Validation of the Integration of Stressful Life Experiences Scale–Short Form in a Bereaved Sample

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The Integration of Stressful Life Experiences Scale (ISLES) is an assessment of meaning made of stress that has been used successfully with bereaved individuals and other vulnerable populations. Drawing upon information from 741 bereaved respondents, the present study tests the validity of the ISLES–Short Form (ISLES-SF), which is a 6-item version of the original 16-item measure. Tests of concurrent and incremental validity yielded highly similar patterns of results for the full ISLES and ISLES-SF, supporting the use of this briefer version of the scale. Results also highlighted the unique association (controlling for demographics, circumstances of the death, and prolonged grief symptoms) between greater meaning made of loss and higher levels of mental and physical health. These findings add to a growing body of literature that supports theoretical models that view meaning-making as a crucial determinant of adjustment to loss among many grievers.

Meaning making is often a key aspect of adjustment following bereavement and other stressful events (for reviews, see Davis, Wortman, Lehman, & Silver, 2000; Gillies & Neimeyer, 2006; Neimeyer & Sands, 2011). According to Neimeyer (2006), losing a loved one can present a problematic “micro-narrative” that is difficult to integrate into one’s life story or overarching self-narrative. Park (2010) similarly suggested that experiences of loss and/or stress in general can violate dimensions of global meaning that allow for a needed sense of cohesiveness and purpose in life (e.g., core beliefs, values). Research has demonstrated that bereavement in particular can precipitate a protracted search for meaning in these instances that are frequently associated with psychological distress (Coleman & Neimeyer, 2010). Cross-sectional studies with bereaved parents (Keesee, Currier, & Neimeyer, 2008) and more diverse samples (Currier, Holland, & Neimeyer, 2006) also found that an inability to make sense of loss was uniquely correlated with the types of grief reactions that have been linked with a range of mental and physical health problems (i.e., now termed prolonged grief; see Prigerson & Jacobs, 2001, for a review). When controlling for preloss levels of distress, Davis, Nolen-Hoeksema, and Larson (1998) also found that a possible lack of resolution for meaning violations (i.e., lower sense made of one’s loss) was predictive of greater distress symptomatology at 6 months postloss in another mixed group of grievers.

These results support the recent proliferation of interest in meaning making. However, in many ways theory has outpaced empirical research, and measurement concerns have particularly limited the knowledge base.
Namely, until recently the meaning made of stress was primarily assessed using in depth qualitative analyses with small groups or with single, face valid items inserted into longer quantitative questionnaires. Drawing on available theory and research, Holland, Currier, Coleman, and Neimeyer (2010) therefore developed the Integration of Stressful Experiences Scale (ISLES) to provide a multidimensional instrument for assessing the degree to which a salient life stressor has been adaptively incorporated into one’s global meaning system. Although the full ISLES has shown many psychometric strengths and emerged as a robust predictor of mental and physical health (Currier et al., 2013; Holland, Currier, Coleman, & Neimeyer, 2010; Lichtenthal, Burke & Neimeyer, 2011), there are a number of reasons to support the development of a short form. For example, in situations in which participants’ time is limited or when completing the 16-item scale requires too much mental and/or physical effort, a short form could provide a viable alternative. In addition, developing a briefer tool for assessing meaning made of stress will allow researchers to attend to other dimensions of meaning making in their studies. Doing so would address the call for investigators of relevant models to capture multiple aspects of meaning making in their research, rather than just the outcome or product of the process (Park, 2010). We therefore conducted this study to create a short form of the ISLES that might reduce the number of items while still preserving the favorable properties of the full-length instrument and to assess the incremental validity of both versions in predicting deleterious outcomes in bereavement.

METHODS

Participants and Procedure

Following institutional review and approval of the project, 741 bereaved participants who lost a loved one in the past 2 years were recruited from introductory psychology courses at a large southern research university. Participants completed surveys using an online system sponsored by the institution’s psychology department, and they provided demographic information, information about their loss, and also completed the ISLES as well as other measures used to establish concurrent validity.

On average, participants were 21.7 years old ($SD = 6.1$), and 79.6% were women. Most had experienced the loss of an extended family member or friend (86.6%) due to natural causes (71.8%). The sample was racially/ethnically diverse, with 54.8% of individuals identifying as a member of a racial/ethnic minority group.

