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A CLINICAL STUDY OF WIDOW BEREAVEMENT

INVOLVING VARIOUS MODES OF DEATH

by

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DISSERTATION

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A CLINICAL STUDY OF WIDOW BEREAVEMENT INVOLVING VARIOUS MODES OF DEATH

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ABSTRACT

This study involved the bereavement process over time in young widows whose husbands died various modes of death: natural, accidental, suicidal and homicidal. Efforts were directed toward strategies that proved effective in assisting widows to cope with the adjustments engendered by the sudden deaths of their husbands.

The loss of a loved one through death is recognized universally as one type of event singularly powerful in its capacity to give rise to acute emotional pain and major life readjustments for the survivor-victims who suffered the loss. The labels applied to this loss are bereavement, mourning and grief. By examining the aftermath of death in the survivors, identification of those circumstances which inhibit or enhance the emotional pain can begin.

Efforts were directed toward selecting as homogeneous a group of widows as possible. To accomplish this homogeneity, widows were selected from the following demographic variables of the deceased husband: age range: 30-39; Caucasian; Protestant;

English as a first language; born in the United States; and Los Angeles County residence. The sample size was limited to three widows from each category of mode of death, plus an additional three from the 40-49 age group whose husbands died a natural death. All the deaths were sudden, regardless of mode. The sample was derived from the records of the Los Angeles' County Department of Medical Examiner-Coroner.

Unstructured, semi-focused interviews were conducted with each widow over the thirteen month period following the deaths of her husband. All interviews were tape-recorded.

Two hundred interviews were conducted. Twelve of the seventeen widows completed the study through the thirteenth month. The five who did not complete the study were interviewed at least four times before they left the study. The widows were distributed as follows: four from 30-39 Natural death, four from accidental, four from suicidal, two from homicidal and three from 40-49 natural.

Taped interviewed were transcribed, coded for widow responses, recurrent issues and problems and postvention techniques that were especially helpful.

Findings were presented through a qualitative discussion of the response patterns of widows and bereavement postvention. Response patterns of widows included three conceptual areas:

(1) widows continuing to experience the presence of their husbands, (2) Uncoupled Identity--a process of bereavement resolution; (3) the relationship between reality activities and affective expression.

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My deepest appreciation is extended to the widows in this study. They had the courage to share with me their personal experiences from a tragic time in their lives, a time when the tendency is to pull back into oneself. Only out of their courage was this study possible. I value the friendships with them that I gained during the course of our working together.

Four years ago the members of this committee agreed to participate in this project. They knew then the study was likely to be four years from start to finish. Throughout this time, they have continued to be enthusiastic and supportive. Faculty support of this caliber is rare, and I am grateful to the committee as a whole.

Each committee member, however, made a special contribution. Anne Davis, the chair, was instrumental in my progress throughout my entire doctoral program. She created procedures where there were none; provided honest, timely advice and was always accessible. Her best teaching realm was the provocating, stimulating dialogue, where old ideas were re-examined and new ideas born. Betty Dambacher personalized support and encouragement with an uncanny timing for finding those

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CHAPTER I

CONCEPTUAL FRAMEWORK

1.1. Statement of the Problem

The concept "population-at-risk" as applied to the field of mental health was the broad topic underlying this project. Recent approaches to this concept in community psychiatry yielded the identification of some types of life events which are likely to leave people distressed to the extent of interfering in their abilities to cope effectively with the tasks of daily living. (Holmes and Rahe 1967).

The loss of a loved one through death is recognized universally as one type of event singularly powerful in its capacity both to give rise to acute emotional pain and to necessitate major life readjustments for those who suffered the loss. Death is harsher for the survivor.

> This, as I see it, is the capital fact about the relation between living and dying. There are two parties to the suffering that death inflicts; and in the apportionment of this suffering, the survivor takes the brunt. (Toynbee 1968:271).

Even in death's finality, differences exist for both the person experiencing the death and for those left behind. Shneidman

has asserted that all deaths are not equal in the brunt of suffering left to the survivor: "The algebra of death's suffering is a complicated equation. But in suicide, the anguish of the survivor's bereavement is nearly always special: sharp, prolonged and inimical." (Shneidman in Cain 1972:x).

All deaths cannot be treated as equal. The sudden death is known to be especially harsh for those left behind to continue, although the death itself might have been easier, less painful for the person who died. We know little of those variables which are likely to alter the nature of the bereavement experience or even how the bereavement process is most likely to be altered.

Suicide is one category of death with greater strength to evoke distress among survivors. Suicidal deaths increase the risk for the population of bereaved left in its wake. Other factors or clusters of circumstances around the death itself may also act to increase or decrease the degree of risk involved for the population of bereaved.

The modes of death themselves offer accessible distinctions to begin to explore differences in subsequent bereavement which might have impact on the inherent degree of risk for the population of bereaved.

1.2. Purpose of the Study

This study explored the bereavement process in young widows whose husbands died from four modes of death: natural, accidental, suicidal and homicidal. For each mode of death a small number of widows was chosen to study the bereavement process as it occurred, over time. Similarities and differences in these widows were sought. In addition, efforts were focused on identifying those therapeutic strategies which were most effective in assisting the widows to cope with the adjustments engendered by the deaths of their husbands.

1.3. Population-at-Risk

The distresses which motivate most people to seek psychiatric assistance cannot be viewed through a microscope lens or the shadow-outline of X-ray. Neither can the causative conditions be isolated and studied as one would study a bacterial organism. The concept, "population-at-risk," was extended from the field of public health to the field of mental health by Caplan:

> Population-at-risk includes all members of the population who under appropriate circumstances might suffer from the disorder; thus, if the disorder under consideration is puerperal psychosis, defined as a mental illness of indefinite duration occurring within three months following childbirth, the population-at-risk will be all women who have ever given birth; if we are interested in involutional depressions in men, which begin in the age range fifty-five to sixty-five, the population-at-risk will be all men over fifty-five. (1964:89)

Once the populations-at-risk for specific disorders have been identified, attempts can begin to be more precise about differentiating the conditions (environmental, social, genetic, physical and psychological) which serve to increase or decrease these risks. Little is known about those conditions which serve to increase or decrease the risks for most of the conditions treated by health professionals in the field of mental health. Certain types of events have been identified as potentially harmful. Some beginning attempts, initiated by Caplan, to differentiate those groups at special risk began more than a decade ago:

> In exploiting this list of allegedly harmful factors in a program of primary prevention, the public health concept of 'populations-at-special-risk' is particularly useful. Many harmful factors are not likely to be equally pathogenic to all groups in the population. The pathogenicity varies according to age, sex and other characteristics of those exposed. (1964:34)

Basic to prevention in any field of practice is the identification of those people who are particularly vulnerable. The traditional mode of assessing vulnerability in psychiatry was to examine, in depth, those stumbling points in personality development of the individual. A more recent dimension of inquiry into population vulnerability was to search the inter-personal environment for those harmful, or dire, events. Effective identification of populations-at-risk and further differentiating of special risk require

assessment both of the individuals and those factors in the environment which increase vulnerability of people. Caplan presented a broad listing of these dire events:

> Examples of hazardous circumstances include biological and role transitions (birth, puberty, climacteric, illness or death of a family member); entry into kindergarten; transfer to grade school; transfer to high school; leaving school; getting the first job; moving to a new community; getting a new job; undertaking new social or occupational responsibilities; and the like. (1964:42-43)

A less broad and more focal framework of hazardous circumstances was provided by Parkes. Labeled "psycho-social transitions," Parkes characterized these to be "those major changes of life space which are lasting in their effects, which take place over a relatively short period of time and which affect large areas of the assumptive world." (1971:103) Psycho-social transitions were essentially what Shneidman (1964) termed "endings." The events generally thought of as traumatic, dire, harmful or hazardous. Most of these inimical events are usually (1) loss situations, (2) relatively abrupt in their onset or their realizations and (3) require a major readjustment in how one views and copes with the world.

Many situations are endings: commencement from college; major surgery, such as a hysterectomy; marriage; death of someone close; birth of the first child; major geographic relocation; job change;

loss of a limb. The degree of the shift in "how one views and copes with the world" is not constant from one ending to another. All endings were included in the concept studied by Holmes and Rahe and labeled life change events:

> Thus, each item has been constructed to contain life events whose advent is either indicative of or requires a significant change in the ongoing life pattern of the individual. The emphasis is on change from the existing steady state and not on psychological meaning, emotion, or social desirability. (1967:217)

Rahe explained the method of estimating differences in the degrees of intensity of change inherent in one type of ending from another; the practical results from this work is that quantitative estimates can be given to the various endings which result in a total life change score for the individual using the rating scale. (Rahe 1972; Masuda and Holmes 1967; Holmes and Rahe 1967). These findings confirmed the common sense perspective that the ending, death of a spouse, could be counted with the same intensity as, for example, a residential move. (Rahe 1972:252)

Further differentiation is needed. The residential move from one house to another in one's home town does not seem to equal moving from one culture to another. Within types of endings, further calibration should occur to determine better the virulence,

the pathogenic potential of the ending. Death of a spouse is one type of ending to which scant attention has been paid in the sense of refining the differentiation.

> It is obvious that some deaths are more stigmatizing or traumatic than others; death by murder, by the negligence of oneself or some other person, or by suicide. Survivor victims of such deaths are invaded by an unhealthy complex of disturbing thoughts about the death, seeking reasons, casting blame and often punishing themselves. (Shneidman 1973:34)

Accidental, suicidal and homicidal deaths often are sudden and unexpected; natural deaths may extend in time from sudden to many years. Some modes of death may be more stigmatizing for the families and friends--suicide, for example, or even accidental death when the victim died while engaged in illegal activity. These variations point to potential gradations in the subsequent suffering by the survivor victims, where the suffering probably is related to the nature of the ending. This was inferred most strongly by Wallace:

> The suicide of a conjugant is a life-threatening action, and it produces the most intense grief of any type of death. Some researchers call it "complicated" and others term it "acute" grief, but by any name its intensity is searing. (1972:229)

The assertion that the grief engendered by suicide is the most intense grief, needs to be examined more closely. Demi's (1978) comparison of the social adjustment of widows from the two high

risk areas, survivors of suicide and survivors of sudden death, revealed variables other than suicide that influenced how well the women adjusted. The acknowledgment of ambivalence was associated with a better adjustment. She also pointed out that all deaths by suicide were not totally unexpected. (1978:13)

The modification of the intensity of grief by mode of death, nature of the relationship, age, suddeness of the death, stigma, and other factors has not been systematically evaluated. Intensity of grief may be a critical feature which affects the degree of risk of the bereaved individual or family.

Many factors influence the bereaved person's ability to respond to the situation engendered by the death of someone close, such as one's spouse. Lopata (1973) found that widowhood may almost be synonymous with poverty, since she found so many widows had income levels below the poverty limits. This lack of money could itself be a barrier to activities which facilitate adjustment to new roles and relationships necessary for full recovery from grief. Accessibility to support systems and people may also serve to alter one's place of the risk scale.

1.4. Bereavement: Definitions

The aftermath of death, for relatives and friends, has been a human concern spanning cultures and generations; only recently

has it become a focus of scientific and professional study. The nature of this aftermath is poorly understood, although most humans will experience personally its impact, as Klein (1972:865) stated so succinctly, "Obviously, bereavement has a very high incidence; we shall all be bereaved, if we do not bereave others." Since Lindemann's (1944) classic report of bereavement, which emerged largely from his work with those who lost relatives or friends in Boston's Coconut Grove Fire, the interest of the scientific community in the study of bereavement has been sustained. Progress has been apparent in such fundamental issues as differentiating normal, or typical, grieving from pathological, or atypical, grieving: identifying the sequellae (morbidity and mortality) of bereavement; specifying the time ranges for one's life to settle down from the hiatus left by death; and beginning to specify differences in the vocabulary of bereavement. Pine agreed on the importance of clarifying definitions in the progress toward concept development:

> Too frequently, the words grief, bereavement and mourning are used with no specification of their difference and on the assumption that their meanings are understood. Since definitions are important in the conceptual development of a general theory, the definitional distinctions among the three terms should be clarified. (Pine 1976:106)

Distinctions in meaning exist among the terms grief, mourning and bereavement. Volkart and Michael (1957:282) defined bereavement very broadly:

> Bereavement is usually understood to indicate the emotional state, behavior, and conduct of the survivors immediately following the experience of separation by death from a person who fulfilled dependency needs, especially needs related to emotional interactions.

Pine (1976:106) defined bereavement as the loss per se, while allocating the psychological state to grief and the social state to mourning. Showalter combines grief and bereavement and emerges with a broad definition closer to Volkart and Michael's: "I shall consider bereavement and grief as the subjective state and observable reactions of an individual who has suffered the loss of a person with whom there has been a significant loving relationship . . ." (Showalter 1975:172) This definition shifted the emphasis of the relationship from "dependency" needs to a "significant loving" relationship, while expanding the focus from the emotional to the subjective state.

Thus far, the definitions of bereavement have remained broad; they included provision for the expression of emotions to be incorporated under this term. Perhaps the broadest use of the term bereavement was offered by Rosenblatt, et al.:

> By bereavement we mean both the period of time following a death, during which grief occurs, and also the state of experiencing grief. (1976:2)

They had previously defined grief:

> By grief we mean the sorrow, mental distress, emotional agitation, sadness, suffering and related feelings caused by a death. (Rosenblatt, et al., 1976:2)

Neither of these definitions tried to include the nature of the relationship involved in the defined responses to death.

Of the terms, grief, mourning and bereavement, the greatest concensus of meaning, implied or stated in the literature, occurred with the term bereavement. I also used the term broadly--to refer to the overall reactions engendered by the death of someone close. Overall reactions included feelings, behaviors, adjustments in the day-to-day activities of living and both the social and psychological processes of the survivors.

Grief and mourning were difficult to differentiate from each other and to discover a common core of agreed-upon meaning. Freud attempted to understand the nature of melancholia by comparing its features with mourning. Both terms have the same type of environmental causes:

> Moreover, the exciting causes due to environmental influences are, so far as we can discern them at all, the same for both conditions. Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, and ideal, and so on. In some people the same influences produce melancholia instead of mourning and we consequently suspect them of a pathological disposition. (Freud 1971:243)

Freud considered mourning and melancholia to share many of the same traits. The critical difference he acknowledged was the disturbance of self-regard absent in mourning.

Bowlby's definition of mourning paralleled Freud's. He differentiated grief from mourning:

> 'Mourning' will be used to denote the psychological processes that are set in train by the loss of a loved object and that commonly lead to the relinquishing of the object. 'Grief' will denote the sequence of subjective states that follow loss and accompany mourning. (Bowlby 1961:318)

Bowlby made explicit what Freud implied: the psychological "work" involved in mourning proceeds in a sequential process. Showalter's (1975:172) definition of mourning was consonant with Bowlby and Freud: the intrapsychic response to the loss, a response considered to be adaptive. In a totally different realm, Pine placed mourning as "a social state of grieving the loss of a significant other" (1976:106). Another pivotal shift in perspective on mourning was provided by Rosenblatt (1976:2): "By mourning we mean the culturally defined acts that are usually performed when a death occurs. The mourning period is the culturally defined time or typical period of time during which these acts of mourning are conventionally performed."

Both Rosenblatt and Pine placed the psychological component responses to loss within the parameters of grief--the very

parameters used by other authors for mourning. An entirely different approach was:

> . . . and grief being the response of emotional pain (including, as the use of the work "emotional" always should, certain physiological accompaniments to the deprivation).
> (Switzer 1970:12)

> The process of mourning involves learning to live with memories of the deceased and with the affect connected with the both positive and negative. Until the memories are called to mind and reviewed and the emotions expressed, the images will continue in a self-disruptive manner.
> (Switzer 1970:50)

The conflict evident in the definitions of the basic terminology reflects, in part, the recentness of bereavement as a topic of interest and study. It also reflects the common usage of those terms by people who encounter death in their communities. Most students and colleagues indicated they use the words somewhat interchangeably, without ever thinking about distinctions among the terms. Many indicated that distinctions probably did exist, but they would need to give it more thought before they could articulate the nature of the differences.

Originally, I had defined bereavement as the overall reactions engendered by the death of someone close. Grief and mourning I defined as interchangeable referring to the psychological processes which occurred subsequent to the loss of someone close. I continue to perceive bereavement as the broad, umbrella term which cushions

and gives context to mourning and grief. I believe grief should be the term that refers to the psychological processes in response to loss: including the emotions and memories experienced, the affect expressed, the intrapsychic processes and dynamics. I selected Rosenblatt's cultural approach to mourning as consonant with and supplemental to the definition I used for bereavement and grief:

> By mourning we mean the culturally defined acts that are usually performed when a death occurs. The mourning period is the culturally defined time or typical period of time during which these acts of mourning are conventionally performed. (Rosenblatt 1976:2)

1.5. Bereavement: Morbidity and Mortality

The consequences of bereavement for the survivor-victim have included a variety of psychosomatic illnesses, increased life threatening disorders (particularly cardiovascular), reduced financial resources, increased rate of consultation for mental health problems, and increased natural death rate. With such an extensive range of reactions, considerable doubt has been expressed about the validity of bereavement as a specific stressor.

> In reviewing the literature, most of which comes from psychiatric practice, the first impression is of a bewildering variety of reactions; these range from ulcerative colitis to mania, and from leukemia to hysteria. One is tempted to think that there may be nothing specific about bereavement as a stressor and that the reaction to it may be entirely determined by the personality and predisposition of the bereaved.

> That this is not the case, however, is evident since grief and its variants all represent highly specific forms of response. (Parkes 1965:13)

On the other hand, all discomforts and ailments experienced by those who have suffered recent losses by death cannot be ascribed automatically to bereavement: " . . . it is necessary to take care that chance associations are not mistaken for causal relationships." (Parkes 1964:275) Increasingly, studies which explore the morbidity or mortality of bereavement have included matched, control groups in the sample as one method to minimize the possibility of such erroneous conclusions.

One of the earlier studies (Kraus and Lilienfield, 1959) examined the relationship between marital status and mortality. They reported the major finding that the death rate was lower for the married group at every age than for the single, widowed or divorced groups. The young widowed group (under age 35) were an especially high risk for mortality--more than ten times the risk of mortality than found in the married group. Later, a study of 4,486 widowers (aged 55 or over) was conducted, covering a five-year period, to assess the duration of the risk of mortality in the bereaved.

> The conclusion is that the excess mortality in the first six months is almost certainly real. In other words, widowhood appears to bring in its wake a sudden increment in mortality--rates of something like 40% in the first six months. This increase is

> eventually followed by a fall back to the level for married men in general. (Young, Benjamin and Wallis 1963:455)

A carefully conducted survey was made in a semirural area to explore the mortality produced by bereavement (Rees and Lutkins 1967). During the six-year period covered by this study, significant evidence of increased mortality was found among the bereaved group when contrasted with the mortality rate of the control group:

> It was found that 4.6% of bereaved close relatives dies within one year of bereavement compared with 0.68% in the control group. This sevenfold increase in risk between the bereaved and control group was significant at the 0.001% level, and risk of mortality. This risk was found to be greater for male than for female relatives: 6.4% of the 391 male relatives at risk died, compared with 3.5% of 512 female relatives. This difference in risk between the sexes was significant at the 5% level. (Rees and Lutkins 1967:16)

Of all the close relatives studied, widowed people had the highest mortality rate when compared with the control group. Rees and Lutkins (1967) also found significant relationships between the place of death (home, hospital, other) and the subsequent mortality of the close relatives:

> The risk of close relatives dying during the first year of bereavement is doubled when the primary death causing bereavement occurs in a hospital compared with at home. This difference in risk was significant at the 5% level.
>
> If the primary death occurs at some site--for example, a road or field--other than at home or

> hospital, the risk of a close relative dying during the first year of bereavement is five times the risk carried by the close relatives of people who die at home. This difference in risk was significant at the 0.01% level, though the small size of the sample reduces the significance that can be attributed to the result. (Rees and Lutkins 1967:16)

No information about the mode of death or the expected--unexpectedness of the primary death was cited; either of these variables could have interacted to distort the statistics of the place of death. Specifically, death occurring in the field or on the road (classified as other) might be expected to include a larger number of accidental and unexpected deaths than when the primary deaths occurred in the home or hospital.

