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THE OCCURRENCE OF LEARNED HELPLESSNESS IN SURVIVORS OF SUDDEN DEATH VERSUS SURVIVORS OF NON SUDDEN DEATH

Jennifer Doyce Wyatt

An Abstract Presented to the Faculty of the Graduate School
of Lindenwood University in Partial Fulfillment of the
Requirements for the Degree of
Master of Art
September, 29 1998

Abstract

The purpose of this study was to investigate the occurrence of learned helplessness in survivors of sudden death versus survivors of non sudden death. Forty-six participants were volunteers from grief support groups. Participants were classified as survivors of sudden death or survivors of non sudden death. Sudden death was defined as death in which there was no previous warning, such as an accident. Non sudden death was defined as death in which there was diagnosis or previous warning, such as cancer. Learned Helplessness was measured by the Learned Helplessness Scale. It was hypothesized that there will be a greater occurrence of learned helplessness in survivors of sudden death than survivors of non sudden death. However, it was found that there was no significant difference in the occurrence of learned helplessness in the survivors of sudden death and the survivors of non sudden death.

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Table of Contents

List of Tables

Chapter I

Introduction

The death of a loved on is one of the most traumatic experiences humans encounter in their lives. The survivor has suffered a great change and his/her identity has been altered. For example, the mother is now a mother without a son or a husband without a wife. The survivor must somehow continue life without his or her familiar attachment. The avenues grief can travel are different for each individual, but almost every person most travel through some sort of grief process. Grief assaults the mental and physical well being of the survivor. One of the most important determiner of the grief response is the mode of death (Worden, 1991; Rando, 1993; Kalish, 1982; Doka, 1996). A person can die of either a sudden death or a non sudden death. Examples of sudden death are suicide, accidental deaths, heart attacks, and murders. Grief after sudden loss is often intensified because there is little or no opportunity to prepare for the loss, say good-bye, or take care of unfinished business. Non sudden death occurs when the death is anticipated. Examples of non sudden death include AIDS and cancer. The survivor of non sudden death can make prior arrangements and plan ahead for the impending death. It is also believed a survivor of non sudden death may begin the grieving process before the loved one dies (Worden, 1991).

One of the more salient feelings experienced by any survivor of death is helplessness (Worden, 1991; Hodgkinson, Joseph, Yule, & Williams, 1995; Rando, 1993). When death occurs the survivor feels powerless because in most cases the survivor had no control over the death. The term helplessness or hopelessness comes from the theory of learned helplessness that has been serving as a model for clinical depression since its accidental finding by Seligman and his colleagues at the University of Pennsylvania in 1975. Because the original learned helplessness theory was devised using animals in the laboratory setting, the theory

needed some revisions before it could be applied to humans (Klein, Fencil-Morse, & Seligman, 1976). The result was the Reformulated Learned Helplessness Theory (Abramson, Seligman, & Teasdale, 1978) . The advocates of the reformulation claim that the newer expanded theory accounts for things left out of the original theory. Because the original learned helplessness theory was developed using animals, human attribution was left out. The reformulated theory includes human attribution and is able to explain behaviors unique to humans such as: why outcomes are uncontrollable for some people but not for others, why a depressed person would lose self esteem and blame themselves for events which they perceived they had no control over, and how helplessness can become chronic versus temporary.

Although many experimenters and practitioners have used the reformulated learned helplessness theory as models for many different types of depression, Peterson, Maier, and Seligman (1993) have maintained that learned helplessness is only a model for what they call normal depression. As defined by Peterson, Maier, and Seligman (1993), normal depression is the result of normal pain and loss that comes from being human. For example, a man may experience normal depression after losing his job.

Learned helplessness is not caused by just a traumatic experience, but rather a traumatic experience that a person feels he/she cannot control (Miller, Rosellini, & Seligman, 1977). Helplessness occurs when a person learns and expects that an outcome or outcomes are uncontrollable. Once expectations of uncontrollability set in, voluntary responses decrease and motivation decreases. The sudden death of a loved one is an example of an environmental element that can cause learned helplessness. Many studies (Parks, 1975; Shanfield, Swain, & Benjamin, 1986-87; Hodgkinson, Joseph, Yule, & Williams, 1995; Lundin, 1984a; Lundin, 1984b) have found that sudden death causes a more severe grief reaction than non sudden

death. Learned helplessness, or the perceived loss of control is very prevalent in survivors of sudden death. Therefore, it would be expected that learned helplessness would be found more in survivors of sudden death than survivors of non sudden death. Such a finding would suggest that there is a different type of grief response in survivors of sudden death than survivors of non sudden death. This could suggest that the treatment for the two groups should differentiate depending on the type of loss.

Statement of the Problem

The purpose of this study was to find if there was a greater occurrence of learned helplessness in survivors of sudden death than in survivors of non sudden death. Sudden death was defined as death in which there was no previous 24 hour warning, such as an accident. Non sudden death was defined as death that is diagnosed or that there was previous warning, such as cancer.

Chapter II

Review of Related Literature

The Grieving Process

The loss of a loved one is one of the most traumatic events many humans experience in their lives. The survivor has suffered a great change and a loss. The person's identity has changed. They are now a wife without a husband, a father without a son, or a daughter without a mother. The survivor is faced with trying to continue his/her life without a familiar personal attachment. After the death of a loved one, there are many avenues grief can follow. Each person is different and experiences the process of grief in his/her own way. Just as the griever is different so too, are the different grieving processes suggested by therapists. However, one of the key factors to remember during the grief process is that each person is an individual and, therefore, different.

Therapists of every kind commonly explain grief as a process of stages or phases. One such grieving process is Worden's (1991) Four Tasks of Mourning. The first task is to accept the reality of the loss. After a death, the survivor may experience a feeling that the death was not real and that, "he/she will come strolling through the door any moment". The first task of grieving is to face the reality that the person is dead and he/she will not return. Coming to an acceptance of the reality of the death takes some time. It requires an emotional and intellectual acceptance that the loved one is truly gone. The second task is working through the pain of the grief. This pain can range from emotional hurt and anguish to actual physical pain. There is no meter or measure of the intensity of pain that a person must feel. Everyone experiences different intensities and reacts in a different way. However, it is impossible to encounter the death of a loved one without experiencing some level of pain. It is necessary to acknowledge and work through this pain or it will manifest itself through some other symptoms or other form of

disruptive behavior. The second task is very hard to work through and often times survivors need the help of therapy to deal with their pain.

The third task of Worden's (1991) Four Tasks of Mourning is to adjust to an environment in which the deceased is missing. The survivor has suffered a change and there must be an adjustment to a new environment without the loved one present. Adjusting to this new environment means different things to different people and depends on the roles the deceased filled. Many survivors have to learn many new skills and take on new roles that were formerly held by the deceased. Some survivors refuse to adapt to the loss and instead work against themselves by not developing the skills they need to cope. They often become helpless and withdraw from the world. The final task is emotionally relocating the deceased and moving on with life. The survivor should not give up his/her relationship with the deceased, but find an appropriate place for the deceased in his/her emotional life. This enables the survivor to go on living in his/her new environment.

