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# Grief Support Groups: Preference For Online Vs. Face To Face

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GRIEF SUPPORT GROUPS: PREFERENCE FOR ONLINE  
VS. FACE-TO-FACE

being

A Thesis Presented to the Graduate Faculty  
of the Fort Hays State University in  
Partial Fulfillment of the Requirements for  
the Degree of Master of Science

by

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## ABSTRACT

Grief is a reaction to loss and will be experienced to some degree by everyone in his or her life. For most, this is a brief process lasting a few weeks or months, after which they regain their focus and return to their normal lives. For a percentage of the population, however, it is more difficult to return to normal life functions. The grieving process can further diminish low social support and social support networks. However, generally providing the opportunity to talk about their feelings is sufficient to help most work through their grief without therapy (Burke, Eakes, and Hainsworth, 1999; Neimeyer, 2008).

The purpose of this research was to determine if individuals preferring online to face-to-face grief support groups come from different populations. Participants were asked to fill out a questionnaire to measure aspects of social support unavailability, avoidant personality traits, Asperger's syndrome traits, introversion traits, loneliness, and computer self-efficacy. A religiosity scale also was included as a control measure. Participants were given four hypothetical scenarios concerning loss and asked if they would prefer online to face-to-face support if they were in that situation. It was expected that individuals with higher scores on the six scales other than religiosity would be more likely to prefer online self-help. The results did not support this expectation. None of the full scales were found to have a significant correlation with preference for type of support group.

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## INTRODUCTION

The Internet has become a part of our daily lives. It seems that almost everything can be done over the “net.” Although the primary use of the Internet is as a communication medium, online banking, shopping, and even dating are commonplace. There is a chance that the person taking your order at your favorite drive-through restaurant is sitting at home in front of a computer in a different state. It is unusual for businesses not to have their own websites and many experts agree that the last presidential election was won in part by the use of information presented and donations made online (Miller, 2008; Wagner, 2008, Wikipedia, 2010). It should not be surprising that the Internet has also been used for psychotherapy.

One rapidly growing area on the Internet is support groups. A person can go online and find support help for bipolar disorder, substance abuse, anxiety, personality disorders, posttraumatic stress disorder, and even the Special K diet (<http://groups.google.com/?pli=1>). Although research has been done on how Internet use can affect our lives and emotional well being, most of the research has been correlational in nature. In this study, I am proposing that specific individual differences might influence whether a person prefers the Internet or a more traditional face-to-face setting for therapeutic support in the case of grief after loss of an important individual.

## Facets of Grief

### *The Grieving Process*

Grief is a universal and natural response to loss. There are many types of loss, loss of loved one, a job, a limb, a pet, an expectation. Almost any major life change can be considered to be a loss. Everybody will experience loss at some time in their lives, but most will recover on their own, suffering only minor stress. Individuals in grief will grieve, mourn, and in a few weeks or months regain equilibrium and move on without any further serious disruption of their lives. Grieving is the process of coping with loss and should be expected, even encouraged. It is a way to transition through the disruption in their social connections, recognize that their lives have changed, and accept what has happened. To repress grief can be self-destructive resulting in physical and emotional disturbances (Burke, Eakes, and Hainsworth, 1999; Gordon, 2009; Matheson, 2003; Neimeyer, 2008).

Grief can be intense, with feelings of sorrow, anger, guilt, pain, bouts of crying, depressed mood, confusion and suspicion of the motives of others. These symptoms would be diagnosed as a psychiatric disorder under normal conditions. The bereaved may also ruminate about the events leading up to the loss and place the blame for the event on themselves or others. These symptoms are considered normal grief reactions and generally can be worked through without treatment (Neimeyer, 2008; The Harvard, 2006).

### *Comorbidity with Grief*

Most people adapt to the loss and regain their psychological equilibrium within a few weeks or months, although the loss can be felt for a considerably longer length of time in some cases. However, responses of the bereaved can vary greatly. Some return to a normal state of life, while others use the loss as an opportunity for growth.

Unfortunately, research has shown that in people who have lost a spouse, up to 40% experience generalized anxiety or panic syndromes in the first year after the loss. For about 10% of the population the loss will trigger post-traumatic stress disorder (PTSD) or major depression (Neimeyer, 2008).

According to the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders 4<sup>th</sup> edition, text revision (*DSM-IV-TR*, 2000), PTSD is defined as the development of symptoms following the exposure to a traumatic stressor involving direct traumatic personal experience, such as learning of the death or harm to a family member or close associate. A person's response must involve intense fear, helplessness, or horror to be considered PTSD. Symptoms include the persistent re-experiencing of the traumatic event through distressing dreams or flashbacks, creating psychological distress and hyperarousal. Deep feelings of guilt about surviving when others did not are common. Symptoms may be more severe or longer lasting if the event is not natural (e.g., cancer) but of human origin (e.g., war, accident). Symptoms must persist for at least one month for a diagnosis of PTSD.

Depression also can be seen as a reaction associated with grief. "As part of their reaction to loss, some grieving individuals present symptoms characteristic of a Major

Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss)” (*DSM-IV-TR*, 2000). Individual and cultural differences influence the manner and length of mourning, making a distinction between “normal” bereavement and a depressive episode difficult. Symptoms of a Major Depression Episode that are not explainable by normal bereavement may include 1) guilt not related to the loss, 2) thoughts of death other than those arising from the loss, 3) preoccupation with feelings of worthlessness, 4) retarded psychomotor actions, 5) slowed physical responses and reactions, and 6) hallucinations other than visions in which the person briefly hears the voice of or sees the image of the deceased. If these symptoms are present or the depressed mood lasts for longer than 2 months, a diagnosis of a Major Depressive Episode may be given. (American Cancer Society, 2009; *DSM-IV-TR*, 2000). People at risk of Major Depression are those who have suffered from depression previously, have major life stressors, have alcohol or drug problems, or have a weak social support system (American Cancer Society, 2009; The Harvard, 2006).

### *Complicated Grief*

Another disorder has been proposed as a psychiatric disorder by the APA, comprising features of both PTSD and depression. As it has not yet been officially recognized, it can have several titles including complicated grief (CG), chronic sorrow, or chronic, unresolved, protracted, traumatic, or extended grief (Burke, Eakes, & Hainsworth, 1999; Neimeyer, 2003; The Harvard, 2006). Symptoms of CG may include continued disbelief or inability to accept the loss, flashbacks of memories intruding into everyday thoughts, severe and prolonged grief symptoms, keeping fantasy relationships

with the deceased with the feeling they are always present, a continuous yearning and searching for the deceased, a disruptive sense of meaninglessness in one's life, and strange or abnormal behavior. These patterns of bereavement adaptation may interfere with work or family or social functioning for at least six months (Gordon, 2009; Neimeyer, 2008; The Harvard, 2006).

Although most research on CG has focused on the loss felt by parents dealing with a physically or mentally disabled child, CG also may be experienced by parents whose child has a chronic illness or individuals having experienced a death (Burke, Eakes, & Hainsworth, 1999; Gordon, 2009). Early childhood experiences such as death of a parent or divorce may leave some people with abandonment anxieties that may predispose them to CD. In adulthood, loss of a person central to their life, such as a partner, sibling, or child, as well as an unanticipated or violent death, also may make a person more likely to suffer CG. Centrality of the loss is correlated with the inability to integrate the loss and feelings of a dream like state (Boelen, 2009; Matheson, 2003; Neimeyer, 2008).

Complicated Grief, while sharing some of the symptoms of both PTSD and depression, has unique characteristics (Neimeyer, 2008). PTSD is distinguished by fear, panic, and attempts to avoid stimuli that would bring up memories of the trauma. Feelings of vulnerability are a prominent symptom. Depression is distinguished by feelings of despair, loneliness, and the loss of interest or pleasure in all activities. The individual may feel unworthy of living and may have suicidal ideations (*DSM-IV-TR*, 2000). In comparison, symptoms of CG are characterized as a sense of profound loss, and

memories of the person (or expectations) actually seems to stimulate the pleasure center of the brain leaving people prone to ruminate about the loss (Neimeyer, 2008). Brain imaging has also shown physiological differences between depression and CG.