The 4,486 widowers studied by Young, Benjamin, and Wallis (1963) for the mortality rate during the first five years of their bereavement were re-examined during the ninth bereavement year. This nine-year follow-up included additional data on certified causes of death and social class. The investigators had considered the possibility that a post five-year risk in mortality in the widowers might occur; this was not borne out. The mortality rate for the widowers from the fifth to the ninth year was slightly below the mortality rate for married men of the same age. The findings of this study, then, confirmed the increased risk of mortality for widowers is confined to the first six months after the death of the

spouse. Parkes, Benjamin, and Fitzgerald (1969:743) reported the following causes of this increased mortality:

> The findings reported make it clear that the increased mortality is not explained by an increase in deaths from accidents or infectious disease which might have been shared with the wife. In fact, the greatest increase is found in the group diagnosed "coronary thrombosis and other arteriosclerotic and degenerative heart disease," which accounts for 53% of the increased mortality.

In discussing the meaning of this finding, they concluded that in bereavement, coronary thrombosis is unlikely to be the sole cause of death; rather, bereavement more possibly acted as an aggravating factor. They also discussed the association between bereavement and heart disease as a relationship which cuts across social class.

In summary, mortality certainly is one sequella of bereavement. Some of the factors which seem critical in increasing or decreasing this particular risk are: (1) the nature of the kinship; (2) the sex of the survivor-victim; (3) the place of the primary death; (4) the stage of bereavement; (5) the age of the survivor-victim; and (6) a susceptibility of coronary artery disease in the survivor-victim.

Since the increase of mortality in bereavement is associated with natural causes, an increase in morbidity may also occur. Investigations of morbidity during bereavement have yielded mixed results. On the more general level, studies have revealed two significant conclusions: (1) widows consulted their physicians more

frequently during bereavement than do widowers (Parkes 1964; Weiner 1976) and (2) widows (in Boston and Sydney) reported a significantly higher prevalence of health deterioration than did their respective non-bereaved control groups (Madison and Viola 1968).

Several studies attempted to examine the relationship between bereavement and mental illness (Parkes 1964, 1968; Stein and Susser 1969; Crisp and Priest 1972; Weiner, et al., 1975; Clayten 1968, 1975; Schwab, et al., 1975). The consultation rate for psychiatric symptoms in widows under 65 more than tripled during the first six months of bereavement (Parkes 1964). Similarly, Stein and Susser (1969) concluded that widowhood is associated with the inception of psychiatric consultation which closely follows the event of bereavement. They also found no chronic disablement arising from mental illness among widows. Through a standardized self-rating inventory (Middlesex Hospital Questionnaire), Crisp and Priest (1972) attempted to score the range of neurotic illnesses for a bereaved group and a control group. The most striking finding they reported was lack of particularly high scores in the bereaved group. The losses suffered by the bereaved group included all the following relationships: parents, spouses, siblings, aunt/uncles, grandmothers, cousins, nieces, brothers/sisters-in-law, fathers/mothers-in-law, foster mother, and friends.

They did not report any attempt to examine the score obtained on the Middlesex Hospital Questionnaire (MHQ) according to closeness of relationship.

Early publications linked such disorders as peptic ulcer, ulcerative colitis and bronchial asthma to bereavement (Lindemann 1945; McDermott and Cobb 1939). Maddison and Viola (1968) were unable to demonstrate an increase of frequency or severity in any of these disorders. They cautioned, however:

> The present findings in no sense disprove the notion that bereavement may be one significant precipitant of such illnesses; while our sample is a large one from one point of view, it is relatively small in the context of an uncommon disease such as ulcerative colitis. (Maddison and Viola 1968:303)

Evident from these studies is the confusion surrounding the issue of morbidity in bereavement. Large scale epidemiological studies are necessary to begin to sort out the confusion. None has been reported.

1.6. Bereavement Process

Most knowledge concerning the nature of bereavement remained within the realm of literature and folklore until Lindemann's study of one hundred and one people who were bereaved through the loss of either relatives or friends. He listed five pathognomonic features of normal acute grief: 1) somatic distress, 2) preoccupation with the image of the deceased, 3) guilt, 4) hostile reactions, and

5) loss of patterns of conduct. From normal grief, Lindemann (1944:142) differentiated two morbid grief reactions: delayed grief and distorted grief. The behaviors which may signal distorted grief were:

> (1) over-activity without a sense of loss;
>
> (2) the acquisition of symptoms belonging to the last illness of the deceased;
>
> (3) a recognized medical disease, namely, a group of psychosomatic conditions, predominately ulcerative colitis, rheumatoid arthritis, and asthma;
>
> (4) alteration in relationship to friends and relatives;
>
> (5) furious hostility against specific persons;
>
> (6) absence of emotional display in facial expression and actions;
>
> (7) lasting loss of patterns of social interactions;
>
> (8) most of one's activities are detrimental to social and economic existence; and
>
> (9) agitated depression. (1944:144-146)

Lindemann's sample was composed of psychiatric and non-psychiatric patients who were bereaved through accidental deaths during the Coconut Grove Fire and through natural deaths. He did not indicate the frequency of the syndromes he so vividly described. His interviews with the bereaved began very soon after the death of the friend or relative; he did not report on how long he continued

seeing these patients or how frequently he saw them. Lindemann concluded that acute, uncomplicated grief work, with the assistance of a psychiatrist, could be settled in eight to ten interviews over a span of four to six weeks. (1944:144) Later reports of grief and bereavement largely have supported Lindemann's description of the content of the grief process, but have extended thoughts of how soon even the acute process is settled. (Parkes 1970, 1972; Bowlby 1961; Bowlby and Parkes 1970).

Although features and symptoms of grief vary among individuals, several feelings and behaviors are characteristic of grief. Initially, people respond to death with a sense of numbness, disbelief or unreality, even when the death was expected. (Engel 1964; Glick, et al., 1974; Lindemann 1944) Estimates on how long this lasts, ranges from a few minutes to several months. The variation in time estimate, probably, in part, attests to different aspects of the characteristic being addressed.

Depressed types of feelings, described variously as sadness, despair or painful dejection probably constituted the best known and most expected feature of bereavement. (Engel 1961; Weiner, et al. 1975; Glick, et al. 1974; Freud 1917; Clayton, et al. 1968; Parkes 1970) These feelings emerged early, and were likely to persist in varying degrees of intensity and periods of frequency over time.

Unexpected encounters with objects, people or holidays have triggered these feelings with surprising intensity for those who believed the acute, affective involvement with these emotions had given way to less sharp versions of this sadness.

Rosenblatt, et al. (1976) reported crying as the best-described emotional behavior in the cross-cultural literature. They could identify only one culture group, the Balinese, in whom crying as an expression of grief was completely absent. Most authors writing about bereavement cited crying as a behavior characteristic of bereavement for both men and women. (Clayton, et al. 1968; Weiner, et al. 1975; Engel 1961; Glick, et al. 1974; Parkes 1970)

Although many other feelings and behaviors were reported, they were not reported as widely as the three (numbness, depressed feelings and crying) just discussed. Some investigators described feelings and behaviors as pathological that others consider normal. I consider the behaviors discussed in this section as part of normal, uncomplicated grief--not pathological processes at all.

Disruptions in sleep pattern can either take the form of sleeping much more than usual or the form of sleeplessness. (Silverman 1972; Rosenblatt, et al. 1974; Engel 1961; Clayton, et al. 1968) Preoccupation with the image of the deceased was not reported by many writers (Lindemann 1944; Parkes 1970); others,

however, report happy and sad memories (Weiner, et al. 1975) which may be on the same continuum. The difference may lie with the degree of intrusiveness of the memory and with the focus on the physical image of the deceased, as opposed to remembering a shared event or moment.

Anger at self, others or the deceased is a prominent feature of grief, although it was an emotion particularly difficult to acknowledge when the focus of the anger was the deceased. (Weiner, et al. 1975; Glick, et al. 1974; Rosenblatt, et al. 1976; Parkes 1970) General irritability and increased episodes of anger were typical, rather than a sustained feeling of clearly defined anger. Anger directed toward the self does not take the place of anger directed toward others: "But in fact, in our data, self-directed and other-directed anger and aggression are associated. The more there is of one, the more there is of the other." (Rosenblatt, et al. 1976:19)

Most reports of activity level changes, described restlessness and sometimes aimless motions--not the slow and ponderous pattern associated with depression. (Lindemann 1944; Parkes 1970) Association with the increase activity level was a concommitant lack of interest in the activities: going through the motions only, since the meaning was lost along with the loss of the person. This

restlessness was considered by Parkes (1970:451) to be a feature of searching and, separately, also associated with anger. Although Freud did not identify a retardation of activity, he did include "inhibition of all activity" as one of his distinguishing features of mourning. (Freud 1917:244) This avoidance of all activity, not associated with the lost person, did not reflect a decrease in psychomotor activity so much as it reflected a decreased interest and involvement in activities per se.

Guilt was less prominent than anger in acute bereavement and ran the gamut from mild self reproach to feeling totally responsible for the death. Most bereaved people examine the time and events immediately prior to the death, partly to search and examine their personal liability in the death. (Lindemann 1944; Parkes 1970; Engel 1961) Episodic feelings of guilt are common; they do not generally become sustained.

Fear is not mentioned in the literature on grief as often as is probably warranted; this may be a function of language. (Rosenblatt, et al. 1967:19) Viewing the world as an unsafe and undesirable place was not labeled fear by Parkes (1970), but was associated with anger and irritability. Fear of loss of control, particularly as related to expressing feelings, has been identified as one, specific fear. (Glick, et al. 1974) Another was the fear of carrying on alone.

Feelings of emptiness are intense. They seem to focalize the loneliness that was felt so sharply and persistently. (Weiner, et al., 1975; Engel 1961) Lindemann's reference to emptiness was very specific, "Common to all is the following syndrome: sensations of somatic distress occurring in waves lasting from 20 minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, an empty feeling in the abdomen, lack of muscular power . . ." (1944:211) Other somatic symptoms have included anorexia and weight loss. (Engel 1961; Clayton, et al. 1968)

In Agee's classical novel, A Death in the Family (1959), the idealization of the dead began before the death itself was confirmed. This process seem to be one of the more common and prevailing features of grief, although its intensity may abate over time. (Parkes 1970)

Engel (1961:18) perceived normal grief, labeled "uncomplicated" by him, as having a predictable course with phases: (1) initially, a phase of shock and disbelief; (2) phase of developing awareness with acute affective features; (3) finally, a phase of restitution and recovery. Silverman (1972:189) described three phases as well in the process of grief: (1) impact where the person seems dazed; (2) recoil, a time of growing awareness; (3) recovery which involves acceptance of new relationships and new roles.

Parkes' work (1970) extended our knowledge of grief as a process. He interviewed twenty-two London widows, each on five separate occasions, during the thirteen months following the natural deaths of their husbands. Almost all of the twenty-two widows were still grieving, albeit with lessened acuity, at the end of thirteen months. Parkes labeled the three phases of grief found in these widows to correspond with the categories used by Bowlby (1961) with the addition of the relatively brief, initial phase of "Numbness." The four phases of bereavement found by Parkes (1970) in widows he studied were: (1) Psychic Numbness, (2) Protest and Yearning, (3) Disorganization, and (4) Reorganization. About two-thirds of the widows he studied were still in the Disorganization phase when his study ended, and had not progressed to the fourth phase, Reorganization.

Although the number of phases varied among authors, as did the labels for the phases, agreement does exist on bereavement as a process: a dynamic and evolving progression, rather than the more static condition called a state. Transition between phases are indistinct, gradual and sometimes incomplete. Time boundaries for the phases are approximate, since they have not been established precisely.

The most useful presentation of phases is that formulated and described by Parkes out of his work with the London widows. (1970; 1972) He makes clear that grief is not a set of symptoms that begin after a loss; rather, it resembles more a "succession of clinical pictures which blend into and replace one another." (1972:7) (1) NUMBNESS: This is the briefest of the phases. It lasts a few hours to a few days for most people; some widows described it as lasting a few months. (2) YEARNING AND PROTEST: Four major components comprise the yearning. One feature is the pining for the dead person with thoughts constantly focused on him/her. Another is the tendency to seek out people, places and things that are associated with the deceased. Along with this searching out is the tendency to be finely attuned to any stimuli which are reminders of the lost one. Crying also is a prominent component. Protest is easily recognized through the manifestation of restless irritability and bitterness. This second phase peaks during the second to fourth weeks, then gradually gives way. (3) DISORGANIZATION: Characterized by apathy and aimlessness, this third phase involves going through the motions without much meaning or satisfaction. A disinclination to look to the future is also a persistent feature of this phase which lasts beyond the ending of the

first year. (4) REORGANIZATION: Although recovery has its origins in earlier phases, regaining a sense of meaning and identity is often not completed for two or more years after the death occurred.

The phases described by Parkes and others appear to refer more to phases of grief and not of bereavement.

Parkes's use of the term "numbness" differs markedly from Lifton's (1969) in describing, retrospectively, the responses of the victims of the atomic bomb in Hiroshima. Lifton used the phrase "psychic numbing" to refer to a more lasting type of blunting; he used the words, "psychic closing-off," to refer to the less severe emotional blunting which occurred in so many of those who were exposed to the horrors of the atomic bomb. "Psychic closing-off could be transient or it could extend itself, over days or even months, into more lasting psychic numbing. In the latter case it merged with feelings of depression and despair . . ." (Lifton 1969:33) Parkes' phase of numbness parallels Lifton's description of psychic closing-off.

Other features of widowhood possibly contribute to the bereavement process and may be found to mitigate, in some way, the grief process. Lopata's (1973:37) study established that the income level of most widows was not only lower than the income while the husband was still alive, but that it was generally below

the poverty line. This, of course, could greatly influence the extent to which the widow could afford to socialize, continue friendships, or form new relationships.

Rosow's (1967) study of widowhood in older people did not reveal any tendency to increased dependency on children because of age. He found that it took widows between five and ten years to adapt to being a widow. (Rosow 1967:206) Apparently, the age of the widow when the husband dies may be a critical factor in how she progresses through bereavement.

Attention has been given to the suddenness and expectedness of death as factors which alter grief: the more sudden the death, the more difficult time the survivors have in trying to cope. Lastly, stigma surrounding the death invaribly increases the difficulties of bereavement. (Demi 1978; Parkes 1970)

1.7. A Framework of Services

Studies of morbidity and mortality have established bereavement as a high risk period for the survivors. Health professionals concur in this judgment that the death of a family member is one of society's most stressful endings. No agreement exists, however, on whether professional intervention for the bereaved is warranted, and if warranted, what the nature of this

intervention should be. Freud described the prevailing attitude of his time, an attitude persistent today:

> It is also well worth notice that, although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on its being overcome after a certain time, and we look upon any interference with it as useless or even harmful. (1917:243-44)

We have only begun to develop knowledge about the types of services needed by the bereaved. Also, only a beginning knowledge exists about the types of circumstances which impede the effectiveness of the coping strategies used to work through grief and adjust to new roles. Lack of information in both of these areas have curtailed involvement by health professionals, subsequently restricting the development of health and community services for the bereaved.

Perhaps the most influential factor which inhibited the development of resources has been the attitude that bereavement is a normal process to be experienced by all people at least once, if not many times, before we ourselves die. Certainly recent attempts to have grief considered a disease entity (Engel 1961; Parkes 1972) have been motivated, in part, by the need to justify and to encourage interest in the study of bereavement by the health community.

Most health services are organized to respond to pathological conditions and to provide their services only after requested.

Pregnancy has the rare status of being defined as a "normal" condition, yet enjoys active intervention by the medical community. Generally, though, labeling an event, process or condition as "normal" is sufficient to discourage either major development of services or serious inquiry and study. This has been true of bereavement. Most of our health services are structured to respond to requests from individuals or families who feel they require professional assistance: services are provided after the request for assistance was initiated by the person experiencing the distress. One major exception to this structure was in communicable disease where the public health dictated a more active and intrusive role for health personnel. Even these instances have been focused on events and conditions associated with pathology.

Shneidman (1970) developed a conceptual framework which contained parameters for organizing the delivery of health care services to individuals and groups. The framework centered around types of stressful events, illnesses, or other endings; it provided a focal perspective for investigating the natural history of disorders as they develop among people, and gave direction to therapists and health workers about the nature of help they offer. The framework consists of a rearrangement of already familiar and well used concepts: prevention, intervention and postvention. Shneidman (1970:145) explained these terms:

> a. Prevention (to come before), that is to do those things that will avert or ward off the inimical event or make it unnecessary or impossible to occur. This includes what is, in conventional public health parlance, called 'primary prevention.'
>
> b. Intervention (to come during or between), that is to do those things during the crisis that will mollify or reduce the intensity of the crisis or event that has already begun to occur; or to do those things that come between the present crisis and any possible future one, with the goal of making the occurrence of a future crisis less likely. This is conventionally referred to as 'secondary prevention.'
>
> c. Postvention (to come after), that is to do those things after the dire event has occurred that either (1) serve to mollify the aftereffects of the event in the victim, or (2) deal with the inimical sequelae in other persons affected by the event (for example, in the case of committed suicide, to deal with the mental health needs of the survivor-victim). This is often called 'tertiary prevention.'

This model has provided a useful approach in identifying populations-at-risk when the stress events are outside the illness, or medical model, while allowing the same perspective to be used when faced with assessing illnesses. This model also has the added flexibility of being applicable at either the individual or the community level; whereas the term, primary prevention as developed and applied by Caplan (1964) was restricted to the community level:

> Primary prevention is a community concept. It involves lowering the rate of new cases of mental disorder in a population over a certain period by counteracting harmful circumstances before they have had a chance to produce illness. It does not seek to prevent a specific person from becoming sick. (Caplan 1964:26)

The boundaries among prevention, intervention and postvention are blurred; for example, the assistance rendered to people in crisis can be labeled either intervention, postvention, or both. Similarly, the assistance given to the family survivors after the suicide of a parent can be both postvention in its immediate effects, and prevention in its long range effects. This model, then, cannot be viewed as a linear concept where one begins at some point and then progresses on to other levels. A crude representation of the model is probably more on a circular plane:

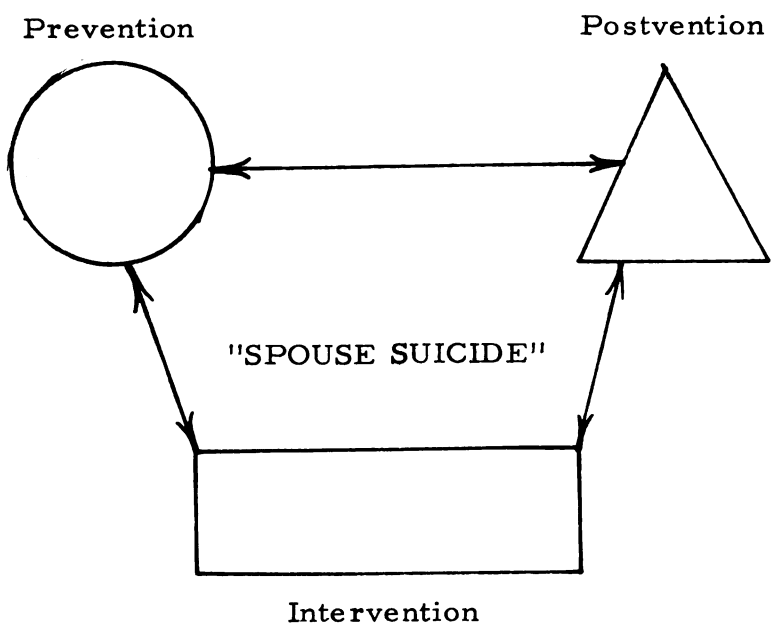

Figure 1. A Model of Prevention, Intervention, and Postvention in Interaction.

