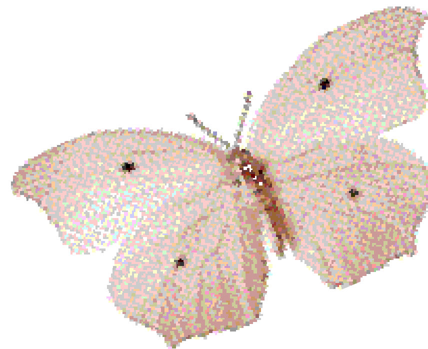
Grief and Trauma Reactions after Losing one's Child

The Efficacy of Support Groups for Parents Bereaved due to Illness or Accident



C.J.C. van der Kraan (0106275)

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Supervised by:

M. Stroebe, PhD	H. Schut, PhD	S. Fleming, PhD
Utrecht University	Utrecht University	York University
The Netherlands	The Netherlands	Canada

The death of a child

The death of a child.
It's something you read about in newspapers;
something that happens to other people.
Not to you, not to your child.

Until early one morning your doorbell rings
and you find two policemen standing there,
asking you to describe what your 18-year-old daughter
was wearing when you last saw her.

Until a specialist tells you that the flu your family doctor
diagnosed in your 8-year-old son is really terminal cancer.
There are six to nine months left, and no hope.

Until a neighbor's child tells you the toddler you left playing
in your carefully fenced backyard is now two blocks away
in the neighborhood wading pool.
Your head knows what your heart refuses to acknowledge:
your child cannot swim.

Children die, quickly, in sudden, impossible accidents
and slowly, bit by bit before your eyes, victims of long and painful illnesses.
Whatever the circumstances, the parents are thrown into a state of shock
that is the gateway to a narrow, tortured corridor of horror without an exit.

Joan Sutton
Bereaved Families of Ontario (BFO)

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Preface

A little girl so bright and shining

Like a butterfly on earth...

She flew away too early

What's left is pain and love for her

Exactly one year ago, I came back in Utrecht after a wonderful time in Toronto. During my stay over there I wrote this little poem for Meike, a girl I used to baby sit, who died due to cancer in December 2002. The butterfly at the front page is a remembrance of her.

I went to Toronto to take over a longitudinal research on bereaved parents. My gratitude for the parents participating in this study is immense. Without their disclosure and continuing participation this project would not have been possible. I am BFO and the Coping Centre grateful to get me in contact with these bereaved parents. Moreover, BFO gave me the opportunity to take part in a volunteer training in which I learnt a lot about bereavement and also about myself. This experience I'll take with me in my professional as well as my personal life.

It was a great honour to work under supervision of Margaret Stroebe, Henk Schut and Stephen Fleming. Their ambition and dedication to their work has been of great inspiration to me. Especially the narratives of Stephen's practice have made me even more enthusiastic to work as a counselor in the bereavement or/and trauma field in the future.

I've been struggling quite a bit while writing this thesis and the support of my family and close friends were of great importance in this ambivalent past year. The encouragement I received per mail, phone and in real life always made me smile even in somewhat darker days. I'm thankful for having such wonderful people around me. And I am very happy to be able to spend more time with them again.

Claartje van der Kraan
December 15, 2008

Abstract

Despite of resilient trajectories displayed by many of the bereaved, traumatic bereavement may result in symptoms of complicated grief (CG) and posttraumatic stress disorder (PTSD) in survivors. Loss of a child is frequently defined as traumatic and bereaved parents have a high risk of poor bereavement outcome. In this study cause of death (i.e. illness, accident) was proposed as an additional risk factor, whereby parents bereaved due to an accident seemed to be at elevated risk for developing CG compared to parents bereaved due to illness, whereas bereaved parents in general seemed to be at risk for developing PTSD.

Identifying bereaved parents as high risk has important clinical implications, since selecting participants by screening for risk level raises the chances of intervention leading to positive results. A quasi-experimental control group design was employed to examine efficacy of mutual support groups for bereaved parents. CG and PTSD symptoms of 58 parents were measured pre-intervention as well as post-intervention, whereby cause of death (i.e. illness, accident) was included as an additional independent variable. However, support groups did not show to have a positive effect on symptoms of CG and PTSD; neither for parents bereaved due to illness nor for parents bereaved due to accident. This might have been due to the small sample size of current study. Furthermore, the limitation of pre-existing groups may have had a considerable influence on the results. More research is needed for definite conclusions about efficacy of support groups for bereaved parents.

Introduction

An extreme event like losing one's child may lead to considerable, mostly lengthy, changes in adjustment and health (Kleber & Brom, 2003). At the same time however, disorders or prolonged consequences are not present in every bereaved parent, and reactions differ greatly depending upon the person and the situation. Every mode of death (e.g., illness or accident) brings with it its own issues and complications. It may be that mode of death is a risk factor for poor bereavement outcome.

The death of a child is frequently defined as traumatic. Prior research has, nonetheless, often failed to measure both grief and trauma reactions among bereaved parents. While it is important to identify bereaved parents as high risk of poor outcome. As Schut, Stroebe, van den Bout and Terheggen (2001) reported, selecting participants by screening for risk level raises the chances of intervention leading to positive results.

To make the research questions and hypotheses of this investigation clear, in this chapter the concepts and the reactions of bereavement and trauma will be introduced first, followed by the concept of traumatic bereavement. Thereafter, mode of death will be reviewed as a risk factor for poor outcome in general and then related to the loss of a child. At last the focus will be on efficacy of intervention, in the form of mutual support groups, for bereaved parents.

Bereavement and Trauma

The objective situation of having lost someone significant is referred to as *bereavement* and the usual reaction to it is termed *grief.* This is a primarily emotional reaction, which incorporates diverse psychological and physical manifestations (Stroebe, Hansson, Stroebe & Schut, 2001). Findings suggest that the loss of a loved one may have an impact on basic assumptions about the self and the world (Schwartzberg & Janoff-Bulman, 1991). Our 'assumptive worlds' (Parkes, 1975), which enable us to set goals, plan activities and order our behavior, are shattered. These assumptions include beliefs concerning the predictability and controllability of the world, that the world is meaningful, that it operates according to principles of fairness, and that one is safe and secure (Janoff-Bulman, 1992). In bereaved individuals, the degree to which global negative beliefs were endorsed, has been found to be highly associated with the severity of symptoms of depression, anxiety and grief (Boelen, Van den Bout & Van den Hout, 2003).

Although the death of someone close is among the most stressful events that people can encounter in life, most people manage to adjust to a loss without suffering severe emotional problems (Bonanno, Wortman & Nesse, 2004). Nonetheless, a minority of bereaved people develop symptoms of *complicated grief* (CG). This is a form of grief marked by elevated and persistent separation distress (e.g., yearning, searching) and traumatic distress (e.g., trouble accepting the death, bitterness) for at least 6 months, to the point of seriously impaired functioning (Prigerson & Maciejewski, 2005). Several factors may influence the way people react to the death of a loved one. These factors may interact in complex ways to produce difficulties and have been categorized in the person (e.g., personality, socio-demographic variables), the interpersonal context (e.g., social support), in coping styles (e.g., appraisal processes), and the bereavement situation (e.g., kinship relationship, mode of death) (Stroebe, Schut and Stroebe, 2007).

If the nature of the bereavement event is drastic, horrendous, or shocking, then it is generally considered to classify as a traumatic event (Stroebe & Schut, 2005). Traumatic experiences force an individual to challenge existing assumptions and to built a new assumptive world if needed. Three aspects characteristic for an individual in traumatic situations are powerlessness, acute disruption of daily life and extreme discomfort (Kleber & Brom, 2003). These three elements are the result of an interaction between the demands of the environment on the one hand and the skills, expectations and characteristics of the individual on the other hand. Some circumstances lead to such discrepancies more readily than do others and one individual more readily experiences an event as traumatic than another (Kleber & Brom, 2003). After a while, most people manage to cope with the trauma, even though the memory does not disappear. Some, however, experience symptoms of *posttraumatic stress disorder* (PTSD). This is an anxiety disorder, marked by re-experiencing, avoidance and hyper-arousal, for more than 1 month, to the point of seriously impaired functioning (APA, 2000).

Bereavement and trauma are distinct phenomena; some bereavements are not traumatic (e.g., a loved one may die peacefully after a long and fulfilling life), and some traumatic events do not entail bereavement (e.g., nobody has died in an armed robbery). Sometimes, however, people may suffer bereavement and trauma simultaneously (e.g., people survive accidents that their loved ones do not, family members are murdered and children die suddenly). This co-occurrence has been termed *traumatic bereavement* and is in the literature mainly defined in objective terms as ‘a sudden and violent mode of death’ that is characterized by suicide, homicide, or a fatal accident (Currier, Holland, & Neimeyer, 2006).

Also untimely deaths as of a child or a young spouse are often defined as traumatic bereavement (Stroebe et al., 2001).

In sum, despite of the resilient trajectories displayed by many of the bereaved (Bonanno et al., 2004), traumatic bereavement may result in symptoms of CG and PTSD in survivors.

Mode of death

This study will focus on mode of death as a risk factor for developing CG and PTSD in survivors. Aspects related to the mode of death that have been associated with poorer outcomes include unexpectedness, suddenness, violent or stigmatized deaths (e.g., homicide, suicide, or AIDS), untimely deaths (e.g., death of a child) and instances involving multiple losses (Green, 2000). These aspects of the death are also those that are associated with traumatic bereavement (e.g., Currier et al., 2006; Stroebe et al., 2001).