Depression has depressive effects on what appears to be the centers responsible for personal memories, whereas CG seems to stimulate them. This stimulation also differs from those who go through normal bereavement and those who suffer from CG. In individuals suffering from CG the nucleus accumbens, a region that is activated by feelings of reward, is activated. Thus, even though the memory of the loss causes pain, the memory brings a pleasure that they are reluctant to forgo. They have a physical craving and yearn for the reward of a painful memory (Kersting, 2004; Neimeyer, 2008).

People can suffer from any combination of depression, PTSD, or CG. The disorders do show unique characteristics, but also a high rate of comorbidity. Those diagnosed with CG at 6 to 12 months are more likely to be diagnosed with a psychotic disorder within the next year. The inability to find meaning in life after the loss or “make sense” of a traumatic, or premature death, as well as a previous history of depression is associated with CG, and the resulting rumination is predictive of long-term depression and anxiety. Not surprisingly, these conditions are also correlated with low social support. However, it is not clear if these disorders are caused by low social support or that already weak social support networks are further diminished by the burden of caring for a distressed individual (Beutel, Deckart, von Rad, & Weiner, 1995; Neimeyer, 2008).

One of the most common triggers of CG is comparison with social norms that cause the bereaved to see themselves as being different. Being able to accept their grief as

normal and providing them with opportunities to express their feeling may be sufficient to allow them to work through the grieving process (Boelen, 2009; Burke, Eakes, & Hainsworth, 1999). However, it may have become more difficult to accept grief as "normal" in modern societies. As mourning rituals have deteriorated in our societies we are more likely to remain distressed after loss than in cultures that still sanction ritualized public displays of grief. Because we stigmatize public displays of grief, this may lead to inadequate resolutions of the grieving process (Bolton & Camp, 1986-87). Rituals serve to help overcome physical and psychological difficulties, to maintain social bonds, and to provide a model for behavior (Castle & Phillips, 2003).

During World War I, the massive casualties of war caused death to lose its uniqueness, and this led to a psychological distancing from death to the point that public grief almost became taboo. This can be seen in England with the loss of strict Victorian mourning rituals, often lasting as long as two years including covering mirrors and wearing elaborate clothing (Hunter, 2008). Unlike more traditional cultures that balance "holding on" and "letting go," Western funeral rituals now have a cultural model that focuses on "letting go" and "moving on" with one's life. This may seem ineffective or inauthentic to some individuals, as it is common today for mourners to spend the day with colleagues that may never have met the deceased (Romanoff & Terenzino, 1998, Stroebe, 2001, Walter, 2009). This lack of a transitioning period and a means for social transformation may not allow an individual the chance to effectively work through the grieving process.

## Therapies for Grief

### *Treatment for Complicated Grief*

Treatment for CG is based on the theory that people are in denial: people become “stuck” and are unable to work through their grief (Kearney, 1994; Matheson, 2003). However, there are some researchers that suggest denial is an adaptive coping mechanism that allows an individual to feel better by having a buffering effect (Kearney, 1994). Matheson (2003) describes the bereaved as “their attitudes and behaviors become like a roller-coaster ride during the grieving process. Usually at the heart of their grief is an intense desire to have their job back, partner back, and life back just the way it was.”

It should not be surprising then that there is a need for grieving individuals to not only receive professional support, but also to explore their feelings through stress relieving exercises such as journaling or prescribed writing assignments. Seeking out social situations where they can express their feelings with others in similar situations also has been found to be highly beneficial. To supplement local resources and local support groups, it has been recommended that health professionals provide credible Internet resources to help individualize coping interventions for self-awareness and acceptance (Gordon, 2009; Neimeyer, 2008).

Social comparison appears critical not only for susceptibility to and continuation of CG symptoms, but also to acceptance of the loss. The ability to accept the loss and arrive at a closure point is considered imperative to healthy adjustment, whereas not being able to overcome anger, sorrow, and guilt, and the inability to refocus attention outwards is considered maladaptive (Kearney, 1994). Acceptance and closure are not

about forgetting, but constructing a “continuing bond” with the deceased person, thinking of them often and even having mental dialogs with them (Haley, Larson, Kasl-Godly, & Neimer. 2003). This continuing of communication with the deceased is a method of taking control over a situation that would otherwise seem out of their control (Kearney, 1994).

The belief that they can take control of their lives and be successful is a prominent attribution in recovery (Kernery, 1994; Kinnier, Hosfsess, Pongratz & Lambert, 2009). Communicating with others who have suffered similar events and have already achieved healthy adjustment is an important part of this process. The literature indicates that individuals who have recovered from a variety of illnesses believe that having people caring for them, believing in them, and giving them reassurance was an important part of their recovery. Although 90 percent of both therapists and individuals who have recovered from illness recommend several interventions and encourage individualized interventions, social support was 6<sup>th</sup> on the list of interventions for stress and 3<sup>rd</sup> for depression (Kinnier, Hosfsess, Pongratz & Lambert, 2009).

The bereaved not only have to deal with the pain of loss, but also with new social roles and identity change. The ability to rely on family and friends has always been the main source of solace and social stability, but this seems to be changing. With families dispersing due to ease of travel, frequent job changes, and divorce, this traditional source of support has been diminished. This combined with the stressors unique to the bereaved make social support difficult to receive (Gentry & Goodwin, 1995; Galegher, Sproull, & Kiesler, 1998).

### *Support Groups*

With the need for social support being so vital to recovery, and the availability of solid social networks in a nation-wide decline, the added complication of stressors inherent in the grief process leave the bereaved especially vulnerable to psychological disorders. This has prompted an expansion of support groups. A search of Google's directory of support groups found 69 different support groups for grief and bereavement. Perhaps ironically, 57 were found for pet loss. Although online support groups are a relatively new phenomenon, Face-to-Face (FtF) support groups have been the traditional arrangement, and most, but not all, individuals find some form of support groups to be beneficial (Gentery & Goodwin, 1995).

Benefits of support groups are both emotional and practical. Some of the benefits include feeling understood, having a place to find hope, the ability to have someone to share experiences with, and help finding information including where to find other sources of support (Gray, Fitch, Davis, & Phillips, 1997; Phillips, 1996). Belonging to a group and identifying with their ideology helps develop a sense of unity with others and a new self-identity. Having others that can identify with one's personal issues creates a powerful cohesion and feeling of being accepted which might be lacking in their daily lives. Members not only get support, encouragement, and validation, but also an opportunity to help others in the same predicament (Lieberman, 1990). This common sentiment might be especially helpful in cases of bereavement where themes of distrust can be prevalent (Lewis, 2008).

*Online vs. Face-to-Face*

Though beneficial, some individuals may feel overwhelmed by FtF groups or simply find them too painful. The anonymity of indirect contact may provide the bereaved with an environment that feels safe enough to open up and share their memories (Fitzgerald, 2008). The individual does have the option of choosing a stigma-free source of support. The freedom from stigma of an online help group has been shown to allow people to share more openly. Individuals often share more intimate details with online members of a support group than with the people locally available around them (Bessiere, Keisler, Kraut, & Boneva, 2004; Houston, Cooper, & Ford, 2002; Lewis, 2008).

In today's technologically advanced world, online support groups are easy to find, but research currently has been done on the effect of FtF groups only and little is known about the functioning of online self-help groups (Grey, Fitch, Davis, & Phillips, 1997; White & Dorman, 2001). Few quantitative studies have focused on the types, effectiveness, or the interface between these Internet resources and FtF care (Houston, Cooper, & Ford, 2002). In addition, most studies have had methodological problems that make conclusions difficult to draw on their effectiveness. They use a wide variety of interventions, measurement tools, and look at different populations. Many studies evaluate complex interventions or have "less than optimum research designs with few subjects" (Eysenback, Powell, Englesakis, Rizo, & Stern, 2004). There is a lack of data on how much additional support is needed from a practitioner to be optimal, and who is in the best position to provide guidance (Proudfoot, 2004). Although the effectiveness of

online support remains unclear, it should be noted that in their study of electronic support groups, Eysenbach et. al. (2004) state that no negative effect or harm was found.

