A DESCRIPTIVE ANALYSIS OF HELPFUL BEHAVIOUR
FOR ASSISTING THE WIDOWED IN BEREAVEMENT

by

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ABSTRACT

Widowhood and bereavement was explored in depth to determine an effective criteria for helping the widowed through bereavement, based upon their descriptive recall of the experience of grief. Fifteen adult women, who had engaged in group therapy, were interviewed. The critical incident technique was used to identify what factors hindered or facilitated the widows during grief in the two hundred and forty-one experiences collected. Each incident was categorized according to which factors were considered helpful and which factors were considered harmful. The study yielded two levels of categorization: categories and sub-categories. Five categories of helpful incidents emerged from the data which were labelled taking action, receiving support, sharing the grief, verbal reassurance and physical comfort. Five categories of hindering incidents emerged from the data which were inability to act, lack of support, feeling alone, verbal criticism and physical distress. Of these, the largest number of incidents in both the helpful and harmful categories were found in receiving support and lack of support. In the receiving support sample, perceived support whether initiated or received by the widow was experienced as helpful. In the lack of
support sample, the widow expected or needed to be treated differently and when others responded in a way she did not expect the widow perceived it as lack of support. Independent judges found these categories reliable. Results are examined by comparing the data generated to relevant literature and suggesting some criteria for helping the widow through grief.

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ACKNOWLEDGEMENT

The loss of a husband who is dearly loved brings great emotional pain and grief. I am deeply indebted to the fifteen women who offered to recall painful memories to contribute to the knowledge of the grieving process. Their suffering and their determination to reintegrate into life bears witness to the strength of the human spirit.
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CHAPTER ONE

Introduction

Overview

Widowhood is a phenomena that has become a serious subject of scientific research. It appears that many distressing experiences occur during the "crisis" time of bereavement, especially the early months: these include both bodily and psychological experiences. They are often experienced as symptoms and may lead bereaved widows and widowers to seek medical care. Clayton, Halikas, and Maurice (1971) have carefully viewed symptomatology during the first month in bereaved widows and widowers. They conclude that crying (94 percent), depressed mood (84 percent), and sleep disturbance (80 percent) were the major symptoms of bereavement. Anorexia, weight loss, tiredness, difficulty concentrating, poor memory, and loss of interest in television and friends were frequent. Only 15 percent saw or called a physician for these symptoms. Bereavement has also been significantly associated with first entry into psychiatric care (Stein and Susser, 1969) or psychiatric admission (Parkes, 1965).
There is much to suggest an impairment of physical health in the bereaved, even to the degree of an increased mortality risk in close relationship to the bereavement. Parkes, Benjamin, and Fitzgerald (1969) describe an increased mortality from cardiovascular disease in widowers aged fifty-five and older during the first six months following the death of a spouse, and conclude this is a psychosomatic consequence of bereavement, that these men died of a "broken heart". Greenblatt (1978) also comments on higher mortality in widows, resulting from heart disease and arteriosclerosis but there is no discussion on the time relationship to the bereavement. Cottington et al. (1980) recently studied sudden cardiac death in women aged twenty-five to sixty-forty. They found that these women were six times as likely as the control populations to have experienced the death of a significant other within the preceding six months. Bereavement has also been suggested as a cause for ulcerative colitis (Lindemann, 1944); neoplastic disease, such as carcinoma of the breast, carcinoma of the cervix, and leukemia (Klerman and Izen, 1977); thyrotoxicosis (Lidz, 1949); and asthma (McDermott and Cobb, 1939).

A number of studies have been conducted to determine the manifestations or stages of grief (Lindemann, 1944;
Parkes, 1972; Glick, Weiss and Parkes, 1974; and Kubler-Ross, 1969). Each of the studies have described the stages of grief in different ways. The important point is that grief does appear to be a process where some common reactions can be anticipated. Both Kavanaugh (1972) and Kubler-Ross (1969) delineate the stages as denial, anger, bargaining, depression, panic, worry and a "goodbye" or acceptance stage. Schnieder (1980) postulated a model of grief that encompassed a growth potential in the resolution of grief.

Grief is distinguished from bereavement by most writers as a psychological reaction to loss and separation. They are not synonymous terms. Our society expects that a person will or should express grief if bereaved (Volkart and Micheal, 1957). For bereaved persons who are genuinely grieved, it is imperative that they find the opportunity to resolve their grief. For those who are simply bereaved, but not grieved, however, it would appear to be inappropriate and possibly emotionally harmful to insist that they express feelings they do not have (Fulton, 1970).

Yet, while grief does appear to be a process, it is also a unique experience for each individual. There are a
number of factors that influence the quality and the intensity of the grief response (Lindemann, 1944). Not all persons will experience all the reactions to grief that have been categorized and the stages of grief may be experienced in different order, all at once, or with time gaps (Kubler-Ross, 1969). Greenblatt (1978) described this process when he stated:

Grieving is not a steady state; it is a process, one phase fading gradually into another. Form and manifestation may vary greatly as a function of education, personality, rituals and culture. The time it takes to move from one phase to another is also highly variable (p. 44).

In an attempt to work toward developing a theory of grief more emphasis needs to be placed on the specific variables that determine behaviour. One of the more crucial problems in all mental health research is to discover why some persons are more vulnerable to particular situations or experiences than others (Leighton, Clausen and Wilson, 1957). Parkes (1965) states, "much more work needs to be done to establish the full range of reaction to bereavement and to find out what factors determine a particular response" (p. 228).
Bereavement is a complex experience with many factors involved. Maddison and Viola (1968) followed by replicating studies (Maddison, Viola, and Walker, 1969) concluded that a number of variables played an important part in the widows successful completion of the grief process. The findings were that for a "good outcome", the degree and quality of support during the bereavement crisis, the long standing personality characteristics of the survivor, and the intrapsychic aspects of grief and mourning played an important part. The specific factors that seemed to contribute to an "unsatisfactory outcome" of bereavement were young age, number of dependent children, financial problems, multiple crises, lack of family or professional support and interpersonal problems not related to death. Lopata's study (1979) of Chicago widows shows that even though many had been bereaved for an average of eleven years, half said loneliness was their most serious problem, and a third said it was their second most serious problem.

It appears the key variables influencing outcome are the preexisting relationship, the nature of the death, other crisis, and perceived social network (Parkes, 1975; Raphael, 1978, Volken, 1970). A knowledge of these factors could be useful in preventative counselling for those conjugally
bereaved, thus lessening the risk of pathological outcome (Raphael, 1977; Singh and Raphael, 1981).

Research Questions

The research is intended to contribute to the growing body of knowledge of social and psychological factors that help produce emotionally stable survivors, particularly to establish effective criteria for helping the widow. It is clear that a comprehensive study of the factors relating to resolution of the grief process is needed. In a longitudinal study of bereaved widows, Vachon (1979) found that 38% of the respondents were experiencing a high level of distress after one year. Two years after the loss, she reports that one-quarter of her sample was still experiencing a level of psychological distress sufficient to warrant psychiatric assessment. The evidence suggests that a simple expectation of acceptance or recovery from grief is unwarranted for a large majority of people. Most studies find significant levels of distress after a year, and those that follow their sample for a longer period of time have not typically found substantial improvement (Glick et al., 1974; Parkes, 1975; Vachon, 1979). What factors are helpful in determining why 40% of the bereaved continue to experience intense anxiety two to four years after their loss (Glick et al., 1974)?
It may be difficult to define what is good coping behaviour in the bereaved in absence of normative data regarding how people respond to that event. For example, it would be difficult to regard "freedom from intense emotional distress" as an indication of good coping among the recently bereaved, since most evidence indicates that most bereaved manifest that type of distress. Since it is now recognized that depression is a common feature of the bereavement experience, this symptom may no longer have diagnostic value. In fact, depression following the loss of a loved one has been dropped from the diagnostic categories of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980).

Schoenberg, Carr, Paretz and Kutscher (1969) surveyed physicians and found that 52% expect the bereaved to have early "experiences of pleasure" - within a few weeks after the death of a spouse. In contrast, only 19% of the bereaved widows and widowers they surveyed anticipate such pleasant feelings (Schoenberg, et al., 1975). The lay public may be even less aware of the adjustment problems of the bereaved. In review of the literature on the bereavement crisis, Walker et al. (1977) concludes that "widows frequently report that even intimates do not support
the need to mourn their loss beyond the first few days after the death" (p. 38).

Both the professional care giver and the lay person will be involved with bereaved people and will need to know what would be beneficial in working with the widowed person. What type of behaviour would facilitate a supportive and trusting relationship? What kinds of help would the widowed population prefer and what kinds of help would they find harmful? Given this fundamental lack of information of the social and psychological factors that help produce emotionally stable survivors and the lack of established criteria for helping the bereaved this study proposes to gather pertinent data from the widowed themselves in order to begin establishing an effective criteria for helping the widowed through bereavement. The question that will be asked the widowed will be, "What has been helpful or harmful for you during your experience of grief?"
CHAPTER TWO

Review of Literature

Carey (1980) conducted an interview with 119 widows and widowers to help identify factors relating to adjustment during bereavement and to identify problems of widowed persons. The clearest finding was that widowers were significantly better adjusted than widows. Several factors were considered in analyzing this finding. A number of important factors came from the comments of the respondents suggesting that the difficulty widows experienced in making decisions and in handling financial matters alone, their concern about personal safety and worry about dependent children outweighed the difficulty widowers experienced in maintaining emotional needs of the children alone.

When asked to name the main problems faced after the death of their spouses, loneliness was named by 27% of the widowers and 54% of the widows as being a great problem. They also stated that they feel lonely doing things by themselves. The widowed had a "need to be needed by someone". The widowed, especially without children, found it difficult to find someone with whom to share their feelings and burden of their grief.
The respondents were also asked which people within and outside the hospital gave them help (little? some? great?). If the widowed responded using the category "great help" or said they were disappointed in some person or group they were asked their reasons. Physicians were rated as offering great help by 47% of the widowers and 40% of the widows. They were considered of great help when they were "honest, compassionate, available, not hurried, and comforting to the family". Yet, 27% of the widowers and 33% of the widows expressed disappointment in the physicians. They failed to be helpful because they were not honest with the patient and/or family, avoided the family, lacked gentleness, had a "poor bedside manner", were cold, impersonal, conconcerned and misdiagnosed patients.

Nurses, chaplains, social workers, family, funeral directors, local clergy and neighbours were rated in the same manner. Of all non-hospital personnel, the family was rated as the most helpful group to the bereaved. Those people who were rated as great help seemed to have the characteristics of support, understanding, gentleness and honesty. Carey concludes that a physician may assist adjustment in bereavement by "clearly, gently and tactfully" informing a wife of the seriousness of her husband's
conditions. He also suggested that non-technique humanistic aspects of health care delivery were seen as having great value by families of patients who are seriously ill. Both physicians and nurses were esteemed for their honesty and gentleness as they were for their technical competence.

Sheskin and Wallace (1976) conducted a comparative study of bereavements which attended suicide, natural and accidental death for widows. Bereavement was found to be a lonely and isolating experience regardless of the cause of death of a spouse. In effect, the loss of the widow's relationship with her husband is only one of several that the woman must sustain. The death of her husband triggers losses in other relational spheres. Another problem was that there were few good listeners available to bereaved persons. Members of the clergy were rarely cited as sources of help in this study whereas in Carey's study 56% of widowers and 62% of widows rated the clergy as great help. Sheskin and Wallace (1976) concluded that recovery is facilitated by both imagined as well as real life independence, in identity, role and relationship.

