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A Comparison of Depression in Males and Females After the Loss of a Spouse

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A COMPARISON OF DEPRESSION IN MALES AND FEMALES AFTER THE LOSS OF A SPOUSE

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ABSTRACT

The purpose of this research was to explore differences in depression between males and females after the loss of a spouse. After a review of the literature, a twenty-one item inventory, the Beck Depression Inventory was given to thirty nine surviving spouse's (17 males and 22 females). A T-test of difference between means of the three factors of the Beck Depression Inventory, (negative self-attitudes, physiological symptoms, and sadness) was performed and the hypothesis that there were differences in depression between males and females after the loss of a spouse was not supported.

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Table of Contents

Tables

CHAPTER I

Introduction

The loss of a spouse through death is clearly one of the most devastating and potentially disruptive events an individual ever encounters (Zisook & Shuchter, 1986). Spousal bereavement can be devastating and difficult whether it was sudden or an unexpected death due to a long illness. Depression is common to an individual after the loss of a spouse (Zisook & Shuchter, 1986).

The literature is filled with articles which document the challenges and problems of depression after the loss of a spouse (Sable, 1991; Thompson, Thompson, Futterman, Gilewski, & Peterson, 1991; Feinson, 1986; Siegel & Kuykendall, 1990; Leahy, 1993; and Umberson, Wortman, & Kessler, 1992). Some of the challenges and problems of depression include: crying; sleep disturbance; weight loss or gain; irritability; difficulty concentrating; loss of interest in TV, news, friends, and job or church; depressed mood; self-condemnation; suicidal thoughts; somatic symptoms; and feeling tired (Feinson, 1986; Siegel & Kuykendall, 1990; and Thompson, Thompson, Futterman et. al.). Loneliness has been described as a major expression of widowhood, having the most impact on prolonged depression and grief resolution (Leahy, 1992-1993). Changes in an individual's opportunities for social integration can increase the loneliness

(Feinson, 1986; Leahy, 1992-93; & Umberson, Wortman, & Kessler, 1992). Widows and widowers must shift their identity to that of a single person. According to Feinson, (1986) widowers were least likely to be church members, to attend church services, or belong to or participate in formal organizations or groups. The primary benefits of marriage for men may include increased social connectedness and having someone to perform household tasks (Umberson, Wortman, & Kessler, 1992).

Females think over depressive thoughts and overreport depression, whereas males deny such thoughts and underreport depression (Thompson et. al., 1991). Both men and women may weep for the lost spouse, yearn for their presence, or remember the spouse fondly. Following loss men or women will describe depressive symptoms differently (Thompson et. al., 1991).

The present study explores possible differences in depression between males and females who have lost a spouse. The Beck Depression Inventory (BDI) was used to delineate depression symptoms of these two groups.

The purpose of this research was to compare the depression experienced by males with the depression experienced by females after the loss of a spouse. The null hypothesis is that there is no difference in levels of depression between males and females after the loss of a spouse.

The secondary purpose of this research was to compare differences in mean scores on the three different factors of the BDI. The following are three null hypothesis from this secondary purpose:

(1) The first null hypothesis is that there is no difference in negative self-attitudes between males and females after the loss of a spouse.

(2) The second null hypothesis is that there is no difference in physiological symptoms between males and females after the loss of a spouse.

(3) The third null hypothesis is that there is no difference in sadness between males and females after the loss of a spouse.

A t-test to show the difference between the means was used to show if any difference in depression between males and females existed.

Chapter II

Review of Related Literature

Stages of Grief

Spousal bereavement is not always a neat package with clearly defined boundaries, limits, or resolutions. The loss of a spouse is widely recognized as an extremely painful and distressing experience, associated with risk of psychological and physical distress (Sable, 1991). According to Zisook and Shuchter (1986), "There is no prescription for how to grieve properly for a lost spouse, and no research - validated guideposts for what is normal vs. deviant mourning" (p. 288). Grief is an individualized phenomena with differences among cultures as well as individuals.

Kubler-Ross (1969) was the leader in the work in the area of death, grief and loss, with her elaboration of the stages of the death and dying process. After a person loses someone he or she loves the individual goes through three stages of grief. Santrock (1992) described three stages of the grief process. Stage one includes feelings of shock, disbelief, numbness, and often weeps or becomes easily agitated. At stage two there is painful longing for the dead, memories and visual images of the deceased, sadness, insomnia, irritability, and restlessness. At stage three there is a resumption of ordinary activities, a greater

probability of recalling pleasant memories about the deceased. This is also the establishment of new relationships with others.

The stages of grief are also relevant to the conceptual model of Bowlby. Bowlby (in Demi, 1989) identified three stages in the grief process: the urge to recover, disorganization, and reorganization. The urge to recover stage is marked by shock or initial numbness, protest or a reliving or pining for the past. Disorganization includes a feeling of aloneness, indecision, and uncertainty. Reorganization includes an integration in discovering new relationships and new outlets (Demi, 1989 & Morycz, 1992). Paski then (1972) built upon Bowlby's theory and identified normal time frames for each stage: (1) numbness lasting from the death to one week; (2) yearning / protest lasting from one week to two months; (3) disorganization lasting from two months to nine months; and (4) reorganization lasting from nine months on.

Many of the stages of grief revolve around some experience of the sense of denial of the loss, disorganization as a reaction to the loss, and eventual accommodation (Morycz, 1992). Katz and Florian (1987) propose a three-dimensional model of psychological reaction to loss. This includes a process or stage dimension, subjective reactions, and psychosocial factors. The process or stage dimension of loss includes shock, mourning, and adjustment (Parkes & Brown, 1972; Rando, 1984; Demi, 1989;

Shuchter, 1986; and Levy, Martinkowski, & Derby, 1994). The shock of the process or stage dimension may be experienced as a sense of numbness or unreality, it may have a dreamlike quality, or it may be a state of normal thinking and functioning. Mourning is an emotional catharsis for the survivors. Adjustment is to make modifications in life without the deceased.

Particular responses or reactions to loss include feelings of depression or grief, somatic production of symptoms, guilt, denial, and reestablishment of the meaning of life. (Parkes, 1975; Zisook & Shuchter, 1986; Shuchter, 1986; Marris, 1974; Lister, 1991; Umberson, Wortman, & Kessler, 1992; and Nuss & Zubenko, 1992). In depression as well as grief, there are symptoms of sleep disturbance, appetite disturbance, and intense sadness. However, in a grief reaction, there is not the loss of self-esteem commonly found in most clinical depressions. Another frequent and painful affect of grief is guilt, whether in the form of survival guilt or a sense of responsibility for the death or suffering of the spouse. Denial is often experienced by the survivor in the form of not believing that the spouse died. The survivor then reestablishes himself or herself back into life.

Psychosocial factors of Katz and Florian's model (1987), include: gender, age, religion, mode of death, educational level, and occupational history (Morycz, 1992). Family considerations

including history or marital relation and perception of the family's role in the mourning process and sociocultural environment where society changes toward a person who is widowed are also included. Any religious traditions or cultural customs attached to mourning may provide some structure or expectations for the survivor (Morycz, 1992).

