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Evaluation of a Model for Prevention of Maladjustment in Young Widows

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EVALUATION OF A MODEL FOR PREVENTION OF MALADJUSTMENT IN YOUNG WIDOWS

by

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LIFE

The author, Penelope Miller Burdette-Finn, is the daughter of Milton and Elizabeth Miller. She was born March 3, 1951 in Memphis, Tennessee.

Her elementary and secondary education was obtained in the public schools of Martin, Tennessee. She entered the University of Tennessee, Martin on the early college admission program after her junior year of high school. She attended the University of Tennessee, Martin from September, 1968 through January, 1972 at which time she transferred to the University of Tennessee at Knoxville. She received the degree of Bachelor of Science in June, 1972.

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INTRODUCTION

In 1968 there were approximately 11,000,000 widowed individuals in the United States. Women were becoming widows at the rate of 13.9 per 1000 or 592,000 per year. Of women who die of old age, the average woman has been widowed for 18.5 years (Silverman, 1972). Berardo in 1968 pointed out the dearth of research on widowhood and called it a "neglected aspect of the family life cycle (p. 191)." He suggested that death had replaced sex as our new taboo subject for general discussion. Fortunately, since 1968 interest in research on widowhood has increased. Sociological and medical studies are now more common. Professionals now know exactly what the "normal" reactions to grief are and which of these normal reactions are likely to persist into abnormal ones, but not enough has been done to devise intervention techniques to aid the widow during this crisis period to prevent her from developing disabling problems.

Grief is a normal reaction to the loss of one's husband, but the degree of grief does not have to be atypically deep or prolonged for it to disrupt the functioning of a widow and to a degree be pathological. As Parkes (1965) said, "Grief is a mental disorder since it is associated with mental discomfort and loss of function." The fact that grief is usually a transient condition and most widows survive and even recover without psychological help does not negate the fact of its pathology and its disruption function even as a burn

treated at home is pathological and requires adjustment. Even if the widow recovers from her grief, an intervention program to smooth this recovery would seem to be desirable.

Often, however, the recovery is not smooth or normal. Widows have a higher rate of mortality, a higher suicide rate, and a higher incidence of mental illness than other women their age. Of the approximately 10 million widows in the United States today, research has shown that one of four will have made a poor adjustment to life one year after the death of her husband. Van Coevering (1974) found one out of four women to be experiencing little life satisfaction and many psychosomatic symptoms such as insomnia, depression, and chronic tiredness. For young and middle-aged women, Maddison (1968) found substantial health deterioration in one of five. Bornstein and associates (Bornstein, Clayton, Halikas, Maurice & Robbins, 1973) evaluated their group of widowed persons in terms of a clinical diagnosis of depression. They found 17% of their sample to be clinically depressed after one year. An additional 4% of their sample had died.

Women who are widowed face a bewildering array of problems. They have lost their life companion, their security, and often their closest friend. They must learn to deal with their grief and to define what it means to live as a widow rather than a wife. They must learn how to perform tasks to which their spouses used to attend such as balancing a checkbook or getting the car repaired. Friends

are often uncomfortable around a widowed woman, and so she must adjust her social life to a new set of expectations and relationships. Loneliness is a major problem for widowed women.

Recent intervention programs for widows include psychoanalytically based regrief work (Volkan & Showalter, 1968) in which therapists help patients resolve the conflict of separation, selective ego support (Raphael, 1977) in which therapists support the expression of grieving affect and a review of the relationship, and relatively informal counseling in the home (Polak, Egan, Vandenbergh & Williams, 1975). Most of the widows contacted felt these services were helpful, although in the Palak study people who were contacted by professionals were more worried about their adjustment level than were people who were not contacted. Being contacted by professionals may be assumed by the layman to be an indication of illness or inability to cope rather than support during a difficult time. A method of overcoming this label of illness was found in the Widow-to-Widow program. In using trained lay people who themselves had been widowed, Silverman (1967) found helpers who were viewed as aides rather than doctors and who were especially sensitive to the needs of the people with whom they worked.

One-to-one contact is effective in working with widowed women, but the number of people it can reach is limited by the number of helpers available. Group counseling has been shown to be effective for working with widows (Barrett, 1978). In this way, each helper

can contact three to ten times more women.

NAIM, a Catholic group for widowed people, was chosen as the program for investigation because it seemed to fit many of the requirements for a workable, inexpensive, effective program. All members of NAIM are widows or widowers. Professionals may be brought in to speak at the monthly meetings, but the ongoing caregivers are the widows themselves. This both reduces the stigma of illness in joining NAIM and enables members to find their strengths in helping others. The meetings alternate between meetings in which the members hear a lecture or discuss aspects of widowhood and social meetings with dances or entertainment lectures. The NAIM group seems to meet the need of widows for factual information to help them reorganize their lives, for support as they seek a new identity, and for new social relationships as a single person.

The purpose of this study was to evaluate the NAIM model as a possible prototype for an intervention program to be expanded to reach people who are not Catholic. Members of NAIM were compared with Catholic women who had never heard of NAIM and so had no choice of joining and women who were invited but chose not to join NAIM. The groups were compared in their psychological adjustment, life satisfaction, and their ability to cope in their lives by means of a mailed questionnaire. Members of NAIM and people who had a choice but chose not to join NAIM were expected to be better adjusted than women who did not have any contact with this helping organization.

Women who were aware of the group were expected to be able to determine for themselves whether they were in need of intervention of this kind. It was available for those who felt they needed it. The no contact group of widows was expected to include many women who would have adjusted more easily with the aid of the unoffered group.

REVIEW OF RELATED LITERATURE

Problems of Widowhood

The normal reaction to news of the husband's death is a period of numbness which may last from several hours up to a month. The usual length of this reaction is one to seven days (Parkes, 1970). Very often at the funeral the widow appears calm and able to cope with her various responsibilities. She plans the funeral as her husband would have wanted it. She is still her husband's wife and has not yet accepted the fact of her widowhood. As the numbness lifts, the widow may "fall apart" psychologically as she feels the real pain and anguish of reality (Silverman, 1972). Attacks of panic when the widow is cornered into accepting the reality of her husband's death are not uncommon at this time. One woman was forced to leave her house at 6:00 each evening for this was the time she would usually be meeting her husband at the door as he returned from work. His absence caused uncontrollable anxiety and she was forced to flee (Parkes, 1970).

As the numbness lifts and the widow accepts the reality of her husband's death, true mourning or "grief work" begins (Lindeman, 1944). Parkes (1970) calls this second phase of grief the period of Yearning and Protest. The widow feels pangs of intense pining for the dead person. She has the impulse to call and search for the lost person and at the same time the tendency to deny such useless

behavior. The widow is preoccupied with thoughts of her husband and may direct her attention toward places and objects associated with him. She may misidentify people in the street and run toward them only to discover a stranger rather than her husband. She is disposed to pay attention to things that suggest the presence of her husband and to ignore those things that do not. The widow may smell her husband's pipe smoke or hear his rocker creak in the shadows and feel that her husband is present. A telephone ring may inspire the forlorn hope that he is calling to say he will be home later. There are periods of intense crying for the lost person.

The widow may socially withdraw and show anger and resentment toward someone she feels caused her husband's death, a doctor or nurse at the hospital or a relative or friend. She may turn her anger inward and feel guilt for not preventing his death, going over the events again and again in her mind to see what she should have done.

Increased irritability and anger, bitterness and protest against the world and the unfairness of his death are common. Restlessness, tension and insomnia cause the widow to fill her days with busyness to minimize the time for thought.

Various types of identification phenomena may occur during this period as the widow seeks to bind the memories of her husband even closer to her. She may begin to behave or think more like her spouse, eating the foods he liked, going to places and events he

would have enjoyed. Conversion reactions may occur in widows who felt resentment against their husbands, especially if a long illness caused them to unconsciously wish at times for his death. Developing physical symptoms that closely resemble those of her husband before he died seems to help relieve her guilt feelings and make her feel closer to her husband. Some widows feel as if their husbands are inside them directing their actions and giving advice and comfort. Other widows see their husbands in their children and keep his memory alive in this way. All of these reactions to grief are normal if they do not persist for more than six to nine months. Serious maladjustment is indicated if the symptoms do not diminish in intensity after this period.

Gorer (1965) has identified several different types of mourning, different ways in which people try to deal with their grief. Some women deny the permanence of death either believing that death is merely a changing of states, a passing into another life, or that their husband's soul is permanent and will be reincarnated into another body. For others, especially when a long illness is involved, both partners may share the grief of future separation. The widow may complete much of her grief work prior to her husband's actual death. Some widows believe that giving way to grief is morbid and psychologically unhealthy. These individuals "carry on" and "keep busy" in an attempt to hide their grief and not make their family and friends unhappy. "Time limited" grief is the most common type. The widow gives way to intense grief usually for six to twelve weeks

and then gradually begins to make an adjustment to her new life. "Unlimited grief" is typified by the comment "I'll never get over it." By proclaiming her continued grief, the widow feels she is being true to her affection for the memory of her husband. Mummification is a form of unlimited grief in which the widow keeps everything exactly as it was when her husband left. His pipe is loaded and his slippers are by his favorite chair waiting for him to come home. Despair is a part of all mourning at times, but the person who has no defenses against her grief is apt to feel that she will always hurt and there is nothing to look forward to. Suicide is a real danger for this person.

The third phase of grief is called disorganization. For two-thirds of the widows this occurs by the end of the first year. The widow has finally accepted the destruction of her past world but has not yet begun to build her new one. The primary symptoms manifested at this time are feelings of apathy, aimlessness, and disinclination to look to the future (Parkes, 1970). One widow expressed it as feeling exhausted and not wanting to struggle any more.

Sometime between the end of the first year and the beginning of the third year the normal widow will enter the recovery phase. She begins to go out and make new friends, to join clubs in which she is interested, to follow her career with more interest. She begins to look toward the future instead of dwelling entirely in the past (Silverman, 1967). Evidence gathered from the Widow-to-

Widow program suggests that the widow never passes out of the phase of recovery; one never recovers from grief. Her whole life is different and her self concept is different. Rather than recovering from grief, the widow makes successively more adequate adjustments to her new life. Hopefully, she learns to look with optimism toward the future, but the pangs of yearning and protest never entirely go away.

Widowhood is a change in role from wife to widow with which the woman is usually entirely unprepared to deal. With the lower death rate and the increased use of hospitals, professionals such as hospital personnel are now the only people who deal directly with death (Silverman, 1969). Death is the new taboo subject. Funeral directors go to great lengths to make the body "look natural" and deny the fact of death. Although it is common to rehearse for marriage during courtship, no provisions have been made to prepare the partners for the dissolution of their marriage. Even the mourning rituals common in the past have now been put away. The widow is no longer allowed the role of wife and has no consensus of social expectations to guide her as she seeks to find her new niche in society.

In cultures where widowhood is clearly defined the widow has a new, albeit unpleasant, role immediately. There is less of the lost, anomic feeling of American widows in such cultures. Most societies have evolved some sort of rite de passage, a formal

withdrawal from society, a period of seclusion and then a formal reentry into society. The fact that these rituals have evolved in so many societies indicates that they fill a real need in human societies, and abnormal societies are those who do not supply their members with this support. The lack of mourning rituals in America deprives the widow of the support of society in her method of showing grief, the length of her period of social withdrawal and the rate of her reentry to society. There are no longer any rules as to how to treat a person in mourning so she is often avoided to spare embarrassment over knowing what to say (Gorer, 1965).

Fulton (1965) pointed out that the decline of formalized mourning rituals deprives the bereaved persons of accepted ways for discharging their emotions. In the England of the early 1900's, a widow signified her grief publicly by wearing black clothing and a long black veil. The veil was shortened, then a dash of white was added to relieve the severity of the black at the proper calendrical moments. The widow was allowed to express her grief publicly and was allowed to grieve for a prolonged period of time. Today's widow is often expected to hide her grief after a short period of mourning and then act outwardly as if nothing has happened.

The traditional Jewish mourning ritual requires friends and relatives to offer their condolences with the phrase "I wish you long life." After this phrase is offered, conversation is normal (Gorer, 1965). Modern condolences are often painful for both the

widow and the well-wisher. Platitudes ("You'll feel better soon."), advice ("Keep a stiff upper lip."), and misdirected sympathy ("I know just how you feel.") often give more pain and anger than comfort. Speaking of the dead and expressing love and sincere sympathy seem to be the most helpful offerings for most people, although even these expressions were difficult for the widows who reacted to grief by withdrawal and who sought to avoid their own emotions grateful acceptance of condolences is one of the most reliable signs that the mourner is dealing adequately with the grief (Gorer, 1965) . The lack of experience in comforting bereaved friends coupled with modern America's distaste for overt emotion and any realization of mortality often causes the widow's friends to busy themselves elsewhere. There is no ritual to break the ice of her new status and to tell them how to relate to her now.

In Japan, traditional religious women whose ritual of ancestor worship denies the permanence of the death separation report less intense discomfort and markedly reduced rates of mental illness in contrast to their more modern sisters. The traditional beliefs give a defined role to the widow. The widow is allowed and even expected to keep her husband's memory alive. Feeling his presence and expressing her grief are accepted and approved things. Friends are told by their culture what to expect from her and how to relate to her (Yamamoto, Okonazi, Iwasaki, & Yashinura, 1969).

American widows are given no such help and support. In

addition to coping with the loneliness and yearning for the missing husband, the woman must formulate a new identity for herself. She must discover who she is as a widow and accept the fact that she is no longer a wife without the aid of transition rituals.

Lopata (1973) defined identity as "the collective aspect of characteristics by which a thing is known" or "the personality of an individual regarded as a persisting entity" (p. 407). Identities are defined by others. As Lopata points out, identities are formulated in social interaction and involve symbolic definitions of the self, the other, and the situation. Repeated interaction with the other results in stabilized identities. These identities change as the self, the other, or the definition of the situation changes. The removal of the other necessitates reformulation of the identity.

Marriage is probably the major social relation for most women. Only the parent-child relationship is expected to approximate it in importance. In the modern nuclear family marriage, the partners are required to meet the major portions of their spouses' needs. For a relationship of the intensity and closeness of modern marriage to survive, the husband and wife must reformulate their identities to enable them to meet the needs of their common world. Not only are their definitions of their own identities changed by their adaptation to each other's needs, but their relationships with friends and relatives change as people react to the relationship and the role they have built for each other.

While this reformulation and redefinition of self affects the man, he usually has a fairly constant identity at work which is a carryover from his identity in childhood and at school. The woman, especially in couples in their fifties or older, was expected to become oriented primarily toward family welfare. He is a man who is married; she is a wife. The style of life, residence, and indeed the rhythm of life tend in most families to be built around the husband's role as provider. When the woman married, she took on a whole new role in life in many instances. She made all the adjustments to married life that her new husband made, plus a new occupation, new life style, and often new friends. Her past identity seemed to vanish. She is no longer Mary Smith, she is now Mrs. John Jones.