Several studies have examined the effects of two common modes of death (i.e. illness and accident) as risk factors for developing CG and PTSD. Studies which compared spouses bereaved by illness and by traffic accident, found that the group of bereaved after accident developed the most serious and long-lasting grief reactions (Grad & Zavasnik, 1998; Middleton, Raphael, Burnett & Martinek, 1998). Moreover, Middleton et al. (1998) has shown that groups where the death was not expected, had significantly higher grief scores than groups where the loss was expected. A loss due to accident is always considered to be unexpected, whereas a loss due to a more natural cause may be expected (e.g. terminal illness) as well as unexpected (e.g. heart attack). However, results of a study of Currier et al. (2006) revealed that the element of suddenness was not crucial in developing symptoms of CG. The participants in the sample who lost loved ones to sudden, violent causes indicated greater difficulties on grief outcomes than participants bereaved by sudden natural causes.

Consistent with these findings, bereaved participants who had lost a spouse due to violent deaths were found to have significantly more PTSD symptoms than bereaved participants who had lost a spouse due to natural causes. Among the natural death cohort, there were no significant differences in terms of the number of symptoms between bereaved individuals who had sudden losses and those who had losses with a longer terminal interval (Kaltman & Bonanno, 2003; Zisook, Chentsova-Dutton and Shuchter, 1998). Moreover, a study of conjugal loss, in which most of the bereaved lost their spouse following an illness, found that those who said they anticipated the loss were less likely to experience PTSD symptoms than those who said they did not expect the loss to occur. A more objective

measure of forewarning, the length of the final illness, was not found to be related to PTSD symptoms (Schut, De Keijser, Van den Bout & Dijkhuis, 1991). Therefore the violence and unexpectedness of a death seems to be a risk factor for poor bereavement outcome and not the suddenness of a loss.

Despite the general consensus that bereavement following violent death holds significant risk for CG and PTSD, the mechanisms underlying this associations have only been investigated recently. In a study of Currier et al. (2006) a sample of recently bereaved college students completed the Inventory of Complicated Grief (ICG) and questions assessing the degree of sense-making and the circumstances surrounding their losses. The findings of this investigation provides initial support for a model of grief in which failure to find meaning in a loss is conceptualized as a mediator of violent deaths and symptoms of CG. It may be argued that the failure to find meaning may also result in symptoms of PTSD. Such an explanation is consistent with models of bereavement and trauma which propose that the loss of a loved one may shatter one's assumptive worlds (Janoff- Bulman, 1992; Kauffman, 2002), whereby people strive to reconcile these old belief systems with new information through a search for meaning (Kleber & Brom, 2003). In line with this notion Davis, Wortman, Lehman and Cohen-Silver (2000) suggested that one of the most important determinants of whether a search for meaning will be initiated concerns whether the event can be reconciled with one's assumptions about the world.

In sum, it is proposed that violent and unexpected deaths are most likely to shatter people's basic assumptions and therefore may lead to a search for meaning in the loss whereby a failure to find one may result in symptoms of CG or/and PTSD.

Loss of a child

Besides when death is violent or unexpected, also untimely deaths are a risk factor for poor bereavement outcome. Bereaved parents show more intense bereavement responses than bereaved spouses (Middleton et al., 1998). Moreover, parents who lost an adult child to a terminal illness were less likely to be able to make sense of the loss than were adult respondents who lost a sibling, a spouse, or a parent to this same cause of death (Nolen-Hoeksema & Larson, 1999). The 'unnaturalness' of a child's death constitutes a major violation of the parent's assumptive world, in that it challenges the pre-existing expectation that parents will die before their children, at least in the western world (Rubin & Malkinson, 2001). The more reconstruction and modification required of the parent, the more complicated

the grieving process becomes (Matthews & Marwit, 2003). Therefore, a violent death of a child may be an additional risk factor of poor bereavement outcome in bereaved parents.

Table 1 presents an overview of empirical studies of the last decade, to date on mode of death of a child as a risk factor for developing CG and PTSD in bereaved parents. Most studies shown, have only measured one of these outcomes, with the exceptions of Murphy et al. (1999) and Dyregrov, Nordanger and Dyregrov (2003).

As shown in Table 1 parents who lost their child due to a violent death had more grief symptoms than those who lost their child due to a more natural cause (Dyregrov et al., 2003; Wijngaards-de Meij et al., 2005). Moreover, different studies indicate that more negative world views predict higher levels of reported grief (Matthews & Marwit, 2003; Wickie & Marwit, 2001).

Furthermore, parents bereaved due to accident experienced more symptoms of PTSD than parents bereaved due to a more natural cause (Dyregrov et al., 2003). Murphy and colleagues have examined the prevalence of PTSD among parents bereaved by violent deaths. Longitudinal studies as shown in Table 1 have demonstrated that, compared to women and men in the general population, significantly more mothers and fathers meet the criteria for PTSD immediately following the loss of a child (Murphy et al., 1999), and five years later as well (Murphy, Johnson & Lohan, 2002). Reported levels of PTSD differed among parents whose children died by suicide, homicide, and accident (Murphy et al., 1999; Murphy, Johnson, Chung & Beaton, 2003; Murphy, Johnson, Wu, Fan, & Lohan, 2003).

In sum, bereaved parents have a high risk of poor bereavement outcome and mode of death is proposed as an additional risk factor, whereby death of a child due to a violent cause is a higher risk factor for developing CG and PSTD than death due to a more natural cause.

Table 1. Empirical studies on mode of death of a child as a risk factor for parents' poor bereavement outcome.

Author	Research question	Details (N, age, measures)	Findings	Limitations
Dyregrov, Nordanger & Dyregrov (2003)	Examining differences and possible predictors of psychosocial distress for parents bereaved by suicide, accident and Sudden Infant Death Syndrome (SIDS).	- N = 232 - Deceased children < 30 years - Impact of Event Scale (IES) and ICG	- No significant differences between suicide and accident. - 57% of SIDS sample CG symptoms. - 78% of suicide and accident samples CG symptoms. - 34% of SIDS sample PTSD symptoms - 52% of suicide and accident samples PTSD symptoms	- Parents within couple used as individual cases in analysis. - Differences in mean age of parents and deceased in samples. - Only SIDS sample had survivor organization. Effect of support is not controlled for.
Matthews & Marwit (2003)	Examining assumptive world views and grief symptoms of parents bereaved by homicide, accident and illness.	- N = 135 - Deceased children < 26 years - World Assumptions Scale (WAS) and Revised Grief Experience Inventory (RGEI)	- Parents bereaved by homicides and accidents most negative on benevolence of world. - Illness survivors higher sense of self-worth and most negative on meaningfulness of the world. - Negative world views predict higher levels of grief.	- PTSD symptoms not measured. - Information regarding support group attendance was not collected until late in study.
Murphy, Braun, Tillery, Cain, Johnson & Beaton (1999)	Examining prevalence PTSD among parents bereaved by homicide, suicide and accident.	- N = 261 - Deceased children 12-28 years - Traumatic Experiences Scale (TES) and Grief Experiences Scale (GES)	- Parents' gender and child's cause of death predict PTSD. - Twice as many parents bereaved by homicide met PTSD. - Parents with PTSD higher rates of mental distress, i.e., more intense grief responses. - Two years post death 21% of mothers and 14% of fathers still PTSD.	- Only focused on violent deaths. - Only focused on deaths of adolescents and young adults.
Murphy, Johnson, Chung & Beaton (2003)	Examining how the initial level of PTSD and the rate of change over time are influenced by 9 predictors among parents bereaved by homicide, suicide and accident.	- N = 173 - Deceased children 12-28 years - Brief Symptom Inventory (BSI) and TES	- At baseline, cause of death, parents' gender, concurrent mental distress, repressive and affective coping, and intervention provided in early bereavement period significant predictors of PTSD. - Parents' gender and perceived social support predicted change in PTSD over a 5-year time frame.	- Only focused on violent deaths. - Only focused on deaths of adolescents and young adults. - Small sample size of parents bereaved by homicide (n=17). - No use of grief-specific measures.
Murphy, Johnson & Lohan (2002)	Examining mental distress and PTSD among parents bereaved by accident, suicide, or homicide 5 years post death.	- N = 173 - Deceased children 12-28 years - BSI and TES	- 61% of mothers and 62% of fathers met diagnostic criteria for mental distress 5 years post death. - 28% of mothers and 13% of fathers PTSD 5 years post death.	- Only focused on violent deaths. - Only focused on deaths of adolescents and young adults. - Small sample size of parents bereaved by homicide (n=17). - No use of grief-specific measures.
Murphy, Johnson, Wu, Fan & Lohan (2003)	Examining parents' outcomes 4 to 60 months following their children's deaths by accident, suicide, or homicide.	- N = 173 - Deceased children 12-28 years - BSI and TES	- Bereaved parents due to violent deaths can be expected to experience mental distress and PTSD. - Homicide significantly influenced parents' greater reports of PTSD symptoms. - Time had a significant effect on parent's distress and trauma symptoms.	- Only focused on violent deaths. - Only focused on deaths of adolescents and young adults. - Small sample size of parents bereaved by homicide (n=17). - No use of grief-specific measures.

Wickie & Marwit (2001)	Examining impact of murder and fatal accident of child on assumptive world views and grief symptoms of bereaved parents.	- N = 70 - Deceased children < 26 years - WAS and RGEI	- Worthiness of self less affected by trauma than benevolence and meaningfulness of the world. - Assumptive world views predictive of grief intensity.	- Only focused on violent deaths. - Small accident sample (*N* = 12) - PTSD symptoms not measured.
Wijngaards-de Meij, Stroebe, Schut, Stroebe, van den Bout & Dijkstra (2005)	Examining relative impact of major variables for predicting adjustment (depression and grief) among bereaved parents.	- N = 219 couples - Deceased children < 30 years - ICG and depression subscale of Symptom Checklist–90 (SCL-90)	- Grief predicted mainly by age child, cause and unexpectedness of death, and number of remaining children. - Depression predicted by gender, religious affiliation, professional help seeking and number of remaining children. .	- Parents bereaved by accident, SIDS, suicide and homicide in one sample. - PTSD symptoms not measured. - Only focused on couples, hard to generalize results to single parents.

