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Bereavement and sexual functioning

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Abstract

"With the death of a husband, you lose your present; with the death of a parent the past; but with the death of a child you lose your future" (Linzer, 1977, p. 11). There is no more devastating experience for parents than the death of their child. The impact of a child's death is profound because the parent-child relationship is generally regarded as the most reciprocally intense interpersonal relationship (Parker, 1979). A parent's grief is often inconsolable and never ending.

BEREAVEMENT AND SEXUAL FUNCTIONING

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Chapter One

INTRODUCTION

"With the death of a husband, you lose your present; with the death of a parent the past; but with the death of a child you lose your future" (Linzer, 1977, p. 11). There is no more devastating experience for parents than the death of their child. The impact of a child's death is profound because the parent-child relationship is generally regarded as the most reciprocally intense interpersonal relationship (Parker, 1979). A parent's grief is often inconsolable and never ending.

Loss of this parent-child dyad is the most significant of all losses. Sanders (1980) studied the grief reaction of persons who have experienced the death of either a parent, a spouse, or a child. According to Sanders, the death of a child evokes the highest intensity of bereavement and the widest range of reactions such as depression, anger, guilt, despair, and somatic distress than those who have experienced the death of a parent or spouse. Such a loss may alter, forever, the course of a parent's life and even the parents' relationship to each other.

Parents react to the tragedy of their child's death in unique manners. However, there are similarities in how parents experience the bereavement process. Kubler-Ross, in her book, On Death and Dying, (1969) summarized similarities she found in the grief processes of terminal patients into five typical stages of normal grief reactions; denial, anger, bargaining, depression, and acceptance. While it is true that Kubler-Ross dealt with terminal patients, she noticed that family members experienced similar

adjustment stages. She said, "Just as the patient goes through a stage, the immediate family will experience the same emotional reaction" (p. 169).

The first grief stage is denial. This stage functions as a buffer and allows persons to collect themselves. This is oftentimes the stage that carries persons through the funeral, but with the funeral ceremony, denial becomes reality because of the viewing of the dead body.

The next stage of grief is anger. "Why me"? is the question often asked. Emotional responses in this stage may become rage, envy, and resentment. Oftentimes, parents express their anger (Doyle, 1980). An expression of anger could be damaging to a marital relationship if either spouse directs anger towards the other. Worden (1982) found that wives often become angry with their husbands. The wife may feel that her husband does not care enough about the death because he does not cry when she does. Also, there is a tendency for husbands to resent the attention given to their wives. "Doesn't anyone care how I feel? one man asked" (Jensen, 1980, p. 15).

The third stage is bargaining. A bereaved mother or father might promise to be a good, perfect person in order to receive a reward of being with their child again. For example, one mother said, "If I had my child back, I would promise that I would never make another mistake" (Jensen, 1980, p. 10). This stage is usually a short one because it is soon discovered that death is not going to be changed.

The fourth stage, depression, is perhaps the most obvious and most difficult. The depression experienced in this stage can vary from brief

spells of moodiness to serious illness. Generally, grief depression is mild to moderate in intensity, but occasionally can be severe. It may last from three months to a year and generally improves with time, although it can become chronic. Doyle (1980) has found that sleep and eating disturbances may be typical of grief depression resulting in weight loss and poor health.

Guilt feelings often accompany the depression experienced in this phase. Depressed persons tend to blame themselves for the death of their child; for example, when a child dies by accident, parents are likely to feel guilty because of their poor decision-making. Somehow parents feel that their own inadequacy contributed to the death of their loved one.

The research team studying Sudden Infant Death Synadrome (SIDS) (Williams and Nikolaisen, 1982) note that parents of the dead infants frequently suffer excessive guilt reactions. This guilt sometimes leads to blaming. One spouse will blame the other which could lead to broken homes and can wreck the interpersonal relations of couples.

Many times the feelings of guilt hinder the parents from trying to put the pieces of their lives back together. Costello (1976) found that one of the most characteristic things about the depressed person is loss of interest in environmental events. Some parents think that becoming social or active means that they are forgetting their child.