Ball (1977) in a study to discover if widows who experience anticipatory grief would resolve the bereavement
crisis in an easier manner than those who experienced the sudden death of the spouse asked in her questionnaire what the widow considered most helpful to her. Children, friends and relatives were seen as the greatest help. Keeping busy and a religion or philosophy of life were also important for adjusting. The biggest problem since bereavement was loneliness, learning to take responsibility and make decisions, economic and financial problems and children. Ball suggests that the descriptive evaluation of the questionnaires could offer clues to other evidence contributing to a widow's adjustment. A consensus of the widows' advice to others would be to maintain a certain amount of independence and decision making ability, see that financial support is sufficient in the event of a death and maintain a social life with good, trusting and loyal friends. Ball states that a study suggested by her research would be one that helped establish criteria of how the lay person can assist friends, relatives and others during their bereavement crisis.

In all three studies the qualitative reports of the widows and widowers revealed a consistent theme of loneliness being the biggest problem and the most helpful people were those who were trusting, available and
compassionate listeners. When advice was given by the respondents the themes of independence and friendship continued through the three studies. It appeared in the studies that the degree and quality of support during the bereavement crisis affected the successful completion of the grief process. Regardless of the variables of age, type of bereavement, or gender of the bereaved, it appeared that there was a commonality of qualities in perceived helpfulness and a commonality of qualities in perceived harmfulness. The experience of isolation and loneliness was perceived as the most difficult task of bereavement as well as a loss of identity for the widows. These common themes suggest further research in what types of behaviour and experiences may prove helpful or harmful to the bereaved person.

A detailed study of specific interactions of the widow with her social network and its influence on the bereavement process comes from Maddison's work (Maddison and Walker, 1967; Maddison, Viola and Walker, 1969). He explored widows perceptions of their social-network interactions in quite specific terms of actual interactions (for example, what others said or did), their perceived helpfulness or unhelpfulness, and needed interactions that did not occur. He also investigated the particular relationships involved.
The findings were as follows: widows who went on to poor outcome perceived themselves as having many more unsatisfied needs in interpersonal exchanges during the bereavement crisis than did those with good outcome. They felt that they needed more encouragement and support in expressing their affects, such as grief and anger. They needed more opportunity to talk actively, particularly about the husband and their life together. These widows wanted support to talk both negatively and positively about their lost relationship. They wanted nonjudgemental acceptance of the expression of their feelings of guilt. They also wanted practical support.

Poor outcome was also associated with interactions perceived as unhelpful in that they blocked the widow's expression of affects: others may have been shocked by her feelings; told her to control herself and pull herself together; suggested that she think of the suffering of others; advised her not to be angry or guilty; or told her not to cry. The widows also felt that interactions which advised her to think of the future and to think of remarriage were unhelpful.

There is evidence to suggest that the bereaved may commence or increase the use of psychototropic drugs.
Tranquilizer use increased significantly in Parkes and Brown's bereaved widows and widowers (1972), Maddison and Viola's widows (1968), and antidepressant use in fifty-two percent of Clayton, Halikas, and Maurice's widows, (1972). Not only did many of these widows and widowers commence such drug use for the first time following the bereavement, but for many it was maintained for a long period afterward, becoming part of a pattern of chronic drug use that appears to do little for the bereaved's condition and adjustment. Although it is difficult to sort out cause and effect relationships, studies do suggest that such drugs may not improve outcome in bereavement (Maddison and Raphael, 1972; Bowman, Striemer, and Perkins, 1981), and may even become a further factor hampering outcome.

Hiltz (1975) found that in conducting therapeutic discussion groups at the Widows Consultation Center that "the fact that someone is a psychiatrist and has a relationship with a well-known institution is not a guarantee that he or she is able to deal with widows effectively". The key to success of a widow discussion group was an effective leader and she advised that it would take some "trial and error" to obtain an effective leader. Silverman (1970) developed a program where widowed
caregivers called "aides" were trained to work with leaders in order to bring new widows into the program and accomplish the goal of preventing emotional illness in a population of bereaved people. Silverman found the aides were accepted as friends because they understood the bereavement process and the "common problems" of widowhood.

Vachon et al. (1980) conducted a study of 162 widows under 70 years of age, 68 randomly selected widows were offered one-to-one and later group support from other widows. These helping widows had resolved their own bereavements and were trained by Vachon's team to "reach out with an offer of help". The widows who received help and a control group were followed up 6, 12 and 24 months after death. While there was no significant differences in general health measures between the groups, there were three measures of psychological change that favoured the group that had received support. Those widows who had high scores on the general health questionnaire (GHQ) at 1 month, before the offer of help was made, and were assumed to be a high-risk group, seemed to be particularly likely to be helped by the program in that they were much better at follow-up than high-risk subjects who had received no support. The findings so seem to indicate the value of self-help organizations for the bereaved.
The Silverman (1970) and Hiltz (1975) research shows that many caregivers are ill equipped to deal with the problems of widows. A program is likely to be successful that utilizes widows themselves to reach out to the newly bereaved (Vachon, 1980). In the last decade much attention and research has been devoted to grief and bereavement in hopes of understanding the phenomena and aiding the widowed population who are prone to emotional and physical illness. It seems curious that little research has been conducted which asks the bereaved what would be helpful or what would be harmful in aiding them during this time of change. Silverman found that the widowed caregivers "quickly corrected the notion that within 1 year, or less, a widow has recovered from her bereavement". The widows felt that although the acute stage of grief may be over, the widow may not be recovered and in fact depressed by her growing awareness of loss.

In summary, the loss of a spouse will inevitably be painful. Not only is there the crisis of loss, but also the difficult longer term social adjustments to new roles, identity and interaction. The support of significant others will be vital to most of those who are so bereaved. It is clear that a comprehensive study of the factors relating to
resolution of the grief process is needed. Ball (1977) suggests that studies are needed to isolate the social and psychological factors that produce strong, independent, emotionally stable survivors who carry out grief work and to establish criteria of how the lay person can assist friends, relatives and others during their bereavement crisis.
CHAPTER THREE

Methodology

The Critical Incident Technique

Justification for the Choice of Methodology

The critical incident technique (Flanagan, 1954) consists of a set of procedures for collecting information from people about their direct observations of their own or other's behaviour. These independent descriptions are subjected to an inductive categorization process which captures the essential features of an identified aim.

The aim of this study is to gather pertinent data from the widowed themselves in order to generate effective criteria for helping the widowed through the experience of grief. Preliminary work of this sort must be descriptive and qualitative. Therefore, statistical hypothesis testing is not appropriate at this exploratory stage.

Flanagan (1954) developed the technique from studies in the Aviation Psychology Program of the United States Army Air Forces in World War II. The procedure aided in establishing critical factors that were effective or
ineffective in accomplishing a specific activity, such as learning to fly or being a good leader.

In the 30 years since Flanagan's original study this technique has been a useful methodology for psychological studies. Cohen and Smith (1976) used it to study group process. The authors found that critical situations arise within groups where a group leader must choose an appropriate intervention.

Dachelot, Wernett, Garling, Craig-Kuhn, Kent, and Kitzman (1981) used the critical incident technique to examine conditions which facilitated clinical training of nurses. Categories were developed which provided information on activities which occurred in clinical settings and the ways in which these activities were perceived by both educators and students. Rimon (1979) examined the psychological aspects of nursing by collecting the nurses' observations of the critical aspects of their role in providing psychological care of the patient in the hospital.

Weiner, Russell, and Lerman (1979) used the critical incident technique for theory development. They collected
critical incidents to study the connection between cognitions and emotions in achievement related contexts.

Flanagan (1978) conducted a study of the American quality of life. He collected 6,500 incidents from a large sample in an attempt to define the critical features of the quality of life of Americans.

The critical incident technique can be considered as a phenomenological approach as it legitimizes the experience and perceptions of individuals. As an experiential research approach, it assumes the importance of perceived as compared to objective reality as the basis for human behaviour (Colaizzi, 1978). It, therefore, enables exploration of dimensions of human life that may be difficult to measure or operationalize. Flanagan (1984) found that subjects' recalled events were essential to the purposes of his study as a source of rich and useful information regarding the quality of life of Americans.

The critical incident technique is an exploratory, qualitative research methodology that is highly flexible (Woolsey, 1985). It, therefore, is an appropriate methodology for the generation of data from the subjects of
this study in order to begin to establish effective criteria for helping the widowed through the experience of grief.

**Collection and Classification of Data**

The Critical Incident Technique refers both to a set of procedures for collecting direct observations of human behaviour and to the analysis of data. The incidents are collected through the use of interviews or questionnaires. In order for an incident to be considered as a "critical incident", Flanagan (1954) states that it must be defined as an extreme behaviour that significantly contributes, either positively or negatively, to the objectives being studied. It is easier to identify extreme behaviour than behaviour which is more nearly average in character.

The critical incident technique is frequently used to gather data on observations which were previously made and are reported from memory. Accuracy of reporting incidents can be determined by the incident itself. If the person can give full and precise details, the information can be relied upon as accurate, whereas vague reports may indicate that the incident is well remembered and the data incorrect (Flanagan, 1954).
Flanagan (1954) defines an incident as any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act. To be critical, an incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer, and where its consequences are sufficiently definite to leave little doubt concerning its effect.

In order to ensure objectivity, Flanagan (1954) has established a set of guidelines to be followed prior to collection of data. These guidelines ensure objective, clear evaluation, recording and classification of all behaviours, both positive or negative, which are relevant to the general aim of the activity. Included in these guidelines is the use of probability estimates to provide more objectivity in studying the actions which influence the situation being observed. Flanagan (1954) states that the interview procedure must be designed in advance to provide for delineating clearly the purpose of the study; the special qualifications of the person being interviewed and the research question asked the observers.

After the collection of the critical incidents, the data must be summarized and described in an efficient manner
Flanagan (1954) identifies three primary problems: (a) the selection of the general frame of reference that will be most useful for describing the incidents; (b) the inductive development of a set of major area and subarea headings; and (c) the selection of one or more levels along the specificity-generality continuum to use in reporting the requirements.

Flanagan (1954) discusses solutions to these problems as below:

a) **Frame of reference.** The selection of the frame of reference should be based on the intended use of the data. The preferred categories will be those believed to be most valuable in using the statement of requirements.

b) **Category formulation.** A tentative classification framework is done inductively by sorting a small number of incidents into piles labelled with descriptive titles. After these tentative categories have been established, brief definitions of them are made, and additional incidents into them. A process of redefinition of categories, and reclassification of incidents, occurs until all items are distributed.

c) **General behaviours.** This is the problem of weighing advantages of the specificity achieved in specific
incidents against the simplicity of a relatively small number of headings. Strict criteria are outlined, in advance, for the headings of categories, which include: providing clear cut and logical organization; conveying meanings without needing explanations; reflecting a similar level of importance; being neutral in tone with critical requirements defined in positive terms; and are comprehensive and inclusive of all significant incidents. Finally, frequency counts of incidents in each category are tallied and interpretations of them are made with respect to the identified problem.

The size of the sample is considered to be the number of critical incidents obtained from the interviewing procedure, not the number of people interviewed. Only one incident is required to form a category. There is no precise test for sample size but when repetitive patterns begin to develop and no new categories are formed, it is assumed sufficient incidents have been collected.

Reliability and Validity of the Technique

Flanagan (1954) derived a method of checking the reliability of the categories by submitting the incidents and categories to one or more independent raters (Flanagan,
The rater is trained in the method of categorization that was used by the researcher and is instructed to sort the incidents into the appropriate categories. A criterion established in advance, such as 80% agreement, determines whether the categories are reliable. An 80% agreement can be expected if the categories are well-formed and the raters are trained in the method of categorization.

Construct validity of the categories can be partly assumed by the fact that the experience of the subject is reported independently. The independence created by the critical incident technique provides for a variety of observations where individual biases are eliminated (Flanagan, 1984). The data generated by the critical incident technique can be compared with relevant literature. This comparison technique can provide an addition check of construct validity and provide an opportunity for discrepancies to be analyzed and explained.