Most of the controversy centers on the fact that the Internet tends to produce weaker social ties than FtF interactions (Cummings, Butler, & Kraut, 2002). However, Constant, Sproull, and Kiesler (1996) argue that the capacity of weak ties to bridge spatial, logistical, and social barriers gives people the ability to come into contact with more resources. There is a concern over the lack of professional leadership in the groups (Lewis, 2008). One support group for medical problems found health care providers wrote only 5.3% of the messages and 60% of the messages were providing personal experience alone (Culver, Gerr, & Frumkin, 2002). However, online support groups are often more knowledgeable about their particular problems than doctors (Larandro, 1999; Lewis, 2008).

Another concern is that individuals might abandon their FtF groups in preference of unproven online self-help groups. However, a study of an online depression group showed that one third of the group had never participated in a FtF group, and that those that had did not abandon the FtF group but used the online group experiences as an enhancement to their FtF care (Houston, Cooper, & Ford, 2002).

Online support groups resemble FtF groups in that they are comprised of people that share a common diagnosis or problem, yet vary in some important ways. Face-to-face groups normally gather at a set place and time where a small population is drawn from a small geographical area, often from a single community. Although confidentiality is expected regarding group participation and activities, the inherent need for their

physical presence creates a possibility of undesired public exposure. Members also may experience pressure from the group to actively participate and share thoughts and feelings. These factors make FtF groups less anonymous and more conformist than online support groups, conditions that individuals already feeling stigmatized might want to avoid (Galegher, Sproull, & Kiesler, 1998).

Simply discussing problems that appear to have negative personal or social implications for an individual can be difficult, even if the discussion is with his health care provider. This can be seen in studies that show, when disclosing potentially embarrassing or stigmatizing information, people may feel more comfortable disclosing to a computer than their primary care giver (Newman, Consoli, & Taylor, 1997). One survey of individuals who might benefit from self-help therapy found that 91% of the people who responded stated that they wanted to be able to have computer access to self-help (Graham, Franses, Kenwright, & Marks, 2001).

It is understandable that people might feel uncomfortable discussing personal and sensitive matters face to face, where judgment or blame might be placed on them. The anonymity of the Internet might be an ideal environment to gain insights or promote communication for people in these circumstances. Simply being able to communicate is possibly the best aspect of Internet support groups, and has been shown to reduce stress (Bass, McClendon, Brennan, & McCarthy, 1998).

These electronic support groups can be accessed anywhere there is internet accessibility. They have the ability to communicate 24/7, or they can just read the postings and there is no need to reveal their identity or even their presence. Although

Internet support groups are large, often with thousands or tens of thousands of members, and public, the communication does not differ greatly from other patterns of written or oral communication. People enter to ask and respond to questions, challenge controversial statements, and enforce group norms. However, unlike FtF groups, there is no need to respond to others, messages can be dismissed as illegitimate or ignored, and there is no pressure to actively participate or share in discussions (Galegher, Sproull, & Kiesler, 1998).

Research by Cummings, Butler, and Kraut (2002) suggests that while frequency of communication is predictive of emotional closeness in FtF interactions, this might not be the case for Internet relationships. Not only are online relationships characterized by less communication, but communication is not predictive of psychological closeness. There seems to be camaraderie involved that participants cannot find, or at least cannot recognize, in their close contact cohorts. This possibility might be reflected in Shklovski, Kiesler, and Kraut's (2004) meta-analysis of studies on how Internet use can affect social interaction. The cross-sectional studies in the analysis found positive effects between Internet use and unspecified or "loose knit" relationships, but negative effects with social interactions in FtF friendships. Longitudinal studies, however, showed an increase in social interactions for FtF friendships also. Although rare, there have been individuals who have made friendships through online support groups that rival lifelong in-person relationships (Larandro, 2002).

### Individual Differences

There seem to be differences between those who participate in online communication and those who prefer to participate in FtF interactions. Communication where there is limited social constrictions and fewer perceived risks appears to be more attractive to some people. People using computers appear to be more comfortable, less inhibited, and produce a wider range of ideas (Kraut, Kiesler, Boneva, Cummings, & Helgison 2002). These conditions might be especially important for those without good social skills. It should not be surprising that people without good social skills might not be comfortable in FtF situations and have lower real-world social support, and might go online to gain it.

This hypothesis was supported by Houston, Cooper, and Ford's (2002) research that found that users of online support groups were a select group with low social support. Compared with individuals that used primary care givers to combat major depression, the people who chose online support reported less social support, with 18% to 25% reporting no tangible social support at all. Online support group users also reported more depression, using more anti-depressant medications, and were less likely to be married or be employed. People with low social support are more likely to use the Internet to meet new people, use chat rooms, and for entertainment. This increase in Internet use has been found to have positive correlations with social and psychological wellbeing. More use of the Internet was associated with larger social circles, more FtF communication, trust in people, and positive affect (Bessiere, Kiesler, Kraut, & Boneva, 2004; Kraut, Kiesler, Boneva, Cummings, & Helgison, 2002). However, this increase in

the size of a person's social support network has not always been found, even when an increase in positive affect was found (Houston, Cooper, & Ford, 2002).

Graham, Franes, Kenwright, and Marks (2000) found that more than one in four people in the UK would rather use the internet for health advice and counseling about depression than visit their primary care giver. Two-thirds stated ease of access and reduced stigma or embarrassment as reasons for their preference. An individual's personality could make them more prone to feel embarrassment or shame for needing help in such delicate situations. People with different personality types respond differently to Internet use and it is possible that psychological differences might lead a person to choose online support over FtF support. This is a problem when attempting to evaluate the efficacy of online support groups in comparison with traditional FtF groups. Research indicates that people that have low social support, are lonely, or depressed tend to prefer online communication (Chaplan, 2003), and there is reason to believe that this will hold true for online self-help groups. It is possible that the online population of support groups is different from that of FtF groups for a variety of reasons.

#### *Social Support Unavailability*

As mentioned above, it is expected that those without easily accessible social support will be forced into considering online self-help groups. This may not be their preference so much as their perception that no social support is readily available to them.

#### *Avoidant Personality*

People who might actually prefer an online self-help group may have some of the characteristics of an avoidant personality. One possible reason for loneliness, low social

support, low self-esteem, or depression might be Avoidant Personality Disorder (APD). The DSM-IV-TR (2000) describes ADP as a "pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts." Reasons may include avoidance of activities that require interpersonal interaction out of fear that they will be criticized, disapproved of, or rejected; an unwillingness to become involved with others unless they are certain they will be liked; restraint in personal relationships out of fear of being shamed or ridiculed; fear of being criticized or rejected in social situations; inhibition in new relationships due to feelings of inadequacy; self-perceptions of social ineptness or inferiority; or reluctance to engage in activities they might find embarrassing (DSM-IV-TR, 2000).

APD is prevalent in about 1.0% of the general population and up to 25% of individuals seeking psychiatric care (Alden, Laposa, & Taylor, 2002). Despite their strong desire to have an active social life, their tendency to react strongly to interpersonal cues of criticism and to exaggerate the dangers of social interactions makes creating new interpersonal relationships difficult (DSM-IV-TR, 2000). Because of these exaggerated perceptions, people with APD are inhibited and will avoid new situations. Sometimes their longing for social contact may lead to fantasy relationships. They are likely to be seen by others as shy, timid, lonely, or isolated. Because they are hypersensitive to these situations, they will be extremely hurt by these situations and therefore tend to have difficulty talking about themselves or to engage in open and intimate conversations. There also appears to be an overlap in symptoms between APD, generalized social

phobia, and other personality disorders (DSM-IV-TR, 2000), suggesting that these disorders might lay on a spectrum rather than being distinctly separate.

In their study on Internet addictions, Whang, Lee, and Chang (2004) found that individuals highly dependent on the Internet had high interpersonal difficulties and stress in real life. They also found that those classified as Internet-addicted showed behavioral patterns similar to people who were lonely in real life, including spending more time in superficial relationships with strangers than with family or friends. These individuals went online to meet new friends in order to avoid what they felt were stressful real life relationships. Although these individuals went online to avoid reality, they showed a tendency to reveal personal concerns. This might be seen as dysfunctional social behavior, but this likely was the only opportunity these types of individuals found to share their feelings, something they might not be able to do in real life.

