THE RELATIONSHIP BETWEEN CAUSE OF DEATH, PERCEPTIONS OF FUNERALS, AND BEREAVEMENT ADJUSTMENT

THESIS

Presented to the Graduate Council of the University of North Texas in Partial Fulfillment of the Requirements For the Degree of MASTER OF ARTS

By

Dina P. Ragow, B.A.
Denton, Texas
August, 1995
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Although funerals are seen as universal rituals to honor the death of a loved one, their value in facilitating the grief process is not known. The present study explored the relationships between cause of death, feelings and attitudes toward the funeral, and subsequent bereavement adjustment. 438 volunteers who had experienced the death of a loved one in the past three years completed a questionnaire including questions relating to their loss, their opinions about funerals, and several established measures of bereavement adjustment.

Analyses revealed that individuals experiencing the expected death of a loved one were more likely to participate in rituals both prior to and after the funeral.

Also, individuals holding more positive attitudes toward the funeral, exhibited less anger and guilt, and those individuals who perceived the funeral as more meaningful were found to be more fearful of the deaths of others.
ACKNOWLEDGMENTS

There are several individuals whom I would like to thank for their assistance, guidance, and support during the development and completion of this research project. Dr. Bert Hayslip Jr., my major professor, provided me with valuable assistance, direction, and most importantly the encouragement and support needed to successfully complete this task. He often went above and beyond the "call of duty", and his time and efforts are greatly appreciated. I would also like to thank my committee members, Dr. Angela Burke and Dr. Chuck Guarnaccia for their suggestions in helping me refine this study.

I am very fortunate to have the unconditional support of my family and friends. I especially want to thank my stepfather, Ron Larsen for his encouragement and undying belief in me over the years. I also wish to thank my father, Steve Ragow, for his constant love, support, and interest in my pursuits. I would also like to thank Ranette Boyd and all the other members of my "extended family" for being so supportive, caring, and giving, and for making my life truly complete. Jennifer Schwartz, Don and Susan Cox, Ken O'Brien, and all the other special people who have touched and enriched my life in so many ways deserve special acknowledgement as well. Most importantly I would like to thank my mother, Faith Ragow, who fostered in me the love of learning and the belief that the attainment of anything is possible if you put your heart into it and believe in yourself.
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CHAPTER I

INTRODUCTION

The differential impact of anticipated versus sudden death has been a widely debated issue. Even though many researchers believe that sudden, unexpected deaths often lead to more adverse problems for bereaved individuals, little is known about variables potentially affecting bereavement adjustment within these two domains. For example, despite the fact that the funeral is a common ritual after the death of a loved one, its value in facilitating the grief process has not been studied. It is clear that there is a conspicuous lack of research in this area. This dearth of knowledge supports the study of how cause of death possibly affects perception of the funeral process and subsequent bereavement.

Bereavement research and theory have traditionally approached death, regardless of its nature, as a generic event that is followed by a typical, related group of symptoms. However, it is now known that the premise all modes of dying are followed by a similar and predictable bereavement, is false (Rynerson 1986). Most research suggests that sudden or
unexpected loss, due to the lack of time to psychologically prepare, is initially more difficult to cope with and is more likely to lead to long-term problems, than a loss that can be anticipated (Lehman, Wortman, & Williams, 1987; Parkes & Weiss, 1983). Unexpected deaths are typically defined by researchers as those occurring due to accidents (such as automobile, drowning, etc...), as well as those due to homicide, suicide, and heart attacks. Sudden unexpected death has been shown to have a debilitating effect on the bereaved, and the shock acts to prolong grief, as well as to produce excessive physical and emotional trauma (Lundin, 1984; Parkes & Weiss, 1983). This seems partly due to the fact that these types of deaths are often premature, can be abhorrent and mutilating, and are often seen as potentially preventable. Also, since the death is unexpected, the bereaved have no opportunity for psychological preparation, and consequently no anticipatory grief is possible (Lundin, 1987). However, the differential impact of cause of death has been widely debated. Some researchers have found that parents whose children died after a lengthy illness had poorer subsequent adjustment than did other parents whose children died suddenly, presumably because the illness exhausted their coping resources and abilities (Rando 1983).
Glick et al. (1974) found that sudden death was such a shock, that the bereaved's capacity to cope was diminished and full functioning was not recovered by some people even four years following the death. He found that in contrast to cases of anticipated deaths where widowed women were forced to cope with the impending death of their spouse, those widowed by sudden death were ill prepared for the future. These women were doubtful that they could manage loss and isolation, and feared a nervous breakdown. Glick attributed this fear to the lack of anticipatory time to prepare for the death, and consequently to begin preparing for a new role. This lack of preparation time predisposed these women to develop a "fantasy relationship". He noted (p.28), "Widows dwelled obsessively on what had happened and continually searched for its cause; widows were unsure it was their husband who had died and it was difficult for them to accept the reality, even upon viewing the body". Nine of the widows in his sample reported feeling that their husbands were alive or near them, and these were all cases of unanticipated bereavement. Another interesting finding in this study, was that many of the widows dealing with anticipated losses cited the funeral director as a source of help. Glick found that these individuals were grateful to the directors for their helpfulness and kindness. Planning the funeral also helped
the women in attainment of self-confidence. If the funeral went well, these women were able to attribute the success to their ability to cope and recover. This is an important attribution that is relevant to this study. Since funeral directors may often be perceived by some individuals as exploitive, these findings could have been due to the nature of the death. In this particular case, anticipated deaths allowed these widows to plan the funeral before the death actually occurred. However, in cases of sudden or unexpected death, extensive planning has usually not occurred, which could partly account for the negative perception of funeral directors. In a study by Wallace (1973) which looked at widows whose spouses had committed suicide, only one widow reported that the funeral director had been helpful, and several complained they felt exploited in their grief.

Parkes (1975) found that mode of death was one of the primary predictive factors involved in spouses' bereavement outcome. One variable that contributed to poor outcome was the lack of opportunity to prepare for the death. From these findings, Parkes described a condition he termed "unexpected loss syndrome," characterized by social withdrawal, continued bewilderment, and protest over the death. He concluded that "this syndrome impaired functioning so severely that
uncomplicated bereavement could no longer be expected" (p.52).

Sanders (1980) longitudinally studied 86 individuals two years after a loss. She found that survivors of sudden death situations showed more anger than those whose family members had died of a chronic illness. They also had elevated scores on the Somatization and Physical Symptom scales of the Grief Experience Inventory, supporting the observation by other researchers of an increase in physical complaints during bereavement (Lindemann, 1944; Parkes, 1972;) The unexpected deaths left survivors with feelings of loss of control, and loss of faith in a world in which they had previously placed their faith and trust.

Spinetta, Swarner, and Sheposh (1981) looked at effective parental coping following the death of a child from cancer. They found that those parents who were best adjusted after the death of their child were those who accepted the diagnosis and course of the illness, those who had a viable and ongoing support system, and those who truthfully gave their child an appropriate level of information and emotional support during the illness. The study did not mention how deeply, if at all, the parents discussed death and funeral arrangements with the child. Perhaps if funeral plans were
discussed and agreed upon, the funeral would consequently become an important and sentimental part of acceptance.

