THE CATHOLIC UNIVERSITY OF AMERICA

An Examination of Attachment Styles and Distress Among Parents Who Have Lost a Child
to Cancer

A DISSERTATION

Submitted to the Faculty of the

National Catholic School of Social Service

Of The Catholic University of America

In Partial Fulfillment of the Requirements

For the Degree

Doctor of Philosophy

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By

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Washington, D.C.

2010

An Examination of Attachment Styles and Distress Among Parents Who Have Lost a Child to Cancer

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This study of bereaved parents whose child died of cancer, investigated how retrospective insecure attachment and social support impact both the individual and the couple in dimensions of marital satisfaction, grief, and psychological distress. The impact of levels of discrepancy in retrospective attachment styles between spouses, on marital satisfaction, grief, psychological distress, and social support were examined. The study also explored the impact of insecure attachment and social support on grief oscillation (ref: Dual Processing Model of Grief) (DPM).

The study utilized a cross- sectional correlational survey design. Couples bereaved in the last five years, still living together at diagnosis of deceased child, were invited to participate through support organizations such as Candlelighters in both the U.S. and Canada. The survey consisted of seven standardized tools: Retrospective Attachment Questionnaire (RAQ), Brief Symptom Inventory (BSI), Dyadic Adjustment Scale (DAS), Hogan Grief Reaction Checklist (HGRC), Texas Revised Inventory of Grief (TRIG), Inventory of Daily Widowed Life (IDWL), and Social Support Index (SSI)). Demographic data was also collected.

The sample consisted of 86 individual and 32 couples. The data was analysed using SPSSS and multivariate analysis of three hypotheses were performed. Results showed mixed support for all three hypotheses. Insecure attachment was a stronger predictor of grief, than gender. Insecure attachment and social support were both predictors of psychological distress. Retrospective attachment style was not a significant predictor of marital

satisfaction/distress however, the control variable gender and social support were. Discrepancy of anxious ambivalent attachment in the couple increased the level of social support. An interaction between discrepancy in disorganized attachment and gender impacted levels of grief. In terms of oscillation balance of grief insecure attachment was the only significant predictor with social support trending.

This study supports aspect of the DPM, specifically the claim that attachment styles have an impact on individual and to some extent on couples grieving outcomes. The findings support the DPM concept of oscillation balance and that loss and resolution orientations are separate grieving tasks. Retrospective attachment was stronger predictor of grief than gender. Researchers and clinicians should consider retrospective attachment styles as an important variable in grief.

This dissertation by Philip Domingue fulfills the dissertation requirement for the doctor of philosophy in Social Work approved by Karlynn BrintzenhofeSzoc Ph.D., as Director, and James Zabora Sc. D., Barbara Early Ph.D. as Readers.

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This dissertation is dedicated to the
memory of my mother
Françoise St. Laurent Domingue

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Acknowledgements

My gratitude first goes to all the bereaved parents who accepted to participate in this study and to share information regarding the death of their child. I am also very grateful for the help and support of the 18 agencies who believed enough in the importance of the project to forward my invitation to participate in the study to bereaved parents they serviced.

A doctoral dissertation is not done alone, it requires the contribution of numerous people who all have my gratitude. First and foremost are my father Marcel, stepmother Estelle and daughter Gabrielle who have stood by me all along. Marcel and Estelle by taking Gabrielle and me into their home while I completed this project, and for proofreading all my papers throughout the doctoral process. Gabrielle for putting up with a big change in my financial stability during this time and for just being herself.

My gratitude then goes to Dr. BrintzenhofeSzoc, my faculty advisor and dissertation chair, who has graciously mentored me throughout the doctoral process. I found an unwavering and consistently available support in her. I want to thank my readers Dr. Sue Johnson, Dr. Babara Early and Dean James Zabora. Dr. Johnson who some 10 years ago told me I should make my interest in bereaved parents and couples into a doctoral dissertation and who encouraged me to persevere by supporting me all the way. Dr. Early and Dean Zabora for their ongoing and unwavering support throughout the doctoral process. I was welcomed and felt well surrounded at National Catholic School of Social Service (NCSSS). My gratitude then goes to all the faculty and staff of the NCSSS. It was 6 years ago this month that I walked through the doors of NCSSS and found a home for my research and clinical interests. NCSSS also provided me with much needed scholarships without which I would

not have been able to continue. I also want to acknowledge my clinical supervisor in Ottawa Dr. Martin Rovers for his ongoing support and encouragement and who gave me much needed work during my research and dissertation process as well as opportunities to present my research in Ottawa.

I also want to acknowledge the assistance of my friend and neighbour in Chevy Chase Joan Prince for helping me with mailing of surveys to subjects and with data entry. Her constant support has meant a lot to me and helped me to keep going. My gratitude also to the Crosson family and to the late Michael Sullivan and his wife Marie Moylan and to my classmate and friend Ravita Maharaj and her husband Doby Welton for their generous hospitality during my frequent trips to Washington in the past 4 years.

I want to thank the American Cancer Society for their doctoral-in-social-work scholarship, clearly it made an enormous difference in mine and my family's quality of life and to a great extent permitted me to pursue this project.

Finally, I want to thank Dr. Martin Rovers, Dr. Roland Lecompte, Susan Richarson, and Dr. Corin Greenberg for their letters of reference permitting me to enter the doctoral program at NCSSS.

Ottawa, Canada, March 15, 2010

<div align="center">**Chapter I**</div>

<div align="center">**Introduction**</div>

This study focuses on the issue of retrospective attachment styles and distress in individual parents and in couples who have lost a child to cancer. This study moves beyond strictly individual conceptualizations of grieving. In addition, the study seeks to contextualize the experience of bereaved parents as a dynamic process embodied within a universal neurophysiological response to loss, previous personal experience, and the present relational and social context. The study promotes a vision of the complexity of human experiences as it is understood in the social work profession (Berlin, 2002; Bowlby, 1988).

The present chapter will introduce the study by stating the problem, describing the background of the problem, and describing the interest of the researcher in the problem. Then, the purpose of the study, and the research questions will be presented. The significance of the study for social work theory, practice and research will also be discussed. Finally, the chapter will conclude with a summary, an introduction, and a description of the subsequent chapters.

Purpose

  Statement of the problem.

  Incidence of death of children in the U.S and Canada.

In the U.S. a total of 57,051 children between the ages of 0 to 20 years died from all causes in 2006 (Center for Disease Control [CDC], personal communication, 10/2009). Childhood cancer is the second leading cause of death in children between the ages of 0 to 20 years of age second only to accidents (Heron, Hoyert, Murphy, Xu, Kochanek, &Vera,

<div align="center">1</div>

2009). In 2006 approximately 2,493 children between the ages of 0 to 20 died of cancer

(CDC, personal communication, 10/2009). In Canada 2,045children died from all causes and

135 died from cancer in 2005 (Statistics Canada, 2009). Attending to the needs of families who lose

children is an ongoing and consistent challenge.

Scope of issues for bereaved parents.

Li, Hansen Precht, Bo Mortensen, and Olsen (2003) accessed national registers in

Denmark and were able to look at mortality rates in 21,062 parents who had lost a child from

various causes. Compared to a large matched comparison group of parents who had not lost a

child, they found that the loss of a child "is associated with an overall increased mortality in

mothers and a slightly increased early mortality from unnatural causes in fathers" (Li et al., p.

365). Mothers had a significantly increased hazard ratio of 1·43 over an eighteen year period

of observation. The highest rates were mostly in the first three years at 3·84, but a higher rate

of death from natural causes 1·44, ten to eighteen years later. Fathers only had an increased

rate of death from unnatural cause of 1·57 in the initial grieving period. Li et al. also

observed "that the sudden unexpected death or death from unnatural causes, of a child

resulted in higher relative maternal mortality rates (1·72) than did the expected death of a

child" (p. 366).

In a similar study on the prevalence of psychiatric problems following the loss of a

child, Li, Munk Laursen, Hansen Precht, and Olsen (2005) used Danish central registers to

identify all of the parents who lost one or more child in Denmark between 1970 and 1999.

These researchers cross referenced these bereaved parents with the national registry of

psychiatric hospitalizations during that same period. Their findings indicated that parents

who lost a child had a combined relative risk of a psychiatric hospitalization of 1.67 compared to the general population.

Mothers who lost only one child had a relative risk of 1.78 compared to fathers who had a relative risk of 1.38. Mothers who lost more than one child had a relative risk of a psychiatric hospitalization of 3.35 compared to non-bereaved mothers. Fathers who lost more than one child had a relative risk of 2.39 compared to non-bereaved fathers. For both mothers and fathers the risk was at its highest in the first year. For mothers, the risk declined over 5 years or more but remained elevated compared to the general population. For fathers the risk of hospitalization for psychiatric treatment declined significantly after the first year and "only the risk of hospitalization for substance abuse remained significantly elevated after five years" (Li et al.2005, p. 4). The risk of a psychiatric hospitalization was higher for parents who lost their only child.

As Li et al. (2005) noted, only in-patient hospitalizations were examined, consequently, out-patient treatments were not analysed. Given the significance of the increase of psychiatric hospitalizations in both mothers and fathers, higher incidence of mental health issues that do not lead to psychiatric hospitalization is likely, and these patients probably still required outpatient professional intervention and support.

Rogers et al. (2008) used pre-existing data from the Wisconsin Longitudinal Study (WLS) to study the long term impact (up to 18 years) of the death of a child. The study was comprised of a large sample of 10,317 men and women who had originally been randomly recruited for the study in 1957 in high schools throughout Wisconsin. Rogers et al. used the 1992 data from contacts with the study subject obtained in 1992 from 144 fathers and 284

mothers whose child had died. Findings indicated that half of the child-bereaved men in this longitudinal study omitted having lost a child. The authors attributed the omission of this significant fact to men's tendency to use grief avoidance as a coping mechanism. Bereaved parents reported almost double the rate of depression, compared to the non-bereaved subjects in the WLS. Eighty-three percent of the bereaved parents reported that the depression occurred within three years of the child's death. Rogers et al. also found that as a group, bereaved parents exhibited significantly lower psychological well-being than the comparison group even 18 years following the death of their child.

Bereaved parents also reported a higher rate of religious participation than the comparison group. Bereaved parents also had lower scores on purpose in life compared to the control group. By itself the differences between bereaved parents and the comparison group in purpose in life were not significant, but in bereaved parents lower scores of purpose in life contributed significantly to increases in depression and in cardiovascular problems. Rogers et al. (2008), interpret their findings as indicative of long-standing mild psychological distress, and associated cardiovascular problems in bereaved parents. The researchers also note that most bereaved parents return to their previous levels of social functioning, but that there is a discrepancy between how they feel and how they need to present themselves in the social environment. The significantly lower scores of purpose in life in bereaved parents, and the significant relationship between levels of purpose in life, depression, and cardiovascular problems supports the need for more research in this area (Rogers et al.).

Rogers et al. (2008), state that they could not determine if their results for the bereaved- parents group, that were generally significantly high for depressive symptoms,

cardiovascular problems, and marital disruption, represented a selection bias of families with more problems than usual. Was it indicative of how bereaved parents, overall, strived to return to normal levels of functioning while hiding, from the social realm, how they really felt? Clearly most bereaved parents in their study went on with life without seeking help to address their psychological distress and low sense of purpose in life. This type of reaction could be the new normal for bereaved parents (Klass, 1986).

Rogers et al. (2008) also found that marital disruption was significantly higher in bereaved couples, and that this was mediated by having other children. Parents with remaining children separated or divorced less often than bereaved parents with no remaining children. The issue of marital disruption has been a controversial one and Rogers et al.'s study reopens the debate with strong data. In a randomized control study of death by vehicle accidents, Lehman, Lang, Wortman, and Sorenson (1989) found that 9 out of 39 bereaved couples had divorced within a four-to-seven-year-period compared to 3 out of 39 in a matched control group of non-bereaved couples. Although well constructed, the study by Lehman et al. was considered too small to generalize the results.

In his review of the literature on divorce following the loss of a child, Schwab (1998) states that a higher rate of divorce among bereaved parents is not proven at all and that it is in fact a myth that needs to be dispelled. He refers to a number of studies that describe marital strain in couples during the terminal phase of a child's illness, as well as during the acute phase of grief. However, he states that many studies failed to make the important distinction between marital strain and divorce. Klass (1988) and Oliver (1999) both stated that increased divorce rates had neither been confirmed nor refuted because of the lack of studies

with samples that were not self-selected.

Murphy, Clark-Johnson, and Lohan (2003) report that in a study on separation and divorce of bereaved parents, 5 of 46 married couples surveyed (9%), were found to have gone through divorce by the end of the five-year span of the study. Divorce rates in the state of Washington, where the study took place, were 62% during the span of the study, so the finding of a 9% divorce rate in bereaved couples during the study was much lower than might have been expected. Murphy et al. and Malkinson and Bar-Tur (2005) suggest that couples who have been married for a longer time may well be able to manage the stress better together than those couples who had married more recently. Murphy et al. conclude their study by stating that the rates of divorce in bereaved couples have been greatly exaggerated. Because of the small sample size it is inappropriate to generalize these results to all bereaved parents. Rogers et al. (2008) obtained completely different results likely due to their large sample size. In their longitudinal study spanning eighteen years (N= 10,317), they found a statistically significant difference between the rate of separation and divorce among bereaved parents (30%) and a non-bereaved comparison group (24%).

The two Li et al. (2003, 2005) studies and the Rogers et al. (2008) study strongly support increased death rates, and long term even lifelong difficulties, as a result of the death of a child. The Rogers et al. study also brings more strength to the hypothesis that there is a significant though small (24% to 30%) difference in separation and divorce rates in bereaved couples. These three studies also bring important data in support of the need for continued studies of bereaved parents and of bereaved couples.

Defining the problem and the study variables.

Present context.

The cancer experience of a child is invariably set in health care institutions dominated by the medical model which tends to promote a vision of individual pathology. Social workers involved with oncology programs must be equipped with a theoretical perspective which promotes the perspective of the person in the environment (Holosko, 2003; Berlin, 2002). Thus, the need for a social work understanding of parental loss informed by a foundation such as attachment theory, that accounts for biologically and evolutionary based behaviors, which in turn, are mediated by personal experience and the present relational and social context. Such a perspective gives the social worker a fuller understanding of grief as it inexorably occurs in the daily task of treating and supporting parents who are in the process of the child's death from cancer.

The loss of a child is one of the most difficult ordeals a family can experience. The impact on family members is known to be very trying, if not devastating, on the various relationships in the family system but particularly to couples (Archer, 1999; Bowlby, 1998/1982; Byng-Hall, 2004/1991; Rando, 1986; Stroebe & Schut, 2002; Walsh & McGoldrick, 2004). Parents who have lost a child to cancer often struggle to support each other in their grief (Cook & Oltjenbruns, 1989; Digregov & Digregov, 1999; Gilbert & Smart, 1992; Oliver, 1999: Schwabb, 1998). Various hypotheses have been presented to explain why some grieving couples have a difficult time supporting each other. The most widely presented hypothesis is the one of gender differences in coping with grief. Essentially, women tend to grieve more openly and seek to communicate about their loss and find support. Women also tend to avoid having sex following the loss of a child and prefer

cuddling or being close (Fish, 1986; Oliver, Rando). For their part, men tend to grieve less openly and to avoid communicating around the loss. Men tend to seek sexual contacts with their wives for comfort (Fish; Oliver; Rando). These differences in gender grief coping tend to create a sense that each spouse possesses unique needs and may not be there for each other, thus creating and/or increasing marital distress (Cook & Oltjenbruns; Fish, Gilbert & Smart, Oliver; Parkes, 2006; Schwabb; Stroebe & Schut, 1999).

Retrospective attachment styles.

An emerging hypothesis that is gaining support is that retrospective attachment styles play a mediating role in how individuals process grief (Fraley & Shaver, 1999; Parkes, 2002/2001, 2006; Shaver & Tancredy, 2002/2001; Stroebe, Schut, & Stroebe, 2005, Wijngaards-de Meij et al., 2007). Bowlby (1998/1980) postulated that grief processing, psychological distress, and grief oscillation are mediated by the coping preferences of the individuals due to the attachment style established in childhood. Bowlby (1998/1980, 1988) credits Mary Ainsworth (Ainsworth et al., 1978) for the development of the construct of attachment styles in children. The attachment styles described by Ainsworth and her colleagues were secure, insecure anxious avoidant, and insecure anxious ambivalent. The disorganized attachment style was later added to the three original attachment styles (Hesse, 1999).

These attachment styles are developed by the child as an adaptive response to the parent's patterns of availability and responsiveness. If the parent is consistent in providing a nurturing and secure response to the child's needs then the child develops a secure sense of self and of others. This sense of security or of insecurity corresponds to what Bowlby

(1998/1980) called internal working models. If the caregiver is consistently rejecting, inconsistent, or chaotic in its care, the child will develop insecure internal working models. As the child develops as an adult, it follows a developmental pathway leading to experiences confirming or changing internal working models of self and of others. Developmental pathways or experiences lead individuals towards either more or less security in their internal working models (Bowlby, 1988; Mikulincer & Shaver, 2007). Thus the term retrospective attachment styles used in this study refers to the four attachment styles described above. These styles are retrospective in the sense that they are thought to be developed in childhood and adolescence attachment experiences.

Bowlby's hypotheses regarding the mediation of retrospective attachment styles in grief processing in adults are only now being looked at more closely (Mikulincer & Shaver, 2007; Stroebe, Schut & Stroebe, 2005; Worden, 2008). Bowlby (1998/1980) theorized that secure individuals do grieve, but they are usually able to process the death of a loved one more easily than insecure individuals. When a child dies, parents' natural action tendencies of attachment behaviors such as numbing, protest, yearning, guilt, despair, and reorganization are activated during grief processing depending on the appraisal of the death mediated by the bereaved parents' attachment style (Parkes, 2006; Shaver & Tancredy, 2001/2002; Mikulincer & Shaver). The appraisal of the death of a child from a secure retrospective attachment style is theorized to facilitate a grief process that leads to a progressive reorganization of the relationship with the deceased. The appraisal of the death of a child from an anxious ambivalent attachment style is thought to lead to a chronic grief process. The appraisal of the loss from an avoidant attachment style is thought to lead to an absence

of grief process. The appraisal of the death of a child from a disorganized attachment style is thought to lead to a chaotic and disorgazined grieving process.

Social support.

Social support has also been found to be a mitigating factor in grief (Bowlby, 1998/1982; Klass, 1997; Lepore, Silver, Wortman & Wayment, 1996; Parkes, 2002/2001, 2006; Rubin & Malkinson, 2002; Shaver & Tancredy, 2002/2001; Stroebe, 2002; Stroebe & Schut, 1999). Many authors have discussed the importance of social support as a means of assisting the bereaved individual in processing grief emotionally and cognitively (Bonano & Kaltman 1999; Bonano, Papa, Lalande, Zhang, & Noll, 2005; Hogan & Schmidt, 2002; Klass, 1988, 1997; Lepore, Silver, Wortman, & Wayment; Parkes, 2006; Stroebe, Folkman, Hanson, & Schut 2006, Worden, 2008). Social support can stem from spouses, family members, support groups, community, and religious rituals. There is a consensus in the bereavement literature regarding the benefits of a variety of social supports in grief coping and processing. However, more studies need to be done in order to bring further evidence as well as a better understanding of the mechanisms at play between retrospective attachment styles, grief processing and social support. Archer (1999), Bowlby (1998/1980; 1988), and Parkes (2006) have argued that social support is part of human beings' survival strategies as there is safety in numbers. These authors considered social support to be a form of attachment behavior. The obtaining and perception of social support is thought to be partially mediated by attachment styles. If secure and preoccupied attachment styles have a tendency to seek out and accept social support during the grieving period, individuals with an avoidant attachment style may not seek out or readily accept social support. Individuals with

disorganized attachment styles most likely are quite isolated and unsure about the possibility of social support from those around them.

Given the close relationship between retrospective attachment styles and social support, and their apparent role in coping with grief, it is important to use both as independent variables. This will help in distinguishing interactions between both variables.

Grief.

In recent years there has been a growing interest in attachment styles and coping with grief (Bing-Hall, 1999; Fraley & Shaver, 1999; Parkes, 2002/2001, 2006; Stroebe, 2002; Stroebe Schut and Stroebe, 2005; Wijngaards-de Meij et al., 2007; Worden, 2008). This has appeared in the context of serious challenges to traditional grief therapy known as "grief work" (Bonano & Kaltman, 1999; Bonano et al., 2005; Fraley & Shaver; Parkes, 2002/2001; Shaver & Tancredy, 2002/2001; Stroebe & Schut, 1999). Grief work is mainly based on psychoanalytic notions of the grief process and confrontation to the loss is one of its central tenets (Fraley & Shaver; Shaver & Tancredy; Worden). Separating emotionally from the deceased and moving on with life by reinvesting in other relationships was also considered important in grief work. Major proponents of grief work were Lindeman (1944/1979), Rando (1986), and Worden (1982, 2008) with his grief task model. Grief work has been challenged in terms of the need for everyone to confront the loss (Bonano & Kaltman; Bonano et al.; Fraley & Shaver; Parkes, 2002/2001, Stroebe & Schut). Bonano and Kaltman and Bonano et al. consider that grief avoidance is in fact a healthy way to cope with grief and that grief avoidance may well be more healthy than grief confrontation. Fraley and Shaver have reviewed "grief work" using attachment theory and attachment styles to explain that for

individuals who are avoidant, it is most likely harmful to force them to confront their loss because grief confrontation would go counter to how they are organized in their attachment style.

Grief work has also been challenged in terms of the emphasis on severing bonds with the deceased (Klass, Silverman & Nickman, 1996; Fraley & Shaver, 1999). Klass et al. (1996) have convincingly argued that bereaved individuals in fact benefit from maintaining bonds with the deceased and that putting emphasis on breaking these bonds in grief intervention would be detrimental to the bereaved. Various references to other cultures in which bonds are maintained and to historical texts that demonstrate that prior to the 19th century, people in the Western culture maintained much stronger bonds with the deceased were used in the argumentation of continuing bond proponents.

As part of the ongoing questioning of the grief work model, Stroebe and Schut (1998, 1999) presented their Dual Processing Model (DPM) as an integration of various ideas in grief theory. The notion of grief work was integrated in the DPM but it is described as only part of the process in grief coping. The DPM describes grief coping as a self-regulatory process of oscillation between loss orientation (grief work), and resolution orientation, (adapting to the world without the deceased). The DPM is useful in understanding that there are many ways of responding to and coping with grief. Stroebe, Schut, and Stroebe (2005) have more recently integrated the DPM with concepts of attachment theory and the mediating effect of attachment styles on oscillation.

Grief oscillation.

The central and dynamic process of the DPM is oscillation between grief-coping

orientations (Stroebe & Schut, 1999). Within each grief-coping orientation, there is also an

oscillation process between positive and negative emotions and cognitions. For Stroebe and

Schut, grief coping involves a process of confrontation and avoidance of various stressors.

Oscillation implies a "waxing and waning, an ongoing flexibility, over time" (Stroebe &

Schut, p. 213). This regulatory movement that appears to prevent the bereaved from being

overwhelmed by grief is idiosyncratic to every individual, but is also influenced by the

individual's context. Oscillation is considered to be part of optimizing mental and physical

health throughout the process of adjustment to the loss (Stroebe & Schut).

Stroebe, Schut, and Stroebe (2005) have associated the DPM and the process of

oscillation with attachment theory. They suggest a number of implications in terms of the

various attachment styles and oscillation. They hypothesize that individuals with an anxious

preoccupied attachment style, will tend to be more focused on loss orientation. They can

become rigidified in what Bowlby (1998/1980) described as "chronic mourning" because

they cannot easily oscillate to resolution orientation or take pauses in grieving (Stroebe &

Schut, 2001/2002a). Individuals who are very avoidant are described as more restoration –

oriented and will have a tendency to be rigidified in what Bowlby described as "more or less

prolonged absence of conscious grieving" (Bowlby, p. 139).   Individuals who are very

avoidant cannot oscillate easily towards loss orientation because they tend to be rigidified in

the restoration aspects of the grief and in the avoidance of their separation anxiety.

Individuals with a disorganized attachment style will lack organization or coherence in their

grief process and will have a tendency to be very chaotic in their grief. Thus patterns of

oscillation will not be as easy to observe as in other attachment styles (Stroebe, Schut & Stroebe).

Marital distress.

Marital distress is defined by Johnson and Greenberg (1988) as a "…negative interaction cycle (most commonly, a pursue- distance cycle)…" (p. 175), with decreased accessibility and responsiveness between the couple. Marital distress exists in many couples who are not bereaved (Bradley & Furrow, 2004; Feeney, 2002; Gottman, Driver, and Tabares, 2002; Johnson, 2004; Johnson & Whiffen, 1999; Kobak & Hazan, 1991; Mikulincer & Shaver, 2007). In the context of clinical practice with non-bereaved couples, Johnson reports that the majority of couples in marital distress requesting therapy have discrepant, or different, attachment styles and thus may have more difficulty or inability to support each other. Most of these couples are described as being in a pursue-withdraw dynamic in which the woman is usually the pursuer and the man the withdrawer. The description of the pursuer is based on attachment theory's anxious/ambivalent (preoccupied) attachment style, and the description of the withdrawer is based on the avoidant attachment style.

Summarizing a number of studies on marital distress and attachment, Mikulincer and Shaver (2007) explain that most studies show that couples in which both spouses are secure tend to be more stable and have less marital distress. Couples in which one or both spouses have insecure attachment styles tend to have more marital distress. Given that the death of a child creates significant psychological distress and attachment insecurity, the death of a child can either bring about or increase already existing marital distress in couples. In bereaved couples (as in non-bereaved couples) attachment styles vary and are seldom similar.

Consequently appraisal of the death of a child and the resulting coping strategies will be different and often discrepant. Some authors (Parkes, 2002, 2006; Stroebe & Schut, 1999; Stroebe, 2002) propose that discrepant retrospective attachment styles in one or both of the parents underlie the difficulty of grieving parents to support each other.

       The most often described combination of attachment styles that is likely to be problematic and a source of marital distress and of psychological distress in a couple following the loss of a child is one Johnson (2004) calls pursue-withdraw. Such a dynamic occurs when there is an anxiously preoccupied attached mother (who expects and needs increased support) and an avoidant father (who tends to withdraw and avoid feelings of loss). In such circumstances the mother would pursue the husband for support but the husband is typically unavailable to his spouse when needed (Parkes, 2006; Wijngaards-de Meij et al., 2007). Based on study results Wijngaards-de Meij, Stroebe, Schut, Stroebe, van den Bout, van der Heijden, and Dijkstra (2008) have also argued that loss oriented mothers (most often preoccupied) can isolate themselves in attempts to focus on the relationship with the deceased child and be unavailable to their spouse. This can make their husband's adjustment to the loss of their child more difficult because it limits the possibilities for the couple to be future oriented. Wijngaards- de Meij et al. (2008) suggest that such a dynamic may well make the rebuilding of the relationship difficult.

       Relying on Mikulincer and Shaver (2007), Parkes, 2006, Wijngaards-de Meij et al., (2007) as well as on Johnson's (2004) description of non-bereaved couples in marital distress, it is also proposed in this study that discrepancies in attachment styles can create attachment insecurity which, in the grieving couple, can be amplified by the death of the

child. These converging vectors of insecurity can be construed as an erosion of attachment

security both at an individual and at the couple level (Clulow, 2001; Johnson). This creates

an expanding and vicious negative communication cycle that leads to diminished social

support, to marital and psychological distress (Fish, 1986; Gordon Walker et al., 1996;

Johnson; Parkes, 2006; Moriarty et al., 1996; Wijngaard-de Meij et al.). There is also the

potential for higher levels of grief (Gilbert, 1997; Rando, 1986, 1997), as well as decreased

grief oscillation.

Psychological distress.

That psychological distress is an inherent aspect of grief is a widely accepted notion.

The main points of contention of the past 40 years of grief research have been around the

mechanics of grief (Freud, 1995/1917) and how these mechanics explain the variations in the

grief experience among individuals. Freud's attempts to explain these mechanisms using his

concepts of identification and regressive identification and their impact on the process of the

detachment from the deceased put the emphasis on arbitrary criteria of healthy grieving

(Archer, 1999). This tended to stifle curiosity among researchers and clinicians regarding the

underlying processes of grief and the purpose and usefulness of variations in grief processing

(Archer).

Most studies of grief in the past 30 to 40 years tended to be descriptive, and tended to

pathologize grief responses that were considered too intense, too prolonged or did not fit with

the grief work model of grief confrontation (Archer, 1999; Fraley & Shaver, 1999; Klass

Silverman & Nickman, 1996). Studies by Parkes (1964, 1965) demonstrated how grief

responses are either ignored or patholigized, contributing to a high rate of psychiatric

hospitalizations of bereaved individuals (Parkes). A recent study by Li et al. (2003) demonstrated clearly how the psychological distress related to the loss of a child still puts parents at a higher risk for psychiatric hospitalizations. Part of the reason for such hospitalization may well be the lack of prospective models of grief that explain and normalize some of the extremes of psychological distress during grief (Klass, 1996).

Bowlby and Parkes (1970), Bowlby (1998/1980, 1988), and Parkes (1972/1998, 2002/2001, 2006) have striven to establish such a prospective model with the development of attachment theory. In their joint article in 1970, Bowlby and Parkes introduced the notion that part of the psychological distress related to the death of a significant other is genetically programmed as separation anxiety. Bowlby (1998/1980) later proposed that how separation anxiety is dealt with in each circumstance of loss is also mediated by the attachment style of the bereaved individual by the existence, availability and responsiveness of the socio-cultural support network as well as on the type of attachment relationship that was lost.

Until recently, most studies have examined psychological distress by itself, psychological distress as influenced by gender, or psychological distress as in the grief work model. Rando (1986, 1993, 1997) and Klass (1988) were both exceptions to this trend because these authors focused on parental grief and the extreme psychological distress accompanying such a loss. Much of their work has been to normalize the extreme reactions of parents whose child dies. Wijngaards-de Meij et al. (2007) have also observed from their data that the death of a child is a bereavement that elicits much more psychological distress compared to other bereavements and that the experience is a prolonged one. These authors

bring more support to one of Bowlby's (1998/1980) hypotheses that different kinds of losses are not similar in terms of the grief reaction and psychological distress elicited.

In recent years various constructs have appeared in the grief theory literature in order to propose ways to ascertain the individual biopsychosocial starting point in the grief experience. Prime examples of these constructs are: hardiness, (Lang, Goulet, Aita, Giguère, Lamare and Perreault, 2004), self confidence (Murphy et al.,), functional and culturally mediated emotions (Bonanno & Kaltman, 1999; Bonanno, 2002/2001), emotional regulation and attachment styles (Shaver and Tancredy, 2002/2001), retrospective attachment styles (Parkes, 2006), and the Dual Processing Model (Stroebe & Schut, 1999, Stroebe, Schut & Stroebe, 2005). Attachment theory and the work of Bowlby (1998/1980, 1988) of Parkes and Bowlby (1970) and Parkes (1972, 2001/2002, 2006) are at the core of this transformation in grief research and theory.

Attachment theory has first of all firmly anchored the grief process as separation anxiety, a form of psychological distress, that is normal and that human beings are genetically organized to experience. The various forms of psychological distress experienced in grief act as action potentials, motivating human beings to maintain proximity and retrieve an attachment figure or a child for which one is a parent and a caregiver. Attachment theory and the concept of retrospective attachment styles help explain how individuals manage psychological distress in a variety of ways because of their formative relational experiences with their primary caregivers. These attachment styles also help to explain the importance of social support as a contributor to a sense of security throughout one's lifetime and in the context of grief.

Attachment theory has the potential to explain both intrapsychic and extrapsychic difficulties in obtaining and maintaining social support. Attachment helps to explain how intrapsychic and extrapsychic difficulties contribute to marital distress, psychological distress, grief and grief oscillation. Attachment theory also helps explain how all of these variables appear to be interconnected in determining the pathway of the grief experience for both individuals and couples. Compared to the other constructs proposed in the more recent grief studies, attachment theory appears to be more encompassing and well grounded in various areas of research. Given the frequency of certain variables in the bereavement literature the impact of gender of parents, number of surviving children, age of child at death, and time since child's death will be controlled in this study.

Interest in the Study and its Conceptualization

Personal interest.

Working for six years as a social worker in a pediatric oncology program and as a member of a pediatric palliative care program in Ottawa, Canada, I observed that parental bereavement has major psychosocial consequences for the families who have the misfortune of experiencing the tragedy of the loss of a child. Unfortunately, as important as can be the aftershocks of such a tragedy, parental bereavement is most often an afterthought of hospital services, and few if any resources in communities in the U.S. or in Canada exist to deal with these aftershocks. Adding to the difficulty is the fact that social workers and other health care professionals are thrust in traumatic situations with little or no training in palliative care or in parental and family bereavement.

Conceptualization.

To focus on one cause of death, namely death from cancer, would simplify the study in many respects. For sampling purposes, one disease entity such as cancer would provide a higher degree of homogeneity within the sample. Cancer is the most common fatal illness in children for both the U.S. and Canada (Herond et al., 2009; Canadian Cancer Society). The pediatric oncology patients are often serviced by community-based organizations such as Candlelighters and Cure who have contact information for cancer bereaved parents, potentially facilitating the recruitment of bereaved parents. Most families who lose a child to cancer have spent from six months to five years supporting their child in their fight against cancer. This fight for their child's life occurs in fairly similar environments, those of medical centers throughout North America. The long periods of stress for the parents, the treated child and their siblings (when there are siblings) result in an experience that is similar for all these bereaved families. The extent of the struggle through the cancer treatment is a very different experience in the process of the loss than for example someone who loses a child unexpectedly through an accident or violent incident (Murphy et al., 2003).

An important motivation for this dissertation was to understand better the grieving process of individuals and of couples and to add to the existing knowledge that could then be shared with parents, social workers and other health care professionals. Finally, the final motivation for this study was to honour the memory of children who died of cancer and their families with whom the student had the privilege of sharing very difficult parts of their lives.

Research questions.

The two primary research questions were:

Is there a relationship between individual attachment insecurity and levels of marital

distress, psychological distress and levels of grief in parents who have lost a child to cancer?

Is there a relationship between a discrepancy in spouses' levels of attachment

insecurity and levels of social support, marital distress, psychological distress, and grief?

Other research questions were:

Is there a relationship between gender, social support, age of the child at death,

number of surviving children, and levels of marital distress, psychological distress, and grief.

Is there a relationship between attachment insecurity and grief oscillation.

Purpose of the study.

The main purpose of this study was to investigate whether and how retrospective

attachment insecurity and social support in bereaved parents affect psychological distress,

marital distress, and levels of grief. Discrepancy in retrospective attachment insecurity within

couples, social support, gender, age of child at death, and number of surviving children will

also be investigated in terms of their impact on psychological distress, marital distress, and

grief. A secondary purpose was to investigate how retrospective attachment insecurity

impacts on grief oscillation. The identification of high risk couples for higher levels of

distress and grief was the final purpose of the study.

Significance of the Research for Social Work

Implications for social work theory.

Through perspectives such as the person in the environment, cognitive behavioural

theories, systems theory, psychoanalytic theory, the structural approach, feminist thinking,

the family life cycle (Berlin, 2002;Walsh & Mc Goldrick, 2004; Turner, 1996) to name a

few, social work has promoted a multifaceted view of our understanding of the human being. This study's objective of understanding the impact of the loss of a child on the couple and on the individual parent through the biological and relational lens of attachment theory and the DPM will contribute to the social work body of knowledge.

Attachment loss and grief touches everyone throughout the course of their lives. Studying these concepts with the assumptions in this study is in fact to study the core mechanisms of adaptation in human beings. This study uses a self-administered measure of attachment insecurity and indirectly of discrepant attachment insecurity in couples to explain marital distress, psychological distress, and levels of grief. This study is a response to calls in the grief research literature regarding the need for more studies on the impact of the death of a child on couples (Digregov & Digregov, 1999; Murphy et al., 2003; Sirkia et al.2000; Stroebe, 2002, Wijngaards-de Meij et al., 2007; Wijngaards-de Meij et al., 2008).

The use of a measure of grief oscillation is an original contribution to the field of bereavement and of social work. By helping to test out and develop such a measure this study will contribute to a better understanding of grief dynamics in the bereaved couples leading to a more relational understanding of grief as part of social work theory.

More and more attachment theory is being linked with neurobiology (Bowlby, 1968, 1998/1980; Berlin, 2002; Carter, 1998; Grüdel, O'Connor, Littrell, Fort, & Lane, 2003). Many historical models of social work were influenced by an organismic metaphor such as systems theory, eco-systemic theory, psychoanalysis, and gestalt psychology and therapy. These theories and forms of therapy spoke more of general principles of functioning of the human organism, because of historical, cultural, and technical limitations to observe the

human body (Bowlby, 1988). Primarily based on attachment theory this study considers that the paradigm of inquiry is empirical. Bowlby (1988) considered his work to be guided by a "…philosophy of evolutionary epistemology" (p.74). Thus, knowledge and understanding of a phenomenon evolves as our collective understanding develops. This is set within contextual and historical constraints.

Bowlby (1988), clearly states that by the integration of Ethology ("...the study of animals and of human beings in their natural environment, informed by the Darwinian notion that some behaviours are guided by heredity throughout the phylogenetic ladder" (http://www.answerscom/topic/ethology) within his general framework Bowlby was setting his prospective model of mental health in the empirical biological sciences and in evolution theory. Bowlby considers that if evolution and genetics had a strong impact on the individual and psychopathology, the environment has an even greater impact on the way our basic personalities develop:

> …whatever influence variations in genetic endowment may be exerting on
> personality development and psychopathology, an immense influence is
> unquestionably being exerted by environmental variables of the kinds now being
> systematically explored. (Bowlby, p.160).

Here, both nature and nurture are intimately entwined to create a goal driven biologically and evolutionary based model from which stems a socially and relationally impacted or malleable ontological perspective of individual, development and psychopathology. Thus giving social work theory's most central tenant, of the person in his/her environment, solid ground.

Implications for social work practice.

Probably the most significant contribution of this study is the use of attachment styles to understand bereaved parents both at an individual and at a couple level. Fraley and Shaver (1999) believe that it is most useful, and probably most ethical approach for clinicians is to examine the differences in grieving patterns between clients of different attachment styles. Thus, the traditional notion of grief work and confrontation to the loss needs to be considered according to attachment styles (Fraley & Shaver; Stroebe, 2002, Stroebe & Schut, 1999). The DPM and attachment theory become very useful tools for practice in terms of understanding how different individuals will have different grieving presentations and difficulties depending on the attachment style that developed as children with their own parents or caregivers. This study also has implications for social work interventions, in the context of adult and pediatric psychosocial oncological care as well as to a variety of social work clinical situations such as emotionally focused individual and couple interventions.

The original contribution of this study is the use with grieving couples of a measure of attachment insecurity the Retrospective Attachment Questionnaire (RAQ) and of the DPM for the assessment of the difficulty of couples to support each other. In the presence of insecure attachment styles and of discrepant attachment styles, both members of the couple need to be supported and intervened with in a way that is congruent with their respective attachment style (Bing-Hall, 2004; Cudmore & Judd, 2001; Johnson &Wiffen, 1999). The use of the Inventory of Daily Widowed Life (IDWL) (Caserta & Lund, 2007) adapted for bereaved parents is also an original contribution of this study with bereaved parents. As Wijngaards-de Meij et al. (2008) have demonstrated in their use of a DPM grief orientation

scale on bereaved couples interesting findings in terms of the difference in loss orientation between spouses that can be explored and applied to work with bereaved couples.

Grieving has most often been an individual issue in social work intervention, but this study will bring more pertinent knowledge in order to support bereavement interventions that consider the relational aspects of the grieving process. The time has come to go beyond the clinical description and apply quantitative approaches to the study of bereaved couples in order to develop evidence-based practice in this clinical area.

The question of the use of emotions and cognition in therapy is also an underlying theme in this study. Grieving is an emotional experience and the integration of emotions and cognition in human coping is an important implication of this study. The use of Attachment Theory, the DPM and the concept of oscillation certainly move the social work profession in this direction.

Implications for social work research.

There is an important difference between the concept of adult attachment used in many studies of couples and the concept of retrospective attachment used in the developmental field (Bouthillier et al., 2002, Crowell et al., 2004). Following an extensive review of the literature and discussions with various researchers, a new scale published by Parkes (2006) the Retrospective attachment questionnaire (RAQ) was selected for use in this study. As its name indicates the RAQ assesses individuals in terms of their childhood attachments. The RAQ will permit us to empirically test the concept of attachment insecurity as a predictor of grief and distress. Also, the RAQ will help to identify high risk couples for distress and grief according to discrepancies in attachment insecurity.

Summary

Chapter 1 provided the rationale for this study. The population was described and basic statistics on the number of children who die every year in the U.S. and Canada were stated. The problems related to individual and couple parental bereavement were described with the help of pertinent literature. The variables included in the study were presented and the relationship between the variables, retrospective attachment, social support, grief, grief oscillation, marital distress, and psychological distress were discussed. A discussion of the interest and purpose of the study was also presented. The reasons for limiting the sample to cancer-bereaved parents were explained. The research questions and the related hypotheses were stated. The chapter concluded with a discussion of the significance of the study for social work theory, practice, and research.

Chapter 2 reviews the literature in adult grief theory and research as well as the literature specific to bereaved parents. This will be followed by the description of an approach from which to understand parental bereavement. The variables used in the study will be described through a review of the literature. Chapter 3 describes the methodology, including: the research hypotheses, the study instruments, and the data analysis plan. Chapter 4 presents the socio- demographic characteristics of the respondents in the study and the results of the data collected. Chapter 5 gives a summary of the research and discusses recommendations for social work theory, practice, and research.