According to Gilliland and James (in Lister, 1991), a survey of 18 different models of grief indicated that Schneider's is the most complete model. Schneider (1984) describes eight stages in the grief process:

Stage 1: Initial Awareness of Loss. This stage includes such reactions as shock, numbness, disbelief, and disorientation.

Stage 2: Holding On. At this point the individual is warding off immobility generated by such reactions as muscle tension, sleep disturbance, bargaining, and guilt by mobilizing coping responses which have worked in the past.

Stage 3: Letting Go. Individuals at this stage are separating from their attachment to the lost person. Common responses are depression, anxiety, pessimism, self-destructive thoughts, and a cynicism which can lead to the loss of formerly held ideas.

Stage 4: Awareness of Loss. This is the stage most commonly associated with mourning. People may experience

intense pain, loneliness, helplessness, weakness, emptiness, and exhaustion.

Stage 5: Gaining perspective. This is the stage where the griever is coming to terms with the loss, balancing positive and negative aspects, and gaining perspective on responsibility for the loss.

Stage 6: Resolving the Loss. This is the stage of saying good-by and of moving on to other life activities unconnected with the loss and which are not a reaction to the loss. Individuals may experience self-forgiveness, restitution, and a completion of unfinished business.

Stage 7: Loss as Context for Growth. The griever has now reconciled the loss as a challenge for personal growth. At this point, an individual may seek better balance among the various aspects of life. Some reactions at this point include curiosity, spontaneity, enhanced sensory awareness, and even joy.

Stage 8: New attachment. The individual may experience a greater integration of physical, emotional, cognitive, behavioral, and spiritual qualities so that life is approached with more openness. Reactions may include a sense of wholeness, creativity, deeper empathy, and commitment.

A failure to resolve any stage of the Schneider model may mean a blocking of the grief, which may lead to a pathological

outcome or may mean residuals of the loss could influence the later life course of the bereaved (Schneider, 1984).

Stroebe and Stroebe (1987) identify several types of grief which are considered "pathological": chronic grief, delayed grief, and inhibited grief. A chronic grief reaction is one that is excessive in duration and never comes to a satisfactory conclusion. The person undergoing the reaction is very much aware that he or she is not getting through the period of mourning. Delayed grief reactions are sometimes called inhibited, suppressed, or postponed grief reactions. The person may have had an emotional reaction at the time of the loss, but it is not sufficient to the loss. At a future time the person may experience the symptoms of grief over some subsequent and immediate loss, but the intensity of his or her grieving seems excessive.

Tasks of Mourning

According to Worden (1991), each bereaved person must accomplish four necessary tasks: "(1) accept the reality of the loss, (2) experience the pain of grief, (3) adjust to an environment in which the deceased is missing, and (4) withdraw emotional energy and reinvest it in another relationship" (p. 10).

The first task in accepting the reality of the loss is to realize the person is dead and will not return in overcoming the natural denial response (Demi, 1989). There are many ways in which

bereaved persons can actualize the finality of death. The traditional methods are to view the body, attend the funeral, and visit the place of burial (Leming & Dickinson, 1990). Some other ways to accept the reality of the loss are to view the body before the funeral and talk, view pictures, and distribute possessions of the deceased (Leming & Dickinson, 1990).

Part of coming to grips with death is experiencing the emotional and physical pain caused by the loss (Leming & Dickinson, 1990). Many people try to attempt to avoid the pain by rejecting the emotions and feelings they are experiencing. "By fully experiencing the pain, it ultimately provides relief to those who suffer" (Leming & Dickinson, 1990, p. 13).

The third task requires the bereaved to take on some social roles performed by the deceased (Leming & Dickinson, 1990). For many widows it takes a considerable period of time to realize what it is like to live without their husbands. This begins to emerge around three months after the loss and involves coming to terms with living alone, raising children alone, facing an empty house, and managing finances alone. For widowers this involves coming to terms with living alone, raising children alone, doing all of the household chores, facing an empty house, and performing the roles that his deceased spouse did. According to Worden (1991), by not doing this task or refusing to develop the skills necessary in

daily living will ultimately lead to a withdrawal from life.

The final task is often a hard one because when someone starts a new relationship he or she feels disloyal or unfaithful to their dead loved one (Leming & Dickinson, 1990). The final task then becomes not to help the bereaved give up their relationship with the deceased, but to help them find an appropriate place for the death in their emotional lives or a place that will enable them to go on living effectively in the world (Worden, 1992). Some people find loss so painful that they make a pact with themselves never to love again. Other people are unable to start in a new relationship because they are unwilling to experience again the pain caused by the loss.

Normal Grief Reactions

What are some normal reactions to losing a loved one? Normal grief is sometimes referred to as uncomplicated grief and encircles a broad range of feelings and behaviors that are common after a loss (Worden, 1991).

What are some of the feelings experienced after loss of a loved one? Sadness is the most common feeling found in the bereaved (Worden, 1991; Lister, 1991). Many of the newly bereaved go through a period where anger becomes a significant part of their grief (Worden, 1991; Shuchter, 1986). Anger can be one of the most confusing feelings for the survivor and can be the

root of many problems in the grieving process (Barbato & Irwin, 1992). This anger can come from two sources: "(1) from a sense of frustration that there was nothing one could do to prevent the death, and (2) from a kind of regressive experience that occurs after the loss of someone close" (Worden, 1991, p. 22). In the loss of a loved one there is a tendency to feel helpless , to feel unable to exist without the person, and to experience the anger that goes along with these feelings of anxiety (Worden, 1991; Shuchter, 1986; & Raphael & Nunn, 1988). The anger that an individual experiences has to be identified in order to bring it to a healthy conclusion.

Another frequent and painful affect is guilt, whether in the form of survivor guilt or a sense of responsibility for the death or suffering of the spouse (Shuchter, 1986; Barbato & Irwin, 1992; Lister, 1991). An individual can experience guilt over not being kind enough, over not taking the person to the hospital sooner, over not taking care of the individual properly, and the like (Worden, 1991).

Anxiety in the survivor can also be experienced (Barbato & Irwin, 1992; Raphael & Nunn, 1988). According to Worden (1991), anxiety comes from two sources: First, the surviving people fear they will not be able to take care of themselves on their own. Second, anxiety relates to a heightened sense of personal death

awareness - the awareness of one's own mortality heighten by the death of a loved one (Worden, 1991).

After losing a spouse with which an individual had developed a close relationship, loneliness is a frequently felt experience (Worden, 1991; Shuchter, 1986; Lister, 1991). Even though they are very lonely, many widows will not go out because they feel safer in their own homes. The feeling of helplessness is frequently experienced in the early stage of a loss (Barbato & Irwin, 1992). Widows in particular often feel extremely helpless.

The feeling of shock most often occurs in the case of a sudden death (Worden, 1991; Lister, 1991). The shock may be experienced as a sense of numbness or unreality, it may have a dreamlike quality, or it may be a state of normal thinking and functioning (Shuchter, 1986). Yearning is a normal response to loss and the British call this "pining." When longing for the loss of a loved one decreases, it may be a sign that mourning is coming to an end (Worden, 1991).