Identity reformulation does not affect all women to the same degree. Lopata (1973) found the identities of lower class, less educated women to be more separate from that of wife. The primary identifying role for these women was mother. Major events in their lives were given as the births of their children rather than marriage as was given by the middle-class women. The less educated women felt that they had no share in, and no control over, their husband's life work. Their contribution was to feed him well and nag him to get a better job. These women had different friends, different interests, and different levels of community participation than their husbands. These couples' lives seemed to be parallel but segregated, with little understanding or knowledge of the other person's world. In

contrast, the more educated woman assigned more influence in her identity formulation to being married to this particular man and being part of the couple. She felt that she influenced his work and therefore their lifestyle by her actions with friends and business associates or by being able to understand and discuss his problems. She shared with her husband a definition of the world and built a set of social relations with him which include couple-companionate relations, neighboring, membership in voluntary associations, etc. The death of her husband would require more severe identity reformulation and adjustment of associations than would the death of the husband of a less educated, less involved woman (Lopata, 1973). Older women may have less stable individual identities. The consciousness raising of the last few years with more consideration of the careers of wives who wish to work will enable them to have more stable and complex identities separated from that of wife.

When her husband dies, the woman experiences many direct and indirect changes in her life. Primarily the new widow has lost her partner, the main person with whom she has shared the process of building a life. The new widow often reports trying to live as she would have had her husband still been alive, but gradually her memory of his definitions of the world dims and she must seek to discover her own. Each person in a partnership usually takes over certain functions. The widow now has no one to share the division of labor and may find herself frustrated by chores that previously her husband had performed. Strong feelings of inadequacy may result

from struggles with the automobile or battles with the checkbook. The widow may feel unfeminine doing things she considers to be man's work and may feel she is an incomplete person because of areas with which her experience has not prepared her to cope.

In interactions with others the widow is most apt to encounter identity problems. People see her differently and do not treat her the same way as before, while the widow tries to interact as the person she has "always been." Friends who knew the husband will see her as the widow of that particular man and are reminded of their own mortality. Some widows report being literally shunned because the late husband's friends are made so uncomfortable by their presence. Other widows report their mutual friends as regarding the new widow as a woman out to get another man and therefore dangerous around husbands. Friends are at times fearful of the demands of the widow either for services or sympathy. They are afraid the widow will attach herself to them and take up all their time (Lopata, 1973; Silverman, 1972).

The widow is undergoing a status passage with no rules of the road. Her identity is no longer stable. It is changing with no clearly definable end product. Since the new widow is not a stable and predictable identity, she threatens the stability and the identities of the people around her. Roles and situations are no longer defined as they once were, and the ambiguity is too uncomfortable for many friends to bear.

Identity reformulation, painful as it might be, seems to be a positive part of recovery from grief. In a Chicago survey, most of the women who were aware of changes in themselves reported positive reformulation after the initial "grief work" was completed. They felt that they were more independent and competent, freer and more active or more socially engaged. Only 18% viewed the changes in negative terms, finding themselves more prone to worry, less sociable, or more suspicious. Feeling fuller and freer or feeling that she had rounded out her personality which may have been restricted or limited during marriage did not mean the widow had a poor marriage. These same people listed loneliness as the worst problem of widowhood (Lopata, 1973).

The loneliness that is usually mentioned is composed of many separate needs. The widow loses someone to talk to. She loses someone who gives her love as well as a person for her to give love to. She needs a relationship of the depth and intimacy of marriage in which she can share her joys and sorrows and be understood. She needs another human being in the house for company. She must now do all the work around the house herself including the tasks her husband once performed for her. She may be homesick for the lost style of life or for the activities she and her husband enjoyed. She may miss friends she and her husband had as a couple. She may feel alienation due to the status-drop from John's wife to widow. Most of all, she may feel a lack of friendly support in her grief and despair at ever filling her life again with loving people (Lopata,

1969).

People need relationships and interactions with other humans to avoid loneliness, but is the widow lonely because her husband is gone or is her loneliness a cumulative effect of her bereavement and the defection of mutual friends? Weiss (1969) by studying members of Parents Without Partners, found that friends and activities can make the loneliness easier to bear, but they cannot end it or even appreciably diminish it. A study of corporation wives revealed that upon moving to a new neighborhood, their relationship with their husbands could not make up for the lack of friends. Apparently husbands and friends fill different needs and each is necessary to a fulfilling life for most people.

Weiss points out that most relationships are relatively specialized and suggests five categories of relational functions. All of these functions seem to be necessary for well-being.

1) Intimacy: Individuals need to be able to express their feelings freely and without self-consciousness. There may or may not be sexual involvement for intimacy, but this function is usually met by a spouse or a close friend of the opposite sex.

2) Social integration: Relationships in which participants share concerns either because of similar limitations (we're all in the same boat) or because they are striving for similar objectives (work colleagues). These relationships provide sharing of experiences, ideas, information and assistance for short periods of time.

Friends and colleagues provide this function. The absences of social integration is social isolation.

3) Nurturant behavior: An adult takes responsibility for the well-being of a child. A wife sympathizes and gives support to her husband after a hard day.

4) Reassurance of worth: Relationships that attest to the individual's competence in some role. Work relationships provide this security for the male, and successful family life is the measure of the female who does not work.

5) Assistance: The provision of services is expected long term only from close kin. The absence of any relationship providing the assurance of assistance leads to anxiety and vulnerability.

6) Guidance is an extra category more necessary for some people than for others. This need is usually filled by the clergy, mental health professionals, or a close family.

Restlessness, loneliness, and boredom were found to result from deprivation of these six needs. Individuals vary in the degree of importance each function has in their lives, but most people need relations to fill all six categories (Weiss, 1969).

When her husband dies, not only does the widow have to cope with a complete reorganization of her life and her identity, but she is also likely to have problems of relational deficit. Her main source of intimacy is immediately removed. Her reassurance of worth which came primarily from her husband and her children (if she does not work) is severely threatened. In social interactions the

widow may feel like a "fifth wheel," a "defective couple" (Silverman, 1972). Her self-esteem falls rapidly. For many adult women, the only guidance they receive, the reassurance that they made the right decision, also comes from their husbands. This source of guidance is removed and the widow must either cope by herself or seek another source. The need for assistance is usually met for the first few months by family and friends. As the widow begins to appear more normal, the relatives go back to their own lives and she is often left more or less on her own.

As Weiss said, relationships are relatively specialized. People enter relations with tacit contracts as to the expectations and limitations. Going beyond the underlying assumptions of a relationship can endanger it. After losing her husband the widow is suddenly left with many needs unmet. Her attempt to enlist friends to fill the needs for assistance, intimacy and reassurance, or the friend's fear that she will do so, may alienate her friends and deprive her of social integration. Thus her needs or her friends' fears and jealousies deprive her of yet another relational function and she is led into social isolation.

The absence of an intimate relationship means that a person's emotional responses are not communicated. Since they are not shared with others, they are not corrected by another's perceptions. The result may be distortions either in the direction of pathological distrust or of depression that are difficult to interrupt

(Weiss, 1969).

Factors in Adjustment

Supportive or non-supportive interactions in the environment were the main factors influencing widows who made a good adjustment to their new lives and those who did not in Maddison's 1968 study. Longstanding personal characteristics probably contributed to the outcomes since crisis events were filtered through the individual's perceptual framework, but the individual's perception of her environment during the first three months after her husband's death was found to be the determining factor in predicting outcomes of bereavement. The widows who made poor adjustments reported many unhelpful interactions in their social network or a lack of interactions and many of their needs unmet. They felt that they lacked permissive support from their environment as they experimented to develop new methods of coping. Expression of affect was blocked either overtly or covertly by friends who were shocked or rebuked by their grief or who attempted to minimize it by telling them how well off they were. At times other people acted upset to a point the widow felt was inappropriate and even competitive or they were incongruously cheerful or insisted they knew how she felt. Environmental opposition to the widow's need to review the past and to talk about her husband was maladaptive because it interrupted the desensitization necessary to begin to leave the past. Well-meaning people pushing the widow into new activities and new relationships before she was ready to leave the old ones were not helpful. Talk of remarriage

or evangelical approaches to religion were often reacted to with anger by widows in the three months after their husbands died (Maddison, 1968; Maddison & Walker, 1967).

The characteristics of a widow who runs a high risk of making a poor adjustment are as follows: a high proportion of social needs unmet, blockage of affect expression, review of past relationship blocked, inability to withdraw sexual attachment, under 45 with dependent children, pre-existing pathological marital history, pre-existing overt neurosis, husband suffered protracted death pain and disfigurement, pathological reaction to death of another family member, additional crisis in close temporal arrangement to husband's death, disturbed relations with her mother or her husband's family, long-continued reaction formations against dependence, and deliberate avoidance of affect expression (Maddison, 1968). Widows with these characteristics are most likely to develop mental pathologies or take their own lives.

Maladaptive responses to the stress of widowhood are apt to be of four types. The widow may experience psychological difficulties. She may develop increased somatic complaints. She may increase her use of tranquilizers, sleeping pills or alcohol to dangerous levels, or she may take her own life (Clayton, 1973).

Depression in widowhood is not a model for psychotic depression. It is not more common or more severe in those women who have a family history of psychological illness nor is it more severe at the time

of widowhood in women previously treated for depression. Grief depression seems to stem from unmet social needs. Widows who have children to whom they feel close living nearby reported less depression. Women who had long-time close friends reported less depression (Bornstein, 1973; Clayton, Halikas, & Maurice, 1972). Suicide seems to occur when there is some other family crisis on top of the husband's death and the wife is not able to handle it without the support which her husband used to provide and friends are now unable to provide (Berardo, 1968).

Significantly more women die after the death of their spouse than die in a matched control group in which the spouse is not dead (Rees & Lutkins, 1967). The death rate is highest in widows 34 years old or younger. The higher rate for younger widows may be influenced by the unexpectedness of the death of a young husband and the strain of hiding grief from young children (Maddison, 1968).

The increased suicide rate among widows is not the only reason for these higher death rates. One in five widows experiences substantial health deterioration after the death of her husband (Kraus & Lilienfeld, 1959). London widows were found to consult with their physicians three times as often in the first six months after bereavement than they had previously done. This increase was found, however, only in widows under 65 (Parkes, 1964). When a control group of married women was compared to widows under 45, more widows were admitted to the hospital within a year than were the married women

($p > .05$). The bereaved women had major illnesses as opposed to the minor illnesses of the married women. When compared for frequency of psychosomatic or hypochondriacal illnesses there were no significant differences (Parkes & Brown, 1972). The stress of widowhood apparently precipitates real physical illness.

Anxiety, insomnia, depression, despair, anorexia, irritability and social withdrawal are normal parts of the typical grief reaction. However, if these symptoms do not begin to decline within 6 months, the typical reaction may change to a pathogenic one.

A chronic grief reaction is most likely to occur in either the very old or the very young. These widows experience prolonged grief that may even be intensified rather than relieved after six months. They attempt to avoid reminders of their husbands and seek to keep their minds on something else. Accessory symptoms of this grief reaction are guilt feelings and identification phenomena.

Inhibited grief is most common in young children or very old women. In this reaction there is a short or non-existent period of overt grief and then life continues apparently as normal, but there is residual yearning for and anger against the departed person at the unconscious level. The bereaved feels that she has been deserted and is unconsciously angry for being left. Accompanying symptoms for this reaction type are clinging and possessiveness, irritability, jealousy, temper tantrums, incapacity for other deep attachments, and depressive illnesses in later life.

A short period of numbness is normal after the death of a spouse, but if this numbness extends beyond two weeks it is called a delayed reaction (Parkes, 1965). Parkes (1970) found a negative correlation between affect during the first week and that during the third month. A delayed reaction lengthens the time of initial grief and may intensify it.

Morbid grief reactions may be merely distortions of normal grief reactions. "Keeping busy" may become a pathological reaction if activity is used to avoid grief until the woman is exhausted and overwhelmed. The identification phenomena discussed earlier sometimes become a way of life for the widow and are thus disruptive and maladaptive. Grief repressed may develop into ulcers, high blood pressure, colitis or other psychosomatic reactions. The widow may lose her capacity to feel warmth for her friends and become irritable and reclusive. The not unusual hostility against people connected with the husband's death may develop into paranoia. The widow may become almost schizophrenic--going through the motions of living with no affect or motivation. Indeed, some widows find simple decisions beyond them and must be taken care of as if they were children. Agitated depression is another possible morbid grief reaction. The widow is filled with tension, insomnia, feelings of worthlessness, and self-accusation. Suicide is a danger with these women. Previously obsessive-compulsive personalities with a history of depression are particularly prone to agitated depression (Lindeman, 1944).

Widows are six times more likely to be hospitalized for psychological problems than the normal population. They are most likely to be hospitalized for affective disorders (Parkes, 1964). A comparison of bereaved patients who were placed in psychiatric hospitals and those who were not hospitalized revealed that both groups experienced about the same amount of depression, insomnia, apathy, sense of presence of the deceased, and deliberate cultivation of his presence. The psychiatric patients, however, had a longer duration of intense grief (one to six years) and more difficulty in accepting the reality of their loss. They attempted to avoid their grief either by complete refusal to believe that the person was dead or by avoiding reminders of the person and trying to forget him. Some patients even created hallucinations to prove that their spouses were not gone. This repression resulted in attacks of panic and choking whenever the patient was cornered into facing the fact of separation. The most dramatic difference between psychiatric and normal widows was the degree of self blame or blame of others for the death ($p < .001$). The primary requirements, then, to avoid mental illness as a result of widowhood seem to be the ability to accept and express grief feelings and to accept the fact of death without attaching blame.

Widow Help Seeking

Abrahams (1972) found that the primary problems that widows sought help for were loneliness and isolation. The widow needed an opportunity for unguarded conversation with an understanding listener

who was not emotionally involved with either the widow or the late husband. She needed to be able to air her hurts and talk about the past without the worry of the effects her pain had on the other person. She needed help and encouragement as she strugged with the building of her new identity. Learning to live by herself and learning to make decisions on her own were scary experiences, and a strong counselor was helpful. The widow often needs help in learning to adjust herself to the role of widow without feeling worthless or defective. Skills at making new friends and relating to old ones need polishing. The widow often needs help in finding places to meet new friends (Silverman, 1972).

The new widow needs help with practical problems also. The death of her husband has usually not only removed the person in the family who handled the finances but at the same time has sharply reduced the income. The widow often needs a place to receive specific information on finances, employment, housing, legal matters, professional care for herself or her children, health facilities, and housekeepers or child care (Abrahams, 1972).

Another primary problem for most widows is the need to develop a new identity as a useful, valued person. The woman whose husband has died is no longer a wife nor is she a "single girl." She may take refuge in the role of "mother" if the children are still at home, but if the children are grown, she may be somewhat at a loss. Older women whose peers have also lost their spouses may have role

models available as to how to live as a "widow," but young women are often denied even this help. The widow must learn to live with loneliness and find a new purpose for her life (Lopata, 1975; Silverman & Cooperband, 1975).

There are no official services where a widow can call and either get the information she needs or be referred to the appropriate agency. No provisions at all have been made in the past for helping the widow re-people her social life with friends of the same or opposite sex (Lopata, 1970). When Abrahams (1972) asked widows who helped them the most with grief and adjustment problems, 46% replied relatives, 22% friends, 3% a club group, 3% their clergyman, and only 4% replied that some professional had helped them. These people did not reply how much they were helped, just if they were helped at all. Twenty-one per cent of the widows felt that there was no one at all who gave them help.