Caplan's (2003) research on problematic Internet use identifies a number of features of Internet communication that might appeal to people who are lonely, depressed, or have low self-esteem. Internet communication allows for greater anonymity and self-preservation. Individuals may perceive Internet communication as a place where their lack of interpersonal skills is less noticeable, and there are fewer adherences to social norms. They have the ability to edit or modify personal information that might be perceived as negative or harmful, and thus have greater control over the impressions others may have of them. Because individuals with ADP desire interpersonal contact, but see themselves as socially inept and personally inferior, they are prone to avoiding new and potentially embarrassing activities. Greater control could give them the assurance of the

uncritical acceptance they need to create intimate bonds. These features of Internet communication would seem to make individuals with any of the characteristics of APD more prone to seek out online help.

### *Asperger's Syndrome*

Similarly, people who have some of the characteristics of Asperger's Syndrome also may prefer an online self-help group. Asperger's Syndrome (AS) was first identified in 1944 by Dr. Hans Asperger and is one of five autism-related pervasive developmental disorders. Once considered a rare disorder, in the past decade the number of children who have been diagnosed with AS is estimated to have increased by as much as a factor of 20 (Silberman, 2001; Woliver, 2009). Although AS shares many features of Higher Functioning Autism (autism without mental retardation), it differs in that the onset is usually later, speech is not significantly delayed, and motor defects are more common. Although research is being done, little is understood about this social learning disability and data regarding its prevalence is lacking (*DSM-IV-TR*, 2000; Klin & Volkmar, 1995).

Diagnostic criteria for AS include: (a) Qualitative impairment in social interactions including impairment of nonverbal cues; failure to develop appropriate peer relationships; failure to share interests or activities with others, and lack of social or emotional reciprocity. (b) Restricted repetitive and stereotyped patterns of behavior, interests, and activities, including abnormal preoccupation with one or more stereotyped and restricted patterns of interest; inflexible nonfunctional routines or rituals; repetitive motor movements; or preoccupation with parts of objects. (c) Impairment of social, occupational, or other areas of functioning. (d) No significant delay in language,

cognitive development, self-help skills, adaptive behavior (except social interactions), or curiosity about their environment in childhood (*DSM-IV-TR*, 2000).

People with AS have characteristics that make social interactions difficult. Before the time children start preschool and interact with same-age peers, the disorder may go unnoticed or does not raise concern. Children may even seem gifted in verbal or other abilities. It is only when children start having problems in interacting with their cohort that the disorder becomes apparent (*DSM-IV-TR*, 2000). Individuals may seem odd, have behavioral quirks, show little concern about their appearance, and are often seen as impolite or rude. Often their motor awkwardness, over-activity, inattention, and inability to recognize nonverbal cues contributes to peer rejection and social isolation. Some may even develop symptoms of depression. Although often self-described as loners, like those with APD, they typically desire friendship and social interaction. However, these desires are invariably thwarted due to their inability to make emotional connections with others (Klin & Volkmar, 1995; Woliver, 2009).

Individuals with AS usually have normal to superior IQ, and although some are even mildly retarded, Asperger's has been called the "nerd disorder" or "little professor's syndrome." It is thought that many of the world's greatest thinkers and musicians had some degree of AS. Bill Gates, Albert Einstein, Thomas Jefferson, and Charles Darwin are all thought to have AS (Woliver, 2009). Although the cause of AS is unknown, there is likely to be a genetic component. In his blog "My life with Asperger's" on the Psychology Today web site, John Robinson (2008) makes the claim that it might be our computer-mediated communication that is to blame for the recent rise in AS. Most

individuals learn to read people's emotions, but those with AS do not pick up on signals that trigger their automatic response to stimulate the learning process. It might be that if more time is spent on electronic communication, then FtF communication skills are lost or never develop, particularly complicated nonverbal communication skills. Without constant interpersonal FtF contact, neural pruning may degenerate the ability to communicate in person (Robison, 2008).

For those with a lack of interpersonal skills, poor nonverbal communication, obsessive interests, and a tendency to have sensory overload issues, the computer might be an ideal environment. The computer offers a controllable, unthreatening, comfortable environment in which beneficial communication and sociability may occur (Morris, 2008). This seems to be the case in Silicon Valley where respect and rewards are based on the ability to write computer code, and ignoring social norms is the norm. A person can be socially awkward or a "lone-wolf" and still be considered successful. Computer "geeks" are now fashionable, even seen as sexy, and are associated with financial success (Silberman, 2001). Woliver (2009) quotes Dr. Temple Grandin as saying "nerd is another word for Asperger's. Computer geek is another word for Asperger's. They are the same thing. And they're called geeks. They're called engineers. They're called musicians. It's the same thing."

If this is the case, and individuals with AS have found a place where their unique way of thinking and behaving is not only accepted but even seen as chic, it is possible that they are reproducing at a greater rate. As AS does seem to have genetic links, not only would higher rates of reproduction mean higher rates of AS, but people with AS

would be drawn to these professions and technology hotspots where there would be greater contact with each other. If individuals that are carrying the genes for AS are mating with each other, the chance that the genetics will be passed along to their children is also greater (Silberman, 2001).

Although the causes of AS are not clear, the diagnostic criteria fuzzy, and the rates of AS are going up worldwide, there has been a particularly significant increase in California. In 1993, there were 4,911 cases of autism in California's Department of Development System (DDS). This number does not include cases of AS. In 2001, though, there were 15,441 cases in the DDS database. This sharp increase is especially noticeable in Santa Clara County's Silicone Valley where the DDS San Andreas Regional Center director Santi Rogers states that the increase in cases in Santa Clara county is "higher enough to be worrisome, ... There's a significant difference, and no signs that it's abating." (Silberman, 2001).

### *Introversion*

People who have some of the characteristics of introversion might prefer an online self-help group over a FtF support group. Extroversion, the opposite of introversion, can be defined as wanting an increased quantity and quality of interpersonal interactions, an innate need for stimulation, and possessing the capacity for joy. Extroversion/introversion is an assessment of interpersonal involvement and energy, and contrasts individuals who rate high on these traits with those who are more reserved and quiet (Piedmont, 1998).

Cross-sectional studies have found a negative correlation between Internet use and real life social interactions. One explanation is that people with few friends and small social networks may be going online to find them. Due to a personality trait such as introversion, people may prefer online to FtF communication because the anonymity and privacy inherent to online chat is more comfortable to them. Although people who feel isolated, such as introverts, may use the Internet to seek out new friendships, little research has been done on what personality traits may cause people to prefer the internet (Shklovski, Kiesler, & Kraut, 2004). Introversion is not the only reason for loneliness, but it is likely that any reason for loneliness might predict a preference for Internet use.

### *Loneliness*

Loneliness is a strong predictor for those who might suffer from complicated grief. While there is little research that shows individuals suffering from complicated grief would be more likely to use self-help groups, it is likely that, because of the duration and intensity of their grief, they might be more motivated to do so. Loneliness has also been positively correlated with depression, AS, APD, introversion, and Internet addiction. Lonely individuals are more likely to go online to chat and meet new people, and loneliness has been found to be a stronger predictor of problematic Internet use than both depression and computer efficacy (Ceyhan & Chehan, 2008). In general, though there could be reasons why individuals who are not particularly lonely might want to shun computer use, there is every reason to believe that lonely individuals would be very willing to go online for social support.

### *Religiosity*

Due to the feelings of religiosity that are often brought forward by loss and death, there might be a preference for FtF interactions due to the interpersonal nature of organized religion. However, due to the melding of the Internet into the daily lives of individuals, this does not seem to be the case. Religious groups are colonizing cyberspace and their popularity is growing (Hackett, 2006).

People go online to seek religious information (Howard, Rainie, & Jones, 2001) and can even attend virtual church. The services are much like regular church, prayers are said, sermons are given, and your avatar can socialize with other members before and after church. There is an emotional aspect to the meetings that is comparable to real-world services (Schroeder, Heather, & Lee, 1998). There are also affiliation-focused sites like MyChurch that claims 36,297 churches as members. Member churches can post and answer prayer requests, watch videotaped sermons, blog, or make announcements. While their size is limited by their target demographic, their existence shows that religions are as willing to embrace this form of media as they have radio and television (Boyd, & Ellison, 2007).