Anderson and Nilsson (1964) have researched the reliability and validity of the critical incident technique in the analysis of the job of a store manager in a Swedish grocery company. Inspection of the classification of incidents into categories and rating of data by independent
judges, as well as inquiries into the importance of the elicited incidents resulted in the following conclusions:

According to the results of the studies reported here on the reliability and validity aspects of the critical incident technique, it would appear justifiable to conclude that information collected by this method is both reliable and valid. (p. 402)

Subjects

Selection of the Sample

Volunteers in this study were widows 65 years and younger whose spouses had died within 2 years of the contact date with North Shore Family Services. Those over 65 years of age were excluded so that the effects of advanced age would not be confused with the effects of bereavement. Previous studies have suggested that the very old show a different type of reaction to bereavement with less overt responses as a consequence of the normal aging process (Parkes, 1970). North Shore Family Services has an existing program for the recently bereaved and have established a referral relationship with Lions Gate Hospital Palliative Care Unit. A 6 month interim period since bereavement was considered before contacting the widowed participants in
order to show consideration of their personal feelings. Clayton, Desmaris, and Winokur (1968) found that in normal bereavement acute grief had subsided by the sixth month.

The volunteers were sent a letter (see Appendix A) asking if they would consider being a part of the study. The letter was followed up by a telephone call from the interviewer of this research. It was assumed the population would be more willing to participate with this study since the interviewer is the leader of the North Shore Family Service grieving group and has a working relationship with Lions Gate Hospital and many North Shore nurses and physicians. All the respondents agreed to be interviewed and the interview was held in each of the participants private residence.

The participants were given duplicate consent forms (see Appendix B) which were read aloud outlining clearly that: participation was voluntary and could be determined at any point; the interviews would be taped, however all data would be confidential and tapes erased upon completion of the analysis; and involvement in the research would in no way effect the relationship the subject had with North Shore Family Services. All subjects signed the consent form in duplicate and kept one copy themselves.
A total of 15 adult women were interviewed altogether, out of an anticipated 20 participants. Fifteen respondents provided a sufficient number of critical incidents to meet the redundancy criterion (Flanagan, 1954).

Profile of Participants

Woolsey (1985) states that it is important to gather relevant descriptive biographical data about respondents in critical incident research. The detailed demographic questionnaire (Appendix C) produced the following profile of the widows interviewed in this study. Actual statistics are presented in Tables 1 and 2.

General Information. The women in this study are primarily Canadian with an average age of 54. The average age of 54 reflects the Canadian statistics since more than a third of Canadian widows are under the age of 65 and the average age to become a widow in Canada is 56 (Sutton, 1978). They were married to their husbands for an average of 28 years with the exception of 1 respondent who was married only a year and it was her second marriage. Again, with the exception of 1 widow, the women had children whose average age was 26.6. They were primarily protestants who were only slightly involved in their religion. The majority
Table 1

Demographic Data: General Information

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Age</th>
<th>Marital Status</th>
</tr>
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<tbody>
<tr>
<td>Canadian: 12</td>
<td>40-44: 3</td>
<td>first marriage: 14</td>
</tr>
<tr>
<td>English: 3</td>
<td>45-49: 2</td>
<td>second marriage: 1</td>
</tr>
<tr>
<td></td>
<td>50-54: 0</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Length of Marriage</th>
<th>Age</th>
<th>Age of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
<td>60-64: 6</td>
<td>0-10: 4</td>
</tr>
<tr>
<td>1-4: 1</td>
<td>average</td>
<td>11-20: 6</td>
</tr>
<tr>
<td>5-9: 0</td>
<td>age: 54.4</td>
<td>21-30: 13</td>
</tr>
<tr>
<td>10-14: 2</td>
<td></td>
<td>31-40: 18</td>
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<tr>
<td>15-19: 1</td>
<td>Children</td>
<td>average age: 26.6</td>
</tr>
<tr>
<td>20-24: 1</td>
<td>0: 1</td>
<td></td>
</tr>
<tr>
<td>25-29: 2</td>
<td>1: 0</td>
<td>Occupation</td>
</tr>
<tr>
<td>30-34: 2</td>
<td>2: 6</td>
<td>Homemaker: 7</td>
</tr>
<tr>
<td>35-39: 3</td>
<td>3: 4</td>
<td>Secretary/Clerk: 2</td>
</tr>
<tr>
<td>40-45: 3</td>
<td>4: 3</td>
<td>Preschool Teacher: 2</td>
</tr>
<tr>
<td>average length: 27.9</td>
<td>5: 1</td>
<td>Nurse (RN): 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pysiotherapist: 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small Business: 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>Religious Involvement</th>
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</thead>
<tbody>
<tr>
<td>Catholic: 4</td>
<td>Involved: 2</td>
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<tr>
<td>Protestant: 9</td>
<td>Moderate: 4</td>
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<tr>
<td>Other: 3</td>
<td>Slight: 9</td>
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<td>Freelance Writer: 1</td>
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</tbody>
</table>
# Table 2

**Demographic Data - Death of Spouse Information**

<table>
<thead>
<tr>
<th>Type of Death</th>
<th>Place of Death</th>
<th>Date of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected: 2</td>
<td>Hospital: 7</td>
<td>1982: 6</td>
</tr>
<tr>
<td></td>
<td>Other: 4</td>
<td>1983: 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric Help Since Bereavement</th>
<th>Financial Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes: 5</td>
<td>Easy: 7</td>
</tr>
<tr>
<td>No: 10</td>
<td>Moderate: 8</td>
</tr>
<tr>
<td></td>
<td>Difficult: 0</td>
</tr>
</tbody>
</table>
of the women were homemakers with 7 women working outside the home as preschool teachers, health care professionals, clerks, or as an owner of a small business.

Death of Spouse Information. Studies evaluating bereavement both retrospectively and prospectively delineate the importance of the nature of death in defining the outcome of conjugal bereavement (Raphael and Maddison, 1976). Thirteen of these women stated that their husbands died suddenly, although 4 stated that their husbands had been seriously ill. The knowledge of their husband's illness did not help them to anticipate the death of their spouse and, in fact, they felt their spouses death was sudden. Raphael (1983) states even when death is anticipated and seems timely, it may not come at the time it is expected, thus producing shock effects. Sudden, unexpected and untimely deaths are associated with greater problems for the bereaved than are anticipated deaths: greater difficulties with acceptance of the loss and adjustment to it; greater difficulties with health and with a return to normalcy (Lehrman, 1956; Parkes, 1975). Sudden deaths prove to be a risk factor for poor outcome following bereavement (Raphael, 1977). One widow's husband committed suicide. Suicides are deaths of special significance. Here
the person has chosen to die, to desert those who are bereaved. They leave a legacy of suicide (Cain, 1966), of uncertainty, of guilt, of blame, and hostility. There were only 2 widows who expected that their husband would die. Anticipation of the death, as with terminal illness, seems to give a greater chance for preparation. There may be anticipatory grief and mourning.

Four of the spouses of these women died away from home or hospital. The sudden nature of these 4 deaths and the inability of these women to see the body of their spouse may add to the problem of accepting the finality of the loss (Singh and Raphael, 1981). The remaining women reported 7 of their spouses died in hospital and 4 spouses died at home.

The women had become widows from 1981 to 1983 and the group was distributed evenly in the length of their bereavement from 6 months to 2 years. There is no fixed end point of grieving during the first or even second year, but much of the work of relinquishing the bonds is accomplished in the early months and continues gradually, in steps and phases, over the first year (Raphael, 1983).
Psychiatric help in coping with the loss of spouse was sought by 5 of the 15 widows. Both widows who expected the death of their spouse attended psychiatric care after the death of their spouse.

Parkes (1975) suggests that socioeconomic factors may lead to greater "survival" problems for the widow and her family. Maddison and Viola (1968) found that financial problems were a specific factor contributing to "high risk" widows (those experiencing an unsatisfactory outcome of bereavement). Eight widows rated their financial status as moderate and 7 rated their status as easy. The problem of financial loss did not effect the women in this study. In fact, 2 of the women who ranked their financial situation as easy complained of feeling guilty because their lifestyle improved due to the death of their spouse.

Procedure and Data Collection

Assumptions

For many participants, a significant length of time exists between the experience of incidents and the recollection of these incidents in the interview. Given this fact, the assumptions made by the researcher prior to the collection of the data are identified as follows:
1. subjects will recall incidents in detail as they happened;
2. the recall of incidents will be essentially factual; and
3. subjects will be able to distinguish between critical incidents that were helpful during their experience of grief, and those that were harmful during their experience of grief.

Interview Structure

Prior to commencing the interview, the participants were given a detailed demographic questionnaire (Appendix C) including basics such as age, marital length, and occupation, as well as facts about the death of their spouse. The facts considered included type of death, place of death, date of death and counselling received. Upon completion of this questionnaire, subjects were then interviewed by the researcher, according to the structure detailed in Appendix D.

Pilot Study

The pilot study had two main objectives. The first of these was to determine whether or not subjects were able to recall specific events that were helpful or harmful to their
experience of grief. The pilot study was also conducted to test the interview structure (Appendix D), based on Flanagan's (1954) Critical Incident Technique.

Three women, who had volunteered to participate, were interviewed for the pilot study. One woman was 40 years of age and it had been 18 months since the death of her husband. It had been a prolonged death and she had required psychiatric counselling during her bereavement. The other two women were 64 years of age and both their husbands had died a year prior to the interview. The deaths of their husbands had been sudden and neither had required counselling. One woman defined herself as only slightly involved in her religion, while the other two were involved actively in the functions of their church. Therefore, these 3 women were representative of the population that this study would be interviewing.

The interviewer adhered to the interview structure as outlined in Appendix D.

The three women had little difficulty recalling specific incidents that were helpful or harmful during their experience of grief. The follow-up questions did insure
that important criteria cited by Flanagan (1954) was met by the incidents reported: the actual behaviour was reported; it was observed by the reporter; relevant factors of the incident were given; the observers made definite judgments regarding the criticalness of the behaviour; and why the behaviour was judged critical. The interviews lasted approximately 2 hours.

Each of the 3 women interviewed stated that they had derived some personal value from the interview process. It allowed them to reflect on the death of their husband and their bereavement from a different perspective. Two of the women stated that they had not realized how well they were coping with their grief until they talked about the helpful and harmful incidents with the researcher.

In summary, the pilot study resulted in the determination that the interview structure met the criteria established by Flanagan (1954) and that the subjects were able to recall specific events. The pilot study respondents were included in the sample because they met the criteria. The most valuable insight about the interview format was the claim from the subjects that they had derived some therapeutic benefit from looking at their experience of grief. The researcher found that it was necessary to
lengthen the time of the interview due to the nature of the topic and to insure that the respondent did not consider the interview, itself, a harmful incident.

Data Analysis

The critical incidents from the taped interviews were extracted and transferred onto 3 x 5 cards. An incident was judged to be critical if the subject could recall details of the experience and remember what it was about the incident that was helpful or harmful in the experience of grief.

Category formulation was done inductively. The incidents were sorted into clusters that seemed to have the same theme. The result of the first attempt at categorization was unhelpful. Several more attempts at categorizations proved unsatisfactory. The interviewer added information to the incident cards, such as, the agent. The agent is who made the difference in the incident - the respondent, a relative, a friend, or a professional.

It was helpful to review the taped interview. Woolsey (1985) asserts that the analysis of critical incident data is the most difficult and frustrating aspect of the method. Flanagan (1954) states that the trial and error procedure is typical of critical incident studies.
A satisfactory categorization resulted from including the source, that is what really made the incident so helpful, as the basis for category formation. Woolsey (1985) states that it is important to continue working with categories until a subjective point is reached where it seems the researcher has discovered some underlying structure and not an artificial order. Helpful and harmful incidents were both classified in this manner.

