MONTANA STATE UNIVERSITY

Problems of the bereaved 13-36 months after death of spouse
by Roxlyn Robinson Woosley

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University
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Abstract:
Although it was once thought that the symptoms of grief lasted only a few months, it is now known that the stresses of widow(er)hood persist for years after the spouse's death. Acknowledgement of the extension of grief has not resulted in descriptive research which expands the knowledge of the nature of extended grief. This study was conducted for the purpose of examining the problems of the bereaved in the 13-36 month period after the death of the spouse.

This study utilized a qualitative approach which was based on grounded theory. The sample was comprised of fourteen widows/widowers, five men and nine women. All had been clients of the Big Sky Hospice prior to and approximately one year after the death of their spouses. The data were collected by conducting face-to-face interviews, which . were taped, transcribed, and analyzed. The two major analytic strategies characteristic of grounded theory were utilized; these strategies were the constant comparative method and theoretical sampling. The interview transcriptions were reviewed and memos were written and coded. A conceptual paradigm emerged for viewing spousal loss during the 13-36 month period of bereavement; in addition, the major problems of the bereaved, the dimensions of the problems, and tactics for coping with grief were identified. This study concurred with the works of other researchers who have acknowledged the longevity of grief beyond the first year of bereavement.

A major contribution of this research was the emergence of a paradigm for examining spousal loss during the 13-36 month period postloss. The major implications of this study are the need for further descriptive research of extended grief, for. conceptual validation, and for extended models of bereavement care. This study identified the need for further nursing research investigating long term effects of time on the patterns of grief; the effects of anticipatory grief, extended caregiving, and the suffering of the deceased upon the bereaved; validation and refinement of the emergent concepts and paradigm; and, conceptual validation of the problem issues of grief.

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by

Roxlyn Robinson Woosley

A thesis submitted in partial fulfillment
of the requirements for the degree

of

Master of Nursing

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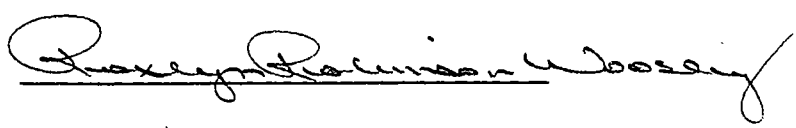
Signature 

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ABSTRACT

Although it was once thought that the symptoms of grief lasted only a few months, it is now known that the stresses of widow(er)hood persist for years after the spouse's death. Acknowledgement of the extension of grief has not resulted in descriptive research which expands the knowledge of the nature of extended grief. This study was conducted for the purpose of examining the problems of the bereaved in the 13-36 month period after the death of the spouse.

This study utilized a qualitative approach which was based on grounded theory. The sample was comprised of fourteen widows/widowers, five men and nine women. All had been clients of the Big Sky Hospice prior to and approximately one year after the death of their spouses. The data were collected by conducting face-to-face interviews, which were taped, transcribed, and analyzed. The two major analytic strategies characteristic of grounded theory were utilized; these strategies were the constant comparative method and theoretical sampling. The interview transcriptions were reviewed and memos were written and coded. A conceptual paradigm emerged for viewing spousal loss during the 13-36 month period of bereavement; in addition, the major problems of the bereaved, the dimensions of the problems, and tactics for coping with grief were identified. This study concurred with the works of other researchers who have acknowledged the longevity of grief beyond the first year of bereavement. A major contribution of this research was the emergence of a paradigm for examining spousal loss during the 13-36 month period postloss. The major implications of this study are the need for further descriptive research of extended grief, for conceptual validation, and for extended models of bereavement care. This study identified the need for further nursing research investigating long term effects of time on the patterns of grief; the effects of anticipatory grief, extended caregiving, and the suffering of the deceased upon the bereaved; validation and refinement of the emergent concepts and paradigm; and, conceptual validation of the problem issues of grief.

CHAPTER 1

INTRODUCTION

Grief is a reality in the life of human beings. By adulthood, most persons have experienced significant losses in their lives. The universality of loss as a human experience, especially loss through death, makes grief an issue of relevance to society and to individuals. The death of one's spouse has been ranked at the top of the list of negative life events (Holmes & Rahe, 1967). As a severe stressor, the death of one's spouse has impacted the psychological and physiological health of the bereaved. Studies consistently have found bereavement to be a medically significant process which is associated with increases in overall mortality, morbidity, and dysphoria (DeVaul, Zisook, & Faschingbauer, 1979).

Nursing plays an important role in the care of persons and families who are dealing with major loss. There are many false expectations, professionally and societally, about the nature and the duration of the grief process. A review of the nursing literature indicates that the concept of acute grief has been the prevailing paradigm on which interventions were based (Murphy, 1983). Hence,

expanded professional understanding of grief, beyond the acute phase, should guide the professional care of the bereaved. Further, the provision of comprehensive care demands a knowledge base which is dynamic and holistic. This expanded knowledge of grief would provide the basis for nursing interventions to meet effectively the needs of the bereaved.

Statement of the Problem

Death research began during the 1940's and has drawn from the disciplines of psychiatry, psychology, and sociology. After 1960, interest spread across a variety of academic and applied fields. Formal nursing research into death, dying, and terminal illness began in the decade between 1960 and 1970 (Benoliel, 1983).

The development of nursing research on this topic reflects the influences in the educational backgrounds of the nurse researchers, primarily the fields of education, sociology, and psychology. This variability has complicated the picture due to the lack of standardization which has been guided by a central paradigm. Benoliel (1984), a nurse researcher, suggested the merits of the qualitative paradigm as an organizing framework within which to build a body of systematic knowledge.

Specifically, grief has been viewed as the normal reaction to loss and as a universal experience (Rando, 1984). "Grief is the process that allows us to let go of that which was and be ready for that which is to come" (p. 17). Loss might be real or imagined; nevertheless, a grief response is the result. All losses create deprivation and, to a greater or lesser degree, a grief reaction occurs (Rando, 1984). The nature, intensity, and duration of the grief response depends on a large number of variables, which include the significance of the lost object. As a result, the loss of significant persons and the disintegration of social relationships present the individual with significant grief.

Normal grief is presented as a syndrome of physical, emotional, cognitive, social, and spiritual components (Clayton, 1974; Clayton, Desmaris & Winokur, 1968; Greenblatt, 1978; Lindemann, 1974; Parkes, 1972; Parkes & Weiss, 1983; Rando, 1984, Schneider, 1984). The manifestations of this syndrome are affected by a wide variety of inherent biopsychosocial factors in the bereaved and situational factors which surround the death event (Albrecht, 1986; Bornstein, Clayton, Halikas, Maurice & Robbins, 1973; Bugen, 1977; Parkes & Weiss, 1983; Osterweis, Solomon, & Green, 1984; Rabkin & Struening, 1976; Rando, 1984; Worden, 1982). Actually, grief is demonstrated as an extremely individualized

process yet with a strong thread of commonality among the grieving. The understanding of normal grief has provided professionals with the necessary background to develop standards of short-term bereavement care.

The death of a spouse has been identified as a severe stressor which has affected both the morbidity and mortality rates of the bereaved (Helsing & Szklo, 1981; Maddison & Viola, 1968; Marris, 1958; Parkes & Brown, 1972; Raphel, 1983; Rogers & Reich, 1988; Stroebe, Stroebe, Gergen & Gergen, 1982; Vachon, 1976). In addition to the agonies of normal grieving, the bereaved are felt to be at risk for a variety of physical problems which include infectious diseases and heart disease (Engel, 1961; Fredrick, 1981; Maddison, 1968; Schmidt, 1983), as well as depression (Briscoe & Smith, 1975; Bornstein, Clayton, Halikas, Maurice & Robbins, 1973; Parkes, 1965; Schneider, 1980, Schoenberg, Carr, Peretz & Kutscher, 1970; Wahl, 1970). The extent to which nurses are involved with people, both the patient and his/her family, presents a strong argument for increased understanding of the bereavement process and the risks which are associated with coping with death (Murphy, 1983).

Although researchers once thought that the symptoms of grief extended only six months, symptoms have been recognized which have taken years to be resolved (Rando, 1984). Several researchers concurred that the stresses of

widow(er)hood persisted for years after the spouse's death (Barrett & Schneweiss, 1980; Wujcik, 1984; Zisook & DeVaul, 1984).

The longevity of the grief response has been identified, however, little has been written about the nature of this extended grief. A paucity of descriptive research which defined grief past the acute stage was noted. The lack of descriptive research findings which was coupled with the need for understanding the nature of grief beyond the first year provided the rationale for this study.

Statement of the Purpose

The purpose of this study was to identify the problems of a select group of bereaved adults 13-36 months after the death of the spouse.

Definition of Terms

Grief--the process of reacting intellectually, psychologically, somatically, socially, or spiritually to the perception of the death of one's spouse.

Loss--the state of deprivation from something (someone) one has previously had (Schoenberg, Gerber, Weiner, Kutcher, Peretz, & Carr, 1975). The loss might be either physical (tangible) or symbolic (psychosocial)

(Rando, 1984). The object of loss, in this research, was the spouse of the bereaved person.

Bereavement--the state of having suffered the loss of one's spouse from death. For the purpose of this research, the terms grief and bereavement were used interchangeably.

Bereaved Adults--a select group of clients of Big Sky Hospice who had experienced the death of a spouse 13-36 months prior to participation in the research project. All of the clients had been Hospice clients prior to the death of the spouse and for approximately 12 months into the bereavement period.

Spouse--a husband or a wife; either member of a married couple which was spoken of in relation to the other (Webster, 1983).

CHAPTER 2

REVIEW OF THE LITERATURE

Most theorists have agreed that some form of grief reaction follows any loss that was perceived as significant (Werner-Beland, 1980). This loss entailed either the loss of a significant person or object or the loss of a significant function or relationship (Averill, 1968; Schoenberg, Carr, Peretz, & Kutscher, 1970; Silverman & Cooperband, 1975; Werner-Beland, 1980). Following the loss there was a state of thinking, feeling, and activity that was the direct consequence of the loss, commonly called grief (Schoenberg, et al., 1970).

"Disagreement arises because of the positions taken by various theoreticians to explain the dynamics of these thinking, feeling, and activity states" (Werner-Beland, 1980, p. 7). This disagreement was enhanced further by the lack of consensual agreement in the use of terms.

By definition, the term grief referred to the set of "emotional responses that occur following the perception of or anticipation of a loss of one or more valued objects" (Roy, 1984, p. 7). Grieving was viewed as the total response to the loss which included thoughts,

feelings, and behaviors (Averill, 1968, Bowlby, 1961; Davidson, 1984; Martocchio, 1985; Parkes, 1970; Silverman & Cooperband, 1975). Rando (1984) included somatic responses in her definition: specifically grief was "the psychological, social, and somatic reactions to the perception of loss" (p. 15). Grief involved the entire process of moving through the pain of loss (Martocchio, 1985), with potential for growth (Byock, 1986; Murphy, 1985). Also, grief was viewed as the expression of profound conflict between contradictory impulses: the preservation of past and, at the same time, the reestablishment of new relationships in which the loss was accepted (Marris, 1974).

The terms grief and bereavement were used interchangeably by some authors (Murphy, 1983; Rando, 1984). Others suggested that the term bereavement encompassed a societally recognized response to loss by death as well as other physiological and psychological effects (Averill, 1968; Lindemann, 1944; Schultz, 1978, Vachon, 1976). Conversely, bereavement had been called a paradigm of reactive depression (Vinokur & Selzer, 1975) and a mental wound which healed slowly and left scars (Marris, 1974). For some, the term bereavement implied the value of the lost relationship as being one of importance relative to sustenance, comfort, and security (Vachon, 1976) and/or a loving relationship (Martocchio, 1985).

The stage theories of grief had been the prevailing paradigms in recent years. These theories were based on the notion that "individuals follow a predictable, orderly pattern of emotional responses" (Murphy, 1983, p. 193) after the death of a significant other. These emotional responses were given a variety of descriptive names. For example, Bowlby (1961) identified three stages: protest, despair, and denial. Parkes (1972) designated these stages as alarm, search, mitigation, anger, guilt, and gain of a new identity. Kübler-Ross's (1969) five-stage conceptualization of anticipatory grief: shock and denial, anger, bargaining, depression, and acceptance was accepted widely by the laity and by those who work with dying patients. Engel (1963) delineated shock and disbelief, awareness, and restitution and recovery as proposed stages.

"Data from stages of grief are descriptive in nature and some are primarily from unspecified observational techniques, anecdotal reports, and interviews" (Murphy, 1983, p. 194). These data were not considered evidence for the existence of stage responses to the death of a significant other since procedures had not been standardized (Barrett & Schneweis, 1980-81; Metzger, 1979-80).

Researchers also designated the grief response as a series of phases from shock to repatterning. Bowlby (1980) referred to numbing, yearning and searching,

disorganization and despair, and reorganization and new life. Marris (1958) identified feelings of uncertainty, physical disturbances, clinging and pining, anger and hostility, withdrawal and apathy, and a search for meaning. According to Marris, all of these feelings progressed to finding meaning in the loss, reintegration, and reformulation of a new life. Schneider (1984) proposed a holistic model but had identified phases within the process: initial awareness, attempts to limit the loss, awareness of the loss, gaining perspective (healing and acceptance), resolving the loss, reformulation, transformation, and transcendence.

The term tasks also had been applied to the grief process, especially in the context of recovery. Worden (1982) identified these tasks of grieving as (1) to accept the reality of the loss; (2) to experience the pain and grief; (3) to adjust to an environment in which the deceased is missing; and (4) to withdraw emotional energy and reinvest it in another relationship. Parkes and Weiss (1983) formulated a similar classification: (1) intellectual recognition and explanation of the loss, (2) emotional acceptance; and, (3) formulation of a new identity. Saunders (1981), likewise, had emphasized task completion in the resolution of bereavement, specifically the uncoupling of identity.