### *Computer Self-efficacy*

There is a logical assumption that can be made that people who would prefer an online self-help group over a FtF self-help group would tend to be confident in their computer skills. This assumption is supported in research by Kraut, Keisler, Boneva, Cummings, and Helgison (2002) that found computer skills increased with Internet use. Chaplan (2003) and Whang, Lee, and Chang (2004) found that individuals who were

prone to problematic computer use had many of the same characteristics as those who were likely to suffer from complicated grief. Poor psychosocial skills and interpersonal difficulties, which may lead an individual to seek out self-help groups, also may lead to higher rates of problematic computer use. If an individual who would suffer from CG is the same type that would prefer online communication, and greater online use is positively correlated with increased computer skills, it is likely that those with higher computer self-efficacy would prefer online to FtF self-help.

### Hypotheses

It is the intent of this study to look at some possible reasons that might create attitudes that would attract people to online self-help groups for grief over FtF groups.

Hypothesis 1: People with a perception of social support unavailability would prefer an online self-help group to FtF.

Hypothesis 2: People who score higher on an Avoidant Personality Scale would prefer an online self-help group to FtF.

Hypothesis 3: People who score higher on an Asperger's Syndrome Scale would prefer an online self-help group to FtF.

Hypothesis 4: People who score lower on an Extroversion Scale would prefer an online self-help group to FtF.

Hypothesis 5: People who score higher on a Loneliness Scale would prefer an online self-help group to FtF.

Hypothesis 6: People who score higher on computer self-efficacy would prefer an online self-help group to FtF.

Hypothesis 7: There will be no difference in religiosity or spirituality between those who prefer an online self-help group to FtF.

## METHODS

### Participants

The participants were drawn from the FHSU student body. They were recruited from undergraduate psychology and sociology classes through the FHSU psychology website and from a notice on the psychology department bulletin board where were directed to an online survey. No incentives were allowed to be given to participate in the research.

Sixty students responded to the online survey, one participant failed to complete the survey and was not included in analysis. Nineteen of the participants were male (32.2%) and 49 were female (67.8%). Six of the participants were freshmen (10.7%), 11 were sophomores (18.68%), nine were juniors (15.25%), 22 were senior (37.29%), and 11 were graduate students (18.64%). Their GPA ranged from 2.0 to 4.0 ( $M = 3.22$ ,  $SD = .53$ ). The age of participant's ranged from 17 to 51 ( $M = 26.36$ ,  $SD = 7.87$ ). Forty-three (74.14%) reported being Caucasian or European, seven (12.07%) reported being American or Alaskan native, five (8.62) reported being Black or African American, 2 (3.45%) reported being Hispanic, and 1(1.72%) reported being Asian. Six (10.17%) participants rated their computer skills as excellent, 31 (52.54%) as above average, 21 (35.59%) as average, and one (1.69%) reported their computer skills to be below average.

### Materials

The survey consists of three parts. The first part asked participants to consider four scenarios that are expected to produce varying degrees of grief, and to rate on a 5-point Likert type scale their preference for choosing a face-to-face support group versus

their preference for an online group. According to the Holmes and Rahe Stress Scale (1967), different types of loss can be expected to produce different amounts of stress. It was thought that by giving several different loss situations and using an average of these situations, a more accurate measurement could be obtained. The second part contained 51 questions from six different personal assessment scales that have been placed in a randomized order. The third part consisted of a small number of demographic questions, such as age, gender, and race.

The first personal assessment scale, Social Support, was measured using the appraisal subscales from the Interpersonal Support Evaluation List-12 (ISEL-12). The second scale, Avoidant Personality, was created by the author from the criteria for APD in the DSM-IV-TR. The Asperger's Scale is the shortened version of the Asperger's scale created by the Cambridge Lifespan Asperger Syndrome Service. The Introversion/Extroversion Scale was taken from the Big Five Inventory. The Loneliness Scale used was UCLA loneliness scale (version 3). Questions taken from the Duke Religion Index were used to measure religiosity. Sections of the Computer Self-Efficacy Scale, created by Olivia Khorrami-Arani, were used to measure computer self-efficacy.

The first four scales were chosen because they were thought likely to be associated with susceptibility to complicated grief. Lack of social support, introversion, loneliness, and computer self-efficacy have been correlated with higher or problematic computer use. Avoidant personality and Asperger's like personalities are also traits that could be related to higher or problematic Internet use. For ease of use, the questions for

all seven scales were set as four-point Likert scales (I agree strongly, I agree a little, I disagree a little, I disagree strongly).

### *Social Support*

Social support was measured using the four items comprising the appraisal subscale of the Interpersonal Support Evaluation List – 12 (Cohen, Mermelstein, Kamarck & Hoberman, 1985). Kraut, Kiesler, Boneva, Cummings, & Helgison (2002) found that individuals with low social support were more likely to use the Internet to meet new people and use online chat rooms. This trend is expected to be found among those who use online self-help groups. Questions that comprise the appraisal subscale used are “I feel that there is no one I can share my most private worries and fears with,” “There is someone I can turn to for advice about handling problems with my family,” “When I need suggestions on how to deal with a personal problem, I know someone I can turn to,” and “If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.”

### *Avoidant Personality*

The measurement scale for avoidant personality traits was created by the author from the diagnostic criteria in the *DSM-IV-TR* (2000). It is thought that the behavioral traits expressed by individuals with avoidant personality disorder, fear of social rejection and low threshold for detection of criticism might draw them to online self-help groups due to its anonymity, and their ability to control others' perceptions of them. There are seven criteria for APD, five of which are needed to be met for a diagnosis of APD. In order to avoid questions thought to be highly correlated with questions on other measures

and best capture the traits of the disorder, three of the seven criteria were selected for use. Questions used are “I avoid work related activities where other people have a chance to criticize me,” “I constantly worry about being criticized or rejected by others,” and “I rarely let new people I meet get to know me, because they will not like me.”

### *Asperger’s Syndrome*

The scale for AS traits was constructed by The Cambridge Lifespan Asperger Syndrome Service (CLASS) and obtained off the Autism Research Institute (ARC). The ARC is situated within the School of Clinical Medicine in the Department of Psychiatry, Section of Developmental Psychiatry, at the University of Cambridge. The full-length Adult Asperger’s Assessment (AAA) uses more stringent criteria than the DSM-IV and is considered more conservative. The original AAA is 60 questions long and covers five areas: social skills, attention switching, attention to detail, communication, and imagination. CLASS has also put out a 10-question questionnaire based on the AAA, for preliminary diagnosis. The 10 questions used were adapted from this 10 questionnaire (e.g. “I find social situations confusing,” “I find it hard to work out what other people are thinking and feeling,” “People often say I was rude even when this was not intended,” and “I feel that some things need to be done the exact same way every time or they are not right”).

### *Extroversion*

The questions for extroversion were taken from the Big Five Inventory (BFI). The BFI is a readily accessible assessment in the public domain that has been used extensively in research. It has been found to capture the commonalities among most of

the existing systems of personality description. Only the eight questions from the extroversion scale of the BFI were used (e.g. “I see myself as someone who is talkative,” “I see myself as someone who has an assertive personality,” “I generate a lot of enthusiasm”).

### *Loneliness*

Loneliness was measured from Items off the UCLA Loneliness Scale version 3 (UCLA loneliness Scale, n.d.), retrieved from the Shasta Collage web site. The UCLA Loneliness Scale has become one of the most widely used measures of loneliness. First designed on statements used by lonely individuals to describe feelings of loneliness in 1978, it has been revised twice to reduce negative wording and simplified to facilitate administration to less educated populations. Participants were asked if they agreed or disagreed with the 11 questions of the scale (e.g. “I feel unhappy doing so many things alone,” “I often feel starved for company,” “I feel shut out and excluded by others”).

### *Religiosity*

The Duke Religion Index (Koenig, Meador, & Parkerson, 1997) was used to measure religiosity. Created at the Center for Spirituality, Theology, and Health at Duke University, it has been found to have excellent internal consistency, reliability, and construct validity. Questions chosen for use are: “I often spend time in private religious activities, such as prayer, meditation, or Bible study,” “My religious beliefs are what really lie behind my whole approach to life,” and “I feel the presence of a higher power in my daily life.”

### *Computer Self-Efficacy*

Computer self-efficacy was measured using the sections of the Computer self-efficacy scale designed by Olivia Khorrami-Arani (Khorrami-Arani, 2001) and a question asking the participants to rate their computer skills. Questions used are: “I feel angry towards computers”, and “I feel confident when working with computers.”