Bereavement interventions

Selecting participants by screening for risk level raises the chances of intervention leading to positive results (Schut et al., 2001). The main functions of bereavement interventions are helping the bereaved to reframe or reinterpret the meaning of their loss experience, encouraging emotional disclosure, and offering social support (Raphael & Nunn, 1988).

Schut et al. (2001) conducted a review of the bereavement literature separating interventions into three groups, namely primary preventive interventions offered to all bereaved individuals (to prevent grief-related complications), secondary preventive interventions that target individuals at higher risk for bereavement-related complications, and tertiary preventive interventions aimed at individuals who suffered from complicated grief. Schut et al. (2001) concluded that primary preventive interventions have not proved effective for individuals who were referred to counseling (outreaching) for no other reason than that they had suffered bereavement. However, this may not apply to bereaved individuals who themselves feel a need for help and take the initiative to join intervention programs (in-reaching). Findings regarding secondary preventive interventions were somewhat more positive. Bereaved individuals who were at high risk for developing bereavement-related problems tended to show better results for the interventions. Tertiary interventions which focused on bereaved individuals who had already developed complicated grief were most effective. Yet, individuals participating in these interventions tend to be looking for an intervention rather than accepting an intervention by agreeing to participate in a study (Schut et al., 2001).

In summary, not only is intervention likely to be more effective for high risk groups, but it is most likely to be helpful specifically for those who actually in-reach.

Support groups for bereaved parents

Bereaved parents have a high risk of poor bereavement outcome and therefore interventions for bereaved parents could be considered to be secondary preventive interventions. Though, child loss may be too massive a bereavement for intervention to be effective. There may be a need to differentiate within the category of bereaved parents and make more fine-grained comparisons (Murphy et al., 1998). Mode of death is in this study proposed as an additional risk factor, whereby death of a child due to a violent cause is a higher risk factor for developing CG and PSTD than death due to a more natural cause.

This study will examine efficacy of intervention, in the form of mutual support groups, for bereaved parents. A mutual support group is defined as a group of people sharing a similar

problem, who meet regularly to exchange information and to give and receive psychological support (Levy, 2000). Groups are led particularly by voluntary leaders who have had their own experiences of loss, rather than by professionals (Pistrang, Barker & Humphreys, 2008). The assumption underlying the wide use of bereavement support groups appears to be that attending such groups may have a positive outcome for the person suffering loss. Qualitative studies often describe benefits that members experience in terms of identity, life narrative reconstruction, spiritual development, and sense of feeling cared about (Pistrang et al., 2008). However, self-perceived benefits by the participants themselves are subjective evaluations being subject to many biases. They are not designed to yield evidence about causal relationships between group involvement and reduction of symptoms.

In order to study how effective mutual support groups are and to demonstrate that an evidence base exists, it is important to use quantitative measurements (Pistrang et al., 2008). Evidence-based practice is the use of interventions for which there is sufficiently persuasive evidence to support their effectiveness in attaining the desired outcomes (Rosen, Proctor, & Staudt, 2003). Although research has been conducted with mutual support groups, many studies that are frequently cited in the literature as providing evidence for the effectiveness of mutual support have not fulfilled criteria concerning either quantitative outcome measures, or research design (Pistrang et al., 2008). Concerning design it is important to include non-intervention control persons for comparison with respect to the course of adjustment (Schut et al., 2001). One study fulfilled the above criteria to examine effectiveness of support groups for bereaved parents. Murphy et al. (1998) studied the efficacy of a 10-week mutual support group on parents who had recently lost a child to homicide, suicide, or accident. Identified as a high-risk group, these parents were randomly assigned to a support group or a no-treatment control. For grief symptoms and PTSD there was a significant interaction between treatment and baseline values for mothers both immediately post treatment and 6 months later. Of note was the trend that mothers starting the intervention with high amounts of grief symptoms and high levels of distress improved more in the intervention group than in the control group. Conversely, those experiencing relative low levels of grief were worse off in the intervention than those in the control group, suggesting that for those with normal grieving, intervention may in fact be negative. Furthermore, fathers did not appear to benefit from the intervention at all. To investigate these unexpected results for fathers, further research is needed since the fathers sample size in this study was too small.

Given that parents bereaved due to a violent death are at high risk, broader effects of intervention would have been expected. It seems likely that the failure of the parental

bereavement support group to show more effects is, due to an outreaching mode. As noted previously, those bereaved who take the initiative themselves to ask to participate in intervention are likely to be the ones to benefit from it. They may be better motivated and are likely to have suffered more distress, leaving more room for improvement (Schut et al., 2001). Therefore the current study will only select bereaved parents who in-reach.

In sum, some bereaved parents not only do not benefit from treatment but in fact experience increased distress. However, there is evidence that when individuals are suffering CG and/or PTSD and/or seek assistance for distress, support groups can be effective. This is specifically proposed for bereaved parents experiencing a violent death of their child.

Current study

In bereavement studies a wide variety of losses are often considered together under the term ‘violent death’. It may be argued that bereavement due to accident, suicide, and homicide are qualitatively distinct and should not be grouped together. Prior research has tried to identify risk factors for bereaved parents, but none has focused on two major causes of child’s death, illness and accident, as distinctive groups (i.e. taking accidents a separate subgroup and excluding other violent causes of death). Furthermore previous research often failed to measure both grief and trauma reactions among bereaved parents. Therefore, in this study parents bereaved due to illness and accident, will be compared on symptoms of CG and of PTSD. It is hypothesized that loss of a child due to accident is a greater risk factor for developing these disorders than loss of a child due to illness. This is in line with the evidence from previous studies reviewed above.

Identifying subgroups of bereaved parents as high risk of poor outcome has important clinical implications. As Schut at al. (2001) reported, selecting participants by screening for risk level raises the chances of intervention leading to positive results. It is therefore hypothesized that intervention will have more efficacy for parents bereaved due to an accidental death of their child compared to parents bereaved due to illness.

Method

A quasi-experimental control group design was employed to examine efficacy of mutual support groups for bereaved parents. CG and PTSD symptoms were measured pre-intervention as well as post-intervention, whereby cause of death (i.e. illness, accident) was included as an additional independent variable.

Respondents

The sample was composed of a total of 84 bereaved parents. Respondents were primarily female (66 %), Caucasian (81 %), and ranged in age from 32 to 70 years (M= 50.2, SD= 9.5). The age of the deceased children ranged from 11 days to 42 years (M= 20.2, SD= 10.3). The sample consisted of parents who had participated in a mutual support group (n=55) and a control group who had not (n=29). Among the mutual support group respondents 27 had lost their child due to a terminal illness and 28 due to an accidental death. In the control group 14 parents were bereaved by terminal illness and 15 by accident.

There were 12 couples among the parents in the sample. The remainder of the parents were either single or participated without their partners. Because of the small sample size, it was not possible to separate the couples from single parents or couples from only one parent in the study analyses. This may confound the results, therefore results were interpreted in the light of this limitation (see discussion).

Recruitment

Respondents were recruited for this study from May 2004 until October 2007. Experimental group participants were recruited through the bereavement organisations Caring for Other People In Grief Centre (Coping Centre) and Bereaved Families of Ontario (BFO). These organisations provide mutual support groups for bereaved parents, who enrolled in these groups on their own initiative (in-reaching). The support groups were similar to each other in number and length (10 meetings of 2 hours, once a week), the content of the meetings and the composition of the groups (parents bereaved by various causes of death in one group). In addition, all facilitators were bereaved parents themselves, trained to facilitate a group. It needs to be emphasized that the research trajectory and the interventions trajectory are completely separate and that any decision of the parent regarding participation in the research project will have no effect on the help being offered by the Coping Centre and BFO.

The control group participants were recruited either via a newspaper advertisement, through a radio interview with one of the involved researchers, or they were informed and

recruited at a conference of Mothers Against Drunk Driving. It was stipulated that, in order to participate, the person should at the time of the study not be involved in a mutual support group.

The non-response rate was high in both groups. The reasons for non-response were not investigated, but most likely the heaviness of the loss of a child plays a role here.

Exclusion criteria for this study were neonatal death or stillborn and loss of a child by suicide or homicide. Parents who lost more than one child were also excluded from this study, given that they are likely to experience additional difficulties. Furthermore, outliers in the data regarding time since loss were removed, in order to increase the homogeneity of the data. This means that 3 control group participants were excluded.

Drop outs

Parents who did not fill out the post-intervention questionnaire were treated as drop outs. From the experimental group 19 parents (35%) dropped out, of whom 13 were bereaved by illness and 6 by accident. From the control group 7 parents (21%) dropped out, of whom 1 was bereaved by illness and 6 by accident. No significant differences between drop outs and continuing participants were found. The reasons for not sending back the questionnaire were not known.

Differences in groups characteristics

See Table 2 for gender and age of the parents, age of the deceased child and time since loss per group. For statistical comparison of group differences in age of the parents, age of the deceased child and time since loss per group, a two-way ANOVA with factors Intervention (experimental, control) and Cause of death (illness, accident) was performed. Significant interactions were followed-up by independent samples t-tests comparing groups within each level of the other factor. Significant differences are indicated by superscripts.

No significant differences occurred in age of the parents, all $F\text{s}(1,54) < 4.0$, all $p\text{s} > .05$. However, significant differences were found in age of the deceased child, as the Intervention x Cause of death interaction was significant, $F(1,54) = 7.6$, $p = .008$. As can be seen in Table 2, the age of the deceased child due to illness in the control group was lower than in the other groups. Furthermore, time since loss was significantly higher in the control than in the experimental group, $F(1,54) = 39.8$, $p < .001$. Pre-existing group differences may confound the results, therefore these variables are taken into account as potential covariates in the analyses.

Table 2: Statistical comparison of groups characteristics.

