

Volume 1

Experiencing the death of a significant
other: A preliminary investigation of factors
associated with the risk of long term
psychological distress in older people.

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Abstract

Attachment Theory is regarded as relevant from 'cradle to grave' but little research has focused on older people. It has also been established as an important framework within which to understand individual reactions to the death of a loved one. The reactions to grief are wide ranging and for some people can be extremely long lasting and have detrimental effects on physical and mental health. Research on younger adults has identified a number of common risk factors (mode of death, relationship to the deceased, previous mental health difficulties and social support) after a death. The primary aim of the current study was to explore the effects of attachment and the identified risk factors in younger people, in a sample of older people who had lost a significant other.

The study utilised a retrospective non-randomised post-test only design with thirty two people aged over sixty-five. The participants were drawn from four sources (bereavement support groups, bereavement counselling service, psychologists for older people, the community) and had been bereaved for between nine months and thirty years. Only two people were interviewed from the community and thus these two were not included in sub-group comparisons. There were no systematic differences between the other three source groups in terms of gender, marital status or occupation. All participants were assisted in completing a number of self-report questionnaires relating to their psychological well-being, attachment style, relationship with their parents during childhood, social support and questions about the bereavement.

Despite the length of time that some people had been bereaved, the death of a significant other had a lasting impact on all the participants. The findings indicated that attachment style and quality of parenting did not have any significant relationship with psychological well-being. Further findings indicated that the other risk factors identified in younger people after a bereavement were important in an older sample. Older people experienced less psychological well-being if the death had been sudden, if the death was of an adult-child, if they had experienced a number of deaths within a short time frame, if they were not satisfied with their social support and if they had few social supports. The measure of psychological well-being used had a strong effect on the importance of the various risk factors.

The findings of the study are limited by the possible biases of a retrospective, non-randomised design and also by the measures of attachment and quality of parenting that were used. These measures were not validated with the current sample (i.e. older and bereaved) in mind. Despite these limitations the findings offer some support that after a death of a significant other, older people suffer from the same factors of risk as younger people. There is also a strong indication that the impact of the death of a significant other has a lifelong effect on psychological well-being which is not easily altered by the experience of receiving psychological or supportive help. These findings will be discussed in relation to the experiences of older people and the implications for health professional. Suggestions will be made for future research.

Chapter 1: Introduction

Overview

Experiencing the death of a significant other is a common human experience. In modern society the most likely time to suffer a significant loss is during old age (Parkes 1992, McKiernan 1996). Although bereavement may lead to “personal growth” (Parkes 1996) in some, there are many who experience extreme mental and physical suffering.

This study focuses on the grief experiences of people aged over sixty-five. It is important to study this group for several reasons. Firstly, although there is a large field of research in bereavement it has been slow to focus on older people. Bereavement is a complex phenomenon and it can be difficult to make generalisations between individuals let alone across age groups. The age at which people experience the death of a loved one may have a strong impact on their reaction (Wortman & Silver 1990). Many people assume that it is easier for older people to cope following the death of a loved one because old age is the time when people are expected to die. However the evidence for this is limited (e.g. Breckenridge et al 1986). Secondly, many have suggested that grief is for a finite period (Gorer 1965) but researchers are beginning to acknowledge that people may actually never “get over it” (Meuser et al 1994 -95). A greater understanding of the impact of death at a time when many other physical, social and financial changes are taking place could be achieved if research focused on the grief experience of older people. Thirdly, researchers have found that a prevalence of about 20% of bereaved people (including older people) suffer complications following the death of a loved one, e.g. poorer long term physical and mental health (e.g. Prigerson et al 1995a). The elderly population in the

UK (as elsewhere in the developed world) continues to grow (an expected 6.8 million people over 75 by 2034) and will place increasing demands on physical and mental health services. It is now more likely that people experience their first major loss through death when they are over sixty-five. Combining this phenomenon with the fact that the elderly population is growing means that the demand for physical and mental health services is increasing considerably. Given that bereavement has such wide ranging consequences and can have such a negative impact on some it is important to identify those who are vulnerable and to understand why they and not others succumb (Stroebe & Stroebe 1993a, Kato & Mann 1999, Cassidy & Shaver 1999). Health services need to be able to identify those people who are at risk of needing further support following the death of a loved one, so that resources can be specifically targeted at this group.

This study is a preliminary investigation into the psychological well-being of older people following the death of a loved one including the factors that might be important in identifying those most at risk of developing a complicated grief reaction.