Research on Intervention Programs

Recent research has attempted to identify those persons who are most likely to make a poor adjustment to widowhood. They have succeeded in identifying a number of risk factors and risk markers that are correlated with poor adjustment. The term risk factor will be used for conditions in which without amelioration it is highly likely that the person will adjust poorly. Risk marker is used for conditions which are not amenable to intervention but which describe groups of persons who are more vulnerable to the relevant risk factors

(Grundy, 1973)

The most frequently mentioned risk marker is the amount of warning the widowed person had before the spouse's death (Carey, 1977; Clayton, Desmarias, & Winakus, 1968; Lehram, 1956; Lopata, 1975; Pentney, 1964; Rees & Lutkins, 1967; Sheskin & Wallace, 1976; Smith, 1975). The person whose spouse dies as a result of an accident or sudden illness or who suddenly dies during a serious illness is much more likely to be depressed 13 months after the death than are persons whose spouse died of a chronic illness. According to Carey, warning of imminent death is particularly important if the spouse has experienced prolonged suffering or if there are serious problems in the marriage. Lopata hypothesizes that the lack of warning produces unfinished business with the husband and lack of closure on the role of wife that a woman must first deal with in addition to her grief before she can begin to build a new life. Sheskin and Wallace believe that warning of death enables the survivor to at least fantasize her new role and what her new life is likely to be like before she is thrust into living it while also coping with her grief. Sudden death, particularly in the case of younger women, precipitates a loss of trust in the world as a predictable and benign place. The widow is exposed to all kinds of fears since she can no longer count on her husband or a sense of a just world to protect her.

Another important risk marker is the presence in the widowed person's life of additional crises around the time of the spouse's

death (Maddison, 1968) especially those crises involving the disturbance of the marital relationship (Parkes, 1975). Numerous life stresses at the same time have been shown to cause physical illness (Rahe, Meyer, Smith, Kajer & Holmes, 1964) and depression (Paykel, Myers, Dienelt, Klerman, Lindenthal & Pepper, 1969). Rahe and associates found that employees at a tuberculosis sanitorium who experienced many life stresses contracted TB significantly more frequently than did employees who led calmer lives. Depressed patients were found by Paykel to have had more negative life events occur prior to their depression than had a general population. These patients experienced approximately the same number of desirable events, but were more likely to have significant losses. Loss of a spouse is a major stress. If other undesirable events are occurring in the life of the widowed person, the probability of a poor outcome is increased.

There are other markers which have been found to occur more frequently in groups of people who experience poor outcomes. People who have less than $10,000 per year in income tend to do poorly as do people who do not have a high school education (Carey, 1977; Parkes, 1975). People who had never attended church prior to the death are twice as likely to be depressed after 13 months as are people who have had some contact with established religion (Bornstein, et al., 1973). The presence of a severe anniversary reaction or of an ambivalent marriage are markers of possible poor adjustment (Maddison, 1968). Surprisingly, people who had had no previous

deaths among relatives in their lifetime were more likely to adjust poorly. Bornstein et al. (1973) found that 25% of his depressed people and only 4% of his non-depressed people reported this pattern. Having experienced previously the death of a relative or close friend seems to help in the current bereavement. Silverman and Cooperband (1975) felt that there are patterns for grieving that a person may learn that can be carried over to help in a later bereavement. Perhaps a person who has suffered a loss learns that she can deal with the pain and that the pain will lessen. This may help her deal with a later death.

Some conditions that would seem logical markers for susceptibility to poor adjustment did not distinguish between groups who adjusted well and those who did poorly. Persons with long or good marriages were no more likely to be clinically depressed than not (Bornstein, 1973). Reported happiness in the marriage was not found to be related to later adjustment (Carey, 1977). Previous psychiatric histories of the surviving spouse or her close relatives did not distinguish between depressed and non-depressed people. People depressed after 13 months did not take more sleeping medication or tranquilizers or visit their physician more frequently (Bornstein, 1973). In fact, Raphael (1977) in her study of preventive intervention for widows found that if the visits by the intervener were counted as "doctor visits," her intervention group received exactly the same amount of "doctoring," leading her to hypothesize that a certain amount of "doctoring need" exists for most widowed people,

but this need may be fulfilled in a variety of ways and does not seem to be related to risk factors.

Risk factors are those conditions which if not changed are likely to lead to poor adjustment. The primary risk factors for the widowed person are depression, lack of intimacy, and poor self-esteem. Bornstein et al. (1973) found that "the most powerful predictor of depression at 13 months was the presence of (clinical) depression at one month" (p. 565). Fifty percent of the people who were clinically depressed at one month were depressed at 13 months. Intervention seems to be useful for persons who are clinically depressed at one month.

The second risk factor is unmet intimacy needs. When her husband dies, the woman not only loses the companionship of that particular person, she often loses her primary source of intimacy, sharing, nurturance, reassurance of worth, assistance and guidance (Weiss, 1969). Family and friends cannot completely supply these needs, but the woman whose needs are not met is much more likely to adjust poorly to her new life. Women who are most likely to need help live alone and have no family nearby to whom they feel close (Clayton et al., 1972; Silverman & Cooperband, 1975; Bornstein et al., 1973). Women with children, especially children living at home, are less likely to be depressed than women with no children, and women with larger families were less depressed than women with small families (Carey, 1977; Smith, 1975). The strongest finding was the need for

one intimate other--male or female--with whom the widow could share her thoughts and feelings (Pomeroy, 1975; Van Coevering, 1974).

When a husband dies, the woman often feels "shattered," "defective," "not normal." She doesn't understand her feelings and she wonders why this happened to her. She may experience distance from her friends. She must perform tasks such as balancing a checkbook at which she may not be proficient. She may have trouble making decisions especially if she was very dependent on her husband. All these things can be destructive to her self-esteem. Poor self-esteem, a feeling of helplessness and an inability to cope, is a major risk factor (Pomeroy, 1975; Smith, 1975; Van Coevering, 1974). Women often need help in learning to do specific tasks and in learning to experience their own capabilities.

In 1968, Volkan and Showalter published a report of one of the first psychotherapy programs designed specifically for bereaved persons. They called it "re-grief" work. Volkan (1971) stated that the purpose of the analytically-based therapy was to help a patient suffering from pathological grief to resolve the conflict of separation--no matter how much time had passed since the death. He felt that the disturbances of people who were suitable for re-grief work were somewhat more severe than an uncomplicated grief reaction but less severe than a neurotic reaction and usually occurred after the death of a "loved-hated" person. Disturbance was most likely in people who were not permitted to participate fully in the funeral.

These people were most likely to exhibit what Volkan called "splitting." Splitting occurs when the person knows his loved one is dead yet at the same time does not believe it. Volkan (1970) found this type of grief often to be manifested in people who were overly concerned about the coffin--its size and whether it was properly sealed and waterproofed to protect the body. They worried about the amount of weight placed on the grave, and one young man spent the night lying on his father's grave to keep him from rising again. Volkan speculated that this may also be the symbolic function of the tombstone. Finally, people who exhibit grief suitable for re-grief work rarely have ever visited the grave.

Volkan's re-grief work takes about two months seeing the patient four times per week. It is divided into three phases--demarcation, externalization, and reorganization. The demarcation phase of treatment is an attempt to help the patient separate what is himself and what was the dead person. A detailed history of the patient's relationship to the dead person is compiled from nondirective interviews. In the externalization phase of the treatment, the patient is asked to recall the specific circumstances of the death, his feelings on learning of it, the funeral, etc. Anger toward the deceased person and often abreactions may then occur. The therapist then explains and interprets the patient's need to keep the lost one alive. When the patient has come to understand his need not to know of the loss, the therapist will encourage him to think about when he first knew the deceased person was dead. Volkan calls

this revisiting the point where the splitting took place in order to reevaluate reality. Often the patient will be surprised to discover that he never really made sure the person was dead. It is also characteristic that these people do not remember seeing the lost person buried. They have been unable to let the reality of the death into their awareness.

Volkan reports that as patients become aware of the death, they frequently disorganize and may be flooded with primary process thinking. Most of his patients required hospitalization at some point in their treatment. In the final phase of treatment, the patient reintegrates and begins to grieve and feel sad. He realizes his anger at the dead person and understands what that person meant to him. Suggestions and interpretations for his continued life in the face of his loss are provided. He is encouraged to visit the grave and then discuss his feelings about it. The therapist then provides help as the patient seeks to direct his energies toward new objects (Volkan, 1970).

Polak and associates (Polak, Egan, Vandenbergh & Williams, 1975) attempted a more general type of intervention with the families of people who died suddenly at a metropolitan hospital. They contacted the families within a few days of the death and offered to talk with them at their homes. The intervention took place in two to six sessions over one to ten weeks. The professionals who went to the homes talked to any family members present about either

practical matters such as funerals and finances or about their feelings concerning the death. After six months the familes who received help were assessed using self reports, interview ratings, and social questionnaires and were compared to people who did not receive treatment. The self reports assessed frequency of physical illnesses, depression, psychiatric and neurotic symptoms, family functioning, crisis coping, and intellectual functioning. No significant difference in adjustment was found between the group treated by professionals and those people who received no formal treatment. On later analysis it was found that the loved ones of the treated group died with less warning than did the loved ones of the untreated group, but this difference does not totally account for the lack of effect of the treatment. Palak concluded that short term treatment by professionals does not have the power to overcome the effect of the bereaved person's natural social systems. The only significant difference was that treated persons were more concerned over their economic and social well-being six months later. Might this have been an effect of professional help, i.e., being labeled as sick?

To study the effectiveness of preventive intervention preventing poor adjustment after the husband's death, Raphael (1977) worked with widows who were at risk according to four indices she devised. Index one was "a high level of perceived nonsupportiveness in the bereaved's social network response during the crisis" (p. 1450). Index two was moderate non-support with sudden or traumatic deaths. Index three was an ambivalent relationship with the decreased,

and Index four was the presence of a concurrent life crisis. Women who were felt to be high risks were randomly assigned to treatment or control groups. The treatment Raphael used was a technique she called "selective ego support for ego processes stressed by the crisis experience" (p. 1451).

> Specifically, for the adult conjugal bereavement crisis, this involved support for the expression of grieving affects, such as sadness, anger, anxiety, hopelessness, helplessness, and despair, and facilitation of the mourning process with its review of the positive and negative aspects of the lost relationship. The technique used and tested for effectiveness was this type of ego support carried out during the period of the crisis. Such general aspects would be tailored further to the specific needs of the particular individual receiving the intervention, e.g., working through the marked levels of ambivalence where this had existed previously with the lost relationship, or encouraging the expression of anger or guilt where this was indicated by the bereaved to be an area in which the social network had failed to provide adequate support and care. The intervention was limited to the initial three-month crisis phase following the death.
>
> Although the intervention was in this instance carried out by a dynamically trained psychiatrist, the model was evolved to be applied with varying levels of psychodynamic sophistication. Social workers, community nurses, and others have been successfully trained to carry out similar supportive measures.
>
> Sessions were two or more hours long carried out in the widow's own home, and essentially nondirective in character, although focus was kept on the dynamic issues of relevance to the bereavement. All intervention was terminated by three months after the husband's death.
>
> The intervenor terminated the intervention as a final arrangement between her and the widow, with no intimation of future contact. The average number of sessions was four, the range, one to nine sessions. Where significant others e.g., dependent children, were present, their needs were incorporated with the widow's in intervention sessions.
>
> In essence, the intermediate goals of the intervention were the promotion of normal grieving--expression of bereavement affects, and the accomplishment of a significant degree of mourning--review of positive and negative aspects of lost

relationship and gradual going over and giving up.

(Raphael, 1977, p. 1451)

A general health questionnaire was used to evaluate the effectiveness of the intervention program. It was mailed to all subjects 13 months after the death. At risk widows who received Raphael's intervention were significantly less likely to suffer major health impairment at 13 months than were at risk widows who did not receive her intervention.

Although it has been shown that intervention to prevent poor adjustment is most useful if it occurs within the first few months after bereavement, therapists often find that newly bereaved persons are usually too disorganized and too unsure of their needs to reach out and ask for assistance. Some method of initiating contact must be incorporated into a successful intervention program (Silverman, 1972). Contact will not be successful if the widow does not see the program as meeting her particular needs or if she feels uncomfortable accepting help. To give help a program must first overcome the widow's feelings about the privacy of her grief and her denial that she is having any problems for which she needs help. A widow will usually first turn to friends and relatives for support. Her next step is usually the family doctor. She progresses along normal channels of assistance and will not consider external professional or psychological help until she is in enough discomfort to redefine the situation as a crisis. Only then will she relinquish her "attraction to normality"--her tendency to define her problems as normal

conditions--and seek outside help (Gerber, 1969). A successful intervention program must therefore be available immediately (covering one to three months after death), able to reach out to all who need it, have community approval (so no stigma is attached to using it and widows will not need major problems to accept help), and be flexible enough to meet a wide range of needs.

By these criteria, programs developed by psychologists have the obstacle of stigma to overcome at the onset. Gerber (1969), in his study of relatives of patients who died at Montefiore Hospital and Medical Center, attempted to overcome this problem by having the initial contact and introduction made by the family's physician. Three days after the actual death, the family physician sent a letter of condolence. Eight days after the death, the physician contacted the family for the purpose of introducing the service and, if possible, eliciting a statement of acceptance. Regardless of whether the family accepted, rejected, or was undecided about the service, the social worker called them. She identified herself as a colleague of the physician and offered her condolences and attempted to arrange an appointment to call on the family in their home. When asked what help she had to offer, the social worker explained that the physician was aware of the way pain weighs on people and he thought talking to a person who was not a friend or relative might help. Eighteen out of 22 family units contacted accepted the service when it was presented in this way. Of the four who rejected the service, two later accepted four months later when they found that family and

friends were unable to give the needed assistance and emotional problems they thought they could handle were still present. (The situation then became a crisis and the "attraction to normality" was reduced enough for them to seek professional help.)

The service offered was "brief psychotherapy" by a social worker under the supervision of staff psychiatrists based on the consideration that the normal grief reaction includes realization of object loss, "emancipation from strong emotional bondage of the deceased, readjustment to the environment in which the deceased is missing, and forming new relationships and patterns of behavior" (p. 490). Consistent with this orientation, the primary methods of therapy were:

1) permitting and guiding the patient to put into words and express the affects involved in (a) the pain, sorrow, and finality of bereavement, (b) a review of the relationship to the deceased, and (c) feelings of guilt toward the deceased;

2) acting as a primer and/or programmer of some of the activities of the patient and organizing among available, suitable friends or relatives a flexible, modest scheme for the same purpose;

3) assisting the patient in dealing with reality situations, care of children, and legal problems;

4) mediating referrals to family doctors for prescriptions of psychic energizers, if necessary, for excessive depression and insomnia;

5) the offer of assistance in making future plans.

During the treatment sessions, family members were led to talk about the deceased person and their relationship with him(her). Survivors were encouraged to examine and eventually accept their feelings of rejection, desertion, and anger at having to suffer such a loss while the "whole world went on as usual." In practice, the service was mainly emotionally supportive in nature, with the addition of professional assistance in areas of employment, offspring's school problems, and family financial problems.