Many people experience a sense of relief after the death of a loved one, especially if there was a lengthy or painful illness (Barbato & Irwin, 1992; Shuchter, 1986). Some people report a lack of feeling or numbness (Worden, 1991). Numbness often occurs early in the grieving process and is usually right after learning of the death. Numbness can serve as a protection from

the flood of feelings someone experiences after being told they lost a loved one (Raphael & Nunn, 1988).

What are some thoughts that an individual experiences after losing a love one? There are many thoughts that mark the experience of grief. Disbelief is often the first thought to occur after hearing of a death, especially if the death was sudden (Worden, 1991). Many people report their thinking is confused, and that they are experiencing difficulty concentrating.

Sometimes individuals will be preoccupied with the thoughts about the deceased (Worden, 1991). A sense of presence of the deceased can also be in person's cognitive framework. Hallucinations of both visual type and the auditory type are included in the list of normal behaviors because they are a frequent experience of the bereaved (Worden, 1991; Shuchter, 1986).

There are number of behaviors which are associated with normal grief reactions. Sleep disturbances are not unusual for people who are in the early stages of loss (Worden, 1991) These may include difficulty in going to sleep or waking up early in the morning. Appetite disturbances is also common in mourning situations (Worden, 1991). This can include overeating or undereating, but undereating is more common.

The newly bereaved may find themselves absent - minded.

This may cause them inconvenience or possible harm (Worden, 1991). It is not unusual for people who have had a loss to want to withdraw from other people. This can include a loss of interest in the outside world, such as not reading the newspaper or watching the television.

It is very common to dream of the dead person, both normal dreams and nightmares (Raphael & Nunn, 1988). These dreams can serve the purpose of finding out where the person is in their course of mourning, which would be beneficial to counselors. Another behavior of individuals after an experience of loss is to avoid reminders of the deceased (Shuchter, 1986; Raphael & Nunn, 1988). Sometimes someone will remove everything in sight that reminds them of the deceased. This is usually not healthy behavior.

Sometimes the individual will "call out" The name of the deceased person. An example of this is: "Larry, Larry, Larry. Please come back to me" (Worden, 1991, p.29)! Another possible behavior by a survivor is restless overactivity (Raphael & Nunn, 1988). According to this author, some people just have to keep busy all the time.

The behavior of crying can have some potential healing power. Tears do relieve emotional stress caused by the death of a loved one (Raphael & Nunn, 1988). Some people will carry

objects or visit places that remind the survivor of the deceased. Also, some people will treasure objects that belonged to the deceased (Raphael & Nunn, 1988).

Abnormal Grief Reactions

Abnormal grief appears in several forms and has been given different labels. It is sometimes called pathological grief, unresolved grief, complicated grief, chronic grief, delayed grief, or exaggerated grief. (Worden, 1991; Zisook & Shuchter. 1986; Stroebe & Stroebe, 1987). There are several ways to discuss complicated grief reactions. One of the more useful ways to describe them are under four headings: "(1) chronic grief reactions, (2) delayed grief reactions, (3) exaggerated grief reactions, and (4) masked grief reactions" (Worden, 1991, p. 71).

According to Worden (1991), "a chronic grief reaction is one which prolonged, is excessive in duration, and never comes to a satisfactory conclusion" (p. 71). This type is easy to diagnose because the person undergoing the reaction is very much aware that he or she is not getting through the period of mourning. This sense is strong when the grief has gone on for several years and the person is feeling unfinished (Worden, 1991 & Stroebe & Stroebe, 1987).

"Delayed grief reactions are sometimes called inhibited, suppressed, or postponed grief reactions" (Worden, 1991, p. 72).

In this case the person may have had an emotional reaction at the time of the loss. At a future date the person may experience the symptoms of grief over some immediate loss. Such delayed reactions can also occur when someone is watching someone else go through a loss or when watching a film (Worden, 1991 & Stroebe & Stroebe, 1987).

The third category has to do with unusually exaggerated grief responses (Worden, 1991). Feeling anxious following the loss of a loved one is normal. However, if this anxiety develops into a phobia, then it becomes an abnormal grief response (Worden, 1991). Often these phobias are centered around death.

"Masked grief reactions are interesting in that patients experience symptoms and behaviors which cause them difficulty but do not see or recognize the fact that these are related to the loss" (Worden, 1991, p. 73). Masked grief generally turns up in one of two ways. Either it is masked as a physical symptom or through some maladaptive behavior. Persons who do not experience grief directly may develop medial symptoms similar to those which the deceased had while they were dying (Worden, 1991).

Depression Aspect of Grief

Depression is the single most common medical disorder encountered by widows and widowers (Shuchter, 1986; Clayton,

Halikas, & Maurice, 1972; Morycz, 1992; Siegel & Kuykendall, 1990; Nuss & Zubenko, 1992; and Zisook, Shuchter, Sledge, Paulus, & Judd, 1994). "The term "depression" refers to a transient state lasting from minutes to hours, often in response to an acute upset, and consisting of lowered mood or sadness accompanied by general pessimism or apathy, self-depreciation, and a lack of pleasure or energy" (Shuchter, 1986).

Spousal bereavement was found to be an important risk factor for major depression (Zisook, Shuchter, Sledge, Paulus, & Judd, 1994). Several investigators (Clayton, 1990; Gilewski, Farberow, Gallagher, et. al., 1991; Bruce, Kim, Leaf, et. al., 1990; Futterman, Gallagher, Thompson, et. al.,1990; Zisook & Shuchter, 1991) have documented the high prevalence of major depressive episodes in widows and widowers.

Bereavement is frequently associated with the onset of major depressive syndromes. Thus, it serves as the only life event that is specifically excluded as a factor for major depression. The DSM - III - R (1987) introduced the V-code "Uncomplicated Bereavement" to capture the frequency with which major depressive syndromes follow bereavement and to suggest these depressive reactions often are best understood as "normal" reactions to life events rather than as an illness. However, Zisook et. al. (1994) have suggested that many of these "uncomplicated

bereavements" are not so uncomplicated. These uncomplicated bereavements are prolonged and/or recurrent and are associated with prolonged suffering, disability, suicidal ideation, interpersonal difficulties, and poor overall adjustment to grief (Gilewski, Farberow, Gallagher, et. al., 1991 & Zisook et. al., 1994). When major depression occurs with bereavement, it often is minimized, neglected, or overlooked, and much needed treatment may be withheld.

There are a number of persistent depressive symptoms following depression. Clayton (1990) reported that over half of all widowed subjects had crying spells, sleep disturbances, low mood, loss of appetite, fatigue, and poor memory at some time during the first year of bereavement. In general, somatic symptoms gradually improve while psychological symptoms (e.g., hopelessness) persist.