In an article by Lindeman et al., (1973), the phrase "preventive intervention" was used to discuss the long range effects of intervention with a young child whose father had committed suicide. This concept is a roundabout way of expressing what is meant by postvention.

One purpose of postvention is to effect an "appropriate recovery" from the traumatic event, parallel to Weisman's (1973) concept of an appropriate death as the purpose of intervention with a dying patient.

Postvention enjoins the therapist to be listener, confidant, teacher, interpreter, supportive counselor and therapist. Wallace (1973), in his work with twelve widows whose husbands had committed suicide, commented on the role of listening which emerged from the listening his interviewers engaged in during data collection:

> Listening to someone talking. How simple! And how few do it. When engaged in, at least we experienced it, the process had invaluable benefits. At times material was brought up that made the women uncomfortable, yet in the long run they realized the benefit. (Wallace 1973:241)

Wallace had originally planned a section of his findings to report on the widow's interaction with caregivers, but had to drop the entire section since one hundred and four interviews failed to produce

sufficient material: "Some family members and friends did listen to the widows, but most did not. Neither did the professionals with whom these women were in contact." (Wallace 1973:214)

Silverman (1972) contrasted the reaction of a widow whose husband committed suicide with the reactions of two other widows whose husbands died suddenly, one from a heart attack and the other from an automobile accident. One of the most critical differences was that Mrs. O'Hare, whose husband committed suicide, "received no support of outpouring of sympathy and help from her neighbors." (Silverman 1972:198) In the examples described by Silverman, the widow's accessibility to even the most elemental portion of postvention from friends and neighbors seemed to be linked conversely with the mode of death. Specifically, when the mode of death carried with it the potential to evoke greater guilt or stigmatism, the widow's need for postvention was enhanced while accessiblity to postvention was diminished.

Other factors besides suicide can, of course, increase the survivor's need for postvention. This need will vary in accordance with the effectiveness of the coping methods used, as well as the way the ending interacts to increase or to block accessibility to the support measures normally available in a community. This was a major feature reported by Cain and Fast (1972:148):

> The bereaved spouse of the suicide frequently finds no such support; rather, an obvious avoidance by many of those from whom they would ordinarily expect and receive sustenance. But the reaction generally did not stop at this; rather, there was active blaming and finger pointing at the surviving spouse.

As more of the factors become known that place people in positions of special risk, we can better decide when postvention is critical for the bereaved to achieve an appropriate recovery.

What may prove more difficult to establish is the form postvention programs should take. For example, should these programs be staffed by professionals, or by people who themselves have worked through the turmoils of bereavement? Silverman's (1976) pioneering Widow-to-Widow program was established in 1967. This program retains its critical, founding features: (1) use of widows who befriend and counsel widows; (2) an active outreach program which seeks out the "new widow" to offer help. Other self-help groups (these would be more accurately called peer-aid groups) have proliferated and have taken many shapes and forms: educational classes offered through community colleges or adult education centers; groups where other widows are met and programs are presented on issues of common concern; special focus groups--Catholic groups or single parents; groups for the adult previously attached, but now is separated, divorced or widowed. Groups are

both religious and secular in their orientation. All have at least the dual aim of reducing the loneliness inherent in widowhood and providing an environment where practical problems can be presented for assistance.

Most of these programs have not been evaluated formally to determine either their overall effectiveness or to identify their effectiveness with special populations or problems. Professional bereavement programs are hard to find. Services are offered in unspecialized programs along with other counselling or therapeutic activities. People who already have difficulty reaching out for help find little available in the community once they have asked.

The role of professional health care personnel has not been determined for either peer aid programs or programs focused especially on the bereaved. Truly effective programs could include unusual partners or community resource contacts; lawyers to assist with estate issues; bankers or investment counsellors to explain investment possibilities; funeral directors to strengthen services during the immediate crisis; welfare agencies to provide emergency food and shelter; law enforcement personnel to explore more humane methods of "breaking the news." Certainly postvention programs should consider health programs which monitor those conditions of bereavement found to have a higher incidence in the morbidity and mortality.

To address only counselling services for postvention programs would be to ignore the existing data on the nature of bereavement. Counselling services need to be offered along with other services which address needs and problems that include social, legal, and spiritual components.

CHAPTER II

RESEARCH DESIGN

2.1. Introduction

The research design arranges conditions for the collection of data to proceed in a manner that combines relevance of the research purpose with economy in methodology. (Selltiz, et al. 1976) The purpose of this study involved examining the bereavement process over time in a small number of human subjects. The characteristic, bereavement, which made the object eligible for inclusion in the study, required the design be especially sensitive to its potential adverse and painful effects. A non-intrusive methodology was needed more than one with rigorous controls or careful experimentation. (Frey 1976) An earlier researcher on grief supported this: "Clearly, the grief situation does not readily lend itself to experimental manipulation, not even to the usual forms of controlled observation. The situation is simply too sensitive to be intruded upon by a methodology which in anyway make a person's reaction more painful." (Switzer 1970:13) An effective buffer between the research process and the bereavement process was

adequate flexibility in the research approach. A critical characteristic of the exploratory descriptive design used in this study was flexibility. (Brink and Wood 1978:79)

2.2. Research Approach

On the broadest level of consideration, this study was exploratory-descriptive. Since the purpose of the study involved describing the events of bereavement, rather than discovering the general laws underlying the bereavement process, the nature of this study, in its purpose, was ideographic, rather than nomothetic. (Windleband 1914) The ideographic approach, however has been associated with a level of comprehensive, in-depth study which was not attained with the limited series of semi-focused interviews used in this study. According to the distinction made by Glaser and Strauss (1965:261), the design was more closely aligned with inductive building of theory, as opposed to deductive testing, or extension of theory. Since I made use of previous data and concept formation when I developed the framework and expectations, the inductive approach was the better fit, though not an exact one.

Semi-focused interviews were used with the dual aim of (1) collecting information from the subjects about their experiences during bereavement, while (2) assisting each subject, via interview techniques, in their efforts to cope with emotional pain and reality,

stresses which accompanied bereavement. This study, could be considered a clinical study:

> The distinction between clinical research and other types of research should be made. The former is investigation carried out in any clinical setting in which nurse and patient are together. It may be in a hospital unit, a clinic, or in a patient's home. Such investigation employs clinical methods of data collection and direct observation of the patient. It is directed toward improving or altering some phase of patient care. (Verhonich 1971:80-81)

It involved interaction with the "patient" in the home setting and was directed toward improving "patient care." The broadness of Verhonich's definition compromised its usefulness. Refinement of a perspective of the clinical approach to research was given by Davis (1973:225):

> It is this clinical approach which emphasizes observation, interview, and interpersonal relations in an attempt to understand the patient's definition of the situation. In my opinion, this clinical research more perfectly fits conceptually the phenomenological approach.

The definition of the phenomenological approach used by Davis seemed to fit best the research approach in this study. Observations and serial interviews over time were used to identify and understand the bereavement process. Since the interaction occurred in the widow's home, the information was collected in her natural context, an effort designed to minimize the inherent distortion of the interview situation. A guideline was established in Wallace's (1976)

study of twelve women whose husbands committed suicide, "Questions were rarely asked in a prestructured format, but rather allowed to emerge in terms of their relevance for an individual person." (Wallace 1973:249) Following his guideline, the interviews were semi-focused and the specific questions were not prestructured. This strategem was employed to enhance the development of an interpersonal relationship between researcher-subject which diminished the intrusiveness of the research process and enhanced the postventive efforts of the researcher.

2.3. Method of Data Collection

I scheduled the initial interviews with each widow weekly, then negotiated the frequency of subsequent interviews. My minimum schedule of interviews was patterned to correspond with those used by Parkes (1970): the end of the first month, third month, sixth month, ninth month and thirteenth month. I had originally planned to begin my interviews very early in the bereavement process, and to have interviews at least weekly during the first month. If I could not initiate contact with the widow by the end of the first month, then I would not consider her eligible for my sample.

I was unable to maintain this criterion. Unexpectedly, several widows retained the information I had sent for several weeks

before they contacted me. This necessitated either my dropping them from the study or scheduling their initial appointments beyond the one month criterion. I decided to extend the time boundaries, a decision which gave precedence to the clinical component of this study.

The interviews were tape recorded and then transcribed verbatim to increase accessibility of the data. No methods of data collection were used outside of the interview situation. The interviews were not prestructured, although most of them began with the widow "catching me up" on events and interactions since our last appointment. Despite the attempts to reduce the obtrusiveness of the method of data collection, the very act of investigating bereavement changed the bereavement responses and the widow's manner of coping with their problems. Shneidman (in press) noted this act of investigating's capacity to change the event being studied, whether the tool of investigation used was a microscope, or a human observer. The degree of change can not be tallied; only the existence of influence acknowledged.

I condensed each transcribed interview further by summarizing it on a five by eight card. This was done to facilitate the identification of major occurrences either in the life of the widow or in my interventions.

2.4. Protection of Human Rights

Participation in this study was voluntary and without financial remuneration. No indirect coercion existed such as possible for perceived loss of access to health care, since this study was not sponsored by a health service agency. Only adults were included as subjects. No prisoners were used. No known physiological risks existed as interviewing was the only method of data collection; however, some psychological risks were anticipated. These risks (activation of painful memories, heightened awareness of loneliness) were discussed with each perspective subject prior to obtaining her permission to participate. Each widow was advised that she could withdraw at any time--either during an interview or by cancelling scheduled interviews.

Both direct and indirect gains were identified for those participating in the study. The direct gains stemmed from receiving postvention through the scheduled interviews. Since postvention consisted of active listening with the establishment of a therapeutic atmosphere, the widows could engage in honest emotional exchanges and could explore puzzling questions or feelings without fear of retaliation. (Shneidman 1973; Wallace 1973) The indirect gains were derived from the study's potential to identify some of the variables which increase the degree of risk for bereaved

widows, and from discovering some therapeutic strategies which are effective interventions. Participating in this endeavor could give widows the sense of helping others through sharing their own difficulties.

Each widow was assured that the information from these interviews would be used for professional purposes only; any written documents or publications which might emerge from this study would carefully protect the identity of each participant, by name and by demographic details.

Each subject was given a code number; tapes transcribed by a professional office service agency were identified only by this code and by date of the interview. The completed transcriptions did not contain the subjects full name: first names were used by subject and investigator during the interview. The transcription was filed according to the code number. Each widow was told about the procedure used to transcribe and store the materials from the interviews.

The procedures used for this study were fully reviewed and approved* by the University of California at San Francisco Committee on Human Research (Approval Number 930104). The

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*The proposal was also reviewed and approved by Human Subject Protection Committee at University of California at Los Angeles, File Number 76-4-228 and by Research at Brentwood V.A. Medical Center.

Committee approved all documents used in this study: (1) the initial letter of introduction and condolence from Dr. Noguchi, Chief Medical Examiner-Coroner, (Appendix A); (2) my letter which initially introduced the study and invited further inquiry (Appendix B); (3) the consent form developed for this study (Appendix D).

The widows were sent Dr. Noguchi's letter and a few days later the letter from me which explained the nature of the study and asked them to either telephone or return the enclosed postcard if interested in further information. I initiated no further contact with the widow. Once the widow contacted me, I answered immediate questions on the telephone and then inquired about making an appointment to explore their interests and questions. Several women called who did not want to participate, but needed information from the Coroner's Department. I was able to furnish them with the needed information or refer them to the appropriate resource. No pressure was used to obtain their participation as subjects.

The study's purpose and format were reviewed personally with each widow during our first appointment in her home; she then read the consent form, was asked if she had further questions. After the consent form had been signed, I set up the tape recorder to begin taping.

This study continued to be reviewed and approved by the University of California at San Francisco Committee on Human Research throughout the data collection period (1976 and 1977).

2.5. Sample Selection

I considered many sources for obtaining a sample of widows to study: newspapers, funeral homes and hospitals. My major concern was to have access to a "normal" sample, that is, a group of widows engaged in usual life activities, not widows in a special treatment program, such as a psychiatric facility.

First, I considered using the obituary column of the daily newspapers to identify widows. Wolanin (1976) was able to study availability of family support during bereavement through the obituary columns of Tuscon newspapers. The information there provided more complete data than are available in the Los Angeles papers. In Los Angeles, the obituary columns did not provide the information I needed. Everyone who died in Los Angeles was not listed, the manner of death was not disclosed, and the information given did not include ages or addresses of the survivors.

Next, I considered funeral homes. This would have necessitated selecting a circumscribed area of Los Angeles, then contacting the funeral homes within those boundaries. Several disadvantages existed for this approach: review of the census tract information about Los Angeles did not reveal an area that was

manageable in size for one researcher, yet included a cross section of the population. It seemed too ambitious an undertaking for this level of study.

My third possibility was to arrange with a local hospital to have access to information about their deaths. This seemed possible, although several hospitals would have been needed to find the necessary cross section in sufficient numbers for sample selection to occur within a reasonable time frame.

Since my study involved widows from all modes of death, one source seemed ideal: the Los Angeles County Department of Medical Examiner-Coroner.* I arranged an appointment with Dr. Noguchi, Chief Medical Examiner-Coroner, Los Angeles County, explained my study to him, and requested access to the department files to obtain my sample. I also asked Dr. Noguchi to write a letter of introduction for me to use with widows who met the criteria for my study. His reception of my study was encouraging. Dr. Noguchi stated that he had been concerned for some time about how his department could increase their services to the bereaved. He saw this study as one step in that direction. I was appointed an

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*Also referred to as the Coroner's Department in this study.

Assistant Deputy Coroner n/c** and began an orientation to the Coroner's Department.

The orientation introduced me to the complex resources and functions of the department so I could, in fact, represent that office in my interactions with widows. The orientation was conducted over a three month period; I spent one afternoon a week visiting the various sections, talking with the staff and observing many activities. I accompanied investigators on their visits to scenes of death and learned how they conducted this part of the investigation. Later, I explored how this initial investigation contributed to the medical investigation which followed. A critical outcome of this orientation was to learn how the information flowed through the Coroner's Department and the types of records that are kept. This enabled me to construct a procedure to obtain the various data I needed.

2.5.1. Processing a Coroner's Case: An Overview

The Coroner's Department was notified about a death via telephone. An intake worker gave a case number and took the initial information about the situation, the deceased and the person making the telephone call. This was relayed to the Senior

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**n/c = non-compensatory, i.e., without pay

Investigator who entered the information into the Daily Report Sheet (Appendix E), made the initial determination of possible mode(s) of death, and assigned an investigator to the case. The investigator went to the location of the death where s/he interviewed people at the scene, collected relevant documents or physical evidence (appointment card for a doctor's visit), photographed the body as it was found, made other pertinent observations, then transported the deceased to the Coroner's Department. There, the investigator "logged in" the date and time of arrival, name, age and sex of the deceased, and location space in the morgue. Then the investigator weighed the body, determined the height, drew a blood specimen, took a full set of fingerprints, and listed the personal effects. The investigator then began writing the report, although more data could still be otained through additional telephone calls or visits.

In the meantime, the physician assigned to the case had ordered laboratory tests, X-rays, or other diagnostic procedures needed to determine the mode and cause of death. Further tests would be ordered over time as the need for them was determined. Autopsies were not automatically performed on all deaths that were Coroner's cases. Determining the cause and mode of death could take months, although both were usually completed within a few days after the person died. When autopsies were performed,

the physician hand wrote a summary of the findings; the final typewritten report often took weeks before it appeared in the file.

When the cause and mode of death could not be determined completely within a few days, a temporary death certificate was issued with as much information as was available. Later, when the cause of death had been fully determined, the death certificate was amended.

2.5.2. Sample Selection Characteristics

The sample size was kept small to allow involvement with widows over time. Specifically, the sample was limited to three widows from each category of mode of death of the husband: Natural, Accidental, Suicidal and Homicidal. To correspond with the area of jurisdiction of the Coroner's Department, I selected widows whose geographic residence was within the County of Los Angeles.

If variations in the bereavement process were to emerge, then criteria were needed to control, where possible, those intervening variables that could be identified. I recognized that few variables could be controlled, since the only information available was about the husbands, not about the women used in the sample. To minimize variability in the sample group, some restrictions on demographic variables were decided: Race (Caucasian), Religion

(Protestant); Linguistic Group (English as a first language); and Country of Birth; (the United States).

I needed to restrict the age range of widows for this study, since the bereavement process could vary tremendously on the basis of age. I was interested in bereavement among young widows for two reasons: (1) youth has been recognized as a high risk group in bereavement since the study by Kraus and Lillienfield (1959) revealed this age group to be at higher risk for mortality, than their counterparts who were older. Young widows may not have had as much experience with death, consequently, were likely to know less about responses and resources. (2) Younger widows seemed more likely to have children in age groups requiring their mother's support and caring, rather than having children old enough to be of direct assistance to the mothers. The Biennial Report of the Chief Medical Examiner-Coroner (1971-72, 1972-72:30) showed the only major difference in death rates of men in Los Angeles County between the ages 30-39 and 40-49 was in Natural deaths:

Table 1

Male Deaths, Los Angeles Co., 1972

by Mode of Death and Age Groups

Age Group	Natural	Accidental	Suicide	Homicide	Un-determined	Total
30-39	184	244	130	156	20	734
40-49	553	196	131	107	20	1007

The number of male deaths remained fairly constant across modes, other than natural, for this period. I decided to use the younger age group, 30-39, as my sample for all modes of death categories, and to have a contrast group of widows whose husbands were 40-49 and who had died a natural death.

In summary, sample criteria were as follows: Caucasian, Protestant, English as a first language, born in the United States, and lived within Los Angeles County. In addition, the widow's husbands were between the ages of 30-39, except one contrast group of three widows whose husbands were 40-49 at the time of death.

2.5.3. Procedure for Identifying the Sample

Beginning in July, 1975, I visited the Coroner's Department weekly to identify widows for my sample. I began each visit by reviewing the Daily Report Sheets for the preceding week to

identify men who had died. Initially, I reviewed the files of all men within the specified age group, regardless of the mode of death. Eventually, I had filled my sample of three women from some of the modes of death; with some categories completed, I could focus my efforts on those remaining categories which were harder to fill, such as Homicide. I developed a summary form (see Appendix F) to transpose the data I needed from the Daily Report Forms. Before consulting the individual file, I began a five by eight card for each person on my summary form. I used these cards for more detailed data.

With the summary forms and the five by eight cards, I consulted the individual files stored in the clerical section. Often, several weeks lapsed before the complete information was in the files; however, some pertinant demographic data were available long before the mode and cause of death had been determined officially. For example, both race and marital status were available early. From these initial data, I could make a beginning judgment about eligibility for my sample. If the initial characteristics were within my criteria, I kept checking the file weekly until other information emerged to determine eligibility, or until too long a time had lapsed since the husband's death. Usually, I considered a month the maximum time before dropping the case from consideration. Sometimes, the individual file could not be

located. This was often due to someone's using the file without signing it out. Many staff used these records, and I learned to look many places before giving up on locating the record.

I reviewed many records to find the few who met my criteria for inclusion in the sample. Once the name of a widow was selected as a possible subject, I mailed her the letter of introduction from Thomas Noguchi, M.D., Chief Medical Examiner-Coroner (see Appendix A). A few days later I mailed my own letter. (see Appendix B).

2.6. Analysis of Data

The tapes were transcribed, then further reduced to five by eight cards to facilitate content analysis. All interviews were analyzed for critical topics and recurrent themes. Tapes, transcriptions and five by eight cards were coded to include the mode of death as well as length of time after the death the interview had occurred. This allowed each topic or theme to be examined for similarities and differences across modes of death as well as when issues emerged.

Initially, cards were tagged for specific events, activities, emotions, incidents and other very specific types of reactions. Repeated examination of the cards and rearranging them allowed more general categories to emerge from the specific types of

reactions. Continued analysis of the content of the interviews through sorting of the cards and reflection on the content gradually resulted in the beginnings of concept categories out of the general categories. Data were then reviewed in light of the concept categories to determine what specific events and reactions fit, and what ones did not. Particular attention was given to those specific events that seemed somewhat at variance with the concept category to discover inconsistencies in the concept, or to determine possible extentions.