Rando (1984, 1993) divides the grief response into three time periods or phases. Each period or phase is characterized by a major response towards the loss. Each phase is not discrete and the survivor will most likely moved back and forth between them depending on what issue(s) is relevant at the time. The first phase is the avoidance phase. This phrase covers the time period in which the news of the death is received and briefly thereafter. It is defined by the desire to avoid acknowledgment that the loved one is dead. Just as the body may go into physical shock during a physical injury, the psyche goes into shock with the realization of the death of the loved one. The survivor may feel numb, confused, dazed, and unable to comprehend what has happened. As recognition of what has happen sets in, the shock and numbness begins to ware off and denial takes its place. Denial serves as a healthy buffer to allow the survivor to absorb the reality of the death.

The second phase is the confrontation phase (Rando, 1984, 1993). During this painful phase, the survivor confronts the reality of the loss and realizes what it means. It is a painful time when learning takes place and the survivor comes to understand that the loved one is gone and changes must be made. Each time the desire or need for loved one is not met, the survivor learns that the loved one is gone. The confrontation phase involves coming to terms with the loss, learning about it, and reacting psychologically, behaviorally, socially, and physically to it. The final phase is the accommodation phase. During this phase there is a gradual decline of the painful symptoms of grief and the beginning of the social and emotional entry into everyday life. The survivor learns to enter and participate in the world without the loved one. The survivor learns to make internal and external changes to adjust to the absence of the loved one while finding new different ways to keep the relationship alive. The loved one is not forgotten, but the survivor learns to live with the loss in a healthy way.

Attig (1996) believes there is a common pattern within the theories of the grieving process. Attig studied the different theories of grief and came up with a theory of grief that he believes encompasses the similarities of the many different grieving theories. Attig suggests that when a person is first told of a death he/she becomes immersed with grief. The survivor first experiences emotions such as shock, disbelief, longing, preoccupation with the deceased, numbness, withdrawal, and denial. After the first phase, Attig (1996) suggests that the survivor becomes immersed in the full impact of the intensity of the death and the often over-whelmingly painful experiences. In the middle phase the survivor experiences the full force of bereavement manifested in somatic distress. The survivor experiences intense emotions such as sadness, depression, anxiety, despair, helplessness, anger, frustration, and guilt. Many times the survivor becomes so helpless and

unmotivated he/she becomes isolated from others and experiences a break-down of familiar daily life.

Somehow, the survivor emerges from the middle stage and finds some kind of new equilibrium in living. Attig (1996) explains that the survivor begins to experience the abating of somatic effects and reduction in the intensity of the emotional preoccupation with the deceased. A emotional equilibrium is restored and an acceptance of the death begins to form. The survivor begins to reestablish social contacts and adopt new roles and skills. The survivor begins to have the ability to remember the deceased without pain and a sense of hopefulness begins to develop.

Other theories include John Bowlby's (Bowlby, 1961) attachment theory. Bowlby believes individuals grieve in three phases: the urge to recover the lost object, disorganization and despair, and reorganization. Bowlby's basic tenet is that humans are affected and motivated by attachment and they seek to maintain it. Bowlby's theory seeks to explain what happens to individuals when an attachment is lost.

There is no time limit for the grieving process. Many professionals warn of stage theories of bereavement that may pigeonhole mourners into inappropriately applying models to help himself/herself (Worden, 1991; Rando, 1984). The grieving process is more of a schema with similar progressions and feelings (Rando, 1984). It is different for every person. In most cases it is a long term process. Some have described the grieving process as an emotional roller coaster with many emotional ups and downs. The completion of the grieving process can be benchmarked when the survivor is able to think about the deceased without experiencing pain (Attig, 1996; Worden, 1991). When people can feel hopeful, adapt new roles, and exhibit an interest in life, the survivor may begin to see the end of the grieving process.

There are many emotions that a survivor experiences during the grieving process (Worden, 1991; Rando, 1993; Attig, 1996). A person may feel sadness that he/she will never see his/her loved on again. A survivor may feel guilt that he/she did not tell the deceased he/she loved him/her or a survivor may feel guilty about an unresolved argument. Some survivors may feel angry over the person leaving him/her.

However, one of the most damaging feelings experienced by a survivor is helplessness (Attig, 1996). Seligman (1975) suggests that helplessness experienced during grief may even lead to the death of the survivor. Helplessness is usually experienced during the early stages and middle stages of a loss (Worden, 1991). When death occurs, the survivor often feels powerless. He/she had no control over the death. Similarly the death brings great disruption and chaos to the survivor's life. The survivor comes to realize that he/she cannot escape the traumatic impact. The survivor feels that his/her control and power appear useless. Bereavement is choiceless and in many instances causes the survivor to incline toward helplessness, where the survivor feels at the mercy of events that are beyond his/her control (Attig, 1996). The feelings of helplessness may become generalized to all areas of the survivor's life and he/she may not feel in control of anything. Learned helplessness can be a chronic grief reaction leading to anger, frustration, guilt, depression, and poor health if it never comes to a satisfactory conclusion. But what exactly is learned helplessness?

The Original Theory of Learned Helplessness

The First Laboratory Studies of Learned Helplessness

The theory of learned helplessness grew out of a discovery made by researchers at the University of Pennsylvania who were doing research on the

relationship of fear conditioning to instrumental learning (Seligman, 1975). The researchers restrained mongrel dogs and were carrying out a classical conditioning task by giving the dogs tones followed by shocks. The dogs were unable to escape from the mild shocks and soon whining and barking began. The dogs were released from the restraint and placed in shuttle boxes. By jumping over the barrier in the box from one side to another, the dog could turn off the shock or avoid any shock by jumping over the barrier before the shock started. The researchers were trying to teach the dogs to avoid the shocks so the effects of tones could be tested in relation to the dogs' avoidance behaviors. However, this is not what the researchers observed.

A naive dog, or a dog not previously exposed to unavoidable shock, placed in the shuttle box would eventually learn that it had to somehow get past the barrier to escape shock (Seligman, 1975; Peterson, Maier, & Seligman, 1993). After a few trials of running around frantically, the naive dog learned to smoothly jump over the shuttle and avoid receiving a shock. A dog that had previously been exposed to inescapable shock, or a yoked dog, and placed 24 hours later in a shuttle box initially acted like the naive dog and ran around frantically. However, after a few seconds the dog laid down whining and made no attempt to escape shock. During following trials, the dogs continued to fail to escape shock and received as much shock as the experimenter administered.

The yoked dogs exhibited another interesting behavior. When a yoked dog would occasionally jump the shuttle and escape shock, the dog would revert back to receiving the shock (Seligman, 1975; Seligman, 1968). Despite the fact that the yoked dog had made a successful escape from the shock it still failed to learn that jumping over the barrier will cease the shock. However, a naive dog that jumped the shuttle and avoided shock would eventually continue to jump the shuttle to avoid shock.

This accidental finding led to the term learned helplessness which in dogs was defined by two types of behavior (Seligman, 1975; Peterson, Maier, & Seligman, 1993). First, the yoked dogs failed to initiate the behaviors to avoid shock and were slower in making responses than naive dogs. Secondly, if the yoked dog turned off the shock it had a harder time learning that its response turned off the shock than the naive dog.

Learned Helplessness Theory and Validating Studies

The theory of learned helplessness proposes that when inescapable aversive events are presented, they interfere with instrumental learning (Seligman, 1975). To validate the learned helplessness theory, similar experiments were done with rats, cats, and fish (Peterson, Maier, & Seligman, 1993; Seligman, 1975). Learned helplessness was produced in all of these species . Decreases in motivational and cognitive behaviors where believed to be the major symptoms of learned helplessness (Seligman, 1975; Klein, Fencil-Morse, & Seligman, 1976). The lack of ability to control outcomes resulted in lowered motivation and the inability to learn that responding produces reinforcement.