Reliability of Categories

The classification system developed was tested for reliability by two independent judges, both of whom were graduate students in Counselling Psychology. The judges were trained in the category system to be used. The percentage of agreement by the judges with the investigator's classification of incidents provided the measure of reliability. Andersson and Nilsson (1964) suggest that reliability is reached if raters can classify 75-85% of the incidents into the categories. A minimum of 80% agreement was decided in advance to indicate reliable categories. All 241 incidents were tested by each judge. The following results were obtained:
Table 3
Reliability of Classification System
(Percentage Agreement)

<table>
<thead>
<tr>
<th>Judge</th>
<th>Helpful Category</th>
<th>Harmful Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>80%</td>
<td>79%</td>
</tr>
<tr>
<td>B</td>
<td>80%</td>
<td>69%</td>
</tr>
</tbody>
</table>

Based on the results of the judges categorization, the harmful incidents were re-evaluated by the investigator.

Difficult decisions occurred during the categorization process. Traditionally, all members of a category are equally good examples of that category. McCloskey and Glucksberg (1978), and Rosch (1975) suggest that there is a continuum of category membership which leads to the notion of "fuzzy sets". There is no clear boundary between categories so that some of the fuzziest objects can be category members and non-members simultaneously.

Cognitive psychological research into category formation is not a purely subjective process. Critical incidents contain incidents that form a continuum of category membership ranging from prototypical incidents easily categorized by independent raters to fuzzy incidents
which possess attributes of more than one category. It is this phenomena that can produce less agreement among independent raters.

Seven incidents were placed in different categories when it was discovered that both judges A and B had placed those incidents in the same different categories. It was assumed that these seven incidents possessed attributes of more than one category and, in fact, were better represented in a different category. Additionally, the researcher placed more information on the 3 x 5 cards after reviewing the tape to insure that all the necessary information for each incident was available.

The judges were asked to sort the harmful incidents for a second time. The following results were obtained:

Table 5
Reliability of Classification System
(Percentage Agreement)

<table>
<thead>
<tr>
<th>Judge</th>
<th>Harmful Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>87%</td>
</tr>
<tr>
<td>B</td>
<td>85%</td>
</tr>
</tbody>
</table>
CHAPTER FOUR

Results

A total of 241 independent critical incidents were extracted and transcribed from the taped interviews of the fifteen female participants. Of these, one hundred and thirty were factors that were considered helpful, and one hundred and eleven were factors considered harmful. The average number of incidents per subject was sixteen.

The study yielded two levels of categorization: categories and sub-categories. The helpful incidents and hindering incidents fit in similar categories, one having a positive valence and the other a negative valence. Both the helpful incidents and hindering incidents had the same number of categories. The sub-categories were different both in nature and number for the two types of incidents. The sub-categories provided the categories with a richness of detail. Table 6 reveals the distribution of critical incidents within each of the categories. Below are the definitions for each of the categories and sub-categories. Meeting the original assumptions, the women offered their experiences in precise, factual detail. The women's exact words will be used to illustrate the sub-categories.
Table 6

<table>
<thead>
<tr>
<th>Helpful Category</th>
<th>Helpful Incidents</th>
<th>Harmful Category</th>
<th>Harmful Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking Action</td>
<td>30</td>
<td>Inability to Act</td>
<td>19</td>
</tr>
<tr>
<td>Receiving Support</td>
<td>48</td>
<td>Lack of Support</td>
<td>30</td>
</tr>
<tr>
<td>Sharing the Grief</td>
<td>29</td>
<td>Feeling Alone</td>
<td>27</td>
</tr>
<tr>
<td>Verbal Reassurance</td>
<td>9</td>
<td>Verbal Criticism</td>
<td>24</td>
</tr>
<tr>
<td>Physical Comfort</td>
<td>14</td>
<td>Physical Distress</td>
<td>11</td>
</tr>
<tr>
<td>Total Incidents</td>
<td>130</td>
<td>Total Incidents</td>
<td>111</td>
</tr>
</tbody>
</table>

TOTAL = 241 Incidents

Helpful Incident Categories

Taking Action

As shown in Table 6, thirty out of one hundred and thirty helpful incidents could be classified in this category, accounting for approximately 23% of the helpful incidents.

Definition: This category seems to encompass a growth potential in the experience of grief. The incidents enhance the sense of personal power of the respondent in an area where she feels she has become out of balance since the death of her husband. She may experience a growth in her competence, that is, handling the crisis and managing by herself. It is an act that results in the widow empowering herself.
Sub-Categories: There are five sub-categories which are based on the type of actions that the widows took. Table 7 shows the frequency of incidents in each of the five sub-categories found in the Taking Action Category. Examples reflecting these sub-categories are:

Table 7

<table>
<thead>
<tr>
<th>Distribution of Incidents in the Taking Action Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back to Work</td>
</tr>
<tr>
<td>On a Trip</td>
</tr>
<tr>
<td>Coping with Depression/Anxiety</td>
</tr>
<tr>
<td>Social Life</td>
</tr>
<tr>
<td>Coming to Terms with Death</td>
</tr>
<tr>
<td>Total incidents</td>
</tr>
</tbody>
</table>

1. Back to Work: I became a trustee of S.P. Hospital and I feel like I am becoming involved in life again. I don't want to play bridge and golf every day ... it gives me direction.

2. On a Trip: I went on a trip by myself - on my own. It makes me feel strong. I don't say that with pride. I say that with determination.
3. Coping with Depression/Anxiety: I had an overwhelming pain. I ran into the bedroom and kneeled by the bed. I was crying. I had my arms outstretched and said, 'Help me, Lord. I can't manage alone ...' I cried. I began to feel empty and exhausted and in the end, I was able to carry on.

4. Social Life: I gave myself a birthday party. I invited all the people who had cared about me. It was great! Four cakes! I turned a possible negative into a positive.

5. Coming to Terms with Death: I was playing golf on the eighteenth tee by a lake and it struck me - there is where to put his ashes. He always loved to golf. We went at dusk ... my eldest son scattered them. We all felt relief. We were not sad. I felt he was free and we were free ... I had made an important decision.

The underlying feature of these incidents is that the widows had an awareness of a choice, and gained a measure of control in the incident through exercising an option and
experiencing the consequence as gaining some sense of personal power.

**Receiving Support**

As shown in Table 6, forty-eight out of one hundred and thirty helpful incidents could be classified in this category, accounting for approximately 37% of the helpful incidents.

**Definition:** The bereaved widow is very dependent on the support of others during the time of grief. The incidents in this category deal with the widow perceiving support from others and being able to give support to others. Support may be seen as anything from practical assistance to reassurance of worth. It is a sense that people care about the widow and can help her in the experience of grief.

**Sub-Categories:** There are four sub-categories which are based on the actions of others or the widow's action. The result of these actions is the widow experiencing support either from others or by giving it to others. Table 8 shows the frequency of incidents in each of the four sub-categories found in the Receiving Support category. Examples reflecting these sub-categories are:
1. Professionals Providing Services: I had a session with a counsellor. I could be myself and express my feelings. There was no disapproval. When the session was over, I got rid of a great load ... a weight lifted off.

2. People Providing Support: A male friend helped my buy a car. He knew about cars and helped me make the best, practical decision. His practical advice helped me.

A friend came over and when I asked if she wanted tea she said, 'no, my husband would be upset if I didn't take you to our house'. She took me to her house until 2:00 a.m. I felt love and support.

3. Widow Giving Support: I wrote a letter to D. F., the judge who was arrested for hit and run while impaired. I told him to know to bargain. A year from now it will be better. I got a wonderful letter back. It felt good to reach out and support someone.
4. Linking With Others With The Same Experience:
I attended a bereavement group. I heard other peoples reaction to grief. I had a sense of sharing ... a sense of wholeness.

The perceived support in these incidents whether initiated or received by the widow, was experienced as helpful.

Support appears to have many components. The first incident involved expression of positive affect. In the last incident support was conveyed by providing information that the widow was a part of a network - a support system. As displayed in Table 8, half of the incidents in this category were located in the sub-category People Providing Support.

Table 8
Distribution of Incidents in Receiving Support Category

| Professionals providing services, concrete, empathy, understanding | 14 |
| People providing support                                             | 24 |
| Widow giving support                                                  | 6  |
| Linking with others with same experience                              | 4  |
| Total incidents                                                       | 48 |
Sharing the Grief

As shown in Table 6, twenty-nine out of one hundred and thirty helpful incidents could be classified in this category, accounting for approximately 22% of the helpful incidents.

**Definition:** This category reflects the widow's perception of the communication of empathy from another person that provides her with validation of some feelings and a sense that she has permission to talk. She also can experience the freedom to ventilate her feelings but the intensity seems to depend upon the relationship she has with the individual. A key feature of this category is that when the widow engages in this type of sharing, she does not feel alone in grief.

**Sub-Categories:** There are three sub-categories which are based on the actions of others or the widow's action. Table 9 shows the frequency of incidents in each of the three sub-categories found in the Sharing the Grief category. The result of these actions is a sense of being understood by another or understanding another. Examples reflecting these sub-categories are:
1. Personal Bond: It was sunset. I asked the grandchildren to join me at the front door and watch it with me. It was the first time we could talk about K. The kids asked me questions ... the sunset became grandpa's painting ... the sunset. I felt a bond.

The minister came to the house and wanted to talk about J. He said 'Is there anything you want to tell me about your husband' ... no one had wanted to talk about J.

2. Information and Inspiration: A woman came to the house who was studying theology who I did not know. She visited me to comfort me. She just came to listen and to share her experiences as a widow.

My mother, who was widowed with four small children, had set an example. I could follow her example ... be as strong as her.

3. Grim Warnings: I was with a friend who was very depressed and I realized that I was close to ending up like that. It gave me strength to fight my depression.
Table 9

Distribution of Incidents in Sharing the Grief Category

1. Personal Bond - crying, acknowledging/sharing grief, being able to talk about feelings and husband 18
2. Information and Inspiration 7
3. "Grim Warnings" 4

Total incidents 29

The sense of sharing in these incidents whether initiated or received by the widow was experienced as helpful. An important aspect of this category seems to be the expressing agreement with, or acknowledgement of, the appropriateness of a person's beliefs or feelings as well as encouraging the open expression of such beliefs and feelings.

**Verbal Reassurance**

As shown in Table 6, nine out of one hundred and thirty helpful incidents could be classified in this category, accounting for approximately .07% of helpful incidents.

**Definition:** Weiss (1974b) outlines a series of "provisions" or needs that are normally met in relationships. One of
these is called reassurance of worth which means attesting to a person's competence. A widow experiences the potential loss of reassurance when her husband dies. She turns to others for support and she is also much more influenced by the responses of others to her than she would be at a non-crisis time (Caplan, 1964). The incidents in this category are the verbal responses of others that the widow experiences as reassuring.

Sub-Categories: There are two sub-categories which are based on the widow receiving responses from others or giving a response (talking to self) which she perceives as reassuring and giving her a sense of personal competence. Table 10 shows the frequency of incidents in the two sub-categories found in the verbal reassurance category. Examples reflecting these sub-categories are:

1. People telling widow she could do something or that she was coping: My best friend reassured me by saying, 'I know you're going to be alright. Things will turn out alright.' She had a faith in my ability to cope.
I went to a teacher interview for my son and the teacher said I was doing a good job with my child. It was good to hear I was doing okay because I had just felt like I was running around in circles.

2. Reassuring or telling self she could go on alone: I felt down - like a dried up witch. I sat down and talked out loud to myself for a long time ... self talk. I could see if it made sense and I decided to make new memories.