<center>**Chapter II**</center>

<center>**Review of the Literature**</center>

This chapter will begin with a definition of grief as it will be used in the study. A review of the main historical developments in the field of grief theory leading to the present main questions in the field will be presented. Subsequently, a review of the literature pertaining specifically to bereaved parents and couples will be discussed. This will be followed by the description of an approach for understanding parental grief at both the individual and relational level using the Dual Processing Model (DPM), attachment theory, and couples theory. A review of the literature surrounding the variables used in the study will follow. The chapter will conclude with a summary and an introduction of the next chapter.

Defining the terms

      Bereavement, mourning, and grief.

      Grief.

Stroebe et al. (2002) define grief as a set of reactions to bereavement by individuals. These reactions are most often comprised of important distress and "… defined as a primarily emotional (affective) reaction to the loss of a loved one through death. It incorporates diverse psychological (cognitive, social – behavioral) and physical (physiological – somatic) manifestations" (Stroebe et al., 2002, p. 6). Parkes (2006) defines grief as a reaction to a loss comprised "… of intense pining or yearning for the object lost (separation anxiety). Without these reactions a person cannot truly be said to be grieving" (p. 30).

For the purpose of this study, grief will be defined much in the way it is defined by Stroebe et al. (2002) as a primarily emotional response, in an individual, to the loss of a

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significant other "…through death. It incorporates diverse psychological (cognitive, social –

behavioral) and physical (physiological – somatic) manifestations" (p. 6). It often involves

an ongoing relationship and sense of presence of the deceased. Moreover grief is defined as a

syndrome (Archer, 1999; Bowlby, 1998/1980; Freud,1995/1917; Lindemann, 1944; Parkes,

1972, 2006; Rando, 1977; Rando, 1997; Stroebe & Schut, 1999) in which the organism

performs oscillation, an approach/avoid process designed to progressively integrate the

multifaceted realities of the loss of a significant other.

There are often variations in the way researchers use the terms grief, bereavement,

and mourning to discuss the loss of a close family member or friend and the subsequent

responses that follow. Some of the differences in the use of these terms are due to historical

contexts and the evolution of the meaning of these terms (Archer, 1999). Coping with losses

of things and animals other than someone close also involves neurological systems and

structures that are involved in coping with the loss of a significant other (Archer, 1999;

Bowlby, 1998/1980; Parkes, 2006). As well, some authors' emphasis on the cultural impact

of the expression of loss leads to differences in the use of these three terms (Archer, 1999;

Bowlby, 1998/1980; Parkes, 2006). The following section will define the terms of

bereavement, mourning and grief for the purpose of the study.

Bereavement.

The term bereavement defines the loss of a significant other (Stroebe, Hanson,

Stroebe, & Schut, 2002; Stroebe, Schut, & Stroebe, 1998). When one is bereaved one is in a

situation of coping with loss and is in the process of mourning and or grieving. Bereavement

includes all the behaviors and the state of being that results from the loss of a significant

other (Stroebe et al., 2002). Klass (1988) explains that once one has lost a child or a very

close family member one is bereaved the rest of one's life. Some authors such as Archer

(1999), Bowlby, (1998/1980), Parkes (2006), and Rando (1986) recognize that there are

many kinds of losses that cause emotional distress but for the purposes of this study,

bereavement will entail only the loss of a significant other.

Mourning.

The term mourning is used less often today than it was thirty or forty years ago.

Throughout the grief literature it is often interchanged with the term grief (BrintzenhofeSzoc,

1995; Rando, 1986). Bowlby (1998/1980), Bowlby and Parkes (1970), and Rando explained

that in psychoanalytic literature mourning had a very restricted use to describe the specific

task of detaching from the deceased, as Freud had initially claimed was the ultimate goal of

the mourning process. Refusing such a narrow use of the term, for both theoretical and

semantic reasons, Bowlby preferred to use the term mourning as describing "…a fairly wide

array of psychological processes set in train by the loss of a loved person irrespective of their

outcome" (p. 17). Bowlby, Archer (1999), and Stroebe et al. (2002) also explain that the

discipline of anthropology uses the term mourning as all forms of public expressions of grief.

This definition permits the acknowledgement of cultural differences in the experience of loss

but it puts little or no emphasis on the individual experience of loss (Archer). Archer,

Bowlby, and Rando, tend to use the terms mourning and grief interchangeably, whereas

Stroebe et al. propose to distinguish the terms by maintaining the anthropological use of the

term mourning and grief as the more specific set of individual responses to loss. Nonetheless,

there are overlaps between mourning and grief as when a bereaved individual cries and

shows distress at the funeral of a loved one. These are both ritualized and personal responses to the loss (Stroebe et al.).

A Review of the Adult Grief Literature

Archer (1999) builds on Freud's work and the description of grief and the influence that psychoanalytical model had to construct a view of grief that puts the emphasis on the aspects of "mental suffering [and] harmful physical effects" (p. 249) as well as an insistence on pathology rather than on the normalcy of the reactions to the loss of a significant other. Archer also considers that the notion of grief work and of detachment described by Freud were so entrenched in grief theory that these have only recently been questioned in research and practice. The notion of detachment from the deceased really was a central goal in the process of grief work as described by Freud. Freud presents a view of the individual who is independent and needs to stand alone and move on in front of the harsh realities of the world. Archer (1999) and Hogan and Schmidt (2002) state that Freud's notion of grief work seriously limited the possibility of scientific research because of the overbearing and unquestionable authority Freud's ideas had on the field.

Lindemann (1970/1944) considered grief as a syndromic response to the loss of a loved one. The typical responses were: "1) somatic distress, 2) preoccupation with the image of the deceased, 3) guilt, 4) hostile reactions, and 5) loss of patterns of conduct [in terms of social interaction]" (p. 63). In some patients whom Lindemann considered to be close to pathological grief, there appeared an identification tendency to take on characteristics of the deceased. Such as symptoms of the deceased's illness, their way of walking or talking or even personality traits. In situations of pathological grief, the typical responses were

heightened and Lindemann (1970/1944) described these as distortions of normal grief. Of note, that Lindemann (1970/1944) put more emphasis on the difficulties encountered in confronting the reality of the loss and on grief postponement than on chronic grief (Archer, 1999). Quite possibly, the sudden, unexpected, and untimely deaths of the Coconut Grove fire victims made their family members, whom Lindemann (1970/1944) primarily used as study subjects, more prone to postponed or absent grief and to denial of the loss.

Normal grief process for Lindemann (1970/1940) seemed to hinge on the internal dimension of the client's ability to do "grief work" and on the external dimensions that impact the individual, such as the intensity of the relationship, changes in family structure and socio-economic deprivation caused by the loss. If Lindemann (1970/1940) had renounced Freud's idea that morbid grief was different in kind from healthy grief (Bowlby, 1998/1980) he nonetheless kept Freud's notion of the need for grief work and its accompanying reality principle. Lindemann identified eight elements of grief work that needed to be completed in the grief work process by a patient:

He has to accept the pain of the bereavement. He has to review his relationships with the deceased, and has to become acquainted with the alterations in his own modes of emotional reactions. His fear of insanity, his fear of accepting the surprising changes in his feelings, especially the overflow of hostility, have to be worked through. He will have to find an acceptable formulation of his future relationship to the deceased. He will have to verbalize his feelings of guilt, and he will have to find persons around him whom he can use as "primers" for the acquisition of new patterns of conduct. (Lindemann, 1979/1944, p. 75)

This quote clarifies that for Lindemann (1979/1944) grief work involves the

confrontation of the bereaved with various elements of the internal and external reality that

are inherently aversive and painful. The attempts to avoid the intense feelings related to the

loss are typical according to Lindemann (1979/1944). The avoidance of confronting various

issues related to the loss is described as blocks to normal grief. These obstacles or blockages

to normal grief can be overcome with the assistance of a psychiatrist, minister, or social

worker (Lindemann, 1979/1944; Nichols, 1986).

Worden (1991/1982) and Rando (1986) both had very similar publications that were

prominent in the field of grief in the 80's and 90's, especially in health care. Both gave

detailed accounts of the importance of grief work by detailing the tasks of grief as described

by Freud and by Lindemann. Worden's first edition, dated 1982, used the term decathexis in

describing the task of detachment from the deceased. Rando (1986) also uses the term

decathexis as part of the central issues of grief work. Both authors then give multiple

examples of issues that can block or interfere with a bereaved individual's grief work and

achievement of any of the four tasks of grief articulated by Worden according to

Lindemann's work (Rando, 1986). Rando (1986) states that the emphasis in grief work is too

often on the separation anxiety of the bereaved rather than on the "…cognitive and

intrapsychic processes of grief that mandate changes in the inner world…" (p. 345), namely:

"(1) decathexis, (2) development of a new relationship with the deceased, and (3) formation

of a new identity" (p. 345). The grief work entails the use of the reality of the loss in a review

and processing of "…feelings, thoughts, memories, expectations, hopes, and fantasies, that

she had about the [deceased] child" (Rando, 1986, p. 346). A failure to do such work will

result in the bereaved "…still emotionally bound to the deceased child in an unhealthy way

(Rando, 1986, p. 346). Rando (1986) does acknowledge the need for the development of a new relationship with the deceased. This has to be done while being very conscious of the distinction between alive and dead, so as not to interfere with the process of detachment as well as the possibility of developing bonds with others (Rando, 1986). Failure to do so could promote unhealthy grief. Some ways of maintaining a healthy relationship with the deceased are through "…rituals, anniversary celebrations, prayers, commemorations, memorialization, caring about the concerns and values of the deceased, and healthy identification" (p.347). Identification is described by Rando (1986) as an internalization of the mental image of the deceased in order to preserve the deceased and manage the separation anxiety evoked by the loss. Identification becomes unhealthy or pathological when the process is not in support of decathexis but rather used as a way of avoiding the experience of the loss or of relinquishing the deceased. (Rando, 1986). The works of Lindemann (1979/1944), Rando (1986), and Worden (1991/1982) are very good examples of the prevalence of Freud's overwhelming influence in the field of grief theory.

As discussed in the following few pages, Archer (1999), Bowlby (1998/1980), Klass (1988, 1997), Parkes (2002), Shaver and Tancredy (2002), Silverman and Klass (1996) all present convincing arguments questioning the mechanisms of the grief work process as well as what is considered pathological grief and what needs to be reconsidered and put to the test of research. Clearly these authors all agree with Freud that grief is a process through which the bereaved individual assimilates and accommodates for the loss of a loved one. However, what Freud proposed as the mechanisms through which assimilation and accommodation takes place, as well as what he considered as the nature of healthy and pathological processes

have been questioned more and more through systematic research.

In essence, most of the grief models agree that grief is a process that falls somewhere along the lines of the concept of grief work articulated by Freud (1995/1917). Confrontation to loss, ambivalence regarding painful realizations, and the enormous internal and external work that a significant loss entails, adjusting day by day to the reality of the absence, and permanent separation from a significant other which Freud (1995/1917) was the first to articulate are found in all the models of grief. How each model interprets the different components of the grief process is what distinguishes one model from another.

The different elements of "grief work" are in fact issues to which bereaved individuals have ambivalent responses. These ambivalent responses are understood today to be an inherent part of the grief process involving both cognitive and emotional reactions. The terms most often used to describe the ambivalent process in grief are: approach/withdrawal, "…denial/inhibition and intrusion/facilitation…" (Rando, 1997, p. xvii), and oscillation (Bowlby, 1998/1980; Parkes, 1998/1972, 2006; Stroebe & Schut, 1999). The review of these issues in a more contemporary perspective begins with the work of Bowlby.

Bowlby is considered by some, to be the most important theoretician in the field of grief, up to now, eclipsing even Freud in terms of grief theory (Fraley & Shaver, 1999). His work with children during and following the Second World War led him to understand the deprivation of a mother's affection as an important aspect in problems of mental health in childhood and also in later adult life (Bowlby, 1982, 1988, 1998/1980). In the late 1950's he came to consider that childhood maternal deprivation also had important ramifications in how we grieve as adults (Bowlby, 1980/1969, 1988, 1998/1980, 1982,).

As attachment theory was developed, a distinction between the attachment system per se and the goal-oriented behaviors motivated by the attachment system was articulated (Bowlby, 1980/1969). The attachment system is the genetically set internal working model that gives children an innate sense of the physical and emotional availability of the caregiver and creates a range of felt security or insecurity. At birth, crying, protesting, and despair are innate or instinctual behaviors that can be initiated by the attachment system. As the child develops and learns, these behaviors become progressively influenced and modulated by development, experience, learning, and a constant feedback loop with the immediate environment. A child's sense of security becomes both externally and internally determined. For Bowlby (1998/1980, 1982, 1988), environment has a bigger impact than genetic endowment on an individual's behavior. This is not so for clear cases of congenital or genetic problems (1998/1980).

Bowlby (1988) explains that it was not until the late 1950's that he became aware of the similarities of adult grief responses with those of hospitalized children Robertson had studied (Bowlby &Robertson, 1952, as cited in Bowlby, 1982, 1988). This occurred when Bowlby was made aware of the results of the seminal study by Parkes (1964 as cited in Parkes 2006) on adult bereavement, demonstrating the predominance of unresolved grief in mental health patients. Bowlby and Parkes (1970) subsequently published a paper describing the phases of grief, adding an initial period of numbing that can last a few hours to a few days before the phases of protest, despair, and detachment observed in children begin (Bowlby, 1980/1969; Parkes, 2006). As Bowlby's thoughts on attachment evolved, his phases of grief evolved as well; the final form incorporated the notion of reorganization as

the last phase of grief (Bowlby, 1998/1980; Bowlby & Parkes, 1970). Bowlby (1998/1980) describes the phases of grief in this way:

1)   The phase of numbing that usually lasts from a few hours to a week and may be interrupted by outbursts of extremely intense distress and/or anger.

2)   Phase of yearning and searching for the lost figure lasting some months and sometimes for years.

3)   Phase of disorganization and despair.

4)   Phase of greater or less degree of reorganization. (p.85)

Bowlby (1998/1980) explains that these phases are not clear-cut, that they tend to overlap, and that one oscillates between the different phases. This notion of oscillation is very important and it was made a central piece of the Dual Processing Model (DPM) (Stroebe, & Schut, 1999). Oscillation refers back to Freud's notion of ambivalence in the process of grief work and maintains Freud's idea regarding the function of ambivalence in order to avoid flooding the self with too much change at the same time (Stroebe & Schut, 1999). This oscillation contains the conceptualization of an incremental process of reality testing or of reality integration. Field, Gao, and Paderna (2005) explain that Bowlby (1998/1980) proposed that the permanence of the loss takes a long time to be established, by the parts of the organism that control separation responses. The bereaved individual struggles with the separation and the possibility that the loss is permanent. Bowlby (1998/1980) gives the end point of this reality testing process a clear purpose by calling it reorganization. The concept of reorganization also contains the understanding that everyone goes through this process in his/her own way depending on both past experience and the

context of the loss.

Bowlby (1998/1980) describes in multiple instances how, in both children and adults, the relationship with the deceased continues to be important to the bereaved person. The nature of this relationship with the deceased would explain the ongoing "yearning and searching, and also the anger, prevalent in the second phase, and the despair and subsequent acceptance of loss as irreversible that occur when phases three and four are being passed through successfully. It explains, too, many, and perhaps all, of the features characteristic of pathological outcomes" (Bowlby, 1998/1980, p. 86). Absence of grief and of chronic grief are the pathological outcomes of grief for Bowlby. For him, attachment is an intrinsic part of grief and it is how individuals have constructed their attachment styles, as well as the context of the loss that determine the variations in grief processing from one individual to the next. Therefore it is essential to discuss some notions of attachment theory in order to better convey Bowlby's perspective on grief.

Understanding that the grieving process in children is identical to the grieving process in adults was key to Bowlby's ethological and evolutionary biological framework of attachment theory (1969/1982). It meant that attachment theory is pertinent throughout the life cycle and that throughout our lives it is important to have attachment figures that will care for us and protect us when we need to be protected and comforted. According to Bowlby (1998/1980; 1982/1969), dependence on long-lasting, close, and intimate relationships is a biologically programmed survival strategy throughout the course of our lives and should not be automatically considered as pathological as he claimed was the case in psychoanalytic tradition. As children, long-standing and intimate relationships with our parents and other

secondary caregivers keep us in proximity, and offers the best strategy for our individual survival (Bowlby, 1980/1969, 1998/1982, 1988). The long-standing relationship with a spouse or sexual partner ensures the reproduction of the species but also helps assure our own survival through mutual protection and caregiving. When loss of an attachment figure or of a recipient of our caregiving is threatened or when the relationship is in peril, we are all, whether children or adults, emotionally driven by our biologically evolved attachment and caregiving systems to initiate attachment and caregiving behaviors that ensure proximity, availability, and responsiveness as survival mechanisms. Complex emotions beginning with "…frustration, anxiety and sometimes despair…"(Bowlby, 1988, p. 81), but most often, reunion, reassurance, comfort, love, and affection all act as parts of plans or hierarchical systems of goal corrected action potentials aiming at re-establishing a sense of security for all individuals (Bowlby, 1988). A sense of security that is so centrally indispensable to our sense of wellbeing, that human beings and most mammals will go through any length to try to maintain it (Bowlby, 1980/1969, 1980/1998, 1988). As Archer (1999), Bowlby (1988), and Parkes (2006) explain, love and the many pleasant emotions and physiological pleasures it brings are the "prizes" (Bowlby, 1988, p.81) and grief and its painful emotional and physiological components are the "penalties" (Bowlby, 1988, p.81) of the evolutionary evolved survival strategy of attachment and caregiving and their subsequent behaviors.

Bowlby has shown with attachment theory that grief is a syndromic or phasal response turned on by separation (Field et al., 2005). When reunion occurs, this syndromic response shuts down and the body returns to a normal state. However, when reunion does not occur, bereaved adults may know in their conscious minds that their attachment figure or

caregiving figure is gone forever or is dead, but the attachment and caregiving systems are still turned on with no possibility of completing the shut down sequence usually triggered by reunion. These grief reactions are autonomous hardwired responses that are very strong that extinguish themselves very slowly and provoke considerable emotional pain and suffering in the process.

The other important element that Bowlby (1998/1980) brings to the understanding of grief is that the extremes of grief, namely grief avoidance and chronic grief, are mediated by the coping preferences of the bereaved due to the attachment style established by the bereaved in childhood. Bowlby (1998/1980, 1988) credits Mary Ainsworth (Ainsworth et al., 1978) for the development of the construct of attachment styles in children. The attachment styles described by Ainsworth and her colleagues were secure, insecure anxious avoidant and insecure anxious ambivalent. These attachment styles are developed by the child as an adaptive response to the caregiver's patterns of interaction and of caregiving. Secure individuals do grieve but they are usually able to process the death of a loved one more easily than insecure individuals. Insecure anxious avoidant individuals will resort to grief avoidance. On the other hand insecure anxious ambivalent individuals will have a tendency to resort to chronic grief after the loss of a loved one (Bowlby, 1998/1980.

In concordance with Freud's notion of grief work, Bowlby (1998/1980) considered that someone who suffered from absence of grief still needed to process the loss. Fraley and Shaver (1999) concede that Bowlby (1998/1980) may have over emphasized the need to process grief for people who show absence or avoidance of grief. A study done by Bonnano et al. (2005), supports the hypothesis that individuals with a more avoidant attachment style

do not need to process grief as much as individuals who are resilient or those individuals who have an anxious ambivalent attachment style. On the other hand a study by Wijngaards-de Meij, Stroebe, Schut, Stroebe, van den Bout, van der Heijden, and Dijkstra (2008) found that avoidant individuals are a high risk group and that if they reach a certain point of anxiety their avoidant strategies no longer work and they become very distressed.

Parkes (1998/1970) is primarily recognized for shedding light on the fact that many adult mental health problems such as "…affective disorders (notably anxiety states and clinical depression) (…and) other disorders including chronic grief and delayed/inhibited grief" (p. 29) are related to bereavement issues (Stroebe, 2002; Parkes, 2006). Archer (1999), Stroebe (2002), and Bowlby (1998/1980) all credit Parkes for the first truly empirical studies of adults and bereavement. Parkes (2006) explains that his work in 1983 with Weiss showed that an important variable in complicated grief was the type of attachment the bereaved had with the deceased. Namely: "a dependant relationship was found to predict chronic grief [and] an ambivalent relationship was found to predict conflicted grief" (Parkes, 2006, p.28).

In the early 1970s Parkes had the original idea of studying individuals who had lost limbs instead of loved ones (Parkes, 2006). He found that people who lost limbs actually had grieving responses very similar to the loss of a close person.

Most amputees, like bereaved people, found it hard to believe what had happened. They   were preoccupied with and pining for all that they had lost and, most striking of all, they   had a strong sense of the presence of the lost part. (Parkes, 2006, p.31)

For Parkes (2006), the grief reaction to the loss of a limb could not be motivated by

the attachment system. The grief reactions can still be mediated by the coping strategies

established by the attachment system (Parkes, 1982), but the loss of things such as limbs or a

house or a way of life has more to do with our assumptive world (Parkes, 1982, 2006).

Parkes "…coined the term 'the assumptive world' for that aspect of the internal working

model that is assumed to be true (Parkes, 1971)" (Parkes, 2006, p. 31). The notion of

assumptive world is the central concept of what became Parkes' psycho -social transition

theory to explain how we also grieve some of our fundamental premises regarding how the

world is supposed to be in order for it to make sense to us and to feel secure in the world

(Parkes, 1970/1998, 2006). The assumptive world is the construction of the world as it is

influenced by our environment and different experiences of the world. As such it is not exact

as it is a subjective interpretation of the world. Thus the assumptive world is acquired

through experiences and is part of the central processing system of all the networks of

internal working models and regulatory systems such as the attachment system. Parkes'

concept of assumptive world fits very well in Bowlby's attachment theory and in his

description of the mind in the third book of his trilogy (1998/1980). The assumptive world

encompasses the relational paradigms Bowlby spoke of (1980/1969, 1980/1998, 1982, 1988).

The assumptive world is incorporated at the core of the various parts of the mind, of the

memory systems, and of the various regulatory systems and is particular to every individual

(Parkes, 2006). Parkes (2006) explains that the main purpose of the assumptive world is to

ensure survival of infants by acting as a basic cognitive and emotional map in order to avoid

potential threats or deal with them when these threats are not avoided. As such the

assumptive world is a basic or central system of principles that "…direct our attention and

judgement (sic)" (Parkes, 2006, p. 34). Parkes (2006) distinguishes the psycho-social transition theory from constructivist and narrative or meaning systems. Although the assumptive world creates meaning systems in constructivist terms, Parkes insists on its genetically based role of ensuring survival functions and distinguishes it from fantasy making functions of the mind.

Most days the assumptive world is simply expanded and there is often pleasure in discovering new things that will expand our map of the world (Parkes, 2006). Certain events such as the loss of a loved one, of a limb, or the occurrence of traumatic events force a review of the assumptive world. In the case of the loss of a loved one there is not only the need to grieve the loss but also the "need to revise our assumptive world" (Parkes, 2006, p. 34) without the presence of the loved one. Revision of the basic fundamental premises of the assumptive world, involves a difficult and often painful cognitive and emotional process (Parkes, 2006). This revision process of a bereaved individuals assumptive world appears very similar to Piaget's notions of assimilation and accommodation in which assimilation involves adding to pre-existing information or schemas, whereas accommodation involves a more profound revision of preexisting cognitive and emotional schemas (Berlin, 2002). There is an assumption here that cognitive and emotional schemas also involve hormonal regulation (Ainsworth, 1982; Bowlby, 1998/1980; Field et al., 2005). Thus notions of change in one's assumptive world take time and are painful because our bodies are also readjusting to how they will accommodate the changes in the premises. The notion of how amputees have "… a strong sense of the presence of the lost part" (Parkes, 2006, p. 31) is key here. One can understand how, if one loses a limb, one is confronted not only to how the world has

changed in terms of one's ability to get around and do things, but also to the body's response

in terms of nerve endings, the vascular system, and bone and cartilage, but also in terms of

the parts of the brain that controlled that limb seeking the feedback signals that it so requires

to continue its normal functioning. The brain and limb connection needs to create a sense of

the arm still being present even if the conscious part of the mind knows that the arm is gone.

The loss of a loved one functions in much the same way and as described by many experts in

bereavement, people invariably have a strong sense of the presence of the lost person

(Bowlby, 1998/1980; Field et al., 2005; Klass, 1986, 1997; Parkes, 1970/1998, 2006). The

attachment or caregiving systems as part of the assumptive world take a long time to

reorganize around the loss of a significant other, a limb, a home, or even a belief or view of

the world shattered by a traumatic event. In Bowlby's and Parkes' complementary view of

internal working models and of the assumptive world in the context of grief and loss there is

a complex neuro-biological adaptive process. Like Bowlby (1998/1980), Parkes (2006)

proposes that this process is, at least in part, mediated by retrospective attachment styles.

Parkes (2006) makes use of the (DPM) by Stroebe and Schut (2001, as cited in Parkes, 2006)

in order to help describe how changes to basic fundamental premises of the assumptive world

take place and how retrospective attachment styles potentially mediate this process. Parkes

(1998/1970, 2006) has brought much needed clarifications to the notion of grief work and

has proposed many interesting innovations in this area.

Rubin (1981, 1982, 1984a, 1984b, 1985, 1990a, 1992, 1993b as cited in Rubin, 1996)

proposes a Two Track Model of Bereavement in which track one assesses components of

overt functioning, namely: "anxiety, depressive affect and cognitions, somatic concerns,

symptoms of psychiatric nature, familial relationships, general interpersonal relations, self-esteem and self- worth, meaning structure, work, investment in life tasks" (Rubin, 2002/2001, p. 223). Track two assesses the relationship to the deceased: "imagery and memory, emotional distance, positive affect vis-à-vis the deceased, preoccupation with loss and the lost, idealization, conflict, features of loss process (shock, searching, disorganization, and reorganization), impact on self perception, memorialization and transformation of the loss and the deceased" (Rubin, 2002/2001, p. 223).

Rubin (1996) explains that grief research has put most of its emphasis on overt functional behavior in order to assess grief outcome. He then proposes that the field of grief research should make a distinction between more overt coping and adaptation to separation anxiety "…the painful unavailability of the deceased…" Rubin (1996, p. 219) which he describes in track one of his model. In track two, he defines the (mourning) grieving process as the "…process of reorganizing much of the covert internalized relationship with the deceased…" (p 219). He suggests exploring and assessing with the bereaved his/her inner representations of the deceased. These inner representations can be construed as similar to relational internal working models proposed by Bowlby (1980/1998, 2005/1979, 1988) with the difference that the inner representations of the deceased are not maintained by present and future interactions but by the bereaved through recollection.

Rubin (1996) describes the work he has done looking at grieving patterns of parents who had lost an adult son in military operations in Israel in the previous 13 years. He and his colleagues found that parents who used various strategies of grief avoidance such as avoiding others, denying the reality of the loss, not expressing their feelings and using alcohol or drugs

to manage their distress did not appear to be doing differently in the first year than bereaved

parents who did not use avoidance. It is in the long term, 4 to 13 years after the death, that

parents who use avoidance show significant differences in the severity of "…emotional,

social, cognitive, and somatic difficulties…" (Rubin, 1996, p. 223). Although Rubin and his

colleagues have not been able to link general coping styles or personality styles to the way

one approaches grief work, the research he describes does point in that direction.

Klass (1986) uses the psychoanalytical concept of identification in combination with

coping style and social environment as the main constructs to describe the grief process

(Klass, 1986, 1997). He considers that Bowlby's rejection of identification in psychoanalytic

theory to explain grief is not acceptable because of attachment theory's failure to clarify

> the centrality of the amputation metaphor in parents' descriptions of their grief and
>
> the central role the internalized dead child plays in their ongoing life after the
>
> resolution of bereavement shows that there is more to the resolution of parental
>
> bereavement than adjusting to a changed social environment. (Klass, 1986, p. 214)

Klass's (1986) point of view is interesting but it has been amply demonstrated,

through the discussion of Bowlby's (1998/1980) grief processing and Parkes' (1970/1998,

2006) psychosocial model of grief, that attachment theory involves both an internal and an

external world to adjust too. Clearly, affectional bonds are central to the existence of all

individuals in attachment theory.

Klass (1986, 1997) describes a model of grief based both on his long experience as a

participant observer with groups of bereaved parents and on theory available in the corpus of

the bereavement field, mostly psychoanalytic theory. For Klass (1986) a child is part of the

self, and to lose a child is comparable to an amputation of the self. Consequently the self itself needs to be redefined. Borrowing from Volkan (1981 as cited in Klass, 1986) Klass describes how the internalization of representations of the deceased child to replace the internalizations of representations of the child alive is the "…basic task of grief…" (Klass, p. 50) as this leads to both internal and social equilibrium and to comforting memories and solace. Two kinds of internalizations of the deceased are described by Volkan (1981 as cited in Klass, 1986), identification and introjection. Identification is described as the healthy internalization of the deceased because there are no pre-grief overwhelming conflicts in the self in which case the internalization of the deceased is experienced as an enrichment of the self providing solace and a new found autonomy once the integration has been completed.

Introjection is a pathological way of internalizing the deceased. Introjection is pathological because in such cases the self is not able to integrate the internalized object representations of the deceased and these end up as separate parts of the self. The object-representations of the deceased, still represent the deceased as being alive and the relationship is not transformed but kept intact (Volkan, as cited by Klass, 1986). This view is very similar to Rando's description of pathological grief (1986). Klass (1988) explains that he accepts the notion of identification but that if he were to accept the notion of introjections as pathological grief, he would have to consider all or most bereaved parents he has seen as going through pathological grief.

Klass (1988, 1997) is a strong proponent of normalization of phenomena frequently observed in the grief process by psychoanalytically driven grief work models. For Klass (1988) phenomena such as linking objects, hallucinations, and a strong sense of continuing

presence during bereavement should all be considered normal grief responses. He quotes

Rando (1986) in support of this claim and considers that there is no sense in seeing pathology

in such symptoms if the bereaved individuals find comfort in these. For Klass (1988)

pathology can be found outside of grief symptoms "…first in preexisting personality patterns

of the parent that were expressed in the parent's bond with the child. Second, pathology may

be based in inadequate or conflicted social support" (p. 177).

In terms of the Two Track Model, one could describe Klass' focus much more on

Track Two. Here is the definition Klass(1988) gives of inner representations:

Inner representations can be defined, following Fairbairn (1952) and Kernberg

(1976), as the part of the self actualized in the bond with the person, characterizations

and thematic memories of the person, and the emotional states connected with the

characterizations and memories. A child, living or dead, plays many roles within the

family and psychic system. (p. 150)

Western cultures offer very few possibilities of supporting the process of developing

an inner representation of the deceased (Klass, 1997). Some Asian cultures, Japan is one

example, permit the social expression of a relationship with the deceased through ancestor

worship (Klass, 1997). Such practice appears to facilitate and support the reorganization of

inner representations of the deceased. Klass (1988, 1997) proposes the study of the functions

of inner representations in grief resolution "…within individuals' membership in families

and communities" (1997, p. 173).

Bonnano (2002/2001), Bonnano and Kaltman (1999), and Bonnano Papa, Lalande,

Zhang, and Noll (2005) propose a focus of studies on coping styles and emotional regulation

through the lens of their own theoretical perspective, The Social-Functional Approach to

Emotion (SFAE). Based on cognitive stress theory, attachment theory, and trauma theory the

perspective makes a distinction between emotions and grief and proposes as study variables

the social-function of both internal and external emotions and coping strategies involved in

loss. According to the SFAE model, positive and negative emotions have both internal and

social communication functions. This process is mediated by cultural dictates and family

structure in terms of the expression of emotions (Bonnano & Kalman, 1999).

Emotions are very short- lived "lasting between a few seconds and several hours"

(Bonnano 2002, p. 494). The function of emotions is to manage the short-term coping and the

immediate challenges of both the internal and the social context related to grieving and assist

in the progressive and overall changes that occur in the adjustment to the loss process. The

SFAE also acknowledges that emotions can be elicited by autonomous processes (Bonanno

& Kaltman 1999). Grief itself is part of long-term appraisal and encompasses long-term

coping and adjustment strategies involved with a changing of identity and social environment

of the grieving person. Important elements of the social- functional perspective challenge the

curative assumption of grief work (Bonnano et al., 2005). These researchers interpret their

results as supporting the hypothesis of grief processing as rumination and as not supporting

traditional grief work. They consider that grief coping in western cultures is on a continuum

between "…resilience and rumination, with low or absent grief processing among resilient

individuals and excessive or ruminative levels of grief processing among more acutely or

chronically grieved individuals" (Bonnano et al., 2005, p.20). Working through the grief,

that Bonnano et al. (2005) label as rumination was often encouraged in grief counseling

without any evidence of its effectiveness (Bonnano & Kaltman, 1999; Wortman & Silver, 2002).

The resilient individual described by Bonnano et al (2005) compares well with Bowlby's (1998/1980) and Parkes' (2006) descriptions of a secure individual and with the model of hardiness in bereaved parents supported in a study by Lang, Goulet, and Amsel (2004). Basically, resilient, secure, or hardy individuals have the inner resources to acknowledge the loss and the pain surrounding the loss but they have the ability to do so while keeping a certain hope and optimism regarding the process of redefining who they are and what their social world is like without the deceased. There is however an important difference between Bowlby's secure individual and Bonnano et al.'s (2005) resilient individual. Bowlby' secure individual is not as immune or resilient to grief. Bowlby was suspicious of the individual who does not experience grief and was far from proclaiming absence of grief a healthy situation. Shaver and Tancredy (2002) note that normal grief reactions will involve a constriction of cognitions and emotions focused on searching, protest, and despair.

The large and mounting research evidence of the relational difficulties of avoidant children and adults who typically cope with grief with low or absent expressions of grief processing is difficult to ignore. (see, Ainsworth, 1982 ; De Zelueta, 1993; Fraley, 2006; Main & Weston, 1982; Mikulincer & Shaver, 2007; Mugai, 1999; Johnson, 2004). The fact that study participants who used deliberate grief avoidance report poorer perceived health (Bonnano et al., 2005) is reminiscent of the poor health outcomes in subjects who use avoidance as a grief processing strategy reported by Rubin (1996). These subjects develop

poor health over time compared to those who do not use avoidance (Rubin). Measuring grief

processing and its associated emotional regulation without benchmarking them with how the

spouse (in the case of the loss of a child) or other family members (in the case of the loss of a

spouse) experience the the grief processing is questionable. The issue of the adaptive value of

high resilience to grief as described by Bonnano et al. (2005) is unavoidable. In a systemic or

interpersonal coping perspective (Cook & Oltjenbrun 1998; Klass, 1986; Parkes, 2006;

Walsh & McGoldrick, 1991/2004), what are the social and interactional attributes or qualities

of people who show very low grief or absence of grief? How do these social and interactional

attributes impact the grief process of those around them? The same questions need to be

asked of people who show chronic grief. As stated by Archer (1999) grief per se is not

adaptive, but separation distress and the quality of attachment and caregiving relationships

are.

Shaver and Tancredy (2002/2001) propose a model of emotion theory that can be

empirically tied to attachment styles and grief processing as proposed by Bowlby

(1998/1980) and other attachment theorists such as Main and Solomon (1986, 1990, as cited

in Shaver & Tancredy, 2002) and Main and Hesse (1992). Shaver and Tancredy explain that

they consider grief to be a "…complex of emotions rather than a single emotion…" (p.69)

this view is in line with Archer (1999), Bonnano et al. (2005), and Bowlby (1998/1980,

1988). Emotions have an evolved purpose. Fear for example, propels towards safety, anger

will help a person to stand her/his ground in front of an enemy, or to attempt to retrieve

something that has been taken away. Shaver and Tancredy (2002/2001) explain that it has

been a great struggle for researchers to agree on the function of grief and sadness. They refer

to Archer (1999) who considers sadness and depression in grief as contributing "… to the abandonment of unattainable goals (eg. Archer, 1999; Klinger, 1975, 1977)" (Shaver & Tancredy, 2002/2001, p. 69). This function of sadness and depression is very much like Bowlby's (1998/1980) description of the reorganisation of internal working models. Individual appraisal of what triggers emotions is both genetically programmed and learned. Individual emotions during grief are individual action potentials that occur in response to the "…set of natural action tendencies and behavior…" (Shaver & Tancredy, 2002/2001, p. 67). These natural action tendencies can be considered as the four phases of grief as described by Bowlby (1998/1980). They are numbing, protest, despair, and reorganization. These stages are the backdrop to the specific individual's appraisal of events. According to Shaver and Tancredy (2002) these appraisals are different for every individual based on their specific internal working models regarding the expression of emotions. Based on retrospective attachment styles and social constraints, there is "Appraisal of the event in relation to goals, wishes and concerns [as well as] appraisal and emotion- specific thought and action tendencies (and their underlying physiology) [which lead to] expressions, thoughts, behaviors, and subjective feelings" (Shaver & Tancredy, p.67). They consider that coping and self-regulation are basically the same thing and that it is useful to consider grief process as impacted by both the personal experience and the social context. They consider the work by Bowlby (1998/1980) on attachment styles and grief to be empirically based and propose more empirical research on correlations between retrospective attachment styles as appraisal systems, and the corresponding emotions evoked during grief. They explain that focusing on emotions as action potentials mediated by grief, retrospective attachment style and social

constraints makes for a more complex model of grief than simply looking at depression or distress as it has been the case in the past (Shaver & Tancredy).

Shaver and Tancredy (2002/2001) also propose the notion of resolution of grief as the ability to speak of the loss in a coherent and organized manner. They cite Main and Hesse (as cited in Shaver &Tancredy) as the first to describe resolution of loss in this manner. This follows work by George, Kaplan, and Main (as cited in Shaver & Tancredy) and by Hesse (as cited in Shaver & Tancredy) on the Adult Attachment Inventory (AAI). In their studies of adult attachment styles, individuals having insecure attachment styles were further described as resolved or unresolved based on the coherence of discourse regarding childhood events. This coherence is both cognitive and emotional. Shaver and Tancredy (2002/2001) as well as Rubin (1996) propose a similar assessment model for grieving individuals. For example, individuals who ruminate about a loss are not able to speak of the loss in coherent and organized ways. Individuals who are classified as avoidant would have a tendency to appear as resolved in their grief sooner than secure and anxious individuals, but Shaver and Tancredy (2002/2001) insist that it would be a mistake to classify secure individuals doing grief work in the same category as avoidant individuals.

Shaver and Tancredy (2002) advocate for the inclusion of disorganized attachment as a category in grief theory. This category of disorganized attachment was first described by Main and Solomon (as cited by Shaver & Tancredy, 2002/2001). Individuals with disorganized attachment were never able to develop an organized or coherent attachment strategy in front of unpredictable and frightening behavior of their caregiver. These individuals would have a very difficult time coping with grief in a coherent fashion because

they are disorganized both at a cognitive and emotional level. They would tend to have very erratic and unsure cognitive and emotional responses to the death of an attachment figure. In fact they would tend to manifest very complicated grief.

How grief is processed is an important marker in terms of making distinctions between normal grief and complicated grief. These distinctions are still somewhat elusive and controversial within the grief research community but a consensus around the contributions of attachment theory and of emotion theory appears to be slowly emerging.

Dual processing model.

The Dual Processing Model (DPM) is based primarily on attachment theory and on research in grief and trauma (Stroebe, Shut, & Stroebe, 1998; Stroebe & Schut, 1999, Stroebe, Schut, & Stroebe, 2005). The DPM is a taxonomic model that explains grieving as a dynamic process in which individuals oscillate, in order to achieve self-regulation, between two types of essential grieving stressors: the loss and the restoration orientations of coping with grief (Stroebe & Schut, 1999, 2002). Both orientations include cognitive and emotional coping with the death. The loss oriented stressor refers to being focused on the loss of the deceased, involves denial/avoidance of restoration changes and such processes as:

> …rumination about the deceased, about life together as it had been, and the circumstances and events surrounding the death. It also encompasses yearning for the deceased, (…) or crying about the loved person. It is evident that a range of emotional reactions are involved, from pleasurable reminiscing to painful longing, from happiness that the deceased is no longer suffering to despair that one is left alone."
> (Stroebe & Schut, 1999, p. 212-213)

The restoration oriented stressor involves "attending to life changes, doing new things, distraction from grief, denial/avoidance of grief, new roles, identities/ relationships" (Stroebe & Schut, 1999, p. 213). Restoration orientation can be generally described as attendance to all the secondary issues tied to the loss, from role changes, to new tasks to attend, as well as attending to the relational consequences (both positive and negative) of losing a significant other in the family system. Part of the function of restoration oriented stressors is to distract from grief and even to help in the denial and avoidance of grief.

The central and dynamic process of the DPM is oscillation between grief-coping orientations (Stroebe & Schut, 1999). Within each grief- coping orientation there is also an oscillation process between positive and negative emotions and cognitions. For Stroebe and Schut (1999), grief coping involves a process of confrontation and avoidance of the various stressors. At the beginning of grieving, attention tends to be more loss-oriented and focused on the bonds with the deceased. With time, the attention moves towards resolution orientation. Oscillation implies a "…waxing and waning, an ongoing flexibility, over time" (Stroebe & Schut, 1999. p. 213). This regulatory movement that appears to prevent the bereaved from being overwhelmed by grief is idiosyncratic to every individual but is also influenced by the context the individual evolves in (Stroebe & Schut, 1999). Oscillation is considered to be part of optimizing mental and physical health throughout the process of adjustment to the loss (Stroebe & Schut, 1999).