	Experimental group		**Control group**	
	Illness	Accident	Illness	Accident
Gender parent				
(women/men)	11/ 3	13 / 9	8 / 5	6 / 3
Age parent				
(M, SD in years)	53.4, 8.9	49.1, 9.0	46.8, 11.5	52.7, 7.3
Age child				
(M, SD in years)	23.6^{a}, 10.6	20.5, 8.0	12.9^{ab}, 12.2	24.6^{b}, 7.6
Time since loss				
(M, SD in months)	9.7^{a}, 6.5	10.7^{b}, 6.7	41.5^{a}, 30.1	42.7^{b}, 26.9

Note. a, b = significantly different, all ps < .05

Procedure

Experimental group

Bereaved parents of support groups were introduced to the research during the first support group meeting. Parents who were willing to consider participation were provided with a package including an introduction letter, an informed consent form and a pre-intervention questionnaire (Appendix A) which was supposed to be filled out before the third group meeting. It was stated that participation was completely voluntary and that participants had the right to withdraw from the study at any time. On the basis of thorough information about anonymity and confidentiality, the parents who were willing to participate gave written consent.

Ten weeks later, after conclusion of the support group, each participant was mailed a post-intervention questionnaire and a pre-stamped return envelope. If the questionnaire was not returned within one month, a letter was sent to remind the participant politely of the questionnaire.

Control group

Bereaved parents who were not involved in a support group were mailed an introduction package when they showed interest in participating. This package included as well an introduction letter, an informed consent form, and a pre-intervention questionnaire. Apart from the difference in recruitment, the procedure for the control group was similar to the

experimental group; the same time schedule was followed and similar measures were given. Questions regarding the intervention were excluded for the control group. It was stated that participation was completely voluntary and that participants had the right to withdraw from the study at any time. On the basis of thorough information about anonymity and confidentiality, the parents who were willing to participate gave written consent.

Measures

Participants filled out several questionnaires in each of the two sets. Only the instruments which are needed for the current research are described below.

Personal history and background

Socio-demographic data about the parents and the deceased child were gathered, such as gender and age. Obtained information included also date of loss, cause of death, whether the death was expected/unexpected and additional life stressors in addition to the child's death. Furthermore, respondents were asked about current attendance of support groups and current consultation of other professional help (e.g. psychiatrist, psychologist, social worker, etc.). Unfortunately, information regarding consulted intervention in the past was not collected until late in the study, leaving insufficient information to control for the effects of these interventions.

Inventory of Complicated Grief- revised (ICG- R)

Grief symptoms were measured with the ICG-R along the dimensions of separation distress and traumatic distress (Prigerson, Kasl & Jacobs, 1997). Respondents rate the frequency with which they experience each item on a 5-point scale, ranging from 'never' to 'always'. Prigerson et al. (1995) developed the Inventory of Complicated Grief (ICG) to measure maladaptive symptoms of loss and predict complicated grief and long-term dysfunction. To identify symptoms distinct from bereavement-related depression, it measures preoccupation with thoughts of the deceased, searching and yearning for the deceased, disbelief about the death, crying, being stunned by the death, and not accepting the death. In the ICG-R items were added to come to a total of 30 items, which describe an emotional, cognitive, or behavioural state associated with grief (see 'Feelings about the loss' in Appendix A). Internal consistency, measured pre-intervention, of the subscales 'separation distress' (Cronbach's alpha = .74) and 'traumatic distress' (Cronbach's alpha = .88) were good. Furthermore, good

internal consistency (Cronbach's alpha = .92) and divergent validity were found for the total scale (Prigerson et al., 1997).

Impact of Event Scale – Revised (IES-R)

PTSD symptoms were measured using the IES-R (Weiss & Marmar, 1997). Respondents rated how much they were distressed or bothered by each item on a 5-point scale, ranging from 'Not at all' to 'Extremely'. The stressor was eliminated from the questions, as the precipitating event was designated a priori as the death of the child. The subscales 'intrusion', 'avoidance' and 'hyper arousal' of the IES-R parallel the DSM-IV (APA, 2000) criteria for PTSD. Intrusion (8 items) is characterized by unbidden thoughts, images, dreams and strong emotional reactions. Avoidance (8 items) involves denial of the meanings and consequences of the event, and the blunting or numbness of emotions and sensations. And hyper arousal (6 items) includes anger and irritability, heightened startle response, difficulty concentrating and hyper-vigilance (see 'Stressful events' in Appendix A). The internal consistency of the subscales, measured pre-intervention, was good; Cronbach's alpha for 'intrusion' was .88, for 'avoidance' .73 and for 'hyper arousal' .83. Cronbach's alpha for the total scale concerning the current sample was .89.

Analyses

The data were analyzed in two ways. First, a one-way between groups multivariate analysis of variance (MANOVA) was performed to examine the effect of cause of death on CG and PTSD symptoms. The advantage of using MANOVA is that it 'controls' or adjust for an increased risk of a Type 1 error. This error occurs when it is accepted that there is a difference between groups, although in fact there is no difference (Pallant, 2007). Two dependent variables were used, respectively the pre-intervention ICG-R and the pre-intervention IES-R. The independent variable was Cause of death (illness, accident).

Second, a two-way between groups multivariate analysis of covariance (MANCOVA) was employed to evaluate the effects of the intervention program on CG and PTSD symptoms of the groups bereaved by illness and by accident. The choice of this analysis was based on an essential confound in the data set. That is, pre-existing group differences in age of child, time since loss, and pre-intervention scores were found. Time since loss and pre-intervention scores correlated significantly with the dependent variables and were therefore included as covariates.

Results

CG and PTSD symptoms following loss of a child

To investigate whether loss of a child due to accident is a greater risk factor for developing CG and PTSD than loss of a child due to illness, the symptoms of parents bereaved due to illness and accident, were compared. A one-way between groups MANOVA was performed to examine the effect of cause of death on CG and PTSD symptoms. Two dependent variables were used, respectively the pre-intervention ICG-R and the pre-intervention IES-R sum scores. The independent variable was cause of death, divided into illness and accident.

Preliminary assumption testing was conducted to check for sample size, normality, outliers, linearity, and multicollinearity, with no serious violations noted. Also the assumption of equality of covariance matrices was not violated (Box's Test $F(3,1589782) = .14$, $p = .94$).

There was a significant difference between the illness and accident group on the combined dependent variables, $F(2, 55) = 3.82$, $p = .03$; Wilks' Lambda = .89; partial eta squared = .12, which represents that 12 percent of the variance in perceived CG and PTSD symptoms scores can be explained by cause of death. This indicates that the cause of death of a child had some effect in developing CG and PTSD in bereaved parents.

To investigate if the illness and accident group differ on CG as well as PTSD symptoms, the univariate ANOVAs were inspected for the questionnaires separately. A significant difference between the illness and accident group was found on the ICG- R ($F(1,56) = 7.5$, $p < .01$). To find out which group had higher scores an inspection of the mean scores is performed. The accident group had a higher ICG-R sum score (M = 96, SD = 18) than the illness group (M = 83, SD = 19). Thus, parents bereaved due to accident experienced significant higher levels of CG symptoms compared with parents bereaved due to illness.

No significant differences between the illness and accident group were found on the IES-R sum score ($F(1,56) < 1$, *ns*). Thus, parents bereaved by illness and accident showed similar levels of PTSD symptoms (illness: M = 30, SD = 15, accident: M = 36, SD = 15).

In conclusion, the hypothesis that loss of a child due to accident is a greater risk factor for developing CG than loss of a child due to illness was confirmed, whereas the hypothesis that loss of a child due to accident is a greater risk factor for developing PTSD than loss of a child due to illness was not confirmed.

Efficacy of support groups for bereaved parents

To examine whether support groups have a positive effect on CG and PTSD and to establish which subgroups of bereaved parents benefit most, symptoms of parents bereaved by illness and by accident were measured pre- and post-intervention (see Table 3 and Table 4). These outcomes were compared with a non intervention group to control for natural changes in CG and PTSD over time. A two-way MANCOVA was conducted to deal with the significant pre-existing differences, such as pre-intervention scores and time since loss, of the intervention and the control group. The independent variables were Cause of death (illness, accident) and Intervention (support group, control group). The dependent variables were sum scores of the ICG-R and the IES-R, measured following completion of the support group. Time since loss, and pre-intervention scores were thereby included as covariates, because these variables correlated significantly with the dependent variables. Time since loss was moderately correlated with the post-intervention sum scores of the ICG-R (r = -.34) and the IES-R (r = -.32), indicating that the more time since loss had passed, the less symptoms the bereaved parent experienced. Strong correlations were also found for pre-intervention and post-intervention sum scores on the ICG-R (r = .82) and the IES-R (r = .79), indicating that the more symptoms were experienced pre-intervention, the more symptoms were experienced post-intervention. The covariates were not too strongly correlated with one another ($r < .72$).

Data conformed to the assumptions of normality, linearity, multicollinearity, homogeneity of regression slopes, and reliable measurement of the covariates. Also the assumption of equality of covariance matrices was not violated (Box's Test $F(9,10671) = 1.4$, $p = .21$). Therefore, no objections were found to conduct the MANCOVA.

None of the MANCOVA effects; Intervention ($F(2,50) = 1.3$, $p = .27$), Cause of death ($F(2,50) = .03$, $p = .97$), and interaction of Intervention and Cause of death ($F(2,50) = .24$, $p = .79$), were significant. The non-significant main effect of Intervention indicates that after controlling for the effect of time since bereavement and the pre-intervention scores, the parents who did or did not attend a support group did not differ in their post-intervention levels of CG and PTSD symptoms. Likewise, the non-significant main effect of Cause of death indicates that after controlling for the effect of time since bereavement and the pre-intervention scores, the parents bereaved by illness and by accident did not differ in their post-intervention levels of CG and PTSD symptoms. The non-significant interaction between Intervention and Cause of death, showed that after controlling for the effect of time since bereavement and the pre-intervention scores, the intervention and control group did not differ in their post-intervention levels of CG and PTSD symptoms of parents bereaved by illness

and by accident. In other words, the support group did not have a significant positive effect; not for parents bereaved due to illness nor for parents bereaved due to accident. The hypothesis that intervention will have more efficacy for parents bereaved due to an accidental death of their child compared to parents bereaved due to illness was therefore not confirmed.