Table 10

Distribution of Incidents in Verbal Reassurance Category

1. People telling widow she could do something or that she was coping 7
2. Widow reassessing or telling self that she could go on alone 2
Total incidents 9

The incidents in these categories are characterized by verbal messages that give the widow a sense of competence that she is, in fact, coping with her grief because others see her as doing so. The mental exercise of self-talk seems
to function in the same manner for the widow and helps her establish a sense of self-direction.

**Physical Comfort**

As shown in Table 6, fourteen out of one hundred and thirty helpful incidents could be classified in this category, accounting for approximately 1% of helpful incidents.

**Definition:** The most basic of human responses to those who are grief-stricken and distressed involve the offering of comfort and consolation. The appearance and behaviour of the bereaved person is usually such as to evoke caring responses from others. The natural response is to hold, touch, and murmur sympathy to this person. The incidents in this category are physical responses from others or the physical responses the widow gives which the widow experiences as comfort.

**Sub-Categories:** There are two sub-categories which are based on physical comfort. Table 11 shows the frequency of incidents in the two sub-categories.
Table 11

Distribution of Incidents in Physical Comfort Category

1. Being touched or hugged by someone  8
2. Widow touching or holding a pet  6
Total incidents  14

Examples reflecting these sub-categories are:

1. Being touched or hugged by someone: I was in a bereavement group. A widower reached out and touched me ... comfort ... I could be me.

   My friend's minister came the day my husband died. He touched me. He held my hand. It was important. I felt like I was putting weight somewhere ... it helped me.

2. Widow showing or holding pet: I felt so deprived of touch. My cat jumped up on my lap and I could pet him. I realized how much it comforted me.

   I ran my hand through my dog's hair and she acknowledged me and rubbed her nose on my hand. I felt comforted.
Harmful Incident Categories

Inability to Act

As shown in Table 6, nineteen out of one hundred and eleven harmful incidents could be classified in this category, accounting for approximately 17% of the harmful incidents.

Definition: This category reflects the widow's sense of powerlessness. Shontz (1975) states that one phase of reaction to crisis is the encounter phase in which the individual begins to experience profound helplessness, disorganization and panic. The individual can become overwhelmed by reality and feel unable to plan or engage in active problem-solving to improve the situation. In this category, the women would either attempt to do something or find themselves in a situation where they were unable to act or come to a resolution of a problem.

Sub-Categories: There are three sub-categories in which the women are unable to act or feel overpowered. The sub-categories are divided by the widow wanting to act to protect her children; trying to do something with a friend or family member; or feeling overpowered by a situation involving a task or the television and radio. Table 12
shows the frequency of incidents found in the Inability to Act category.

Table 12
Distributions of Incidents within Inability to Act Category

1. Wanting to act to protect children 5
2. Trying to do something with friend/family and failing 4
3. Widow overpowered by situation (task, T.V., radio) 10
   Total incidents 19

Examples reflecting these sub-categories are:

1. Wanting to act to protect children: My young son asked me questions about dying and God. I couldn't answer him. I wanted to. I wanted to find the answers for myself! I wanted to help him. I wanted to do more for him.

2. Trying to do something with friend or family and failing: One week after A's death I went to lunch with a friend. I couldn't join in the conversation. I began to panic.
3. Widow feeling overpowered by a situation (task, T.V., radio): I was working with an old man who had a stroke. I kept feeling I couldn't help him. How can I help anybody? I couldn't even keep my husband alive.

I was watching T.V. I was seeing violence ... an ambulance. I felt glued. I couldn't move. It brought back painful memories. I felt stunned - as if it was happening again.

In these incidents, the widow finds herself in situations where she feels a sense of helplessness and her coping strategies are no longer successful in mastering the problem.

**Lack of Support**

As shown in Table 6, thirty out of one hundred and eleven incidents could be classified in this category, accounting for approximately 27% of the harmful incidents.

**Definition**: The incidents found in this category are ones in which the widow perceived a lack of support in her social or family network. The lack of support may have been in
terms of specific needs for encouragement of grief, lack of practical advice, or reassurance of worth. Some of the widows felt a need to talk about their husband and their past life together. Many of the widows needed more encouragement and support to permit them freer expression of affects, particularly grief and anger. All these incidents reflect the widow experiencing the environment as failing to provide an opportunity of support.

Sub-Categories: There are two sub-categories which are based on the lack of support category. The first sub-category reflects the widow's experience of people discouraging her to talk about her spouse or her feelings. The second sub-category addresses the phenomena discussed in the verbal reassurance category in which the widow is viewed as being much more influenced by the responses of others (Caplan, 1964). In this case she experiences responses as hurtful because her feelings are not acknowledged. Table 13 shows the frequencies of incidents in the two sub-categories of the Lack of Support category.
Table 13

Distributions of Incidents within Lack of Support Category

1. People refusing or unable to talk about death of spouse or listen to widow's feelings 10
2. Ordinary hurts becoming extraordinary due to grief 20
   Total incidents 30

Examples reflecting the sub-categories are:

1. People refusing or unable to talk about death of spouse or listen to widow's feelings: A medical health officer who was a friend of mine met me in the hall and only said 'Hi'. It was the first time he had seen me since A died. He could say nothing about me, A, or my sorrow.

I was going into my house and saw the neighbours. I waved and they turned away. They didn't want to get involved.

2. Ordinary hurts becoming extraordinary due to grief: I would phone friends to keep in touch and they said, 'we'll have to get together something.'
No invitations came. No calling back. I was disappointed.

The doctor said right out that I had to have a hysterectomy. He did not break it to me gently. I was in shock.

These incidents represent the widow expecting or needing to be treated differently. When others responded in a way she did not expect, the widow perceived it as a lack of support.

**Isolating Experience**

As shown in Table 6, twenty-seven out of one hundred and eleven harmful incidents could be classified in this category, accounting for approximately 24% of the harmful incidents.

**Definition:** Loneliness was reported to be the source of great emotional distress and despair for the women in this study. The incidents were ones where the widow felt alone. Lopata (1971) points out how much society is oriented to couples. The widow used to the couple-relationship in socializing, found herself the "odd one out" at dinner.
parties with family or friends. She found herself traumatized by her solo status and suspected that others did not feel comfortable with her although they had previously shared familiar patterns of social interaction.

Sub-Categories: There are three sub-categories which reflect the feeling of aloneness in different ways. The first category the researcher calls the Empty House category since the feeling of loneliness occurred upon returning to the home alone after a trip or evening out. It was reported by many widows that the anticipation of returning to an empty house kept them from coming home or required them to leave their stereo or radio on to create the feeling that someone else was in attendance at their home. The second category reflects those social situations which the widow experienced as anxiety-provoking. The women reported feeling traumatized by their single person status and also feeling that others may not feel comfortable with them although they previously shared familiar patterns of social interaction. The third category includes incidents where the widow realizes her spouse is dead and experiences the realization as harmful. It is important to note that this is not the "peaceful acceptance" that stage models of grief describe as the optimal end-product of the grief process.
Rather, it is the beginning of the widow's awareness of the loss of her spouse and, therefore, the immediate implication is loneliness and helplessness. Table 14 shows the frequency of incidents in the three sub-categories of the isolating experience category.

Examples reflecting the sub-categories are:

1. Returning home to an empty house: I came back home from a trip to California. I had been with my daughter's family. I went into my house. It was empty ... quiet ... nobody but me. I felt abandoned ... alone.

2. Feeling isolated in social or group experiences: I went to Parksville ... a resort. There were the couples we used to be with ... I felt uncomfortable - out of place. They talked about life - what they had done. What could I contribute?

I went to visit my son and daughter-in-law. It made me sad when they held hands. It hurt because I felt so alone. I had no one to hold my hand.
3. Realizing for the first time that the spouse is dead: I put my husband's ashes on the water. I realized it was really final. He was dead.

I stopped crying. No more tears. I realized this is the way it would be from now on - no future. I must live one day at a time to survive.

Table 14
Distribution of Incidents within Isolating Experience Category

1. Returning home to an empty house 9
2. Feeling isolated in social or group experience 10
3. Realizing for the first time that the spouse is dead 8
Total incidents 27

The women reported that even though children may need them, or stay with them, it did not usually help to diminish the widow's sense of loneliness. A need for adult attachment seems to be a significant part of the loneliness the women experienced. Weiss (1974a) sees the complaint of "loneliness" as the emotional response to the loss of the adult attachment bond. The incidents cited in this study
lend support to this view and also indicate that it can be the loss of social integration or reassurance of worth.

**Verbal Criticism**

As shown in Table 6, twenty-four out of one hundred and eleven harmful incidents could be classified in this category, accounting for approximately 22% of the harmful incidents.

**Definition:** The incidents in this category were perceived by the widow as harmful in that they blocked the widow's expression of affect: others may have been shocked by her feelings; told her to control herself and pull herself together, or suggested that she minimized her grief by thinking of the suffering of others.

**Sub-Categories:** There are two sub-categories which separate perceived criticism into critical with the widow feeling hurt or alienated and hostile with the widow feeling angry. The last category has to do with the specific advice given to the widow to find another man. It seemed that what was critical in these incidents was the suggestion of a new man in the life of the widow. Table 15 shows the frequency of
incidents in the three sub-categories of the verbal criticism category.

Table 15
Distributions of Incidents within Verbal Criticism Category

1. Receiving opinions or advice from others as critical and feeling hurt or alienated 10
2. Receiving opinions or advice from others as hostile and feeling angry 10
3. Being told to find a man or remarry 4
Total incidents 24

Examples reflecting the sub-categories are:

1. Receiving opinions or advice from others as critical and feeling hurt or alienated: Three weeks after J's death I went to see my physician. He told me that I had to block my feelings to get over my grief. He told me to go to a stress management seminar. I never went back.

A male colleague took me out to lunch. He said 'I told your colleagues what you need is a good kick in the ass to get over it'. I was hurt.
2. Receiving opinions or advice as hostile and feeling angry: My friend's husband talked to me at my desk where people walk by. 'I had a wife that died too. I had to carry on with my life. Look at the Korean plane that went down. What about them?' I got angry. I am what I am.

A minister came to visit me ten days after the death of my husband as a source of spiritual support. He said, 'it is time you quit feeling sorry for yourself'. I felt let down. I felt angry. He was out of line. I asked him to leave.

3. Widow being told to find a man or to marry: My doctor, after three months, said go to Hawaii and meet a man. 'You're just the type'. I was really angry. I didn't like it.

A friend said, 'It won't be long until you remarry'. I felt insulted, as if I wasn't a person without a husband.

The incidents in this category were associated with verbal interactions that were viewed as criticism because
they blocked the widow's expression of affect and were perceived as inadequate in the face of crisis.

**Physical Distress**

As shown in Table 6, eleven out of one hundred and eleven harmful incidents could be classified in this category, accounting for approximately 1% of the harmful incidents.

**Definition:** The widows spoke of many "symptoms" that may represent simply the psychological distress of the bereavement crisis. The incidents that were experienced in this category dealt with the symptoms of insomnia, nervousness, chest pains, palpitations, sleep loss, appetite loss, general aching and fatigue, and reduced capacity to work. It seemed that distressing experiences occurred during the early months of bereavement. A majority of the widows stated that they began taking tranquilizers and antidepressants shortly after, if not immediately after, the death of their husbands.

**Sub-Categories:** Table sixteen shows the frequency of incidents in the two sub-categories of the physical distress category. The two categories are divided into the physical reaction to stress and the physical reaction to medication.
Table 16
Distributions of Incidents
within the Physical Distress Category

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<td>1.</td>
<td>Physical Reaction to Stress</td>
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<td>2.</td>
<td>Physical Reaction to Medication</td>
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<td><strong>Total incidents</strong></td>
<td><strong>11</strong></td>
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Examples reflecting the sub-categories are:

1. Physical reaction to stress: I was a volunteer at the hospital. When I came home that day I felt physical pain. I was drained, like running to the point of exhaustion and accomplishing nothing.