Soon learned helplessness experiments were being done with human subjects (Gatchel & Proctor, 1976; Hiroto & Seligman 1975). Hiroto and Seligman (1975) used a finger shuttle box as a similarity to the original shuttle box. A variation on the original shuttle box included a handle which was attached to the top of a rectangular shuttle box. The subject could then move the handle from one end of the shuttle box to the other to escape loud noise. Subjects that had been exposed to inescapable loud noise were impaired in their ability to learn to move the handle on the shuttle box to escape loud noise. Subjects who were not exposed to loud noise and subjects who were exposed to escapable loud noise where able to learn to move the shuttle handle to escape the noise.

Hiroto & Seligman (1975) also found that subjects who experienced inescapable noises or who worked unsolvable problems were impaired in learning to shuttle to escape loud noise and solve anagram problems. Subjects who listened to escapable noise or worked solvable problems were able to shuttle to escape noise and solve five letter anagram problems.

In another study to asses learned helpless in humans (Gatchel & Proctor, 1976), 48 undergraduate students were randomly assigned to three groups: the first group was pretreated with inescapable aversive tones, the second group was pretreated with escapable aversive tones, and the third group was pretreated with aversive tones and did not try to escape. After the pretreatment, the subjects were given an anagram task. The learned helplessness model predicts that the group pretreated with inescapable aversive tones would do poorly on the anagram task. The results of the study confirmed that prediction. The group pretreated with the inescapable aversive tones performed worse than the other two groups on the anagram task. These studies, and others (Klein, Fencil-Morse, & Seligman, 1976) assessing learned helplessness in humans, led Seligman and others to believe that the learned helplessness that they had created in dogs could be created in human subjects and that their findings were not due to chance.

Learned helplessness is not caused by just a traumatic experience, such as shock, but rather a traumatic experience that a person or animal cannot control (Miller, Rosellini, & Seligman, 1977). Helplessness occurs when a subject learns and expects that an outcome or outcomes are uncontrollable (Seligman, 1975). Once expectations of uncontrollability set in, voluntary responses decrease and motivation decreases. The helpless subject starts to expect that responses will not effect any outcome. Once this stage is reached, the helpless subject cannot learn that new responses produce new outcomes. The learned helplessness theory suggests that depression develops when a helpless subject comes to learn that

outcomes are uncontrollable. This type of helplessness is very common in grief (Worden, 1991). When a loved one dies it is often one of the worst experiences a person has to survive. In most cases, the survivor had no control over the death or the changes in environment after the death. The survivor may generalize the feeling of uncontrollability to the rest of the events in his/her life. The survivor may begin to withdraw believing that he/she cannot go on without the deceased.

Motivational, Cognitive, and Emotional Effects of Learned Helplessness

The driving tenant in the learned helplessness theory is that subjects who become helpless learn that responding and trauma are independent and that the traumatic event or events are uncontrollable (Seligman, 1975; Miller, Roselline, & Seligman, 1977). Once a subject learns that traumatic outcomes are uncontrollable there are three effects: a motivational effect, a cognitive effect, and an emotional effect.

The motivational effect of learned helplessness is seen when subjects become passive in their attempt to escape from a traumatic event such as a loud noise or shock (Miller, Rosellini, & Seligman, 1977). If a subject learns that his/her responses will not effect outcomes, then the subject forms an expectation to fit this belief. The subject's motivation is undermined by the expectation of no control. For example, Seligman (1975) found that when yoked dogs became helpless, they laid down and whined and received as much shock as the experimenter administered. The dogs' helplessness, in a sense, had taken their motivation to escape the shock away. After the death of a loved one, a survivor may start to believe that he/she cannot go on with life without the deceased and withdraw and give up on life.

The cognitive effect of learned helplessness is seen when subjects do not learn that responses do not effect outcomes (Seligman, 1975; Miller, Rosellini, & Seligman, 1977). For example, when the yoked dogs successfully jumped over the

shuttle to escape the shock they did not repeat this behavior as did the naive dogs. The yoked dogs did not learn that their responses could provide relief from the traumatic event , the shock. In the grief example, the survivor may continue to give up unable to recognize their successes without the deceased. Another cognitive example can be seen in the responses of the subjects in the Gatchel and Proctor (1976) study (Peterson, Maier, & Seligman, 1993). The subjects who were pretreated with inescapable adverse tones did worse on the given anagram task than the subjects who were not exposed to unavoidable loud noises. This suggests that the created helplessness had a cognitive effect on the subject's ability to complete a task.

The emotional effect of learned helplessness is seen in helpless subjects' behaviors (Miller, Rosellini, & Seligman, 1977). In animals, uncontrollable shock produced more weight loss, defecation, conditioned fear, and ulcers than controllable shock (Miller, Rosellini, & Seligman, 1977; Seligman, 1968). In the grief example, the survivor may become depressed and withdrawn.

A study done by McKean (1994), tested whether learned helplessness was found in students who displayed disabilities in behavioral, cognitive, and affective areas. Therefore, it was hypothesized that students who procrastinated more on academic tasks (behavioral), did more poorly on academic work (cognitive), and suffered more dysphoria when dealing with negative outcomes (affective), would be students at the greatest risk for developing learned helplessness. To measure performance in each area and learned helplessness, McKean (1994) administered three inventories and obtained the subject's grade point averages. The three inventories were: the Procrastination Assessment Scale for Students which was used to measure procrastination, the Explanatory Style Questionnaire which was used to measure how subjects dealt with negative outcomes, and the Learned Helplessness Scale which was used to measure subjects' levels of helplessness.

The subjects' current grade point average was used as a measure of cognitive performance. McKean found that learned helplessness was manifest in all three areas. Students who procrastinated the most, did the worst on academic tasks, and over-reacted the most to negative outcomes, reported the higher level of learned helplessness.

Reformulated Model of Learned Helplessness

In 1975, Seligman argued that the symptoms of learned helplessness were similar to the symptoms of depression and therefore, learned helplessness could serve as a model of depression. However, Seligman began to receive criticism that the learned helplessness model was incomplete. Because the learned helpless model was developed using animals in a laboratory setting, the theory needed some revisions before it could serve as a model for human depression (Klein, Fencil-Morse, & Seligman, 1976). Abramson, Seligman, and Teasdale (1978) revised the model to make it more applicable to human behavior.

One major problem with the original theory was that it did not distinguish between outcomes that are uncontrollable for all people and outcomes that are uncontrollable for some people (Peterson, Maier, & Seligman, 1993; Abramson, Seligman, & Teasdale, 1978). Although some outcomes are uncontrollable, they do not cause depression. What determines which negative outcomes will upset a person and which negative outcomes do not affect a person? Another problem was that the theory did not explain why a depressed person would lose self esteem and blame themselves for events in which they perceived they had no control over. Why can some grief survivors fill the roles of the deceased regardless of their flaws while others attempt to fill the deceased's roles, fail, and feel worthless. The theory also did not explain when helplessness becomes chronic versus temporary. Why

do some survivors of grief become helpless for a short while and others become chronically helpless?

Human Attribution

To solve these problems, the reformulated learned helplessness theory took into account the important component of human attribution, which is a major factor in human depression (Abramson, Seligman & Teasdale, 1978; Peterson, Maier, & Seligman, 1993; Miller, Rosellini, & Seligman, 1977). The reformation of the learned helplessness model states that when people perceive non-contingency, they are likely to become helpless. Once a person becomes helpless, they attribute their helplessness to some cause. The attribution may be stable or unstable, global or specific, or internal or external.

