2000

Intensity of Grief and Belief in Personal Control

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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

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Abstract

Much research has focused on stress and its consequences. Some studies have indicated personal control helps an individual handle stress better and remain healthier. Little research, however, has examined the role personal control plays in bereavement as a stressful life event. This correlational study examined the relationship between belief in personal control and grief intensity experienced from losing a loved one to death. Volunteer subjects primarily from Grief Support Groups completed the Belief in Personal Control Scale and the Texas Revised Grief Inventory. Results demonstrated some instances when higher belief in personal control resulted in lower intensity of grief in the present, when variables of time since death and mode of death were considered. Lack of belief in personal control was shown to be a risk factor for poor outcome in some instances.

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2000

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Dedication

I dedicate this thesis to my husband, Harry, who provided me a secure base on which I have balanced the many roles I have undertaken. I am extremely grateful.

Acknowledgments

I thank my friends Sr. Teresa Haug, SSND, Sara Johnson, and Margaret Lindsey, who have provided encouragement, prayerful support, and technical assistance in the production of this thesis. I am most appreciative.

Table of Contents

List of Tables

Chapter I

Introduction

Everyone will experience the death of a loved one sometime in life, whether that loved one be a parent, spouse, child, sibling or friend. Surviving the death of a loved one is truly a universal phenomenon. In 1998, there were 2,337,256 deaths reported in the United States (Murphy, 2000), and the U. S. Census Bureau (2000) states there is a death every 14 seconds. The sheer number alone points research in the direction of attempting to understand the aftermath of loss within the personal, familial and communal strata of society. The need is great to look for ways to assist those who survive the death of a loved one.

Holmes and Raye (1967) revealed that surviving the death of a spouse ranked as the most stressful life event, while surviving the death of a close family member ranked fifth and surviving the death of a close friend ranked fifteenth. Much research since that time has been conducted on identifying stressful life events and their effects. Current popular periodicals continually present articles on the effects of stress on the body and how to manage it. Scientific research exists which identifies effects of stress on the body following bereavement. Fields of study include biobehavioral consequences in nonhuman primates, neuroendocrine changes, immunologic consequences, and psychological and physical morbidity and mortality among widows and widowers (M. S. Stroebe, Stroebe, & Hansson, 1993). In light of these and other studies, it is becoming even more imperative to learn ways of dealing with grief and its ensuing disruption to life.

Bereavement, according to M. S. Stroebe, Stroebe, and Hansson (1993), is the objective situation of having lost someone significant, and grief the emotional response

to that loss. While bereavement is a universal phenomenon and the individual's experience of mourning reflects practices of one's culture, the experiencing of grief as the emotional response to one's loss is unique to the individual. It is that experience which has been the subject of much research, e.g., M. S. Stroebe, Stroebe, and Hansson; Wass and Neimeyer, 1995; and Zisook, 1987.

Some individuals seem to navigate the experience of grief with less disruption to their lives than do others, although Raphael (1983) estimates that "one third of all major bereavements result in problems where professional help is required" (cited in Sanders, 1993, p. 255). Research can provide a fuller understanding of the grief process in order to assist those who have a more difficult time of adjusting to, resolving, or growing from their experience of grief. Continued research on which factors assist the bereaved individual in ameliorating grief and in mourning successfully will benefit a great number of individuals. This information is useful both pre- and post-bereavement in the fields of education and therapy. Society at large will benefit, too, for interpersonal relationships, family life, and work are affected by the needs of the grieving individual. Politically, communities at all levels need sound research in order to best address the needs of those whom elected officials seek to serve, when decisions are made in utilizing the limited resource of public moneys (M. S. Stroebe, Stroebe, & Hansson, 1993).

The scientific study of grief began by identifying morbidity and mortality phenomenon (W. Stroebe & Stroebe, 1992). Research continues to study the physical consequences of grief, and from the time of Freud (1917) sought to theoretically understand its psychological implications and consequences as well. Current theoretical formulations propose an understanding of grief from many different vantage

points, and the current need is to shift from a univariate concept to a multi-dimensional construct of grief (Hansson, Carpenter, & Fairchild, 1993).

The theoretical framework for understanding grief in relationship to this study includes stress and cognitive theories. Stress theories as applied to bereavement understand bereavement as a stressful life event and address not only its physical health consequences but its psychological effects as well, e.g., The Deficit Model of Partner Loss of W. Stroebe, Stroebe, Gergen, and Gergen (1980, 1982). Cognitive stress models posit that stress, such as bereavement, results from "a perceived imbalance between situational demands and individual coping resources" (W. Stroebe & Stroebe, 1992, p. 7). Personality is thought to be an important component in the outcome of a life crisis such as the loss of a spouse (Lowenstein, Landau, & Rosen, 1994). Personality traits play a part in the individual's assessing both the situational demands of surviving the loss of a loved one and one's coping resources to meet those demands, as well as the manner and the extent to which one utilizes personal and environmental resources to meet those demands. Personal control is one such personality trait that influences this assessment and utilization, and is thought to be a buffer in responding to the deficits in life brought about by loss.

The purpose of this study was to identify whether one's belief in personal control significantly relates to the grief intensity experienced in bereavement. Variables of interest included grief intensity and belief in personal control. Grief intensity was defined as the degree of the emotional response to one's loss of a loved one as measured by the Texas Revised Inventory of Grief (TRIG). Belief in personal control was defined as the extent to which an individual believes his or her outcomes are self-produced as measured by the General External Control subscale of the Belief in

Personal Control Scale (BPCS). The following hypothesis was tested: There is a significant degree of relationship between intensity of grief experienced and belief in personal control.

Chapter II

Literature Review

Grief

Although grief is usually considered the emotional reaction to the death of a loved one, it has more recently been generalized to include the reactions to many other types of loss experiences (Kaczmarek, Backlund, & Biemer, 1990). Parkes (1993) claimed "there are some bereavements that are not a cause for grief and many griefs that have causes other than bereavement by death" (p. 92). Ruple (1985) identified those elements of a life occurrence which cause grief to result: loss, value, and emotional reaction. The work of Mitchell and Anderson (1983) identified six major types of losses that lead to grief.

First is material loss, which occurs when one loses either an object or access to a place after emotional ties had been formed (Mitchell & Anderson, 1983). Work by Graham, Henjum, and Freeze (1991) on the loss of one's family farm and Espin (1993) on political dislocation demonstrated this type of loss and its resultant grief. Secondly, there is intrapsychic loss, which occurs at the loss of an image one has of the self or of the possibilities, plans, or dreams one has for the future. The suffering of parents of children with a handicap, in losing the "perfect child" (Ellis, 1990), terminations within psychotherapeutic relationships (Burrall, 1991), and infertility (Williams, 1997) illustrate this type of loss.

Another type of loss is functional loss, which occurs when the physical body does not function optimally. The work of Hayes, Potter, and Hardin (1995) in studying the ramifications of spinal cord injury, and that of Zinner, Ball, Stutts, and Mikulka (1992) in the aftermath of brain injury illustrate this type of loss and the grief which

accompanies it. Role loss, the fourth type of loss, occurs when the place one has in society is lost. Examples of this type are the losses in societal roles incurred through parental custody mediation settlements (Grebe, 1986) and as a result of job loss (Archer & Rhodes, 1993).