I couldn't cry. I felt so much I couldn't cry. I had swallowed my feelings.

2. Physical reaction to medication: I went to a psychiatrist and he gave me pills and said that I would have no reaction. I did. He said it was all in my head.
The doctor gave me an antidepressant and after one pill I began to panic. I was feeling out of bounds. My reaction was a nightmare.

These incidents illustrated that many distressing experiences can occur during bereavement, especially in the early stages of grief. They are bodily experiences as well as psychological. They are often experienced as symptoms and may lead the widow to seek medical care.
CHAPTER FIVE

Discussion of Results

Taking Action and Inability to Act

All the women in this study cited at least one incident in the Taking Action category. They all spoke of an incident where they did something which gave them a sense of control or competence. It did not involve consulting or asking anyone else for direction. Each circumstance was such that the widow chose to act because she felt she was capable of acting and the result confirmed the fact that she could handle the situation. The incidents had varying degrees of intensity from putting the television on to deciding where to place the ashes of the spouse.

Most of the women cited an incident in the Inability to Act category. They spoke of an incident where they were unable to do something which gave them a sense of powerlessness, confusion or panic. In many cases it did involve trying to respond to another person or simply doing an activity that they would have felt capable of doing prior to the death of their spouse.
Both these categories reflected the woman discovering what she was capable or incapable of doing. Identity seems to be one factor that is strongly affected by the death of the spouse. The identity of the widow may have been defined by mutual roles, by the satisfaction of mutually gratifying experiences, or by the reinforcement of competence. The definition of self may have relied so strongly on the spouse that it is very difficult for the widow to find a new identity without him. It may be painful and difficult as demonstrated by the Inability to Act category or satisfactorily worked through as demonstrated by the Taking Action category.

The sub-categories of these two categories show some distinctions between the incidents. In Taking Action the widow chose to do the activity when she felt she was able or she engaged in an activity such as praying, poetry, gardening or work that she had done prior to the death of her husband. In Inability to Act the widow felt compelled to respond when her children needed help with their grief or a decision had to be made. Additionally, she would try to engage in an activity that she had done prior to her husband's death but fail and feel a sense of panic because she "should" be able to do it.
Shontz (1975) holds that a person's first reaction to crisis is shock. Following the initial shock, an encounter phase occurs in which the individual begins to experience profound helplessness, disorganization and panic. It is at this time when an individual may be unable to plan, reason or engage in problem-solving to improve the situation. Because the experience is so intense, individuals begin to manifest a type of avoidance that Shontz calls "retreat". He views an adaptive sequence as one that is characterized by a continual shifting between encounter and retreat from crisis. Each time an individual begins to face reality, feelings of anxiety, frustration or depression may occur. Shontz argues that these feelings may not be maladaptive, but are necessary precursors to positive psychological growth. These cycles "occur progressively less frequently...until they become virtually unnoticeable when adaptation is complete (1975, p. 166)". One experiences a renewed sense of personal worth and lowering of anxiety.

The incidents in the Inability to Act category were all in the first three months of grief. It is a time when affective responses are intense. The bereaved knows intellectually that the spouse is dead; yet the whole assumptive world (Parkes 1972; Woodfield and Viney 1982) is
still oriented toward him and the widow has not realigned herself to a new set of assumptions. One important new assumption seems to be that she is a person without him. As cited in Chapter Two, Sheskin and Wallace (1976) found that independence in identity, role and relationship facilitated recovery. The incidents in Ability to Act tended to be around three to six months into the experience of grief. After the initial crisis of the early weeks and months, the intensity of grief and preoccupation with the mourning process lessen (Raphael, 1983). It may be that these two categories reflect the sense of power and powerlessness of the widow at different stages of bereavement. It may be that Shontz (1975) model of coping with crisis is reflected in the reported incidents of inaction with a sense of powerlessness or panic and action with a sense of personal power or competence. It is clear that the result of attempting to act is an important factor as well as the widow perceiving she had a choice to act.

Receiving Support and Lack of Support

As shown in Table 6, the largest number of critical incidents in both the helpful and harmful categories were found in Receiving Support and Lack of Support. As cited in
Chapter One and discussed in Chapter Two, the variable of social-network may be critical to the outcome of the grief process.

The women in this study cited more incidents of support from family and friends than from professionals. It was reported that the family and social group came together to offer emotional support and practical assistance immediately following the death of the spouse. The widow was perceived as the principal bereaved person in the family and was usually comforted by her children. Most helpful incidents with professionals occurred with counsellors who provided emotional support or practical assistance that family or friends were unable to provide. Some widows received support from other widows when they attended bereavement groups held by the North Shore Family Services. "I could express how I was feeling and people understood."

The widows who experienced lack of support recalled incidents where they sensed people's reluctance to be involved whether it was the neighbour "turning away" or a child's lack of communication. They expected or needed to be treated differently. Ordinary hurts seem to become extraordinary, such as a son leaving on a hiking trip after
the funeral or a priest who seemed too busy to see a widow for as long as she needed.

Both these categories reflected the widow's perception of support or lack of support. However, Heller (1979) noted that people who are poorly adjusted or in ill health may underestimate the amount of support available to them or may lack social competence, and therefore drive others away by engaging in socially inappropriate behaviour (Maddison and Walker, 1967). Heller (1979) states that deficits in social competence may "produce the poorer levels of adjustment reported for unsupported individuals, as well as accounting for the lower levels of support they receive (p. 375)."

The incidents in the Lack of Support category may have involved people who were well-meaning in their attempts to support the widow. The widow may perceive the attempt as inadequate and possibly hostile.

A friend said to me, 'you are strong. You'll get over it.' I felt weak and that she was saying she would not support me.

A friend insisted I attend her daughter's wedding though I found it difficult to cope or drive. She
did not hear me. She just kept putting the pressure on.

It is evident from these incidents that more attention should be paid to the possible deleterious effect of behaviours that are intended to be supportive. Maddison and Walker (1967) asked widows to indicate how people responded to them in the first three months of bereavement and to indicate which reactions were helpful. They report that a number of responses that are frequently made to widows (e.g. being told "about the need to get out among people again and make new friends" or being told that "I must control myself and pull myself together (p. 1066)") were regarded as unhelpful. Coates and Wortman (1980) have provided a theoretical analysis that illustrates how others well-intentioned statements (e.g. "Cheer up", "it's not as bad as it seems") can block meaningful communication about a crisis.

It may be that people can best support a widow by providing an opportunity for free expression of feelings and concerns.
My friend, Agnes, popped in without calling to see how I was doing and she didn't care if I was crying. It was important for me. I felt support.

I joined a grieving group. I could express how I was feeling and people understood.

Again, it is important to note that the widows in this research reported that they derived some personal value from the interview process. It may be the opportunity to express their experience of the death of their spouse and the grief process were helpful. Researchers investigating reactions to undesirable life events have reported that many respondents are quite eager to discuss their experiences and concerns and readily cooperate with an interviewer (Bulman and Wortman, 1977; Hamburg and Adams, 1967; Hinton, 1963; Schwab et al., 1975).

**Sharing the Grief and Feeling Alone**

In the Sharing the Grief category, the widows reported incidents where they were able to talk about their experience of grief with others. The category reflected the desire of the widow to express feelings and concerns and to receive feedback that those feelings are understood by
others and are appropriate for a woman whose husband has died. It, therefore, was more the desire to express feelings than the desire to obtain support.

A friend from England came to stay. I talked the whole time and I cried with her for days. She never stopped me. 'It was a real mountain I climbed.

It was not only the widow's ability to share her feelings that was helpful. It was important that the result of her sharing created a sense of being understood or the widow being able to understand another.

A colleague said to me, 'I don't know what to say or what to do.' I appreciated that she let me know where she was at and I thanked her.

I went to a party. A stranger came up and talked to me about her experience as a widow and asked about mine. It gave me courage.

In the Feeling Alone category, the major theme was loneliness. Loneliness was experienced when returning home.
to an empty house or when involved in a social event. It
did not lessen by other companionship, except temporarily.
Weiss (1974a) views the loneliness as a reaction to the
absence of the loved one rather than to bereavement itself.
Thus the loneliness is likely to continue over time until
the deficit state is resolved. Bahr and Harvey (1979)
studied widows following a mining disaster and found that
they manifested very high levels of personal loneliness but
not of perceived community underinvolvement. As cited
earlier, Lopata's study (1979) of Chicago widows shows that
even though many had been bereaved for an average of eleven
years, half said loneliness was their most serious problem,
and a third said it was their second most serious problem.

Another important aspect of this category was the
widow's realization that her husband had died and that
realization was not necessarily experienced as helpful or
empowering. It was experienced as a harsh reality that
required her to face the rest of her life alone without the
love and support of her husband. These incidents were
reported as debilitating and hindering any progress that the
widow felt she was achieving in her grief process. Again,
this may be indicative of a "retreat phase" in Shontz's
(1975) model of coping. A problem with this perspective is
determining what is the appropriate duration of particular phases such as "encounter" or "retreat", or the length of the cycles that occur? How does one determine whether a person is remaining in a particular phase, such as retreat, for too long?

Glick et al. (1974) reported that some of the widows in his study believed that:

sorrow can be treated as an entity that exists in a certain quantity, and that expressing sorrow uses it up or expels it. Therefore, it should be possible for the individual to 'get it all out', to fully externalize or discharge it (pp 58-59).

In this study widows' expression of feeling became helpful or harmful dependent on the type of feedback they received from others. A question that requires further exploration is whether widows who express their feeling but elicit negative responses from others are better off than those who withhold their feelings?

**Verbal Reassurance and Verbal Criticism**

These categories illustrated the importance of verbal responses that the widow received from others. In all of
the 33 reported incidents, the widow could easily remember the specific statement that the person made to her. It was as if these responses occurred at a time when the widow needed the support and specific feedback from another. When she received the feedback the incident was perceived as helpful. It was usually the person telling the widow she was capable of doing a particular act or that she was capable of coping with the experience of grief. Two of the incidents in the Verbal Reassurance category were incidents where the widow herself was engaged in "self talk", that is, talking to herself in an objective, reassuring manner.

When the widow received feedback from others in the Verbal Criticism category the feedback was not what the widow expected to receive. The feedback was seen as critical or hostile and the widow felt alienated, hurt or angry.

I asked a nephew to come and stay for awhile. My husband's brother and sister said I should learn to deal with my loneliness by being alone without help.

The incidents in these categories reflect not only a desire to obtain support, but also a desire to express
feelings and concerns and to receive feedback that those feelings are understood by others and appropriate under the circumstances. The incidents contained verbal remarks that either reassured the widow or criticized the widow for a behaviour or feeling. The widows stated that following the incidents in the Verbal Criticism category they felt impelled to behave in certain ways in terms of expression of grief, review of the lost relationship with their husband, and discussion of their husband that was contrary to their real feelings. It is important to note that Maddison and Walker (1967) in attempting to identify those factors associated with a decline in physical and/or mental health during the first year of bereavement found that widows who experienced such a deterioration reported a large number of unhelpful interactions in which expression of feelings was directly or indirectly blocked. Are the benefits of expression of feelings dependent on the type of feedback one receives from others? As asked earlier, are widows who express their feelings but receive negative feedback from others better off than those who withhold their feelings? Will beneficial feedback more likely occur with some people (i.e. other widows) than others?
A third sub-category represented in the Verbal Criticism category was the widow being told to find a man or that remarriage would resolve the grief experience.

When I went in the hospital my friend said, 'You need a man. If you had a man all this would be seen in perspective.' I was flabergasted.