Normal or healthy grieving implies being able to dynamically oscillate from one spectrum of the DPM to the other and to take "time out" (Stroebe, 2002, p. 134) from either tasks or from grief all together. Oscillation is described by Stroebe and Schut (1999) as a

dynamic cognitive process that allows for a progressive and necessary confrontation of the loss as well as progressive attempts to do things in a world that does not involve the deceased anymore. Oscillation was used in a number of occasions by Bowlby (1998/1980) to describe a progressive integration of a painful reality, and oscillation also refers back to Freud's notions of ambivalence in the process of grief work and reality testing. Parkes (1998/1972, 2006) also gives oscillation an important place in the grief processing.

The restoration-orientation tends to be future-oriented and the loss-oriented end of the spectrum tends to be past-oriented. Both restoration and loss orientations are part of the restoration process involved in the grieving process. Stroebe (2002) explains that

According to the DPM, then, adaptive grieving is not just 'grief-work' as traditionally defined, but a complex process of confrontation and avoidance of the positive and negative emotions and cognitions associated with loss, on the one hand, and its consequences for ongoing life, on the other." (p. 134)

The process of oscillation implies that the more one is secure in terms of attachment style and/or has social support, the more easily emotions, cognitions, and tasks related to the loss can be confronted and processed (Stroebe & Schut, 1999, 2002).

More recently, Stroebe, Schut, and Stroebe (2005) have clearly associated the DPM with attachment theory, suggesting that individuals who have an anxious attachment style will tend to be more focused on loss orientation. They can become rigidified in what Bowlby (1998/1982) described as "chronic mourning" because they cannot oscillate to resolution orientation or take pauses in grieving (Stroebe & Schut, 2001/2002a). Individuals who are very avoidant are described as restoration – oriented and will have a tendency to be stuck in

what Bowlby (1998) described as "…more or less prolonged absence of conscious grieving…" (Bowlby, 1998/1982, p. 139). Furthermore, avoidant individuals cannot oscillate towards loss orientation because they tend to be rigidified in the restoration aspects of the grief and in the avoidance of their separation anxiety (Stroebe & Schut, 1999).

Anxious avoidant attachment and anxious preoccupied attachment and their corresponding grief orientations also correspond somewhat to Freud's (1995/1917) description of narcissistic and hysteric regression, to Lindemann's (1979/1944) two categories of morbid grief, the postponement of grief and chronic grief, to Rubin's (1995) description of avoidance and of idealization of the deceased in coping with grief, and to Bonnano et al.'s (2005) categories of resilient and excessive rumination of grief.

Shaver and Tancredy (2002/2001) state that the natural oscillation that occurs in the grieving process as described in the DPM can explain the changes in salient emotions during the grieving process. The notion of oscillation also permits the tracing of the coping strategy preference of individuals as mediated by retrospective attachment style and social constraints of the expression of grieving.

For Parkes (2006), the DPM describes the interplay between the autonomous response of the attachment system and the assumptive world which is conscious of current events. The autonomous responses of the attachment system calls for a retrieval and reunion with the deceased and is painfully frustrated. At the same time, the assumptive world seeks to use elements of the existing but lagging assumptive world in order to create new security and meaning without the presence of the deceased in the world. This interplay involves the building of a continuing bond with the deceased that becomes part of the assumptive world,

and that progressively permits one "to let go of the person 'out there' simply because we realize that we never lost them 'in here' " (Parkes, 2006, p.35).

The work of Bowlby (1969/1982, 1998/1980, 1988), Parkes (1964, 1965a, 1965b, 2006), and Strobe and Schut (1999), all are major contributions to grief theory and have pushed our understanding of coping with loss. Building on each other's work and on empirical evidence, some notions that Freud called the "unknown economics of grief" (Freud, 1995/1917, p.589) are beginning to be more clearly understood. Attachment theory, the psycho-social transition theory and the DPM lead to better understandings of the complexities of the individual grieving process, and of the discrepancies found in this process. Attachment theory, the psycho-social transition theory and the DPM also allow expression of reservations regarding traditional grief intervention such as grief work (Bonano & Keltman, 1999; Bonano et al., 2005; Parkes, 1982, 2001, 2006; Fraley & Shaver, 1999; Riches & Dawson, 2000; Stroebe & Schut, 1999)

The Review of the Parental Grief Literature

The loss of a child is considered by many to be more difficult than other types of losses. The grieving process appears to be longer and more complex (Archer, 1999; Klass, 1988, 1997; Klass & Marwit 1988; Malkinson & Bar-Tur, 1999, 2005; Rando,1984, 1986, 1997; Sauders, 1980; Rubin & Malkinson, 2001; Wijngaards-de Meij et al.,2005, 2007). Grief associated with the death of a child is especially intense in the first year (Bohannon, 1990; Digregov & Digregov 1999; Klass, 1988), and has been found to still be present five to eighteen years later in some circumstances (Digregov & Digregov, 1999; Jiong et al. 2005; Li et al., 2003, 2005; Murphy, 2002; Rogers et al., 2008; Rubin & Malkinson, 2002).

Rando (1986) called for the creation of a specific category of grief expectations for bereaved parents, explaining that the grieving process is often much longer for them. When seeking help from professionals, bereaved parents' intensity and length of grief is often considered as pathological or chronic mourning because there is not a recognition of the difference between parental grief and other grief. Rando (1997) considers that the loss of a child is a criterion for traumatic grief. Klass (1988) describes parental grief as acute in the first year, and then becoming progressively less acute in years two and three, however, he states that these time frames vary according to the individual. Klass (1988, 1993, 1997), Malkinson and Bar-Tur (1999, 2005), Riches and Dawson (2000), and Rubin and Malkinson (2001) explain that parental grief is a lifelong process that evolves, but never ends.

Many researchers observe the fierce desire of bereaved parents to maintain a relationship with their deceased child (Klass, 1988, 1993, 1997; Malkinson & Bar-Tur, 1999, 2005; Murphy, Johnson, & Lohan, 2003; Riches & Dawson, 2000, 2002; Rubin, 1995; Rubin & Malkinson 2001). If Bowlby and Parkes (1970) and Bowlby (1998/1980) first contested Freud's notion of decathexis (1995/1917), the most recent questioning of detachment-from-the-deceased hypothesis certainly came from studies and clinical observations of bereaved parents (Klass, 1988; Klass, Sylverman, & Nickman, 1996; Rubin, 1996; Malkinson & Bar-Tur, 1999, 2005). The DPM is useful here again, as it permits one to consider that attachment styles would make a difference in terms of the intensity and length of the continuing bond with a deceased child by bereaved parents. Bereaved parents at either extremes of the DPM will theoretically present different continuing bonds with their deceased children.

Berrera et al. (2007) and Rando (1986) refer to Bowlby (1998/1980) in explaining that the attachment bonds between parents and children are different from other attachment bonds and that these differences should be explored. Archer (1999) hypothesizes that the loss of a child is more difficult to adjust to because of two evolutionary considerations. First of all the child shares 50% of parent's genes and human beings seem to be organized to ensure the survival of their genes. This very consideration actually underpins the need for close bonds and parental care of children in order to ensure the survival of the species (Archer).

This could explain the observation by Parkes (2006) and Rubin and Malkison (2001), that taking care of children is like caring for the self and that loss of a child has important self-redefining impacts (Klass, 1986, 1993; Rando, 1983; Riches & Dawson, 2000). The study of these two issues and of their impact on the grief process in the loss of a child is suggested by Archer (1999, 2002/2001) in his discussion of grief from an evolutionary perspective. The loss of an only child would also be very difficult both because of the intensity of the caregiving bond but also because of the only child's more important reproduction value (Archer).

Berrera et al. (2007), Field, Gao, and Paderna (2005), and Wijngaards-de Meij et al., (2007) also note that the loss of the child is probably the most difficult of all losses partly because it is the loss of a caregiving relationship. Field et al. (2005) explain that there is no research trying to establish correlations between certain types of attachment relationships, such as the parent/child caregiving relationship, and the type of continuing bonds that appear following a death. Field and colleagues suggest that the main function of the caregiving

system is to provide protection to the child, "It therefore follows that the death of a child should activate the caregiving system such that the parent will attempt to recover the lost child in the service of protection. A dominant concern then is whether the child is safe." (p. 291)

Field et al. (2005) propose that parental bereavement is a struggle with negative or positive representations or continuing bonds that tend to evolve around the notion of protection and whether the child is safe or not, in a good place or not. These investigators also suggest that this process will be influenced by attachment styles and that more research needs to be done in this area. For example, their findings suggest that the parentification of a deceased child could be interpreted as symptomatic of an anxious insecure attachment style.

This concurs with Bowlby's (1980) and Rubin's (1995) notions of internal representations and the continuing and reorganizing relationship with the deceased. Field et al.'s (2005) notion of continuing bonds is also close to the work of Klass (1988, 1997) and Riches and Dawson (2000) who describe a process of relocation of internal representation of the child from alive to dead. Because of their post-modern approach, which makes the social environment a key element of the bereavement process, social support such as group work is the way Klass and Riches and Dawson envisage how this transition is actualized. Thus, attempts at categorizing individual patterns of grief processing is not a focus of their research and work with bereaved parents. Rather it is in defining what works or does not work for parents in terms of support. For example, having parents present their child in a support group and bring photos and discuss their life with their child before and after the child died is an important part of the process of relocation of internal representations approach used in

both the work of Klass and Riches and Dawson.

The parental bereavement literature also frequently focuses on the fact that bereaved parents present important emotions of anger, blame, guilt, and despair (Barr & Cacciatore, 2008; Hogan, Greenfield, & Schmidt, 2001; Possick, Sadeh, & Shamai, 2008; Rando,1983, 1986; Rubin & Malkinson, 2001/2002; Surkan et al., 2006; Wing, Burge-Callaway, Clance, & Armistead, 2001). Bowlby and Parkes (1970) and Bowlby (1998/1980) have described how these emotions are syndromic and part of a loose phasal evolution of the grieving process aimed initially at the retrieval of the lost beloved person. These responses were hypothesized by Bowlby (1980) to be mediated by attachment styles and the social environment.

Barr and Cacciatore (2008) report on an online survey of 441 women who suffered miscarriage (67), stillbirth (194), neonatal death (78), and infant or child death (102). In their statistical model, time since loss explained 13% of the variance in grief. This research team also found that personality-based envy explained a further 16% of the variance. Predisposition to guilt accounted for 6% of the variance, shame explained 5%, and jealousy 3% of the variance. In terms of the relationship between jealousy and grief, Barr and Cacciatore suggest that there could be a shared correlation with an unmeasured variable such as an attachment style or that grief and jealousy are "…separate but related compound emotions or 'passions' evoked by loss" (p.342). Barr and Cacciatore (2008) conclude, that in their sample of bereaved mothers, if negative emotions are preexisting to the loss of a child, the grieving process will be aggravated or complicated.

More studies are needed to explore or examine the relationships between parental loss

and the intensity and patterns of these syndromic responses in relation to attachment styles as well as to the quality of social support. All of these notions fit well with the DPM and add to the discourse around the dynamics of bereavement depending on the type of loss, coping style of the bereaved parent, and the quality of the social support.

Parkes (2006) did not find that bereaved parents have more intense grief than adults who have other losses. However, Parkes considers that Archer's (1999) hypotheses are valuable contributions to the understanding of the grief process, but that such an outlook should not discount or deplete the emotional content of human relationships (Parkes). Thus Parkes concludes "The child I love represents me both genetically and symbolically" (Parkes, p. 175), and this statement also explains that our nurturing relationships with our children are often the closest relationships we have and will ever have. There is an element of our own self-nurturance when we care for our children as children reciprocate the love we give them. Often as parents we use the relationship with our children to "redress the imbalance of our own deprivation. If we then lose that child we are doubly bereaved and our dreaded world becomes our assumptive world" (Parkes, p. 175). Parkes then concurs with Klass (1988) to state that "the child is part of the psychic structure of the parent" (p.175).

Fish (1986), Klass (1988, 1993), Parkes (1998/1972, 2006), Wing Clance, Burge-Callaway, and Armistead (2001), and Rando (1983) all use the notion of amputation to describe the grieving process. For Klass (1988, 1993), this metaphor is particularly fitting to the loss of a child as the amputation metaphor describes the depth and intricacy of the relationship between the parent and the child. The amputation metaphor also helps us understand how there is a neuro-biological connection between parent and child (Ainsworth,

1982) which needs to be reorganized following the death of a child (Bowlby, 1998/1980, Parkes, 1998/1972, 2006). Klass and Marwit (1988) speak of the loss of a child as "rather complex reorganizations of the psychobiologic regulatory systems" (p. 46). As described previously, Klass (1988, 1997) conceptualizes the process of grieving the loss of a child as a reworking of the self in which one has to let go of the inner representations of the living child, for the inner representations of the child as dead. It is a long and difficult process in which linking or transitional objects, denial, hallucinations, and feeling the presence of the deceased child are common occurrences (Klass, 1988, 1993, 1997). Most often, these phenomena are not pathological but rather can be seen as regulatory or hormonal changes in the bereaved parents. They are steps towards achieving a certain solace or resolution when thinking of the child.

Bonanno et al. (2005) and Pressman and Bonanno (2007) both found a significant difference between cultures in terms of the lost relationship type. In the PRC the conjugally bereaved scored higher on levels of grief processing, and not the bereaved parents as was the case in the U.S. (Bonanno et al.; Pressman & Bonanno). These results and those of Parkes (2006) would put into question the hypothesis of parental loss as the most difficult of the losses universally. It is interesting however that in the data presented by Pressman and Bonanno, the variable of avoiding thinking about the deceased is significantly higher for the Chinese parentally bereaved subjects than the Chinese conjugally bereaved and higher also than both the parentally bereaved and conjugally bereaved U.S. participants. This could be interpreted as an indication that the death of a child is not as important culturally as the loss of a spouse in the PRC, leading the parents to use more avoidance of thinking of the child

than in the U.S. where the loss of the child is recognized as a painful loss and where the

relationship with the child is as valued as the relationship with the spouse if not more.

Clearly, more research is needed in this area of cross cultural grieving rituals and their impact

on individual grief.

Anderson, Marwit, and Vanderberg (2005) studied a sample of 57 mothers who lost

their child from a sudden unexpected death and who were an average of four years post loss.

In this group, mothers who used avoidance coping had less intense grief and were

functioning better than mothers who used emotional coping. Anderson et al. concluded that

four years post loss, avoidance coping is beneficial and propose that "the rumination quality

of emotion-oriented coping is detrimental to psychosocial functioning" (p. 821). The

researchers explain that the sudden loss of a child combined with time probably have an

impact on their results. Anderson et al. also report a significant interaction between task

oriented coping (that is similar to resolution oriented coping in the DPM) and positive or

constructive coping. The researchers states that the way some communities use religious

beliefs to cope with the death of a child should also be given more consideration in studies of

bereaved parents.

Matthew and Marwit (2004) report that bereaved parents have significantly more

negative assumptive world views compared to parents who have not lost a child. Bereaved

parents "see the world as less benevolent and less meaningful, and experience the self as less

worthy of good events" (p. 130). This is very similar to Rogers et al.'s (2008) findings

regarding a lower sense of purpose in life for bereaved parents. Their study found that

parents who lost a child to illness were able to maintain a view of the "world as good and

decent (benevolent) and themselves as worthy, yet find it hardest to make sense of their loss" (p. 131). There is a great sense that the world is random and unpredictable in parents who have lost a child by illness and much of their work around rebuilding their assumptive world revolves around this issue. Matthew and Marwit also found that "…more negative views regarding the benevolence of the world, meaningfulness of the world, and worthiness of the self significantly predict higher levels of reported grief " (p. 133). Although not explored in this study, it is conceivable that bereaved individuals who are considered secure (Parkes, 2006; Stroebe, 2002; Stroebe, Schut, & Stroebe, 2005) or resilient (Bonnano et al., 2005; Lang et al. 2004) would have less of a tendency towards negative views of their assumptive worlds.

Wijngaards-de Meij et al. (2008) studied the circumstances surrounding the loss of a child to see whether they had any influence on the levels of grief in parents. The researchers found that parents who either directly or symbolically said farewell to their child had significantly lower levels of grief than those who did not find a way to say farewell. Wijngaards-de Meij et al. also found that parents who showed their deceased children in the home, before the funeral, had significantly less grief than those who showed their children in the funeral home, before the funeral. There is no way of knowing if the improvement is in the act of saying farewell or showing the child at home or if the parents who did so had certain other qualities that motivated their actions and by the same token facilitated grief. Koocher (1986) states that children whose parents were open about their child's cancer diagnosis did better psychologically than children whose parents had not been open about the diagnosis. Parents who were able to say farewell to their child were possibly more open in their

communication styles and were also more secure or resilient. Wijngaards-de Meij et al. also found that parents who lost a neonate have less grief than a parent who loses a child through illness and those parents whose child died after an illness have less grief than those who lose a child suddenly through an accident. These findings were observed at three points in time, 6 months, 13 months, and 20 months after the death. A number of studies have also noted higher levels of grief with sudden and unexpected deaths (Lohan & Murphy, 2002; Wijngaards-de Meij et al., 2005).

Wijngaards-de Meij et al. (2005) found it important to clearly distinguish between grief and depression. The researchers state that too often in grief research intensity of grief is associated with levels of depression and, according to their study of couples who have lost a child, this is a mistake. Wijngaards-de Meij et al. found that the variables most predictive of grief were those that were shared by the parents, namely "child's age, cause and unexpectedness of death, and number of remaining children" (p. 617). The number of surviving siblings also contributes to the levels of grief of parents, the greater the number of surviving siblings the lower the grief. The cause of death and the unexpectedness of the loss also influence levels of grief; death by accidents, suicide, and murders all bring about higher levels of grief in parents (Wijngaards-de Meij, et al.).

Lang and Gottlieb (1993) and Lang et al. (1996) both found that sudden unexpected loss of a neonate or infant led to higher levels of grief in bereaved parents. Sanders (1980) does not note a difference between parents who lost a child following an illness or through sudden unexpected death (however the sample was very small, 14). Fish (1986) found that sons evoked higher levels of grief in fathers at all ages than loss of daughters; for mothers,

the loss of a son only evoked higher levels of grief when the child died under the age of two. Lang and Gottlieb and Lang et al., also noted that anniversaries of loss and of birthdays tend to increase levels of grief even years following the loss. These observations are in line with Rando's (1993) concept of subsequent temporary upsurges of grief (STUG) that she described as a normal reaction forever after the death of a significant person in one's life. STUG occurs at birthdays, anniversaries, and other important events in the lives of those who survive.

Wijngaards-de Meij et al. (2007) found that attachment styles in bereaved parents explained 14% of the variance of grief and 16% of the variance of depression. Contrary to previous studies (Field & Sundin; Fraley & Bonano; Wayment & Vierthaler, all cited by Wijngaards-de Meij et al., 2007), parents who scored high on avoidant attachment, experienced significant negative effects to the loss of their child. Contrary to studies by Bonano et al. (2005), for example, they conclude that "bereaved parents whose interpersonal relationship style is characterized by discomfort with and wariness of closeness or intimacy are not resilient, do not use defense mechanisms effectively, and are not psychologically well adjusted" (Wingaard-de Meij et al., p. 544). The researchers explain that in the case of the death of a child, parents who prefer avoidance or deactivation as a coping strategy are not able to shut off attachment emotions or separation anxiety related to their children. Such parents find themselves overwhelmed by unmanageable feelings of loss. Wingaard-de Meij and colleagues conclude that bereaved parents with high avoidance should also be considered a high risk group just as much as parents who are high on anxious attachment. Results of their study also showed no relationship between levels of grief, levels of depression. and the

insecurity of the spouse, nor was there a relationship between grief and gender.

Wijngaards-de Meij et al. (2008), explored interdependence in grieving using constructs emerging from the DPM. The researchers found that men had a tendency to be more resolution-oriented and women tended to be more loss-oriented. Parents who were resolution oriented showed better adaptation to grief over time. Whereas parents high on loss-orientation had a tendency to be more depressed and show less adaptation to grief. Having some levels of resolution-orientation when high on loss orientation, had a mediating effect on depression. Overall men who were resolution oriented would be affected in terms of levels of depression and grief not only by their own coping orientation, but also by the coping orientation of their wives. The more the wife was loss oriented the higher the levels of depression and of grief in the husband. Conversely, the more resolution oriented the wife the less depression and grief in the husband. Women who were loss oriented were not affected by their husband's coping orientation. The authors explain this as being due to the loss-oriented women being more emotionally focused on their ongoing relationship with their deceased child rather than on their husbands. Wijngaards-de Meij et al. (2008), propose that it is difficult for the partner who is more resolution-oriented to process their grief if their partner is continuously focused on the loss. It also appears that resolution orientation is more dependent on social support than loss orientation. The researchers conclude that looking at a combination of intra and extra personal variables in parental grief processing is essential (Wijngaards-de Meij et al).

The results of these numerous studies appear to support the notion that parental grief is a complex and multifaceted syndromic response to the loss of a child influenced by

evolution, biology, intrapersonal attributes, and socio-cultural relations (Archer, 1999; Field et al. 2005; Lang et al., 1996; Rando, 1986; Sanders, 1980; Stroebe, Folkman, Hanson, & Schut, 2006; Wijngaards-de Meij et al., 2008). Grief processing is both a universal yet very individual and contextual phenomenon that is still being circumscribed and in fact may well be best considered in terms of pathways as in the DPM (Stroebe et al., 2006) and attachment theory (Bowlby, 1988).

The studies described here all offer their perspectives of what influences and modulates the parental syndromic manifestations of grief such as anger, blame, guilt, despair, reorganization of the self, or of the assumptive world. To continue exploring parental grief is worthwhile, in order to help normalize the importance and intensity of this type of grief but also to see if relationships between some types of grief reactions and variables such as attachment styles can be found.

The DPM and bereaved parents.

An important contribution of the DPM is that this model helps take into consideration the universal aspect of the individual and the relational aspects of grief. The DPM facilitates an understanding of how individuals need to process the reality of the loss and what can happen when there are internal and/or social and relational obstacles to oscillation (Stroebe & Schut, 1999). For example, with the help of the DPM we can more easily understand the findings by Lepore, Silver, Wortman, and Wayment (1996) that bereaved mothers who reported social constraints in discussing the loss of their child , experienced significant levels of negative intrusive thoughts as well as a relationship between intrusive thoughts and depressive symptoms. The reverse relationship was also found, such that, mothers who did

not report social constraints to discuss the loss of their child, did not show a relationship between intrusive thoughts and depressive symptoms (Lepore et al., 1996. The loss of the child creates attachment insecurity (Bowlby, 1998/1982) in both spouses. Attachment security has to be re-established. This is a major challenge if the spouses cannot be supportive and understanding of each other (Stroebe & Schut, 1999, Cook & Oltjenbruns, 1998). A good example of this is Wijngaards's et al. (2008) finding that in bereaved fathers, the more their wives were loss-oriented, the more the fathers tended to be depressed. The more their wives were resolution-oriented, the less the fathers were depressed. The grief coping orientation of the husband did not impact women who tend to be loss-oriented.

Discrepancy in attachment styles and/ or discrepancy in insecurity begins or enhances a negative communication cycle (Johnson, 2004; Johnson & Wiffen, 1999). Johnson (2004), a couple therapy researcher, reports that the majority of couples requesting therapy and in marital distress have insecure and /or discrepant attachment styles. This brings about more difficulty or an inability to support each other and creates insecurity in the couple that leads to marital distress. In the grieving couple, it is quite possible that this insecurity is heightened by the death of their child. This then could lead to an erosion of attachment security between the spouses (Bing- Hall, 1999; Clulow, 2001; Johnson, 2004), creating an expanding and vicious negative communication cycle that leads to marital distress (Gordon Walker et al. 1996; Johnson, 2004, Parkes, 2006), psychological distress, and the potential for higher levels of grief (Gilbert, 1997; Cook & Oltjenbruns, 1998; Rando, 1986, 1997).

The DPM is very useful in bridging the theoretical and research literature on bereaved couples that is primarily focused on gender grief coping discrepancies in couples. For

example, it can give a strong theoretical basis to some observations that gender based differences in grieving strategies in couples are not universal. Digregov and Digregov, (1999) present three studies that found approximately 20% of fathers have symptoms of grief which exceed that of their female partner (Benfield, Leib & Vollman, 1978; Dygregov & Matthiesen, 1987b; Zeanah et al, 1995, as cited in Digregov & Digregov, 1999). According to the DPM and to attachment theory men can have a preoccupied and loss-oriented grieving style while women can have an avoidant and resolution oriented grieving style. Thus it is possible that retrospective attachment styles and the ensuing grief orientation could predict a larger percentage of the variance than gender in grief discrepancy in bereaved couples.

In a study on the DPM coping styles of loss orientation and resolution orientation, Wijngaards-de Meij et al. (2008) found that if a parent utilized one or the other grief coping orientation styles, the researchers were not able to find an effect of gender on levels of grief. Thus, the main effect on levels of grief was grief coping orientation rather than gender. In terms of depression, Wijngaards-de Meij et al. found a significant interaction between gender and restoration-orientation. This interaction was stronger for women than men. When women were high on restoration-orientation, this was associated with lower levels of depression than in men who were also high on restoration-orientation. Further analysis also found an interaction between men who are restoration-oriented and the grief coping orientation of their spouse/partner. The more resolution oriented the bereaved mother the less the restoration-oriented father was depressed (Wijngaards-de Meij et al.). There were no such interactions for loss-orientation. The researchers note that loss-orientation appears to be a self-absorbed process that is not impacted by gender or by relational issues.

The previous discussion on the DPM suggests that what has been considered as gender-based discrepant grief in couples historically, could now be explained in terms of discrepant attachment styles.

This discussion is quite congruent with the DPM according to which Stroebe and Schut (1999) state that women tend to be more loss-oriented, to focus more on the emotional and relational aspects of the loss, and to be more past oriented in their grief than men. Men tend to be more resolution oriented, to use more avoidance of grief, and be more task and future oriented. Stroebe and Schut, explain that extremes in both types of grief strategies female or male would tend to create individual grief complications or unhealthy grief, but also would have a tendency to create incremental grief as explained by Cook and Oltjenbruns (1998). For Stroebe and Schut, the ability to oscillate from the female to the male task of grieving is the optimal grief strategy and would promote resilience to loss. As people go from one task to the other, they are attempting to go through the painful process of accommodating the loss by both acknowledging the loss and its emotional consequences as well as acknowledging the need to master the outside world without the person they have lost. These ideas follow along the lines of Bowlby's (1980, 1988) argument that secure individuals have less difficulty processing grief. To stay in one grief orientation or the other can be considered as only a partial acknowledgement of and an attempt to deal with the loss through assimilation as opposed to accommodation which would be the result of oscillation. Hence, a parent (more often mothers) who tends to restrict their grieving to a loss-oriented strategy and who focuses on maintaining the relationship to their lost child will be less open to challenges to the fragile balance they are trying so hard to maintain in terms of staying true

and engaged with their lost child when there is no child to reciprocate. Any threat to this fragile balance is experienced as threatening and as a new potential loss. If the spouse feels threatened by this grieving strategy, or is not able to understand or support it, then, this creates incremental loss and an inability for the spouses to support each other. A similar pattern will ensue in a couple with a spouse who is more resolution-oriented in his/her grieving strategy and the other spouse challenges this strategy or feels threatened or isolated by it. Couples in which each of the spouses are extreme in their grieving strategies will most likely have more difficulties supporting each other.

In terms of the couple and gender grieving differences, the DPM is a useful theoretical and evidence based model to help us understand some of the important relational dynamics that come to play following the loss of a child.

Secure and insecure attachment.

Secure attachment.

Through the repeated experience of reassurance and availability of the caregiver the secure child develops a conviction or an emotional-cognitive working memory (Berlin, 2002) permitting him/her to be confident of the availability of others when he or she needs them (Bowlby, 1998/1980; Cassidy, 1999; Fraley & Shaver, 1999; Johnson & Whiffen, 1999; Weinfield, Sroufe, Egeland, & Carlson, 1999). The secure child grows up to believe in the possibility that the world is a safe place and that whatever happens he or she will be able to achieve a return to a comfortable state of attachment security in which distress and anxiety are manageable (Berlin, Fisher, & Crandel, 2001). The secure child will also be able to use coping strategies such as avoidance and protest in a spontaneous way in order to assist him or

her to achieve his or her goals (Bowlby, Bretherton, & Munholland, 1999). The secure child

grows up confident that others will hear and support him in times of distress (Berlin, 2002).

For children who have an environment that promotes security and open communication there

will be little or no "defensive exclusion of information" (Bowlby, 1982, p. 674) or

dissociative processes and the child develops as an adult who can explore the environment

and more easily integrate challenges such as loss and bereavement emotionally, cognitively,

and symbolically. Adults who grew up with a secure attachment style will be able to have a

healthy dependence on others and accept that others are dependent on them. Grieving will

still be painful and difficult with numbing, pining, yearning, despair, and reorganization as

normal grief and coping reactions (Bowlby). The secure individual will meet this challenge

by understanding that grieving is a process that takes time but in which he or she will be able

to adapt. A secure individual will also be better able to give support and to ask for support

and comfort when needed (Bowlby; Parkes, 2006; Wijngaards-de Meij et al., 2007).

Insecure attachment.

Bowlby (1988) was also interested in explaining mental health problems of children

and eventually adults who suffered from poor parenting and difficult life events or what he

called developmental pathways that lead to insecure attachment styles. In cases where

children do not experience open communication and consistent or reassuring availability of

the primary caregiver, the child will be put in a situation of frustration, anxiety, despair, and

reorganization in order to adjust to the loss of security. A child cannot stay in despair for a

very long time, he/she must grieve for the loss of the innate sense of security and then adapt

emotionally, physiologically, and cognitively to the circumstances at hand when the

caregiver is either hostile, distressed, depressed, or anxious and cannot help the child achieve

emotional regulation and attachment security (Berlin, 2002; Bowlby, 1980/1969, 1998/1980;

Liotti, 1993; Main & Hesse, 1990). If the relational environment is not secure, the child will

have no other recourse but to protest, despair (grieve), and then adapt by reorganizing the

way he/she regulates emotions. The child will have to develop habitual internal working

models of behaviors, emotions, and cognitions that involve defensive exclusion (Bowlby,

1982) to achieve as much security as possible (Bowlby, 1998/1980, 1988; Bretherton &

Munholland, 1999). Mikulincer and Shaver (2007) described this process as secondary

attachment strategies of hyperactivation, deactivation, or a combination of the two.

Secure or optimal attachment stops being a direct goal because to seek it and expect it

has become a painful and grieved experience; this is adaptive reorganization in a less healthy

or less optimal developmental pathway (Bowlby, 1998/1980; Cassidy, 1999; Weinfield,

Sroufe, Egeland, & Carlson, 1999; Mikulincer & Shaver 2007).

Bowlby (1980/1969, 1998/1980) considered that young children in stressful situations

tend to consciously and defensively exclude various pieces of internal information and learn

to ignore outside information in order to develop internal working models that permit them to

seek security in their environment, even if they do not achieve it (Bowlby, 1998/1980;

Bretherton & Munholland, 1999). With time, children take the strategies adopted out of

necessity as their normal state of being (Bowlby, 1998/1980).

These cognitive and physiological strategies of emotional regulation establish

themselves between the two poles of avoidant and ambivalent attachment styles (Bowlby,

1998/1980; Fraley, 2006). Aggressive rejection of a child's expression of attachment

security needs will push the child towards a strategy of self-regulation based on avoidance (Bowlby, 1988; Bretherton & Munholland, 1999; De Zulueta, 1993). In order to accomplish this, the child will have to deactivate or defensively exclude signals from the attachment system. This involves defensive exclusion processes within the various types of memory as well as ignoring signals or felt responses of a need for security-enhancing behaviors with the caregiver (Bowlby, 1998/1980; Bretherton & Munholland, 1999). In the case of detachment and of an avoidant attachment style, for example, the strange situation has shown that security and availability are still sought, but at a distance in terms of the primary caregivers (Ainsworth, 1982; Main, 1982; Kobak, 1999; Mikulincer & Shaver, 2007).

A child who is only intermittently responded to in terms of his/her security needs and is made to feel dependent on a parent and unable to cope in the outside world will have to adopt an anxious attachment style in which attachment insecurity is often or always primed and the child is in frequent search for security in an angry and frustrated way (Parkes, 2006). The child with an anxious ambivalent attachment style will use protest and ambivalence in its interactions. He/she seeks reunion and availability but is so uncertain that it cannot tell if it has it or not. The child can no longer believe in the comfort it is offered. He/she is more familiar with the protest phase of the reunion process and tends to stay there clinging and crying angrily (Bowlby, 1998/1980, 1988; Main, 1982; Parkes, 2006). Again, this attachment process involves a defensive exclusion process in terms of different types of memory and a restriction of his/her experience towards the regular or constant external confirmation of security.

Children who show a disorganized pattern of attachment tend to have highly

disturbing and inconsistent communication with the primary caregiver (Main, 1982; Main & Hesse, 1990; Lyons-Ruth & Jacobvitz, 1999). Such children will use both avoidance and anxious ambivalence to the extreme (Mikulincer & Shaver, 2007; Parkes, 2006). Children who are disorganized in their attachment are also known to use paradoxical behaviors during the Strange Situation reunion with their caregivers such as walking backwards towards parents (Main & Hesse, 1990; Liotti, 1993) and to use dissociation and freeze behaviors (Main & Hesse, 1990; Liotti, 1993; Parkes, 2006). Children who manifest disorganized attachment patterns are the least secure of all children and are chronically anxious (Main & Hesse, 1990). There is some evidence that certain children with disorganized attachment later adopt compulsive caregiving or compulsive controlling behaviors (Parkes, 2006).

Attachment patterns are somewhat stable through life but can be transformed, depending on experiences throughout a person's life which will either confirm or inform certain parts of an internal working model (Alonso-Arbiol et al., 2002; Bouthillier et al. 2004; Bowlby; Iwaniec, & Sneddon, 2001; Johnson & Wiffen, 1999; Kobak, 1999). Bowlby (1988) described how a person's developmental pathway would impact positively or negatively a person's internal working model throughout the course of their lives.

For Bowlby (1988, 1998/1980), these attachment styles or relational internal working models are the individual's paradigms through which he/she will experience all life events including loss and grieving. The influence of attachment styles on grieving processes have also been discussed by numerous authors (Parkes, 2002/2001, 2006; Parkes & Weiss, 1983; Shaver & Fraley, 1999; Shaver & Tancredy, 2002/2001; Stroebe, Schut, & Stroebe, 2005; Wijngaards et al. 2007). More studies are needed to explore the amount of variance

attachment styles have on the grieving process of individuals and how these impact the ability or inability of spouses/partners to support each other following the loss of their child.

Attachment and gender.

For reasons that still need to be explored, socialization produces a predominance of anxious attachment styles in women and a predominance of avoidant attachment styles in men (Alonso-Arbiol, Shaver & Yarnoz, 2002; Doyle & Moretti, 2000; Marris,1982). This socially generated gender-based influence of attachment patterns can also explain exceptions to the discrepant grief phenomenon. Instances where mothers and fathers present discrepant grieving styles which are reversed in terms of usual gender presentation for example 20% of fathers who had higher grief symptoms than mothers reported by Digregov and Digregov (1999) can be explained in terms of attachment styles being reversed where the father is anxiously attached and the mother would be secure or avoidant.

Studies on the issue of the predominance of anxious attachment style in women and of avoidance in men explain that insecure men and women appear to over identify with traditional gender roles (Mikulincer & Shaver, 2007). This would have a tendency to amplify the distinction between gender stereotypes of female capacity for emotional expression and intimate relationships and male capacity for autonomy and self confidence. Secure men and women appear to be able to integrate and use both male and female psychological attributes and be more androgynous in their psychological identity (Mikulincer & Shaver).

In terms of anxiously attached men and avoidant women, attachment conditions or developmental pathways that made the opposite gender traits and opposite attachment style

more adaptive to circumstances were elicited as secondary attachment strategies. Even though they stray from the usual gender-specific attachment style, they are none the less restrictive in terms of future adaptation (Mikulincer & Shaver, 2007).

This discussion of gender identity and attachment styles actually would explain much of the research observations of polarized, or discrepant, grieving styles based on gender. If the premise supported by Mikulincer and Shaver (2007) that insecure men and women tend to over identify with their own gender roles is right, then most couples who are observed having polarized or discrepant grieving styles along gender lines will be more or less insecure and less able to support each other through grief. Their over identification with their gender roles and with their preferred coping style would make them resistant and/or unable to understand their partners way of coping.

Oscillation.

The concept of oscillation was first introduced by Bowlby (1998/1980) in an updated description of the four phases of mourning that he had previously described in an article written with Parkes (Bowlby & Parkes, 1970). "Admittedly these phases are not clear cut, and any one individual may oscillate for a time back and forth between any two of them" (Bowlby, p. 85). Parkes (2006) explains that he and Bowlby had never meant for the phases of grief to be fixed or implied that one needed to finish one phase to start another. To the contrary, Bowlby and Parkes considered the phases of grief to be different for every individual and also dependent on the context of the loss. Most likely, Bowlby was looking to clarify the dynamic processing of the phases of grief by introducing the concept of oscillation as part of these. As far as can be ascertained, Bowlby did not develop the concept of
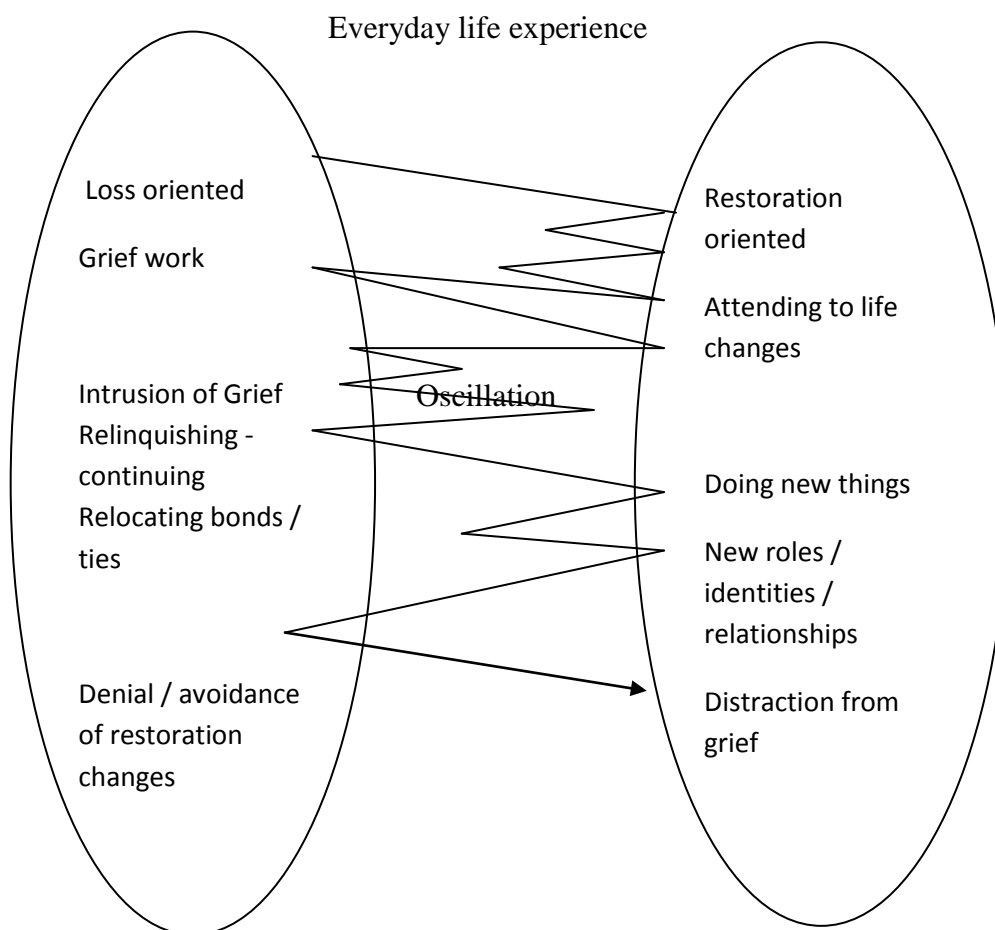
oscillation any further.

Stroebe and Schut (1998, 1999, 2001/2002) integrated the concept of oscillation in their Dual Processing Model of bereavement. It is used to convey the dynamic process in which one appears to self-regulate, both consciously and unconsciously, the pain and despair of the loss itself and the social repercussions of the loss (Stroebe & Schut, 1999, 2001/2002; Stroebe, Folkman, Hanson, & Schut, 2006; Stroebe, Schut, & Stroebe, 2005). Stroebe and Schut (1999) explain that adaptive grieving requires "dosage" of the various stressors; this is the core idea that distinguishes the DPM from other grief models. The DPM explains that healthy grieving is a dynamic process in which individuals oscillate between primary and secondary grieving tasks called loss-and-resolution orientations. (Stroebe & Schut, 1999; Stroebe, Schut, & Stroebe). Loss-oriented grieving tasks are the primary grieving tasks, being focused on the loss of the deceased. Confronting and dwelling on the loss are part and parcel of loss-orientation. In essence loss-orientation has to do with the processing of separation anxiety following the loss of a significant bond. At the beginning of bereavement, individuals tend to be more loss-oriented and then progressively spend more time in resolution-orientation. Reminders of the deceased are often painful and it tends to be difficult to imagine or absorb that the loss is permanent. When avoidance from the loss is necessary, the DPM explains that bereaved individuals will then oscillate to resolution-oriented tasks or take a break from grief in order to help self-regulate the intensity of the emotions. Protest, despair, yearning, rumination, and a progressive reorganization of the relationship with the deceased are all part of loss-orientation (Stroebe, Schut, & Stroebe, 2005; Schut & Stroebe, 1999, 2001/2002). However, Stroebe et al. (2005) insist that the DPM is not a phasal model

like Bowlby's (1998/1980) but rather that reorganization occurs throughout the grieving

process and not just at the end. As depicted in Figure 1, loss orientation comprises the notion

of "grief work, intrusion of grief, breaking bonds/ties/relocation of the deceased person, [it

also involves] a denial/avoidance of restoration changes" (Stroebe & Schut, 2001/2002, p.

