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THE STATE OF THE BEREAVED EGO--AN
EXAMINATION OF CONJUGAL
BEREAVEMENT IN LIGHT OF BIBRING'S
HYPOTHESIZED MECHANISM OF
DEPRESSION.

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THE STATE OF THE BEREAVED EGO--AN EXAMINATION
OF CONJUGAL BEREAVEMENT IN LIGHT OF BIBRING'S
HYPOTHESIZED MECHANISM OF DEPRESSION



by

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A Dissertation
Submitted to the Faculty of Graduate Studies
through the Department of Psychology
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Requirements for the Degree
of Doctor of Philosophy at the
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1980

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DEDICATION

To Frank Sugrue, my father, from whom I have learned the meaning
of words such as honesty, integrity, and self-confidence;

To Diane Sugrue, my mother, from whom I have learned the meaning of
words such as sensitivity, understanding, and compassion;

To Bernadette Sugrue, my wife, from whom I have learned the meaning
of words such as patience, sacrifice, and support. Because
of my love for her and for our child she now carries, all of
these efforts seem worthwhile.

ABSTRACT

The author proposed that Edward Bibring's egoanalytical hypotheses on the mechanism of depression may serve as a useful model for understanding the dynamics of bereavement. Bibring's position suggests that both bereaved and depressed persons experience a fall in self-esteem in response to the experience of helplessness in achieving narcissistic aspirations. It was predicted that persons who gave evidence of dependency concerns, negative attitudes towards a lost love-object, or an unresolved oedipal conflict would be especially prone to experience a fall in self-esteem.

In order to test these hypotheses, the author compared three groups: 30 women whose husbands had died recently, 30 women who were clinically depressed, and 30 women, not bereaved and not depressed, who constituted a comparison group. Women from the bereaved group and the comparison group, matched on age, were recruited from the patient population of a large metropolitan hospital. The depressed group was recruited from the psychiatric population of the same hospital. Participants from all three groups were interviewed and were administered the Janis-Field Feelings of Inadequacy Scale, Rosenberg's Self-Esteem Scale, and a projective, story-telling test. Scales to measure self-esteem, dependency, negative attitudes towards males, and unresolved oedipal attachments were developed for the projective stories.

The author compared the three groups on measures of self-esteem. In addition, he studied the bereaved group more intensively in order to discover the relationship between self-esteem and three other variables: dependency, negative attitudes towards males, and unresolved oedipal attachments. Findings from the various psychological tests confirmed that bereaved women experience less self-esteem than do women from the comparison group. Bereaved women who evinced negative attitudes towards males had lower self-esteem than did bereaved women who did not evince negative attitudes. There were no significant relationships between self-esteem measures and measures of dependency and of oedipal attachments. One-half of the bereaved sample had a sufficient number of psychophysiological symptoms to be considered clinically depressed. Black bereaved women had more depressive symptoms than did white bereaved women. Women living alone and women living with children had more depressive symptoms than women living with other adults.

It is concluded that as Bibring proposed bereaved individuals do suffer a fall in self-esteem. Also, as expected, there was a relationship between negative attitudes towards a lost love-object and fallen self-esteem. No support was found, however, for two other hypotheses that proposed a relationship between dependency concerns or unresolved oedipal conflicts and fallen self-esteem.

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Finally, I would like to express my gratitude to the 30 bereaved
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I have learned more from these women than what could ever be reflected
by the statistics and tables contained in this dissertation. From
these women I have learned about the courage and strength of the
human spirit to survive and overcome incredible pain and tragedy.

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CHAPTER I

INTRODUCTION

In a world where mortality is the rule which allows no exception, the death of a loved one is nevertheless one of the most traumatic human experiences. One never becomes proficient at giving up a loved one to death; at best one can with pain acknowledge the harsh reality, with protest accept it, and with courage continue the course of living. Few of us escape bereavement. Yet many of those who lose a loved one through death never successfully complete the task of mourning. Some of these bereaved people do not acknowledge death; others never accept; and others encounter dramatic changes in their social, physical, and psychological status, as a result of the loss.

Researchers have attempted to classify the symptoms of bereavement, to distinguish normal and abnormal bereavement, to specify which factors precipitate abnormal bereavement, to identify high risk factors for mortality and morbidity following the death of a loved one; and to establish methods for responding effectively to both normal and abnormal grief. And yet, after all this research, and even though bereavement occurs with alarming frequency, we know little about the bereaved ego. The purpose of the present study is to apply Edward Bibring's theory of depression -- a theory utilizing the concepts of psychoanalytic ego-psychology -- to the problem of understanding the bereavement process. Using this theory, I have made

certain predictions and have tested them empirically.

Theoretical Background

Although our knowledge of the bereaved ego based on empirical research is limited, we do not lack for psychoanalytic theories of bereavement. Most of these discussions on bereavement have taken as their point of departure how grief is similar to or different from clinical depression. The linking of these two states of the ego comes about because the depressed ego and the bereaved ego not only share a common mood (depressed), but also often have a common precipitating event (loss of a significant object). It is therefore difficult to discuss the state of the bereaved ego without also considering the state of the clinically depressed ego.

Freud--"Mourning and Melancholia" (1917)

In "Mourning and Melancholia" (1917/1956) Freud attempted to understand the dynamics of melancholia by contrasting this psychological condition and normal mourning. Although he emphasized the difference between death-related grief and psychotic depression, many commentators have argued that Freud's theory could be expanded to explain any significant loss on the one hand, and any depressive syndrome on the other (e.g., Sachar, MacKenzie, Binstock, & Mack, 1968).

Freud began this paper by noting the numerous similarities and the one significant difference between the two affective states. He observed that the melancholic experiences a painful dejection, loses an interest in the outside world, forfeits a capacity to love, is

inhibited in all activities, and displays a self-reproach often marked by delusional expectations of punishment. The person who mourns has an identical presentation with the notable exception that there is no fall in self-esteem.

Freud was, however, somewhat misleading when he emphasized the similarities between the two conditions. A number of commentators, including Siggins (1966), have concluded that Freud was suggesting that a person who mourns shares with the melancholic an inability to love. A close reading of the text reveals, however, that one who mourns retains the capacity to love but loses the capacity "to adopt any new object of love which would mean a replacing of the one mourned" (Freud, 1917/1956, p. 153).

The mourning process is initiated by a loss, usually due to death. When suddenly the loved object is taken away, a severe strain on the individual's capacity for testing of reality occurs. Libido (the individual's strong loving attachment) must be withdrawn from the object. Freud indicated, however, that the psyche never gives up a libido-position easily. The resulting intrapsychic struggle is fierce. The ego clings to the object through a mechanism similar to the hallucination of wish fulfillment experienced by an infant when the source of gratification is conspicuously absent. These theorized dynamics are consistent with the initial denial described by many observers of the bereaved (Parkes, 1970; White & Gathman, 1973). They are also consistent with empirical observations that visual and auditory hallucinations in bereavement are common enough to be accepted as a normal response to loss (Vachon, 1976b).

The weight of reality inevitably crushes resistance, but not without a compromise. The love-object, the lost person, is kept alive in the mind so that the ego may slowly relinquish the attachment, one small bit at a time. With great pain, the bereaved person recalls countless memories which bound the libido to the object, each memory with its cathetic energy being dissipated through a process of hypercathexis. This process requires time and significant cathetic energy; this diversion of energy, according to Freud, explains the inhibition characteristic of bereavement. Freud was, however, somewhat at a loss in trying to explain in terms of psychodynamic theory why there is such intense pain involved, even though the pain of grief is universally accepted as being normal. Nevertheless, when the process is completed, the ego is again free and uninhibited.

This relinquishment of the object is not as absolute as Freud's "Mourning and Melancholia" would lead the reader to believe. In a later writing, a letter to Binswanger, Freud (1929/1960, Letter 239) stated:

Although we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And actually, this is how it should be, it is the only way of perpetuating that love which we do not want to relinquish.

Melancholia, according to Freud, is also precipitated by loss, perhaps even a loss by death. However, in melancholia, unlike in bereavement, the real loss is recognized only at the unconscious level. Even when the death of a loved one is the precipitant of the depression, the melancholic's ego is aware of who was lost, but not of what was

lost. For example, the love-object may have satisfied strong dependency needs. With its passing, not only is the loved one absent, but also a fundamental sense of security. It is the latter loss that escapes the conscious awareness of the melancholic's ego.

The melancholic's ineffective psychological efforts to relinquish the lost object consume significant cathetic energy, just as mourning required a substantial expenditure of energy, which results in an overall inhibition of the ego. With depression, as is not true for mourning, self-esteem drops precipitously. The depressed person presents himself as a person of little value, asserting also that he was worthless even before the loss had occurred. This delusional attack against the ego, which is primarily a moral assault, is often accompanied by sleeplessness, anorexia, and suicidal ideation. The depressed ego is an impoverished one. As Freud (1917/1956) expressed it in his often quoted statement: "In grief, the world becomes poor and empty; in melancholia, it is the ego itself" (p. 155).

Freud noted that the self-accusations of the depressed person are rarely accompanied by shame. Rather than attempting to hide his self-indictment, the person makes it open for the scrutiny of all. Yet at the same time, the melancholic is easily offended by even the slightest of insults or oversights. These observations might appear to be contradictory. One might expect that a person who is burdened with an extraordinary sense of guilt would shamefully attempt to hide it. One might also expect that a person who scorned himself to the extent of considering self-destruction would either be impervious to outside criticism, or

welcome it as an ally to his efforts at self-flagellation. But this is not so. Furthermore, Freud noted that a careful analysis of the self-accusations reveals that they do not apply to the depressed person, but to the lost love-object. On the basis of this point, Freud proposed his now famous position on the role of identification as an integral dynamic of the psychotic depressive syndrome.

Postulating the course of events, Freud suggested that when the loss occurs, perhaps a loss in the form of a disappointment by a love object, the libido is detached. The object cathexis is weak (whereas, for the grieving person it was strong), and the detachment is immediate and complete. Rather than being attached to some new object, the detached libido is withdrawn into the ego. This withdrawal of the libido serves to form an identification with the lost object. The conflict between the object and the ego is internalized and is transformed into a sadomasochistic relationship between what Freud called the "criticizing faculty of the ego" (Freud, 1917/1956, p. 159; later referred to as the superego) and the ego as it had been transformed by the identification.

Two questions may be raised at this point. First, why is the object-libidinal relationship so readily severed when Freud maintained that the ego gives up a libidinal relationship most reluctantly? Secondly, what purpose is served by this identification process?

In answering these questions, Freud reasoned that while there must be a strong fixation to the love-object, the object cathexis must have little power of resistance. In order to clarify this

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paradox, Freud referred to the writings of Rank and concluded that the object choice of the melancholic is largely determined by narcissistic considerations. Therefore, when obstacles in the resulting relationship arise, the melancholic regresses to an early narcissism. Just as the incorporative process of the oral stage tends to preserve object relations, so a narcissistic identification becomes important to the melancholic because it preserves the love relationship.

As a result of the identification, the relationship between the melancholic and the love-object undergoes a transition. Ambivalence was most likely characteristic of the earlier relationship with the narcissistic object choice. The suffered loss, hurt, or wound will therefore heighten the hate dimension of this ambivalence and provide this dimension with a reality base. The ego, altered by the identification, becomes the target of the heightened ambivalence. The originally erotic cathexis with the object regresses to a sadism characteristic of the oral stage of development. The melancholic's ego therefore directs at itself an intensity of sadistic rage sufficient to overcome even the most basic of ego instincts, the instinct of self-preservation.

Freud's position can be summarized as follows:

--Although bereavement and depression are both associated with the loss of a significant love-object, they represent two different psychodynamic processes.

--The loss of bereavement is consciously perceived while the loss of depression is more often experienced only at the unconscious level.

--Bereavement is a response to the dissolution of an object-libidinal relationship. Depression, on the other hand, follows from the dissolution of a narcissistic relationship and a subsequent regression to primary narcissism.

--In bereavement, libidinal ties are slowly dissolved through a process of hypercathexis. The detached libido is then free to form new relationships. In depression, the libido is detached and taken up into the ego to form an identification with the lost object.

--Whereas ambivalence is not a significant dynamic in the bereavement process, in depression, the heightened hate of ambivalence and regressive sadistic impulses are directed at the ego which, through introjection, has come to represent the lost object. As a result, there is a dramatic fall in the depressed person's self-esteem.

There are a number of points in Freud's theoretical formulation which have been judged to be inadequate by other theorists and have served as points of departure in their attempts to explain bereavement and depression. The most notable disputed issues include the notion of predisposing experiences in psycho-sexual development, ambivalence, identification, and self-esteem. These four issues will provide a convenient framework not only for evaluating Freud's theory, but also for presenting other psychoanalytic theories of bereavement and its relationship to depression.

Predisposing Experiences

Bowlby (1960b) observed that even though the influence of early trauma upon later adjustment had a central position in Freud's theoretical framework, Freud often failed to apply this proposition to

many of his psychodynamic formulations. "Mourning and Melancholia" poses two important questions regarding the possible influence of early predisposing experiences upon grief and depression. The first question is: what events in a person's psychosexual development might predispose him to become depressed rather than bereaved? The second is: can children grieve, or are there early experiential prerequisites necessary for the development of the capacity to grieve?

Although Freud did not address these issues directly, his references to narcissistic regression and incorporative processes strongly implied a relationship between melancholia and oral fixation. Also, although Freud never stated it explicitly, his theory is consistent with the idea that achievement of psychosexual maturity is a prerequisite for mourning. Relationships in earlier stages of development are characterized by narcissism and ambivalence. It would therefore be expected that loss during these stages would be dealt with through mechanisms of denial, guilt, anger, or substitution. Only an object-libidinal relationship characteristic of adolescent and post-adolescent development, a relationship marked by a wholesome sense of self, could undergo the type of separation process suggested by Freud.

Psychoanalysts have by and large agreed that the child's first experience with loss, which occurs during the oral stage, influences the outcome of similar experiences in later life (Abraham, 1911/1953). This initial experience cannot occur before the second half of the first year of life because a person can only experience loss when sufficient individuation has occurred to result in the establishment

of ego boundaries. The threat to the infantile ego of losing the mother and the actual experience of her absence are believed by many writers to be prototypes for future experiences of loss (Bowlby, 1960a; Klein, 1940).

Fleming (1972) viewed object deprivation in early childhood, not necessarily limited to the oral phase, to be a critical factor influencing the outcome of adult mourning. Early object deprivation may lead to a demanding, inflexible pattern of establishing relationships which are substitutes for the lost object. As an adult, such a person will utilize childhood defenses when faced with any significant loss.

Based on the above statements, it would be expected that depressed adults, as a group, should have a higher percentage of parental loss in early childhood than the general population. Research findings have been contradictory mainly because of methodological discrepancies. Brown, Harris, and Copeland (1977) reported a relationship between past loss and the type and severity of depression. Wilson, Alltop, and Buffaloe (1967), utilizing MMPI profiles of depressed patients, found that depressed patients who had experienced the death of a parent in early childhood had higher elevations on the psychotic tetrad than depressed patients without a history of parental loss. We can conclude from these studies that while the relationship between parental loss in childhood and adult depression is still not clear, there is strong evidence that parental loss in childhood increases the severity of depression if depression does occur.

The second question proposed--can children grieve--has received frequent attention in psychoanalytic literature. A number of writers have maintained that children cannot grieve. Wolfenstein (1966), for example, stated that only in adolescence can one begin to mourn. She described adolescence itself as a time of mourning with the lost object being the parent-child relationship. Rochlin (1959) took the position that a child is capable neither of depression nor of mourning. Rather, when confronted with loss, the child withdraws and undergoes a regression marked by a distorted identification process. Both Wolfenstein and Rochlin based their position, at least in part, on the premise that grief is not possible in children because of the inadequate formation of their object-relationships. While Deutsch (1937) agreed with their conclusion, she dismissed their premise. Rather, she argued, the child's ego has not developed the stamina to bear the strain of loss. Some mechanism of narcissistic self-protection is therefore utilized, leading to a regression characterized by the presence of anxiety or the omission of affect.

Other writers, however, disagree with these authors, suggesting that children may indeed experience grief. Furman (1964) believed that a child is capable of understanding the notion of death at the age of 2 or 3, and that by the age of 3 1/2 or 4, the child is capable of the painful decathexis required for grieving. This latter point is reminiscent of Loewald's hypothesis (1962) that the resolution of the oedipal conflict is a prototype for mourning. Furman concluded that the child is indeed capable of experiencing grief, and that environmental factors such as adult support at the

time of loss will largely determine whether the child will experience grief or will regress to a more primitive pattern of coping. Both Bowlby (1960a, 1961) and Klein (1940) proposed that the experience of loss or separation in early infancy does not differ substantially from the experience of adult grief. They maintained, however, that if the early loss was traumatic, the child could be predisposed to future psychopathology.