Fifthly, systemic loss is the loss experienced not only by the individual members of a system but by the whole system to which they belong as well. This loss occurs when an individual member no longer performs some activity. Such loss is demonstrated by individuals who develop fibromyalgia (Kelley, 1998) or a serious and persistent mental illness (Solomon & Draine, 1996). Their condition not only affects their own lives but the entire family unit as well. Lastly, relationship loss is "the ending of opportunities to relate oneself to, talk with, share experiences with, make love to, touch, settle issues with, fight with, and otherwise be in the emotional and/or physical presence of a particular other human being" (Mitchell & Anderson, 1983, p. 37). Much research has been conducted on this particular type of loss and its subsequent grief. Examples include pet loss (Gosse & Barnes, 1995), the end of a romantic relationship (Kaczmarek et al., 1990), spousal bereavement (W. Stroebe & Stroebe, 1987), perinatal grief (McGreal, Evans & Burrows, 1997), and parental death (Silverman & Worden, 1993).

Effects of Grief. These major types of loss encompass the broad range of life occurrences that can result in grief. It was, however, the observed relationship between surviving the death of a loved one and later-developing physical concerns that prompted the systematic study of grief. Robert Burton, in his Anatomy of Melancholy (1621/1977), argued "that bereavement leads to depression, physical illness, suicide, and even death from natural causes" (cited in W. Stroebe & Stroebe, 1992, p. 3).

Parkes (1964) observed that two hundred years after Burton, "griefe" [sic] was officially regarded as a cause of death" (p. 198). W. Stroebe and Stroebe (1992) noted Farr (1858/1975) had found a relationship between the married state and mortality, i.e., married individuals lived longer than singles who lived still longer than the "have-been married."

M. S. Stroebe, Stroebe, and Hansson (1993) stated that although "bereavement does not operate on one's bodily system in the same way as some alien bacteria do, [n]evertheless, it is associated with a variety of mental and physical health consequences" (p. 9). M. S. Stroebe and Stroebe (1993), in reviewing spousal bereavement studies, found there was not only increased morbidity but mortality as well. Heart disease and cancers occurred at increased rates. They claimed "excessive causes of death reflecting a lack of the will to live (e.g., suicide), failure to care for oneself (accidents), immune system depression (infectious diseases), or unhealthy living (liver cirrhosis) could all be seen as direct consequences of grief" (p. 193). A "broken heart" hypothesis was formulated to explain the increased mortality among spousal survivors (M. S. Stroebe, Stroebe, Gergen, & Gergen, 1981). They additionally found it was possible to generalize the findings of the increased spousal bereavement-mortality relationship to include the death of other family members as well, such as parents, children and even siblings or grandchildren.

Beyond these studies on the morbidity and mortality of bereaved survivors, other work on the physical consequences of grief has been conducted. Such research includes immunologic function in widows (Irwin & Pike, 1993), neuroendocrine changes in depression and anxiety, "the most frequent psychiatric complications of bereavement" (Kim & Jacobs, 1993, p. 146), and biobehavioral consequences in

nonhuman primates (Laudenslager, Boccia, & Reite, 1993). The latter of these three W. Stroebe and Stroebe (1993) believe holds promise in applicability to the human physiological, endocrinological and immunological responses to grief.

Theories of Grief. The psychological study of the reactions to grief began in the last century with the theoretical formulation of Freud (1917/1959) in Mourning and Melancholia (W. Stroebe & Stroebe, 1993). Freud presented a psychoanalytic approach to grief and object loss (W. Stroebe & Stroebe, 1987), and delineated normal grief, or mourning, from abnormal grief, or melancholia, now known as clinical depression (Rando, 1995). Freud stated

> the distinguishing mental features of melancholia are a profoundly painful dejection, abrogation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. (p. 153)

All features of melancholia but for the fall in self-esteem are the same as in mourning.

Bowlby (1980) proposed another depression model, an ethological approach to the study of grief and loss of attachment (W. Stroebe & Stroebe, 1987). Rando (1995) claimed Bowlby "initially took a psychoanalytic perspective... [but] subsequently incorporated into his work on mourning principles from ethology, control theory, and cognitive psychology" (p. 214), and as a result can be credited with demonstrating the biological basis for much acute grieving behavior. Bowlby understood uncomplicated grief responses to incorporate the following phases: numbing, yearning and searching, disorganization and despair, and reorganization (Rando, 1995). He claimed these characteristics of healthy mourning, when identified by their severity and later time of onset, become pathologically oriented in three forms of disordered attachment: anxiety

attachment, compulsive self-reliance, and compulsive care-giving (W. Stroebe & Stroebe, 1987).

A. A. Lazarus (1968), in seeking to "avoid the snares of subjectivity" (p. 84) of previous work on grief, contributed to a behavioral explanation of a psychological approach to depression, according to W. Stroebe and Stroebe (1987). He described operational factors which he claimed lent themselves to a more objective assessment of grief, e.g., base rate of frequent weeping and decreased food intake, and presented treatment techniques, such as time projection with positive reinforcement. Lazarus saw no therapeutic usefulness in separating the normal emotion of grief from a morbid condition as Freud had theorized.

A cognitive approach to grief and loss of control by Seligman and colleagues (Abramson, Seligman, & Teasdale, 1978; Seligman, 1975) was based on the work on learned helplessness (W. Stroebe & Stroebe, 1987). The original hypothesis, ensuing from the observation that depression and grief reactions share symptomatology, was based on the assumption "'that when an animal or person is faced with an outcome that is independent of his [sic] responses, he learns that the outcome is independent of his responses'" (Seligman, 1975, p. 46, cited in W. Stroebe & Stroebe, 1987, p. 70). Abramson et al. later reformulated this hypothesis to accommodate inconsistencies regarding the uncontrollability rather than the aversiveness of the outcome, seeking to answer the question as to why uncontrollable good outcomes do not lead to depression. They concluded that "for helplessness to be induced, individuals must also expect that future outcomes are uncontrollable" (W. Stroebe & Stroebe, 1987, p. 71).

The learning model became transformed into an attribution theory which stated that "a certain attributional style, when combined with bad outcomes, causes

depression" (Seligman, Abramson, Semmel, & von Baeyer, 1979, p. 247). This attributional style encompassed dimensions of internal-external, stable-unstable, and global-specific. Further work by Seligman et al. found a relationship between attributional style and depression, i.e., depressed as compared to nondepressed individuals "attributed bad outcomes to internal, stable, and global causes... and good outcomes to external, unstable causes" (p. 242). This cognitive approach using causal attribution theorized depression as a result of bereavement, since internal attribution of bad outcomes contributes to lowered self-esteem and hence, depression. Stable attribution of bad outcomes, predicted to contribute to a feeling of helplessness over time, and global attribution, to a wider generalization of helplessness over other situations, are additional dimensional components of the attributional style found to be correlated with depression when a bad outcome occurs or is anticipated.

Parkes (1987; Parkes & Weiss, 1983) outlined the etiology, description and treatment of three identifiable pathological grief syndromes: anticipated grief, conflicted grief, and chronic grief (Rando, 1995). This work revealed "there were no differences between psychiatrically disturbed mourners and individuals appearing to evidence typical reactions, and that there were no symptoms peculiar to pathological grief per se" (Rando, 1995, p. 215). Parkes allowed, however, that pathology could develop when extreme guilt, identification symptoms, and delayed grief were present.