Though the terminology varied from stages, to phases, to tasks, most researchers have viewed grief as a process. Greenblatt (1978) stated: "grieving is not a steady state; it is a process, one phase fading gradually into another" (p. 44). Bowlby (1961) concurred by viewing grief as a process and emphasizing the continuum in feeling between anxiety and despair with the griever traveling back and forth between the two. Others alluded to the process of grieving (Murphy, 1985; O'Toole, 1984; Parkes & Weiss, 1983; Ramsay, 1977; Zisook & DeVaul, 1984). Wambach (1985-86) observed the grief process as a social construct which suggested inclusion of the social realities of the grief process in a model of investigation and intervention. Researchers (Aldrich, 1974; Benoliel, 1974; Benoliel, 1985; Blank, 1974; Bourke, 1984; Budner, 1974; Gerber, 1974; Reed, 1974; Schoenberg, Carr, Kutscher, Peretz, & Goldberg, 1974; Silverman, 1974) applied the conceptualization of the grief process to anticipated grief. Researchers agreed that the predeath and postdeath periods of anticipatory grief were susceptible to the threat of emerging conflicts and manifested different symptoms; therefore, careful assessment and individualized models were required for resolution.

Additional theoretical perspectives on bereavement have included Weisman's (1973) conceptualization of the

timeliness/untimeliness of the death event as an effecter of the process. Bugen's (1977) model of human grief asserted that the degree of grief was predicted by the closeness of the relationship and the perception of preventability. Learned helplessness, another theoretical model for predicting the bereavement process, was dependent on the survivor's perception of control (Abramson, Seligman, & Teasdale, 1978; Bennett & Bennett, 1984).

Patterns of grief have been specified by Parkes (1965) as typical grief, inhibited grief, delayed grief, or prolonged grief. Other researchers identified these or similar patterns (Averill, 1968; Lazare, 1970; Lindemann, 1944; Marris, 1974; Rando, 1984; Raphel, 1983; Woodfield & Viney, 1984-85). In addition, a differentiation was made between normal grief and abnormal grief (Deutsch, 1937; DeVaul, Zisook, & Faschingbauer, 1979; Engel, 1961; Freud, 1917; Lindemann, 1944; Parkes & Weiss, 1983; Ramsay, 1977; Schneider, 1980; Wahl, 1970; Zisook & DeVaul, 1983) with interventions and planned strategies for each. Rando (1984) grouped all the variants of atypical grief into one category which she called unresolved grief, because there has been some disturbance in the normal progress towards resolution" (p. 59).

Models of Grief

Generally, seven distinct models emerged to explain the dynamics of the grief process (O'Toole, 1984). The first category of models was psychoanalytic or psychodynamic (Averill, 1968; Fenichel, 1945; Freud, 1917; Johnson-Soderberg, 1981; Lindemann, 1944; Parkes, 1970; Worden, 1982). These models relied heavily on the work of Freud and centered on the belief that grieving represented the process of relinquishing a love object by gradually withdrawing libido (O'Toole, 1984). New proponents of these theories investigated relationship variables and pregrief personality in addition to psychic structures, defense mechanisms and intrapsychic process as effecters of the grief process.

A second category was the attachment model or interpersonal theory (Bowlby, 1961, 1969, 1973, 1980). These models focused on the interpersonal or relational aspects of the bereaved to the lost object. In these models, bereavement might be viewed as an unwilling separation with resolution which occurred only with a redefinition of self.

The third category of models centered on stress and crisis (Aguilera & Messick, 1982; Christensen & Harding, 1985; Constantino, 1981; Hoff, 1984). Stress or crisis models were based on the idea that personal loss created an intrapsychic crisis which demanded reliance on

strategies. The quality of the intervening social support was viewed as an important factor in the healthy resolution of grief. The capacity for growth through crisis was also an inherent component in most crisis theories (Christensen & Harding, 1985).

The fourth category was cognitive and behavioral models (Parkes, 1970; Ramsey, 1977; Raphel, 1983). These models were based on the concept that the bereaved person's feelings and behavior depended on the individual's perceptions and personal constructs. The grief process and recovery, according to these models, depended on relinquishment of assumptions that included the lost person, with the development of new assumptions in line with reality. The emphasis was on the behavior of the bereaved and the environmental factors which affected those behaviors.

The fifth category was illness and disease models (Engel, 1961; Kraus & Lilienfeld, 1959; Lindemann, 1944; Parkes, 1972; Rees & Lutkins, 1967; Vachon, 1976). Most models avoided classifying grief as an illness; however, bereavement often was suspected as a major contributor to the onset of illness. Lindemann (1944) described a grief syndrome. Engel (1961) and Fredrick (1981) concurred with a group of symptoms which were produced by grief.

Sociobiologic models were the sixth category (Lopata, 1970; Marris, 1974; Vachon, 1976; Vachon, 1980,

Vachon, et al., 1982). These models "view grief as a universal experience among humans as well as higher primates" (O'Toole, 1984, p. 25). Here grief was conceptualized within the cultural and social determinants of the individual and society. Grief also was viewed as a cohesive and bonding force within the human species, which added a sense of affirmation to the bereaved by mobilization of the social network.

Finally, the seventh category was the holistic models (Marris, 1974; Rando, 1984, Schneider, 1984). These models viewed grief within emotional, physical, behavioral, cognitive, and spiritual parameters, which attempted to encompass the whole person. The importance of previous loss as an effecter of present coping was acknowledged, along with the importance of supportive intervention. The spiritual aspect of this model recognized the possibility of health, growth, and transformation through the bereavement experience (O'Toole, 1984, p. 25). Important to note was the fact that overlap might occur from model to model. Overlap was dependent upon the primary influence and the theoretical additions of the individual researcher.

Intensity and Duration of Grief

The intensity and duration of the grief process have been difficult to measure and highly speculative

(Hauser, 1983). Lindemann (1944) said that within eight to ten interviews in a period of four to six weeks, uncomplicated grief could be settled. However, indications that this was an underestimation of the time involved were apparent (Barrett & Schneweis, 1980-81; Hauser, 1983; Vachon, Lyall, Rogers, Freedman, Letofsky, & Freemen, 1980; Wujcik, 1984; Zisook & DeVaul, 1984). The suggestion has been made that subjects noted a decrease in symptoms and a sense of improvement six to ten weeks after the death (Clayton, Desmaris, & Winokur, 1968). Unrelenting despair had been reported to decrease after several months with a gradual diminishing of restlessness, tension, irritability, and preoccupation with memories (Glick, Weiss, & Parkes, 1974). By the end of the first year, most widows in a longitudinal study reported longer durations of feeling stabilized and an emergence of energy levels similar to those prior to bereavement (Glick, Weiss, & Parkes, 1974; DeVaul, Zisook, & Faschingbauer, 1979; Parkes, 1972; Williams & Polak, 1979).

Although the intensity of grief apparently decreased after the first year, a strong indication was that the duration of grief was much longer than one year (Barrett & Schneweis, 1980-81; Bornstein, Clayton, Halikas, Maurice & Robbins, 1973; Davidson, 1984; Marris, 1974; Parkes, 1970; Parkes & Brown, 1972, Parkes & Weiss, 1983, Vachon, Lyall, Rogers, Freedman, Letofsky, & Freemen, 1980; Silverman &

Cooperband, 1975; Wujcik, 1984; Zisook & DeVaul, 1984; Zisook, DeVaul & Click, 1982). Conjugal and parental grief generally were considered to be the most severe (Rees & Lutkins, 1967; Sanders, 1979-80; Schwab, Chalmers, Conroy, Farris, & Markush, 1975).

The intensity and the duration of grief also have been examined within the contexts of anticipated versus unanticipated loss (Glick, Weiss, & Parkes, 1974; Parkes, 1975; Parkes & Weiss, 1983; Sanders, 1982-83) with no absolute conclusions as to differences in the severity of the response but rather in the predictions of the outcome. Bugen (1977) related the intensity of grief to the closeness of the relationship and the perception of preventability. The conclusions were that the closer the relationship of the deceased to the bereaved, the more intense the grief response. Perceived preventability was believed to intensify grief.

Factors Affecting the Grief Process/Outcome

Although each person's grief will be idiosyncratic, various factors which affect the grief process were found to be important determinants of bereavement or grief outcome. These factors included the circumstances of the death event, the widow(er)'s biopsychosocial attributes, and the characteristics of the support network (Hauser,

1983; Rando, 1984; Silverman, 1976; Silverman & Cooperband, 1975).

Specifically, three identified factors related to the death event were the suddenness of the death event, the degree of violence which was associated with the death event, and concurrent stresses or crises. The sudden death event has been associated with more difficulty in grieving than death that was anticipated (Glick, Weiss, & Parkes, 1974; Maddison & Walker, 1967; Parkes, 1975; Parkes & Brown, 1972; Parkes & Weiss, 1983; Polak, Egan, Vanderbergh & Williams, 1975). Sudden loss "overwhelms people and so severely reduces their functioning that recovery becomes very difficult" (Rando, 1984, p. 52). The degree of violence also was found to affect grieving negatively confounding the process (Cowan & Murphy, 1985; Kalish, 1981; Polak, Egan, Vanderbergh & Williams, 1975; Rando, 1984; Sanders, 1982-83; Saunders, 1981; Sheskin & Wallace, 1976). "The griever may be confronted with ongoing stresses related to the death that may add to the vicissitudes of the bereavement experience" (Rando, 1984, p. 54). Research also has indicated that the presence of concurrent life crisis was associated with poor outcome (Cowan & Murphy, 1985; Parkes, 1975; Raphel & Maddison, 1976).

Biopsychosocial attributes of the individual which have been investigated include individual perception of

the death event (Rabkin & Struening, 1976) and demographic characteristics such as age, education, income, and occupation (Rabkin & Struening, 1976). Other psychosocial factors have included the young age of the bereaved (Carey, 1977; Glick, Weiss & Parkes, 1974; Rees & Lutkins, 1967), low socio-economic status (Parkes, 1975), and ambivalent feelings toward the deceased (Lindemann, 1944; Maddison & Viola, 1968; Parkes, 1975; Sanders, 1979). The duration of the inhibition of grief also has been equated with negative outcome (Averill, 1968, Bowlby, 1961; Freud, 1917; Lindemann, 1944; Schneider, 1980). The coping behaviors, personality, and mental health of the bereaved also were believed to have influenced the response to grief (Rando, 1984; Rubenstein & Shaver, 1982).

Although research in the area of bereavement and its relationship to social networks was sparse, three studies were noted. One study (Maddison & Walker, 1967), with relationship to outcome, focused on the widow's perception of the degree of supportiveness of her social network during the first three months of bereavement; one conclusion reported an appreciation of permissive support from others. A second study concerned elderly widows in the Chicago area of which a sizeable number were found to be relatively isolated (Lopata, 1970). A third study reported characteristics of widows of varying ages which were involved in a widow-to-widow program (Strugnell,

1974). This study identified loneliness as one of the most prevalent and pervasive problems.

Psychosocial factors which were investigated and were indicated to have positive effects on bereavement, included deep religious beliefs, (Polak, Egan, Vanderbergh, & Williams, 1975), advanced educational levels (Carey, 1977), adaptability of the widow's personal construct system (Woodfield & Viney, 1984-85), successful engagement in new social roles (Lopata, 1970), and identity reconstruction (Lapato, 1975; Parkes & Weiss, 1983; Saunders, 1981). The perceived degree of supportiveness of the widow's social support system also was identified as a determinant of positive outcome (Kutscher, 1970; Lemasters, 1978; Maddison & Walker, 1967; Strugnell, 1974; Vachon, 1980).

Rabkin and Struening (1976) defined mediating, predisposing, and precipitating factors. Mediating factors were those characteristics of the stressful event, of the individual, and of his social support system that influenced his perception of or sensitivity to stressors. Predisposing factors were long-standing behavior patterns, childhood experiences, and durable personal and social characteristics that altered the susceptibility of the individual. Precipitating factors referred to life changes which altered an individual's social setting and/or required a change in the individual's ongoing life

pattern (Rabkin & Struening, 1976). "According to this theoretical position, the greater the intensity, duration and/or number of stressful events, the less impact that mediating factors exert" (Hauser, 1983, p. 27).

The measurement of grief has been explored by researchers (Demi, 1984; Jacobs, Kasl, Ostfeld, Berkman, Kosten, & Charpentier, 1986; Parkes & Weiss, 1983; Zisook & DeVaul, 1984; Zisook, DeVaul, & Glick, 1982). Quantitative and qualitative consensus has not been reached.

Further factors influencing grief have been identified as positive or negative effecters of grief outcome. Parkes and Weiss (1983) noted that outcome proved to be particularly difficult to assess because it has embraced so many different issues. "Good outcome" might involve a return of feelings of well-being, a regained capacity to cope with problems of everyday life, or a decline in preoccupation with grief (Parkes & Weiss, 1983, p. 29).

Poor bereavement outcome has been measured by the degree of physical and/or mental deterioration within a year after the spouse's death (Hauser, 1983). Poor outcome has been equated with pathologic grief (Greenblatt, 1978; Vachon, Sheldon, Lancee, Lyall, Rogers, & Freeman, 1982; Worden, 1982) or conflicted or chronic grief (Parkes & Weiss, 1983; Rando, 1984).

Recovery

The concept of recovery (Parkes & Weiss, 1983) was comprised of intellectual and emotional acceptance of the loss and an adjustment of the external world to match the new reality. Worden (1982) formulated a similar classification of the tasks of grieving and, thereby, recovery from loss: acceptance of the reality of loss, experiencing the pain, adjustment to an environment in which the deceased was missing, and the withdrawal and reinvestment of emotional energy. Schneider (1984) viewed the recovery process as a reformulation of loss into a context of growth and the transforming of loss into new levels of attachment. Dush (1988) described a gradual restoration of balance in all spheres of functioning.

Parkes and Weiss (1983) developed an expanded list of assessments indicating recovery:

1. Level of functioning in comparison with prebereavement level.
2. Movement toward a solution of outstanding problems.
3. Acceptance of the loss (absence of distortion, dissipation of the grief through interchange, integration of the event into the widow's world view).
4. Socialization, as active and effective as before bereavement.
5. A positive and realistic attitude toward the future, including problem solving.
6. Current health as good as it had been before bereavement.