I will now summarize Bowlby's (1961) views on the mourning process. Research on ethnology, especially investigations into imprinting, strongly influenced Bowlby's thought. He noted that an animal's first response to loss is one of protest; there is a great deal of crying, wailing, and aggressive behavior. On that rare occasion when the lost object is not recovered, the animal becomes withdrawn and restless, its appetite decreases, and it rejects any new object which might serve as a possible replacement. Eventually, however, a detachment is effected and the animal again resumes active interaction with its environment. If the lost object returns during this latter stage, the animal usually treats it with indifference.

On the basis of these observations, Bowlby concluded that the process of experiencing a loss is an instinctual one. He therefore proposed three stages of mourning shared by infant and adult, animal and human alike.

Pining. Separation followed by reunion is the rule of nature; unretrievable loss is the rare exception. The organism's instinctual cry when the object is gone represents an effort to retrieve that which is missing. For example, the cry of the infant child normally brings a responding mother. Bowlby suggested that even the tears of a

grieving adult find their origin in the same instinctual source.

The organism reacts with anger to separation even when the object returns. Bowlby noted that this reaction serves an adaptive function because it lessens the possibility of a future reoccurrence of abandonment. He cited the example of a child sulking after a stay in the hospital. Her anger at the parents may be quite effective in generating guilt and assuring their conscious commitment to stay close to the child. In mourning, this anger is not only directed toward the deceased, but also towards anyone convenient to blame, including the mourner himself.

As Freud had suggested, eventually reality gains the day: the loss is painfully acknowledged and efforts to recover the object subside. Pathological mourning results, however, if these attempts at retrieval are "successful" (i.e., at the fantasy level).

Despair. Once the weight of reality settles over the bereaved, behavior ceases to focus on hopes for reunion. The organism becomes disorganized because it lacks the object around which it had been previously organized. Signs of this stage are withdrawal, restlessness, despondency, and despair. This stage is painful yet important, for it allows the now obsolete attachment to be dissolved, a step necessary for successful re-entry into external involvements.

Bowlby pointed out that because of the pain associated with this disorganization, many individuals will establish a regressive organization based on various defense mechanisms. The outcome of such a response will be pathology.

Bowlby viewed clinical depression as a complication of this

stage of mourning. Any loss will initiate the responses of pining and despair. Some individuals, however, are unable to eventually detach themselves from the object, and the state of despair and disorganization intensifies. Depression becomes an all-absorbing defense against the pain of experiencing loss. Residual anger associated with pining accounts for the characteristic hostility which is directed toward self and the lost object. Additional defensive maneuvers such as faulty identification contribute to the final complex of depressive symptoms.

Detachment. Finally, if the first two stages are completed successfully, the person begins to reorganize around some new object. Bowlby referred to the estrangement which occurs when prisoners of war are reunited with their families after long imprisonment as a dramatic demonstration of how powerful the detachment of mourning can be.

Ambivalence

Freud's position on the role of ambivalence in the mourning process remains a mystery. He presented mourning to be a process free of ambivalence. On the other hand, he identified ambivalence to be one of the key dynamics in melancholia. Even when the relationship is not based on a narcissistic object-choice, Freud maintained that the presence of ambivalence causes the grief to be pathological. He illustrated this latter point by describing the impact ambivalence has upon the mourning process of an obsessive neurotic. With the death of the loved one, the person experiences

ongoing self-reproach because of the negative feelings he has long harbored. At the unconscious level, his superego concludes that his hate was responsible for the loved one's death. Guilty ruminations come forward as a blatant symptom of this particular grief reaction.

Freud's position on grief stands in apparent contradiction to his writings elsewhere. For example, in "The Dynamics of the Transference" (1912/1958), "Thoughts for the Times on War and Death" (1915/1961), and "Totem and Taboo" (1912-13/1957), Freud acknowledged that even mature love relationships are not free of ambivalence. How then does one grieve free of ambivalence?

Edith Jacobson (1957) is one of the few psychoanalytic writers to hold a position similar to Freud's on this point. She maintained that grief, a special form of sadness, differed from depression because it "does not involve an aggressive conflict, either with external reality or endopsychically" (p. 87). She reasoned:

An increase of aggression in the cathexis of the self and the world, that would lead to either angry or depressed mood is prevented by the previous memories of a happy past and a previously rich self. (p. 89)

Jacobson thus was proposing that even though a person may possess ambivalent feelings toward the love-object, these feelings are overshadowed by genuine sadness when the relationship had been predominantly satisfying and wholesome.

Overall, the majority of psychoanalytic writers acknowledge the presence of ambivalent feelings in normal grief reactions. Research findings (Lindemann, 1944; Parkes, 1970) and clinical observations (DeVaul & Zisook, 1976) have consistently demonstrated the common if not universal presence of anger in bereavement.

Identification

A review of psychoanalytic literature shows an evolution from Freud's initial view that identification was unique to melancholia, to the view he later held (with Abraham, 1924/1953, and others) that identification is common to both mourning and melancholia, to the more recent position of writers such as Klein, Loewald, and Smith, that the qualitative aspects of the identification process actually serve as the major source of distinction between depression and grief.

Freud originally believed that identification was not a dynamic component of the normal grief process (1917/1957). On the contrary, according to Freud, identification was one of the factors which distinguished melancholia from mourning. It was only later, in the "Ego and the Id" (1923/1964), that Freud acknowledged "it may be that this identification is the sole condition under which the id can give up its objects" (p. 36).

The evolution in Freud's thinking to this latter position is not surprising. Many writers at that time believed that the oral phase was the crucial prototype for dealing with loss. Therefore, just as the primordial loss experience, represented by the removal of the mother's breast, was universally counteracted by the psychological incorporation of the mother, so also would the loss of a loved one in adult life be counteracted by a similar incorporative process. It did not, however, occur to either Freud or to most other early theorists that the identification process in mourning might be different from the narcissistic identification characteristic of melancholia (Jacobson, 1967).

Melanie Klein was one of the first writers to make a distinction between the identification of one who mourns and the identification of one who is clinically depressed. Her thinking, as pointed out by Bowlby (1961), was highly influenced by the work of Abraham. It was the position of Abraham that although depression is the result of fixation in early life (viz., the oral sadistic phase), paranoia represents an even more primitive psychodynamic mechanism and results from an even earlier point of fixation than that of depression. Consistent with this position, Klein (1934/1940) proposed that a child from birth experiences a persecutory anxiety, possibly the result of a vague projection of the death instinct. The child's early relationship with the mother serves as a defense against this anxiety. As the child's ego begins to differentiate itself from the mother, however, the threat of loss reactivates this persecutory anxiety. Frustration of nurturance needs, or at least the threat of frustration, generates anger and hostility. Because the child's newly developed oral aggression often promotes the mother's decision to wean, Klein reasoned that the child would inevitably feel responsible for the mother's "rejection" and would subsequently experience guilt. The resulting fear, anger, and guilt, highly cathected parts of self, are projected onto the mother. This projection effects a discharge of cathetic energy. The child, in an effort to retain the love object, then incorporates the mother, projections and all, into its own intrapsychic structure. From this Klein concluded that all grief as well as all depression in later life would be marked not only by an incorporative process, but also by hostility, paranoid fear, and guilt.

The identification with the mother suggested by Klein consists of both the positive dimensions of the nurturing breast as well as the negative dimensions of the infant's projections. A primitive splitting takes place within the child, causing these two dimensions to become separate introjects. Klein further suggested that nurturing behavior by the mother reinforces the positive identification, and as a result, predisposes the child to develop increased confidence in the goodness of self and others. A rejecting mother figure, on the other hand, reinforces the negative introjects. This early pattern, according to Klein, influences whether a person will react to loss in later life with a positive or negative style of identification.

Loewald (1962) and Smith (1971) also focused on the qualitative differences between the identification characteristic of mourning and that of depression. They both suggested that from its very first occurrence, the experience of loss becomes an opportunity for establishing ego boundaries and, ultimately, individuality. The infant's first realization of its separateness from the mother, while threatening and painful, becomes an essential experience for developing its own sense of identity. Forced relinquishment of oedipal relationships is another example of a significant yet necessary loss experience. Identification initially serves as a defensive attempt to retain the fused ego boundaries. Ultimately, however, the identification should allow the person to relinquish negative components of the lost object and to incorporate positive aspects into the ego-ideal. Loewald stressed that the latter dynamic

is a growth oriented process in which the superego's introjects continue to develop and become ego-traits rather than ego-demands. In the case of depression, on the other hand, global, unintegrated introjects remain unchanged as they serve to deny the loss.

Self-Esteem

Freud (1917/1956) highlighted self-esteem as the major point of distinction between mourning and melancholia. He stated that, unlike the depressed person, the bereaved person does not experience a fall in self-esteem as a result of his loss. Jacobson (1957) is one of the few other writers to hold a similar view: "inasmuch as the sad person cherishes the past, he will feel deprived, but not bad or worthless, or empty" (p. 89).

Clayton, Herjanic, Murphy, and Woodruff (1974) have reported empirical evidence supporting Freud's and Jacobson's positions on self-esteem. In a comparative study of 34 depressed and 34 bereaved persons, the authors reported that 53% of the depressed group felt worthless and 53% felt guilty. For the bereaved group, only 3% of the group felt worthless and 26% felt guilty. Unfortunately, the inherent weakness of self-report data and the absence of an appropriate control group make these findings inconclusive.

Siggins (1966) concluded from her review of the literature that most other psychoanalytic writers have departed from Freud's position on self-esteem and its relationship to bereavement. The majority of writers have acknowledged that a lowering of self-esteem is common to both depression and normal bereavement. Edward Bibring (1953) is one of the many theorists who fall into this latter category.

His egoanalytical approach to defining the mechanism of depression represents a dramatic departure from the general trend of psychoanalytic thought and warrants close consideration.

Edward Bibring--Depression and Bereavement

All of the theorists discussed thus far, with the exception of Bowlby, have viewed depression and bereavement as being qualitatively different clinical entities. All of these writers, with the possible same exception, have described depression as a regression to a point of oral fixation. Finally, all of these writers, this time Bowlby included, considered the lowering of self-esteem in depression to be associated with either guilt over ambivalent feelings or faulty patterns of identification. With all three of these points, Bibring took notable exception.

Different clinical entities. Bibring stated that depression represents a state of the ego, an affective state, which is common to bereavement, neurotic depression, and most probably, to psychotic depression. The state of the depressed ego is one of helplessness, a helplessness so pervasive that most efforts to meet the demands of daily living become meaningless. This paralyzing sense of helplessness provides an explanation for depressive inhibition. This explanation differs from Freud's, because Freud had proposed that inhibition is either a defense against encountering further anxiety, or the result of the ego's exhaustion from defensive activities.

Bibring compared and contrasted depression with other basic ego states. The state of anxiety, for example, exists when the ego is confronted with danger and is subsequently prepared to respond

through fight or flight mechanisms of survival. In depression, on the other hand, the ego is immobilized by the crushing conclusion that it is incapable of defending itself from the danger. Bibring did acknowledge that these two states are not mutually exclusive. Because the sense of helplessness may be only related to specific elements of the ego's experience of itself, both depression and anxiety may exist concurrently within the same person. Finally, Bibring said that the elated ego, unlike the depressed or anxious ego, experiences the actual or imaginary gratification of narcissistic needs. Unlike the defeated ego of the depressed person, the elated ego experiences itself as triumphant.

Although Bibring paid only passing attention to the dynamics of grief, he did assert that these dynamics are no different from those already described:

In the instance of an actual loss of a love-object, the resulting tension can be described as a longing for the lost love object, and a wish to retrieve the loss (maintenance of object and goal). The depression, sometimes accompanied by a feeling of pain, appears to derive from the fact that here too the ego is confronted with an inescapable situation, since it does not have the power to undo the loss. (Bibring, 1953, p. 27)

Depression--regression to oral fixation. Bibring departed from the classical psychoanalytic position that depression primarily results from a conflict between the ego and either the environment, the id, or the superego. According to the classical view, the impact of loss is heightened by fixation at an early stage of psychosexual development. Because of this fixation, the inevitable regression results in utilization of primitive defense mechanisms characteristic of that early stage of development. Bibring, on the

other hand, proposed that the conflict of depression occurs within the ego itself. He argued that the ego possesses various narcissistic aspirations including: (1) the wish to be loved, to be worthy, to not be inferior; (2) the wish to be strong, to be superior; and (3) the wish to be loving, to be good, to not be hateful or destructive. Depression is the result of the ego becoming painfully aware of its real or imagined inability to live up to these aspirations. The resulting sense of helplessness becomes incapacitating.

Bibring recognized that predisposing experiences were significant to the etiology of depression. His formulation of the depressive mechanism suggested, however, that depression is not a phenomenon unique to oral-dependent persons. Rather, persons whose ego aspirations were frustrated during any of the early psychosexual stages may be prone to display depressive features when encountering similar frustrations in adult life.

Frustration of narcissistic aspirations during the oral phase would of course occur most frequently because the ego is relatively dependent and helpless during this stage of life. The ego's aspirations at this stage of development include needs to gain affection, to be loved, to be cared for, or defensively, to be independent and self-supporting. When a situation renders the adult ego helpless in achieving these early narcissistic goals, the person will experience varying degrees of depression, depending upon the degree to which the infantile ego had experienced a sense of helplessness in attempting to meet those same aspirations.

The anal-sadistic phase, on the other hand, presents a totally different set of challenges to the ego. The child at this stage has normally developed a certain amount of ego strength. During this phase, he seeks a new sense of mastery over his body and over objects in his environment. Inevitable conflicts of will between the child and authority figures precipitate defiance and aggression. The perpetual threat of punishment involved in these conflicts generates a sense of fear, guilt, and remorse. The ego subsequently develops adaptive aspirations to be good, not to be hostile or defiant, but to be loving. The experience in later life of being unable to control libidinal or aggressive impulses will precipitate feelings of helplessness similar in intensity to those experienced by the infantile ego.

During the phallic stage of development, new aspirations of the ego once again emerge. The child, immersed in the oedipal conflict, has strivings to compete with and to overcome his rival, and to win the esteem of the love object. The emerging ego-aspirations therefore involve the need to be admired, to be respected, to be strong and victorious, to not be defeated. As was the case for the two previous stages, the adult ego's inability to achieve these aspirations effects a regressive repetition of the earlier ego-experience of itself.

Bibring's own words would best summarize what has been discussed thus far:

What has been described as the basic mechanism of depression, the ego's shocking awareness of its helplessness in regard to its aspirations, is assumed to represent the core of normal, neurotic, and probably psychotic depression. It is further assumed

on the basis of clinical material that such traumatic experiences usually occur in early childhood and establish a fixation of the ego to the state of helplessness. This state is later on regressively reactivated whenever situations arise which resemble the primary shock condition, i.e., when for external or internal reasons those particular functions which serve the fulfillment of the important aspiration, prove to be inadequate. (p. 39)

Low self-esteem due to guilt or faulty identification. Although most writers have suggested that a depressed person experiences self-depreciation because of guilt arising from ambivalent feelings or because of faulty identification patterns, Bibring took a different view. He believed that the individual takes as his criterion of self-evaluation whether he has fulfilled the various ego-aspirations described earlier. When the individual sees himself as helpless to achieve these aspirations, he suffers a decline in self-esteem. Loss of self-esteem is therefore an inseparable component of depression; it is also an inseparable component of grief.

Bibring's theory does not rule out guilt or identification as important aspects of depression or bereavement; but it makes them unessential and secondary. What is essential to depression and grief is the ego's experience of helplessness; this experience produces depressed affect, inhibition, and loss of self-esteem. In uncomplicated grief, sufficient ego strengths and adequate environmental support allow the ego gradually to regain confidence in its ability to achieve narcissistic aspirations. In clinical depression, because such resources are missing, the ego ultimately resorts to faulty identification processes, to denial, to projection, and to other defense mechanisms in desperate efforts to retrieve what has been lost or to defend against the painful reality of loss.

Statement of the Problem

Thus according to Bibring, the state of the bereaved ego is one of helplessness. The experience of significant loss forces the ego to encounter a reality which cannot possibly be changed. Any number of narcissistic aspirations might be threatened by the ego's sense of impotence; and the resulting depressed mood, lowered self-esteem, and inhibition will be commensurate with both the intensity of the circumstances surrounding the present loss and the degree that the infantile ego had experienced helplessness when striving for those same aspirations during earlier development.

Bibring's position, if supported by research data, would have significant implications for both theoretical and applied issues. For example, the proposed mechanism of depression would provide a conceptual framework to account for the similarities and differences between bereavement and depression. Intervention strategies for both clinical depression and abnormal grief reactions would also be suggested, especially focusing on narcissistic aspirations and the ego's sense of helplessness. It would also provide a model to help account for factors which predispose certain persons to have unusual difficulty mourning the loss of a loved one.