CHAPTER III

DESCRIPTION OF THE SAMPLE

3.1. The Sample

The sample for this study was obtained through the Los Angeles Coroner's Department. Criteria for the selection of the sample included women whose husbands had died who were (1) between the ages of 30-39 (with a contrast group added later of age 40-49); (2) Protestant; (3) Caucasian; (4) born in the United States; (5) lived in Los Angeles County.

Seventeen women comprised the sample for this study, although only twelve of them remained in the study beyond the first anniversary of their husband's death. The women were alike in many ways. All of them lost their husbands suddenly and unexpectedly. They all lived within the boundaries of Los Angeles County. They shared the times of their husbands' death: from the summer of 1975 through the summer of 1976.

They were not alike however, in many dimensions of their lives. Some had children, others did not. Some had been married before; for others, this was their first marriage--a brief marriage of a few months for some; others more formidable than ever, while occasionally, the sudden abundance of money itself became awkward.

An overview of the widows who either Completed or Dropped out of the study is provided in Table 2. Completion of Study According to Mode of Death. Three of the five widows who dropped out of the study were from the Suicidal mode of death, with one each from Natural and Accidental modes of death. The Natural category widow moved north about three months after her husband died. I knew she would be moving north and unable to complete the study from our telephone conversation prior to our first interview. In a sense, her dropping out of the study was planned. We have kept in touch with each other through occasional telephone calls. The Accidental category widow who dropped out of the study also warrants further discussion: her husband died in the middle of a fight. For all practical purposes her husband was murdered. Because of the thorough and complete investigation conducted by the Los Angeles Coroner's office, data were uncovered to change the official classification of mode of death from Homicidal to Accidental. The Coroner's office determined that the injuries received in the fight were not sufficient to cause death; subsequently, they discovered two chemical agents as responsible for his death. The dilemma here is, which category is most appropriate?

One other variable seemed prominent among those who dropped out of the study: four of the five who dropped out of this study moved from where they had resided; three of those left no

Table 2

Completion of Study According to Mode of Death

MODE OF DEATH	DROPPED	FINISHED	TOTAL
Natural	1	3	4
Natural Contrast	-	3	3
Accidental	1	3	4
Suicidal	3	1	4
Homicidal	-	2	2
TOTAL	5	12	17

forwarding address; and one moved too far to continue participating in the study. One who did not move was from the Suicide category. Two others who moved were also from the Suicide category and had financial difficulties. They apparantly did not encounter the blame phenomenon, (i.e., being blamed for their husbands' deaths) from neighbors described by Cain and Fast (1972) and Silvermann (1972). Continuing to live in the house where the deaths occurred proved very uncomfortable for three of the women who reported intrusive and painful images of their dead husbands. The continued discomfort with their residence, may have played some part in their moving, but they attributed the move to their inability to afford to continue living there, even when the financial status was unchanged from before the death. Only one who moved and dropped out of the study improved her financial status following her husband's death.

A summary of all seventeen widows is presented in Table 3 Demographic Data of the Sample Group, Classified by Mode of Death. This Table summarizes information on the following variables: Age group of the Widow; Change in Financial Status; Length of the Marriage; Whether or not they were separated at the time of death, Educational Level of the Widows; and Completion of study.

Table 3

Demographic Data on the Sample Group, Classified by Mode of Death

Mode of Death	Age			No. of Marriages			Length of Marriage				Number of Children				Separated at DOD*			Working at DOD*		Finances since DOD*			Educational Level			Termination of Study	
	20-30	30-40	40-50	One	Two	Three or more	Less than 1 year	One to five years	Five to ten years	Over ten years	Preschool	Primary	Secondary	Adult	Yes	Only overnight	No	Yes	No	Better	No change	Worse	Less than high school	High school	Some college	Dropped out	Completed
Natural	1	2	1	1	1	2	1	1	2		1	3	1	10	1		3	3	1	1	1	2	1	2	1	1	3
Accidental	1	3		3	1			1		3	1	4	2	3			4	3	1	2	1	1	1	2	1	1	3
Suicidal	2	2		2	2		1	1	1	1	1	4				2	2	2	2	1	1	2	1	3		3	1
Homicidal	1	1		1		1		2					1	5	1		1	1	1		1	1	1		1			2
Natural Contrast**		1	2	3						3	1	2	2	7	1		2	1	2	1		2		1	2		3
TOTAL	5	9	3	10	4	3	2	5	3	7	4	13	6	25	3	2	12	10	7	5	4	8	4	8	5	5	12

*DOD = Date of Death **Natural Contrast = Widows whose husbands died a natural mode of death and who were 40-49 years old.

As indicated in Table 4 Time Lapse Until First Interview, According to Mode of Death, eleven of the seventeen widows did have their first interview within a month after their husbands' death. Those seen for the first time after a month had lapsed were well distributed across Modes of death. No trend was apparent to differentiate those widows who completed or dropped this study on the variable of lapse of time prior to the first interview.

Figure 2, Distribution of Widows Across Los Angeles County According to Mode of Death and Completion of Study portrays a fairly even spread. This evenness of distribution seemed even more remarkable since these seventeen widows came from the 400 square miles that constitute Los Angeles County. One section of the county had no widows represented in the study, the Western region. I cannot account for this omission.

I have prepared a brief profile of each widow which began with a description of the circumstances of the husband's death. All the names have been changed; occasionally other minor, demographic data have been adjusted to insure the anonymity of each widow.

Table 4

Time Lapse Until First Interview

According to Mode of Death

WEEK	MODE OF DEATH					
	N	A	S	H	NC	Total
2 & Under	-	-	2	1	-	3
3	2	2	1	-	-	5
4	1	-	-	-	2	3
5	-	1	-	-	-	1
6 & Over	1	1	1	1	1	5
TOTAL	4	4	4	2	3	17

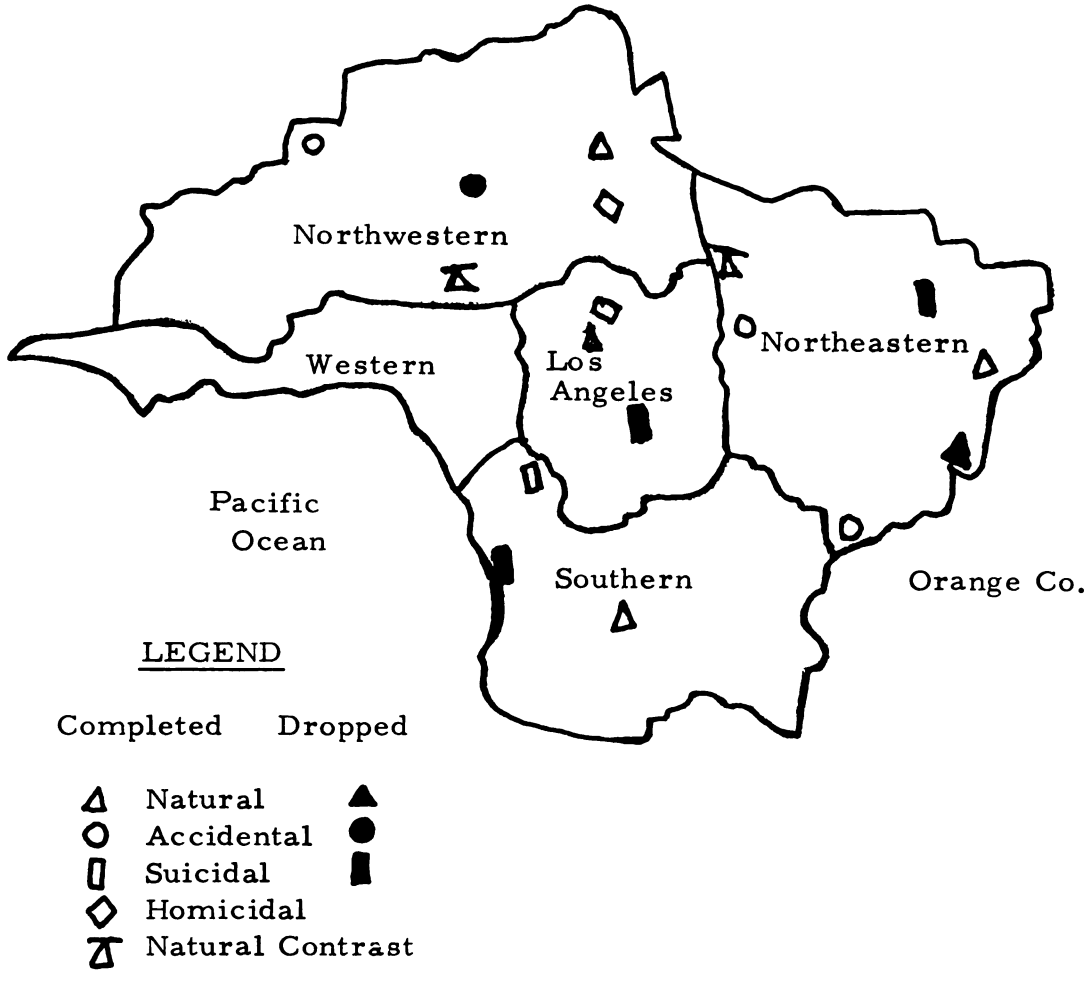
Figure 2

Distribution of Widows Across

Los Angeles County According to Mode

of Death and Completion of Study

MAP: LOS ANGELES COUNTY



3.2. Brief Profiles of Each Widow

Natural

1. Jeanne — Dropped

Chad came home from work complaining of indigestion. He refused to see a doctor. He continued to feel ill throughout the evening. He collapsed suddenly. Jeanne called the Paramedics and began mouth to mouth resuscitation. Pronounced dead at the hospital.

Jeanne was 29 and was employed part time as a clerk. She did not return to work. This was her first marriage; they had been married seven years. Their only child, a son, was 3 1/2 years old. They had just purchased their first house; she sold the house to rejoin her family in Oregon. She had several years of college. Her financial status improved after Chad's death.

2. Lucille — Completed

Lucille and Dan had taken their daughter to the local Emergency Room to have an infected cut examined. Dan suddenly collapsed and died. He had complained of a slight headache earlier.

Lucille was 45. Her only employment was babysitting in her home; she continued this. Both she and Dan had been married previously; this was her third marriage, his second. They were married eight years. Between them, they had eight children. They owned their house and she continued to live there. She was a high school graduate.

3. Rose — Completed

Bud was late in meeting Rose for an alcoholics anonymous meeting they were to attend; when he didn't arrive after the meeting to pick her up, she became anxious and called a taxi to take her home. She found Bud collapsed in the bathroom. She called the rescue squad even though she believed he was already dead. She also called their physician who advised her to return to the hospital.

Rose was 39 years old. She was employed as a government worker when Bud died. She returned to work part time some time after Bud died and also began school (Community College). She and Bud had been married just under a year. This was her third marriage. She had one son in primary school who still lived with her; her other

Natural - continued

children were grown and had left home. She never returned to their house; she moved in with her mother after Bud's death. Her financial situation was worse following his death.

4. Joyce — Completed

Erik was taken to a hospital emergency room by friends who dropped him off and left. He was responding to treatment for a comatose condition when he suddenly went into cardiac arrest and died. Joyce and Erik had been separated a year, so she learned of Erik's death through official channels.

Joyce was 34 years old. She was employed as a factory worker when Erik died, and returned to her job soon after his death; she only kept the job a few more weeks. This was Joyce's second marriage; they were married about four years, although they had been separated the last year of the marriage. Joyce's two children from a previous marriage, one son was in secondary school, the other primary school. Her financial situation was not changed by Erik's death. She continued living in the house they owned after his death.

Accidental

5. Jane — Dropped

Sean impulsively decided to attend a party in the apartment upstairs. He had been gone about an hour when someone banged on the door and yelled that Sean was dead. He had argued with two men at the party; they fought in the hallway and stairway; Sean died during the fight. Later, the cause of death was determined to be due to an overdose of two drugs. The mode of death was changed from homicide to accidental.

Jane was 28 years old. She was not working when her husband died and did not begin working. This was her second marriage; they had been married nearly five years. Two of the three children were from a previous marriage; her youngest daughter was from this marriage. They lived in an apartment, but she moved soon after Sean died. Her financial status worsened as a result of his death. Although she had not finished high school, her drive for further education was strong.

Accidental - continued

6. Lisa Completed

Howard collapsed while working on his car with a friend. Lisa arrived right after he collapsed and began giving him artificial respiration. He was pronounced dead at the Emergency Room. Howard had a motorcycle accident five months before; later it was determined a different, minor accident five weeks previously had caused the injury which led to his death.

Lisa was 33 years old. She was employed in a bank when her husband died; she resumed working within a few weeks. This was her first marriage; they had been married 12 years. They had one daughter who attends primary school. They had just bought a house, but escrow had not closed. She completed the purchase in her own name, and moved in soon after. Her financial status improved after Howard's death. She had attended college.

7. Joan Completed

Fred went fishing after work. The boat owner's wife called, said there had been an accident and that the Coast Guard was searching. Many hours passed before Joan learned her husband was dead.

Joan was 39 years old. She was employed part time as a waitress. She tried to resume work six weeks after Fred died, but wasn't able to. She did return to work in three months. This was her only marriage, one of more than twenty years duration. They had five children; all of them still lived at home. She was a high school graduate. Her financial situation improved as a result of Fred's death. They owned their home, and she continued to live there.

8. Sarah Completed

Gene wasn't home when Sarah came in from work. After waiting awhile, she went on to keep their engagement with friends. When she returned an hour later, he was upstairs drunk. She went to bed. The next morning, Sarah went into his room: he was very still; she could find no pulse. He had been dead for hours. His death was caused by an accidental overdose of alcohol.

Sarah was 31. She was employed as a buyer in the garment industry. This was her first marriage. They had been married twelve years. Although they were not separated, she had "divorced" Gene a few weeks previously; they were living together for a year to see if he

Accidental - continued

could stop drinking and they could resume their marriage. She later discovered a clerical error had prevented the divorce. Their only daughter was twelve years old. Her difficult financial status was not changed by Gene's death; she continued moving toward bankruptcy. She continued living in the condominium they had purchased. She had completed high school.

Suicidal

9. Ann — Dropped

Joe killed himself early one morning by closing himself in the garage with the motor of his car running. He died of carbon monoxide overdose. Ann had gone out to a party the night before; she stayed the night since she became sleepy. They were not quarrelling; nor were they separated. He left no note.

Ann was 23. She was not employed. This was her second marriage. They had been married five months. They had no children. They lived in an apartment; another woman lived with them. She had to give up the apartment after Joe died; she lived with one friend or another. Ann was a high school graduate. Her financial situation was worse after Joe's death.

10. Dinah — Completed

Paul shot himself in the head. He and Dinah had quarrelled the night before, and she and their daughter went to stay with her parents. He called and threatened to kill himself. Dinah called Paul's mother, then decided to go herself. She found him still breathing and called an ambulance.

Dinah was 27 years old. She was not employed when Paul committed suicide; she began working as a secretary slightly over two months after Paul's death. This was the second marriage for both Paul and Dinah. They has been married 3 years. Their only daughter was two years old. She did not return to their apartment to live; she and her daughter stayed with her parents for about six months. Her finances were worse after Paul's death; she filed bankruptcy.

Suicidal - continued

11. Cindy — Dropped

Ed had been unemployed for about a year. Cindy finally left him one day after many quarrels about his girlfriend. She returned the next day, escorted by police, to pick up some of her belongings. A few hours later he shot himself in the chest, then staggered out to the front yeard and requested help from a neighbor. He died within a few minutes from his injuries.

Cindy was 37 years old. She was employed in a factory when her husband died; she resumed working three weeks after his death. This was Cindy's first marriage; Ed's second. They had been married for seven years. They had no children. Although they owned their home, they had begun bankruptcy procedures and the house was for sale. She continued to live there during the eight months she participated in this study; at our scheduled ninth month appointment, no one appeared to live in the house. She had completed bankruptcy.

12. Susan — Dropped

Darrel was convinced that Susan was having an affair; his drinking increased. After an argument, he left the house threatening to get it over with--make her pay. He shot himself in the head; never regained consciousness. After many discussions, Susan gave permission for his kidneys to be used in a transplant. The surgery occurred seven days after he shot himself.

Susan was 33 years old. She was employed as a clerk when Darrel died. She returned to work about three weeks after his death. This was a first marriage for each of them; they had been married fourteen years and had four children. All the children were in primary school. She and the children continued living in the house they owned. Her financial status was improved following her husband's death.

Homicide

13. Sharon — Completed

Steve was stabbed several times in an altercation with two men and two women during a disagreement that began in a neighborhood bar. Sharon learned about the death while watching the late news on television. The newscaster mispronounced the name, but she had a

Homicide - continued

feeling it was Steve. She called the Morgue; they confirmed Steve's death. She was with her boyfriend, who was also her husband's brother, when she learned of the death.

Sharon was 24 years old. She was not employed. This was her first marriage. She and Steve were married and living together for three years, then separated for another two years. During this two year period, Sharon had been with her husband's brother. Her financial situation was unchanged by her husband's death. She did not have a stable residence. Since she and her boyfriend were broke, they were living with a friend. Sharon did not complete high school; she quit school and ran away from home when she was eighteen years old.

14. Patricia Completed

David was shot by Patricia's step-father. Patricia and David were intervening in a family quarrel. Patricia was threatened, but was not shot. Her mother received a gunshot wound in her head and partially recovered. Her husband died immediately from his wounds, although Patricia was not aware of his death for several hours.

Patricia was 37. She was employed as a schoolteacher, although they were on summer break. She resumed work after the summer vacation ended. This was her third marriage; they had been married for four and a half years. She had six children by her previous marriages; none from this marriage. Only one of the six children still lived at home, attending high school. She had some College and was attending evening school when her husband was murdered. Her financial status worsened as a result of David's death.

Natural Contrast

15. Lillian Completed

Lillian answered the door bell one night and found a police officer standing there. He rather abruptly informed her that "a Mr. _____ had died." (The police officer did not expect this to be the wife.) Bruce died in his girlfriend's apartment across town. He had gone in to take a nap and died soon after laying down.

Natural Contrast - continued

Lillian was 42 years old. She and Bruce had been married twenty three years, a first marriage for both. Two children were in secondary school, the other two were adults. Three of the children were living at home. Lillian was working part time, attending school part time when Bruce died. She resumed working immediately after Bruce's death, and began making plans for a career change. Her actual financial status was not changed by her husband's death. They continued living in the house they owned and had lived.

16. Evelyn Completed

Patrick complained of a slight headache when he came home from work. Decided to go for a walk before going to bed, but he returned in a few minutes: vomiting and reeling. Called Paramedics. Took him to local hospital, but they couldn't revive him despite extensive efforts.

Evelyn was 47 and was not employed when Patrick died. This was a first marriage for each of them and they had been married 25 years. Their five daughters were all young adults; two still lived at home. Although they owned their house, Evelyn could not afford the payments, so it was sold and they moved to an apartment. Her financial status was worse after Patrick died.

17. Ilene Completed

Jeffrey had gone in for a regular check-up at Ilene's urging. He collapsed at the doctor's office within seconds after an exercise had begun. Nothing was effective in reviving him. Ilene learned about his death several hours later. She returned from running errands when a friend telephoned and told Ilene she should call the Doctor's office. The physician, a stranger to Ilene, told her on the telephone about her husband's death.

Ilene was 37 years old. Although Ilene was not working when Jeffrey died, she was a full time student in graduate school. She resumed classes two weeks after Jeffrey's death, but quit school at the end of the term. Neither Jeffrey nor Ilene had been married before. They had been married 13 years. Two of their three children were in primary school; the youngest was a pre-schooler. Ilene and the children continued to live in the house purchased the year before when the family had moved to California. Her finances were improved.