Table 3: Pre- and post-intervention ICG-R sum scores of bereaved parents.

Intervention	**Cause of death**	**Pre-intervention (M, SD)**	**Post-intervention (M, SD)**	**N**
Support group	**Illness**	87, 16	84, 23	14
	Accident	99, 15	94, 13	22
Control	**Illness**	79, 21	78, 19	13
	Accident	89, 22	88, 23	9

Table 4: Pre- and post-intervention IES-R sum scores of bereaved parents.

Intervention	**Cause of death**	**Pre-intervention (M, SD)**	**Post-intervention (M, SD)**	**N**
Support group	**Illness**	35, 14	33, 14	14
	Accident	37, 13	35, 12	22
Control	**Illness**	25, 15	22, 13	13
	Accident	33, 20	31, 20	9

Note: Scores of 33 or greater indicate clinical PTSD (Weiss & Marmar, 1997). In this sample 24 of the 58 participants (41%) scored above this cutoff score pre-intervention as well as post-intervention.

Discussion

The aim of this study was two-fold. First, this study examined if cause of death of a child (i.e. illness, accident) is an additional risk factor for parents to develop symptoms of CG and PTSD. It was hypothesized that death of a child due to an accident is a higher risk factor for developing these symptoms than death due to illness. This section will start with a focus on data of this research question and implications of these findings.

Second, this study examined efficacy of mutual support groups on parents bereaved by illness and by accident. It was hypothesized that intervention will have more efficacy for parents bereaved due to an accident compared to parents bereaved due to illness. The data and implications of these findings will be discussed in the latter part of this section. Followed by limitations of current study and suggestions for future studies.

CG and PTSD symptoms following loss of a child

The unnaturalness of losing one's child constitutes a major violation of the parent's assumptive world, in that it challenges the pre-existing expectation that parents will die before their children, at least in the western world (Rubin & Malkinson, 2001). It is suggested that unexpected and violent deaths are most likely to shatter people's basic assumptions and therefore lead to a search for meaning in the loss whereby a failure to find one may result in symptoms of CG (Currier et al., 2006). Findings of current study seem to confirm this theory: Parents bereaved due to accident experienced higher levels of CG symptoms compared with parents bereaved due to illness. This is in line with previous research in which parents who lost their child due to a violent death had more grief symptoms than those who lost their child due to a more natural cause (Dyregrov et al., 2003; Wijngaards-de Meij et al., 2005). As Matthews and Marwit (2003) suggested, the more reconstruction and modification required of the parent, the more complicated the grieving process becomes. Unfortunately due to lack of a cut-off score of the ICG-R, it is not known how many parents in current study experienced such high levels of grief symptoms that risk of CG is indicated.

Contrary to the hypothesis, parents bereaved by illness and by accident showed similar levels of PTSD symptoms. This is in contrast with the study of Dyregrov et al. (2003) which found that parents bereaved due to accident experienced more symptoms of PTSD than parents bereaved due to a more natural cause (SIDS). However, only the SIDS sample had a survivor organization and the effect of support was not controlled for. It might be that the SIDS sample had less PTSD symptoms due to positive effects of support of this organization.

This limitation may explain the inconsistency with findings of current study. No difference in level of PTSD symptoms following different causes of child death may be explained due to the 'unnaturalness' of any child's death. In other words, regardless of the cause of death, losing one's child can be seen as a traumatic event. A close look at the current data set seems to support this notion, 41% of the participants had such high levels of PTSD symptoms that risk of clinical PTSD is indicated.

In sum, parents bereaved due to an accident seem to be at elevated risk for developing CG compared to parents bereaved due to illness, whereas cause of death did not seem to have an effect on PTSD. Considering the high levels of PTSD symptoms of parents in current study, bereaved parents in general seem to be at risk for developing PTSD. The reason why this does not seem to apply for CG is discussed in more detail below.

Implications

These findings seem to implicate that cause of death is only a risk factor for bereaved parents in developing CG and not in PTSD. As noted above, parents bereaved due to an accident seem to be at elevated risk for developing CG compared to parents bereaved due to illness, whereas cause of death did not seem to have an effect on PTSD. Moreover, these findings confirm that CG and PTSD are two distinct disorders (Boelen, Van den Bout, & De Keijser, 2003). Conclusions about bereavement outcome based on data measured by only grief-specific or only trauma-specific scales should therefore be interpreted with caution.

Findings of previous studies support the assumption that a search for meaning is common and essential for parents bereaved due to different modes of death (Matthews & Marwit, 2003; Murphy, Johnson & Lohan, 2003; Wickie & Marwit, 2001). The failure to find meaning may result in symptoms of CG and PTSD. However, this cannot explain why death due to accident is an additional risk factor for parents in developing CG and not in developing PTSD. It might be that the search for meaning is oriented differently in the development of these disorders. In spite of the complexity of the concept of search for meaning, two major components can be identified; trying to understand and make sense of the death (Wheeler, 2001).

To understand the death of a loved one, bereaved individuals seek out information about the sequence of events leading up to the loss. One of the possible explanations is that parents bereaved due to illness may understand the death of their child better, whereas parents bereaved due to an accident, see the death of their child as a fate, to which there is no rational explanation (Wheeler, 2001). Moreover, parents bereaved due to illness may comfort

themselves that the deceased child is better off now. The child might have been suffering for a long time and there seemed to be no other way out but the death (Grad & Zavasnik, 1998). Considering the results of this study, failure to understand the child's death may more likely result in symptoms of CG than in symptoms of PTSD.

To make sense of a child's death is more difficult and is hard for any bereaved parent. It involves philosophical and/or religious beliefs about life and death. As a participant of the current study commented; *'My worst problem is I keep going back to her illness and what she went through at times, like difficult breathing (the worst), asking: 'Why is this happening to me mom?'*. Considering the high amounts of PTSD symptoms in bereaved parents, the failure to make sense of a child's death might play an important role in the development of PTSD. More research is needed to confirm these suggestions.

Efficacy of support groups for bereaved parents

Intervention is more likely to be effective for high risk groups (Schut et al., 2001). Bereaved parents are at high risk of poor bereavement outcome and therefore interventions for bereaved parents is expected to be effective. The study of Murphy et al. (1998) showed that bereaved parents in general seem not to benefit substantially from participation. Therefore mode of death is in current study defined as an additional risk factor, whereby death of a child due to an accident is found to be a higher risk factor for developing CG than death due to illness. Still, bereaved parents in general seem to be at risk for developing PTSD.

Contrary to expectations, support groups did not have a positive effect on symptoms of CG and PTSD; neither for parents bereaved due to illness nor for parents bereaved due to accident. This is in contrast with the study of Murphy et al. (1998) which found that support groups were effective for mothers who had recently lost a child to homicide, suicide, or accident and who experienced high amounts of grief symptoms and high levels of distress. However, mothers experiencing relative low levels of grief were worse off in the intervention than those in the control group, suggesting that for those with normal grieving, intervention may in fact be negative. Furthermore, fathers did not appear to benefit from the intervention at all. To investigate these unexpected results for fathers, Murphy et al. (1998) suggested that further research is needed since the fathers sample size (n=90) in their study was too small. It is reasonable that no effect of support groups was found in current study as well due to a small sample size (n=58).

In the study of Murphy et al. (1998) parents were randomly assigned to a support group or a no-treatment control. The failure of their study to show more effects of support

groups seemed to be due to an outreaching mode. Current study used pre-existing groups whereby the treatment group did ask for help. It was expected that support groups are effective for individuals who actually in-reach. They may be better motivated and are likely to have suffered more distress, leaving more room for improvement (Schut et al., 2001). Yet, this cannot be confirmed by findings of current study. Once again, this might be due to the small sample size. Moreover, pre-existing group differences may have had a considerable influence on the results (see limitations). More research is needed for definite conclusions about efficacy of support groups for bereaved parents.

Implications

The assumption underlying the wide use of bereavement support groups appears to be that attending such groups may have a positive outcome for the person suffering loss. Murphy et al. (1998) were able to show some positive effects of support groups, but only for mothers who were highly distressed at the outset. The overall implication to be drawn is that intervention should probably be targeted toward those who are at high risk of poor outcome.

Remarkably few systematic attempts have been made to evaluate the effectiveness of support groups for bereaved parents. The majority of studies are not evidence-based. Current study overcomes shortcomings of many studies so far by using quantitative measurements and by including a non-intervention control group. Moreover, parents of current study did participate in support groups on their own initiative. However, no positive effects of support groups were found, even though a great amount of these parents were shown to be at high risk of CG and PTSD. It is important to further establish what this disappointing results mean. It is, for example, possible that bereaved parents may experience no decrease in symptoms of CG and PTSD as an immediate and short-term effect of a support group, but that this happens in the long term. Although attending a support group may be helpful, it is very intense and emotional. Moreover, a confrontation with other's misfortune may evoke feelings of vulnerability and helplessness (Wortman, 2004). It is plausible that bereaved parents have come to terms with these intense feelings, before they are able to experience decrease in symptoms.

Limitations

Importantly, there are limitations to the present study that should be considered in the interpretation of the results. A first important caveat is, as mentioned above, that the sample was relatively small. The resulting lack of power may well have obscured some associations

between the proposed variables and symptoms that would have reached significance with a larger sample. Furthermore, there were 12 couples among the parents in the sample and therefore the potential correlation of scores within couples on study measures. In other words, parents within a couple lose the same child and have therefore more in common than two independent parents who lose different children. Consequently, bereavement outcome of parents within a couple might be influenced by the fact that they share numerous factors and their adjustment is therefore not independent. Statistical tests lean on the assumption of independence of observations. If this assumption is violated, the estimates of the standard errors of statistical tests are too small, resulting in spurious 'significant' results (Hox, 2002). However, if the couples' data were analyzed separately from the remaining individuals, both samples would be too small for adequate power for the desired statistical procedures.