The present study is an attempt to begin to seek out this necessary research support. Four hypotheses suggested by Bibring's work were therefore subjected to empirical investigation.

Hypothesis I: Both bereaved and clinically depressed individuals will experience a fall in self-esteem.

Bibring's theory implies that the depressed mood and the general

inhibition characteristic of both the clinically depressed individual and the bereaved individual are the results of the ego's experiencing itself as helpless in the face of some threat or danger. As stated earlier, self-esteem is based upon the ego's ability to achieve its aspirations. The experience of overwhelming helplessness would therefore effect a fall in self-esteem, because suddenly certain aspirations are perceived as unobtainable. Although both groups would be expected to display a fall in self-esteem, the self-esteem of the depressed group would be expected to be lower than that of the bereaved group, because of the long-standing character problems of the depressed group. Nevertheless, contrary to Freud's theory, bereaved persons should display less self-esteem than an appropriate comparison group would.

Hypothesis II: The self-esteem of a bereaved individual will be inversely related to the person's degree of dependency concerns.

An important aspiration of the ego during early development is to be cared for and loved. For some individuals, this aspiration is an elusive one. Many children never receive enough nurturance to feel confident that they are loved, and for them dependency concerns remain salient even in adulthood. For this kind of person, any loss which represents an elimination of a source of love and nurturance is expected to reactivate the insecurity and sense of helplessness characteristic of the infantile ego. The adult who as a young child was overindulged also will tend to be excessively sensitive to continuing nurturance or its lack. As a child, this person did experience love; but the overindulgence thwarted the development of self-sufficiency and independence. Thus the ego remained

totally dependent upon external sources for security and it never developed the confidence that it could survive without these sources. The ego became vulnerable to a regression to such earlier attitudes of helplessness when encountering a threat to narcissistic supplies. Therefore, whether the fixation to an attitude of helplessness has its source in deprivation or in overindulgence, an adult with this over-concern about dependency would have more difficulty coping with the death of a loved one and would suffer a loss of self-esteem.

Hypothesis III: The self-esteem of a bereaved individual will be inversely related to the degree the person experiences negative attitudes towards the lost love-object.

The ego also develops in its early years the aspirations to be good and loving. If, however, an individual harbors resentment and hostility towards a love-object, then the death of the love object will in all likelihood intensify the bereaved ego's helplessness to achieve its aspirations to be good, worthy, and loving. It follows, therefore, that the more negative the attitude, the greater the ultimate awareness of helplessness. The person's lowered self-esteem in this case would very likely be associated with a strong sense of guilt. Obviously this dynamic does not necessarily require any specific fixation in early psychosexual development. However, following Bibring's line of reasoning, if the infantile ego had unusual difficulty in achieving these early aspirations characteristic of the anal phase of development, the impact of a negative attitude towards the deceased would be even greater in terms of moral self-devaluation. Likewise, the ego regression would be more total and more

resistive to spontaneous recovery than if there were no exceptional difficulties in earlier development.

Hypothesis IV: The self-esteem of a bereaved individual will be inversely related to the degree that the person is unable to relinquish the original oedipal object.

The potential impact of oedipal dynamics upon bereavement is not quite as straightforward as is the case for dependency or ambivalence. Obviously, the faulty resolution of oedipal dynamics can effect numerous distortions in adult personality functioning. This particular hypothesis is focusing upon only one dimension of the oedipal conflict--the relinquishment of the oedipal object..

Bibring correctly pointed out that the narcissistic aspirations of the phallic stage are primarily competitive--the wish "to be admired, to be the center of attention, to be strong and victorious; not to be defeated, and so forth" (Bibring, 1953, p. 39). Successful resolution of the oedipal conflict necessitates the realistic frustration of these aspirations along with the identification of the child with the parent of the same sex. One who successfully resolves this crisis accomplishes two important goals. First, the individual obtains vital experience in letting go of or losing a love-object. Secondly, the person learns to develop strategies to compensate for this loss by striving to be "victorious" in other, more feasible relationships. Unfortunately, an individual whose initial phallic aspirations were achieved, either in fantasy or fact, is ill prepared to lose or surrender a love object. Both the person who has passed through a normal resolution of the Oedipus complex, and the person who has not,

will experience a painful sense of helplessness when a loved one dies; but one who has normally resolved this complex will be more adept at facing the loss, since from experience he can be confident that those aspirations will be met in other ways. Although this dynamic should apply to the loss of any significant love object, it should be most clear in the case of conjugal bereavement.

CHAPTER II

RESEARCH DESIGN AND RATIONALE

In order to test the four hypotheses stated earlier, I compared three groups: conjugally bereaved women, clinically depressed women, and women who are neither bereaved nor depressed. Participants from all three groups were interviewed and were administered two self-concept inventories and a projective, picture-story test. I compared the groups on measures of self-esteem derived from the tests. In addition, I studied the bereaved group more intensively in order to examine the relationship between self-esteem and three other variables: dependency, negative attitudes towards males, and unresolved oedipal attachments.

Participants

Bereaved Sample

Because it is difficult to recruit recently bereaved individuals, I limited the number of participants to the minimum required to test the hypotheses. This decision necessitated restrictive selection criteria so that covariance would be minimized. Previous studies have shown that length of bereavement, physical health, and psychological stability during bereavement are influenced by a number of variables such as cause of death, the presence of emotional

support, relationship to the deceased, age of the bereaved person, and previous experiences with death. Because self-esteem might correlate with some of these variables, I examined the literature for guidance in determining selection criteria.

Time of assessment. It is generally agreed that bereavement is not a static state but, rather, a process. Accordingly, a number of authors have proposed "stage" theories to explain the dynamics of bereavement (among others, Bowlby, 1961; White & Gathman, 1973). It would follow that data for comparisons of bereaved individuals should be collected at a relatively uniform point or stage in the bereavement process.

When the researcher is trying to decide the point most appropriate for data collection, two questions emerge. First, he wants to know the time span in which the experience of grief is most similar for the majority of bereaved persons. Secondly, he would like to know--if his focus is like that in the present research--what time span of the bereavement process is most frequently characterized by symptoms similar to other depressive disorders.

The research literature has addressed itself to both questions. Clayton, Halikas, and Maurice (1971) reported that 84% of the 109 widows and widowers they studied displayed depressed mood during the first month of bereavement. Eighty percent of the same group complained of sleep disturbance and 94% stated they had cried during that period of time. Clayton, Desmarais, and Winokur (1968), from a study of 40 bereaved persons, reported that 81%

dated their improvement to from six to ten weeks following the loss of a love object. Most of the participants in the study of Clayton et al. (1968) were not conjugally bereaved and therefore they probably did not experience grief as intense or as long-lasting as that of those who are conjugally bereaved. Raphael (1971) viewed bereavement as a period of crisis, with the first three months marked by increased vulnerability. Yamamoto, Okonogi, Iwasaki, and Yoshimura (1969) described the first 72 days as the acute phase of bereavement. White and Gathman (1973) observed that painful longing and preoccupation with memories of the deceased were most intense during the first three months. Parkes (1970) interviewed 22 widows on five different occasions during a 13-month time span. His data revealed that only during the first three months did all widows experience some degree of emotional disturbance.

Because of the findings described above, I attempted to interview and to test the participants in the current study within the first three months of their bereavement. In some cases, however, it was impossible to visit the bereaved participant within this restricted time period. The length of bereavement for this sample therefore varied from 3 weeks to 23 weeks. 25 of the 30 bereaved participants were interviewed within the first 4 months of their bereavement. The average length of bereavement was 11 weeks.

Type of bereavement. It is logical to assume that the intensity of bereavement will vary according to whether the lost object is a child, a parent, a spouse, a sibling, a friend, a pet, a limb, or an ideal. Experts on bereavement do not agree about whether an adult

who loses a child is more distressed than one who loses a spouse. Sanders (1978) votes for greater impact of losing a child; Conroy (1977) argues for greater impact of losing a spouse. Because of the two conjugal bereavement is more frequent, I studied persons who have lost a spouse.

Sex. Armchair reasoning might lead one to expect that women will have more difficulty than men in dealing with bereavement. For example, in conjugal bereavement, the widow is more likely than her male counterpart to experience severe financial adjustments, to have difficulty remarrying, and to be unprepared to assume a role of independence. Any of these factors could make adjustment more difficult, and there are authors who have reported that females do indeed have greater difficulty dealing with loss (Kraus & Lilienfeld, 1959; Romm, cited in David, 1975). On the other hand, Vachon (1976a) after reviewing the literature concluded that males have more difficulty with grief than females.

For this study, I recruited only females. Chances are high that there are significant sex differences in the bereavement process, although the nature of those differences are not totally clear. However, since widows outnumber widowers four to one (Vachon, 1976a), they offer the advantage of being more accessible for research.

Age. There are a number of references in the literature suggesting that bereavement is more difficult for the younger survivors. Maddison and Walker (1967), who studied bereaved persons between the ages of 45 and 60, concluded that deterioration in health

following the death of a loved one was greater for younger individuals. Kraus and Lillienfeld (1959), who studied mortality statistics, arrived at a similar conclusion. Smith (1975) reported that younger bereaved persons were more likely to experience death anxiety. Ball (1976-1977) observed that young widows (18 to 46 years of age) displayed more restlessness than older widows did. On the other hand, Clayton, Halikas, and Maurice (1972), in a study of 109 widows and widowers during their first month of bereavement, found no relationship between age and the presence of depressive symptoms.

In reference to the elderly, Stern, Williams, and Prados (1951) have reported that the psychodynamics of bereavement for the elderly differ from those characteristic of the young and middle aged. From observations of 25 elderly widows and widowers, the authors concluded that older persons experience less guilt, display fewer overt signs of grief, and tend instead to somaticize their subjective distress. While Clayton et al. (1971) concluded that there was no difference in the bereavement of individuals under 60 and over 60, their data did reveal that three times as many bereaved individuals under 60 experienced guilt as compared to bereaved individuals over 60.

For this current study, I decided to include only participants under the age of 65. There is evidence suggesting that the dynamics of grief for the elderly differ qualitatively from those of the young. I chose the age of 65 as the upper age limit because it is commonly associated in contemporary society with the beginning of retirement. I did not establish a lower age limit for

two reasons. First of all, even though the findings of Maddison and Walker, Kraus and Lilienfeld, Smith, and Ball suggest that younger individuals have greater difficulty with bereavement, their data are less relevant than that of Clayton et al. (1972), who reported no age differences. The former researchers' data were collected anywhere between six and thirteen months following the death of a loved one. The data of Clayton et al. (1972), on the other hand, were collected within the first month of bereavement, a time span compatible with that proposed for this study. Likewise, Clayton's dependent variable, namely, depressive symptoms, is more closely aligned to the direction of the current study than the variables of restlessness, physical deterioration, and death anxiety. Secondly, individuals experiencing a primary depression tend to be younger than people experiencing conjugal bereavement (Clayton, et al., 1974). Because the present study included a comparison with a sample of clinically depressed persons, the age range had to be young enough to facilitate this comparison.

Social class. There is no consistent evidence suggesting a relationship between social class and bereavement. Rather, the findings have been highly contradictory. For example, Lopata (1973) reported that the higher the social class and education of a widow, the greater her sense of loss. Clayton et al. (1972) found that the appearance of depressive features in bereavement did not vary according to social class. Bornstein, Clayton, Halikas, Maurice, and Robbins (1973) reported that a lack of financial support correlated with poor bereavement outcomes. Glick, Weiss,

and Parkes (1974) concluded that persons from the lower class had the greatest difficulty with grief.

Because there is a lack of evidence that social class has a predictable impact upon the bereavement process, I did not consider this variable when selecting participants for the study. I did obtain data, however, on educational and employment levels so that a score of social position could be computed for each participant.

Emotional support. There appears to be consistent evidence in the research literature that lack of emotional support has a negative impact upon the course of bereavement. Maddison and Walker (1967), in a study of 132 widows, reported that persons who experience mental or physical difficulties during bereavement tended to perceive their environment as non-helpful. They viewed their environment as forcing them to focus on the future and to avoid thoughts of the past or expressions of affect. Smith (1975), in his study of 120 widows, concluded that women who had children coped with bereavement better than those who did not. Childless widows were more depressed than widows with children. Bereavement was less traumatic for persons with large families and for those with at least one child living close to the widow. Clayton et al. (1972) likewise reported from their study of both widows and widowers that fewer bereaved persons showing symptoms of depression had children living near them. Bunch (1972) in a study of bereavement found a relationship between suicidal behavior and a lack of support from relatives.

The evidence strongly suggests a relationship between emotional

support and the outcome of bereavement. It would be difficult, however, to operationally define and measure this variable in such a way to reflect the variety of findings reported above. Therefore, I neither selected participants in the study according to how much support they had, nor did I measure this variable.

Variables related to the death. Many researchers have studied the relationship of bereavement to the length of illness before death and to how much warning the survivor had. Lindemann (1944) reported that advanced warning helped the bereaved person to cope with his loss. Ball (1976-1977) concluded that anticipatory grief was helpful for young widows (18 to 46 years of age). Vachon (1976b) found that widows experienced more stress if their husbands had a final illness of less than two months than if their husbands had a final illness of one year or more. Contrary findings were reported by Sanders (1978), who failed to find any evidence of a relationship between the length of illness and the degree of grief, and by Maddison (1968), who also found that duration of the final illness was unrelated to the course of bereavement. Furthermore, Clayton, Halikas, Maurice, and Robins (1973) concluded from their research that persons who experienced anticipatory grief had greater adjustment problems after the first month of bereavement.

Because of the evidence about the relationship of anticipatory grief to the bereavement process is so contradictory, I did not deal with the variable of length of illness.

Although they have not provided empirical support for the proposition, DeVaul and Zisook (1976) asserted that causes of

death which evoke embarrassment, shame, or guilt (e.g., suicide) complicate the grief reaction. In light of this possibility, cases involving death either by suicide or by events following the commission of a crime were excluded.

Premorbid history. Only three premorbid features of the bereaved have received any significant attention: premorbid psychiatric history, family history of psychiatric problems, and previous experience with death. Sanders (1978) concluded from his study of 102 adults grieving the loss of a spouse, parent, or a child that adjustment to bereavement was more a function of the premorbid level of adjustment than of the type of bereavement or the conditions under which it occurred. Bunch (1972) reported a relationship between suicide in bereavement and a previous psychiatric history. On the other hand, Clayton et al. (1972) found no relationship between depression in bereavement and either previous psychiatric treatment for depression or family history of affective disorders or alcohol abuse.

In reference to earlier experiences with bereavement, Huston (1971) suggested that prior losses may strengthen a person's capacity to cope. Bornstein et al. (1973), consistent with Huston's findings, observed that a relationship existed between uncomplicated grief reactions and previous experiences with bereavement, regardless of the nature of the earlier bereavement. Smith (1975), on the other hand, concluded that a poor adjustment to an earlier bereavement served as a poor prognostic sign for future bereavements.

Because of the lack of clear and consistent evidence, I did

not try to control for these premorbid characteristics of the mourner.

Quality of the relationship with the deceased. There are conflicting findings in regards to the question whether the quality of the relationship between the deceased and the mourner has any impact upon the bereavement process. Lindemann (1944) concluded from his research that ambivalent relationships often precipitate abnormal grief reactions. Clayton et al. (1972) on the other hand reported that the emergence of depressive features in conjugal bereavement was not associated with either the length of the marriage or the presence of marital problems. It should be noted that Lindemann's conclusions were based in part on observations of persons who experienced bereavement while participating in therapy. The data of Clayton et al. were obtained from a random sample of the general population and should therefore be more representative of the normal grief process.

Religious and cultural variables. Researchers have examined a number of other variables that might be related to grief. Pomeroy (1975) and Clayton et al. (1972) reported that religion has no significant impact upon the bereavement outcome. Other researchers considered the impact of cultural practices on bereavement. Vachon (1976a) cited unpublished research in which Fulton found that, at least among upper-class professional males, when these men did not participate in a funeral service for their loved one, they coped less well with the loss; and this was so even if they did have a memorial service after cremation of the body.

Gorer (1965), while not citing statistical data, concluded from clinical observations that people who participated in the ritual of viewing the corpse and burying it were more likely to have uncomplicated grief reactions than people who opted for cremation. Yamamoto et al. (1969) argued that the Japanese custom of ancestor worship provides an important adaptive function for the bereavement process.

While religious and cultural variables may have a significant influence upon the course of bereavement, their study is beyond the scope of the current research.

Sampling method. To obtain a sample of individuals experiencing normal bereavement is a challenging task. Because bereaved individuals, unlike many other groups of people, do not typically present themselves for treatment, one cannot simply select such people from applicants for therapy. The very nature of their subjective experience motivates them to withdraw from most involvements; this withdrawal increases their reluctance to participate in any research. Finally, the question always lingers as to how representative of normal bereavement are persons who volunteer to participate in research?