CHAPTER IV

CONCEPTS RELATED TO THE FINDINGS OF THE PRESENT STUDY

4.1. Widow Response Patterns

What follows is a qualitative discussion of the findings of the present study. The discussion has been organized under two general headings. The first, and major focus addressed the response patterns of the widows. Three types of response patterns have been presented: (1) Widows continuing to experience the presence of the deceased husband; (2) A process of bereavement resolution through an identity transition toward an uncoupled identity; (3) The relationship between reality activities and affective expression. The second focus of the qualitative discussion of the findings described some bereavement postvention issues which seemed especially relevant for the clinical work with widows in this study.

4.1.1. Continuing Presence

All widows in this study reported feeling a sense of their husbands' continuing presence during the first few weeks of bereavement. Sometimes this presence was experienced as a general,

sustained feeling; other times it was restricted to a more fleeting sense of his nearness. The descriptions varied from simply feeling near the deceased husband in some special way to the more intense experience of believing, momentarily, that his voice had been heard. This awareness of their husbands' presence was more than the usual awareness characteristic of memories. Widows described these experiences as having almost an uncanny realness to them. They felt as if he were there, as if he were still alive, at least momentarily, yet they knew cognitively that he was dead. They indicated the experiences were so real that if they turned their heads, they almost expected to actually see him standing there.

Many types of events evoked this sense of the husbands' presence. The presence could be evoked in two broad ways: internally and externally. Internal stimuli consisted largely of memories and reflections; while external ones usually were objects, events or situations closely associated with the husband. Internal triggers seemed to emerge from moments of privacy and aloneness. The precise chain of events which resulted in the memory giving rise to the particular experience was difficult to reconstruct. Conversely, external stimuli were identified easily and concretely; such as a special song, a personal object, a situation formerly handled by the husband, or a place they had visited together.

Experiences with the husbands' presence varied in intensity. Knowing that the husbands were aware of special happenings within the family was a less intense experience with the continuing sense of presence than hearing his voice directly. Hearing the husband's voice (similar to auditory hallucinations) or mistaking someone in a public place for the husband, (illusionary experience) that is, really believing for a moment that the stranger was the husband, were highly intense experiences. In the range of intensity of experience, being convinced of the husbands awareness of special family events was a low range of intensity, while the "hallucinatory" or "illusionary" experiences were at the other extreme. The entire range was "normal" within the context of acute grief. Most experiences were moderate in intensity and fit the description of seeming real, while cognitive awareness of the death remained. The intensity of the experience seemed independent of the nature of the precipitating event, i.e., both internal and external events could evoke experiences of all degrees of intensity.

One widow commented on this sense of the presence of her husband by protesting, "He died, but he won't go away!"

Three variants of a continuing sense of presence were found among widows in the current study and may be labelled: (1) Friendly Presence; (2) Constraining Force; and (3) Consulting

Guide. The three variants were evoked by different types of stimuli triggers and seemed to serve quite different functions for the widows. This sense of presence has been described generally and briefly in the literature and was presented as a single type of experience, without the variants found among widows in this study. For example, Parkes (1970) found that fifteen of the twenty-two widows in his London study reported a sense of a persisting presence of the lost husband. Parkes linked these experiences with alleviation of the pain of their loss. In this study, Friendly Presence most closely corresponded to what has been discussed in the literature as a sense of presence, and was also the form that gave credence to presence in its capacity to mitigate suffering. That type of continuing presence called Constraining Force represented a feeling about the husband which judged, disapproved and inhibited the widow's behavior. The third **variation, Consulting** Guide, referred to the experience of problem situations which were formerly in the domain of the husband, but were left to the widow to resolve. In these situations, some widows experienced her husband's presence in a way which allowed her to review how he would have managed the situation step by step, as a partial result of this, most widows acquired the problem-solving skills necessary to resolve the situation successfully.

The three forms of continuing presence served different needs of the widows. Sometimes the experiences were positive and comforting; other times the experiences were unpleasant and restrictive. Experiencing the dead husband as a Constraining Force or as Consulting Guide was limited to a few widows in the study (across the modes of death); whereas, friendly presence was the form experienced by all widows. The three variants did not seem to exist on any type of continuum--i.e., one form of presence did not seem to emerge from any of the other experiences. Experiencing the presence of the husband as a Constraining Force did not seem either to facilitate or to impede the widow's experiencing her husband as a Consulting Guide. The three variants will be discussed in greater detail in the following section.

4.1.1.1 Friendly Presence

Each widow in this study experienced the presence of their husbands in the form labelled Friendly Presence. Friendly Presence involved both an acute awareness of the dead husband and an almost constant preoccupation with him. He was perceived, at least momentarily, as being nearby. Early in bereavement reminders were everywhere: in conversations, music, personal objects, and even in places that were visited. Sometimes routine daily activities set in motion thoughts of the husband that resulted

in the special and comforting sense of his nearness. Especially during the first weeks of bereavement, the husband was perceived as present often, without effort. For brief moments, he seemed to be a part of most of the important events. Widows accepted Friendly Presence as a normal part of their acute grief; they were comforted by the experiences, not frightened.

> SHARON: I keep looking at his picture, running into more peole that used to know him. Every place I go reminds me of him. We met around here.

> SARAH: Oh yes, it's a very personal thing. Right after he died, I would say for two or three days, probably up until the funeral, which was six days, I talked to him. If I had the house to myself I would walk through the rooms and I would talk to him. . . . Oh my God, What am I going to do now and what would you have done? He had just put up these shelves, had that speaker wired and this one wasn't. I'm saying, so you know how to wire speakers but how the hell am I going to do that: Like someway I could feel his presence and then I got feeling much like these occult things, you know, like he's here somewhere. It was a very strange feeling but it was like he hadn't left me.

Friendly Presence cushioned his loss. Generally, the widows found comfort through these experiences, although on occasion, they experienced the sharper edge of bitterness and anger:

> DINAH: I feel like everything I do, everything I feel, or I touch reminds me of him and I feel angry about it. I wish that I didn't have a lot of those good memories to remember. I feel like instead of good memories, he used to tell me how we'll just keep making memories, we're going to make good

> memories for the rest of our lives. All of the good memories he gave me are really turning out to be a thorn in my side.

Although memories were sources for evoking this sense of presence, memories in turn could themselves be evoked by experiencing the husband's presence, as indicated in the above quotation. Another consequence of the experience was an occasional struggle for composure when the trigger evoked the sense of presence unexpectedly and publicly.

> DINAH: Today I was very busy again. There was background music, but you could recognize the tune. This song was playing and I found myself just stopping what I was doing, thinking, listening to it. Things like that really creep in all the time.
>
> Today, listening to that music, listening to that song, I thought no one here knows what's going through my mind and no one knows what I'm thinking. No one knows what that song means. Only myself, and I thought, I know I can't do it; I know it would look ridiculous; I know it's stupid but I would love to just get out and run. I sat there and told myself, O. K. this is how you feel, but that's not going to solve it. And consequently, I kind of put myself back together. I'm not patting myself on the back or anything but I feel like sometimes, certain things, I just have to go on.

Most of these early experiences involved spontaneous encounters with the sense of presence, although the events which stimulated them could be either internal or external. Widows seemed to accept the occurrences as they happened. As the

frequency of the events decreased over time, some of the widows tried to extend the incidents, and the comfort they found, by seeking stimuli in order to solicit the Friendly Presence itself:

> SARAH: Oh yeah. I walked around in his cowboy hat for a couple of days. He used to run up in the hills with bricks in his pack to build himself up and he didn't jog. He ran! He was such a hearty person and I thought it very hard to collect his clothes that had been worn. There wasn't much that hadn't been laundered cause he had done all the laundry before going on his last trip. And I sort of didn't even want to wash the clothes. I kept the bandana all wadded up for a while just, you know, tied in a knot and there was the circle that had been around his head. Something comforting about it.
>
> Q. It's almost like to wash them means he was going to go away.
>
> A. Yeah, everything will be clean and sterile again and there will be nothing left of him. His shirt had his scent on it, you know, just things you recognize as people. It wasn't a cologne, it was just you put it up to your face and he was there. I could close my eyes and he was there. I slept with that shirt for two nights. And I found myself, I still do sleeping with some weight on that side of the bed . . . books, magazines, or the laundry basket.
>
> I have a big empty trunk upstairs and I may just put his things in the trunk and keep them and look at them when I need to. Certain things. There are some old cozy flannel shirts from mountain trips. I can't give those away.
>
> Q. It's not a matter of just an article of clothing.
>
> A. No, I'm completely impractical about it, but it's like, if it's something I can hang on to that looks like him, that I'm comfortable with. His bathrobe still hangs right next to mine on the bathroom door, and I have no intention of moving it. It's not hurting

> anybody. I can't think it's hurting me. Sometimes when I've had a really rotten day, I'll go bury my face in it and cry, but that's kind of like having a shoulder to cry on. It's like having him there, in a way. Which is deluding myself, but if it's a comfort you know, then I'm going "to go suck my thumb and have my blanket."

Seeking out Friendly Presence was undertaken by widows in the hope they would find comfort and alleviate the acute loneliness--within keeping with what Parkes termed "to mitigate the pain." (1970:57) Actively soliciting this experience occurred fairly early in bereavement, although after the first few weeks of feeling that "he's everywhere" had begun to subside. Widows continued to experience the husband in the form of Friendly Presence, both solicited and unsolicited, throughout the first three months of bereavement, however, not all widows reported actually taking steps to seek out their husbands presence.

Just as widows accepted their early experiences with Friendly Presence as natural and comforting, they begn to develop doubts about the experiences when they continued to sense their husband's presence beyond the time they had defined as acceptable.

> JEANNE: I'm starting to think, you know, like talk is weird, but talking to him . . . when he first died, Ithought he can see us or hear us still, you know, wherever he is or whatever. Now I really don't know if I believe in any of that either, so it's harder. It's like he's not around, and the stuff I was saying really doesn't do any good. I should have said it when he was still alive.

> JANE: Time that I've sat here alone and I've actually thought I heard Tom talking to me. Maybe there's something wrong with me or something. I just wondered . . . am I the only one?

Wondering if something were wrong because of experiencing the continued presence of the husband did not occur during the first two months of the husband had died. Only as the "acuteness" of the situation lessened did widows begin to question the continuing experience of their husband's presence as not "normal." Even then, widows did not question this as an acceptable experience during the time of the experience--rather, they questioned the experience after the incident was over.

4.1.1.2. Constraining Force

The second form of the continuing sense of the husbands' presence was termed, Constraining Force, In this form, the sense of presence was the perception of the husband as a strong disapproving force in relation to the widow's behavior in certain situations. He actually became a barrier for her in some instances. Experiencing the husband's continuing presence as a Constraining Force was reported by fewer widows and it was experienced later in bereavement than Friendly Presence had been. The earliest impression of the husbands presence as a Constraining Force was reported at seven weeks.

> DINAH: I feel like he's standing between everything I want to do. I feel like if I ever meet anybody else, he's going to be right there in front of me.

Contraining Force was evoked by dating or some situation that had been a source of conflict during the marriage. Both internal and external stimuli were identified. Thinking about driving the car into an area unfamiliar to her, precipitated an encounter with the husband for one widow. The specific type of conflict situation which served as a trigger to evoke Constraining Force was a situation likely to arouse ambivalent feelings. In these instances, the widow's confrontation with her own ambivalence was postponed and diluted by placing the disapproval outside herself, into her dead husband.

One widow described the experience as a dream, although she pointed out she was not really asleep. She was not sure how to label the phenomena, so called it a dream, as it occurred frequently when she was awakening from sleep.

> CINDY: It scares me half to death. I'll wake up and I'm so scared that I'm going to look up and he's going to be standing in the room, or if I come home, I'm afraid to open up the bedroom door. And, I talked to my girlfriend about it and she said what it is, is what I'm doing I feel guilty about. You see, I'm spending money. An I'm doing things that I know he wouldn't approve of and I'm feeling guilty about the things I'm doing.

> Really, in the back of my mind, I feel that any time I do something that he would object to, it is in the back of my mind all the time, no matter what I do. He's back, and I know he can't come back, but I keep thinking it. A lot has to do with the house, but I buy things I know he wouldn't approve of. I can hear that voice saying no, you can't have it, you don't need it.
>
> Sometimes I feel just like he is here no matter what I am doing. I know every well. It's just like he is standing here telling me, no, don't do it, you don't need it.
>
> Sometimes it's an angry thing. I can't get him out of my mind. He is between everything I do. And, for other people it is a dependent thing. He is watching over me and taking care of me and helping me make decisions. But whether it is an angry thing or a comfortable thing, it still is true and early on during these first few months he died but he will not go away.

Although the behaviors involved activities that either were a source of conflict during the marriage, or were a current source of conflict as the widow tried to move beyond the marriage relationship, the activities themselves may have been positive. Sometimes widows experienced their husbands as a Constraining Force in response to activities necessary for progress toward furthering individual identity and independence.

> CINDY: Well, the whole thing is that I do things that I know he wouldn't like and he wouldn't approve of one bit, and I do 'em. I always remember, he always said I could never take care of myself without him. It's just like I'm telling him, I can do it myself now. I can make my own decisions. I don't need somebody around telling me what to do and how to do it. And that's why he felt that I needed him. And I didn't. I've found out I can do things on my own.

These comments occurred after that widow had related several things she had accomplished recently that she had not thought she could do: handling the finances, or making daily decisions. These were all areas in her marriage that were managed or directed by her husband.

Other widows who mentioned examples of Constraining Forcedid not cite their behavior being so directly affected; rather, it related more to a feeling of constraint, or a sense of disapproval, while their behavior remained unaltered.

> SHARON: New Years, I was thinking how great he would've loved that. New Year's day was real nice out. That's about it, I don't hate him. I kinda feel bad that he's dead, he's missing out on so much. But, well he wouldn't have used it right anyway. But maybe he's not dead anyway, I have a feeling he's around watching me somewhere. Cause like even when I broke up with Earl, I had a feeling Steve was round going, Oh no, what did you leave him for that creep for, he's just like me.

In the above excerpt, Sharon had left Earl (Steve's brother with whom she had been living for some time even before Steve's death). While she and Earl were apart, she lived with another man.

Guilt and anger seemed to be prominent features of Constraining Force. Still, behind these strong, negative feelings lived acute yearning:

> CINDY: I still have "the dreams" once in a while. It's the same old thing . . . why doesn't he die? And I'd come up with the same answer. It's me. I'm the one that's keeping him alive. I won't let him die. I don't know if it's just because he was very affectionate, very loving, and I miss it a lot.

4.1.1.3 Consulting Guide

As widows reported how they handled the situations and problems that were formerly managed by their husbands, the third form of presence, Consulting Guide, was identified. This third sense of their husbands presence enabled them to approach situations outside their realm of experience and competence. Experiencing the husbands as a Consulting Guide followed the same pattern:

> I just didn't know what to do. I had never handled that, so I just got a cup of coffee and sat down and talked it over with John. I told him what the problem was and asked him how he would handle it. Somehow, as I talked it over with him, I could create what he would do, how he would handle the situation. Then I could figure out what to do from there.

As they "talked things over" with their husbands, the widows reported the feeling that their husband's nearness seemed so real that they could almost hear his inflection, or see the characteristic pauses as he reflected on the best way to solve the problem at hand. The widows did not cope with each situation as their husbands would have; rather, they used the "discussion" to think through the steps involved and find an approach they could use. This consulting

process, then, was different from that described in other accounts when the widows tried to imitate what their husbands did. There appeared to be two dimensions inherent in Consulting Guide: one involved the actual information in the problem situation; the second contained the steps in resolving the problem. The problem solving steps, was the feature reported by most widows.

External stimuli were identified which evoked the husbands' presence as Consulting Guide. These precipitating events all included specific and concrete problems, such as, repairing the car, replacing a water pump, remodeling a kitchen or choosing a financial investment program. The husbands presence as Consulting Guide was experienced in those areas where they felt vulnerable as women, and when they expected people to take advantage of them.

> EVELYN: And I'm thinking, well you better pull yourself together, and you better start trying to think like a man, because you are responsible for yourself. Now recall back what Patrick would do in a situation.

Experiencing the husband's presence in the form of Consulting Guide occurred later in the bereavement process, as had Constraining Force. Invariably the Consulting Guide presence was a positive influence for widows--one which helped them to bridge their perceived gap of inadequate knowledge and skill for situations they needed to manage.

4.1.2. A Process of Bereavement Resolution: Uncoupled Identity

When well meaning friends and relatives advise women to remarry, it is the recovery from grief that the friends often have in mind. Professionals have used remarriage as one of the key indicators that widows have recovered from their loss. Remarriage is cited as a characteristic of the final phase of bereavement, termed Recovery by most workers in this field. The problem with this focus on remarriage is that it draws attention to only one possible end result of bereavement resolution and obsures other possible results, as well as examination of the process leading to the recovery. Successful resolution of spouse bereavement requires the emergence of an identify which involves perceiving oneself as an individual alone, no longer one of a couple. This has been called Uncoupled Identity in order to focus attention on the process involved in attaining the shift in self concept. Progression along this process of identity transition is complicated and painful. Freud (1917) linked the source of pain of mourning to the efforts to unattach oneself from the person through death. Lindemann (1944) characterized the first stage of bereavement as breaking the bonds to the person who died. The process of effecting an identity transition to that of an un-attached person is initiated through breaking those bonds to the person lost through death; however, more is involved. One can remarry without recognizing fully the loss, breaking the bonds,

and negotiating the attitude of self image readjustments which culminate in an Uncoupled Identity. Successful resolution of grieving cannot be measured by remarriage without looking at how well and completely the individual has negotiated the process necessary to complete the mourning of the lost relationship.

Identity formation is addressed extensively in the literature concerned with childhood during the formative years, and to a lesser extent during puberty. More recently, identity issues of adulthood have been examined. (Erickson 1959; Lidz 1968; Gould 1978; and Jacques 1965). Jacques' (1954) appraisal of the mid-life crises of the mid-30's to the mid-40's paralleled Erikson's (1959) discussion of Integrity vs. Despair. Ego integration is the critical factor in successful negotiation of issues confronting adults at this time of their lives. Gould has extended our knowledge of the complexity of the growth and tasks to be accomplished during adulthood. Mid-life tasks become mid-life crises for many adults who have been lulled into thinking that adjustment problems of adulthood were rare. They become frightened of growing older, of being constrained by choices and styles selected earlier in life. Career choices, marriage partners, living locale and life styles are reexamined while the individual tries to determine new directions.

Existing information from these areas of identity issues and transitions of adulthood may contribute to our understanding of the tasks necessary to accomplish the identity transition to uncoupledness made necessary by the death of one's spouse.

The women confronted this new state of singleness in many small ways as they shopped, established credit and cashed checks. One widow had difficulty purchasing a bedroom suite because the salesperson was insistent that she would want to discuss it with her husband before she made a final decision. Another widow was asked the routine question of where her husband worked when she cashed a check for some purchases. She gave the information about where he had worked before he died, because she was caught off guard and could think of no other answer. She realized then that she would have to establish her own credit information. Situations such as these in everyday life forced the women to begin to acknowledge to themselves the implications of widowhood. One of these implications was the necessity of becoming more self reliant, since they could no longer turn to the husband as the source for many types of transactions.

The transition in identity was not sudden. Rather, it occurred unevenly, slowly and in small steps. Two general categories of tasks and situations were central to the process of foregoing an Uncoupled Identity: pivotal identity transition tasks and social

interaction transitions. These tasks provided experiences directly confronting their husband's death, and subsequently of being a single woman. The two pivotal identity transition tasks discussed here were (1) sorting the personal belongings of the husband and (2) resolving the dilemma of whether a widow had the right to continue wearing her wedding ring.

The second category discussed in this section as critical to the process of Uncoupled Identity was termed social interaction transitions. The two topics under this category were social patterns and dating. Many social relationships established during marriage did not continue throughout widowhood. As widows tried to continue their relationships with couples, they realized a certain awkwardness of being unattached while interacting with people who viewed life through a "coupled orientation." New patterns of social interactions had to be established. Dating provided to most direct and sometimes frightening experiences related to breaking the bonds to the dead husband and facing full implications of being a single woman.