A followup questionnaire mailed to survivors who accepted the service evaluated how helpful the service was. Only two of the 26 survivors within the 18 families who accepted the service indicated that the service was not very helpful. Of the 24 respondents who thought the service was "very helpful" or "helpful," ten reported that the service was beneficial because it was good to talk to someone who "was not a relative or friend." Eight indicated that because they had a chance to talk to "a professional" their anxieties were reduced. The remaining six respondents thought the service was helpful for various reasons, such as it gave them a chance to "get out of the house," "to meet new people," or it offered a chance "to stop thinking so much about the past" (Gerber, 1969).

Silverman (1967) found the problem of acceptance to be at least partially overcome if the care-giver was a widow. Another widow seemed to have a legitimate interest in helping and could act in the context of neighbor or friend who had had a similar experience. It

was hypothesized that a widow caregiver would be able to use her own experience to help others, that her special empathy would enable her to understand the support needed, that she could accept the new widow's distress over an extended period of time, and that she would be accepted if she offered her assistance. The fact that the caregiver is a widow allows the new widow to unburden herself knowing that the widow will understand. A widow, who has been through it all, can counsel patience and waiting for time to heal and be believed. The caregiver widow can serve as a role model and a promise to the new widow that she too can build a new life (Silverman, 1972).

Two intervention programs using widows as caregivers have been implemented in Boston. A telephone hotline was manned by 13 widows and five widowers. It was publicized through newspapers, churches, radio and TV as the Widowed Service Line and offered specific information or just a sympathetic ear. Seven hundred and ninety calls were received in the first eight months. Forty-six percent of the callers served were widowed within the last two years. Those people widowed within the last year mostly needed a sympathetic ear. Among those widowed for three years or more (41%), the primary requests were for meeting new friends and for specific information. These calls reflected a second critical period for widows--the time after the children grow up and leave home. The widow now also loses her defining role of mother and may face living along for the first time (Abrahams, 1972). It is these people for whom the telephone hotline seems to be the best, and possibly the only, method of contact.

The Widow to Widow program was developed to offer a more personal and a more unstructured relationship than could be provided by psychologists or by telephone. A public health model of prevention was adopted, that of seeking to reach every widow under 60 years of age in a given community, even those who did not need any assistance at that time. Not every widow needed the help of a widow-aide. Some had well-developed lives outside of their marriages; others could accept their loneliness and felt no need to change their style of life; still others became dependent upon their children and moved in with them. Whatever their range of options, these women did tolerably well. Many of them were glad to see the aide and accepted her additional support; others refused her help. Women who accepted the service found a sympathetic ear, practical advice, and friendship (Silverman, 1972).

The widows used as the primary caregivers in the program waited three weeks after the husband's death before contacting all the wives of men whose death certificates were registered with the bureau of vital statistics. The three week delay was to allow the woman time to give up her role as a wife and to begin to identify herself as a widow. Three weeks after the death, a letter of explanation of the program was sent to each widow along with references from three religious organizations. The letter gave the day and time that a widow aide would call. Widows were requested to telephone if they preferred that the aide did not come or if the time was inconvenient.

The aide who called and offered assistance in making the transition from married to single spoke with the voice of experience. It was not necessary for the new widow to clarify or justify how she felt. The aide could help the widow feel that she was not all alone. The aide was comfortable talking about her own grief and her difficulties in accomodating to it and was thus able to help the widow experience her grief. The aide was not upset by the tears or distressed at the length of time it took for the new widow to find a new direction, but she could get annoyed and push if she felt it was time to progress further.

The aide was also a bridge person back into the real world. She introduced the widow to other people who shared her interests. She could arrange to have the widow taught skills that she needed to make her new life--how to drive a car, balance a checkbook, or get a job. She organized groups of widows to talk about their common problems and overcome the feelings of worthlessness. She served as a model of what the role of widow could be.

When the widow developed some positive definition of herself in the new role, the process of intervention was completed. Many of the widows moved from clients to caregivers. Caregiver was one role the widow could build into her new identity. The widow could then continue her new life by helping others (Riessman, 1971).

The Widow to Widow program is much like a self-help program since the caregiver is a widow and she is helping other widows. All

members and officers of the organization are former clients. A widow caregiver bears no stigma of illness or disability. To take help from her does not reflect on personal competence. She is able to aid the new widow in her expression of grief, to support her as she builds her new identity, and to help her re-people her life (Silverman, 1967, 1969, 1972).

McCourt and associates (McCourt, Barnett, Brennan & Becker, 1976) were aware of the limitations of a traditional mental health setting in trying to aid the widowed person. They wanted to devise a program that would define the widowed person as attempting to cope with a difficult life situation rather than suffering from an illness. They wanted to get away from the impersonal nature of many therapeutic encounters to meet the needs of the widowed person for a more personal, active relationship. They especially wanted the capacity to reach out and initiate contact.

To do this, they began a program through a community mental health center to hire and train widow counselors. To gain community acceptance of the program and access to widowed persons, they contacted local churches and social agencies and requested referrals and permission to use their names on the program's letterhead. They also publicised their program through a biweekly column in the local newspaper. The column was written by one of the widow counselors describing the program and the problems of widowed persons.

The program consisted of a widow telephone line, home visits,

social gatherings, and community seminars. The telephone line was staffed five days a week from 9 A.M. to 5 P.M. by a widow counselor. The counselor was available just to talk to or intervene with a home visit if she felt it was necessary. Home visits were used to contact newly bereaved people and to tell them about the program as well as an intervention technique for people in distress. People often feel more comfortable receiving the counselor in their own homes, and the condition of their homes and families told the counselor much about the type of help this family might need. Social gatherings were held every two weeks and include a wide range of activities from trips to dances. They allowed the widowed person to meet others like herself who had coped with loss and aided the widow in re-peopling her life. Biweekly seminars were held in the community and dealt with such issues as adjusting to the new life style, sex, dating, and socializing. People who had coped with their new life style for longer periods of time were encouraged to share their experiences with these issues.

No formal evaluation of the effectiveness of this program has been made. When 100 people who had had contact with the program were questioned by telephone, 85% felt the program had been helpful to them.

Individual contact between widows and professionals or widows and widow helpers seems to be useful in enabling the recently bereaved person to adjust more effectively to her new life style. One to one contact, however, is expensive both in financial terms and in volunteer

man-hours. Barrett (1978) investigated the effectiveness of group interventions with widows thereby enabling one caregiver to reach eight to ten people with the same investment of time. She compared the effectiveness of "self-help" groups (with a professional catalyst), confidante groups, and widow's consciousness raising groups. All groups met for two hours once a week for seven weeks. Two clinical psychology graduate student women led each group. The purpose of the self-help group was to encourage participants to help each other find solutions to the problems of widowhood. The therapists referred all direct requests for advice back to the group and praised group members when suggestions were offered to others. (Although Barrett called one of her groups a self-help group, having professional leaders who organize and control the group meetings is contrary to the milieu of self-help groups. Due to this occurrence, the label does not seem completely appropriate.) The purpose of the confidante group was to facilitate the development of a close friendship between pairs of widows. Subjects were paired for the duration of the group. The group format consisted of intimacy training tasks and later discussions of the experience. The tasks increased in difficulty from a request to find three things the pair had in common to a request to share personal problems and to make an explicit offer of help to one's confidante. The purpose of the consciousness raising group was to facilitate the participants' awareness of how their experiences as widows related to them as women. Each week the group chose a sex role topic and discussed it sharing personal experiences.

The widows in Barrett's study had been widowed from less than one month to 22 years with a median duration of three years nine months. These were not primarily recently widowed women. Eighteen personality, behavioral, and attitude measures were used to evaluate the effect of the groups. All women increased in self-esteem, intensity of grief, and negative feelings toward remarriage. Interestingly, the untreated women increased their self-esteem more than any of the experiential groups. Could this be due to a feeling of competence in handling the crisis on their own without needing the help of a professional? Could the negative feelings toward remarriage be due to the raised self-esteem and the woman's experiencing her own ability to live alone? Although the outlook of the control group improved, the treatment groups were somewhat successful in facilitating greater change than that experienced in the control group. The most effective of the treatment groups seemed to be the consciousness raising group. Possible reasons for this finding might be that the structure of the group required all members to participate and the focus on women and sex role oppression provided a natural external target for anger. This expression of anger may have been useful in treating the depression of the widows. Improvement of the control group may have in part been due to the promise of help (admission to the groups) in two months' time. It may have been due to hope.

Groups have been shown to be both cost effective and efficient in helping widows adjust to their new life patterns. Widows as caregivers avoid the problems of stigma and impersonality often inherent

in traditional mental health programs. An additional benefit of using widows as the primary caregiver in an intervention program is that they know firsthand the problems their clients face in a way non-widowed psychologists can never know. The widow caregiver can advise the professional on the effect of the program and as a contact person is more likely to share the background, values, language, and interests of the clients than most professionals. Using widow caregivers frees up the time of professionals for supervisory tasks and expands the professional's effective range. A program that incorporates member movement from care-receivers to care-givers provides a model for the new members and a useful role for older members. It would seem that the ideal intervention program would be able to reach out and contact widowed people within one to three months of their spouse's death, would be available to all who needed it, would have no illness stigma attached to acceptance of help, and would be flexible in providing for different types of needs. The ideal program would aid in handling grief and depression and in discovering new life roles. One of the most effective patterns for the intervention program would seem to be a self-help group in which widowed people taught other widowed people how to cope and in which the pupils could become the teachers.

Program Under Investigation--NAIM

The current study is part of a research plan to develop an effective, practical intervention program for widows that could be used in many parts of the country. Choice of the program to study

was greatly influenced by these considerations. NAIM was chosen because it seemed to fit many of the requirements for a workable, inexpensive, effective program.

NAIM is an organization that is open to all Catholic widowers or widows or the spouses of deceased Catholics. The goals of NAIM are clearly outlined in this quote from their monthly newsletter.

> NAIM
>
> IS organized for Catholic widows and widowers and the spouses of deceased Catholics.
>
> ATTEMPTS to help the widowed adjust to their new life by bringing them together with others who are facing and solving similar problems.
>
> IS NOT a lonely hearts club. It is true that we have had marriages occur, but this is not the purpose of NAIM.
>
> GIVES members the benefit of basic legal, psychological and financial information.
>
> DOES plan social gatherings for its members to help them face the loneliness that is inevitable for a widow or widower.
>
> CONDUCTS conferences for the newly widowed throughout the year.
>
> HELPS those left with children face the problems of discipline and understanding in a one parent family.
>
> REALIZES that the needs of a widow or widower may change as years pass, and works to help meet all of these.

A typical first contact with NAIM might occur when a friend or the pastor gives the name and address of a recently bereaved person to the central NAIM office. Volunteers from the office would then mail out at three different times invitations for that person to

attend a NAIM conference. NAIM conferences are held four to six times a year. They are meetings in which people who have been members of NAIM for several years talk about their experiences with widowhood and tell the new people what NAIM has done for them. Practical information from lawyers and insurance people is also presented. After the conference, members are invited to attend meetings at several chapters before choosing which chapter to join.

There are regular chapter meetings scheduled once a month at 26 locations in the Chicago area. The size of a chapter may range from eight to 200 people. Different chapters have somewhat different chapter formats depending on the needs of their members, but most begin with a business meeting and end with either an entertainment or an educational program. Chapters are encouraged to develop their own characteristics. Some chapters consist mostly of senior citizens and others consist of parents with young children, but most chapters have a mixture of ages. Some chapters serve tea and cookies at the monthly meeting, while other chapters have full dinners or an open bar. Programs can vary from chapter to chapter also. Most chapters seem to have entertainment (dances, magicians) at least twice as frequently as they have "serious" programs (lawyers, psychologists, priests). Several hours of socializing usually take place after each meeting. In addition to the monthly meetings are social events (theatre parties, dinner-dances) that occur about once a month, fund raising dances (beer and banjo, polka), all chapter events (picnics, dinner-dances), contact dinners (for new people), and spiritual retreats. The NAIM

members are encouraged to attend the functions of chapters other than the one to which they belong in addition to their own. It is theoretically possible for a NAIM member to attend NAIM events 15-20 times per month.

NAIM chapters have a president, vice-president, secretary, and treasurer who are elected officials. The larger chapters also have a number of committees to further delegate the many responsibilities of running the organization. Father Sullivan chapter, the chapter studied, had a courtesy committee (to contact hospitalized members, send condolences, etc.), a contact committee (plan contact dinners, call new potential members), a hospitality committee (welcome visitors at the meetings), a program committee, a publicity committee, a fundraising committee, a spiritual committee (plan the retreats), a children's committee (to plan programs involving the children), a refreshments committee, a ways and means committee (to sell raffle tickets during meetings to raise money for the children's committee), and several other committees. Usually there were at least three people on each committee. In addition, they had chosen 35 people as board members to meet in executive planning sessions. Of the 200 members in the chapter, 60 or more of the members were actively involved in the running of the chapter. Although NAIM is nominally under a director appointed by the Catholic Church, he has little contact with the individual chapters. All offices in the chapter are filled by widows and widowers.

Although the members of NAIM refer to it as a club, NAIM seems

to fit the description of a self-help or mutual-help group given by Silverman and Murrow (1976, p. 411).

> A mutual-help group composed of these helpers may be defined as:
>
> A group or organization in which membership is limited to people with a common problem. These members use their common experience to find solutions to these problems or to learn from each other ways of dealing with them. This mutuality makes the term mutual help more accurate than self-help. To qualify as a helper in such a program, one has to have successfully coped with the same problem, and be willing to use the experience to help others. The programs are run by members, for members.

NAIM is a group where the helping contacts are made by other widowed people. This type of group is often more effective in contacting people since it is run by "regular folks" rather than professionals. Gerber (1969) has found that for bereaved people to accept help from a professional they must give up their "attraction to normality." They must redefine their situation as a crisis and as a crisis that they cannot handle by themselves. Only after they feel unable to cope using "regular" methods such as friends or the priest or pills will the person reach out for professional help. One of the main advantages of a self-help group is that there is less need to define the self as powerless to deal with a crisis before joining. The people in the self-help group are perceived as normal people who understand and have experienced the widowed person's special pain. Silverman (1972) found that widows were the most accepted and the most effective caregivers in reaching out to other widowed persons. She felt that the fact that the other person was

also a widow allowed her clients to unburden themselves knowing that the widow would understand and not be uncomfortable in the presence of her grief. Silverman's widows and the people of NAIM can counsel patience to the widow as she waits for her grief to end and can be models for the fact that she can go on living and can develop a new life.

There are other advantages to self-help groups as a therapy model. Widow helpers who have experienced the problems are often more able to give specific and concrete suggestions when asked for advice about a problem. Silverman and Cooperband (1975) believe that a major part of the widow's role anomie is due to the patterns for grieving no longer being passed on by friends or extended family or close community. A group for widows can give each other this support. The fact that widows are the ones giving the support can be therapeutic in itself. The women who are giving are enabled to further work through their feelings of loss, and the new women have a model to work toward. The help and support in a self-help group is informal and personal and probably for that reason much more appropriate than a "therapy" situation for these women in transition. Most of the NAIM contacts take place in a group setting. A program based on this model would be able to reach many people with a minimum investment of money or professional time.