A number of methods have been attempted to recruit participants for bereavement studies. Lindemann (1944) studied patients who experienced loss during therapy, survivors of disaster victims (in the Coconut Grove fire), and relatives of World War II fatalities. It is questionable as to how representative any of these conditions are of normal bereavement. Parkes (1970) and

Blanchard, Blanchard, and Becker (1976) have studied bereaved individuals referred by physicians and clergymen. Samples based upon such referral sources may be biased, since either religious involvement or a survivor's visit to the family physician influenced selection. Pomeroy (1975) recruited participants by advertising through the Los Angeles Times. It would be difficult to argue that a bereaved person who reads the classified ads of a metropolitan newspaper is representative of all bereaved people.

To help insure generalizability of findings, some researchers have obtained names of potential participants from a random sampling of death certificates (Clayton et al., 1971; Maddison & Viola, 1968). While this latter method is superior to other procedures discussed thus far, it presents problems when the researcher goes about obtaining his comparison group. For example, Clayton (1974), in efforts to establish a group for comparison with bereaved individuals identified through the use of death certificates, matched individuals on the basis of marital status, age, voting district, and, if possible, street of residence. Despite these extensive efforts, Clayton found herself with a control group that was better educated and of higher socio-economic status than the bereaved group. Clayton concluded that the use of voting registrations as a source for identifying potential controls introduced a bias, since apparently those who register to vote tend to be better educated and to have higher socio-economic status than the general population.

For the current study, I decided to recruit bereaved

participants from the survivors of people who died in a large metropolitan hospital. Lindemann (1944) and Clayton et al. (1968) have reported utilizing a similar source for bereavement research. While such a sampling frame--people who died in a particular hospital--may not be as broad-based as a listing of community death certificates, it happens that the catchment area of the hospital which I used is heterogeneous in ethnic and socio-economic characteristics; in fact, the distribution of these characteristics in the hospital's clientele approximates that of the metropolitan area. The major advantage of utilizing this sampling frame was that depressed and non-bereaved persons were also sampled from the hospital's files, thus maximizing the desired homogeneity between groups.

How representative are volunteers of the general population? More specifically, are the bereaved individuals who volunteer to participate in research experiencing a less intense grief than those who do not volunteer? Clayton et al. (1971) reported that 58% of the bereaved individuals contacted agreed to participate in their study. Maddison and Viola (1968) reported participation by 66% of the bereaved individuals contacted. Only 67% of the prospective control subjects in Clayton's mortality and morbidity study (1974) agreed to participate. The similarity between these statistics for bereaved and control prospective subjects suggests that the decision by some bereaved individuals not to participate does not arise because their grief is more intense, but comes about as a result of general personality characteristics

that play similar roles in both bereaved persons and controls. Maddison and Walker (1967), as well, presented evidence that the refusal of bereaved individuals to be interviewed was not necessarily related to their mental and physical health.

Nevertheless, with a projected acceptance rate of only one-half to two-thirds of the prospective subjects, we ran the risk of a selection bias.

Depressed Sample

The depressed sample was drawn from the clinically depressed patients seeking psychiatric treatment at Henry Ford Hospital. In choosing clinically depressed individuals, I used the operational criteria for the DSM-III diagnosis of a depressive episode (Spitzer, Sheehy, & Endicott, 1977). Spitzer, Endicott, and Robins (1975) reported an inter-rater reliability coefficient of .88 for application of these criteria.

Non-Bereaved Comparison Group

Women whose husbands had successfully undergone surgery for minor, non-life-threatening conditions composed the non-bereaved comparison group. Because these women are, on average, younger than bereaved women, I selected women from those whose husbands not only had surgery, but also were the same age as the husbands of the bereaved women, thereby matching the two groups on age.

Self-Esteem

Although the notion of self-esteem has figured prominently in both psychological theory and research, there is no general

consensus on its meaning (Wylie, 1974). For the purposes of this research, I adopted Bibring's definition of self-esteem. Bibring proposed that the ego's self-esteem is based on its perceived ability to achieve its aspirations. Self-esteem, therefore, may be defined as an attitude about oneself based on conscious and unconscious evaluations of one's own competence, one's virtue, and one's worthiness to be warmly regarded by others.

Phenomenal Self-Esteem

Self-report instruments are often used to measure self-esteem. I decided to use two such inventories. My choice of questionnaires to use was guided by these criteria: ease of administration, brevity, and substantiated reliability and validity. The Janis-Field Feelings of Inadequacy Scale (Eagly, 1967) and the Self-Esteem Scale (Rosenberg, 1965) seemed to meet these criteria best.

The Janis-Field Feelings of Inadequacy Scale (FIS) was originally designed for a study of personality and persuasibility (Hovland & Janis, 1959). Eagly (1967) revised the original test, balancing the direction of the items to avoid acquiescence response-bias. The revised version consists of 20 items answered on five-point Likert scales. Items pertain primarily to aspects of social self-esteem. Eagly reported split-half reliability coefficients of .72 (1967) and .88 (1969) for two different samples. She reported a correlation of .54 between positive and negative items (Eagly, 1967). The inventory is self-administered, requiring 10-15 minutes to complete. The reader is referred to Crandall (1973) for a review of validity data and for other

information relevant to this test. The FIS will be found as Items 1 through 20 of the self-esteem questionnaire in Appendix G of this paper.

Rosenberg's Self-Esteem Scale (RSE) is a ten-item scale, with each item requiring answers on a four-point rating scale with descriptors ranging from "strongly agree" to "strongly disagree." Although Rosenberg intended the scale to function as a global measure of self-regard, the items for the most part deal with self-acceptance. Silber and Tippett (1965) reported a test-retest correlation of .85 over a two week period of time. The scale is self-administered and requires approximately five minutes for completion. The reader is referred to Crandall (1973) and to Wylie (1974) for reviews of validity data and for other information about this test. Items 21 through 30 on the self-esteem questionnaire in Appendix G of this paper constitute the RSE.

When one uses self-report data, two important issues arise. First of all, what influence does the social-desirability response-set have on subjects' responses to a self-esteem inventory? Does a person's tendency to present himself in a favorable way impair the validity of the instrument? Although this issue has been investigated and debated extensively (e.g., Wylie, 1974), I do not judge that the matter has been satisfactorily resolved. Secondly, it would be reasonable to assume that self-evaluation is not a totally conscious phenomenon. It is highly questionable that self-report data can adequately represent the non-phenomenal dimensions of self-esteem.

Non-Phenomenal Self-Esteem

The phenomenal self-esteem often shows the workings of defensive processes. For example, a person with strong tendencies to self-disparagement may deny and repress these tendencies. Through the defense of reaction-formation, this individual may then strive to excel and may actually come to perceive himself, consciously, as a superior person. He would also very likely get a high score on a self-report measure of self-esteem. Despite achieving success in life, such a person would be driven incessantly to achieve still more; his unconscious sense of inferiority would motivate these strivings. While this dimension of self-esteem would not be accessible to consciousness, it is nevertheless significant because of its influence on behavior.

The importance of non-phenomenal dimensions of self-esteem and the influence of social desirability upon self-report instruments led me to use a projective measure of self-esteem, as well as self-report measures.

Wylie (1974), who reported several attempts to measure self-esteem by projective methods, also criticized these attempts for lack of evidence that the measures are valid. One could hardly expect that a projective test, designed to tap non-phenomenal self-esteem, would be strongly correlated with self-ratings of self-esteem; the projective measure should in part be measuring something not expressed in self-report data. Therefore, ironically, the higher the concurrent relationship between a phenomenal and a non-phenomenal measure of self-esteem, the less justification for

using the new measure. A problem also exists if behavior is used as a criterion, for what behavior reflects an unconscious sense of low self-esteem? Depending on the uniqueness of the individual's defensive structure, low self-esteem may manifest itself either in social isolation or in manic involvement, in self-defeating behavior or in an ongoing drive for achievement, in self-disparagement or in grandiose overestimates of self-worth.

Unfortunately, many critics become preoccupied with the absence of reassuring validity coefficients, and fail to consider other evidence bearing on construct validity. The rationale of construct validity is extremely important to the use of many projective measures. Constructs are developed to represent realities which are only partially observed and partially understood. Each new piece of information modifies our understanding of a particular reality, and any measure which furthers this understanding assumes an indisputable validity. Using the current study as an example, the hypothesis is presented that self-esteem will differ in a predictable direction for depressed, bereaved, and non-bereaved groups. Now if a projective measure with acceptable reliability yields data conforming with this prediction, we are taking a step closer to understanding the relationship of self-esteem to depression and bereavement. And whenever the outcome of the measurement is consistent with the hypothesized relationship, we may claim to have offered evidence for the validity of this measure. Neither our new understanding of the construct nor the reputed validity of the measurement would be definitive, but one

more piece of evidence would have been successfully accumulated.

An APA monograph (1954) on technical recommendations for psychological tests summarizes this position on construct validity well:

One tends to ask regarding construct validity just which is being validated--the test or the underlying hypothesis? The answer is, both, simultaneously. If one predicts an empirical relationship by supposing a certain personality organization, the verification of this prediction tends to confirm both the measurement and the component suppositions that gave rise to it. True, there might be plausible alternative hypotheses, but this is always the case in science... A further characteristic of this type of validity inference is that the construct itself undergoes modification as evidence accumulates... We actually reformulate or clarify our characterization of its nature on the basis of new data. (pp. 15-16)

Development of the Projective Instrument

Previous successful efforts at scaling TAT material for various personality variables have been reported in the literature (see, for example, Zubin, Eron, & Schumer, 1965). A picture story-telling test similar to the TAT was utilized for the current study. In order to obtain reliable, objective data, I devised scales for the following variables: low self-esteem, dependency concerns, negative attitudes towards males, and unresolved oedipal issues.

Test Format

The test format was patterned after Amin's (1974). The participant was given a test booklet with the following instructions on the cover:

This is a study of your imagination and creativity.

Inside, you will find some pictures. Your task will be to make up as dramatic a story as you can for each picture. Try to fill up the two pages allowed for each one. It should not be necessary to spend more than five minutes per story. Write your thoughts as they come to you, keep in mind the following:

1. What has led up to the incident?
2. What is happening now?
3. What are the characters thinking and feeling?
4. What will be the outcome?

When she opened the booklet, the participant found on each upper, left-hand page a picture and a summary of the instructions. The remainder of that page and all of the right-hand pages were blank, allowing space for the participant to write her story. The booklet had five pictures in it.

Picture Selection

Initially, I chose 12 pictures from a variety of sources, including Murray's TAT (1943), Symond's pictures used in research on adolescent fantasy (1949*), and pictures in popular magazines. I selected pictures which, in my judgement, were likely to evoke stories expressive of the four critical variables. I then collected 15 written stories for each of the 12 pictures from a mixed clinical population. In the preliminary study, both a colleague who is an experienced clinical psychologist and I scored each story for the presence or absence of each of the four variables. Our overall rate

of agreement was 87%, with a phi coefficient of .65. On the basis of our ratings, I selected the five pictures which were most successful in evoking the four themes (see Appendix H).

Development of the Scoring System

I attempted to develop a reliable rating scheme for the five selected pictures. I first reviewed the stories to the five pictures from the pilot sample, and created a descriptive phrase to summarize any story which reflected low self-esteem, dependency, negative attitudes towards males, or unresolved oedipal attachments. I divided these descriptors into four lists, depending on which of the four variables they reflected. Each list consisted of 10 to 12 descriptors. I then presented these lists to two experienced clinical psychologists and instructed them to rate each descriptive phrase on a scale of 0 (variable not evident) to 5 (variable highly evident) according to the degree of intensity with which the descriptor represented the list variable. I served as a third judge, also rating the four lists of descriptors. An intraclass correlation coefficient was computed for the three sets of ratings according to the procedure described by Fisher (1970); this coefficient was .83. Table 1 presents an analysis of variance for the raters and the descriptors. In Table 2, the correlation coefficients between the pairs of raters are presented.

After the ratings had been done, I then decided upon the appropriate score for each descriptor. When two judges agreed, I chose their consensus as the appropriate score. When there was no

TABLE 1
 ANALYSIS OF VARIANCE: RATINGS OF DESCRIPTOR
 PHRASES

Source	<u>df</u>	<u>MS</u>	<u>F</u>
Between Descriptors	41	4.160	5.99*
Within Descriptors	84	0.698	
Between Raters (2)		0.889	1.28
Residual (82)		0.694	
Total	125	1.834	

Note. Intraclass $r = 1 - 1 / F_{btwn}$

* $p < .01$

TABLE 2
 DERIVATION OF THE PROJECTIVE SCORING SCALES:
 CORRELATION COEFFICIENTS AMONG RATERS *

	Rater 1	Rater 2	Rater 3
Rater 1	---	.739	.703
Rater 2	.739	---	.435
Rater 3	.703	.435	---

Note. 42 descriptor phrases were rated.

agreement among judges, usually I chose the middle rating of the three as the appropriate score. In three instances, I made an exception to this rule because, in my opinion, to have chosen the middle rating as the appropriate score would have made the scoring of the descriptor inconsistent with the way other descriptors had been scored.

Finally, the two original raters scored the sixty stories from the pilot sample according to the newly devised rating scales (see Appendix I). An inter-rater reliability coefficient of .85 was achieved.

CHAPTER III

METHOD

Selection of Participants

In beginning the task of selecting a sample of bereaved women, I made a list of all men under the age of 65 who had died at Henry Ford Hospital within the most recent three-month period. I continued to update this list during the course of data collection. The medical record of each man on the list was examined. This name was deleted if the cause of death was suicide or was crime-related, or if he had not been married at the time of his death. By this procedure, I obtained a total of 69 names.

The physician attending the family of each of these patients was then consulted to determine whether the physician had any serious concerns about the widow's mental status. In eight of the cases, the attending physician requested that the family not be contacted. The physicians' reasons for refusing permission ranged from concern for the widow's health to concern over possible legal proceedings. After this screening, I sent a letter to all of the widows whose physicians had assented to their inclusion in the study, describing the purpose of the study and requesting their participation (see Appendix A). I made a follow-up telephone call one week after the letter was mailed, inquiring whether the widow was willing to participate.

I was unable to contact six of these women. Two of the widows could not speak English; 23 of the widows refused to participate in the study. The remaining 30 widows were successfully interviewed and tested.

After interviewing each widow, I attempted to recruit a non-bereaved, married woman whose husband was about the same age as the widow's husband (see Appendix B). This comparison group was sampled from the daily list of men who had undergone minor, non-life threatening surgery. Women were excluded if they had experienced the loss of a spouse, a parent, or a child within the past two years. I began with a list of 77 women. I was unable to contact seven of them. Three women were unable to speak English; 32 women refused to participate in the study. The remaining 35 women agreed to participate. The first 30 of these women to be successfully interviewed and tested were included in the study's comparison group.

The rate of acceptance by both the bereaved and non-bereaved women was about the same as researchers in the studies reviewed earlier had achieved. In the present study, 57% of the widows contacted and 52% of the non-bereaved women contacted agreed to participate. There were no significant correlations between refusing to cooperate and age or race, in either the bereaved or the comparison group.

The sample of depressed women was also taken from the patient population of Henry Ford Hospital. Women seeking psychiatric treatment from this hospital were screened according to DSM-III's operational criteria for the diagnosis of a depressive episode (see Appendix C). Each woman was also diagnosed by her therapist according to the DSM-II classification system. This procedure was

not part of the current study and did not influence the selection of participants. Table 3 presents the range of diagnostic categories represented by the depressed group. Five of the depressed participants were receiving treatment in the hospital's inpatient psychiatric unit. The remaining 25 participants from the depressed sample were involved in therapy through the hospital's outpatient clinic.

Because of the difficulty of obtaining a significant number of bereaved and depressed women from a similar age group, I did not attempt to match the depressed group with the other two groups according to age. The mean age of the depressed sample is 37.5 years ($SD = 11.0$). The mean age of the bereaved group is 52.8 years ($SD = 10.5$), and the mean age of the comparison group is 52.3 years ($SD = 8.37$). Table 4 presents a comparison of age distributions for the three groups.

The marital histories differ between the three groups. Eleven of the 30 bereaved women have been married twice, while only six members of the comparison group have been married more than once. Nevertheless, the average length of marriage is very similar for both groups. The average length of marriage for the bereaved group is 27 years ($SD = 12.4$); members of the comparison group have been married, on the average, for 27.5 years ($SD = 10.5$). The current marital status of participants from the depressed group is presented in Table 5.