Measures

Participants completed the ISLES, which is an assessment of meaning made of stress, and were instructed to respond to this measure with regard to the loss of their loved one. The ISLES yields two subscales: Comprehensibility gauges one’s ability to make sense of a stressor (e.g., “I have made sense of this event”), and Footing in the World assesses the extent to which one’s worldviews (e.g., goals, sense of purpose/direction, values, belongingness) have (or have not) been disturbed (e.g., “My beliefs and values are less clear since this event”). Higher scores indicate more adaptive meaning made of a loss. The overall measure and both subscales have good internal consistency, test-retest reliability, and convergent validity with scales of psychiatric and bereavement distress. Additional psychometric details on the ISLES have been provided elsewhere (Holland et al., 2010).

Two measures were used to gauge concurrent and incremental validity in the current study. The Inventory of Complicated Grief–Revised (ICG-R) is a 30-item measure rated on a 5-point scale, ranging from 1 (never) to 5 (always), that gauges severe and prolonged grief reactions (Prigerson & Jacobs, 2001). The ICG-R has displayed high internal consistency ($\alpha = .94$), concurrent validity with another grief measure ($r = .71$), and good test-retest reliability across about a 2-week interval ($r = .92$; Boelen, van den Bout, de Keijser, & Hoijtink, 2003).

The Short Form-36 (SF-36) Health Survey is a well-validated questionnaire with eight subscales of physical and mental health (Ware, Kosinski, & Gandek, 2000). The SF-36 scales have been shown to have strong internal consistency in a number of past studies (with $zs$ generally hovering around $.8$). Furthermore, predictive studies of validity have linked the SF-36 scales to important outcomes such as use of health care services, depression, loss of employment, and mortality (see Ware, 2004, for a review). These scales include four indices of physical health, including physical functioning (i.e., ability to carry out specific tasks), physical role functioning (i.e., ability to play important roles considering one’s physical health), bodily pain (i.e., pain in the body and its impact on daily activities), and general health (i.e., overall subjective sense of health). The four mental health indices include mental health (e.g., general sense of psychological well-being; lack of depression/anxiety), emotional role functioning (i.e., ability to play important roles considering one’s emotional state), social functioning (i.e., ability to engage in social activities and meaningful relationships), and vitality (i.e., subjective energy level). Higher scores on all eight scales are indicative of better health.
Plan of Analysis

Confirmatory factor analysis (CFA) was performed to test the extent to which the previously supported two-factor model for the ISLES (Holland et al., 2010) fit the data in the present sample. The three items with the highest factor loadings on the Comprehensibility and Footing in the World factors were retained to create the six-item ISLES-SF. In evaluating the overall fit of the CFA model, we relied upon a variety of fit indices, including the \( \chi^2 \) goodness-of-fit test, comparative fit index (CFI; Bentler, 1990), standardized root mean square residual (SRMR), and the root mean square error of approximation (RMSEA; Browne & Cudeck, 1993). CFI values >.90 and SRMR values <.10 are generally regarded as favorable (Hu & Bentler, 1999; Kline, 2005). Likewise, RMSEA values ≤.05 are considered close approximate fit, values between .05 and .08 suggest reasonable fit, and values ≥.10 are indicative of poor model fit (Browne & Cudeck, 1993). Parameters were estimated using a maximum likelihood robust procedure, which is robust even in the face of nonnormality.

A series of univariate analyses were performed as a way of initially assessing the concurrent validity of ISLES, ISLES-SF, and its subscale scores (as full versions and short forms). In particular, we examined correlations with demographic factors, including age, gender (coded as 0 = men, 1 = women), race/ethnicity (coded as 0 = Caucasian, 1 = racial/ethnic minority), and the highest level of education attained in one’s family of origin. Other variables included cause of death (coded as 0 = natural/other causes, 1 = violent causes), relationship to the deceased (coded as 0 = extended family/friends, 1 = immediate family), prolonged grief symptoms, and mental and physical health (as assessed by the SF-36 scales). These associations were tested with Pearson correlations. Beyond testing these bivariate associations, the unique effects of meaning made were then assessed by examining multivariate associations between participants’ meaning made of their loss and the SF-36 scales, after accounting for demographic factors, relationship to the deceased, cause of death, and prolonged grief symptoms. In the first step of each analysis, these control variables were entered in the statistical model. We then entered scores on the ISLES in a second step. These analyses were also repeated with the ISLES-SF to examine the congruence between results obtained with the full scale versus the short form. All analyses were performed in MPlus, Version 6.1 (Muthén & Muthén, 1998–2010), and missing data were handled using multiple imputation.