Parkes (1971, 1993) additionally developed the theory of psychosocial transitions to explain the processes of adaptation to change. He based his work on life-change events research, the characteristics of which he identified as the criteria for psychosocial transitions. These characteristics are (1) the necessity of revising one's assumptions about the world, (2) the lasting rather than passing consequences of those

revisions, and (3) the little time for preparation to make them. His cognitive approach to understanding the processes involved in adaptation to change claimed that the assumptions and expectations of the bereaved individual became invalidated upon the death of the loved one. The internal world of the bereaved individual had to change as a result.

W. Stroebe and Stroebe (1987) claimed the theoretical focus of the depression models of grief had traditionally been either the emotional reaction to loss or its health consequences. The stress models, however, which view bereavement as a stressful life event, provided a complement to the depression models and suggested an explanation for the physical health consequences of bereavement, a facet that was not the predominant focus of the depression models (M. S. Stroebe, Stroebe, & Hansson, 1993).

One stress model is that of Selye (1936, 1976), whose work, in demonstrating the physiological responses to stressors, provided an impetus to adapt stress theory to bereavement (W. Stroebe & Stroebe, 1987). His research on the sympathetic adrenal medullary and the pituitary adrenal cortical systems paved the way for his identification of "diseases of adaptation" as those that developed directly from how the body processes worked in defense against stress. It was this link between event exposure and illness that was the focus of the early phases of life event research (Ormel & Sanderman, 1989).

Lindemann's (1944) grief work, which memorialized the Coconut Grove fire in Boston, provided another stress model. From his work with the survivors of that fire, he identified characteristics of acute grief he claimed were pathognomonic for grief: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions,

and loss of patterns of conduct. A sixth characteristic was sometimes shown by individuals bordering on pathology, who exhibited traits of the deceased, especially those symptoms of the deceased's last illness, or behavior shown at the time of the tragedy. He presented a course of normal grief reactions and claimed morbid grief reactions, i.e., distortions of normal grief, could be either a delay or postponement of reaction, or a distorted reaction. These distorted reactions could be identified through nine distinguishing characteristics which Lindemann listed as: overactivity without a sense of loss, acquisition of symptoms belonging to the last illness of the deceased, presenting of a recognized medical disease, alteration in relationships to friends and relatives, furious hostility against specific persons, affectivity and conduct resembling schizophrenic features, lasting loss of patterns of social interaction, actions detrimental to his or her own social and economic existence, and agitated depression. While this work presented the psychiatric outcome of grief in some individuals, Lindemann's (1950) other work on ulcerative colitis demonstrated a link between grief and physical illness as well, indicating the validity of a psychosomatic approach to stress models of grief (W. Stroebe & Stroebe, 1987).

W. Stroebe and Stroebe (1987) stated that the physiological and psychosomatic approaches of the stress models neglected the questions of why certain experiences are perceived as stressful and how the perception of stress is made. The psychological approach to stress sought to address these questions. These theories viewed stress as the result of a relationship between the demands of the situation or experience and the coping resources of the individual when the resources are not believed to be sufficient.

Folkman (1984) stated R. S. Lazarus and his colleagues (e.g., Coyne & Lazarus, 1980; Folkman, Schaeffer, & Lazarus, 1979; Lazarus, 1966, 1981) had

theoretically proposed the existence of two processes, cognitive appraisal and coping, both of which mediated stress and the stress-related adaptational outcomes. Regarding the interaction of these two processes, W. Stroebe and Stroebe (1987) claimed "the extent of the stress experienced in a given situation neither depends solely on the demands of the situation nor on the resources of the person but on the relationship between demands and resources" (p. 88).

Cognitive appraisal is "an evaluation process which determines why and to what extent a particular situation is perceived as stressful by a given individual" (W. Stroebe & Stroebe, 1987, p. 8). There are three forms of cognitive appraisal identified by R. S. Lazarus: primary appraisal, secondary appraisal, and reappraisal. An individual in primary appraisal will determine if a situation is irrelevant, benign-positive, or stressful according to its significance to his or her well being. Upon deciding a situation is challenging or stressful, individuals in secondary appraisal evaluate what coping resources they have available to them. This evaluation enables the individual to decide which coping strategy will be the most effective in achieving a desired outcome, the coping options being to take control of either the situation or their emotional reactions to the situation or both.

W. Stroebe and Stroebe (1987) stated R. S. Lazarus and Folkman (1984) distinguished problem-focused coping from emotion-focused coping. Problem-focused coping is behavior intended to manage the situation by trying to change it, thereby attempting to take control of the problem. Emotion-focused coping is behavior intended to manage the emotional reaction by attempting to transform the situation. One such emotion-focused coping strategy is using cognitions in an attempt to reappraise the situation as less threatening. Coping resources belonging to the person,

such as physical and psychological resources, and those that are environmental, such as social support, are not fully utilized due to "constraints." Constraints, such as pride or fear, are factors that interfere by restricting or impeding the ways individuals utilize their resources.

R. S. Lazarus (1996) thought the coping process critical to understanding the emotions. He claimed the problem-focused and emotion-focused functions of coping were not distinctive types of action, but interdependent, having been distinguished from each other as a result and for the purposes of research. He believed, too, coping was not to be separated from the person who was doing the coping, and that coping could not be viewed apart from the emotion process. Due to the methods and tradition used in psychology of separating the stimulus and response, however, emotions and coping had been viewed as separate events or processes that were assumed to be connected through learning. Lazarus believed this separation had led to an underemphasis on coping as an integral feature of emotion, which could not be understood without paying close attention to the coping process.

Stages of Grief Resolution. Faschingbauer, DeVaul, and Zisook (1977) understood the process of grief to possess at least three partly overlapping phases: (1) an initial period with characteristics of shock, disbelief, and denial; (2) an intermediate period with concomitant somatic and emotional distress as well as social withdrawal; and (3) a final period of resolution (Shuchter & Zisook, 1993). It is during this second period that pathological grief may or may not originate. Rando (1995) identified a range of responses which can occur during this second period of the grief process and listed them as: (1) psychological responses of affects, cognitions, perceptions, and defenses and attempts at coping; (2) behavioral responses; (3) social responses; and (4)

physical responses of symptoms indicative of biological indices of depression, and symptoms indicative of anxiety and hyperarousal (see W. Stroebe & Stroebe, 1987 for another listing). These psychological, behavioral, social and physical responses have provided the experiential and theoretical foundation for grief research.

Risk Factors for Pathological Grief. Sanders (1993) identified risk factors of pathological grief, even while cautioning that sample selection biases, differences in research methodology, and use of varying instruments prevent a definitive prediction of which bereaved individual will develop a pathological grief reaction. Risk factors for bereavement either make the individual more vulnerable to the stress involved in grieving, or obstruct in some way the resolution of that grief (W. Stroebe & Stroebe, 1993). Sanders (1993) delineated the high-risk factors for poor outcome of bereavement into four general categories: biographical/demographic factors, type and mode of death, circumstances following the loss, and individual factors.

Biographical/demographic factors include age of the survivor. Most studies, which have been done within a spousal bereavement context, showed differing results as to whether younger or older widows show more health consequences either at the time of bereavement or at a later time. Another factor was gender, again with lack of agreement, even as to whether there exists any significance at all between widows and widowers. Parental bereavement showed mothers grieving more deeply than fathers, and reduced material resources indicated a harder time in adjustment (Sanders, 1993).

Mode of death factors that negatively impact bereavement include sudden unexpected death, the death of a child, and stigmatized deaths, such as suicide and AIDS. Circumstances following the loss that have been shown to cause problems in

grieving include lack of social support and experiencing concurrent crises (Sanders, 1993).