Index of Social Position

The Index of Social Position (ISP) was computed according to a method devised by Myers and Bean (1968). The ISP is based on occupational status and level of education (see Appendix F). Table 6

TABLE 3
DIAGNOSTIC CLASSIFICATIONS OF THE DEPRESSED

SAMPLE

Diagnosis (DSM-II Classifications)	<u>n</u>
Depressive Neurosis	17
Manic-Depressive Disorder - - Circular	5
Characterological Depression	5
Involutional Melancholia	2
Psychotic Depression	1

TABLE 4
 AGE DISTRIBUTION WITHIN THE BEREAVED,
 COMPARISON, AND DEPRESSED GROUPS

Age Range	Bereaved	Comparison	Depressed
under 35	2	1	13
36 - 45	6	7	12
46 - 55	8	8	6
56 and older	14	14	1

TABLE 5

MARITAL STATUS OF THE DEPRESSED GROUP

Marital Status	<u>n</u>
Widowed	2
Single	4
Married	11
Separated/Divorced	13

presents racial and social status characteristics of the three groups sampled for this study.

Data Collection

Members of the bereaved and of the non-bereaved comparison groups had the option to be interviewed and tested either at home or at the hospital. All of the bereaved women and 28 of the 30 non-bereaved women from the comparison group opted to be interviewed in their homes. Because members of the depressed group were receiving therapy, they were interviewed during one of their regularly scheduled visits at the hospital.

Interviews were conducted either by me or by a registered nurse who had received special training for this study. It took approximately an hour and a half to do the interviewing and testing of each participant. First the interviewer introduced himself (or herself) and attempted to establish rapport, then he (she) asked the woman to fill out the two self-report inventories (Appendix G), then he (she) presented the story telling test, and finally, he (she) conducted a brief, structured interview (see Appendix E). The tests preceded the interview with the aim of preventing the potentially disturbing content of the interview from influencing the test responses.

Test Scoring

Upon the completion of the testing and the interview, all materials were numerically coded. The author and a colleague who had been trained to use the scoring system developed for this study blindly rated the projective-test protocols. A participant's score for each

TABLE 6
 RACE AND SOCIAL STATUS OF THE BEREAVED,
 COMPARISON, AND DEPRESSED GROUPS

Social Status	Bereaved		Comparison		Depressed	
	B	W ^a	B	W	B	W
I - Upper Class	0	0	0	1	0	0
II - Upper Middle Class	1	2	0	5	2	2
III - Lower Middle Class	1	10	1	5	1	3
IV - Upper Lower Class	6	5	11	5	7	8
V - Lower Class	3	2	0	2	5	2
Total	11	19	12	18	15	15

^aBlack and White

variable was derived from the sum of the two raters' scores. An overall inter-rater reliability coefficient of .82 was achieved for the entire sample of projective stories. Table 7 presents the inter-rater reliability coefficients for each of the four variables measured by the projective test. Self-report tests were scored according to the standard scoring instructions found in the respective primary references (see Appendix G).

TABLE 7
INTER-RATER RELIABILITY COEFFICIENTS
FOR THE FOUR PROJECTIVE SCORING
SCALES

Scale	<u>r</u>
Self-Esteem	.8302
Dependency	.6629
Negative Attitudes towards Males	.7595
Unresolved Oedipal Attachments	.7431

CHAPTER IV

RESULTS

Descriptive Statistics

In order to examine the distributions of data, I first computed descriptive statistics for each dependent measure. Skewness and kurtosis were computed according to procedures described by Bliss (1967). All distributions of data approximated a normal curve with only the following exceptions: the Janis-Field Feelings of Inadequacy Scale (FIS) scores from the bereaved sample, the Rosenberg Self-Esteem (RSE) scores from the bereaved sample, the RSE scores from the comparison group, and the scores for Negative Attitudes towards Males (NEG) from the comparison group.

I noticed that one bereaved participant had an extreme score on both the FIS and the RSE. Because of the small size of the sample, one extreme score could bias the distribution so that it would not accurately reflect the parameters of the underlying population. I used Dixon's gap test (1950, 1951) as a procedure to determine whether the questionable scores were extreme enough in relationship to other scores in the samples to be identified as outliers and to be rejected. In both instances, the test was significant. I therefore eliminated the extreme scores from their respective samples. After these two scores were removed, the skewness and kurtosis of both distributions fell within normal limits.

The distribution of the NEG scores for the comparison group also had an outlier. However, because this distribution of scores would not be used for testing the four hypotheses of the current study, I decided to not remove the outlier from the sample.

The distribution of RSE scores for the comparison group was leptokurtic and positively skewed. Because this test measures low self-esteem, it was understandable that the distribution of scores from a sample of the normal population would cluster at the lower end of the scale.

Table 8 presents the mean, standard deviation, skewness, and kurtosis for each of the dependent variables.

Relationships among the Projective Measures

I computed bivariate correlation coefficients for all of the dependent variables for each of the three groups participating in this study. Table 9 presents these correlation coefficients.

The projective measure of Non-phenomenal Self-Esteem (NPSE) correlated significantly with both Dependency (DEPD) scores and the NEG scores. Because all four projective measures were derived from the same set of stories, the measures were not experimentally independent of each other. Therefore, these significant correlations may have only reflected the overlap in scale ratings rather than an actual relationship between the constructs being measured. For example, a story about a woman being rejected by her husband was scored as depicting both low self-esteem and a negative attitude towards males. Such an overlap may have caused a spurious correlation between the two measures. The question thus became--did

TABLE 8
 MEANS, STANDARD DEVIATIONS, SKEWNESS, AND
 KURTOSIS FOR THE DEPENDENT MEASURES

Dependent Measure	Group		
	Bereaved	Comparison	Depressed
Feelings of Inadequacy Scale (FIS)			
Mean	21.72*	20.67	43.93
SD	11.94*	7.18	18.00
Skewness	0.42*	0.27	-0.28
Kurtosis	-0.85*	-0.27	-0.83
Rosenberg Self-Esteem Scale (RSE)			
Mean	1.14*	0.43	3.87
SD	1.16*	0.68	1.93
Skewness	0.75*	2.03	-0.54
Kurtosis	-0.26*	5.67	-0.83
Non-Phenomenal Self-Esteem (NPSE)			
Mean	13.37	12.17	18.13
SD	4.51	5.21	5.95
Skewness	0.66	0.77	-0.23
Kurtosis	-0.27	0.25	-0.68
Dependency (DEPD)			
Mean	11.97	11.93	13.50
SD	5.93	7.26	7.41
Skewness	0.39	0.18	0.06
Kurtosis	0.61	-1.19	-0.50
Negative Attitudes towards Males (NEG)			
Mean	10.67	11.20	14.53
SD	4.89	5.60	5.87
Skewness	-0.33	1.34	0.49
Kurtosis	-0.75	2.48	-0.16

Continued

TABLE 8 CONTINUED

Dependent Measure	Group		
	Bereaved	Comparison	Depressed
Oedipal Attachments (OED)			
Mean	4.93	4.07	6.90
SD	2.96	2.65	4.20
Skewness	0.39	0.30	0.26
Kurtosis	0.07	-1.00	-0.75

Note. $n = 30$ unless indicated otherwise.

* Outlier removed, $n = 29$.

TABLE 9
 INTERCORRELATIONS AMONG DEPENDENT
 VARIABLES FOR THE BEREAVED, COMPARISON
 AND DEPRESSED GROUPS

Group	Variable	Correlation Coefficients					
		FIS	RSE	NPSE	DEPD	NEG	OED
Bereaved							
	FIS	---					
	RSE	.724**	---				
	NPSE	-.291	-.146	---			
	DEPD	-.125	-.146	.350*	---		
	NEG	.251	.381*	.401*	.269	---	
	OED	.080	.063	.296	.246	.235	---
Comparison							
	FIS	---					
	RSE	.193	---				
	NPSE	-.282	-.031	---			
	DEPD	-.220	-.141	.328*	---		
	NEG	-.205	.031	.490**	.299	---	
	OED	.175	.060	-.091	.237	.269	---
Depressed							
	FIS	---					
	RSE	.812**	---				
	NPSE	.415*	.330*	---			
	DEPD	-.023	.085	-.023	---		
	NEG	.017	.098	.248	-.103	---	
	OED	.496**	.339*	.340*	.348*	.081	---

Note. $n = 29$ for all correlations involving FIS or RSE scores from the bereaved group. For all other correlations, $n = 30$.

* $p < .05$, uncorrected for multiple comparisons.

** $p < .01$, uncorrected for multiple comparisons.

a person who displayed low self-esteem in a story for one picture tend to display dependency or negative attitudes towards males in a story for a different picture?

In order to answer the above question, I first had to examine the internal consistency of the four projective scales using the SPSS Reliability program (Nie & Hull, 1977). The alpha coefficients (ranging from .239 to .309) were statistically significant, which means that the ratings for individual stories correlate with composite scale scores. With that fact established, I was then justified to compare ratings on self-esteem for one picture with dependency, negative attitude, or oedipal ratings for the remaining four pictures. I therefore computed a correlation between self-esteem ratings for Picture 1 with the composite of dependency ratings from Pictures 2, 3, 4, and 5. This procedure was repeated for all five pictures and for all three projective measures.

If the scales were internally consistent and if the correlations between low self-esteem and the other scales were a result of an actual relationship between the constructs the scales supposedly measured, then the item-composite correlation coefficients should have reflected this relationship between constructs. The correlation coefficients, however, were not significant. I also repeated the above procedure after deleting first one, and then two ratings from each scale. The deleted items were those which contributed the least to the scale's internal consistency. There was still no evidence of any significant relationship between the self-esteem measure and any of the three other variables.

Because the scales were not experimentally independent, and I had

not been able to demonstrate relationships among these variables when contamination of the scores had been avoided, I decided to not include NPSE scores when any comparison would be made between self-esteem scores and scores for dependency, negative attitudes, or unresolved oedipal attachments (OED).

Hypothesis Testing

In order to test the hypotheses, I used multivariate techniques with data largely coming from scales that are unarguably ordinal, but may not have equal-interval properties. Although some authors have argued that so called higher-order statistical procedures are inapplicable to data that do not have ratio or interval scale properties (e.g., Stevens, 1951, 1968), the more recent writers such as Harris make a strong case for using these statistics with scales that are "reasonably ordinal" (Harris, 1975, p. 229).

Hypothesis-I: Both bereaved and clinically depressed individuals will experience a fall in self-esteem.

In order to test this hypothesis, I first examined the differences in self-esteem scores among the depressed, the bereaved, and the comparison groups by a one-way multivariate analysis of variance (MANOVA). Wilks's lambda, $\lambda(3, 2, 86) = .409$, and the corresponding F statistic, $F(6, 168) = 15.801$, for the test of the overall null hypothesis were significant, $p < .01$. Table 10 presents the F statistics for each of the dependent measures as well as for paired comparisons between the groups.

The self-esteem scores of the depressed group differ significantly from the scores of the other two groups. The results show that the

TABLE 10
 ONE-WAY MANOVA: SIGNIFICANCE STATISTICS FOR
 LOW SELF-ESTEEM MEASURES AND FOR PAIRED
 COMPARISONS BETWEEN THE THREE GROUPS

Dependent Variable	df	F	Groups Compared	df	F
FIS	2,84	1.47	Bereaved/Comparison	3,84	2.34
RSE	2,84	12.74*	Depressed/Bereaved	3,84	21.80*
NPSE	2,84	2.25	Depressed/Comparison	3,84	34.37*

Note. Bereaved $n = 29$; Comparison $n = 30$; Depressed $n = 30$.
 * $p < .01$, corrected for multiple comparisons ($p < \alpha/k$, p = probability of Type I error, $\alpha = .01$, and k = number of comparisons).

RSE is the most successful of the three dependent variables in discriminating among the groups.

Although this MANOVA supported the hypothesis that the depressed group would have higher scores on low self-esteem measures, it failed to demonstrate a difference in self-esteem scores between the bereaved group and the comparison group. The non-significant F ratio in this MANOVA does not, however, preclude our finding a significant difference between the two groups. Rather, it tells us that a combined self-esteem variable which has been statistically weighted to discriminate maximally among the three groups, fails to discriminate between two of those three groups. If only two groups were being compared, the combined variable could be weighted differently. I therefore computed a one-way MANOVA, this time comparing self-esteem scores from only the comparison group and the bereaved group. Wilks's lambda, $\lambda(3, 1, 57) = .834$, and the corresponding approximate F statistic, $F(3, 55) = 3.646$, for the test of the overall null hypothesis were significant, $p < .05$. Table 11 presents the F statistics for each of the three dependent measures.

On this second MANOVA the self-esteem scores of the bereaved group differ significantly from the scores of the comparison group. The RSE is the most successful of the three dependent variables in discriminating between the two groups.

To sum up: Hypothesis I is confirmed.

Hypothesis II: The self-esteem of a bereaved individual will be inversely related to the person's degree of dependency concerns.

In order to test this hypothesis, I computed a multiple regression.

TABLE 11
 ONE WAY MANOVA: SIGNIFICANCE STATISTICS
 FOR LOW SELF-ESTEEM MEASURES FROM THE
 BEREAVED AND COMPARISON GROUPS

Dependent Variable	df	F
FIS	1,55	1.29
RSE	1,55	9.30*
NPSE	1,55	0.61

Note. Bereaved $n = 29$; Comparison $n = 30$.

* $p < .01$, corrected for multiple comparisons ($p < \alpha/k$, p = probability of Type I error, $\alpha = .01$, and k = number of comparisons).

coefficient, using the DEPD scores as the criterion and the two measures of phenomenal self-esteem as the predictor variables. The resulting multiple correlation coefficient of .149 was not significant, $F(2, 26) = 0.295$; $p > .05$. A correlation between the FIS and the DEPD was computed and was not significant, $r(29) = .125$, $p > .05$. The correlation between the RSE and the DEPD was likewise not significant, $r(29) = .146$, $p > .05$. Therefore, Hypothesis II is disconfirmed.

Hypothesis III: The self-esteem of a bereaved individual will be inversely related to the degree the person experiences negative attitudes towards the lost love-object.

In order to test this hypothesis, I computed a multiple regression coefficient, using the NEG scores as the criterion and the two measures of phenomenal self-esteem as the predictor variables. The resulting multiple correlation coefficient of .382 was not significant, $F(2, 26) = 2.22$, $p > .05$. A correlation between the FIS and the NEG was computed and was not significant, $r(29) = .251$, $p > .05$. The correlation between the RSE and the NEG was significant even when the alpha level was adjusted to take into account the double comparison, $r(29) = .381$, $p < .05$ (corrected for multiple comparisons, $p < .05/2$). Therefore, Hypothesis III is confirmed.

Hypothesis IV: The self-esteem of a bereaved individual will be inversely related to the degree that the person is unable to relinquish the original oedipal object.

In order to test this hypothesis, I computed a multiple regression coefficient, using the OED scores as the criterion and the two measures of phenomenal self-esteem as the predictor variables. The

resulting multiple correlation coefficient of .081 was not significant, $F(2, 26) = 0.085, p > .05$. A correlation between the FIS and the OED was computed and was not significant, $r(29) = .080, p > .05$. The correlation between the RSE and the OED was likewise not significant, $r(29) = .063, p > .05$. Therefore, Hypothesis IV is disconfirmed.

Interview Data

I examined what participants had said during the structured interview in order to learn more about the bereavement process. Table 12 presents a comparison of what the three groups said.

A number of the significant differences among the three groups are readily explainable. The finding that fewer depressed individuals had been bereaved in the past is very likely the result of age differences between groups. The mean age for the depressed group is 15 years less than mean ages for the other two groups. It is reasonable to assume that the likelihood of losing a close relative increases with age. Differences between groups for the number of people living alone are, in part, the consequence of the criteria for group membership. In order for a woman to be recruited for the comparison group, she had to be married and to be living with her husband. Members of the bereaved group were widowed, on the other hand, which increased the probability of them living alone. Although the depressed group has a much higher frequency of recent hospitalizations (63% of the sample), only 30% of the depressed participants have been hospitalized during the past year for general-medical rather than for psychological reasons.

The interview questions which reveal the most distinct and

TABLE 12
 COMPARATIVE CONTENT ANALYSIS OF THE STRUCTURED
 INTERVIEW

Interview Item	% of Participants		
	Bereaved	Comparison	Depressed
Previous Grief Experience			
-- bereaved previously	90	93	70*
-- unusual or severe reaction	10	17	30
-- lost parent or sibling when 10 yrs. old or younger	17	3	3
-- lost parent or sibling when 18 yrs. old or younger	10	10	10
-- lost parent, sibling, or spouse as an adult	83	90	63*
Current Grief Experience			
-- more than one month warning	50	--	--
-- talks with the deceased	63	--	--
-- finds talking with the deceased helpful	79 ^a	--	--
Current Living Situation			
-- living alone	30	0	10*
-- children living at home	50	60	77
-- childless	10	10	17
-- described marriage in very positive terms	67	57	8 ^{b**}
Religion			
-- considers self as religious person	90	87	67*
-- believes in life after death	63	73	47
-- role of religion has changed since loss	40	--	--
-- religion had favorable impact on grief	67	--	--
Health			
-- Serious medical problems ^c	57	37	47
-- taking prescribed medication	70	47	83**
-- taking psychotropic medication	40	7	63**
-- hospitalized during past 12 months	20	20	63 ^d
-- average one visit a month or more to physician ^e	30	10	43*
-- past history of alcohol abuse or emotional problems	23	17	90**
-- family history of emotional problems	17	17	53**
-- recent increase in smoking	7	3	27*

Continued

TABLE 12 CONTINUED

Interview Item	% of Participants		
	Bereaved	Comparison	Depressed
Health (Cont'd)			
-- recent increase in alcohol consumption	3	0	3
-- recent increase in consumption of prescribed medication	17	0	17
-- recent increase in consumption of non-prescribed medication	7	0	17
Symptoms of Depression			
-- appetite disturbance	67	23	73**
-- sleep disturbance	63	30	83**
-- anergia (loss of energy)	57	27	83**
-- decline in cognitive functioning	53	23	73**
-- anhedonia (loss of interest)	47	13	83**
-- increased thoughts about own death	63	37	87**
-- suicidal ideation within past 3 months	20	0	70**

Note. $n = 30$ for each group.