### Procedure

Participants went to an online survey site where they read an informed consent form providing them a description the survey and the approximate length of time to complete it. Participants were informed that there will be several scenarios concerning death and loss, and that if they believe that this might distress them, not to continue. Participants were informed that taking the survey implied consent. No incentives were offered to take the survey. After participants completed the survey, they read a debriefing statement which described the purpose of the study and whom they should contact if they were disturbed or troubled by the content of the survey.

## RESULTS

Four scenarios were given to cover a range of possible grief situations and the average response to them will be treated as the dependent variable. Some of the scenarios are expected to promote a greater amount of hypothetical grief than others and although the intent is to combine the scores for analysis. They will also be investigated individually for correlations with the independent variables. The independent variables, inter-mixed in randomized order on the questionnaire, were separated into their component parts and assessed for intercorrelation. Questions 11, 20, 36, and 44 were on social support, with questions 11 and 44 reversed scored. Questions 2, 7, 25, 31, 35, 46, and 49 were on AP traits. Questions 1, 6, 9, 12, 15, 26, 27, 37, 47, and 51 were on AS traits. Questions 10, 14, 17, 29, 33, 34, 38, and 45 were on introversion/extroversion, with questions 14, 17, and 29 reversed scored. Questions 5, 13, 16, 18, 22, 23, 30, 32, 39, 42, and 50 were on loneliness. Questions 3, 19, 28, 40, 41 and 43 were on Computer Self-Efficacy, with questions 19 and 28 reversed scored. Questions 4, 8, 21, 24, and 48 were on religiosity.

An overall correlational analysis failed to find support for any of the test hypotheses (except the control Hypothesis 7, no difference in religiosity or spirituality between those preferring an online self-help group to FtF). The highest correlation found was on the Asperger's Scale,  $r(58) = -.225$ ,  $p = .086$ , which was approaching statistical significance though in the direction opposite to that expected in hypothesis 3.

Post-hoc analyses were done on the four different grief scenarios and, as expected, there was a difference in type of counseling group preferred when looking at

expected severity of the loss. The mean preference rating of the combined grief scenarios was 2.26 ( $SD = 1.04$ ), where 1 would be the strongest preference for a FtF group and 5 the strongest preference for an online group. The scenario for loss of a parent, expected to be the most severe, showed the highest preference for a FtF counseling group ( $M = 1.72$ ,  $SD = 1.15$ ), followed in order by expected severity of loss, loss of a close friend ( $M = 2.02$ ,  $SD = 1.28$ ), loss of a grandparent ( $M = 2.34$ ,  $SD = 1.45$ ), and loss of a pet ( $M = 3.03$ ,  $SD = 1.38$ ). A dependent measures  $t$  test showed that the differences in preference means were statistically significant between all of the scenarios except that of loss of a friend and loss of a grandparent, which was only close to significance,  $t(57) = -1.71$ ,  $p = .09$ .

Further post-hoc analyses were run to determine if there was any correlations between the seven scales and preference for type of counseling group for the individual loss scenarios (rather than averaging all the scenarios together). For the loss of a parent scenario, the avoidant personality scale was found to be significantly correlated with preference for online counseling,  $r(58) = .34$ ,  $p = .05$ , and in the correct direction as predicted in hypothesis 2. For the loss of a pet scenario, the Asperger's scale was found to be significantly correlated with preference for FtF counseling,  $r(59) = -.33$ ,  $p = .01$ , in the direction opposite to that predicted in hypothesis 3. No other statistically significant correlations were found between any of the scales and preference for type of counseling group.

The last level of post hoc analysis was to look at individual questions. It was thought that perhaps a few relatively predictive questions might be getting lost in a larger

group of non-predictive questions. For the loss of a parent scenario, question 7 (I fear being myself, even around people that I am close to, because they might not approve of me),  $r(57) = .407, p < .01$ , and question 31 (I constantly worry about being criticized or rejected in social situations),  $r(58) = .472, p < .01$ , from the AP trait scale were significantly correlated with preference for an online counseling group. For the loss of a grandparent scenario, question 37 (I can focus on certain things for very long periods),  $r(58) = -.33, p = .01$ , and for the loss of a pet scenario, question 51 (I have unusually strong, narrow interests),  $r(59) = -.23, p = .08$ , were correlated (significantly or approaching) with preference for a FtF counseling group. These two questions were AS trait questions, and the two correlations were in the direction opposite to that predicted in hypothesis 3. For the loss of a grandparent scenario, question 10 (I see myself as someone who is outgoing, sociable),  $r(57) = -.282, p = .04$ , was correlated with preference for a FtF counseling group. The other way to interpret this last result is that individuals with traits more similar to introversion (low on the Extroversion Scale) would be more likely to prefer an online group, as predicted by Hypothesis 4. No other statistically significant correlations were found between specific questions and preference for type of counseling group.

In summary, out of 51 questions, only 7 and 31 of the AP Scale, 37 and 51 of the AS Scale, and 10 of the Extroversion Scale produced statically significantly correlations for counseling preference, and only for the specific loss scenarios described above. The direction of correlation on the two AP Scale and one Extroversion Scale questions were in the correct direction as predicted by Hypotheses 2 and 4, but the direction of

correlation on the two AS Scale questions was in the direction opposite to that predicted by Hypothesis 3.

## DISCUSSION

As stated in the hypotheses, a positive correlation was expected to be found between the perception of social support unavailability and preference for online support groups. This would confirm the research by Kraut, Kiesler, Boneva, Cummings, & Helgison (2002) that individuals with low social support would be more likely to go online to meet new people and participate in online chat. Although an individual could have many reasons for low social support, low social support and discomfort in social situations would likely predispose people to prefer online support. However, there was no correlation between social support and preference for type of support group. This could indicate that these individuals do desire FtF interactions, but are simply unsure how to seek them out. It is plausible that they are willing to accept social interaction with others from any quarter without preference. It could also just simply indicate that social support availability is not a contributing factor in the decision of determining preference for counseling group type.

A positive correlation was expected to be found between AP traits and preference for online support groups. This would fit in with the general description of AP traits. The expected positive correlation was found, but only on the loss of a parent scenario. In two other scenarios, loss of a friend and loss of a grandparent, there also were small nonsignificant positive correlations. However, a small nonsignificant negative correlation on the loss of a pet scenario, indicating a preference for the FtF group, pretty much cancelled the positive correlations out when averaging all of the loss scenarios

together. The best that could be concluded here is that there was only partial support for the hypothesis that individuals with AP traits have a preference for online support groups.

A positive correlation was expected to be found between AS traits and preference for online support groups. Because of the social nature of the disorder, the inability to read nonverbal communication, and tendency towards sensory over stimulation (*DSM-IV-TR*, 2000), individuals with AS traits should prefer computer mediated communication. The AS scale had the highest correlation with type of counseling group preference of all the scales when the loss scenarios were averaged together, but this correlation failed to reach significance and was in the opposite direction of the hypothesis. On the loss of a pet scenario there was a statistically significant negative correlation, indicating a preference for the FtF group. This result is puzzling as it is completely counter to what was expected. It could be the case that individuals with AS traits might be more able to bond with pets than people, so the loss of a pet would be considered the most severe type of loss, even to the point that a FtF support group would be preferable to the more convenient online support group.

Extroversion was expected to be positively correlated with a preference for FtF support groups. However, a near zero correlation was found instead. This might be explained by extrovert's ability to use whatever social tool is most advantageous at the time. They might just be interested in receiving help and be equally comfortable in receiving it from either type group, so that extroversion itself may not be a contributing factor in the decision of determining preference for counseling group type.

Those who are lonely are more likely to go online to meet people and use online chat rooms, and loneliness has been found to be one of the strongest correlations with problematic Internet use (Ceyhan, and Chehan, 2008). It was therefore thought that loneliness would be positively correlated with preference for online support groups. A near zero correlation was found. This might be an indicator that the lonely individual desires friendship or has good social skills, but is unable to find real world companionship for some situational reason. Or, of course, it could just mean that loneliness is not a contributing factor in the decision of determining preference for counseling group type.

Religiosity had been added as a control variable and was not expected to be correlated with the dependant variable. As predicted, no correlation was found for this variable. However, as no correlations were found for any of the scales (for all loss scenarios combined), its utility as a "control" variable was pretty much negated.