Examining the manner in which widows faced the pivotal identity transition tasks and the social interaction transitions led to a greater understanding of how widows managed the process of shifting to an Uncoupled Identity.

4.1.2.1.1. Disposal of Personal Belongings

For many widows, the most difficult task of early bereavement was sorting through their husbands' personal belongings to decide what to do with them. Both pleasant and unpleasant memories were a part of the clothes in the closet or the photography equipment in the garage. Complicating this already difficult task was the occasional friend or relative who was demanding, and sometimes greedy, in their requests for specific items. One widow's in-laws asked for her husband's diamond ring and his car; this request was made the day before the funeral. Other requests that were neither demanding nor greedy proved equally difficult to fulfill, and served to increase the strain of the situation. Simply because a particular object was infused with memories and symbols made the widow's choice of what to do a task to be approached with special care. Widows whose children were still young exercised particular concern in choosing items to keep that would have meaning over time, as the children grew, and memories faded.

Most widows did not attempt to sort the belongings during the initial two months after the death of the husband. Even then, it was difficult.

> EVELYN: Memories didn't bother me, then I started dragging out things to pack, and I got slower and slower. I just felt like sitting in the middle of the floor and crying. I had to really fight that.

Another widow described packing some of her husband's clothes from their closet, becoming overwhelmed, so she unpacked everything and rehung them in the closet. She repeated this process several times over a two week period before she was able to complete the task. One widow acknowledged that the day she packed her husband's things was the hardest day she had experienced since his death. After three months, another widow made a beginning by writing his family to ask them what they wanted. She decided to send them what they asked for, then pack everything else away in a trunk and contend with it later.

A few of the widows were forced by the circumstances of having to move to sort through their husband's belongings very soon after his death, sometimes within the first few weeks. These widows did not report the same emotional wrenching associated with this chore as had the other widows who faced this a few months later. Maybe they "steeled" themselves for the task, or perhaps they were still within the cushion of numbness characteristic of early bereavement. At this earlier time, they did seem to accomplish the task with greater ease than did those widows who undertook this task later--around the third month after the death. Widows who accomplished this task earlier, also were forced by external circumstances to confront and accomplish the sorting of

belongings; whereas, widows who disposed of the belongings later in bereavement also chose the time themselves. Whether time, self-selection, or some other factor was the important variable, the fact remained that those who disposed of the belongings earlier felt less distress with this task. Also, they did not experience the same sense of accomplishment and growth the other widows reported. Persistently, those who accomplished this task later, and at a time of their own choosing, described this time in terms of distress and pain. Also these widows felt they had completed a difficult task and were proud of themselves for this accomplishment. They had been frightened of encountering both pain and memories, because they were unsure of their ability to handle them. Invariably, the widows reported a sense of relief that they were able to meet the demands involved in this experience. Widows pointed to this as a beginning step they had taken toward moving ahead. This task was a tangible way of saying, "He's gone. I have to continue, to move on with life somehow." They believed they had made an important beginning.

Some of the distress inherent in sorting the personal belongings did seem bound to a time factor. Two widows had to sort more belongings after about nine months. They found the task not so troublesome this time as it had been earlier. One widow had moved out of her apartment at the time of the death, and did not

obtain a place of her own for about nine months. She then had to decide whether to keep and use the furniture she and her husband owned, but had stored with friends. She couldn't afford to buy new furniture, so despite her dread, she decided to have the furniture brought to her apartment. She too found it bothered her very little. She was surprised and pleased.

A majority of widows in this study sorted and disposed of the personal belongings of their husbands three to five months after the death. Completing this chore meant they were strong enough emotionally to handle a most difficult task. Also, they had made critical inroads to the feelings of helplessness that had been so pervasive since their husband's death. Helplessness could not continue its prominence once a widow had successfully completed such a painful and central task. It also signaled a concrete beginning in breaking the bonds to the dead husband so they could continue progress toward an Uncoupled Identity.

4.1.2.1.2. Dilemma of Wearing The Wedding Ring

The wedding ring has been the unspoken statement in this society that one is married. Custom is clear: before marriage, neither men nor women wear a wedding ring. Even today's standards and life styles which support unmarried couples living together in a shared household, neither men nor women in that

situation wear wedding rings. When a marriage has been terminated through divorce, the individuals involved remove their wedding rings. Some do so quietly and privately, while others discard the ring with great ceremony. The wedding ring has continued as the accepted symbol of marriage. The following excerpt supported this:

> A. I was at work the other day and one of the girls seen my rings and she says, Oh, you got married again! And I said, You're kidding! I said, me married again? Those are the same rings I've been wearing. I haven't gotten married again and I have no intentions on getting married again. But they thought I did.
>
> Q. Had you not been wearing the rings for a while?
>
> A. I've been wearing these rings all along, same rings. I haven't changed them.
>
> Q. I wonder why she noticed them all of a sudden.
>
> A. I don't know. I've been wearing them for over a year and I haven't taken them off. But she just happended to see those rings and she thought I had gotten married.

No clear guidelines have been provided to widows or widowers in our society about wearing wedding rings. This lack of guidelines through tradition or custom posed problems for the widows in this study: of whether or not to wear the wedding ring.

First widows asked themselves, "Do I have a right to continue wearing the ring since I am no longer a married woman?" Through this question, women began confronting the reality of their

new status as unmarried women. Most of the widows believed they should not continue wearing the wedding ring, but could not follow through to take it off at the time they first realized the dilemma. Some tried, but they felt exposed and vulnerable without it. These widows put the ring back on to wear until "I can handle it better." A few widows expressed the concern that people would disapprove of their continuing to wear the ring when they had no "right" to do so. In the instances this was expressed, the widows were particularly worried about what their husband's family would think, since relationships with them were already strained.

The other major question widows raised about the dilemma of wearing versus not wearing the wedding ring was, "If I am not wearing a wedding ring, then won't people think I am advertising my availability to men?" One woman expressed this fear early--within the first three months after her husband died.

> A. I have a kid, but I'm not like them. (other young mothers) And, also, that men are so set--you know, a lot of them make passes more at women who are widows. I haven't noticed that but that's one reason why I kept my wedding rings on, too. I thought, geez, I don't know what I would do if someone ever did that.

The issue here was vulnerability to interactions widows felt they were not ready to handle. Marriage had been worn as a protective coat; giving up the wedding ring meant discarding the protection of

that coat. Most women felt unready to cope with the dating invitations or sexual overtures that might result after the ring had been removed, so they continued to wear the ring as their buffer between them and awkward situations. Another facet of this issue involved the social approval of the widows themselves of their behavior. Widows reported that removing the ring might be construed as not missing their husbands anymore, that is, of not grieving sufficiently.

Within the two questions of "right" and availability was the internal struggle that each widow experienced as she tried to come to terms with being unmarried. More important than messages conveyed to the world was the internal identity shift made mandatory through the husband's death. Raising and resolving the questions posed by the dilemma of continuing to wear the wedding ring provided widows with experiences which made them say to themselves, "I am no longer a married woman." The next step involved saying the same statement to society through removing the wedding ring. Between the two steps were many moments of reflection, and subtle shifts in self concept. Widows progress in their own individual style and timing with this task. Some came to terms with this beginning identity transition task within a few months, and had removed the wedding ring; others required more time. Some moved the ring to the right hand; others removed it altogether. One widow did not feel comfortable without a ring on her finger; she resolved

it by replacing her wedding ring with a cameo ring that had been her grandmother's. One of the more innovative solutions was from a widow who took her engagement ring and her husband's ring to the jewelers where she had a dinner ring fashioned from the two rings. She then wore this dinner ring on the finger where she had previously worn her wedding ring. As widows found their own solutions--solutions suited to them--they accomplished a working through, privately, of a changed perspective of themselves.

In summary, most women felt they should not continue wearing the wedding ring after becoming a widow. Resolving the questions inherent in the decision to stop wearing the ring involved confronting that the marriage was ended, at least in a sense.

> LISA: I talked to her (daughter) yesterday, hey, Jill (you notice they're switched, in stages) I says, you know. I'm gonna have to think about switching my rings over pretty soon, not wearing my wedding ring.
>
> She goes, yeah, 'cause if you keep wearing them, Mother, nobody's ever gonna ask you out.
>
> I says you're right, but it's an emotional thing, Jill, because if I, when I switch and I said it to her, 'cause I'm saying it to myself just to say it out loud, when I take them off, I'm acknowledging the marriage is over and that bothers me.
>
> But that's the way I feel, Jill, and I started crying. I don't want to switch rings. I don't know, it's a start. It's a step. It doesn't really say the marriage is over, it's another step. I can just go so far at one time, then I have to pull back and wait for the next step.

Carrying out the act of rewearing the wedding ring signaled important private and public acknowledgments necessary in the widow's identity transition.

4.1.2.2. Social Interaction Transitions

4.1.2.2.1. Social Patterns

Parkes noted that more widows decreased the amount of time spent in social contact with friends and relatives and he concluded that the widows did not seek social relations as a substitute for companionship formerly enjoyed with their husbands. (1972:100) Certainly, the women in this study altered both their patterns and their sources of social interactions; this alteration was less of their own choosing and was not related to companionship with husband as was found by Parkes. Most widows tried for a while to continue friendships with those people who had been close to them when their husband was still alive. Few relationships survived the husband's death beyond the first few, acute months. Most widows felt out of place, like "fifth wheels" when they spent an evening with these couples. Occasionally a widow took the initiative in ending social contact with couples.

> JOAN: One couple we used to be with a lot kept inviting me. I told them, No, I have to tell you the honest to God truth. I think you are a really nice couple, and you have been very nice to me, and I really enjoy your company. But it's just not right, because you are a couple and I am by myself.

Few widows were as forthright as Joan was, but most shared her sentiments. One widow initially did continue many of the social contacts she and her husband had enjoyed, but by the end of the year, this widow too had noticed fewer contacts were occurring. Often, the awareness of the awkwardness came from friends, not from the widows. Gradually, the invitations stopped.

The portrayal of the widow as the conniving man-chaser, has been a popular stereotype: a person to be avoided at all costs, since she pursues men persistently and singlemindedly. The characterization became all too real to widows through social situations where they were actively shunned by wives who formerly had been their husband's friends or business acquaintances. Some widows felt these wives now perceived them as a danger, as someone to be avoided in the eyes of these wives. On the other hand, some of the husbands of these same wives underscored the reality of the "inherent danger" in the situation by making passes at the widows. Widows, in these few instances, were seen as "fair game." When these incidents happened, the widows responded with intense anger and hurt.

Socially, the widows believed they no longer belonged with any group. Weekends and evenings became a time of lonely trial for many of them, especially those who had been accustomed to active social lives with other couples. Most widows attempted to

respond constructively to this altered social status by increasing their activities with other unattached women. This was only partially successful since many of the widows did not know many women. Those widows who worked seemed to make the shift more easily, since they frequently met other unmarried women at work.

Generally family were very supportive, particularly during the early days. After a while, families seemed uncomfortable with continued talk of the dead husband, and began letting the widow know in subtle ways that it was time to start moving ahead. Sometimes this attitude curtailed frequency of interaction with family; more often, however, it simply placed constraints on what could be talked about, and with whom she could turn to for support.

The social pattern changes discussed so far were true in some degree for every widow in this study regardless of age or mode of death. One major difference was apparent only with women whose husbands committed suicide. All four widows whose husbands killed themselves experienced rejection from either friends, the husband's family, or both. All also felt accused to some degree. The blaming phenomenon associated with suicide has been described previously. (Silvermann 1972:198) Silverman's description of blaming included social isolation, active shunning by neighbors and others, and she believed blaming was a factor in the

family moving out of the neighborhood. Widows in this study experienced isolation and feeling of being cut off from friends and family. An important dimension of this isolation was the loss of the husband's family as a valued resource for sharing memories and experiences about one they both had loved. A sad consequence of the ostracism of in-laws was the deprivation for the children in never fully knowing their grandparents. However, blaming was not prevalent in attitudes of neighbors of widows in my study and did not contribute to decisions to move; it seemed restricted to the husbands families.

An extension of this blaming phenomenon occurred with two of the four widows whose husbands killed themselves. These two husbands' families actually contacted authorities to question the degree of the wife's involvement in the death and to ask if it might have been greater than originally reported. The families seemed to be suggesting that the blame be moved to a more formal, legal level, although they did not explicitly charge the widows with homicide. One of the widows reported this from information she had learned from others in her own family. The other incident was not known by the widow; this information was obtained from the Coroner's Department.

Despite a lack of sophistication among the widows in psychological explanations for events, the widows who experienced

this rejection and blame developed their own explanations in order to understand what was happening. Their rationale emerged similar to the following composite representational statement:

> They have to find someone to blame so they won't have to look at the possibility of their own contribution. That's just too painful for them to even ask about now. Blaming me is just all they can handle right now.

The partial understanding implied in the above composite was the compassionate part of their reaction. This blaming by the relatives hurt them intensely and evoked expressions of direct, open anger. They agreed that the blaming was especially painful, since it hooked into their own sense of self blame that was also a part of their reaction. This self blame typically had been examined in a cursory fashion by them, then dismissed. The family's blame made them aware of their own unfinished business in this area.

Changes in friendships, in social activities and in use of leisure time served to unfold a gradual awareness of the magnitude of the meaning of the new role and status as widow. Lonely evenings challenged widows to search out new companions and new activities. In so doing, widows learned of their own dependence on their husbands and their routines. Use of time and relationships now require active thought and planning. Social pattern changes often were tedious, boring and discouraging. Widows had to force themselves

to telephone a friend for a dinner engagement or movie. The activities became vehicles for widows to use as they developed a sense of independence and self reliance necessary for the single woman of today. Coming to terms with the social dimensions of widowhood provided its own pathway to assist widows in their progress toward the resolution of mourning.

4.1.2.2.2. Dating

All the widows in this study discussed dating during our interviews. Some had begun or continued dating--in the cases of women who were separated from their husbands at the time of the death--without apparent conflict. Most wanted to begin dating, although at the same time they were frightened. Most widows did not automatically link dating with marriage, at least they did not consciously associate dating for themselves as a means to the end of marriage. Dating was viewed simply as an entity of itself. The widows had missed both the conversation and companionship of men, and looked toward dating as a means to fill partially this void in their lives. They wanted social activities, coupled with male companionship, of going to a movie, out to dinner, or just the relaxed review of the day over a drink. Some widows enjoyed social activities with women friends; others didn't relate well to women and weren't interested in developing social activities with women friends. Implied

in these discussions of dating was widow's perception of the higher status in socializing with a man (instead of being with a woman), and an accompanying "feeling more like a woman" when in the presence of men.

A distinct and puzzling pattern of dating activities emerged among widows in this study: all the widows whose husbands were 30-39 were dating by the first anniversary of their husband's death; whereas, none of the widows whose husbands were 40-49 were dating by this time. Interestingly, the age of the widow in this study did not always follow the customary "slightly younger than the husband" tradition. One widow from the 30-39 group was ten years older than her husband, yet she was dating before the anniversary of the death of her husband. Further examination of the data revealed associations among the four variables examined: (1) Mode of death; (2) Time dating was initiated; (3) Quality of the marriage, and (4) Length of marriage.

Table 5 has presented the findings for the three variables (1) Time after death when dating was initiated; (2) Quality of marriage and (3) Mode of death. Two of the widows already were dating when their husbands died. As they had been separated from their husbands for some time before the death. Three widows (the natural contrast group) had not resumed dating during the

Table 5

Time in Dating Initiated Post Death
According to Mode of Death* and
Quality of Marriage

Quality of Marriage	Con't**	Time in Months After Death				Dating	Total
		1-3	3-6	6-9	9-13		
Positive			A A H	-	N	NC*** NC	6
Average		S S	A	-	N N		5
Negative	H N	A S	S	-		NC	6
TOTAL	2	4	5	-	3	3	17

* = N A S H (Natural, Accidental, Suicidal, Homicidal)

** = Widows were separated from husbands and dating when their husbands died. They continued dating.

*** = Natural Contrast, widows whose husbands were 40-49, as contrasted with widows whose husbands were 30-39 and also died a natural death.

thirteen month interview period. Nine of the remaining twelve widows began dating within six months following their husbands' deaths. This finding was contrary to other studies of sudden bereavement, where dating was reported rare until much later in the bereavement process.

Three categories were developed to describe the quality of the marriages: Positive; Average; or Negative. Individual marriages were assigned into the categories primarily from comments the widows made about their marriages. If the couples had been separated over time, or if divorce had been considered actively, the marriage was assigned to the negative category. When the relationship was described with terms such as close, or sharing, it was rated positive. Most of those rated as average were described as an "average" marriage by the widow herself. All marriages had a mixture of positive and negative qualities in them; none totally Positive or Negative. The seventeen marriages were evenly distributed according to quality: six marriages were Positive; five were Average; and six were Negative. One difference which emerged when examining the mode of death with the quality of the marriage was none of the Suicidal deaths were from Positive marriages. Also, no one from a positive marriage initiated dating during the first three months following their husbands' death; some widows from the categories Average and Negative marriages

initiated dating during that time span. The third, and last, difference was that all women from the 30-39 group whose marriages were Negative had begun dating within six months after the death of their husbands. Quality of marriage seemed to have a strong association with dating patterns among widows in this study. No one began dating during the six to nine month period after the death of the husband. No explanation emerged for this finding at all.

Three of the four women, whose husbands had committed suicide, began dating during the first three months following the death; the fourth began dating during the three to six month time frame. The reverse was found with Accidental deaths: three began dating in the three to six month period, while the fourth began during the first three months. All three of the women whose husbands died natural deaths, and who began dating (as opposed to continued dating) did so in the final period of the interviews, i.e., between nine and thirteen months following the deaths of their husbands.

The data were examined to determine the relationship between length of marriage and the time that dating had been initiated. Table 6, The Relationship Between Initiation of Dating and Length of Marriage with Correspondent Mode of Death and Quality of Marriage, has summarized that data. At first glance, length of marriage was not related to when dating was initiated: widows who had been

Table 6

Relationship Among Initiation of Dating, Length of Marriage, Correspondent Mode of Death and Quality of Marriage

Length of Marriage in Years	Initiation of Dating, in Months Following Husband's Death						
	Continued Dating	1-3	3-6	6-9	9-13	Not Dating	Total
Less than One		S ‡			N ‡		2
1-5	N - N -	S ‡	A ‡ H +				5
5-10			S -		N ‡ N +		3
Over Ten		A - S -	A + A +			NC - NC + NC +	7
TOTAL	2	4	5		3	3	17

N = NATURAL
A = ACCIDENTAL
S = SUICIDAL
H = HOMICIDAL
NC = NATURAL CONTRAST

\- = Negative quality of marriage
‡ = Average quality of marriage
\+ = Positive quality of marriage

married more than ten years began dating in the first six months following their husbands' deaths as did those who had been married less than one year. The two women who had been married less than one year, began dating at the two extremes of the time span: one within the first month; the other between nine and thirteen months. All four women who had been married over ten years (from the 30-39 group) began dating during the first six months: two in the first three months had negative marriages; two in the three to six months had positive marriages. Also, those married between one and five years all had begun their dating within the first six months: one in the first three months, the other two in the three to six month period. Length of marriage did not show a steady trend, such as the greater the length of the marriage the longer, or shorter time before dating is initiated. On the other hand, two of the three women who had been married between five and ten years did not begin dating until nine to thirteen months after the deaths of their husbands.

Of the four variables examined, Mode of death seemed to be most closely associated with initiation of dating, although quality of marriage also seemed relevant. Widows whose husbands committed suicide more often began dating during the first three months; widows whose husbands died accidental deaths more often began dating three to six months after the death; women whose husbands

died natural deaths more often began dating between nine and thirteen months after their husbands died.

