DEVELOPMENT, IMPLEMENTATION, AND EVALUATION OF
A GRIEF WORK PROGRAM FOR CIGARETTE SMOKERS
DESIRING TO QUIT SMOKING

DISSERTATION

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By

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Grief work is a process associated with persons experiencing various types of loss and ensuing grief. This dissertation reports an investigation of the relationship between an individual's quitting cigarette smoking and experiencing grief. The study posed two questions: (1) If persons experience grief when they give up cigarettes, would grief work help them achieve their goal to stop or reduce smoking? and (2) Specifically, would a programmed progression through certain grief stages be of assistance to persons desiring to reduce or quit cigarette smoking?

The investigation involved three procedural areas. The first was the development of a "Grief Work Treatment Program" designed for smokers who wanted to quit or reduce smoking. The second was the use of the program in experimental research in order to distinguish a relationship between structured grief work and cigarette-smoking reduction. The third area of investigation concerned evaluation of the program in terms of the subjects' goals for their smoking behavior.

A grief work program was designed and implemented in the research based upon a view that smokers who quit undergo a
grief process in which the object of significant loss is cigarettes. Thus, the process parallels, in perhaps a lesser degree, the grief a person experiences when losing a dear friend or relative. The treatment consisted of four weekly sessions utilizing the techniques of progressing through structured stages of grief; relaxation and visualization exercises; instruction about cigarette smoking, methods of quitting, and adjusting to loss; and behavioral tasks. Twenty-two volunteer subjects divided into a control and an experimental group made use of the program as an experimental group treatment. The study sought an answer to the question of whether a significant difference would exist in the number of cigarettes smoked by the experimental group after treatment and four weeks later compared to the control group.

Results of the study indicated that the Grief Work Treatment Program was effective. A statistical comparison of treatment and control subjects using Analysis of Covariance, with number of cigarettes smoked daily at the beginning of the program as the covariate, produced a significant $F$ at the 0.05 level on measures taken immediately after the treatment and four weeks later. Thus, in terms of the subjects' respective goals, the grief work program was effective in assisting subjects to quit or reduce smoking. In addition, correlational tests concerning the treatment group indicated significant relationships existed between the variable, decrease in number
of cigarettes smoked daily, and the variables: length of time a subject smoked prior to treatment; importance of cigarettes to the subject; and number of cigarettes smoked daily at the outset of the program. On comparisons of these variables, significant Spearman-Rank and Pearson Product Moment Correlational Coefficients ranged from 0.67 to 0.85.

The experience of conducting the research study provided information about formulation of a professional grief work program for smokers. Suggestions for further research prompted by the study included investigating the harmful physical effects of individuals who stop smoking and applying the program to other kinds of grief such as that connected with alcoholism, divorce, and aging. Implications of the study are that current stop-smoking programs might consider the variable of grief present in individuals who are quitting or reducing cigarette smoking, and that grief work as a distinct area of counseling should be considered.
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CHAPTER I
INTRODUCTION

Grief is a universal human experience. It is commonly connected with losing a loved one through death. Of course, loss of a loved person is an obvious loss. Grief reactions, however, have also been associated with a loss or separation from any loved object or person (see Becker, 1973; Freese, 1977; Hodge, 1972). Grief resulting from loss of an object may not seem obvious but is nevertheless very real. Colgrove, Bloomfield, and McWilliams (1976) state that this kind of loss includes loss of money; loss of a job; moving; illness, i.e., loss of health; success, i.e., loss of striving; and loss of a cherished ideal. In sum, giving up an object that has been valued is a genuine loss (Bellwood, 1976).

Grief work, first labeled by Freud (1915), is a process associated with persons experiencing such losses and grief. It was his belief that in order to become free of the tie to a lost object, the grieving person must do grief work. Grief work is not pleasant and may be very painful. According to Hodge (1972), though, if the grief work is not actively pursued, its therapeutic effects may be prematurely arrested, aborted, or delayed. Moreover, a distorted form of grief work may appear, possibly as some other symptom.
Engaging in grief work after the experience of losing an object may be as important as grieving after the experiencing of losing a person. The case is true especially if the object is highly significant. Cigarettes, for example, are considered very important by many smokers. To quit smoking cigarettes often is as serious as saying good-bye to a dear friend or to a member of the family (McKean, 1976).

The ultimate goal of grief work is acceptance of the loss, whether it be cigarettes or any other object. Heikkinen (1978) has broken down the grief process into progressive stages: shock and denial, anger and guilt, depression, and resolution and reintegration. Each stage is important and must be completed if the grief work is to be finished.

The intent of this study was to relate the two concepts of grief and cigarette-smoking cessation. Two questions were posed: (1) If individuals do indeed grieve when they give up cigarette smoking, would a program of grief work help them to progress through the stages of grief while giving up cigarettes? (2) Would a programmed progression through the stages of grief enable smokers to attain their goal of quitting or reducing cigarette smoking?

Statement of the Problem

The problem that was investigated in this study was the nature of the relationship between a person's quitting cigarettes and experiencing grief.
Purpose of the Study

The purposes of the study were the following: (1) to develop a grief work program designed for cigarette smokers who wanted to quit smoking, (2) to evaluate the effectiveness of a grief work program on the smoking behavior of smokers who wanted to quit or reduce their smoking habit, and (3) to investigate the relationship between structured grief work and cigarette smoking reduction.

Research Questions

The study reported in this dissertation involved the following research questions.

1. Is there a significant difference in the number of cigarettes smoked by an experimental group and a control group (a) immediately following treatment, and (b) four weeks after treatment?

2. Within the experimental group, is there a relationship between length of time the subjects smoked prior to treatment and their success rate in the treatment, measured by the decrease in the number of cigarettes smoked at the completion of the treatment?

3. Within the experimental group, is there a relationship between the importance of cigarettes to the subjects and their success rate in the treatment, measured by the decrease
in the number of cigarettes smoked at the completion of the treatment?

4. Within the experimental group, is there a relationship between the number of previous attempts made by the subjects to stop smoking and their success rate in the program, measured by the decrease in number of cigarettes smoked at the completion of the treatment?

5. Within the experimental group, is there a relationship between number of cigarettes smoked daily at the outset of the program and success rate in the program, measured by the decrease in number of cigarettes smoked at the completion of the treatment?

Background and Significance of the Study

In recent years the publication of material pertaining to death and grief has increased. Information about grief appears in articles and books based on both practical and clinical experience. In grief-related literature, a recurring conclusion is that the experience connected with a major loss has important and lasting effects on an individual.

In 1923, Freud pointed out that many emotional disturbances in adults can be traced to unresolved feelings from previous death situations. Freud's work with Breuer (1893) examined the relationship between a recent precipitating event and the particular symptoms that follow. Freud
used the term grief work as a label for the psychological work which enables an individual to adapt to a loss.

Another commentator in this field, Lindemann (1944, p. 141) describes grief as "a normal reaction to a distressing situation." He published a classic study of grief reactions during and after the fire disaster of the 1940's at the Coconut Grove nightclub in Boston. According to Lindemann, duration of grief reactions among survivors or their families depended upon the success with which each of them carried out their grief work. A big obstacle to this grief work was that many subjects tried to avoid both the intense distress connected with the grief experience and the emotion connected with such distress. In this connection, researchers agree that to complete grief work, individuals must think through their loss, face its reality, express the emotions previously experienced, and reorganize life into new patterns. Lindemann's principles have become a basis for grief intervention research and application.

Along with Lindemann and Freud, Parkes (1972, p. 11) attempts to define and describe personal loss. He perceives it as separation from a person, place, or thing that requires a change in behavior or life style. Such a change, Parkes feels, can lead to growth which leaves an old life style behind and acquires a new one. Whatever the change in lifestyle may be, the change results in giving up the old; thus, the person involved experiences a loss.
To measure this kind of disruptive life event, Holmes and Rahe (1967) developed the Social Readjustment Rating Scale (SRRS). Units on their scale represent life changes such as moving or death of a relative. Holmes and Holmes (1974) found that although voluntary losses may differ from involuntary losses, the same stress component is present. They also found a positive correlation between physical illness and stress-producing life changes. It seems a fair conclusion from the Holmes research that if losses are not resolved so as to lower stress, harmful physical consequences may occur.

As examples of the harmful physical effects of loss and the accompanying stress, stress-related diseases such as ulcerated colitis and hypertension are not uncommon. Freese (1977) found these ailments among persons experiencing grief for a prolonged period. Clearly, then, stress reduction in a grieving individual may be of value in alleviating pathological effects. A counselor or other care-giving professional may be a valuable source of assistance, especially if the caregiver has knowledge of the grieving process and realizes the importance of expressing the feelings involved in grief.

Further research shows that postponing such grief work is not healthy. Several studies (Lindemann, 1944; Parkes, 1972) indicate that repression of emotions connected with loss and denial of the reality and finality of loss can lead to emotional and physical problems and inappropriate
behaviors. In fact, denying the grief connected with any important loss may lead to a psychosomatic disorder in place of the grief state (Hodge, 1972). The psychosomatic disorder can be a symptom substitution or a replacement. It seems possible that if the loss is cigarettes, then the substitution may be food, and the replacement may be resumption of cigarette smoking.

Hickey and Szabo (1973) have studied how subjects can avoid psychosomatic disorders in handling grief. They begin by postulating that grief manifests itself in many ways: tears, expression of an overwhelming sense of loss, desire to be alone, fears, and various physical symptoms. If the expression of feelings associated with the grief is encouraged and accepted, then, according to Hickey and Szabo, grieving individuals seem to face reality more quickly, reorganize life, and go on to productive living. Support systems, including friends, relatives, or a therapy group, are valuable for individuals as they progress through this painful period. The Hickey and Szabo study supports a view that the pain experienced by a grieving person can be eased by the knowledge that grief is a common experience, with a beginning and an end.

A group counseling program incorporating grief work is one means of providing assistance and support for persons experiencing a common grief. The purpose of such a program
would be to help the individuals experience rather than avoid the grieving. Grief work could be a therapeutic experience.

With regard to giving up cigarettes, many treatment methodologies and techniques are available. Systematic desensitization, aversive conditioning, information dissemination, and hypnosis are all methods to help a smoker quit. In a review of experimental research on attempts to stop smoking, Bernstein and McAlister (1976) found that most methods for treating cigarette smokers are effective at the time but tend to have short-lived results. Indeed, a relapse to near pre-treatment rates of smoking occurs in 75 per cent of the cases. In addition to studying what treatments are effective, Mausner and Platt (1971) have studied the personality characteristics of smokers, the psychological effects of nicotine, and the reinforcing qualities of smoking activity on sensory receptors.

Since the first Advisory Committee's Report to the Surgeon General on smoking and health in 1964, the general population has become aware of the dangers connected with smoking. The recent 1979 Advisory Committee's Report to the Surgeon General points to additional hazards connected with smoking. Despite a positive relationship between cigarette smoking and respiratory and cardiovascular problems resulting even in death, approximately 35 per cent of the United States population continues to smoke cigarettes (Flaxman, 1976).
Most smokers are aware of the dangers of smoking, and many want to but are unable to quit. According to the American Cancer Society (1974), approximately 30 per cent of smokers who want to quit are successful. Motivation seems to be a factor. Whether a person's motivation develops because his physician tells him he will die if he does not stop smoking, or whether it is because cigarettes are too expensive, a smoker makes a decision based upon his own priorities. He cannot be made to quit, but can obtain assistance during the process of quitting (McKean, 1976). Some cigarette smokers who have quit or reduced the quantity of cigarettes smoked have done so without apparent help. Many other persons recognize that they want and need help through this painful process. The many persons who seek treatment and therapy are evidence that help is frequently necessary.

A review of the literature indicates a need for a new method of therapeutic intervention for smokers who seek help. No single method has proven to be effective over time. Literature pertaining to the subject of grief and loss is increasing, with investigators discovering the importance of grieving over any significant loss. A few grief work treatments have been devised for persons experiencing grief. Recognition that a person experiences a grief reaction when encountering any personal loss leads to the question of whether grief is experienced by cigarette smokers who give up cigarettes, a significant object.
Limitations

Three limitations were inherent in the design of the study reported in this dissertation. One is the possibility of experimenter bias; the researcher worked directly with the subjects. The second limitation was the small number of subjects who volunteered for the study. Finally, the treatment was limited in length to control for recidivism. This third point is a limitation which was unavoidable, given the fact that smokers have a high rate of recidivism during most smoking reduction treatments.

Basic Assumptions

This study depended upon an assumption that grief is involved in quitting or significantly reducing cigarette smoking. It also followed an assumption that the subjects responded honestly and objectively to the questions concerning their smoking behavior.

Definition of Terms

Grief work—an active process of adapting to a loss.
Motivation—the predisposition of a smoker to want to stop or reduce smoking due to a multitude of factors within himself or the environment.

Chapter I suggests that grief is involved in quitting cigarette smoking and proposes that a grief work program would be a means of helping persons stop or reduce cigarette smoking. Chapter II presents a review of the literature pertaining to
grief, and also reviews grief work as a treatment for loss. Finally, the chapter focuses on the effectiveness of treatments designed for cigarette smokers wishing to quit smoking.