The attribution the person chooses predicts whether future helplessness will be broad or narrow, chronic or acute, and to what extent self-esteem will be lowered or stay the same (Peterson, Maier, & Seligman, 1993; Abramson, Seligman & Teasdale, 1978) . Individuals who attribute negative outcomes internal, stable, and global (it's me, it's going to last forever, it's going to mess up everything I do) and good events external, unstable, and specific (it's not because of me, it won't ever happen again, it's just a freak occurrence) are more likely to become helpless and have a higher tendency of becoming depressed. The longer the helpless person attributes negative outcomes internally, stable, and globally, the more severe the depression will become and the greater self esteem will be lowered.

When a bad event occurs, some people believe that they caused the negative event and also believe the repercussions will last far into the future, and will effect everything they do. These people will be at a higher risk of depression instead of just suffering from a bad mood (Peterson, Maier, & Seligman, 1993). The individual is also more prone to a loss of self-esteem because every time he/she experiences a failure he/she will attribute it to his/her own inadequacies (Peterson,

Maier, & Seligman, 1993; Abramson, Seligman & Teasdale, 1978). The person also does not take credit for good events. Instead, the person will blame the good event on some external event. Therefore, the person is unable to build his/her self-esteem back up.

Metalsky, Abramson, Seligman, Semmel, & Peterson, (1982) studied students' reactions to low test scores. The students' learned helplessness, attribution styles, and depression were measured by questionnaire three times during a semester class. The questionnaires were given before taking a midterm, just before receiving the midterm grade, and after receiving the midterm grade. It was hypothesized, according to the learned helplessness model, that students that attributed a bad grade internally, stable, and globally would be more likely to develop depression after receiving a poor midterm grade.

The study (Metalsky, Abramson, Seligman, Semmel, & Peterson, 1982) found that students who showed a higher tendency of learned helplessness and depression attributed a low midterm grade internally, globally, but not stable. However, this study only measured depression caused by classroom outcomes which are not the only outcomes experienced by college students. It could be possible that students are more likely to attribute academic outcomes internally and globally, but attribute non academic outcomes as stable. However, in another study done in an academic setting by McKean (1994) measuring all areas of college life, it was found that students learned to be helpless by explaining inability to control events by blaming internal, global, and stable causes.

In one study, Seligman and Schulman (1986) tested the reformulated learned helplessness theory in a work setting. In a cross-sectional study of 94 experienced life insurance sales agents, those who had a positive attributional tendency (attribute negative outcomes external, unstable, and specific) sold 37 percent more insurance than agents who had a negative attributional tendency

(attribute negative outcomes internal, stable, and global). Seligman and Schulman also studied 103 newly hired agents. Those who had a positive attributional style when hired stayed at the job at twice the rate and sold more insurance than those having a negative attributional style.

Peterson and Seligman (1984) carried out cross-sectional studies, longitudinal studies, experiments of nature, laboratory experiments, and case studies to test the reformulated helplessness model of depression. The studies used college students, women from lower socioeconomic class, elementary children, patients, and prisoners as subjects. Each of these studies supported the depression model of learned helplessness. Not all of the studies testing learned helplessness have produced results favorable to the learned helplessness model (Alloy & Abramson, 1982; Alloy & Abramson, 1979; Frankel & Snyder, 1978). However, it has been argued (Peterson & Seligman, 1984) that these studies were not carried out in a naturalistic setting which caused the conflicting results.

In 1986, Sweeney, Anderson, and Bailey performed a meta-analysis of 104 studies, 75 published articles, and 29 unpublished papers that looked at the relationship between depression and explanatory style. The meta-analysis included data from over 15,000 subjects. The study found that depressed subjects made more internal, stable, and global attributions for bad events than non depressed subjects. Depressed subjects also made more external, unstable, and specific explanations for good events than did non depressed subjects.

In summary the reformulated theory of helplessness makes three predictions (Peterson, Maier, & Seligman, 1993):

1. Individuals who are not depressed now but have a depressive explanatory style are at greater risk for becoming depressed in the future.

2. Individuals who are depressed now but have a nondepressive explanatory style will tend to become less depressed in the future.
3. Individuals who undergo a change in explanatory style (as in therapy or preventative procedures) will have their depression changed accordingly. (p. 196)

A depressive explanatory style is not the only sole requirement for depression to develop (Abramson, Seligman, & Teasdale, 1978). It is only when bad events occur and the person attributes them to internal, stable, and global causes the depression is more likely to occur.

Learned Helplessness and Normal Depression

Learned helplessness does not attempt to serve as a model for all depressions. Peterson, Maier, & Seligman (1993) introduced what they call normal depression which they explain as the inevitable pain and loss that comes from being human. For example, a college student may experience normal depression after flunking a midterm. However, they believe that unipolar depression is a continuum of normal depression and that they are, "the same phenomenon, differing only in the number and severity of symptoms" (Peterson, Maier, & Seligman, 1993, p. 184). This is the depression that learned helplessness serves as a model (Miller, Rosellini, & Seligman, 1977; Peterson, Maier, & Seligman, 1993). Learned helplessness does not serve as a model for bipolar depressive disorders or severe cases of dysthymic disorder. Miller, Rosellini, and Seligman (1977), write that helplessness depressions are:

> embodied in passive people who have negative cognitive sets about the loss of an important source of gratification....Learned helplessness attempts to understand depressions like that of the man whose wife had died. His slowness in initiation responses, his belief that he was

> powerless and hopeless, his negative outlook on the future all began as a reaction to having lost his control over gratification and relief from suffering. (p. 106)

Learned helplessness serves as a model of reactive depressions which are caused by environmental elements not internal elements (Peterson, Maier, & Seligman, 1993).

Death and Learned Helplessness

The death of a loved one and the following grief is one of the most disruptive traumas experienced by humans. Just like a head wound is a trauma the body must recover from, grief is a trauma that assaults the mental and physical well being of the survivor. However, in the case of grief, there is no diagnosis or time frame for making a "full recovering" as there is in the case of a physical injury. A central figure of the trauma of grief appears to be the helplessness and powerless it creates (Attig, 1996; Rando, 1993). Realizing that one cannot escape the trauma, that one's control and power are useless, and that one is unable to escape what has happened or recover what has been lost assaults one's sense of competence. The survivor is forced to confront his/her own sense of incompetence. Fear escalates with helplessness. In many cases, childhood feelings of powerless and inadequacy begin to resurface (Rando, 1993; Seligman, 1975).

Feelings of anger, frustration, sadness, numbness, anxiety, and fear may occur but often feelings of helplessness predominates (Rando, 1993). For many, helplessness may not only be the most distressing and threatening aspect of the death, but the most difficult to integrate and the most traumatic to the survivor's behaviors. Often times, the survivor will feel paralyzed and withdraw from any social contact (Rando, 1993; Attig, 1996). As a result of the perceived loss of control, the survivor may feel that the world has become an unsafe place (Sanders, 1989). Instead of using some sort of outside support system, the survivor falls

deeper into his/her own helplessness. Seligman (1975) suggests that such a pattern could lead to the death of the survivor. Seligman believes that helplessness weakens the sufferer's resistance to physical pathogens that up until then had been warded off. In a study (Seligman, 1975) of 51 women who had regular pap smears, 18 were found to have experienced a significant loss in the past six months. Each of the 18 responded to the death with feelings of hopelessness and helplessness. Of the 18 who experienced helplessness, 11 subsequently developed cancer. Of the other 33 women, only eight developed cancer.