396).

Figure 1

Two types of essential grieving tasks:

(Stroebe & Schut, 1995, 1999, 2002, 2005)

Everyday life experience

Loss oriented

Grief work

Intrusion of Grief
Relinquishing -
continuing
Relocating bonds /
ties

Denial / avoidance
of restoration
changes

Restoration
oriented

Attending to life
changes

Oscillation

Doing new things

New roles /
identities /
relationships

Distraction from
grief

In terms of the denial/avoidance of restoration changes, the DPM explains that it is

possible to be rigidified in loss orientation. This is best described as the inability to let go of

the grief because letting go would feel like a betrayal or an abandonment of the deceased.

This behavior involves avoidance of oscillating to resolution-oriented tasks, as a way of

clinging to the deceased and of denying or avoiding the reality that the world has changed

and that there are restoration- oriented activities that require attention (Stroebe, et al., 2006,

p. 2,443).

Restoration-oriented grieving tasks are the secondary grieving tasks. These tasks have

to do with the social consequences of the loss and being able to confront or avoid them.

Examples of restoration-oriented tasks are: learning to do new tasks, or just being able to

bring oneself to perform the tasks that the deceased used to do in the household, returning to

work, resuming activities that were done with the deceased, adapting to the loss of a

caregiving role and identity, and dealing with a changed financial and social status (Stroebe

& Schut, 1995, 1999, 2002/2001; Stroebe et al., 2005; Stroebe et al. 2006). Stroebe and

Schut (1999) explain that resolution orientation should not be confused with specific

outcomes. Restoration-orientation can and often involves emotional processing as it is part

of reviewing how the world has changed with the loss of the deceased. Restoration-

orientation should not be considered as strictly problem solving. Distraction from grief

involves bereaved individuals doing things that have nothing to do with the loss such as

watching TV or a movie; taking a break from grief every once in a while is described as

healthy and necessary by the DPM. In terms of denial/avoidance of grief, the DPM explains

that a bereaved individual can be rigidified in restoration-orientation. This is best described

as strictly attending to tasks, some that need to be done because of the loss and some that are

unrelated to the loss. For example, losing oneself in work or in various activities in order to avoid oscillating towards loss orientation. Stroebe et al., (2005) explain that difficulties in oscillation are both "…psychologically (and physiologically) exhausting" (Stroebe et al., 2005, p. 52).

Stroebe and Schut (1999, 2001/2002) explain that the concept of oscillation puts to use notions of cognitive appraisal according to which different bereaved individuals would consider certain situations with either positive or negative appraisals depending on both intrapersonal make-up and on interpersonal circumstances. According to Stroebe and Schut (1999, 2001/2002) both positive and negative cognitive appraisals within either grief- coping orientations (loss-orientation and restoration-orientation) are important for healthy grieving and require a certain balance through oscillation. Stroebe and Schut (2001/2002) explain that positive appraisal in either of the grief-coping orientations is not sufficient for healthy or optimal grief processing. Negative and positive cognitive appraisal is another level of oscillation within each grief- coping orientation. Stroebe et al., (2005), explain that there is short term moment to moment oscillation as well as larger patterns of oscillation between grief-coping orientations (loss and restoration) that are more long term.

Reviewing some of the literature on attachment theory and Bowlby's (1998/1980) hypothesis regarding attachment styles and their impact on individual's approach to grief, Stroebe et al. (2005) tie attachment theory to the DPM. These researchers propose that individuals with secure attachment will have an easier time oscillating from one grieving-task orientation to the other, as well as from positive to negative appraisal and back again. The only instances where secure individuals would have a harder time with oscillation is when

the loss they have experienced is a traumatic death (i.e. tragic avoidable accident, violent death). Nonetheless, individuals who have secure attachment styles fare better in traumatic loss than insecure individuals. Secure individuals have both the inner resources and the social support to regulate their grief, taking the time to confront their loss then taking time off from grief, addressing resolution-orientation tasks and then moving back to loss orientation as they progressively reorganize both their inner and outer worlds to the loss (Parkes, 2006; Stroebe et al., 2005; Worden, 2008).

Individuals with an anxious ambivalent attachment style have a tendency to be more rigidified in loss-orientation or chronic grief than those with other attachment styles. Stroebe et al. (2005) explain that research has demonstrated that individuals with an anxious ambivalent attachment style tend to have a negative view of self and a positive view of the deceased. This creates a situation in which bereaved individuals with an anxious attachment style feel as if they cannot live without the deceased. Their grief, rumination, thoughts, and extreme preoccupations are all that remain of the deceased and so the bereaved individual with anxious ambivalent attachment stays in loss-orientation, avoids resolution-oriented tasks, and seldom takes breaks from grief (Stroebe et al.).

Individuals with an avoidant attachment style have a tendency to become rigidified in restoration-orientation because such individuals need to deactivate the separation anxiety they experience following a loss (Parkes, 2006; Stroebe et al., 2005). Thus individuals with an avoidant attachment style have a strong tendency to find ways to distract themselves from grief and to use restoration-orientation-tasks to do this. For example, dismissive avoidant individuals have a tendency to see themselves as having a positive self and others as having a

negative self, thus minimizing the need to grieve and to express grief. The chronic self-reliance of individuals with an avoidant attachment style prevents them from feeling the need for others. Nonetheless, in terms of loss of a child Wijngaards-de Meij et al. (2007) found that bereaved parents with an avoidant attachment style are at high risk of becoming depressed. These researchers propose that in the case of the loss of a child deactivation of separation anxiety by being more resolution oriented appears more difficult for individuals who have an avoidant attachment style.

In terms of disorganized orientation or disorganized attachment styles, Stroebe et al. (2005) suggest that oscillation will have a tendency to be chaotic with both loss and restoration orientations being approached but not processed consciously. Individuals with a disorganized attachment style have neither a positive self or a positive view of others, and so it is difficult to respond to grief in an organized fashion as is the case with the three other attachment styles. Self –regulation of grief is very difficult and individuals with disorganized attachment styles will have a tendency to experience grief as others would have a tendency to experience traumatic events. They become rigidified in a vicious cycle of extreme intrusion and avoidance (Stroebe et al., 2005). In such a vicious cycle the disorganized bereaved parent would have difficulty or would be unable to control memories of painful events and of overwhelming feelings related to the death or to traumatic events associated with the death. In such a traumatic experience this inability to control intrusion brings about constant distress. Extreme effort is expended to avoid any internal or external reminders, thoughts, or events that could trigger a new cycle of intrusive thoughts and memories. This is the avoidant part of the vicious cycle often leading to such behaviors as denial "amnesia, inability to

visualize memories, and evidence of disavowal" (Stroebe et al, 2005, p. 62).   There is very little sense of personal control or of agency in the grief experience of someone who copes according to a disorganized attachment style. Oscillation can only be described as chaotic. This is diametrically opposed to how someone with secure attachment experiences grief. The extension of the DPM with current research in attachment theory is a promising way of understanding the individual differences in grief processing.

        In a study of bereaved widows and widowers, Caserta and Lund (2007) tested a new scale designed to measure loss orientation, resolution orientation, and oscillation balance, called the Inventory of Daily Widowed Life (IDWL). Their study found that subjects who were more loss oriented had more difficulties in their adjustments to the loss and demonstrated significantly higher levels of depression, loneliness, and grief than people who were more balanced in their oscillation or more restoration oriented (Caserta & Lund). The researchers also found that widows and widowers more resolution-oriented scored significantly higher on scales of self care, daily living skills, and personal growth. Levels of oscillation balance were higher in the early period of the loss and with time the oscillation tended to be more balanced towards resolution orientation (Caserta & Lund).

        Caserta and Lund (2007) conclude that the scale does support important assumptions of the DPM in terms of the advantages of a more balanced oscillation, that high loss orientation with low resolution orientation is less adaptive than having a balance between the two. According to the researchers the IDWL also supports the hypothesis of the DPM that initially grief involves more loss orientation and that with time the emphasis shifts towards resolution orientation.

Social support.

Social support of the bereaved has always been part of the human perspective and is at the core of longstanding funeral rites across most cultures (Klass, 1997; Lindemann, 1944). In the grief work prescription for successful bereavement based on psychoanalytic theory the reinvestment of energy into other relationships speaks of the importance of social support in the grieving process (Davies, 2003; Lindemann, 1944; Rando, 1986, Worden, 1982, 2008).

For Bowlby (1982/1969; 1980/1998), social support in the context of grief is an underlying theme. In his view not only are we genetically organized to bond with significant others but we also maintain bonds with the deceased (Bowlby, 1980/1998). We are also genetically organized to live in communities that hopefully recognize and support our close relational bonds and offer support and the possibility of new bonds in the context of grief and loss (Bowlby, 1998/1980, 1988).

Klass (1988, 1993, 1997) proposes that rituals around loss, such as religious ones and support groups, in which parents can openly express their grief and the inner representations of their deceased child, facilitate the progressive internalization of the deceased child. Klass, Riches and Dawson (1996, 1998, 2000, 2002), speak of the culture of bereaved parents that serves to help them express freely who they are in a social group that understands why this process is essential in terms of establishing that healing congruence between their inner and outer world. This process leads to progressive solace for parents. Klass states that modern Western society offers few opportunities for the acknowledgement of continuing bonds between bereaved parents and their deceased child. This creates a lack of coherence between

the inside and the outside worlds of bereaved parents creating grieving difficulties and a

sense of alienation (Klass, 1997). Thus grieving becomes more difficult in a society that does

not accept the expression of the inner representation of a deceased child. For Klass (1997)

"socially shared inner representations of the dead" (p.171) are the "core transforming agent"

(p.171) in the grieving process.

Lalande and Bonanno (2006) conclude that the PRC rituals that focus on and support

continuing bonds with the deceased in the first year of bereavement serves to help moderate

the distress associated with grief in the longer term. Lalande and Bonanno (2006) explain

that for the U.S. sample social support practices do not encourage continuing bonds with the

deceased. The bereavement practices in the West are not collective but rather individualistic

and tend to value autonomy of the bereaved individual rather than continuing bonds. As

such, Western communities often do not offer the support needed by the bereaved in terms of

maintaining bonds with the deceased, Bonanno et al. (2005) and Lalande and Bonanno

(2006) also found that in both countries, 18 months post-loss, the bereaved individuals who

still had high levels of continuing bonds and of grief processing continued to have high levels

of distress. This needs to be investigated further as it seems that in both countries rituals and

support dwindle off after the first year and the needs of this group are not met socially or

culturally.

The findings of Bonanno et al. (2005) and of Lalande and Bonanno (2006) would

tend to support the hypotheses of Klass (1988, 1993, 1997) and of Riches and Dawson (1996,

1998, 2000, 2002) that the social support of the expression of inner representations of the

deceased appears to help bereaved parents, achieve a higher, more effective level of grief

processing. Interestingly, Hastings (2000), in her qualitative study of bereaved parents,

comes to the same conclusions as Klass (1997) that many U.S. parents adopt or develop for

themselves a perspective similar to the Chinese and rather than considering the loss of their

child as an ending they continue their relationship as the parent of their deceased child.

Hastings also describes how the self in the Chinese culture is defined through the collective

of relationships which also includes a continuing bond with the deceased. Thus the ongoing

relationship with the deceased child is supported by the community, contrary to the Western

culture in which such a continuing bond is often frowned upon, especially if it is openly

displayed.

In her study, Hastings (2000) found that bereaved parents in the U.S. often receive

negative non-verbal facial messages from friends and family regarding the possibility of self-

disclosure. Still according to Hastings, such negative messages make grief processing more

difficult for bereaved parents because of the importance of self-disclosure in grief processing.

In a qualitative study of parents who lost a child in traumatic ways (suicide, SIDS, or

accident), Dygregov (2003) found that bereaved parents are often disappointed by what is

termed the social ineptitude or unhelpfulness of the community members in the face of their

loss. Most often, fear of triggering sadness in the bereaved parents leads the social network

members to avoid the subject of the lost child. Dygregov also extracted from his interviews

the term openness which refers to the bereaved parents' ability to inform their social network

on what they are going through and what kind of support they are hoping to obtain.

Dygregov describes how communication restraints between the social network and bereaved

parents can come from one or both sides of the social equation. Dygregov observes that

there is a lack of social norms that could structure the support given by the extended family and the community to bereaved parents. Which echoes the observations of Klass (1986, 1993, 1997), Hastings (2000), and Riches and Dawson (1996, 1998, 2000, 2002). Both Dygregov and Hastings suggest community programs for enhancing communication around supportive needs in bereaved parents. Going beyond the community and making a more ambitious call Malkinson and Bar-Tur (1996) state that society needs to understand and promote the culture of bereaved parents as a valid social phenomenon. Supporting bereaved parents by giving them various rituals to ensure the memory of their deceased child is an important assistance to them (Malkinson & Bar-Tur).

Koocher (1994) comments on the fact that, in America, social support is important in the first few weeks and then progressively diminishes to levels lower than previous to the loss because the social network tends to try to return to pre-loss levels of functioning when bereaved parents are often not able to do so. Koocher describes a "shift from social integration to social differentiation" (p. 378) for bereaved families. Differences in coping styles between members of the community and members of bereaved families make social integration more difficult (Koocher). Other authors have suggested the possibility that grief can also become incremental when social support is different from the expectations of the bereaved (Gilbert & Smart, 1992; Oliver, 1999, Skinner Cook & Oltjenbruns, 1989/1998; Stroebe & Schut, 1999; Stroebe, 2002).

Lepore et al., (1996) found that bereaved mothers who were supported in the expression of their grief about the loss of their child had significantly fewer intrusive negative thoughts about their child and less depressive symptoms than mothers who were

socially constrained and thus avoided the topic.

Surkan et al. (2006) found that lack of support for parents during the palliative care and death of their child from a malignancy actually appeared to increase parent's experience of guilt and other psychological distress during bereavement, because they felt that they did not cope well enough for their child during their difficult last days or weeks.

In their study of bereaved mothers, Laakso and Paunomen-Ilmonen (2002) found that bereaved mothers actually lost friendships either permanently or temporarily because non-bereaved mothers found it too difficult to support the bereaved mothers. This was experienced as very emotionally difficult by the bereaved mothers.

Lang et al. (1996) found that bereaved couples who do not turn inwards and withdraw, but rather remain open and reach out to their shared social network do better at processing their grief than couples who do not share with friends and tend to withdraw. This finding is similar to Digregov's (2003) observation that some bereaved parents tend to contribute to their own social isolation.

In a study of bereaved parents post-fetal/infant death, Lang et al. (2004) found that mothers and fathers who were high on scores of hardiness tended to view spousal and social support available more positively than parents who had lower scores on the hardiness scale. Mothers tended to find social supports more helpful than marital supports and men tended to see their spousal support as more helpful than social supports. Bereaved parents who score higher on hardiness, the presence of social support had an additive value that increased the possibility of viewing a traumatic life event more positively and of leading to an eventual sense of personal growth. Absence of social support appeared to make it more difficult for

bereaved parents to draw on their personal resources which also affected their health

negatively (Lang et al.). Wijngaards-de Meij et al. (2008) suggest that bereaved parents who

are more anxious ambivalent probably expect more social support than others and are

probably more often frustrated that the social support does not meet their expectations.

In a study of bereaved parents who had lost older children (mean age 20.35) of

sudden and unexpected deaths, Hogan and Schmidt (2002) found that social support is an

important variable in the grief process. These researchers' data shows the importance of

acceptance of the bereaved person's expression of grief and healing attempts in their

redefinition of the self that occurs following the loss of a child. In a series of path analysis

models, Hogan and Schmidt found that the strongest model was one that supported, in part

the DPM, that grief lead to intrusivity that lead to avoidance that in turn lead to social support

that finally lead to personal growth. Hogan and Schmidt consider that personal growth is an

intrinsic part of grief and that bereaved individuals do not return to a previous state of

functioning but rather develop a new sense of self in the world. Like the DPM proposes,

Hogan and Schmidt found that grief processing does appear to involve confrontation to loss

and grief avoidance. They add the notion of personal growth to the process. The researchers

also found a negatively correlated direct path between grief and personal growth. This

supports the notion in the DPM that too much loss orientation makes personal growth

difficult in the grieving process.

The results of most of the studies reviewed above support the notion that without

social support being at least perceived as adequate, grief can be more prolonged or

complicated to process for bereaved parents. Cultures in which the bond of the bereaved

parent with the dead child is supported by rituals appears to facilitate the grieving process for the majority of bereaved parents. Some individuals are better able to take advantage of their social support network than others.

Marital satisfaction/distress

The issue of marital distress is a much researched area in non-bereaved couples, and it is useful to look at some of the theory and research in this area before discussing the issue in bereaved couples. Marital distress is defined by Johnson and Greenberg (1988) as a "…negative interaction cycle (most commonly, a pursue- distance cycle)…" (p. 175), with decreased accessibility and responsiveness between the couple. Gottman, Driver, and Tabares (2002) describe seven bad habits of maritally distressed marriages:

1) More negativity than positivity (the ratio of negativity to positivity in stable marriages is 1:5, whereas in couples headed for divorce it is 0.8:1, this is a huge difference in the affective climate of the marriage). 2) The four horsemen of the Apocalypse (criticism, defensiveness, contempt, and stonewalling) and gender differences in these (female criticism, male stonewalling). 3) The failure of repair attempts. 4) Negative perception in the 'subtext' that accompanies interactions – that is, negative sentiment override, negative attributions, recasting the history of the marriage negatively. Another gender difference is that men rehearse distress- maintaining thoughts more than women. 5) Flooding (feeling overwhelmed by one's partner's complaints), and the 'distance and isolation cascade' (a series of events from flooding through parallel lives to loneliness) that accompanies this flooding. 6) Chronic, diffuse physiological arousal and immunosuppression. 7) The failure of

husbands to accept influence from their wives, manifested in one of two patterns: (1)

male emotional disengagement (this eventually becomes mutual emotional

disengagement), or (2) male escalation (belligerence, contempt, defensiveness) in

response to female low–intensity negative affect (complaining). (p. 378)

Gottman (2000) explains that he and his colleagues were able to distinguish between

couples who will survive and couples who will separate or divorce with a 95% accuracy rate

based on these seven habits. This makes it likely that certain combinations of recurrent

behaviors such as those found in insecure attachment styles affect both appraisal of spousal

behavior and consequent responses. Many of the bad habits of maritally distressed couples

described by Gottman et al. (2002) are in fact described in various studies exploring the link

between individual attachment styles in spouses and the corresponding dynamics of spouses

in their marital relationships (Bradley & Furrow, 2004; Feeney, 2002; Johnson, 2004;

Johnson & Whiffen, 1999; Kobak & Hazan, 1991; Mikulincer & Shaver, 2007). Feeney

(2002) found that "secure individuals hold more stable perceptions and expectations of their

partners" (p. 54). They therefore have less of a tendency to be negative about everyday

behaviors and events than individuals with insecure attachment styles (Feeney). Secure

individuals appear to have a more positive outlook on life and relationships, making it less

likely for them to begin focusing on everyday irritants as a growing confirmation that the

spouse will be unreliable. Feeney found that insecure individuals and especially fearful

avoidant individuals tend to be more reactive and stay focused on what they perceive as

negative behavior on the part of their spouse.

In an extensive review of the literature on attachment and couple functioning,

Mikulincer and Shaver (2007) found numerous studies supporting the hypothesis that couples composed of two individuals who are secure report more marital satisfaction than couples in which only one of the spouses is secure. Couples composed of only one secure individual report more marital satisfaction than couples composed of two insecure individuals. Mikulincer and Shaver when looking at gender as the main variable found that anxious ambivalent and anxious avoidant attachment styles in women are equally predictive of women's relational dissatisfaction within a couple. The researchers also found that in men avoidance was a greater predictor of relational dissatisfaction than anxious attachment.

Overall Mikulincer and Shaver (2007) report that most studies on the subject have found significant relationships between insecure attachment and relational distress for both women and men. Gotman et al.'s (2002), seven bad habits of maritally distressed couples is echoed in this following statement in Mikulincer and Shaver:

> Findings indicate that maladaptive ways of coping, negative beliefs about relationship partners, and problems in conflict management underlie the heightened relationship dissatisfaction of anxious and avoidant people. Moreover, whereas negative affectivity also contributes to anxious people's relationship dissatisfaction, lack of nurturance and deficits in interpersonal expressivity and sensitivity are additional mediators of avoidant people's satisfaction. (p. 312)

Mikulincer and Shaver (2007) explain that a certain inconsistency of results in studies on attachment and distress in couples most likely means a certain overlap between behaviors of secure and insecure spouses. These overlaps are most likely due to "…couple-type and interactional effects resulting from both partner's attachment orientations" (p. 323). They

also state that the small number of studies that have looked at interactional effects of attachment styles in both spouses have noted only a moderate-effect size, indicating that there is a complexity of other factors involved in couples' satisfaction and dissatisfaction.

In the context of clinical practice with non-bereaved couples, Johnson (2004) reports that the majority of couples in marital distress requesting therapy have discrepant, or different, attachment styles and thus may have more difficulty or inability to support each other. Most of the couples she sees are described as being in a pursue-withdraw dynamic in which the woman is usually the pursuer and the man the withdrawer. Her description of the pursuer is based on attachment theory's anxious ambivalent attachment style and her description of the withdrawer is based on the avoidant attachment style. Based on Johnson's description of non-bereaved couples in marital distress, it is proposed in this study that discrepancies in attachment styles can create insecurity which, in the grieving couple, can be amplified by the death of a child and the insecurity of a shaken assumptive world. These converging vectors of insecurity can be construed as an erosion of attachment security (Clulow, 2001; Johnson, 2004), creating an expanding and vicious negative communication cycle that leads to marital distress (Fish, 1986; Gordon Walker et al., 1996; Johnson, 2004; Parkes, 2006; Moriarty et al., 1996), psychological distress (Wijngaard-de Meij et al., 2007), and the potential for higher levels of grief (Gilbert, 1997; Rando, 1986, 1997).

Johnson's (2004) description of the dynamics of marital distress in couples is an application of attachment theory to adult relationships. The description Johnson (2004) makes of the pursuer is similar to that made by Stroebe and Schut (1999, 2002/2001) and Stroebe, Schut, and Stroebe (2005) of a person who is using a loss-oriented strategy of

coping with grief, and her description of the withdrawer is along the same lines as the person who is using a resolution-oriented strategy of coping. The DPM and the work by Johnson's models help us understand that spouses in couples who have discrepant or polarized coping styles can be threatening to each other as one tends to reach out for support and becomes more aggressive and insecure while the other withdraws into tasks and avoidance because of his or her need to keep a distance from threatening emotions (Rando, 1983, 1986; Moriarty et al., 1996; Wijngaards-de Meij et al., 2007).

Mikulincer and Shaver (2007) use the terms "hyperactivation of the attachment system vs. the deactivation of the attachment system" (p. 73). The negative communication cycle in couples described by Johnson (2004) provides a much needed description of the adult relational aspects of retrospective attachment styles and assumptive worlds. Johnson (2004) argues convincingly that, as in children, attachment figure availability and responsiveness are important elements in the task of maintaining a healthy couple relationship. This may be even more the case in situations of loss and stress.

In terms of marital distress in bereaved couples, some have suggested that insecure attachment styles underlie the difficulty of grieving parents to support each other (Parkes, 2002, 2006; Stroebe & Schut, 1999; Shaver & Tancredy, 2002/2001). However, only one study Wijngaards-de Meij et al. (2007) has looked at this relationship. Given that spouses are often the primary sources of support for each other, (Cook & Oltjenbruns, 1989; Gilbert & Smart, 1992; Oliver, 1999; Stroebe & Schut, 1999) their findings support the need to explore the dynamics of the couple relationship to better understand the relational aspects of the grieving process.

In terms of clinical work, Walsh and McGoldrick (2004), both social workers, have written on the topic of bereavement in the family from a family systems point of view, advocating a systemic and inter-generational perspective of loss. Byng-Hall (2004) has also written about family bereavement from a systemic and attachment theory perspective. Walsh and McGoldrick, Bing–Hall, and Cudmore and Judd (2001), bring insight from their clinical practices to support the hypothesis that family and couple relations have an impact on the way grief is processed.

Bing-Hall (2002) and Cudmore and Judd (2001) describe their work with bereaved families as an attempt to create attachment security within the therapy sessions. Both state that in their bereavement interventions they attempt to help families and or couples move from insecure patterns of support to secure patterns of support which can be used by the family outside of the therapy session.

In terms of clinical observations and theoretical hypotheses regarding bereaved couples, Walsh and McGoldrick (2002) have described extensively the relational and family systems aspects of loss and the importance of clear communication and of acknowledgement of the loss. Bing–Hall (2002) and Cudmore and Judd (2001) have both described the experience of grieving as an opportunity to reconsider attachment patterns causing difficulties within a couple and a family. This is further support by calls in the bereavement literature for research on the relational aspects of coping with loss in couples who have lost a child (Digregov & Digregov, 1999; Moriarty et al., 1996; Oliver, 1999; Rubin & Malkinson, 2001; Sirkiä, Saarinen-Pihkala, & Hovi, 2000; Stroebe & Schut, 2002; Wijngaards-de Meij et al., 2007).

A number of qualitative and quantitative studies have found that couples who lose a child often experience difficulties in supporting each other in their grief process (Fish, 1986, Murray et al., 2000, Vance et al., 2000). Some studies find that some couples are even unable to support each other at all (Cook & Oltjenbruns, 1989; Dyregrov & Dyregrov, 1999; Gilbert & Smart, 1992; Malkinson & Bar-Tur, 1999; Rubin & Malkinson, 2001; Oliver, 1999; Sirkiä et al., 2000).

Various studies explore dimensions of the relationship in bereaved couples that most likely have some impact on marital distress. For example, Fish (1986) discusses the fact that, in his study, changes in sexuality are important. Fish calls this sexual distress, and states that 60% of wives express guilt because they are not able to find pleasure in sex while being aware that their husbands would want to resume sexual activity. Fish, Oliver (1999), and Rando (1986) explain that mothers are less likely to take pleasure in sex when their child has passed away, whereas fathers seem to perceive sex as a source of comfort and intimacy. Rando (1986) explains that "if the barriers to feelings are let down in order to experience the closeness of sexual intimacy, then the spouse may also be vulnerable to other less positive feelings, such as pain, loss, and grief. Since sexual intimacy and orgasm can put the spouse in touch with feelings at a deep level, she may seek to avoid it for fear of tapping into painful emotions" (p. 29). Fish (1986) describes a "vicious cycle of emotions" (p. 420) behind a mother's sexual distress which can result in the husband then feeling rejected and abandoned.

Lang and Gottlieb (1993) and Lang, Gottlieb, and Amsel (1996) also discuss study results showing that discordance in sexuality and post-loss of neonates and infants, can become part of a negative cycle between spouses. According to results in both studies, men

tend to seek physical intimacy and comfort, but often feel rejected by their wives who tend to avoid sexual intimacy during grief. Mothers also tend to be resentful of their husband's sexual advances because they feel unheard by them in terms of their own needs for emotional and intellectual intimacy. For mothers, sexual intimacy was positively correlated with more yearning for and sense of loss of their child. For fathers, sexual intimacy was negatively correlated with stigma (Lang & Gottlieb). In the Lang et al. study, using the same measurement instruments, but a different sample, sexual intimacy only showed a negative significant correlation with isolation and a positive significant correlation with somatization for men and did not show up as a predictor of yearning for the child by mothers as was found in the Lang and Gottlieb study.

Spousal differences in sexuality post-loss of a child are good examples of issues that can feed the vicious cycle of negative emotions. Similar examples are found throughout the literature on bereaved parents (Fish, 1986; Hagemeister & Rosenblatt, 1997; Oliver, 1999; Rando, 1986). These findings appear to coincide with the DPM and would add to it. For example, for men who tend to be more resolution oriented, sexual intimacy and physical comfort are dimensions of the grieving process and possibly an outlet permitting them to avoid certain emotions related to grief (Fish, 1986; Hagemeister & Rosenblatt, 1997; Oliver, 1999; Rando, 1986). Whereas for women who tend to be more loss oriented, emotional and intellectual intimacy are the preferred coping strategies and sexual intimacy is aversive. Sexuality may be more resolution oriented than loss oriented. Wijngaards-de Meij et al. (2008) explain that in their study, women who were high on loss orientation tend to be emotionally focused on maintaining their relationship with their deceased child. They also

explained that they appeared impervious to the resolution orientation of their husband's. It

may well be that sexual intimacy and the accompanying emotions interfere with the fragile

relationship with the deceased child (Hagemeister & Rosenblatt, 1997; Oliver, 1999). This

appears to impact the relationship and potentially increase marital distress. Hagemeister and

Rosenblatt state that a decrease or interruption in sexual relations in bereaved couples is quite

frequent and understandable. These researchers state that interruption in sexual relations in

bereaved couples needs to be normalized.

The literature on bereaved parents often discusses the question of incongruence or

discrepancy in grief that has the potential to feed marital distress within the couple. In their

qualitative study of bereaved couples, Gilbert and Smart (1992) reported that the majority of

their 27 married couples had discrepant (polarized) grieving styles which they described as

either public or private grieving. This polarization in grieving often led to dissatisfaction

with their partner's support. Gilbert and Smart, Gilbert (1996), and Rando (1983) also note

that some of the marital distress in bereaved couples comes from the expectation that they

should be grieving in a similar fashion. Gilbert and Smart and Gilbert note that for some

partners the realization that there is a difference in their and their partner's way of grieving

was experienced like the rejection of a shared meaning making in their mutual quest of

rebuilding their assumptive worlds. On the other hand, Gilbert also notes that couples who

were able to accept each other's different grief coping styles appeared to be strengthened in

their relationship by the experience. A parallel needs to be made here between the two poles

of grieving described by Gilbert and Smart (1992) as public or private and attachment styles.

A more public way of grieving could be considered to be the product of an anxious

ambivalent style while a more private way of grieving would be the product of an anxious avoidant attachment style. Couples who become distressed because of the difference in grieving style would likely be insecure while those able to acknowledge and appreciate each other's grieving styles would have a tendency to be composed of one or more secure individuals.

In another qualitative study of older war-bereaved parents in Israel, Malkinson, and Bar-Tur (1999, 2005) report that some bereaved couples in their study described the period of acute grief as naturally isolating. "It is important to stress that in the initial acute stage, grief is naturally personal and intense and cannot be shared with another person no matter how close that person is" (p 120). The researchers explain that such pain is difficult to share and that there is a discrepancy or polarization in grieving between members of the couple. They also consider that this discrepancy is stronger in younger marriages than in older marriages. Malkinson and Bar-Tur also found that most couples could resume supporting each other following the stage of acute grief.

Fish (1986) describes what he calls incongruence or discrepancy in grief between bereaved mothers and fathers. Incongruence manifests itself at a level of grief intensity and at a level of quality of the issues or content of the grief. For example, following the loss of an infant the results on the Grief Experience Inventory (GEI) show that mother's highest mean scores are despair, loss of control, and social isolation. For fathers the highest mean scores were guilt, loss of control, and social isolation. "Differences in parental grief intensity are traceable to sex and age of child, age of parent, manner of death, and length of bereavement" (p. 248). Fish also notes that the incongruence in scores are highest in the second to the

fourth year and then begin to progressively decline. Fish also found that seventy percent of

bereaved couples showed significant levels of marital stress associated with the loss.

Feeley and Gottlieb (1988) reported that couples bereaved by stillbirth, neonatal

death, or sudden infant death showed more concordant coping strategies than discordant

ones. What was different between mothers and fathers was the use of certain coping

strategies at different times in the grieving process. "Fathers were found to use replacement

with a role less as time since the death increased. Fathers may use this strategy soon after the

death, while mothers may only begin to use this strategy in the later stages of their

bereavement" (p. 64). Feeley and Gottlieb also reported that couples experienced severe

communication difficulties in the first six to twenty four months post loss, but that the

difficulties gradually resolved within the same 6 to 24 months period.

Bohannan (1990) reported on a study in which only 19 out of 64 parents expressed

having negative feelings about their marriages early on following the loss. Bohannan reports

that the death of a child and grieving were not associated with thoughts about divorce for

fathers, but that for bereaved mothers there were thoughts of divorce and that these had

significant relationships with higher scores of social isolation and somatisation. Bohannan

also reported that the negative feelings of mothers tended to abate over time. Lehman et al.

(1989) reported a significant difference in divorce rates between bereaved couples whose

child had died from a motor vehicle crash 4 to 7 years earlier and their matched control

group. However, they found no significant differences between the two groups on the Dyadic

Adjustment Scale and on the Perlin and Schooler contentment-with- partner subscale.

Lehman et al. did find a significant difference on the marital stress as measured by the Perlin

and Schooler (Partner) Role Strain Scale compared to a non-bereaved control group. Bereaved parents were more irritable and worried in their day to day interactions with their spouses than the non-bereaved controls. Lehman et al. conclude by calling for studies looking at discrepancies in coping styles in bereaved couples. Lehman et al. (1989) state that the coping of bereaved parents really needs to be assessed over time, looking at how it evolves during the grieving process.

Lang and Gottlieb (1993) present results in which both father's and mother's grief was partially mediated by the marital relationship. This is less clear for fathers in the Lang et al., (1996) study, but still very clear for mothers. Murray et al. (2000) concluded that for low-risk couples marital satisfaction was not an important issue, however in the high-risk control group which received no intervention, marital distress was important. High risk was defined by the researchers according to the mean score of each parent on seven indicators. These indicators were:

1. Lack of perceived social support, 2. ambivalent relationship with the baby, 3. particularly traumatic circumstances surrounding the death, 4. other difficult life circumstances, 5. difficulty with coping in the past, 6. problematic individual characteristics and, 7. unsatisfactory relationship within the nuclear family. (Murray et al., 2000, p. 283)

The experimental high-risk group for bereavement difficulties followed the course of the low-risk groups, thus offering supportive intervention to high risk parents showed positive results.

Murphy (2001) reported that when members of a couple participated in a

bereavement group together communication between them was improved compared to couples where only one spouse or partner attended the group. Some couples do benefit from support in communication with each other following the death of a child.

For their part Kamm and Vandenberg, (2001) found that there was a significant relationship between women's attitudes towards grief communication and marital satisfaction. Women who had more open attitudes towards grief communication had higher marital satisfaction and women who had a closed attitude towards communication around grief demonstrated marital distress even five years after the loss of a child. This was not the case for men.

Paradoxically, Vance et al. (2002) found that when bereaved mothers were themselves distressed following the death of their child, but that their spouse/partner was not distressed, this increased significantly the marital dissatisfaction in the mothers over the long term. Vance et al. also found that that 43% of their sample showed marital distress at two months and 25% at 15 months compared to 13% in a non–bereaved comparison group of parents at both measurement times.

In a study of parents who had lost a child during pregnancy or in the first year of life, Lang et al. (2004) found that mothers tend to be less satisfied with their marital support than their social supports and that paradoxically this is reversed for fathers. Both mothers and fathers in couples in which at least one of the spouses considered separation following the loss did not score as high on the health variable the study was assessing. Hardiness (an internal ability to appraise situations positively) was the most important and significant predictor of health for mothers, whereas marital support was the most important significant

predictor of health for fathers, followed by the internal resource of hardiness. Results of the study also showed that " mothers and fathers had a higher health index across time when they scored higher on hardiness at baseline (T1), were more satisfied with their marital and social support at T1, T2, and T3, and were not part of a couple that had considered separation" (p. 875). Mikulincer and Shaver (2007) equate the concept of hardiness with a secure attachment style.

In the only existing study on attachment styles and parents' adjustment following the loss of their child, Wijngaard-de Meij et al. (2007) looked at the relationship between adjustment and the combination of attachment styles in the couples. The results showed that at 6, 13, and 20 months, bereaved parents with insecure anxious ambivalent attachment had lower marital satisfaction and, when this was the case, they showed higher levels of depression. For parents who were high on both avoidance and depression there was no relationship with marital satisfaction. The authors also hypothesize that there is no relationship between depression and marital distress with parents who score high on the avoidant dimension because they tend to shut down feelings of attachment and therefore do not expect to be supported and receive caregiving.

Wijngaard-de Meij et al. (2007) explain that parents who score high on anxious attachment would be more likely to expect support and caregiving from their partner. Given that the spouse is also grieving he/or she is likely not able to meet those needs. To complicate matters, if the spouse is more or less avoidant there is an even greater likelihood that the needs of their anxiously attached partner are not met. Using a statistical analysis model called Actor- Partner Interdependence Model (APIM), Wijngaards-de Meij et al. found that

the more anxiously attached an actor is, the lower the marital satisfaction in both the actor

and the partner. The researchers also found that the more actor and partner were high on

polarized attachment styles, the more the marital distress in both the actor and the partner. In

other words, "there was a significant interaction between the partner's avoidant and the

partner's anxious attachment on marital satisfaction" (p. 547). These findings are similar to

those described in the non-bereaved literature on marital distress reported by Mikulincer and

Shaver (2007) describing significantly higher marital distress in spouses who are insecurely

attached because they are either anxiously attached or avoidant.

Psychological distress.

In this study, psychological distress is conceptually defined as an aversive cognitive

and/or somatic response to perceived internal and/or external stressors and which leads to

actions cognitive and /or somatic aimed at addressing, adjusting to or ignoring stressors.

Rando (1986) identified a sizable number of symptoms of psychological distress in

bereaved parents. Rando points out that in the context of the death of a child such symptoms

are to be considered normal while they would be considered pathological in the absence of

loss. In 1997, Rando took an even stronger stance on the issue of parental loss and stated that

the death of a child should be considered as a traumatic loss. These comments follow the

findings of Anderson (as cited by Parkes, 2001/2002) and of Parkes (1964) that grief

reactions are often misinterpreted as mental illness. In a 1964 study, Parkes reported that

among 3,245 admitted psychiatric patients 2.9% had lost a parent, a spouse, or a child. As

referenced previously Li et al.'s (2005) census study of bereaved parents found that bereaved

parents had an increased risk of psychiatric hospitalization of 1.67. Throughout the literature

review there is general agreement that psychological distress is a normal reaction to the death

of a child. Given such a general agreement, a next step in research of bereaved parents could

be to link a prospective coping model, such as attachment theory, to psychological distress in

order to differentiate the ways that coping with grief and psychological distress play

themselves out. Not all bereaved parents have the same amount of psychological distress or

the same way of coping with the death of a child.

Based on Bowlby and Parkes (1970), Bowlby (1998/1980), and Rando (1986) there

are phases of loss associated with specific psychological distress symptoms. The first phase

is the avoidance phase, which Bowlby and Parkes called the numbing phase. Rando describes

this as a period of disbelief or of shock that is often followed by denial. Rando adds a number

of other possible symptoms that will depend on the parent's personality. These are most often

"anger or hysteria, quiet withdrawal, mechanical action, or depersonalization. Confusion and

disorganization are common" (Rando, 1986, p. 14).

Rando (1986) calls the second phase the confrontation phase, this phase incorporates

both the protest and despair phases of Bowlby and Parkes (1970), and the psychological

distress identified by Rando is broadly described as "angry sadness" (p. 14). Fear, anxiety,

anger, guilt, separation anxiety and longing, depression, despair, important difficulties in

concentrating, obsessive rumination, disorganization, pangs of grief, social withdrawal,

restlessness, and insomnia are all part of this phase. Physiological manifestations are also

part of this phase:

> anorexia and other gastrointestinal disturbances, loss of weight, inability to sleep,
>
> crying, the tendency to sigh, a lack of strength, physical exhaustion, feelings of

emptiness and heaviness, feelings of something stuck in the throat, heart palpitations and other indications of anxiety, nervousness and tension, loss of sexual desire or hypersexuality, lack of energy and psychomotor retardation, restlessness and searching for something to do, and shortness of breath. (Rando, p. 22)

The next phase, according to Rando (1986), is the reestablishment phase which corresponds to the reorganization phase for Bowlby and Parkes (1970). This phase is characterized by a decrease in the intensity of symptoms of psychological distress. Survivor's guilt tends to appear as the parents catch themselves beginning to enjoy life again without their child. There may also be a strong sense of betrayal and of abandoning the child.

Rando (1986) explains that each parent will have different responses to the loss. These are based on a rather lengthy list of variables as presented in Table 2.1.

Fish (1986) discusses how through the use of the Grief Experience Inventory (GEI) he measured nine categories of emotional distress during parental grief. These are despair, anger, guilt, social-isolation, loss of control, rumination, depersonalization, somatization, and death anxiety. Fish commented on the fact that mothers score higher than fathers on anger and that the difference increases over time. The researcher's interpretation was that mothers were angry at their child, who had disappeared, and they redirect their anger to those around them creating social isolation. Bowlby (1988) has a somewhat different interpretation of anger as part of grief. Bowlby (1988) clearly qualifies anger as a response to separation anxiety and that anger is part of healthy grief. In the context of grief, Bowlby explains that it serves as an action potential or a mobilizing force to seek and retrieve the lost person. The anger will have a tendency to be "directed at third parties, the self, and sometimes at the

person lost" (p. 32).