Individual factors that complicate the grieving experience include personality factors, a conflicted relationship with the deceased as regards ambivalence and dependency, and poor health before bereavement. While Sanders (1993) stated that personality factors do make an impact on how the individual reacts to stress, she claimed the impact of personality factors on bereavement has been little studied. Work that has been conducted includes that of Sanders (1980) who found four types of reaction to bereavement: a "disturbed" group, a "depressed" high-grief group, a "denial" group, and a "normal grief-contained" group. Vachon et al. (1982) examined positive personality characteristics that enable the grieving process to move toward resolution, and found the "low distress" group scored emotionally stable, mature, conscientious, conservative, and socially precise. Parkes (1985) identified the "grief-prone personality," and found insecurity, anxiety, or fear creates a higher risk for bereaved individuals (Parkes & Weiss, 1983).

Personal Control

Ormel and Sanderman (1989) stated "there is no thing like the construct of control" (p. 195, emphasis in original). There exist a multitude of theories and constructs that define the concept on which much research has been conducted. Ormel and Sanderman identified theories of locus of control, self-efficacy, stress and coping, mastery, hardiness, learned helplessness, and attribution as all having been proposed to explain control.

Atwater and Duffy (1999) claimed the concept of personal control has its roots in stoical self-control and philosophical self-determination. They stated Seligman's

theory of learned helplessness moved the concept of personal control toward a scientific basis when he stressed its psychological and social factors. Besides learned helplessness, other conceptualizations of personal control have been used. Those which have predominated in the stress, control and depression models, Ormel and Sanderman (1989) identified as locus of control, sense of coherence, sense of mastery or competence, fatalism, hardiness, and self-esteem. This diversity is an outgrowth of the issues which surround it, which, according to Ormel and Sanderman, include the following: (1) whether control is a coping mechanism, or rather a belief or an appraisal; (2) whether control beliefs are general or situation-specific; and (3) over what control is intended.

Atwater and Duffy (1999) cited a general theory of personal control formulated by Peterson and Stunkard (1989) which consists of five main points. First, the amount of personal control an individual believes he or she is able to exercise in life differs between individuals. Second, how an individual exercises his or her personal control depends on two factors, internal individual characteristics and external environmental characteristics. Third, what the individual believes as to whether he or she can (1) bring about a particular outcome, (2) choose among several outcomes, or (3) deal with the consequences of those decisions and/or have an understanding of them, is an important component. Fourth, having a strong belief in one's personal control is advantageous in many situations, for it helps in accomplishing the desired outcome in spite of obstacles. Fifth, what happened in the past regarding successes or failures might influence but does not necessarily cause what will happen in the current situation.

Two sources of perceived control, the aspect of personal control that has perhaps received the most attention (Atwater & Duffy, 1999), are internal locus of control and external locus of control. Individuals with a high internal locus of control (internals) perceive they have a high degree of control over the events that occur in their lives. Individuals with a low internal locus of control (externals) perceive they have little control over those events.

Rothbaum, Weisz, and Snyder (1982) mentioned a growing awareness that cultural influences play a part in determining how locus of control is valued, while Weisz, Rothbaum, and Blackburn (1984) indicated general agreement regarding the beneficial aspect of a high internal locus of control (Atwater and Duffy, 1999). However personal control is valued, Conway, Vickers, and French (1992) claimed optimal adjustment for the individual occurs when the amount of actual control approximates what is needed or desired in the situation (Atwater & Duffy, 1999).

Atwater and Duffy (1999) identified four characteristics of individuals with high internal locus of control: (1) they seek knowledge and information about matters which pertain to them, e.g., their health; (2) they take responsibility for outcomes in their life; (3) they are less likely to become socially pressured into behavior and more likely to participate in social action; and (4) they are strongly motivated toward achievement. Some benefits Atwater and Duffy claimed for individuals having high internal locus of control are being less anxious and better adjusted. They cited Reed, Taylor, and Kemeny (1993) who found high internals cope better with illness, even that which is life-threatening, such as AIDS.

Ormel and Sanderman (1989) stated some of the literature on control examined the individual's behavioral and cognitive response to stress. Most, however, addressed

what the individual believes about how the situation can be affected. These beliefs consider either how the situation can be changed, in what way the meaning of the situation can be changed, or how their own actions and emotional reactions can be modulated.

Ormel and Sanderman (1989) found two general approaches have been used in studying stress and ill health, a traditional, global or structural viewpoint, or a process-oriented, transactional conceptualization. They cited Brown & Harris (1978, 1986) who took the more traditional approach to personal control and stress and looked at vulnerability (long-term) and provoking (shorter-term) personal or environmental factors and how they interact in the origination of depression. Ormel and Sanderman identified the work of R. S. Lazarus and Folkman (1984) as a transactional approach in which a person's attribution about control is a factor. Main transactional variables of primary and secondary appraisal, as well as problem-focused and emotion-focused coping, demonstrate the interactional rather than stimulus-response nature of stress.

Personal Control and Grief

W. Stroebe, Stroebe, Gergen, et al. (1980, 1982) applied the interactional stress theory of R. S. Lazarus to the psychological stress model of bereavement in their Deficit Model of Partner Loss. This model provided a means to analyze the situational demands found predominantly in widowhood. These demands were understood as losses of instrumental, validational, and emotional support, as well as intrapersonal and interpersonal coping resources needed to deal with those demands. The Deficit Model also provided a method to note individual differences in psychological and physical reactions to loss (W. Stroebe & Stroebe, 1987).

Personal control was used as a measure by W. Stroebe and Stroebe (1987, 1993) in studying grief resulting from spousal bereavement. They stated, "[I]intuitively, personality variables would seem to be among the most important determinants of adjustment to loss....[because] according to the theory of learned helplessness... control beliefs should play an important role as stress moderators" (p. 217). W. Stroebe and Stroebe (1987, 1993) reported conflicting results from prior research. Ganellen and Blaney (1984) and Johnson and Sarason (1978) in their non-experimental studies found those with low personal control beliefs were more likely to develop depression, while the experiment of Pittman and Pittman (1979) demonstrated individuals with high personal control beliefs reacted with more depression in an uncontrollable situation.

W. Stroebe and Stroebe's (1987, 1993) longitudinal study of Tübingen widows revealed no evidence that control beliefs had a significant influence on the depression of bereaved and nonbereaved individuals, except when the loss was highly unexpected. Personal control then acted as a buffer. Greater depression was demonstrated by those bereaved individuals with low internal control beliefs when the loss was highly unexpected than by those with high internal control beliefs.

The Tübingen study followed sixty widowed and sixty married counterparts for two years. The mean age was 57.5 years. The bereaved sample had lost their spouses four to seven months prior to the beginning of the study. Subjects were interviewed three times over the course of two years. Depression was measured with the Beck Depression Inventory, and locus of control, one of two personality variables examined, was measured with the German version of Levenson's Interpersonal Control Scale.

General results did not support the hypothesis that the personality variable of personal control influences bereavement according to the theory of learned helplessness. When the mode of death variable of unexpected loss was factored into the Tübingen study, however, results showed individuals with low personal control beliefs responded significantly with greater depression than those with high internal control beliefs.