Sanders (1983) interviewed eighty-six bereaved individuals shortly after the death of a loved one, and again eighteen months later in order to compare the effects of sudden vs. chronic illness death on bereavement outcome. Subjects were divided into three groups: sudden death, long-term chronic illness, and short-term chronic illness. No significant differences between types of death and bereavement outcome were found in this study, yet certain important trends were indicated. While both the sudden death and long-term chronic illness death groups sustained more intense bereavements at eighteen months than the short-term chronic illness groups, there were qualitative and quantitative differences between them. The sudden death group experienced more anger, guilt, shock, and exhibited an internalized emotional response described as "anger in," causing them to experience prolonged physical stress. According to Sanders, this anger was a result of the loss of control and helplessness they experienced after the unexpected deaths. "Anger in" respondents accepted blame, turned their anger inward, and suppressed their feelings. The guilt can be explained in terms of the inability to complete unfinished business and the inability to prevent the
death. Although at the initial interview, the sudden death group indicated fewer physical problems than either of the other two groups, at follow-up the sudden-death group manifested an increase in problems associated with physical health. Sanders attributed this to the diminished resources when confronting a sudden death. The long-term chronic illness group expressed an "anger-out" response which allowed them to vent their high levels of frustration and social isolation, and this seemed to prevent the prolonged physical stress noted in the other groups. The individuals making the best adjustment to the loss were those in the short-term chronic illness group. Although initially they resembled the other groups on measured levels of grief, when compared at the eighteen month follow-up, they had lower overall scores on all scales of the Grief Experience Inventory. From these data, it appears that there is value in some preparation for the loss, as long it is not an extended chronic illness which can often result in a withdrawal of social support.

In a descriptive study, Rynerson (1983) specifically looked at individuals who lost a relative through homicide. Here homicide was defined by having two characteristics: the death was violent, and the death was publicized. These individuals exhibited cognitive, behavioral, and affective reactions associated with the homicide. These symptoms
matched symptoms of post-traumatic stress disorder as noted in the DSM III. One interesting finding of this study was that all participants had previously experienced the non-homicidal death of another relative. It was their (the participants) unanimous observation that their reactions following the homicidal death differed from previously experienced forms of bereavement. All subjects reported the presence of intrusive and repetitive thoughts such as how their relative died and the helplessness they suffered. Fear was also a big issue, and seemed directly related to the violent nature of the death since there was preoccupation with anticipated violence to self and others. This fear lasted in many cases for eight months, and the future was seen as less secure and less fulfilling. These individuals obviously were suffering trauma from the violent and unexpected nature of the death, and were forced to relive the event over and over in order to process and accept the death. When these homicides go unsolved and unpunished, the internalization of the death remains a painful and real issue (Rynerson, 1983). In other words, solving the crime and punishing the criminal brought some degree of closure and externalization of the death to the individual. Maybe it would be useful to examine other methods that may aid the individual in closure (perhaps a positive funeral
experience), especially since all homicides are not solved and punished appropriately.

Rando (1983) examined grief adaptation in 54 parents whose children had died of cancer two months to three years prior to the study. She found that parents whose children had sustained longer illnesses, had lower levels of anticipatory grief, and those who had previous losses fared more poorly. There appeared to be an optimum length of the illness. If the illness either exceeded this time (greater than 18 months) or prematurely ended (less than six months), parental preparedness and subsequent adjustment levels were lower. The level of anticipatory grief was directly related to bereavement adjustment. Those parents that were classified as having medium to high levels of anticipatory grief had higher levels of postdeath adjustment than those classified as having low levels of anticipatory grief. The small number of participants in this study and the retrospective nature of the study warrants replication with a larger sample of bereaved parents.

Parkes and Weiss (1983) compared the reactions of those who had brief or no forewarning of their spouse's death, with those who had longer than two weeks to prepare themselves for the bereavement. At one year following the loss, only 9% of individuals in the "brief or no" forewarning
group were rated as having a good outcome. In the longer preparation group, 56% were rated as having a good outcome one year following bereavement. A long-term follow-up two to four years following the deaths revealed that only 1 of the 18 participants (6%) with brief or no warning was reported as doing well. In contrast, 63% of the 41 participants in the longer forewarning group were rated as doing well. This seems to support the notion that those recovering from a sudden death or a death in which there was little time to prepare, are more likely to suffer long-term adjustment problems.

Lundin (1984) found that 45 respondents who experienced a sudden death had more somatic and psychiatric illness, compared to 65 persons who had experienced an anticipated death. While the bereaved who had anticipated losses most often were in poorer health before bereavement (most likely due to the stress and impending death of their loved one), they suffered no increase in health consequences after the loss. Eight years later, there were no differences between the groups based on good versus poor outcome. Another study by Lundin (1984) examined the morbidity rates following sudden/unexpected bereavement. He found there was increased morbidity and somatic and psychiatric illness in this group, but not in the control group. He recommended that these individuals be identified as a high-risk group.
Miles (1985) compared the emotional and physical symptoms of parents whose children had died after a chronic disease, an accident, and those who were not bereaved. Parents bereaved from accidental death experienced death causation guilt. They felt guilty about having given the child permission to engage in the activity that resulted in death. The sudden nature of the death led to delayed numbness and shock, helplessness, and intense yearning for the child. Memories of the mutilation and disfigurement troubled the parents and made them concerned about how much the child suffered. If parents were not able to see their child either before or after the death, or if the body was never found, there were often prolonged feelings of denial. This prolonged denial may lead to long-term adjustment problems for the bereaved.

Lundin (1987) looked at the stress resulting from unexpected bereavement. Following 28 bereaved relatives for a two-year period, he looked at several variables including: guilt feelings, the separation process, defense mechanisms, seeing the grave, and the process of coping. He found that the suddenness of the death seemed to make the guilt worse and that there was often a prolonged initial denial of the death. He also found that due to this initial denial, the gravesite was especially important in unexpected deaths. He
argued that the grave had an important psychological function— to fill the emptiness left by the deceased, and in time to serve as a measure of reality. Since the death was so sudden and unexpected, the truth was often denied in the beginning since it did not seem real that the death had occurred.

Rando (1987) in a descriptive study, attempted to call attention to the unrecognized impact of two types of losses: sudden death in a slowly progressing terminal illness, and in improving convalescence. According to Rando, when a loved one dies during these time periods, it can produce more of a shock then if the death had occurred suddenly in everyday life. She attributed this to the unmet and violated expectations the survivors are suddenly faced with, due to the hope and confidence they have been given in either the slow deterioration or improving health of their loved one. She likened the violated expectations and their impact to parental bereavement following the loss of a child. In both cases there is a violation of natural expectations. The unanticipated nature of the death prevented there being time for a gradual shift in expectancies. Mourners suffered from extreme feelings of bewilderment, anxiety, self-reproach, and depression. There was difficulty accepting the loss, and often guilt accompanied acceptance. Since this study only
presented two case examples, the question of generalizability remains. However, her findings do support the findings of many other researchers, suggesting that those individuals mourning a sudden death, do have the added violated expectations and unpreparedness to deal with, in addition to the normal grief reactions.

Lehman, Wortman, and Williams (1987) examined the long-term effects of sudden, unexpected loss of a spouse or a child in a motor vehicle crash. Motor vehicle crashes are the number one cause of traumatic deaths in the U.S. today (Baker, O'Neill, and Karpf, 1984). They too found that sudden or unexpected loss is associated with long-term distress of bereaved individuals. They looked at the spousal group and the child group separately, while pairing both groups with matched controls. Comparison of the bereaved and control spouses revealed significant differences on a variety of measures of coping and adjustment. Bereaved spouses indicated a higher prevalence of depression and other psychiatric symptoms, impaired social functioning, decreased quality of life, and preoccupation with future worries/concerns. Bereaved parents and controls also demonstrated significant differences, although they were not as pervasive in the spousal group. An increase in depression was substantial, as well as dissatisfaction with relatives in their response to
the loss. In both bereaved groups, an increase in mortality was significant (suggesting mortality rates increase as a result of bereavement), and a higher divorce rate was noted. Participants in both bereaved groups reported that the loss continued to occupy their thoughts and conversations, thereby causing distress. A large percentage of participants (30%-85% depending on the question) continued to ruminate about the accident or what might have been done to prevent it, and they appeared to be unable to accept, resolve, or find any meaning in the loss.