The last of Kubler-Ross's stages of grief is acceptance. This stage should not be confused with a happy state however. It is generally characterized by a stage of full, or nearly full, functioning. Many

couples eventually achieve the acceptance stage, but for some, their grief has consumed more than the loss of their child; it has also taken their marital relationship. In SIDS there may be an intensification of suspicion and hostility between parents that leads to a higher than average rate of separation and divorce. (Linzer, 1977). These feelings may also be true for many other bereaved parents. Schiff (1977) found that as high as 90 percent of all bereaved couples are in serious marital difficulty within months after the death of their child. Marital difficulty has many meanings. There is a great deal of bitterness, resentment, and hurt in every marital difficulty. Forgiveness never really works (Guerin, 1976). The exact reasons for these difficulties for bereaved couples are only speculative.

The large amount of stress experienced after the death of a child could be one reason for the marital difficulties that the family unit encounters. Worden (1982) found the divorce rate for parents whose shildren had died of leukemia was 70% in the subsequent two year period. This study concludes that the main reason for this high percentage is due to stress experienced by the parents during the bereavement process.

Another possible reason for marital difficulty after the death of a child could be communication (Rapheal, 1983). Ann Morrow Lindbergh (1962) in her book, Dearly Beloved, said, "Grief can't be shared. Everyone carries it alone, his own burden, his own way" (p. 60). Spouses mourn as individuals, separately. In our culture, men and women are expected to grieve differently. Men are supposed to be strong and women are supposed to be weak and in need of intense care (Schiff, 1977). These cultural norms

make communication between husband and wives difficult because of predetermined mode of expressing feelings.

Marital difficulty after the death of a child could also be explained by the fact that many couples have problems resuming "normal" activities. In many relationships one of the partners, if not both, find that they are unable to accept pleasure. Inablility to accept pleasure is much like the guilt discussed earlier in the depression stage of grief. Often spouses may believe that they should not engage in pleasureable activities because their child has died (Schiff, 1977).

The idea of, "pleasure is wrong", is closely related to another probable cause for marital difficulty after the death of a child which could be sexual problems. While the manner of sexual expressiveness between a husband and a wife is ever changing, the loss of a child often results in abrupt changes. A wife or husband may frequently refuse sex because the idea of pleasure has become repugnant. Schiff (1977) presents an example of one woman who divorced her husband because he wanted to indulge in sex within a week after their daughter died.

Conversely, some couples find their sexual relationships enriched. Their grief has allowed them to come closer in touch with the other's feelings. A deepening and consolidation of inter-family relations may be produced (Burton, 1974). Sexuality becomes a way of comforting each other.

Impaired sexual functioning can become one of the many symptoms of grief. Sexual functioning means that there is no impairment either of desire for sexual gratification or in the ability to achieve it (Colemand,

Butcher, & Carson, 1980).

Tavris and Sadd (1977) support the essential nature of satisfactory sexual functioning. Their findings show that women who report their marriages to be good also report their sex lives to be good, but none of them said that their marriages were good and their sex lives were bad. One woman said, "If you've got the one, you've got the other" (p. 63). Other researcher (Shaver & Freeman, 1980; Rhyne, 1981) have supported Tavris and Sadd's findings that overall marital satisfaction is based on one important factor-sexual satisfaction. Marital satisfaction has many characteristics, love and affection, friedship and interest, and sexual satisfaction (Rhyne, 1981). Since it is true that bereaved married couples are a subset of all married couples, it is safe to compare the research findings on all married couples that point out the importance of sexual functioning to marital satisfaction.

The reactions of a couple to the death of their child includes grief, stress, and lack of communication. Research regarding these reactions show that these responses negatively effect sexual functioning and thus marital satisfaction in all couples. These factors produce ill effects and it is no suprise that as difficulities increase, sexual activity declines (Edwards & Booth, 1976).

One of the factors interrupting sexual functioning and marital satisfaction is stress. Cooper (1969) found stress to be a contributing factor in 94% of the cases of adult males with an erectile disorder. Similarly, Kaplan (1974) concludes that women may also experience acute

stress and feelings of sexual inadequacy. This stress reaction can be devastating to those couples who have lost a child.

Another factor that can play a role in the satisfaction of sex in a marriage is communication. "Communication is an intricate complexity of words, gestures, signs, and symbolic actions that have meaning to the communicating people" (Schulz & Williams, 1969, p. 207). Masters and Johnson (1974) state that sexual functioning is effective when there is a free flow of verbal and nonverbal communication. In the Tavris and Sadd's (1977) study reported earlier, women rate verbal communication just as important as physical communication when dealing with their sexual feelings.