W. Stroebe and Stroebe (1993) stated sudden death, i.e., those with less than one day warning, "seemed to increase the immediate vulnerability to the loss experience, but the effect weakened over time as the bereaved who had suffered a sudden loss had had a chance to adjust" (p. 220). When personal control was factored in, the authors understood the significant results to suggest those with high internal control beliefs responded by taking responsibility to "come to terms with the unexpected change in their lives... and make more of an effort to recover from depression" (p. 221). To those with low personal control beliefs, however, it seemed as though "the sudden death confirmed their belief that they have no control over their outcomes" (p. 221) and they were more likely to "respond with resignation, make only feeble efforts to recover, and remain depressed" (p. 221)

Purpose of Study

The grief and personal control literature reveals contradictory findings as to whether personal control is a risk factor for pathological grief. This study presented another attempt to determine whether low belief in personal control is a risk factor. If belief in personal control is found to be a personality variable significantly related to grief, then focusing on its development in the course of therapeutic treatment for the

resolution of the grieving process or in preventative educational settings would be sound practice and policy.

This study attempted to replicate in a modified way that of W. Stroebe and Stroebe's Tübingen study (1987). Bereavement by death of a loved one was used as the scope in this study, rather than that of spousal bereavement only. Personal control was defined as locus of control as was in the Tübingen study, although this study used a different instrument of measure, the General External Control subscale of the BPCS. The focus in this study was narrowed in its identification of risk factors, concentrating on belief in personal control.

The hypothesis of this study proposed that there is a significant relationship between intensity of grief and belief in personal control. Intensity of grief, the impact on emotions, activities, and relationships, was measured by the TRIG, and belief in personal control by the General External Control subscale of the BPCS.

Chapter III

Research Methodology

Subjects

The target population for this study was adults who have experienced the death of a loved one. Thirty-four individuals who had experienced such a loss participated in this study by completing the TRIG and the BPCS.

Demographic information from the TRIG (see Table 1) revealed the age of the subjects ranged from 25 to 79 years of age, with the mean age of 55.31 (SD = 14.40). The mean level of education was 14.06 years of formal schooling completed. The proportion of subjects who were White was 94.1%, and Protestants comprised 58.8% of the subjects. There were nine males and 25 females. The age of the deceased ranged from 0 to 84 years of age with a mean age of 53.55 years (SD = 20.00).

Table 1

Bereaved Characteristics (N = 34)

	N	%	Range	M	SD
Age*	32		25 - 79	55.31	14.40
Years of formal schooling*	31		8 - 17	14.06	2.29
Race*					
White	32	94.1			
Oriental	1	2.9			
Religion					
Protestant	20	58.8			
Catholic	12	35.5			
Jewish	1	2.9			
Other	1	2.9			
Sex					
Male	9	26.5			
Female	25	73.5			

Note * N < 34 Not all data provided.

Relational characteristics (see Table 2) revealed that 68.8% (N = 21) of the bereaved experienced their loved one's death as unexpected. Twenty-two of the bereaved (64.7%) claimed this relationship was closer than any other before or since. No one claimed the relationship as not very close at all. Fifty percent of the bereaved were surviving the death of their husbands, and twenty-six percent the death of their wives, making three-fourths of the sample grieving the loss of a spouse. Forty-four per cent (N = 15) of the sample had lost a loved one in the last year.

Table 2

Relational Characteristics (N = 34)

	N	%
Mode of death*		
Expected	5	14.7
Unexpected	21	61.8
Slow	2	5.9
Sudden	3	8.8
Closeness of relationship		
Closer than any relationship I've ever had	22	64.7
Closer than most relationships I've ever had with other people	6	17.6
About as close as most of my relationships with others	5	14.7
Not as close as most of my relationships	1	2.9
Not very close at all	0	0
Relationship to bereaved		
Father	1	2.9
Mother	1	2.9
Brother	3	8.8
Sister	2	5.9
Husband	17	50.0
Wife	7	20.6
Son	0	0
Daughter	1	2.9
Friend	1	2.9
Other	1	2.9
Time since death		
Within the past 3 months	4	11.8
3-6 months ago	3	8.8
6-9 months ago	3	8.8
9-12 months ago	5	14.7
1-2 years ago	5	14.7
2-5 years ago	9	26.5
5-10 years ago	1	2.9
1-20 years ago	2	5.9
More than 20 years ago	2	5.9

Note * N < 34 Not all data provided.

Instruments

Texas Revised Inventory of Grief. The TRIG is a three section instrument used to measure the impact of grief following bereavement on emotions, activities, and relationships. It includes demographic information of age, sex, race, level of formal schooling completed, religion, relationship of the deceased, closeness of the relationship, age of the deceased at time of death, amount of time since the person died, and mode of death, i.e., expected or unexpected, slow or sudden. Each inventory was completed for one deceased individual only. An 8-item Past Behavior subscale measures feelings and actions at the time of bereavement or loss. A 13-item Present Feelings subscale measures current feelings about the person's death. Both subscales use the Likert scale of scoring: Completely true = 5, Mostly true = 4, True and False = 3, Mostly false = 2, and Completely false = 1. High scores reflect a high level or intensity of grief. An additional section, Related Facts, identifies attendance at funeral, perception of depth of grieving, perception of current level of functioning, level of feeling at anniversary of death, and perception of identification with deceased's illness. These five items are rated True or False. Additionally, an open-ended question for any thought or feeling to be made known to the researcher is included.

Alpha coefficient reliability for Part I was reported to be 0.77 and split-half reliability 0.74. Part II has a coefficient alpha of 0.86 and split-half reliability of 0.88. No information on the validity of the TRIG is available.

Belief in Personal Control Scale. The BPCS is a 45-item questionnaire used to measure dimensions of personal control. All questions use a Likert scale: Never true = 5, Rarely = 4, Sometimes true = 3, Often true = 2, and Always true = 1. Subscales measure three dimensions of personal control. The 19-item General

External Control subscale (F1) rates the level and direction of direct control by which outcomes are believed effected. High scores reflect internality and demonstrate a belief in direct personal control over one's outcomes. Low scores reflect externality and ascribe control over outcomes to others. The 17-item Exaggerated Internal Control subscale (F2) assesses the extent to which the individual possesses an unrealistic belief in his or her power to control outcomes. These items, reverse-scored, measure in the direction of internality, with high scores reflecting a more exaggerated belief in one's personal control. Low scores reflect a more realistic belief in one's personal control. The 9-item God-Mediated Control subscale (F3), designed to account for mediated control of outcomes, rates the level and direction of direct internal control by which outcomes are believed effected. High scores demonstrate internality, and low scores reflect a belief that outcomes are controlled through God.

Reliability analysis shows alphas of 0.85 (F1), 0.88 (F2), and 0.97 (F3), demonstrating very good to excellent internal consistency. Four-week test-retest correlations show very good stability with alpha coefficients of 0.81 (F1), 0.85 (F2), and 0.93 (F3).

Procedures

Selection of the sample began by contacting grief support groups affiliated with two local funeral homes (one identified over the Internet and the other by community residents), and two local hospitals (both identified over the Internet). One funeral home and both hospitals agreed to participate in this study. In addition, the researcher's academic advisor invited graduate counseling students who were known to have experienced the loss of a loved one to participate.

A letter stating the researcher's intentions and the academic and ethical parameters of this study was mailed (Appendix A) to the grief support group facilitators. Later, a proposed script to read at the grief support group meetings was provided (Appendix B). A cover letter from the researcher (Appendix C) along with copies of the TRIG and the BPCS (Appendix D and E) and an envelope addressed to the researcher for the return of the instruments were additionally provided. These materials were distributed at the grief support group meetings by the facilitators. The grief support group members were invited to participate in the study and were encouraged to return the materials even if they chose not to fully complete the instruments after they returned home. Those were who willing to participate then took the materials home and brought back the instruments in the envelope provided to the next grief support group meeting. The facilitator collected them and returned them to the researcher.