7. The general level of anxiety or depression.
8. The general level of guilt or anger.
9. The general level of self-esteem.
10. The respondent's apparent ability to cope with future loss.

Anticipated Grief

Much of the literature discussed the death event by employing the dichotomy of expected death (anticipated) or unexpected death (sudden), which were not always mutually exclusive events (Murphy, 1983). Because of the potentially adaptive value, anticipatory grief was studied in both the seriously ill who were facing death and the surviving members of the family after the death event (Benoliel, 1985; Blank, 1974; Schoenberg, Carr, Kutscher, Peretz, & Goldberg, 1974; Woodson, 1978).

Knowledge of impending death was purported to reduce the intensity of the grief response because the significant persons were said to have had some time to accept the impending loss, to rehearse new roles, and to mobilize their support services. The importance of anticipation of the death as a determinant in the grief process and in the adequacy of recovery was noted (Blank, 1974; Gerber, 1974; Glick, Weiss & Parkes, 1974; Parkes, 1975; Parkes & Weiss, 1983; Sheskin & Wallace, 1976).

In theory, anticipatory loss ought to be less aversive because of the predictability factor. However, not all persons were capable of initiating appropriate coping mechanisms and/or processing the information to diminish the impact of the death (Glick, Weiss & Parkes, 1974; Silverman, 1972, 1974). Silverman (1972) contended that anticipatory grief was not possible if the relative stayed involved actively with the patient through the illness. The therapeutic effects of anticipation were interpreted as valuable in permitting certain kinds of anticipatory preparation that helped to keep the loss from being unexpected (Rando, 1984).

Saunders (1982-83) found that a long period of chronic illness prior to death left survivors with feelings of social isolation, less emotion control, rumination, and loss of vigor; and, as a result, a picture of dejection, frustration, exhaustion, and loneliness was created. The negative effects of an extended period of forewarning were reported by others (Maddison, 1968; Rando, 1984; Schwab, Chalmers, Conray, Farris, & Markush, 1975).

Widows/Widowers

Widowhood has been the frequent subject of inquiry with a wide variety of parameters being assessed. The physical effects of loss through death have been investigated (Clayton, 1974, 1979; Glick, Weiss &

Parkes, 1974; Maddison & Viola, 1968; Maddison & Walker, 1967; Parkes, 1970, 1972; Parkes & Brown, 1972; Raphel, 1976; Reese & Lutkins, 1967). "All of these concluded that the death of a loved one carries with it a definite physical risk for the griever much greater than the normal population" (Rando, 1984, p. 71).

For example, Maddison (1967) compared the health status of women, 13 months post-bereavement; he found a significant deterioration in health in the bereaved groups. Glick, Weiss, and Parkes (1974) reported on the symptomatology of widows who required medical attention. Parkes and Brown (1972) found a 50% increase in autonomic symptoms of widows. Heinemann (1982) provided rationale for studying widowed women based on their potential for more difficult and more varied adaptation to loss of spouse than widowers. This difficulty in adaptation was attributed to lack of accessiblity to formal societal supports, including medical care.

The mortality statistics also suggested an increased mortality risk to the bereaved. Kraus and Lilienfeld (1959); Maddison and Viola (1968); Marris (1958); Parkes and Brown (1972); Helsing and Szklo (1981); Raphel (1976); Rogers and Reich (1988) found an increase in death rates for widows in the United States. Rees and Lutkin (1967) found increased mortality in widowed people and close relatives with a mean age of 69.7 during the first year of

bereavement. Jacobs and Ostfeld (1977) found an association between conjugal bereavement and elevated death risk in young women that extended possibly through the second year of bereavement.

The sociological analysis, which emphasized self concept and/or identity, social relations, and social roles, was the focus of other researchers (Christensen & Harding, 1985; Constantino, 1981; Lopata, 1970; Vachon, et al., 1980; Silverman, 1972; Strugnell, 1974). Though women were not the only category of bereaved that was studied, loss of spouse for women presented especially serious risks to the psychological and physical health of those survivors (Greenblatt, 1978).

Men also have been the focus of some attention relative to spousal loss. Young, Benjamin, and Wallis (1963) reported a 40% increase in the mortality rate of British widowers during the first six months. This finding was confirmed by Jacobs and Ostfeld (1977) and by Stroebe and Stroebe (1983). Investigation into the gender-related differences in conjugal bereavement reactions (Sroebe & Stroebe, 1983) also identified men to be at greatest risk shortly after bereavement while for widows the peak of risk occurred during the second or third year. Men also were identified by Rogers and Reich (1988) to be a more vulnerable population than women.

Nursing

Death-related research in nursing began to appear in the 1960's. Formal nursing research into death, dying, and terminal illness began in the decade between 1960 and 1970. The character of the research was influenced greatly by the movement of nurses toward doctoral study (Benoliel, 1983). Prior to that time, the nursing literature on death and dying was meager and focused principally on the technical tasks to be done at the time of death (Quint, 1964, 1967).

The substantive contribution to nursing knowledge about death, dying, and terminal illness was divided into three categories (Benoliel, 1985): "These areas of investigation focused on (a) nurses' responses to death and terminal illness, (b) patients' and families' adaptations to death, and (c) environments and social processes affecting adaptations to death, terminal illness, and bereavement" (p. 110).

Bereavement responses which followed the death of a spouse have been examined by nurses for variations in the age of the survivor with no clearly defined age-related correlation to adaptation (Vachon, 1982). Other studies viewed premorbid personality characteristics (Sanders, 1979); adjustment following suicide (Demi, 1978), and type of death (Saunders, 1981). Vachon, et al. (1982) showed

that the best predictor of stress levels two years after the death was the scores on the Goldberg General Health Questionnaire as well as evidence of poor health. The evidence to date suggested that healthy and unhealthy adaptations to widowhood came about through an "interplay of personal and social variables, and sophisticated research to understand these complex relationships is essential for the discipline of nursing" (Benoliel, 1983, p. 118). Other nurse researchers have explored bereavement responses, specifically with the focus on meeting the needs of the grieving (Dracup & Breu, 1978; Martinson, Diamond, MacElveen-Hoehn, & Barrett, 1984; Murphy, 1983).

In the area of social structure, social interaction, and socialization, one study by Vachon, (1980) was pertinent. This longitudinal study of widows provided the basis for a model of adaptation to bereavement and demonstrated how social support might function to influence the process and the outcomes of bereavement over a 24 month period.

Theoretical perspectives which were concerned with anticipatory grief in nursing were concerned primarily with adjustment to real and to impending loss. The transition services model was one model of nursing practice designed to offer personalization and continuity of care in the face of progressive physical deterioration

(Tornberg, McGrath & Benoliel, 1984). "This model conceptualizes the nurse functioning in two inter-related roles: a problem-focused support system for patient and family, and a communication link between the patient-family system and the larger health care provider-community system" (p. 131).

Crisis intervention theories and principles (Aquilera & Messick, 1982; Hoff, 1984) have been implemented in the nursing of dying patients and families, especially in the hospice setting (Christensen & Harding, 1985). The goal of this approach has been to help the patient and the family through crisis while allowing them autonomy and enhancement of effective coping skills and self-esteem.

The theories and models produced to date have provided direction for future research. Concepts which have been identified as potential sources of further research include the concepts of multiple losses (Benoliel, 1971), grief themes (Johnson-Soderberg, 1981), and existential philosophy (Taddy, 1976).

In summary, nursing research on death, dying, and terminal illness has produced primarily factual knowledge and, to a lesser extent, conceptual knowledge. "Despite these contributions, the outcomes overall show the need for paradigm-directed nursing research with a sound integration of central concepts and research methods, if

systematic knowledge about the meanings of death, dying, and terminal illness is to move forward" (Benoliel, 1983, p. 122).

Conceptual Framework

In the formative stages of this research the intent of the researcher was to apply the adaptation model of Roy (1984) to extended grief. The approach considered would have applied the Roy Adaptation Model format of identifying behaviors and of influencing factors from which to derive nursing diagnoses (1984). These nursing diagnoses would have provided the bases from which goals and interventions might have been derived (Duespohl, 1986; Gebbie & Levin, 1975; Gordon, 1982; Murray & Zentner, 1979, 1985). The goal of this nursing process would have been to enhance adaptation or adjustment to loss.

As the adapted paradigm was developed to serve as a framework for the research design, problems began to emerge. The review of the literature did not produce descriptive studies of grief beyond the acute period which could provide the basic principles from which hypotheses were to be drawn. To draw conclusions about a process that had not been studied descriptively or empirically tested was premature. In addition, to make assumptions about a process that was little understood and to attempt to force those assumptions into another's framework was

artificial. Therefore, the deductive approach did not seem appropriate.

The Roy Adaptation Model described persons as adaptive systems which interacted with the environment and moved towards the goals of adaptation and health (Roy, 1984). The grief theories of Parkes and Weiss (1983) and Worden (1982) defined adaptation to loss as recovery. Recovery was identified as the accomplishment of a series of tasks, which provided indication of adaptation to loss. However, these models did not provide a comprehensive picture of the processing of loss.

Another grief theorist, Schneider (1984), did provide a comprehensive framework for examining grief. This framework was a holistic framework which encompassed emotional, physical, behavioral, cognitive, and spiritual parameters. Schneider's framework had potential usefulness but lacked empirical testing.

An inductive approach which was based on grounded theory was selected for the examination of spousal loss during the 13-36 month period of time. The grounded theoretical approach provided for the systematic collection and analysis of the qualitative data for the purpose of generating explanatory theory (Chenitz & Swanson, 1986).

As was characteristic of grounded theory, the conceptual framework emerged from the data. This

conceptual framework which examines spousal loss is discussed in Chapter 4.

CHAPTER 3

METHODOLOGY

Design

A qualitative approach which was based on grounded theory was utilized to gain information about the problems of the bereaved in the 13-36 month period which followed the death of spouse. Grounded theory provides a useful approach to understanding social processes and problems. The examination of grief, as a complex dynamic process, is suited especially to the grounded theory approach. A theoretical framework was sought from the study to serve as a guide in understanding spousal loss during this period of time.

Grounded theory, which emerged from the symbolic interactionist perspective, was developed through the works of George Herbert Mead (1934), Herbert Blumer (1969), and Barney Glaser and Anselm Strauss (1967). The symbolic interactionist perspective provided a useful approach to understanding human behavior and interaction (Chenitz & Swanson, 1986). Symbolic interactionists view human behavior as the process whereby the individual

interprets events to derive meaning, perceived meaning then serves as a guide to action (Chenitz & Swanson, 1986). Increased understanding of the perceived meaning and the interpretation of spousal loss by the bereaved was the goal of this study.

Health care implications of research which are based on this approach center around grief as a complex process and an effecter of health. It was predicted by the researcher that the grounded theory approach would facilitate the development of a new perspective on the problems of the bereaved and the process of extended grief.

Subjects

The potential participants for the study were clients of Big Sky Hospice prior to and for approximately one year following the death of their spouses. All potential participants had been closed to further bereavement follow-up by the Hospice staff. The widows and widowers were residents of the Billings/Laurel communities. Also, the subjects were assessed to be unknown to the researcher prior to being selected as potential participants. Furthermore, the participants were perceived to be functioning adults who were adapting reasonably well to spousal loss and were capable of providing voluntary informed consent. Finally, the demographic characteristics of the proposed subject population varied in age,

sex, religious convictions, family structure, race, socio-economic status, and circumstances prior to and following the death event.

Data Collection Process

A list of sixty-five potential participants were identified. Fifteen persons were selected randomly for the initial sample. Subsequent sampling occurred in waves of five; letters were mailed every two weeks. Thirty five letters were mailed; of those, five letters were returned as undeliverable due to lack of a forwarding address. Fourteen widows/widowers of the 35 potential participants who received letters agreed to be interviewed and therefore participated in the study.

The potential participants were randomly selected by the Hospice secretary. As potential subjects were selected, letters of explanation of the project (see Appendix A) and a consent to participate (see Appendix B) were mailed with a return envelope. Upon return of the signed consent forms, the researcher made the initial contact to arrange for an interview. All interviews occurred in the homes of the participants.

The interview method was selected to collect information about this problem because it allowed for obtaining information within the context of the

individuality of each person and situation (Garrett, 1942). Also, the method allowed for the interviewees to share feelings and experiences within the security of their own homes. The goal of the research interviews was to bring to light new knowledge of the problems of these bereaved adults within the designated 13-36 months postloss. The data were collected by conducting face-to-face interviews which provided the opportunity for spontaneous sharing. Participants were encouraged to share spontaneously and to describe their perceptions of grief. Open-ended questions were utilized to clarify, to maintain focus, or to summarize.

Prior to the interview, an opening statement was read (see Appendix C). A demographic questionnaire was completed by the researcher (see Appendix D). The initial two demographic questionnaires have been completed prior to the interview. Those questionnaires, conducted prior to the interview, impeded the spontaneity of the participant's response. Subsequent interviews were followed by the demographic assessment.

Following the opening statement, permission for taping was obtained. Early in the interview, several participants made reference to feelings of self-consciousness, but appeared to become more at ease as the interview progressed. Two widowers requested discontinuation of taping midway into the interview due to tearfulness.

However, taping was resumed after a break of a few minutes. Following completion of the interview process, five to ten minutes were spent in debriefing. The taped interviews then were transcribed in preparation for data analysis.

Protection of Human Subjects

The rights of the subjects were protected throughout the research project. The assurance of anonymity, the ongoing protection of confidentiality, and adherence to the outlined procedures for informed consent were maintained. The study was submitted and approved by the Human Subjects Review Committee of Montana State University, Bozeman, Montana (see Appendix E). Big Sky Hospice agency approval was granted by the Administrator of Northern Rockies Cancer Center (see Appendix F) and was reflected in the minutes of the Big Sky Hospice Advisory Committee, December 1, 1987.

Prior to being contacted by the researcher, subjects had been unknown to the researcher and had read, signed, dated, and returned consent forms which granted permission to be interviewed. Participation was voluntary and included ongoing assurance of the right to withdraw at any time. None of the participants were identified individually in the findings of this study. The signed consent forms were stored in locked files on the Billings

Extended Campus of Montana State University and were to be destroyed in three years. The interview tapes were erased after the completion of the transcriptions.