In another study (Parkes, 1973), women suspected of having cancer of the womb were diagnosed by a psychiatrist with great accuracy. The women had a routine vaginal smear which revealed the presence of cells of which may or may not indicate cancer. The psychiatrist, ignorant of whether the women had cancer or not, interviewed each woman and asked about her feelings about any recent loss in her life. When he found evidence of both loss and feelings of helplessness or hopelessness he predicted that the woman would have cancer. In 71 percent of the cases his diagnosis proved correct.

As stated before, one of the prime symptoms of the development of learned helplessness is the perceived loss of control of outcomes. When a loved one dies, the survivor comes to realize that he/she had no control over the death. The survivor feels small and insignificant in the face of such overwhelming events. The feelings of powerlessness and helplessness can paralyze the survivor leaving him/her to wonder if there is any room for control in his/her life. Often times, to try to gain some power back, the survivor will turn to books for help. Unfortunately, the ideas in many books reinforce the feelings of powerless and helplessness (Attig, 1996). The messages contained in many of the books on grief is that the survivor is either subjected to sequences of stages or phases or afflicted with a syndrome of some kind. Neither view stresses that when a person grieves he/she actively

responds to what has happened. Neither view suggests that the survivor has any choice or control over his/her grief process. This reinforces the already troubling feelings of helplessness and powerless (Attig, 1996). Grieving persons need to hear that while death is out of his/her control, grieving the death is an active process controlled by the survivor. However, this message is frequently left out of the descriptions of the grieving process.

Mode of death as a Determinate of Helplessness

One of the most important determinates of grief responses is the mode of death. How the person died will say something about how the survivor grieves. People left behind after a death often feel very anxious and fearful. Much of the anxiety stems from feelings of helplessness, feelings that they cannot get along by themselves or survive on their own (Worden, 1991). Sudden death, when the survivors do not have time to plan ahead, is directly related to learned helplessness (Worden, 1991; Hodgkinson, Joseph, Yule, & Williams, 1995; Rando, 1993).

Sudden deaths are those that occur without warning and require special understanding and intervention (Worden, 1991; Doka, 1996; Rando, 1993). Examples of sudden death are suicidal deaths, accidental deaths, heart attacks, and murders. One of the main elements of surviving a sudden death is the sense of helplessness that it elicits on the part of the survivor . As Worden (1991) writes, "This type of death is an assault on our sense of power and our sense of control" (pg. 99). A number of complicating factors inherent in sudden, unexpected death combine to make it a high-risk factor for complicated morning. The shock effects of the death can become so stressful as to overwhelm the ego, which becomes flooded by trying to master the helplessness and other emotional reaction (Rando, 1993). The suddenness and lack of anticipation adversely influence the survivor's internal world and coping abilities, which leads to trauma. Another reason why

survival of sudden death is so hard is because the survivor does not have the time to plan ahead and assemble support systems (Kalish, 1982).

Grief after sudden loss is often intensified since there is little or no opportunity to prepare for the loss, say good-bye, or take care of unfinished business (Doka, 1996). Survivors of sudden death often experience a heightened sense of vulnerability and anxiety. For them, nothing may seem safe anymore. Activities previously casually undertaken, such as driving a car, can seem fraught with danger. Survivors of sudden death may experience secondary losses also due to lack of anticipation. Survivors may not be financially ready to loss a second income which can lead to further losses. This may lead to a heightened sense of helplessness.

Non sudden death or expected death occurs when the death is anticipated (Worden, 1991). Examples of non sudden death include cancer or AIDS. The major difference between the two types of death is anticipation. The survivor of a non sudden death can make prior arrangements and plan ahead for the impending death. One of the more salient factors of non sudden death is anticipatory grief. Anticipatory grief refers to grieving that occurs prior to the actual loss. When deaths occur with forewarning, there is usually a period of anticipation. It is during this period that the potential survivor begins the task of mourning and begins to experience the various responses of grief (Worden, 1991). However, as mentioned above a survivor of sudden death cannot prepare himself or herself for the death which can lead to other losses. Therefore, there it is more likely that a person will feel helpless after a sudden death. The sudden death survivor has no warning or any way to prepare himself/herself.

Sudden Death Versus Non Sudden Death

There have been a number of studies that have followed people for a number of months following a loss to assess the resolution of bereavement. In

most of these studies, the conclusions are similar. Sudden deaths are more difficult to grieve than other deaths in which there is some prior warning that death is imminent (Parks, 1975; Shanfield, Swain, & Benjamin, 1986-87; Hodgkinson, Joseph, Yule, & Williams, 1995; Lundin, 1984a; Lundin, 1984b). In a study done by Parkes (1975), it was found that widows with a short period of preparation before their bereavement had a poorer outcome compared with those who had been prepared for the death for a longer time. In another study, Weinberg (1994) found that people who were grieving deaths from natural causes (long term illnesses) realized better recoveries than did those who were grieving deaths from unnatural causes (murders, suicides, or accidents).

In a study done by Hodgkinson, Joseph, Yule, and Williams (1995), the Expanded Texas Inventory of Grief (ETIG) was used to compare grief reactions of those bereaved by the Zeebrugge Ferry disaster or other sudden deaths to those affected by bereavements which were expected. The ETIG scores showed that those bereaved by the disaster or other sudden deaths scored higher than those affected by bereavements which were not expected. The researchers found that avoidance, denial, and post-traumatic reactions were central to the prolonged grief reactions of the sudden death survivors. It was also found that sudden violent deaths lead to more intense grief reactions. This study suggested that sudden death causes greater grief reactions than non sudden death.

In another study (Shanfield, Swain, & Benjamin, 1986-87), the grief reactions of parents who had lost their children in traffic accidents were compared to parents who had lost their children from cancer. The parents were found to differ in their grief reactions. The circumstances of the death appeared to be an important determinant of the shape and form of grief in the two groups. The accident parents had a bereavement pattern which was characterized by more psychiatric symptoms as well as by more health complaints. The increased health

complaints were especially surprising because the accident parent were significantly younger than the cancer parents. As the researchers write, "the accident parents are younger, more symptomatic and grief ridden, have more health complaints, experience the loss of an adult child as being more painful than cancer parents" (pg. 296). The researchers suggested that the suddenness of the loss was one of the most important factors that accounted for the accident parents' symptoms.

Lundin (1984), compared relatives who had suffered a sudden and unexpected bereavement to relatives who had suffered an expected death. Ludin was interested in finding if there was an increase in morbidity in the two years following the death compared to the pervious two years. Lundin hypothesized that the reactions to sudden and unexpected death should be more serious than when the death has been expected due to the absence of anticipatory grief. Lundin found that there was increased morbidity, especially psychiatric morbidity, following sudden and unexpected bereavement group but not in the expected group. It was concluded that persons exposed to sudden and unexpected loss of a close relative were subject to increased psychiatric morbidity and should be regarded as a high-risk group. In a follow-up study, Lundin (1984) investigated the same group of subjects eight years after the bereavement using the ETIG. It was found that relatives of persons who had died suddenly and unexpectedly had more pronounced grief reactions than those whose deaths were expected. The sudden group bereavers had a higher degree of mourning, significantly more guilt feelings, more numbness, missed the deceased person more, and had a greater need to cry. The original study and the follow-up study suggest that relatives of persons who have died unexpectedly have a poorer mental health status than those persons whose death are more expected, both during the first years after the bereavement and in the long term. Lundin's two studies suggest that there are different grief reactions suffered by sudden death

survivors and non sudden death survivors and a different approach should be taken by mental health facilitators when working with the two groups.