Chapter III has a description of a grief work treatment program for cigarette smokers designed in the research along the lines of a specified theoretical framework. A final discussion in the chapter reports the use of the grief work program in a research study. A presentation and analysis of the statistical results of the study are included in Chapter IV. A summary is reported in Chapter V along with recommendations and implications for future research.
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CHAPTER II

REVIEW OF RELATED LITERATURE

Chapter I includes the suggestion that a grief work program be applied to the question of how to quit smoking cigarettes. The chapter defines grief work as an approach to alleviating the emotional and psychosomatic stresses which accompany the loss of a dear relative, friend, or object. In the case of smokers who wish to quit their habit, the object or loss, is cigarettes. Accordingly, literature concerning grief is reported in this second chapter. Chapter II also reports research on grief work as a treatment for loss. A final section of Chapter II reviewing the literature reports an overview of the state of the art with respect to the specific treatment of cigarette smokers.

Grief

A review of psychological literature relating to grief reveals that the subject has long been ignored by scientists in human behavior. Interest in the subject of death and grief, though, has increased in recent years. More books and articles about death, grief, and bereavement have appeared during the last 12 years than during the preceding 150 years (Fulton, 1977). It appears that not until after the publication of a book by Kubler-Ross (1969) was the public interested
in the death phenomenon per se. Indeed, Durmont and Foss (1972) believe that Americans traditionally cope with their emotional response to death by developing an attitude of denial. Believing that death will not happen to them, they live their lives free from conscious fear of death. Thus, discussion on death is clearly a taboo in American culture.

A loosening of the long-standing taboo on the subject of death is evident in recent interest in the dying-process and the "life after life" (Moody, 1974) phenomenon. Today high schools and universities offer courses relating to death and dying. Members of helping professions are becoming interested in the subject. Some are looking for better ways to help persons who experience stress, crisis, and emotional and physical problems connected with death and other traumatic loss.

A recent best seller, Passages (Sheehy, 1977), deals with the crises in various life changes. Each "passage" is connected with a loss, i.e., death, of a particular span of life and the beginning of a new life span. The popularity of this book reflects an upsurge of interest in creative change. Individuals are using crises as a means to realize new potentials.

Along with the rising interest in stress, loss, and death, researchers are beginning to look closely at the human reactions which are associated with these life occurrences. Grief is becoming a subject of concern to investigators
of human behavior by focussing on various physical, emotional, and behavioral responses connected with loss and crisis.

Granted, the grief situation does not lend itself readily to experimentation or controlled observation. This incongruity is due in part to the sensitivity of the grief experience and in large measure to the American view of death and loss. American society has emphasized the future. As mentioned earlier, Americans cope with death by disguising it and pretending that it is not a normal condition. If they can ignore the loss, then they can also ignore the resolution of the grief.

Although the American culture provides better living standards, health care, and education than do many other countries, it deprives people of an opportunity to complete the grieving process within a socially acceptable context. This society tends to reinforce what it views as self-control and rationalism, that is, a restraint of overt grief behavior. In other societies, however, persons are free to express grief as socially acceptable. In other countries, a griever can weep openly, fast, make a pilgrimage, wail, or disfigure clothing or even one's self as an outward manifestation of inner feelings. Kutscher (1969) believes that these vents for expression have their use in helping a mourner complete the mourning process.
A number of other observers have defined loss and grief. Hodge (1972) has called grief a state of pain, discomfort, and mental and physical disfunctioning associated with a loss, or separation from a loved object or person. Several authors such as Parkes (1972), Colgrove, Bloomfield, and McWilliams (1976), Freese (1977), and Heikkinen (1978) state that practically any loss may result in grief. They include as causes of grief the loss of a loved one, loss of money, loss of a body part, loss of a job, divorce, abortion, moving, loss of a long-term goal, childbirth, loss of youth, menopause, retirement, and loss of childhood dreams. Similarly, Keleman (1974, p. 53) refers to loss as an ending:

Endingness is an important part of the mourning process. Working through our endings allows us to redefine our relationships, to surrender what is dead and to accept what is alive, and to be in the world more fully to face the new situation. Just as mourning is a time of emotional freedom, endings present the possibilities for expressing that freedom.

Evidently, Keleman feels that endings provide individuals an opportunity for emotional growth. Heikkinen (1978) believes that in order to resolve the loss, i.e., the ending, grief work must be done.

In Schoenberg, Carr, Peretz, and Kutscher (1970, pp. 4-6), Peretz also defines loss. Peretz states that some losses are predictable and others unpredictable. Losses may be sudden or gradual, traumatic or nontraumatic. He further classifies loss in four ways according to the object lost:
1. A significant loved or valued person lost through death, divorce, or separation. Here the loss may be partial, permanent, or temporary.

2. An aspect of the self such as health, body functions, sensations, or bodily drives lost through physical decline. The loss may also involve self-definitions deriving from one's occupation, profession, and position in the family.

3. An external object such as possessions or home.

4. A stage in personal human development. For example, children lose the breast or bottle, their teeth, a secure position, or gratification provided by other persons.

As Peretz's fourth class points up, infancy and childhood are particularly vulnerable times for loss to occur. Nevertheless, losses at other times that are necessary and predictable may be traumatic because of limited physical or emotional capacity for integrating and mastering the loss.

While the writers mentioned thus far have connected grief with loss, Freese (1972) recognizes grief in the gains as well as the losses of life. According to Freese, in order to live a full life a person must use grief for growth and change. To do so, he or she must recognize grief in its many guises:

...psychotherapy has shown that only by facing up to the real underlying problems can one hope to deal
with them successfully, to do the necessary work of mourning when grief is that problem. (p. 150)

Even the Coconut Grove fire (see Chapter I) produced change and growth, according to Freese (1977).

Like Freese, Elliott (1933) advocates an open discussion of grief. Nearly fifty years ago, he recommended its empirical study (1930). In a later article (1948), Elliott defines grief within a class of traumatic frustration-situations: sorrow results from arrested impulse or thwarted habit. For the person experiencing grief, a loved object is gone, but the associated habits, needs, and memories still live in his or her mind.

Freud, too, has defined grief. He views it as "a reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one" (1917, p. 245). Freud's theory of psychoanalysis deals primarily with the abnormal expressions or the relationship of grief to abnormal conditions. In this theory, emotional disturbances in adults are the effects of unresolved losses. Grief, according to Freud (1923), is the means for progressively withdrawing the energy which ties an individual to a lost object.

Along with attempts to define grief, Lindemann (1944) provided the first intensive investigation of grief reactions. Lindemann studied four types of persons experiencing grief:
1. Psychoneurotic patients who lost a relative during the course of their treatment.

2. Relatives of patients who had died in a hospital.

3. Bereaved disaster victims of the Coconut Grove Fire (see above and Chapter I) and their close relatives.

4. Relatives of persons away in the armed forces.

The investigation consisted of a series of psychiatric interviews to record symptoms of individuals suffering from acute grief. Common symptoms included tightness in the throat, loss of muscular power, tension, preoccupation with an image of the lost loved one and guilt feelings. The subjects in Lindemann's study were often hostile toward friends and relatives. Frequently they were unable to complete tasks. They were also restless and constantly looking for something to do. Typically, they lacked ability to maintain organized patterns of activity. Still, most of them worked through their grief in four to six weeks.

Lindemann considered his study relevant to actual death reactions as well as to grief reactions connected with any separation. In fact, he found grief reactions in patients who had experienced separation rather than death. For instance, one subject had grief symptoms from the departure of a family member to enter the army. Clearly, Lindemann's
study of grief constitutes the beginnings of an understanding of the process of grief.

Another tragic event which has been the topic of study is the assassination of President John F. Kennedy. Sheatsley and Feldon (1964) found grief reactions to the death of the President similar to those among Lindemann's subjects. The individuals in the Sheatsley and Feldon poll responded to Kennedy's death as if Kennedy were a close relative or friend. Indeed, Americans reacted to this national tragedy as if it were a personal loss. According to Freese (1977), reactions to the presidential assassination concerned a symbol, whereby the President represented a father or parental image. Thus, the President served as a substitute for other types of losses which individuals could not deal with psychologically.

Further studies have investigated the relationships between a recent loss and the physical and psychological symptoms which follow. One (Fredrick, 1977) discusses grief as a disease process. Fredrick reviewed several studies pointing to a relationship between grief as a stress mechanism and its consequences on the immunity system. Stress seems to lower the body's defense against disease. Another study, (Reese and Lutkins, 1967), surveyed deaths occurring during a six-year period. A group of close relatives--spouse, child, parent, or sibling--was compared to a control group of 371 persons matched by sex, age, and marital status. The experimental group had a much higher mortality rate during the first
year after the loss than did the control group. Moreover, among widowed individuals, 12.2 per cent died compared to 1.2 per cent in the control group. In this connection, Kraus and Lilienfeld (1959) found that at every age widowed males and females experience a higher mortality risk than do married persons of the same age.

Another investigation of the relation between loss and body symptoms is one of Fredrick (1972). From a review of studies of stress reactions following grief, Fredrick concluded that biochemical and physiologic accompaniments of sustained or intense grief may directly or indirectly strain an already weak or defective system. Grief stress may also accelerate or uncover a latent pathological process like infection or malignancy. Fredrick (1977) recommended that endocrinologists, immunologists, and biochemists conduct basic research in order to establish a model for treating grief as a disease.

Actually, studies prior to Fredrick's studies point out that grief may precipitate or aggravate illness. Some of these illnesses include ulcerative colitis and rheumatoid arthritis (Brewster, 1952); asthma (McDermott & Cobbs, 1939); hyperthyroidism (Lidz, 1949); and coronary thrombosis, blood cancers, and cancer of the cervix (Feller, 1952; Parkes, 1969; Parkes, 1972). Moreover, some empirical studies show that persons experiencing grief from a loss share common symptoms (Maddison, 1968; Parkes, 1972). Symptoms in persons
grieving over losses of loved ones include nervousness, depression, feelings of panic, persistent fears, insomnia, loss of appetite or excessive appetite, fatigue, and restlessness. The degree of overall intensity of symptoms tends to vary directly with the degree of commitment or investment of self to that which is lost (Parkes, 1972).

For persons grieving over a lost loved one, Maddison and Walker (1967) sought to discover factors affecting the outcome of bereavement. Specifically, they sought factors which might be associated with unfavorable resolutions of grief over a loss. In a comparison of 'good outcome' subjects with 'bad outcome' subjects, using health as the criterion, Maddison and Walker found an interesting relationship. Widows with bad outcomes perceived themselves as having many more unsatisfied needs in interpersonal exchanges during grief crises than did widows with good outcomes. They also tended to find the environment actively unhelpful during a crisis.

A 1968 study by one of these researchers, Maddison, was the subject of a replication by Parkes and Brown (1972). Maddison's research had revealed factors contributing to a bad outcome after a loss. The sample studied by Parkes and Brown consisted of a control group matched to the experimental group of 49 widows, together with 19 widowers under age 45 whose spouses had been dead at least 14 months. This research found that some factors which contribute to a bad outcome are a prior history of severe reaction to death of a family member,
additional stress or crisis in close temporal relationship to the death, and deliberate avoidance of affective expression of hostility and anger. Importantly, the investigators considered these factors to be predictors only in terms of probability, and not because of a cause and effect relationship.

In other studies of stress related to grief (Engel, 1973; Fredrick, 1971; Reese & Lutkins, 1967; Selye, 1974), grief itself appears to be a psychological stress evoking biological body changes. The initial reaction to a loss can be intense and can result in denial or disbelief (Fredrick, 1971). Indeed, the stress response was recognized as such by Cannon in 1929. He posited that bodily changes take place during fear, pain, hunger, and anger. Stress causes a fight or flee reaction, accompanied by an increase in adrenalin flow. The reaction enables animals to fight back or to run away. In modern man, however, these reactions may be damaging because of an over-production of adrenalin and other hormones. According to Parkes (1972), the grieving person is in a high arousal state approaching panic during much of the time that he is under stress.

Caplan (1961, 1964) also studied this kind of stressful situation. He termed any major stress of life a crisis. Such a crisis forces and enables an individual to alter behavior and plans, and it imposes upon him or her a need
for psychological work. According to Caplan, major life stresses have limited duration but still may endanger mental health. If the stress is moderate, most individuals learn rapidly and accept the need to change more readily than at less stressful times in their lives (Parkes, 1972). Obviously, Caplan's work indicates that a crisis can lead to personal growth, especially if the persons involved seek help and support (Colgrove, Bloomfield & McWilliams, 1977).

With regard to stressful life events, Holmes (1974) has studied these in relation to major illnesses. Holmes compiled a list of forty-three major stressful life events and rated them according to the degree of problems they created during a given year of an individual's life. By adding up the points allotted to each type of stressful event, Holmes feels that one can predict the onset of major illnesses. Illnesses caused by stresses as labeled by Holmes, all involve loss, separation, and change.