The funeral home distributed 19 sets of the two instruments. Seven individuals returned fully completed sets of instruments, five returned incompletely finished or completely blank instruments, and seven did not return their instruments at all. One hospital chaplain returned five completed sets out of an unknown number distributed. The second hospital chaplain distributed 53 sets, 19 sets of which were returned fully completed, seven were returned incomplete, and 27 sets were not returned at all. From the university, three sets were distributed and all were returned fully completed. In order to inform the participants about the group results, plans were made to distribute such results to the grief support group facilitators, who would then make the results available to the participants of this study in a suitable manner.

A correlational design was used in order to determine if any relationship existed between intensity of grief experienced and belief in personal control.

Chapter IV

Results

The TRIG identifies several behaviors associated with bereavement and allows the participants to report their responses. The data analysis showed mixed results (see Table 3). Most of the bereaved had performed a commonly understood dimension of grief work in that 94.1% (N = 32) attended the funeral. Such action encourages a reality-based component to bereavement which assists in the transition after death. The data reported that 82.4% (N = 28) felt they had really grieved, and 88.2% (N = 30) claimed they did not feel as though they had the same illness as the deceased, both signs of positively maneuvering the bereavement process. However, only 50% (N = 17) claimed to be functioning as well as before the death, and 44.1% (N = 15) claimed to get upset each year at about the same time as the death. These results could be a function of the length of time since the death, representing an aspect of grief work not yet fully resolved, or they could represent the fact that 15 (44.1%) of the bereaved had begun bereavement less than a year ago, and hence had not experienced a year(ly) anniversary of the death at the time of this study. Review of the data showed that eight of the nine who did not respond to this question experienced the loss of their loved one less than one year ago and therefore a year anniversary of the death had not yet occurred for them.

Table 3

Bereavement Behaviors

	N	%
Attended funeral (N = 33)		
True	32	94.1
False	1	2.9
Really grieved (N = 33)		
True	28	82.4
False	5	14.7
Functioning as well as before (N = 33)		
True	17	50.0
False	16	47.1
Upset at anniversary (N = 25)		
True	15	44.1
False	10	29.4
Same illness (N = 32)		
True	2	5.9
False	30	88.2

Table 4 shows the descriptive statistics for both the TRIG and the BPCS. The score distribution for the God-Mediated Control subscale seems to reflect a low mean score (M = 18.49) suggesting that the sample tended to endorse a belief that outcomes are God-mediated.

Table 4

Descriptive Statistics for TRIG and BPCS (N = 34)

Scale (Possible Range)	Range of Scores	M	SD
TRIG			
Past Behavior (8 - 40)	9 - 38	22.63	7.79
Present Feelings (13 - 65)	17 - 59	39.97	11.69
BPCS			
General External Control (19 - 95)	52 - 87	68.88	9.48
Exaggerated Internal Control (17 - 85)	29 - 59	43.84	6.98
God-Mediated Control (9 - 45)	10 - 39	18.49	7.85

Further statistical analysis involved computing correlations using the Past Behavior (PB) and Present Feelings (PF) subscales from the TRIG, as well the total score of Grief Intensity (GI) derived from combining those two subscales, and the three subscales of the BPCS (F1 - General External Control, F2 - Exaggerated Internal Control, and F3 - God-Mediated Control). Although all three subscales measure belief in personal control, and all are scored in the direction of personal control, they each measure such distinct aspects of personal control that they were analyzed separately (see Table 5). Data analysis revealed significance only in the relationship between Present Feelings of grief intensity and General External Control ($r = -.407$, $p < 0.05$) for the overall sample ($N = 34$). Therefore, the null hypothesis that there is no relationship between grief intensity and belief in personal control was partially retained. Only the aspect of grief intensity identified as Present Feelings was found to be negatively related to General External Control.

Table 5

Overall Correlations Between TRIG and BPCS (N = 34)

	PF	PB	GI	F1	F2	F3
Present Feelings (PF)						
r	-					
significance						
Past Behavior (PB)						
r	.278	-				
significance	.111					
Grief Intensity (GI)						
r	.880**	.701**	-			
significance	.000	.000				
General External Control (F1)						
r	-.407*	-.072	-.338	-		
significance	.017	.686	.051			
Exaggerated Internal Control (F2)						
r	.007	.012	.011	-.106	-	
significance	.967	.948	.950	.550		
God-Mediated Control (F3)						
r	.115	-.222	-.024	.084	.125	-
significance	.516	.208	.893	.637	.481	

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

Further analysis studied the element of time as it related to grief intensity. The bereaved were placed into one of two categories based upon the length of their bereavement: all those whose death of a loved one occurred less than one year ago (Time1, N = 15, 44%), and those one year or more ago (Time2, N = 19, 55.9%). For those grieving less than one year, no significant relationship was found at all, although a moderate correlation (r = -.421) was found between Present Feelings of grief intensity and General External Control. The lack of significance could perhaps be explained by the small sample size (see Table 6). For those grieving one year or more, a significant

relationship was found between Present Feelings of grief intensity and General External Control ($r = -.550$; $p < 0.05$) (see Table 7).

Table 6

Correlations Between TRIG and BPCS for Time1 Sample Bereaved Less Than 1 Year (N = 15)

	PF	PB	GI	F1	F2	F3
Present Feelings						
r	-					
significance						
Past Behavior						
r	.035	-				
significance	.900					
Grief Intensity						
r	.913**	.439	-			
significance	.000	.101				
General External Control						
r	-.421	.146	-.319	-		
significance	.118	.603	.246			
Exaggerated Internal Control						
r	-.124	.068	-.084	-.252	-	
significance	.660	.811	.767	.364		
God-Mediated Control						
r	.132	.031	.132	-.032	.049	-
significance	.638	.911	.640	.909	.862	

**. Correlation is significant at the 0.01 level (2-tailed).

Table 7

Correlations Between TRIG and BPCS for Time2 Sample
Bereaved 1 Year or More (N = 19)

	PF	PB	GI	F1	F2	F3
Present Feelings						
r	-					
significance						
Past Behavior						
r	.493*	-				
significance	.032					
Grief Intensity						
r	.891**	.835**	-			
significance	.000	.000				
General External Control						
r	-.550*	-.117	-.410	-		
significance	.015	.633	.081			
Exaggerated Internal Control						
r	.153	-.008	-.093	.027	-	
significance	.532	.976	.705	.911		
God-Mediated Control						
r	-.070	-.368	-.237	.016	.231	-
significance	.775	.121	.329	.947	.341	

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

The characteristics of death categories were combined to form two groups. The Expected and Slow characteristics of death were combined to form Type1 ($N = 7$, 20.6%) and the Unexpected and Sudden characteristics to form Type2 ($N = 24$, 70.6%). Data analysis for those who experienced either an expected or slow death of a loved one (Type1) showed a significant relationship between Past Behavior of grief intensity and Exaggerated Internal Control ($r = .854$, $p < 0.05$), although the sample size was very small (see Table 8). For those grieving either an unexpected or sudden

death (Type2), a significant relationship was found between Present Feelings of grief intensity and General External Control ($r = -.477$, $p < 0.05$) (see Table 9).