Lehman (1989) looked at long-term consequences of sudden death on surviving family members. With respect to marital relationships, he found a polarization effect in which some relationships strengthened, but many divorced or separated. Yet, most bereaved parents reported that the relationship between them and their surviving children strengthened. Parental reports also suggested that the death of a parent or sibling is overwhelmingly negative for children. However, this study looked only at postloss adjustment and did not take into account family dynamics before the death occurred. Also, the effects of the death on the children were reported by the parents, and may not represent objective experiences.
Vargas, Loya, and Vargas (1989) explored the multidimensional aspects of early grief reactions in relatives and friends of victims of accidental deaths, suicides, homicides, and sudden natural deaths. Results indicated the prominence of depression. A grief reaction measure found 99% of the sample endorsed items on the depressive symptoms factor, and 56% endorsed items on the suicidal ideation factor. Anger at the deceased (decedent-directed anger) was also found. The authors suggested that, although anger is a normal part of the grief reaction, here it may be partly due to the sudden and untimely nature of the death. Since anger usually does not fully surface until later in the grief process, and this study examined people in relatively early stages, this may explain why only 43% endorsed items involving decedent-directed anger which suggests an "anger in" mode. Strengths of this study included deriving the sample from a general, non-psychiatric population, representing all four modes of sudden death, and including people from three distinct racial and ethnic groups. Limitations of this study included an under representation of men in the sample, a lack of homogeneity in the respondents (since accidental deaths and homicides tend to occur in younger populations, the respondents in these groups were likely to be parents), and the exclusion of
natural or anticipated deaths. This prevented conclusions being made about whether survivors of natural or anticipated deaths experience grief in the same manner.

Sanders (1988) examined risk factors in bereavement outcome by looking at biographic/demographic variables, gender, socioeconomic status, personality, preloss health, relationship to the deceased, mode of death, and amount of social support. She concluded that sudden, untimely or stigmatized deaths, multiple losses, lack of social support, and poor preloss health are all considered debilitating risk factors for bereavement outcome. She noted that because the survivors of those lost to unexpected or untimely deaths are generally younger people, health-related consequences characterizing poor bereavement outcome, may not be seen for many years.

Kalish and Reynolds (1990) looked at the bereaved's perspective following suicide and other types of death by studying fifty-seven university students who had recently lost a friend or relative. He found that those who lost a loved one to suicide or an accidental death (an unexpected/untimely death) said that people treated them differently after the death. Also, those bereaved by suicide and accidents felt they were expected to explain the nature of the death to others in the community, and these survivors
admitted to lying more about the cause of death. These bereaved individuals struggled to find a reason for the death, as well as having to face questions from others. There are data to indicate that the community may hold the bereaved more responsible for suicidal or accidental deaths than for natural or anticipated deaths (Calhoun, 1980; Ginn, 1988). Even though a control group that experienced unanticipated but natural deaths was included, respondents may have been more psychologically prepared for the death due to the victim often being older. The authors suggested, therefore, that future research should control for the age of the deceased.

Range and Niss (1990) examined long term bereavement from suicide, homicide, accidents, and natural deaths by studying 68 undergraduate students in a psychology course. They noted that although short-term bereavement from suicide has been found to be different from other types of death, not much was known on long-term bereavement. They found that the bereavement process was similar over time, regardless of the cause of death. The one exception, however, was that accidental deaths were perceived as less real than other deaths. A limitation of this study was that all subjects were college students. Again, age was a confound, since those dying of a natural death tended to be older.
individuals. Also, a group of those mourning the loss of a friend or relative to an anticipated death or long-term illness, was not included. Despite these limitations, the authors concluded that perhaps the short-term differences seen based on cause of death dissipate over time and, hence, are not crucial to long-term recovery.

Thompson and Range (1990) examined recent bereavement from suicide and other types of death to see if 96 non-bereaved individuals could imagine the situation as it really was. They concluded that, in most cases, non-bereaved individuals could imagine the impact and prognosis for recovery. However, they were not able to properly perceive the amount of social support usually received before and after the death of someone to suicide. Those bereaved from suicide received less social support and had a poorer prognosis for recovery than those dealing with a natural death. This finding may be due to the unexpected dimension of the death and/or receiving less social support.

The age confound for naturally occurring deaths presented again. The author suggested that, with the increasing incidence of AIDS, perhaps a younger group of natural anticipated deaths can be included in future research studies. A strength of this study was that the bereaved subjects were recently bereaved. Also, the fact that non-
bereaved individuals could not accurately imagine or predict levels of social helpfulness supports the idea that bereaved suicide survivors may need more, or need to perceive more, social support after the death than other bereaved individuals.

Fanos and Nickerson (1991) examined long-term consequences for adolescents surviving a sibling death from cystic fibrosis. This disease was chosen because it is the number one cause of death for Caucasian children today. They found that the age of the surviving adolescent at the time of death was statistically significant. Those that were between the ages of 13 and 17 experienced the most symptoms. They experienced a global sense of guilt, guilt over handling the sibling's illness and death, and guilt over survival. They also manifested global anxiety, bodily concerns, fear of intimacy, excessive concern for others, and sleeping difficulties. A limitation of this study was that adults were interviewed who had lost siblings when they were adolescents. Since this was not a longitudinal study, other events in the adults life along the way could have biased the results. Also, since only Caucasians were included, no generalizations regarding race could be made. Knowing the long-term consequences, researchers and helping professionals should concentrate on what factors or events could help
mediate some of these outcomes (i.e., helping parents not to neglect the well child, getting the adolescent professional help before the death, and pulling together as a family after the death for the funeral, and by seeking family counseling).

Martinson, Davies, and McClowery (1991) studied parental depression in 66 parents following the death of a child from cancer. They found that parental bereavement following the death of a child from cancer was not time-limited, and that even after seven years, many still felt an "empty space" in their lives, and consequently still manifested signs of depression. The authors noted that those families with higher amounts of concurrent life stresses were at an elevated risk for continued depression. These additional stressors could be responsible or add to the existing depression. Alternatively, the death of a child could have permanently altered one's attitude toward life (Seligman 1975).

Miles and Demi (1991) compared the guilt feelings in bereaved parents whose children died by suicide, accident, and chronic illness. The authors found that, although all groups experienced some degree of guilt reactions, those bereaved by suicide reported the highest amount of guilt feelings (92%), and also claimed that this guilt was the most distressing aspect of their grief. None of the accident or
chronically ill bereaved parents indicated guilt as the most distressing aspect. Instead, they reported loneliness as the most distressing aspect. Edelstein (1984) stated that mothers who experienced the unexpected death of a child commonly experienced guilt due to perceived responsibility for the death. Johnson-Sodorberg (1983) found that parents who had little or no time to prepare for their child's death experienced more guilt than did parents who had more warning. The two main limitations of this study were collection of data from primarily middle-class white parents involved in self-help groups, and the wide age range of the deceased children.

Hazzard, Weston, and Gutterres (1992) examined factors related to parental bereavement in 45 parents whose children died six months to four years earlier. They found that parents of children who died suddenly experienced more despair, anger, guilt, and depersonalization. The decreased or complete lack of anticipatory grief, and decreased involvement during the child's short hospitalization (if applicable), were related to these feelings of anger, hostility, and guilt. The small sample size and limited scope of the study (parental grief) were limitations of this study. However, the implication for professionals in this area was that the provision of support after the death
of a child may decrease the likelihood that parents experience atypical or maladaptive grief reactions.