RESULTS

We first tested the previously validated two-factor model of the ISLES, with five items loading on a Comprehensibility factor and 11 items loading on a Footing in the World Factor (Holland et al., 2010). This model was found to fit the data well—\( \chi^2(103) = 384.564, p < .001 \); CFI = .935; .935; SRMR = .059; RMSEA = .061—and all factor loadings were statistically significant at the \( p < .001 \) level. In constructing the ISLES-SF, the three highest loading items on each of the two factors were selected, which included Items 4, 6, and 8 for Comprehensibility and Items 9, 12, and 14 for Footing in the World (as numbered in the original ISLES; Holland et al., 2010). Notably, these items have also displayed particularly high factor loadings in previous factor analytic investigations of the ISLES as well (Currier et al., in press; Holland et al., 2010).

Total scores for the ISLES, ISLES-SF, and its subscales (as full and short forms) were created by summing the corresponding items for each, and the full and short forms correlated highly for Comprehensibility (\( r = .932 \), \( p < .001 \)), Footing in the World (\( r = .925 \), \( p < .001 \)), and the total ISLES (\( r = .951 \), \( p < .001 \)). As shown in Table 1, bivariate correlations revealed that higher scores on the ISLES, ISLES-SF, and ISLES subscales (including full and short forms) were all significantly associated with older age, loss of an extended family member or friend, loss of a loved one due to natural causes, fewer prolonged grief symptoms, and greater mental/physical health (as assessed by the SF-36 scales). All results that were found to be statistically significant for the full ISLES and its subscales were also significant for the short forms of these scales, indicating that little information was lost when using the briefer version of the scale. Though not a central focus of the present investigation, it should also be noted that women tended to score significantly lower on the Comprehensibility subscale, even when examined in a shorter form.

Incremental validity was tested for the ISLES and ISLES-SF in several multiple regression analyses that controlled for age, gender, ethnicity, highest level of education in one’s family, relationship to the deceased, cause of death, and prolonged grief symptoms. SF-36 scales served as the dependent variables. These analyses showed that after controlling for these variables, ISLES and ISLES-SF scores significantly predicted bodily pain (ISLES: \( \Delta R^2 = .007, \beta = .122, p = .024 \); ISLES-SF: \( \Delta R^2 = .008, \beta = .125, p = .017 \)), general health (ISLES: \( \Delta R^2 = .019, \beta = .212, p < .001 \); ISLES-SF: \( \Delta R^2 = .018, \beta = .197, p < .001 \)), mental health (ISLES: \( \Delta R^2 = .042, \beta = .307, p < .001 \); ISLES-SF: \( \Delta R^2 = .037, \beta = .279, p < .001 \)), emotional role functioning (ISLES: \( \Delta R^2 = .019, \beta = .205, p < .001 \); ISLES-SF: \( \Delta R^2 = .017, \beta = .183, p < .001 \)), social role functioning (ISLES: \( \Delta R^2 = .013, \beta = .174, p = .001 \); ISLES-SF: \( \Delta R^2 = .015, \beta = .179, p < .001 \)), and vitality (ISLES: \( \Delta R^2 = .022, \beta = .222, p < .001 \); ISLES-SF: \( \Delta R^2 = .017, \beta = .188, p < .001 \)). However, neither ISLES nor ISLES-SF scores
TABLE 1
Bivariate Correlations With ISLES, ISLES-SF, and ISLES Subscales (N = 741)