Most sexual problems are not matters of mechanics; they are failures of communication. Many people do not learn how to express their needs and feelings, even to their lovers, so resentment and misunderstanding can build. When marital partners are unable to share their joys, anger, fears, and hopes, they no longer share a personal intimacy. A symptom of this loss of personal intimacy is usually sexual dissatisfaction or dysfunction (Schultz & Williams, 1969). In other words, sexual functioning is not only a physical act, but a means of deepening and strengthening intimacy. Thus, the cause of marital problems appears to be the lack of effective communication between marriage partners that results in decreasing intimacy and overall sexual dissatisfaction. This could be a complication drawn from the lack of communication that could exist between couples.

Depression is another factor that has an effect upon sexual functioning.

in marriage. Just like depression in grief, depressed people tend to have sleeping and eating disturbances and lose all enjoyment or pleasure in previously satisfying activites (Marks, 1978). One of these previously satisfying activites could be sexual relationships. Depression can cause orgasmic dysfunction in women and impotence in males (Kennedy, 1977).

Summary

The literature discussed provides an account of how a child's death can effect the parent's relationship. Clearly the death of a child is the most devasting experience of a parent's life. As a consequence of a child's death, parents will experience the grief stages of denial, anger, bargaining, depression, and acceptance. These stages have ramifications for the marital relationship of bereaved parents. Marital difficulties could be caused by stress, lack of communication, inability to accept pleasurable experiences, and the inability to relate sexually to one another.

Sexual functioning is effected by degree of stress, quality of communication, and symptoms of depression experienced by all couples. Both the sexual and grief experiences are so entwined that the specific effects of grief on sexuality are profound.

Statement of Problem

In helping counselors to work with bereaved couples it is important for them to understand how the bereavement process effects sexual functioning. Therefore, it is important to determine whether or not a relationship exists between sexual functioning and bereavement. If this relationship is significant, counselors should understand this relationship and intervene appropriately.

The statement of problem incorporated in this study is, "What is the relationship between bereavement and sexual functioning?"

Consequently, the purpose of this study is to conduct a survey to collect information from subjects experiencing this grief process as a result of the death of their child to assertain their level of sexual functioning.

Thus, the research question addressed is "What is the relationship between bereavement and sexual functioning?"

Definition of Terms

Specific terms that will be used throughout this study are as follows:

Bereavement: This is the actual state of deprivation or loss (Doyle, 1980, p. 6).

Grief: This is the response of emotional pain to the deprivation (Doyle, 1980, p. 6).

Grief Stage: Kubler-Ross's stages of grief (1969):

1. Denial: This stage functions as a buffer and allows the person to collect themselves. "I can't believe he/she is gone",is a common statement.
2. Anger: This may become rage, envy, and resentment towards self, others, or God. "Why me"? is often the question asked.
3. Bargaining: This stage the bereaved tries to be good in order to gain a reward of being reunited with the deceased.

4. Depression: This stage can vary from brief spells of moodiness to serious illness. Guilt may accompany this stage.

5. Acceptance: This stage is one of full or nearly full functioning of life's tasks. Not mistaken for a happy stage.

Marital Difficulty: Feelings of bitterness, resentment, and hurt (Guerin, 1976, p. 331).

Stress: An internal response caused by application of a stressor (Colemand, Butcher, & Carson, 1980, p. 109).

Stressor: Any adjustive demand that requires coping behavior on a person (Colemand et al., 1980, p. 116).

Communication: An intricate complexity of words, gestures, signs, and symbolic actions that have meaning to the communicating people (Schulz & Williams, 1969, p. 207).

Sexual Functioning: There is no impairment either of desire for sexual gratification or in the ability to achieve it (Colemand et al., 1980, p. 531).

Chapter Two

REVIEW OF LITERATURE

Literature that describes a relationship between bereavement and sexual functioning is extremely limited; case study accounts for most of the information available. Many books include statements like one found in Amy Hillyard-Jensen's Healing Grief, (1980), "The continued absence of sexual relations desperately needs resolution" (p. 16). Such advice is incomplete and without methodological foundation. The purpose of this study is to conduct a survey and collect information from subjects experiencing this grief process to assertain their level of sexual functioning.

Robert Michaels's paper, "A Doctor Discusses Sexuality and Bereavement" (Linzer, 1977) is one of the few resources available dealing specifically with this subject. Michaels says that oftentimes individuals will experience a shift in sexual behavior and interest. Shifting away from sexual functioning could be caused, he believes, by guilt, unhappiness, and disallowance of personal pleasure. Tension can also build up after a death of a loved one resulting in one or both members of the couple not desiring sexual relations (Worden, 1982). Some other factors that influence sexual functioning with bereaved couples are fatigue, pre-existing marital difficulties, fear of pregnancy, loss of self-confidence, self-punishment, and decrease of sex drive.