Other features of NAIM that seemed to fit the literature recommendations for an intervention program for widowed women were its

availability and flexibility. The NAIM program technically is available to all Catholic widowed persons or the spouses of deceased Catholics. With its 26 chapters in Chicago with between eight and 200 members per chapter, there is no need to turn people away because they could not be included in the program. Although NAIM suffers somewhat from a "lonely hearts club" stigma, generally it is socially acceptable to join NAIM. The flexibility of NAIM in meeting the differing needs of its members was evidenced in the chapter studied by the variety of programs at the chapter meetings (from pure entertainment to socials to serious speakers) combined with the spiritual retreats and the informal sharing that takes place between people who meet at NAIM. The meetings themselves seem primarily set up to meet the needs of people in the recovery phase of mourning. When asked if NAIM helped them with their grieving, women frequently replied that the help they had gotten was from individuals they talked with after the meetings.

Lindeman (1944) states that the task of the widow in grief work is to emancipate herself from her "bondage" to the deceased, to readjust to living in a world where the deceased is missing, and to learn to form new relationships. NAIM seems to help the widow with all three of these tasks. Some of the norms observed at NAIM meetings that seem to encourage the widow to "emancipate herself" are an emphasis on the fact that she is "no longer married," that the past is gone and the future distant, and that the time to live is in the now. In private, women seem to be encouraged to express their anger

and depression but their loss, but in public they are admonished to try to reach out again and begin a new life. NAIM's norms support the need of the woman to "leave her house of mourning" rather than overtly pining for the dead. The pressure to be ashamed of laughing or dating after the death of a spouse mentioned by Levin (1975) is not found in NAIM.

Learning to live in a world in which the spouse is missing is probably the most difficult task for the widow. Talking to other widows is probably the best way to learn to cope with this task (Golon, 1975; Silverman, 1976). Older members of NAIM can tell the newly bereaved woman what to expect in terms of the pain and the depression. They can let her know the worst pain is time-limited and can show her someone who has been there and survived. The officers and members are available by telephone and in person to anyone who begins to feel panic over her depression or a decision to be made. They give support and advice or can suggest the person contact an authority if necessary. Members are available on a friendship basis to share fears and feelings and accomplishments. Women who have learned to live alone are available to talk about how they coped with the loneliness. People who also have had to deal with the feelings of guilt and anger over their loss may be sought out. Each person has her story to tell of how she found a new purpose for her life. And she is willing to share the story--formally or informally.

Most obviously NAIM helps the widow learn to form new relationships. Friendships with married couples often are strained after the

death of a spouse, and NAIM provides opportunities for the widow to make friends as a single woman rather than a member of a couple. NAIM gives the woman a socially acceptable place to seek friends. She is no longer limited to a singles' bar. The members of NAIM overtly encourage women to make other women friends and most do, but special status is yet reserved for the woman who has made a male friend.

Since the purpose of this study is to evaluate NAIM as a model of intervention during the crisis of widowhood, women will be studied who have been widowed between 6 months and 5 years.

Abrahams (1972) found that the primary need for women who had been widowed from one to two years was an understanding listener. Women entering the recovery phase (two to six years) were "looking for new ways to reengage in the social system, find new roles, and build a new network of social relations." NAIM was expected to be most helpful to women as they enter the disorganization or recovery phase and begin to build a new life.

The NAIM chapter chosen for the sample is a fairly young, middle class, active chapter. This particular chapter was chosen because it is the original chapter of NAIM and seems to be one of the chapters that best exhibits the NAIM goal of involvement and outreach. To be included in this study, the women must be middle class and under 66 years of age, and this chapter has a high proportion of people who would fit this category.

The primary reasons for choosing to limit the study to people under 66 were to avoid confounding the problems of widowhood with those of old age and because young widows are more apt to adjust poorly to their new lives. Women under 66 are more apt to experience deterioration of their health (Kraus & Lilienfeld, 1959; Parkes & Brown, 1972). They are more apt than older women to need help coping. They are less likely to be prepared since they don't expect to lose their spouse (Silverman, 1969).

The stipulation that the widows be from the middle class is based on Lopata's work (1973). She found that there were differences in the ways women wove being married to this particular man into their own identities and therefore differences in the degree of trauma when the man dies.

Women were chosen rather than including men and women in the study for several reasons. The problems of men and women do not seem to be exactly comparable. The man does not experience the traumatic identity change that a woman does. At least in this cohort, the woman's identity is frequently based on being a wife. A man has a primary identity based on his work role and this does not change. He does share the loss of intimacy that the women experiences and his pain is just as real. He does not, however, face many of the social and psychological pressures the woman faces in going out to meet people and build a new life for herself. Another reason for not including men in this study is that fewer men seem to need (or perhaps

seek) help. Of the 960 telephone calls Abrahams received, only 78 were from widowers. Carey (1977) found that in general the widowers were less depressed and better adjusted after 13 months than were the widows. Men also were more likely to remarry and they remarried sooner than did widowed women of the same age (Cleveland & Gianturco, 1976). Women seem to be more likely to need help coping with the transition from wife to widow to single woman.

Measures of Adjustment

The outcome measures that were used in the current study are the Hopkins Symptom Checklist (anxiety and depression), the Rosenberg Self-Esteem Scale, the Pearlin Mastery Scale, the measures of health, and the Neugarten Life Satisfaction Index A. These five measures defined the criteria of this study for the widow's good adjustment to her life after being widowed.

The 35-item form of the Hopkins Symptom Checklist was used to assess the degree of anxiety and depression experienced by the women. Depression was the trait found to be present in more than 50% of the widows studied by Bornstein et al. (1973). An early form of the Hopkins Symptom Checklist (HSCL) was developed as an improvement measure for research in psychotherapy (Parloff, Kelman, & Frank, 1954). The basic 58-item inventory was first used as a criterion measure in psychotropic drug trials by Lipman, Cole, Park and Rickels (1965). The HSCL may be used to measure five factors: somatization, obsessive-compulsive, interpersonal, sensitivity, depression, and anxiety. The

reality of these constructs has been supported by factor analysis (Williams, Lipman, Rickels, Covi, Uhlenhuth & Mattsson, 1968) and clinical clustering studies (Lipman, Covi, Rickels, Uhlenhuth & Lazar, 1968). When highly experienced clinicians were asked to assign the symptoms to clinical clusters, four clusters were found. These clusters were anxiety, depression, anger-hostility, and obsessive-compulsive-phobic. The factor analysis found the five clusters previously mentioned.

Three sets of normative data are available for HSCL. The "anxious neurotic" sample was obtained from 1435 patients newly admitted to three large Eastern clinics. These patients presented functional neurotic complaints involving high levels of manifest anxiety. The "neurotic depressive" sample were 367 outpatients at four Eastern hospitals. They exhibited clinical depression as their primary disorder. The "normal" sample was obtained from 735 non-institutionalized individuals living in Oakland, California (Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974).

The reliability of a test affects the accuracy with which the trait is measured. The alpha coefficients for internal consistency in the HSCL are uniformly high, ranging from .84 to .87. Test-retest reliability over a one-week period with 425 anxious neurotic patients produced coefficients ranging from .64 to .87. When 15 outpatients were rated by a pair of trained clinicians using the HSCL, the correlations ranged from .64 to .80. The HSCL appears to be a reasonably

reliable instrument as a self-report or a rating scale (Derogatis et al., 1974).

One of the criteria that has been used to assess the validity of the HSCL is the instrument's sensitivity to the effects of psychotropic drugs. The HSCL has been shown to be sensitive to changes after the administration of antianxiety agents (Rickels, Lipman, Park, Covi, Ohlenhuth & Mock, 1971; Uhlenhuth, Rickels, Fisher, Park, Lipman & Mock, 1966), minor tranquilizers and antidepressants (Covi, Lipman, Pattison, Derogatis & Uhlenhuth, 1973; Raskin, Schulterbrandt, Reatig & McKeon, 1970; Covi, Lipman & Derogatis, 1973).

The HSCL has been shown to be able to correctly classify 65-70 per cent of a group of neurotic outpatients as to their primary diagnosis of anxiety or depressive neurosis (Prusoff & Klerman, 1973). Perhaps the most dramatic evidence for the ability of the HSCL to discriminate distress levels comes from the work of Rickels, Lipman, Garcia and Fisher (1972). They contrasted the distress levels of gynecological normal patients with the levels found in past treatment in anxious neurotic patients. The normal patients were further classified as emotionally labile or nonlabile by their gynecologist. The neurotic patients were rated by an independent doctor as unimproved, mildly improved, or markedly improved. The study showed rank ordering of the five groups on all five HSCL dimensions from the gynecologically nonlabile at the lowest distress levels to unimproved neurotics at the highest. The differences between the groups were

statistically significant.

The Hopkins Symptom Checklist seems to be effective in assessing the distress levels of normal or neurotic persons. It is most effective in measuring depression and anxiety. Depression and anxiety are hypothesized to be one of the major symptoms of poor adjustment for the widows to be studied. Although the 58-item version of the HSCL is the instrument on which most the research data has been gathered, Wheatley (1972) has shown the 35-item to be reliable and almost equally clinically sensitive.

New widows frequently report feelings of being "shattered" or "not normal." They are under a great deal of stress due to the pain of their loss and to the many requirements that they cope with new situations such as living alone or handling the children by themselves. The widow must now deal with situations that her husband used to handle, and she may not be able to cope adequately with all of them. Her major role of wife in which much of her self-esteem may have been based is gone. The widow's self-esteem has been challenged.

Self-esteem is important as an outcome measure for two reasons. Pearlin and Schooler (1978) found that high self-esteem and feelings of mastery were the most important variables in predicting who would be best able to cope with their daily stresses. In addition to its' function as a predictor of coping ability, high self-esteem (having positive feelings about oneself and few negative feelings) may be seen

as a desirable psychological outcome in itself.

The Rosenberg Self-Esteem Scale was used in this study (Rosenberg, 1962, 1965). Rosenberg is a Guttman scale that consists of ten items answered on a four-point basis from strongly agree to strongly disagree. The scale items are presented in Appendix A. This scale combines economy of time with impressive evidence of validity. Since there are no "know groups" or "criterion groups" of high or low self-esteem people to use in validation of the scale, Rosenberg (1965) attempted to show that the scores on his self-esteem scale were associated with other data in a meaningful way. It is a familiar clinical observation that depression often accompanies low self-esteem. Rosenberg found that volunteers who appeared depressed on a Leary scale filled out by nurse observers also scored as having low self-esteem. He also found that only 47 per cent of people were "highly depressed" on a Guttman scale of "depressive affect." Some clinicians characterize low self-esteem as one of the basic factors in neurosis. When neurotic soldiers were compared with normal soldiers in terms of self-esteem and psychophysiological symptoms of anxiety such as sleeplessness, nervousness, hand trembling, and sweating, each step down in self-esteem found a larger portion of soldiers with the psychosomatic symptoms. Sixty per cent of the highest self-esteem soldiers had few symptoms. Only 16 per cent of the low self-esteem soldiers showed this pattern.

Self opinion is highly influenced by what others think of a

person. Rosenberg correlated self-esteem in high school students with the ratings given them by other students and with the ratings the student stated he expected. People with low self-esteem were less likely to be chosen as class leaders (15% vs. 47% for high self-esteem), less likely to be seen as active class participants (18% vs. 31%), more likely to be seen as socially invisible (67% vs. 43% for high self-esteem), and less likely to expect other people to think well of them (8% vs. 38% of high self-esteem). If self-esteem is defined as a positive or negative attitude toward the self, the Rosenberg Scale showed differences in the expected direction.

A more rigorous test of the validity of the Rosenberg Self-Esteem Scale was conducted by Silber and Lippett (1965). They used Campbell and Fiske's concept of convergent and discriminant validity to compare a number of self-esteem and self-image stability measures. Campbell and Fiske (1959) recommend that a concept be compared with a similar, but independent, concept to assess the validity of a measure. The score on the measure should be compared with the score from the same concept measured by another method and with a separate concept measured by the same method and a different method. The two measures of the same concept by different methods should correlate more highly than the measures of the different concept by the same method. By comparing the concept correlations with the method correlations, an estimate of measurement error can be obtained. Silber and Lippett found that the Rosenberg Self-Esteem Scale correlated .83

with the Self-Image Questionnaire (Heath, 1966), and .67 with the Role-Repertory Test (Kelly, 1955), and .55 with interview ratings of self-esteem. The concept of self-image stability (defined as the degree to which a person's self-image changes over a two-week period) was used as the other concept. The highest correlation was with the Rosenberg Self-Image Stability Scale which was also a Guttman, self-report scale. The correlation was .53. Correlation with the different concept and different methods ranged from .20 to .40. Silber and Lippett speculate that the high contribution of method factors may have been because both Rosenberg scales required rather global responses and were therefore more susceptible to bias, such as presenting a good facade. They also found (Lippett & Silber, 1965) that self-esteem and self-image stability were not completely independent concepts, and this inflated the different concept correlations.

Self-esteem has been defined as "feelings of satisfaction or dissatisfaction about the self which reflect the degree of congruence between a person's self-image and his own ideal self-image" (Silber & Lippett, 1965, p. 1049). Positive attitudes about the self may take the form of feeling superior to other people but inadequate in terms of the high standards set for the self. High self-esteem may also take the form of acceptance of the self as a person of worth.

> The individual respects himself, considers himself worthy; he does not necessarily consider himself better than others, but he definitely does not consider himself worse; he does not feel that he is the ultimate in perfection but, on the

> contrary, recognizes his limitations and expects to grow and improve.
>
> Low self-esteem, on the other hand, implies self-rejection, self-dissatisfaction, self-contempt. The individual lacks respect for the self he observes. The self-picture is disagreeable, and he wishes it were otherwise (Rosenberg, 1965, p. 31).

This latter self-acceptance is the form of self-esteem measured by the Rosenberg.

Test-retest reliability for the Rosenberg over a two-week period has been reported as .85 (Silber & Lippett, 1965). The scale has been used successfully to evaluate adolescents (Rosenberg, 1965), to assess therapy changes in older adults (Liberman & Gourash, 1978), and to study coping in a cross-section of Chicago adults of all ages (Pearlin & Schooler, 1978). It seems to be reliable, valid, and appropriate for use with this sample.

The other factor Pearlin and Schooler (1978) found to be important for success in coping with stressful situations was a "feeling of mastery." Mastery is concerned with the extent a person regards his life as being under his own control as opposed to being "up to the fates." The mastery scale used was developed by Pearlin for the coping study. It consists of seven items to be answered on a four-point scale from strongly agree to strongly disagree. The text of the scale is presented in Appendix A.

Deterioration of health has been shown to be a major hazard in widows. An important outcome for an intervention program would be to

prevent that deterioration. To assess this factor, the widows were asked a series of health-related questions regarding frequency of illness and medication use and general descriptions of their health. In several studies, people's self-ratings of their health have been shown to correlate highly with physicians' ratings and their medical records (Anderson & Anderson, 1967; Anderson & Lerner, 1960; Liberman & Gourash, 1978; Simmons & Bryant, 1952; U.S. National Health Survey, 1965). The health questions are presented in Appendix A.

