/	P/6	56	50	6	67	69	-2	45	40	16	21	51	48	2	3	
	P7	64	65	9	0	G	F	0	0	YES	12	-	-	.	C/6	60	61	-1	-	-	-	48	49			-	-			
	P8	59	63	49	48	F	G	2	0	YES	16	1250	1667	/C	P/6	69	65	4	-	-	-	55	52	-	-	-	-		-	
	P9	61	63	17	36	G	G	3	0	YES	12	750	400	/C	/5	69	45	24	-	-	-	55	36		-				-	
	-	50.89	52.33	18.88	17.57	G/F	G/F	2 1	89	-	13.33	1000	852.83	-	5.67	58.33	50.78	7.56	70.00	69.50	50	46.66	40.66	25.67	27.00	51.41	42.50	1.83	2.33	<--=MEAN
	-	14.29	14.66	14.73	21.38	-	-	1.05	1.17		1.73	364.70	589.50	-	-	7.21	10.32	10.45	10.28	9.71	2.74	5.63	8.29	5.75	5.06	11.34	10.09	0.752	1.50	< =SSD
NON PARTICIPANTS	N1	44	45	15	12	E	E	2	0	YES	12	1200	500	/C	P/6	40	40	0	48	51	-3	32	32	18	17	30	34	3	2	
	N2	66	66	1	1	P	P	1	0	YES	10	-	-	/	P/6	60	39	21	54	38	16	48	31	16	13	38	25	2	3	
	N3	62	66	51	0	E	F	5	1	NO	8	LOW	MORE	P/C	C/6	53	46	7	70	63	7	42	37	24	23	46	40	3	2	
	N4	55	57	21	84	F	G	1	0	YES	12	700	175	/	P/6	33	44	-11	57	67	-10	26	35	22	23	35	44	2	3	
	N5	33	35	22	5	G	G	3	3	NO	12	1400	900	P/	P/5	45	35	10	61	62	-1	36	28	24	29	37	33	1	3	
	N6	46	48	21	48	G	G	3	0	YES	12	-	-	/C	C/6	60	48	12	73	61	12	48	38	26	19	47	42	1	1	
	N7	51	52	12	16	G	G	1	0	YES	12	900	400	/C	P/6	60	54	6	66	65	1	48	43	22	24	44	41	1	3	
	N8	65	72	84	MNY	E	E	0	0	YES	16	-	800	P/	P/6	35	51	-16	48	44	4	28	41	21	18	27	26	3	3	
	N9	58	59	19	2	P	P	4	0	YES	10	800	400	P/C	C/6	48	56	-8	81	75	6	38	45	24	17	57	58	1	1	
	N10	67	68	10	2	G	G	3	0	YES	10	68 5	193	/	C/6	33	34	-1	58	54	4	26	27	15	13	43	41	3	3	
	N11	52	53	20	12	-	F	2	2	NO	12	-	-	P/	P/6	38	46	-8	47	55	-8	30	37	17	23	30	32	1	1	
	N12	69	73	48	60	F	P	2	0	YES	8	292	250	/	P/5	50	60	-10	64	53	11	40	48	29	23	35	30	3	3	
	N13	48	50	21	3.5	G	G	6	3	NO	12	-	-	/	C/6	36	41	-5	56	50	6	29	33	13	13	43	37	1	1	
	N14	53	59	72	120	E	F	3	0	YES	12	-	-	/C	P/5	51	50	1	50	51	-1	41	40	17	12	33	39	3	1	
	N15	53	61	101	24	G	G	4	0	YES	12	1158	400	-	P/1	43	33	10	48	45	3	34	26	24	20	24	25	1	3	
	N16	65	65	8	72	G	F	4	2	NO	13	1167	815	P/	P/1	41	35	6	-	-	-	33	28	-	-	-	-	-	-	
	N17	59	62	26	0	G	G	3	0	YES	12	-	-	P/C	P/6	40	49	-9	-	-	-	32	39	-	-		-	-	-	
	N18	73	73	1	MNY	F	F	5	0	YES	12	OK	OK	/	P/1	-	-		69	72	-3	-	-	21	23	48	49	1	1	
	-	56.61	59.11	30.72	28.56	G	G/F	2.89	61	-	11.50	853.94	483.30	-		45.05	44.76	29	59.38	56.63	2.75	35.94	35.76	20.81	19.37	38.56	37.25	1.88	2.12	<--=MEAN
	-	10.23	10.43	28.84	37.09		-	1.60	1.09	-	1.82	442.98	266.42	-	-	9.43	8.13	10.05	10.34	10.37	7.06	7.53	6.56	4.42	4.96	8.85	8.99	96	96	< =SSD