The widows were distressed by premature attempt to suggest involvement with men. All of the incidents in this sub-category occurred in the first six months of grief. Maddison and Walker (1967) found that premature suggestions about remarriage are perceived as unhelpful and may interfere with the resolution of bereavement. It may be that incidents in this category would have been viewed as helpful if they had occurred later in the grief process.

Physical Comfort and Physical Distress

The incidents in these two categories involved physical comfort or discomfort. The widows stated a need for nurturance, body comforting and contact. It is not to be confused with sexuality and sexual needs. The widows stated that the need related to sexuality was limited or, in some cases, totally inhibited. In reviewing the literature
concerning "normal" sexual response patterns in widows following a partner's death, it seemed that these patterns are varied and individual. The physical comfort described in the Physical Comfort category was being touched or hugged by someone or the widow stroking or holding a pet. The result of the physical response was the widow feeling comfort and consolation. It seemed that the comforting was offered automatically in empathic response to the widow's distress.

I went to talk with a minister of a grieving group at a church and he put his hand on my arm. He was sensitive and I felt he cared.

It is important to note that 6 out 15 of the incidents in the Physical Comfort category were a widow stroking or holding a pet. The pet seemed to be the chief source and receptacle of nondemanding affection.

The dog was feeling all alone and anxious. He jumped on my lap and I pet him and groomed him. I could take care of him. He wants to be with me .... unconditional love.
In the Physical Distress category, the widows related incidents where they had physical reactions in situations.

I went to $1.49 day at Woodwards with my girlfriend. I got dizzy and a pain in my chest. I thought I was going to die."

I was sure I was having a heart attack. I had a great pain in my heart. I went to the doctor and the tests showed nothing wrong.

Maddison and Viola (1968) found that forty percent of the widows they studied had major difficulties with symptoms such as chest pains, palpitations and insomnia. In this research, fifty percent of the widows experienced physical distress and the incidents reported occurred during the early months of bereavement. The widows in this research reported attending at their general practitioner's office with greater frequency than they had prior to their husband's death. It is important to state that one widow in this study was fortunate to have gone to her general practitioner because she received an early diagnosis of cancer of the cervix and was able to successfully treat the cancer.
Two of the eleven Physical Distress incidents were related to a strong physical reaction to medication. These incidents were described as producing detrimental physical effects for the widows and an additional problem to deal with in a time of great distress. Both of these incidents occurred in the first three months of bereavement. Do drugs help improve the outcome of bereavement or can they be a further factor hampering resolution?

Significance of the Study

Theoretical Significance

The stage theory of grief assumes that grief is a process which varies among individuals. Specific stages have been developed in order to illustrate the process in which an individual moves while grieving. Stages do not have a clearly defineable beginning or end. The acceptance of the loss is the optimal end-product. Time is a dimension of this process which, dependent on the theorist, can be from a few weeks to several years. The number of stages and the importance of each is also variable across theorists.

It seems that the purpose of knowing which stage an individual is in has some value in gauging how close or far away the person is from final acceptance. In this research,
it demonstrated that in the beginning of grief widows experienced an inability to act, distress at suggestions of involvement with men and strong physical reactions to grief. Lindemann (1944), Parkes (1972) and Engel (1961) view grief as a process, but with an emphasis upon reactions. There may be denial or shock, somatic disturbances, guilt, anger, identification with the deceased, a recovery period and some sense of duration and intensity. The results of this research support the emphasis upon reactions. As shown, response to engaging in a task, receiving suggestions from others and physical reactions to stress seemed to be perceived by the widow as harmful in the first three months of grief. These findings support the notion that "process" contains stages which are characterized by specific symptoms.

All the stages of grief are ordered so that "peaceful acceptance" is likely to be viewed as an end-product of the grief process. In the Isolating Experience category, a sub-category labelled Realizing for the First Time the Spouse is Dead revealed 8 incidents where widows experienced the realization that their spouse was dead. These realizations were viewed as harmful followed by experiences of loneliness or helplessness. The results suggest that the
expectation of moving toward "acceptance" as a value of the stage model may not be a value to the griever. What becomes of a widow who does not achieve this implicit goal? Schneider (1980) postulated a model of grief that encompassed a growth potential in the resolution of grief. It contains six stages that include self-actualization and transpersonal awareness as a part of the grief process. One phase is the Awareness of Loss. The purpose of this phase of grieving is an intensive exploration of the extent of loss and the implications it presents such as loneliness, helplessness, exhaustion, etc. It may well be as the findings of this study suggest that a model of grief needs to incorporate the idea of grief as multidimensional.

Perceived support has been shown to be associated with emotional adjustment among the bereaved (Borstein et.al., 1973; Cary, 1974; Clayton, Halikas and Maurice, 1972; Jamison, Wellisch, and Pasnov, 1978; Weisman, 1976). The largest number of critical incidents in both the Helpful and Harmful categories were found in receiving support and lack of support. Approximately thirty-seven percent of helpful incidents were incidents where the widow perceived support from others and being able to give support. Approximately twenty-seven percent of harmful incidents were incidents
where the widow perceived a lack of support in her social or family network. The study did support the evidence which suggests that social support facilitates the coping process. It also suggested that when the widows received unexpected responses, they perceived it as lack of support. It may be that support is not a unitary concept and that it has many different components. Kahn (1979) and Walker, MacBride and Vachon (1977) found that a distinct kind of support involves expressing agreement with, or acknowledging of the appropriateness of a person's beliefs, interpretations, or feelings.

Clearly, one factor which seemed to be important in determining whether an incident was harmful in all of the harmful categories was the widow experiencing feedback as unexpected and/or negative. Additionally, many of the widows stated that they felt they had to behave differently after receiving harmful feedback. This finding supports Glick et al. (1974) research in which less than one-half of the sample of widows were able to express their grief freely with at least one other person. Sixty-seven percent reported that those who allowed or encouraged such conversations were helpful. In a survey conducted by Schoenberg, Carr, Peretz, Kutscher and Cherico (1975) eighty-eight
percent of those bereaved felt that "expression rather than repression of feelings, and crying, should be encouraged at least sometimes (p. 365)." Are the benefits of expressing feelings dependent on the type of feedback one receives from others? Perhaps work on successful grief resolution should contain an educative emphasis for those in the widowed person's close personal support network.

Loneliness was reported to be a source of emotional distress for the widows in this study. This finding confirms the current research which suggests that loneliness is a serious problem for widows (Bahr and Harvey, 1979; Clayton, 1975; Lopata, 1979; Weiss, 1979a).

Physical comfort defined as the physical responses from others or the physical responses the widows gave to pets was experienced as helpful. The responses were defined as both natural and automatic. Rapheal (1983) states that comforting is most necessary at the acute times of loss, or when the reality of the death and loss finally breaks through the initial shocked denial. The widows in this research vividly remembered the incidents in this category and stated that they were very powerful in helping them through the initial stage of grief.
Finally, the reports by the widows confirm many of the characteristic behavioural and emotional responses outlined by Shontz (1975) in his theory of reaction to crisis. While isolated critical incidents do not comprise the entire process of reaction and recovery, the panic, disorganization, helplessness, depression and shock reported by the widows confirms that the grieving experience for them constituted a crisis experience.

**Practical Significance**

Both the professional care giver and the lay person will be involved with bereaved people and will need to know what type of behaviour would facilitate a supportive and trusting relationship. What kinds of help would the widowed population prefer and what kinds of help would they find harmful. The results of this study suggest some criteria for helping the widow through bereavement.

The first three months of grief seemed to be an important variable in the widow's ability to cope with both the physical and psychological aspects of grief. It seemed that although people were well-meaning in their attempts to support the widow, their efforts could be perceived as harmful and could cause the widow to block her feelings. It
appears that widows who perceive their social networks as failing to encourage or support their talk of the dead husband could be helped by interventions that facilitated this. The caring person can give a clear indication that he is willing to talk about the death and sees it as important to the widow. Many of the widows in this study said that the use of the word "death" was reassuring to them. The use of cliches or euphemisms sent the message to the widow that the person they were communicating with was reluctant or unable to talk with them about their grief. The feedback the widows received was fundamental in their perception of whether the sharing of their feelings was helpful or harmful.

Practical support immediately following the death of a spouse was regarded as helpful as emotional support. Incidents of practical support ranged from food preparation, information on wills, purchasing cars to painting and general house repair. Many widows stated that they were unable to request help with practical or emotional problems for fear that they would alienate their perceived support system by being seen as "demanding" or that they simply did not know what to ask for. The friend who arrived with food or "just dropped in" to check on the widow was seen as supportive.
Emotional support came from the ability to cry, be held or to talk about their feelings with another without being told to act or feel differently. Again, the widows felt vulnerable and reacted strongly to unexpected feedback especially in the first three months of grief.

When the widow would attempt an action which she felt she could choose to do without pressure and which may have been an activity she engaged in prior to her husband's death, the result of the action would be empowering. When the widow felt she had to act to protect her children or to attempt to find meaning in her husband's death for the children she would experience a sense of helplessness. Assistance with the children by providing books on death and dying or by including the children in the decision making process around some aspects (regardless of importance) of the funeral was found helpful for some of the widows. It provided them with a sense of having the ability to cope with the grief for both themselves and their children. It was also discussed that many television programs which contained dying scenes or ambulances created a high level of stress in the first six months of grief. Music was also mentioned as a powerful agent in arousing feelings for the widow which the widow felt as overpowering or too painful.
Loneliness was consistently mentioned as a major problem for the widows. The Empty House sub-category of the Isolating Experience category contained the experience of arriving home to an empty house and feeling isolated, frightened and alone. It was considered that leaving lights and the radio playing was helpful in all nine incidents. All the widows who responded to this sub-category stated that the knowledge that these feelings could occur upon returning home did not help to ease the experience. It was cited by six of the widows that the experience of having a pet helped ease the loneliness and provided them with at least one source of unconditional love. The ability to stroke, hold and groom a pet was experienced as helpful.

Engaging in social activities as a single person was decidedly stressful for many of the widows. The widows stated that they found society was oriented to couples. These events were regarded as helpful when the widow was included in group discussions, asked how she was feeling and given time to respond. It was also stated as helpful when friends talked about the widow's husband and/or the activities he or they as a couple had engaged in prior to his death.
In the Information and Inspiration sub-category of the Sharing the Grief category the widows felt that talking to another widow was helpful because she understood and could offer information and support in a way that no one else could. Additionally many widows found a great deal of help by attending grieving groups. The groups provided a support network of people who were going through the same experience.

Professionals were viewed as helpful when they provided both practical and emotional support. The practical support ranged from helping the widow establish family rules to phoning for information regarding pension benefits. The most frequent comment regarding emotional support from the professional was a sense that the widow had permission to talk and that the professional was not only empathetic but would validate her feelings. It seems that it is important for the counsellor to communicate his/her recognition of the pain involved for the widow and to provide an opportunity for the widow to express the affects involved as well as to provide data on the process of grief to help normalize the process for the widow.

Two of the widows stated they had a strong reaction to the medication that was given to them. The remaining
thirteen widows stated that they felt it was important to go through the grief with little or no medication. Six of the widows used a mild tranquilizer to sleep at night. The use of these mild tranquilizers ceased after six months for five of the six widows. All of the widows spoke of medication as a deterrent for them in their ability to express grief. In fact, most of the widows felt that the suggestion of medication use was, in fact, telling them that they should not be feeling pain or depression because their spouse had died.