The focus of the introductory chapter is to explore the current literature on grief in older people and to pay special attention to those people who suffer complications in this process. This exploration will be separated into three sections. The first section focuses on the phenomenon of grief (which includes definitions of normal and complicated grief, the time period of grief and the effects of grief on physical and psychological well-being). The second section explores theories of grief and pays particular attention to Attachment Theory (Bowlby 1969, 1973, 1980). This theory provides an important

conceptual model of how psychological well-being in adulthood is influenced by childhood experiences (in particular the quality of care received). It is also recognised as one of the major theories of grief (Stroebe & Stroebe 1987) and provides an important explanation of why some people might develop complicated grief as opposed to others. The third and final section is a review of the current literature on risk factors for low psychological well-being following a death. These will inform the current study. The research question and hypotheses for the current study will be presented at the end of the chapter. Before moving on to the rest of the chapter, it is important to acknowledge that this research is based on the Western view of grief. A brief discussion of this view is set out below.

Western view of grief

Although grief is expressed and understood differently across cultures, the loss of a loved one appears to elicit profound distress in humans everywhere (Rosenblatt et al 1976). It is sometimes imagined that non-industrial societies have more helpful ways of expressing grief (Walter 1999) and that people have fewer subsequent psychological problems as a result. However all societies 'police' their grief albeit in very different ways. "I know of no society in which the emotions of bereavement are not shaped and controlled, for the sake of the deceased, the bereaved person, or others" (Rosenblatt 1997 p.36). There is always the possibility that some people in any society will find it hard to follow the 'policed' view. It is these people who may be regarded as having difficulties. However, what is considered a difficulty will differ from culture to culture.

Bereavement can affect people's identity, emotions, the spiritual meaning they give to life, the managing of practical everyday tasks, their physical health, their finances, their lifestyle and their roles in the family and community. Despite the wide ranging impact of bereavement, in Western society the dominant view is that the emotional aspect of grief is the most important (Walter 1999) This view involves the three elements of expressivism, resolution and a notion of normal and abnormal grief. These three elements remain even though it is becoming increasingly recognised that there is great diversity in the grief experience. It is generally believed that expressing feelings and resolving the loss are aspects of normal grief and abnormal grief develops from not appropriately managing either of these two elements. People might express too much for too long or too little. Services are willing to provide help to those people who do not get the 'right' balance.

In a personal communication to Walter (1999, p.157) Parkes defends this position: "The observation that everybody grieves differently is not incompatible with the idea that some ways of grieving give rise to more problems than others. It is a weakness that anthropological studies seldom attempt to measure differences in psycho-social adjustment between cultures, and tend to assume that whatever is culturally 'normal' is psychologically healthy."

Even within Western society there are differences in the expression of grief. Elias (1985) argues that there are two dimensions within which all cultures' modes of grieving can be described. These are expressive/reserved and formal/informal. Walter (1999) used these

two dimensions to describe the view of grief in a number of Western cultures. The English view of grieving is informal and reserved. Elias (1985) suggests that this is the group that will have greatest difficulty coping, because mourners are no longer able to express their emotion either through ritual (termed 'informal') or openly in public (termed 'reserved'). Australia and the Netherlands are also in this category. In Scotland he suggests they are reserved and formal (accept ritual) and in Ireland they are formal and expressive.

It seems that in England the pattern of mourning has become a matter of individual choice (Gorer 1965). Unfortunately this individual choice makes people uncertain about how to react. As Walter (1999, p.141) says "Bereavement is a time of insecurity, the most unlikely moment for people to become pioneers or eccentrics. Bereavement organisations often comment that their clients need to know that their emotions are normal and not signs that they are going mad; they are grateful to be informed that their emotions and responses are within the range of normal". If English people grieve in their own preferred style it can be hard for others to always accept or understand because it is a style different to their own.

In Western society there is an accepted notion that some expressions or lack of expressions of grief are "abnormal" (Walter 1999). There is also an accepted view that the health service and voluntary organisations will help those who are having difficulties. These organisations have a need to know how to differentiate what is 'normal' from 'abnormal'.

1.1 The phenomenon of grief

Parkes (1993, p.92) summarises grief as “essentially an emotion that draws us towards something or someone that is missing. It arises from awareness of a discrepancy between the world that is and the world that “should be””.