Parkes (1993) examined psychiatric problems in seventeen individuals following bereavement by murder or manslaughter. He found that vicious, repetitive thought cycles often accounted for the symptom persistence. These symptoms fitted the diagnostic categories of post-traumatic stress disorder, anxiety states, panic syndromes, obsessive revenge seeking, and depression. Parkes suggested that the combination of the sudden and horrific nature of the death, the rage and guilt, and the overwhelming strain on the family, was bound to interfere with "normal grieving". The emotional shock generated anxiety and vivid mental imagery, as well as intense anger towards the offender and legal system. There is a decrease in ability to trust others, and an increase in guilt at having survived and not having been able to have prevented the death. All of these feelings tended to cycle and increased in intensity as time went by. Parkes suggested that intervention needed to be aimed at helping individuals feel control again over their thoughts, and in helping them break this cycle of rumination.

Statement of the Problem

Although research results are mixed concerning bereavement adjustment based on cause of death, many
researchers support the belief that sudden, unanticipated deaths are more likely to lead to long-term problems psychologically and physically. Whether this is due to a lack of anticipatory grief, to the often abhorrent nature of the death, or to a combination of factors, survivors of those lost to violent and unanticipated deaths experience intense symptomology such as increased guilt feelings, perception of decreased social support (as in suicides), and often remain in denial for longer periods of time. Since funerals and the events surrounding them are seen as universal rituals to honor the death of a loved one, and many contextual variables (cause of death, relationship to the deceased, etc.) may interact with this process, it seems necessary to question how cause of death affects perception of the funeral process and subsequent bereavement adjustment. This relationship has been difficult for researchers to study since many of the contextual variables listed above are potential confounds.

Based on the available literature, it was hypothesized that the funeral, which serves as a means of closure, may thus be viewed as a more important and necessary process by survivors of those lost to an unexpected or violent death, especially in cases where this type of death is unexplained or unsolved (as noted in Rynerson, 1983), than to survivors of other types of death. Survivors from these types of deaths
may "need" the funeral and the events associated with it to help make the death more real, to have the presence of loved ones around in order to perceive more social support, and to get some closure since anticipatory grief is not possible.

Secondly, it was hypothesized that the funeral may be seen as just as essential to survivors dealing with the death of chronically ill patients when there were low levels of participation in treatment (as noted in Rando, 1983; Hazzard, Weston, and Gutierrez, 1992). These survivors may "need" the funeral and the events associated with it to deal with feelings such as anger, denial, and guilt over not being more involved while the deceased person was still alive, and to receive some social support after the death.

The third hypothesis was that persons reporting a positive attitude towards the funeral and events surrounding it can potentially be helped in their bereavement adjustment, and that this is especially true for those dealing with a sudden, unexpected loss. If such bereaved persons see funerals as meaningful and report a positive attitude to them, this may positively influence their subsequent bereavement and consequently, may reduce the possibility of maladaptive, long-term grief responses. This would most notably be seen by participants in the study assigning a high degree of meaningfulness to funeral practices, and there
being a close relationship between the meaningfulness of these practices and the relationship to the deceased (Lester-Blustein Attitudes Toward Funerals Scale). Participants would also likely have higher scores on the Past Behaviors and Present Feelings scales of the Texas Revised Inventory of Grief which would suggest higher levels of grief resolution, and they would be likely to have participated in various post-funeral rituals as noted by Bolton and Camp (1986). Finally, participants who had positive experiences with the funeral process, would likely have lower scores on the Negative Affect Dimension of the Bradburn-Affect Balance Scale, less fear of death or death anxiety as measured by the Templer Death Anxiety Scale and Collett-Lester Fear of Death Scale, and fewer negative bereavement reactions to the deceased as measured by the Bereavement Experience Questionnaire.

If people in the study reported a negative attitude towards the funeral experience, did not participate much in the funeral process, and did not perceive a high degree of meaningfulness or helpfulness in the funeral ritual, the quality of their adjustment could be influenced negatively, and consequently be correlated with an increase of maladaptive responses. This would most likely be seen by participants reporting more negative feelings on the Present
Behaviors section of the Texas Revised Inventory of Grief (suggesting a lower degree of grief resolution), experiencing more negative reactions to the deceased as measured by the Bereavement Experience Questionnaire, and reporting more fear of death or death anxiety as noted by higher scores on the Templer Death Anxiety Scale and Collett-Lester Fear Scale. Participants would also most likely report a higher degree of somatization, sensitivity, depression, and anxiety as noted by the symptom dimensions of the Hopkins Symptomology Checklist. The experiences surrounding the funeral and the perceptions of this process by bereaved individuals may very well be influenced by cause of death, and therefore be another factor related to bereavement outcome.
CHAPTER II

METHOD

Participants
The sample consisted of 438 individuals (104 males, 334 females) all over the age of 18, who had experienced the death of a family member or friend within the past three years, regardless of the circumstances surrounding the death. Participants were recruited from various bereavement organizations throughout the state such as Hospice and Compassionate Friends, as well as from various sources in the community such as a local university and local area newspapers. The sample was purposefully heterogeneous regarding various sociodemographic factors such as age, gender, ethnicity, religion, geographic location, and cause of death. The average age of participants was 35 years, and the average amount of education completed was 13 years. The sample was comprised of Caucasians (N = 364), African-American (N = 32), Hispanic (N = 21), American Indian (N = 5), Asian (N = 11), and Other (N = 5). The majority of individuals reported their religious affiliation to be
Protestant (N = 226), and most of the participants were single (N = 232). Only 137 participants in this sample reported having any training/courses dealing with the subject of death and dying prior to the loss of their loved one. In terms of survivors of the deceased, 50 had experienced the death of a Spouse, Grandparent (N = 101), Grandchild (N = 1), Mother (N = 40), Father (N = 40), Sister (N = 4), Brother (N = 7), Close friend (N = 77), Aunt (N = 26), Uncle (N = 18), Son (N = 18), Daughter (N = 8), and Other (N = 66). Moreover, 121 individuals reported that their mother was already deceased, while 144 individuals reported that their father was already deceased.

Individuals were divided by cause of death into two main groups: expected versus unexpected. The expected death group included 173 individuals who had lost loved ones to circumstances including cancer, AIDS, and other serious illnesses such as diabetes and pneumonia. The unexpected death group included 265 individuals who had lost loved ones to circumstances such as murder, car accidents, heart attacks, strokes, drowning, fire, aneurysms, plane crashes, and suicide. For those in the expected death group, (57) individuals reported their loved ones were sick for more than two years prior to their death, while only (7) reported that
their loved one was sick for one month or less. The average length of time loved ones were sick was 7-12 months.

Instruments

Participants completed a questionnaire which contains scales assessing their attitudes towards funerals and death, as well as self-report questions which assess their experiences with and involvement in various activities surrounding the funeral, their perceived level of adjustment, and general demographic data.

Lester-Blustein Attitudes Toward Funerals Scale. The Lester-Blustein Attitudes Toward Funerals Scale (Lester, 1980) is a 12 item inventory which was designed to investigate three main areas: attitudes toward the funeral industry, attitudes to viewing the body of the deceased, and attitudes toward funerals in general. Questions are presented in a Likert-type scale format. Normative data was determined by giving items to two samples of approximately 50 students each. Scores on the three subscales were found to be significantly correlated in both samples (r=0.32-0.52). Since subscale scores did not correlate consistently with age, sex, external locus of control, fear of death of self, death of others, dying of self, or dying of others, investigators concluded that attitudes toward funerals
constitute an independent component of attitudes toward death and dying.