Breckenridge, Gallagher, Thompson, & Peterson (1986), reported that a number of depressive symptoms were frequent in recently bereaved elders, although the severity of symptoms was most often mild. Bereaved individuals scored significantly higher on 6 (out of 21) Beck Depression Inventory Items. These include: sadness, tearfulness, dissatisfaction with self, insomnia, appetite loss, and weight loss. Loneliness remains an important and frequent symptom for a least two years after bereavement, but also

feeling blue, having trouble going to sleep, feeling no interest in things, thoughts of death or dying, and feeling hopeless about the future are noted by over one third of all widows/widowers for as long as two years after their spouse's death (Zisook et. al., 1994; Bruce, Kim, Leaf, et. al., 1990; & Futterman, Gallagher, Thompson, et. al., 1990). In the person who has lost a spouse, the mood shifts may be "triggered" by any reminder of one's loss or by loneliness.

Signs of depression are seen when the bereaved shifts from when they are busy and involved to when they are unoccupied, alone, and at home with reminders of their loss (Shuchter, 1986). Regardless of the events or stresses that initiate depression, it can persist and progress to the point where its effects continue independent of what causes the effects in the beginning.

The signs and symptoms of full-blown depression include biological alterations in mood with persistent feelings of sadness, despair, helplessness, and hopelessness (Shuchter, 1986). Appetite disturbances can be in overeating or undereating. Shuchter (1986) described two types of depression: retarded depression and agitated depression. Retarded depression includes increased appetite with weight gain, excessive sleeping, lack of energy and interest in life, loss of anticipated and perceived pleasure, and slowing down of physical and mental processes.

Agitated depression includes loss of appetite, weight loss, sleep loss, excessive contemplation and agitation, irritability, and an inability to concentrate or focus one's thinking.

A person may also display features of social withdrawal and physical symptoms, including pain, constipation, lethargy, and weakness. The individual's outlook becomes very negative , and suicidal feelings may emerge (Shuchter, 1986).

Zisook, Shuchter, Sledge, et. al. (1994), previously have found that the 83% of bereaved spouses who met criteria for a major depressive syndrome, according to DSM-III-R, (1987) received no antidepressant medications for their depressions. When major depression follows bereavement, it often is minimized, overlooked, or ignored, and much needed treatment is withheld.

According to Zisook, Shuchter, Sledge, and et. al. (1994), about 50% of all widows and widowers meet criteria for a major depressive syndrome at some time during the first year of bereavement, and 8% to 13% are depressed for the entire year. Major depressive syndromes have been found to occur in 29% to 58% of widows and widowers one month after their spouse's death (Clayton, 1990, and Gilewski, Farberow, Gallagher, & Thompson, 1991). The risk factors that have been identified for a major depressive syndrome after a spouse's death include a past

personal history of major depression, poor prior medical and mental health (Nuss & Zubenko, 1992), prebereavement depression (Norris & Murrell, 1990), lack of social supports (Dimond, Lund, & Caserta, 1987), and early depressive syndromes in the first months after the loss (Gilewski, Farberow, et. al., 1991). The fact that such a large proportion of spousal bereavement individuals can be expected to suffer from a major depression of various duration several treatment issues arise.

Gender Differences in Depression

Depression is a particularly common response to widowhood, at least in the first year or two following the death (Umberson, Wortman, & Kessler, 1992). Several studies suggest that men and women respond to widowhood differently. Some investigators claim that women are more likely to become depressed (Thompson, Thompson, Futterman, Gilewski, & Peterson, 1991; Gallagher, Breckenridge, Thompson, & Peterson, 1983; and Carey, 1979). Gender has been found to be a significant factor in explaining levels of depression in bereaved individuals (Leahy, 1993; Stroebe & Stroebe, 1987).

According to Thompson et. al., (1991), women, regardless of bereavement status, report more depression than men. In his study women reported greater depression at two months and 12 months, but not at 30 months compared to men. Women reflect

over depressive thoughts and over report depression, whereas men deny such thoughts and underreport depression. Different gender-related behavioral styles are compatible with findings of gender differences in depression regardless of bereavement status. Following loss or any other stressor, men and women will express depressive symptoms differently (Thompson et. al, 1991). However, studies including widowers indicated that men suffer more serious health consequences than women and that the first six months to one year postbereavement is a time of particular vulnerability for men (Siegel & Kuykendall, 1990; Stroebe & Stroebe, 1983; and Umberson, Wortman, & Kessler, 1992).

Men receive more advantages from marriage than do women in the form of household tasks. Following widowhood, the necessity of taking over household tasks handled previously by one's spouse may form an important source of strain for men. Women are more likely than men to have a close confiding relationship with another person and especially more likely than men to have a close friend in addition to their spouse. Women provide more emotional support to their spouses than do men. Wives also are more likely than husbands to initiate and sustain the couple's relationship with others (Umberson, Wortman, & Kessler, 1992).

The exclusive nature of male social involvement and reliance on their wives to facilitate social participation may lead men to depend more on their spouses for intimacy, social participation, and social support. Widowhood may be more likely to leave men socially and emotionally isolated. Since social contact and emotional support are beneficial to the well-being of both men and women, greater social deficits among men could lead to male vulnerability to depression following the loss of a spouse (Siegel & Kuykendall, 1990 & Umberson, Wortman, & Kessler, 1992).

Other studies argue that there are no gender differences in depression following widowhood (Nuss & Zubenko, 1992; Feinson, 1986). Behavioral studies indicate different patterns of social participation, but do not support the perception of men as more affected by bereavement than women. The mortality studies provide tentative support that widowers in some age categories may be at higher risk than widows. The data available at this time suggest that there are no gender differences in depression (Feinson, 1986 & Nuss & Zubenko, 1992).

Thus, there is a difference in opinion of whether males or females suffer from depression more after the loss of a spouse. Apparently, it might depend on the variable of depression that the individual has looked at in their study. One reason reactions to

bereavement are worthy of attention is that all families are touched at some point by loss through death.

Gender Differences in Grief

According to the 1984 U. S. Bureau of Census (in Morycz, 1992), the average age of widowhood is 69 years old for men and 66 years old for women. Widowhood happens more often to women then to men. The population has more women due to a higher death rate for the male population and the more rapid improvement in mortality for women (Morycz, 1992).

An individual going from a married person to a widowed person can create a challenging role change. Adaptation to this life event depends upon many psychosocial factors. According to Heinemann (in Morycz, 1992), there is some evidence that women have more difficulty in adjustment to spousal bereavement and have experienced more somatization, depression, and physical symptoms following the loss of a spouse. Also, widows have been found to have more health difficulties than widowers. Widows show the expression of feeling of distress more freely than males , which may be the reason that on some depression scales women score higher than males (Morycz, 1992).

Since men earn, on average, substantially more than women, women obtain more financial advantages from marriage. This means that widowhood probably leads to greater financial

strain for women (Smith & Zick, 1986). Morgan (in Umberson, Wortman, & Kessler, 1992) suggested that the apparent effects of widowhood on women's distress are due primarily to the effects of financial strain.