Fatigue or dimished time for intimate solitude may disrupt sexual

functioning between bereaved couples (Burton, 1984). The couple simply might not have the time to relate sexually to one another and psychological reasons might not be the factor.

Dr. Frank M. Kline has found that giving up sex might also be a way to try to give up the relationship (Yamameto, 1973). Also in other words, the pre-existing relationship between the husband and the wife is very important. If there were marital problems such as communication, extra-marital affairs, and general apathy before the child's death, then they would be there after the event as well.

There are some psychological factors that might influence sexual functioning between bereaved parents. One could be the fear of pregnancy. This fear can come from two sources, one from the sorrow of the previous loss and two, from the fear of a future loss. Here is one woman's account of her feelings about pregnancy:

> At first, after the usual six weeks waiting, I really felt like resuming our sex life. However, as we sought an answer as to why Jennifer had died, I began to question my ability to produce a healthy baby. I really became afraid of sex. I didn't want to go through that again (Peppers and Knapp, 1980, p. 83).

Another factor that can influence a couple's functioning is loss of self-confidence. Self-confidence is defined as feelings of anxiety and concern about one's own actions (Colemand et al., 1980). The lack of confidence and esteem often manifests itself in the sexual arena (Peppers & Knapp, 1980). Many parents have a decreased self-confidence which leads to a lack of desire to be sexually attractive.

One husband related that his wife had no desire to take care of herself and thus became less appealing to him (Peppers & Knapp, 1980).

One other factor that may accompany the loss of self-confidence is self-punishment. This type of feeling often stems from guilt. The behavior is disallowance of personal pleasures. Couples will often diminish their sexual activities as a form of self-punishment (Peppers & Knapp, 1980). From this reaction comes a refusal of joy, of happiness. of allowing oneself to have a good time, and of letting someone help. Especially critical at this point within the marital relationship is the hesitancy to have sexual relations because these are enjoyable and good. "How can I enjoy myself and have sex with my husband when I know that my child is alone in the grave"? (Margolis, Raether, & Kutscher, 1981, p. 13).

Of all the effects on sexuality discussed in this chapter, the most commonly reported one is the decreased sex drive. Sex drive is defined as the desire to engage in sexual contact (Mahoney, 1983). A decrease in sex drive is a common symptom of depression and an integral part of the grief process (Peppers & Knapp, 1980; Linzer, 1977). This reaction is quite normal and very disturbing to both the husband and the wife if these feelings persist overtime.

Summary

The review of literature reveals that lack of research dealing with the relationship between bereavement and sexual functioning. Although several personal accounts are provided, the research to support a

theoretical foundation is nonexistent.

The literature does explain a few factors that influence bereavement and sexual functioning. They are guilt, unhappiness, disallowance of personal pleasure, tension, fatigue, pre-existing marital difficulties, fear of pregnancy, loss of self-confidence, self-punishment, and decrease of sex drive.

There is a great need for further research in this area. This would help rid parents of additional problems following their child's death such as sexual misunderstandings resulting in marital difficulty. Further research would also be useful for counselors to have in order for them to understand the relationship between bereavement and sexual function and intervene appropriately. H. S. Schiff, in her book, The Bereaved Parent, (1977) puts it this way, "Value your marriage; you've lost enough" (p. 82).

Chapter Three

METHODS

Introduction

The intent of this study is to determine whether or not a relationship exists between the grief stage of bereaved parents and their level of sexual functioning. This exploratory study will more fully describe the experience of bereaved parents. The goal is to provide counselors and researchers information they might use to better help the bereaved parent population.

Hypothesis

The Null Hypothesis of this study is that there is no relationship between grief and sexual functioning. That is to say, that there will not be a correlation between the total scores obtained on the grief scale and total scores obtained on the sexual functioning scale.

Research Design

In order to assertain the relationship between grief and sexual functioning, a cross-sectional survey is constructed and administered. This survey measures grief as defined by a score on a grief scale and sexual functioning which is defined by a score on a sexual functioning scale. The scale is constructed so higher scores in either section indicate greater levels of severity in states of grief or sexual dysfunction.

Sampling

A non-probability sampling form of quota-sampling is used in

this study. The quota matrix of the population is the death of their child.and voluntary membership in the self-help group called Compassionate Friends, Incorporated.