**Garmen and Kidd's Attitudes Toward Funeral Scale.** Garmen and Kidd (1983) administered a questionnaire at a state university to investigate knowledge and attitudes towards the funeral industry. No reliability data were provided. This is considered to be an experimental measure.

**The Extent of Participating in Rituals Scale.** A measure by Bolton and Camp (Bolton, et al. 1986) was designed to investigate the frequency with which 50 bereaved widows engaged in various rituals before, during, and after the funeral. Pre-funeral rituals included such things as selecting the burial site, type of service, and placing public notices of the death. Participation in funeral rituals included such things as delivering a eulogy and preparing the music for the service. Participation in activities following the funeral was also assessed. Examples included acknowledging memorials such as food and donations, and making visits to the gravesite. Participants answered questions about their participation and their belief on whether these activities helped or hindered their bereavement. Although data did not support a significant relationship between the amount of ritual participation and degree of adaptive grieving or well-being, results did
suggest that post-funeral acts may play a role in aspects of grief adjustment such as health and happiness. Although reliability and validity coefficients were not stated, results seem to show that a general statement can be made regarding the potential of post-funeral rituals in the facilitation of grief adjustment.

**Perceptions of the Meaningfulness of Funerals Scale.**

Swanson and Bennett's Perceptions of the Meaningfulness of Funerals scale (Swanson and Bennett, 1983) was designed to investigate the attitudes of 94 females and 58 male bereaved individuals toward selected funeral practices based on perceived closeness to the deceased at the time of death. Six selected variables (3 dealing with aspects of the bereaved and 3 dealing with aspects of the death) were examined by Likert scale questions and found to be correlated with components of the funeral. The three selected characteristics of the bereaved were sex, closeness to the deceased, and religious preference, while the three selected conditions of the death were time of death, location of funeral service, and viewing the body. These characteristics were used to identify the meaningfulness to the bereaved of selected funeral practices, and if there is a relationship between the closeness of the bereaved's relationship to the deceased and meaningfulness of these
practices. The researchers stated that test-retest reliability was established, although it was not stated in the study. Other psychometric properties were not reported by the researchers.

Texas Revised Inventory of Grief. The short form of the Texas Revised Inventory of Grief (Zisook and DeVaul, 1983) was designed to assess the bereavement adjustment of individuals. This inventory includes fifty-eight items and two scales which examine the feelings and behaviors of the bereaved after the death of their loved one (Past Behaviors), and how they presently feel in relation to the deceased (Present Feelings). It is a self-report measure presented in a Likert-type scale with possible responses ranging from Completely True to Completely False, and has established psychometric properties ($r=0.74$ to 0.89). The initial sample consisted of friends and acquaintances of the test developer to obtain normative data. Using the Unresolved Grief Index, a measure used to identify unresolved grief, researchers found that all of those in the resolved grief group had higher overall scores on the Past Behaviors ($p<.01$) and Present Feelings ($p<.01$) lists. This suggests that this inventory positively correlates with levels of grief resolution.
Bereavement Experience Questionnaire. The Bereavement Experience Questionnaire (Demi, 1984) is a 67 item, eight subscale self-report measure presented in a Likert-type scale format. It was designed to assess bereavement reactions to the deceased such as anger, guilt, stigma, meaninglessness, yearning, morbid fears, isolation, and depersonalization. Scores range from "1" (never) to "4" (always). Each of the eight subscales measures the impact of having lost a loved one over the past month. Hayslip and Guarnaccia (1993) found evidence for a one or two factor model. Good reliability was found using coefficient alphas. Internal consistency was found to be 0.95, and correlation coefficients were computed to determine construct validity of .3 to .7.

Bradburn Affect-Balance Scale. The Bradburn Affect-Balance Scale (Bradburn, 1969) is a ten item scale which was designed to measure bereavement adjustment by concentrating on psychological well-being. The scale focuses on the respondents' experiences during the last few weeks, and is divided into two affect dimensions: positive and negative. The two dimensions are independent of each other, but together offer an index of psychological well-being. The stated reliability of the two dimensions ranges from 0.86 to 0.97.
Coping Inventory. The Coping Inventory (Horowitz and Wilner, 1980) is a thirty-three item scale designed to assess strategies utilized in coping and adjusting to significant life events. The three subscales of socialization, working through, and turning to other activities are presented in a Likert-type scale format where the participant chooses either "does not apply", "does apply", or "does apply and was very helpful". The psychometric properties of reliability and validity have not yet been established, as the instrument is still considered experimental.

The Templer Death Anxiety Scale. The Templer Death Anxiety Scale (Templer, 1970) assesses anxiety related to death and dying. An example question from this inventory is, "The sight of a dead body is horrifying to me." The fifteen items are presented in a true-false format and the scale has test-reliability of $r=0.83$ and an internal consistency coefficient of 0.73. A validity coefficient of 0.74 has been established for this measure.

The Collett-Lester Fear of Death Scale. The Collett-Lester Fear of Death Scale (Lester, 1990) is a thirty-six item self-report measure which was designed to assess four separate issues of death fears or anxieties: fear of death, fear of dying, fear for self, and fear for others. This
measure combats heterogeneity of item content that has been encountered with many other similar scales. Responses are scored along a six point continuum where participants rate the extent they agree or disagree with the statement. Even though this is an unpublished test assessing death concerns, reasonable reliability and validity has been established. Test-retest reliability has been reported by Rigdon and Epting (1985) with a mean of .55.

The Incomplete Sentence Blank. The Incomplete Sentence Blank (ISB) is a ten-item sentence completion inventory designed to assess any unconscious fears the individual may have about dying. Each stem is coded either "0" or "1" based on the absence or presence of such fear dimensions as loss of control, loss of goals/achievements, injury or disease, existence/stagnation, death-related pain and suffering, mention of death/dying, and separation or isolation from others. Scores for each dimension range from 0 to 25 while the total score ranges from 0 to 255. Hayslip, Galt, and Pinder (1993) reported adequate reliability and validity for this measure of unconscious death anxiety.

The Hopkins Symptom Checklist. The Hopkins Symptom Checklist (Derogatis, 1974) is a fifty-eight item self-report inventory designed to measure psychological symptoms that
have been experienced by the participant within the past seven days. Participants rate themselves on each of the five symptom dimensions: somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, and anxiety using a four-point Likert-type scale. The Chronbach alpha coefficients for the five dimensions range from 0.84 to 0.87 (Derogatis et al., 1974).

**Self-Report of Health.** A self-report of health designed by Rider and Hayslip (1994) was included to assess the physical and emotional health of the bereaved individual over the past three months up until the past two weeks. Reliability and validity measures have not been established yet for this measure.

**Social Desirability Scale.** The short form of the Social Desirability Scale (Crowne and Marlowe, 1960) was designed to control for response bias. The scale consists of forty-seven items presented in a Likert-type scale format. The normative sample consisted of thirty-nine undergraduates in introductory psychology courses. Test-retest reliability was found to be 0.89 while the internal consistency coefficient was 0.88.