According to Lister (1991), widowers remarry at higher rates than women and that they generally do so earlier than women who remarry. Does this mean their grief is less, or less intense; or is it just different? The advice for males is to do what they have been socialized to do: Get active, find some outlet, get on with it (Lister, 1991).

Berardo (1970) found that widowers were less likely to be church members or belong to or participate in formal organizations or groups. The nature of male social involvement and reliance on their wives to promote social participation may lead men to depend more on their spouses for intimacy, social participation , and social support. Therefore, widowhood may be more likely to leave men socially and emotionally isolated (Feinson, 1986; Lister, 1991; and Morgan, 1984). Since social contact and emotional support are beneficial to the well-being of both men and women, greater deficits among men could lead to male vulnerability to depression following widowhood (Umberson, Wortman, & Kessler, 1992). Women's greater access to supportive nonmarital relationships may lend some psychological

advantages to women following widowhood.

Men also typically receive substantially more advantages from marriage than do women in the form of household services (Feinson, 1986). After widowhood, the necessity of taking over household tasks handled previously by one's spouse may be a source of strain for the bereaved spouse, especially for men (Berardo, 1970). Widowhood then might actually result in the reduction of some types of strain for women.

CHAPTER III

Methodology

Subjects

The subjects for the study were 17 males and 22 females who had experienced the loss of a spouse and had been widowed less the two years. The 22 females ranged in age from 29 to 65 with a mean of 56.55. The 17 males ranged in age from 32 to 72 with a mean of 49.85. The 22 females length of marriage ranged from 3 years to 43 years with a mean of 32.09. The 17 males length of marriage ranged from three years to 48 years with a mean of 23.42 (Refer to Table 1). The majority had been in long-term relationships.

The bereaved widows and widowers were drawn from one county in a major metropolitan area (St. Louis) in November of 1995. It was the research's hope to secure a sample composed of multiracial, multiethnic respondents of varying socioeconomic backgrounds. Despite the researchers effort to obtain ethnic diversity the sample composed all Caucasian males and females and was a sample of convenience.

Criteria for inclusion in the sample involved having the death of a spouse within two years. Twenty four respondents were solicited from a Growing Through the Seasons of Grief Workshop on November 18, 1995. Fifteen respondents were solicited

through friends, counseling professionals, and churches in the St. Louis area.

Procedure

The 22 widows and 17 widowers were given a Beck Depression Inventory (BDI). In November, 1995, the widows and widowers were voluntarily asked to answer each question of the BDI.

There was 24 subjects who completed the BDI at a grief workshop. The rest of the subjects were each given the BDI and voluntarily asked to fill out the questionnaire. All of the subjects were selected on the basis of having experienced the death of a spouse within two years.

Participants were provided with verbal instructions that discussed that the researcher is conducting the study for his Masters Thesis in Counseling at Lindenwood College. The specific variables examined in the study were not discussed because the researcher believed that the information was not necessary knowledge for the participants. If the participants knew the variables being tested their answers to the questions may have been influenced.

Instrument

The Beck Depression Inventory is a 21 - item instrument designed to provide a quantitative assessment of the intensity of

depression (Beck & Steer, 1987). This multiple - choice inventory includes 21 items, each of which corresponds to a depressive symptom and is followed by four self-evaluative statements. The statements are answered from 0-3 on a 4-point scale in terms of severity. In this way, the total Beck score is weighted for both the number and severity of depressive symptoms. According to Beck and Steer (1987), scores from 0-9 are considered within the minimal range; scores of 10-16 indicate mild depression; scores of 17-29 indicate moderate depression; and scores of 30-60 indicate severe depression. According to Nuss and Zubenko (1992), "Each of the nine DSM-III-R symptom criteria for major depression is addressed by at least one of the items included in the Beck inventory (depressed mood: Beck items 1,10,11; diminished interest or pleasure: items 4, 12; weight of appetite change: items 18, 19; sleep disturbance: item 16; psychomotor retardation: item 15; loss of energy: items 15, 17; Feelings of worthlessness or guilt: items 3, 5-8; inability to concentrate or indecisiveness: item 13; suicidal ideation: item 9; p.348)."

There are previous studies using the Beck Depression Inventory studying grief. A study of depression was done by Leahy (1992), using the Beck Depression Inventory - Short Form (BDI-Short Form). This Inventory is a 13-item inventory that includes

statements reflecting the cognitive, affective, and somatic domains of depression. Each item consists of four statements that ate ranked from zero to three to reflect the severity of a particular symptom. A total depression score is the sum of the statements for each item. The range of scores on the inventory is from zero to 39. Scores between 5 and 7 reflect a mild depression, between 8 and 15 for moderate depression, and over 16 for severe depression (Leahy, 1992).

This report focused on the reliability and validity of the BDI short-form and examined the intensity of depression in a group of bereaved females who had suffered the loss of a spouse, a child, or a parent (Leahy, 1992). A coefficient of .88 was obtained for internal consistency of this study. This result indicates that the BDI-Short Form has satisfactory reliability in a bereaved population.

This study showed two different factor structures that are similar to the factors reported by Foelker et. al. (1987). The first factor included those items related to the affective and somatic domain of depression. The second factor included those items that related to the cognitive domain and can be labeled negative self-esteem (Leahy, 1992). This structure supports the construct validity of the short-form BDI because the factors validate the cognitive, affective, and somatic fields of depression.

In a study done by Breckenridge (in Zisook et. al., 1994),

"Bereaved individuals scored significantly higher on six (out of 21) beck Depression Inventory items: sadness, tearfulness, dissatisfaction with self, insomnia, appetite loss, and weight loss" (p, 31). Zisook et. al. (1994), also reported that loneliness remains an important and frequent symptom for at least two years after the loss, but also that feeling blue, having trouble going to sleep, feeling no interest in things, thoughts of death or dying, and feeling hopeless about the future are noted by over one third of all widows and widowers as long as two years after their spouse's death.

The Beck Depression Inventory served as the principal dependent variable in a study done by Nuss and Zubenko (1992). The mean age of the study group was 68.5 years with a mean duration of widowhood of 11.6 months. The mean Beck depression score for the 50 widows was 7.4, but twelve of the 50 had scores of 10 or higher. The mean Beck depression score of this group of 12 widows was 14.6. Ten (83.3%) of the 12 widows whose Beck scores were 10 or higher met the DSM-III-R symptom criteria for major depression, and the remaining two widows had at least three of the five depressive symptoms required to satisfy these criteria. All of the widows who had depressive symptoms at the time of this study dated the onset of the symptoms to the deaths of their husbands.

Campbell, Burgess, and Finch (1984) did a factorial

analysis of the BDI which yielded the following factors: (1) negative self-attitudes, (2) physiological symptoms, (3) and sadness. Negative self-attitudes are assumed by items 7-12, physiological symptoms are assumed by items 13-21, and sadness is assumed by items 1-6. The current study used these three factors in studying the levels of depression after the loss of a spouse.

CHAPTER IV

Results

The mean age for the 17 males was 49.85 and the standard deviation was 13.25. The mean age for the 22 females was 56.55 and the standard deviation was 2.85. The total mean age for the sample was 53.2 with a standard deviation of 8.05 (Table 1).