The risk of potential psychological stress which would be created by the interview process and the resultant reminiscing was identified by the researcher prior to the conduct of the research project. The interview approach allowed the participant to share as much or as little as he/she desired, with no noted untoward effects. Two of the participants required a break, midinterview, to allow for tearfulness and for regaining composure. The offer to discontinue the interview was refused by the participants. Several participants expressed appreciation for the opportunity to share their thoughts and feelings.

Demographic Characteristics of the Sample

The demographic characteristics of the sample are provided in Appendix G. The sample was comprised of a group of adults which ranged in age from 38 to 81 years. The participants were spousally bereaved 13-35 months earlier. The sample was comprised of five men and nine women. The sample included a wide range of occupational and educational backgrounds. The widows/widowers reported affiliation with a church and the majority expressed that their faith was very important.

Two of the participants had dependent persons at home at the time of the death event. One widow had three children/young adults who resided at home. A second participant had resided with his 35-year-old severely developmentally disabled son. None of the subjects were remarried at the time of the interview, and only one reported a significant relationship with a member of the opposite sex.

The vast majority of the sample had lost spouses to cancer. The majority had assumed primary caregiving roles for their spouses for periods which ranged from two to sixty months. The death events occurred primarily in the homes of the participants.

Data Analysis

Two major analytic strategies are jointly used in the grounded theory approach: the constant comparative method and theoretical sampling" (Buehler, 1982, p. 122). The constant comparative method is a procedure by which concepts, their properties, and relationships between concepts and properties emerged from the data. Major operations of this method are open coding and the constant comparison process.

Coding in the grounded theory approach is considered open in that categories, concepts, properties of concepts, and relationships between concepts emerged from the data,

rather than being preconceived (Buehler, 1982, p. 122). The comparisons process refers to comparing datum to datum (incident to incident) and category to category in order to establish underlying uniformity. Each of these operations will be discussed in the context of its specific use in this study.

During the interview process, initial coding began. The researcher jotted notes and ideas as the participants shared their experiences. Usually, coding begins later in the process; however, due to the professional exposure of the researcher to bereavement, some of the concepts emerged during the interviews.

Following transcription of the interviews, further coding occurred which involved underlining all relevant data and placing potential codes in the margins. The researcher then returned to the initial notes which were taken during the interview, and compared the content. The first interviews were read and coded by the members of the thesis committee to increase rater reliability.

As the concepts emerged from the raw data, the verbatim information was transferred to 5" x 9" cards. The initials, sex, and duration of bereavement of the interviewee were noted in the upper right-hand corner of the memos. This coding served as a guide for referring to the original data and/or to assist the researcher in

observing trends related to gender or duration of bereavement.

The memos also were coded categorically as the concepts or the dimensions of the concepts emerged. As the data (or memos) were reviewed, the researcher found that recall of the literature occurred; those citations were noted on the back of the cards for later use. Over time, a conceptual paradigm began to emerge. The comparison process consisted of the comparison of incident to incident; the comparison of concept to concept; and, finally, hypotheses emerged.

The second analytic strategy characteristic of the grounded theory approach which was discussed by Buehler (1982) was theoretical sampling. Theoretical sampling "is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser & Strauss, 1967, p. 41). In this research, the convenience sample was preidentified; and, the researcher did not collect data from outside the sample. However, the later interviews were influenced by the earlier interviews; therefore, the concept of theoretical sampling was applied.

CHAPTER 4

FINDINGS

Qualitative Analysis

The focus of this study was to identify the problems of bereaved adults 13-36 months after the death of spouse. A qualitative approach which was based on grounded theory was selected to examine this problem. This theoretical approach was selected due to appropriateness for the analysis of social problems and processes and for usefulness in generating theory relative to those processes. An essential analytic technique characteristic of grounded theory was the constant comparative method of analysis. This was the procedure whereby concepts, their properties, and relationships emerged from the data (Buehler, 1982, p. 122). These relationships were identified by coding and by comparative processes. As the concepts and the properties of the concepts emerged, the paradigm for examining the processing of loss 13-36 months after the death of spouse evolved. This paradigm is presented in Figure 1.

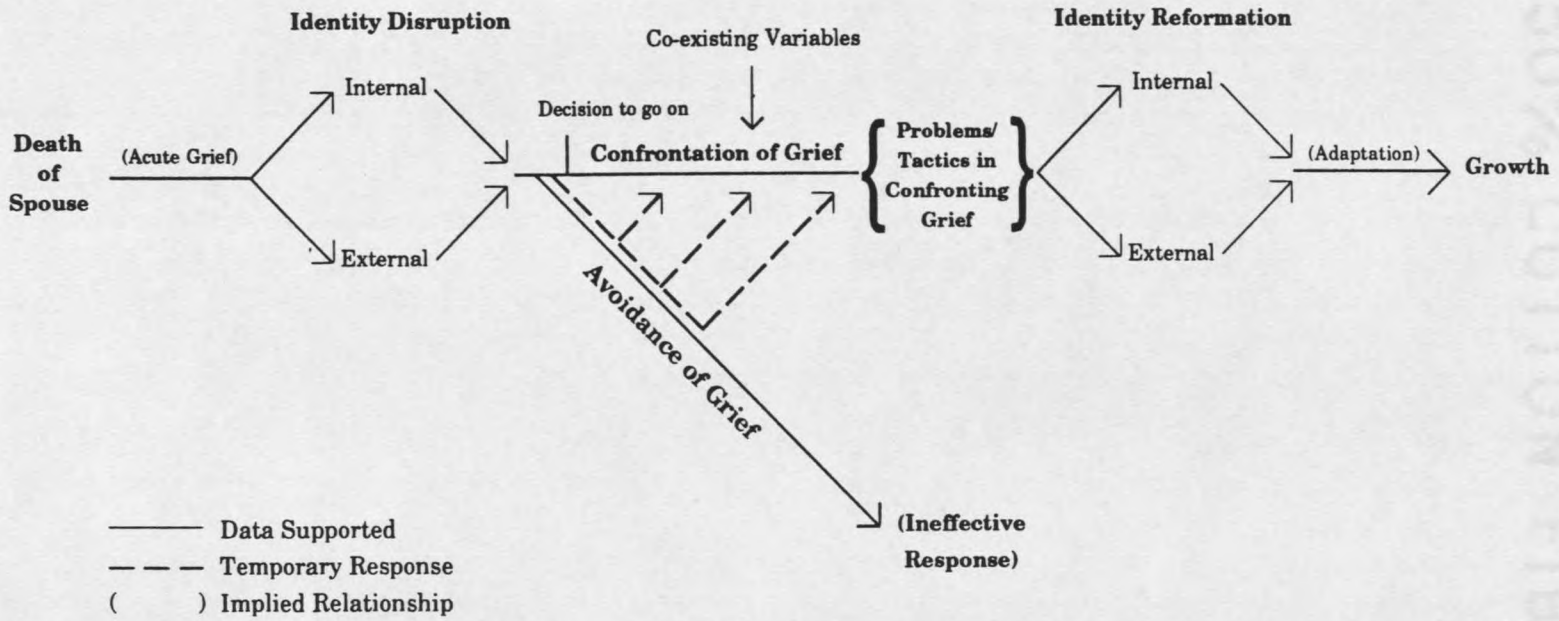

Figure 1. A Paradigm for Viewing the Processing of Loss 13 - 36 Months After the Death of Spouse

Processing Loss

The major core variable which emerged in this study was the processing of loss in the 13-36 month period after death of spouse. The processing of loss in the 13-36 month period of bereavement, as depicted in Figure 1, was comprised of several major concepts. These concepts included identity disruption, confrontation/avoidance of grief, identity reformation, problems/tactics in confronting loss, and growth resultant from working through grief.

Dimensions and properties of these major concepts also emerged and are discussed in detail in the following text. Although the processing of loss was depicted as a developmental progression in the paradigm, the process did not occur in an orderly progression. In reality, processing grief was comprised of a series of progressions and regressions.

Identity Disruption

A major concept of the process of dealing with loss, as identified by participants in this study, was identity disruption. Identity disruption was described as "the destruction of (one's) integrity" by an elderly widower who went on to explain: "one-half of you is gone; and when you've been married so long (54 years), there's nothing

left of yourself. It's difficult to go on living." The concept of identity disruption was applied to that internal change in the perceived sense of self which was precipitated by the death of one's spouse.

Occurring as a consequence of the death of a spouse, identity disruption involved two dimensions: first, the internal disruption of the sense of self; and, secondly, the external disruption of one's social world. The properties of those dimensions, internal and external, are described in Figure 2.

Internal Identity Disruption

Internal identity disruption was reported to be one of the most disturbing and surprising effects of spousal bereavement. This disruption of the perceived sense of self was described as the loss of "who and how I once was."

This disruption of internal identity was comprised of at least four properties as reported by the participants. (1) the loss of one's self-integrity; (2) the loss of self as an extension of the other; (3) the loss of identity support; and, (4) the loss of affectional intimacy.

Loss of One's Self-Integrity. The loss of one's self-integrity was described as the disruption of intellectual, emotional, and spiritual aspects of one's internal self, which had been intact prior to the death event. One 64-year-old widow stated: "I absolutely felt

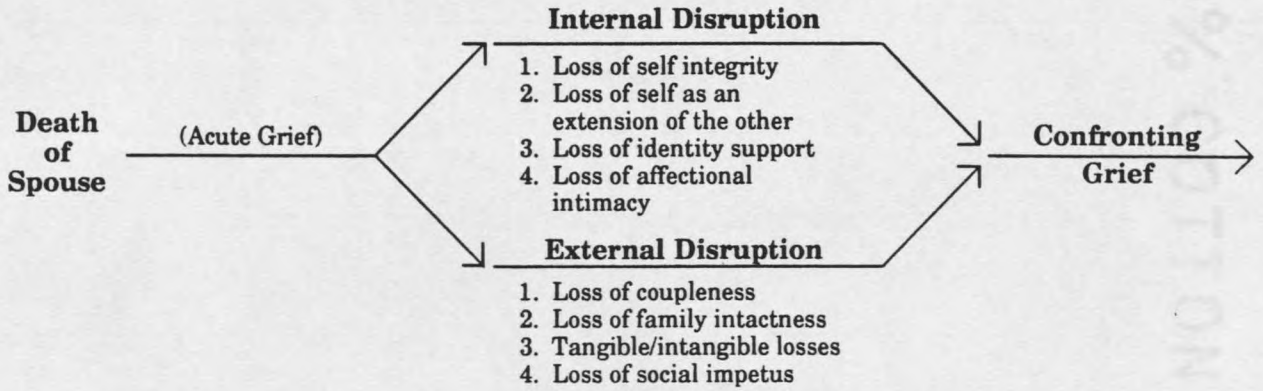

Figure 2. A Diagram Depicting Identity Disruption Subsequent to the Death of Spouse.

as though I had been split apart. I completely lost my memory; I felt stupid. Emotionally, I was shattered."

Intellectual disruption was identified as one aspect of this loss of self-integrity. This intellectual disruption was described as "confusion," "difficulty organizing one's thoughts," "inability to concentrate," "loss of memory," and lack of the "ability to sort out the past chronologically." Several participants stated that the death of spouse became the primary reference point around which other events pivoted. These cognitive problems reportedly were unexpected and were problematic for the bereaved and those around them. A widow complained, "I was totally 'unaccountable' and that bothered my friends; they didn't seem to understand."

Emotional disruption was a second aspect of the loss of self-integrity. This problem was identified as the loss of emotional control. "I used to be so calm and composed," reported one widower, "not anymore." He went on to describe that he had "prided himself" on this emotional control and was extremely distressed by this loss. Two of the elderly widowers, who were bereaved 28 and 33 months, reported hesitancy to attend a grief group, "even yet," "for fear of breaking down." They reported being embarassed by tearfulness that had "lasted so long."

A spiritual component to this loss of self-integrity also was described by these participants. The spiritual

aspects of the loss of self-integrity centered around the "loss of faith," "loss of confidence in God," and the need to "re-examine" one's own belief system. Commonly reported was that personal faith constructs "had been shaken." For several this was temporary, for some "anger at God" persisted for extended periods of time; and, for others, personal belief systems emerged stronger.

Loss of Self as an Extension of the Other. The second aspect of the disruption of the internal identity centered around the performance of roles and the interconnectedness of those roles as performed by and for each other. One aspect of this property was role performance from the standpoint of caring behaviors. As was identified, the majority of the bereaved had assumed primary caregiver roles for their ailing spouses for an average of 18 months. The death of spouse resulted in the loss of that caregiving role and the resultant loss of "sense of purpose." A 63-year-old widower stated: "Caring for her gave my life meaning; when she died, I was lost."

The second aspect of role loss involved confrontation with tasks or roles previously performed by the deceased. These were roles for which the bereaved did not feel prepared. This second aspect of role loss was described as the loss of someone "to share the load" and/or to "do the things that are hard for me to do, and that

I really don't want to do anyway." These role performance challenges resulted in loss of self-confidence which, for some, was temporary. Assumption of these roles and tasks reportedly "forced me to stand on my own two feet without my husband to lean on."

The widows reported difficulty in assuming responsibility for financial decisions, legal issues, and mechanical problems. The widowers complained of greatest difficulty with domestic and social issues.

Loss of Identity Support. The loss of identity support centered around the loss of the sense of being valued. That sense of being valued was dependent upon reinforcement from the spouse. A 64-year-old widow, who was bereaved 24 months said, "You just don't have that encouragement at home anymore." Others identified the loss of being made to feel "special," "pretty," "capable," or "the best husband around." Two of the bereaved expressed that the loss of encouragement and affirmation became increasingly significant as time went on.

Secondly, the loss of identity support was reflected as the loss of "your reference point." One 75-year-old widow, 25 years younger than her husband, became "old" and reported "looking toward the end" since the death of her husband. She explained that in her husband's eyes,

she always had been "his bride," although he was 100 years old at the time of his death.