For Fish (1986) higher scores of despair in mothers' results in "lower self -esteem and a more pessimistic outlook on life" (p. 419). The direction of this causal path, described by Fish, runs counter to current formulations of coping with grief. For example, Murphy et al. 2003 propose that self-esteem is an important variable in the outlook of bereaved individuals and in their ability to cope with the loss. For Bowlby (1998/1980) insecure attachment styles will lead to higher despair and a more negative outlook on life. Lang's (2004) use of the concept of hardiness is very similar to Bowlby's concept of attachment security and leads to a similar causal path (Mikulincer & Shaver, 2007). In other words, lower self-esteem and a more pessimistic outlook on life pre-date despair and will contribute to the level of despair a parent will experience at the death of a child. Fish (1986) also found that mothers tend to score higher thanfathers on depersonalization. Fish states that mothers with high depersonalization scores have an increased difficulty in returning to the level of activity previous to the loss. This is likely due to being extremely loss-oriented (Stroebe & Schut, 1999; Winjgaard et al. 2008). Moriarty, Carroll, and Cotroneo (1996) reported on the psychological distress of two samples of bereaved couples. One group's psychological distress was measured by the Symptom Checklist = 90RL (50 couples) and while the others was measured by the Brief Symptom Inventory (BSI) (60 couples). The researchers found that both groups of bereaved parents scored significantly higher than the non-patient norm group on mean global distress scales. Bereaved parents also scored lower on mean global distress than both the established outpatient psychiatric and the psychiatric inpatient group norms. Further, mothers scored significantly higher than fathers on the global distress scores (Moriarty et al.).

Table 2.1

The psychological factors influencing the bereaved parent's response to the death of the

child. (pp. 23, 24)

Characteristics and meaning of the loss sustained and the relationship severed	**Characteristics of the grieving parent**
The unique nature and meaning of the relationship severed The individual qualities of the relationship lost The roles that the child occupied in the family The characteristics of the deceased child The amount of unfinished business between the parent and the child The parent's perception of the child's fulfillment in life The number, type, and quality of secondary losses for the parent	The parent's coping behaviors, personality, and mental health The parent's level of maturity and intelligence The parent's past experiences with loss and death The parent's social, cultural, ethnic, and religious/philosophical background The parent's sex- role conditioning The parent's age The presence of concurrent stresses or crises in the parent's life
Characteristics of the death	**The social factors influencing the bereaved parent's response to the death of the child include the following:**
The death surround The timeliness of the death The parent's perception of the preventability of the death Whether the death was sudden or expected The length of the illness prior to death The amount of the parent's anticipatory grief and involvement with the dying child **The physiological factors influencing the bereaved parent's response to the death of the child include the following**: The parent's use of drugs and sedatives The parent's nutrition The amount of rest and sleep the parent receives The parent's physical health The amount of exercise the parent gets	The parent's social support system and the acceptance and assistance of its members The parent's socio-cultural, ethnic, and religious/philosophical background The parent's educational, economic, and occupational status The funerary rituals utilized

Lepore et al. (1996) found that bereaved mothers, who reported social constraints in discussing the loss of their child at three weeks post-loss, experienced significantly higher levels of negative intrusive thoughts as well as a relationship between intrusive thoughts and depressive symptoms at three and 18 months. The inverse relationship was also found, such that, mothers who did not report social constraints to discuss the loss of their child at three weeks, did not show a relationship between intrusive thoughts and depressive symptoms at 18 months.

In a census study of 449 parents who had lost a child to a malignancy, Surkan et al. (2006) found that 19.2% reported daily or weekly episodes of guilt in the first year following the death. The parents' impressions that their child received quality care for physical (symptom and pain relief) as well as for psychological support were significant variables impacting the feelings of guilt during the bereavement period. Quality of communication with the treatment teams were also significantly correlated with levels of guilt during bereavement. Surkan et al. used a systemic perspective to articulate their study and interpret their results. Thus, in their model, contextual factors during the palliative care phase had an important role to play in the way parental grieving unfolded. According to Surkan et al.'s findings the medical and social support obtained during the child's struggle with cancer is a variable to consider when looking at psychological distress in bereaved parents. .

Drew, Goodenough, Maurice, Foreman, and Willis (2005) found that parents whose child had gone through a stem cell transplant suffered from significantly higher anxiety, stress, and depression than parents whose child died from cancer but who did not go through a stem cell transplant. Overall, however, Drew et al. found that irrespective of stem cell transplants, parents of children who died in the hospital reported significantly higher anxiety,

stress, depression, and more intense grieving than those of children who died at home. There are a couple of explanations for such results. Compared to children who die at home, children who die in the hospital tend to have more complex symptom management issues that are distressing and painful to remember. The second explanation, that does not exclude the first one, is that parents who opt to palliate their child in the hospital might be more insecure and have less social support and/or more psychosocial issues. This could then explain the higher psychological distress and more intense grief of parents of children who die in the hospital.

In their examination of bereaved parents who came out of the Wisconsin Longitudinal Study (WSL), Rogers et al. (2008) found that cohort members who had a child die reported having suffered from an episode of depression at almost twice the rate as cohort members who had not had a child that died. Eighty-three percent of the cohort members who had a child that died and reported depression did so in the first three years following the loss (Rogers et al., 2008).

In their study comparing bereaved parents with a non–bereaved matched comparison group, Znoj and Keller (2002) found that grieving parents learn to cope with the very difficult emotions related with the loss of their children. These researchers made a call for studies that look more closely at how emotional regulation is learned and improved on in the context of parental loss.   Znoj and Keller also suggest that studies should look at effective versus problematic coping styles in attempts to achieve emotional regulation.

Bonnano et al., (2005) articulated a functional approach to emotions in the context of loss in general, as well as parental loss in both the U.S. and China. As in attachment theory, these researchers looked at a continuum of high grief processing vs. high avoidance of grief but this continuum is not linked to attachment theory. In fact, Bonnano et al. claim that high

avoidance of grief is preferable and more adaptive than high grief processing. The researchers found that bereaved parents in the U.S. who manifest higher grief processing generally had poorer outcomes, whereas in China bereaved parents overall showed higher grief processing than U.S parents and yet showed a more rapid recovery from their loss. According to Bonanno et al.'s study, culture may influence psychological distress in the context of grief.

Barr and Cacciatore (2008) report on their survey of 441 women who experienced miscarriage, stillbirth, neonatal death, or infant/child death. The study explored the relationship between women's pre-existing proneness to envy, jealousy, shame, guilt, and level of grief following the death of a child. Their model found that four problematic emotions and time since death explained 43% of the variance in grief following the death of a child. Barr and Cacciatore propose that grieving mothers who suffer from more intense psychological distress may well be dealing with preexisting dispositional negative emotions. These tend to exacerbate their grief. Barr and Cacciatore discuss how it is possible that part of the variable explaining grief could include attachment styles but that these were not explored in the study. This study on the relationship of dispositional negative emotions and higher levels of grief illustrates how linking psychological distress with insecure retrospective attachment styles would be useful tools in exploring variations in levels of grief in bereaved parents.

Wijngaards et al. (2005) found that depression in bereaved parents was mainly associated with "gender of the parent, religious affiliation, and professional help seeking" (p. 626). In terms of gender, women had higher levels of depressive symptoms than men, but the researchers were not sure if these findings simply reflect basic gender differences in

psychological distress, or if they also reflect loss-specific dynamics. Religious parents scored

higher on the depression scale than parents who were not religious, and this finding

contradicts other studies and more studies need to be done to understand this phenomenon.

The results regarding professional help seeking and its relationship with depression is also

not a clear picture. Wijngaards-de Meij et al. first state that the obvious interpretation of this

data is that depression leads to help seeking, however, the researchers also raise the

possibility that in the short term going to see a professional and bringing up negative issues

can increase depressive symptoms. The researchers also note that in their study, professional

help seeking was associated with depression and not grief.

Wijngaards-de Meij et al. (2008) found that being female was significantly

associated with depression following the loss of a child. The researchers also found that age

of the child at death was significantly correlated to depression in bereaved parents. The older

the child at death, the higher the level of depression.

Wijngaards-de Meij et al. (2007) found that 16% of the variance of depression in

bereaved parents was explained by their attachment dimensions. Bereaved parents who

scored high on either of the insecure attachment dimensions reported high levels of

depression following the death of their child. Individuals with avoidant attachment styles

suffer from significant depression levels and this finding was unexpected. This is contrary to

results of studies such as Bonnano et al. (2005). Wijngaards-de Meij et al. explain that in

child loss, parents cannot shut off the thoughts of the loss of the child. This becomes very

problematic for parents with an avoidant attachment style because they then lose their only

way of coping. Without their ability to access and maintain their usual deactivating

strategies, parents with an avoidant attachment style are left vulnerable to psychological

distress. The authors state that child loss appears to overwhelm avoidant individuals and that they should also be considered a high risk group for psychological distress. Wijngaards-de Meij et al. found that depression was not significantly associated with the attachment insecurity of the spouse of an avoidant spouse.

This section demonstrates the role of psychological distress following the death of a child. According to attachment theory, emotions are action potentials that serve the purpose of protesting the loss, experiencing and expressing the despair of not achieving reunion with the deceased attachment figure, and of reorganizing one's life without the attachment figure as an external regulator of psychological stasis (Bowlby; Parkes, 2006; Klass & Marwit, 1988; Rando). Attachment theory further postulates that the intensity and duration of patterns of emotional or psychological distress will be mediated by the attachment style and security of the person who is bereaved as well as by the quality of the relational bond that was lost (Archer, 1999; Bowlby; Parkes; Stroebe, Schut, & Stroebe, 2005). Attachment theory proposes that psychological distress is a negative but necessary component of grief (Archer; Bowlby; Shaver & Tancredy, 2002/2001).

The literature from the 80's tends to be descriptive and attempts to inventory all the manifestations of psychological distress that could be observed. Only Bowlby (1980/1998) and Bowlby and Parkes (1970) were able to move from the descriptive to a prospective model of grief. As a result of their work, the idea that psychological distress was inherent or syndromic to the loss experience became more widespread. Rando (1986, 1997) really promoted the notion that parental grief was inherently more distressing than other losses. It is only recent, however, that researchers are trying to understand the many mediators that have an impact on the intensity of psychological distress after the death of a child. These

mediators can be summarized by the bio-psycho-social context. As Bowlby and Parkes (1970) have proposed, separation and loss stimulates innate responses aimed at reunion otherwise known as separation anxiety. Without a reunion with the child, the psychological distress continues and cannot be extinguished . This is the biological part of psychological distress during grief. These innate responses are then mediated by parents' varied psychological make-up or, as stated in attachment theory, by attachment styles. Gender appears to interact with attachment style to determine grief orientation as per the DPM. This is the psychological aspect of grief. Studies by Bonnano et al. (2005), Lepore et al., (1996), Pressman and Bonnano (2007), and Surkan et al. (2006) have shown how the social context appears to also mediate psychological distress in the situation of child loss. This is the social aspect of psychological distress in grief.

Control variables.

Based on the literature, the following control variables were selected for this study: gender of the bereaved parents, (Archer, 1999; Cook & Oltjenbruns, 1998/1989; Digregov & Digregov, 1999; Smart, 1993; Wijngaards-de Meij et al., 2007), number of surviving children, (Archer, 1999; Barrera et al., 2007;, Levak ,1980;, Klass, 1988, 1997; Klass and Marwit, 1988; age of child at death (Fish,1986; Rubin & Malkinson,2001/2002; Sanders, 1980; Wijngaards-de Meij etal.,2005), time since child's death (Rando, 1986; Feeley & Gottlieb 1988; Kamm & Vandenberg 2001; Rogers et al.2008 ; Wijngaards-de Meij et al., 2005)

Summary

Chapter 2 reviewed grief theory and research in order to provide a sound basis for the study. A definition of grief as it is used in the study was presented. This was followed by a

review of the main historical developments in the field of adult grief theory, leading to the

present main questions in the field. A review of the literature pertaining specifically to

bereaved parents and couples followed. An individual and relational approach to understand

grief in bereaved parents was articulated around the DPM and other theoretical and research-

based information. The model proposes that retrospective attachment styles and social

support have an impact on how individual parents will process grief. A review of the

literature surrounding the specific variables used in the study was presented.

   Chapter 3 presents the study methodology.

Chapter III

Methodology

This study is a cross-sectional correlation survey design using eight self-administered quantitative measures including a demographic questionnaire. One purpose of this study is to investigate the relationship, of individual parents who have lost a child to cancer, between retrospective attachment styles, social support, grief, psychological distress, marital distress, grief, and oscillation balance. The second purpose of the study is to investigate the relationship of levels of discrepancy in retrospective attachment styles within the bereaved couples, with levels of psychological distress, marital distress, and grief.

This chapter will present the hypotheses, the sampling plan, and the data collection plan. The conceptual and operational definitions of the variables, including data on reliability and validity, will be presented followed by the data analysis plan.

The attachment styles and distress model among parents who have lost a child to cancer operationalized in this study is that retrospective attachment styles and social support are correlated with psychological distress, marital distress, grief, and oscillation balance. Control variables are included in the model based on findings of previous studies of bereaved parents (Archer, 1999; Wijngaard et al., 2005). The control variables are: gender of the individual parent, number of surviving children, age of child at death, and time since child's death. Demographic data collected are age, education, level of family income, marital status, number of times married, if the parents had medical insurance for the medical expenses of their child, if their child's illness had provoked financial hardship, and if parents had sought counseling before or after the loss of their child.

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This study is guided by three multivariate hypotheses which are as follows: H1: Controlling for gender of parent, number of surviving children, age of child at death, and time since child's death, among individual parents whose child died of cancer the higher the insecurity in retrospective attachment style and the lower the social support, the higher the psychological distress, martial distress, and grief.

H2: Controlling for gender of parent, number of surviving children, age of child at death, and time since child's death, among couples whose child died of cancer, the greater the discrepancy in retrospective attachment styles, the lower the social support in the individual parent, the higher the marital distress in the couple, and the higher the psychological distress and grief in the individual parent.

H3: Controlling for gender of parent, number of surviving children, age of child at death, and time since child's death, among individual parents whose child died of cancer, the more a parent is insecure in retrospective attachment style and the lower the less social support, the less the parent will be able to oscillate from one spectrum of the DPM to the other.

Sampling Plan

The population for this study was couples who had lost a child to cancer. The sample design is a non-probability convenience sample consisting of individuals who lost a child to cancer in the last 6 to 60 months, the child was 20 years old or younger, who reside in the US or Canada, and became aware of the study by community parental support programs (e.g. Candlelighters Children Cancer Foundation, Cure Cancer) and supported by professional organizations (e.g. Association of Pediatric Oncology Social Workers).

The researcher contacted over 90 community parental support organizations throughout Canada and the U.S. The researcher approached all of the chapters by letter followed by a phone call to discuss interest in assisting in the study. The letters were mailed following the dissertation proposal being approved by The Catholic University of America. The follow-up phone calls started one week after the mailing until all organizations had been contacted. Both in the letter and in the phone conversation, the researcher explained the purpose of the study and what was being asked of the organization.

The organizations were asked to compile a mailing list of bereaved parents whose child died of cancer, produce two sets of mailing labels, and affix one set of labels to the postage paid envelopes containing an initial invitation to take part in the study. Once the mailing list of bereaved parent was compiled, the organizations contacted the researcher with the number of invitations needed. The researcher sent the letters via FedEx or UPS. The second set of mailing labels was used for the follow-up invitation that the organizations were asked to mail out three weeks after the original letter. The follow-up letters were provided by the researcher, with postage paid, to the organizations.

The letter forwarded by the participating organizations to bereaved parents was written, stamped, and sealed by the researcher (see Appendix C). The letter explained the study and how to contact the researcher in order to participate in the study. This could be done either by mail with a return postage- paid envelope or by email to the researcher's university email address.

Asking the organizations to produce the mailing list and affix the labels to the envelopes maintained the confidentiality of those bereaved parents affiliated with the support

agencies. Only those parents who decided to participate in the study became known to the researcher.

Fifteen agencies agreed to participate by forwarding an invitation letter to the bereaved parents to whom services were provided. Three agencies offered to send a modified version of the invitation. One of those agencies gave some information about the study to a group of bereaved parents and the other sent an abbreviated version of the letter by email to parents who qualified. One agency wrote a small notice about the study and how to reach the researcher in their agency newsletter. The three agencies that had sent modified versions of the invitation were not asked to send reminders.

A letter was also sent to members of the Association of Pediatric Oncology Social Workers (APOSW) to inform them of the purpose of the study and to direct them to contact the researcher if they had any questions or concerns (see Appendix B). This step was taken so that if potential respondents contacted their deceased child's social worker regarding the legitimacy of the request, the social worker would be aware of the study. APOSW members were not asked to recruit participants.

The survey for this study is composed of seven standardized scales and of one demographic questionnaire and made available either online or as a hard copy. The hard copy was sent by mail (if requested), and it was sent with postage-paid return envelopes. All standardized tools were chosen based on reported reliability and validity in measuring the various variables being studied. Ease of completion was also a criterion of selection of the scales. The survey could be completed in approximately 50 minutes.

Conceptual and Operational Definitions of the Variables.

       Control variables.

Gender of parents, number of surviving children, age of child at death, and time since child's death will be collected on the demographic questionnaire.

Dependant variables.

Psychological distress is conceptually defined as an aversive cognitive and/or somatic response to perceived internal and/or external stressors and which leads to actions cognitive and /or somatic aimed at addressing, adjusting to or ignoring stressors. Psychological distress was operationalized by using the Brief Symptom Inventory (BSI) (Derogatis & Melisaratos, 1982) a 53-item 5-point Likert scale. The Global Severity Index (GSI) a subscale of the BSI will be used in the analysis: the higher the score, the higher the psychological distress.

The BSI is a 53 item self-report scale that uses a 5 point (0-4) Likert scale that ranges from "not at all" = 0 to "extremely" = 4 . The BSI has three global scales and nine sub-scales. The global scales include the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST) (Derogatis & Spencer, 1982). Of these three global scales only the GSI is used in the analysis in this study. The GSI is scored by summing the responses to the 53 items and dividing by the number of items answered.. The raw scores on all the scales are converted into standardized T-scores. The T-scores for the GSI range from 33 to 80 for females and from 35 to 80 for males. The higher the score the higher the overall psychological distress. Missing data up to 25% of the items do not affect the interpretation of the GSI. The denominator is decreased by the number of items missing to calculate the GSI raw score (Derogatis & Spencer, 1982).

The nine subscales of the BSI correspond to "…primary symptom dimensions…" (Derogatis & Spencer,1982, page number) these subscales are: 1. Somatization (SOM),2. Obsessive-Compulsive (O-C), 3.Interpersonal Sensitivity (I-S), 4. Depression (DEP), 5.

Anxiety (Anx), 6. Hostility (HOS), 7. Phobic Anxiety (PHOB), 8. Paranoid Ideation (PAR),

and 9. Psychoticism (PSY). All of the sub-scales are used in the analysis of this study. Raw

scores for all of the sub-scales range from 0 to 4 and the standardized T-scores range from 30

to 80 for females and from to 39 to 80 for males. The higher the score on each of the sub-

scales the higher the symptoms of the particular sub-scale. For each of the nine subscales one

missing item for any given subscale has been reported to not affect the interpretation of the

scale. If one item was missing from any subscale the denominator was decreased by one in

the calculation of the scores for the subscales. If more than one item was missing that

subscale was not used in the analysis for that individual (Derogatis & Spencer, 1982).

The BSI is reported as reliable and valid by Derogatis and Spencer (1982) and

Derogatis and Melisaratos (1983). Stability of the BSI was evaluated using a test retest of 60

non-psychiatric subjects with a two week interval and obtained reliabilities ranging from .80

to .90 for the global scales. Internal reliability for the nine subscales was done using

Chronbach's coefficient alpha analysis on data from 719 psychiatric outpatients. The

Chronbach alpha for the nine sub-scales are: SOM, .80; O-C,.83, I-S, .74, DEP, .85, ANX,

.81, HOS, .78 , PHOB, .77 , PAR, .77 , and PSY, .71 . High convergence between the

different scales of the BSI and the MMPI were reported by Derogatis and Spencer (1982).

Factor analysis showed good construct validity and multiple studies have demonstrated the

predictive validity of the BSI (Derogatis & Spencer, 1982).

Marital distress in the couple is conceptually defined using Johnson and Greenberg

(1988) definition which is that marital distress is a "negative interaction cycle (most

commonly, a pursue-distance cycle)" (p. 175) with decreased accessibility and

responsiveness between the couple. Marital Distress was operationalized with the Dyadic

Adjustment Scale (DAS) (Spanier, 1976). A high score on the DAS indicates marital adjustment while low scores indicate marital distress. The DAS is a 32 item measure that uses mostly Likert scales (28 items), two No/Yes items, and two multiple choice items. The response set for the Likert scaled items included 0 to 4, 0 to 5, and 0 to 6 (Spanier, 1976). The DAS has four subscales: Dyadic Cohesion; Dyadic Satisfaction; Dyadic Consensus and Affectional Expression, though only the overall DAS score is used in this study.

The range of the scores of the total DAS is 0 to 151. The mean score was established by Spanier (1976) as 114.8 for married couples. Walker et al. (1992) explain that Spanier (1976) did not make a distinction between married couples and married couples with children. They describe how the means for couples with children is lower at 107 compared with couples with no children at 113 in a number of studies (Houseknecht, 1979, Kazak & Marvin, 1984; Kazak, Reber & Snitzer, 1988, as cited in Walker et al., 1992). Reporting on their own study of parents with a chronically ill child, Walker et al. suggests a cut off for marital distress of 109.7 in one member of a couple. Couples who had a child with cancer were considered as having a chronically ill child by Walker et al., (1992), therefore their cutoff criteria will be adopted in this study.

Scoring the DAS is done by summing the responses to all the items. In the present study some of the items had the two middle scales collapsed together by accident. A specific computation of scores with different weights was programmed in the SPSS syntax in order to compensate for the fact that certain items were scored 0 to 4 instead of 0 to 5. Missing data was adjusted for by substituting item means for missing values. If more than 20% of the DAS data was missing for one participant, no data from that participant was used in the analysis.

The DAS was described as reliable with a Chronbach's alpha of .96 for the total scale (Spanier, 1976). Spanier and Filsinger (1983) reported that the DAS was shown to have content, convergent and construct validity. Eddy, Heyman and Weiss (1991) performed factor analysis, maximal decomposition factor analysis and classification analyses and found that the DAS has good discriminate validity between distressed and non-distressed couples. Walker, Johnson, Manion and Cloutier (1992) have done studies that confirm the criterion validity of the DAS. Given that the DAS measures both marital satisfaction and distress the variable used to measure marital distress was called marital satisfaction/distress for the remainder of the study.

Grief is conceptually defined using Stroebe et al. (1998) definition, which is that grief is the reactions to the loss of a significant other that are "dominated by negative affect, but also cover a wider range of emotional, cognitive, behavioral, and physiological reactions (these to some extent overlap)" (p. 85). Grief will be operationalized by using the Hogan Grief Reaction Checklist (HGRF) (Hogan, Greenfield, & Schmidt, 2001). The HGRF is a 61 - item 5 point Likert scale $(1 - 5)$. The HGRF has been reported by Hogan et al. (2001) to be reliable and valid and was developed with bereaved parents as part of the sample of subjects. The HGRF has six domains: Despair, Panic Behavior, Personal Growth, Blame and Anger, Detachment, and Disorganization. The potential ranges for each subscale range from 7 to 70 based on the number of items for each. There is no total score for the HGRC as the personal growth domain is negatively correlated with the other subscales. Each subscale is scored individually by summing all of its items. For each subscale the higher the score the higher the various behaviors described in each scale. For the purpose of this study the decision was made to create a composite grief scale using the six domains of grief of the HGRF. For this

purpose personal growth was reverse coded. This way the higher the score of personal growth the lower the score on the composite grief scale. On the composite grief scale the higher the score the more difficult the grief. Missing data were accounted for by substituting item means for missing values. If more than 20% of the HGRF data was missing for one participant, no data from that participant was used in the analysis.

The HGRF is reported to be reliable with Chronbach's alphas as follows for each domain of grief: Despair, $\alpha=.89$; Panic Behavior, $\alpha=.90$; Personal Growth, $\alpha=.82$; Blame and Anger, $\alpha=.79$; Detachment, $\alpha=.87$; and Disorganization, $\alpha=.84$ (Hogan et al., 2001). Hogan et al. (2001) reported that the validity of the HGRC was established through a confirmatory factor analysis. Convergent and divergent validity were established with the Texas Revised Grief Inventory (TRIG), the Grief Experience Inventory (GEI) and the Impact of Events scale (IES). Hogan et al. (2001) also state that the DPM's suggestion that "…bereaved individuals oscillate between confronting grief and avoiding grief, was supported."(p. 12) thus establishing good construct validity. The HGRC was also found to have good discriminate validity in a sample of bereaved mothers whose children died of illness, accident, suicide or homicide and was able to distinguish between the different groups based on the differences in the more salient scales of the HGRC. The HGRC was also able to distinguish a group effect between parents who had lost a child less than three years ago vs. those who were bereaved more than three years. There is no reliability and validity reported on the composite grief scale of the GHRC.

Oscillation balance during grief is conceptually defined as a cognitive and emotional shift between loss-orientation (LO) and resolution-orientation (RO). The more one tends to be in one orientation, the less one is thought to achieve oscillation balance. Oscillation

balance was operationalized using the Inventory of Daily Widowed Life (IDWL) (Caserta &

Lund, 2007) adapted for bereaved parents. Oscillation balance between grief tasks was

operationalized using the Inventory of Daily Widowed Life (IDWL) adapted by the

researcher for bereaved parents. For the purpose of this study the name of this instrument is

the Inventory for Daily Parental Bereavement Life (IDPBL). The changes made in the

original instrument was to change wording from the death of your spouse to the death of your

child. The IDPBL is a 22-item measure using a Likert scale from 1 to 4. The IDPBL is

composed of two subscales, the Loss Oriented (LO) and the Resolution Oriented (RO)

subscales. The LO subscale includes items 1 to 11 and has a range of 11 (Low) to 44 (High).

The RO subscale includes the items 12 to 22 and also has a range of 11 (Low) to 44 (High).

Calculation of oscillation balance is done by subtracting Lo from RO (RO – LO =

Oscillation) range is from -33 (Exclusively Loss - Oriented) to +33 (Exclusively Restoration

– Oriented). A 0 indicates a perfect oscillation balance. Missing values were accounted for

by substituting item means for missing values. If more than 20% of the IDPBL data was

missing for one participant, no data from that participant was used in the analysis (Caserta &

Lund, 2007). The study results showed good congruent and divergent validity with the other

grief- related scales used in the study. There was no correlation between the LO and RO

scales showing good divergent validity. On the other hand both grief orientation scales

demonstrated good correlation with oscillation balance scale, showing good convergent

validity in this area. These findings show correspondence of the IDWL with the DPM

demonstrating construct validity. Discriminate validity was partially statistically supported;

bereaved subjects were more resolution oriented at 12-15 months post-loss than earlier in

their grief. Loss orientation shift to resolution orientation was not statistically significant.

These findings partially correspond with the DPM giving the IDWL added construct validity.

Independent variables.

Insecurity in retrospective attachment styles is conceptually defined as the embodied

experiences of early childhood that form background premises or schemas from which

individuals understand their own self as well as the world around them and from which they

strive to achieve emotional regulation of self and with others (Bowlby, 1998; Parkes, 2006).

Retrospective attachment styles will be measured by the Retrospective Attachment

Questionnaire (RAQ) (Parkes, 2006)

Discrepancy in retrospective attachment styles is conceptually defined as the

difference in insecurity in the retrospective attachment style between members of the couple.

It will be calculated by subtracting one parent's RAQ from the other parent's RAQ insecurity

score.

Insecurity in attachment style was operationalized by using the Retrospective

Attachment Scale (RAQ) (Parkes, 2006). The RAQ is a 157-item questionnaire that uses

mostly a two point Yes/No scale. There are also three 3-point items, 5 items requiring a

continuous numerical response, and one multiple choice item. The RAQ is divided into four

sections. Section I, About your parents, is composed of 28 questions pertaining to both

Mother and Father, this brings the total number of items to 56 in this section. Section II,

About your childhood, is composed of 31 items. Section III, About your life as an adult, is

composed of 44 items. Section IV, About you now, is composed of 34 items.

Sections I and II are the only two sections of the RAQ used in this study. Section I

has seven subscales that when summed make up the Overall Problematic Parenting Scale.

Section II also has seven subscales, which when summed results in the Childhood Overall

Vulnerability Scale. The sum of Overall Problematic Parenting and of Overall Childhood

Vulnerability make up the Secure/ Insecure Attachment Score that has a range of 0 to 76. A

low score represents security and a high score represents insecurity. In a sample of bereaved

adults, the average score for the Secure/Insecure attachment scale is 17; below 11 can be

considered as secure, 11 to 21 are intermediate levels of insecurity, and 21 is the cutoff for

insecure attachment (Parkes, 2006).

There is a scale for each of the insecure attachment styles: anxious/ ambivalent,

avoidant and disorganized/disoriented. For these three scales, low scores mean low levels and

high scores mean high levels of the particular attachment style. The Anxious/Ambivalent

Attachment Score has a range of 0 to 32; an average score of 7 and scores of 10 or more are

considered to be high. The Avoidant Attachment Score has a range of 0 to 10, an average

score is 3.8 and a score of 6 and above is considered high. The Disorganized/Disoriented

Attachment Score has a range of 0 to 26 with an average score of 4.5 and scores of 6 and

above are considered high. The RAQ is reported as reliable by Parkes (2006) with a

Chronbach's alpha of .85 for the Problematic Parenting score, of .90 for the Overall

Childhood Vulnerability, of .91 for the Anxious/Ambivalent Attachment score, of .80 for the

Avoidant Attachment score, of .87 for the Disorganized/Disoriented Attachment Score, and

of .94 for the Secure/Insecure Attachment score.

Parkes (2006) states that the results of his study support discriminate validity of the

different scales of the RAQ. Clustering of responses had good correlations for questions

about parents and for questions about childhood. Parkes (2006) also found that the clustering

of responses to the RAQ "…confirms and corresponds to Ainsworth and Main's categories

of secure and insecure attachment" (p. 61). Parkes (2006) established criterion validity by comparing 3 different groups of subjects, a group of bereaved psychiatric patients, a group of bereaved non- psychiatric women and a group of non-bereaved non-psychiatric women. For the three groups "…the same patterns of attachment are associated with the same patterns of adult relationships and feelings" (p.220).

Scoring the RAQ is done by summing the various subscales as indicated by Parkes (2006). Items are scored as Yes=1 and No=0. This required recoding of responses in this study due to the manner in which the online survey system automatically codes response items. The manner in which missing data was handled is based on the type of response. In a series of Yes/No questions, when a respondent has only made Yes responses and left other responses blank, blanks were scored as No. When continuous numerical data is missing the mean for the whole sample is used. In section I if the answer to "Are your parents still alive?" is missing for either or both Mother/Father then the item is scored as 0 or Alive. If the same question is scored as 0 or Alive then all missing questions in section I as 0 or No. In section 2, for the questions "Did you lack self confidence as a child?" "Did people often think of you as tougher as or more capable than you really were?", "Did you find it hard to ask other people to help you?", and "Were you stubborn?" missing data is scored as .5. "Were you born outside the U.S. or Canada?" is scored as 0 or No if data is missing. If this question is scored as Yes and "Age at time of entry into country is missing, substitute mean for your sample" (Parkes, 2006, p. 306). . All other missing data is scored as 0 or No in this section. The following three questions require a reverse coding resulting in a Yes = 0 and No = 1: "Were you brought up by your true Mother/Father?"; "Are your Mother/Father still alive?" "Was your birth planned and wanted by your Mother/Father?" (Parkes, 2006)

For the question "How often did you cry?" the responses Never/Sometimes/Often were subdivided into two variables where: Never cry = 1, Sometimes or often = 0 and Often cry = 1 and Never or Sometimes =0. (Parkes, 2006)

Social support is conceptually defined as the perception by an individual that help is available: they can count on the extended family and /or the immediate community for assistance. Social Support was operationalized by the Social Support Index (SSI) (Mc Cubbin, Patterson & Glynn, 1996). The SSI is a 17 item self-report measure; all items use a 5 point Likert scale from 0 to 4. The scale requests subjects to rate their responses to all the items from Strongly disagree=0 to Strongly agree=4. The range of the SSI is from 0 to 68. The SSI is reported as reliable and valid. It has a Chronbach's alpha of .82 (Mc Cubbin, Patterson & Glynn, 1996). McCubbin et al., (1996) found that the SSI had a ".40 validity coefficient with the criterion of family well-being…" (p. 358). Discriminative validity was also established in numerous studies; the lowest point of community/social support for most families is when children are of school age and it progressively increases until the empty nest stage (McCubbin et al., (1996). In multiple studies of various cultures, higher scores on the SSI were positively correlated with family resilience, demonstrating good predictive validity. A path analysis showed that "…community/ social support was an indirect predictor of family distress, operating through family schema and family problem -solving communication (McCubbin et al., 1996, p. 358).

Items 7,9,10,13,14,15 and 17 are reversed scored. Scores are summed, the higher the score the higher the Social Support for an individual subject. Missing values were accounted for by substituting item means for missing values. If more than 20% of the SSI data is missing for one participant, no data from that participant is used in the analysis.

Sample

Four hundred and twenty invitations were sent to the potential support organizations (this does not include the agency that advised parents of the study in their news letter). Forty seven letters were returned to sender as no such person at the given address. One phone call was received by the researcher explaining that there was a mistake and that their child had been successfully treated for cancer and was still alive.

One hundred and six parents responded to the letter inviting them to participate in the study. Of those, ninety surveys were received and determined to be complete. Of these, four did not meet the inclusion criteria resulting in a final sample size of eighty six which represents a response rate of 20.5%. Of these 64 respondents were coupled resulting in 32 couples for hypothesis two.

Data Collection

Data was collected using either a mail survey or an online survey. Parents who wished to do the survey on the hard copy were sent a packet via U.S. or Canada Post containing two of the following: a covering letter with instructions, two copies of the informed consent, one for them to send back with the completed survey and one for their records, the instrument, and a stamped, pre-addressed envelope to return the completed survey. The two packets were sent in the same envelope but each member of the couple had his/her own return envelope.

For the online survey, once parents had identified themselves as wanting to complete the survey online, the researcher sent a standard email to both members of the couples. When the couples provided two email addresses the standard email and the unique identification number and URL were sent to the corresponding email addresses. When the couples gave

only one email address, the researcher sent both unique identification numbers to the same address. The participants accessed the website using their secure unique identification number. The survey site would open to an instruction letter. Participants could not begin the survey until they completed the informed consent. The survey was hosted on Vovici's secure website.

Fifty surveys were completed using the mail-in survey while forty surveys were completed online. A second reminder was sent to all the participants who had identified themselves to the researcher but had not submitted their surveys approximately two months after identifying themselves.

Preparation for data analysis

Data from those participants who chose to complete the survey online was in one file while the data from hard copies were entered into a separate online file by the researcher and an assistant at regular intervals. A coding scheme was used to maintain confidentiality of results for both online and mail responders by replacing names with a unique identification number.

Plan of Analysis

The data from both the online surveys and the hard copy surveys were downloaded from Vovici directly into SPSS version 17 for analysis (SPSS, 2007).

All the data collected were reviewed by performing frequencies, measures of central tendency, and measures of dispersion. Pearson's correlation analysis was used as an initial overview of the data and to find correlations between the various study variables. For the final analysis, multiple regression analysis was used to analyze the relationship between the

dependant variables and the independent variables. The level of significance used in the

analysis was .05.

Summary

This chapter described the research methodology utilized in this study. The research

design was described and the three hypotheses of the study were presented. The sampling

plan, the instruments used in the study, the sample, the data collection, and the data analysis

process were described.

Chapter 4 will describe the findings.

Chapter IV

Findings

This chapter describes the findings of the study. It begins with a description of the socio-demographic information about the respondents. The independent and dependent variable scale means, standard deviations, potential scale ranges, and actual ranges will be presented. This will be followed by the results of the bivariate analysis between the independent variables, the dependent variables, and the control variables. The multiple regression analyses (MRAs) used to test the three hypotheses will be presented and described.

Socio-Demographic Characteristics of Respondents

The sample included 86 respondents. Socio-demographics indicate that respondents were primarily female at an almost perfect 60/40 split. The majority (91.8%) of the subjects were white; their level of education was quite high, with a majority (63.9 %) of respondents reporting having received a college or graduate diploma. 60 % of subjects declared a combined family income of $75,001.00 to $350,000.00. Most of the respondents were in their mid-forties. It was interesting to note that there were no respondents younger than 30. The majority of the subjects (77.5%) were in their first marriage and the mean length of the marriages was 14.7 years ($SD =$ 7.8); 91.8 % of couples were still together following the death of their child, indicating a stable group. Just under 18% of parents had no health insurance for their child's illness and 32.3% of parents considered that their family experienced financial hardship because of their child's illness. This suggests that health care insurance was not a guarantee of avoiding financial hardship during the illness of a child.

Table 4.1

Demographics of sample

Variables	N	%	
Gender			
Female	51	59.3	
Male	35	40.7	
Race			
White	78	91.8	
Non-white	7	8.2	
Still married			
Yes	78	91.8	
No	7	8.2	
Times married			
1	62	77.5	
2	13	16.2	
3	5	6.3	
Education level			
High school	19	22.1	
Some college	12	14.0	
College	24	27.9	
Advanced degrees	31	36.0	
Family income			
$10,000-$25,000	7	8.8	
$25,001-$50,000	16	20.0	
$50,001-$75,000	13	16.2	
$75,001-$150,000	33	41.2	
$150,000-$350,000	11	13.8	
Health insurance			
Yes	71	81.6	
No	16	18.4	
Financial hardship			
Yes	29	33.7	
No	57	66.3	
Sought therapy			
Before death of child			
Yes	31	35.6	
No	54	64.4	
After death			
Yes	53	62.4	
No	32	37.6	
	Mean	**SD**	**Range**
Age of parents	43.5	7.1	30 - 59
Years married	14.7	7.8	1 - 33

Fifty-three (62.4%) parents sought therapy following the death of their child, compared to 31

(36.5%) during the illness (Table 4.1).

The majority of the children that died were male (61.1), the mean age of the children

at time of diagnosis was 8.3 (*SD* = 6.3), and the average age of the child at death was just

over 10.7 (*SD* = 6.2). The average time between the death of their child and the completion

of the survey was 29 months (*SD* = 19). 11 (13%) of the parents had no surviving children,

while the remaining 74 had an average of 2 surviving children. (See Table 4.2).

Table 4.2

Demographics of deceased children (N= 54)

Variables	N	%	
Gender [a]			
Male	33	61.1	
Female	21	38.9	
Is this your biological child?			
Yes	75	87.2	
No	11	12.8	
Is this your only child? [a]			
Yes	7	13.0	
No	47	87.0	
How many surviving children do you have? (mean 2.0; *SD* 1.4) [a]			
1	33	44.6	
2	21	28.4	
3	12	16.2	
4 – 7	8	10.8	

	Mean	*SD*	**Range**
Age at diagnosis	8.3	6.1	1 - 20
Age at death	10.7	6.1	1 - 20

[a] responses calculated from 32 couples and 22 singles.

Summary Statistics of the Dependant and Independent Variables

Dependent variables.

The dependent variables included psychological distress, marital satisfaction/distress, grief, and oscillation balance. Reviewing the summary statistics of the dependant variables, most of the results fall in the mid range of the scales. The mean score of the sample (59.4) was below the cut-off score of 63 that is established for the Brief Symptom Inventory (BSI). Study subjects did express psychological distress above the standard t-score of 50, but on average subjects did not suffer from overwhelming psychological distress. The results show that on average the couples in the study were not maritally distressed. That is, the mean score of 110.5 was not significantly different from the cut-off score of 110 that is established for the Dyadic Adjustment Scale (DAS). In terms of grief, while there are not established cut-off scores for the six domains of the Hogan Grief Reaction Checklist (HGRC) or for the composite grief score, the results show the same trend most subjects reported average levels of grief. The results of the Inventory for Daily Parental Bereavement Life (IDPBL) show the same pattern for oscillation balance, with   the sample being very slightly towards loss orientation, however this would be expected given that the sample was 60% female (Stroebe & Schut, 1999; Wijngaards-de Meij, 2008) (See Table 4.3).

Independent variables.

The study's two independent variables were retrospective attachment style and social support. In terms of the summary statistics of the two independent variables, average scores on the Retrospective Attachment Scale (RAQ) were below the mid-range for insecure attachment styles but subjects demonstrated relatively strong scores of social support. For insecure attachment, the RAQ was comprised of the three more specific scales of insecure attachment, namely the anxious ambivalent, the avoidant, and the disorganised attachment scales. All of the insecure attachment scales indicated that on average subjects in the study

were not highly insecure. None of the average scores (insecure 14.1, anxious ambivalent 6.2,

anxious avoidant 2.4 and disorganized 4.3) exceeded or approached any of the cutoff scores

(21, 10, 6, 6). In terms of the social support variable, the mean score on the Social Support

Index (SSI) was quite strong, indicating that on average the study sample considered it had

good social support as indicated by a mean score of 47.8 out of a total possible score of 68.

(See Table 4.3)

Table 4.3

Overall Statistical Results for all the Scales

Scale	Mean	Median	Cut-off	SD	Actual range	Potential range
Psychological Distress	59.4	59	63	9.5	42-80	33-80
Marital Satisfaction/Distress	110.5	113.5	110	19.0	62.6-146	0-146
HGRC Despair	31.5	30.5	n/a	11.7	13-63	1-65
HGRC Panic Behavior	28.1	26	n/a	10.3	14-63	1-63
HGRC Personal Growth	33.5	31.5	n/a	10.1	12-59	1-60
HGRC Blame and Anger	11.6	11	n/a	4.3	7-24	1-35
HGRC Detachment	15.2	14	n/a	7.2	8-40	1-40
HGRC Disorganization	15.9	15	n/a	6.1	7-31	1-35
Composite Grief	75	68.5	n/a	31.6	18-166	1-166
Oscillation Balance	-.06	-1.0	0	9.1	-23 - +21	-33 - +33
Insecure Attachment	14.1	13	21	9.1	1-40	0-74
Anxious Ambivalent Attachment	6.2	6	10	4.6	.00-22	0-22
Anxious Avoidant Attachment	2.4	2	6	2.1	.00-8	0-9
Disorganized Attachment	4.3	3	6	3.3	1-14	0-26
Social Support	47.8	48.5	n/a	10	23-66	0-68

Bivariate Statistical Analysis

Preliminary bivariate statistical analyses between the control, the dependent, and the independent variables was performed using the Pearson's product- moment correlation. This establishes if there are linear relationships between the variables. Results of the Pearson's correlation are reported in Table 4.4.