Normal Grief

Grief seems to be a natural phenomenon but what is ‘normal’ grief? The field of bereavement research is still struggling to validate the concept of normal grief (Middleton et al 1993). Given that grief (in England at least) is such an individual process it may be an almost impossible task.

Shuchter and Zisook (1993) recognise the difficulties of defining normal grief and have instead taken a more multidimensional approach to grief. They describe six independent dimensions which they suggest make up the grief process: (1) emotional and cognitive responses to the death of a spouse, (2) coping with emotional pain, (3) the continuing relationship with the dead spouse, (4) changes in functioning, (5) changes in relationships, (6) changes in identity. Within these dimensions are a multitude of thoughts, feelings and behaviours which people can and do experience. Thus they suggest that normal grief includes all these dimensions.

Time period for grief

Clinicians indicate that grief becomes complicated if it goes on for too long (see page 8). Early investigators suggested a period of weeks to months (Engel 1961). The traditional

view of grief is that it lasts for between six and twelve months (Biondi & Picardi 1996). However, Thompson et al (1991) found that the experience of grief persists for at least thirty months in both older men and women who have lost a partner. Other researchers suggest that many older people may actively grieve for periods much greater than this (Wortman & Silver 1989, Horacek 1991). These findings suggest that perhaps the normal grief response is to live with grief rather than 'get over it' (Meuser et al 1994-95). Some aspects of grief work may never end for a significant proportion of otherwise normally bereaved individuals (Goin et al 1979).

Grief and psychological well-being

Grief is a highly individual experience (Shucter & Zisook 1993). Although grief is not a mental illness it often affects a person's mental health either in the short or long term. The main effects found have been complicated grief, loneliness and depression. These are described below.

Psychological well-being: Complicated Grief

As noted above, in Western society there is a belief that some people experience 'complicated' grief. Researchers are not all agreed on what this involves. This other aspect of grief has been labelled 'abnormal', 'unresolved', 'traumatic', 'pathological', 'neurotic' and 'truncated' by various researchers. Rando (1992-93) prefers the term 'complicated grief' as it suggests that grief has somehow become complicated and can therefore again become uncomplicated. It also avoids the pejorative tone of many other terms. The term 'complicated grief' shall be adopted throughout this chapter.

Shuchter and Zisook (1993) suggest that complicated grief is either an absent, delayed, intensified or prolonged aspect of normal grief. Bowlby (1980, p.138) suggested that these disordered forms of grief can be arrayed along a single conceptual dimension running from “chronic mourning” to “prolonged absence of conscious grieving”. Chronic mourning is characterised by protracted grief and prolonged difficulty in normal functioning. In contrast the absence of grief is characterised by a conspicuous lack of conscious sorrow, anger or distress.

Middleton et al (1993, p.44) say “where grief for a particular individual, in a particular culture, appears to deviate from the expected course in such a way that it is associated with excessive or prolonged psychological or physical morbidity, it may be labelled as pathological”. Implicit in the definition above is the notion that there has to be an ‘excessive’ aspect to the grief but that this may vary from one culture to another. For example, in some parts of Greece after a death, the body lies in an elaborate marble grave for five years (Danforth 1982). Every evening the widow or closest female relative goes to the grave to look after and pray for the dead person. At the end of five years they dig up the grave and inspect the bones. If the bones are white they are placed in a communal grave as the soul is seen as having been cleansed. The marble grave can then be re-used. In Western culture it is not expected that a widow would go to the grave every day for five years and people would not expect others to dig up the bones. Friends, relatives and mental health professionals would probably regard both these as excessive behaviours and see them as indications of complicated grief.

Different views of complicated grief

No two researchers describe complicated grief in exactly the same terms. For example, Horowitz et al (1980) distinguish three forms of complicated grief. These are (1) rigid denial, (2) overwhelming intrusions which are visible in states of panic, anger and guilt, and (3) prolonged grief in which people cannot work through to a resolution or form new bonds.

Zisook (1995) distinguishes three slightly different categories: (1) chronic grief which is seen as unremitting distress, (2) hypertrophic grief (an intense reaction often seen after a sudden and unforeseen death), and (3) delayed grief with the absence of any signs of grief.

Finally, Parkes (1985) differentiates another three categories: (1) the unexpected grief syndrome (occurring after an unexpected or untimely loss), (2) the ambivalent grief syndrome and (3) chronic grief. Without generally accepted standard criteria for complicated grief it is difficult to investigate its prevalence rates, risk factors and consequences (Prigerson et al 1995a). Such criteria would also help researchers and clinicians to distinguish complicated grief from other bereavement related disorders such as depression. In thinking about intervention it may be that complicated grief responds differently from those for other disorders.