Loss of Affectional Intimacy. The fourth aspect of internal identity disruption was the loss of affection, which was provided by the deceased. The loss of affection was reported by several of the participants, both men and women; significantly, this problem persisted beyond the first year. "You just need someone to hug you," reported a 73-year-old widow, bereaved 15 months. Another widow said, "I just miss his touch and holding his hand. Sometimes I sit in his chair to recapture that sense of his touch." The affectional void had been addressed for several of the participants with the substitution of pets.

In summary, the loss of spouse affected the internal identity or self-perception of these bereaved adults. This internal disruption was reflected in the perception of self-integrity, in the perception of self as a part of the other (spouse), in identity support, and in affection. These components of internal disruption distorted the assumptive worlds of the bereaved. This distortion continued to be a significant problem for the participants in this study.

External Identity Disruption

Identity disruption, which was created by the loss of one's spouse, also extended into the social words of

these bereaved adults. This social dimension of identity disruption was identified as external identity disruption.

External identity disruption was described as a composite of other losses: (1) the loss of coupleness; (2) the loss of family intactness, (3) tangible/intangible losses; and, (4) the loss of social impetus. This composite of losses affected both the intimate (family) relationships and the less intimate (social network) relationships of these bereaved men and women.

Loss of Coupleness. The loss of coupleness was reportedly the most significant of the social losses. "Facing being single was the hardest thing for me to face up to," reported one 58-year-old widow, bereaved 15 months. This widow added, "I still use 'Mrs.' in front of my name and I don't care." Others reported resenting having to indicate a category other than married when completing demographic information. Several refused to identify themselves as single or widowed; they continued to designate married when given the option.

In addition to categorical singleness or loss of coupleness, other social implications of singleness were reported to be distressing. A 63-year-old widower stated, "When you lose your wife, you lose your married friends; it's never the same. Couples don't like to come over because there's nobody for the wife to visit with; she

just has to sit and listen to men talk." This loss of married friends was identified as significant by the majority of these widows/widowers.

A few of the widowers in the study reported accentuated concern for self as a consequence of singleness. These men expressed the fear, "what will happen to me if I become ill?" They had depended on their wives should "something happen." Self-concern was not identified by the widows in the study.

Loss of Family Intactness. A second aspect of external identity disruption was the change in family structure which resulted in a loss of intactness of the family unit. The death of a pivotal family member changed the relationships of the family as a whole. This change was described by the bereaved as "something missing" or "it just isn't the same for me."

Several participants had married adult children; they reported that this change in the sense of family extended secondarily into these families. The loss of the family matriarch or patriarch was experienced by the grown children. In some families, this loss provided the impetus for growth; in others, the family bonding was said to have been weakened by the event.

Tangible/Intangible Losses. The third aspect of external identity disruption consisted of the integration

of tangible/intangible losses subsequent to the death of one's spouse. Several widows in the study reported significant financial implications which resulted from the death of the husband. Social changes were created by the financial loss and resulted in changes in social status. These status changes then impacted the survivor's own identity. The implication was that one major loss precipitated a series of minor losses. All of these composite changes impacted the survivor.

Loss of Social Impetus. Social roles and social impetus that had been provided by the spouse of the bereaved were losses identified by the participants. One widower said, "she was my push socially; I have to force myself now." Another described fighting the tendency toward social isolation without the presence of his/her spouse to initiate and to arrange socialization. Several of the participants explained that the spouse had assumed full responsibility for the social activities as a couple.

In summary, external identity disruption was identified as the disruption of the social worlds of these bereaved men and women. This disruption was precipitated by the death of spouse. The impact of this loss was felt in both their intimate worlds and in their extended social networks.

Coexisting Variables

Prior to discussion of what the bereaved men and women did to confront or avoid grief, an examination of variables identified by them as affecting their processing of grief was made. Coexisting variables were factors which occurred or existed postloss that were identified by these participants as exacerbators of the bereavement process. Factors which were identified by the participants in this study included: (1) the poor health status of the bereaved, both preloss and postloss; (2) depletion of one's social network due to the isolation of long-term illness or depletion due to death of friends; (3) concurrent losses; and, (4) previous experience with loss.

Several of the participants in the study demonstrated or reported poor health status as an isolating factor which affected dealing with grief. A 60-year-old widow said, "I guess when you're well you can handle things better, but when you don't feel good, it's harder." A 78-year-old widower reinforced those comments and added that not being able to "get around like I once did leaves me with too much time at home just to think." The poor health status of the bereaved complicated the process of grieving.

A second coexisting variable which was identified by the participants was depletion of the social network of the bereaved, which resulted from long-term illness and/or the death of friends due to advancing age. The chronic illness of a spouse and long-term caregiving demands are obvious social isolators. This social isolation led to a perceived decrease in the postloss support of several of the subjects. A second example of depletion of the social network was cited by an 81-year-old widower: "All my friends are dead. Over time, you lose them one by one; then there's no one left when you need them." This depletion was an apparent consequence of advancing age. Other factors which created social isolation were the long-standing preloss demands of caring for a severely handicapped child and childlessness as reported by three of the participants.

Concurrent losses comprised a third category of identified coexisting variables which seemed to exacerbate the grieving process. Several participants in the study had experienced an intensification of the grief process due to the concurrent loss of a significant person. One 58-year-old widow described losing her mother exactly four months after her husband's death, and she reported "that really made things worse." A second example was the loss of a grandchild by a 53-year-old widower "at the time when I should have 'been over' my wife's death. That brought

everything back, and my friends thought I was losing it." These subsequent losses reportedly intensified the grief of spousal loss.

Although three of the coexisting variables seemed to accentuate the grieving process, one factor was identified as positively impacting grief. That factor was previous experience with loss which resulted in the confidence that the bereaved "could get through it again."

Confrontation vs. Avoidance of Grief

The bereaved in the study demonstrated individual differences in the processing of grief; however, the majority gradually were restoring balance in some or all spheres of functioning. One step in that processing, which was identified by several of the participants as a turning point was the "decision to go on." This decision was described as either a conscious decision to confront the grief or an avoidance strategy. A 64-year-old widow who was bereaved 24 months stated, "I think you have to come to a point that you decide to go on ... given that decision, then you kind of withdraw inside yourself, with your own grief; and you process it. After that, you're ready to make an effort and start to live again." (See Figure 3). This identified turning point was described as either a conscious choice or as a decision which was reached by default. A 78-year-old widower

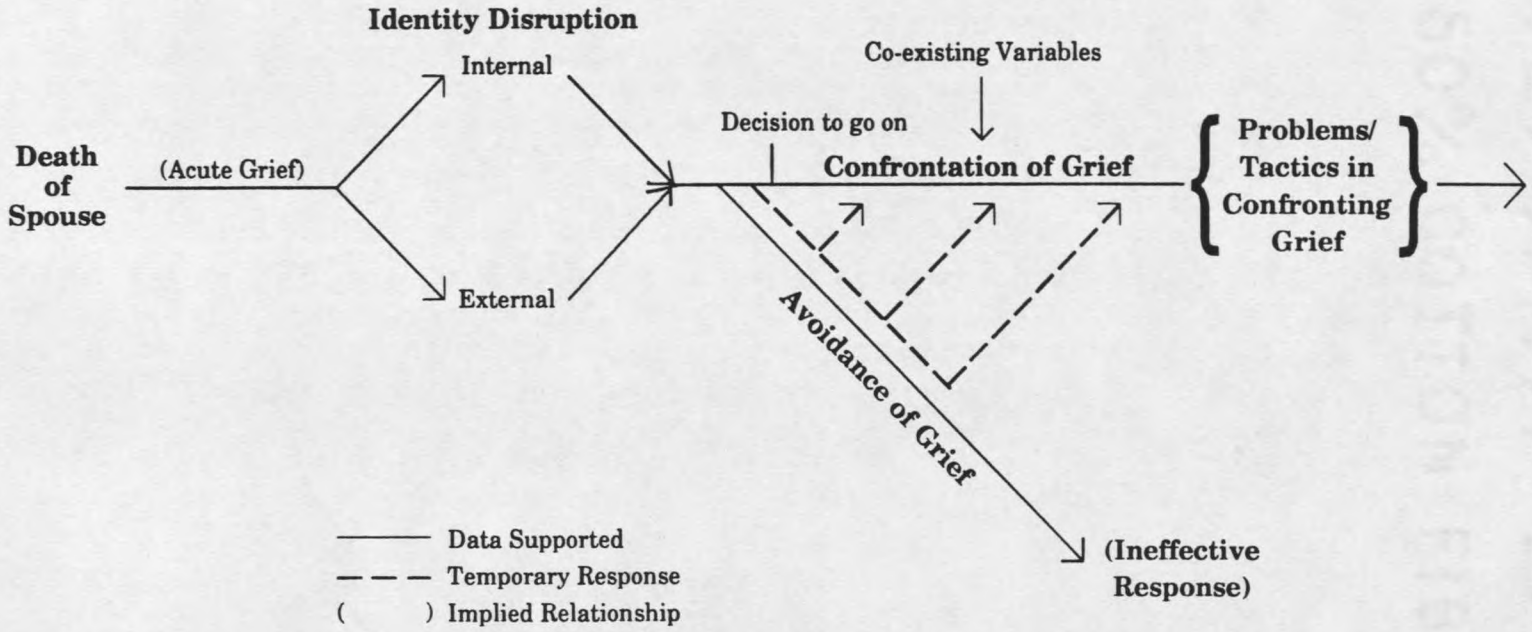

Figure 3. Confrontation vs. Avoidance of Grief

described this second alternative as "what choice do you have; you have to decide to go on." The respondents described decision-making as an ongoing and recurring process.

Several of the participants in the study demonstrated avoidance of grief with resultant failure to recover. One widower demonstrated prolonged avoidance of grieving by continuous hyperactivity. This behavior seemingly was a defense against depression which had been a preloss problem. The bereaved's life was one of continual volunteerism and substitution of another intimate, which left little time to deal with his problems. The immediate bonding to another woman served to isolate him further from his support systems as friends were not ready to include another woman in his wife's place.

A second widower was complicating his grief with overreliance on alcohol as a means of coping resulting in emotional and social withdrawal. The third person demonstrated avoidance by projection of anger at the deceased spouse; this anger was expressed as "feeling abandoned" by the deceased spouse. The widow continued to vacillate between a focus on self and past issues with little acknowledgment of personal implications of the loss and the continual projection of anger at her deceased spouse and others.

Other avoidance techniques which were employed or identified by persons who were processing grief were temporary avoidance and/or the struggle for reunion (symbolically). Temporary avoidance appeared to serve the purpose of providing respite from grief. One participant stated: "there are times when you just have to get away from it. You can't continue to deal with your pain every minute of every day." Another person described temporarily avoiding current pain by mentally thinking of the reunion that would occur at the time of her own death. The bereaved who described these avoidance techniques demonstrated additional constructive ways of handling their grief.

The focus of this study was to identify problems of normal grief during a select period in the grieving continuum. The demonstration of avoidance techniques stimulated theoretical questions that demanded further inquiry especially as the concept of grief has been expanded to include the extended duration of normal grief. The majority of the participants demonstrated grief that was being processed with expressed progress as indicated by decreased intensity and reduced frequency of severe recurrence; however, several of the participants demonstrated problems that suggested need for intervention.

Problems Reported by the Bereaved and Tactics Employed in Resolution

Problems which were reported by the bereaved in confronting or working through grief comprised the substantive content of this research (see Table 1). The major problems and dimensions of those problems were identified and described by the research participants.

Dealing with Guilt

Working through guilt was reportedly a major problem for these bereaved adults. Three dimensions of guilt were shown. Those three dimensions were (1) dealing with regrets, (2) dealing with self and societal expectations, and (3) survival guilt.

The first, and most significant dimension of guilt, was dealing with regrets. This dimension was reported by the vast majority of participants. Dealing with regrets was described as the mental processing of omitted and committed actions or attitudes toward the deceased that were later regretted by the bereaved. Examples of actions or attitudes which were omitted and were later regretted included: "I wish I had taken more time to ...", "I wish I had been more comforting"; or, "I wish I had been a little nicer."

TABLE 1

Problems Reported by the Bereaved and Tactics Employed in Resolution

Problem	Dimension of the Problem	Tactics Employed in Resolution
Guilt	Dealing with regrets	Mental review (omissions / commissions). Forgiving self.
	Dealing with expectations (self and societal)	Coming "to grips with" expectations. Sharing the irrationality of guilt. Reality testing.
	Survival guilt	Resolving the loss philosophically. Self-aggrandizement.
Memories	Developing realistic memory of deceased	Reminiscing.
	Dealing with pivotal events	Accepting difficult times.
	Processing dreams	Mental review of dreams.
	Dealing with contextual stimuli	Direct confrontation/avoidance of stimuli.
	Dealing with anticipatory grief	Reflecting on the positive and negative effects. Accepting time for recovery.
	Dealing with suffering	Viewing death as release. Mental escape.
Loneliness	Dealing with loss of spouse	Increased social activity (quantitative/qualitative). Nurturing behaviors.
	Dealing with loss of coupleness	Developing new social roles. Nurturing behaviors.
Forgetting	Dealing with fear of forgetting (self)	Holding on to memories and images of deceased.
	Dealing with others forgetting	Sharing in reminiscing.

TABLE 1 - Continued

Problem	Dimension of the Problem	Tactics Employed in Resolution
Promises to Deceased	Fulfillment of promises to deceased	Completion of tasks and/or projects. Purchasing promised objects. Adaptation in lifestyle.
Longevity of Grief	Accepting longevity of grief (self vs. others)	Learning to accept that it takes a long time. Accepting anniversary reactions. Becoming informed about grief.
Stigma	Resolving internal stigma Resolving societal implications of stigma	Building a self-concept of singleness. Developing a philosophy about aloneness. Fostering a circle of single friends.
Abandonment	Resolving the intraphysic struggle. Reconciliation of the memory of the deceased	Maintaining a cognitive awareness of reality. Reconciliation of the memories. Increased sense of competency. Developing a philosopy about the death.
Betrayal	Dealing with the sense of betrayal (if involved with another)	Achieving perspective on status of old relationship.
Emotional Control	Dealing with fear of losing emotional control	Avoiding others. Not talking about it. Allowing for passage of time.