Good health, high self-esteem, and the absence of depression did not in themselves seem to adequately define the good adjustment to life after widowhood that the researcher wanted to measure. Some sense of the widow's feelings about her life, her satisfaction with her adjustment, was needed. Neugarten's Life Satisfaction Index A (Neugarten, Havinghurst & Tobin, 1961) was chosen to measure this factor. The Life Satisfaction Index consists of 25 attitude items to which respondents reply agree or disagree. The questions were derived to tap five factors found to be components of "morale" by Neugarten et al. (1961) and by Cumming (Cumming, Dean & Newell, 1958). Neugarten defined morale as measured by the Life Satisfaction Index as "the individual's own evaluations of his present or past life, his satisfaction, or his happiness" (Neugarten et al., 1961, p. 134). She conducted extensive interviews with 177 residents of Kansas City aged 50-89 to try to determine what morale consisted of and how it could be measured. She derived five relatively independent components of

morale. Her components were: 1) zest vs. apathy measured the degree of enthusiasm and involvement a person feels for his life. A knitter who truly loved her hobby could rank just as high as an athlete. Physical evergy expended is not necessarily part of this component. 2) Resolution and fortitude is the measure of the extent to which a person accepts responsibility for his/her life. The opposite of this component might be resignation or passive acceptance of what life brings. 3) Congruence between desired and achieved goals, the extent to which the person feels he has attained his goals in life whatever those goals may be, is Neugarten's third factor. 4) Self-concept measures concept of physical appearance including personal grooming as well as psychological and social attributes. High ratings go to the person who feels he/she is wise or mellow, who feels proud of his accomplishments, who feels he/she is important to someone else. 5) Mood tone is the fifth factor. High ratings went to people who expressed happy and optimistic attitudes and moods, who took pleasure from their lives. Low ratings were given to people who felt depressed, bitter, or angry.

Neugarten and associates found that when subjects were rated on these five components by two independent judges who had read transcripts of lengthy interviews, the judges' ratings' coefficient of correlation was .78. Ninety-four percent of the paired ratings agreed exactly or within one step on the five-point scale. These components of morale are readily evaluated by outside observers.

To check the validity of the Life Satisfaction Ratings, the

judges' scores were compared with the blind ratings made by a clinical psychologist after an extensive interview. Although the psychologist saw the subjects 18-24 months after the judges' interviews had taken place, the correlation between the ratings was still .64.

The Life Satisfaction Rating Scales seemed to be reliable measures of something Neugarten called morale. To administer this scale took at least one lengthy interview by a trained professional. Therefore the Life Satisfaction Index A was devised as a briefer, self-administered instrument. Index A scores showed a correlation of .55 with scores on the Rating scale.

Summary of Hypotheses

For the sake of brevity, the hypotheses will be studied in logically consistent groups.

1. Women in NAIM will be less depressed, less anxious, more satisfied with their lives, and have better health and higher self-esteem than women who are in the "no choice" group.

2. These differences will be more pronounced in the women who have been widowed from one to three years than it will be in women more recently widowed or women widowed for a longer period of time.

3. Women who chose not to join NAIM will adjust less well than women in NAIM.

4. All women who had a choice and joined or did not join NAIM will be better adjusted on the experimental measures than women in the "no choice" group.

5. There will be significant differences on the outcome measures between women in the four time-since-death groups.

METHOD

Subjects

The subjects were 75 Chicago-area women whose spouses had died within the past five years. The women and/or their spouses were members of the Catholic Church. The women were less than 66 years old and from middle class homes. There were three independent samples of widows. One sample was women who were members of the Father Sullivan chapter of NAIM. A second sample was formed by random selection of 120 names from a NAIM list of people who had been invited to a NAIM conference. The third sample was obtained by contacting the widows of 159 men who had been buried in nine Catholic parishes in the past five years. From these samples three groups were formed: women who had been members of NAIM for more than three months (a person must also attend at least three meetings before becoming a member), women who had been invited to join NAIM but had chosen not to join, and women who had never heard of NAIM and therefore had no chance to choose.

Instruments

Assessment of adjustment was carried out by means of a 35-page survey questionnaire. Although the questionnaire covered many aspects of the widow's experience, only part of the data collected was selected to be included in this study. Degree of depression or anxiety, life satisfaction, feelings of mastery, descriptions of health changes

and feelings of self-esteem were used as the outcome variables.

The 35-item form of the Hopkins Symptom Checklist was used to assess the degree of depression and anxiety the widow was experiencing. The Hopkins is a self-report symptom inventory. The subject rated herself as to the degree she was bothered during the past week by symptoms such as sweating, trouble getting her breath, loss of sexual interest or appetite, feeling hopeless about the future, or mind going blank. She used a four-point scale--not at all, a little, quite a bit, and extremely--and scores were obtained by summing the rankings.

Neugarten's Life Satisfaction Index (LSI) was used to assess the widow's feelings about her life, her satisfaction with her adjustment. The LSI is composed of 25 items to which the subject responds agree or disagree. The subjects in this study were offered a four-point scale including strongly agree or disagree and somewhat agree or disagree. The scores were then collapsed and analyzed as positive or negative.

To measure self-esteem a Guttman scale, the Rosenberg Self-Esteem Scale, was used. It consists of ten items on which the subject indicates her agreement or disagreement. The items have been presented in Appendix A.

The Coping Mastery Scale assessed the degree to which the subject felt she was in control of her life and was able to direct

its course. It consists of the 11 items presented in Appendix A and is scored for positive or negative answers on a four-point scale. Higher scores indicated better coping.

To assess the subject's health, she was asked to indicate quantitative facts such as the number of days she had been confined to a hospital as well as qualitative information such as her rating of her health as excellent, good, fair or poor. The items are included in Appendix A. Each health question was compared separately between groups, and the questions indicated in Appendix A were also combined into a total sickness score.

Procedure

Contact with NAIM was established by explaining to the chapter president the researcher's desire to observe NAIM for the purpose of understanding its effect on widowed people. Permission was obtained to attend chapter meetings and conduct interviews with the members. Two researchers were introduced to the NAIM members as representatives of a University of Chicago research team who would be attending meetings to observe what NAIM did. The researchers attended a special dinner where new people were invited to get acquainted and two chapter meetings prior to telling them about the questionnaire to be mailed and requesting their cooperation.

In order to obtain names of people who had been invited to join NAIM but who had chosen not to join, the president of NAIM was asked for the mailing list of people who had been contacted by NAIM by

mail. The researchers were told that the NAIM organization had sent at least two letters to these people inviting them to a conference. When the questionnaires were returned, five of the 15 people who responded said that they had never heard of NAIM. Due to a change in NAIM management it was said to be possible that the letters were never sent to some of the people. For this reason the researchers chose to classify subjects' degree of contact with NAIM according to the subjects' reports. It is possible that some of the subjects classified as no contact with NAIM may in fact have received invitations to a conference but have forgotten the incident.

The parish sample of NAIM was obtained by contacting parish priests in Chicago Catholic parishes that fit de Vries' classification as middle class according to an article published in the Chicago Daily News (1977) ranking Chicago neighborhoods according to socio-economic measures. The names and addresses of the surviving spouses --men who were 67 years old and younger and who had been dead 5 years or less--were obtained by the researchers from the burial permit records in six parishes. In three other parishes, the priest was not willing to let the researcher see the records, but he agreed to mail out the questionnaire himself.

All questionnaires were mailed to the subjects with a stamped envelope for return to a University of Chicago address. The parish and conference list people received questionnaires which contained a cover letter from the researcher. The cover letter for NAIM members was from the research team (See Appendix B). The impersonal cover

letter for NAIM members was an attempt to partially rectify the imbalance in personal contact with the researchers between the groups. In addition, the parish questionnaires contained a letter from their parish priest reassuring the subject of complete confidentiality (See Appendix B). Two weeks after the mailing of the questionnaire, a reminder letter was sent thanking the subjects for returning the questionnaire and asking those who had not yet responded to please do so.

The questionnaires were marked prior to mailing so the researcher knew from which list the name was taken, but there was no recording of the individual's name on the questionnaire. A space was provided on the last page for subjects to write their names and addresses if they wanted to volunteer to be interviewed in a follow-up study.

RESULTS AND DISCUSSION

Evaluation of Hypotheses

Four hundred and forty-three questionnaires were mailed. Forty-one were returned due to out of date addresses. One hundred and seventy-eight questionnaires were completed and returned. Group rates of returned questionnaires ranged from 68 per cent for the NAIM member sample (N=89) and 41 per cent for the parish sample (N=61) to 22 per cent for the list of people invited to a NAIM conference (N=28). After the subject limits for this study were defined (widowed less than five years, under 66 years of age, middle socio-economic status, female), 16 of the NAIM questionnaires, 40 of the parish sample, and 16 of the conference sample could be used. For analysis, the mailing group samples were combined into groups defined by their degree of contact with the NAIM organization. Group 1 was composed of all people who had been members of NAIM for three months or more (N=21). Group 2, No Contact, was composed of people who had never heard of NAIM (N=28), and Group 3, Choose No, was composed of people who had heard of NAIM and had been invited to a NAIM function, but who had chosen not to join NAIM (N=23).

One of the comparisons that had been planned was between subjects who had been widowed differing lengths of time. The researcher expected NAIM to be more helpful for women who had been widowed less than three years and expected the NAIM members to be better adjusted

during this time period than women who had chosen not to join or women who had no contact with NAIM and thus no choice. Due to the fact that NAIM does not seem to be reaching the recently widowed as they hope to do and that people continue to be members of NAIM for up to 20 years after the death of their spouse, the NAIM sample is heavily composed of women who have been widowed three to five years. The list of people who had been invited to join NAIM which the researcher obtained from the NAIM records included mostly people who had been widowed from one to three years; thus the sampling distribution is heavily skewed. Tables 1 and 2 show the length of widowhood distribution as it appeared by mailing group and by groups used for analysis. With such uneven distributions the comparisons of women who had been widowed less than one year were not valid.

The independent variables were analyzed by analysis of variance for the interval data and the Kruskal-Wallis $\underline{H}$ test for the ordinal level variables. The analysis groups were found to be not significantly different from each other in socioeconomic status, age, education level, children at home, employed outside the home, church attendance, warning prior to death, or degree their life changed after their husband's death. The groups were significantly different in terms of their length of widowhood ($X^2(2) = 23.67$, $\underline{p} < .000$), with NAIM members being widowed the longest, Choose No women next longest, and No Contact women the most recently widowed. Mean ranks were 51.96, 39.39, and 28.89.

Table 1

Length of Widowhood in Mailing Groups

Mailing Groups	Length of Widowhood		
	0-1 year	1-3 years	3-5 years
NAIM members	0	3	13
Conference List	1	15	0
Parish Sample	12	15	13

Table 2

Length of Widowhood in Analysis Groups

Analysis Groups	Length of Widowhood		
	0-1 year	1-3 years	3-5 years
NAIM	1	4	16
No Contact	11	14	3
Choose No	1	15	7

Since the majority of the dependent measures were of an ordinal ranking nature (strongly agree, somewhat agree, somewhat disagree, strongly disagree), nonparametric statistics were used in the analysis. The tests used were the Kruskal-Wallis $\underline{H}$ test, the Mann-Whitney $\underline{U}$ test, and Spearman's rho.

The hypothesis that women who are members of NAIM are less depressed ($\underline{U}_Z = -.3044$, $\underline{p} < .76$), less anxious ($\underline{U}_Z = -.5764$, $\underline{p} < .56$), more satisfied with their lives ($\underline{U}_Z = -.8719$, $\underline{p} < .38$), and have higher self-esteem ($\underline{U}_Z = -.7001$, $\underline{p} < .48$) than women in the No Contact group, and the hypothesis that these differences are more pronounced in women who have been widowed from one to three years than in women who have been widowed three to five years were not supported. There were no significant differences on the psychological adjustment measures between members of NAIM and women who had not heard of NAIM. Contrary to expectation, NAIM members were found to be more interpersonally sensitive (critical, irritable, easily hurt) than were No Contact people ($\underline{U}_Z = 2.2246$, $\underline{p} < .026$) and more likely to be seriously ill ($\underline{U}_Z = -1.9764$, $\underline{p} < .05$). The only difference that was found to be more pronounced during early periods of widowhood was interpersonal sensitivity ($\underline{U}_Z = 2.0892$, $\underline{p} < .04$). After the women had been widowed three to five years, there was no significant difference in interpersonal sensitivity between the two groups ($\underline{U}_Z = -.05637$, $\underline{p}$ .57).

All women who had a choice to join NAIM were expected to be better adjusted and be less ill than are women who had no contact

with NAIM. This hypothesis was not supported. There were no significant differences between subjects who knew about NAIM and those who did not except that women who knew about NAIM were more interpersonally sensitive than were women who had not heard of NAIM ($\chi^2(2) = 4.89$, $p < .03$). Table 3 presents the critical values of this analysis.

The hypothesis that women who chose not to join NAIM would be slightly less well-adjusted than members of NAIM was not supported (See Table 4). While there were no significant differences between all NAIM members and all Choose No subjects, there was a trend for NAIM members to be more anxious ($U_z = -.172$, $p < .08$) and have poorer health ($U_z = -1.75$, $p < .08$) than the Choose No women. NAIM members were significantly more likely to state that they had had a major illness since their husband's death ($U_z = -2.0585$, $p < .04$), to state that their health frequently got in the way of what they wanted to do ($U_z = -2.1183$, $p < .03$), and to report complaints on the somatizing scale of the Hopkins Symptom Check List ($U_z = -2.2153$, $p < .027$) than were Choose No women. In this comparison, there was a dramatic effect of length of widowhood. Table 5 illustrates how NAIM members were in more psychological distress than Choose No women if they had been widowed less than three years and were in more physical distress than Choose No women if they had been widowed three to five years.

Contrary to expectations, NAIM members were found to be less psychologically adjusted and less healthy than either No Contact or Choose No people. Since the NAIM people were not assessed prior to

Table 3

Women Who Made a Choice About NAIM Compared to Women Who Had No Choice About Joining

Hypothesis	Mean Ranks		Observed Critical z Value	Probability Level
	Choice	No Choice		
NAIM less depressed	38.13	37.79	-0.0665	0.95
NAIM less anxious	37.35	39.00	-0.8499	0.40
NAIM more satisfied with their lives	38.46	37.23	-0.0190	0.98
NAIM better health	40.32	34.11	-0.0852	0.93
NAIM higher self esteem	37.77	38.39	-0.6348	0.53

Note. The test used in this analysis was the Mann-Whitney U Test.

Table 4

NAIM Members Compared to Women Who Chose Not to Join NAIM

Hypothesis	Mean Ranks		Observed Critical z Value	Probability Level
	NAIM	Choose No		
NAIM less depressed	23.81	21.30	-0.6495	0.51
NAIM less anxious	25.95	19.35	-1.7273	0.08
NAIM more satisfied with their lives	24.12	21.02	-0.8029	0.42
NAIM better health	26.05	19.26	-1.7507	0.08
NAIM higher self esteem	25.12	20.11	-1.3729	0.17

Note. The test used in this analysis was the Mann-Whitney U Test.