**Procedure**

After being recruited by the various means previously discussed, subjects were given a questionnaire via mail or in...
person. Each questionnaire included an overview of the study, an informed consent form with a phone number provided if participants had any questions or problems, and a list of directions and things to remember when completing the study. Following these initial pages, subjects who chose to continue filled out several pages of demographic data. Questions about individual circumstances, involvement in the funeral, and measures of bereavement adjustment followed. Subjects were given the opportunity to make comments freely on the questionnaire and to indicate if they would like a copy of the results.
CHAPTER III

RESULTS

Data analysis began by performing a one way multivariate analysis of variance test (MANOVA) on the entire sample to analyze the relationship between cause of death and feelings/attitudes towards funerals. The extent of participation in the funeral process, the perceived meaningfulness of funeral practices, and the perceived helpfulness of funeral practices were the dependent variables, while the nature of the death (expected vs. unexpected) was the independent variable. This reflects the first hypothesis which stated that survivors of unexpected deaths may need the funeral more in order to make the death more real or to get some closure, and consequently that their level of participation in the funeral and evaluation of the meaningfulness of the funeral could be affected by cause of death. Feelings and attitudes toward the funeral were designated by: the extent of participation in the funeral process (denoted "preritual", "ritual", "postritual"), the perceived meaningfulness of funeral practices (denoted "meaning"), and the perceived helpfulness of funeral
practices (denoted "helpful"). A significant multivariate effect was not found ($F(1, 434) = 1.53$, $p > .05$). Table 1 contains the means and standard deviations of the dependent variables for both the expected and unexpected groups. Post hoc univariate analysis revealed that the cause of death was significantly related to participation in various activities prior to the funeral ($F(1, 429) = 5.55$, $p = .019$). Individuals for whom the death of their loved one was expected, tended to participate more in activities prior to the funeral itself such as gathering with friends before the service, selecting the grave marker, and placing public notices about the death. There was also a trend for individuals experiencing the expected death of a loved one to participate more in postfuneral activities ($F(1, 429) = 2.78$, $p = .096$), such as acknowledging food/gifts, making visits to the gravesite, and getting rid of personal belongings of the deceased. Overall however, the data suggest that cause of death does not affect the general perceived helpfulness or meaningfulness of funerals.

A second one way MANOVA was performed to analyze the relationship between level of involvement in the chronically ill person's treatment (where applicable), and feelings and attitudes towards funerals. The extent of having a
Table 1

Observed Means and Standard Deviations for the Expected and Unexpected Death Groups When Crossed with Helpfulness, Meaningfulness, and Extent of Participation in Pre-Funeral, Funeral, and Post-Funeral Rituals.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Expected(1)</th>
<th>Unexpected(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Helpful</td>
<td>29.08</td>
<td>6.99</td>
</tr>
<tr>
<td>Meaning</td>
<td>31.72</td>
<td>6.29</td>
</tr>
<tr>
<td>Preritual</td>
<td>21.23</td>
<td>7.46</td>
</tr>
<tr>
<td>Funeral ritual</td>
<td>9.08</td>
<td>4.49</td>
</tr>
<tr>
<td>Postritual</td>
<td>20.12</td>
<td>6.94</td>
</tr>
</tbody>
</table>
positive attitude associated with the funeral, and the perceived meaningfulness and perceived helpfulness of funeral practices were the dependent variables, while the extent of participation during the deceased individuals' illness was the independent variable. This reflects the second hypothesis which stated that the funeral may be seen as just as essential to survivors of chronically ill patients where there was a low level of treatment participation. The extent of having a positive attitude was designated "Attitude 1" and "Attitude 2" which denoted two separate measures of attitudes toward the funeral. Again, no significant multivariate effects were found ($F(1, 64) = 0.81, p = .522$). Consequently, whether a bereaved individual was involved or not in their loved ones pre-death illness had no effect on their attitude toward the funeral, or the perceived helpfulness and meaningfulness of the funeral (see Table 2).

Finally, a three way MANOVA using the entire sample was performed to analyze the impact of the nature of the death, attitudes toward the funeral, and perceived meaningfulness of the funeral on bereavement adjustment, where expected vs. unexpected death was one independent variable, and the extent of having a positive attitude towards the funeral and the perceived meaningfulness were the remaining independent variables. Dependent variables were scores on measures of
Table 2
Observed Means and Standard Deviations for the Perceived Meaningfulness, Perceived Helpfulness, and Extent of Positive Attitude Toward the Funeral When Crossed with Involvement during Pre-death Illness

<table>
<thead>
<tr>
<th></th>
<th>Involved(1)</th>
<th>Not Involved(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>*Attitude 1</td>
<td>41.02</td>
<td>6.34</td>
</tr>
<tr>
<td>**Attitude 2</td>
<td>36.41</td>
<td>6.40</td>
</tr>
<tr>
<td>Meaning</td>
<td>31.69</td>
<td>5.81</td>
</tr>
<tr>
<td>Helpful</td>
<td>30.06</td>
<td>6.02</td>
</tr>
</tbody>
</table>

* Lester Blustein Attitudes Toward Funeral Scale
**Garmen and Kidd's Attitude Toward Funeral Scale
bereavement adjustment such as the Hopkins Symptom Checklist, Bereavement Experience Questionnaire (BEQ), Templer Death Anxiety Scale (TDAS), Collett-Lester Fear of Death Scale (denoted "death of self", "death of others", "dying of self", and "dying of others"), and the Texas Revised Inventory of Grief (denoted "past behaviors" and "present behaviors"). This reflects the third hypothesis which stated that persons with more positive attitudes toward the funeral could potentially be helped in their bereavement adjustment, especially those suffering a sudden, unexpected loss.

Meaning, and Attitude 2 (which examined attitudes towards things such as requirements of funeral directors cost of funerals, and the ways bereaved individuals should be treated) were split at the median in order to denote alternate measures of higher and lower levels of these independent variables. A significant multivariate main effect was found for attitude ($F(9, 414) = 3.20, p < .001$).

In other words, individuals that had more positive attitudes towards things such as funeral directors and the treatment of bereaved individuals, exhibited fewer signs of negative grief reactions such as anxiety, anger and guilt (See Table 3). Post-hoc tests conducted at the univariate level revealed that individuals who had a more positive attitude
Table 3

**Observed Means and Standard Deviations for the Two Levels of Attitude When Crossed with Various Measures of Bereavement Adjustment**

<table>
<thead>
<tr>
<th>Measures of Adjustment</th>
<th>Attitude (1)</th>
<th></th>
<th>Attitude (2)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Hopkins</td>
<td>87.99</td>
<td>24.55</td>
<td>91.10</td>
<td>28.68</td>
</tr>
<tr>
<td>DAS</td>
<td>22.22</td>
<td>3.07</td>
<td>22.47</td>
<td>3.35</td>
</tr>
<tr>
<td>Death of Self</td>
<td>26.90</td>
<td>6.05</td>
<td>26.67</td>
<td>5.98</td>
</tr>
<tr>
<td>Dying of Self</td>
<td>20.35</td>
<td>3.79</td>
<td>20.37</td>
<td>3.64</td>
</tr>
<tr>
<td>Death of Others</td>
<td>33.95</td>
<td>5.54</td>
<td>34.77</td>
<td>5.30</td>
</tr>
<tr>
<td>Dying of Others</td>
<td>28.83</td>
<td>5.83</td>
<td>29.84</td>
<td>5.32</td>
</tr>
<tr>
<td>TRIGPAST</td>
<td>20.29</td>
<td>7.68</td>
<td>19.50</td>
<td>7.56</td>
</tr>
<tr>
<td>TRIGPRES</td>
<td>39.31</td>
<td>14.30</td>
<td>42.59</td>
<td>14.55</td>
</tr>
</tbody>
</table>
toward the funeral were found to have higher scores on the "Dying of Others" scale on the Collett-Lester Fear of Death Scale, suggesting that they are more fearful of other people dying, than those individuals with less positive attitudes toward the funeral ($F(1, 422) = 3.23, p < .07$).