M=Mental
P=Poor
F=Fair
G=Good
E=Excellent

P=Previous
C=Current

C=Catholic
P=Protestant
1=Low Intensity
6 =High Intensity

Sample Standard Deviation =SSD

BIBLIOGRAPHY

BIBLIOGRAPHY

Bachman, C.C. Ministering to the Grief Sufferer. Englewood Cliffs, New Jersey: Prentice Hall, 1964.

Barrett, Carol J. "A Comparison of Therapeutic Intervention for Widows." Paper presented at the 26th Annual Meeting of the Gerontological Society, Miama Beach, Florida, 1973. Abstract published in the Gerontologist 13 (1973):66.

_____. The Development and Evaluation of Three Therapeutic Group Interventions for Widows. Ph.D. thesis, University of Southern California, 1974.

_____. Strategies for Preventing the Stresses of Widowhood. Paper presented at the Southwestern Psychological Association Annual meeting, New Orleans, Louisiana, 1978.

_____. "Women in Widowhood." Signs: Journal of Women in Culture and Society 2 (1977):856-68.

Bellin S.S. and Hardt, R.H. "Marital Status and Mental Disorders Among the Aged." American Sociological Review 28 (1958):155-62.

Berardo, Felix M. "Social Adaptation to Widowhood Among a Rural-Urban Aged Population." Washington State Bulletin 689 (December 1967):1-31.

Bernard, J. Remarriage: A Study of Marriage. New York: Dryden Press, 1956.

Birtchnell, J. "Depression in Relation to Early and Recent Parent Death." British Journal of Psychiatry 116 (1970):299-306.

Bonnard, A. "Truancy and Pilfering Associated with Bereavement." Adolescents: Psychoanalytic Approach to Problems and Therapy. New York: Harper Brothers, 1961.

Bornstein, Phillipp E. "The Depression of Widowhood after Thirteen Months." British Journal of Psychiatry 122 (May 1973):561-6.

Bowlby, J. "Processes of Mourning." International Journal of Psychoanalysis 42 (1961):317.

Brown, F. "Childhood Bereavement and Subsequent Psychiatric Disorder." British Journal of Psychiatry 112 (1966): 1035-42.

Bunch, J. "Recent Bereavement in Relation to Suicide." Journal of Psychomatic Research 16 (1972):361-5.

Bureau of the Census. 1970. U.S. Census of Population Washington, D.C.: Government Printing Office.

Caplan, G. Principles of Preventive Psychiatry. New York: Basic Books, 1964.

Carter, H. and Glick, P.C. Marriage and Divorce: A Social and Economic Study. Cambridge, Massachusetts: Harvard University Press, 1970.

Chevan, A. "The Widowed Who Live Alone: An Examination of Social and Demographic Factors." Social Forces 51 (1972):45-53.

Clayton, Paul. "The Bereavement of the Widowed." Diseases of the Nervous System 32 (September 1971):597-604.

_____. "Depression of Widowhood." British Journal of Psychiatry 120 (January 1972):71-7.

Cosneck, B.J. A Study of the Social Problems of Aged Widowed Persons in an Urban Area. Ph.D. thesis, Florida University, 1966.

Cox, P. and Ford, J.R. "The Mortality of Widows Shortly After Widowhood." Lancet (1964):163-4.

Decker, B. and Kooiman, G. After the Flowers Have Gone. Grand Rapids, Michigan: Zondervan, 1973.

Durkheim, Emile. "Suicide: A Study in Sociology." The Free Press Glencoe, Illinois: 1951.

Egelson, J. and Egelson, J. Parents Without Partners: A Guide for Divorced, Widowed or Separated Parents. New York: Dutton, 1961.

Epstein, Gerald; Weitz, Lawrence; and Roback, Howard. "Research on Bereavement." Comprehensive Psychiatry 16 (November/December 1975):537-46.

Faschingbauer, T.R. "Development of the Texas Inventory of Grief." American Journal of Psychiatry 134 (June 1977):696-8.

Faschingbauer, Thomas; DeVaul, Richard; and Zisook, Sidney. Texas Revised Inventory of Grief, 1978.