^aPercentage of those who do talk to the deceased.

^bPercentage of those who are married.

^cAny medical conditions which could be life threatening without intervention.

^d30% if psychiatric hospitalizations are excluded.

^eDoes not include visits to a psychiatrist.

* $p < .05$, uncorrected for multiple comparisons.

** $p < .01$, uncorrected for multiple comparisons.

consistent differences among the three groups are questions pertaining to the symptoms commonly associated with depressive disorders. Each of these symptoms are psychophysiological indicators of an individual's current affective state. When there is a clinical disorder of affect, usually at least four of these symptoms are present. In order to compare the affective states of participants from the three groups, I summed the psychophysiological symptoms present for each participant. I decided to exclude increased thoughts about one's death because such thoughts are rather predictable for the state of bereavement. Table 13 presents the distribution of sums for the psychophysiological symptoms.

Only two of the depressed participants failed, during their interview, to acknowledge four or more symptoms. The inclusion criteria for the depressed sample included these six symptoms plus two others: evidence of self-reproach and psychomotor agitation or retardation. All 30 participants had been judged, prior to the interview, to be displaying at least four of these eight symptoms. The failure of two of the participants to display four psychophysiological symptoms at the time of their interviews might have been the result of: (a) a rapid improvement during the time between the initial screening of participants and the data collection, (b) defensiveness during the interview, or (c) the omission of two of the original inclusion criteria from the interview questions.

Fifteen of the bereaved participants acknowledged a sufficient number of symptoms to suggest a clinical disorder of affect. This number was three times greater than the number of participants from

TABLE 13
 A COMPARISON BETWEEN GROUPS:
 THE NUMBER OF PSYCHOPHYSIOLOGICAL
 SYMPTOMS EXPERIENCED BY EACH
 PARTICIPANT

Number of Symptoms	Number of Group Members		
	Bereaved	Comparison	Depressed
1	1	0	1
2	4	15	0
3	10	10	1
4	6	4	3
5	5	1	12
6	4	0	13
Total <u>n</u>	30	30	30
Mean	3.73	2.70	5.13
Standard Deviation	1.36	0.83	1.11

the comparison group who indicated the presence of at least four of the six psychophysiological symptoms.

In order to discover variables which might be associated with an increased occurrence of these symptoms, I computed a multiple regression, using the sum of psychophysiological symptoms as the criterion, and responses to questions in the interview as the predictor variables. I obtained a multiple correlation coefficient of .914, $F(17, 12) = 3.58$, $p < .05$. When the size of the sample is small and the number of variables is large, a multiple correlation coefficient is a biased estimate of the population parameter. This bias occurs because the regression analysis takes advantage of the idiosyncracies of the sample when determining optimal regression weights. Therefore, if the same regression weights were applied to a second sample, the resulting multiple correlation coefficient would very likely be smaller. Herzberg (1969) described a formula which estimates the amount of "shrinkage" that will take place because of the bias in the correlation coefficient. When adjusted for shrinkage, the correlation coefficient for the current problem becomes .603. Table 14 presents individual correlation coefficients, beta coefficients, and F statistics for each of the predictor variables.

The results of the multiple regression suggest that black women who are conjugally bereaved display more psychophysiological symptoms than do white women who have lost their husbands. Women who are living alone or who still have their children living at home with them also display more symptoms than women who are living with other adults.

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TABLE 14
MULTIPLE REGRESSION: THE RELATIONSHIP BETWEEN
INTERVIEW RESPONSES AND THE SUM OF
PSYCHOPHYSIOLOGICAL SYMPTOMS FOR
THE BEREAVED GROUP

Predictor	Simple <u>r</u>	Beta	F(1,12)
Age	-.557	.155	0.092
Race (Black = 1, White = 2)	-.255	-.447	6.701*
Length of bereavement (weeks)	-.278	.033	0.032
Index of social position	.023	-.165	0.876
Years married	-.196	-.578	1.270
First marriage (yes = 1, No = 2)	-.416	-.591	3.708
Quality of marriage (1 = very negative, 5 = very positive)	.073	-.270	1.381
Previous bereavement (yes = 1, No = 2)	.315	.247	1.772
Previous bad reaction to loss (Yes = 1, No = 2)	-.066	-.135	0.483
Living with another person (Yes = 1, No = 2)	.185	.502	5.111*
Children at home (Yes = 1, No = 2)	.000	-.545	4.915*
Considers self religious (Yes = 1, No = 2)	.481	.312	3.385
Belief in life after death (Yes = 1, No = 2)	.048	.084	0.311
Talks with the deceased (Yes = 1, No = 2)	-.468	-.231	0.633
Psychiatric history (Yes = 1, No = 2)	.125	.062	0.101
Family history of psychological problems (Yes = 1, No = 2)	.190	.085	0.272
Advanced warning about loss (Yes = 1, No = 2)	.072	.207	1.422

Note. $n = 30$

* $p < .05$

I was also interested in discovering whether data from the interview might help predict which bereaved individuals are most prone to experience low self-esteem. I therefore computed a canonical correlation using the three self-esteem measures as one set of variables, and responses to interview questions as the other set of variables. The canonical correlation of .936 was not significant. The greatest characteristic root = .876, a value that is not statistically significant according to the tables given by Harris (1975). (Here, $m = 6.5$, $n = 4$, and $s = 3$.) Thus, we can conclude that there is no relationship between the set of self-esteem measures and the set of interview variables.

Because low self-esteem and the presence of psychophysiological symptoms could both serve as indicators of poor adjustment to bereavement, I was interested in the relationship between these variables. I therefore computed a multivariate regression, using the sum of symptoms as the criterion, and the three self-esteem measures as the predictor variables. The resulting multiple correlation coefficient of .404 was not significant, $F(3, 25) = 1.624$, $p > .05$. Table 15 presents the bivariate correlation coefficients, beta coefficients, and F statistics for each of the predictor variables: When the alpha level is adjusted to take into account multiple comparisons, none of the bivariate correlation coefficients are significant. One can therefore conclude that the self-esteem measures are not related to the number of depressive symptoms.

The women spontaneously offered a substantial amount of information during the structured interview. Although these data do not lend themselves to statistical analysis, they do provide hints

TABLE 15
 MULTIVARIATE REGRESSION ANALYSIS: THE
 RELATIONSHIP BETWEEN LOW SELF-ESTEEM
 MEASURES AND THE SUM OF PSYCHO-
 PHYSIOLOGICAL SYMPTOMS FOR THE
 BEREAVED GROUP

Predictor	Simple <u>r</u>	Multiple <u>R</u>	Beta	<u>F</u>
FIS	.393*	.393	.348	1.593
RSE	.290*	.394	.024	0.008
NPSE	-.200*	.404	-.095	0.246

Note. n = 29

* p > .05/3

about the dynamics of bereavement. In the following sections I present a summary of this additional information.

Anticipatory grief. Research findings on the impact of anticipatory grief have been highly contradictory. A finding of the current study may suggest the reason for the lack of consistent empirical findings. Many women in the bereaved sample had been informed of the potentially fatal nature of the illness well in advance of their husband's death. Nevertheless, most of these women denied the reality; they refused to acknowledge the possibility of loss. This finding suggests that an operational definition of anticipatory grief should not be "length of illness" or "amount of advanced warning before the death." The critical issue is whether the survivor knew and accepted the reality of imminent loss.

Although many researchers have reported that anticipatory grief has a favorable impact upon bereavement, Clayton, Halikas, Maurice, and Robins (1973) reported the paradoxical finding that widows and widowers who had advanced warning of their spouse's death, had greater difficulty with grief four weeks after the loss than did widows and widowers who had little or no advanced warning. This finding becomes understandable in light of information provided by many of the participants in the current study. Women whose husbands went through long, painful ordeals, experienced a sense of relief, both for themselves and for their husbands, at the time of death. One woman commented, "His death wasn't hard, it was the watching." In such circumstances, the impact of loss was delayed; the intense grieving process began days, weeks, or even months after the death. This pattern differed from the pattern of grief experienced by the women

whose husbands died suddenly and unexpectedly. These women, who had little or no advance warning, reported that the onset of intense grief began as soon as the initial shock or sense of numbness wore off.

Guilt. Findings from this study have shown that many women who had highly ambivalent relationships with their husbands experienced a fall in self-acceptance. This conflict was likely experienced largely at the unconscious level. However, a number of the women consciously struggled with guilt over a variety of issues. For example, one woman continued to question her decision to terminate the hospital's life-support efforts for her husband. Another woman expressed guilt over her reluctance to discuss with her husband the realities of his serious illness and pending death. A third woman indicated that she had difficulty accepting her decision to withdraw periodically from her dying husband by escaping into reading or gardening.

Anger. A large number of the bereaved women who participated in this study, as well as of the women who declined to participate, displayed considerable anger. The hospital, the nursing and support staffs, and the attending physicians were the most frequent targets of their anger. Two of the participants spontaneously discussed their anger at their deceased husbands. One woman reported that she now bitterly asks, "Why did you give up? Why didn't you fight harder?" Another woman described her anger at her husband for leaving her without adequate financial security. Other women did not blame anyone for their current grief, but nevertheless struggled with anger over the loss. One woman complained, "It isn't fair that he

should die; he was so good, and there are so many rats running around." Another woman expressed concern over her pattern of displacing her rage unto her adolescent son.

Meaningful support. Many of the women indicated that well-intentioned relatives and friends inadvertently made the bereavement process more difficult. Friends and relatives were reluctant to reminisce with the widow. They frequently advised the widow to stop dwelling on the past, to start thinking about the future, and to become active and involved in day-to-day activities. These women found that the most meaningful support came from individuals who allowed the bereaved woman to talk, to cry, and to remember. More than one woman indicated that the research interview was the first opportunity she had had to discuss her loss.

Health. There have been a number of studies which have suggested increased morbidity and mortality for recently bereaved individuals. A number of explanations have been offered, including the physiological impact of stress, the natural pairing of physically weak individuals, and the common risk shared by a husband and wife who come from a dangerous environment or impoverished background. Another possible explanation, which I became aware of while doing this study, is that a number of women during their husband's illness tended to neglect their own health. They postponed needed operations, failed to fill prescriptions for antihypertensives, and did not keep doctor's appointments. Such actions could contribute to the increased mortality and morbidity rates reported in previous studies.

Some studies have used the number of visits to a doctor's office

as a criterion for health during bereavement. An increase in doctor's office visits during bereavement, however, is not surprising. Sixty-three percent of the bereaved women in the current study acknowledged that they were thinking more frequently of their own death. With the probable emergence of death-anxiety at the time of loss, the widow would become more motivated to seek medical help, medical help she had ignored during her husband's illness.

Dreams. Dreams may serve as a valuable indicator of the current state of the bereaved ego. A number of women described dreams in which their husbands were alive and were involved in normal activities. These women often reported experiencing disappointment and pain when they waked up from these dreams and realized that their husbands were dead. Such dreams probably reflect the ego's denial of loss as well as its efforts to retain the love-object. Other women reported dreaming that their husbands were in pain or in jeopardy. These dreams may express the ego's continued struggle with the trauma of a significant loss. Finally, some women described dreams in which their husbands returned from death in order to comfort them. One woman provided a moving example of this type of dream:

Right after his death, I would cry every night when I went to bed. I felt empty and alone. One night, in a dream, I felt the warmth of him next to me. I could feel his arms around me as he said 'It's okay moms, I'm happy now and I'm not in anymore pain. I want you to be happy too.'

More than one woman referred to this type of dream as a turning point in her bereavement. This type of dream very likely represents the ego's acceptance of reality and its affirmation of continued life.

Speaking with the deceased. The question arises whether speaking with the deceased is an adaptive or maladaptive behavior in bereavement. Many psychoanalytic writers have insisted that any behavior which serves to deny the reality of separation and loss complicates the grieving process. Pollock (1961), for example, stated that "in instances where the death of the object is not realistically appreciated, the object may continue to exist as an unassimilated introject with whom internal conversations can be carried out" (p. 342). On the other hand, Yamamoto, Okonogi, Iwasaki, and Yoshimura (1969) reported that ancestor worship in Japan, which includes conversing with the deceased, has a beneficial impact upon the bereavement process.

In the current study, 63% of the women reported that they spoke with the deceased. Seventy-nine percent of these women reported that the experience was helpful. I question whether speaking with the deceased serves as a denial of loss. In my therapy experiences with abnormal grief reactions, I have found that for many patients speaking with the deceased first requires an acceptance that the loved one is indeed dead. The patient who still sets an extra place at the dinner table and waits for the deceased to walk through the door at the end of a work day is usually unable to speak with the deceased. Speaking with the deceased may be a very adaptive behavior because it may facilitate grief work by lessening the normal incapacitating influence of loss and by providing an opportunity to resolve unfinished business involving the lost object.

CHAPTER V
DISCUSSION

The Hypotheses

The results of the present study support Bibring's hypothesis that an irretrievable loss results in a drop of self-esteem. Borrowing from psychoanalytic theory, and from Bibring's theory in particular, we may speculate on the psychodynamic process which occurs during normal bereavement. Before the loss, the individual had formed a meaningful, loving relationship with another person. A great deal of cathetic energy was devoted to this relationship. The strict, well-formed boundaries of the ego were relaxed sufficiently to allow an identification with the loved one. Because of this identification, any success for the love-object was also experienced as a success for the individual; any pain endured by the love-object was also a pain endured by the individual. When the love-object was suddenly lost through death, the survivor encountered a reality which could not possibly be altered. The survivor, because of his close identification with the love-object, experienced the harsh realization of his own mortality. Mourning, therefore, is a time when an individual experiences a sense of helplessness and vulnerability. This experience of helplessness is reminiscent of earlier moments of helplessness when the nurturing breast was absent, or when the

punishing parent reacted to norm-violating behavior, or when the beloved oedipal object had to be relinquished. As Bibring had pointed out, these moments of helplessness are moments when the individual perceives self as inadequate, unworthy, and unloved.

Of the three self-esteem measures used for this study, the RSE most clearly reflected the differences in self-esteem between the bereaved group and the comparison group. As I stated earlier, the RSE is a measure of self-acceptance. We infer from the high RSE scores, therefore, that members of the bereaved group perceive themselves as less worthy and less capable than they viewed themselves before the loss.

The FIS, on the other hand, is a measure of social self-esteem. On evidence from this scale, we believe that the widow's perception of her social skills does not undergo a significant change as a result of her loss. She accurately assesses her past competence in engaging effectively in social interactions, and she does not question whether she still retains this competence. It is her interest in social interactions which diminishes during her bereavement, not her judgement about the quality of her social skills.

The NPSE is a projective measure of self-esteem. This measure is very likely influenced by an individual's unconscious perception of self, a long-standing perception which is seldom altered by a single experience, crisis, or setback. In other words, the NPSE is most likely a measure of a personality trait rather than of a personality state. Therefore even though a bereaved woman may struggle with guilt and with a lack of self-acceptance during her grief, an underlying,

wholesome sense of self, the premorbid sense of self, persists.

Eventually this persisting sense of self facilitates the natural recovery which occurs after normal bereavement.

The same natural recovery is atypical of clinical depression because the unconscious self-esteem is very low as a result of a long history of failure in efforts to achieve ego aspirations. For the clinically depressed individual, the phenomenology of the loss tends to confirm the long-standing perception of self as helpless. Under these circumstances, recovery is seldom natural; more often, recovery requires an extensive mobilization of defenses or an intensive therapeutic intervention.