The subjects are selected from a mailing list of 500 people that Compassionate Friends provided. The subjects reside in a four state area, Iowa, Minnesota, Missouri, and Wisconsin. A questionnaire is sent to each name on the mailing list.

Instrument

The instrument used for this study is a closed-ended questionnaire voluntarily self-administered by the subjects. A cover letter accompanies each questionnaire (Appendix A) which explains who is conducting the survey, what the survey is about, how to complete the questionnaire, and that the survey intent is voluntary participation with no harm intended to the subjects. Along with the cover letter, an additional answer sheet is sent (Appendix B) to be used for the spouse to complete.

The questionnaire (Appendix C) is divided into three sections. The first consists of demographic questions (1-11b) such as age, sex, occupation, years of marriage, age of child at the time of death, and so on. These questions are included in order to obtain a descriptive profile of the respondents..

The second section (12-33, and 48) contains items designed to assess grief stage. These item scores will be treated as interval data and will be totaled to yield a total grief score. Grief questions included in the survey are based on Kubler-Ross's (1969) theory of grief

stages. Specific questions are designed to measure each grief stage (Kubler-Ross, 1969) as follows:

Denial.

12. Do you still find it hard to believe that your child has died?

Anger.

13. Do you strongly feel "Why me"?

Bargaining.

14. Do you feel that if you are a "good" person that your child will be returned to you someday?

Depression.

15. Are you able to talk about your child without crying?

16. How often do you visit your child's grave?

17. Are you able to be socially active again?

23. Have you ever thought about ending your own life since the death of your child?

24. Have you ever attempted to end your own life?

26. How many members of your family have had a history of depression?

27. Are your moods generally:

28. When you think about yourself as a person, do you usually think:

29. Do you find your ability to make decisions:

30. Since the death of your child, have you found that your alcohol drinking behaviors have:

33. Do you find that you've lost interest in your personal appearance and attractiveness?

48. Taken all together how would you say things are these days?

In addition to Kubler-Ross's stages, the grief scale measures guilt and stress. Many parents have many guilt feelings connected to their child's death (Johnson-Soderberg, 1982). It is also important to examine the assortment of physical symptoms that may occur after a death (Doyle, 1980). The questions measuring these factors are listed below:

Guilt.

22. Do you feel in any way responsible for your child's death? (Worden, 1980)

25. Do you have secret feelings about your child's death that you haven't shared with anyone? (Johnson-Soderberg, 1982)

31. Do you find that you have dreams about your child? (Worden, 1982)

32. Do you find that you have experienced halluciations or illusions of your child's presence? (Worden, 1982)

Stress.

18. Do you find that it is hard for you to relax? (Worden, 1982)

19. Since your child's death have you been hospitalized for mental problems? (Murray, Parkes, Weiss, 1983)

20. Since your child's death have you been hospitalized for physical problems? (Murray et al., 1983)

21. Please check the following physical symptoms that you've experienced since the death of your child: high blood pressure, ulcers, heart disease, itching, tremors, insomnia, increased heart rate, shallow breathing, chest pains, back pains stomach aches, head aches, appetite loss, weight gain, weight loss, fatigue, other. (Doyle, 1980)

21b. Do these continue today? (Doyle, 1980)

The third and final section of the questionnaire deals with items designed to assess sexual functioning. The scores of these items are treated as interval data and will be totaled to yield a total sexual functioning score. Specific questions designed to measure sexual functioning are as follows:

35. Since the death of your child would you say that the frequency of sexual intercourse with your spouse has: increased, remained normal, returned to normal after increase, returned to normal after decrease, decreased, became nonexistent ? (Linzer, 1977)

35b. If there was a change in frequency, who would you say was the main figure influencing this change? (Linzer, 1977)

35c. If there was a change in frequency, what would you say the main reasons are related to this change? (Peppers & Knapp, 1980)

36. If the death of your child was anticipated, during that period of anticipation would you say that the frequency of sexual intercourse with your spouse was: increased, remained normal, returned to normal after increase, returned to normal after decrease, decreased, became nonexistent? (Linzer, 1977)

37. How long after the death of your child did your sexual intercourse with your spouse return to normal? (Parkes, Colin, Murray, 1972)

38. When and if your sexual activity with your spouse returns to normal, would you feel: you are recovering from grief, you are betraying your child, there is no chance of recovery, you would feel close to your spouse again? (Margolis, Raether, Kutscher, 1981)