Table 8

Correlations Between TRIG and BPCS for Type1 Sample
Mode of Death - Expected & Slow (N = 7)

	PF	PB	GI	F1	F2	F3
Present Feelings						
r	-					
significance						
Past Behavior						
r	.533	-				
significance	.218					
Grief Intensity						
r	.952**	.767*	-			
significance	.001	.044				
General External Control						
r	-.374	-.518	-.472	-		
significance	.409	.234	.285			
Exaggerated Internal Control						
r	.477	.854*	-.671	-.560	-	
significance	.279	.014	.099	.191		
God-Mediated Control						
r	.484	.159	.424	-.568	.118	-
significance	.272	.733	.343	.183	.801	

*. Correlation is significant at the 0.01 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

Table 9

Correlations Between TRIG and BPCS for Type2 Sample
Mode of Death - Unexpected & Sudden (N = 24)

	PF	PB	GI	F1	F2	F3
Present Feelings						
r	-					
significance						
Past Behavior						
r	.254	-				
significance	.232					
Grief Intensity						
r	.865*	.705**	-			
significance	.000	.000				
General External Control						
r	-.447*	-.006	-.331	-		
significance	.029	.977	.115			
Exaggerated Internal Control						
r	-.128	-.227	-.212	.003	-	
significance	.550	.287	.320	.988		
God-Mediated Control						
r	-.024	-.388	-.219	.315	.129	-
significance	.912	.061	.304	.134	.547	

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

Chapter V

Discussion

The results of this study partially supported the hypothesis that there is a relationship between intensity of grief experienced when a loved one dies and belief in personal control. However, grief intensity as a general measure of both past behavior and present feelings was not moderated by a belief in personal control. Although contrary to the proposed hypothesis, this result confirmed that obtained by W. Stroebe and Stroebe (1987, 1993) in their Tübingen study. The small sample size of this study, in addition to the broadly defined range of the variables "time since death" (less than 3 months to more than 20 years) and "relationship to bereaved" (spouse and multiple non-spouse categories), may have contributed to the lack of support of the hypothesis.

When the measures of past behavior and present feelings were individually accounted for, however, present feelings as a measure of grief intensity was impacted by belief in personal control. Those with higher belief in personal control had lower intensity of grief in the present. This was demonstrated by the larger percentage of subjects who self-identified as having really grieved, and who claimed they did not have the same illness as the diseased. There had been no effect of higher belief in personal control on intensity of grief in the past, however. This result could perhaps be explained by the fact that the variable "time since death" in this study was broadly defined.

When time since death was accounted for in the analysis of this study, belief in personal control again acted as a buffer for intensity of grief, especially in the long run. Those with higher belief in personal control who were bereaved for one year or more had lower intensity of grief in the present. This suggests that belief in personal control

has less effect on the process of bereavement immediately following the loss but more in the long run. Perhaps the year-long series of "first anniversaries" without the deceased, once experienced, enabled them to employ their sense of their personal control in adjusting to bereavement, as had been suggested by W. Stroebe and Stroebe (1993).

When mode of death was considered, there was a relationship between grief intensity and belief in personal control. Those with higher exaggerated belief in personal control demonstrated higher grief intensity in past behavior when death was expected or slow. When bereavement could be planned for, those with a more unrealistic belief in their personal control did not seem to handle bereavement at the time of death better than those with a more realistic belief. This is confusing, as those with a more exaggerated belief in personal control are characteristically overly optimistic and striving, which would seem to benefit them particularly when there was time to prepare for the death. Those with a more realistic or less exaggerated belief in personal control seemed to have benefited more by the time to prepare for the death than those with a less realistic or more exaggerated belief. The lack of a similar significant relationship of grief intensity of present feelings and belief in personal control could be explained by the passage of time since the death. Although not significantly, those very characteristics of exaggerated internal control, i.e., excessive optimism and striving, perhaps began to sustain them or were employed in a way which helped them past the initial time of adjustment.

Those with higher belief in personal control demonstrated lower grief intensity in present feelings when death was unexpected or sudden. This finding only partially concurred with that of W. Stroebe and Stroebe (1987, 1993), for grief intensity of past

behavior and belief in personal control were not likewise significantly related. The Tübingen study showed that suddenness or unexpectedness of death to have significantly impacted those with lower internal control across the entire two years the bereaved were followed. The passage of time for the subjects in that study and more than 41% in this one differs and would perhaps partially explain the differences between them. The explanation of W. Stroebe and Stroebe for the impact of unexpectedness on grief intensity and belief in personal control holds for this study as well: Those with a higher belief in personal control would perhaps attempt to rectify the situation by taking charge of their adjustment. Those with a lower belief in personal control would perhaps see bereavement, especially that unexpected or sudden, as another instance of a life-event beyond their control and would be prone to respond with resignation.

These results identify a lack of belief in personal control as a risk factor for poor outcome in some instances. Although most bereaved demonstrate a large degree of recovery mentally and physically by the end of two years (Hansson et al., 1993), there are some who are at risk for pathological grief to develop.

Limitations

Limitations of this study included the very nature of the subject of grief. Because the bereaved were already feeling the pain of their loss, great need for sensitivity existed in order not to increase their pain. Based on this sensitivity, other limitations occurred. Only a small number of subjects could be approached and the use of volunteer subjects was required. The setting for obtaining the subjects had been predominantly grief support groups, either from a hospital or a funeral home, which may have incurred selection bias. Although there were a few participants in this study

from the university setting, there was no involvement by members of hospice, churches or synagogues, or the community at-large. All subjects came from a large mid-west urban area, and demographic variables were not randomized. The universal nature of grief presents an enormous challenge in procuring a representative sample. Cultural and societal confounding variables are additionally difficult to fully account for. The retrospective and subjective nature of the data collected for this study was another concern, as was the lack of a non-bereaved control group.

Recommendations

Recommendations for further study include that relationship to the bereaved be more stringently controlled. Most studies studied spousally bereaved only, and very few had a control group of non-spousally bereaved. Having a study where different relationship categories are studied both individually and together would provide valuable data regarding differences in intensity of grief and belief in personal control. Also, time since death could be more narrowly controlled for in order to explore more fully the two-year marker noted by Hansson et al. (1993). A prospective and longitudinal study would allow the variable of belief in personal control to be accounted for without retrospective bias, and using objective measurement would eliminate the subjective bias inherent in self-report.

Further work to identify risk factors for pathological grief is important for therapeutic intervention and educational prevention strategies. Personal control can be developed (Atwater and Duffy, 1999). If it is indeed a significant personality variable as related to grief, then it is imperative that knowledge be incorporated into the therapeutic and educational settings.

Appendices

Appendix A

Introductory Letter to Grief Support Group Facilitators

Date

Name and Address of Grief Support Group Facilitator
Funeral Director or Hospital Chaplain

Dear N.,

Thank you so much for your interest in supporting me in my research study.

As stated, this study is to fulfill academic requirements for a graduate degree in Professional Counseling at Lindenwood University. This research focuses on the intensity of grief one experiences when a loved one dies and the individual's personal characteristics, specifically a belief in one's personal control. The two instruments I am using to determine if any relationship exists between intensity of grief and personal control, and if so how strongly, are the Texas Revised Inventory of Grief and the Belief in Personal Control Scale.

I am enclosing X copies of each instrument for your use, a proposed cover letter from me to the participants, and a proposed script you might use in discussing this study when approaching participants in the N. Grief Support Group, or anyone else you know is appropriate for this study. If you have any concerns about the instruments, script or letter, please call me. Although I cannot make changes to the instruments, I am quite willing to discuss changes to the letter or script as you deem in the best interest of the individuals. I realize some details will have to be worked out. Each set of questionnaires and cover letter is placed within the flap of an envelope on which I've placed my name, to assist you in distributing the materials and the grief support group participants in returning the completed questionnaires. The questionnaires are identified by letter and number (i.e., A1, A2, etc.), only in order for me to organize the data for computer input.