Table 5

Women Who Chose Not to Join NAIM Compared With NAIM Members

Across Length of Widowhood

Variable	All Women			Widowed 0-3 Years			Widowed 3-5 Years		
	Mean Ranks		Probability Level	Mean Ranks		Probability Level	Mean Ranks		Probability Level
	NAIM	Choose No		NAIM	Choose No		NAIM	Choose No	
Major illness	25.43	19.83	0.04	10.50	11.16	n.s.	13.09	9.50	n.s.
Health interfere	26.52	18.83	0.03	12.80	10.44	n.s.	13.66	8.21	0.06
Total illness	26.05	19.26	0.08	9.20	11.56	n.s.	13.88	7.71	0.05
Somatising	26.95	18.43	0.03	13.80	10.13	n.s.	13.94	7.57	0.04
Interpersonal sensitivity	24.55	20.63	n.s.	14.90	9.78	0.09	11.56	13.00	n.s.
Anxiety	25.95	19.35	0.08	16.60	9.25	0.02	12.50	10.86	n.s.
Hopkins Checklist	25.55	19.72	n.s.	15.60	9.56	0.05	12.38	11.14	n.s.
Total psychological distress	25.33	19.91	n.s.	15.00	9.75	0.09	12.44	11.00	n.s.

their entering the group, group effects are of necessity confounded with selection variables. One explanation for these findings might be that NAIM is actually detrimental to a woman's adjustment. Another explanation is that the people who choose to join NAIM are more distressed initially than those who choose not to join. Still another explanation is that NAIM members learn to express their distress physiologically rather than psychologically and become ill rather than depressed.

NAIM members were found to be more apt to be seriously ill and to be more interpersonally sensitive than No Contact people, especially in the first three years of widowhood. After three years there were no significant differences. This might indicate that people who chose to join NAIM were the least healthy widows, but that after some years, if supported, they became as healthy as a control sample of widows. If this were true, then the Choose No group of women should be the other half of the sample of women who knew about NAIM. In fact, when the NAIM and Choose No samples were combined, there were no significant differences between the contact with NAIM subjects and the No Contact subjects except that contact people were more interpersonally sensitive ($\chi^2(2) = 4.891$, $p < .03$). (People who would hear about NAIM may be more social and less isolated.) Choose No people should be the more healthy half of the contact sample and therefore more healthy than the No Contact people and much more healthy than the people who chose to join NAIM. No Contact people were much more likely to have their health interfere with what they wanted to do than

were Choose No people (U_z = -1.9245, p <.05). Choose No people were not only more healthy than the No Contact people, they also tended to be more healthy than the NAIM people (U_z = -1.75, p <.08).

A possible explanation for the finding that NAIM members were less well adjusted than the rest of the widows is that the more ill people who knew about NAIM chose to join.

Additional support for this explanation might be found if women who choose to join NAIM are women who are under unusual amounts of stress. People often respond to stress by becoming physically ill as Selye's General Adaptation Syndrome (GAS) would imply. The experience of being widowed can itself be seen as a stressful situation which might lead in some people to increased physical illness. Selye (1955, 1965, 1974) describes three stages of response to stress. The first stage, the alarm phase, in which the person experiences a shock and lowered resistance, closely parallels the numbness phase of widowhood. The stressed person mobilizes her defenses in the second phase of the GAS. If these defenses do not handle the stress, physical deterioration then begins in the third phase. The increased psychological distress NAIM members are exhibiting may be the mobilization of the psychological defenses. The increase of physical illness may be the result of the failure of those defenses to neutralize the stress as the woman enters the third phase of the GAS.

Cofer and Apply (1964) describe a similar sequence of responding that may also be helpful in understanding the response to stress of

the widows. They elaborate on the psychological manifestations of the response to stress. The first reaction to systematic stress is increased emotionality. Emotions are stronger and more labile. The second response is subjective feelings of distress, and the person seeks to reduce these feelings by taking defensive action to cope with the threat or to reduce the dysphoric feelings. Usually, the person has a choice of several mechanisms based on behavioral, cognitive or decisional choices to attempt to control the possible harm. She may attempt a direct action on the environment to avert or decrease the threat. (This behavioral choice is not available to the widow unless she attempts to quickly replace the lost husband.) She may exert cognitive control by reinterpreting the events in a less stressful manner using psychological defensive mechanisms such as denial, repression or intellectualization. (NAIM seems to foster these mechanisms by their focus on life ahead to the exclusion of discussion of the past.) She may make a decisional choice between separate courses of action or combinations of coping mechanisms (Averill, 1973). (The stressed widow may choose to join NAIM or to use other resources.)

The person under psychological stress undergoes behavioral changes in addition to those already mentioned. One of these changes has been shown to be an increase in suspiciousness, in hostility, in sensitivity to stimuli, and irritability (Cofer & Apply, 1964). NAIM members were shown to be more interpersonally sensitive (critical of others, irritable, easily hurt) in the first three years than No Contact women ($\underline{U}_Z = -2.22$, $\underline{p} < .02$) and tended to be more sensitive

than Choose No women (U_z = -1.65, p <.08). These differences disappeared after three years. This would lead one to suspect that the women who join NAIM are indeed under strong stress which they attempt to handle by psychological defense mechanisms, but which may lead, at least in the case of women who remain in NAIM, to physical deterioration. The women who choose not to join NAIM may not be under the same degree of stress, perhaps due to their other, more diverse, support systems.

A logical expectation that if NAIM members were less psychologically healthy initially and under the most stress, these women should also be the risk-marker women mentioned in the literature as being most likely to adjust poorly was not supported. NAIM members were no more likely to have had no warning of their spouse's death ($\chi^2(2)$ = 2.09, p <.35), to have had additional crises around the time of the spouse's death ($\chi^2(2)$ = .0218, p <.89), to attend church less frequently ($\chi^2(2)$ = 1.05, p <.59), or to have children living at home ($\chi^2(2)$ = .458, p <.80). There was a trend for NAIM members to have a lower income ($\chi^2(2)$ = 5.669, p <.06). Since most of the women had been widowed for several years and the risk-marker research assessed people 13 months after the spouse's death, perhaps the risk-marker differences do not last beyond two or three years.

If NAIM members are not in more distress than other widows initially, a differential selection factor may be involved. Physically ill people may stay in NAIM while physically healthy people drop out,

or NAIM members may learn to express their psychological distress through physical ailments.

Support for the hypothesis that NAIM members learn to express their distress through the perhaps more socially acceptable medium of physical ailments comes from the fact that there is a trend for NAIM members to be more likely to be physically ill if they have been widowed from three to five years (U_Z = -1.7340, p <.08) than if they have been widowed less than three years. There are no significant differences in illness and length of widowhood in the Choose No (U_Z = -1.1033, p <.27) or No Contact groups (U_Z = -1.1145, p <.27). There is no expectation in NAIM members that their health is worse than most people their age ($\chi^2(2)$ = .303, p <.86), and they are as likely to rate their health as excellent or good as are the members of the other two groups ($\chi^2(2)$ = .342, p <.89). This would seem to indicate that the illness is a normal fact of life in their sub-culture.

Why would NAIM members find it more acceptable to be ill than to be depressed or anxious? From comments made by members and chapter presidents, it seems not out of line to speculate that the party line of NAIM is to teach denial of psychological distress. Members mention as the most positive things about NAIM meetings seeing the "courageous outlook" of other NAIM members, knowing that "others have suffered like me, but keep on going," and finding out that "a lot of people are less fortunate than I." The most negative thing about a NAIM meeting was once described as "the fear and loneliness in the

new member's eyes." The NAIM culture emphasizes putting the past behind because life is now and the future. Members are encouraged not to talk about their dead spouse and are looked on as disturbed if they continue to do so after two or three meetings. Rarely do members discuss the circumstances of the spouse's death. Expression of current feelings is encouraged and practical solutions for dealing with them are offered. The primary emphasis seems to be on encouraging people to feel better, and it may be speculated that not to feel better might be interpreted as failure or the oft-quoted phrase in NAIM, "wallowing in self-pity." Never has this researcher overheard a remark censuring a member for physical indisposition, but she has heard many of the "self-pity" variety.

A second emphasis in this chapter of NAIM and in fact the most frequently mentioned reason for joining this chapter is to make friends or reestablish a social life. Members are encouraged to actively seek new friends, and the best members are held to be those who meet the most people and become involved in the committees. While depression or anxiety may not be an acceptable reason for missing a date or a meeting, perhaps physical illness might be.

Length of widowhood is expected to make a significant difference in the subject's adjustment. Since there were only two people in NAIM and Choose No who had been widowed less than one year, groups one and two were combined and a Mann-Whitney U was used to compare women who had been widowed less than three years with women who had

been widowed three to five years. As can be seen from inspection of Table 6, women who had been widowed three to five years were significantly more likely to have been hospitalized, more likely to have low self esteem, more likely to be interpersonally sensitive, and more likely to have difficulty coping than women who had been widowed less than three years. Although major illness is a significant difference, since the question asks if the subject has had a major illness since the spouse's death and a longer widowhood encompasses more time for this illness to occur, this result must be interpreted cautiously. The trend for total sickness to be greater for the three to five year group supports the expectation that this might be a real difference. The only instance in which women widowed less than three years were less adjusted was in the area of satisfaction with support received from friends. There seemed to be no way to judge if recently widowed women needed more support than was available or got less support. For widows in general, the period of 3-5 years after the death of the spouse appears to be the time of greatest distress.

Other Results of Interest

Women who had been widowed three to five years seemed to be experiencing more distress than were more recently widowed women. The experimenter was interested to explore at what length of time since the death of the spouse the widow experienced the most difficulty. Although no parish or conference lists people who had been widowed more than five years, among NAIM members there were 21 subjects who had been widowed up to 20 years. A Kruskal-Wallis H test compared

Table 6

Adjustment Compared with Length of Widowhood

Table of Discussed Significant Variables

Variable	Mean Ranks		Observed Critical z Value	Probability Level
	0-3 Years	3-5 Years		
Major illness	35.27	42.85	-2.0765	0.04
Days hospitalized	35.04	43.26	-1.9798	0.05
Total sickness	34.79	43.70	-1.7001	0.09
Coping ability	33.53	45.94	-2.4022	0.02
Self esteem	34.06	45.00	-2.2209	0.03
Interpersonal sensitivity	33.97	45.17	-2.1615	0.03
Satisfaction with friend support	4.27	32.19	-1.8482	0.06

on a number of dependent variables NAIM members who had been widowed (1) up to one year, (2) one to two years, (3) two to three years, (4) three to five years, and (5) over five years. The two to three year period after the death of the spouse was found to be the time people who became members of NAIM were significantly more likely to have a major illness ($\chi^2(8) = 10.757$, $p < .03$) or be hospitalized ($\chi^2(8) = 13.936$, $p < .009$). NAIM members' life satisfaction was significantly lower if they had been widowed less than five years ($\chi^2(1) = 7.66$, $p < .006$). On all dependent variables, the rankings for the first five years showed more distress than did the latter five years, supporting the contention of previous researchers that distress diminishes with time and that the first five years are the most stressful at least among members of NAIM. Perhaps the reason these results showed two to three years to be the most difficult time in contrast to the earlier results when zero to three years were compared to three to five years is that women do not report as much distress during the first two years of widowhood.

How much the fact of widowhood changed the widows' lives was the variable that was most predictive of psychological adjustment, but it seemed to have little correlation with physical deterioration. As Table 7 shows, women whose lives had changed very much as a result of their spouse's death were lower in self esteem ($\chi^2(2) = 6.38$, $p < .04$) more interpersonally sensitive ($\chi^2(2) = 6.42$, $p < .04$), more distressed on the Hopkins Symptom Checklist ($\chi^2(2) = 7.26$, $p < .03$), and were generally in more psychological distress ($\chi^2(2) = 6.18$, $p <$

Table 7

Effect on Dependent Variables of Amount of Life Change as a Result of Spouse's Death

Variables	Mean Ranks Degree of Life Change			Observed Critical χ^2 Value	Probability Level
	Very Much	Somewhat	Only a Little		
Self esteem	41.94	28.38	31.60	6.384	0.04
Anxiety	41.76	30.42	26.20	5.364	0.07
Obsessional characteristics	40.91	28.50	41.90	4.585	0.10
Depression	41.50	32.19	22.50	5.187	0.08
Interpersonal sensitivity	41.99	30.81	22.40	6.418	0.04
Somatizing	41.80	29.75	28.20	5.254	0.07
Hopkins Checklist	42.51	27.83	27.70	7.261	0.03
Total psychological distress	42.37	27.89	29.00	6.183	0.03
Satisfaction with friend support	33.97	48.11	43.50	6.790	0.03

Note. The test used in this analysis was the Kruskal-Wallis H Test and the degrees of freedom were 3. No one responded to the fourth category--no life change at all.

.03) than were women whose lives had changed less. Women whose lives had changed a lot, however, fared best in terms of satisfaction with the support given by friends and relatives ($\chi^2(2) = 6.79$, $p < .03$). In this case, women whose lives had changed "somewhat" were the least satisfied. Since the question asked was if the woman was satisfied with the support she received, it is unknown if friends rally around a very distressed woman whose life is changed a lot more than they would a woman who seems to be coping or if the distressed woman is unable to utilize support as well as a less distressed woman and so does not feel its absence. Whichever the case may be, women whose lives have changed somewhat feel most in need of additional support systems.

According to Smith (1975) the amount of depression a widow experiences should be highly correlated with the amount of warning she had before her husband's death. More depression should occur with a shorter warning period. The results of this study did not support this correlation ($r = -0.0329$, $p < .36$). Nor did a comparison of women with children with women who had no children ($r = -0.0916$, $p < .17$) support the conclusion that childless women were more depressed. When women whose children still lived at home were compared with women with no children at home, there was no significant difference in amount of depression ($r = -0.1021$, $p < .15$).

Comments on NAIM's Effectiveness

As investigation of NAIM proceeded, it became more and more

clear that this self-help group is not an appropriate model for early intervention with recently widowed women. Most NAIM members do not join until they have been widowed between one and three years. Comparatively rarely are women ready for the social life of NAIM until they have passed through the numbness of bereavement and dealt with their grief. NAIM seems to be most effective during the recovery phase of mourning. This phase usually begins between the first year and the third year after the spouse's death. The widow begins to reorganize her life, seeking new friends, looking forward more than backward, planning the rest of her life (Silverman & Murrow, 1976). From the answers on the open-ended questionnaires it seems that NAIM members feel that the group aids them in these challenges. There is no way to tell from this study at what price. Longitudinal follow-up of a large sample of widows from the first few weeks of widowhood will be necessary before it is known if NAIM helps the more disturbed widows or if concentration on the widow identity or denial of their dysphoric feelings retards the women's recovery.

Analysis of the total membership of the NAIM chapter (no sex, age, time, or socioeconomic limits) by Bankoff and Bond (note 1) has indicated that NAIM functions primarily as a social network for handling crises. They found members and non-members of NAIM to be similar with regard to their informal social networks, but members felt that their informal network had been less effective in helping them deal with their grief and they had less confidence that they could depend on their friends or relatives for help in the event of

an emergency. They did not expect NAIM to function as a therapy group. Members of NAIM were even more likely than nonmembers to have consulted professional help for problems of widowhood than were nonmembers.