The work of Holmes and the development of the Social Readjustment Rating Scale (SRRS) by Holmes and Rahe (1967) emphasize the interrelationship between grief, stress, and disease. Even self-imposed, voluntary changes appear on the SRRS by representing losses. True, voluntary losses do differ from involuntary losses in that the individual has some control over the loss. Still, any change results in a loss according to Heikkinen (1978). Since change and loss are
inevitable, the accompanying stress and grief is also inevi-
table. If intervening aid occurs during the grief and stress
reaction, perhaps an individual can lessen the probability of
illness following a major life change.

While Holmes was interested in disease vis-à-vis grief,
Ramsey (1976) sought its possible relation to phobia. Using
a behavioral approach, Ramsey suggested that potential phobics
tend to avoid confrontations and to escape from grief. In
this way, actually, they fail to experience grief reactions.
If a person deliberately avoids situations and stimuli illic-
iting grief reactions, their control cannot take place. Just
as a phobic can become more anxious or depressed with time,
so can a grieving individual who continually avoids and
escapes grief stimuli and reactions.

The attempt to avoid or escape grief is also relevant
to aging. Old age is a time of loss, change, and separation.
Typically, Americans deny the aging process by focusing upon
youth. By learning to work through griefs due to life's many
changes, however, Americans can learn to cope with age.

As the studies recounted thus far indicate, systematic
description and investigation of the grief experience has
increased. Clearly, grief is now a valid topic of investiga-
tion. As researchers understand more about grief by examin-
ing it more carefully, they have become better able to treat
grief just as any other part of the life experience. More-
over, the treatment itself can be the topic of investigation.
Grief Work as a Treatment

The term grief work aptly describes the grieving process. The reason is that grieving is a task which can be painful and hard, for it requires rethinking, relearning, refeeling, and reexamining one's past life. In this connection Freese (1977) writes as follows:

This is the work whose rewards are the most precious in life, for only through this grief can a human being hope to learn really to live, to be able to face the human life of constant loss and separation, to face and make the most of life and age and even death, to add life to one's years instead of merely years to one's life. Through grief one can learn to enjoy life to its fullest, and how to turn loss into gain. (p. 48)

Accordingly, if individuals give themselves permission to accept grief as an important element in the process of change, then they can enable themselves to also experience the joy and rewards that result from change.

Others in the field have also been concerned with the treatment of grief over death. Of course, the funeral is a traditional ceremony filled with symbolism connected with the finality of death. It is a ceremonial process whose message seems clear for those who choose to participate. According to the anthropologist Geoffrey Gorer (1965), such rites, rituals, and ceremonies may be the most valid and easily accessible resources available for working out deep feelings. In fact, Jackson (1977) reports that the oldest-known evidence of human ceremonial activity consists of
remnants of a funeral event in Persia sixty thousand years ago.

The kinds of ceremony studied by Gorer and Jackson rely on ritualized expression to surround important events. By making it easy for an individual to become part of a supportive group, ceremonies with ritualized behavior can be helpful if there is much stress surrounding an event. The reason is that many persons who are experiencing a sizeable amount of emotion and stress have difficulty putting their thoughts and feelings into words. A funeral can provide them a time for acting out feelings difficult to put into words.

The ceremonial process can even provide a means for total involvement. Jackson (1977) feels that this process is important for working through powerful emotions:

To try to cope with strong feelings through a limited process such as intellectualization may do more harm than good, for the denial of feelings may lead to their repression and adverse forms of acting out, or rather acting in. Much illness apparently can be traced to the unwise handling of feelings by various forms of denial. (pp. 72-73)

Expressing rather than suppressing feelings connected with a loss appears to be a physically and psychologically healthy means of working through and finishing the grief work.

One study of grief work (Maddison & Raphael, 1972, pp.191-192) points out the various defense mechanisms which can operate during grief. The study indicated that denial of the loss
can be a major defense leading to unreal hopes. Isolation of affect may permit the individual in grief to function and cope with responsibilities. Sublimation serves the same function as isolation of emotion. Maddison and Raphael also found that repression is likely to accompany aggressive wishes and frustration of dependent needs. Displacement of hostility or dependent and sexual needs may occur. The grieving individual may use projection as a defense for hostile and dependent wishes. Maddison and Raphael base all of these views on clinical impressions of individuals experiencing grief.

In treating grief, therapists and others in the helping profession need to recognize the variables which affect the grieving process. Heikkinen (1978) lists several variables:

1. Acceptance of the loss, as a loss, can be a problem if the loss is by choice and if its finality is uncertain.
2. Fear of dealing with new losses can be a problem for individuals who have a history of difficulty with resolving past losses.
3. Fixations at one of the stages of grieving by overemphasis or underemphasis can prevent a grieving individual from completing the process.
4. Lack of information about what to expect from experiencing a loss may be a problem for some individuals in grief, especially if the loss is
thought to be minor, i.e., not due to a death. The grieving individual may have difficulty accepting and expressing apathy, depression, irritability, and loneliness if he/she did not anticipate these feelings.

5. Individuals experiencing grief may be prone to accept negative suggestions from others and to feel wrong for experiencing and thinking what they naturally feel and think.

6. Recognition and manipulation of feelings of self-reliance may be necessary if the grieving person was inordinately dependent on the lost person, place, or object.

7. Grieving may be a masochistic process which an individual continually sets up in order to validate a "victim" lifestyle. The victim continually sets up himself or herself to lose. The problem may require that an individual change some basic components of his or her personality in order to not need to feel victimized.

It is evident from Heikkinen's list of variables that the treatment of grief involves intrapersonal as well as interpersonal variables. Therefore, the development of a useful grief work program must consider these many variables.
Grief work that is successful enables new patterns of behavior to emerge. The degree of success is dependent upon a variety of factors. Where little success results, Volkan (1972) believes that the causes of inadequate grief work relate to several factors. For one thing, pathological grievers generally have a history of unexpected or sudden losses. When a loss is unexpected, a greater likelihood of inadequate grief work may be associated with difficulties on the job, and physical illnesses than otherwise. If the relationship with the lost object has been ambivalent and accompanied by anger or hostility, grief work may be inadequate and may leave a griever feeling an unusual amount of guilt. Another factor which Volkan found to affect grief work is any "unfinished business"—which an individual feels connects with the lost object. The unfinished business may relate to patterns of separation that the individual has learned from birth.

Another investigator who has written extensively on grief and mourning (Bowlby, 1960) has delineated three phases of grief. Observations of humans at all ages and of species of several animals indicated that the physiological sequence of grief begins with craving, angry efforts to recover the lost object, and appeals for help, followed by a period of apathy and disorganization of behavior. Finally, the griever begins to identify with new objects and feel satisfaction without the lost object.
That individuals progress through stages as they grieve is also a finding in Parkes, 1970; Kubler-Ross, 1975; Freese, 1977; Ramsay and Happeé, 1977; and Heikkinen, 1978. According to Heikkinen (1978) the initial stage is shock or denial. Individuals may feel numb and out of contact with the self, as though viewing themselves from a distance. In other words, they do not fully realize their loss. The second stage is anger over the loss, an anger which may turn inward on the self as guilt. Pain can be intense at this time. Individuals may fight against reality and still try to accept it. The third stage in working through grief is depression and the beginning of resolution. During this adjustment stage, individuals learn to live without the lost object. In the final stage, the post-resolution stage, grievers experience new growth; they feel confident about living without the lost object and begin to reintegrate life without it.

A focus upon grief as readjustment is especially evident in the rehabilitation of amputees. They must learn to live and function successfully without a lost limb. In this special type of grief work, individuals are not grieving so much for the dead limb but rather for themselves: they are giving up their former selves and must learn new roles, expectations, and behaviors.

From studies of amputees, Parkes (1972) found that the stages through which amputees progress are the same grief stages through which widows progress. Just as widows experience
a denial of loss at first, so does an amputee have difficulty accepting the loss of a limb. Indeed, he frequently feels that it is still present. Out of 46 amputees studied by Parkes, all had a feeling of persisting presence of the lost limb. An overwhelming 87 per cent forgot that the limb was missing and attempted to use it. Clearly, an amputee and a person who has lost a loved one have similar difficulties in realizing the extent of their loss.

Bellwood (1975) devised a grief work program for alcoholics. Bellwood contends that grief is an important factor in the problems of alcoholics. By progressing through the stages of grief—the loss itself, shock, depression, anger, and guilt—alcoholics have an opportunity to reconstruct their lives without alcohol. At the Fort Logan Mental Health Center in Denver, Colorado, Bellwood's alcoholic patients take part in group therapy, art therapy, and psychodrama as methods of working through their feelings to resolve past griefs. These methods also help with the present grief work connected with the loss of the bottle.

Bellwood has made the important contribution of emphasizing the importance of doing grief work at the time of any loss or separation. He proposes that alcoholics are in a chronic state of grief due to incomplete grief work. In order to give up alcohol, the patient needs to express and resolve the grief connected with losing the significant object of alcohol. Bellwood states further that successful completion of the grief
work is an important component in the successful outcome for alcoholics at the Fort Logan Mental Health Center.

Similarly, Ramsey and Happeé (1977) advocate "bereavement therapy." This is not a treatment for reducing pain but a method for shortening the time of working through the grief process.

Irion (1973) has worked as a clergyman with persons going through the grief process. He feels that therapy must address both the intellectual and emotional dimensions of an individual. Thus, both the thinking and the feeling aspects of an individual experiencing grief are important. A complete grief work program, in Irion's view, needs to include didactic and experiential dimensions.

In a somewhat different approach, Ramsay (1978) advocates a behavioral treatment for unresolved grief. His treatment focuses on individuals with special problems in resolving losses. This treatment is for pathological grief, as opposed to normal grief reactions, in which individuals remain in an early stage of grief. The treatment is basically a behavior therapy approach of relearning how to feel and express emotions in an appropriate manner.

Greenberg (1974), who has used a grief work treatment with children, advocates working within the family unit. Here, an individual proceeds through four phases:

1. Announcement: describing the loss in an experiential sense, including affective recall of
details and feelings along with perceiving it as a significant loss.

2. Acknowledgement: dealing with the irreversibility of the loss.

3. Mourning: directly expressing and dealing with feelings of anger, guilt, and helplessness.

4. Renewal: exploring the environment for appropriate replacement objects to meet one's needs, perceiving and planning for the future without the deceased, and realizing inner resources and resources in the environment.

As seen above, Greenberg stresses the importance of expressing the grief feelings as part of a structured grief work treatment.

Another study based upon clinical experience (Bugen, 1977) includes a model for predicting and intervening in the grief process. The degree of kinship and the degree of the griever's perception of preventability of the death are prime predictors of the intensity and duration of the grief, according to Bugen. He disagrees that stages exist in the grieving process. Instead, he proposes the existence of a variety of emotional states. If the relationship between the griever and the lost object is a central relationship and if the loss is perceived as preventable, Bugen speculates that the grief process will be intense and prolonged. In the opposite way,
if a relationship is peripheral and the loss unpreventable, then the grief reaction will be mild and brief.

While Bugen's model purports to predict grief, Heikkinen (1978) has a model for counselor intervention in the grief process, based upon group treatment. Heikkinen believes in the importance of giving clients permission to feel grief as a means of accepting the loss. He also advocates saying goodbye aloud to a lost object for its cathartic effect. Visualization of the loss is another means of approaching a loss. He also believes that anger toward the counselor may be part of the grief process, of which a counselor should be aware. Finally, Heikkinen suggests the use of bibliotherapy and other means of information dissemination. His model is appropriate within a group format where the group functions as a means to help reestablish self-esteem and a sense of community.

Treatment of the Cigarette Smoker

According to Koenig and Masters (1965), habitual smoking fits precisely the theoretical and practical requirements for investigations of treatment methods, for three reasons: (1) the behavior is maladaptive and within the paradigm of neurotic behavior, thus providing motivation for the volunteering subjects to change their behaviors; (2) the behavior is observable and occurs in particular units; and (3) the behavior occurs frequently in the population at large.
Keutzer, Lichtenstein, and Mees (1968) provide further support for smoking as a subject of investigation. They investigated various treatment studies and reported a synopsis of a large number of studies. They conclude that the behavior of smoking affords an opportunity for comparative study of behavior-change methods in a naturalistic context while lending itself to controlled investigation.

Because of the investigative possibilities connected with smoking, much has been written about the subject. Emphasis has been on the health hazards connected with it. As early as 1944, correlational associations between smoking and lung cancer became evident (cited in Sobel, 1978, p. 164). Twenty years later, health warnings appeared on cigarette packs. In 1971 the U. S. Government banned cigarette advertising on television. Despite this measure, Americans continue to smoke.

If cigarette smoking is a health hazard, a logical question is why so many Americans begin or continue the habit. Investigators have studied smoking behavior and find that most smokers begin smoking shortly before, during, or after puberty. According to a survey carried out by Lieberman Research, Inc. for the American Cancer Society (1969), the median age at which individuals begin smoking is twelve, and one-fourth try cigarettes before age ten.