I am ethically bound to discuss the following with you regarding this research: that the instruments do not get distributed without you having a plan for their return. It is quite preferable that the instruments are completed at the time they are distributed, and that the specific research topic, of which you are aware, not be discussed prior to the individuals completing the instruments, in order to avoid any influence on their responses. If you have any questions about these concerns, please call me (phone number provided).

When the data is analyzed, I will send you the results in group format for you to make available to the participants as is their right to know. Confidentiality and anonymity of the individuals and their responses are assured. Identification numbers

on the instruments are for my use alone, in order to keep the two instruments together in case of a mishap in handling. Although one instrument has a place for the individual's name, it is not encouraged.

N. is my local contact person in case you need information and cannot reach me. She can be reached at (phone number provided). I will notify her of the need for her to arrange a time of picking up the completed questionnaires from you. She will then mail the envelopes to me.

You will, as I stated, receive a copy of the thesis and as many copies of a summary report of the analyzed data as you deem necessary. I trust you will be able to disseminate the information to the participants as you are able. I suspect at least some of the individuals who participated in this study may not be involved still in your grief support groups by the time I have the data analyzed. For them, then, I am doubly grateful for their participation.

Thank you again for your willingness to be of whatever assistance you can be.

Sincerely,

Appendix B

Proposed Script

Proposed script for use prior to distribution of questionnaires

Diana Alferink is a graduate student at Lindenwood University, working toward a master of arts degree in professional counseling. She has an interest in working with people who have experienced the death of a loved one. Part of her studies requires her to perform research, and she has chosen to study the grieving process in order to learn how better to help those who are experiencing grief due to the death of a loved one.

Ms. Alferink contacted me to see if I would approve of her requesting you to participate in her study. I have reviewed the questionnaires she is using, and find them appropriate. There is no requirement for you to complete the questionnaires, but your participation will assist her in her endeavor. Your anonymity and confidentiality are ensured. Group data will be made available when the data have been compiled and analyzed, in order for you to have feedback from your participation.

Completing the questionnaires will take only a few minutes. Please take a copy, read her cover letter, complete the questionnaires, and return them to me (before you leave). Thank you.

Appendix C

Introductory Letter to Grief Support Group Members

Date

Dear Member of N. Grief Support Group,

My sympathy to you in the death of your loved one. I wish you to know I am aware this is a time of sorrow and adjustment for you, and it is with sensitivity to your grief that I request the assistance you are able to give me. I assure you, however, that the assistance I am requesting will be worth your time.

As a candidate for Professional Counseling at Lindenwood University, I am seeking to study factors which will enable those in the helping professions to be better able to provide for the needs of those grieving the death of a loved one. This study will further the gains already made in understanding the personal factors which are part of the grieving process. I am enclosing two questionnaires for you to complete which will help me in this regard. Together they will take only a few minutes of your time.

Anonymity and confidentiality are assured. You do not have to provide your name. No identification of the information you provide will be possible. While results will be made available to all participants through the grief support group with which you are affiliated, these results will be displayed in a group format. Individual information will not be disclosed.

N. (your grief support group facilitator) has reviewed the questionnaires, and has agreed to providing me the opportunity to enlist your participation. The information you can give to this endeavor will be of help to all those who are experiencing the grieving process. Enclosed are the two questionnaires and an envelope with my name on it. Please complete the questionnaires, place them in the envelope, seal it (for your additional anonymity), and return the envelope on X. He/she will collect them and return them to me. Thank you very much for your assistance.

Sincerely,

Diana M. Alferink
Candidate for Professional Counseling
Lindenwood University

Appendix D

Texas Revised Inventory of Grief

Appendix E

Belief in Personal Control Scale

This questionnaire consists of items describing possible perceptions you may have of yourself, others, and life in general. Please respond to each of the statements below by indicating the extent to which that statement describes your beliefs. For each statement circle the number that best describes your feelings.

1 = Always true
2 = Often true
3 = Sometimes true
4 = Rarely
5 = Never true

1. I can make things happen easily.
   1 2 3 4 5

2. Getting what you want is a matter of knowing the right people.
   1 2 3 4 5

3. My behavior is dictated by the demands of society.
   1 2 3 4 5

4. If I just keep trying, I can overcome any obstacle.
   1 2 3 4 5

5. I can succeed with God's help.
   1 2 3 4 5

6. I find that luck plays a bigger role in my life than my ability.
   1 2 3 4 5

7. If nothing is happening, I go out and make it happen.
   1 2 3 4 5

8. I am solely responsible for the outcomes in my life.
   1 2 3 4 5

9. I rely on God to help me control my life.
   1 2 3 4 5

10. Regardless of the obstacles, I refuse to quit trying.
    1 2 3 4 5

11. My success is a matter of luck.
    1 2 3 4 5

12. Getting what you want is a matter of being in the right place at the right time.
1 2 3 4 5

13. I am able to control effectively the behavior of others.
1 2 3 4 5

14. If I need help, I know that God is there for me.
1 2 3 4 5

15. I feel that other people have more control over my life than I do.
1 2 3 4 5

16. There is little that I can do to change my destiny.
1 2 3 4 5

17. I feel that I control my life as much as is humanly possible.
1 2 3 4 5

18. God rewards me if I obey his laws.
1 2 3 4 5

19. I am not the master of my own fate.
1 2 3 4 5

20. I continue to strive for a goal long after others would have given up.
1 2 3 4 5

21. Most things in my life I just can't control.
1 2 3 4 5

22. God helps me to control my life.
1 2 3 4 5

23. I have more control over my life than other people have over theirs.
1 2 3 4 5

24. I actively strive to make things happen for myself.
1 2 3 4 5

25. Other people hinder my ability to direct my life.
1 2 3 4 5

26. What happens to me is a matter of good or bad fortune.
1 2 3 4 5

27. When something stands in my way, I go around it.
1 2 3 4 5

28. I can be whatever I want to be.
1 2 3 4 5

29. I know how to get what I want from others.
1 2 3 4 5

30. Fate can be blamed for my failures.
1 2 3 4 5

31. With God's help, I can be whatever I want to be.
1 2 3 4 5

32. I am the victim of circumstances beyond my control.
1 2 3 4 5

33. I can control my own thoughts.
1 2 3 4 5

34. There is nothing that happens to me that I don't control.
1 2 3 4 5

35. Whenever I run up against some obstacle, I strive even harder to overcome it and reach my goal.
1 2 3 4 5

36. By placing my life in God's hands, I can accomplish anything.
1 2 3 4 5

37. I am at the mercy of my physical impulses.
1 2 3 4 5

38. In this life, what happens to me is determined by my fate.
1 2 3 4 5

39. My actions are the result of God working through me.
1 2 3 4 5

40. I am the victim of social forces.
1 2 3 4 5

41. Controlling my life involves mind over matter.
1 2 3 4 5

42. When I want something, I assert myself in order to get it.
1 2 3 4 5

43. The unconscious mind, over which I have no control, directs my life.
1 2 3 4 5

44. If I really want something, I pray to God to bring it to me.
1 2 3 4 5

45. I am not really in control of the outcomes in my life.
1 2 3 4 5

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