Theory and Hypothesis

In much of the literature on the survival of sudden death, helplessness is listed as one of the more prevalent features of sudden death survival. However, there appears to be very limited, if any studies comparing the amount of learned helplessness in survivors of sudden death versus survivors of non sudden death. The literature would suggest that there would be a greater occurrence of learned helplessness in the survival of sudden death due to the suddenness of the event. The survivor of sudden death does not have the time to prepare himself/herself for the death. He/she also lacks the time to set up coping skills and the appropriate support systems. The survivor of sudden death does not begin to grieve until the death has occurred compared to a non sudden death survivor who experiences anticipatory grief.

Statement of the Hypothesis

Based on the outcomes of the studies on sudden death versus non sudden death and the literature on the learned helplessness theory, it is hypothesized that there will be a greater occurrence of learned helplessness (as measured by the Learned Helplessness Scale) in survivors of sudden death than non sudden death. Such a finding would suggest that the therapy for non sudden death survivors and sudden death survivors should differ in its approach.

Chapter III

Method

Subjects

There were 46 participants in this study. The participants were volunteers taken from 15 area support groups in an urban area in the midwest. All subjects were White Caucasians. The participants varied in age from 22 to 79 (mean=51.41, SD=14.49) years old. The subjects were either classified as "survivors of sudden death" (N= 25, 54.3%) or "survivors of non sudden death"(N=21, 45.7%). There were 11 (23.9%) males and 35 (76.1%) females. Five males and 20 females were survivors of a sudden death and six males and 15 females were survivors of a non sudden death. The cause of death ranged from cancer to drowning (see Table 1). All of the participants had experienced the death of a his/her loved one within a 36 month period (mean=13.5, SD=10.85). The relation to the deceased ranged from nephew to wife (see Table 2). Volunteers who experienced the death of his/her loved past the 36 month period were not included.

Table 1. Cause of death of subjects' loved ones

Cause of Death	Frequency	Percent
Non Sudden Death	21	45.7
Cancer	18	39.1
Parkinson's Disease	2	4.3
Anemia	1	2.2
Sudden Death	25	54.3
Cerebral Hemorage	2	4.3
Car Accident	7	15.2
Accidental Gun Shot	1	2.2
Hit & Run	1	2.2
Heart Attack	2	4.3
Murder	3	6.5
Aneurism	2	4.3
Suicide	2	4.3
Drowning	1	2.2
Shock	1	2.2
Stillborn	2	4.3
SIDS	1	2.2
Total	**46**	**100**

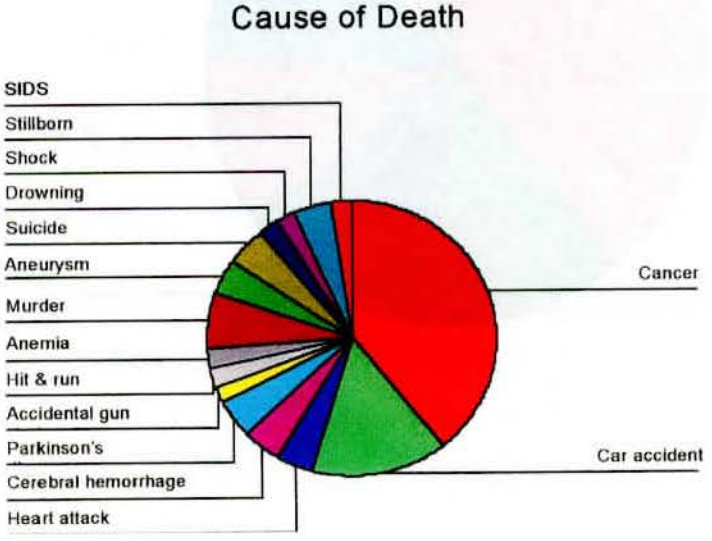
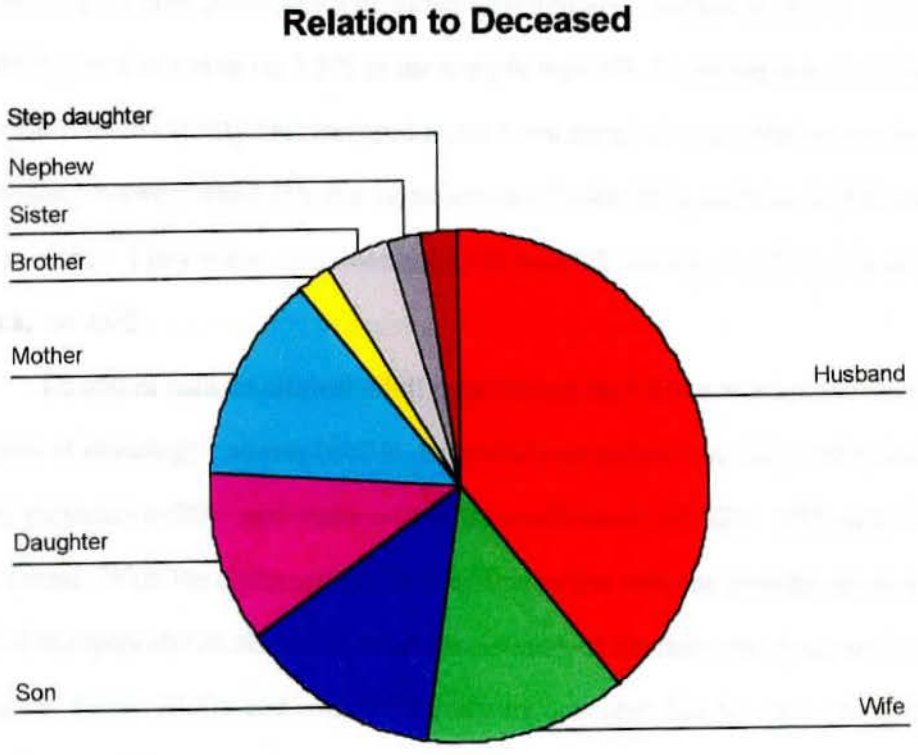


Table 2. Relation of subjects' to dead loved ones

Relation	Frequency	Percent
Husband	18	39.1
Wife	6	13
Son	6	13
Daughter	5	10.9
Mother	6	13
Brother	1	2.2
Sister	2	4.3
Nephew	1	2.2
Step Mother	1	2.2
Total	**46**	**100**



Instruments

The Learned Helplessness Scale (LHS; Quinless & McDermott-Nelson, 1988) was used to detect the amount of helplessness in subjects (See Appendix A). The LHS is a 20-item scale in which respondents are asked to read the 20 statements and then indicate how closely they agree or disagree with each item's description of themselves. For example, the participants are asked how closely they agreed with the statement " I feel that anyone else could do better that me in most tasks". The participants' responses were rated on a on a four-point Likert scale ranging from strongly disagree (4) to strongly agree (1) . The scale is very easy to administer. Scores range from 20 to 80, with higher scores suggesting greater helplessness. No training was required to administer the LHS.