The mean length of time since the loss for the 17 males was 7.06 months with a standard deviation of .36. The mean length of time since the loss for the 22 females was 6.08 months with a standard deviation of .22. The total mean length of time since the loss was 6.57 months with a standard deviation of .29.

The mean length of marriage for the 17 males was 23.42 years with a standard deviation of 14.28 years. The mean length of marriage for the 22 females was 32.1 with a standard deviation of 3.28 years. The total mean length of marriage was 27.76 years with a standard deviation of 8.78 years.

There were four males who were receiving counseling which equals 23 per cent. The females had six who were receiving counseling which equals 27 per cent (Table 1).

The 39 completed inventories were examined to explore mean differences between the male and female respondents. A t-test was used to compare mean score differences between males and females for the total survey. Then the mean scores for

negative self-attitudes, physiological symptoms, and sadness were compared and analyzed using a t-test. Both t-tests used an alpha of .05.The null hypothesis for this survey was that there was no significant difference in depression between males and females after the loss of a spouse. Additional hypothesis were that there was no difference in negative self-attitudes, physiological symptoms, and sadness between males and females after the loss of a spouse.

Total Scores

All twenty one questions were calculated on a given measured tract for males and females after the loss of a spouse. A t-test for the difference between means was the test the researcher chose. Table two is a t-test of the independent variable gender and the dependent variable total scores of the BDI. The null hypothesis that is being tested in Table two is that there is no difference in depression between males and females after the loss of a spouse.

The 17 males in the study had a mean of 13.18, with a standard deviation of 4.03 and a standard error (SE) of the mean of .98. For the 22 females in the study the mean was 11.91, with a standard deviation of 8.09 and a (SE) of the mean of 1.72. The mean difference between the males and females was 1.27. Underneath the mean difference is the Levene test, which tests the

null hypothesis to see if in the population the variances of the two groups would be equal. Since the observed significance level for the Levene test (P=.061) is larger than the alpha of .05 the null hypothesis is not rejected that the two population variances are equal. Therefore, the equal variance t-test (homogeneity) column is used.

The observe significance level associated with the t-value .59 is .558. The t-value .59 does fall between the 95% confidence intervals for the population mean difference. The intervals are from -3.082 to 5.617. Therefore, the null hypothesis can be accepted that there is no difference in depression between males and females after the loss of a spouse.

Negative Self-Attitudes

Table 3 is a t-test of the independent variable gender and the dependent variable (factor) negative self-attitudes. The null hypothesis that is being tested in Table 3 is that there is no difference in negative self-attitudes between males and females after the loss of a spouse. The 17 males in the study had a mean of 3.29, with a standard deviation of 1.26 and a SE of the mean of .306. For the 22 females in the study the mean was 2.81, with a standard deviation of 2.46 and a SE of the mean of .525. The mean difference between the males and females was .4759.

Underneath the mean difference is the Levene test, which

tests the null hypothesis to see if in the population the variances of the two groups would be equal. Since the observed significance level for the Levene test (P=.067) is larger than the alpha of .05 the null hypothesis is not rejected that the two population variances are equal. Therefore, the equal variance t-test (homogeneity) column is used.

The observed significance level associated with the t-value .73 is .473. The t-value .73 does fall between the 95% confidence intervals for the population mean difference. The intervals are from -.854 to 1.806. Therefore, the null hypothesis can be accepted that there is no difference in negative self-attitudes between males and females after the loss of a spouse.

Physiological Symptoms

Table 4 is t-test of the independent variable gender and the dependent variable (factor) physiological symptoms. The null hypothesis that is being tested in Table 4 is that there is no difference in physiological symptoms between males and females after the loss of a spouse. The 17 males in the study had a mean of 5.35, with a standard deviation of 1.93 and a SE of the mean of .47. For the 22 females in the study the mean was 5.50, with a standard deviation of 3.57 and a SE of the mean of .761. The mean difference between the males and females was .148.

Underneath the mean difference is the Levene test, which

tests the null hypothesis to see of in the population the variances of the two groups would be equal. Since the observed significance level for the Levene test (P=.007) is not larger than the alpha of .05 the null hypothesis is rejected that the two population variances Males and Females are equal. Therefore, the unequal variance - test (heterogeneity) column is used.

The observed significance level associated with the t-test value -.16 is .870, the t-values -.16 does not fall in the 95% confidence intervals for the population mean difference. The intervals are from -1.964 to 1.670. Therefore, it appears unlikely that physiological symptoms are similar between males and females after the loss of a spouse (rejection of null hypothesis). It appears there is a difference in physiological symptoms between males and females after the loss of a spouse.

Sadness

Table 5 is a t-test of the independent variable gender and the dependent variable (factor) sadness. The null hypothesis that is being tested in Table 5 is that there is no difference in sadness between males and females after the loss of a spouse. According to Table 5, the 17 males in the study had a mean of 4.5294, with a standard deviation of 1.505 and a SE of the mean of .365. For the 22 females in the study the mean was 3.5909 with a standard deviation of 2.631 and a SE of the mean of .561. The mean

difference between the males and females was .9385.

Underneath the mean difference is the Levene test, which tests the null hypothesis to see if in the population the variances of the two groups would be equal. Since the observed significance level for the Levene test (P=.178) is larger than the alpha of .05 the null hypothesis is not rejected that the two population variances are equal. Therefore, the equal variance t-test (homogeneity) column is used.

The observed significance level associated with the t-value 1.31 is .198. The t-value .73 does fall between the 95% confidence intervals for the population mean difference. The intervals are from -.511 to 2.388. Therefore, the null hypothesis can be accepted that there is no difference in sadness between males and females after the loss of a spouse.

Table I

Clinical Variables With Beck Depression Inventory

Variable	Male Mean	Female Mean	Total Mean	Male S.D.	Female S.D.	Total S.D.
Age	49.85	56.55	53.2	13.25	2.85	8.05
Length of Time Since Loss	7.0643	6.0848	6.5746	0.3643	0.2277	0.296
Length of Marriage	23.4215	32.0982	27.7599	14.2786	3.2768	8.7777
Receiving Counseling (Y or N)	0.2857	0.2947	0.2902	0.2857	0.0803	0.183

N = 22 Females N = 17 Males

TABLE 2

t-tests for independent samples of gender

Variable	N	Mean	SD	SE of Mean
TOTAL				
male	17	13.1765	4.035	.979
female	22	11.9091	8.088	1.724

Mean Difference = 1.2674

Levene's Test for Equality of Variances: F= 3.728 P= .061

t-test for Equality of Means					95%
Variances	t-value	df	2-Tail Sig	SE of Diff	CI for Diff
Equal	.59	37	.558	2.146	(-3.082, 5.617)
Unequal	.64	32.31	.527	1.983	(-2.772, 5.307)

TABLE 3

t-tests for independent samples of gender

Variable	N	Mean	SD	SE of Mean
NA neg. self-attitudes				
male	17	3.2941	1.263	.306
female	22	2.8182	2.462	.525