In terms of the control variables, only gender had significant linear relationships with any of the variables. There was a weak, negative linear relationship between gender and marital satisfaction/distress ($r = -.26$, $p < .05$), meaning that women reported more marital distress than do men. There was a weak, positive linear relationship between gender and insecure attachment ($r = .24$, $p < 05$). Women were more likely to report more insecure attachment than men. There was a statistically significant weak, positive linear relationship between gender and grief ($r = .26$, $p < .01$), suggesting that women reported more grief than men in the sample.

In terms of grief there was a statistically significant strong, positive linear relationship between composite grief and psychological distress ($r = .71$, $p < .01$), the higher the grief the more the psychological distress. There was a statistically significant moderate, positive linear relationship ($r = .46$, $p < .01$) between insecure attachment and composite grief. The higher the insecure attachment the higher the grief. There was a statistically significant moderate, negative linear relationship ($r = -.52$, $p < .01$) between composite grief and oscillation balance. The higher the grief the less the oscillation balance between loss orientation and restoration orientation.

The linear relationships with marital satisfaction/distress were as follows. There was a statistically significant weak, negative linear relationship ($r = -.32$, $p < .01$) between marital

satisfaction/distress and psychological distress. The greater the marital satisfaction, the lower the psychological distress.

In terms of the relationships between marital satisfaction/distress and the two independent variables these were both trending towards significance. The trending linear relationship with insecure attachment was negative and situated itself at ($r = $ -.21, $p = $ .059). The higher the marital satisfaction, the lower the insecure attachment. The trending linear relationship with social support was positive and situated itself at $p = $ .056 ($r = $.21). The more the marital satisfaction, the more the social support.

The linear relationships with psychological distress, were as follows. There was a moderate, negative linear relationship between psychological distress and oscillation balance ($r = $ -.52; $p < $ .01). The higher the psychological distress, the more oscillation was focused on loss orientation. There was a statistically significant moderate, positive linear relationship between psychological distress and insecure attachment ($r = $ .54; $p < $ .01). The more insecure the attachment, the more psychological distress. There was a statistically significant moderate, negative linear relationship with social support ($r = $ -.48; $p < $ .01). The more psychological distress, the less social support.

Table 4.4

Bivariate statistical analysis

Scales	1	2	3	4	5	6
1. Gender						
2. Composite Grief	.36 **					
3. Marital Satisfaction	-.26*	-.18				
4. Psychological Distress	.12	.71**	-.32**			
5. Oscillation Balance	-.18	-.52**	.18	-.52**		
6. Insecure Attachment	.24*	.46**	-.21	.54**	-.39**	
7. Social Support	.15	-.08	.21	-.48**	.26*	-.17

*$p < .05$ (2 tailed); ** $p < .01$ (2 tailed)

The significant linear relationships regarding oscillation balance, were with the independent variables. There was a weak, negative linear relationship between oscillation balance and insecure attachment ($r = -.39$; $p < .01$). The more attachment insecurity the more oscillation was situated in loss orientation. There was a weak, positive linear relationship between oscillation balance and social support ($r = .26$; $p < 05$). The higher the social support the more oscillation balance was focused in resolution orientation.

A second series of preliminary bivariate analyses were performed in order to explore the linear relationships of four specific attachment styles as IVs (the discrepancy in the couple for insecure, anxious ambivalent, anxious avoidant, and disorganized attachment styles) with the dependent variables of the study, namely, psychological distress, marital satisfaction/distress, and grief.

Table 4.5

Bivariate analysis results for discrepancy of attachment styles in couples and four dependent

variables.

Variables	1	2	3	4
1. Insecure Attachment Discrepancy				
2. Anxious Ambivalent Discrepancy	.78**			
3. Anxious Avoidant Discrepancy	.34**	.07		
4. Disorganized Attachment Discrepancy	.78**	.44**	.21	
5. Social support	.11	.25*	-.20	.01
6. Marital Satisfaction/Distress	-03	.03	.10	-.05
7. Psychological distress	.14	.02	.19	.17
8. Composite Grief	.07	-.04	.19	.17
9. Time since death	-.23	-.05	-.33**	-.12

*p<.05 (2 tailed) **p<.01 (2 tailed)

There were statistically significant linear relationships between insecure attachment discrepancy and the other three discrepancy scores, a strong, positive linear relationship between insecure attachment and anxious ambivalent discrepancy ($r = .78$, $p < .01$), a weak, positive linear relationship between insecure attachment discrepancy and anxious avoidant discrepancy ($r = .34$, $p < .01$), and a strong, positive linear relationship between insecure attachment discrepancy and disorganized attachment discrepancy ($r = .78$, $p < .01$). Insecure attachment discrepancy was not found to have statistically significant linear relationship with any of the dependent variables.   There was a negative trending linear relationship ($r = -23$; $p < .073$) between insecure attachment discrepancy scores of the couple and time since death. Insecure attachment discrepancy decreases as time since death of the child increases.

There was a statistically significant moderate, positive linear relationship between anxious ambivalent discrepancy and disorganized attachment discrepancy ($r = .44$, $p < .01$). There was a statistically significant weak, positive linear relationship between anxious ambivalent discrepancy scores and social support ($r = .25$; $p < .05$). The higher the score on anxious ambivalent discrepancy in the couple, the higher the individual scores of social support. There was a statistically significant weak, negative linear relationship between anxious avoidant attachment discrepancy scores and time since death ($r = .33$; $p < .01$). The more time since death, the less the avoidant attachment discrepancy scores.

Multi-Variate Analysis

A series of multiple regression analyses (MRAs) were computed to test the three hypotheses.

MRAs for hypothesis 1.

Hypothesis 1 stated that controlling for gender of parent, number of surviving children, age of child at death, and time since child's death, among individual parents whose child died of cancer the higher the insecurity in retrospective attachment style and the lower the social support, the higher the psychological distress, martial distress, and grief. In the analysis testing the hypothesis, each of the dependent variables were treated individually. All four control variables were entered into block one using the enter method and the independent variables were entered in block two as enter using the enter method. Variables that were not significant were deleted from the model and the MRAs were repeated.

In the MRA with psychological distress as the dependent variable, insecure attachment was the strongest statistically significant predictor ($Beta = .470$, $p < .000$), followed by social support as a negative significant predictor ($Beta = -.399$, $p < .000$). The

model explained 45% of the variance, indicating that bereaved parents who were more

insecure in their retrospective attachment style, and lower in their social support had greater

psychological distress ($F = 33.265$; $p < .000$). This provided support for hypothesis 1. (See

Table 4.6)

In the second MRA marital satisfaction/distress was the dependent variable.

Controlling for gender social support was a positive predictor (*Beta* = .258, $p < .016$). The

model explained 13% of the variance ($F = 6.146$; $p < .003$) indicating those who scored

higher on social support expressed more marital satisfaction. This only partially supported

hypothesis 1,the more social support the more the marital satisfaction, however, the part of

hypothesis 1 that stated that insecure attachment would influence marital/satisfaction distress

was not supported as insecure attachment was not significant (See Table 4.6).

In the third MRA, composite grief was the dependent variable.   Controlling for

gender and age of child at death attachment insecurity was a significant predictor of

composite grief (*Beta*=.410, $p < .000$). The model explains 30% of the variance in grief ($F=$

11.351; $p< .000$), controlling for gender and time since death the more insecure the

attachment the higher the

Table 4.6

MRA results for the Psychological Distress, Marital Satisfaction/Distress, and Grief

Variables	B	Beta	t	Sig.
Dependent variable:				
Psychological Distress				
Independent variables				
Insecure Attachment	.490	.470	5.666	.000
Social Support	-.379	-.399	-4.809	.000
Constant	70.679		16.718	.000
$R^2 = .45$, $F = 33.265$, $p < .000$				
Dependent variable				
Marital satisfaction/distress				
Control and independent variables				
Gender	-11.598	-.302	-2.863	.005
Social Support	.493	.258	2.449	.016
Constant	93.883		9.692	.000
Initial $R^2 = .068$; Final $R^2 = .133$, $F = 6.146$, $p < .003$				
Dependent variable				
Composite Grief				
Control and independent variables				
Gender	16.680	.262	2.727	.008
Age of child at time of death	.878	.169	1.778	.077
Insecure Attachment	1.417	.410	4.233	.000
Constant	35.502		4.312	.000
Initial $R^2 = .141$; Final $R^2 = .30$, $F = 11.351$, $p < .000$				

reported grief. This partially supported hypothesis 1 as social support was not significant and

hypothesis 1 stated that both attachment insecurity and social support would have an impact

on composite grief (See Table 4.6).

MRAs for hypothesis 2.

Hypothesis 2 stated that controlling for gender of parent, number of surviving

children, age of child at death, and time since child's death, among couples whose child died

of cancer, the greater the discrepancy in retrospective attachment styles, the lower the social

support in the individual parent, the higher the marital distress in the couple, and the higher

the psychological distress and grief in the individual parent. As in hypothesis 1, a series of

MRAs treated each of the dependent variables individually. The four control variables were

entered in block 1 and only retrospective attachment style was entered in block 2 as an

independent variable. (In this series of MRAs social support was treated as a dependent

variable). Variables that were not significant were deleted from the models and the MRAs

repeated. Tables 4.7 and 4.8 present the significant and trending results of the MRAs

performed to explore the impact of discrepancy in attachment styles on the four dependent

variables psychological distress, marital satisfaction/distress, composite grief, and social

support – testing hypothesis 2.

Table 4.7

MRA Results for couple discrepant attachment styles and Social Support

Variable	B	Beta	t	Sig.
Dependent variables				
Social Support				
Control and independent variables				
Gender	4.594	.234	1.947	.056
Discrepant anxious ambivalent attachment	.536	.252	2.096	.040
Constant	42.894		19.648	.000
Initial R^2 = .055; Final R^2 = .12, F = 4.091, $p < .022$				

The first significant model involved social support as the dependent variable. Discrepant anxious ambivalent attachment in the couple was found to be a positive significant predictor on the dependent variable of social support (*Beta*=.252; *p*<.040). This model accounted for 12% of the variance in social support (*F*= 4.091; *p*< .022). This suggested that while controlling for gender the greater the discrepancy in the couple in terms of anxious ambivalent attachment the more the social support. This does not support hypothesis 2 as the reverse impact was predicted in terms of discrepant insecure attachment styles and social support (see Table 4.7).

The second significant model involved composite grief as the dependent variable. All the control and independent variables were entered into the model and based on the findings there appeared to be a potential interaction effect. Based on this a new variable was calculated, an interaction term, disorganized discrepancy x gender.   A MRA used to test an interaction model using gender, discrepant disorganized attachment in the couple, and the interaction between gender and discrepant disorganized attachment in the couple was conducted. As presented in table 4.8 in the first step gender was the only predictor (*Beta*=.326, *p* < .01) and explained 10.6% of the variance of composite grief (*F* = 7.363, *p* < .01). In the second step, gender was again a significant positive predictor (*Beta*= .326, *p* < .01) and discrepant disorganization in the couple was not a significant predictor (*Beta*= .122, *p* = .313). This model explained 12.1% of the variance of composite grief (*F* = 4.201, *p* < .02). In the third and final step, the Beta changed significantly for both gender (*Beta*= .094) and discrepant disorganization in the couple (*Beta* = -.076) and neither of the two variables were significant predictors of composite grief. However, the interaction between the two variables disorganized discrepancy x gender (*Beta* = .366, *p* = .095) was a trending positive

predictor of composite grief. The overall model explained 16.1% of the variance ($F = 3.844$,

$p < .014$). This indicated that composite grief was influenced by an interaction between

gender and discrepancy in disorganized attachment in the couple.

Table 4.8

MRA Results for couple discrepant attachment styles and Grief

	Step 1	Step 2	Step 3
Dependent variable	*Beta*	*Beta*	*Beta*
Composite grief			
Control and independent variables			
Gender	.326	.326	.094
Disorganized Discrepancy		.122	-.078
Disorganized discrepancy x Gender			.366
	$F = 7.363$,	$F = 4.201$,	$F = 3.844$,
	$p < .009$	$p < .020$	$p < .014$
	$R^2 = 10.6\%$	$R^2 = 12.1\%$	$R^2 = 16.1\%$

MRAs for hypothesis 3.

Table 4.9 presents the results of the MRA done to test Hypothesis 3 stating that

controlling for gender of parent, number of surviving children, age of child at death, and time

since child's death, among individual parents whose child died of cancer, the more a parent is

insecure in retrospective attachment style and the lower the less social support, the less the

parent will be able to oscillate from one spectrum of the DPM to the other (Oscillation

balance). For hypothesis 3, a series of MRAs were performed using all four control variables,

insecure attachment, and social support as the independent variables with the dependent

variable, oscillation balance. All four control variables were entered into block one as enter

method and insecure attachment and social support were entered into block two as enter

method. Variables that were not significant were deleted from the models and the MRAs

repeated.

In the final model insecure attachment was a negatively related predictor (*Beta*= -

.354, *p* < .001). Social support was a trending positively related predictor (*Beta*=.196, *p* <

.054). Insecure attachment was the stronger predictor of the two. The model accounted for

18.7% of the variance of oscillation balance (*F*= 9.571, *p*< .000) indicating that in this

sample of bereaved parents, the more secure the attachment and the higher the social support

the more balanced the oscillation. This supports hypothesis 3.

Table 4.9

MRA Results for Oscillation Balance.

Dependent variables	B	Beta	t	Sig.
Oscillation balance				
Independent variables				
Insecure attachment	-.352	-.354	-3.521	.001
Social support	.178	.196	1.955	.054
Constant	-4.627		-.947	.347
R² =. 18.7, F = 9.571, p< .000				

Summary

To summarize, the objective of the analyses presented in this chapter was to explore

the predictive value of insecure attachment and social support on various dimensions of the

coping experience of parents who have lost a child to cancer. Socio-demographic

characteristics of respondents were first reviewed. Summary statistics of the dependant and

independent variables were presented and discussed. The means, standard deviations, and potential and actual ranges of the results on the different scales were presented.

Hypothesis 1 was partially supported in the MRAs; insecure attachment significantly predicted composite grief and psychological distress. It did not however have an impact on marital satisfaction/distress. Social support did not predict composite grief. It did have an impact on psychological distress as well as marital satisfaction/distress. The control variable, gender, was a significant predictor for composite grief. It was also the strongest predictor for marital satisfaction/distress. The control variable age of child at death was a positive trending variable for composite grief.

Hypothesis 2 was mostly not supported by the results of the MRAs. However, an interaction effect was found between discrepancy in disorganized attachment in couples and gender impacting composite grief.   Hypothesis 2 was partially contradicted by a finding that discrepancy in anxious ambivalent attachment actually increased levels of social support rather than decreasing social support as had been predicted.

Hypothesis 3 was supported, insecure attachment was a predictor of grief oscillation balance in the directions predicted but the impact of social support was only trending. The next chapter will present the summary and conclusions of the study.

Chapter V

Summary and Conclusions

The main purpose of this study was to explore the impact of retrospective attachment insecurity and social support on levels of psychological distress, marital satisfaction/distress, grief, and grief oscillation for individual parents and for couples who had a child that died of cancer. The integration of the concepts of retrospective attachment insecurity and social support in grief theory development using quantitative data was also part of the purpose of this study. In addition, the influence of four control variables on the dependent variables was explored. This study offers more information on what underlies variations in individual coping with grief and it also helps to describe quantitatively what underlies the difficulties that couples face in supporting each other through the grieving process.

This chapter presents the summary and the conclusions of the study. A short review of the purpose of the study, a synthesis of the literature review, the methodology and findings, and a discussion of the conclusions, limitations, contributions, and recommendations. Evidence-based understanding of the variables impacting grief processing in parents is still very limited. Research has shown that parental grief can be long and can threaten physical and mental health, it can even have an influence on the length of life (Li et al., 2003, 2005; Rando, 1986, 1997; Rogers et al, 2008). Research has also shown that bereaved parents can have difficulties supporting each other (Cook & Oltjenbruns, 1989; Digregov & Digregov, 1999; Gilbert & Smart, 1992; Oliver, 1999; Schwabb, 1998; Wijngaards de Meij, 2008). Until recently, gender differences in coping with grief have been at the center of research inquiries to explain grief dynamic differences in couples (Cook & Oltjenbruns, 1989; Fish, 1986; Gilbert & Smart, 1992; Oliver, 1999; Parkes, 2006; Rando,

1986; Schwabb, 1998; Stroebe & Schut, 1999). This study is a departure from this gender-based research and is primarily grounded in attachment theory as articulated by Bowlby (1998/1980) and Parkes (2006). It is also based on the dual process model (DPM) of grief (Stroebe & Schut, 1999, 2005) that describes how, among other variables, retrospective attachment style and social support have an impact on how grief is processed by an individual.

Synthesis of the Literature Review

       Adult grief.

       The literature review explored both the literature on adult grief and on parental grief. The literature review began by describing the distinction between mourning, bereavement, and grief. This led to a definition of grief as a primarily emotional response, in an individual, to the loss of a significant other "…through death. It incorporates diverse psychological (cognitive, social – behavioral) and physical (physiological – somatic) manifestations" (Stroebe, Hansson, Stroebe, & Schut, 2001/2002 , p. 6). Grief often involves an ongoing relationship and sense of presence of the deceased. Moreover grief is defined as a syndrome (Archer, 1999; Bowlby, 1998/1980; Freud,1995/1917; Lindemann, 1944; Parkes, 1972, 2006; Rando, 1977, 1997; Stroebe & Schut) in which the organism performs oscillation, an approach/avoid process designed to progressively integrate the multifaceted realities of the loss of a significant other.

      The literature review then proceeded to an overview of major contributions to the study of grief. The influence of Freud (1995/1917) had both positive and negative ramifications on the field of grief research (Archer, 1999; Bowlby, 1998/1980). Freud's (1995/1917) conception of the importance of independence of the individual, and of the

reality principle justified the importance of detachment or of decathexis from the deceased. Freud's views set the stage for a strong tendency to consider many grief responses as pathological rather than normal processes of the grieving process (Archer, 1999; Bowlby, 1998/1980; Klass, 1988; Parkes, 1964, 1965a, 1965b; Parkes & Weiss, 1983).

Much of the work of Bowlby (1969/1982, 1998/1980, 1982, 1988), of Bowlby and Parkes (1970), and of Parkes (1964, 1965a, 1965b, 2001/2002; 2006), has been to bring new perspectives to some of Freud's seminal ideas in respect to grief. Parkes (1964, 1965a, 1965b), found that bereaved individuals were six times more likely than the general population to be diagnosed with a psychiatric illness (mostly with affective disorder) and to be admitted to a psychiatric clinic within six months of a loss. The tendency to diagnose grief reactions as pathological or as a psychiatric illness still exists today as demonstrated by Li et al.'s (2005) study that showed that parents who lost a child had a combined relative risk of a psychiatric hospitalization of 1.67 compared to the general population in the first 5 years post loss.

Central to Bowlby's and Parkes's work has been the notion that attachment and loss are at the core of human beings' sense of well-being and of their mental health. Parents, attachment figures, and offspring are an inherent part of individuals' emotional regulatory system and sense of security (Ainsworth, 1978; 1982; Bowlby, 1988; Marwitt & Klass, 1988; Parkes, 2006). Bowlby's (1969/1982; 1998/1980, 1982, 1988) ethological and evolutionary biological framework of attachment theory helps to understand the emotional and physiological necessity of maintaining a "sense of continued presence of the deceased" (1998/1980, p. 98).

Bowlby and Parkes (1970) argued that grief is a universal phenomenon that occurs in

very young children as well as adults. They proposed that grief can be considered as a flexible chain of emotional action potentials, described as: 1. numbing; 2. yearning and searching for the deceased; 3. disorganization and despair; and 4. reorganization. Bowlby (1998/1980) added the dynamic process of oscillation to the four phases, most likely to insist on the flexibility and on the very personal nature of this set of phasal action potentials. Thus oscillation appears to play an important function in the adaptation to loss by managing separation anxiety in an avoid/confront process. This oscillation progressively leads to reorganization around the loss of the deceased (Bowlby, 1998/1980, Shaver & Tancredy, 2002/2001; Stroebe, Schut, & Stroebe, 1998, 2005; Stroebe & Schut, 1999).

Attachment theory helped clarify that difficult emotions such as fear, anger, and anxiety are adaptively triggered by separation. Emotions were described by Bowlby (1980/1969, 1998/1980, 1988) as action potentials that motivate us into goal-corrected action. Separation anxiety is resolved only by achieving the goal of reunion. Reunion, reassurance, comfort, love, and affection all act as parts of plans or hierarchical behavioral systems of goal-corrected action potentials aiming at re-establishing a sense of security for all individuals (Bowlby, 1995/1980). If reunion between a parent and a child is not achieved, then grief is triggered. Grief is a genetically preset series of syndromic responses to separation (Archer, 1999; Bowlby, 1998/1980).

Bowlby (1998/1982, 1988) further proposed that individual variations in the phasal process of grief caused by the death of a significant other such as a spouse or child would be mediated in part by the attachment style of the bereaved as well as by the social support at hand for the bereaved individual. Parkes (2006) explained that his studies of widows, with Weiss, in 1983, showed that an important variable in complicated grief was the type of

attachment the bereaved had with the deceased. Namely "a dependant relationship was found to predict chronic grief [and] an ambivalent relationship was found to predict conflicted grief" (Parkes, 2006, p.28). As Marwitt and Klass (1988) explain, the loss of an attachment figure is the loss of an external part of the emotional regulatory system. In Bowlby's (1998/1980) and Parkes' (2006) complementary view of internal working models and of the assumptive world in the context of grief and loss, there is a complex neuro-biological adaptive process. Like Bowlby (1998/1980), Parkes (2006) proposes that this process is at least in part mediated by retrospective attachment styles set in place by the individual in childhood in order to adapt to its immediate environment.

A common thread throughout the literature review was the description of complicated grief which entailed two poles, absent grief and chronic grief. Bonanno et al. (2005), Freud (1995/1917), Bowlby (1980/1969, 1998/1982, 1988), Klass (1988), Lindemann (1979/1949), Parkes (1998/1972, 2001/2002; 2006), Parkes and Weiss (1983), Rando (1986), Rubin (1996), Fraley and Shaver (1999), Stroebe, Schut, and Stroebe (1999), Shaver and Tancredy (2001/2002), Wijngaards de Meij et al. (2007), and Worden (1982) have all reported observing these poles in bereaved adults and have attempted to explain the phenomena from various paradigms and theoretical points of view. The position of Bonanno et al. (2005) according to which absence of grief is healthy and indicates resilience in grieving was not supported by longitudinal findings of Rubin (1996) nor by more recent findings of Wijngaards de Meij et al. (2007). Wijngaards de Meij et al. found in their study that bereaved parents who used avoidant grief coping strategies (absence of grief) showed important signs of distress and of depression following the death of a child. The findings of Rubin and of

Wijngaards de Meij et al. are more in keeping with Bowlby's (1998/1980) own observations and descriptions of absence of grief in individuals with avoidance as a defensive process.

The literature also showed the important role of emotions in the grieving process (Archer, 1999; Bonanno & Kaltman, 1999; Bonnano 2002/2001; Bowlby, 1998/1980, 1988; Shaver & Tancredy, 2002/2001, Stroebe et al., 2005). Central to this discussion on the role of emotions in the grieving process is attachment theory and the phasal grieving model of Bowlby and Parkes (1970) and of Bowlby (1998/1980).

The literature suggested that authors and researchers in the field of grief are focusing more and more on a combination of variables in order to explain coping with grief. These variables include: variations of internal personal resources, as described by psychoanalytic theory (Freud, 1995/1917; Klass, 1988; Rando, 19986; Worden, 1982); by attachment theory (Bowlby, 1998/1980; Fraley & Shaver, 1999; Parkes, 2002/2001, 2006; Shaver & Tancredy, 2002/2001); by track two in the Two Track Model of Grief (Rubin, 2002/2001); by the concept of hardiness, (Lang et al. 2004); the concept of resilience (Bonanno & Kaltman, 1999; Bonnano et al., 2005); and the concept of self-confidence (Murphy et al., 2003).

A second important variable is that of social support and its impact on the processing of grief (Bowlby, 1998/1980, 1988; Klass, 1988; Lepore et al. 1996; Parkes, 2006; Pressman & Bonanno, 2007; Riches & Dawson, 2000; Shaver & Tancredy, 2001/2002). A third important variable is that of gender (Fish, 1986; Gilbert & Smart, 1992; Kamm & Vandenberg, 2001; Stroebe & Schut, 1999, Wijngaards et al. 2008).

The literature review also helped to ascertain that the Dual Processing Model (DPM) (Stroebe & Schut, 1999, 2002/2001; Stroebe, Schut, & Stroebe, 2005) is a model of grief processing that encompasses important elements found in the literature reviewed. The DPM

was therefore integrated as part of the theoretical background of the present study of bereaved parents. As discussed in the literature review, the DPM considers that grief processing is a dynamic and "complex process of confrontation and avoidance of the positive and negative emotions and cognitions associated with loss, on the one hand, and its consequences for ongoing life, on the other" (Stroebe, 2002, p. 134). The DPM is a taxonomic model that explains grieving as a dynamic process in which individuals oscillate, in order to achieve self-regulation, between two types of essential grieving stressors: the loss and the restoration orientations of coping with grief (Stroebe & Schut, 1999, 2002, 2005).

The central and dynamic process of the DPM is oscillation between grief-coping orientations (Stroebe & Schut, 1999). Stroebe and Schut explain that at the beginning of grieving, attention tends to be more loss-oriented and focused on the bonds with the deceased. With time, the attention moves towards resolution orientation. Oscillation implies a "waxing and waning, an ongoing flexibility, over time" (Stroebe & Schut, 1999, p. 213). This regulatory movement, that appears to prevent the bereaved from being overwhelmed by grief, is idiosyncratic to every individual but is also influenced by the context the individual lives in in (Stroebe & Schut, 1999). Oscillation is considered to be part of optimizing mental and physical health throughout the process of adjustment to the loss (Stroebe & Schut, 1999).

More recently, Stroebe, Schut, and Stroebe (2005) have clearly associated the DPM with attachment theory, suggesting that individuals who have an anxious ambivalent attachment style will tend to be more focused on loss orientation. They can become rigidified in what Bowlby (1998/1982) described as "chronic mourning" because they cannot oscillate to resolution orientation or take pauses in grieving (Stroebe & Schut, 2001/2002a). Individuals who are very anxious avoidant in their attachment are described as more

restoration-oriented and will have a tendency to be rigidified in what Bowlby (1998)

described as "more or less prolonged absence of conscious grieving" (Bowlby, 1998/1982, p.

139). They cannot oscillate towards loss orientation because they tend to be rigidified in the

restoration aspects of the grief and in the avoidance of their separation anxiety (Stroebe &

Schut, 1999). Individuals who are disorganized in their attachment will tend towards a

chaotic and disturbed grieving process, lacking in an organized or coherent oscillation

(Stroebe, Schut, and Stroebe, 2005).

Parental grief.

The literature review revealed that many authors consider parental grief to be more

intense and prolonged than other types of grief (Archer, 1999; Klass, 1988, 1997; Klass &

Marwit 1988; Lindemann, 1944/1979; Malkinson & Bar-Tur, 1999, 2005; Rando, 1984,

1986, 1997; Sauders, 1980; Rubin & Malkinson, 2001; Wijngaards-de Meij et al., 2005,

2007). Rando (1986) called for a specific category of grief for bereaved parents explaining

that such a category would avoid pathologizing normal grief reactions. Rando (1997) stated

that the death of a child should be considered and treated as a traumatic experience. Klass

(1986, 1997) also advocated for the normalization of extreme grief reactions of bereaved

parents. A few other authors have also noted the importance of parental grief as well as its

length, with grief still being present some 18 years later. (Digregov & Digregov, 1999; Jiong

et al. 2005; Li et al., 2003, 2005; Murphy, 2002; Rogers et al., 2008; Rubin & Malkinson,

2002). Klass (1988) is the clearest in terms of duration of parental grief explaining that the

first years are very intense and that this intensity diminishes progressively during years two

and three. It is usually only after the third year that bereaved parents find themselves

enjoying moments of life. Klass (1988) does explain that this timeframe will vary. Rando

(1993) describes the phenomenon of sudden subsequent temporary upsurges of grief (STUG) that occur at anniversaries and with certain triggers for the rest of a bereaved parents lifetime. Lang and Gottlieb (1993) and Lang et al. (1996) also note that anniversaries and special dates will trigger grief years later.

Parkes (2006) states that his study findings do not support the idea that grief for a child is more intense than grief for other types of losses. Bonanno et al. (2005) and Pressman and Bonanno (2007) found that in China spousal grief is more intense than the grief associated with the loss of a child. These findings put in question the universality of the greater intensity of grief associated with the loss of a child.

If Bowlby and Parkes (1970) first contested the Freudian notions that grief has an end point and that decathexis from the deceased should be the goal of the grieving process, studies of bereaved parents have helped to review the notion of decathexis (Klass, 1988, 1997; Klass, Sylverman, & Nickman, 1996; Malkinson & Bar-Tur, 1999, 2005; Rubin, 1996). Bowlby (1998/1980), Field et al. (2005), Klass (1988, 1997), Klass, Sylverman, and Nickman (1996), Parkes (2006), Riches and Dawson (2000), and Rubin (1996) all discussed the normalcy of adjusting to the death of a loved one by maintaining and internalizing the relationship with the deceased.

The literature review described various points of view to explain the grieving process in the context of the loss of a child. Bowlby (1998/1980) explained that there are different types of attachments and that the caregiving relationships of parents with a child need to be distinguished from other types of relationships (Berrera et al., 2007; Rando, 1986). The evolutionary perspective of Archer (1999, 2002/2001) describes the death of a child as the loss of 50% of a biological parent's genes. Human beings, like all living beings, are

genetically organized to ensure the reproduction and protection of their genes. When a child

has 50% of one's genes the death of this child is very much the loss of part of the self at the

biological, symbolic, and psychological levels (Archer, 1999; Parkes, 2006).

The parent-child relationship is the closest relationship human beings can have and in

caring for children parents in effect care for themselves (Parkes, 2006; Rubin & Malkinson,

2001). The loss of a child therefore has important ramifications in terms of a parent's

identity (Klass, 1988, 1993; Rando, 1993; Riches & Dawson, 2000). A child is part of

parents' psychic structure like no one else can ever be (Klass, 1988; Parkes, 2006), this

makes their death even more devastating than other losses. Parkes (2006) explains that

parents often try to redress their own childhood issues through the care that they give to their

own children. When their children die, life appears that much more unfair and the death of a

child can confirm our worst perceptions of the world. A perception that becomes very

difficult to overcome. In their studies, Matthew and Marwit (2004), and Rogers et al.

(2008), report that bereaved parents have significantly more negative views of the world and

a lower sense of purpose in their lives than parents who have not lost a child.

The literature review identified a few authors such as Fish (1986), Klass (1988,

1993), Parkes (1998/1972, 2006), Wing Clance, Burge-Callaway, and Armistead (2001), and

Rando (1983) who use the metaphor of amputation to describe the loss of a child. This

metaphor is very powerful in helping to describe how, for parents a child is an external

neuro-biological regulator (Ainsworth, 1882) that suddenly disappears causing the need for a

"reorganization of the psychobiological regulatory system" (Klass & Marwill, 1988, p. 46).

The literature review described a study of bereaved parents by Wijngaards-de Meij et

al. (2007), in which attachment styles of bereaved parents explained 14% of the variance of

grief. The Wijngaards-de Meij et al. study produced results that were contrary to other studies of bereaved parents, such as Bonnano et al. (2005) and Anderson et al. (2005) who had both found that avoidant coping was effective and led to better psychosocial functioning than emotional coping with ruminative qualities. Wijngaards-de Meij et al. found that bereaved parents who scored high on avoidant attachment were not resilient or effective in their coping with the loss of a child and like parents who scored high on ambivalent attachment should be considered high risk for complicated grief. It appears that part of the work in grief research is to define and measure more adequately the extremes of the coping spectrum, namely avoidant, ambivalent, and disorganized attachment styles that become less effective in coping during the grief process. The DPM appears as a good reference point for researchers to exchange views, and study results, in this effort to define problematic grief descriptions and how to assess or measure them.

The literature review also described a number of studies of bereaved parents that commented on the importance of extreme emotions in following the death of a child. Barr and Cacciatore (2008) and Field et al. (2005) suggest that there could well be relationships between quality of emotions during the parental grieving process and attachment styles. Other studies of bereaved parents reviewed also describe strong emotions of anger, blame, guilt, and despair (Hogan, Greenfield, & Schmidt, 2001; Possick, Sadeh, & Shamai, 2008; Rando, 1983, 1986; Rubin & Malkinson, 2001/2002; Surkan et al., 2006; Wing, Burge-Callaway, Clance, & Armistead, 2001). However these studies do not make the association between quality of emotions during parental bereavement and attachment styles.

In their study on bereaved parents and attachment styles Wijngaards-de Meij et al. (2007) did not find a relationship between levels of grief of one parent and the attachment

style of their spouse. This finding is contrary to hypothesis two of the present study. In another study Wijngaards-de Meij et al. (2008) explored the impact of the differences between bereaved spouses' grief-processing orientation on levels of grief. They found that men were more often resolution oriented and that women were more often loss oriented. They also found that being high on loss orientation was less adaptive and that such bereaved parents were not influenced by their partner's grief coping orientation. Parents who were more loss orientated were more detached from others in their grieving process because of their focusing on the relationship with their deceased child. At the other end of the spectrum parents more resolution oriented were positively impacted by social support and suffered less from grief and depression when their spouses did not score high on loss orientation. Resolution oriented parents married to someone high on loss orientation scored higher on measures of grief. The DPM clearly associates attachment styles and grief orientation choices. How and why the attachment style of one parent does not appear to impact the level of grief of the other spouse while grief orientation does is clearly a subject that requires further investigation.

The literature review identified numerous variables that could be considered as control variables in any study. Among them are time since death (Anderson et al., 2005), age of child (Wijngaards-de Meij et al., 2005), gender of child (Fish, 1986), sudden, accidental, violent, or from an illness death of a child (Lang & Gottlieb, 1993; Lang et al., 1996; Lohan & Murphy, 2002; Matthew & Marwit 2004; Wijngaards-de Meij et al., 2005), and number of surviving children (Wijngaards-de Meij et al., 2005).

The literature review supports the notion that parental grief is a complex and multifaceted syndromic response to the loss of a child influenced by evolution, biology,

intrapersonal attributes, and socio-cultural relations (Archer, 1999; Field et al. 2005; Lang et al., 1996; Rando, 1986; Sanders, 1980; Stroebe, Folkman, Hanson, & Schut, 2006; Wijngaards-de Meij et al., 2008). Grief processing is both a universal, yet very individual and contextual phenomenon still being circumscribed and may be best considered in terms of developmental pathways as in the DPM (Stroebe et al., 2005; Stroebe et al., 2006) and attachment theory (Bowlby, 1988).

The DPM and bereaved parents.

The DPM is very useful in helping to understand grief processing in both individuals and in couples (Parkes, 2006; Shaver & Tancredy, 2002/2001). To date a study by Wijngaards-de Meij et al. (2008) is the only study that has used DPM constructs of grief orientation to explore interdependence of a couple in grief. A significant finding in the study is that even though women were mostly loss-oriented and men were mostly resolution-oriented, gender did not have a significant impact on the outcomes. The loss and resolution orientation had the greatest effect on the dependent variable of grief in either gender. More studies of grief orientation as described by the DPM on individual and relational grief processes are needed.

Secure and insecure attachment.

Secure attachment.

The literature review provided a clear understanding of secure attachment through the description of numerous authors (Bowlby, 1998/1980; Berlin, 2002; Bretherton, & Munholland, 1999; Cassidy, 1999; Fisher, & Crandel, 2001; Fraley & Shaver, 1999; Johnson & Whiffen, 1999; Kobak, 1999; Liotti, 1993; Main, 1982; Main & Hesse, 1990; Parkes, 2006; Weinfield, et al., 1999; Wijngaards-de Meij et al., 2007).

Secure attachment is achieved in early childhood through the repeated and consistent experience of availability and responsiveness of one's parents or caregivers. Secure and consistent availability and responsiveness of one's parents or caregivers permits the establishment of internal working models of self and others in which the individual sees themselves as worthy of love and security and also sees others in the same manner. Such individuals will experience the loss of an attachment figure by understanding that the pain of loss is normal and this will eventually lead to adaptation. A secure individual will be able to provide support to a grieving spouse but will also be able to ask for support when needed.

Insecure attachment.

The literature review also provided a way to define insecure attachment patterns. Various authors were quoted in this endeavor (Ainsworth, 1982; Berlin, 2002; Bowlby, 1980/1969, 1998/1980, 1982; Bretherton & Munholland, 1999; Cassidy, 1999; Kobak, 1999; Liotti, 1993; Main, 1982; Main & Hesse, 1990; Mikulincer & Shaver, 2007; Weinfield et al., 1999). The three insecure attachment patterns, anxious avoidant, anxious ambivalent, and disorganized were described. These were described as self-and-other relational paradigms. Mikulincer and Shaver (2007) call insecure attachment styles secondary attachment strategies because the goal of establishing security in the relationship with the caregiver is abandoned to the benefit of these secondary attachment strategies. Children who develop insecure attachment styles do so in order to adapt to hostile refusal, inconsistent or chaotic availability and responsiveness of parents or caregivers. Attachment styles can change depending on the developmental pathway of the individual. It was hypothesized by Bowlby (1998/1980), and supported by studies by Parkes (2006), and by Wijngaards-de Meij (2007) et al. that attachment styles have an impact on how grief is processed. The separation anxiety provoked

by the death of a child will be appraised and dealt with in different ways depending on the level of security/insecurity and attachment style.

Attachment and gender.

A study by Alonso-Arbiol, Shaver, and Yarnoz, (2002) and discussions by Doyle and Morretti, (2000), Marris (1982), and Mikulincer and Shaver (2007) introduce the notion that cultural socialization produces a predominance of anxious attachment styles in women and a predominance of avoidant attachment in men. Mikulincer and Shaver (2007) discuss the results of various studies that would indicate insecure men and women overidentify with traditional gender roles. This overidentification would have a tendency to amplify the distinction between gender stereotypes of female capacity for emotional expression and intimate relationships and male capacity for autonomy and self-confidence. Secure men and women appear to be able to integrate and use both male and female psychological attributes and be more androgynous in their psychological identity (Mikulincer & Shaver).

This discussion of gender identity and attachment styles actually might explain much of the research observations of polarized, or discrepant, grieving styles based on gender. If the premise, supported by Mikulincer and Shaver (2007), that insecure men and women tend to over identify with their own gender roles is right, it follows that most couples who are observed having polarized or discrepant grieving styles along gender lines will be more or less insecure and less able to support each other through grief. Their over identification with their gender roles and with their preferred coping style would make them resistant and/or unable to understand their partners way of coping.

Oscillation.

According to the DPM oscillation is a construct that helps to illustrate the dynamic

process in which one attempts to self-regulate, both consciously and unconsciously, the pain and despair of the loss itself and the social repercussions of the loss (Stroebe & Schut, 1999; Stroebe, Schut & Stroebe, 2005). Stroebe and Schut (1999) explain that adaptive grieving requires "dosage" of the various stressors. According to the DPM the optimal way to grieve is to oscillate from loss orientation to resolution orientation, this is called oscillation balance (Caserta & Lund, 2007; Stroebe & Schut, 1999). The two grief orientations represent essential grieving tasks that have both aversive or overwhelming impacts and also relief and security-enhancing impacts. For example, in the context of the death of a child, being focused on the loss is a way of maintaining a relationship with the deceased child but at the same time, such a focus can become exhausting and isolating requiring a shift to taking a break from grief and oscillating to resolution orientation. Shifting to resolution orientation enables one to attend to more practical issues related to the loss and may diminish isolation and increase social support. Oscillating to resolution orientation may however provoke guilt feelings of taking too much distance from the deceased, emotionally, and this creates an oscillating movement back to loss orientation. This back and forth process will have a tendency to repeat itself over and over in order for the individual to integrate the various aspects of the loss and to regulate the various emotions that emerge during the process. It is important to note that the differences in oscillation lies in the very personal way individuals appraise various internal and external events. These appraisals are thought to occur differently depending on the individual's specific attachment style and the context of the loss (Stroebe, Schut, & Stroebe, 2005). The literature review provided information on how attachment styles are thought to influence grief oscillation. The development and trial of standardized tools to measure grief oscillation is a worthwhile endeavor.

Social support.

The literature review showed that many authors consider social support to be an important if not essential variable in the processing of grief (Bonanno et al. 2005; Davies, 2003; Dygregov 2003; Klass, 1986, 1993, 1997; Lalande & Bonanno, 2006; Lindemann, 1944/1979; Hastings, 2000; Hogan & Schmidt, 2002; Pressman & Bonanno, 2007; Rando, 1986; Riches & Dawson, 1996, 1998, 2000, 2002; Stroebe et al., 2005, Stroebe et al., 2006; Worden, 1982, 2008).