<table>
<thead>
<tr>
<th>Variable</th>
<th>ISLES</th>
<th>ISLES-SF</th>
<th>C</th>
<th>C-SF</th>
<th>FW</th>
<th>FW-SF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.148**</td>
<td>.158**</td>
<td>.185**</td>
<td>.175**</td>
<td>.117**</td>
<td>.100**</td>
</tr>
<tr>
<td>Gender</td>
<td>-.042</td>
<td>-.081*</td>
<td>-.133**</td>
<td>-.174**</td>
<td>.004</td>
<td>.030</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>-.026</td>
<td>-.023</td>
<td>.000</td>
<td>.008</td>
<td>-.036</td>
<td>-.051</td>
</tr>
<tr>
<td>Family education</td>
<td>.058</td>
<td>.038</td>
<td>.039</td>
<td>.030</td>
<td>.062</td>
<td>.038</td>
</tr>
<tr>
<td>Relationship to the deceased</td>
<td>-.249**</td>
<td>-.212**</td>
<td>-.180**</td>
<td>-.157**</td>
<td>-.257**</td>
<td>-.215**</td>
</tr>
<tr>
<td>Cause of death</td>
<td>-.238</td>
<td>-.261</td>
<td>-.328**</td>
<td>-.331**</td>
<td>-.174**</td>
<td>-.124**</td>
</tr>
<tr>
<td>Prolonged grief symptoms</td>
<td>-.733**</td>
<td>-.704**</td>
<td>-.617**</td>
<td>-.584**</td>
<td>-.715**</td>
<td>-.652**</td>
</tr>
<tr>
<td>SF-36: Physical Functioning</td>
<td>.156**</td>
<td>.158**</td>
<td>.150**</td>
<td>.135**</td>
<td>.144**</td>
<td>.142**</td>
</tr>
<tr>
<td>SF-36: Social Role Functioning</td>
<td>.225**</td>
<td>.228**</td>
<td>.175**</td>
<td>.174**</td>
<td>.227**</td>
<td>.227**</td>
</tr>
<tr>
<td>SF-36: Bodily Pain</td>
<td>.319**</td>
<td>.310**</td>
<td>.282**</td>
<td>.263**</td>
<td>.306**</td>
<td>.282**</td>
</tr>
<tr>
<td>SF-36: Emotional Role Functioning</td>
<td>.315**</td>
<td>.311**</td>
<td>.267**</td>
<td>.264**</td>
<td>.306**</td>
<td>.283**</td>
</tr>
<tr>
<td>SF-36: Social Role Functioning</td>
<td>.283**</td>
<td>.276**</td>
<td>.286**</td>
<td>.270**</td>
<td>.255**</td>
<td>.216**</td>
</tr>
</tbody>
</table>

Note: ISLES = Integration of Stressful Life Experiences Scale; SF = Short Form; C = Comprehensibility; FW = Footing in the World. Gender, race/ethnicity, relationship to the deceased, and cause of death were dichotomous variables, coded as 0 = men and 1 = women, 0 = Caucasian and 1 = racial/ethnic minority, 0 = extended family/friend and 1 = immediate family, and 0 = natural/other causes and 1 = violent causes, respectively.

*p < .05. **p < .01. ***p < .001.

reached statistical significance when predicting physical functioning on the SF-36 (ISLES: $\Delta R^2 = .002$, $\beta = .070$, $p = .197$; ISLES-SF: $\Delta R^2 = .003$, $\beta = .081$, $p = .119$) or physical role functioning (ISLES: $\Delta R^2 = .003$, $\beta = .076$, $p = .168$; ISLES-SF: $\Delta R^2 = .005$, $\beta = .097$, $p = .057$).

DISCUSSION

Overall, these results provide support for the use of the ISLES-SF, and it appears that similar patterns of results can be obtained when using this shorter version, compared to the full version of the measure. These findings also add to a growing body of literature showing that the ISLES is uniquely associated with important outcomes even after controlling for potential confounds. In particular, higher scores on the ISLES and ISLES-SF were found to be uniquely associated with mental and physical health outcomes, including bodily pain, general health, mental health, emotional role functioning, social functioning, and vitality. However, after controlling for demographic factors, relationship to the deceased, cause of death, and prolonged grief symptoms, the unique associations between the ISLES and physical functioning, as well as between the ISLES and physical role functioning, did not reach statistical significance.

Of course, different patterns of results may be obtained with older individuals who are experiencing greater health problems, as this study was limited by its reliance on primarily young adult participants. In addition, these results indicate that older individuals in the sample may tend to report higher levels of meaning made of loss, which also points to the possibility that developmental considerations and life experience may play an important role in these processes. Other notable limitations of this study include its cross-sectional design and inability to establish causality or temporal relations, inclusion of a relatively small proportion of individuals who experienced the loss of an immediate family member, and exclusive reliance on self-report measures.

Notwithstanding these limitations, these results offer initial psychometric support for the ISLES-SF as well as providing evidence for the unique link between meaning made of loss and physical/mental health functioning. If replicated in longitudinal research with more diverse samples, these findings could have implications for theoretical models that view meaning made of stress as a crucial determinant of adjustment following difficult life events among many persons.