Computer self-efficacy was expected to be positively correlated with preference for online support groups. This was a logical assumption as computer self-efficacy has been found to be positively correlated with increased computer use (Kraut, Keisler, Boneva, Cummings, & Helgison, 2002). A near zero correlation was found, which is difficult to explain. It could be that individuals with high computer self-efficacy would be equally at home with online or FtF communications, with no preference either way. However, it is also likely that as the survey was done by college students that their computer efficacy was generally higher than what would ordinarily be the case with a broader population, regardless of their self-perceptions.

So, in summary, there was little to no support for the research hypotheses. This could have been for a number of reasons. One might be that the hypotheses are simply not correct. Another might be that the independent variable trait scales were not properly constructed, or that the sample of college students were very normal with little variation on their character traits. More specifically, most of the students were likely to have been towards the functional end of all of the scales. A third possibility could be that the dependent variable loss scenarios were not constructed well enough (or graphic enough) to cause the research participants to truly imagine the loss. This also may have been due to the relatively young age of typical college students and their lack of having experienced a severe loss in their life.

In future research in this area, a closer examination of the scales and the questions constituting the scales is strongly warranted. Given the relatively high degree of inter-correlations between questions, the development of a new set of scales with better separability would be useful. Rather than concentrating on personality-like traits, perhaps scales concentrating more on communicative skills would produce stronger correlations with type of counseling group preferences.

Future studies might also want to consider interviewing individuals in the actual different types of group settings to determine why those groups were chosen. It would be very interesting to find out if groups chosen were by preference or convenience, and to determine whether counseling efficacy was affected by the reason for choosing one type of group over the other.

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APPENDIX A

Informed Consent Statement

## CONSENT TO PARTICIPATE IN RESEARCH

*Department of Psychology, Fort Hays State University*

### **Study title: Grief Support Groups: Preference for Online VS. Face-to - Face**

*Name of Researcher: Kris Fox*

*Contact Information: krisfox1965@yahoo.com*

*Name of Faculty: Stephen Kitzis*

*Contact Information: skitzis@fhsu.edu*

**You are being asked to participate in a research study. It is your choice whether or not to participate.**

Your decision whether or not to participate will have no effect on benefits or services to which you are otherwise entitled.

#### **What is the purpose of this study ?**

This research project is designed to determine if there is a difference in the population between those who would prefer online grief support to face-to-face support for grief.

#### **What does this study involve ?**

You will read several scenarios depicting situations in which death occurs and to imagine yourself distressed by those situations. These scenarios will ask you to think about the loss of family and friends and may be troubling to some individuals. You will then be asked for your personal preference between an online support group and face-to-face support group if you were in these situations. Next, you will be asked to complete a questionnaire asking about your social support, loneliness, religiosity, personality characteristics, and computer self-efficacy. These questions are looking at general traits and should not be considered a psychological evaluation or indication of mental illness. A brief demographic questionnaire will conclude the survey.

**If you decide to participate in this research study, after you understand what will happen to you, you are confirming your willingness to voluntarily participate in this study and that you are 18 years old or over.**

The length of time of your participation in this study is 15-20 minutes  
Approximately 75 participants will be in this study.

**Are there any benefits from participating in this study ?**

There may be benefits to you should you decide to participate in this study. If you are taking this survey for extra credit, please be aware that there are other means of obtaining extra credit. Your participation will help us learn more about the characteristics of people who would prefer online to face-to-face self help groups.

**Will you be paid or receive anything to participate in this study ?**

No. You will not receive any compensation if the results of this research are used towards the development of a commercially available product.

**What about the costs of this study ?**

There are no costs for participating in this study other than the time you will spend completing the survey.

**What are the risks involved with being enrolled in this study ?**

This survey has been reviewed by the departmental ethics committee and might pose some psychological risk for individuals. If you have suffered a recent loss, know someone suffering from a chronic illness and believe you might be disturbed or adversely affected by completing this survey, please stop now.

Sometimes thinking about these subjects cause people to be upset. You do not have to think about any subjects you do not want to think about, and you may stop participating at any time. You may feel uncomfortable thinking about your feelings or behaviors, or may become frustrated when trying to complete an activity that is being measured. You may discontinue participation, either temporarily or permanently. If you feel distressed or become upset by participating, please contact The Kelly Center at Fort Hays State University, 600 Park Street, Hays, KS 67601-4099 call (785) 628-4401 or contact High Plains Mental Health Center at (785) 628-2871 or 1-800-432-0333.

### **How will your privacy be protected?**

The information collected as data for this study includes: Data collected will include preference for online or face-to-face support groups, social support unavailability, traits of avoidant personality, Asperger's syndrome, introversion, loneliness, religiosity, and computer self-efficacy. A brief demographic questionnaire will conclude the survey. No identifying information will be collected. All information collected on an electronic database and stored on electronic files accessible only to the researcher. All information on the database will be destroyed at the end of data collection and data collected by the researcher will be maintained for five years.

Efforts will be made to protect the identities of the participants and the confidentiality of the research data used in this study. All data will be numerically coded and no identifying information will be collected. All data will be stored on password protected electronic files.

The information collected for this study will be used only for the purposes of conducting this study. What we find from this study may be presented at meetings or published in papers but your name will not ever be used in these presentations or papers.

### **Other important items you should know:**

- **Withdrawal from the study:** You may choose to stop your participation in this study at any time. Your decision to stop your participation will have no effect on the availability of proof of participation.

### **Compensation for Injury**

I have been informed and I understand that Fort Hays State University is not required to provide medical treatment or other forms of reimbursement to persons injured as a result of or in connection with participation in research activities conducted by Fort Hays State University or its faculty, but that Fort Hays State University may provide such treatment or reimbursement at its discretion. If I believe that I have been injured as a result of participating in the research covered by this consent form, I should contact the Office of Scholarship and Sponsored Projects, Fort Hays State University at 785-628-4349.

**Whom should you call with questions about this study ?**

Questions about this study or concerns about a research related injury may be directed to the researcher in charge of this study: xxx at (xxx) xxx-xxxx.

If you have questions, concerns, or suggestions about human research at FHSU, you may call the Office of Scholarship and Sponsored Projects at FHSU (785) 628-4349 during normal business hours.

**CONSENT**

I have read the above information about Grief Support Groups: Preference for Online VS. Face-to –Face. By continuing with this survey, you are confirming your willingness to voluntarily participate in this study and I have been able to print a copy of this consent document for my own records. I understand that I can change my mind and withdraw my consent at any time. By continuing with this survey, I understand that I am not giving up any legal rights. I am 18 years or older.

APPENDIX B

Grief Scenarios

**Imagine that you are in each of the following four scenarios.**

**Please select the type of grief support group that you would prefer in each case.**

1. One of your parents has died after a long battle with cancer. You feel as if you are not dealing well with the situation. You can't stop thinking about them, and it has started to interfere with your day-to-day life. You feel as if no one you know understands what you are going through and need to discuss the situation with people that can relate to what you are feeling.

You have been informed that there is a local face-to face grief support group available, but have also been told about online grief support groups. On a scale of 1 to 5, how strongly do you think you would prefer one type of support group over the other?

The face-to-face group 1 - 2 - 3 - 4 - 5 The online group

2. About a month ago, one of your close friends died in an automobile accident. You have tried to put it behind you and move on with your life, but you find yourself continually thinking about your friend and what might have been if not for this needless accident. You feel as if you need help dealing with this situation.

You have been informed that there is a local face-to face grief support group available, but have also been told about online grief support groups. On a scale of 1 to 5, how strongly do you think you would prefer one type of support group over the other?

The face-to face group      1      2      3      4      5      The online group

3. One of your grandparents has recently died. Although they were getting old and you knew they did not have many years left to live, they were in good shape for their age. Since your grandparent has passed, you have been feeling down and a little depressed most of the time. You miss your grandparent a great deal and find yourself often thinking about how close you were. However, this always leaves you feeling sad. You have decided to get some help working out your feelings and have thought about joining a grief support group.

You have been informed that there is a local face-to face grief support group available, but have also been told about online grief support groups. On a scale of 1 to 5, how strongly do you think you would prefer one type of support group over the other?