The LHS was administered to a normative sample of 241 healthy adults with a mean age of 39.8 years (Quinless & McDermott-Nelson, 1988). The majority of the sample were females (72%). The majority of the sample were married high school graduates with either a technical or professional job. The alpha reliability coefficient of the LHS in the sample was .85. To determine concurrent, criterion-related validity Pearson product moment correlation coefficients were established between the LHS, the Hopelessness Scale (HS), and the Self-Esteem Scale (SES) . They were: between the LHS and HS scores, r=.252; LHS and SES scores, r=-.622.

To obtain data on clinical adult populations the LHS was administered to samples of oncology patients (n=24), hemodialysis patients (n=30), and spinal cord injury patients (n=20) and alpha reliability coefficients of .828, .923, and .944 were found. With the alpha reliability coefficients for both the healthy adult and the clinical samples above .82 the internal consistency of the instrument seems to be adequate. Face validity and content validity are considered to be very strong due to the inclusion of learned helplessness researchers in the scale's development.

The LHS has never been administered to a grieving population. However, the scale remains the only published measure of helplessness-related expectations and will be used despite its limited use and meager establishment of reliability and validity.

A demographic questionnaire (Appendix B) was developed for this study to obtain relevant demographic data from each subject.

Procedure

During a month long period, several grief support groups were visited in an urban area. At the designated starting time, members of the support group were asked to volunteer for a study on grief. Those agreeing to participate were handed a stamped envelop with the return address and mailing address of the experimenter . Each envelope contained a consent form (Appendix C), a demographic questionnaire (Appendix B), the Learned Helplessness Scale (Appendix A), and a debriefing statement (Appendix D).

The volunteers were instructed to sign the consent form (Appendix C) and hand it back to the experimenter to ensure that they would be kept separate from the envelops to ensure confidentiality. The volunteers were then instructed to fill out the remaining contents of envelop at his/her earliest convenience. The participants were told that they could stop participating in the experiment at any time. The participants were also informed that there were no right or wrong answers and that there was no time limit. The volunteers were instructed that when he/she completed the contents of the envelop, he/she were to put the all the contents back into the envelop and mail the envelop to the experimenter. Each participant was thanked and a piece of paper was provided for the participants to submit his/her address if he/she would like the results of the study.

Chapter IV

Results

Means and standard deviations for learned helplessness and a t test (see Table 3) for independent samples (α = .05) was used to compare the groups ("survivors of sudden death" and "survivors of non sudden death"). The results of the test indicate that there was no significant difference between survivors of sudden death and survivors of non sudden death (see Table 3).

Table 3.

Means, Standard Deviation and t Test for Survivors of Sudden Death and Survivors of Non Sudden Death and Occurrence of Learned Helplessness

Mode of Death	N	Mean	SD	t	P
Sudden	25	39.8	7.023	-.478	.64
Non Sudden	21	41.05	10.57		

A t test for independent samples (α = .05) indicated that there was a significant difference between subjects who had experienced another loss and those who had not and the occurrence of learned helplessness (see Table 4).

Table 4.

Means, Standard Deviation and t Test for Subjects Who Had Experienced Another Loss and Occurrence of Learned Helplessness

Another loss	**N**	**Mean**	**SD**	**t**	**P**
Yes	32	42.09	8.66	2.098	.04
No	14	36.43	7.85		

As Table 3 indicates the occurrence of learned helplessness in survivors of sudden death did not differ significantly from the occurrence of learned helplessness in survivors of non sudden death. Therefore, the hypothesis that there would be a greater occurrence of learned helplessness (as measured by the Learned Helplessness Scale) in survivors of sudden death than non sudden death was not supported.

Chapter V

Discussion

Survivors of sudden death were found not to differ from survivors of non sudden death in the occurrence of learned helplessness. This result could suggest many different things. First, the literature comparing survivors of sudden death with survivors of non sudden death (Lundin, 1984; Scanfield, Swain, & Benjamin, 1986-87; Parkes, 1975; & Weinberg, 1994) suggested that survivors of sudden death experienced a harder grieving process. The research suggested that survivors of sudden death experienced worse recoveries, had higher grief reactions, and had higher psychiatric morbidity than survivors of non sudden death. However, the increased difficulty that survivors of sudden death may face may not include an increase in learned helplessness. As much of the literature suggests (Attig, 1996; Rando, 1993; Worden, 1991; Seligman, 1975), learned helplessness seems to be a phenomena experienced by most survivors of any type of death.

In Seligman's (1975) study of woman who had pap smears, 18 had experienced a significant loss to which they responded to with feelings of helplessness and hopelessness. Of those 18 women, 11 developed cancer. However, Seligman did not mention whether the women had experienced a sudden death or a non sudden death. The results of this study could suggest that survivors of sudden death and non sudden death experience learned helplessness at similar levels.

Rando (1993) has suggested that survivors of sudden death differ from survivors of non sudden death due to complicating factors. Rando believes that when a loved one dies suddenly complicated factors are added to the survivors grief. Therefore, the survivor of a sudden loss is more prone to experience complicated mourning. However, higher levels of learned helplessness in survivors of sudden death may not be a complicating factor. Although survivors of

sudden death may experience learned helplessness, it may exist in similar levels in survivors of non sudden death.

It was found that subjects who experienced another loss had lower learned helplessness levels than those who had not experienced another loss. This may suggest that experiencing a previous death may some how lower the feelings of helplessness experienced during subsequent deaths. Worden (1991) suggests that previous losses may help grieve subsequent deaths only if the previous losses were grieved adequately. Rando (1993) suggests that experiencing previous secondary losses may teach or prepare a person better for a primary loss.

It is interesting to note that the mean learned helplessness score for survivors of non sudden death (mean=41.05) was higher than the mean learned helplessness score for survivors of sudden death (mean=39.8). Although this difference was not significant, it may suggest that survivors of a death in which the loved one must be cared for experienced more learned helplessness. Of the 21 survivors of non sudden death, 20 had lost his/her loved one to a prolonged cause of death (18 cancer, 2 Parkinson's disease). Rando (1983, 1993) suggests that when illnesses are too long, survivors are less prepared. In a 1983 study, Rando found that family members who had loved ones die of an illness lasting more than 18 months appeared to be least prepared for the death.

One reason for this outcome could be the prolonged ups and downs of medical treatment (Rando, 1993). A new treatment for a cancer patient may produce hope in family members, however if the treatment does not succeed than disappointment may follow. As each medical treatment fails, helplessness may increase as family members foster a belief that he/she has no control over the illness. Learned helplessness may increase as family members experience one disappointment after another. Once the family member dies of a prolonged illness, helplessness levels may be higher than family members who lost a loved one to a

sudden death (Rando, 1993, 1983). Although shock levels are higher with a sudden death, survivors of sudden death can only feel helplessness towards the death, however survivors of a non sudden death in which there was a prolonged illness may feel helplessness towards the death and the prolonged illness.

Another reason for increased helplessness in prolonged illnesses could be the role of the family members as caregivers (Rando, 1993). After devoting his/her life, a family member may be confused after the death about what to do in life besides care for the dying person. A family member may become helplessness not knowing what to do with his/her self now that the loved one is dead. Caring for the loved one may have been the only control the survivor felt and now that the loved one is dead, the survivor's control is gone and helplessness may set in.