Furthermore, the limitation of pre-existing groups may have had a considerable influence on the results. It is maintained that neither ANCOVA, nor another analysis can adequately control for group differences when group membership is determined non-randomly (Miller & Chapman, 2001). It was found that the experimental group had less time elapsed since death, compared with the control group, this might have been an essential part of the grouping variable. Experimental group participants might have been in an earlier stage of the bereavement process and therefore experiencing more symptoms, compared with the control group. When controlling for time since bereavement and pre-intervention symptoms, an essential proportion of the group variance was removed, and the remaining part of the grouping variable may have become meaningless. Therefore reducing the likelihood of obtaining a significant result. In addition to this, the treatment group did ask for help, the no-treatment group did not, indicating that the groups differed systematically on more than the covariates used in current study. Performing an ANCOVA with time since bereavement and pre-intervention symptoms as the only covariates seem to be inappropriate, since other differences would stay intact, thus biasing the treatment effect.

Another limitation to the current study is that self-report standardized measures were used to assess dependent variables. Important dimensions of the grieving process may be missed simply because the questionnaire did not include certain topics. For example, parents may have been more distressed while filling out the questionnaire when the anniversary of their child was coming up. Future studies should therefore preferably include interview-based assessments of variables. This way, depth can be added to the assessment of the grieving process and answers can be interpreted in light of individual circumstances.

Furthermore, there are limitations in the selection of variables in this study. The focus was on CG and PTSD, leaving out other relevant dependent variables (e.g., depression, physical responses). Moreover, this study has been restricted to the examination of one risk factor, the cause of death. This limitation has an important consequence, since spurious results may be reported due to confounding effects of other variables. It is unclear whether the elevated risk on CG for parents bereaved by accident is due to the unexpected nature of these losses, to other specific aspects related to violent deaths, or to other relevant factors. Moreover, this study focused only on loss of a child due to illness and due to accident, leaving out other causes of death. Yet, it is suggested that every cause of death brings with it its own issues and complications. Further investigation could extend the scope by including more risk factors as well as dependent variables.

Suggestions for future studies

The limitations described above are not only of interest for the current research, but also for future studies. The reason that no definite conclusions can be made whether support groups are effective for bereaved parents, is probably because difficulties arise when choosing a methodological sound design. When investigating the effectiveness of a treatment, a no-treatment control group is needed. A suggestion for further research is the use of a waiting list reference group. Participants need to be randomly distributed between the treatment condition and waiting list condition. Both groups have to consist of bereaved parents who did ask for help. An important limitation, however, is that it might be unethical to let bereaved parents wait to join an intervention, since it is likely that they are in need for help (Sales & Folkman, 2000). Schut et al. (2001) noted another shortcoming of a waiting list design, that is, no long-term effects can be assessed.

Furthermore, future studies are needed to test the effects of interventions in the treatment of CG and PTSD. It may be suggested that therapeutic procedures aimed at finding meaning in a loss are important in treating CG and PTSD. Murphy, Johnson and Lohan (2003) found that parents who attended bereavement support group were 4 times more likely to find meaning than a control group. Cognitive restructuring, in which shattered world assumptions are systematically identified, disputed, and modified, may be useful in this regard. It would be interesting for such studies to examine the extent to which a lessening of symptoms is linked with changes in assumptions to find meaning and what interventions are most effective in producing these changes.

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Appendix A

Questionnaire Package

A questionnaire regarding grief related symptoms

A research project between Bereaved Families of Ontario

and:

Dr. S. Fleming

Department of Psychology

York University

Toronto, Canada

and

Dr. H.A.W. Schut

Dr. M.S. Stroebe

Centre for Bereavement Research & Intervention,

Department of Psychology

Utrecht University

Utrecht, The Netherlands

Instructions

This is a questionnaire which looks at a number of aspects in your life that may have been affected by your grief. We would like to ask you to complete the questionnaire alone, without discussing it with others until you have returned it to us.

Please start at the beginning and work your way through till the end. It is important to read the specific instructions within each section of the questionnaire carefully (note that the answer categories vary across the different parts). Finally, we suggest you do not ponder too long over each question. We are interested in learning about your personal experiences and opinions, for which there are no right and no wrong answers.

When you have completed the questionnaire, please place it together with the consent form in the envelope provided, seal the envelope to ensure confidentiality, and hand it in to your group facilitator. For research purposes it is important you do this before or on the **third** group meeting.

If you have any questions or remarks, please do not hesitate to contact us.

On behalf of the research team,

Dr. Stephen Fleming

Telephone: 416 736 5202
E-mail: sfleming@yorku.ca
Department of Psychology
York University
4700 Keele Street,
Toronto, Ontario, M3J 1P3

Personal history and background

1. Gender
   - ❑ Male
   - ❑ Female

2. Age …… years old

3. Currently, do you have a partner?
   - ❑ Yes
   - ❑ No. *There are questions regarding a partner below. If you have answered 'No', please leave these questions blank.*

4. Age of partner …… years old

5. How long have you been with your current partner? …… months or years (*Please circle).*

6. Please specify your educational level
   - ❑ elementary school
   - ❑ high school
   - ❑ community college
   - ❑ university: undergraduate degree
   - ❑ university: graduate degree

7. Please specify the educational level of your partner
   - ❑ elementary school
   - ❑ high school
   - ❑ community college
   - ❑ university: undergraduate degree
   - ❑ university: graduate degree

8. What is your current occupation?

   ____

9. What is your partner's occupation?

   ____

10. What is your annual income?
    - ❑ under $ 25,000
    - ❑ $ 25,000 - $ 50,000
    - ❑ $ 50,000 - $ 75,000
    - ❑ over $ 75,000

11. And your partner's?
    - ❑ under $ 25,000
    - ❑ $ 25,000 - $ 50,000
    - ❑ $ 50,000 - $ 75,000
    - ❑ over $ 75,000

12. What is your work situation?
    - ❑ Employed full time
    - ❑ Employed part time
    - ❑ Unemployed
    - ❑ Homemaker
    - ❑ Retired

13. What is your partner's work situation?
    - ❑ Employed full time
    - ❑ Employed part time
    - ❑ Unemployed
    - ❑ Homemaker
    - ❑ Retired

14. What is your spiritual affiliation?
    - ❑ None. *Please proceed to question number 17.*
    - ❑ Christian
    - ❑ Jewish
    - ❑ Muslim
    - ❑ Hindu
    - ❑ Buddhist
    - ❑ Other : ____

15. Spiritual beliefs and/or activities:
    - ❑ were and still are high
    - ❑ increased since death
    - ❑ decreased since the death
    - ❑ Was not very involved before, still not

16. Is your spirituality helpful in grieving?

    Very much □ □ □ □ □ not at all

17. What is the cultural heritage you most strongly identify with?

    ____

18. What is your race?

    ____

19. What is the race of your partner?

    ____

20. What is the date of the loss(es)? (format: dd/mm/yyyy)

    ____

    ____

21. About the child(ren):
    Please specify gender (*for multiple losses, please indicate a number)*
    - ❑ male
    - ❑ female

22. How old was (were) your child(ren)?

    ____

    ____

23. What was your child's place in the family?
    - ❑ oldest
    - ❑ youngest
    - ❑ only child
    - ❑ other, namely

    ____

24. What was the cause of death?
    - ❑ illness. Please specify

      ____
    - ❑ accident. What kind of accident?

      ____
    - ❑ homicide
    - ❑ suicide
    - ❑ other

25. What can you tell us about the expectedness of your child(ren)'s death?
    - ❑ unexpected
    - ❑ expected
    - ❑ comment

    ____

    ____

26. Additional stressful experiences prior to, or subsequent to the death of your child(ren) (*please mark all that are applicable to you*).
    - ❑ Unemployment / change in employment status
    - ❑ Divorce / separation
    - ❑ Personal illness/injury
    - ❑ Illness/injury of someone else close to you
    - ❑ Other losses through death
    - ❑ Financial difficulties
    - ❑ Other(s), namely:

    ____

    ____

    ____

27. Are you currently consulting other mutual help groups or professionals?
    - ❑ no

    If yes, please specify:

    - ❑ internet (i.e. grief / loss websites)
    - ❑ psychiatrist
    - ❑ psychologist
    - ❑ social worker
    - ❑ pastor
    - ❑ Other(s), namely:

    ____

    ____

    ____

28. Have you consulted other mutual help groups or professionals in the past?
    - ❑ no

    If yes, please specify:

    - ❑ Mutual support group
    - ❑ internet (i.e. grief / loss websites)
    - ❑ psychiatrist
    - ❑ psychologist
    - ❑ social worker
    - ❑ pastor
    - ❑ Other(s), namely:

    ____

    ____

29. Who took the initiative in your contact with BFO?
    - ❑ I did, I contacted them (by phone, letter, email or in person).
    - ❑ BFO did, they contacted me (by phone, letter, email or in person).

Stressful events

The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **during the past seven days** with respect to the loss of your child.

How much were you distressed or bothered by these difficulties?

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Any reminder brought back feelings about it.	☐	☐	☐	☐	☐
2.	I had trouble staying asleep.	☐	☐	☐	☐	☐
3.	Other things kept making me think about it.	☐	☐	☐	☐	☐
4.	I felt irritable and angry.	☐	☐	☐	☐	☐
5.	I avoided letting myself get upset when I thought about it or was reminded of it.	☐	☐	☐	☐	☐
6.	I thought about it when I didn’t mean to.	☐	☐	☐	☐	☐
7.	I felt as if it hadn’t happened or wasn’t real.	☐	☐	☐	☐	☐
8.	I stayed away from reminders about it.	☐	☐	☐	☐	☐
9.	Pictures about it popped into my mind.	☐	☐	☐	☐	☐
10.	I was jumpy and easily startled.	☐	☐	☐	☐	☐
11.	I tried not to think about it.	☐	☐	☐	☐	☐

12.	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	□	□	□	□	□
13.	My feelings about it were kind of numb.	□	□	□	□	□
14.	I found myself acting or feeling like I was back at that time.	□	□	□	□	□
15.	I had trouble falling asleep.	□	□	□	□	□
16.	I had waves of strong feelings about it.	□	□	□	□	□
17.	I tried to remove it from my memory.	□	□	□	□	□
18.	I had trouble concentrating.	□	□	□	□	□
19.	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	□	□	□	□	□
20.	I had dreams about it.	□	□	□	□	□
21.	I felt watchful and on guard.	□	□	□	□	□
22.	I tried not to talk about it.	□	□	□	□	□

Quality of Relationship

The following questions have to do with the quality of the relationship you have with your partner. Please indicate how often the mentioned situations occur in your relationship. If you do not have a partner, please skip the following nine questions.