Klass (1986, 1993, 1997) states that it is the social support of the expression of inner representations (inner representation is simply put the memories and images that a bereaved parent has of their child)of the deceased that appears to help bereaved parents achieve a higher, more effective level of grief processing that leads to solace. For Klass (1986, 1993, 1997) normalizing and supporting parental grief through the expression of the inner representations of the child as dead rather than alive helps create a congruence between the inside and the outside social world that facilitates the processing of the loss. The description of this process is very similar to Bowlby's (1998/1980) and Parkes' (2006) ideas around grief processing, but Bowlby (1980/1998) uses the terms of internal working models and Parkes (2006) speaks of the assumptive world. Like Klass, both Bowlby and Parkes insist on an interaction between the individual and the environment. It is important to be aware that attachment styles can be used to understand a person's abilities and/or difficulties in finding and in accepting social support but that a sense of internal security goes hand in hand with a supportive environment.

Variations of these themes of inner resources vs. community resources are found throughout the literature. Some authors put more emphasis on the social obstacles to healthy

parental grief (Klass, 1997; Hastings, 2000; Laakso & Paunomen-Ilmonen, 2002; Lepore et al., 1996). These authors discuss, in their own way, how bereaved parents suffer from a cultural lack or absence of rituals, and how in this cultural vacuum of rituals, bereaved parents are often misunderstood by their extended families and their communities. This often leads to the social alienation of bereaved parents (Bonanno et al. 2005; Dygregov 2003; Hastings, 2000; Klass, 1997; Koocher, 1994; Lalande & Bonanno, 2006; Laakso & Paunomen-Ilmonen, 2002; Lepore et al., 1996; Malkinson & Bar-Tur, 1996). Digregov (2003) and Lang et. al. (1996) found that some bereaved couples contribute to their own isolation even though social support is available.

Bonanno et al. (2005), Lang et al. (2004), Parkes (2006), Murphy et al. (2003), Stroebe, (2002), Stroebe et al. (2005), and Wijngaards-de Meij (2007, 2008) all discuss using various concepts, such as resilience, hardiness, secure attachment and self confidence, and the importance of inner resources in order to better accept social support and benefit from its availability.

Other authors have suggested the possibility that grief can also become incremental when social support is different from the expectations of the bereaved (Gilbert & Smart, 1992; Oliver, 1999; Skinner Cook & Oltjenbruns, 1989/1998; Stroebe & Schut, 1999; Stroebe, 2002). It was also suggested that grief can become incremental and a negative communication cycle ensues between spouses when the social support given by either spouse is different from the expectations of the other spouse (Oliver, 1999; Stroebe, 2002; Parkes, 2006).

Marital satisfaction/distress.

The literature review found that in couple research more and more studies use

attachment styles as a construct to understand marital satisfaction/distress. Study results are showing that couples in which both partners have a secure attachment style are more stable and experience less negativity than couples in which one or both spouses have an insecure attachment style (Bradley & Furrow, 2004; Feeney, 2002; Johnson, 2004; Johnson & Whiffen, 1999; Kobak & Hazan, 1991; Mikulincer & Shaver, 2007). Johnson (2004) argues convincingly that, as in children, spousal availability and responsiveness are important elements in the task of maintaining a healthy couple relationship. In couples, maladaptive ways of coping associated with insecure attachment, create a vicious cycle of negative communication in which spouses increasingly doubt the availability and responsiveness of their partner (Gottman et al., 2002; Johnson, 2004; Johnson & Whiffen, 1999; Kobak & Hazan, 1991; Mikulincer & Shaver, 2007). From an extensive review of the literature Mikulincer and Shaver (2007) report that for women, anxious ambivalent or anxious avoidant attachment styles, are equally predictive of marital distress. For men, anxious avoidant attachment predicts marital distress more than anxious ambivalent attachment.

Many studies report that bereaved spouses have varying levels of difficulties in the ability to support each other (Cook & Oltjenbruns, 1989; Dyregrov & Dyregrov, 1999; Gilbert & Smart, 1992; Malkinson & Bar-Tur, 1999; Oliver, 1999; Rubin & Malkinson, 2001; Sirkiä et al., 2000). Achieving availability and responsiveness in couples who are grieving and experiencing extreme separation anxiety provoked by the death of their child, appears to be an immense challenge in certain couples (Gilbert & Smart, 1992; Gilbert, 1996; Oliver, 1999; Rando, 1983; Rubin & Malkinson, 2001; Sirkiä et al., 2000).

The literature review described numerous studies of bereaved parents. Various concepts such as sexuality (Fish, 1986; Lang & Gottlieb, 1993; Lang et al. 1996; Rando,

1986), discrepancy in public vs. private grieving styles (Gilbert & Smart, 1992), communication difficulties (Kamm & Vandenberg, 2001; Murphy, 2002), attachment styles (Bing–Hall, 2002; Cudmore & Judd 2001; Wijngaards-de Meij, 2007), hardiness and marital support (Lang et al., 2004), and grief coping styles (Lehman et al., 1989; Stroebe & Schut, 1999) were all used to describe coping discrepancies that can lead to marital distress within bereaved couples. These incongruences were mostly described as being divided along gender coping styles. Many of the discrepancies were linked to attachment theory and to the DPM.

The only study looking at bereaved couples and attachment styles found that there was a significant impact of anxious ambivalent attachment style on marital satisfaction/distress. The greater the anxious ambivalent attachment style the lower the marital satisfaction (Wijngaards-de Meij, 2007). Wijngaards-de Meij also found that the higher the polarization in attachment between bereaved spouses the lower the marital satisfaction.

Attachment theory and the DPM provide useful constructs to help study bereaved parents and relational issues that may contribute to marital satisfaction/distress following the loss of a child.

Psychological distress.

Studies by Fish (1986), Parkes (1964, 1965a, 1965b, 2006), Li et al.'s (2005), Rogers et al. (2008), and writings by Archer (1999), Bowlby (1998/1980), Klass (1988, 1997), Rando (1986, 1993, 1997), and Riches and Dawson (200) support the notion that psychological distress is part of a normal rather than pathological grieving process. Rando (1997) proposes that the death of a child should be considered as a traumatic experience.

Phases of grief, as first described by Bowlby and Parkes (1970), and Bowlby

(1998/1980), and as expanded upon by Rando (1986), were reviewed. The similarities and differences between Bowlby and Parkes (1970) and Bowlby's (1998/1980) phases were also discussed. Phases of grief imply a syndromic origin to psychological distress and explain how certain types of psychological distress will be more predominant at different phases of the grief process.

The literature review suggested that most of the research done on psychological distress in bereaved parents before and until the years 2000 tended to be descriptive in nature. Researchers were often impressed by the intensity of psychological distress in bereaved parents (Fish, 1986; Klass, 1988, 1997; Lang et al. 1996; Lepore et al., 1996; Moriarty et al., 1996; Rando, 1986). Researchers used various tools to measure psychological distress and explored mostly gender differences and external variables that could impact the intensity of psychological distress (type of death, sudden vs. chronic illness, lack of support pre and post death of a child).

A number of authors, (Archer, 1999, 2001/2002; Barr & Cacciatore, 2008; Bonanno & Keltman, 1999; Bonanno et al., 2005;Lang et al., 2004; Murphy et al., 2003; Stroebe, 2002; Stroebe & Schut, 1999; Znoj & Keller, 2002) all discuss, from their own points of view, the importance of developing overarching models of grief processing to explain differences in psychological distress. Biologically based action potentials, the personal attributes of the bereaved, the quality of the social support available pre and post death of the child, and the quality of the relationship with the deceased have all been explored in order to develop prospective and predictive models of grief processing. Such prospective models are essential in understanding what will make a difference in determining levels of psychological distress in bereaved parents.

Throughout the discussion on psychological distress both attachment theory, and the DPM were used to organize some of the data and theoretical ideas that have been presented over the years to describe and explain psychological distress in parental grief. Latest studies such as those of Barr and Cacciatore, 2008; Wijngaards-de Meij (2007), and Znoj and Keller (2002), support the notion that attachment styles and grief-coping orientations such as the DPM are worthwhile constructs to explore in order to better understand what influences psychological distress.

Control variables.

The following variables were found in the literature and will be controlled for in the analysis: gender of the bereaved parents, (Archer, 1999; Cook & Oltjenbruns, 1998/1989; Digregov & Digregov, 1999; Smart, 1993; Wijngaards-de Meij et al., 2007), number of surviving children, (Archer, 1999; Barrera et al., 2007; Klass, 1988, 1997; Klass & Marwit, 1988; Levak ,1980) age of child at death (Fish,1986; Rubin & Malkinson, 2001/2002; Sanders, 1980; Wijngaards-de Meij et al.,2005), and time since child's death (Feeley & Gottlieb 1988; Kamm & Vandenberg 2001; Rando, 1986; Rogers et al.2008 ; Wijngaards-de Meij et al., 2005).

Methodology.

This study was a cross-sectional correlation survey design using eight self-administered quantitative measures including a demographic questionnaire. One purpose of this study was to investigate the relationship between retrospective attachment styles, social support, grief, psychological distress, marital distress, and oscillation balance of individual parents who have lost a child to cancer. The second purpose of the study is to investigate the relationship between levels of discrepancy in retrospective attachment styles within the

bereaved couples, with individual levels of psychological distress, grief, and social support. Discrepancy in retrospective attachment style in the couple was also explored in a relationship with marital satisfaction/ distress using the lowest score within couples.

Data were collected at one point in time through a mail or online survey. The online survey was hosted by Vovici, a secure online survey site. All of the received mail surveys were also entered into Vovici by the researcher and an assistant.

The study population.

The population for this study were couples who had lost a child to cancer. The sample design was a non-probability convenience sample. The criteria for inclusion in the study were:

1) Individuals who lost a child to cancer in the last 6 to 60 months; 2) whose child was 20 years old or younger at death; 3) resided in the US or Canada; 4) became aware of the study by community parental support programs (e.g. Candlelighters Children Cancer Foundation, Cure Cancer); and 5) agreed to participate in the study.

The study instrument.

A fifteen-page self-report mail and online survey was constructed for this study by putting together seven standardized scales and one demographic survey. Standardized scales were chosen based on their reported validity and reliability in measuring the variables in question and for their reported ease of completion. The instrument took approximately 50 minutes to complete.

The initial contact with the bereaved couples was a letter inviting them to participate in the study. The letter was sent by community parental support programs who had agreed to forward the letters without giving the researcher information on the parents in order to

maintain their client's anonymity. The researcher would have contact information only if the parents contacted the researcher. A second reminder letter was sent to bereaved couples through the same participating community parental support programs.

Fifteen agencies agreed to participate by forwarding an invitation letter to the bereaved parents they had provided services to. Three agencies offered to send a modified version of the invitation. One of those agencies gave some information about the study to a group of bereaved parents and the other sent an abbreviated version of the letter by email to parents who qualified. One last agency wrote a small notice about the study and how to reach the researcher in their agency newsletter. The three agencies that had sent modified versions of the invitation were not asked to send reminders.

A letter was also sent to members of the Association of Pediatric Oncology Social Workers (APOSW) to inform them of the purpose of the study and to direct them to contact the researcher if they had any questions or concerns. Informing APOSW members was done so that they would be aware of the study if approached by community members or bereaved parents.

Four hundred and twenty invitations were sent to the potential support organizations. One hundred and six parents responded to the letter they received. Of those, ninety surveys were received and determined to be complete. Of these, four did not meet the inclusion criteria resulting in a final sample size of eighty six which represents a response rate of 20.5%. Of these, 64 respondents were coupled, resulting in 32 couples.

The study scales.

Dependent variables.

Psychological distress was conceptually defined as an aversive cognitive and/or somatic response to perceived internal and/or external stressors and which leads to actions cognitive and /or somatic aimed at addressing, adjusting to or ignoring stressors. The dependent variable psychological distress was operationalized by The Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982). The BSI is a 53 item self-report scale that uses a 5 point (0-4) Likert scale that ranges from "not at all" = 0 to "extremely" = 4 . The BSI has three global scales and nine sub-scales. Of these scales only the GSI was used in the analysis in this study. The GSI is scored by summing the responses to the 53 items and dividing by the number of items. The raw scores on all the scales are converted into standardized T-scores. The T-scores for the GSI range from 33 to 80 for females and from 35 to 80 for males. The higher the score the higher the overall psychological distress.

Marital distress is defined by Johnson and Greenberg (1988) as a "…negative interaction cycle (most commonly, a pursue- distance cycle)…" (p. 175), with decreased accessibility and responsiveness between the couple. The dependent variable marital satisfaction/distress was operationalized by the Dyadic Adjustment Scale (DAS) (Spanier, 1976). A high score on the DAS indicates marital adjustment (satisfaction) while low scores indicate marital distress. The DAS is a 32 item measure that uses mostly Likert scales (28 items), two No/Yes items, and two multiple choice items. The response set for the Likert scaled items included 0 to 4, 0 to 5, and 0 to 6 (Spanier, 1976). The DAS has four subscales: Dyadic Cohesion; Dyadic Satisfaction; Dyadic Consensus; and Affectional Expression, though only the overall DAS score is used in this study. Scoring the DAS is done by summing the responses to all the items. The scoring used in investigating discrepancy the marital satisfaction/distress was the lowest score of the two spouses was used.

Grief is conceptually defined using the Stroebe et al. (1998) definition, which is that grief is the reactions to the loss of a significant other that are "dominated by negative affect, but also cover a wider range of emotional, cognitive, behavioral, and physiological reactions (these to some extent overlap)" (p. 85). Grief was operationalized by using the Hogan Grief Reaction Checklist (HGRC) (Hogan et al., 2001). The HGRC is a 61 - item 5 point Likert scale (1 – 5) composed of six subscales. The HGRF six subscales or domains of grief are: Despair, Panic Behavior, Personal Growth, Blame and Anger, Detachment, and Disorganization. Each subscale is scored individually by summing all of its items. For each domain, the higher the score the higher the various behaviors described in each domain. For the purposes of this study a composite grief scale was calculated by summing all the scales together in order to measure grief. Personal growth was reversed coded in order to ensure the impact on composite grief was in the opposite direction. Thus the more personal growth reported by a subject the lower the composite grief score.

Oscillation balance during grief is conceptually defined as a cognitive and emotional shift between loss-orientation (LO) and resolution-orientation (RO). The more one tends to be in one orientation, the less one is thought to achieve oscillation balance. Oscillation between grief tasks was operationalized using the Inventory of Daily Widowed Life (IDWL) (Caserta & Lund, 2007) adapted for bereaved parents. The IDWL is a 22-item measure using a Likert scale from 1 to 4. The IDWL is composed of two subscales, the Loss Oriented (LO) and the Resolution Oriented (RO) subscales. The LO subscale includes items 1 to 11 and has a range of 11 (Low) to 44 (High). The RO subscale includes the items 12 to 22 and also has a range of 11 (Low) to 44 (High). Calculation of oscillation balance is done by subtracting Lo

from RO (RO – LO = Oscillation) which has a range from -33 (Exclusively Loss - Oriented) to +33 (Exclusively Restoration – Oriented). A 0 indicates a perfect oscillation balance.

Independent variables.

Insecurity in retrospective attachment styles is conceptually defined as the embodied experiences of early childhood that form background premises or schemas from which individuals understand their own self as well as the world around them and from which they strive to achieve emotional regulation of self and with others (Bowlby, 1998; Parkes, 2006). Insecurity in attachment style was operationalized by using the Retrospective Attachment Scale (RAQ) (Parkes, 2006). The RAQ is a 157-item questionnaire that uses mostly a two point Yes/No scale. There are also three 3-point items, five items requiring a continuous numerical response, and one multiple choice item. The RAQ is divided into four sections. Section I, About your parents, is composed of 28 questions pertaining to both Mother and Father, this brings the total number of items to 56 in this section. Section II, About your childhood, is composed of 31 items. Section III, About your life as an adult, is composed of 44 items. Section IV, About you now, is composed of 34 items.

Sections I and II are the only two sections of the RAQ used in this study. Section I has seven subscales that, when summed make up the Overall Problematic Parenting Scale. Section II also has seven subscales, which when summed, result in the Childhood Overall Vulnerability Scale. The sum of Overall Problematic Parenting and of Overall Childhood Vulnerability make up the Secure/ Insecure Attachment Score. A low score represents security and a high score represents insecurity.

Social support was conceptually defined as the perception by an individual that help is available: they can count on the extended family and /or the immediate community for

assistance. Social Support was operationalized by the Social Support Index (SSI) (McCubbin, Patterson, & Glynn, 1996). The SSI is a 17 item self-report measure; all items use a 5 point Likert scale from 0 to 4. The scale requests subjects to rate their responses to all the items from Strongly disagree=0 to Strongly agree=4. Seven of the items are reversed scored. Scores are summed, the higher the score the higher the Social Support. Social support was a dependent variable in one of the hypotheses.

Data Analysis

The data from both the online surveys and the hard copy surveys were downloaded from Vovici directly into SPSS version 17 for analysis (SPSS, 2007). All the data collected were reviewed by performing frequencies, measures of central tendency, and measures of dispersion. Pearson's correlation analysis was used to explore the relationships between the various study variables. For the final analysis, multiple regression analysis was used to test the hypotheses. The level of significance used in the analysis was .05.

The Descriptive Findings

Socio-demographic characteristics of respondents and of their deceased child.

Respondents were primarily female at a 60/40 split. Most of the respondents were in their mid-forties. There were no respondents younger than 30. The majority of the subjects were white. In terms of marital status, 91.8 % of couples were still together following the death of their child, indicating a rather stable group maritally. Eleven (12.8%) of the parents had no surviving children. The number of surviving children varied from one to seven. Respondents were mostly university graduates and middle class. The average time between the death of their child and the completion of the survey was 29 months. In terms of the

demographics of the child relevant to the study: 61.1 were male and 38.9 were female, the average age of the child at death was 10.

Summary Statistics of the Dependent Variables.

Most of the results of the summary statistics of the dependent variables fall in the mid range of the scales. Study subjects do express psychological distress above the standard t-score of 50 but on average subjects do not suffer from overwhelming psychological distress. The results show that on average the couples in the study were not maritally distressed. In terms of grief, the six domains of the HGRC and composite grief show the same trend with most subjects reporting average levels of grief. The results of the oscillation balance scale show the same pattern, the results of the sample was very slightly towards loss orientation but this would be expected given that the sample was 60% female (Stroebe & Schut, 1999; Stroebe, Schut, & Stroebe, 2005; Wijngaards-de Meij et al., 2008). In conclusion, the sample was not experiencing marital distress, extreme grief reactions, higher psychological distress than average but not to the extreme, and more loss oriented than resolution oriented.

Summary Statistics of the Independent variables.

The insecure attachment scale is comprised of three more specific scales of insecure attachment, namely the anxious ambivalent, the avoidant, and the disorganised attachment scales. As in the dependent variables all of the results indicate that on average subjects in the study are not highly insecure. None of the average scores exceed or approach any of the cutoff scores. In terms of the social support, the mean score is quite strong, indicating that on average the study sample considers it has good social support. In other words, the sample was highly insecure and had adequate social support.

Bivariate Statistical Analysis.

The bivariate statistical analysis was conducted to evaluate the linear relationships between the control variables, the independent variables, and the dependent variables. In terms of the control variables, gender had significant linear relationships with the, marital satisfaction/distress, insecure attachment, and composite grief HGRC. The time since death had a statistically significant linear relationship with the personal growth domain of HGRC. Age of child at death and number of surviving children had no significant linear relationships with any of the other variables. It should be noted that there was a positive linear relationship between insecure attachment and gender indicating that women in this sample were more insecure than men.

The preliminary bivariate analysis indicated that attachment insecurity had significant linear relationships with all the dependent variables except for the personal growth domain of the HGRC and marital satisfaction/distress. Though not a statistically significant linear relationship there was a trending relatinoship between attachment insecurity and marital satisfaction/distress. Overall the preliminary bivariate analysis using attachment insecurity did justify moving on to the multiple regression analysis.

The preliminary bivariate analysis indicated that social support had significant negative linear relationships with the dependent variable psychological distress as well as with the grief domains of HGRC blame and anger and detachment. There was a positive linear relationship with the grief domain HGRC personal growth as well as with oscillation balance. There was a negatively trending relationship with HGRC despair. There was no significant linear relationship with composite grief. There was a trending positive relationship with marital satisfaction/distress. Although not as strong as insecure attachment

in terms of significance, the results of the preliminary bivariate analyses still justified using social support in the MRA analysis.

For hypothesis 2, a second series of preliminary bivariate analyses were performed. This was done in order to explore the linear relationships of four additional independent variables (the discrepancy in the couples for insecure, anxious ambivalent, anxious avoidant, and disorganised attachment styles) with the dependent variables of the study, namely, psychological distress, marital satisfaction/distress, and composite grief. In this hypothesis, social support was treated as a dependent variable as well. The four control variables were also used in this preliminary bivariate analysis but only time since death produced significant linear relationships.

In terms of discrepancy of insecure attachment in couples, there was only a trending negative linear relationship with the control variable, time since death. There was a significant weak linear relationship between anxious ambivalent discrepancy scores of the couple and social support. There was a statistically significant weak negative linear relationship between avoidant attachment discrepancy scores and time since death. There were no relationships between any of the discrepancy scores and composite grief. The results of this bivariate analysis for hypothesis 2, although not very strong and certainly not consistent still justified proceeding with MRAs. What about the relationships with composite grief score. As this is the variable used in the analysis it is more important to report than the domains.

MRA analyses and the major study finding.

The three study hypotheses were tested using multiple regression analysis.

The first hypothesis stated that insecure attachment and social support would have an impact on the levels of psychological distress, marital satisfaction/distress, and composite grief in individual parents. All the control variables and the two independent variables were entered in the first model. The control variables were entered in a first block as enter method and the independent variables were entered in block two as enter method. Non significant variables were then taken out and the analysis was rerun. These MRAs partially confirmed hypothesis one.

The MRA performed with psychological distress as the criterion variable found that insecure attachment, social support, and gender, explained 45% of the variance in the level of psychological distress.   This can be interpreted to mean that while controlling for gender that bereaved parents who are more insecure in their attachment style, and have less social support, have greater psychological distress.

The MRA performed with marital satisfaction/distress as the criterion variable resulted in gender and social support being statistically significant explaining 13% of the variance in the level of individual marital satisfaction/distress. These MRA's results can be interpreted to mean that while controlling for gender those bereaved parents who they had more social support expressed more marital satisfaction than marital distress.

The MRA performed with composite grief as the criterion variable found that gender and insecure attachment were positive significant predictors. The age of the child at death was a trending positive predictor. In this study insecure attachment captured 16%, gender 13% and age of child at death 1% of the variance of composite grief. The combination of insecure attachment, gender, and age of child at death represented 30% of the variance of composite grief. The MRA results can be interpreted to mean that while controlling for

gender and age of child at death the higher the insecure attachment the higher the level of grief.

The second hypothesis stated that among couples whose child died of cancer, the greater the discrepancy in retrospective attachment styles, the lower the social support available to the individual parent, the higher the marital distress in the couple, and the higher the psychological distress and grief in the individual parent.

The numerous MRAs performed to test hypothesis 2 found little to support this hypothesis. Of the MRAs using composite grief as the criterion variable, it was found that an interaction between gender and discrepant disorganized attachment in the couple was a significant predictor of composite grief. The interaction between gender and disorganized attachment explained 16.1 % of the variance of composite grief.

One of the MRAs performed using social support as a criterion variable found that discrepancy in anxious ambivalent attachment in the couple and gender were both significant positive predictors of social support. Together these two predictors explained 12% of the variance of social support. Controlling for gender, the higher the discrepancy in anxious ambivalent attachment the greater the social support. These results partially contradict hypothesis two. It was proposed in hypothesis two that the higher the discrepancy in insecure attachment the lower the social support, these results point in the other direction in and state that in terms of a discrepancy in ambivalent attachment in the couple there is a higher level of social support. It appears that in the context of the loss of a child a discrepancy in ambivalent attachment in the couple tends to elicit more social support. This could be explained by the fact that individuals who have an ambivalent attachment style tend to have

more behaviors that elicits support. Within the couple this discrepancy probably means that one spouse elicits the support of the other spouse but also of the community.

Hypothesis 3 stated that among individual parents whose child died of cancer, the more a parent is insecure in retrospective attachment style and the lower the social support, the less the parent will be able to oscillate from one spectrum of the DPM to the other.

The MRAs performed to test hypothesis 3 used oscillation balance as the criterion variable. In the final model, insecure attachment was a significant negatively related predictor and social support was a trending positively related predictor. Together both variables accounted for 18.7 % of the variance in oscillation balance. These results suggested that the higher the insecure attachment of bereaved parents and the lower the social support the more oscillation balance was focused on loss orientation. This supports hypothesis 3.

Interpretation of the Findings

The main purpose of this study was to investigate whether and how retrospective attachment insecurity and social support in bereaved parents affect psychological distress, marital distress, and levels of grief. Discrepancy in retrospective attachment insecurity within couples, gender, age of child at death, and number of surviving children were also investigated in terms of their impact on social support, psychological distress, marital distress, and grief. A secondary purpose was to investigate how retrospective attachment insecurity and social support impacts on grief oscillation. The identification of high risk couples for higher levels of distress and grief was the final purpose of the study.

The results of hypothesis one support the hypothesis that retrospective insecure attachment has a significant impact on the individual grieving process of bereaved parents. The major finding in this study is in hypothesis one, and it is that insecure attachment is a

strong predictor of levels of grief in bereaved parents. This finding is very similar to the findings of Wijngaards-de Meij et al. (2007) according to which attachment variables represented 14% of the variance in grief of bereaved parents. The present study found that retrospective attachment represented 15% of the variance in grief. The findings of this study bring more support to the hypothesis in attachment theory (Bowlby, 1980/1998; Parkes 2006) and in the DPM (Stroebe & Schut; 1999; Stroebe, Schut & Stroebe, 2005) that retrospective attachment styles have an impact on grief.

A second important finding in hypothesis one is that insecure attachment commands a larger proportion of the variance than gender, in grief of bereaved parents. Although women do express more grief than men, the findings of the study regarding attachment variables in parental grief puts in question the traditional emphasis of gender in explaining grief differences in individuals and in bereaved couples (Fish, 1986; Gilbert & Smart, 1992; Kamn, S. & Vandenberg, 2001; Oliver,1999; Parkes, 2006). This study supports the importance of taking attachment styles in consideration, in combination with gender and age of the child at death, when explaining parental grief (Parkes, 2006; Wijngaards-de Meij et al., 2007).

A third important finding in terms of grief in hypothesis one is that social support did not show any impact on levels of grief in bereaved parents. This supports previous findings of BrintzenhofeSzoc (1995) in a study of surviving widows and widowers. One way of explaining these results is found in attachment theory's notion that the attachment bond is discriminated and specific to one individual. If the core grief response is an instinctual and intrinsic (syndromic) response triggered by separation distress following the death of a discriminated individual, then it would make sense that the grieving process cannot be mediated, at least directly, by social support. Also, if the attachment theory notion that

retrospective attachment styles developed in childhood are set in place in order to permit the adaptation to availability and responsiveness of parents, it would follow that such individual strategies of attachment would have an impact on the appraisal of the loss of a significant other. Whether or not the appraisal of the death of a child is different from the appraisal of the death of a spouse or other attachment figure was not ascertained in this study, but authors such as Bowlby (1998/1980), Rando (1986, 1997), Klass (1986, 1988), Parkes (2006) Wijngaards-de Meij et al.'s (2005) have proposed such a difference.

Results for hypothesis one in terms of psychological distress show that both insecure attachment and social support account for 45% of the variance in psychological distress. These are strong results. The fact that psychological distress, unlike grief, is impacted by both variables of insecure attachment and social support is also an important finding. This finding appears to support Wijngaards-de Meij et al.'s (2005) suggestion that grief and the psychological distress (their study looked at depression) that accompanies grief are two distinct, yet associated constructs. A potential explanation for this difference between grief and psychological distress in this study's results lies in Parkes' (2006) description of his psycho-social theory. Parkes (2006) explains how the death of a significant attachment figure forces us to negotiate separation anxiety and to "revise our assumptive world" (p.34). Parkes (2006) explains how the DPM describes this process as the oscillation between loss orientation and resolution orientation. Thus, the explanation for the different results between composite grief and psychological distress could be that social support does not play a significant role in the management of separation anxiety from the death of a child, but that retrospective attachment does. When it comes to the necessary revision of our assumptive

world and the tasks of resolution orientation, then both retrospective attachment and social

support play important roles in helping individuals reorganize around a major loss.

Retrospective insecure attachment failed to reach significance in terms of its impact

on marital satisfaction/distress as hypothesized in hypothesis one. It appears that the factors

impacting marital satisfaction/distress in parental grief are numerous and still elusive (Parkes,

2006). Controlling for gender, social support had a positive influence on marital

satisfaction/distress. It is unclear if there is a causal effect of social support on marital

satisfaction/distress or if simply couples who experience better marital satisfaction tend to

also elicit more social support. It may be that what helps couples manage their marital

relationship also helps them obtain better social support.

The results of hypothesis 2 did not support the hypothesis that discrepancies in

retrospective attachment styles in the couple impact in a significant way the psychological

distress, marital satisfaction/distress and levels of grief of bereaved parents (Wijngaards-de

Meij et al., 2007; Stroebe, 2002). In the statistical analysis of the data for hypothesis 2 there

were only two significant results. The first significant result was the interaction of gender and

disorganized attachment discrepancy in the couple, and its impact on individual levels of

grief. These results could indicate that only in extreme cases of discrepancy such as with

disorganized attachment and in which women express more of the disorganized attachment,

does individual grief become impacted. Wijngaards-de Meij (2007) reported that in couples

where one spouse was high on loss orientation the other spouse tended to have more grief

and psychological distress. It is possible that the results of the Wijngaards-de Meij (2007)

study can help explain the results of the present study. Stroebe et al. (2005), explain that

individuals with disorganized attachment have tremendous difficulty in processing grief in

any organized fashion because the emotions that need to be processed are constantly felt as unmanageable intrusions. Disorganized attachment describes individuals with tremendous difficulties in emotional regulation thus the level of grief becomes very high and is prolonged affecting the spouse in his own levels of grief.

The results of this MRA could also be related to the fact that disorganized attachment had such a strong impact on the level of grief that it comes through even when diluted by a discrepancy in the couple. More analysis of the data involving specific attachment styles such as disorganized attachment need to be done in order to clarify these results.

The other significant result in hypothesis 2 is the impact of discrepancy in anxious ambivalent attachment and of gender on social support. From these results it appears that couples in which there is a strong discrepancy in ambivalent attachment and in which the woman is more anxious ambivalent, receive or perceive more social support than couples with other types of discrepancies. Although the opposite results were expected, (that any attachment insecurity style would affect actual or perceived social support negatively) it is still possible to understand this finding according to adult attachment literature. Accordingly, individuals with an anxious insecure attachment style demand and expect to be supported by their environment and most often perceive a lack of support from the environment (Parkes, 2006; Wijngaards-de Meij, 2007). Thus a discrepancy of anxious ambivalent attachment in the couple in the context of the loss of a child appears to attract more sympathy and social support. Whether this consequence of increased social support happens over an extended or shorter time frame is unclear because of the single measure in time in this study. It should be noted that the subjects in this study did not show extreme scores in terms of the different insecure attachment styles. It is possible that if there were more extreme scores in terms of

discrepancy in anxious ambivalent attachment that result would change. The question then is whether there is a tipping point at which too much discrepancy of anxious ambivalence in the couple brings about different results. More research this area would be required to assess if this is the case.

In hypothesis three, insecure attachment is a significant but negative predictor of oscillation balance and social support is a trending positive predictor. These results appear to show that insecure attachment influences an oscillation balance that is more focused and rigidified towards loss orientation. The higher the level of retrospective insecure attachment the more grief appears to be focused on loss orientation. These results are congruent with the notion that attachment styles have an impact on grief and that it impacts the appraisal of the loss as per the discussion for hypothesis one and as described by Stroebe et al., (2005). In terms of social support, the positively oriented results of the MRA's for hypothesis three appear to support the previous finding in hypothesis one (ie. discussion on psychological distress) according to which social support appears to be associated with the task of resolution orientation and a change in assumptive world. That both variables of insecure attachment and social support have an influence on oscillation balance is added support to the DPM and its focus on both types of grief tasks.

Limitations of the Study

This study was performed with a convenience sample of parents who lost a child to cancer in the last five years and who were living together at time of diagnosis. The parents lived either in the U.S or Canada. The small sample size of 86 parents for the individual analysis and of 32 couples for the couple's analysis, was an obstacle to generalizability. The results can therefore not be generalized to parents who were not part of this study.

Self- selection was clearly an issue in this study, the fact that only 20.5% of potential respondents completed the survey increased the self-selection. Gender, age, race, education level, and income of respondents all demonstrate selection biases in the study. The overall results of the various scales also indicate that most of the study respondents did not suffer from extremes of marital distress, psychological distress, levels of grief, and of oscillation balance. As explained by Oliver (1999) and Vance et al. (2002), bereaved parents who have more difficulties and less resources do not tend to participate in studies and this appears to be the case in this study.

A comparison group of parents whose children completed treatment for cancer and survived would have helped in comparing data obtained from the bereaved parent.

The question of measurement is also a limiting factor in this study. The first measurement issue was the modality of data collection. This study relied only on self report questionnaires with closed ended items, ie. Yes/No and Likert Scales. Such a data collection approach did not give subjects the opportunity to give more personal details about their experience thus limiting the information obtained.

The second measurement issue was the measuring of variables that occurred from early childhood to the present time. The RAQ for example looks at childhood events. Parkes (2006) took great care in asking about concrete events that limit the need for the subject to exercise a qualitative judgment of past events when answering, it is quite possible that some individual's need to idealize their childhoods and their parents could have influenced how they answered the RAQ. This could not be controlled.

The third issue regarding measurement also involves the RAQ. The scale is somewhat unbalanced regarding the measurement of anxious avoidant attachment style; 9 items

compared to 22 for anxious ambivalent attachment and 26 for disorganized attachment. This leads to questions regarding the ability of the scale to effectively measure anxious avoidant attachment.

A fourth measurement issue is the use of the composite grief scale. Hogan et al. (2001) did not intend the various grief domains of the HGRC to be integrated as a composite grief scale. The composite grief scale was therefore not standardized and it appears to be the first time that it is used in this fashion for research.

Recommendations for Theory, Practice, and Further Research.

The results of this study offer an opportunity to formulate recommendations for theory development, clinical practice and further research.

Theory development.

The results of this study bring empirical support to an important hypothesis of attachment theory according to which retrospective attachment styles have an impact on how parents grieve the loss of their child. The variance of grief was shared with gender and age of the child at death. Another important finding impacting theory development is the fact that insecure attachment has a slightly larger share of the variance in grief than gender. In this study insecure attachment took up 1% more of the variance than gender, and the age of the child at death explained 1% of the variance in grief. Together, insecure attachment, gender and age of the child at death explained 30% of the variance in grief. As Fraley and Shaver (1999) Parkes (2006), Shaver and Tancredy (2002/2001) have proposed, attachment styles need to be considered as a variable that influences the appraisal and processing of the death of a significant attachment figure. The results of this study support this position empirically, but in addition attachment security/insecurity should be considered alongside gender and age

of child at death when considering the variables that impact grief in bereaved parents. These are significant findings that require further investigation.

Mikulincer and Shaver (2007) discuss the relationships between attachment styles and gender. They explain that individuals with insecure attachment styles appear to adopt a more rigid gender identity. If one is male and more anxious avoidant, the male stereotype of the strong, stoic, non-emotional man will be adopted. The combination of anxious avoidant and male stereotypes makes for an even more entrenched coping strategy most likely interfering with open communication around coping, in general, but especially around difficult life events such as coping with the death of a child. This issue becomes even more complicated when one thinks of how female gender and an anxious avoidant attachment style become part of the equation.

Another theoretically important finding of this study indicated that social support had no influence on grief but that it has more of an impact on psychological distress. This can be interpreted as supporting the hypothesis of Wijngaards de-Meij et al. (2005) that psychological distress should be distinguished from grief as a construct. The results of the MRA on psychological distress appear to support the DPM's (Stroebe & Schut, 1999; Stroebe et al., 2005) suggestion that processing the loss and processing the social aspects of the loss are two separate stressors between which bereaved individuals oscillate in an ongoing process of reorganization following the loss of a significant other. Loss orientation appears to encompass numbing, protest, and despair (separation anxiety and preoccupation with the deceased) at the inability to reunite with the deceased loved one. Resolution orientation has more to do with the integration of a world in which the deceased child is dead (Stroebe, 1999). As Parkes (2006) explains, resolution orientation tends to be more

associated with the review of the assumptive world of bereaved parents in which the child is dead. This is where psychological distress appears and this is where according to the results of this study regarding psychological distress, most of bereaved individual's responsiveness to social support can take place. Together, insecure attachment and social support account for 45% of the variance in psychological distress. Thus the results of this study appear to support the DPM suggestion that resolution orientation or the review of the assumptive world can be considered as a task of grieving that is separate from the focus on the loss. Resolution orientation, like loss orientation is often aversive and triggers psychological distress for bereaved parents and other bereaved individuals.

The concepts of loss orientation and of resolution orientation in the DPM and the oscillation balance between them or the rigidified and defensive preference of some individuals for one or the other grief orientation bears a striking resemblance with a model of couple intervention EFT (Greenberg & Goldman, 2008; Johnson & Greenberg, 1985; Johnson, 2004; Johnson et al., 2005) . EFT is known for its emphasis on adult affiliation or attachment needs (Johnson & Greenberg, 1985; Johnson, 2004; Johnson et al., 2005). Greenberg & Goldman (2008) have introduced, within the EFT for couples model, a greater emphasis on the question of identity issues in marital distress. The way Greenberg & Goldman describe individuals' needs for affiliation and identity is often on a parallel with the DPM categories of loss orientation (affiliation focused) versus resolution orientation (identity focused). In fact it appears to this researcher, from the DPM and attachment literature, that individuals who are more loss-oriented are more focused on affiliation needs and that individuals who are more focused on resolution-orientation are more focused on identity needs. Klass (1986) and Parkes (2006) have commented on how the question of identity is

an important issue for bereaved parents. For Klass (1986), a central component of the

parental grieving process is the rebuilding of a new identity accommodating for the fact that

their child is now dead and no longer alive. For Parkes (2006), the rebuilding of the bereaved

parent's assumptive world is an important part of the grieving process. An important aspect

of the assumptive world described by Parkes (2006) can be considered to be identity focused.

This distinction between the affiliative and the identity domains and how they are intertwined

may well be an important direction in understanding what other variables contribute to the

grieving process, and how much they contribute to either loss or resolution orientations.

Links with other fields of research in human interaction can be useful in reviewing

hypotheses in the field of grief theory.

In hypothesis one, the fact that retrospective attachment did not influence marital

satisfaction/distress in the MRAs prompts the question of whether or not retrospective

attachment measures such as the RAQ can capture an influence on adult romantic attachment

or if specific scales for adult romantic attachment styles need to be used in studies such as

this one (Mikulincer & Shaver, 2007; Parkes, 2006).

It is possible that the RAQ was able to capture an influence on grief in bereaved

parents because the bond with a child is the closest one gets to the bond with one's parents

(Parkes, 2006). The bond between spouses is different from the bond with parents (Cassidy,

1999; Parkes, 2006; Mikulincer, 2007), and this may explain in part why retrospective

attachment did not influence marital satisfaction/distress (Parkes, 2006; Mikulincer &

Shaver, 2007). It is possible that a scale that measures romantic attachment would have

found an influence between attachment styles in the couple and marital distress (Parkes,

2006; Mikulincer & Shaver, 2007).

For hypothesis two the fact that there were only two significant MRAs was surprising and theoretically disappointing. The notion of discrepancy in how couples cope with the death of their child is a much recognized concept but it has not been proven empirically (Gilbert & Smart, & Oliver, 1999; Kamm & Vandeberg, 2001). In EFT, an effective couple therapy model, marital satisfaction/distress is often explained by a discrepancy between relational and identity focuses of either spouse. The theoretical model of hypothesis two does appear to make sense and is applied effectively in evidence based couple therapy.

Given the findings of the study it would now be surprising to find that discrepancy in insecure attachment styles would affect levels of grief. According to the results of this study it is the actor's attachment style, gender and the age of the child that would impact grief. It is therefore surprising to find that an interaction between gender and discrepancy in disorganized attachment had an influence on grief. More statistical analysis is required on this issue but it may be that the impact of disorganized attachment on level of grief is so strong that it still comes up in an interaction with gender even when diluted in a discrepancy equation. This significant MRA appears to show that couples in which one spouse, especially the female, has disorganized attachment may be considered high risk for more complicated grief. This again supports the DPM (Stroebe et al., 2005).

In terms of the significant results obtained from the discrepancy in anxious ambivalent attachment and its impact on levels of social support, it appears that such couples may be more effective than other couples at obtaining social support. As mentioned in the interpretation of the results, it may be that up to a certain level of insecurity, a discrepancy in anxious ambivalent attachment in the couple can have its advantages in terms of reducing

social isolation during grief. Whether or not this advantage continues to be true beyond a certain level of discrepancy would need to be explored further.

It is not understood at this point why a discrepancy in attachment styles in the couples did not influence psychological distress. According to the findings in hypothesis one, a discrepancy in attachment styles would most likely make social support from a spouse more difficult to obtain and impede to a certain extent resolution orientation tasks and the reworking of the assumptive world causing psychological distress. The results of hypothesis two do not show any of these dynamics at play. This area needs to be explored further in future studies.