REFERENCES


APPENDIX: INTEGRATION OF STRESSFUL LIFE EXPERIENCES SCALE–SHORT FORM

Please indicate the extent to which you agree or disagree with the following statements with regard to (the loss of your loved one). Read each statement carefully and please note that for these statements, a response of 1 indicates that you “strongly agree” and a response of 5 indicates that you “strongly disagree.”

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have difficulty integrating this event into my understanding about the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. This event is incomprehensible to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am perplexed by what happened.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Since this event happened, I don’t know where to go next in my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I don’t understand myself anymore since this event.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. This event has made me feel less purposeful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: A sum of all items can be taken to compute a total Integration of Stressful Life Experiences Scale–Short Form (ISLES-SF) score. Likewise, Items 1, 2, and 3 can be summed to compute the Comprehensibility-SF subscale, and Items 4, 5, and 6 can be summed to compute the Footing in the World-SF subscale. The portion of the instructions in parentheses may be altered to make the measure applicable to different groups of interest. The numbering of items here does not correspond to the numbering used for the full version of the ISLES (Holland et al., 2010).
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Inventory of Social Support (ISS)

Nancy S. Hogan and Lee A. Schmidt

Purpose

Perceived lack of social support by a bereaved person has been identified as a risk factor for difficulty recovering from the death of a loved one (Doka, 1989; Rando, 1993; Stroebe & Schut, 2001; Worden, 1991). However, measuring social support and its effects on bereaved individuals’ outcomes has posed difficulties for researchers (Garnino, Sewell, & Easterling, 1998). The ability of healthcare professionals and others to give appropriate and effective support to bereaved populations is dependent upon the support person’s understanding of how bereaved individuals define things that help or hinder their coping with grief (Hogan & DeSantis, 1994; Hogan & Schmidt, 2002). The purpose of developing the Inventory of Social Support (ISS) was twofold: to operationalize social support as experienced by bereaved individuals and to better understand the role social support plays in adaptation to loss.

Development

The ISS items were initially developed from qualitative data obtained from 157 bereaved adolescents who provided written responses to the questions “What helped you cope with your grief?” and “What made it harder for you to cope with your grief?” The qualitative responses to these open-ended questions were analyzed using content-analysis procedures, with the units of analysis being phrases and sentences written by the participants addressing things that helped (e.g., “just being there for me. If I ever needed someone to talk to day or night, there was always someone I could talk to”), and things that hindered their adapting to their loss (e.g., “The way people talked to me. The way they said, ‘You should be over it by now’”). Participants referred to family members and friends as being helpful to them but there was a total absence of reference to school personnel or healthcare professionals supporting the bereaved adolescents (Hogan & DeSantis, 1994). Most participants in a study of 138 school personnel agreed that grieving students were overlooked (Dyregrov, Dyregrov, & Idsoe, 2013). Data were also obtained from 207 bereaved parents responding to the same “helped and hindered” questions. The data analysis resulted in findings similar to those derived from the adolescent study (Hogan, Greenfield, & Schmidt, 2001). Items for the ISS were developed from these two data sources to measure how bereaved adolescents and adults perceive social support that helps them to cope with the bereavement process.
The ISS is a brief, convenient, and unidimensional measure, which captures social support for grieving as experienced by the bereaved individual. The measure consists of five items that tap the attributes of this support. These include content related to (a) others taking the time to listen to the bereft, (b) the opportunity to express feelings openly and honestly, (c) a nonjudgmental stance of others, (d) the availability of at least one person to the bereft, and (e) getting help for grieving (see Appendix 15.1). Items are scored using a 5-point Likert-type scale, and respondents are asked to use the prior two weeks as a time dimension in rating the items. The measure is scored by adding the response values for each item, and dividing this value by the number of items in the scale.

Conceptually the ISS items represent the degree to which the bereft perceives that there is at least one person who will take the time to listen nonjudgmentally to them while they openly and honestly express their thoughts and feelings about grief. Cronbach’s alpha internal consistency for this scale was .76 in a sample of 209 bereaved parents (Hogan & Schmidt, 2002). The correlation between responses over a 14-day period was .86. Criterion validity was assessed using data from 170 bereaved parents. We predicted negative relationships between ISS scores and both the Avoidance subscale of the Impact of Event Scale (IES) (Horowitz, Field, & Classen, 1993) and depressive symptoms as operationalized through the Beck Depression Inventory II scale (Beck, Steer, & Brown, 1996). As predicted, both correlations were significant and negative (avoidance, r = .38 and depressive, r = .27). These findings indicate that depression and avoiding grief work were negatively associated with a perception of being supported in their grief. An exploratory factor analysis of the ISS using principal axis factoring revealed one factor explaining 51.9% of the variance. Factor loadings ranged from .47 to .74 (Hogan & Schmidt, 2002).