No multivariate effects were found for Perceived Meaningfulness. However, post-hoc ANOVA's suggested that individuals who perceived the funeral as more meaningful had higher scores on the "Dying of Others" scale, suggesting that, they too tend to be more fearful of other people dying, than those who do not place as much value on the funeral process ($F(1, 422) = 3.41, p = .06$). Also, individuals who perceived the funeral as more meaningful had lower scores on the Present Feelings section of the Texas Revised Inventory of Grief (denoted TRIGPRES). This suggests that overall those who found the funeral to be a significant and meaningful experience, were less preoccupied with thoughts about how the deceased person used to be, found recalling memories of the deceased to be less painful, were more able to accept the death, etc... ($F(1, 422) = 5.92, p = .02$).
CHAPTER IV

DISCUSSION

The purpose of the present study was to explore the relationship between cause of death, feelings and attitudes toward the funeral, and subsequent bereavement adjustment, and therefore gain some insight into the role that the funeral, as a ritual, plays in bereavement adjustment. Hypothesis 1 predicted that funerals may be seen as more important to survivors of unexpected death, and therefore they would tend to participate more in activities surrounding the funeral, and view the funeral as extremely meaningful and helpful. Results suggest that overall there are no differences with regard to feelings, attitudes, and participation in various funeral activities as a function of cause of death.

In this study, all causes of death were aggregated and divided into two categories: unexpected and expected. This division may not have accounted for the variability associated with the specific factors associated with different causes of death. Different results may have been
obtained if each cause of death had been analyzed separately, as cause of death most likely interacts with other variables not taken into consideration such as the relationship of the bereaved to the deceased. For example, if relatedness to the deceased were analyzed, one would likely expect an acute and sudden loss to be more relevant for a parent losing a child or child losing a parent, than the loss of a friend, aunt, or uncle. Also, due to the unique characteristics surrounding violent and/or painful deaths, analyzing the data by the inclusion of whether or not the death was violent could yield different results.

It was thought that cause of death may be more of a factor for newly bereaved individuals, whereas over time, when remembering the funeral, the funeral helps to focus on the loss not the cause of death. This study did analyze cause of death by length of time bereaved. However, they did not interact. Therefore, it appears that regardless of length of time bereaved, cause of death does not directly impact a person's attitude or perception of the funeral. However, this study only looked at deaths occurring within the past three years. If deaths that occurred within a broader time frame were considered (such as 5-7 years ago), different results might have been found.
Age is also a factor to be considered in understanding the lack of impact of cause of death on attitudes toward the funeral. In this study, persons were aggregated across age. However, it is reasonable to assume that older individuals have probably had more experiences with funerals and loss, and consequently be more sensitized to issues surrounding the funeral and going through the grieving process, than younger individuals or those without previous experiences. For individuals who have never attended or participated in a funeral, cause of death might be relevant.

Finally, this study did not take into account the extent to which the bereaved were utilizing support services. Just like having prior training or coursework, participation in support services such as counseling and/or support groups might "balance out" the possible effect cause of death might have, especially for those dealing with a sudden or acute loss. It was found that individuals for whom the death was expected tended to participate more in activities both before and after the funeral than those people dealing with an unexpected death. It is not unreasonable to assume in cases of expected deaths that many of the arrangements for the funeral were made ahead of time since the death was anticipated. These people also most likely had ongoing support networks (such as friends and family) present during
the course of the illness and at the time of death to help
the newly bereaved with such things as making arrangements
and selecting the type of service. For those experiencing a
sudden loss, no specific support networks were able to be
formed or mobilized prior to the death. Since these
individuals were most likely in an intense state of shock and
confusion, it is possible these pre-ritual events were
bypassed altogether, or that other family members and friends
took on these responsibilities for the newly bereaved
person(s). As for participation in post-ritual activities,
those for whom the death was anticipated may be more able to
accept the reality and thus "face the death" by doing things
such as visiting the grave and getting rid of personal
belongings. Individuals dealing with sudden and unexpected
deaths tend to be in extended states of shock and denial, and
therefore at times may be unable to participate in activities
that acknowledge the reality of the death such as making
visits to the gravesite and parting with precious
possessions. Cause of death is a complex variable that has
many potential confounds (age, relationship to the deceased,
extent of social support, etc.). Therefore, the data suggest
that cause of death may be an important variable in certain
situations, while not being an important variable in other
situations.
Hypothesis 2 predicted that the funeral may be just as essential to survivors of those who died of a chronic illness when there was a low level of participation in their treatment prior to death. Results suggested that regardless of whether individuals were involved in their loved ones' treatment, they did not differ in their feelings and attitudes toward the funeral. It is possible that those individuals not highly involved in the treatment/care, were less removed from the deceased (i.e. not a first degree relative), or not as close emotionally to the deceased, and therefore might have fewer subjective and/or less strong feelings and attitudes towards the funeral to report. Also, the fact only 17 people in the sample whose loved one died of an illness reported they were not involved in their care prior to death, may account for why no differences were found. This may, in part, be attributable to selective sampling. Since consumers of Hospice care were used as part of this sample and Hospice directly involves the family in the treatment process, this may help explain why only seventeen individuals reported no involvement. Finally, the reliability of a single measure to assess "involvement" might be questionable. More extensive data are needed to make conclusive statements about findings in this domain.
Hypothesis 3 stated that individuals (especially those dealing with unexpected deaths) who hold more positive attitudes and who have a high degree of perceived meaningfulness toward the funeral, would likely exhibit fewer maladaptive grief responses as measured by generic measures of bereavement adjustment. This consequently suggests that the funeral may potentially benefit individuals as they move through the grief process. Results suggested that participants did differ with regard to bereavement adjustment as a function of their attitudes toward the funeral. Having positive and clear ideas about what is expected from funeral directors, what is considered helpful, and how bereaved individuals should be treated appears related to experiencing fewer symptoms such as anger, anxiety, and guilt later on. This may be due to the likelihood that these individuals are more apt to maximize the funeral experience since they are informed and believe funerals are valuable rituals.

These results also suggest those with more positive attitudes are more fearful towards the deaths of others. It could be these individuals are more willing to admit their fears and feelings on these issues. Since they are believers in the value of funerals and are apparently tuned in to specifics about the process, the funeral may bring a sense of heightened awareness of the eventual impending death of a
loved one. It could also be that the positive attitudes
developed out of prior experiences with funerals, and
therefore the reality of death, may be more salient for these
individuals. Funerals, therefore, may sensitize people to
loss and provide them a way to finish unfinished business and
even prepare for future losses.

No differences were found based on perceived
meaningfulness on the overall degree of bereavement
adjustment. However, those people who perceived the funeral
as very meaningful were found to be better adjusted on one
particular measure examining current feelings the individual
had towards the deceased person. People who considered the
funeral more meaningful, were less preoccupied with thoughts
of how the deceased used to be, found it less painful to
recall memories of the deceased, and reported that it was
easier to accept the death. For these individuals the
funeral may have facilitated the processing of various
thoughts, feelings, and emotions since they ascribed a high
degree of meaning to the ritual and activities surrounding
it.

These individuals also ascribed more fear towards the
death of others. Again, the possibility these individuals
have a heightened awareness and sensitivity to the funeral
and its significance could help explain their increased fear of death of other loved ones.

Since marginally significant results were obtained, it is possible that the measures used to determine feelings and attitudes toward the funeral are not robust enough, and should be considered only as preliminary until improved measures are developed.

It is important to keep in mind the retrospective nature of this study. Since participants were asked by self-report to recall details of events up to three years after they occurred, it may be reasonable to question the validity or accuracy of such reports. Peoples' perceptions toward the funeral may change over time as they move farther along in the grief cycle.