Criterion based definition of complicated grief

In a series of studies Prigerson et al (1995a, 1997) have identified a set of distinct symptoms which they call 'complicated grief' and which predict poor functional outcome. Their sample was drawn from the community and included eighty-two recently widowed elderly individuals. They identified a cut off point on the scale and found that those who scored above it at six months post-bereavement were those more likely to suffer functional impairments at eighteen months. The symptoms of complicated grief are a fusion of separation and traumatic distress symptoms. These include elements of separation distress, posttraumatic stress and coping ability. The items include searching, yearning, crying, thoughts of the deceased preoccupying the mind, disbelief that the death is real, feeling stunned by the death and being unable to accept that it has happened. These symptoms in themselves could all be part of a 'normal' grief reaction but it is their severity and the length of time that they are experienced that marks them out as complicated (Prigerson et al 1995a). The items have been combined into a nineteen-item measure called the Inventory of Complicated Grief (ICG). This scale focuses exclusively on symptoms of grief that can become maladaptive, unlike other scales (e.g. the Texas Revised Inventory of Grief, Faschingbauer et al 1987) that measure symptoms of grief in general (i.e. both 'normal' and 'abnormal'). The Inventory of Complicated Grief has been found to have content and criterion validity and be reliable.

A number of studies have used the Inventory of Complicated Grief. Findings from this measure include: complicated grief and bereavement-related depression do have a tendency to occur simultaneously (Prigerson et al 1995b) but Rosenzweig et al (1997)

found that they tend to become less closely related over time. They found a peak in depression and complicated grief at six months post loss, but depression declined thereafter. However depression did not decline in those people who scored above the cut-off for complicated grief. Unlike the symptoms of bereavement related depression, the symptoms of complicated grief have been found to persist despite the passage of time and despite treatment with tricyclic antidepressants (Rosenzweig et al 1997). This suggests that drug treatments for depression will not reduce complicated grief levels. Bierhals et al (1995-96) found that the symptoms of complicated grief remained stable for at least three years for both men and women. Thereafter, widowers' levels of complicated grief tended to increase whilst it decreased among widows. A 20% prevalence rate for 'complications in bereavement' is well established (e.g. Lund et al 1985-86, Jacobs 1993) and this was repeated with the ICG (Prigerson et al 1995a). The Inventory of Complicated Grief seems to identify a group of people for whom there is long-term impairment and who are in need of psychological help.

Psychological well-being: Loneliness

Possibly one of the most common effects of the death of a loved one, is the feeling of loneliness that is felt by the bereaved person (Lund et al 1989). "The loneliness and insecurity of living alone appeared to be one of the most difficult aspects of widowhood to accept" (Bowling & Cartwright 1982, p.71). Loneliness is a feeling that an individual lacks or has been deprived of the company of a specific person or group (Stoddard & Henry 1985). It is to be expected when people grieve the loss of someone to whom they were closely attached (West et al 1986, Revson & Johnson 1984). Lopata (1979) found

that widows who expressed loneliness usually associated it with the absence of a spouse, companion or social support.

Weiss (1975) would argue that the widows in Lopata's study were talking about two different forms of loneliness. Weiss proposes that loneliness is not unidimensional and that there is a fundamental difference between emotional and social loneliness. Emotional loneliness is as a result of the absence of a close emotional attachment such as a partner or a spouse. It is experienced as a sense of being completely alone, whether or not other people are available in the social network (Weiss 1975). Social support will not have any effect on this type of loneliness. However social support should reduce social loneliness. This type of loneliness is as a result of the absence of a social network. It is experienced as boredom, and feelings of being marginalised (Weiss 1975). Stoddard and Henry (1985) agree with Weiss. Although happiness may well depend on having both affectional bonds with an intimate partner and a network of less intense relationships, the loss of the former cannot be compensated for by the latter. The only way that it could compensate was if one of the less intimate relationships underwent a qualitative change to become an affectional bond. People who develop a new intimate relationship may experience less loneliness. Lund et al (1993) found that people who had remarried had lower stress levels and greater life satisfaction and resolution of grief than those who had remained widowed.