Since no clear-cut "character of smokers" has emerged, Mausner and Platt (1971, p. 6) suggest an ecological orientation
to smoking encompassing the same elements used in epidemiology, the study of the determinants of disease. In this theory, ongoing characteristics of the environment and of the person constitute inputs as determinants of unobservable mediating systems, or thoughts. These determinants in turn determine behavior, and each instance of behavior may create feedback, modifying an individual's internal states or environment. Thus, the ecological system of an individual consists of the total pattern of inputs, mediating states, and behavior. For the epidemiologist and psychologist, no simple description of a person who smokes, or who is likely to smoke, exists.

According to a publication of the U. S. Department of Health, Education, and Welfare (1976), a primary reason for smoking is pleasure. Cigarettes may be pleasurable or even enhance other activities. Another reason for cigarette smoking is its purported relaxation power. Hammond and Percy (1958) found that 75 per cent of smokers studied believe that cigarettes relax them. In fact, however, they found nicotine to be a stimulant. Elimination of the need for nicotine, therefore, actually removes the source of much tension experienced by smokers trying to reduce their smoking habit.

Some of the claims made for cigarette smoking pertain to indirect benefits rather than to the direct benefits such as pleasure and relaxation. One indirect benefit claimed is the use of a cigarette, pipe, or cigar as a prop to create an
image of sophistication, maturity, or glamour (Olslavsky, 1977). The author reports other indirect benefits smokers believe they receive from smoking such as: helping the smoker avoid other habits that would be just as bad or worse; helping the smoker keep from becoming irritable and unpleasant to others; and helping the smoker keep from gaining weight.

Since evidence is growing which links cigarette smoking casually to a number of physical disorders, (Doll & Hill, 1950; Godber, 1970) researchers are looking not only at reasons for smoking but also at possible methods for assisting smokers who want to quit. In this direction, behavioral methods lend themselves to investigation (Eysenck, 1960), and have been widely used in controlled studies. Aversive conditioning represent one form of behavior therapy. Other types of aversive conditioning procedures use electric shock and physical stimuli. Janis and Mann (1965) used role-playing methods with subjects who were unaware of the use of such methods to influence their smoking behavior. The subjects, using role playing techniques, assumed the role of patients who discover they have lung cancer. The findings of the study conclude that the experimental group reduced the smoking rates significantly more than subjects in the control group.

Another type of behavioral treatment aims at weakening the smoking habit rather than aiming at abruptly stopping it. An example of this type of treatment is the use of a set of
gradual procedures which are devised to narrow the vast array of stimuli to which smoking is supposedly conditioned. A subject is instructed to carry a portable timer whose buzz signals a legitimate cigarette break. During the course of treatment, the timer is reset for increasingly longer time intervals so that smoking could be eventually scheduled out of existence (Bernard & Efran, 1972).

Although the Bernard and Efran treatment works, other gradual-quitting treatments have been found to have less significant effects than quitting abruptly on a target date (Flaxman, 1974). Flaxman calls for further investigation into the feasibility of a gradual change strategy where the target behavior is suppression of a response.

Bernstein and McAlister (1976) focus on another variable to consider when devising a treatment method for smokers; success of the treatment over time. They found that most of the methods for treating cigarette smokers are effective but they decrease in success over time. Some methods which show immediate success for the smoker are systematic desensitization, information dissemination, hypnosis, drug therapy, support groups, and multicomponent interventions. The issue when devising a treatment for smokers is to determine those techniques which are successful and also to determine the variables which cause resumption of smoking behavior after the treatment ends.
Behavioral methods are used for a variety of problems. These methods have been criticized by psychologists from other orientations because the methods are directed toward an individual's symptoms, ignoring the cause of the problem. These methods have also been criticized for causing side effects called symptom substitutions. An example of symptom substitution is: after completing treatment for cigarette smoking, the ex-smoker begins over-eating, i.e., food becomes a substitute for the cigarette. Shertzer and Stone (1974), in criticism of behavioral counseling, call behavioral methods "cold, impersonal, and manipulative and regulates the relationship to a secondary function" (p. 202).

On the other hand, group treatment is a method which usually considers the relationship as being of primary concern. It is the preferred treatment of the American Cancer Society (1971). The group method, according to those who have worked with smokers, offers long-range help to individuals, and is an easily replicable technique (Saunders, 1971). In addition, group treatment offers members a possibility of greater awareness, increased effectiveness, and a more complete utilization of potentials (Bednar & Lawlis, 1971; Branmer & Shostrom, 1968).

Within a group setting, ambivalent feelings connected with quitting cigarettes can be discussed. According to the American Cancer Society (1971), smokers who have tried to stop many times need to resolve their ambivalence about quitting before they can be successful. The smoker's belief in his or her ability to quit is related to the number of times
he or she has tried and failed. A program for smokers needs
to consider the ambivalence of some smokers and recognize
their built-in failure expectation.

Another variable to consider in devising a treatment
method for cigarette smokers is the high rate of recidivism
of smokers in treatment. It is common for more than one half
of the subjects to drop out of a program (Keutzer et al, 1968). Possibly, a program designed for the shortest duration possible
would help control the smoker's rate of recidivism.

The foregoing discussion supports a view that a treat-
ment for cigarette smokers who want to quit must offer some-
thing different from what is now available if the treatment
is to have permanent effects. From review of the literature
pertaining to grief work programs as well as to stop-smoking
programs, it is evident that no investigator has devised a
comprehensive treatment which considers the element of grief
work involved in giving up cigarettes. As a proposed remedy
to this problem, Chapter III describes a program designed
for cigarette smokers who want to quit. The program developed
emphasizes grief work as a therapeutic variable.
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CHAPTER III

METHODS, PROCEDURES, AND GRIEF WORK TREATMENT MODEL

In Chapters I and II of the dissertation it was suggested that grief work may be a means of helping cigarette smokers to quit smoking. This third chapter turns attention to a theoretical foundation for such an application. In addition, Chapter III has a description of a grief work treatment program designed in the research along the lines of the theoretical framework. A final discussion in Chapter III reports the use of the grief work program as the treatment in a research study involving twenty-two adult cigarette smokers. Following these sections is a final section which presents the materials developed for this research.

Theoretical Foundation

In the study reported in this dissertation, the approach to the problem of helping smokers quit cigarettes is unique in that it utilizes a grief work variable in the treatment. No single method is advocated as a cure for quitting the smoking habit. Instead, various methods and techniques used in the past are considered useful so long as the essence of the treatment is an individual's involvement in a grief work program at the time he or she attempts to quit smoking.
The treatment reported here centered on the view that a smoker should assume responsibility for choosing his or her precise method for quitting cigarette smoking. Also, smokers in the research program established their own objectives. Some of their objectives involved totally quitting cigarette smoking, and other objectives had to do with a decrease in number of cigarettes smoked daily. The therapist's responsibility as group leader was to help the subjects achieve their respective goals.

Thus, the grief work treatment accompanied all of the various techniques used by the participants. The therapist's role was to present information about realistic expectations concerning grief work. The therapist made clear to participants that grief work is one part of a treatment program emphasizing personal responsibility for individual goals.

As recounted earlier, other researchers have connected grief with various kinds of losses. Some have postulated that if individuals confront their particular grief and complete grief work, they are better able to reintegrate their lives without the lost object. As pointed out in Chapter II, none of these studies has specifically connected grief work with quitting cigarette smoking. It is the essence of this study reported here, however, that such a connection exists. In fact, where cigarettes are the lost object, it is possible that only after completing grief work can an individual
truly quit the smoking habit or control it without
developing another compulsive habit or a psychosomatic symptom.

The Grief Work Treatment Program

A grief work treatment was developed in this study
along the lines discussed in the foregoing section. Bas-
cally, it followed Heikkinen's (1978) model for counseling
individuals experiencing personal loss. It utilized the
techniques listed below:

1. Group counseling strategies
2. Gestalt techniques (see Perls, 1969)
3. Progression through affective stages of grief
   (see Kubler-Ross, 1969)
4. Relaxation exercises (see Hamrick, 1978)
5. Visualization exercises (see Samuels & Barnett, 1973)
6. Information distribution (see McKean, 1976)
7. Behavioral tasks, e.g., homework or contracts

The use of these techniques in a group treatment model
afforded many opportunities for group members to give and
receive recognition, as well as to support and understand
each other. The effect was to help alleviate any feelings of
isolation or helplessness which the subjects might otherwise
have experienced.
The grief work model was divided into four segments called "Sessions 1 through 4." The sessions corresponded to specific stages of grief: denial, anger, depression and resolution, and reintegration. Each session was designed to take place over a period of approximately one and a half hours, depending on needs of the individuals and the group as perceived by the therapist as group leader. A replication of the entire program, entitled "Grief Work Treatment Program for Cigarette Smokers" appears at the end of this chapter.

Study Using the Grief Work Program

As mentioned earlier in this chapter, a primary purpose of the study was to use the grief work program developed as part of the research. Accordingly, a group of twenty-two adults, assigned to control and experimental groups, made use of the program as an experimental treatment. This section of Chapter III provides detailed procedures for the implementation of the model. The subsections which follow cover first, the selection of the subjects in the study and their description; second, a description of how the program was used; and third, a brief discussion of the statistical procedures for analyzing the results of the research study.

Description of the Population

The subjects who comprised the population in this study were of two types: students and staff at the University of
Texas at Dallas, and citizens of the Dallas community at large. All volunteered in response to poster advertisements about the researcher's Stop-Smoking Program. A facsimile of the poster appears in Appendix H of the dissertation.

The twenty-two persons who volunteered to serve as subjects in the research study ranged in age from twenty-five to forty years of age. Ten subjects, randomly selected from among the volunteers, constituted an experimental group, and the remaining twelve, a control group. The control subjects were considered to be awaiting treatment during the initial stage of the research. They were offered the same treatment given experimental subjects a month later. None of the subjects were informed that they were participating in an experimental treatment, as this information could have contaminated the results.

Description of the Experiment

Using only the experimental group at first, a treatment was provided consisting of four consecutive weekly grief work sessions. Each session lasted one and a half hours. The treatment group met each week in the same room at the same time. Prior to the treatment, all twenty-two subjects had completed questionnaires concerning their smoking behavior (see Appendix A). Experimental subjects filled out the questionnaire at the beginning of Session 1 of the treatment. Control subjects received the questionnaire by mail three
days prior to the beginning of the experimental group's first session. Control subjects returned the questionnaires to the investigator in stamped, self-addressed envelopes.

The questionnaire contained such questions as number of cigarettes a respondent smoked daily, length of time he or she had smoked, and degree of importance the respondent placed on cigarettes. This last question involved a self-report Likert scale which ranged from zero to five. The subject marked as his or her answer a number on the scale, with zero signifying "not important" and 5 "highly important." The reason for including this question was that other researchers have stressed the necessity of a person's going through the grief process after a substantive loss (see Chapter II). The investigators found that the extent to which a griever must grieve is predictable from the importance he or she places on the object lost.

After completion of the initial questionnaire, all four sessions of the Grief Work Program were conducted for the experimental group. The leader followed the grief work model developed in this research precisely as it appears at the end of Chapter III. The researcher served as group leader for all sessions of the treatment.

At the completion of the treatment, subjects responded to another prepared questionnaire. The experimental subjects marked answers on a questionnaire concerning the exact number of cigarettes they were smoking daily at that
point. A copy of the post-treatment questionnaire appears in Appendix C. Control subjects answered the same question via the telephone. Answers obtained from the telephone calls, the pre-treatment questionnaire, and the post-treatment questionnaire appear in Appendix C. In addition, data collected four weeks after the end of treatment in answer to the same question appear in Appendix C. In this four-week follow-up survey, all twenty-two subjects were contacted by telephone and asked the number of cigarettes they were currently smoking daily.

**Procedures for Analysis of Data**

To analyze and interpret the data shown in Appendix A, Analysis of Covariance with repeated measures was used. This technique tested for significant differences between the experimental and control groups at the 0.05 level of significance. With respect to Research Question 1, Analysis of Covariance was used to determine what portion of the variance of the criterion (i.e., number of cigarettes smoked) existed prior to the experiment. The group means were then adjusted to account for the variability.

On the other hand, Research Questions 2 through 5 were correlational questions. These, therefore, were tested through the use of a Pearson Product Moment Correlation or a Spearman Rank Order Correlation.
Grief Work Treatment Program for Cigarette Smokers

The "Grief Work Treatment Program" consists of four weekly counseling sessions. A group therapist acts as a leader of volunteers who are interested in quitting their smoking habit or in decreasing the number of cigarettes smoked daily. A curriculum for each session appears below, including welcoming activities, instructions, exercises, and closing remarks. Instruments used in the program, such as an "Intake Questionnaire" and a "Self-Help List," all appear in appendices of the dissertation.

Session 1: Denial

(The group leader may wish to call members before the sessions, encouraging them to attend.) After the leader's introduction, for purposes of determining the smoking behavior of each member of the group, the leader may distribute an "Intake Questionnaire" for participants to complete. Also, the leader may distribute a "Self-Help List" of ways to quit or reduce cigarette smoking. The group may discuss the list in brief while the leader explains that participants should choose the method(s) from the list which best fit them. Participants may also add to the list from their own ideas.