Further psychometric evidence for the ISS was obtained in a sample of family members who experienced the loss of a loved one and subsequently made a decision to donate tissues (Hogan, Schmidt, & Coolican, 2014). Data were collected at 6 months (n = 107), 13 months (n = 82), and 25 months (n = 96) post loss. Measures included the Hogan Grief Reaction Checklist (HGRC), the IES, the On-going Attachment Scale, and the ISS. Cronbach’s alpha for the ISS was consistent over time, at .82, .88, and .87 at 6, 13, and 25 months, respectively. Social support was significantly and negatively related to avoidance at 13 months (r = -.298, p = .008) and 25 months (r = -.28, p = .008), but not at 6 months (r = -.11, p = .28). The strongest association between social support and personal growth was noted at the 13-month time point (r = .53, p < .001) followed by 6 months (r = .43, p = .001) and 25 months (r = .30, p = .006). Social support was negatively related, as expected, to the core grief variables of despair and detachment at all time points (despair: r = -.24, r = -.33, and r = -.32; detachment: r = -.35, r = -.29, and r = -.36, all p < .05, at 6, 13, and 25 months, respectively). Data for all variables over the three time points were available for a sample of 20 participants. The mean values from the ISS did not change significantly over time F(2, 38) = 2.00, p = .154 (Hogan et al., 2014).

Theoretical Contributions

In addition to its general usefulness in research on bereavement, social support, as measured by the ISS, has been shown to be an important variable in developing a theory of grief to personal growth. A path model was hypothesized, based on prior work with bereaved adults and adolescents. Using structural equation modeling, research with bereaved adults showed that despair pathways led to social support, which in turn led to the outcome personal growth (Hogan & Schmidt, 2002).

Specifically, we tested two possible pathways through the grief to personal growth process using structural equation modeling. Findings showed that the HGRC Despair and Detachment subscales (Hogan & Schmidt, 2002) path led to the IES Intrusion subscale, which led to the
IES Avoidance subscale, which in turn led to the ISS scale pathway, which terminated at the HGRC Personal growth variable. The second model tested the pathway directly from Despair to Personal growth. Findings from this study showed a negative direct path between Despair and Personal growth, suggesting that personal growth is distinct from grief (Despair and Detachment). The analysis was conducted with cross-sectional data, which requires caution in interpreting the temporal sequencing of events in the model. However, one of the key findings, the relation between social support and personal growth, speaks to the importance of social support as bereaved individuals work through their grief. In other words, social support seems to bridge the anguish of grief with the possibility of personal development in its aftermath. The grief to personal growth theory provides a scientific explanation of the important role social support plays in the bereavement process and provides guidance to clinicians who work with bereaved adults (Hogan & Schmidt, 2002).

Clinical/Support Application

The question I find most helpful in assessing the social support of bereaved adolescents and adults is simply, "Is there at least one person you can talk to about your grief?" This question often results in the bereaved telling stories about how they were helped or hindered by others' words. If they identify that there is no one available to them I help them to find a health professional with expertise in bereavement care.

The content of the social support items suggests that bereaved individuals judge the ability of others to be helpful by the degree to which would-be helpers listen without judgment, which then provides a safe environment for the bereaved to talk openly and honestly about their grief. By extension, for bereaved persons, effective therapeutic interactions by clinicians might better be called "being-listened-to therapy" rather than the classical "talk therapy." In short, healing, in the case of grief, involves hearing.

References


Appendix 15.1 Inventory of Social Support (Hogan & Schmidt, 2002)

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes the way you have been feeling during the past two weeks, including today. Please select the number that best describes YOU and put that number in the blank provided.

1 = Does not describe me at all
2 = Does not quite describe me
3 = Describes me fairly well
4 = Describes me well
5 = Describes me very well

_____ 1. People take the time to listen to how I feel.
_____ 2. I can express my feelings about my grief openly and honestly.
_____ 3. It helps me to talk with someone who is nonjudgmental about how I grieve.
_____ 4. There is at least one person I can talk to about my grief.
_____ 5. I can get help for my grieving when I need it.