For the bereaved and the comparison groups, the NPSE did not correlate with either the FIS or the RSE. The NPSE did correlate, however, with these two measures in the depressed group. Although this finding seems paradoxical, the apparent contradiction can be explained in terms of the trait-state dichotomy I discussed earlier in this section. A person with a wholesome sense of self should score in the normal range on the NPSE regardless of what her current circumstances are. However, her RSE and FIS scores will likely reflect whether she is currently struggling with self-doubt during a time of crisis, or is enjoying self-acclaim because of a recent triumph. On the other hand, we would expect a member of the depressed group to have a long-standing negative perception of self. She would therefore score in the extreme (high) range on the NPSE. Because she is currently depressed, her FIS and RSE scores should also be in the extreme (high) range.

There was a significant correlation between the RSE and the NEG which suggests that the bereaved women who have negative attitudes towards males have more difficulty with self-acceptance than bereaved women who did not have similar negative attitudes. This finding is consistent with Bibring's theory of the mechanism of depression. A basic aspiration of the ego is to be good, to be worthy, to be loving. If a woman harbored resentment towards her husband, his death would become an occasion on which she could not escape the awareness that she had failed to overcome her resentment. According to Bibring's theory, she would become painfully aware of her helplessness to achieve aspirations of being good, worthy, and loving; she would subsequently experience a fall in self-esteem. It is logical that this fall in self-esteem would be more apparent on a measure of self-acceptance than on a measure of perceived social competence.

There was no statistical relationship between self-esteem scores from the bereaved group and either dependency concerns or unresolved oedipal attachments. The failure to confirm these hypotheses may be explained by one or more of the following possibilities: (a) the measures of dependency and oedipal attachments may not be valid; (b) the self-esteem measures may not reflect the dimensions of self-esteem which are related to dependency or oedipal attachments; (c) the sample size may be too small to produce a sufficient number of extreme scores to reflect the hypothesized relationships, especially if the relationships are non-linear; (d) the null hypotheses may be correct. Deciding which of these four possible explanations is correct will require further empirical investigation.

Interview Data

The frequency of psychophysiological symptoms in the members of the bereaved sample in this study is very similar to data reported by Clayton, Halikas, and Maurice (1971) in their study of 109 widows and widowers. Although the frequencies of individual symptoms were similar for the two samples, only one-third of the women in the Clayton et al. sample presented with four or more symptoms, whereas one-half of the current sample presented with four or more symptoms (Clayton, Halikas, and Maurice, 1972). This difference may be due to a difference in mean ages between the two samples. The mean age of the sample from the Clayton et al. study was nine years more than the mean age of the sample from the current study. As I have stated earlier in this dissertation, there have been studies which have shown that younger people have greater difficulty with bereavement than do older people.

The presence of psychophysiological symptoms in bereavement has significant implications for our understanding of clinical depression and its treatment. Research has established that a disorder in the action of neurotransmitters appears to be associated with many forms of clinical depression and accounts for psychophysiological symptoms such as sleep disorder, appetite disturbance, decreased libido, and anergia. Tricyclic compounds and monoamine oxidase inhibitors are two groups of antidepressant medications which have been effective in decreasing the psychophysiological symptoms of depression, apparently by correcting the disorder in the action of neurotransmitters (primarily serotonin and norepinephrine). The responsiveness of many depressions to psychotropic medications has led many therapists to

believe that depressions with psychophysiological symptoms have a biochemical rather than a psychosocial origin. Others have concluded that the presence of psychophysiological symptoms discriminates between endogenous and reactive depressions. This latter line of thinking has influenced many practitioners to refrain from prescribing antidepressants for depressive conditions which appear to be reactive. The presence, however, of psychophysiological symptoms in bereavement demonstrates the basic flaw in these lines of reasoning. The more likely explanation for the interaction of biochemical and psychosocial factors is that certain types of stress may disrupt the normal action of neurotransmitters. Thresholds for this biochemical disruption probably differ from person to person because of genetic and developmental influences. Although there may indeed be biochemical depressions, psychogenic depressions can have biochemical dimensions and can benefit from a psychopharmacological intervention.

Findings in the current study show that black women who are bereaved display more depressive symptoms than white bereaved women do. It is not immediately apparent why this difference exists, especially because factors such as social status were statistically controlled in this study. Bereaved women who live alone also have more depressive symptoms than women who live with other adults. This finding is consistent with Bibring's hypothesis that a supportive environment helps facilitate recovery from a temporary sense of helplessness. Bereaved women who still have children living at home also experience a significantly greater number of psychophysiological symptoms than do bereaved women who have no children at home. This latter finding is possibly explainable by the added pressure a woman

experiences when she still has the responsibility of caring for her children. Certainly responsibilities such as providing for the financial well-being of the children can be overwhelming. Perhaps even more significant, however, is the common tendency of a widow to repress her own grief because of a mistaken conviction that this is necessary for the well-being of her children. Such a woman fails to complete the grieving process and thus becomes subject to the ravages of repressed conflict.

A number of previous studies have demonstrated a relationship between age and severity of bereavement. Data from the current study help to clarify the nature of this relationship. The bivariate correlation between age and the presence of psychophysiological symptoms is substantial, $r(30) = .50, p < .01$. However, the relationship between age and severity of symptoms dropped appreciably when the influence of other variables was partialled out by multiple regression. The influence of two other variables, not living alone and not having children at home, can probably explain the significant bivariate correlation between age and the presence of psychophysiological symptoms of depression. Youth itself, apparently, does not necessitate abnormal bereavement. Rather, younger widows are more likely to have children at home and older widows are more likely to have relatives (widowed, divorced, having children grown and away from home) who are available to live with them.

Conclusion

Women who lose their husbands experience a sense of helplessness and a fall in self-esteem. Unlike depressed women, bereaved women

normally possess an underlying, wholesome sense of self which facilitates a gradual adjustment to loss. This personality resource, not normally evident in clinical depressions, lessens the need for a formal therapeutic intervention. Rather, the most appropriate response to bereavement is to provide a supportive environment which assures the woman she is important, loved, secure, worthwhile, and capable. This support should include ample opportunity for the woman to acknowledge, to grieve over, and eventually to accept the magnitude of her loss.

Widows who have harbored negative attitudes towards males experience a greater drop in self-acceptance than widows who did not display similar attitudes. Individuals who are in a helping role with bereaved women must listen carefully for signs of hostility towards the deceased. The widow should be encouraged to ventilate her anger, and should be reassured that one may be loving yet resentful at the same time. Healing will take place as the woman comes to accept the ambivalent nature of her feelings.

Bereaved women who are living alone display more depressive symptoms than bereaved women who are living with other adults. Women living alone are often deprived of the vital support discussed earlier in this section. Widow-to-widow programs, community outreach services, and church groups are examples of organizations which may respond effectively to the needs of the widow living alone.

Women with children living at home also display a significant number of depressive features. The bereaved mother frequently suppresses her grief in efforts to not disturb the children. The

impact of her loss nevertheless surfaces, frequently through anger displaced on the children, somatization, and psychopathology. The mother's failure to grieve deprives the children of a model for how to cope with loss. The mother's silence is easily misinterpreted as blame; her displaced anger may generate inappropriate guilt in the child. Left alone with confusing feelings, the child may withdraw or may begin to display acting-out behavior. Just as widow-to-widow programs have been successfully developed to meet the needs of bereaved women, family-oriented programs must be developed to meet the needs of bereaved families.

APPENDIX A

LETTER TO BEREAVED WOMEN

Dear (name of bereaved),

I am a psychologist at Henry Ford Hospital, and I recently learned of your husband's death. I am very aware of the grief you are probably experiencing at this time. Please forgive me for intruding on your privacy during this time of mourning, but I have a very important request to make of you.

I need not tell you of the pain one experiences when one has lost a loved one. Unfortunately, counselors and clergy-persons alike know little more about grief than that it is the most painful of all human experiences. We feel that we need to know more about the grief process so that we might be in a position to help those individuals who have great difficulty adjusting to a loss such as yours.

We have therefore begun a research study which involves individuals like yourself and we would very much appreciate your assistance. If you decide to participate in this effort, no more than one and a half hours of your time would be required. You could either come to the hospital to be interviewed, or a member of our research team could visit your home at a time most convenient for you. Any information you would provide would be kept in strictest confidence. We would also be happy to share with you the results of this study at its conclusion.

Please give our request your serious consideration. I will be calling you in about a week to see if you would be willing to participate, and to answer any questions you might have. Be assured, however, that no pressure will be exerted over the phone, and your wishes will be respected.

Thank you for your time and consideration. I will look forward to calling you next week.

Sincerely,

Dennis P. Sugrue, MS
Henry Ford Hospital

APPENDIX B

LETTER TO NON-BEREAVED WOMEN

Dear (name of non-bereaved),

I am a psychologist at Henry Ford Hospital and I am writing to ask for your help in an important research project. We are currently studying the grief process women go through when they lose their spouse. Now we know that your husband is alive and well, but we need to compare widows to a normal sample of women like yourself who have not lost their partner. Since your husband has recently been treated at this hospital, we feel that you would have certain things in common with the widowed group--with the significant exception, of course, that you have not experienced a loss through death.

If you are willing to participate in this study, no more than one and a half hours of your time would be required. You could either come to the hospital to be interviewed, or a member of our research team could visit your home at a time most convenient for you. Any information you would provide would be kept in the strictest confidence. We would also be happy to share with you the results of this study at its conclusion.

Please give our request your serious consideration. I will be calling you in about a week to see if you would be willing to participate, and to answer any questions you might have. Thank you for your time and consideration. I will look forward to calling you next week.

Sincerely,

Dennis P. Segrue, MS
Henry Ford Hospital

APPENDIX C

INCLUSION CRITERIA FOR DEPRESSED SAMPLE

- A. Dysphoric mood or pervasive loss of interest. The disturbance is characterized by symptoms such as the following: depressed, sad, blue, hopeless, low, down in the dumps, "don't care anymore," irritable, worried. The disturbance must be prominent and relatively persistent but not necessarily the most dominant symptom. It does not include momentary shifts from one dysphoric mood to another dysphoric mood, e.g., anxiety to depression to anger, such as seen in states of acute psychotic turmoil.
- B. At least four of the following symptoms:
- (1) Poor appetite or weight loss or increased appetite or weight gain (change of one lb. a week or 10 lbs. a year when not dieting).
 - (2) Sleep difficulty or sleeping too much.
 - (3) Loss of energy, fatigability, or tiredness.
 - (4) Psychomotor agitation or retardation (but not mere subjective feelings of restlessness or being slowed down).
 - (5) Loss of interest or pleasure in usual activities, or decrease in sexual drive (do not include if limited to a period when delusional or hallucinating).
 - (6) Feelings of self-reproach or excessive or inappropriate guilt (either may be delusional).
 - (7) Complaints or evidence of diminished ability to think or concentrate such as slow thinking, or indecisiveness (do not include if associated with obvious formal thought disorder).
 - (8) Recurrent thoughts of death or suicide, including thoughts of wishing to be dead.
- C. The period of illness has had a duration of at least one week from the time of the first noticeable change in the patient's usual condition.
- D. None of the following which suggests Schizophrenia is present:
- (1) Delusions of being controlled or thought broadcasting, insertion, or withdrawal.
 - (2) Hallucinations of any type throughout the day for several days or intermittently throughout a one-week period unless all the content is clearly related to depression or elation.
 - (3) Auditory hallucinations in which either a voice keeps up a running commentary on the patient's behaviors or thoughts as they occur, or two or more voices converse with each other.

D. (cont.)

- (4) At some time during the period of illness had delusions or hallucinations for more than one month in the absence of prominent affective (manic or depressive) symptoms (although typical depressive delusions such as delusions of guilt, sin, poverty, nihilism, or self-depreciation or hallucinations with similar content are permitted).
- (5) Preoccupations with a delusion or hallucination to the relative exclusion of other symptoms or concerns (other than delusions of guilt, sin, poverty, nihilism, or self-depreciation, or hallucinations with similar content).
- (6) Marked formal thought disorder if accompanied by either blunted or inappropriate affect, delusions or hallucinations of any type, or grossly disorganized behavior.

E. Not due to any specific known Organic Mental Disorder.

F. Not superimposed on Schizophrenia, Residual Subtype.

G. Excludes Simple Bereavement following loss of a loved one if all of the features are commonly seen in members of the subject's subcultural group in similar circumstances.

APPENDIX D

INFORMED CONSENT FORM

Protocol Title: The Impact of Loss-Bereavement and Depression

Participant's Name _____ # _____

1. I have been asked to participate in a research study which will involve an interview and psychological testing. I understand that this research study has been designed to gain a greater understanding of bereavement and depression.
2. (For bereaved individuals only) I realize that the interview will include a discussion of my husband's death and this may involve some painful recollections.
3. (For individuals currently receiving psychotherapy at Henry Ford Hospital) I am aware that I have the option to have the results of the psychological tests sent to my therapist. If I wish to take advantage of this option, I will sign the appropriate authorization form for the release of information. Otherwise, all information will be held in strict confidence and used for research purposes only.
4. I have discussed this study with Mr. Sugrue and he has offered to answer any questions I may have concerning the procedure involved.
5. In giving my consent, I acknowledge that my participation in this research study is voluntary and that I may withdraw from it at any time without prejudice to me.

Date

Signature of Participant

Investigator

Witness not associated with
research study but present
during the explanation to the
participant

APPENDIX E

INTERVIEW AND TESTING SCHEDULE

Introduction (15 minutes)

- Researcher introduces self
- thinks participant
- discusses purpose of the study
- presents an overview of the testing and interview
- presents consent form (Appendix D)
- reassures participant that:
 - she is free to discontinue any time
 - results will be confidential

Testing (45 minutes)

- Researcher presents the self-report questionnaire and reviews printed instructions
- Researcher presents picture-story test and reviews printed instructions

Interview (30 minutes)

Marital History

- How long were you married?
- Was this your first marriage?
- How would you describe your marriage relationship?

Previous Experience with Death

- Before your husband's death, have you ever lost anyone close to you? (Who? Relationship? Your age? Your adjustment?)

Circumstances Surrounding Death

- How much advanced warning did you have that your husband was going to die?

Emotional Support

- Are you living with anyone at this time? (Who? Relationship?)
- How many children do you have? (Ages?)
- If no children are living at home, how many miles do you live from your nearest child?

Emotional Support (cont.)

- Who has been most helpful during this time?
(Relationship? How?)

Religion

- Do you consider yourself as a religious person?
- Has the role of religion in your life changed since your husband's death? (How?)
- What impact has religion had on your grief?
- Do you believe in a life after death?
- Have you tried talking to your husband since his death? (How often? Helpful?)

Medical and Psychological Status

- Do you currently have any serious medical problems?
(List? Time of onset?)
- Are you taking any prescribed medication at this time? (Names? For what?)
- During the year preceding your husband's death, were you hospitalized? (Reason? Length of stay?)
- How many times have you visited a physician during the year preceding your husband's death?
- If you smoke, has there been a recent increase in your amount of smoking?
- Has there been a recent increase in your consumption of alcohol? Prescribed drugs? Non-prescribed drugs?
- How has your appetite been recently? (Describe weight gain or loss.)
- How would you describe your energy level?
- Describe what your thinking, memory, and concentration have been like in recent weeks.
- What type of activities do you find enjoyable?
(Any difference from one year ago?)
- Have you recently been thinking about your own death? (Describe.)
- Have you received any previous psychiatric treatment?
- Has anyone in your immediate family ever had serious emotional problems? (Who? Relationship?)
- Have you recently had any bizarre or unusual experiences?
- Have you found these questions difficult to discuss?

Conclusion

- Researcher thanks participant
invites her to call if Researcher can
be of any assistance

APPENDIX F

INDEX OF SOCIAL POSITION

The following summary of the two factor index of social position (Myers & Bean, 1968) is taken from Amin (1974):

Myers and Bean used two factors in determining the index of social position: socioeconomic status and level of education.

There are seven positions on the occupational scale:

1. Executives and proprietors of large concerns and major professionals
2. Managers and proprietors of medium concerns and minor professionals
3. Administrative personnel of large concerns, owners of small independent businesses and semi-professionals
4. Owners of little businesses, clerical and sales workers, and technicians
5. Skilled workers
6. Semiskilled workers
7. Unskilled workers

There are also seven positions on the educational scale:

1. Graduate professional training
2. Standard college or university graduation
3. Partial college training (including individuals who have completed at least one year but not full college requirements)
4. High school graduation (including all secondary school graduates, whether from a private school, public school, or trade school)

5. Partial high school (including individuals who have completed the tenth or eleventh grades but not the full high school requirements)
6. Junior high school (including individuals who have completed the seventh, eighth, or ninth grades)
7. Less than seven years of school

To obtain the index of social position score, the scale value for occupation is multiplied by the factor weight for occupation, which is 7; and the scale value for education is multiplied by the factor weight for education, which is 4. These two values are then added to obtain the index of social position score. By way of example, a physician would receive the following score:

<u>Factor</u>	<u>Scale Score</u>	<u>Factor Weight</u>	<u>score x weight</u>
Occupation	1	7	7
Education	1	4	<u>4</u>
Index of Social Position Score			11

The range of scores on the two factor index of social position is 11 to 77. Myers and Bean group the scores into the following social classes:

<u>Index of Social Position</u>	<u>Social Class</u>
11 to 17	I - Upper Class
18 to 27	II - Upper Middle Class
28 to 43	III - Lower Middle Class
44 to 60	IV - Upper Lower Class
61 to 77	V - Lower Lower Class

APPENDIX G

SELF-ESTEEM QUESTIONNAIRE AND SCORING INFORMATION

Directions: We are interested in how you see yourself, your strengths and your weaknesses. Please read carefully each of the following questions, and circle the answer which best describes how you feel today, that is, right now. Please circle one answer only.