After the discussion of methods for quitting or controlling the smoking habit, the leader raises the question of confidentiality. In order to feel trust and protection,
members ought to know that what they say in the group will be confidential. All members need to understand that they may discuss the overall content of the program with outsiders, but not the names or precise comments of the group members. After the leader promises confidentiality, each member can verbally agree to maintain it as well.

Next, the leader turns to the topic of commitment. Again, in order to foster a sense of trust as well as predictability, the group members are asked to agree to attend the next three sessions. The leader may clarify that this attendance commitment does not signify a commitment to quit smoking. Instead, it is a contract by and among all members of the group, including the group leader, that they will carry out what they have agreed to do, i.e., to complete the program by being present at all four sessions.

To do so, all members are asked to put their commitment in writing. On the Intake Questionnaire, they are asked to write the statement, "I will attend the following three sessions." The leader could point out that a member's promise must derive from a personal desire to attend and participate in the program, rather than from a desire to please others. In this respect, even the group leader explicitly agrees to attend the next three sessions. During all sessions, members are encouraged to seek support from each other and from the group leader.
Participation in the program out of personal motivation and a desire for help also entails responsibility on the part of each group member. The leader can make clear that responsibility for success or failure in the program rests on the individual participant, not on the group leader. The leader, as therapist, though, is ready to offer assistance and information about cigarette smoking and about quitting the habit. The actual decision to revise one's smoking habits is a personal one involving individual accountability.

Exercise: Who Am I?

At this point in Session 1, participants are ready for the initial exercise in grief work. The leader invites members to close their eyes, relax, and simply contemplate their presence in the room. Thus, they are not to try to intellectualize about the task at hand or to analyze the present situation. The purpose of this request is to help the participants be less formal in interacting with each other.

The group leader then asks members to participate in the following activities:

1. Put their names and telephone numbers on a blackboard.
2. Tell their names to the group.
3. Tell what emotions they are feeling at that time, e.g., anxiety, skepticism, or fear.
The leader encourages group members to respond to the third part of this exercise even if they at first deny any specific emotions. The reason for this insistence is that if they are blocking the expression of underlying emotion, such defense mechanisms may be powerful enough to interfere with the necessary grief work.

**Stroking Exercise**

Next, the leader explains the term *stroke*. Stroking is any form of recognition that one person gives to another. The recognition may be positive, like a smile, or negative, like a frown. A person giving a stroke may find it accepted or rejected. In particular, acceptance of a positive stroke usually causes a recipient to feel good.

Participants are asked to take turns standing up and saying their name while the group claps and cheers for them. The purpose of the entire exercise is to give members an opportunity to give and accept recognition. It is a kind of recognition which is unconditional because it is based merely on a respective member's existence as a human being.

**Exercise: "Why Do I Want to Quit?"**

The group leader now invites members to share their reasons for wanting to quit smoking and any personal negative experiences involving smoking. Afterward, the leader recapitulates and summarizes these reasons and experiences. He
or she also cites similarities and differences in the various motivations for choosing to stop or reduce cigarette smoking.

Instruction on Grief

Following the three exercises on "Who Am I?," "Stroking," and "Why Do I Want to Quit?," the leader introduces the concept of grief as it relates to giving up cigarettes. Cigarettes, the group leader explains, are evidently a significant object to each member of the group. In turn, losing such a significant object is like having to say good-bye to a dear friend. The leader gives examples of how members may have kept cigarettes close by at all times, like a close friend, only in a pocket or purse. The therapist especially points out that members are participating in this program because, in a very real sense, they want to learn how to say "goodbye" to this friend, their cigarettes. The therapist also emphasizes that in saying "goodbye," a smoker experiences a sense of loss and accompanying pain. The only difference, then, between a smoker and a person who has lost a close friend is that in lieu of a human being, he has lost an object, cigarettes.

The members now discuss past losses for which they felt grief. During the discussion, they relate what they felt during such times of grief. After they mention typical feelings of sadness, helplessness, anger, guilt, or even joy, the leader remarks that these are all normal feelings in the grieving process.
The leader emphasizes that often grievers deny or block normal feelings of grief. In fact, denial of feeling is an avoidance reaction which enables a person to cope with loss so as to function during other necessary activities. This kind of reaction is especially common at initial stages of grief. A griever may feel fear that if he allows feelings of grief, he may lose control of himself and be unable to function. In addition, the leader emphasizes that denial of grief is a normal stage in the grieving process. He also declares that pain and grief must be confronted and experienced, not denied.

Sharing Exercise

After the instruction about grief and its relationships to giving up cigarettes, the group leader asks participants to engage in another exercise. Members form pairs for the following activities:

1. One member of the pair (A) shares with the other member (B) his feelings, expectations, and fears about giving up cigarettes.
2. B summarizes A's statements.
3. A critiques B's perceptions of A's views.
4. A and B reverse roles, and then they repeat steps 1 to 3.

At the completion of this Sharing Exercise, each pair shares with the entire group what they learned about themselves and each other.
Visualization Exercise

The Sharing Exercise is followed by another exercise which allows members to use their imagination so as to experience a visualization of their own grief. The leader asks members to imagine their grief as a pile lying on the floor in front of them. Then the leader advises that each individual has the power to reduce the size of his pile of grief. During the group experience members will learn how to make it smaller.

The leader further encourages the group to feel hopeful about being able to lessen their pile of grief and thus also feel hopeful about attaining their goals in the program. By thus objectifying their grief, the leader says, they can be able to confront and resolve it. In turn, having confronted grief, they are able to quit or reduce smoking, depending on their goal.

Closing Goodbyes

At the end of the first session, the leader encourages members to maintain contact with each other between sessions. The purpose is for sharing progress as well as pain involved in their attempts to control smoking. Contact, the leader advises, should not involve checking up on each other. In particular, participants are asked not to ask other members about the number of cigarettes smoked daily. Otherwise, competition might result which could cause discouragement.
During these final moments of Session 1, brief physical contact is appropriate by means of hand touches as the leader says "goodbye" and offers encouragement.

Session 2: Anger

Welcome Back

The beginning of Session 2, involves three matters of business. First, the leader may want to record attendance. Second, the leader should encourage participants to say "hello" to each other. Finally, the leader should shake hands with each member of the group or briefly touch each one. The purpose of the welcome is to foster an atmosphere of acceptance in which no member has to go beyond his or her comfort level in interacting with other participants.

Unfinished Business

After the welcoming activities, the leader invites members to raise any issues or questions regarding the first session. At this time they can also report their feelings during the past week about smoking. Members may relate experiences with various emotional and physical withdrawal symptoms such as nervousness, difficulty in concentrating, irritability, loss or increase in appetite, coughing, dizziness, and fatigue. Thereafter, the leader presents a quick overview of the first session and emphasizes cigarettes as a loss.
Sharing Pain and Success

During the next part of Session 2, the leader asks members to describe to the group any pain experienced from quitting cigarettes. The leader encourages members to listen to the reports and to offer support. Other members may have successes to report such as not smoking for an entire day. The group leader should compliment members on their success and encourage other members to do so, as well.

The importance of empathy with other members' pain is as important as empathy with their successes. In this respect the leader should point out that empathic responses encourage openness because they indicate personal involvement.

At this juncture the leader discusses with participants the readjustments which the loss of cigarettes entails. For instance, participants who formerly enjoyed smoking cigarettes with their coffee may have to learn to like coffee without a cigarette. In ways like this, quitting or reducing cigarette smoking initiates a multi-faceted change in life style requiring numerous adjustments beyond the major one concerning loss of a valued object (the cigarette).

Exercise: Saying "Goodbye"

The leader now introduces an exercise which is a kind of dialogue between respective members and the object of loss. Each participant has an opportunity to say "goodbye" to cigarettes. This dialogue is a powerful gestalt technique which
can enable members to become intensely aware of the loss and its meaning to each of them. By confronting their loss in this manner, participants can perceive their situation as truly one of real loss. In turn, the resolution of the loss is thereby rendered approachable.

The detailed steps in the dialogue are as follows. First, the therapist advises that he or she, as a trained professional, will carefully monitor the entire activity. The therapist offers reassurance that no member will be hurt by this kind of gestalt technique. After soliciting a volunteer from the group, the leader asks him or her to sit in a chair across from an empty chair. The leader suggests that the volunteer relax, move at his or her own pace, and avoid any purposeful analysis or thinking. These techniques aid a participant in enacting his or her role in the dialogue and in expressing any feelings without inhibition.

The leader now instructs the volunteer to picture the lost object, i.e., cigarettes, as if they were on the empty chair. When the participant mentally makes this visualization, the leader tells him or her to begin a dialogue with the cigarettes. It may begin by a simple description of the cigarettes. Upon instructions from the therapist at an appropriate interval, the volunteer changes chairs and assumes the role of the lost object, cigarettes. Here the leader may have to prompt the volunteer to complete the dialogue if he or she has no previous experience with a gestalt experience.
The exercise should end with the participant crushing the imagined cigarettes and saying "You're dead" or "you're gone forever." If time permits, other members may want to perform the same exercise. Probably, however, they will not feel a need to do so since they will have experienced it vicariously during the first dialogue.

After the dialogue, the leader invites the entire group to stand up and imagine that their cigarettes are lying in front of them. Participants are encouraged to stomp on and smash the imagined dead ones (cigarettes) with their feet. All the while, they can say, "You are dead. You are not in my life anymore. I am forever through with you. Goodbye." The desired effect is to encourage members to experience the finality of quitting smoking. Before this time, the group members may not have wanted to face this finality. Thus, the "Saying Goodbye" exercise is a confrontation with loss in spite of natural fears.

After the exercise, the leader works to sustain the resulting mood of the group. Several moments of silence are appropriate. Then, the leader may invite members to discuss their individual feelings and impressions.

Instructions

In this phase of Session 2, the leader instructs the group concerning anger as an element in the grief process. He or she points out that feelings of anger were probably
involved in the gestalt exercise. Since anger is not always a socially acceptable emotion, individuals often repress it. In doing so, they can experience guilt, frustration, or helplessness. The repression of these feelings can result in aggressive behavior wherein a griever feels and expresses hostility, restlessness, nervousness, irritability, self-questioning, or loss of self-confidence. The leader needs to assure group members that irritability or anger are normal stages in giving up cigarettes. Logically, people feel frustrated and angry at giving up any source of comfort or nurture.

The leader further instructs the members concerning possible frustration. He or she describes methods which, when used effectively, release pent-up frustrations without harm to self, others, or property. The leader may want to demonstrate pillow-pounding and screaming as techniques of expressing frustration and anger. In addition, the leader tells the group that by expressing frustration they can help themselves alleviate feelings of helplessness. It is important to note, however, that the leader must emphasize the importance of contracts with one's self and possibly others in the environment, agreeing that harm is not intended or anticipated with these techniques.

In this program, instruction about anger conveys to the group the importance of expressing anger instead of repressing it. The ultimate purpose is integration of the behavior change on an intellectual as well as emotional level.
Homework: Get Anger Out

A homework assignment follows the instruction of Session 2. Participants are told to spend at least fifteen minutes each day expressing their anger or feelings of hurt by using the techniques described in the instruction. The leader solicits from the group any other techniques which might be useful. Finally, the leader reiterates that in doing the exercises, members must be careful not to hurt themselves, other persons, or property.

Homework: Nurture

As an extension of the "Get Anger Out" assignment, members are told to also nurture themselves. This activity is necessary daily after their dealings with anger and frustration feelings. Nurture, the leader explains, requires time with no demands: time when members can experience caring for themselves. They may take a warm bubble bath, receive a body rub, or cuddle with a loved-one. Success in this program is partially dependent upon the members taking time to care for themselves.

Closing Goodbyes

A group hug may close this intimate session. The leader encourages members to welcome the powerful touching strokes of a hug. As before, members are encouraged to continue contact with one another between sessions.
Session 3: Depression and Resolution

Welcome Back

After recording attendance, the leader approaches each member of the group. He or she encourages the participants to accept and give positive strokes at this time. The leader can also model the kind of behavior which evidences warmth and caring.

Unfinished Business

After the welcome, group members should report concerning their homework assignment from Session 2. They are encouraged to mention any feelings and problems in connection with the assignment. In addition, members may, if they wish, relate how successful they have been at avoiding cigarette smoking. The group leader does not pressure members to share this information.

Sharing Pains and Wins

Three considerations about sharing pain as well as success are important in the program. They are as follows:

1. If any members are experiencing extensive pain from quitting or reducing cigarette smoking, the leader encourages them to ask for strokes and nurturing. Other group members can provide nurturing in the form requested by the person experiencing pain. Examples include verbal strokes and back rubs.
2. Members need to learn how to accept strokes as well as to give them to others. Fellow-members of a group constitute a good source of support. The group leader needs to point out to participants that reaching out to give others support may involve risk for the person offering the support.