39. After you have sexual intercourse with your spouse do you usually feel: satisfied and relaxed, anxious and tense, guilty and remorse? (Margolis et al., 1981)

40. Since the death of your child, have you had difficulty in any of these areas: difficulty in-getting sexually aroused, maintaining arousal, reaching orgasm, reaching orgasm too quickly, inability to reach orgasm, getting an erection, maintaining an erection, in ejaculation, ejaculating too quickly, disinterest in sex, sexual imagery, other? (Mahoney, 1983)

40b. If any a-k, are any of the above still occuring? (Mahoney, 1983)

40c. Do you see these difficulities as a problem for your marriage? (Mahoney, 1983)

41. Do you find a change in who initiates sexual activity? (Mahoney,1983)

42. Do you find that you and your spouse's communication about sex has: increased, returned to normal after increase, returned to normal after decrease, remained normal, decreased, became nonexistent? (Linzer, 1977)

43. What has been a source for sexual outlets for you since your child's death? (Marks, 1978)

44. Do you find that you and your spouse's need for being close to each other has: increased, remained normal, returned to normal after increase, returned to normal after decrease, decreased, became nonexistent? (Parks et al., 1972)

45. Do any of these behaviors describe you since the death of your child? (Colemand, et al., 1980)

46. With whom have you talked to about your sexuality since your child's death? (Tavris and Sadd, 1977)

47. Do you think this issue of sexuality and sexual functioning is important for grieving parents to discuss? (Mahoney, 1983)

Data Collection and Recording

Data is to be collected by the mail-back method. Questionnaires are to be filled out and mailed to a neutral party by a certain date. This process is also explained in the cover letter (Appendix A). The person who recieves the returns puts those questionnaires in a sealed slotted box. The reciever previously filled out a confidentiality form that stated the questionnaires were to be returned to the researcher un unopened (Appendix D).

The recording is done by hand and the procedure is as follows:

1. The questions on demographics (1-11b) are tallied and the profile of the respondents obtained. The tally is done by counting and recording on a separate sheet of paper the circled answers for each demographic question and then the responses are totaled.

2. The second part of the questionnaire is then tallied on grief stage (12-33, and 48). Numerical scores are recorded for each item then these scores are added together to obtain a total score for the person.

3. The same procedure as described above is used to obtain the sexual functioning score (35-46).

Data Analysis

Descriptive statistics will be used to describe the demographic data.

The total grief scores are computed and placed on a list of all respondents. Pearsons correlation coefficient is then employed to determine if a relationship exists between these variables.

Assumptions

This study makes two basic assumptions:

1. The participants of this study have responded to the questionnaire honestly.

2. The sample group is representative of the total group.

Limitations of Study

This study has several limitations:

1. The data is based on a self-report questionnaire and therefore open to all the biases of the subjects.

2. Limited literature is available on this subject.

3. The data is based on a small sample size because of the sensitive topic area of this study. The expected return rate for this study is 15%-20%.

4. There are certain limitations inherent in non-probability sampling methods. In general, it is regarded as less reliable than probability sampling methods.

Chapter Four

RESULTS

Demographics

Questions 1-11b obtain demographic data for the sample population. The total number of respondents is 77 which is 15.4% of the population surveyed. Nineteen of the respondents are males and 58 are females.

The ages of the respondents is shown on Table 1. The majority of the females are between the ages of 30-45. The majority of the males are also ages 30-45.

The occupations of the respondents (Table 2) shows that the larger majority of females state that their primary occupation is "Housewife". The majority of males state that their primary occupation is "Professional".

The majority of the females and the males said that they have been married twenty years or more (Table 3). There are 3 women and 1 male who are separated or divorced.

Many respondents have experienced previous losses of significant others such as parents, spouse, friends, or other children (Table 4). The majority of the males and females have experienced one previous loss.

The majority of the females and males have 1-2 children in the family (Table 5) and 1-2 children living at home at the time of the child's death (Table 6). Both males and females report that their child died between the ages of 0-4 (Table 7). The females also report having lost many more children between the ages of 15-19 than did the males.

Accidents are the most prevalent cause of death of children for males and females (Table 8). Females report that illness is the second major

cause of death whereas males report "other" as the second most frequant cause.