The findings on dating in this study were not consistent with other studies where less dating and dating initiated later in bereavement were found. (Parkes 1970; Glick, et al., 1974). Parkes conducted his study in London on selected widows who ranged in age from twenty-six to sixty-five, and whose mean age was 48.8 years. The later study in Boston (Glick, et al., 1974) examined bereavement in widows whose husbands were under the age of 45. Both of those studies reported few widows who were dating by the end of the first year. Widows in the current study ranged in age from 22 to 46, with a mean age of 34.8. The Boston study included widows whose husbands had died either Natural or accidental deaths. Only fourteen out of forty-nine of their sample were dating by the year's end. Geographic locale alone did not account for the very different dating behaviors between the widows in the current study conducted in Los Angeles and those widows in the Boston study. The Boston data were collected in 1965-66; the present data in 1976-77, a decade later. Major shifts in attitudes toward women and sexuality occurred during this time. These differences persistently were in the direction of increased latitude on accepted sexual behavior for all, and of increased acceptance of women as human beings who have sexual drives.

Both Parkes (1972) and Glick, et al., (1974) discussed dating in the context of recovery in general, and more specifically as a behavior leading toward remarriage. If dating had been viewed only as a behavior leading toward remarriage, many widows would have felt constrained from dating. Fear of forming new, permanent, close relationships; concern about betraying the husband; or loss of newly found freedom were the issues of constraint if marriage and dating had been perceived as automatically linked activities. During the 1960's, the perspective of dating essentially as a means toward the "end" of marriage was prevalent; by the 1970's dating had become regarded as an activity with its own pleasure in and of itself, not always a stepping stone to matrimony. This tremendous shift in social values, not geographic context, accounted for most of the differences in dating behaviors among the bereavement groups.

Additional to wanting social interactions and concomitant status (higher) associated with dating, widows were motivated to begin dating as a means to reaffirm their sense of femaleness. This sense of femaleness, of seeing oneself as a whole woman, had been impaired through the sudden death of their husband. These many dimensions of dating made it an activity relevant to making progress as widows made adjustments in their identities.

The same shift in social values and attitudes that made it possible for widows to dissociate dating from the automatic linkage

with marriage made it difficult to view dating apart from a potential sexual relationship. The women themselves expressed concern and ambivalence about sex. Several women had not dated since their teen-age, high school days, and they remembered the "teen-age grappling scene." Some were concerned that a date would make greater sexual demands than they could cope with; other worried that their own drives and loneliness would lead them to behave sexually outside their own value system. All women reported missing an active sex life, but this was a problem for some of them, not for all. Most women resumed an active sex life soon after they began dating. A few reported some initial difficulty, but when reported, the difficulties were short lived and not intense. Contrary to the meager reports in the published literature dealing with sexual activity, many widows in this study enjoyed an active sex life without any sense of betrayal to their husbands. In contrast, with all the women whose husbands were under forty reported above, women whose husbands were 40-49 had not resumed dating; consequently, they did not report having any sexual activities.

Most women in this study reported masturbation as an idea uncomfortable to think about or talk about. Most were unable to try this as a means of sexual expression. Many viewed masturbation as a "poor substitute" for an active sex life with a male

partner. Only a few reported having masturbated and experienced some pleasure and sense of release.

In summary, widows aged 30-39 in this study reentered dating and active sexual life far earlier than had been previously reported in the available literature. This was not true for the older, natural contrast group, whose husbands were aged 40-49. Dating variations within the sample seemed most influenced by mode of death; specifically widows whose husbands committed suicide began dating during the first three months after the death; widows whose husbands died accidental deaths began dating the three to six month time span following their husbands' deaths; women whose husbands died natural deaths began dating nine to thirteen months after their husbands died. Widows in the category 40-49 were not dating at all 13 months after the death, in contrast to the rest of the sample. Quality of marriage seem to have an inverse relationship with initiation of dating: Positive marriage initiated dating later; Negative marriages initiated dating earlier; Average marriages were well distributed throughout the time spans. Length of marriage showed no clear trend in association with the initiation of dating.

4. 1.3. The Relationship Between Reality Activities and Affective Expression

Early weeks of bereavement were characterized by a recurrent sense of numbness interposed with a tremendous business of activity. The feelings and the high activity level were bound together and served each other. The husband's death required the surviving widow to make many immediate decisions and to proceed with arrangements for funerals or memorial services. In several instances, widows had to decide whether to return to the area where his family lived for these services. Routine activities of daily living continued to demand attention. The circumstances of the death itself sometimes increased widow's interactions with officials from agencies such as the Coroner's Department and the Police. Most widows had to locate a variety of personal documents to establish rights to benefits from various agencies or sources: Veteran's Administration, Social Security, Social Welfare, and Insurance. Other immediate and demanding activities included writing thank you notes, closing or adjusting bank accounts, writing to notify friends of the death, putting the house on the market, finding a place to live, settling details from his work situation. Many activities were time consuming and resulted in a particularly busy period for widows.. They were grateful for this busy work; they

indicated they did not know how they would have survived this period without having so much to occupy their time and thoughts.

Involvement with the activities seemed to function as a protection for widows to prevent their being overwhelmed with intense and painful emotions they felt ill-equipped to handle. The activities buffered the intensity of the feelings, although widows experienced, to a degree, the whole sphere of emotions: sadness, loneliness, anger, helplessness, tiredness. As the amount of activity subsided, painful emotions came more to the forefront, although probably less intensely than would have been the case a few weeks earlier. Usually, this balance of emotion-busy work lasted only one, or at the most, two months after the death.

> LILLIAN: What I'm experiencing is getting more difficult. It was actually easier; it's getting harder. It's not . . . well, I think the numbness wears off. All of a sudden you say, I have all these tremendous problems to solve.

As widows returned to work, they generally were able to maintain adequate composure, and not lose control frequently by bursting into tears as they had feared they would. Work activity functioned as had the busy work in providing a buffering effect. Occasionally, some unexpected encounter at work would trigger a tearful episode. The widows were encouraged and surprised by the acceptance and understanding they received from their co-workers;

they were pleased it was not the embarrassing experience they had feared.

A few of the women in my study had so many problems and such basic ones (finding a place to live, obtaining money for basic necessities, responding to urgent health problems, trying to curb family crises) that the activities seemed to fill up most of the space and leave little room for them to respond emotionally as the other widows had during this busy work period. Tending to these realities took priority and left emotional expression a second best.

> EVELYN: Yes, that's the whole thing with me is survival right now, and perhaps that's why I feel like I can't waste time and grieving and . . . I know that's not right to put that off, but that's the way I feel. It's a matter of survival.

The balance between activities and emotion clearly was interrupted. Consequently, rather than a temporary, protective buffering, these widows experienced a prolonged numbness. There were considerable accomplishments--winning unwanted praise and admiration from others about how strong they were and how well they were doing. This "imbalance," proved difficult to evaluate; particularly, the long term effects of this apparent shift in the ratio of activity to emotion. The first question which emerged was: "When the energy demanded to provide the basic realities is so great, is less energy then available for the psychological grief

work?" This seemed to be feasible, although it implied the simplistic perspective that a finite amount of energy existed within each widow, an energy to be parceled out between activity and emotion in relation to bereavement. Another question which arose from examining this imbalance was, "Rather than detracting, or subtracting energy from the expression of emotions, could these increased, busy work activities serve as a vehicle for the sublimation of grief work." If this were true, then perhaps the emotions were finding an outlet, rather than being totally contained. If they were not sublimated, however, then what were the consequences of this postponement of emotional expression? Was this affective expression a dimension of grieving which could be handled later just as effectively, or was its postponement one route to complications of grief?

Four of the 17 widows in this study were involved in this "distorted" ratio of activity to emotion. These four did not provide clues about the outcome of the imbalance or the direction of explanation of the dynamics. Two of these widows completed the study; they seemed to be on schedule in their bereavement process at the time our scheduled appointments were finished. Both were functioning well. The other two dropped out of the study. Neither of those who dropped out was doing well at the time they dropped out.

Many of the widows also experienced an increased activity level later in the bereavement. This later business was very different in character and in function than the business of the first month or two. This later peak had a pressure of activity characterized as "a busy to be busy," not activities focused on accomplishing a rush necessary tasks. This later business was created by the widow and seemed to function as an ineffective response to her internal sense of restlessness.

4.2. Bereavement Postvention

Postvention are those therapeutic efforts which come after the dire event, the death of the spouse in this study. (See Chapter I, A Framework for Services) A broad array of activities are included as postvention: befriending, being there to receive a crisis telephone call, consulting with widow's friends or relatives, chiding widows to care for themselves more effectively, counselling, referring widows to specific resources, joining a celebration of a special occasion, or encouraging widows to try a new endeavor. Those postvention efforts involved in the psychological care of the widows are the efforts examined more closely in this section. Initially, some of the more general features of postvention are discussed, then three concepts have been presented briefly: (1) Validation of Reality Perception; (2) Giving Permission; and (3) Didactic

Informing. These three concepts are not intended to represent all the important concepts found or used in the postvention of widows in this study; they were centrally relevant in aiding widows to cope with their bereavement and, therefore, were useful.

Postvention resembled some of the features of traditional psychotherapy: The focus was on feelings, on the affective issues rather than the content of the exchange; The clinician-researcher was perceived as more knowledgeable about bereavement issues, so the exchange was not that of co-equals; The relationship was not one of give and take as it related to assistance in grief--i.e., the clinical-researcher did not seek psychological care from the widows; the emphasis was on identifying recurrent themes.

Broadly defined, thanatology refers to the study of death. Current use of the term in clinical situations has usually referred to care of the dying patient and family when there exists some foreknowledge of the situation. (Feifenberg and Shneidman 1979). This usage was not intended to preclude care of the survivors whose friends or families died sudden death, i.e., without foreknowledge. Shneidman (1978) noted that the survivor is the victim who becomes the patient as the thanatologist moves between intervention with the dying person to postvention with the survivor.

Although postvention resembled many features of traditional psychotherapy, it was not an exact match. The eight features of

thanatological work with dying patients identified by Feifenberg and Shneidman (1979) provided few shared characteristics between the two, bereavement postvention and thanatological work. Bereavement postvention also differed from crisis intervention. The time boundaries were considerably extended in postvention beyond the customary six weeks to three months of active intervention which is characteristic of crisis intervention. Also, in crisis intervention, much of the effort is expended in diagnosing the precipitant(s) of the crisis state; whereas, the precipitant was known in bereavement postvention. The shared awareness of the loss as the precipitant allowed the major effort to be focused on interventions.

Loss, and its consequences, have provided the impetus for many people to initiate treatment through psychotherapy, or to seek crisis intervention. The situation providing the impetus for bereavement postvention was sharper, and more acute in this study: the sudden death of a spouse. The specific nature of the clinical situation (additional to the research situation) provided its own definition to the postvention: a specific response among the widows to the sudden death of the spouse was an acute sense of vulnerability to death, a heightened awareness of their own finiteness of life. They felt this personal vulnerability to death only briefly. Usually the concern was expressed through indirect methods, although occasionally a widow would express the concern directly.

The structural context of the interactions provided further differences in the psychological care provided during the postvention with widows of this study from other psychotherapeutic modes of interaction. In therapy situations, the client has applied for assistance because their needs and problems had moved beyond their abilities to manage alone. The motivation for participating in this study could not be linked to a request for assistance. Most of the widows indicated they would not have sought professional assistance with psychological problems associated with the sudden death of their husbands. Most also indicated they would not have joined a peer-aid (usually called self-help) group. Finally, the interviews usually occurred in the homes of the widows, rather than an office.

4.2.1. Validation of Reality Perception

Some widows described the immediate pain of widowhood in terms which indicated they themselves had been injured physically: "I feel like I have a big, gaping wound. Like I'm not complete. Will I ever be a whole person again?" Their sense of self confidence had been abruptly stripped; they felt vulnerable, unable to take charge of themselves and their lives. They became grateful for the almost automatic activities they could complete without thought, while postponing these decisions and activities which required more of them. The extent of the distress was not apparent immediately even

to those close family and friends in the widow's immediate circle. Instead, they saw a woman who was handling things well, sometimes even stoically.

The diminished self-confidence, sense of incompleteness, and the feelings of vulnerability combined to render many widows unable to trust their own perceptions. They could not rely on their emotions, which formerly had been one of the guides as they tried to make sense out of situations. Now they questioned their perceptions of how others responded to them. They came to question their judgments of situations they faced. The clinician needed to assist widows in the evaluation of their perceptions of what had happened. Sometimes careful listening was necessary even to identify the process as one emanating from a diminished self confidence. The women themselves often were puzzled by their own indecisiveness and inability to make sense out of commonplace situations. This puzzlement was often the clue that the underlying issue, and the one to be addressed clinically, was diminished self-confidence.

The clinical role for this type of situation typically progressed as outlined below:

> (1) Elicit detail about the situation, her conclusions and the clues or reasons for her conclusions. If she had not formed any conclusions, then lead her through the process of examining the situation in order to form conclusions.

(2) If possible, support the conclusions the widow had reached and identify the justification for that conclusion. If a different conclusion seemed appropriate, give the conclusion and the reasons for it.

(3) Together, clinician and widow, explored other possible explanations for the situation and tried to see why one explanation might be better than another.

(4) Move from discussion of a particular reality situation to identify and discuss the widow's self-doubt and indecisiveness. Explore the situation for those factors that fed into diminishing her self-confidence. Review similar past situations to discern if her responses were different outside of bereavement.

(5) Identify ways to recognize the type of situation that triggered the widow's lack of self-confidence in her own perceptions and try to establish ways for her to confront the situation more directly.

Initially, telling a widow that the way she had seen a situation had merit, provided her with reassurance and began to help her restore her self-confidence. This active validation of the widows' perceptions provided the immediate sense of relief which enabled them to explore the situation and their involvement in it without defensiveness. The next step, examining the consequence of diminished self-confidence in relation to the compromised trust of their own intuition and skills, became a critical and natural progression of the clinical interaction. Most women soon began recognizing the process as it began and learned to reverse it within the context of the situation, not just examine it retrospectively.

The need for the postvention effort of validating widows perceptions, usually did not last beyond the first few months (three or four) of the bereavement process.

4.2.2. Giving Permission

Although permission was not given literally to any widow to feel a particular feeling or to try a specific activity--sometimes it seemed as though activities and feelings were sanctioned to the extent of giving permission. Widows frequently initiated the description of a situation with almost a hesitant apology. The tonal inflection contained the question, if not overtly asked, "Is it alright?" Widows seemed to need an external sanction of a feeling, a particular activity, an experimental approach to a problem, or even a possible failure. Although this need for "permission" was related to a mistrust of their own perceptions, it also was tied to the desire to talk things over with another adult. Talking things over was one of the most acute losses of the relationship and was felt most poignantly around the small events of daily living. The larger life events and crises warranted talking things over with family or specific resources (banker, attorney, minister); less momentous events, however, were left to the widow by herself.

Initially, the clinical discussions included more than the realm of sharing. The permission needed by widows ranged from

gentle encouragement to the more directive, "I think you ought to try it." Of particular concern were the feelings widows experienced, but somehow believed they should not be having. Sometimes these were within the negative range of feelings--such as anger, envy, irritation with the children, sexual arousal, relief. Giving permission here included firmly establishing the dictum that feelings do not follow shoulds, i.e., feelings are not rational. Any feeling was acceptable. Gently, the distinction between feelings, and the response to those feelings was introduced.

Often, widows expressed concern about positive feelings, such as a sense of pride or a moment of humor. Widows seemed to consider positive feelings aberrant to the bereavement situation. Clinically, it was necessary to point out that feeling pride in a new accomplishment did not mean the widow did not miss her husband, or that she no longer loved him.

As widows began trying out new ways of looking at a situation and experimenting with new efforts, they needed someone to help them explore the innuendos, and to give them encouragement. As they encountered new situations and developed new skills, widows developed an awareness of their attempts to grow and to create new ways of living. Widows were full of enthusiasm and excitement, simultaneously harboring doubts and fears. All needed examining.

Giving Permission involved a more directive role than is usually associated with supportive psychotherapy; it was more in line with the recommendations of the role of the clinician working with people in suicidal crisis. (Moss and Hamilton 1957)

4.2.3. Didactic Informing

The widows in this current study did not have much experimental or cognitive knowledge about grief in general, or more specifically, about spouse bereavement. Since this study focused on young widows, the women probably had experienced the same exposure to death and its personal consequences for survivors as a similar but older group of women. Also, today's lifestyle is focused on urban living with families separated from each other by many miles, so fewer have encountered death and bereavement. Some of the widows had known other widows, although usually these contacts were with women who were older and were not seen as facing the same problems as they themselves were facing.

Every session brought questions about what other widows in the study were experiencing and encountering. They were eager for guidelines which would enable them to compare their experiences with others in the hope that what they were experiencing was normal grief. They actively sought news of other widows in the study so they could find similar responses and problems as their

own. They were searching for knowledge about what was acceptable and normal; they were fearful that they would learn that their experiences were not normal.

Available knowledge was shared with each widow about situations as they arose. Knowing that irritability was typical of others in the study and was reported extensively in the literature provided comfort to widows. Learning an experience was not unique served to reduce that sense of unease, of differentness, ultimately, the fear of going crazy. On the whole, many women wanted to understand what they were experiencing--not merely to survive the ordeal.

Caines book, Widow, (1974) was recommended to several of the widows. They found comfort in Caines ability to say so well what they felt, but could not articulate. They were particularly pleased to read the descriptions of the "crazy" and ineffective things she had done, since these types of activities so worried them, and even led them to question their own sanity.

Another function of Didactic Informing was to enable the widow to be a more active participant in solving her own problems and reaching an understanding of the dilemmas faced. Greater cognitive knowledge did not lead to an "intellectualization" of the situation.

4.3. A Brief Contrast With Parkes' London Study

This study extended Parkes' study of widow bereavement of natural deaths only by including Accidental, Suicidal and Homicidal modes of death as well. In his work, Parkes characterized grief as a "succession of clinical pictures which blend into and replace one another," (1972:7) as opposed to being a set of symptoms that begin after a loss. He further indicated bereavement was a process organized into four phases: Numbness; Yearning and Protest; Disorganization and Reorganization. Widows' feelings and responses to bereavement, as presented by Parkes, provided a useful and accurate guide to characteristic responses to many of the widows in this current study. All the findings in this study, however, did not parallel those presented by Parkes (1970; 1972). Particularly divergent in the present study from Parkes' findings were some of the characteristics of the phases--at least the first three phases. Like Parkes, the present study found thirteen months too brief a span to examine full recovery, termed Reorganization by Parkes. A brief contrast of some key similarities and differences between the current study and Parkes' London study, organized within the context of phases, is presented.

First, the phase labelled Numbness by Parkes. Parkes indicated that Numbness was the briefest of phases which had a life

span ranging from a few hours to a few days for most people, and a few months for a minority. (1970) Most widows in this study, in contrast, felt numbness was prominent for a few weeks to a few months. Although Parkes had indicated this phase was more sharply delineated from subsequent phases (whereas other phases faded into each other). The widows in this present study described no events or guidelines which pointed to an ending of this phase, a demarcation from subsequent phases. The numbness of widows in my study included a blunting of emotional experiences and a sense of unreality, while activities and necessary chores were completed with efficiency. Intense bursts of affect intruded during this interval. Neither the degree of numbness nor its duration seemed to vary in relation to mode of death.

Parkes' (1970) second phase, Yearning and Protest, peaked during the second to fourth week and then gradually blended into the next phase. The behaviors characteristic of Yearning included constant thought of the dead person, seeking out familiar reminders, and crying. These also were prominent among the widows in my study during this time, although these behaviors coexisted with what widows persistently described as unreality and numbness. Seemingly contradictory, the first month to six weeks could be termed Numbness and Yearning to reflect the most prominent feelings among the nexus of affect experienced. Protest behaviors (restless

irritability and bitterness) were more visible features later in the bereavement process for widows in the current study than was true for the widows in Parkes' study. Although the feelings and behaviors present for widows in Parkes' study were also present for widows in this study, the sequence and the time boundaries varied for the two groups. Clearly, behaviors of Yearning were features of early bereavement. The features of early bereavement found in Numbness, Yearning and Protest did not differ among the various modes of death.