	How often:	All the time	time	than not	Occasionally	Rarely	Never
1.	do you confide in your partner?	☐	☐	☐	☐	☐	☐
2.	do you or your partner leave the house after a fight?	☐	☐	☐	☐	☐	☐
3.	do you, in general, think that things between you and your partner are going well?	☐	☐	☐	☐	☐	☐
4.	do you and your partner quarrel?	☐	☐	☐	☐	☐	☐
5.	do you or have you considered divorce, separation, or terminating your relationship?	☐	☐	☐	☐	☐	☐
6.	do you regret that you married (or live together)?	☐	☐	☐	☐	☐	☐
7.	do you and your partner “get on each other’s nerves?”	☐	☐	☐	☐	☐	☐
8.	do you show your partner that you love him or her?	☐	☐	☐	☐	☐	☐
9.	do you feel that you make a good match?	☐	☐	☐	☐	☐	☐

Intimate Relationships

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you *generally* experience relationships, not just what is happening in a current relationship. Respond to each statement by checking off a square to indicate how much you agree or disagree with the statement.

		Strongly disagree						Strongly agree
1.	When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.	☐	☐	☐	☐	☐	☐	☐
2.	My desire to be very close sometimes scares people away.	☐	☐	☐	☐	☐	☐	☐
3.	I find it relatively easy to get close to my partner.	☐	☐	☐	☐	☐	☐	☐
4.	I get uncomfortable when a romantic partner wants to be very close.	☐	☐	☐	☐	☐	☐	☐
5.	I worry a lot about my relationships.	☐	☐	☐	☐	☐	☐	☐
6.	I worry that I won't measure up to other people.	☐	☐	☐	☐	☐	☐	☐
7.	I am nervous when my partners get too close to me.	☐	☐	☐	☐	☐	☐	☐
8.	I don't feel comfortable opening up to romantic partners.	☐	☐	☐	☐	☐	☐	☐
9.	I prefer not to be too close to romantic partners.	☐	☐	☐	☐	☐	☐	☐
10.	My partner really understands me and my needs.	☐	☐	☐	☐	☐	☐	☐
11.	I feel comfortable sharing my private thoughts and feelings with my partner.	☐	☐	☐	☐	☐	☐	☐
12.	I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.	☐	☐	☐	☐	☐	☐	☐

13.	I feel comfortable depending on romantic partners.	☐	☐	☐	☐	☐	☐	☐	
14.	I tell my partner just about everything.	☐	☐	☐	☐	☐	☐	☐	
15.	It's not difficult for me to get close to my partner.	☐	☐	☐	☐	☐	☐	☐	
16.	Sometimes romantic partners change their feelings about me for no apparent reason.	☐	☐	☐	☐	☐	☐	☐	
17.	I worry that romantic partners won't care about me as much as I care about them.	☐	☐	☐	☐	☐	☐	☐	
18.	I find that my partner(s) don't want to get as close as I would like.	☐	☐	☐	☐	☐	☐	☐	
19.	It helps to turn to my romantic partner in times of need.	☐	☐	☐	☐	☐	☐	☐	☐
20.	I talk things over with my partner.	☐	☐	☐	☐	☐	☐	☐	
21.	My partner only seems to notice when I'm angry.	☐	☐	☐	☐	☐	☐	☐	
22.	I am afraid that I will lose my partner's love.	☐	☐	☐	☐	☐	☐	☐	
23.	I often worry that my partner doesn't really love me.	☐	☐	☐	☐	☐	☐	☐	
24.	I rarely worry about my partner leaving me.	☐	☐	☐	☐	☐	☐	☐	
25.	It makes me mad that I don't get the affection and support I need from my partner.	☐	☐	☐	☐	☐	☐	☐	
26.	My romantic partner makes me doubt myself.	☐	☐	☐	☐	☐	☐	☐	
27.	When my partner is out of sight, I worry that he or she might become interested in someone else.	☐	☐	☐	☐	☐	☐	☐	
28.	It's easy for me to be affectionate with my partner.	☐	☐	☐	☐	☐	☐	☐	
29.	I often worry that my partner will not want to stay with me.	☐	☐	☐	☐	☐	☐	☐	
30.	I am very comfortable being close to romantic partners.	☐	☐	☐	☐	☐	☐	☐	
31.	I prefer not to show a partner how I feel deep down.	☐	☐	☐	☐	☐	☐	☐	

32.	I usually discuss any problems and concerns with my partner.	☐	☐	☐	☐	☐	☐	☐
33.	I find it easy to depend on romantic partners.	☐	☐	☐	☐	☐	☐	☐
34.	I do not often worry about being abandoned.	☐	☐	☐	☐	☐	☐	☐
35.	I often wish that my partner's feelings for me were as strong as my feelings for him or her.	☐	☐	☐	☐	☐	☐	☐
36.	I find it difficult to allow myself to depend on romantic partners.	☐	☐	☐	☐	☐	☐	☐

Symptom Checklist – 90

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please circle one of the numbers to the right that best describes how much discomfort that problem has caused you **during the past week** including today.

How much were you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Headaches	1	2	3	4	5
2. Nervousness or shakiness inside	1	2	3	4	5
3. Repeated unpleasant thoughts that won´t leave your mind	1	2	3	4	5
4. Faintness or dizziness	1	2	3	4	5
5. Loss of sexual interest or pleasure	1	2	3	4	5
6. Feeling critical of others	1	2	3	4	5
7. The idea that someone else can control your thoughts	1	2	3	4	5
8. Feeling others are to blame for most of your troubles	1	2	3	4	5
9. Trouble remembering things	1	2	3	4	5
10. Worried about sloppiness or carelessness	1	2	3	4	5
11. Feeling easily annoyed or irritated	1	2	3	4	5
12. Pains in heart or chest	1	2	3	4	5
13. Feeling afraid in open spaces or on the streets	1	2	3	4	5
14. Feeling low in energy or slowed down	1	2	3	4	5
15. Thoughts of ending your life	1	2	3	4	5
16. Hearing voices that other people do not hear	1	2	3	4	5
17. Trembling	1	2	3	4	5
18. Feeling that most people cannot be trusted	1	2	3	4	5
19. Poor appetite	1	2	3	4	5
20. Crying easily	1	2	3	4	5
21. Feeling shy or uneasy with the opposite sex	1	2	3	4	5
22. Feelings of being trapped or caught	1	2	3	4	5
23. Suddenly scared for no reason	1	2	3	4	5
24. Temper outbursts that you could not control	1	2	3	4	5

How much were you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
25. Feeling afraid to go out of your house alone	1	2	3	4	5
26. Blaming yourself for things	1	2	3	4	5
27. Pains in lower back	1	2	3	4	5
28. Feeling blocked in getting things done	1	2	3	4	5
29. Feeling lonely	1	2	3	4	5
30. Feeling blue	1	2	3	4	5
31. Worrying too much about things	1	2	3	4	5
32. Feeling no interest in things	1	2	3	4	5
33. Feeling fearful	1	2	3	4	5
34. Your feelings being easily hurt	1	2	3	4	5
35. Other people being aware of your private thoughts	1	2	3	4	5
36. Feeling others do not understand you or Unsympathetic	1	2	3	4	5
37. Feeling that people are unfriendly or dislike you	1	2	3	4	5
38. Having to do things very slowly to insure Correctness	1	2	3	4	5
39. Heart pounding or racing	1	2	3	4	5
40. Nausea or upset stomach	1	2	3	4	5
41. Feeling inferior to others	1	2	3	4	5
42. Soreness of your muscles	1	2	3	4	5
43. Feeling that you are watched or talked about by Others	1	2	3	4	5
44. Trouble falling asleep	1	2	3	4	5
45. Having to check and double-check what you do	1	2	3	4	5
46. Difficulty making decisions	1	2	3	4	5
47. Feeling afraid to travel on buses, subways, or trains	1	2	3	4	5
48. Trouble getting your breath	1	2	3	4	5
49. Hot or cold spells	1	2	3	4	5
50. Having to avoid certain things, places, or activities because they frighten you	1	2	3	4	5
51. Your mind going blank	1	2	3	4	5
52. Numbness or tingling in parts of you body	1	2	3	4	5
53. A lump in you throat	1	2	3	4	5
54. Feeling hopeless about the future	1	2	3	4	5
55. Trouble concentrating	1	2	3	4	5