Also, another point to be made concerns the broad issue of selective sampling. First, subjects were predominantly white, Protestant, United States (US) citizens; therefore generalization of these results are limited to this segment of the population. Secondly, as a whole, our culture does not participate in uniform rituals due to the diversity of the population, or have very clear guidelines for how the rituals that are participated in should be done. Many other countries, such as Mexico for example, have set rituals that are observed by everyone when a loved one passes away. The
lack of norms and clear roles in our culture surrounding death could help account for why attitudes and meaningfulness of funerals were not influential in affecting overall bereavement adjustment. Also, some people may have a predetermined positive or negative bias towards funerals, and even bereavement adjustment, that could have affected their responses. The people that volunteered for this study may be fundamentally different from other bereaved individuals who did not volunteer, in that those volunteering might have done so because they are less adjusted and in need of more help dealing with their grief. It is also possible that those volunteering might be more adjusted than those in the general population, and therefore not representative of bereaved individuals overall. Furthermore, many of the respondents were students that had received previous courses and/or training in the area of death and dying which could have influenced their feelings/attitudes toward the funeral, as well as having influenced their bereavement adjustment. If this study analyzed perceived helpfulness, meaningfulness, and attitude towards the funeral dependent on previous training, different results may have been found. Previous training would presumably improve attitudes towards funerals, and therefore by separating people in regard to previous or no training a potential confound would be eliminated. All of
these factors listed above contribute to a restriction of the range which causes a more homogeneous sample to be selected, and consequently undermines the likelihood of finding significant effects.

Implications for Future Research

The purpose of the present study was to explore potential influences of cause of death, level of pre-death treatment involvement, and feelings/attitudes toward the funeral on bereavement adjustment. With regard to cause of death, the findings of this study have some important ramifications. First, cause of death (whether expected or unexpected) does not affect individuals' overall feelings and attitudes towards the perceived helpfulness and meaningfulness of the funeral. Therefore, even though those individuals dealing with unexpected deaths are likely to experience high shock and denial due to their inability to prepare for the death, funerals are apparently no more important to them than they are for individuals dealing with an expected death. Second, those dealing with an expected loss, appear more able to participate in pre and post funeral rituals. Whether this is due to their ability to make arrangements prior to the death, having others around to help with planning, or to their increased ability to "face the death", these individuals were more able to take concrete
steps to acknowledge the death, and begin moving on (i.e., visiting the grave and giving away possessions). Since those dealing with an unexpected loss are consequently unable to make preparations ahead of time, and either many pre-funeral rituals are bypassed altogether or taken care of by family and friends, these individuals are not as likely to participate. This could affect their ability to participate in the post-funeral rituals, as there may still be a sense of disbelief the death actually occurred if certain rituals were bypassed or taken care of by others. It may prove to be a great service to those whose loss is unexpected to strongly encourage they do participate in as many ritualistic activities as possible, even if aid must be provided. This then may increase their ability to participate in the various post-funeral rituals and move towards acceptance in a more expeditious and healthy manner.

A significant main effect regarding attitudes toward the funeral was found for subsequent bereavement adjustment. In other words, individuals with more positive attitudes towards funeral directors and the treatment of bereaved individuals exhibited fewer signs of grief reactions as measured up to three years post-loss. This suggests that the funeral may potentially benefit individuals as they move through the grief process. A positive attitude is likely to come about
when an individual is informed about the process, encouraged
to be an active participant in this process, and also
believes in the value this ritual serves. The goal then,
should perhaps be to help ensure that individuals are
knowledgeable, have their questions answered, and have
options presented to them so they may participate fully and
intelligently. These individuals also appeared to have an
increased awareness or fearfulness of their own death and the
deaths of others. Basically, the funeral may sensitize
people to the inevitable reality of death, including their
own. This in turn may be a valuable factor in helping people
prepare for future losses and may even decrease some of the
shock and denial that may have been experienced with prior
losses. Those individuals who perceived the funeral as
meaningful were less preoccupied with negative thoughts of
the deceased and reported that it was easier to accept the
death. As previously suggested, the funeral may have
provided an affective outlet and helped to facilitate various
feelings and emotions surrounding the loss. Those
individuals who do not ascribe a high degree of meaning to
the funeral ritual, may not be able to use the funeral
process as a way to "work through" their issues and feelings,
and consequently may report having more disturbing feelings
towards the deceased.
It is important to remember that many variables potentially interact with the death of a loved one, and only a handful were examined in this study. Future studies may want to look at analyzing each cause of death separately to more fully account for the variability, as well as crossing the cause of death with various other factors such as the relationship to the deceased or survivors' age at the time of death. The selective sampling issues raised should also be addressed in an effort to achieve a more heterogeneous and unbiased sample.

Therefore, in conclusion, it appears the funeral ritual can serve an invaluable role in helping individuals move towards acceptance of the death, feel more at peace with their feelings toward the deceased person by allowing them to begin to work through their feelings, and possibly even in preparing for future losses by sensitizing them to the reality and inevitability of loss. It is hoped that the findings of this present study, as well as future research in this area, will clarify the range of factors influencing bereavement adjustment and, therefore, enable those in helping professions to better educate and aid grieving individuals.
APPENDIX A

DESCRIPTION OF STUDY
DESCRIPTION OF STUDY

Dear Participant:

At one time or another we all must deal with the loss of a loved one. For most of us who attend the funeral there are a number of experiences we engage in. Little is known about how this funeral process impacts us. We are conducting a study on the funeral process and how its impact affects us. As individuals who have worked closely with grieving families, we are interested in this study from both a professional and personal viewpoint. It is hoped this study will enable professionals to better understand grieving individuals who are dealing with the loss of a loved one and to provide more sensitive and helpful service to them.

You are being asked to participate in this study as an individual who has taken a role in the burial process of a loved one. Participation in the study involves taking approximately 60 minutes to complete a questionnaire. There is no cost or fee to you for your participation, and you can withdraw at any time. Approximately 300 individuals who have helped in the burial process of a loved one will participate in this study. If you choose to participate in the study, your will be kept strictly confidential, and neither your name nor the names of other family members will ever be used. The potential personal benefits from participation are the opportunity to relate your own feelings as an individual who is experiencing the loss of a loved one and in so doing, to help professionals provide more compassionate care to others in similar circumstances. We hope you will choose to participate. Thank you for taking the time to consider this research as worthwhile and beneficial to others who will face the grief of losing someone close to them. We know how valuable your time is, and that is why your participation is all the more appreciated. If you have any questions, please call Dr. Hayslip at 817-565-2675.

Dina Ragow
Master's Candidate
University of North Texas

Bert Hayslip Jr., Ph.D.
Professor of Psychology
University of North Texas
APPENDIX B

RESEARCH CONSENT FORM
RESEARCH CONSENT FORM

The purpose of this study is to investigate your feelings about the services provided by the funeral home handling the death of your loved one. Your participation will involve completing a written questionnaire about your feelings and experiences. The completion of the questionnaire should take approximately one hour. The study is for research purposes, no cost or fee is involved in participation, and you may withdraw from the study at any time without any further obligation.

All information is completely confidential, and neither your name nor information associated with your situation will be used. The primary benefits of participation are to help professionals and caregivers in the area of bereavement provide more compassionate care to people suffering the death of a loved one. You will be provided a summary of the results of this research if you so choose.

Having fully understood the above information, and with the knowledge I may contact Dr. Bert Hayslip at the University of North Texas Department of Psychology at 817-565-2675 if I have any questions or concerns at any time, I voluntarily consent to participate in this study.

Name (print): ___________________________ Date: __________

Signature: _____________________________

Researcher: ___________________________ Date: __________
REFERENCES


Thompson, K., & Range, L. (1990-91). Recent Bereavement from suicide and other deaths: Can people imagine it as it really is? *Omega*, 22(4), 249-259.