Mean Difference = .4759

Levene's Test for Equality of Variances: F= 3.572 P=.067

t-test for Equality of Means					95%
Variances	t-value	df	2-Tail Sig	SE of Diff	CI for Diff
Equal	.59	37	.558	2.146	(-3.082, 5.617)
Unequal	.64	32.31	.527	1.983	(-2,772, 5.307)

TABLE 4

t-tests for independent samples of gender

Variable	N	Mean	SD	SE of Mean
PS physiological symptoms				
male	17	5.3529	1.935	.469
female	22	5.5000	3.569	.761

Mean Difference = -.1471

Levene's Test for Equality of Variances: F= 8.018 P= .007

t-test for Equality of Means					95%
Variances	t-value	df	2-Tail Sig	SE of Diff	CI for Diff
Equal	-.15	37	.879	.961	(-2.094, 1.800)
Unequal	-.16	33.63	.870	.894	(-1.964, 1.670)

TABLE 5

t-tests for independent samples of gender

Variable	N	Mean	SD	SE of Mean
SA sadness				
male	17	4.5294	1.505	.365
female	22	3.5909	2.631	.561

Mean Difference = .9385

Levene's Test for Equality of Variance: F= 1.884 P= .178

t-test for Equality of Means					95%
Variance	t-value	df	2-Tail Sig	SE of Diff	CI for Diff
Equal	1.31	37	.198	.715	(-.511, 2.388)
Unequal	1.40	34.45	.170	.669	(-.422, 2.299)

CHAPTER V

Discussion

The review of the literature illustrated many problems in depression in males and females after the loss of a spouse. Some studies have explored the differences in depression between males and females after the loss of a spouse. Some studies have come to the conclusion that males are more depressed after the loss of a spouse and other studies have come to the conclusion that females are more depressed after the loss of a spouse. Still, other studies have come to the conclusion that there is no difference in depression between males and females after the loss of a spouse (Feinson, 1986).

Therefore, it became clear to the researcher that there was a need for further understanding of whether males or females are more depressed after the loss of a spouse. The ultimate goal was to look at specific factors of negative self-attitudes, physiological symptoms, and sadness of the Beck Depression Inventory and the different levels of depression between males and females after the loss of a spouse. This study came to the conclusion that there was no difference in the total levels of depression between males and females after the loss of a spouse, confirming the literature of Feinson, 1986. Also, there was no difference in the specific factors of negative self-attitudes, and sadness of the Beck Depression

Inventory.

In this study there appeared to be a difference between males and females in the BDI factor of physiological symptoms. This factor included the item content questions of indecision, body image, work inhibition, sleep disturbance, fatiguability, loss of appetite, weight loss, somatic preoccupation, and loss of libido. The previous studies of Siegel and Kuykendall (1990) and Umberson, Wortman, and Kessler, (1992) found differences in depression between males and females after the loss of a spouse in the areas of social support, emotional support, household tasks, and financial advantages. The study's findings does not compare with previous research on depression between males and females after the loss of a spouse.

It was the researcher's notion that there would be a difference in the total score of the levels of depression between males and females after the loss of a spouse. Apparently, that was not the case in the particular study.

Limitations of the Study

Certain limitations of the study need to be acknowledged. Because the sampling plan resulted in a lack of heterogeneity in socioeconomic status and ethnic representation, generalizability beyond the population parameters is uncertain. This limitation appears to be typical of this type of study.

Another limitation of this study is the small sample size. A larger sample might have shown a difference in depression between males and females after the loss of a spouse. Although the sample size meets criteria for analysis, replication with larger samples is needed. Further, too few items represent the factors, and the researcher questioned whether all dimensions of depression are adequately measured. Nevertheless, the researcher felt that these preliminary findings are worth recording.

Another limitation is that the population for this study was not randomly selected. The sample came from a religious or spiritual background. The sample was also individuals going to a workshop on grief. This could show that these individuals are seeking help in handling their grief or depression or at least seeking explanations for why or what is making them feel the way they do. The sample would have been more randomly selected by sending the respondents invitations in the mail to participate in the study. This could have been accomplished by using the Health Department records or the obituaries in the newspaper.

Suggestions for Further Research

There are some different directions for future research that can be done with this type of population. A larger sample is needed to compare the levels of depression in males and females after the loss of a spouse. A multiracial or multiethnic comparison

of depression after the loss of a spouse in each of the different ethnic groups could be done. Is a Vietnamese male more depressed than a Vietnamese female after the loss of a spouse? This type of question could be formulated for all of the different ethnic groups. This could give counselors information on how to work with different ethnic groups more effectively after the loss of a spouse.

Another study could consist of a religious or spiritual group versus a non-religious or spiritual group. Is a male that is spiritual more depressed than a male that is not spiritual after the loss of a spouse? A study could be done to answer this question. Another study could be done to answer the same question with females.

Another area of future study could be remarriage after the loss of a spouse. Remarriage following widowhood is a relatively unexplored topic that can be legitimately examined. Remarriage effects may be particularly important in understanding gender differences in the consequences of widowhood. Remarriage may reduce some widowhood-induced strains or it may introduce new strains - and these processes may differ for males and females. This issue of remarriage needs to be more fully explored and researched for its implications for counselors.

Another area of future study surrounding the bereaved is the company of a pet. Does the company of a pet reduce

loneliness for the bereaved? Does the company of a pet reduce loneliness better for males than females after the loss of a spouse? More research in this area needs to be explored for the implications for counselors.

Another area for future exploration is precisely what is meant by "excellent" or "poor" adjustment to the loss of a spouse (Zisook and Shuchter, 1986). So many widows and widowers who are not totally satisfied with their adjustment to bereavement attest to the fact that grief is often an ongoing, life-long process rather than a crisis that is simply mastered or resolved over a limited period of time. It is clear that the progression of bereavement toward recovery follows a complex path, and has multiple determinants. In order to resolve the difference between widows' and widowers' perceptions of "overall adjustment" more research needs to be done to explore excellent and poor adjustment.

Appendix

Beck Depression Inventory

Are you currently receiving any type of counseling? _____

Length of time since loss: _____ Length of Marriage: _____

Age: _____ Sex: _____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0,1,2,3) next to the one statement in each group which **best** describes the way you have been feeling the **past week, including today**. It several statements within a group seem to apply equally well, circle each one. **be sure to read all the statements in each group before making your choice.**

1 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3 0 I do not feel like a failure.
1 I feel I have failed more than the
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8 0 I don't feel I am any worse than any anybody else.
1 I am critical of myself for weaknesses or mistake.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

____ Subtotal Page 1 (Continued on next page)

11 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12 0 I have not lose interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I am ugly.

15 0 I can work as well as before.
1 It takes an extra effort to get started at doing anything.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything
3 I am too tired to do anything.

18 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes_____ No_____

20 0 I am no more worried about my health usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Subtotal page 2_____
Subtotal page 1_____
Total score _____

References

Barbato, A., & Irwin, H. (1992). Major therapeutic systems and the bereaved client. Australian Psychologist, 27, 22-27.