However, because of limitations in this study, the results must be interpreted with caution. There were some limitations in the selection of the subjects used in this study. It is assumed that the subjects used for this study may differ from the greater population of survivors of a death of a loved one because they were attending a grief support group. Survivors attending support groups may have a tendency to be less helpless because they are reacting to his/her grief. A key factor in learned helplessness is lack of motivation (Miller, Rosellini, &Seligman, 1977). Therefore, it could be suggested that a person having high levels of learned helplessness would lack the motivation to attend a support group. If this suggestion is correct than survivors attending support groups may have less learned helplessness than survivors not attending support groups.

Also, this study used volunteers from a grief support group who may systematically differ from those who do not wish to volunteer. There were also no minorities represented in the sample of this study which effects the study's generalizability. Finally, the sample size does not represent the minimum guideline

for this type of study. Therefore, the small sample size may have effected the statistical tests used in this study and the generalizability of this study's results.

Another problem with the sample, was that the subjects experienced many different types of deaths. The subjects were also in different periods, phases, or points in his/her grieving process and some had experienced other losses in the 36 month time period. It may have been helpful if the subjects used in this sample had experienced a loss in a six month time period instead of a 36 month period. This may have decreased the difference among the subjects in his/her point in his/her grieving process. Also, it may be suggested that subjects who have only experienced one death in a reasonable time frame be used in such a study.

Another suggestion for further research would be to compare learned helplessness levels in survivors of non sudden death who experienced a prolonged terminal illness over 18 months and survivors who experienced a terminal illness of less than 18 months. It would be interesting to see if the length of a terminal illness could increase helplessness levels after the death of the loved one. It would also be interesting to compare the helplessness levels of survivors who had lost his/her loved ones to a prolonged terminal illness and those who had lost his/her loved one to a sudden death such as a car accident. Another stimulating study would be to compare those who had a loved one die of a prolonged illness and were the caregivers and those who had a loved one die of a prolonged illness and were not the caregivers. It would be interesting to see if caregivers experienced more helplessness after the death than the non caregivers.

There has been much research done with learned helplessness in regards to depression but there is a need to do more research on learned helplessness in regard to bereavement and the survival of sudden death and non sudden death. Seligman (1975) did some very good work describing the detrimental effects learned helplessness can cause after the death of a loved one. However, these findings do

not seem to have been followed up. It seems that if it has been discovered that experiencing learned helplessness after a death of a loved one can lead to such things as cancer, it would be a good idea to find what populations of survivors are more prone to experience learned helplessness after a death of a loved one. Therefore, it is suggested that more research of this kind be done.

Appendix A

Learned Helplessness Scale

Instructions to the Participant:

In the following instrument there are statements that you are asked to read carefully. After reading each item, respond as to how closely you agree or disagree with how each item describes you or your feelings about yourself. Place an X in the response box which most closely describes your agreement or disagreement for each item.

ITEM	RESPONSE			
	Strongly Agree	Agree	Disagree	Strongly Disagree
1. No matter how much energy I put into a task, I feel I have no control over the outcome.	☐	☐	☐	☐
2. I feel that my own inability to solve problems is the cause of my failures.	☐	☐	☐	☐
3. I cannot find solutions to difficult problems.	☐	☐	☐	☐
4. I don't place myself in situations in which I cannot predict the outcome.	☐	☐	☐	☐
5. If I complete a task successfully, it is probably because I became lucky.	☐	☐	☐	☐
6. I do not have the ability to solve most of life's problems.	☐	☐	☐	☐
7. When I do not succeed at a task I do not attempt any similar tasks because I feel that I will fail them also.	☐	☐	☐	☐
8. When something doesn't turn out the way I planned, I know it is because I didn't have the ability to start with.	☐	☐	☐	☐
9. Other people have more control over their success and/or failure than I do.	☐	☐	☐	☐
10. I do not try a new task if I have failed similar tasks in the past.	☐	☐	☐	☐
11. When I perform poorly it is because I don't have the ability to perform better.	☐	☐	☐	☐
12. I do not accept a task that I do not think I will succeed in.	☐	☐	☐	☐
13. I feel that I have little control over the outcomes of my work.	☐	☐	☐	☐
14. I am unsuccessful at most tasks I try.	☐	☐	☐	☐
15. I feel that anyone else could do better than me in most tasks.	☐	☐	☐	☐
16. I am unable to reach my goals in life.	☐	☐	☐	☐
17. When I don't succeed at a task, I find myself blaming my own stupidity for my failure.	☐	☐	☐	☐
18. No matter how hard I try, things never seem to work out the way I want them to.	☐	☐	☐	☐
19. I feel that my success reflects chance, not my ability.	☐	☐	☐	☐
20. My behavior does not seem to influence the success of a work group.	☐	☐	☐	☐

Appendix B

Instructions to the Participant:

Please answer the following questions to the best of your ability. If you have any questions please ask the researcher.

1. What is your age now? _____

2. What is your gender? Male Female

3. What is your race? _____

4. Have you experienced the loss of a loved one?
   yes no

If you answered no on question #4 you may stop. If you answered yes to question #4, please continue.

5. What was the relationship to you, of your loved one who died? _____

6. What was the date and year that your loved one died?
   _____

7. What did your loved one die from (eg. cancer, car accident, murder)?_____

8. Do you consider the death of your loved one to have been a sudden death (no 24 hour previous warning such as an accident or sudden heart attack) or a non sudden death (diagnosed, there was previous warning such as cancer)?

_____

9. Do you feel you have a good support network?

Yes No

10. Have you experienced the loss of another loved one?

Yes No

If you answered no to question #10 you may stop. If you answered yes to question #10 please continue.

11. How many losses of loved ones have you experienced excluding the above mentioned in questions #4-8?

_____

12. How recent was the most recent loss of a loved one, excluding the above mentioned in questions #4-8?_____

Appendix C

Statement of Informed Consent

Thank you for agreeing to participate in my experiment. The purpose of this study is to find out more about grief. You will be asked to fill out two questionnaires located in the contents of this Manila envelope. All of the results of the questionnaires are confidential and your name will not be associated with any of the specific materials. If at any time during this study you become uncomfortable you may stop your participation.

I understand, agree to be a participant in this experiment. By signing below, I indicate that I have read this form and understand my right and my responsibilities as a participant in this experiment.

Signature_____Date_____

Appendix D

Debriefing Statement

Thank you for participating in my experiment. Many researchers have suggested that survival of the sudden death of a loved one is grieved differently than the survival of the non sudden death of a loved one. Some researchers have suggested that an occurrence known as learned helplessness is experienced more by survivors of sudden death. Learned helplessness occurs when a person feels they have lost control of all outcomes. The theory states that people who are more likely to feel emotions of helplessness are more likely to become depressed. If there is a difference in the occurrence of learned helplessness in survivors of sudden death versus survivors of non sudden death than it may be suggested that therapy should account for this difference. Therefore, the purpose of this study is to determine if there is a difference in the occurrence of learned helplessness in sudden death survivors versus non sudden death survivors.

The first questionnaire you completed assessed if you are a survivor of non sudden death or sudden death. The second questionnaire assessed your learned helplessness level. I am hoping to get a better understanding of the differences between survival of sudden death and the survival of non sudden death from this study.

If you have any further questions please feel free to ask me. If you would like a copy of the final results please add

your name and address on the "I would like the results of this study" list and I will be happy to send you the final results of my Masters Thesis.

Thanks again,

Jen Wyatt
Master of Arts in Professional Counseling Candidate
Lindenwood University

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