Freese, A.S. Help Your Grief: Turning Emotional Loss Into Growth. New York: Shocken Books Inc., 1977.

Gleuck, S. and Gleuck, I. 500 Delinquent Boys Unravelling Juvenile Delinquency. New York: The Commonwealth Fund, 1950.

Glick, Ira O. The First Year of Bereavement. New York: John Wiley and Sons, 1974.

Glick, I.O.; Weiss, R.S.; and Parkes, C.M. The First Year of Bereavement. New York: John Wiley and Sons, 1974.

Golan, Naomi. "Wife to Widow to Woman." Social Work 20 (September 1975):369-74.

Greer, S. "Study in Parental Loss in Neurotics and Sociopaths." Archives of General Psychiatry Volume 11 (1964):177-80.

Gregory, Ian. "Anteretrospective Data Following Childhood Loss of a Parent." Archives of General Psychiatry Volume 13 (1965):110-20.

Hurvitz, N. "Peer Self-Help Psychotherapy Groups and Their Implications for Psychotherapy." Psychotherapy: Theory, Research and Practice 7 (1970):41-9.

Huston, P.E. "Neglected Approach to Cause and Treatment of Psychotic Depression." Archives of General Psychiatry 24 (1971):505-8.

Jackson, Edgar N. Understanding Grief. Nashville, Tennessee: Abingdon Press, 1957.

Kraus, Arthur S. "Some Epidemiologic Aspects of the High Mortality Rate in the Young Widowed Group." Journal of Chronic Diseases 10 (September 1959):201-17.

Lazare, A. Treatment of Delayed Grief. Tape of Harvard University speech, 6 November 1976.

Lindemann, E. "Symptomatology and Management of Acute Grief." American Journal of Psychiatry 101 (1944):141.

Loewinsohn, R.J. Directory of Services for the Widowed in the United States and Canada. Washington, D.C.: Action for Independent Maturity, N.R.T.A.-A.A.R.P., 1977.

Lopata, Helena Z. "Living Arrangements of American Urban Widows." Sociological Focus 5 (1971):41-61.

_____. "Living Through Widowhood." Psychology Today 7 (July 1973):87-92.

_____. "Loneliness: Forms and Components." Social Problems 17 (1969):248-61.

_____. Occupation: Housewife. New York: Oxford University Press, 1971.

_____. "On Widowhood, Grief Work and Identity Reconstruction." Journal of Geriatric Psychiatry 8 (1970): 29-40.

_____. "The Social Involvement of American Widows." American Behavioral Scientist 14 (1970):41-58.

_____. "Social Relations of Widows in Urbanizing Societies." Sociological Quarterly 13 (1972):259-71.

_____. Widowhood in an American City. Morristown, New Jersey: General Learning Corporation, 1972.

_____. "Widows as a Minority Group." Gerontologist 11 (Supplement) (1971):67-77.

Lowenthal, M.F. and Haven, C. "Interaction and Adaptation: Intimacy as a Critical Variable." American Sociological Review 33 (1968):20-30.

Maddison, A.V. "The Health of Widows in the Year Following Bereavement." Journal of Psychosomatic Research 12 (December 1968):297-306.

Marris, Peter. Widows and Their Families. London: Routledge and Degan Paul, 1958.

Mavis, Ronald W. Social Forces in Urban Suicide. Homewood, Illinois: Dorsey Press, 1969.

Metropolitan Life Insurance Company. Widows in the United States. Statistical Bulletin 58 (September 1977):8-10.

Newman, G. and Denman, S. "Felony and Paternal Deprivation: A Socio-Psychiatric View." International Journal of Social Psychiatry Volume XVIII, No. 1 (1971):65-71.

Nuckols, R.C. Widows Study. Abstracted in the Journal Supplement Abstract Service, Catalog of Selected Documents in Psychology 3 (1973):9.

Palmore, E.B.; Stanley, G.L.; and Cormier, R.H. Widows With Children Under Social Security, the 1963 national survey of widows with children under OASDHI. Washington, D.C.: Department of Health, Education, and Welfare, Social Security Administration, Research Report #16, 1963.

Parkes, Colin M. Bereavement. New York: International Universities Press, 1972.

_____. "Determinants of Outcome Following Bereavement." Omega 6 (1975):303-23.

_____. "Effects of Bereavement on Physical and Mental Health: A Study of the Medical Records of Widows." British Medical Journal 2 (1964):274-9.