The majority of the respondents state that the death of their child happened 2-3 years ago (Table 9). The second most popular answer for males is 0-1 year and 1-2 years for females. No matter what the time has been since the death of their child, the parents still feel that they were not prepared at all for their child's death (Table 10). Only 1 male and 1 female thought that they were prepared for their child's death and 95% of the males and 95% of the females reported that they were totally unprepared.

Survey Results

The total scores for each of the two sections of the survey, bereavement and sexual functioning are compiled and are refered to as bereavement and sexual functioning scales. These scales are examined in order to determine if a relationship exists. The grief stage or bereavement questions that appear on the questionnaire (12-34b, & 44) are evaluated. The lowest score is 23 and the highest score is 64 for a range of 41 on the bereavement scale. The mean bereavement score is 42, the mode 34, and the median 40.

The sexual functioning questions that appear on the questionnaire (35-47) are compiled. The lowest score is 16 and the highest score is 64 for a range of 48 for sexual functioning. The mean score is 34, the modes are 17, 18, 29, and 32, the median score is 32.

Data Analysis

Pearsons correlation coefficient (r) is performed on the bereavement

and sexual functioning scales to see if a relationship exists. A t-score is used because of the sample size. If critical r score (rc) is found to be .188, then there is a positive correlation between the bereavement scores and the sexual functioning scores. This would signify a positive relationship.

The level of significance used for this study is $< .05$ or a 95% confidence level. The correlation coefficient (r) of this study is .47 which is a positive correlation.

Chapter Five

FINDINGS AND CONCLUSION

Findings

This study has shown with 95% confidence that the Null Hypothesis which stated there is no correlation between total scores in bereavement and total scores in sexual functioning must be rejected. The results indicated that an alternative hypothesis must be accepted which is that there is a positive correlation between bereavement and sexual functioning..

Conclusion

The most devastating experience for parents is the death of their child. This grief experienced by parents is often inconsolable and never ending because of the intense interpersonal relationship between a parent and their child. Parents react to the tragedy of their child's death in unique manners. However, there are similarities that have been noted. These are typical stages of grief and include reactions of denial, anger, bargaining, depression, and acceptance.

Bereavement can produce other problems for the couples such as marital difficulties. These marital difficulties are a result of the grief stages, stress, lack of communication, inability to accept pleasurable experiences, and the inability to relate sexually to one another.

Research regarding these reactions of stress, quality of communication, and depression show that these responses negatively effect sexual satisfaction in all couples. Satisfactory sexual functioning is essential to any happy marriage. Therefore, this research and these factors must

also apply to bereaved couples as well.

The purpose of this study is to conduct a survey and collect information from subjects experiencing this grief process as a result of their child's death in order to assertain their level of sexual functioning. Thus this study is designed to help counselors understand how the bereavement process affects sexual functioning so that they will be able to intervene appropriately.. For this reason, it is important to determine whether or not a relationship exists. Therefore, the statement of problem incorporated in this study is, "What is the relationship between bereavement and sexual functioning"?

The research methology used in this study is a survey that is distributed to parents who have had children die. The survey is constructed in three parts, demographics, grief stage, and sexual functioning. The survey is collected by a mail-back process.

The data recording for sections two and three, ie, grief stage, and sexual functioning, consisted of adding the point values of each answer in that section so that a total score could be obtained for all of the subjects. The intent of this survey is to attain correlations of these two scares.

The statistical formula used in this study is Pearsons correlation coefficent. This is used to see if a correlation existed between these two scores. The p value or confidence level used for this study is .05 or 95%.

The findings of this study show that there is a strong positive

correlation between bereavement scores and sexual functioning scores signifying a positive relationship. Therefore, when the level or severity of bereavement is increased, the level or severity of sexual functioning of bereavement is increased, the level or severity of sexual functioning for bereaved couples is also increased.

Implications for Research

The review of the literature indicated a lack of research and information available on this subject. Therefore, the implications for future research are abundant. One implication for research could be a replication of this study to increase its reliability. Another implication for research could be to examine the effects of each specific grief stage in order to assertain what effects that these specific stages have on the sexual functioning of bereaved parents.

Implications for Practice

The implications of this study for future practice are also abundant since the limited literature indicates this subject is virtually ignored by professionals. Counselors and other professionals who are working with bereaved couples should gain a better understanding of the effects that bereavement has on sexual functioning by reading this study. Counselors could develop an appropriate intervention when dealing with couples of this type. These interventions could help bereaved parents understand the changes in their sexual functions so that this form of marital dissatisfaction can be lessened or arrested completely.