Actions or attitudes which were committed by the bereaved included: "I wish I had known her eyesight was failing; I would have handled things differently. I lost my temper when she kept knocking her water off the nightstand." Another example, reported by a 63-year-old widow was: I wish I had not called the ambulance in the room where (he) could hear me. I did not know until later that the hearing probably remains intact until death." Strategies for dealing with these regrets included mentally reviewing these events, searching for one's contribution to the events, and forgiving one's self.

The second dimension of guilt which was reported by the widows/widowers was dealing with expectations which were imposed by self and others. The reported expectations focused on the "shoulds" of widowhood/ widowerhood: appropriate sadness, grieving the right way, guilt over having fun. Whatever the manifestation of this form of guilt, these participants recognized their feelings as irrational. One identified tactic for dealing with these expectations was the "coming to grips with" self-imposed expectations. That included a mental reviewing of what "I really need to do versus what I feel I need to do." A second tactic which was employed by the bereaved for dealing with expectations was the sharing of the irrationality with others. A third tactic was reality testing.

Reality testing was described as testing or affirming how one was doing in the role of bereaved by seeking information from one's close social network. "I really did not know how I was doing. I would say, I don't know, you tell me."

The third dimension of guilt centered around the bereaved's guilt that he/she had survived while the spouse had not. Rando (1984) has called this form of guilt "survival guilt." Two of these bereaved had lost spouses to cancer while surviving cancer themselves. A 58-year-old widow said: "After all, I had cancer and I fought it. I feel bad that he could not have fought it too." One widow shared her tactic for dealing with survival guilt as "developing a philosophy about the loss," thereby releasing herself of the guilt.

One 75-year-old widow stated that she felt that guilt or regretting was a "universal phenomenon though rarely admitted." She added that she felt "societal prohibitions prevented the sharing of guilt." This elderly participant stated that she felt that self-aggrandizement was one way we, as humans, process personal guilt. She explained: "sometimes people's reaction to the sense of guilt is telling you how good they were; you see, they are trying to persuade themselves or release themselves of guilt."

Reworking the Memories

The second problem in working through grief that was identified by this population was the reworking of memories. The dimensions of the problem which were reported by these participants were developing a realistic memory of the deceased, dealing with holidays and anniversaries, dealing with dreams, dealing with contextual stimuli, and processing the effects of anticipatory grief and diminishing the indelible memory of suffering.

Developing a realistic memory of the deceased was one reported dimension of memory reworking. This involved reminiscing, which was described as the process of recalling the past and sharing the story. A 75-year-old widow, bereaved 15 months, stated, "You have to integrate the memories into your own life, the life that you have left. Telling the story to others helps in that process." She added, "there is a sweetness and fondness in those times of remembering, and, at times, some pain." For some, these recollections served the purpose of maintaining the memory of the deceased or of "holding on to her."

A second dimension which was identified was dealing with the pivotal events, i.e., anniversaries and holidays. Several of the interviewees expressed that

those days served as reminders of the aloneness. The participants were surprised at the intensity of the melancholy that would recur. As one widow said, "reality and acceptance aren't the same thing; acceptance is reflected in the day to day, the Sundays and holidays are reality. You feel that you're making it fine, and then they (Sundays) come along." The tactic for coping was expressed as recognizing difficult times; but, as one said, "you get through them, a day at a time."

A third dimension within the reworking of memories was the processing of dreams and dealing with the significance which dreams held for the bereaved. The mental process of dream review involved reflection and remembering. Several of the widows/widowers spoke about dreams and the reflective process that dreams precipitated. A few of the bereaved attached negative meaning to dreaming; either the person felt guilty about the paucity of dreams, or the content of the dreams evoked a feeling of sadness. Another person reported that the dreams served to help put things in perspective; for example, the widow said that her dreams released her from feeling guilty about circumstances which had occurred prior to her husband's death.

Dealing with contextual stimuli was a fourth identified dimension of the dealing with memories.

Contextual stimuli were items or personal effects of the deceased that elicited an intense emotional response in the bereaved. A 58-year-old widow, bereaved 18 months, described going down to her storeroom and discovering a box of automobile maintenance supplies that her husband had prepared for her. She reported her initial moment of extreme sorrow which was followed by a peaceful feeling. Others identified personal effects of the deceased or a favorite food of the deceased as eliciting overwhelming response. Over time, as reported, these recurrences of sorrow decreased in frequency and in intensity.

Direct confrontation was described as a strategy for dealing with the contextual stimuli. A 64-year-old widow, bereaved 24 months, described this phenomenon: "I force myself to do some things that I know will remind me of my own loss but will help me to build my confidence and help me to process my own grief." Examples that she provided included going to a nursing home while knowing that the wheelchairs would be reminders and would elicit painful memories. In addition, spending time with an elderly grieving woman created a resurgence of grief. This widow admitted that these tactics were intentional and that she allowed herself time to "recover, reflect, and reminisce" after each painful experience.

The prolonged effects of the preparatory time, i.e., "anticipatory grief," were reported by the participants as both positively and negatively impacting the grief process. Anticipatory grief as a positive impactor of the grief process was identified as "allowing the time for us to become closer," as reported by a 58-year-old widow, bereaved 18 months. Another positive outcome reported by a widow was that the time allowed her husband to "draw closer to God." Three participants reported that the time of getting ready was helpful to allow for time to adjust to what was ahead, and that the time allowed for winding up some loose ends, or closure. One widow stated that "I began to think in terms of being alone; although, you can never really get ready."

The anticipatory time, although perceived as somewhat beneficial, also reportedly created difficulties. One of the reported problems was the anxiety created by the impending separation. The widow reported an intense anxiety in herself that she had to hide by building up a wall, in order to present her husband with hopefulness. She went on, "I had to be strong because I didn't have any idea what he was going through, absolutely none. That was a terrible period of time for me." The protection of the other (spouse) and the holding in of emotion reportedly created preloss anxiety and depression for the bereaved.

Another widow reported that, although she was allowed one year to prepare for her husband's death, the majority of the time was spent problem-solving rather than dealing with the impending loss; therefore, she felt the time to be detrimental. She reported, "all along I was just coping with problems; the crisis of grief came afterward." The intense caregiving demands which were created by an ailing spouse presented her with the continual need to problem-solve which the widow later perceived as interfering with the anticipatory processing of the grief.

Anticipatory grief as a potentially negative impactor of the grief process also was identified by a 53-year-old widower, bereaved 18 months. He stated that because he had lived with his wife's illness for 10 years, that 10 years would be added to his recovery time. This finding is contrary to the opinion of Rando (1984) that the postdeath reaction may be more abbreviated in cases where a period of anticipatory grieving has occurred.

A final note with regard to anticipatory grief was provided by an elderly interviewee. The 81-year-old widower stated that his wife had been suffering from a chronic long-term illness for many years. She then died prematurely from cancer, and he felt the untimeliness of her death provided him with little time to prepare. The

description of his own grief process approximated a description of sudden loss with an accentuation of shock and denial, which was not reported by other participants.

The final dimension of reworking of memories centered around the issue of suffering. The recurring memories of the ravages of illness and death of a spouse, especially the last moments spent together, were reported as "indelible." Resolution of the pain induced by these memories takes time. It was helpful to the bereaved if they had participated as caregiver and felt that everything possible had been done.

Suffering was viewed as an essential component in the readiness to release their spouse to death. "He had been through so much, it was almost a blessing when he went," reported one 73-year-old widow. Themes of relief were described by several of the widows/widowers. One widow stated it was mandatory for her "to fit the suffering into my (her) own religious perspective, defining God's role in it all." This widow had justified the suffering with the explanation that "God suffers with us." An identified strategy in dealing with suffering was the practice of escaping to a place where the memory of the suffering was absent. A 63-year-old widow described the release she felt when escaping to their cabin at West Yellowstone where she "had not seen suffering."

In summary, memory of the deceased was described as selective and episodic. For some, it came in flashes, often combined with intense feeling. All acknowledged the importance of dealing with and sorting through the memories as an essential component of making sense of the loss.

Dealing with Loneliness

Dealing with loneliness was reportedly a major problem for a majority of the interviewed bereaved, widows and widowers alike. The loneliness resulted from the loss of interaction, reciprocal identity support, absence of someone to care for, and loss of companionship (spousal and other couples). Several of these concepts were discussed earlier in reference to internal/ external identity disruption (see pp. 44-52).

The subjects listed mainly situational reasons for the loneliness, namely loss of spouse. As one 78-year-old widower described, "It's lonely for me now, that's all I can say; it's just lonely." A 67-year-old widow related the loneliness to "aloneness, especially on Sundays and holidays...he enjoyed them so much, and I miss that." Another 63-year-old widow reported that loneliness was the most difficult part: "the loneliness, just being alone. We did everything together; we had been a very close couple." A 63-year-old widower identified an additional

contributor to his loneliness as isolation from "couples that used to come over, and now don't come to see me." He explained this as, "well, I can understand why. The women don't like to come, there's nobody to visit with except the men."

The tactics for dealing with loneliness fell into the categories of increased social activity and interpersonal interaction, developing a new social role, and focusing on self-development. Other strategies which were identified by the participants included keeping busy, getting out among people, and enlarging their social worlds. One 63-year-old widow suggested broadening the base of one's social network as a strategy which had been effective for her. Several of the widows/widowers relied heavily on nurturing behaviors toward others to allay loneliness. Many of the participants identified contributive behaviors as an essential step in allaying loneliness and in coping with one's own grief.

Increased socialization demonstrated both relational and nonrelational dimensions. Some of the participants reported the interactive value of socialization and nurturing of others as a strategy to deal with their own loneliness. A few persons described just going to the mall which was comprised of a nonrelational activity. A few of the widows/widowers adamantly denied that

loneliness was a problem for them with activity being the primary prophylaxis for loneliness.

Fear of Forgetting (Self vs. Others)

Several of the respondents reported the fear of forgetting as being a significant problem during this period in their grief. A need appeared to hold on to the memories and images of the deceased with an expressed fear of forgetting. One person stated: "It's getting hard to remember; I don't want to forget." This holding on seemed to be a legitimate and necessary step in gaining an overall perspective.

The other side of the forgetting issue expressed was that friends were forgetting too soon. One described this phenomenon as "people have a short memory; they act like he never existed." When asked about the desired responses, the comments were: "to mention him by name" or to feel free to "talk about him." Avoidance by others was viewed as a negative or an unhelpful response by individuals in the bereaved's social network. Sharing in reminiscing was reported to be a helpful tactic.

Living Out Promises to the Deceased

Another problem/issue which was identified by the widow(er)s was the living out of (or fulfilling) promises to the deceased. Several participants in the study still

were involved actively in fulfilling promises to their deceased spouses. This fulfillment took the forms of project completion and purchase of objects as well as adaptation in lifestyle. An example of this concept was that one widower had built and had completed their dream home. Another widow had purchased the matching recliner chairs that she had promised her husband. A third example that involved an ongoing lifestyle issue was the initiation and promised continuation of tithing to the church.

These examples demonstrated promissory actions with consequential effects. It was obviously important for the grievers to have the opportunity to close on those promises to the deceased. When those actions threatened the needs of the bereaved, compromising the bereaved, intervention seemed appropriate. In some instances, the completion of promises created financial hardships on the bereaved.

Accepting the Longevity of the Grief Process

Several of the participants in this study identified self-expectations with regard to the appropriate duration of grief. "I didn't think it would last so long," stated an 81-year-old widower bereaved 33 months. Several stated that unrealistic expectations regarding the duration of grieving had exacerbated the problems which they had

encountered. "I was expecting a few months of this" stated a 64-year-old widow, bereaved 24 months, "but not years!" Anniversary reactions were expected and were reported as normal. However, several stated that they did not expect those anniversary reactions to continue beyond a year or two.

In additional to internal expectations (self), societal expectations also created difficulty. "My friends expected me to be over this by now," stated one participant. Another widow said, "I think my family is worried about me; they did not think it would take me so long."

Strategies which were reported by the sample included acceptance of the longevity of grief and acceptance of the recurrence of anniversary reactions. In addition, several stated that they felt it was helpful to become informed or to learn about grief.

Dealing with Stigma

Dealing with the stigmatization of widowhood was reported to be a difficult problem for several of the widows in the study. None of the male participants reported the problem. The aspects of stigma which were reported by some of the widows focused on the internal components of stigma. One described, "I'm still fighting old fashioned ideas such as going out to eat alone; going

out to have a drink alone." Another widow reported: "once in awhile I feel ostracized because I'm alone, but that's not because of others, I think it comes from inside me as a result of my own feelings." The theoretical question of stigma as an internal process, as well as an external or societally induced phenomenon, demands further conceptual inquiry especially as related to the bereaved.

Another dimension of stigma described was social stigma which referred more to the stigmatization that is forced upon the elderly. A 63-year-old widow perceived herself as being "one of the older women who just fade away. Clerks are not anxious to wait on you...it's just different. I don't know if it's age or just a sensitivity to being alone." This was a troublesome phenomenon for her to deal with. She went on to express feeling "insignificant."

The strategies for dealing with stigmatization involved internally "becoming comfortable with being alone" and "developing a philosophy about aloneness in today's world." A second strategy involved dealing with the societal implications which were resolved by developing and "fostering a circle of friends who are also alone."

Dealing With the Sense of Abandonment

Two of the widows, 18 and 20 months into the grief process, described abandonment which was problematic. One of the women expressed a sense of questioning: "How could he do this? How could he leave me?" This was acknowledged as irrational. The woman admitted that intellectually, "I know there was nothing he could have done differently, except maybe to have quit smoking years ago; nonetheless, I feel deserted at times." This intrapsychic struggle seemed to represent the struggle to develop a new (and realistic) relationship with the deceased. A 58-year-old woman was struggling with the issue of abandonment; reporting uncharacteristic behavior of her spouse as a problem. The woman struggled to maintain cognitive awareness of reality and to acknowledge the "irrationality" of this pattern of thinking. Each of the two women shared similar expression of feelings related to abandonment, and both had been bereaved less than two years.