Note

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Prolonged Grief Disorder (PG – 13) ©

Holly G. Prigerson, Ph.D., Paul K. Maciejewski, Ph.D.

PGD is a newly defined syndrome that is a specific reaction to the loss of someone loved very much. There are a particular set of PGD symptoms – feelings, thoughts, actions – that must be elevated at 6 months post-loss and that must be associated with significant functional impairment in order for a person to meet criteria for PGD.

INSTRUCTIONS

Below lie instructions for how to score (diagnose) Prolonged Grief Disorder (PGD). Each of the requirements for Criteria A-E must be met for an individual to be diagnosed with PGD.

A. **Event Criterion:** In order to complete the PG-13, we assume the respondent has experienced bereavement (i.e., the loss of a loved person).

B. **Separation Distress:** The respondent must experience PG-13 questions #1 or 2 at least daily.

C. **Duration Criterion:** The symptoms of separation distress must be elevated at least 6 months after the loss. That is, PG-13 question #3 must be answered as “Yes”.

D. **Cognitive, Emotional, and Behavioral Symptoms:** The respondent must experience 5 of the PG-13 questions #4-12 at least “once a day” or “quite a bit”.

E. **Impairment Criterion:** The respondent must have significant impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities). That is, PG-13 question #13 must be answered as “Yes”.

PG-13 is a diagnostic tool. If a respondent meets criteria for PGD, this would suggest that he or she should seek a more thorough evaluation from a mental health professional. Only an in-person assessment by a mental health professional can determine for certain, the clinical significance of the reported symptoms, and provide recommendations or referrals for treatment.

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PART I INSTRUCTIONS: FOR EACH ITEM, PLACE A CHECK MARK TO INDICATE YOUR ANSWER.

1. In the past month, how often have you felt yourself longing or yearning for the person you lost?
   _____ 1 = Not at all
   _____ 2 = At least once
   _____ 3 = At least once a week
   _____ 4 = At least once a day
   _____ 5 = Several times a day

2. In the past month, how often have you had intense feelings of emotional pain, sorrow, or pangs of grief related to the lost relationship?
   _____ 1 = Not at all
   _____ 2 = At least once
   _____ 3 = At least once a week
   _____ 4 = At least once a day
   _____ 5 = Several times a day

3. For questions 1 or 2 above, have you experienced either of these symptoms at least daily and after 6 months have elapsed since the loss?
   _____ No
   _____ Yes

4. In the past month, how often have you tried to avoid reminders that the person you lost is gone?
   _____ 1 = Not at all
   _____ 2 = At least once
   _____ 3 = At least once a week
   _____ 4 = At least once a day
   _____ 5 = Several times a day

5. In the past month, how often have you felt stunned, shocked, or dazed by your loss?
   _____ 1 = Not at all
   _____ 2 = At least once
   _____ 3 = At least once a week
   _____ 4 = At least once a day
   _____ 5 = Several times a day
**PART II INSTRUCTIONS:** FOR EACH ITEM, PLEASE INDICATE HOW YOU CURRENTLY FEEL. CIRCLE THE NUMBER TO THE RIGHT TO INDICATE YOUR ANSWER.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Slightly</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Overwhelmingly</th>
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<tbody>
<tr>
<td>6. Do you feel confused about your role in life or feel like you don’t know who you are (i.e., feeling that a part of yourself has died)?</td>
<td>1 2 3 4 5</td>
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<td>7. Have you had trouble accepting the loss?</td>
<td>1 2 3 4 5</td>
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<td>8. Has it been hard for you to trust others since your loss?</td>
<td>1 2 3 4 5</td>
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<td>9. Do you feel bitter over your loss?</td>
<td>1 2 3 4 5</td>
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<td>10. Do you feel that moving on (e.g., making new friends, pursuing new interests) would be difficult for you now?</td>
<td>1 2 3 4 5</td>
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<td>11. Do you feel emotionally numb since your loss?</td>
<td>1 2 3 4 5</td>
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<td>12. Do you feel that life is unfulfilling, empty, or meaningless since your loss?</td>
<td>1 2 3 4 5</td>
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</table>

**PART III INSTRUCTIONS:** FOR EACH ITEM, PLACE A CHECK MARK TO INDICATE YOUR ANSWER.

13. Have you experienced a significant reduction in social, occupational, or other important areas of functioning (e.g., domestic responsibilities)?
   _____ No
   _____ Yes