This researcher found similar effects among the young widows. NAIM members were more likely to talk with a professional caregiver three or more times ($\chi^2(2) = 8.71$, $p < .01$) and were more likely to consult with more caregivers ($\chi^2(2) = 9.27$, $p < .01$). The people who chose not to join ranked next in number of contacts, and the No Contact people were least likely to call on a professional. Of the women who had been widowed less than three years, NAIM members were more likely to have an ongoing relationship (three or more contacts) with a caregiving professional ($\chi^2(2) = 5.96$, $p < .05$). No Contact and Choose No people were about equally less likely to be in therapy. There was no significant difference in the number of people the women in the three groups contacted ($\chi^2(2) = 4.31$, $p < .11$). Of the women who had been widowed three to five years, NAIM and Choose No people contacted about the same number of professionals for help, and the No Contact people contacted significantly fewer ($\chi^2(2) = 7.82$, $p < .02$). These facts would also lend support to NAIM members being in more distress than Choose No people. They seek out more therapy-type help. Choose No people seem to have a wider range of support systems they can use effectively. It would also indicate that NAIM members use professional contacts and the NAIM meetings for different reasons. Once again the No Contact people seem generally more

isolated and less likely to reach out than do the contact with NAIM people. This tendency to isolation may be a real bias in the results if the No Contact people are interpreted as being a control group for NAIM and Choose No.

NAIM's goals are stated as

NAIM

IS organized for Catholic widows and widowers and the spouses of deceased Catholics.

ATTEMPTS to help the widowed adjust to their new life by bringing them together with others who are facing and solving similar problems.

IS NOT a lonely heart club. It is true that we have had marriages occur, but this is not the purpose of NAIM.

GIVES members the benefit of basic legal, psychological and financial information.

DOES plan social gatherings for its members to help them face the loneliness that is inevitable for a widow or widower.

CONDUCTS conferences for the newly widowed throughout the year.

HELPS those left with children face the problems of discipline and understanding in a one parent family.

REALIZES that the needs of a widow or widower may change as years pass, and works to help meet all of these.

It seems to meet the majority of these goals with the possible exception of meeting the changing needs of the widows. It was not found to be an adequate model for an early intervention program with young widows.

Problems in Design

The ideal study would of course be longitudinal, but at this time practicality demanded a cross-sectional approach. Since there was indepdendent sampling there is no reason to believe that women in the parish sample or in the conference sample are significantly different in their responses to length of widowhood, and the groups of women may be considered cautiously as if they were a longitudinal study. A major confound may be the propensity of women at differing levels of adjustment to fill out and mail in a 35-page questionnaire. Judging form the only sample in which the researcher was able to know the length of widowhood prior to mailing the questionnaires, the parish sample, there was no strong length of widowhood bias in returning the questionnaires. An approximately equal number of questionnaires was returned in each length of widowhood group. The major known confound is in NAIM members. People who had been members of NAIM but had dropped out were not available to be contacted. When a NAIM member does not pay her/his annual dues, her/his name is dropped from the membership rolls. No figures were available to estimate how many people drop out annually. Perhaps the members of NAIM studied were the least healthy people because people get well and drop out or perhaps they were the most healthy of people who decided to join. The only way to answer this question would be to obtain past membership lists and survey drop-out members or to execute a longitudinal study.

A more effective study of the effect of knowledge of NAIM

would be to assess all the widows in several parishes six months after the death of their spouse and then to follow and assess these same women for five years. This design would enable the researchers to tell if the more poorly adjusted women joined NAIM or if the members of NAIM recover less rapidly from their widowhood. The research could follow members' progress through NAIM and explore who drops out and why. If healthy members tend to drop out, they could be counted into NAIM's success rate.

An additional problem in the design of the current study seems to be reflected in the return rates of 68 per cent of the NAIM sample, 41 per cent of the parish sample, and 22 per cent of the conference sample. The differing return rates indicate NAIM members were more motivated to return the questionnaires. This may be hypothesized to be due to the amount of personal contact between NAIM and the researcher. An unknown bias may also have been introduced into the way people responded on the questionnaire. Each group had differing degrees of personal contact with the experimenter. NAIM people met the experimenter in person; parish people received a letter from their priest as well as one from the experimenter; conference people had only a letter from the experimenter. Since the conference and parish samples were combined to form the analysis groups, there is little reason to expect a bias in these groups. It does, however, seem reasonable to believe that the NAIM members may have felt more comfortable with a personal experimenter and therefore more willing to expose their distress. On the other hand, the NAIM people knew

that the purpose of the questionnaire was "to see what NAIM did," and group loyalty might have led them to answer as positively as possible. In a future study, personal contact with the widows should be identical.

Directions for Future Research

The primary purpose of this study was to evaluate the effectiveness of NAIM as a model for an early intervention program for young widows. While the official purpose of NAIM is to help recently widowed women adjust to their new lives, the results of this study show that as it is presently constituted, women do not join NAIM until they have been widowed for at least one year. The primary reason most women give for joining NAIM is to make new friends or to reestablish a social life. While NAIM is probably useful for the people who join it, it is not an appropriate model of early intervention.

A self-help group is attractive as a model for helping. In a group where the caregivers are also the clients, each client is encouraged to use her own strengths to help others. Often the person who is helped most is the caregiver (Riessman, 1971; Volkman & Cressey, 1969). The helper understands the problems intimately and can communicate this understanding to the clients (Katz, 1965; Silverman, 1967). A group model can reach more people with less professional involvement.

The problems with a self-help model seem typified in NAIM.

Women in severe grief are often not able to reach out for help. The casual contacts of friendly self-help people did not seem to be adequate to encourage recently widowed women to come. Perhaps the most glaring lack in the NAIM model in terms of its usefulness to recent widows was the emphasis on social needs. The death of the spouse was rarely mentioned and the widow was discouraged from re-living her memories of the dead spouse. These attitudes are contrary to the research on what facilitates good adjustment after the spouse's death. The tendency of the NAIM culture to deny the grief and loss feelings of its members points up one of the dangers in using widow caregivers mentioned by Blau (1975). Since the widows themselves are still working through their own pain, there is a danger of the widow projecting her own effective coping mechanisms on to her client in an attempt to also bind her own pain. Supervision of the group by a professional might be a method to keep a subculture from developing that would limit the exploration of the group. Working with feelings about death is not easy, and having a professional in the group is no guarantee that she/he will be able to keep the explorations open. As Levinson pointed out in 1972, therapists also have a difficult time dealing with mourning, but the professional would be able to be more objective.

Another drawback to the NAIM model for the purposes of this experiment was the fact that there were no distinctions in services offered to women who had been widowed six months or women who had been widowed 20 years. An early intervention group to facilitate

grief would need to be time limited with members who had sufficiently worked through their grief graduating to possibly a NAIM-type social group as they entered the recovery phase and were ready to rebuild their lives.

A group model that seems most likely to aid recently widowed women in working through their grief and in facilitating adequate psychological adjustment as they begin their new lives would seem to be a self-help group of widows with a professional as catalyst who allows the women to set the direction of the group and take responsibility for responding to each other while she quietly facilitates sharing of feelings, memories, and information (Jertson, 1975). In keeping with the self-help model and the findings of Bankoff and Bond (note 1), contacts with group members outside the group in times of crisis should be encouraged (Gartner, 1976). The group should have a direct outreach program in which women who have been widowed from one to three months would be contacted by other widows and personally invited to accompany them to a meeting. Group members would enter with the attitude that they are there to explore themselves and to help the others and that there will come a time when they are ready to move out of the group.

One method to overcome the problems of cross-sectional sampling is to begin to contact all members of a community who have been widowed a month or so after their spouse's death and enlist their cooperation in filling out a short assessment form. A random

sample of these women could then be invited to join a self-help group set up by the researcher. All the women who agreed to the initial assessment could then be followed and assessed throughout the next five years. Perhaps the most realistic method of obtaining the names of the recently widowed women might be through contacts with hospitals. The groups might also be run under the auspices of the hospital to increase widow acceptance.

This study evaluating the NAIM self-help group seems to indicate that further research to develop an effective intervention program for recently widowed women might include exploration of a modified self-help system with a professional catalyst. Women might be followed from the time of their spouse's death and some of them randomly chosen to join a time-limited group. These women could then be followed for the next five years. Only by following the same women can the questions about the effect of the group intervention on a widow's adjustment be directly answered.

SUMMARY

The purpose of the study was to investigate NAIM, a Catholic group for widowed people, as a possible model for an early intervention program for young widows to be developed by the experimenter. Women who had been widowed less than five years, who were under 66 years of age, and who were of the middle socio-economic class were mailed a 35-page questionnaire. The questionnaire contained the Hopkins Symptom Checklist for assessing depression and anxiety, the Rosenberg Self Esteem Scale, the Life Satisfaction Index, and nine questions assessing the physical health of the women. Group rates of returned questionnaires ranged from 68 per cent for the NAIM member sample and 41 per cent for the parish sample to 22 per cent for the sample of people who had been contacted by NAIM by mail. The names of these women were obtained from three sources, members of NAIM, women who had been contacted by NAIM by mail, and women whose names were obtained from parish burial records. The comparison groups were NAIM members, women who had been invited to NAIM but who had chosen not to join, and women who had never heard of NAIM.

Contrary to expectation, NAIM members were found to be the most physically and psychologically distressed. There was some indication that this was due to women under more stress being more likely to join NAIM. One of the confounds of the experiment was

that members who dropped out of NAIM were not contacted. Perhaps only the more ill women remained in NAIM to be assessed. Another possibility was that the NAIM focus on the widow identity and the culture that seemed to foster denial was actually detrimental to the woman's adjustment. A longitudinal study would seem to be indicated to explore these factors.

Although NAIM provides a definite social function for people who have been widowed more than one year, NAIM was not found to be an appropriate model for the early intervention program to be designed by the experimenter. Women did not join NAIM until one year or more after the spouse's death. Optimum time for the grief work the experimenter wants to facilitate is three to six months after the death. The culture of NAIM led the experimenter to hypothesize that a totally self-help group that was not intended to be time-limited could not meet the needs of a newly bereaved person and that a better system would be one in which a professional is present as a catalyst, but the responsibility for caregiving functions are assumed by the group members and the group members expect to graduate from the group. A longitudinal study investigating these factors was described.

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APPENDIX A

COPING MASTERY SCALE

HOW STRONGLY DO YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS:

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
There is really no way I can solve some of the problems I have.	1	2	3	4
Everytime I try to get ahead, something or somebody stops me.	1	2	3	4
Sometimes I feel that I'm being pushed around in life.	1	2	3	4
Good luck is more important than hard work for success.	1	2	3	4
I have little control over the things that happen to me.	1	2	3	4
I can do just about anything I really set my mind to do.	1	2	3	4
People who accept their condition in life are happier than those who try to change things.	1	2	3	4
I often feel helpless in dealing with the problems of life.	1	2	3	4
What happens to me in the future mostly depends on me.	1	2	3	4
Planning only makes a person unhappy since plans hardly ever work out anyway.	1	2	3	4
There is little I can do to change many of the important things in my life.	1	2	3	4

HEALTH QUESTIONS

HOW HAS YOUR HEALTH BEEN SINCE YOUR SPOUSE'S DEATH?

1. Better
2. The same
3. Worse

HAVE YOU HAD ANY MAJOR ILLNESSES SINCE YOUR SPOUSE'S DEATH?

1. Yes
2. No

IF YES, PLEASE LIST.

SINCE YOUR SPOUSE'S DEATH, ABOUT HOW MANY DAYS HAVE YOU BEEN HOSPITALIZED? _____

HOW MANY TIMES HAVE YOU BEEN TO THE DOCTOR IN THE PAST YEAR? _____

WOULD YOU SAY YOUR HEALTH IN GENERAL IS EXCELLENT, GOOD, FAIRE, OR POOR?

1. Excellent
2. Good
3. Fair
4. Poor

HOW IS YOUR HEALTH COMPARED TO OTHER PEOPLE YOUR AGE?

1. Better
2. The same
3. Worse

HOW OFTEN DOES YOUR HEALTH GET IN THE WAY OF WHAT YOU WANT TO DO?

1. Most of the time
2. Sometimes
3. Rarely
4. Never

IN GENERAL, ARE YOU EATING AS WELL BALANCED MEALS AS YOU DID BEFORE YOUR SPOUSE DIED?

1. Yes
2. No

DURING THE PAST WEEK, HOW MANY DAYS DID YOU:

Take medicine to calm your nerves? (circle one)

0 1 2 3 4 or more days

Take medicine to put you in a better mood? (circle one)

0 1 2 3 4 or more days

Take medicine to help you sleep? (circle one)

0 1 2 3 4 or more days

Take medicine to give you more energy? (circle one)

0 1 2 3 4 or more days

A total sickness score for analysis purposes was obtained by summing the standard scores on the health questions.

ROSENBERG SELF ESTEEM SCALE

HOW STRONGLY DO YOU AGREE OR DISAGREE WITH THE FOLLOWING STATEMENTS:

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
I feel that I'm a person of worth, at least on an equal basis with others.	1	2	3	4
I feel that I have a number of good qualities.	1	2	3	4
All in all, I am inclined to feel that I am a failure.	1	2	3	4
I am able to do things as well as most other people.	1	2	3	4
I feel I do not have much to be proud of.	1	2	3	4
I take a positive attitude toward myself.	1	2	3	4
On the whole, I am satisfied with myself.	1	2	3	4
I wish I could have more respect for myself.	1	2	3	4
I certainly feel useless at times.	1	2	3	4
At times I think I am no good at all.	1	2	3	4

APPENDIX B

THE UNIVERSITY OF CHICAGO
Department of Behavioral Sciences
5848 South University Avenue
Chicago · Illinois 60637

Committee on Human Development

April 24, 1978

Dear Friend:

My name is Penny Burdette. I am a graduate student in clinical psychology at Loyola University. I, too, have experienced the death of my husband. Out of this painful and difficult time for me came a desire to better understand what life is like for other widowed people. I want to learn if anything can be done to help widowed people deal with this very difficult time in their lives. I am working with a research group at the University of Chicago to try to understand. I would like your help. I am asking you to give an hour or so of your time to fill out this questionnaire so I can know a little bit about how this experience has been for you.

Your questionnaire will be completely anonymous. I will not know who you are and no one else will contact you. I do, however, invite you to contact me by mail at the University of Chicago or by phone at _____if you have any questions about the research.

Please find an hour in the next week or so to fill out and return the questionnaire. Thank you for your time.

Sincerely,

Penny Burdette

CHURCH LETTERHEAD

April 24, 1978

Dear Friend of St. _____ Church,

Death is a serious challenge in this life, especially for the surviving spouse. NAIM is a Catholic organization that for the last 20 years has been supporting widows and widowers as they make adjustments for their future. As a priest concerned for the spiritual well-being of my parish, I am well aware of the benefits it provides. NAIM hopes to continue improving its approach with people who need its help. Your comments on the enclosed survey will give us insights and approaches that truly answer the needs of people as they adapt to living alone.

Our parish has supplied the names and addresses from the parish files of people who have lost a spouse within the last 5 years or so. To insure confidentiality, the questionnaires are completely anonymous and Mrs. Burdette will not contact you other than a reminder letter from us encouraging you to complete the survey if you have not previously done so. After that, any further contact will occur ONLY if you volunteer to be interviewed on the space provided in the questionnaire.

If you would care to contact me personally about this survey, please feel free to call me at _____.

Sincerely,

Rev. _____

APPROVAL SHEET

The dissertation submitted by Penelope Burdette-Finn has been read and approved by the following Committee:

Dr. Alan S. DeWolfe, Director
Professor, Psychology, Loyola

Dr. James E. Johnson
Associate Professor, Psychology, Loyola

Rev. Michael J. O'Brien
Professor, Psychology, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

12/5/79
Date

Alan S. DeWolfe
Director's Signature