The strategies for dealing with the sense of abandonment appeared to center around resolving the intrapsychic struggle. This struggle involved reconciliation of the memories, establishing an increased sense of competency, and developing a "philosophy" about death. "You think your way and work your way through it, knowing all along that his death was not intentional on his part."

Dealing With the Sense of Betrayal

Two widowers expressed that dealing with a sense of betrayal was a problem. An 81-year-old widower shared the sense of betrayal which he would feel if he "became involved with anyone (female) else." He went on to explain that although death had separated him from his wife of 44 years, death had not ended their relationship. He explained that instead of her presence, he now relied on memories of her to keep her alive in his mind. (He was also the person who most strongly reported fear of forgetting as a major issue.) Failure to achieve a balance in the perspective on the new status of the relationship with his wife prevented his willingness to consider reinvesting in another relationship. The advanced age of the bereaved and the longevity of the marriage relationship were apparent contributing factors.

Dealing With the Fear of Losing Emotional Control

Several of the widowers, 28-33 months into the bereavement process, expressed that the fear of losing emotional control was an important factor. One of the men reported, when discussing his invitation to join a widowers' club, "I turned them down because here at home I can keep my composure. I'm still afraid of breaking down" (28 months postloss). He also explained his refusal to join a grief support group for the same reason.

Another widower concurred with the first in explaining his fear of losing emotional control.

Tactics for dealing with the problem included "staying away from others, so I don't break down" and "not talking about it, so I don't cry." One widower said that he dealt with this fear of losing emotional control by "letting time pass, in the hopes it would get better." The refusal to avail themselves of support systems, both therapeutic and social, on the basis of expressed need to maintain emotional composure seemed unfortunate. The implications of this issue, possibly gender related, and generalizability to other populations demanded further exploration.

In summary, the process of dealing with, or confronting grief is a long and multi-faceted process. As one 75-year-old widow stated: "It is all a matter of time, but I think it's how you work with that time that determines how you come out in the end." Problems and process issues for these bereaved men and women, at this time in their bereavement, involved a composite of external and intrapsychic behaviors to facilitate the successful resolution of the loss. The development of successful strategies enabled the problems to be dealt with and the confrontation of grief to occur.

Identity Reformation

As the process of confronting the loss and dealing with the grief occurred, the process of identity reformation began to emerge. This major concept was identified by the bereaved as the consequence of time and effective processing. An expressed awareness was that a transition was taking place as the identity was shifting from a sense of "we" to an increased sense of "I." The reformation process was comprised of two dimensions, internal and external reformation.

Internal Reformation

Reformation of the internal identity was one of the major dimensions of this reformation process. A 73-year-old widow said, "What you have to do is develop your own personality, your own sense of who you are."

The properties of or subprocesses in this reformation of the internal sense of identity included (1) developing a "philosophy" about the loss or "gaining perspective"; (2) personal growth and an increase in self-competency; (3) self-actualization; and, (4) participation in contributory/nurturing behaviors or "giving back" as that rewarded one's self.

Developing a Philosophy About the Loss. The first step in this reformation of the internal identity which

was identified by several of the widows/widowers was developing a philosophy about the loss, or gaining perspective. This process was described as developing an openness to grief to permit new awareness to emerge. One 63-year-old widower stated: "You come to the point that you're almost comfortable with the loss, although you can never really be comfortable, you accept the pain, see some meaning in all that has happened, and come to the point of being at ease with yourself."

Another widower, aged 75, took a more pragmatic position: "You just tough it out; that's all you can do. You go on from there, make your own life, and look for the good in all that's happened." He went on to add that "all things that happen to us can be questioned, but questioning doesn't guarantee answers. You come to a point where you give up questioning and look for the good--and there is good in everything." Several participants expressed the idea of gain through loss.

Personal Growth and an Increase in Self-Competency. A second sub-process in this reformation of identity was the regaining of confidence coupled with an increase in competence. A 64-year-old widow expressed a "sense of pride in her accomplishments," i.e., increased self-competence and the development of new goals which were based on that newly found competence. The widowers

reported the need to develop skills in cooking, laundry, home-management, and, especially, taking the initiative in socialization. Skills were not emphasized primarily, though several expressed their satisfaction in the increase of their own confidence with regard to domestic skills.

The widows reported increased competency in the areas of financial matters, automobile maintenance, academic pursuits, home care maintenance, and decision-making. Several widows stated that getting along was easier for women than for men "because people were more willing to help widows." A few widows reported that they had utilized the anticipatory grief time to get prepared for their time alone.

Self-actualization. Self-actualization was a third property that was identified in this reformation process. This was characterized by an attitude of taking charge with a high level of efficiency and goal directedness. The widows, especially, demonstrated openness and reported themselves to be assertive. This was also a time of "doing something just for myself because I want to." With this reformation process came an additional sense of independence, freedom from responsibility, and the ability to enhance sense of self by seeking activities for self-enrichment.

Participation in Contributory Behavior. A fourth subprocess which characterized this internal reformation was participation in giving behaviors directed toward others. For some, this seemed to be an extension of self-actualization; for others, it seemed to be more of an inherent personality trait, to give of themselves. A 64-year-old widow stated: "reaching out to other people is what makes life worthwhile. I feel I have something to contribute because of my age and what I've been through." Another stated: "Activity for the sake of activity is not fulfilling; it's what you give back that makes life meaningful." This giving back was both directed toward intimates or toward those in one's inner circle (family, and close friends). Intimate "giving back" included the nurturing of grandchildren and supporting friends. Giving back also was directed toward society at large. Societally, the participants became involved in social issues and volunteerism.

External Reformation

The second major dimension of identity reformation involved the reforming of one's social self; this major category was described by the participants and labeled by the researcher as "external identity reformation." The properties of this external reformation of one's world included (1) reinvestment in the outside world or

"reaching out" and (2) the restructuring of one's social world.

Reinvestment in the Outside World. Reinvestment in the outside world was one of the elements of this external reformation. One 64-year-old widow described this process: "One morning you wake up with the desire to reattach to others. You begin to want to reach out, using who you are and what you've been through, for (the good of) others." She went on to add: "by drawing out the isolate, we feel less isolated ourselves." The widows/widowers expressed an awareness of this process and an intentionality in their own actions. This concept was compatible and perhaps represented an extension of the contributive behaviors which were discussed as a component of internal identity reformation.

Restructuring of One's Social World. A second property of external reformation was the restructuring of the social world of the widows/widowers. A 63-year-old widow stated, "A lot of my friends are singles because in our age group the men are gone; the ladies are left. It's very comfortable for us to socialize and develop our own little group." Another widow, age 73, expressed an extension of social adaption and restructuring: "I've always loved to dance; in fact, we both loved to dance. Since he's gone, I dance in rounds with other friends. That way I can still dance, but don't need my partner."

The restructuring process demonstrated intentional efforts by the bereaved to adapt socially to change.

In addition to sharing the processing of loss in the 13-36 month period after the death of their spouse, these widow(er)s shared coping mechanisms and behaviors to facilitate the living out of grief. In addition, the men and women offered advice to persons supporting the bereaved and shared their personal indicators of resolution.

Coping Mechanisms and Behaviors

The participants in this study reported coping mechanisms and behaviors that had enabled them to live productively with their grief, day to day. Frequently reported coping mechanisms included activity and projects (keeping busy), socialization, and volunteerism. Moderately frequently reported behaviors and coping mechanisms included personal faith and church involvement, academic and creative activities, reflective activities such as keeping a journal and writing poetry, "taking one day at a time," and exercising. Other coping mechanisms and behaviors were identified less frequently. Those activities included reading and playing solitaire, going to the mall, "toughing it out," avoiding self-pity, and resolving spiritual conflict.

In addition, several suggestions were directed toward the bereaved themselves. Those suggestions were "focus on the happy memories," "take one day at a time," "guilt is a normal part of the process," "come to realize that love is a wavering relationship," "any kind of feeling is okay," and "get started doing something worthwhile." Interestingly, these suggestions were among the therapeutic suggestions which were outlined by Rando (1984) as supportive interventions to assist those dealing with grief.

Advice from Bereaved to Those Supporting Bereaved

Several of the widows/widowers offered advice to others who might be experiencing spousal loss. A 64-year-old widow, bereaved 24 months, stated: "Everybody feels differently about their losses so, don't say, 'I know how you feel'. No one knows the intimate part of that person and that relationship. Everybody feels differently, everybody grieves differently, and each person has to sort things out for themselves. Healing has to come from within." However, "while the person is processing his own grief, he needs help from outside: people to support them, people to touch them and offer a hug once in awhile."

The importance of the opportunities to reminisce with a nonjudgmental listener was identified by several of the participants. "Let people talk," "let the person tell their own story," "listen without judging," "any kind of feeling is okay," and "they need a nonjudgmental participant," were among the suggestions offered.

Other suggestions to caregivers of the bereaved included allowing the grievers to take the time which they needed to process the grief. The widows/widowers suggested: "Let people go at their own speed," "don't tell the bereaved they should be someplace emotionally or chronologically that they are not," "don't place time limits on people," and "don't expect grief to be a smooth, even progressive course that fits into a time pattern."

Growth From Loss

Several of these participants shared their perceptions of growth and resolution. One of the perceptions of growth which was shared by a 64-year-old widow was the perception of increased competency and self-reliance. She explained, "I never would have thought I could have done it," which described her new-found academic abilities and success in going back to school. A 63-year-old widower described his success with domestic matters as "a matter of survival. You have to do it so you do; then you feel good about it. I was surprised." Another shared

her feelings of self-competency at handling the financial matters and estate issues. Some feelings of increased self-competency and increased self-reliance were shared by all of the participants.

A second indicator of growth or resolution was identified by a majority of the widow(er)s; this indicator was the decrease in the intensity and frequency of the pangs of grief over time. "You begin to feel like you're leveling out," explained a 63-year-old widower, "of course it still hurts, but not so much and not all the time." This emotional leveling off was a common element in the shared perceptions of these participants.

A third indicator of growth and change was the increased empathy and outreach of the bereaved for other bereaved. "If I had not been through what I have, I could not understand the pain of others," explained a 73-year-old widow. "I feel like I can really be of support to others now," expressed a 67-year-old widow. Those widow(er)s who were sharing with others seemed to be transforming the destruction in their own lives to the benefit of others.

Finally, a fourth reported indicator of progress in the processing of loss was the feeling of "becoming myself again; my sense of humor and enjoyment of life has returned." Two of the participants identified sense of

humor as an indicator of a returning sense of stabilization. Both mentioned that, for a period of time, their enjoyment and appreciation of humor had been affected which they attributed to the pain and crisis of grief.

In summary, the participants in this study had experienced spousal loss 13-36 months prior to participation in this research project. The intent of this research was to identify the problems of the bereaved beyond the first year. One year was generally the time frame which was allowed by society at large and the health care professionals for the resolution of grief. The needs, the problems, and the resolution processes extended into the 13-36 month period of time. However, adaptation to loss was occurring as these bereaved began to demonstrate a gradual restoration of balance in all spheres of functioning.

CHAPTER 5

CONCLUSIONS

Discussion

The findings of this study indicated that the majority of the participants were involved actively in the psychological and the social work of processing their grief. Although living with the burden of grief, these widow(er)s were learning gradually how to confront that grief and how to continue on living, in spite of the pain. The participants shared that although the resurgence of grief occurred they were in the procsss of rebuilding themselves and their lives. Although the majority of the subjects expressed continued vulnerability to grief, it no longer interfered with their capacity to go on living.

The findings of this study concur with the findings of other researchers (Davidson, 1984; Rando, 1984; Schneider, 1984; Zisook & DeVaul, 1984) who have acknowledged the longevity of grief beyond the first year of bereavement. Since the formative stages of this research, the extended duration of the grief process has been receiving

acknowledgement in the literature; however, models for extended bereavement care have not been identified.

The bereaved in this study described a wide variety of grief reactions and symptom intensities. This variance was dependent upon a large number of biopsychosocial differences in the bereaved, circumstances which surrounded the death event, factors which related to the previous relationship of the bereaved with the deceased, and variations in patterns of confronting grief. Other researchers have identified the significance of factors which influenced the grief reactions (Carey, 1977; Lopata, 1970; Maddison, 1968; Parkes & Weiss, 1983; Rabkin & Struening, 1976; Ramsey, 1977; Rando, 1984; Saunders, 1981). The intent of this research was not to identify specifically the factors affecting outcome; however, individual differences were identifiable. Additional research is necessary to identify and understand the factors which have impacted positive/negative outcomes.

The gender-related differences in the processing of grief were evident. In this sample, the men appeared to be experiencing the greatest difficulty with domestic role performance, in the social arena, and in maintaining control over their overt expressions of grief. These findings are in concurrence with the writings of Heinemann (1982); Rando (1984); and Rogers and Reich (1988). Conversely, women experienced the greatest difficulty in

the role performance of financial decisions, legal issues, and mechanical problems. These findings are in agreement with Lopata (1970); Parkes (1972); and, Rando (1984). The bereaved men, in this study, seemed to be experiencing the greatest difficulty at the time that the research was conducted.

One major finding of this research, precipitated by the death of spouse, was the emergence of the concept of identity disruption of the bereaved. The findings of this study concurred with the findings of Saunders (1981) and Schneider (1984). However, these subjects expanded the concept of identity disruption and identified the properties of each dimension of the concept. Further theoretical inquiry and validation are indicated to verify the dimensions of identity disruption.

The concepts of identity reformation and growth, as described by the participants in this study, have been identified by other researchers. Parkes and Weiss (1983) have written about recovery; Rando (1984) discusses reestablishment; and Schneider (1984) writes of reformulation. The underlying theme of reformation is apparently in theoretical concurrence with the work of other researchers; however, the descriptions which were provided by these widow(er)s was less comprehensive than was the concept development of other researchers.