_____. "First Year of Bereavement: A Longitudinal Study of London Widows to the Death of Their Husbands." Psychiatry 23 (November 1970):444-67.

_____. "Health After Bereavement: A Controlled Study of Young Boston Widows and Widowers." Psychosomatic Medicine 34 (September 1974):449-61.

_____. "Psycho-Social Transitions: Comparisons Between Reactions to Loss of a Limb and Loss of a Spouse." British Journal of Psychiatry 127 (September 1975): 204-10.

Peterson, Karen J. Normal and Pathological Grief. B.A. thesis, Indiana University, 1978.

Rees, W.D. and Lutkins, S.G. "Mortality of Bereavement." British Medical Journal 4 (1967):13-7.

Ross, Elizabeth Kubler-. On Death and Dying. New York: Macmillan, 1969.

Rushing, William A. "Individual Behavior and Suicide" in Jack P. Gibbs (editor) Suicide New York: Harper and Row, 1968.

Sainsbury, Peter. Suicide in London. London: Basic Books, 1955.

Segal, B.E. "Suicide and Middle Age." Sociological Symposium 3 (1969):131-40.

Seligman, Martin E.P. Helplessness. San Francisco: W.H. Freeman and Co., 1975.

Sidel, V.W. and Sidel, R. Social Policy 7 (1976):66-7.

Siggens, L.D. "Mourning: A Critical Survey of the Literature." International Journal of Psychiatry 3 (May 1967):418-32.

Silverman, Phyllis R. Anticipatory grief from the perspective of widowhood. In Schoenberg, B.; Carr, A.D.; Kutscher, A.H.; Peretz, D.; and Goldberg, I.D., eds., Anticipatory Grief. New York: Columbia University Press, 1974.

_____. "How You Can Help the Newly-Widowed." The Magazine of the American Funeral Director (May 1970).

_____. "Services to the Widowed: First Steps in a Program of Preventive Intervention." Community Mental Health Journal 3 (1967):37-44.

_____. "The Widow as a Caregiver in a Program of Preventive Intervention with Other Widows." Mental Hygiene 54 (October 1970):540-7.

_____. "The Widow to Widow Program: An Experiment in Preventive Intervention." Mental Hygiene 53 (July 1969):333-7.

_____. "Widowhood and Preventive Intervention." The Family Coordinator 21 (January 1972):95-102.

Silverman, Phyllis R. and Cooperband, A. "On Widowhood: Mutual Help and the Elderly Widow." Journal of Geriatric Psychiatry 8 (1975):9-27.

Silverman, Sue E. "The Widow's View of Her Dependent Children." Omega 6 (1975):3-20.

Steele, Donald W. The Funeral Director's Guide to Designing and Implementing Programs for the Widowed. Wisconsin: National Funeral Director's Association, 1975.

Tolstoy, Lev Nikolaevich. War and Peace. Grossett and Dunlap, 1949.

Townsend, P. The Family Life of Old People. London: Routledge and Kegan Paul, 1957.

Vachon, Mary L. "Grief and Bereavement Following the Death of a Spouse." Canadian Psychiatric Association Journal 21 (February 1976):35-44.

_____. "Stress Reactions to Bereavement." Essence 1 (1976):23-33.

Vachon, M.L.; Formo, A.; Lyall, W.A.; Rogers, L.; Cochrane, J.; Freedman, J.; and Freeman, K. "Stress Reactions to Bereavement and Breast Cancer" presented at University of Toronto Department of Psychiatry Research Day, Toronto, 10 September 1975.

Volkan, V.D. "Normal and Pathological Grief Reactions." Virginia Medical Monthly 99 (1972):535-40.

Walpole, Ronald E. and Myers, Raymond H. Myers. Probability and Statistics for Engineers and Scientists.

Woodward, W.R. "Scientific Genius and Loss of a Parent," Science Studies Volume 4 (1974):265.

Woolsey, T.D. "Estimates of Disabling Illness Prevalence in the U.S." based on the current population survey of February 1949 and September 1950. Public Health Service Publication 181. Washington, D.C.: Government Printing Office, 1952.

Zung, William. Self-Rating Depression Scale. Merrell-National Laboratories, Cincinnati, Ohio, 1975.

MICHIGAN STATE UNIV. LIBRARIES
31293105919397