**Recommendations for Future Research**

The stage theorists view grief as a process. Research claims that individuals follow a predictable, orderly path of emotional response following a life crisis. The best known pattern is described by Kubler-Ross (1969): denial, anger, bargaining, depression and acceptance. The number of stages and the importance of each is variable across stage theorists. It is suggested that individuals will resolve the grief crisis, and thus move on to the next stage of their lives. What happens to the widow who does not achieve this acceptance or chooses not to achieve this acceptance? Most studies find significant levels of distress or disorganization after a year, and those that have continued
to follow their sample for a longer period of time have not typically found substantial improvement (Glick et al., 1974; Morris et al., 1977; Parkes, 1975; Vachon, 1979). This research found that for many widows acceptance or recovery is not apparent despite the passage of time. These notions of recovery and acceptance need to be reconsidered. An important question that requires attention is if resolution of grief is not experienced over a long period of time can a stage model account for slow, unsteady progress and be useful in identifying those individuals who are likely to have difficulty in resolving their grief successfully.

There is little evidence to indicate that people go through stages of emotional response following the death of a spouse. What variables may mediate individual coping response and help explain the variety of responses to the death of a spouse? Many investigators have concluded that social support facilitates the coping process. Does expecting and receiving support from family and friends influence people's emotional reactions to a crisis, or help them cope more effectively? Although perceived support has been associated with emotional adjustment among the bereaved can a causal inference be warranted. As stated earlier, Heller (1979) noted that people who are poorly adjusted or
in ill health may underestimate the amount of support available to them. Is it possible that coping and social support are causally related, but that one's coping or prognosis determines the amount of support available? A causal relationship between support and effective long term adjustment could be established by intervention studies in which participants are assigned to treatments which supplement the support available to them.

Considerable value exists in examining the role of physical touch in facilitating the grieving process. Comfort seemed most necessary to the widows at the time of their spouses death or when the reality of the death and loss began to break through the initial shocked denial. Those caring for the bereaved may feel hesitant, not able to touch, because they fear it would break some personal barrier. Those who have been professionally trained may find it difficult to offer comfort because it represents the human side of their response, something they may have learned to detach or disassociate in some therapeutic frameworks. In this study the widows stated that the simplest touch was helpful in dealing with the grief experience. Is physical touch as a response to grief helpful when it is an automatic response? Should caregivers
who feel hesitant, not able to touch, attempt to touch the bereaved or would it be better to offer comfort with a quiet and continuing presence or words of reassurance? Is it helpful for people who are grieving to have pets that they can touch and groom?

The reactions of the widows to the feedback from others suggests that an important area of research would be to examine the possible deleterious affect of behaviours that are intended to be supportive. Walker et al. (1967) discovered that a number of responses that are frequently made to widows were regarded as unhelpful. There was evidence in this research that sharing one's feelings may have facilitated coping. It seems important for future research to identify any limiting conditions on the value of discussing one's feelings. Are the benefits of sharing feelings dependent on the type of feedback one receives from others? Are widows who express their feelings but elicit negative responses from others better off than those who withhold their feelings? Both immediate and long term effects of open expression of feelings need to be considered in future research.
The grief experience has been described as a series of phases, representing some of the processes of adaptation to loss (Kubler-Ross, 1969). As stated earlier, the phases are not clear cut or fixed and that the widow may pass backward and forward among them. The widows in this study stated that in the first three months of grief their whole world seemed disorganized. It was all that they could do to continue the basic tasks of survival. They relied on others to initiate actions to help them form a coherent framework or pattern of daily activity. The most powerful influence for the majority of these women were the family and social network.

As discussed earlier, response to engaging in a task, receiving suggestions from others and physical reactions to stress seemed to be perceived by the widow as harmful in the first three months of grief. If loss is resolved by the individual in his social context through the inner-psychological processes of mourning and their facilitation through interaction with others then the family and social network could assist the widow in forming more accurate perceptions of what behaviours are, in fact, normative. As demonstrated in the Verbal Criticism category, when the widow viewed her behaviour as inappropriate she would not
seek support during times of distress. She would behave in certain ways which were contrary to her real feelings. It seems important for family, friends and health professionals to legitimate the feelings and reactions that commonly occur among the widowed. Can educating the support network of the widow in the reactions of widows in the first three months of grief facilitate resolution of grief for the widow? Will a knowledge of the difference in reactions of the widow to the death of a spouse in the first three months of grief as compared to later stages of grief provide a framework for specific preventative intervention with the bereaved who are at high risk of malresolution?

The value of peer support groups (Hiltz, 1975; Silverman, 1970; and Vachon, 1980) may stem in part from their ability to help realign the norms of the widows. Some widows in this study cited attendance at a peer support group at North Shore Family services as helpful and supportive. Should a program of preventative intervention such as a peer support group be available immediately or soon after the death of the spouse? Given the widow's difficulty in initiating action and requesting help, would the widow be able to avail herself to such a group in the first three months of grief?
It remains to be determined whether preparing the widow for the variety of responses she may encounter and the length of time they may persist will be beneficial. Further research needs to be encouraged to examine such questions as, will expectations of possible long-term difficulties result in added distress for those who are able to adjust more quickly?

Considerable value exists for incorporating mediating variables such as perceived social support and the opportunity for free expression of feelings in future research as it may offer more precise predictions about the conditions under which particular emotional reactions will occur. Empirical research needs to consider variability not only in the initial reaction to the death of a spouse and in coping strategies employed, but also in the time necessary for successful resolution of the grief experience. It is important to stress that although many theorists imply that people will recover from the grief experience and resume their lives, data suggest that the difficulties following a crisis may be experienced indefinitely. What are the implications of this phenomena on the care and treatment received by widows?
Limitations of the Study

A limitation of this study is the unrepresentativeness of the sample. The subjects were widows who sought the help of the North Shore Family Services Bereavement Support Group. Therefore, the women were action-orientated and sought the help of a therapy support group. Their involvement in the group therapy may have elicited recall of certain types of memories of the grief experience which depended on the experience of others in their group. Generalizability of the results of this study are limited, therefore, until replication of this research with other widows, preferably those not in therapy groups, clarifies the influence of these variables.

No statistical hypotheses were formed and tested. The results of this study are not decisive. The purpose of this study was to probe and collect information from the widows to begin to establish an effective criteria for helping the widowed through bereavement. Subsequent research with quantitative methodology is necessary to produce conclusive results.
Summary

The results of this research show that the experience of grief can be affected by: the result of attempting an action, social network support, expression of feeling, verbal feedback from others and physical comfort.

Specifically the results of this study suggest some criteria for helping the widow through bereavement. The first three months of grief seemed to be an important variable in the widow's ability to engage in a task, receive suggestions from others, and cope with the physical and psychological aspects of grief. Practical support was regarded as helpful as emotional support during this three month period.

The widows stated that they were very dependent on the support of others and were often more influenced by the responses of others to them than they would have been before the death of their spouse.

The incidents in this study reflect not only a desire to obtain support, but also a desire to express feelings and concerns and to receive feedback that those feelings are
understood by others and appropriate under the circumstances.

Many of the widows were distressed by premature attempts to involve them socially during the first few months of grief, but as time progressed the reintegration into the social field became increasingly important.

The widows stated a need for nurturance, body comforting and contact. The physical comfort described was being touched or hugged by someone or the widow stroking or holding a pet. The responses were defined as natural, automatic and powerful in helping them through the initial stage of grief.

Considerable support for studies from different sources about the factors that are relevant to the outcome of conjugal bereavement is suggested by this research. Results reveal the importance and influence of social network variables and attempts to increase the specificity of the term by identifying its components. Further research is recommended, highlighting other components of social support.
REFERENCES


McDermott, N., & Cobb, S. (1939). A psychiatric survey of 50 cases of bronchial asthma. Psychosomatic Medicine, 1, 201-204.


Dear ____________: 

My name is Jessica L. Easton and I am the group leader of Growing but Grieving for North Shore Family Services. As a group leader it has become increasingly clear that many people are unsure about how to assist a friend or loved one in bereavement. I have proposed to conduct a study as a Master of Art thesis in Counselling Psychology in the Department of Education at the University of British Columbia. It is a study which will help begin to establish some criteria for assisting you and others in the grief process.

The interview will take about an hour. I will ask you what you have experienced as the most helpful or the most harmful during your bereavement. You have the right to refuse to participate or withdraw at any time without jeopardizing any relationship you may have with North Shore Family Services.

I will be contacting you by phone in the next few weeks to see if you would be interested in helping me by participating in this study.

Sincerely,

Jessica L. Easton
APPENDIX B

I, ____________________________, consent to be a part of the study, A Descriptive Analysis of Helpful Behavior for Assisting the Widowed in Bereavement. I am aware that Jessica L. Easton is the investigator of this project which will be submitted as a Masters of Art thesis in Counselling Psychology in the Department of Education at the University of British Columbia.

The purpose of this study is to collect information about the helpful and harmful incidents associated with bereavement from bereaved people. The participant will be asked the question, "What has been helpful or harmful for you during your experience of grief?" The investigator will tape the response to the question and the process will take approximately one hour.

The identity of the participant will be kept confidential and this will be accomplished by the researcher retaining all incidents in written form, stripped of any identifying data. Tapes of the interviews will be erased. Any inquiry concerning the procedures will be welcome by the
investigator to insure the participant understands the aim and process of this study. The participant has the right to refuse to participate or withdraw at any time he or she chooses without jeopardizing any relationship he or she has with North Shore Family Services.

I, ____________________________, consent to participate and acknowledge a receipt of a copy of this consent form.

I, ____________________________, do not consent to participate and acknowledge a receipt of a copy of this consent form.
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

PARTICIPANT NUMBER: _____________

General Information:

1. What is your age?
2. What is your occupation?
3. What is your religion?
4. Would you describe your degree of religious involvement as slight, moderate or involved?
5. How long were you married?
6. Was this your first marriage?
7. Would you describe your husband’s death as sudden or was the death expected?
8. Where did your husband die? In your home, hospital or elsewhere? If answer is "elsewhere" please be specific as to the location of his death.
9. Have you received any psychiatric help since bereavement?
10. What was the date of your husband's death?
11. Do you have children? If the answer is yes, please state the number of children you have and their ages?
12. What is your ethnic origin?
13. How would you describe your present financial situation since the death of your husband? Is it difficult, moderate or easy?
APPENDIX D

Procedures:

"Before we begin, I will explain to you the procedures that I am required to follow."

"I am taping the interview so that I can listen to the interview again and write down the main ideas from it. No one else will listen to the tape and I will erase it after completion of this study."

"You are not required to participate in this research and your involvement will not affect your present or future relationship with North Shore Family Services. If you decide, at any time, that you do not wish to be interviewed, let me know and I will stop the interview."

"Do you have any questions you would like to ask before we begin?"

Introduction:

"The study I am doing is to find out what helped or what didn't help people during their experience of grief. I'd like to know in specific detail what you learned or discovered that helped you during grief as well as the
specific things that you did or others did that you
experienced as harmful, or that made it difficult for you.

Negative Incidents:

"We'll start with incidents that happened that you felt
were harmful or not helpful. Think back to a specific time
when you found yourself in a difficult situation which was
not helpful to you while you were grieving. What did you do
or what happened to make you feel this way? Take the time
to think of a specific incident in as much detail as
possible. When you have the incident in mind clearly, let
me know..."

Follow-Up Questions:

"What were the general circumstances leading up to this
incident?"

"What actually happened when this incident took place."

"Why was this behavior so harmful?"

"How important was this incident to you at the time?"

"Was this so harmful or unhelpful that it changed your
behaviour for a day, a week, etc.?"

"When did this incident occur? Was it in the beginning
of your grief or later? Can you be specific about the time
it occurred?"
"Do you have anything else you'd like to add?"
"Think of another time ...." etc.

Positive Incidents:

"Now I'd like you to think of a specific time when you found yourself in a situation which was helpful to you while you were grieving. Take the time to think of a specific incident in as much detail as possible. What did you do or what happened to make you feel this way? Let me know when you have a specific incident in mind....?"

Follow-Up Questions:

The same questions used with the negative incidents were asked here.