3. Regarding successes, the leader must encourage members to discuss these with each other and with the group. They are asked to do so regardless of how small a win, that is, a success, may seem to be.

**Exercise: Awareness of Strengths**

After a group discussion of the participants' wins during the program thus far, members take part in an exercise designed to put certain information in writing. The group leader hands paper and pencil to members and asks that they write down their strengths. The entries should be qualities which the respective participants like about themselves. Participants need to make their list contain at least twenty entries listing personal strengths.

**Exercise: Sharing Strengths**

Next, the leader asks members to form pairs for the purpose of confiding their lists of strengths. The leader encourages each pair of group members to be proud of their
strengths, as listed, and to brag to each other about them. The leader asks members to recall that as children they may have been told by parents or other authority figures that they should not show pride. For purposes of the grief work program, however, the leader asks that members feel free to experience pride in themselves regarding their strengths and successes.

The sharing exercise proceeds in the following way: Members of each pair take turns stating their strengths and then listening to the other member do so. As listener, a member may respond with empathy and enthusiasm. Afterwards, the leader asks members to reveal to the group how they felt as they listed their strengths and bragged about themselves.

Instruction: Depression

Following the exercises on pain, wins, and strengths, the therapist instructs participants concerning the relationship between mental depression and the grief process. Here, the leader emphasizes that symptoms of depression include sad feelings, pessimistic attitudes, or lack of energy.

The leader may also use other descriptive terms for a person's being depressed such as low, blue, and down. In such a state of mind, depressed individuals frequently have caused their own condition by turning anger inward upon themselves. The leader also explains that feeling depressed and sorry for one's self is normal behavior, at times;
moreover, such feelings are only temporary. By deliberately engaging in some kind of activity, by giving positive strokes to other persons, and by getting and giving nurturing, an individual who is experiencing depression generally is able to alleviate it. Other methods which group members have found for alleviating depression can be solicited by the group leader.

**Fantasy Exercise: Visualization**

Now the leader dims the lights and guides the group in a relaxation exercise. He or she advises that members also can do this exercise alone at home. In that case, they should record the exercise on a cassette tape for subsequent playback whenever they need aid in relaxing. The exercise itself, "A Trip to the Future," begins with a relaxation exercise developed by Hamrick (1978).

After the relaxation portion of the exercise, the leader conducts a fantasy exercise by means of the following six steps:

1. He or she asks participants to close their eyes and imagine themselves six months hence. They should think about their bodies, particularly their lungs, and to imagine their lungs to be clean and healthy.

2. A fairly lengthy pause ensues.
3. The leader then asks members to relax deeply until they hear counting. At the count of ten, they are to become alert.

4. The leader counts slowly from one to ten.

5. The leader asks participants to open their eyes. He or she states that they should now feel comfortable, relaxed, and refreshed.

6. The leader turns the lights back on.

During this exercise, members should be able to visualize themselves free from the habit of smoking cigarettes. They will also be escaping a feeling of loss in the present, i.e., loss of cigarettes.

**Homework: Anger and Nurturing**

After the relaxation exercise, the leader assigns homework for group members to do during the following week. The homework assignment for Session 3 involves "Get Anger Out" and "Nurture," as described under **Homework** for Session 2.

**Closing "Goodbyes"**

As suggested at the close of Session 2, Session 3 may appropriately conclude with a group hug. Each person should feel free to give other members a hug or touch. At this time the leader can remind members to maintain contact with each other during the interval between group sessions.
Session 4: Reintegration

Welcome Back

After recording attendance at this final session of the Grief Work Treatment Program, the leader personally says hello to each member of the group. Also, he or she tells participants to feel free to touch and hug the other group members.

Unfinished Business

A number of matters need attention before the new work of Session 4. These include the following:

1. Participants give reports on their homework assignment.

2. The leader then asks the group to discuss any unresolved feelings about previous sessions. For example, the leader may ask how members are carrying on other necessary duties and activities without the accompaniment of cigarettes.

3. The leader makes a point of looking for withdrawal behavior in members of the group. If participants seem withdrawn, the leader addresses an explicit request to them that they join in the activities of the session.
Sharing Pain and Wins

At this point in Session 4, the leader initiates a group discussion of individual successes and pain experienced during the past week. Members, the leader insists, should congratulate themselves as frequently as every thirty minutes, regardless of how small a win may seem to be.

In particular, the leader needs to discuss with the group the inevitable times when they will feel a strong desire for a cigarette. In such circumstances members should not avoid a craving for cigarettes but instead confront the desire objectively. One way to do so, the leader may advise, is to say aloud, "I have to have a cigarette!"

Review of the Program

After the group discusses the pain and successes involved in quitting the smoking habit, they discuss the work of their three earlier sessions. This discussion affords an appropriate time for the leader to call attention to the stages of grief and to the group's progress through these stages. Especially, the leader takes time to compliment members on their having completed the entire program. In this connection, the leader remarks on the courage necessary for any human being to make this kind of deliberate change. If the leader wishes to express any personal views about the four sessions, he or she may do so while stressing the advantages of meeting as a group for support.
Exercise: **Memorial Monument**

Following review of the program, participants engage in an exercise with cigarettes. After receiving paper and an assortment of colored pencils or crayons, they are to draw a monument or memorial to cigarettes. The reason for the monument is to memorialize that which formerly, but no longer controls their lives, that is, cigarettes. The memorial picture may be of a building, a site, a sculpture, or whatever represents how they would like to remember their old friend, cigarettes. Afterward, participants may hang their pictures on the walls of the meeting room for the remainder of the session.

Instruction: **Regression**

The next activity of Session 4 is instruction by the group leader concerning the topic of regression. The leader points out that regression is important in growth and change. Although giving up cigarettes effects real personal growth, it also entails some backward movement. The leader defines this kind of backward movement as a feeling of being somewhat "crazy" at times. The result is that participants may experience relapses where they temporarily lose their control over cigarettes. Nevertheless, these will subside if participants go ahead and experience it, as opposed to denying it.
During regression, members need extra support. The leader stresses that members may continue getting support by calling a friend or hugging a loved-one. The important consideration is that the individual ask for some kind of help.

Instruction: New Beginning

A second category of instruction during Session 4 involves developing new interests and meeting new people. In giving up cigarettes and belonging to a supportive group, a member achieves a new way of life to replace the lost one. The leader talks with the group about this suggestion and its role during the period when an individual's sense of loss is subsiding. Methods for developing interests include making new friends, joining an organization, attending school, or resuming a former hobby. Other ideas can come from group members, whom participants should contact regularly for support. The chief guideline in this personal effort should be to go beyond what is required simply to satisfy one's basic obligations.

Exercise: Imagined Disappearance

An exercise in relaxation follows the instruction in the participants' new way of life. The leader dims the lights and conducts the "Fantasy Exercise: Visualization" described in Session 3. In step 1 of the exercise, however, the leader depicts the following scene in lieu of the image of clean and healthy lungs:
The leader asks participants to imagine a quiet peaceful scene where they love to go. This should be a favorite place. A pause follows. Then the leader asks participants to use their senses of feeling, touch, sight, smell, and hearing. He or she asks them to enjoy this tranquil place and to relax. Another pause ensues. Now the leader asks the group to imagine themselves with their old friend, cigarettes. After allowing time for a pause, the leader asks members to imagine tasting, smelling, feeling, and seeing the cigarette smoke, and hear themselves puff the cigarettes. Finally, the leader asks members to imagine blacking out, reawakening, and finding their cigarette smoking ended forever. The leader declares, "They (the cigarettes) are gone."

The leader now completes steps 2 through 6 of the Fantasy Exercise.

Afterward group members recount their feelings during the exercise. In addition, they are asked to discuss their feelings at that moment about facing a future without cigarettes.

Continuation of Homework

At this juncture in Session 4, the leader recommends that group members continue as homework the daily expression of frustration requested earlier in the program. The leader
reiterates that these techniques are helpful in maintaining their resolution to give up or decrease cigarette smoking. The leader should also recommend that the members continue getting and giving nurturing.

Visualization Exercise

The concluding activity of the program is a visualization exercise. The group leader asks participants to create a visual image of the pile of grief or other feelings left over from quitting smoking. Members may describe aloud how large their pile is and tell whether they have been able to decrease its original size. This exercise affords members a reminder that they do have control and power over their grief.

Goodbyes

The conclusion of Session 4 marks the completion of the program. At this time the leader may distribute an evaluation questionnaire for participants to answer (see Appendix B). Then, a final group hug may be appropriate. As a parting note, the leader again encourages participants to maintain contact with each other if possible.
CHAPTER BIBLIOGRAPHY


CHAPTER IV

ANALYSIS OF DATA

Introduction and Rationale

The purpose of Chapter IV is to present and analyze the statistical results of this study, based on the data collected. The investigation concerned cigarette smokers who volunteered for help in attaining either of two goals: quitting or reducing cigarette smoking. The personal goal of each subject was, in fact, the basis for judging success of the treatment in the study. Logically, a valid measurement of success was any decrease in number of cigarettes smoked since all volunteers wanted at least to reduce this number. Specifically, any daily decrease was considered success, and this decrease in number of cigarettes smoked was the criterion for comparing experimental and control groups after the treatment and on a four-week follow-up date.

The investigation used 22 volunteers randomly assigned to two groups. Twelve subjects formed a "waiting group" which received treatment after the experimental treatment. The remaining ten subjects constituted the experimental group. Since all were volunteers, a reasonable assumption was that they were well motivated to find a way to control their smoking. Using these subjects and the grief work program outlined in Chapter III, research was conducted and
the data analyzed. The analysis relied on statistical techniques of Analysis of Covariance, Pearson Product Moment Correlation, and Spearman Rank Order Correlation. A significance level of 0.05 was the basis for acceptance or rejection of the research questions. Appendixes D through G of the dissertation contain the raw data from the study.

Results of Analysis

Statistical tests were run for both numerical and percentage decreases in number of cigarettes smoked. Test results were inconclusive for correlation of percentage of decrease and (1) length of time the subjects smoked prior to treatment, (2) importance of cigarettes to the subjects, (3) number of previous attempts to stop smoking and, (4) number of cigarettes smoked daily at the outset of the treatment. On the other hand, comparisons involving the same four variables and decrease in number of cigarettes smoked showed positive correlations in some instances. For these reasons, the tests using raw numbers of cigarettes smoked are the ones analyzed below.

The detailed analysis which follows contains two main sections. The first section discusses Research Question 1. The second section, dealing with correlations, discusses all four remaining research questions. A final portion of Chapter IV summarizes chief findings in the study.
Research Question 1

Research Question 1, concerning number of cigarettes smoked before and after treatment, read as follows:

Is there a significant difference in the number of cigarettes smoked by an experimental group and a control group (a) immediately following treatment, and (b) four weeks after treatment?

Two measures were involved in Question 1: one immediately following treatment and another four weeks later. The analysis regarding Research Question 1 is therefore divided into two parts, one regarding each measure.

First Measure After Treatment.--To compare treatment and control groups concerning decrease in daily number of cigarettes smoked immediately after treatment, an Analysis of Covariance statistical technique was used. The Analysis of Covariance was chosen because it permits statistical rather than only experimental control of the variables. Analysis of Covariance is used to determine which proportion of the variance of the criterion existed prior to the experiment and then eliminating this proportion from the final analysis. Data from this test are summarized in Table I. The covariate was the number of cigarettes smoked per day at the outset of the program, i.e., the original number smoked before the grief work treatment program. The resulting statistic from this
test was an $F$ of 32.50 with a probability of 0.00001. Accordingly, the result is significant at the 0.001 level.

**TABLE I**

AFTER-TREATMENT COMPARISON OF EXPERIMENTAL AND CONTROL ADJUSTED GROUP MEANS, USING ANALYSIS OF COVARIANCE

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Degrees of Freedom</th>
<th>Sums of Squares</th>
<th>Mean Squares</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20</td>
<td>1859.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>19</td>
<td>686.05</td>
<td>36.11</td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>1</td>
<td>1173.58</td>
<td>1173.58</td>
<td>32.50*</td>
</tr>
</tbody>
</table>

*Significant at a level $\geq 0.05$.

A finding warranted by the covariance statistic is that the experimental treatment was effective. Since the experimental and control groups differed in number of cigarettes smoked immediately following treatment, this difference was probably attributable to the variable, i.e., treatment, in a controlled situation like this. For the experimental group, the adjusted mean was 6.69 cigarettes smoked per day and for the control group, 22.18 cigarettes smoked per day. It is this difference in which significance exists.

**Follow-up Measure After Treatment.**--The second part of Research Question 1 had to do with whether a significant decrease in number of cigarettes smoked would exist among subjects in the experimental group, compared with the control group, four weeks after the treatment. As used for the earlier
measure regarding Research Question 1, Analysis of Covariance was employed. The criterion measure was the number of cigarettes smoked per day four weeks after the treatment ended, and the covariate was the number of cigarettes smoked per day at the outset of the grief work program as treatment. Data from this test are summarized in Table II.