Lonely people generally perceive their health and morale to be lower than do people who do not complain of loneliness. Most lonely people report being unhappy because they are

alone (Stoddard & Henry 1985). In a review of the literature on loneliness in older people, Peplau et al (1982) found that they are not any more lonely than other people. Studies suggest that there may be differences within the older age group. They may not be a homogenous group. Treas (1995) suggests that age 65 is now just an arbitrary marker for entry into old age. She suggests that it is those over 75 or 85 who are most vulnerable to the problems of old age. Two studies (Dean 1962, Tunstall 1967) suggest that those aged over eighty are significantly more lonely than other elderly. This is perhaps due to an increase in physical incapacity and/or decreased money or transportation. Sable (1991) found that even when adjustment was proceeding well, women who had lost their husbands described feelings of loneliness that were difficult for them to overcome.

Psychological well-being: Depression

Another common effect of coping with the death of a loved one, is to experience depression. Several studies have indicated that depressive symptoms only last a few weeks following bereavement whilst others (e.g. Futterman et al 1990) found that roughly 30-40% of adults could be classified as clinically depressed in the first few months following bereavement. The picture may be worse in older people. Mendes De Leon et al (1994) studied a large sample of elderly subjects (aged 65-99 years) and found that depression scores increased during the first year of bereavement but generally returned to pre-widowhood levels thereafter. However, depression scores remained high among 65-74 year olds well after the first year of widowhood.

DSM-IV (American Psychiatric Association 1994) indicates that a diagnosis of Major Depressive Episode (MDE) can be given if the relevant symptoms persist for more than two months. Several studies suggest that the number of depressive symptoms occurring at one month after a loss is one of the strongest predictors of unremitting depression (Rosenzweig et al 1997). Szanto et al (1997) reported that older bereaved individuals with suicidal ideation also usually experienced depressive symptomatology. They were also more likely to have a history of previous psychopathology. MacMahon & Pugh (1965) suggest that the widowed are actually at a higher risk of taking their own lives than non bereaved people. People who suffer long term depression or anxiety after a death, are in need of formal psychological intervention.

The effects of grief on physical well-being

Although many people experience a period of intense grief the majority are then able to return to a normal level of functioning. For some however, there are dire consequences. It has been found that bereaved people have a higher mortality risk than the non-bereaved (Parkes et al 1969, Kaprio et al 1987, Stroebe 1994). Most studies have found that those most at risk are people whose partners have died but a few studies have found increased mortality when another family member dies (e.g. Rees & Lutkins 1967, Roskin 1984). Men have been found to be at greater risk of dying than women, once they have been widowed (e.g. Stoddard & Henry 1985, Jones & Goldblatt 1987). It seems that men in many Western cultures (e.g. Fein 1977) are not encouraged to form affectional bonds (Bowlby 1979) within their friendships and that it is the marriage partnership which is expected to provide the majority of emotional support (Brain 1977). Therefore, when a

wife dies, the man stands a good chance of losing his only affectional bond (Stoddard & Henry 1985). The effect of this loss especially on older men leaves them vulnerable to illness or death. Many studies have also reported an excess in deaths from heart disease among the bereaved particularly in the first six months (Parkes et al 1969). Gallagher-Thompson et al (1993) found in a study of bereaved spouses aged over fifty, that they were 1.4 times more likely to experience a new or worsened illness than a non bereaved control group. They also found that the odds of reporting new and/or increased medication use were nearly two times greater for the bereaved participants.

1.2 Theories of grief

Grief is a highly complex process and there is no one theory that can offer a full explanation of all its complexities. Theories of grief should be able to explain individual psychological and physical differences in reaction to bereavement and indicate methods of intervention that will ameliorate distress and reduce the risk of complicated grief (Stroebe et al 1993b).

Stage versus Process Theories

The majority of theories of grief adopt a view that regards the grief process as a series of stages (Kübler-Ross 1970, Bowlby 1980). Popular culture also adopts this view. Bowlby (1980) describes four phases of grief. These stages involve numbing, protest, despair and reorganisation. Other researchers differ on exactly how many stages there are and what they are. However in general they do all cover the phases of an initial period of shock, disbelief and denial, an intermediate mourning period of acute somatic and emotional discomfort and social withdrawal and a culminating period of restitution (DeVaul, Zisook & Faschingbauer 1979).