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APPENDIX A

Cover Letter

Dear Friends,

I'm _____, a counseling student at _____ _____. You might remember reading about me in your ____ Newsletter from Compassionate Friends. I would appreciate your voluntary participation in the first and only study done to assess the sexual functioning of bereaved parents. Please fil out the questionnaire as honestly and spontaniously as you can. Remember that this questionnaire is totally voluntary and has no intentions of harming the people being studied. Your identity will be anonymous.

I you have more than one parent at your address, please use the numbered sheet attached at the back of the questionnaire to record the second parent's answers. Your answers can be shared with one another but it is best that you do it privately. Mail the questionnaires back to the following address by August 1, 1984:

(Address)

The results of this study will appear in the Compassionate Friends Newsletter sometime this fall.

Your participation is greatly appreciated. I hope that this study will help those who have experienced a death of a child understand their changes in sexuality.

Thank you,

(Name)

APPENDIX B

Additional Answer Sheet

1.
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20.
21.
21b.

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35b.
35c.
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36b.
36c.
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38.
39.
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40b.
40c.
41.

42.
43.
43b.
43c.
44.
45.
46.
47.
48.

APPENDIX C

Instrument

1. Sex: (M) (F)
2. Age:
   a. 75+
   b. 66-75
   c. 56-65
   d. 46-55
   e. 30-45
   f. 15-30
3. Occupation:
   a. Professional
   b. Semi-professional
   c. Skilled manual
   d. Unskilled manual
   e. Unemployed
   f. Housewife
   g. Retired
4. Years of Marriage:
   a. 20+
   b. 15-20
   c. 10-15
   d. 5-10
   e. 1-5

Separated or Divorced ____

5. Previous Losses:

   a. Parents

   b. Spouse

   c. Other child

   d. Friend

6. Number of children in family (including deceased):

   a. 10+

   b. 8-10

   c. 5-7

   d. 3-4

   e. 1-2

7. Number of children still living at home at the time of your child's death:

   a. 5+

   b. 3-4

   c. 1-2

   d. 0

8. Age of child at time of death:

   a. 25+

   b. 20-24

   c. 15-19

   d. 10-14

   e. 5-10

   f. 0-4

9. Cause of child's death:

   a. illness

   b. accidental

   c. suicide

   d. homicide

   e. other_____

10. How long ago did your child die?

   a. 0-1 year

   b. 1-2 years

   c. 2-3 years

   d. 3-4 years

   e. 4-5+ years

11. Length of preparation for child's death:

   a. fully prepared, long period

   b. fully prepared, less than 2 weeks

   c. partly prepared

   d. totally unprepared

   11b.**If you feel that you were prepared, did you find that the preparation time was helpful in your grief process?

   yes ( ) no ( )

12. Do you still find it hard to believe that your child has died?

   yes ( ) no ( )

13. Do you strongly feel "WHY ME?"

   yes ( ) sometimes ( ) no ( )

14. Do you feel that if you are a "good" person that your child will be returned to you someday?

yes ( ) sometimes ( ) no ( )

15. Are you able to talk about your child without crying?

yes ( ) sometimes ( ) no ( )

16. How ofen do you visit your child's grave?

a. everyday

b. occasionally

c. only once

d. never

17. Are you able to be socially active again?

yes ( ) sometimes ( ) no ( )

18. Do you find that it is hard for you to relax?

a. always

b. occasionally

c. never

19. Since your child's death have you been hopitalized for mental problems?

a. yes, 1 time

b. yes, 2-3 times

c. yes, 4-5+ times

d. no, never

20. Since your child's death have you been hospitalized for physical problems?

a. yes, 1 time

b. yes, 2-3 times

c. yes, 4-5+ times

d. no, never

21. Please check the following physical symptoms that you've experienced since the death of your child:

high blood pressure ( )
ulcers ( )
heart disease ( )
itching ( )
tremors ( )
insomnia ( )
increased hear rate ( )
shallow breathing ( )
chest pains ( )
back pains ( )
stomach aches ( )
headaches ( )
appetite loss ( )
weight loss ( )
weight gain ( )
fatigue ( )
other_____
none of the above ( )

21b.**Do these continue today?

a. always
b. occasionally
c. not any more
d. never did

22. Do you feel in any way responsible for your child's death?

yes ( ) sometimes ( ) no ( )

23. Have you ever thought about ending your own life since the death of your child?

a. often
b. sometimes
c. only once
d. not any more
e. never