**TABLE II**

**FOLLOW-UP COMPARISON OF EXPERIMENTAL AND CONTROL ADJUSTED GROUP MEANS, USING ANALYSIS OF COVARIANCE**

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Degrees of Freedom</th>
<th>Sums of Squares</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
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<td>1808.32</td>
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<tr>
<td>Within</td>
<td>19</td>
<td>903.70</td>
<td>47.56</td>
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<tr>
<td>Difference</td>
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<td>904.62</td>
<td>904.62</td>
<td>19.02*</td>
</tr>
</tbody>
</table>

*Significance at a level > 0.05.

Again, the covariance statistic supports a finding that the treatment was effective. The statistic resulting from this test was an F of 19.02 with a probability of 0.0003. Accordingly, this F-value is significant at the 0.001 level of significance. It indicates a significant difference between the experimental and control groups at a four-week follow-up date. The difference is probably attributable to the variable, i.e., the treatment, because the original number of cigarettes smoked was taken into account as covariate. For the experimental group, the adjusted mean was 8.54 cigarettes smoked per day and for the control group, 22.14 cigarettes.
As was true in the case of the measure taken immediately after treatment, the follow-up measure indicated a difference of 8.54 as against 22.14 cigarettes. This is a difference which has statistical significance.

**Correlations**

Research Questions 2 through 5 involved correlational issues. The questions were as follows:

2. Within the experimental group, is there a relationship between length of time the subjects smoked prior to the treatment and their success rate in the treatment measured by the decrease in the number of cigarettes smoked at the completion of the treatment?

3. Within the experimental group, is there a relationship between the importance of cigarettes to the subjects and their success rate in the treatment, measured by the decrease in the number of cigarettes smoked at the completion of the treatment?

4. Within the experimental group, is there a relationship between the number of previous attempts made by the subjects to stop smoking and their success rate in the program, measured by decrease in number of cigarettes smoked at the completion of the program?
5. Within the experimental group, is there a relationship between number of cigarettes smoked daily at the onset of the program and success rate in the program, measured by the decrease in the number of cigarettes smoked at the completion of the treatment?

A Pearson Product Moment Correlation was used to test the degree of relationship between pairs of variables in Research Questions 2, 4, and 5. The Pearson Product Moment Correlation was chosen as an appropriate method of correlating these variables as they are interval level measurements. The Spearman Rank Order Correlation is the appropriate test when one or both variables is on an ordinal scale (Roscoe, 1975). Therefore, the Spearman Rank Order Correlation was chosen for testing Research Question 3 because one of the variables, i.e., importance of cigarettes to the smoker, was an ordinal level measurement.

Use of the statistical techniques just mentioned produced several correlation coefficients. They are displayed in a correlational matrix in Table III. Where an $r$ has statistical significance, an asterisk (*) accompanies its numerical value in the table. The matrix indicates that three correlations of paired variables are significant. Findings about these correlations follow below, arranged in order of research question number.
### TABLE III

CORRELATION OF DATA FROM RESEARCH QUESTIONS 2 THROUGH 5

<table>
<thead>
<tr>
<th></th>
<th>Original Number Smoked</th>
<th>Decrease in Number Smoked</th>
<th>Years of Smoking</th>
<th>Importance</th>
<th>Number of Attempts to Quit Smoking</th>
<th>Percentage Decrease in Cigarettes Smoked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Number Smoked</td>
<td>0.8547*</td>
<td>0.7921*</td>
<td>0.7979*</td>
<td>0.3301</td>
<td>0.0776</td>
<td></td>
</tr>
<tr>
<td>Decrease in Number Smoked</td>
<td></td>
<td>0.6697*</td>
<td>0.7366*</td>
<td>0.3137</td>
<td>0.5235</td>
<td></td>
</tr>
<tr>
<td>Years of Smoking</td>
<td></td>
<td></td>
<td>0.6197</td>
<td>0.2707</td>
<td>0.0256</td>
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</tr>
<tr>
<td>Importance</td>
<td></td>
<td></td>
<td></td>
<td>0.4016</td>
<td>0.3405</td>
<td></td>
</tr>
<tr>
<td>Number of Attempts to Quit Smoking</td>
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<td></td>
<td></td>
<td></td>
<td>0.2752</td>
<td></td>
</tr>
</tbody>
</table>

*Indicates statistical significance at a level of ≥ 0.05 on a one-tailed test.

aAs measured on a Likert Scale from 0 (least important) to 5 (most important).

bDegrees of freedom = 8 for this and all other correlations.
Research Question 2

The first correlational issue in the study, Research Question 2, sought a determination of whether a correlation existed between length of time subjects in the experimental subjects smoked prior to treatment and their success rate in the treatment. For each subject, success in the program consisted of any decrease in the number of cigarettes smoked at the completion of the treatment.

Accordingly, the variables of years of smoking cigarettes and decrease in number of cigarettes smoked daily after treatment were compared statistically. A Pearson Product Moment Correlation Coefficient \( r \) was calculated in connection with each subject. The calculated value of \( r \) for the entire group was 0.67 on a one-tailed test. This statistic represents a moderate-to-high positive relationship.

In order to determine whether this \( r \)-value was a significant correlation, a \( t \)-test for related samples was used. The \( t \)-test involved the following formula: 
\[
t = r \sqrt{\frac{n-2}{1-r^2}}
\]
The \( t \)-value calculated by using the above formula was 2.55. Since the tabled \( t \)-value with eight degrees of freedom, 1.86, is lower than the calculated \( t \)-value, the 0.6697 \( r \)-statistic is significant. Thus, a positive correlation is likely between years of smoking and decrease in number of cigarettes smoked after treatment.
Research Question 3

Another research question sought a determination of whether a correlation existed between importance of cigarettes to the subjects in the experimental group and their success rate in the treatment. Any decrease in the number of cigarettes smoked by each subject at the completion of the treatment constituted success. Accordingly, a Spearman Rank Order Correlation Coefficient $r$ was calculated for all subjects and the overall value of $r$ for the group was 0.87.

In order to determine whether this $r$-value was a significant correlation, a $t$-test for related samples was used. It followed the same formula cited above for Research Question 2. The calculated $t$-value was 4.99. Since the tabled $t$-value with 8 degrees of freedom, 1.86, is lower than the calculated $t$-value, the 0.87 $r$ statistic is significant. Thus, a high positive correlation is likely between importance of cigarettes to the subject and his or her decrease in number of cigarettes smoked after treatment.

Research Question 4

The fourth research question sought a determination of whether a correlation existed between the number of previous attempts to stop smoking made by the subjects in the experimental group and their success rate in the treatment. Again, success was measured by any decrease in the number of cigarettes smoked by each subject at the completion of the treatment.
Accordingly, the variables of number of previous attempts made by subjects to quit and decrease in number of cigarettes smoked daily after treatment were compared statistically. A Pearson Product Moment Correlation Coefficient $r$ was calculated in connection with all subjects, and the calculated value of $r$ for the group was 0.31. This statistic represents a low positive correlation.

In order to determine whether the $r$-value had a significance, a $t$-test for related samples was used. The formula was the one cited for analysis of data on Research Question 2. The $t$-value thus obtained was 0.93. Since the tabled $t$-value with eight degrees of freedom, 1.86, is higher than the calculated $t$-value, the $r$ statistic is not significant. Thus, a positive correlation is not likely between number of previous attempts to quit smoking and decrease in number of cigarettes smoked after treatment.

Research Question 5

The final research question sought a determination of whether a correlation existed between number of cigarettes smoked daily at the outset of the treatment and the subjects' success rate in treatment. As before, success was measured by any decrease in the number of cigarettes smoked by each subject at the completion of the treatment. The number of cigarettes smoked daily at the outset of the treatment and decrease in number of cigarettes smoked daily after the
treatment were compared statistically by means of a Pearson Product Moment Correlation in connection with each subject. The calculated value of $r$ for the group was 0.85, a statistic which appears to be a high positive correlation.

In order to determine whether the $r$-value was a significant correlation, a $t$-test for related samples was used. The formula was the same as the one shown above for Research Question 2. The $t$-value thus calculated was 4.66. Since the tabled $t$-value with eight degrees of freedom, 1.86, is lower than the calculated $t$-value, the $r$ statistic is significant. A positive correlation is likely, therefore, between number of cigarettes smoked prior to treatment and decrease in number of cigarettes smoked daily.

Summary

The foregoing analysis of data affords information on which to base an evaluation of the original grief work treatment model in this study. Significant relationships were found between decrease in number of cigarettes smoked and each of the following: years of smoking, importance of cigarettes to the smoker, and number of cigarettes originally smoked. An extrapolation of the data is the important finding that the grief work treatment program must have been effective among the treatment subjects in terms of their goals in the program. That is, since their objectives involved decreases in number of cigarettes smoked daily, and since
they as a group achieved these objectives, the program was in fact successful. Furthermore, the effectiveness of the program continued four weeks after the treatment ended. Chapter V contains conclusions based on these findings, as well as recommendations for other research studies.
CHAPTER BIBLIOGRAPHY


CHAPTER V

CONCLUSIONS

To accompany the analyses in Chapter IV, this final chapter of the dissertation reports conclusions from the research. It includes a summary of the problem, purposes, and procedures reported in detail in previous chapters. The chapter also reports recommendations, including suggestions for revising the Grief Work Treatment Program and for conducting further research. A final section of Chapter V reports implications of the research with regard to the approach professionals use for cigarette smokers and to grief work in general.

Summary

A survey of the literature indicated that presently-used treatments do not have significant permanent effects for cigarette smokers who want to quit. The review of the literature also indicated that no researchers prior to this study examined the possibility that quitting cigarettes involves personal grief. To meet these gaps in research, the purpose of this study was to investigate the relationship between an individual's quitting cigarettes and experiencing grief. If such a relationship exists, then a program of grief work probably can aid smokers in quitting or controlling their habit.
To investigate the relationship, a grief work program was designed and implemented in the research. The program was based upon a view that smokers who quit undergo a grief process in which the object of significant loss is cigarettes. Thus, the process parallels, in perhaps a lesser degree, the grief a person experiences when losing a dear friend or relative. The treatment, consisting of four weekly sessions, was a group counseling model utilizing the techniques of progressing through structured stages of grief; relaxation and visualization exercises; instruction about cigarette smoking, methods of quitting, and adjusting to loss; and behavioral tasks. A group of twenty-two volunteer subjects divided into control and experimental groups, made use of the program as an experimental treatment. The study sought an answer to the question of whether a significant difference would exist in the number of cigarettes smoked by the experimental group after treatment and four weeks later compared to the control group.

Results of the study showed that the treatment, the Grief Work Treatment Program, was effective. In a comparison of treatment and control subjects, Analysis of Covariance, using number of cigarettes smoked daily at the beginning of the program as covariate, produced a significant F at the 0.05 level on measures taken immediately after the treatment and four weeks later. Thus, in terms of the subjects' respective goals, the grief work program was effective in helping subjects to quit or reduce smoking. In addition, correlational tests
concerning the treatment group indicated significant relationships existed between, decrease in number of cigarettes smoked daily and, (1) length of time a subject smoked prior to treatment, (2) importance of cigarettes to the subject, and (3) number of cigarettes smoked daily at the outset of the program. On comparisons of these variables, significant Spearman-Rank and Pearson Product Moment Correlation Coefficients ranged from 0.67 to 0.85.

Recommendations

Several concluding remarks about the initial problem need mention on the basis of this report. They consist of the recommendations and suggestions which follow below. Included are suggestions for improving upon the materials in the Grief Work Treatment Program and for further research in the area of counseling for grief.

By exploring the possible relationship between controlling cigarette smoking and the grief process, the research sought a new approach to helping smokers who want to stop or control their habit. A Grief Work Treatment Program was developed on the assumption that such a relationship exists. The relationship was further examined in a research study using the newly-developed materials. The experience of the study provided information about formulation of a professional
grief work program for smokers and about revised procedures for research in possible future investigations.

The following specific changes in the grief work program seem advisable, based upon the experience of the research study. The first two were requests made by several group members.

1. Increase the number of sessions.
2. Provide for more than one session weekly.
3. Insert directions to the therapist that activities in each session may be rearranged or expanded according to the participants' needs and wishes.
4. Modify the language of the "Intake Questionnaire" to be more specific. For instance, at the end of question 5, "What is the longest single period of time you have stayed away from cigarettes," add the words "since you first started smoking?" In question 9, specify how many reasons the respondent should list for his decision to quit smoking. Finally, in question 7 on the personal importance placed on cigarettes, include the phrase "as compared with other significant objects or persons in your life." The reason for these changes is to obviate any confusion respondents might experience because of ambiguous wording of the questions.
5. Ensure additional contact among group members between sessions and after the treatment. This modification is needed for the purpose of providing mutual support among group members.

In addition to revisions in the program prompted by the experience of the research study, the experiment also provided data for suggestions about future research. The following conclusions are offered:

1. Whereas the focus of research into quitting smoking has been on the damages of cigarettes on a smoker's body, research needs to study the possible physical damages to a person when he or she stops smoking. This need became evident in the research study, in which treatment subjects experienced agitation, stress, and psychosomatic disorders.