Disorganization, Parkes' third phase (1970), was not well defined in time boundaries. Its features included apathy, going through the motions without much meaning or personal satisfaction and a disinclination to look to the future. This current study revealed this to be a turbulent time for widows: full of peaks and recesses, emotional extremes that sometimes resulted in widows' feeling helpless and out of control. Apathy, tiredness, lack of meaning and satisfaction gave way to optimism, pride of accomplishment, excitement about a potential change only to collapse into the apathy, and meaningless activity. Gradually, the extremes leveled off. Although widows expressed fear of looking to the future, they often were forced by circumstances to do so. This was a time of experimentation with new career options, acquisition of new

household managment skills, and development of new relationship patterns. Disorganization was certainly an apt label for this time in their lives, although apathy was not the most prominent characteristic which had been true for the widows in Parkes' study. Once again, mode of death did not seem to provide a discernible influence in mitigating responses within the phase.

As in Parkes' study, few widows in this study had resolved the loss of their husband, and forged new identities for themselves to the extent of fitting the label Reorganization given to his fourth, and final phase. (1970) Some widows seemed to be progressing in this direction more clearly than others, but I could not discern any clear trends to indicate who might progress slowly versus quickly. Thirteen months was not sufficient time to allow Reorganization to be studied.

Other difficulties emerged in the attempts to use Parkes' phases besides the differences in content, duration and sequence just presented. Much of the difficulty came from the lack of precise boundaries among the phases. This resulted in confusion when attempts were made to assign widows to a specific phase. Often widows seemed to vascillate between phases without fitting any particular phase well. When used retrospectively, the phases proved more manageable as attempts were made to assign widows to specific phases. Another difficulty was specifically tied

to the third phase, Disorganization. This phase was too diffuse and too long for the many changes and responses that occurred within it.

The major purpose of this study involved examining the bereavement process to determine if it were influenced by mode of death. The primary source of the bereavement process was from Parkes'--in particular, his arrangement of the bereavement process into the four phases. Those phases did not seem to be influenced by mode of death. Variations were found in the phases of bereavement; those variations seemed related more to the total group of widows in London from the group of widows in the present study. Differences in the phases within the group of seventeen widows were not found--by mode of death, or by any particular demographic factor.

If phases are to be used, then they need to be arranged into units that more accurately and precisely reflect a progression of clinical features. The responses of widows in this current study have forced the possibility that knowledge of grief responses has not advanced sufficiently to allow arrangement of feelings, or behaviors into phases. Discovering and accurately describing clusters of responses, symptoms, and affective experiences would be more useful and appropriate to the current level of information on bereavement.

CHAPTER V

IMPLICATIONS FOR FURTHER RESEARCH AND CLINICAL PRACTICE

5.1. Introduction

A central function of an exploratory descriptive study is to identify more precise questions to guide future inquiries. Since this study included clinical features in addition to the research focus, suggestions and concerns related to clinical practice also have been discussed. The major emphasis of discussion, however, was directed toward implications for further research.

This chapter was organized around the following topics: Implications Related to the Research Process; Implications Related to the Content of the Research Findings; and Clinical Implications.

5.2. Implications Related to the Research Process

This study examined bereavement in widows whose husbands died various modes of death. Access to a non-treatment sample, usually referred to as normal, rather than a sample of widows engaged in a special treatment program, posed a central issue in determining the most appropriate source from which to obtain the sample. The office of the Medical-Examiner Coroner

provided access to widows experiencing normal bereavement whose husbands had died suddenly from various modes of death. Most of the information needed was readily available in those records.

The nature of the research determines, in large measure, the appropriate sources of sample selection most representative of the population needed for the study. Bereavement, as a young field of study, has tended to produce research which did not require rigorous techniques of sampling. Public records (death certificates, Coroner's reports) and other sources (newspaper obituaries, funeral homes) have been used simply because they were convenient without any critical review of the relationship between the source and the findings obtained. The source used to obtain the sample should be intricately interwoven with subtle characteristics of the sample compositions which could influence subsequent findings and conclusions, yet no information existed about the sources and their relative merits and demerits. Future studies need to address more carefully the nature of the population sampled through the particular source used, and should describe in greater detail the range of sources available in the community.

Once a sampling resource has been chosen, the method of initial contact must be determined (letter, telephone, public notice). Some form of communication must be used which initiates an

explanation of the nature of the project, the qualifications of the researchers, and the potential gains and risks for the subject.

The method of contact used in this study involved a letter of introduction followed by a letter explaining the nature of the study. Interactions after that were initiated by the widow herself. Several widows in this study retained the letter for several weeks before responding; others returned the postcard or telephone soon after receiving the information. The first questions considered was, "Did widows refrain from contacting the investigator until after their immediate support from family and friends became less available?" Another possibility for the delayed response was that contact had been postponed until the busy work subsided, and widows were left with increased affect which frightened them. Perhaps the letter from this study was simply on the bottom of a stack of mail, and the widow had finally cleared away other matters which allowed consideration of this request. Still, the question of the differences between those who responded immediately and those who delayed their responses remained unanswered.

Because this is such a sensitive time to ask for participation in a research endeavor, care must be directed toward determining the effect of asking, as well as the manner of asking. Some methods might be more productive than others, but may be coercive

in the sense of intensifying guilt or helplessness. Since it is likely that people respond differently to various methods of initial contact, studies should include an evaluation of the impact of the initial modes of contact. In this way, a better match between the method of contact and the population characteristics can be achieved. The effect of contacting widows at different times should be considered, since this can be critical for finding out when people who are acutely bereaved are most willing to participate in research.

Source of the sample, initial method of contact and time of the contact all have provided general areas that have been under-emphasized in bereavement studies to date.

5.3. Implications Related to the Content of the Research Findings

The findings of the present study were presented through a qualitative discussion of the response patterns of widows. This included Continuing Presence; Uncoupled Identity as a process of bereavement resolution; and the relationship between reality activities and affective expression. The discussion of the implications of the findings has been presented around those three response patterns and their respective subcategories.

Three variant forms of widows sense of Continuing Presence of their husbands were described in this study under the following headings: Friendly Presence; Constraining Force and

Consulting Guide. The three forms seemed divergent in the functions they served. Friendly Presence paralleled other accounts of sense of presence and seemed to provide comfort to the widow by alleviating her sense of loss. Friendly Presence was evoked by internal cues (memories and reflections) and external cues (personal objects, a song, a place they had visited, and other similar events). Constraining Force was associated with conflict situations which gave rise to feelings of ambivalence in the widow. Both internal and external events evoked the husbands Continuing Presence in the form of Constraining Force. The third form of Continuing Presence identified in this study was labelled Consulting Guide since widows were aided in learning to manage problem solving situations formerly the province of their husbands through their experiences with the continued presence of their husbands. Only external triggers were identified as evoking Consulting Guide. The only form of presence experience by all widows in this study was Friendly Presence.

Future studies should examine experiences among the bereaved who have continued to experience the presence of the person lost through death. More needs to be known about the relationship among the forms of presence experienced and the functions served by these experiences to the bereaved. Friendly

Presence was basic to bereavement of widows in this study, since it was experienced by all seventeen widows. On the other hand, Parkes (1972:58) stated that only fifteen of the twenty-two widows in his study reported a persisting presence of the lost husband. The widows in Parkes' study were bereaved through a natural death of their husbands, and usually after a period of illness. Either the mode of death or the expectedness of the death might influence whether widows were likely to have a continuing sense of their husband's presence. These, and other possibilities need to be investigated.

Fewer widows experienced the husband's continued presence either--to use the terminology of the present study--in the form of Constraining Force or Consulting Guide. The form of continuing presence may be related to a specific need to be met, rather than a general characteristic of bereavement.

Activities and events of daily living provided the widows in the current study with the tools and mechanisms for confronting themselves with their new status of widowhood. Decisions about what to do with the husband's personal belongings, or how long to continue wearing the wedding ring provided pivotal tasks for the myriad of reflections and encounters which forced a growing realization of the reality of the husband's death, and with her necessity to find a way to continue life without him. Other activities were

pivotal in changing patterns of social relationships. Through these pivotal activities and tasks, a matrix was provided for the widow to accomplish the psychological grief processes. The most important outcome was the gradual shifting of the widow's identity from that of a married woman, one of a couple, to that of a single woman.

Psychological processes should not continue to be formulated and discussed in isolation from the activities and tasks that foster and nurture them. Activities themselves, and the manner of accomplishing the activities should be examined in light of their contributions to enhancing or impeding progress through the bereavement process. If research were focused on the interaction between reality experiences and the emotional reactions evoked through the experiences, then beginning explanations about the processes involved can be formulated, and subsequently tested. Since it is likely that the activities and the responses engendered are interwoven, further study will aid in identifying the patterns of interaction, and the conditions which promote departures from the patterns.

Other shifts in identity for adults should be studied for comparisons among them: divorce, spouse bereavement and midlife crises. The degree and nature of the identity shift may vary with the type of situation which causes the identity shift to be

necessary. In other words, the nature of the ending for adults may influence the change in the identity process which results, or the manner of accomplishing the change.

Clinician-researchers should join forces with Coroner's Departments and Public Health Departments to conduct large scale studies necessary to specify more accurately the types and degree of risk inherent in bereavement. These studies should be conducted with rigorous methodology across several communities so results will not be compromised by methodology or by narrowness of locale. Studies should cross urban-rural boundaries while sampling population groups throughout the United States.

In addition to studies totally devoted to morbidity and mortality of bereavement, efforts would be made to incorporate measurements of morbidity of bereavement into other studies which are examining specific disease conditions longitudinally, such as some of the hypertension studies. Morbidity has been elusive in terms of pinpointing relationships of illnesses with bereavement, so efforts to determine the nature of morbidity associated with bereavement may require multifaceted research approaches.

The field of bereavement necessitated both clinical and objective features be incorporated into studies which continue to explore and describe the facets of grief, mourning and bereavement. Exploratory, descriptive studies should not be neglected in the

pressure to progress to more precise designs which examine known relationships among specified variables. Both types of approaches are needed in this complex and critical field of study.

5.4. Implications for Clinical Practice

Do all bereaved people require professional assistance? This central question could serve to polarize resources artificially if discussed from the normal to pathological continuum, or if access to existing services were the only consideration. Currently, resources for the bereaved are inadequate in number, visibility and accessibility. Most of the widows in this study did not define themselves as mentally ill, so would not have considered psychiatric facilities as a relevant source of assistance during their early bereavement period. Most of them, however, wanted a neutral person with whom they could explore their feelings and reactions. They readily acknowledge the need for someone outside their immediate circle of family and friends--someone with whom they could talk openly and honest without fearing they were burdening.

The majority of existing resources are dependent on the client labelling oneself as needing professional assistance, then asking for help--i.e., resources in the tradition of the medical model. Also, the facilities with special programs for bereaved people have not emphasized those programs to make either the

general public or other professionals aware of the features of the program. Peer-aid groups, usually called self help groups, have become available to increasing numbers of bereaved people. This is an excellent development of resource variety that needs encouragement and nurturing if a variety of alternative resources are to become available.

A variety of types of assistance programs and resources are needed, not just counselling services. If check lists of the documents needed to qualify for social service and welfare programs were readily available, the frustration could be reduced in the application process--a frustration that currently seems inherently bound with the application. For example, some services require birth certificates for each child; other services require the death certificate. Simply knowing what to expect of the time boundaries for each phase would assist the widows to determine when to expect a formal response to the request they had made. Checklists, such as these, could be distributed by public agencies as well as by funeral homes. Basic information about the commonly used services could be available in an attractive pamphlet prepared using non-technical terminology. Distribution could be arranged in the languages predominant in the particular geographic area.

Because such a diversity of assistance is needed for the bereaved, communities should strive for a cluster of types of programs and services offered. Liaison should be established among organizations that traditionally offer services to the bereaved in order to reduce fragmentation and duplication of services. These organizations would include churches, funeral homes, emergency rooms and coroner's offices.

Health care professionals have not been taught the features of bereavement to enable them to improve the care they give. All fields of health care need to examine their curricula to assess the adequacy of thanatological content, including issues around bereavement. In addition, educational facilities and organizations providing continuing education programs could initiate courses aimed at the professional who has not received formal courses in the field of bereavement.

As more knowledge is gained about effective therapeutic strategies and techniques specific to postvention with bereaved people, efforts to communicate these techniques to other health care providers should be initiated. Clinicians can be a valuable source of information in identifying pathways to complications of bereavement, so earlier recognition and prevention can be instituted. As information develops, public education programs should be developed about "normal" bereavement, and about resources and complications of bereavement.

APPENDICES

APPENDIX A

COUNTY OF LOS ANGELES
DEPARTMENT OF CHIEF MEDICAL EXAMINER-CORONER
1104 NO. MISSION RD., LOS ANGELES, CALIFORNIA 90033
(213) 226 8024 OFFICE HOURS
(213) 226 8001 AFTER HOURS

THOMAS T. NOGUCHI, M.D.
CHIEF MEDICAL EXAMINER-CORONER

May I offer our sincere sympathy at this time of your sorrow, and our deep concern.

Within the next few days you may expect to hear from Ms. Judith Saunders, Registered Nurse, who is affiliated with this office and with the University of California and who is doing research on how people handle bereavement for her doctorate. She is especially understanding, skilled, and helpful in working with grieving survivors and the problems of grief.

Again, may we express our condolences in your recent loss.

Sincerely,

THOMAS T. NOGUCHI, M.D.
Chief Medical Examiner-Coroner

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

SCHOOL OF NURSING
DEPARTMENT OF MENTAL HEALTH AND
COMMUNITY NURSING, ROOM N505-Y

SAN FRANCISCO, CALIFORNIA 94143

October 22, 1975

Mrs. Mary Smith
10000 Lane Street
Los Angeles, California

Dear Mrs. Smith:

I am a candidate for the Doctor of Nursing Science Degree, University of California at San Francisco, and am exploring the difficulties women have when they have lost their husbands. Although my graduate studies center from the San Francisco Campus, I live and work in Los Angeles.

I am asking you to meet with me several times during this next year to share with me, through conversation your experiences. We will meet wherever it is conventient for you. I would like to tape record our meetings. The tapes, of course, will be handled in a professional manner that ensures confidentiality.

I have no questionnaires to fill out, no tests to be taken, no rating scales to be completed, no specific questions to ask you. I am not "selling" anything.

Learning more about the nature of the difficulties bereaved women face would help me to identify the kinds of services which can assist widows during this painful period. I have worked with bereaved people and hope I can be of help to you personally.

This letter necessarily is brief. I would like the opportunity to explain my work to you more fully. If you will fill out the enclosed post card, or telephone me, I will arrange to contact you. Neither telephoning nor returning the post card commits you to see me.

I thank you for taking the time and energy to read this letter. I wish you the very best in your efforts to cope during these trying days.

Sincerely,

Judith M. Saunders, R. N., M. S.

Home telephone: 360-4222
Work telephone: 478-3711, Ext. 2226

APPENDIX C

JUDITH M. SAUNDERS
17351 TRIBUNE ST.
GRANADA HILLS, CALIF.
HOME: 360-4222
WORK 478-3711, EXT. 2226
YES, PLEASE CALL ☐
TELEPHONE NO.....

Postcard enclosed with investigator's letter to widows

APPENDIX D

University of California, San Francisco
Consent to Act as Research Subject
Bereavement Study

Judith Saunders, the investigator, has explained this study to me. I understand this study has two main purposes: (1) to study the bereavement process as experienced over time by a small number of widows; (2) to identify some of the activities which are particularly helpful to these widows as they attempt to cope with the adjustments made necessary by losing a husband through death.

I understand this study involves a series of interviews over approximately one year's period of time. I also understand, as Ms. Saunders and I talk during these interviews, that I may experience memories painful to me, or become more aware of my loneliness. I understand that sharing my experiences through talking periodically with Ms. Saunders, may or may not provide any comfort to me directly; although it is hoped that the findings from this study may, in some way, benefit widows in the future. I understand clearly that I may withdraw from this study at any time. I realize that I will not receive any money, or other tangible material gain, by participating in this study. I understand that all interviews will be tape-recorded. Ms. Saunders has assured me that the tapes, and any materials from the tapes, will be handled in a manner to ensure confidentiality; any publications resulting from this study will include the necessary precautions to protect my identity.

_____ _____

Date Signature

Approval number: 930104

Judith M. Saunders
Home telephone: 360-4222
Work telephone: 478-3711, Ext. 4277

APPENDIX E

SENIORS

TUESDAY-APRIL [illegible], [illegible] DAILY REPORT — INSIDE

CASE #	DATE	NAME		AGE	REPORTED AS	ALC	DISPOSITION
75-04968	4-20* 0917	S , Lucille		58 1345	App. Natural 4-21-75 BIE Pierce Bros	50	Breton
above case handled in addition to regular assignment 4-21-75							
T/C -04952	4-19* 1925	I ., Silverio	OS	85	App. Natural - cold hx 4-22-75 T/BIB Gutierrez	50	
65 -04973	4-20* 1130	B , Cora RESIDENCE DILDAY	OS	66 1620	Nat? Acci? therapeutic BIB Dilday's	A	CMRP
T/C -04982	4-20* 1332	P Jessie	OS	70+	App. Natural hBP-hrt 4-22-75 T/BIB Callanan (o/c)	50	
73 -04984	4-20* 1600	R Burr W.	OS	60 1620	App. Natural & work 4-21-75 BIB Hotteil's (o/c)	A	CHOI
T/C -04990	4-20* 1923	B Harry 4-19-75	OS	78	App. Natural 4-22-75 T/BIB Callanan	50	
T/C -04994	4-20* 2231	T . Carl	OS	56	App. Natural-diabetes, obesity 4-22-75 T/BIB Pierce Bros	50	
T/C -04995	4-20* 2243	R. Winfield	S. OS	70	App. Natural 4-22-75 T/BIB Chapel of Angels (o/c)	50	
29 -05003	4-21* 0425	R Samuel 4-20-75 PIERCE BROS SIGNE	NE	43	Acci? Natural? fx left leg alcoholic hx	A	
80 -05005	4-21 0652	JOHN DOE #52	1847	45+ 0900	Acci-burns d/t trlr fire BURNED	A	MAI
14 -05006	4-21 0702	B Hugh RES HOME AVOCADO SIERRA QUALITY	NE	72 1015	Sui-o/dose of pills w/ note	A	CHOI
67 -05011	4-21 0935	S Louise WILMINGTON FUN	OS	76 1330	Acci-theraputic	A	SCHN
64 -05012	4-21 0943	O. Linda Ann LA FUN RV	FAIR 63.9	29 1200	Sui-gsw to head w/ note	50	
T/C -05017	4-21 1100	K. Arthur	OS	75	Nat-resection of colon 4-22-75 T/BIB Forest Lawn	50	
4 -05018	4-21 1105	V Howard S.		58 1235	App. Natural- hrt, emphysema		SC
-05020	4-21 1149	S. Michael	OS	65	App. Natural- hrt hx 4-22-75 T/BIB Groman's	50	
38 -05022	4-21 1155	M Steven Lane Miller	NE	22 1350	Sui-gsw to head w/ note transfer c	50	
T/C -05025	4-21 1213	H Wilma	OS	81	App. Natural, hrt, diabetes 4-22-75 T/BIB Forest Lawn	50	
21 -05028	4-21 1255	T Joan Elizabeth Longewood Conv Hosp	NE	/38/ 1450	Sui-gsw to chest not no notes	T&T A	MAI

APPENDIX F

8/26

Name & Address	Case #	Age	Date Rec	Date Place or Death	Marital Status	NOK Notified	Mode	Circumstances
NOK = Mother P , Martin E	9923	38	8/18				A	Acci - hd trauma - fall
N W , Kado Collin	9925	32	8/18				H	GSW off. involved
N G , James	9981	30	8/19				A	auto - pole
John Doe #106	9994	30?	8/20				S	jumper BIB CA-27
N V , George	10136	30	8/24				A	o/d pills/marco
♀ H , Terry	10099	38	8/23				N	alc/blot transfusion
Letter Sent L , James	10100	37	8/23				S	hanging/w note

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