The face-to face group      1      2      3      4      5      The online group

4. It has been over a month since you have seen Raffles, your favorite animal companion. You believe that you will never see it again. You have been with Raffles since it was an infant and feel that a bond that exists between the two of you. You find yourself constantly thinking of Raffles, feeling as though nobody really understands the depth of your loss. You think it might help you feel better if you could find someone who truly understood you.

You have been informed that there is a local face-to face grief support group available, but have also been told about online grief support groups. On a scale of 1 to 5, how strongly do you think you would prefer one type of support group over the other?

The face-to face group      1      2      3      4      5      The online group

## APPENDIX C

### Personal Assessment Scale Questions

**How much do you agree with each of the following statements?**

**Please select the best answer, where 1 means “I agree strongly”, 2 means “I agree a little”, 3 means “I disagree a little”, and 4 means “I disagree strongly”.**

- |  |       |   |   |   |   |          |
|--|-------|---|---|---|---|----------|
| 1) I find it hard to make small talk.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 2) I rarely let new people I meet get to know me, because I feel they will not like me.              | Agree | 1 | 2 | 3 | 4 | Disagree |
| 3) If it were difficult, I would quit trying to solve a computer problem.                            | Agree | 1 | 2 | 3 | 4 | Disagree |
| 4) My religious beliefs are what really lie behind my whole approach to life.                        | Agree | 1 | 2 | 3 | 4 | Disagree |
| 5) I feel unhappy doing so many things alone.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 6) People often say I was rude even when this was not intended.                                      | Agree | 1 | 2 | 3 | 4 | Disagree |
| 7) I fear being myself, even around people that I am close to, because they might not approve of me. | Agree | 1 | 2 | 3 | 4 | Disagree |
| 8) I often attend church, synagogue, or other religious meetings.                                    | Agree | 1 | 2 | 3 | 4 | Disagree |
| 9) I do certain things in an inflexible, repetitive way.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 10) I see myself as someone who is outgoing, sociable.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 11) I feel there is no one I can share my most private worries and fears with.                       | Agree | 1 | 2 | 3 | 4 | Disagree |
| 12) I find social situations confusing.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 13) I often find myself waiting for people to call or write.   | Agree | 1 | 2 | 3 | 4 | Disagree |

- |   |       |   |   |   |   |          |
|---|-------|---|---|---|---|----------|
| 14) I see myself as someone who is reserved.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 15) I did not enjoy imaginative story writing at school.                              | Agree | 1 | 2 | 3 | 4 | Disagree |
| 16) I feel I cannot tolerate being so alone.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 17) I am sometimes shy, inhibited.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 18) I feel completely alone.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 19) I feel angry towards computers.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 20) There is someone I can turn to for advice about handling problems with my family. | Agree | 1 | 2 | 3 | 4 | Disagree |
| 21) In my life, I experience the presence of the Divine.                              | Agree | 1 | 2 | 3 | 4 | Disagree |
| 22) I often feel starved for company.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 23) I feel unable to reach out and communicate with those around me.                  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 24) I try hard to carry my religion over into all other dealings in life.             | Agree | 1 | 2 | 3 | 4 | Disagree |
| 25) I only like to be around people that I know approve of me.                        | Agree | 1 | 2 | 3 | 4 | Disagree |
| 26) I have always had difficulty making friends.                                      | Agree | 1 | 2 | 3 | 4 | Disagree |
| 27) I find it hard to work out what other people are thinking and feeling.            | Agree | 1 | 2 | 3 | 4 | Disagree |
| 28) I do not like problems with computers.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 29) I tend to be quiet.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 30) I feel it is difficult for me to make friends.                                    | Agree | 1 | 2 | 3 | 4 | Disagree |
| 31) I constantly worry about being criticized or rejected in social situations.       | Agree | 1 | 2 | 3 | 4 | Disagree |

- |   |       |   |   |   |   |          |
|---|-------|---|---|---|---|----------|
| 32) I often feel I have nobody to talk to.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 33) I see myself as someone who is talkative.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 34) I am full of energy.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 35) I avoid new situations because I might embarrass myself.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 36) When I need suggestions on how to deal with a personal problem, I know someone I can turn to.                         | Agree | 1 | 2 | 3 | 4 | Disagree |
| 37) I can focus on certain things for very long periods.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 38) I see myself as someone who has an assertive personality.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 39) I feel shut out and excluded by others.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 40) I think working with computers would be fun.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 41) I think about computer problems when they are left unsolved.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 42) I feel as if nobody really understands me.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 43) I feel confident when working with computers.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 44) If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it. | Agree | 1 | 2 | 3 | 4 | Disagree |
| 45) I generate a lot of enthusiasm.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 46) At work, I avoid activities where other people have a chance to criticize me.   | Agree | 1 | 2 | 3 | 4 | Disagree |
| 47) I am good at picking up details and facts.  | Agree | 1 | 2 | 3 | 4 | Disagree |
| 48) I often spend time in private religious activities, such as prayer, meditation, or Bible study.                       | Agree | 1 | 2 | 3 | 4 | Disagree |

- 49) I feel socially inept. Agree 1 2 3 4 Disagree
- 50) I feel shut out and excluded by others. Agree 1 2 3 4 Disagree
- 51) I have unusually strong, narrow interests. Agree 1 2 3 4 Disagree

APPENDIX D

Demographic Questions

## Demographic questions

Age: \_\_\_\_\_

Cumulative GPA: \_\_\_\_\_

Please circle the best answer for each of the following.

Race:

American Native or Alaskan native

Asian

Black or African American

Native Hawaiian or Pacific Islander

Caucasian or European

Other: \_\_\_\_\_

Gender:

Male

Female

Year in School:

Freshman

Sophomore

Junior

Senior

Graduate Student

APPENDIX E  
Debriefing Statement

## Debriefing

This survey has been designed to determine if there is a difference between those who would prefer online support and those who prefer would face-to-face support.

If you feel you have been this survey has caused you any distress, please contact The Kelly Center at Fort Hays State University 600 Park Street Hays, KS 67601-4099 or call (785) 628-4401 or High Plains Mental Health Center: (785) 628-2871 or 1-800-432-0333.

For the results from this research, please go to <http://bigcat.fhsu.edu/psych/academic/thesestitles.php>

## GRIEF SUPPORT GROUPS: PREFERENCE FOR ONLINE VS. FACE-TO-FACE

### Debriefing Statement

This survey has been designed to determine if there is a difference in personal characteristics between those who would prefer online support and those who would prefer face-to-face support when faced with a grief scenario. The study expectations is that those with low social support, some psychological characteristics similar to Avoidant Personality, Asperger-like Personality, Introversion, or Loneliness, and with a relatively high computer self-efficacy will be more likely to prefer an online support group situation over the traditional face-to-face support group situation. There was no expectation that Religiosity would determine a preference either way.

This study is in the nature of an exploratory pilot study. Its purpose is to determine which of the study hypotheses have any validity and, if so, how strong the effects may be. A review of the literature suggests that the factors chosen (except the two controls) may be positively correlated with a preference for Internet use over real-time face-to-face contact, and that this preference should logically extend even to the selection of type of grief support group. The primary analysis will be correlative, and if any effects are large enough to warrant a more sophisticated treatment, a follow-up regression analysis will be performed.

Please note that grieving over a loss is normal and a part of life. Most people get past their grief with the help of their own personal support network of family, friends, and clergy. However, please be aware that excessive or prolonged grief may be a sign that further professional help may be necessary.

If you have any questions about your participation in the study, please contact me, Kris Fox, (krisfox1965@yahoo.com) or my faculty advisor, Dr. Kitzis (skitzis@fhsu.edu).

If you have any questions about your rights as a research participant, please contact Dr. Janett Naylor (jmnaylor@fhsu.edu), Chair of the Psychology Department Ethics Committee or Leslie Paige (lpaige@fhsu.edu), Chair of the University Institutional Review Board. If you do not feel comfortable for any reason after doing this study, you also may contact the Kelly Center, Fort Hays State University, 600 Park Street, Hays, KS 67601-4099 by calling (785) 628-4401, or contact High Plains Mental Health Center at (785) 628-2871 or 1-800-432-0333.

For an abstract of results from this study, please go to

<http://bigcat.fhsu.edu/psych/academic/thesestitles.php>

and look for the thesis entitled

**GRIEF SUPPORT GROUPS: PREFERENCE FOR ONLINE VS. FACE-TO-FACE**