How much were you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
56. Feeling weak in parts of your body	1	2	3	4	5
57. Feeling of tense or keyed up	1	2	3	4	5
58. Heavy feelings in your arms of legs	1	2	3	4	5
59. Thoughts of death or dying	1	2	3	4	5
60. Overeating	1	2	3	4	5
61. Feeling uneasy when people are watching or talking about you	1	2	3	4	5
62. Having thoughts that are not your own	1	2	3	4	5
63. Having urges to beat, injure, or harm someone	1	2	3	4	5
64. Awakening in the early morning	1	2	3	4	5
65. Having to repeat the same actions such as touching, counting, or washing	1	2	3	4	5
66. Sleep that is restless or disturbed	1	2	3	4	5
67. Having urges to break or smash things	1	2	3	4	5
68. Having ideas or beliefs that others do not share	1	2	3	4	5
69. Feeling very self-conscious with others	1	2	3	4	5
70. Feeling uneasy in crowds, such as shopping or at a movie	1	2	3	4	5
71. Feeling everything is an effort	1	2	3	4	5
72. Spells of terror or panic	1	2	3	4	5
73. Feeling uncomfortable about eating or drinking in public	1	2	3	4	5
74. Getting into frequent arguments	1	2	3	4	5
75. Feeling nervous when you are left alone	1	2	3	4	5
76. Others not giving you proper credit for your achievements	1	2	3	4	5
77. Feeling lonely even when you are with people	1	2	3	4	5
78. Feeling so restless you couldn't sit still	1	2	3	4	5
79. Feelings of worthlessness	1	2	3	4	5
80. The feeling that something bad is going to happen to you	1	2	3	4	5
81. Shouting or throwing things	1	2	3	4	5
82. Feeling afraid you will faint in public	1	2	3	4	5
83. Feeling that people will take advantage of you if you let them	1	2	3	4	5
84. Having thoughts about sex that bother you a lot	1	2	3	4	5
85. The idea that you should be punished for your sins	1	2	3	4	5
86. Thoughts and images of a frightening nature	1	2	3	4	5
87. The idea that something serious is wrong with you body	1	2	3	4	5
88. Never feeling close to another person	1	2	3	4	5
89. Feelings of guilt	1	2	3	4	5
90. The idea that something is wrong with your mind	1	2	3	4	5

Thoughts and actions

People think and do many different things when they feel sad, blue, or depressed. Please read each of the items below and indicate whether you *never, sometimes, often,* or *always* think or do each one when you feel sad, down, or depressed. Please indicate what you **generally** do, not what you think you should do.

		Never	Some-times	Often	Always
1.	I think about how alone I feel.	☐	☐	☐	☐
2.	I do something that has made me feel better in the past.	☐	☐	☐	☐
3.	I think about a recent situation, wishing it had gone better.	☐	☐	☐	☐
4.	I do something fun with a friend.	☐	☐	☐	☐
5.	I think “Why can’t I handle things better?”	☐	☐	☐	☐
6.	I try to find something positive in the situation.	☐	☐	☐	☐
7.	I think “I’m going to do something to make myself feel better”.	☐	☐	☐	☐
8.	I think about how passive and unmotivated I feel.	☐	☐	☐	☐
9.	I think about how I don’t feel up to doing anything.	☐	☐	☐	☐
10.	I go to a favourite place to get my mind off the situation.	☐	☐	☐	☐

Please proceed to the next page.

Feelings about the loss

Please mark the box that best describes how you have been feeling about your deceased child over **the past month**.

		almost never	rarely	sometimes	often	always
1.	The death of my child feels overwhelming or devastating.	☐	☐	☐	☐	☐
2.	I think about my child so much that it can be hard for me to do the things I normally do.	☐	☐	☐	☐	☐
3.	Memories of my child upset me.	☐	☐	☐	☐	☐
4.	I feel that I have trouble accepting the death.	☐	☐	☐	☐	☐
5.	I feel myself longing and yearning for my child.	☐	☐	☐	☐	☐
6.	I feel drawn to places and things associated with my child.	☐	☐	☐	☐	☐
7.	I can't help feeling angry about the death of my child.	☐	☐	☐	☐	☐
8.	I feel disbelief over the death of my child.	☐	☐	☐	☐	☐
9.	I feel stunned, dazed, or shocked over my child's death	☐	☐	☐	☐	☐
10.	Ever since my child died it is hard for me to trust people.	☐	☐	☐	☐	☐
11.	Ever since my child died I feel like I have lost the ability to care about other people or I feel distant from people I care about.	☐	☐	☐	☐	☐
12.	I have pain in the same area of my body, some of the same symptoms, or have assumed some of the behaviours or characteristics of my child.	☐	☐	☐	☐	☐
13.	I go out of my way to avoid reminders that my child is gone.	☐	☐	☐	☐	☐
14.	I feel that life is empty or meaningless without my child.	☐	☐	☐	☐	☐
15.	I hear my child speak to me.	☐	☐	☐	☐	☐
16.	I see my child stand before me.	☐	☐	☐	☐	☐
17.	I feel like I have become numb since the death of my child.	☐	☐	☐	☐	☐
18.	I feel that it is unfair that I should live when my child died.	☐	☐	☐	☐	☐
19.	I am bitter over my child's death.	☐	☐	☐	☐	☐

		almost never	rarely	sometimes	often	always
20.	I feel envious of others who have not lost someone close.	☐	☐	☐	☐	☐
21.	I feel like the future holds no meaning or purpose without my child.	☐	☐	☐	☐	☐
22.	I feel lonely ever since my child died.	☐	☐	☐	☐	☐
23.	I feel unable to imagine life being fulfilling without my child.	☐	☐	☐	☐	☐
24.	I feel that a part of myself died along with my child.	☐	☐	☐	☐	☐
25.	I feel that the death of my child has changed my view of the world.	☐	☐	☐	☐	☐
26.	I have lost my sense of security or safety since the death of my child.	☐	☐	☐	☐	☐
27.	I have lost my sense of control since the death of my child.	☐	☐	☐	☐	☐
28.	I believe that my grief has resulted in significant impairment in my social, occupational or other areas of functioning.	☐	☐	☐	☐	☐
29.	I have felt on edge, jumpy, or easily startled since the death.	☐	☐	☐	☐	☐
30.	Since the death of my child my sleep has been disturbed.	☐	☐	☐	☐	☐

Thoughts and Feelings

This questionnaire consists of a list of thoughts and feelings that you may have had since your child died. Please read each statement carefully, and mark the column that best describes the way you have been feeling during **the past two weeks**, including today.

1 = does not describe me at all

2 = does not quite describe me

3 = describes me fairly well

4 = describes me well

5 = describes me very well

		1	2	3	4	5
1.	I have learned to cope better with life.	□	□	□	□	□
2.	I frequently feel bitter.	□	□	□	□	□
3.	I forget things easily, e.g. names, telephone numbers.	□	□	□	□	□
4.	I feel as though I am a better person.	□	□	□	□	□
5.	I am resentful.	□	□	□	□	□
6.	I have difficulty remembering things from the past.	□	□	□	□	□
7.	I feel revengeful.	□	□	□	□	□
8.	I have a better outlook on life.	□	□	□	□	□
9.	I have difficulty concentrating.	□	□	□	□	□
10.	I have difficulty learning new things.	□	□	□	□	□
11.	I blame others.	□	□	□	□	□
12.	I have more compassion for others.	□	□	□	□	□
13.	I am stronger because of the grief I have experienced.	□	□	□	□	□
14.	I want to harm others.	□	□	□	□	□
15.	I am a more forgiving person.	□	□	□	□	□
16.	I have difficulty remembering new information.	□	□	□	□	□

17.	I am more tolerant of myself	☐	☐	☐	☐	☐
18.	I am more tolerant of others.	☐	☐	☐	☐	☐
19.	I get angry often.	☐	☐	☐	☐	☐
20.	I have hope for the future.	☐	☐	☐	☐	☐
21.	I reached a turning point where I began to let go of some of my grief.	☐	☐	☐	☐	☐
22.	I am having more good days than bad.	☐	☐	☐	☐	☐
23.	Tasks seem insurmountable.	☐	☐	☐	☐	☐
24.	I care more deeply for others.	☐	☐	☐	☐	☐
25.	I have hostile feelings	☐	☐	☐	☐	☐

My reasons for attending the group:

Scale: 1 not applicable - 5 very applicable to me

		1	2	3	4	5
1.	To find recognition for the situation I am now in.	☐	☐	☐	☐	☐
2.	To talk about my loss without the need to explain it.	☐	☐	☐	☐	☐
3.	To find answers to why my child died.	☐	☐	☐	☐	☐
4.	To develop and strengthen my contacts with other bereaved parents.	☐	☐	☐	☐	☐
5.	To receive new ideas for solutions to problems to do with my changed identity.	☐	☐	☐	☐	☐
6.	To receive information regarding other sources of help for practical things.	☐	☐	☐	☐	☐
7.	To improve my skills in developing social relationships.	☐	☐	☐	☐	☐
8.	To become less lonely or isolated among others.	☐	☐	☐	☐	☐
9.	To help me gain hope for the future.	☐	☐	☐	☐	☐
10.	To give me a sense of belonging.	☐	☐	☐	☐	☐
11.	Feeling of fellowship with people in a similar situation.	☐	☐	☐	☐	☐
12.	Feeling of solidarity with other bereaved parents.	☐	☐	☐	☐	☐
13.	To share what I have learned about grieving.	☐	☐	☐	☐	☐
14.	To make new friends.	☐	☐	☐	☐	☐
15.	To gain comfort and reassurance that my grieving is normal.	☐	☐	☐	☐	☐
16.	To get advice about how to build up my life again.	☐	☐	☐	☐	☐
17.	To get information about what happened to my child.	☐	☐	☐	☐	☐
18.	To learn new skills for coping with my grief.	☐	☐	☐	☐	☐

19.	To gain help with the family situation.	☐	☐	☐	☐	☐
20.	To understand differences in ways of grieving between my partner and me.	☐	☐	☐	☐	☐
21.	To help others overcome their loss.	☐	☐	☐	☐	☐
22.	To talk about my deceased child.	☐	☐	☐	☐	☐
23.	To feel close to my deceased child.	☐	☐	☐	☐	☐
24.	Other people encouraged me to participate.	☐	☐	☐	☐	☐
25.	I did not want to disappoint other people.	☐	☐	☐	☐	☐
26.	My partner decided to join the group, and asked me to join as well.	☐	☐	☐	☐	☐
27.	I felt I needed help.	☐	☐	☐	☐	☐
28.	I wanted support.	☐	☐	☐	☐	☐

Thank you for taking the time to complete this questionnaire! If you have comments, please do not hesitate to share these with us.

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