Beck, A. T. & Steer, R. A. (1987). Beck Depression Inventory: Manual. San Antonio, Texas: Harcourt. Brace and Company.

Berardo, F. (1970). "Survivorship and Social Isolation: The Care of the Aged Widower." Family Coordinator, 19, 11-25.

Breckenridge, Gallagher, et. al. (1986). Characteristic Depressive Symptoms of Bereaved Elders. Journal of Gerontology, 41, 163-168.

Bruce, M., Kim, K., Leaf, P. et al. (1990). Depressive episodes and dysphoria resulting from conjugal bereavement in a prospective community sample. American Journal of Psychiatry, 147, 608-611.

Campbell,I., Burgess, P., & Finch S. (1984). A factorial analysis of BDI scores. Journal of Clinical Psychology, 40, 992-996.

Carey, R. (1979). "Weathering Widowhood: Problems and Adjustment of the Widowed During the First Year." Omega: The Journal of Death and Dying, 10, 163-174.

Clayton, P. J. (1990). Bereavement and depression. Journal of Clinical Psychiatry, 51, 34-38.

Clayton, P. J., Halikas, J. A., & Maurice, W. L. (1972). The

depression of widowhood. British Journal of Psychiatry, 120, 71-78.

Demi, A. S. (1989). Midlife Loss: Coping Strategies. Newbury Park, CA: Sage Publications.

Dimond, M. F., Lund, D. A., & Caserta, M. S. (1987). The role of social support in the first two years of bereavement in an elderly sample. Gerontologist, 27, 599-604.

Feinson, M. C. (1986). Aging widows and widowers: Are there mental health differences? International Journal of Aging and Human Development, 23, 241-255.

Foelker, G. A., Shewchuk, R. M., & Niederehe, G. (1987). Confirmatory factor analysis of the short form Beck Depression Inventory in elderly community samples. Journal of Clinical Psychology, 43, 111-118.

Futterman, A., Gallagher, D., Thompson, L. W., et al. (1990). Retrospective assessment of marital adjustment and depression during the first two years of spousal bereavement. Psychology and Aging, 5, 277-283.

Gallagher, D., Breckenridge, J., Thompson, L. W., & Peterson, J. A. (1983). Effects of bereavement on indicators of mental health in elderly widows and widowers. Journal of Gerontology, 38, 565-571.

Gilewski, M. J., Farberow, N. L., Gallagher, D. E., et al. (1991).

Interaction of depression and bereavement on mental health in the elderly. Psychology and Aging, 6, 67-75.

Katz, S., & Florian, V. (1987). A comprehensive theoretical model of psychological reaction to loss. International Journal of Psychiatry in Medicine, 16, 325-345.

Kubler-Ross, E. (1969). On death and dying. New York: Macmillian.

Leahy, J. M. (1992-93). A comparison of depression in women bereaved of a spouse, child, or a parent. Omega Journal of Death and Dying, 26, 207-217.

Leahy, J. M. (1992). Validity and reliability of the Beck Depression Inventory Short Form in a group of adult bereaved females. Journal of Clinical Psychology, 48, 64-68.

Leming, m., & Dickinson, G. (1990). Understanding dying, death, and bereavement (2nd ed.). Fort Worth: Holt, Rinehart, & Winton,

Levy, L. H., Martinkowski, K. S., & Derby, J. F. (1994). Differences in patterns of adaptation in conjugal bereavement: Their sources and potential significance. Omega Journal of Death and Dying, 29, 71-87.

Lister, L. (1991). Men and grief: A review of research. Smith College Studies in Social Work, 61, 220-235.

Morgan, L. A. (1984) "Changes in family interaction following widowhood." Journal of Marriage and the Family, 46, 323-331.

Marris, P. (1974). Loss and change. New York: Pantheon Books.

Morycz, R. K. (1992). Widowhood and bereavement in late life. New York: Plenum Press.

Norris, F. H. & Murrell, S. A. (1990). Social support, life, events, and stress as modifiers of adjustment to bereavement by older adults. Psychology and Aging, 5, 429-436.

Nuss, W. S. & Zubenko, G. S. (1992). Correlates of persistent depressive symptoms in widows. American Journal of Psychiatry, 149, 346-351.

Parkes, C. M. (1975). Determinants of outcome following bereavement. Omega Journal of Death and Dying, 6, 303-323.

Parkes, C. M. (1972). Bereavement: Studies of grief in adult life. New York: International Universities Press.

Parkes, C. M., & Brown, R. (1972). Health after bereavement: A controlled study of young Boston widows and widowers. Psychosomatic Medicine, 34, 449-461.

Powers, E. A, & Bultena, G. L. (1976). "Sex differences in intimate friendships of old age." Journal of Marriage and the Family, 38, 739-747.

Rando, T. A. (1984). Grief, dying and death: Clinical intervention for caregivers. Champaign, IL: Research Press Company.

Raphael, B., & Nunn, K. (1988). Counseling the bereaved. Journal of Social Issues, 44, 191-206.

Sable, P. (1991) Attachment, loss of spouse, and grief in elderly adults. Omega Journal of Death and Dying, 23, 129-142.

Santrock, J. (1992). Life-Span development (4th ed.). Dubuque; IA: William C. Brown.

Schneider, J. (1984). Stress, loss, and grief: Understanding their origins and growth potential. Baltimore, MD: University Park Press.

Shuchter, S. R. (1986). Dimensions of grief: Adjusting to the death of a spouse. San Francisco: Jossey-Bass.

Siegel, J. M., & Kuykendall, D. H. (1990). Loss, Widowhood, and Psychological distress among the elderly. Journal of Consulting and Clinical Psychology, 58, 519-524.

Smith, K., & Zick, C. D. (1986). "The incidence of poverty among the recently widowed: Mediating factors in the life course." Journal of Marriage and Family, 48, 619-630.

Stroebe, W., & Stroebe, M. (1987). Bereavement and health: The psychological and physical consequences of partner loss. Cambridge, MA: Cambridge University Press.

Stroebe, W., & Stroebe, M. (1983). Who suffers more? Sex differences in health risks of the widowed. Psychological Bulletin, 93, 279-301.

Thompson, L. W., Gallagher-Thompson, D., Futterman, A., et al. The effects of late-life spousal bereavement over a 30-month interval. Psychology and Aging, 6, 434-441.

Umberson, D., Wortman, C., & Kessler, R. (1992). Widowhood and depression: Explaining long-term gender differences in vulnerability. Journal of Health and Social Behavior, 33, 10-24.

Worden, J. W. (1991). Grief counseling and grief therapy: A handbook for the mental health practitioner (2nd ed.). New York: Springer Publishing Company.

Zisook, S., & Shuchter, S. R. (1991). Depression through the first year after the death of a spouse. American Journal of Psychiatry, 148, 1346-1352.

Zisook, S. Shuchter, S., Sledge, P., et al. (1994). The spectrum of depressive phenomena after spousal bereavement. Journal of Clinical Psychiatry, 55, 29-36.