The major theoretical contribution of this research was the emergence of a paradigm for examining the processing of spousal loss 13-36 months into the bereavement process. This model is a beginning effort at understanding the grief process beyond the first year. Further theoretical inquiry and conceptual validation are required to revise and to refine the paradigm. The works of Worden (1982) and Parkes and Weiss (1983) have outlined tasks of mourning and/or tasks of recovery. The concepts of identity disruption and identity reformation have been identified by these researchers but have not been developed and expanded. Further inquiry is required.

No conclusions are drawn about the effects of time on the process and the patterns of grief. Findings based on one interview at one point in time without the advantage of foreknowledge of the bereaved person, does not allow for the identification of trends. Longitudinal studies are recommended to permit the development of time-related models for examining grief and emerging patterns over time.

In conclusion, the merits of qualitative research for generating theory relative to social processes were reinforced by this research. The examination of grief, as a complex dynamic process, was especially suited to the qualitative method. The richness of the collected data reinforced the appropriateness of this methodological approach.

Limitations

The limitations of the study include the following:

1. The known affiliation of the researcher with Hospice, coupled with the exposure of sample to Hospice care, may have impacted the subjects' willingness to participate. The men and women may have experienced a sense of obligation to Hospice. In addition, the responses of the bereaved may have been affected by the Hospice experience, which may have influenced the results.
2. The average duration of forewarning, (16 months) and caregiving (18 months) may have predisposed the bereaved to poor outcomes (Maddison, 1968; Schwab, Farris, Conroy, & Markusch, 1976). The extended duration of anticipation of the death event and prolonged caregiving demands may have exacerbated the intensity of grief and the problems encountered by these bereaved adults.
3. The average age of the sample (67.9 years) reflected an elderly population who had provided care to their spouses. This extended caregiving may have skewed the results. These two factors, age and extended caregiving, have been identified as negative impactors of bereavement outcome (Lemasters, 1978).

4. The small size (n=14) and convenience selection of the sample precluded generalization to other spousally bereaved adults.
5. The possibility of interviewing participants with unresolved grief was identified.
6. Finally, some limitations were imposed by the methodology. The semistructured interview approach allowed for wide variance in the responses, with less opportunity for the researcher to identify uniformity and/or trends. However, the core variable and the concepts that emerged may be used as hypotheses for further study.

Implications/Recommendations

The findings from this study have implications for nursing, specifically hospice, community mental health, and psychiatric areas of clinical practice. The findings from this study also suggest further study and research.

The first implication of this study relates to the conceptual content which emerged in this study. Further research is needed to verify, to expand, to modify, or to refute the concepts and the paradigms which emerged. Specifically the effects of spousal loss upon the identity of the bereaved demand further verification and conceptual refinement. Identification of the effects of spousal

bereavement enables the development of nursing interventions specific to the needs and the problems of the bereaved.

The second implication of this study relates to support of the qualitative methodology for generating theory relative to social processes. Although the sample consisted of only 14 participants, the depth of the conceptual content substantiated the merits of the research approach.

The third implication of this study relates to the need for extended models of bereavement care. Hospice sets a standard of one year of bereavement follow-up; this standard is accepted nationally as a basic program characteristic. This research substantiated the need for extended care of the bereaved. The identification of problems by these bereaved with the tactics employed in resolution of grief may provide the bases for future nursing diagnoses and planned intervention for the bereaved. The implications of this finding reach beyond hospice into the community mental health, psychiatric care, and preventative health areas.

The fourth implication of this study is the recognition of the need to focus attention on the gender-related, and perhaps differential, needs of men and women. A finding of this research identified that the men in the study had not availed themselves of the structured

bereavement supports available. Modification of the models of bereavement care, as well as the duration of bereavement care, seem appropriate. In addition, the expressed refusal of the men to accept bereavement care due to the fear of losing emotional control demands to be acknowledged in the model of bereavement care designed.

The fifth implication for nursing is the need for further verification, validation, and modification of the models of "recovery" which was provided by Parkes and Weiss (1983) and Worden (1982). The development of an expanded model of recovery from grief will facilitate the development of nursing interventions, hopefully positively impacting the physical and emotional health of the bereaved. In addition, some of the pitfalls in the processing of grief could be avoided by developing a comprehensive plan of intervention.

Finally, the findings of this study clearly indicate the need for further nursing research as related to the needs and problems of the bereaved. The author believes several specific areas are in need of investigation:

1. Longitudinal studies to explore the long term effects of time on the patterns of extended grief with identification of "norms" for grief beyond the acute phase;

2. Research investigating the positive and negative effects of anticipatory grief, extended care-giving, and the effects of the suffering of the deceased upon the bereaved;
3. Research designed to explore, to validate, and to refine identified concepts. These concepts include identity disruption, identity reformation, stigma as an internal and/or external process, and confrontation vs. avoidance of grief. In addition, the relationship of these concepts to the development of a model for viewing grief beyond the acute phase, demands further inquiry;
4. Conceptual validation and refinement of the problem issues of grief during this 13-36 month period of time. These concepts will provide the basis for comprehensive planning of extended bereavement care.

The questions raised by this study must be examined in future studies. The researcher strongly recommends that this qualitative approach be replicated by other researchers, longitudinally, and with different populations. This research will conceptually expand professional knowledge of the grief process beyond the model of acute grief.

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APPENDICES

APPENDIX A

LETTER OF EXPLANATION

APPENDIX A

Letter of Explanation

1006 North 29th
Billings, MT 59101

November 11, 1987

Dear (Survivor's Name):

You are being asked to participate in a research project aimed at identifying the needs/problems 13-36 months after the death of a spouse. I am an RN graduate student in the College of Nursing at Montana State University. I am especially interested in the process of grief after the first year.

Much of the understanding of grief is based on the assumption that grief lasts about one year; now there is evidence that extends the grief process beyond that time frame. Identification of some of the common problems experienced by the bereaved will expand our professional knowledge. Your personal contribution will help to develop that knowledge and understanding.

The administrators of Big Sky Hospice have approved this study. Former clients of Big Sky Hospice were selected to participate in this study as Hospice is the only health care facility in Yellowstone County that routinely conducts follow-up into the bereavement period. The hospice secretary reviewed old records and randomly selected families to be offered the opportunity to participate.

Should you choose to participate, you will be contacted by myself, Roxlyn Woosly, RN; I will conduct a face-to-face interview of no longer than 90 minutes in your home or the Hospice Office, whichever you prefer. Your participation will involve the sharing of your own experiences since your spouse died. I will primarily listen, record your responses, and ask questions. You will be free to interrupt or discontinue the interview at any time. In addition, your questions about the research project will be willingly answered.

Appendix A - Continued

Strict confidentiality and anonymity will be maintained. The signed consent form will be stored in the locked files at the Big Sky Hospice office and, after completion of the project, in the MSU extended campus locked files for three years, and then destroyed. The content of your sharing will be identifiable only to myself and will be reported only when grouped with other data.

Your participation is voluntary. Should you choose to participate, please sign and return the enclosed consent form and I will contact you within two weeks of receipt of your signed consent to set up an appointment for an interview. If you should choose not to participate, you may discard this letter and no further contact will be made.

Your ideas and experiences are important in helping health care providers become more cognizant of the needs of the bereaved. If you are willing to participate, please sign and return the enclosed consent form.

Thank you for your time and consideration.

Cordially,

Roxlyn Woosley, RN
Graduate Student,
College of Nursing,
Montana State University

RW:hg

APPENDIX B

CONSENT TO PARTICIPATE

APPENDIX B

Consent to Participate

Identification of the Needs/Problems of
Bereaved Adults 13-36 months after Death of Spouse

I have read and understand the informational letter from Roxlyn Woosley, RN, Montana State University, Graduate Student, concerning identification of the needs/problems of bereaved adults 13-36 months after death of a spouse.

By signing this attached consent form and returning it in the self-addressed, stamped envelope, I am agreeing to participate in the study.. It is understood that if I change my mind I can withdraw at any time.

I understand that should I choose not to participate in this study my decision will be considered final and no further contact will be made concerning this matter.

_____
Signature of Participant

_____
Date

_____
Telephone Number

APPENDIX C

OPENING STATEMENT

APPENDIX C

Opening Statement

Problems of Bereaved Adults 13-36 Months
After Death of Spouse

I would like to thank you for your willingness to participate in this research project.

Please take a few moments to fill out the demographic questionnaire. (If the interviewee has difficulty, I will assist). Your name will not be included on the questionnaire and the information will only be reported when grouped with other data to protect your identity.

I would like to record your story to enable me to remember everything that you share, in your own words. If you object to taping, I will take notes to record your comments. Do you have any objections to my taping?
(Yes ... No)

As the letter you received stated, much of the understanding of grief is based on the assumption that grief lasts about one year; however, evidence exists that extends grief beyond that time. As a health care professional, specifically a registered nurse, I feel we need to expand our knowledge about the grief process. The personal sharing of your own story will help us to develop our understanding.

Could you start by sharing some of your experience with (spouse's name's) death? I will ask questions or make comments as we proceed. You are free to share whatever you wish.

With your permission, let's begin.

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

APPENDIX D

Demographic Questionnaire

Problems of Bereaved Adults 13-36 Months
After Death of Spouse

1. Surviving spouse: Male _____ Female _____
   Age: 1. 20-30 _____ 2. 31-40 _____ 3. 41-50 _____
   4. 51-60 _____ 5. 61-70 _____ 6. 71-80 _____
   7. Over 80 _____

2. Occupation of deceased: _____
   Occupation of survivor: _____

3. Date of death: _____

4. Highest level of education of deceased:
   High school _____ years; College _____ years;
   Postgraduate _____ years;
   Vocational education _____ years

5. Number of dependent children at home
   at time of death: _____ Ages: _____

   Number of dependent children at home now: _____
   Ages: _____

6. Membership in church? Yes _____ No _____
   Importance of faith to survivor:
   Very important _____; Moderately important _____;
   Unimportant _____

7. Remarried? Yes_____ No_____ If yes, how long?_____
   If unmarried, significant relationship with a member
   of the opposite sex: Yes_____ No_____

8. Cause of death: _____
   If cancer, type: _____

9. Forewarning of the death event: Yes_____ No_____
   If yes, how long? _____

10. The death occurred at: Home _____ Hospital _____
    Nursing Home _____ Other _____

11. Level of involvement in the care of spouse:
    Primary caregiver _____ Assisted with care _____
    Observed care provided by others _____
    All of the above _____ Duration of caregiving _____

APPENDIX E

APPROVAL BY HUMAN SUBJECTS REVIEW COMMITTEE

APPENDIX E

Approval of Human Subjects Review Committee

RESEARCH PROPOSAL FOR HUMAN SUBJECTS REVIEW

Title of Project Identification of Needs/Problems of Bereaved Adults 13-36 Months After Death of Spouse

Investigator Roxlyn Robinson Woosley Date December, 1987

Thesis Committee:

Ruth Vandenhorst Chairperson (signed)

Janice A. Buehler Committee member (signed)

Bernice O. Bjortness Committee member (signed)

Please answer the following questions:

1. X Yes ____ No Does the project involve the administration of personality tests, inventories or questionnaires? If YES, provide the name of the tests, if standard, or a complete copy if not standard.

2. ____ Yes X No For studies to be conducted at hospitals and clinics do the proposed studies involve the use, methods, techniques or apparatus other than those used routinely at these facilities.

3. Human subjects would be involved in the proposed activity as either: X none of the following, or including: ____ minors, ____ fetuses, ____ abortuses, ____ pregnant women, ____ prisoners, ____ mentally retarded, ____ mentally disabled.

Roxlyn Woosley Date 12/3/87
Signature of Principal Investigator

APPROVAL (If disapproval, do not sign and append comments).

_____ Date _____
Committee Member

Teresita Torres-Anlay Date 12/4/87
Committee Member

APPENDIX F

AGENCY APPROVAL

APPENDIX F

Agency Approval

NORTHERN ROCKIES CANCER CENTER
Billings, Montana 59103-0369

1239 North 28th Street
P.O. Box 369

Telephone (406)-248-2212

November 22, 1987

Roxlyn Woosley
511 Woodland Drive
Billings, MT 59102

Dear Roxlyn:

The proposed research project addressing the problems of the bereaved beyond the first year has received approval of both myself and the Board of Trustees of Northern Rockies Cancer Center. As we have discussed, the proposal will also be submitted to the Advisory Committee of Big Sky Hospice for consideration and approval.

The research project which you have designed will potentially benefit the families of Big Sky Hospice as well as the community at large. Good luck with your research.

Sincerely,

Douglas C. Carpenter
Administrator

APPENDIX G

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

APPENDIX G

TABLE 2

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

(N=14)

Sex	
Male	5
Female	9

Age	
31 - 40	1
41 - 50	0
51 - 60	5
61 - 70	4
71 - 80	3
Over 80	1

Duration of Bereavement	
13 - 18 months	5
19 - 24 months	3
25 - 30 months	2
31 - 36 months	4

Occupation of Deceased	
Educator	2
Engineer	1
Farmer/Rancher	3
Grocer	2
Heavy equipment operator	5
Lawyer	1

Occupation of Survivor	
Artist/Draftsman	2
Bus Driver	1
Homemaker	3
Nurse	2
Clerical	3
Student	1
Teacher	2

Educational Level of Deceased	
High School, less than	2
High School	7
College	4
Post-Graduate	1

Educational Level of Survivor	
High School	4
College	5
Post-Graduate	2
Vocational Education	3

Dependent Children at Time of Death	
11 years old	1
17 years old	1
19 years old	1
35 years old*	1

Membership in Church	
Yes	12
No	2

Importance of Faith	
Very important	10
Moderately important	2
Unimportant	2

Remarried	
No	14

Significant Relationship (Opposite Sex)	
Yes	1
No	13

Dependent Children at Time of Interview	
13 years old	1

Duration of Forewarning	
Average	16 months
Range	.5 - 60 months

Location of Death	
Home	10
Hospital	3
Nursing Home	1

Caregiving Role	
Primary caregiver	10
Assisted with care	3
Care provided by others	1

Duration of Caregiving	
Average	18 months
Range	2-60 months

Forewarning of Death	
Yes	14

Cause of Death	
Cancer	13
Noncancer	1

*Developmentally disabled, dependent adult.

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