- 1) How often do you have the feeling that there is nothing you can do well?
- | | | | | |
|------------|--------------|-----------|-----------------------|-------------------|
| Very Often | Fairly Often | Sometimes | Once in a Great While | Practically Never |
|------------|--------------|-----------|-----------------------|-------------------|
- 2) When you have to talk in front of a group of people, how afraid or worried do you usually feel? (e.g., very afraid)
- | | | | | |
|------|--------|----------|----------|------------|
| Very | Fairly | Slightly | Not Very | Not at all |
|------|--------|----------|----------|------------|
- 3) How often do you worry about whether other people like to be with you?
- | | | | | |
|------------|--------------|-----------|-----------------------|-------------------|
| Very Often | Fairly Often | Sometimes | Once in a Great While | Practically Never |
|------------|--------------|-----------|-----------------------|-------------------|
- 4) How often do you feel self-conscious?
- | | | | | |
|------------|--------------|-----------|-----------------------|-------------------|
| Very Often | Fairly Often | Sometimes | Once in a Great While | Practically Never |
|------------|--------------|-----------|-----------------------|-------------------|
- 5) How often are you troubled with shyness?
- | | | | | |
|------------|--------------|-----------|-----------------------|-------------------|
| Very Often | Fairly Often | Sometimes | Once in a Great While | Practically Never |
|------------|--------------|-----------|-----------------------|-------------------|
- 6) How often do you feel inferior to most of the people you know?
- | | | | | |
|------------|--------------|-----------|-----------------------|-------------------|
| Very Often | Fairly Often | Sometimes | Once in a Great While | Practically Never |
|------------|--------------|-----------|-----------------------|-------------------|
- 7) Do you ever think that you are a worthless individual?
- | | | | | |
|------------|--------------|-----------|-----------------------|-------------------|
| Very Often | Fairly Often | Sometimes | Once in a Great While | Practically Never |
|------------|--------------|-----------|-----------------------|-------------------|

- 8) How much do you worry about how well you get along with other people?

Very Fairly Slightly Not Very Not at all

- 9) How often do you feel that you dislike yourself?

Very Fairly Sometimes Once in a Practically
Often Often Great While Never

- 10) Do you ever feel so discouraged with yourself that you wonder whether anything is worthwhile?

Very Fairly Sometimes Once in a Practically
Often Often Great While Never

- 11) How often do you feel that you have handled yourself well at a social gathering?

Very Fairly Sometimes Once in a Practically
Often Often Great While Never

- 12) How often do you have the feeling that you can do everything well?

Very Fairly Sometimes Once in a Practically
Often Often Great While Never

- 13) When you talk in front of a group of people, how pleased are you with your performance? (e.g., very pleased)

Very Fairly Slightly Not Very Not at all

- 14) How comfortable are you when starting a conversation with people whom you don't know? (e.g., very comfortable)

Very Fairly Slightly Not Very Not at all

- 15) How often do you feel that you are a successful person?

Very Fairly Sometimes Once in a Practically
Often Often Great While Never

- 16) How confident are you that your success in the future is assured? (e.g., very confident)

Very Fairly Slightly Not Very Not at all

- 17) When you speak in a discussion, how sure of yourself do you feel?
- Very Fairly Slightly Not Very Not at all
- 18) How sure of yourself do you feel when among strangers?
- Very Fairly Slightly Not Very Not at all
- 19) How confident do you feel that some day the people you know will look up to you and respect you?
- Very Fairly Slightly Not Very Not at all
- 20) In general, how confident do you feel about your abilities?
- Very Fairly Slightly Not Very Not at all

Please indicate whether you strongly agree, agree, disagree, or strongly disagree with the following statements. Please circle one answer only.

- 21) On the whole, I am satisfied with myself.
- Strongly Agree Agree Disagree* Strongly Disagree*
- 22) At times I think I am no good at all.
- Strongly Agree* Agree* Disagree Strongly Disagree
- 23) I feel that I have a number of good qualities.
- Strongly Agree Agree Disagree* Strongly Disagree*
- 24) I am able to do things as well as most other people.
- Strongly Agree Agree Disagree* Strongly Disagree*
- 25) I feel I do not have much to be proud of.
- Strongly Agree* Agree* Disagree Strongly Disagree
- 26) I certainly feel useless at times.
- Strongly Agree* Agree* Disagree Strongly Disagree
- 27) I feel that I'm a person of worth, at least on an equal plane with others.
- Strongly Agree Agree Disagree* Strongly Disagree*

28) I wish I could have more respect for myself.

Strongly Agree* Agree* Disagree Strongly Disagree

29) All in all, I am inclined to feel that I am a failure.

Strongly Agree* Agree* Disagree Strongly Disagree

30) I take a positive attitude toward myself.

Strongly Agree Agree Disagree* Strongly Disagree*

Scoring the Janis-Field Feelings of Inadequacy Scale

Items 1 through 20 of the Self-Esteem questionnaire constitute the FIS. The five possible answers to each item are assigned a score from 0 (no feelings of inferiority) to 4 (very high feelings of inferiority). The participant's total score for the FIS is obtained by adding together the score values for her answers to each of the 20 questions (Janis & Field, 1959, p. 61).

Scoring the Rosenberg Self-Esteem Scale

Items 21 through 30 of the Self-Esteem Questionnaire constitute the RSE. Answers with an asterisk are scored for low self-esteem. Through the use of "contrived items" (Stouffer, Borgatta, Hays, & Henry, 1953), the RSE is scored to yield a 7 point scale. Scale I is contrived from the combined responses to Items 23, 27, and 29. If the respondent answers 2 out of 3 positively, she receives a positive (that is, low self-esteem) score for Scale Item I.

Scale Item II is contrived from the combined responses to Items 24 and 25. One out of 2 or 2 out of 2 positive responses are considered positive for Scale Item II.

Scale Items III, IV, and V are scored simply as positive or negative based on responses to Items 21, 28, and 30.

Scale Item VI is contrived from the combined responses to Items 22 and 26. One out of 2 or 2 out of 2 positive responses are considered positive. (Scoring instructions taken from Rosenberg, 1979).

APPENDIX H
PICTURES FROM THE PROJECTIVE
STORY-TELLING TEST

Picture 1



Picture 2

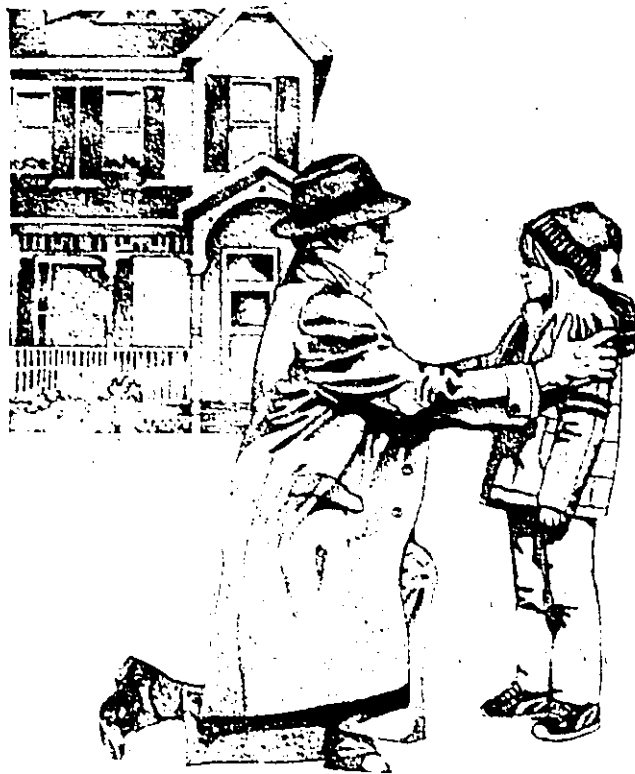


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Picture 3



Picture 4



Picture 5



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APPENDIX I
 RATING SCALES FOR THE PROJECTIVE
 STORY-TELLING TEST

Directions: Please rate each story for the following four variables: Low Self-Esteem, Dependency, Negative Attitudes towards Males, and Unresolved Oedipal Attachments. Ratings should be based on the scales provided below. When evaluating the stories, please keep in mind the following guidelines:

- Score each story for Low Self-Esteem on the basis of how the focal female character is portrayed.
- Score each story for Negative Attitudes towards Males on the basis of how the focal male character is portrayed.
- Score intention in the same manner as you would score the corresponding action.
- Score each theme according to the scales regardless of whether the story situation is resolved or not.
- If the story theme is not similar to any of the scale descriptors, rate the theme from 0-5, attempting to remain consistent with the overall scale.

Self-Esteem

<u>Descriptor</u>	Rating
No evidence of low self-esteem	0
Female is physically ill; females dies.....	1
Female is unsuccessful at an endeavor; female is described in mildly negative terms (e.g., uncaring, insensitive, neglectful); female is afraid, apprehensive, grieving, sad.....	2
Female is rejected, used, victimized, "cheated on"; female is unfaithful; female has a psychological disorder; female is intoxicated or a substance abuser	3
Female experiences shame, guilt, helplessness, worthlessness; female is described as foolish or incompetent; female commits a grave wrong	4
Female is a prostitute; female commits suicide	5

Dependency

<u>Descriptor</u>	<u>Rating</u>
No evidence of dependency	0
Female receives advice, instruction, a gift, supervision, etc.....	1
Female enjoys an intimate or loving relationship	2
Female receives assistance in a time of need (does not rule out possibility that the female could have resolved the issue with her own resources); female strives to be close to another person; female attempts to hold together a relationship; female experiences loneliness	3
Female needs to be rescued from a crisis situation (the issue can only be resolved by outside intervention); female is described as desperate in her efforts to hold together a relationship	4
Female fears inability to carry on without significant other	5

Negative Attitudes Towards Males

<u>Descriptor</u>	<u>Rating</u>
No evidence of negative attitudes towards males	0
Female has a disagreement or argument with male	1
Male is described in mildly negative terms (sad, worried, unavailable, dependent, uncertain, lonely, physically ill, infirm, angry. N.B.: normal grief would not be included in this category unless the grief is accompanied by guilt, confusion, etc.); female disappoints male	2
Female dislikes male; female is angry at male	3
Male is described in moderately negative terms (unfaithful, substance abuser, having a violent temper, rejecting); female is unfaithful to the male; female rejects or leaves male	4
Female kills or desires to kill the male; male kills the female; male rapes the female	5

Unresolved Oedipal Issues

<u>Descriptor</u>	<u>Rating</u>
No evidence of unresolved oedipal issues	0
Male is identified as a father	1
Father is concerned or worried about his daughter; female develops a special relationship with an older male	2
Father-child relationship is described as very close, special, or loving; female is raped	3
Child is propositioned or molested; female prefers her father (husband) over her mother	4
Female gives up a life of her own to be with her father; female wants to live with her father forever; female is involved in an incestuous relationship	5

APPENDIX J

SCORING SHEET FOR THE PROJECTIVE STORY-TELLING TEST

Participant # _____

Rater _____

STORY	NPSE	DEPD	NEG	OED
1				
2				
3				
4				
5				
Total				

APPENDIX K

DATA

GROUP/ NO.	AGE	RACE	FIS	RSE	NPSE	DEPD	NEG	OED	DEP. SYMP.
B/01	54	C	13	0	15	18	7	6	4
B/02	68	C	12	0	19	8	11	3	1
B/03	60	N	24	1	10	10	3	4	5
B/04	51	C	7	1	14	13	7	5	2
B/05	56	N	14	1	14	20	10	0	4
B/06	54	C	14	0	12	18	8	6	5
B/07	66	C	5	0	14	11	10	10	4
B/08	51	N	17	0	10	10	8	2	3
B/09	54	C	42	2	14	12	18	10	4
B/10	58	C	19	1	22	12	8	6	2
B/11	58	N	28	2	14	15	21	0	3
B/12	30	N	42	2	6	5	6	6	5
B/13	45	C	24	3	20	12	17	8	3
B/14	58	C	13	0	19	11	12	6	3
B/15	43	C	7	0	9	0	5	2	3
B/16	47	C	19	1	18	28	19	12	4
B/17	68	N	14	0	10	19	16	2	2
B/18	66	N	38	4	12	12	13	5	3
B/19	65	N	25	0	10	7	8	2	3
B/20	56	C	41	1	10	19	4	6	5
B/21	59	C	26	1	9	7	12	8	3
B/22	47	C	18	1	8	4	4	2	3
B/23	60	C	10	0	24	10	16	6	4
B/24	54	N	18	2	10	7	10	8	6
B/25	64	C	3	0	15	17	4	4	2
B/26	36	N	36	2	19	13	13	4	6
B/27	33	N	74	6	12	15	8	4	6
B/28	37	C	30	2	14	16	16	6	6
B/29	45	C	28	3	8	7	12	1	5
B/30	41	C	43	3	10	3	14	4	3
C/01	43	N	20	1	16	19	8	3	2
C/02	55	N	16	0	14	11	20	2	2
C/03	62	C	12	0	26	26	29	6	3
C/04	45	C	30	0	13	20	10	0	3
C/05	58	N	11	0	12	23	6	2	3
C/06	61	C	9	0	9	16	10	2	2
C/07	29	N	11	1	20	7	10	2	3
C/08	52	C	23	3	5	6	12	2	4
C/09	63	C	32	0	8	7	3	6	3
C/10	53	C	26	0	10	0	4	2	2
C/11	45	C	25	0	6	19	5	2	3
C/12	53	C	23	0	6	5	11	4	5

Continued

DATA CONTINUED

GROUP/ NO.	AGE	RACE	FIS	RSE	NPSE	DEPD	NEG	OED	DEP. SYMP.
C/13	58	C	11	0	8	17	18	8	2
C/14	40	N	11	0	14	4	13	0	2
C/15	56	C	22	0	8	4	8	2	2
C/16	59	C	18	0	12	17	8	8	3
C/17	56	N	19	0	18	10	12	2	3
C/18	51	N	18	0	16	22	16	8	2
C/19	56	C	17	1	22	6	16	4	3
C/20	58	N	15	0	6	14	7	8	2
C/21	43	N	25	1	14	14	6	7	2
C/22	51	C	22	1	14	21	11	4	4
C/23	51	N	26	0	7	2	10	4	2
C/24	41	C	25	1	10	7	12	6	2
C/25	65	C	25	0	8	2	12	4	2
C/26	40	C	21	0	18	16	9	0	2
C/27	49	C	38	1	10	10	12	7	4
C/28	57	N	14	1	6	8	6	4	2
C/29	60	N	31	1	12	19	22	9	4
C/30	59	C	24	1	16	6	10	4	3
D/01	48	N	28	2	12	12	15	10	5
D/02	42	C	62	6	17	21	14	11	5
D/03	40	N	44	5	5	19	7	8	6
D/04	32	N	48	6	15	13	22	2	5
D/05	53	C	21	3	16	23	16	6	4
D/06	31	C	61	4	22	8	8	8	5
D/07	31	N	58	6	26	20	16	15	6
D/08	17	N	37	3	14	4	14	2	5
D/09	37	N	53	4	11	5	9	5	6
D/10	22	C	67	6	22	16	18	14	5
D/11	54	C	42	4	16	2	16	4	5
D/12	41	N	8	1	17	19	8	6	5
D/13	32	C	33	3	18	8	28	2	4
D/14	57	N	31	2	10	17	6	8	5
D/15	39	C	56	5	20	19	16	5	6
D/16	42	N	20	0	15	5	16	2	1
D/17	45	C	51	4	12	17	14	6	6
D/18	44	N	46	1	26	22	16	11	6
D/19	27	N	45	5	21	31	21	10	6
D/20	23	C	72	6	25	4	11	10	4
D/21	20	N	12	3	19	11	21	1	6
D/22	44	N	47	5	14	8	14	6	6
D/23	36	C	19	0	16	18	12	10	6
D/24	33	N	73	5	25	6	26	11	6
D/25	27	N	24	2	25	0	12	0	3
D/26	49	C	61	6	27	20	6	3	5
D/27	43	C	32	2	8	17	13	2	5
D/28	24	C	66	6	21	14	6	8	6
D/29	26	C	57	6	27	9	24	15	5
D/30	37	C	44	5	22	17	11	6	6

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