2. It is notable that no person of an ethnic minority group responded to the recruiting efforts employed for the research study. Perhaps future research should take such groups into account. The reason is that the theory underlying this program involves concepts of loss which undoubtedly vary among different cultures.

3. Replications of this study might provide help for other persons by applying the program to types of grief other than losing cigarettes. Such studies
might investigate use of the program among alcoholics, paraplegics, divorced persons, overweight people, women having an abortion, and the retired or aged. Logically, the use of a grief work program showing significant results for cigarette smokers might provide similar results among persons with other types of loss.

4. Further research needs to address the problem of identifying the various concomitant losses which precede or develop along with the loss of cigarette smoking. The study undertaken here was delimited in such a way as not to investigate the subjects' personal grief beyond that involving simply the loss of cigarettes. Some theorists believe, however, that any present loss can also involve unresolved griefs of other sorts.

Implications

On Stop-Smoking Programs

Perhaps the chief implication of the research described above and in previous chapters of this report centers upon the distinction between the methods and theory concerned with stop-smoking efforts. Data from the research study indicated
that grief work is effective among smokers who attempt to control cigarettes by many different personalized means. These included, for example, relaxation, substitution, or other behavioral tasks. The treatment, then, involved a theory about the relatedness of grief and quitting or reducing one's cigarettes. Therefore, the program, primarily addressed the problem of grief and its resolution, not merely provided techniques for quitting the smoking habit.

As a result, an implication of the study, in terms of the helping professions, is that stop-smoking programs may need to include grief work as well as the precise methods of quitting smoking. In the program developed in this study, each participating smoker established his or her own goals and selected the methods he or she felt appropriate and effective. The common denominator of their success in achieving these goals had to do with working through the grief which resulted from the loss of a valued object, in this case, cigarettes.

On Grief-Work Therapy

A second implication of this study has to do with grief work as a discipline. If, as this study shows, grief work is effective therapy for controlling cigarette-smoking and possibly for other kinds of loss, then grief work should be singled out and recognized as a distinct area of counseling. By such means, counselor education may focus more effectively
on the particular problems of grievers. In addition, coun-
selors in general can thereby be made aware that grief work
is applicable to many sorts of human problems.
APPENDIX A

INTAKE QUESTIONNAIRE
INTAKE QUESTIONNAIRE

NAME: ____________________________ AGE: ________
ADDRESS: ________________________ CITY, STATE: ____________
PHONE NUMBER: ________________ SEX: ____________
OCCUPATION: ____________________ TODAY'S DATE: ____________

MARITAL STATUS: ( ) single  ( ) married
( ) widowed  ( ) divorced or separated

Circle highest completed school year:  8  9  10  11  12
     (college) 1  2  3  4 masters Ph.D.

1. How many times have you made a serious and deliberate attempt to stop smoking cigarettes?_________ ( ) none

2. How many different organized programs have you attended to help you quit smoking? ________ or ( ) none

3. Number of persons in your household besides yourself who smoke ________________.

4. Which brand do you frequently smoke?____________________

5. What is the longest single period of time you have stayed away from cigarettes?
   _____ years _____ months _____ weeks _____ days _____ hours
   ( ) none

6. On an average day, how many cigarettes do you smoke per day?__________________

7. How important are cigarettes to you?
   (Circle number)  0  1  2  3  4  5
   (not important)  (extremely important)

8. How long have you smoked cigarettes?_______years
   ___________ months

9. Why have you decided to quit?_______________________________________
APPENDIX B

LETTER TO WAITING GROUP
LETTER TO WAITING GROUP

Dear ____________________.

I look forward to working with you in the STOP SMOKING PROGRAM. It is scheduled for _____________. I will contact you by phone as to the exact time and place.

I am enclosing an information sheet that I would like for you to fill out. Please take time to fill it out now and return it in the stamped, self-addressed envelope. Thank you for your cooperation.

Sincerely,

Patsy Dahm
APPENDIX C

POST TREATMENT QUESTIONNAIRE
POST TREATMENT QUESTIONNAIRE

NAME:

On an average day, how many cigarettes are you presently smoking?

______________________________

I would like for you to share your impressions about this group experience. Will you comment briefly in the space below?

Thanks,

P.J.D.
### RESPONSES TO INTAKE QUESTIONNAIRE FOR STOP SMOKING PROGRAM

<table>
<thead>
<tr>
<th>Subjects in Pilot Study</th>
<th>Questionnaire Response</th>
<th>Smoking Behavior</th>
<th>Longest Non-Smoking Period</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Age</td>
<td>Sex</td>
<td>Occupation</td>
</tr>
<tr>
<td>Treatment Subjects</td>
<td>1</td>
<td>M</td>
<td>Student</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>F</td>
<td>Writer/ Editor</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>F</td>
<td>Realtor</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>M</td>
<td>Student</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>F</td>
<td>Secretary</td>
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<td>6</td>
<td>F</td>
<td>Student</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>F</td>
<td>Education Diagnostician</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>F</td>
<td>Housewife</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>M</td>
<td>Student</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>F</td>
<td>Housewife</td>
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<tr>
<td>Control Subjects</td>
<td>11</td>
<td>F</td>
<td>Lab Technician</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>F</td>
<td>Executive Assistant</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>F</td>
<td>Student Development Specialist</td>
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<td>14</td>
<td>F</td>
<td>Housewife</td>
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<td>15</td>
<td>M</td>
<td>Accountant</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>F</td>
<td>Household/ Student</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>M</td>
<td>Operator</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>F</td>
<td>Computer Analyst</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>F</td>
<td>Terminal Operator</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>M</td>
<td>Carpenter</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>F</td>
<td>Student</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>M</td>
<td>Student</td>
</tr>
</tbody>
</table>

$^a$ M = Married; S = Single; D = Divorced

$^b$ 12 = high school; 2-3, or 4 = years of college; 5 = masters degree

$^c$ Excluding the subject
APPENDIX E
DATA FROM INTAKE QUESTIONNAIRE
ON THE IMPORTANCE OF SMOKING
RESPONSES OF SUBJECTS IN RESEARCH STUDY TO SELF REPORT ON IMPORTANCE OF SMOKING

<table>
<thead>
<tr>
<th>Subject</th>
<th>Response on Likert Scale*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
</tr>
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<td>3</td>
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<td>4</td>
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<td>3</td>
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<td>7</td>
<td>4</td>
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<td>8</td>
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<td>4</td>
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<td>5</td>
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<td>21</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>5</td>
</tr>
</tbody>
</table>

*The scale presented was from zero to five, and the question asked was "How important are cigarettes to you?"
APPENDIX F
DATA FROM INTAKE QUESTIONNAIRE ON REASONS FOR DECIDING TO QUIT
RESPONSES OF SUBJECTS IN RESEARCH STUDY TO SELF-REPORT ON REASONS FOR DECIDING TO QUIT

<table>
<thead>
<tr>
<th>Subject</th>
<th>Reasons For Deciding to Quit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&quot;Because I want to.&quot;</td>
</tr>
<tr>
<td>2</td>
<td>&quot;Health, offensive odor, expense, hassle&quot;</td>
</tr>
<tr>
<td>3</td>
<td>&quot;To better myself.&quot;</td>
</tr>
<tr>
<td>4</td>
<td>&quot;I don't know.&quot;</td>
</tr>
<tr>
<td>5</td>
<td>&quot;Medical, and I don't like control cigarettes have over me.&quot;</td>
</tr>
<tr>
<td>6</td>
<td>&quot;Want to be self-disciplined and in control of my life.&quot;</td>
</tr>
<tr>
<td>7</td>
<td>&quot;Health and social pressure&quot;</td>
</tr>
<tr>
<td>8</td>
<td>&quot;Health and children.&quot; (Subject was pregnant.)</td>
</tr>
<tr>
<td>9</td>
<td>&quot;I have a cough and worry about aging.&quot;</td>
</tr>
<tr>
<td>10</td>
<td>&quot;Health&quot;</td>
</tr>
<tr>
<td>11</td>
<td>&quot;Health&quot;</td>
</tr>
<tr>
<td>12</td>
<td>&quot;Haven't decided yet.&quot;</td>
</tr>
<tr>
<td>13</td>
<td>&quot;Health&quot;</td>
</tr>
<tr>
<td>14</td>
<td>&quot;Unhealthy and expensive&quot;</td>
</tr>
<tr>
<td>15</td>
<td>&quot;Not good for me.&quot;</td>
</tr>
<tr>
<td>16</td>
<td>&quot;Unhealthy, discolor teeth, expensive&quot;</td>
</tr>
<tr>
<td>17</td>
<td>&quot;Want to recycle my lungs&quot;</td>
</tr>
<tr>
<td>18</td>
<td>&quot;Harmful to health&quot;</td>
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<tr>
<td>19</td>
<td>&quot;Haven't decided yet, but should because of health, odor, and age&quot;</td>
</tr>
<tr>
<td>20</td>
<td>&quot;Health, expensive&quot;</td>
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<tr>
<td>21</td>
<td>&quot;So I can run&quot;</td>
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<td>22</td>
<td>&quot;Health reasons&quot;</td>
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</table>
APPENDIX G

DATA FROM EXPERIMENTAL AND CONTROL SUBJECTS
ON NUMBER OF CIGARETTES SMOKED DAILY
BEFORE AND AFTER TREATMENT
NUMBER OF CIGARETTES SMOKED DAILY BY EXPERIMENTAL AND CONTROL SUBJECTS BEFORE AND AFTER TREATMENT

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of Cigarettes Smoked Daily</th>
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</thead>
<tbody>
<tr>
<td>Code No.</td>
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<tr>
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<td>4</td>
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</tr>
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<td>Exp.</td>
</tr>
<tr>
<td>7</td>
<td>Exp.</td>
</tr>
<tr>
<td>8</td>
<td>Exp.</td>
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<td>9</td>
<td>Exp.</td>
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<td>21</td>
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<tr>
<td>22</td>
<td>Control</td>
</tr>
</tbody>
</table>
APPENDIX H

POSTER ADVERTISEMENT FOR

STOP SMOKING PROGRAM
POSTER ADVERTISEMENT

STOP SMOKING PROGRAM

Quitting smoking can be painful. This innovative group program for smokers who want to be liberated from cigarettes will offer help through this painful process. The group will meet for four sessions lasting one and one-half hours each. For more information call 690-2947 or 349-2536.
APPENDIX I

STOP SMOKING SELF-HELP LIST
STOP-SMOKING SELF-HELP LIST

TWENTY WAYS TO HELP YOURSELF STOP SMOKING

1. Make a contract with yourself to quit for a specified time (for one hour, one day, one month). Write it down.

2. Give yourself positive strokes for your every win. Example: "Wow, Mary, good for you, you didn't smoke during your coffee break!" Celebrate.

3. Avoid putting yourself down for making mistakes.

4. Write down your motives for quitting. Remember these motives and re-write them when you have spare moments.

5. Stay close to people who smoke. Tell yourself that you love being near people who smoke. Enjoy second hand what you don't want for yourself.

6. Light matches, incense, candles and fireplaces and use your cigarette lighter.

7. Keep a list of the ways others have stopped smoking.

8. Have at least three close friends with which to share your good and bad feelings and from which to get support.

9. Rearrange your life patterns which have involved cigarettes. Plan variations on your old theme of a cigarette-to-go-with-everything.

10. Take up an activity that you cannot do when smoking such as jogging or macrame. Use your creativity.

11. Make a list of non-fattening "crunchies" or "chewies" and keep them close at hand to grab in order to have in those empty hands and mouth (like cinnamon gum, apple chunks, sunflower seeds, tangerines, peppermints, mushrooms, granola, parsley, pickles, licorice, and especially spicy foods).

12. Keep something with you to "hold on to" like worry beads, a pencil, Silly Putty, or a phony cigarette.

13. Expect to feel rotten, low, unlikeable, anxious, scared, worried, uptight, mad, hostile, high, glad, happy, joyful, likeable, huggable, comfortable, frustrated, rejected, hurt, inadequate, miserable, sad, depressed, pessimistic, mixed-up, and uncertain. Add more of your own to the list.
If you expect these feelings, then you won't be shocked by them. The negatives will become lesser and lighter when you expect them.

14. Let the need and the want for a cigarette engulf you. Experience the crises. Afterwards write down how you felt. The next one should be easier to withstand.

15. Learn some relaxation exercises. Take time for you - without demands.

16. Make a fun list. Discover new ways of having fun (Remember, sex is FUN!).

17. Give at least twenty-five positive strokes (compliments) every day. (You'll also be stroking you.)

18. Do nurturing things for yourself like taking warm bubble baths, getting a back rub, or being "cuddled."

19. At times of intense stress, express the frustration (or if the time or place is not appropriate, promise yourself that you will do it later) by beating on a pillow, or screaming. Be sure others, such as family, are informed of your intentions beforehand.

20. Look at yourself in a mirror, often; with the realization that you exist - you are alive. You do not need the cigarette smoke billowing out in front of you to validate your existence.

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REPORTS


UNPUBLISHED MATERIALS