As discussed in the interpretation of results the findings for hypothesis three appeared to support the latest developments in the DPM stipulating that grief oscillation is most likely impacted by various attachment patterns as well as by social support (Stroebe & Schut, 1999; Stroebe et al., 2005). As discussed by Parkes (2006), Shaver and Tancredy (2002/2001) and Stroebe et al. (2005), it is in the appraisal of the loss both in loss orientation and in restoration orientation that attachment security/insecurity and social support play a role and influence the fluidity or rigidness of the oscillation balance. This study has brought support to this hypothesis through its results in hypothesis one in terms of grief and of psychological distress, as well as with hypothesis three in terms of both psychological distress and social support impacting oscillation balance.

In terms of identifying high risk individuals for parental grief, the results of this study brought more support to the hypothesis that parents who have an insecure attachment style have more grief, more psychological distress, and are less able to achieve grief oscillation balance. In terms of high risk for couples, this study found that an interaction between

gender and discrepancy of disorganized attachment in the couple increased individual grief in the spouses.

Overall, the results of this study contributed to the growing body of research indicating that attachment theory and social support are helpful in understanding individual and some couple variations in grief processing following the death of a child.

Clinical practice.

This study was developed in part on the necessity for evidence-based practice in the field of clinical intervention with bereaved parents. The findings of this study support the hypothesis that bereaved parents are influenced in their grieving by retrospective attachment styles and in more indirect ways by social support. Fraley and Shaver (1999), Shaver and Tancredy (2002/2001), and Stroebe and Schut (1999, 2005) have suggested that taking in consideration attachment styles in interventions with bereaved individuals is now becoming important and even the ethical thing to do (Fraley & Shaver). The study findings of hypotheses one, two, and three certainly brought more support to the position of considering attachment styles during interventions with bereaved parents. Furthermore, the results of this study support the use of the DPM in conjunction with the notions of attachment styles as conceptual frameworks to understand and explain grief processing, in order to plan and deliver interventions and also as psychosocial teaching tools for bereaved parents. Social workers can explain to bereaved parents and their supportive circle how separation anxiety is a powerful syndromic reaction to the loss of their child. The intensity of separation anxiety and its prolonged activation and unpredictable nature needs to be normalized for bereaved parents and their supportive circle. How separation anxiety will be experienced and expressed depending on attachment styles and grief orientations will be useful information

for both individual parents and for couples. The notion of syndromic separation anxiety can also be used to understand and contextualize bereaved parents' pain and difficult emotions such as anger and despair as action potentials during the grieving process. Anger can be understood to be an attempt at retrieval of the child and despair as a feeling of powerlessness because of the inability to reunite with the dead child (Bowlby, 1998/1980).

Use of attachment theory and of the DPM in interventions with bereaved parents can help social workers understand that individuals who are more avoidant should not be pushed towards loss orientation processes for fear of flooding them with emotions they do not have the tools to process (Fraley & Shaver, 1999; Wijngaards-de Meij et al. 2007). Working with them to understand their tendency to focus on resolution orientation tasks while helping them be aware of their grief coping strategy would appear to be more congruent with how they are organized in their coping styles. Individuals who have a preoccupied attachment style will have a tendency to stay focused on the loss, and pushing them towards resolution orientation will be counterproductive, even harmful and it could interfere with the therapeutic alliance. Work with individuals who have disorganized attachment will be more difficult and chaotic and this needs to be expected and understood. For all of these attachment styles and their variations, slowly introducing the notions of reorganization and of oscillation can help individuals and spouses visualize the task of grieving and the approach/avoid dynamic that is often at play during parental bereavement.

In terms of couples, the use of attachment theory and of the DPM can help the therapist introduce and describe variations in grieving patterns that can help couples understand each other's grieving process so that this does not feed a negative communication

cycle and instead leads to a de-escalation of potential negative communication cycles (Greenberg & Goldman, 2008; Johnson, 2004; Johnson et al., 2005).

Manualized models of interventions that are based on attachment theory and describe emotions as action potentials, such as Emotionally Focused Therapy for Couples (EFT-C) (Greenberg & Goldman, 2008; Johnson, 2004; Johnson et al., 2005), need to be explored in conjunction with the DPM in order to help develop and test out effective models of intervention for bereaved parents. This would answer the call of Wijngaards-de Meij et al. (2007) who suggest couple therapy for bereaved parents.

The use of the RAQ to identify attachment styles in parents whose child has just been diagnosed with cancer would be an added tool and would bring considerable information to pediatric oncology social workers and to the team. Parents who are found to have disorganized attachment could be considered high risk for palliative and bereavement issues. As Wijngaards et al. (2007) have suggested couple therapy could be offered to bereaved couples who are composed of one of the parents with anxious ambivalent attachment.

Need for future research.

Studies of how bereaved parents cope are few and far between (Oliver, 1999). It is essential to explore what is involved in the grieving process of bereaved parents and how much this impacts the marital relationship. Recommendations include a replication of this study using a significantly larger sample and trying to address the selection bias found in this study. A suggestion would be to approach families while the child is still alive, through hospitals for example, in the hope that this would facilitate the inclusion of younger, less educated and less wealthy parents before they lose a child. This would permit to have pre-

death-of-a-child data for bereaved parents. It would also provide a comparison group of parents whose child went through cancer but did not die. The inclusion of siblings in such a study, although increasing the level of difficulty, would be a most needed addition to such a study.

The relationship between retrospective attachment insecurity and marital satisfaction/distress did not reach significance in this study. Given that the 32 couples who participated in the study were older and not in a lot of marital distress it would be interesting and important to see if a larger sample with less selection bias would bring the relationship between retrospective attachment and marital distress to a level of significance in both bivariate and multivariate analysis. Future studies, such as this one, should also incorporate a measure of adult romantic attachment styles; Studies have found relationships with such measures and marital distress (Mikulincer & Shaver, 2007). Mikulincer & Shaver, (2007) and Parkes (2006) have discussed how the AAI that measures retrospective attachment or childhood attachment does not show strong relationships with marital distress. Somehow the relationship between retrospective attachment styles and marital distress is complex and difficult to map out (Parkes, 2006) and the use of the RAQ in this study appears to confirm this.

The question of discrepancy in attachment styles and how it impacts grieving couples still requires investigation. Different ways of defining the discrepancy operationally or of analyzing the data may be useful directions.

The fact that there was no relationship between social support and levels of grief on the composite grief scale of the HGRC needs to be investigated further. Studies to establish validity and reliability of the HGRC composite grief scale are needed.

The contribution to the development and testing of the grief oscillation measure appears to be a worthwhile endeavor. The possibility to assess the oscillation abilities of bereaved parents over time would be an interesting way of measuring how they are progressing through the grieving process. The scale is still in its infancy and as more research is done in this area it may serve as an important model along with the DPM to discuss various elements of grief processing in the process of developing further the evidence based theoretical model of the DPM first developed by Stroebe, Schut, and Stroebe, (1995).

In this study the scale the Inventory for Daily Parental Bereavement Life (IDPBL) did not capture a wide range of scores. They tended to be concentrated closer to oscillation balance point of zero. This did not discriminate very well between individuals. Future studies should consider this issue. It is possible that this was a product of selection bias.

Finding ways of incorporating measures of identity needs and issues during the grieving process may well help discover more of what contributes to the variance in grief, and would appear to be a valuable direction for future studies in bereaved parents. Questions regarding identity could probably be incorporated to the IDPBL in order to bolster the resolution orientation scale. Questions of identity could also likely be considered to bolster the anxious avoidant scale of the RAQ which only has a total score of nine compared to 22 for the anxious ambivalent scale, and 26 for the disorganized/disoriented attachment scores. Ongoing use of the RAQ for research purposes in order to help reproduce results is also needed.

Clearly this study shows that there is still much to do in terms of research to deepen and broaden our understanding of bereaved parents, both at the level of the individual and of the couple.

Conclusions.

This study tested three hypotheses in order to explore individual and couple grieving in parents who have lost a child to cancer. The results were mixed but brought more support to the hypotheses that retrospective attachment styles contribute significantly to the variance in grief, psychological distress and oscillation balance. A significant finding in this study is that retrospective attachment has a larger contribution than gender to the variance of grief, psychosocial distress and oscillation balance.

Retrospective insecure attachment was not a significant predictor of marital satisfaction/distress, and MRAs exploring the impact of discrepancy of attachment insecurity and of insecure attachment styles in couples only reached significance in two MRAs.

The results of this study bring more support to the hypothesis that retrospective insecure attachment contributes to increased grief complications in bereaved parents. The study did not however find the support expected for contribution of insecure attachment to the relational aspects of parental bereavement except to show that anxious ambivalent discrepancy in the couple appears to increase social support and that an interaction between disorganized discrepancy in the couple and gender increases the level of grief in the couple.

The study results also explored the contribution of social support in the variance of grief, psychological distress, marital satisfaction/distress and oscillation balance. A significant finding in this study was that social support did not impact grief. It was proposed in the discussion that this can be explained by attachment theory and its description of separation anxiety with the death of a discriminated significant other. The impact of social support on psychological distress along with insecure attachment was also described as a significant finding from a theoretical perspective. The study results did find that social

support impacted marital satisfaction/distress along with gender. Social support also was a trending variable, along with insecure attachment, impacting oscillation balance.

Although the study results are not generalizable, its results do bring added quantitative information to the contribution of gender, insecure attachment and social support in individual and couples who have lost a child to cancer. It also has brought added support to attachment theory and to the DPM in the understanding of individual and couples grief processing. This study is another small step in affirming the pertinence of attachment theory and of the DPM in theoretical development and future research leading to the application of evidence-based practice in intervention with individuals and couples who have lost a child to cancer.

Appendix A

Dear Candlelighter Chapters:

CUA

THE CATHOLIC UNIVERSITY OF AMERICA
National Catholic School of Social Service
Washington, DC 20064
202-319-5454
Fax 202-319-5093

Dear Candlelighter Chapters:

My name is Philip Domingue, M.S.W. I am presently working on a Ph.D. in social work at The Catholic University of America in Washington D.C. I am also a recipient of a Doctoral Training Grant in Oncology Social Work from the American Cancer Society. Throughout my 7 years in pediatric oncology and palliative care as well as during my academic work. I became aware of the urgent need for a well documented and researched approach to offer assistance and support to bereaved parents who have lost a child to cancer.

It is understood that the experience of such a loss is overwhelming for many couples who find it difficult to support each other. In extreme cases separations occur. You may know of couples in this situation. This is why I decided to work on a dissertation project that will lead to a better understanding of bereaved couples and the kind of support they need.

In order to do this I must gather information from as many cancer - bereaved couples as possible. Drawing on grief, couple and attachment theories, I am looking at how the relationship bereaved parents had with their own parents impact on the way they feel the loss of their child. Also, does the way a bereaved parent feels the loss of his/her child affect the relationship with his/her husband/ wife /partner? My supervisors for the dissertation research

are: Karlynn BrintzenhofeSzoc, Ph.D. (Chair); Barbara Early, Ph.D. (Reader); Sue Johnson Ph.D. (Reader); and James Zabora, Sc.D. (Reader).

I hope that you will agree with me that the project is worthwhile; I am calling on you today to help make this project a success. I am approaching all the Candlelighter chapter and affiliates throughout the United States and Canada to ask for their assistance. If you agree to assist me in the project I will provide you with the letters of invitation in stamped envelopes. I am including a copy of the letter of invitation so you can see what you will be mailing. I will need you to do the following tasks:

1. Compile a mailing list of cancer bereaved parents associated with your organization.

2. Print two sets of mailing labels from the list

3. Tell me how many invitation letters (in the envelope with postage paid) you will need

4. Attach the mailing labels to the envelopes I provide and put them in the mail.

5. One month later I will provide you with another set of invitation letters (in envelopes with postage paid) to be sent as a second request

6. Attach the second set of mailing labels to these envelopes and put them in the mail.

Having you produce the mailing list and the labels allows the names to be unknown to me. Only those parents who decide to participate will become known to me.

For the purpose of the study I have established a 1-800 number and an email address and I will be available to the participants 24/7 in case the survey evokes emotions that are difficult for them to manage. If a bereaved parent contacts me I will work with them until suitable professional support is found.

Eligible bereaved parents will have lost a child to cancer in the past 5 years and were living together when the child was diagnosed. The survey will take about 50 minutes to complete and both members of the couple will be asked to complete a questionnaire. I am hoping to keep the study open for only two months but it will not go beyond 3 months.

This study has been approved by the Human Subjects Committee of The Catholic University of America. All information obtained in this self-administered survey will be kept strictly confidential with the exception of subpoena or other legitimate government request. Individual data will not be reported in this study so that individuals will not be recognizable or traceable. Data will be stored in a secure location inaccessible to the internet.

If a parent would like to learn more about the study they can go to www.bereavedcouples.cua.edu to learn more and request to participate in the survey. The link to the online survey will be on this website. If a hard copy is requested the survey packet (informed consent, survey, and self-addressed postage paid envelope) will be sent to the potential respondent by mail.

For more information I can be contacted at cua-bereavedcouples@cua.edu or you can call this toll free number at 1-888- **to be determined**.

Thank you for your time in considering this matter and for your support.

Sincerely

Philip Domingue M.S.W., R.S.W.

Ph. D. candidate, National Catholic School of Social Service
Adjunct Researcher, Children's Hospital of Eastern Ontario Research Institute
Recipient of a Doctoral Training Grant in Oncology Social Work from the American Cancer Society

Appendix B

Dear Pediatric Oncology Social Worker and APOSW member:

THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093

Dear Pediatric Oncology Social Worker and APOSW member:

      My name is Philip Domingue, M.S.W. I am presently working on a Ph.D. in social work at The Catholic University of America in Washington D.C. I am also a recipient of a Doctoral Training Grant in Oncology Social Work from the American Cancer Society to conduct this research. Throughout my 7 years in pediatric oncology and palliative care as well as during my academic work. I became aware of the urgent need for a well documented and researched approach to offer assistance and support to bereaved parents who have lost a child to cancer.

      It is understood that the experience of such a loss is overwhelming for many couples who find it difficult to support each other. In extreme cases separations occur. You may know of couples in this situation. This is why I decided to work on a dissertation project that will lead to a better understanding of bereaved couples and the kind of support they need.

      In order to do this I must gather information from as many bereaved couples as possible. Drawing on grief, couple, and attachment theories I am looking at how the relationship bereaved parents had with their own parents impacts the way they grieve. Does this have an impact on relationships with spouse and/or life partner during the grieving process? My supervisors for the dissertation research are: Karlynn BrintzenhofeSzoc, Ph.D. (Chair), Barbara Early, Ph.D. (Reader); Sue Johnson Ph.D. (Reader), and James Zabora, Sc.D. (Reader).

      I hope that you will agree with me that the project is worthwhile; I am calling on you today to help make this project a success. In the coming months I will be approaching bereaved parents who have lost a child to cancer in the past 5 years and who were living together when the child was diagnosed. I will be asking them to contribute about 50 minutes of their time to fill out a questionnaire. Should you be approached by either bereaved parents or colleagues or community organizations I would appreciate that you tell them that you know of the study and that you support it. Bereaved couples will be approached for participation anonymously through community support organizations such as Candlelighters across the U.S. and Canada. Because of ethical concerns in your various health care centers and organizations I cannot ask you to become involved in the recruitment of parents in the

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context of your work. My goal is simply to make you aware of the study and ask you to reassure others of the legitimacy of the study if you are asked about it.

Social workers have a tremendous presence throughout the health care system. I believe that when we pull together we can begin a powerful network of support for psychosocial research in Pediatric Oncology. Once the study is complete I will be happy to disseminate the results through APOSW as well as present the results at one of the AOPSW conferences.

This study as well as this letter has been approved by the IRB of The Catholic University of America. **All information obtained in this self- administered survey will be kept strictly confidential with the exception of subpoena or other legitimate government request.** Individual data will not be reported in this study so that individuals will not be recognizable or traceable. Data will be stored in a secure location inaccessible to the internet.

More information about the study can be found at http://www.bereavedcouples.cua.edu. The survey can be filled out either online or by hardcopy – whichever manner is requested by the participating parents. The link to the online survey is at the website noted above and the hard copy can be obtained by the parent returning the postcard included in the letter of invitation or by sending me an e-mail with their mailing information at cua-bereavedcouples@cua.edu .

For more information I can be contacted at cua-bereavedcouples@cua.edu or you can call this toll free number at 1-866-299-1023.
Thank you for your time in considering this matter and for your support.
Sincerely

Philip Domingue M.S.W., R.S.W.

Ph. D. candidate, National Catholic School of Social Service

Adjunct Researcher, Children's Hospital of Eastern Ontario Research Institute

Recipient of a Doctoral Training Grant in Oncology Social Work from the American Cancer Society

Appendix C

Parent's invitation to participate in the study.

CUA

THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093

January 21, 2008

Dear Parents:

      My name is Philip Domingue. I am studying to become a doctor in social work at The Catholic University of America in Washington D.C. I worked seven years in children's cancer and end of life care. During that time I found out that there is a big need for research that can help us give more support to parents like you, who have lost a child to cancer.

      People often say that after losing a child, many couples have a hard time supporting each other. In some cases these couples separate. You may know some people in this situation. This is why I decided to study and understand couples who have lost a child to cancer and develop ways to help them out. In order to do this, I need to get information from as many grieving couples as possible.

      I hope that you will agree with me that the project is very important and that you will give about 50 minutes of your time for this study. This will help people like you who have gone through the loss of a child in the past five years.

      All information in this survey that you fill out on your own will be held in confidence. When the study is finished, a short explanation of what I find in the study can be emailed or mailed to you if you give me your email or address in the survey.

      You can access the survey online at http://research.cua.edu/bereavedcouples or request that it be mailed to you with return pre-paid postage envelopes. Please take time to complete the survey. Please encourage your spouse or partner to also do a survey. For more information I can be reached by at email at cua-bereavedcouples@cua.edu or by telephone at this toll free number 1-866-299-1023.

      This letter was sent to you by the **** Candlelighters, but they did not give me any information about you. They only put your name and address on the letter and mailed it, but they kept your privacy.
Thank you for your time and your help.

Appendix D

Study consent form

CUA

National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093
THE CATHOLIC UNIVERSITY OF AMERICA
CONSENT FORM

NAME: _____   DATE: _____

The name of this research study is: An Examination of Attachment Styles, Distress, and Oscillation Among Parents Who Have Lost a Child to Cancer.

Investigator: Philip Domingue, M.S.W.

Research Supervisors: Karlynn BrintzenhofeSzoc, Ph.D.; Barbara Early, Ph.D.; James Zabora, Sc.D.; Sue Johnson, Ph.D.

I may contact Philip Domingue at 1-866-299-1023 or email him at cua-bereavedcouples@cua.edu if I have any questions or concerns.

Purpose: I understand the purpose of this research is to learn how parents who have lost a child to cancer deal with the loss. This study is being carried out in partial fulfillment for the requirements of a Ph.D. degree in social work at the Catholic University of America.

I understand that this study is trying to answer two questions.

1. Does the relationship that bereaved parents had with their own parents as children have something to do with the way they feel the loss of their child?
2. Does the way bereaved parents feel the loss of their child affect the relationship with their husband/wife/partner?

Procedure: I understand that I will be asked to:

- Answer short questions by checking off the answer that is closest to what I think or feel.
- Fill out my own questionnaire. I will not ask my husband/wife/partner to see their questionnaires. This is very important for the study.
- Take about 50 minutes to complete the questionnaire.

I understand that the questions are about these five (5) topics:

1) My childhood and adult life.
2) My relationship with my wife/ husband/ partner.
3) How I am dealing with the death of my child.
4) The support systems I have available to me.
5) Information such as: my age, age of my child when he or she died, my income, my level of education.

Risks, inconveniences, and/or discomforts: I understand that I might be upset by some of the questions in this study. The questions ask about things in my life that can stir up my emotions. I do not have to answer any questions that I do not want to answer. I don't have to complete the questionnaire at one sitting. I understand that I can stop, put it in a safe place, and come back to it later. I may also decide not to return to the study if it is too upsetting to me. If I am in distress I may call or email the researcher and he will help me find support in my community.

Benefits: I understand that there is no direct benefit to me. The main benefit from being in this study is to help to better understand parents who lost a child to cancer and what services professionals can use to better support these parents.

Confidentiality: I understand that the researcher will know my name. I understand that the researcher will take my name off my questionnaire and replace it with a unique number. This will help protect my identity. The researcher is the only person who will see my questionnaire. The information from this study will be kept private in a locked file in a locked office. In any report, only group information will be used. No information that will make it possible to identify me will be included. My answers to the questionnaire will only be used for research.

Voluntary Nature of the Study: I understand my decision to join this study or to not take part will not change how people treat me in the support agency that told me about this study such as Candlelighters or Children's Cancer Trust. Also, my decision will never have an effect on how I am treated by The Catholic University of America if and when I do business with them. If I decide to take part in the study I am free to stop at any time. In fact no one else but me and anyone I tell, like my spouse or partner, will know if I have joined this study or not.

Contacts and Questions:

The researcher doing this study is Philip Domingue M.S.W.

I may ask any questions I have either before or after the survey.

I may contact the researcher at 1-866-299-1023 or email him at cua-bereavedcouples@cua.edu

If I want to talk to someone other than the researchers, I can call:

The Secretary for the Committee for the Protection of Human Subjects, Office of Sponsored Programs and Research Services, The Catholic University of America, Washington, D.C. 20064; Telephone (202) 319-5218.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I agree to take part in the study.

Print Name _____

Signature_____ Date _____

Please sign a copy of this form and mail it back with your questionnaire in the self addressed envelope and keep the second copy for your records.

Appendix E

Instructions for study.

Bereaved Couples Study
Instructions for Study

First let me thank you for doing this questionnaire.

Start by reading and signing the informed consent form, it gives you more information on the study and on your rights in a study.

Please do not be overwhelmed by the number of questions, the survey has been planned to be read and answered quickly.

There are no right or wrong answers in this survey and it is not a test; mark the first answer that comes to you.

If you do not know the answer to some of the questions or if it is an overwhelming question for you, it is ok to just pass on to the next. You can come back to the question if you want or just leave it blank. Those of you for whom the questionnaire still evokes a lot of emotions that is very understandable. You can take breaks if you need to. The program is set up for you to stop at any time and return to where you left off. Just click on close to get out of the program. When you return to the website to start the survey again you will get a prompt for your unique ID (password) just like when you first came on the site.

You can also stop and just terminate your participation in the survey at anytime. None of the information you entered will be sent to me until you actually click on the Submit button at the very end of the survey.

During the 2 months this study will be open and 1 month after the close of the study if you are upset by the questionnaire and you need help you can call me toll free at 1-866-299-1023 and I will help you to find support services in your area.

Please answer the survey on your own. The survey is not meant to be shared with your spouse or partner. Please do not expect your spouse to show you his/her survey. The reason for this is that research has shown that some questions will not be answered the same way if someone thinks that their spouse or partner will see the responses.

Once more if you have questions, comments or need help finding support in your area you can reach me toll free at 1-866-299-1023 or you can e-mail me at cua-bereavedcouples@cua.edu .

Thank you again for your contribution to this study.

Appendix F

Retrospective Attachment Questionnaire

Retrospective Attachment Questionnaire

Section I: About your parents (or adoptive parents). Please answer for both your Mother and your Father

	Mother		Father	
	yes	no	yes	no
Were you brought up by your true parents?	○	○	○	○
Are your parents still alive?	○	○	○	○

If not, write in how old you were when they died

Mother   _____

Father   _____

Section I

	Mother		Father	
	yes	no	yes	no
Were you separated from either parent for more than a month before the age of 6 years?	○	○	○	○
Were you separated from either parent for more than a month between the ages of 6 and 10 years?	○	○	○	○
Were you separated from either parent for more than a month between the ages of 11 and 16 years?	○	○	○	○
During your childhood were you ever afraid that a parent would die or be killed?	○	○	○	○
Was either parent nervous, insecure or a worrier?	○	○	○	○

Was your parent subject to episodes of gloom or depression?	○	○	○	○
Did your parent ever receive psychiatric treatment?	○	○	○	○
If so, was he/she ever admitted to a hospital for psychiatric treatment?	○	○	○	○
Did your parent ever assault or injure his or her partner?	○	○	○	○
Did either parent obtain your obedience by threatening to leave you or give you away?	○	○	○	○
Did either parent threaten to kill themselves?	○	○	○	○
Did either parent drink more alcohol than was good for them?	○	○	○	○
Was your parent often away or not available?	○	○	○	○
Was your parent inconsistent, sometimes responding, and at other times ignoring your needs for attention and affection?	○	○	○	○
Did either parent discourage you from playing with other children?	○	○	○	○
Did either parent give you the impression that the world is a very dangerous place in which children will not survive unless they stay very close?	○	○	○	○
Did either parent worry a great deal about your health?	○	○	○	○
Did either parent worry a great deal about your safety?	○	○	○	○
Was either parent overprotective?	○	○	○	○
Was your parent dependent on or inclined to cling to his or her spouse?	○	○	○	○
Were you unusually close to your parent?	○	○	○	○
Was either parent inclined to tease you or make you feel small?	○	○	○	○

Did either parent beat you or physically punish you more than most parents?	○	○	○	○
Did either parent sexually interfere with you or expect you to touch their genitals?	○	○	○	○
Was either parent unable to show warmth or to hug or cuddle you?	○	○	○	○
Was your birth planned and wanted by your parents?	○	○	○	○
Did you have mixed feelings of love and hate, affection and resentment, towards either parent?	○	○	○	○

Section II: About your childhood

	yes	no
Were you, at any time before the age of 10, sent to a boarding school, orphanage or children's home for more than a few weeks?	○	○
Were you an only child for more than five years of your childhood?	○	○
Was your family subjected for a long time to serious danger or persecution?	○	○
Did you suffer from severe illness which threatened your life before the age of 6?	○	○
Or a similar illness from 6 to 16?	○	○
Would you describe yourself as an insecure child?	○	○
Would you describe yourself as an anxious child?	○	○
Would you describe yourself as an unhappy child?	○	○
Were you an underachiever, never doing as well at school as your intelligence led people to expect?	○	○
Were you, as a child, always looking after others?	○	○
Did you lack self-confidence as a child?	○	○

Were you afraid to be left alone or easily upset by separation from your parents?	○	○
Were you timid and reluctant to visit new places, meet new people or do new things?	○	○
Were you a passive child, leaving it to others to tell you what to do?	○	○
Did you feel helpless and unable to cope?	○	○
Did people baby you and regard you as sweet and appealing?	○	○
Did people regard you as a delicate or fragile child?	○	○
Did you distrust most adults through much of your childhood?	○	○
Did people often think of you as tougher or more capable than you really were?	○	○
Were you a loner, avoiding others as a child?	○	○
Did you find it hard to ask other people to help you?	○	○
Did you find it hard to accept cuddles, or other demonstrations of affection?	○	○
Were you, as a child, inclined to be suspicious or distrustful of other people?	○	○
Did you find it important to be the one in control, were you "bossy" or inclined to dominate your friends?	○	○
Did you have a bad temper?	○	○
Did you get into trouble for rebellious, aggressive or antisocial behavior?	○	○
Were you stubborn?	○	○

Section II continued

	Never	Sometimes	Often
How often did you cry?	○	○	○

Section II continued

	Yes	No
Did you, as a child, often wish you were dead?	○	○
Were you born outside of the U.S. or Canada?	○	○

If so, at what age did you immigrate or move permanently to the U.S. or Canada?

_____

Section III About your life as an adult

	Yes	No
Do you have children under the age of 16?	○	○
Do you live alone?	○	○

If yes, for how long? _____Years

Section III continued

	Yes	No
Are you suffering from any physical illness or disability?	○	○
Does it threaten your life?	○	○
Does it cause lasting pain?	○	○
Does it prevent you from working?	○	○
Does it prevent you from moving about as much as you would wish?	○	○
Does it interfere with your life in other important ways?	○	○
Do you have anyone in whom you can confide your inner most thoughts	○	○

and feelings?		

Please answer this section of questions in regards to your spouse or partner with whom you cared for your child with.

	Yes	No
Were you or are you very close to this person?	❍	❍
Were you or are you rather dependent on this person?	❍	❍
Were/is this person rather dependent on you?	❍	❍
Is/was this person more than five years older than you?	❍	❍
Do/did you regard him/her as more like a parent than an equal partner?	❍	❍
Do/did you find even short periods of separation from this person distressing?	❍	❍
Do/did you have mixed feelings of anger and affection towards this person?	❍	❍
Do/did you find it necessary to get away from this person from time to time and to reduce tension?	❍	❍
Do/did you find it hard to get this person to talk about matters that were emotional or upsetting?	❍	❍

Most couples disagree about something. Which of the following were/are major areas of disagreement between you and your partner:

	Yes	No
Disciplining children?	❍	❍
Managing money?	❍	❍
Your parents?	❍	❍
Your partner's parents?	❍	❍

Alcohol or drugs?	○	○
Infidelities?	○	○
Time spent away from home?	○	○
Sexual matters?	○	○
Other problems?	○	○

	Yes	No
Has a relative of yours died shortly after the death of another person in circumstances that made you suspect that grief might have contributed to their death?	○	○
Has any person close to you, other than your child, died in the last five years?	○	○

If so, how many have died? _____

(If more than one person died, the questions which follow refer to the loss which you found most upsetting.

	Yes	No
Was the death expected for more than a week before it took place?	○	○
Did you blame yourself in any way for what happened?	○	○
Did you blame other people for what happened?	○	○
Was the death caused by murder or manslaughter?	○	○
Was the death caused by suicide?	○	○
Was the person who died your spouse or partner with whom you cared for your child with? If Yes, ignore the rest of the questions on this page and continue to the next page, section IV .	○	○

If No:

	Yes	No
Would you say that your relationship with the person who died was particularly close?	❍	❍
Were you unusually dependent on this person?	❍	❍
Was the person unusually dependent on you (inclined to cling?)	❍	❍
Did you have mixed feelings of affection and anger towards the person who died?	❍	❍
Were there many things on which you disagreed?	❍	❍
Did you find even short periods of separation from this person distressing?	❍	❍

Was this person your:

- ❍ father/mother?
- ❍ brother/sister?
- ❍ uncle/aunt?
- ❍ husband/wife?
- ❍ daughter/son?
- ❍ friend?
- ❍ Other (please specify)

If you selected other, please specify _____

Section IV: About you now.

	Yes	No
Would you say that you are very anxious?	❍	❍
Would you say that you are very depressed or miserable?	❍	❍
Are you very tense or strung up?	❍	❍
Do you lack confidence in yourself?	❍	❍
Do you find it hard to trust other people?	❍	❍

	Trust in yourself	Trust in others	Neither
Of the two, which is the bigger problem:	○	○	○

	Yes	No
Do you take medicines for your nerves?	○	○
If so, do you take more than you should?	○	○
Do you use alcohol to control anxiety or depression?	○	○
If so, do you take more than you should?	○	○
Do you find it hard to cope with your responsibilities?	○	○
Do you sometimes experience feelings of panic or acute fear?	○	○
Are you very lonely?	○	○
Do you sometimes behave in a childish or immature way?	○	○
Are you very shy?	○	○
Do you spend a lot of time pining or longing for someone or something you have lost?	○	○
Do you sometimes rely on others more than you should?	○	○
Do you often wish that someone would look after you?	○	○

If you got to the end of your rope would you:

	Yes	No
seek help from a friend?	○	○
seek help from your family?	○	○
seek help from a doctor?	○	○
seek help from some other person?	○	○

	Yes	No
shut yourself away from people?	○	○
drown your sorrows with alcohol?	○	○
take an overdose or otherwise harm yourself?	○	○
become irritable or bad tempered with others?	○	○
turn your frustration inwards, feeling guilty or self-reproachful?	○	○

	Yes	No
Have you recently got to the end of your rope?	○	○

	Never	Sometimes	Often
How often do you cry?	○	○	○

	Yes	No
Do you wish you could cry more than you do?	○	○
Do you find it hard to show affection for people who are close to you?	○	○
Would you describe yourself as aggressive or challenging?	○	○
Do you find it hard to express feelings of sadness or grief?	○	○
Are you filled with regret about something which you did or said, but cannot now put right?	○	○

Appendix G

Texas Revised Inventory of Grief

Texas Revised Inventory of Grief

Think back to the time this person died and answer all of these items about your feelings and actions at that time by indicating whether each item is Completely True, Mostly True, Both True and False, Mostly False, or Completely False as it applied to you after this person died. Check the best answer.

	Completely True	Mostly True	Both True and Not True	Mostly Not True	Completely Not True
After my child died I found it hard to get along with certain people.	○	○	○	○	○
I found it hard to work well after my child died.	○	○	○	○	○
After my child's death I lost interest in my family, friends, and outside activities.	○	○	○	○	○
I felt a need to do things that my child had wanted to do.	○	○	○	○	○
I was unusually irritable after my child died.	○	○	○	○	○
I couldn't keep up with my normal activities for the first 3 months after my child died.	○	○	○	○	○
I was angry that my child who died left me.	○	○	○	○	○
I found it hard to sleep after my child died.	○	○	○	○	○

Part II: PRESENT FEELINGS

Now answer all of the following items by checking how you presently feel about this person's death. Do not look back at Part I.

	Completely True	Mostly True	Both True and Not True	Mostly Not True	Completely Not True
I still cry when I think of my child who died.	○	○	○	○	○
I still get upset when I think about my child who died.	○	○	○	○	○
I cannot accept my child's death.	○	○	○	○	○

Sometimes I very much miss my child who died.	○	○	○	○	○
Even now it's painful to recall memories of my child who died.	○	○	○	○	○
I am preoccupied with thoughts (often think) about my child who died.	○	○	○	○	○
I hide my tears when I think about my child who died.	○	○	○	○	○
No one will ever take the place in my life of my child who died.	○	○	○	○	○
I can't avoid thinking about the child who died.	○	○	○	○	○
I feel it's unfair that my child died.	○	○	○	○	○
Things and people around me still remind me of my child who died.	○	○	○	○	○
I am unable to accept the death of my child who died.	○	○	○	○	○
At times I still feel the need to cry for my child who died.	○	○	○	○	○

Appendix H

Inventory for Daily Parental Bereavement Life.

Inventory for Daily Parental Bereavement Life.

Below is a list of activities, tasks, or issues that bereaved parents sometimes need to confront or do in their daily lives. For each item, please indicate how much time you have spent on it *during the past week.*

	Rarely or not at all	Once in a while	Fairly often	Almost always
Thinking about how much I miss my child.	❍	❍	❍	❍
Thinking about the circumstances or events associated with my child's death.	❍	❍	❍	❍
Yearning for my child.	❍	❍	❍	❍
Looking at old photographs and other reminders of my child.	❍	❍	❍	❍
Imagining how my child would react to my behavior.	❍	❍	❍	❍
Imagining how my child would react to the way I handled tasks or problems I faced.	❍	❍	❍	❍
Crying or feeling sad about the death of my child.	❍	❍	❍	❍
Being preoccupied with my situation.	❍	❍	❍	❍
Engaging in fond or happy memories about my child.	❍	❍	❍	❍
Feeling a bond with my child.	❍	❍	❍	❍
Feeling lonely.	❍	❍	❍	❍
Visiting or doing things with others.	❍	❍	❍	❍
Finding ways to keep busy or occupied.	❍	❍	❍	❍
Dealing with financial matters.	❍	❍	❍	❍
Engaging in leisure activities (hobbies,	❍	❍	❍	❍

recreation, physical activity etc.)				
Attending to my own health-related needs.	○	○	○	○
Engaging in employment or volunteer work.	○	○	○	○
Watching TV, listening to music, listening to the radio, reading.	○	○	○	○
Attending to legal, insurance or property matters.	○	○	○	○
Attending to the maintenance of my household or automobile.	○	○	○	○
Focusing less on my grief.	○	○	○	○
Learning to do new things.	○	○	○	○

Section 2: During the past week to what extent have you focused your attention on issues related to:

	Very Little				A Great Deal
	1	2	3	4	5
Grief, emotions and feelings regarding your loss?	○	○	○	○	○
New responsibilities, activities and time away from grieving?	○	○	○	○	○
Are you able to freely move back and forth between grief and dealing with other things like new responsibilities and activities when you need to?	○	○	○	○	○

Appendix I

Demographic Information

Demographic Information

Your name _____

Your age: _____

Your gender
- ○ Male
- ○ Female

Are you of Spanish/Hispanic/Latino?

- ○ Yes
- ○ No

Are you French Canadian?

- ○ Yes
- ○ No

Your race (check one)

- ○ African American or Black
- ○ Asian
- ○ Caucasian
- ○ Multi-racial
- ○ Other (please specify)

If you selected other, please specify _____

Your education level (check one)

- ○ Some high school
- ○ High school
- ○ Some college
- ○ College
- ○ Advanced degree

Information on children

Age of your child at diagnosis? _____

What was the gender of your child?

○ Male
○ Female

How old was your child when he/she passed away? _____

What was the date your child passed away? _____

Are you the biological parent of the child that passed away?

○ Yes
○ No

Is this your only child?

○ Yes
○ No

If no, how many other children do you have? _____

Spouse/partner information

Your spouse or partner's name: _____

Your spouse or partner's age: _____

Your spouse or partner's gender

○ Male
○ Female

Is your spouse or partner of Spanish/Hispanic/Latino?

○ Yes
○ No

Is your spouse or partner French Canadian?

○ Yes
○ No

Your spouse or partner's race (check one)

      ❍ African American or Black
      ❍ Asian
      ❍ Caucasian
      ❍ Multi - racial
      ❍ Native American/Canadian

Years married: _____

Years living together: _____

Number of times you have been married including this marriage:_____

Are you still living together?

      ❍ Yes
      ❍ No

If no when did you separate? _____

Your financial circumstances

Combined family income (in 2006) (check one)

      ❍ $10,000 to $25,000
      ❍ $25,001 to $50,000
      ❍ $50,001 to $75,000
      ❍ $75,001 to $150,000
      ❍ $150,001 to $250,000
      ❍ $250,001 to $500,000
      ❍ more than $500,000

Did you have insurance coverage for your child's illness?

      ❍ Yes
      ❍ No

Did the cost of your child's health care cause significant financial hardship to you and your family?

○ Yes
○ No

Professional help

Did you see a therapist or counselor to help you in your grief:

During your child's illness?

○ Yes
○ No

Following your child's death?

○ Yes
○ No

Do you have any comments that you want to share with us regarding your experience as a bereaved parent?

Thank you.

Appendix J

Summary of results request.

CUA

Summary of Results

Do you wish to receive a summary of the results of the study?

○ Yes
○ No

If yes, do you wish to receive it:

by email, please enter your email address.

_____

or by regular mail:

please enter your mailing address.

_____
_____
_____

Appendix K

Reminders to complete survey,
Mail hardcopy and email versions

CUA

THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093

May 27, 2008

John and Jane Doe
100 Street Name
Any City, USA 01010-0101

Dear John and Jane Doe,

Thank you for your interest in participating in the study on couples who have lost a child to cancer. I mailed you a survey on _____ and have not yet received the completed survey back. I am hoping that you are still interested in participating in the study. If you need another copy of the questionnaire please call me at 1-866-299-1023 and I will get one in the mail to you immediately. If you have any questions or concerns please do not hesitate to call me at 1-866-299-1023 or email me at bereavedcouples@cua.edu.

Thank you again for your interest in this study, it is only through the help of bereaved parents like you that we can learn how to best support parents in the future who are dealing with the loss of a child to cancer.

Regards

Philip Domingue M.S.W., R.S.W.
Ph. D. candidate, National Catholic School of Social Service
Adjunct Researcher, Children's Hospital of Eastern Ontario Research Institute
Recipient of a Doctoral Training Grant in Oncology Social Work from the American Cancer Society

Dear John and Jane Doe,

Thank you for your interest in participating in the study on couples who have lost a child to cancer. I emailed you your code to access the online survey on _____ and have not yet received the completed survey back. I am hoping that you are still interested in participating in the study. Just in case you can't easily find the access information – the website address is _____ and your password is _____. If you have any questions or concerns please do not hesitate to call me at 1-866-299-1023 or email me at bereavedcouples@cua.edu.

Thank you again for your interest in this study, it is only through the help of bereaved parents like you that we can learn how to best support parents in the future who are dealing with the loss of a child to cancer.

Regards

Appendix L

Update of study progress to participating community agencies.

The Catholic University of America
National Catholic School of Social Service
Washington, DC 20064
202-319-5458
Fax 202-319-5093

Dear Candlelighters,

I want to update you on the progress of the study of couples who have lost a child to cancer. My research advisor and I have decided to keep the study open probably until September. Thanks to your help we have had 103 volunteers contact me and ask for the survey. Of those there were 46 couples. This is a good response for a survey study of bereaved parents. (For very understandable reasons, they are notoriously difficult to do.)

I am still waiting for some of the pledged parents to return their completed surveys and this is in part why my advisor and I have decided to keep the study open.

In the meantime, if you know of other bereaved parents who have now reached the six month mark please let me know and I will send you new invitations to the study. This would be very helpful as I am presently approaching other support and service agencies in order to increase the numbers of respondents and obtain stronger statistical power.

In April we ran the analysis on 47 surveys and we are quite excited with these preliminary results. I presented the preliminary findings at three conferences in May and these were very well received.

I want to thank you again for your support. There is a need to do such studies if we are to improve both our understanding of bereaved couples and the type of services they require. Your contribution is essential to this process. Please do not hesitate to contact me if you have any further questions. I will continue to inform you of the progress of the study and will be glad to provide you with the details of the study once it is completed.

Regards.

Philip Domingue M.S.W., R.S.W.
Ph. D. candidate, National Catholic School of Social Service
Adjunct Researcher, Children's Hospital of Eastern Ontario Research Institute
Recipient of a Doctoral Training Grant in Oncology Social Work from the American Cancer Society

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