Within the last decade researchers have increasingly been focusing on the continuing bond with the dead person (e.g. Klass et al 1996) and have argued that stage theories are not able to account for this. Bowlby's four stage theory (1980) has been specifically attacked by the authors in Klass et al (1996). It is argued that Bowlby saw the successful conclusion of grief as being a detachment of the living person from the dead person and a moving on and away from this dead relationship. However, Fraley and Shaver (1999)

argue that Bowlby's ideas have been misinterpreted and they cite many quotations that suggest that he saw grief as a lifelong process (e.g. Bowlby 1980, p.7-8). Bowlby also makes it clear that the stages he describes are not clear cut and that they are phases within which people move around. It seems that he himself did not regard them as linear even if that was the interpretation made by others.

With the increasing acceptance of diversity in grief it is becoming more widely recognised that the stages of grief are not meant to be taken as linear and that they should be seen more as a process and as guidelines through which people flow forward and back.

Psychoanalytic versus Stress Theories

The literature on theories of grief falls into two main strands. The first type is those theories that have emerged from psychoanalytic traditions. These include Freud (1917) and Bowlby (e.g. 1980). Attachment Theory was developed by Bowlby (1969, 1973, 1979, 1980) and he and others (e.g. Parkes 1965) have applied it to the experience of typical and atypical grief.

The focus of Attachment Theory is on grief as an emotional reaction. Attachment Theory argues that the first relationship between an infant and a primary caregiver is vital for the infant's physical and psychological survival and also provides the blueprint for all the other attachments he or she will make in life (Parkes 1991). Conceptualisation of attachment theory emphasises the important patterns of early attachment – anxious ambivalent and avoidant attachments (insecure attachments) and secure attachments –

and how these may influence reactions to temporary or permanent separation. It provides an important understanding of people's emotional symptomatology in response to a loss.

The second group, stress theories, focus more on the physical health consequences of bereavement (e.g. Horowitz 1976/1986). These theories suggest that bereavement is stressful because it requires major readjustment to many aspects of a person's life (e.g. financial, travel, relationship to others). The level of stress experienced will depend upon the individual's ability to cope and this will be determined, in part, by the perceived demands of the situation. The failure to cope will lead to important negative consequences such as a decrease in physical health quality (e.g. Gallagher-Thompson et al 1993) or even death (e.g. Parkes 1996). An adjunct to stress theory is that social support plays an important role in an individual's ability to cope with stress. Social support can buffer an individual against the negative effects of stress on health. This is known as the "buffering effect".

Stroebe et al (1996) tested predictions from stress theory against those of attachment theory about the role of loneliness and social support in adjustment to the loss of a spouse. Stress theory predicts that social support from friends and relatives will compensate for the support previously received from the lost person because others will replace the coping deficits created by the loss. Attachment Theory predicts that social support cannot compensate for the loss of an important attachment figure because that person was unique in being able to engender a sense of security.

To compare the two theories, Stroebe et al (1996) carried out a two-year longitudinal study of sixty bereaved people under the age of retirement (mean age 53.05 years). The comparison group included sixty married people (mean age 53.75 years). Both groups included thirty males and thirty females. The researchers measured perceived social support, emotional and social loneliness, depression and somatic complaints. They developed their own measure for loneliness but used standardised measures for all other variables. They found that social support had no significant impact on symptom levels of the sample. There was no “buffering” of the effects of stress caused by a bereavement. High social support was able to decrease levels of social loneliness (the sense of being alone due to the absence of a social network) but it did not affect emotional loneliness (a sense of being alone due to the loss of an affectional bond). Emotional loneliness could not be reduced by the presence of other support. The absence of a buffering effect is thus consistent with predictions from attachment theory.

It seems that Attachment Theory may provide a coherent account of the reactions to loss and that this can be tested in carefully completed studies. It is recognised as one of the major theories of bereavement (Fraley & Shaver 1999).

1.3 Attachment Theory

Attachment Theory (Bowlby 1969, 1973, 1980) has evolved over six decades into a major framework within developmental psychology that combines elements of ethology and psychoanalysis. It offers an informative explanation of the link between the experiences of lack of care in childhood and the many varied forms of mental distress shown in adulthood, especially those related to grief reactions. At birth the infant is dependent on the caregiver for survival and is therefore pre-disposed to remain close to the caregiver. Bowlby observed that infants have evolved physical adaptations (such as large eyes) and behavioural adaptations (such as crying) that attract the attention of potential caregivers. Infants also possess a motivational system (the attachment system) designed by natural selection to regulate and maintain proximity to a caregiver. Two important concepts within Attachment Theory are those of a secure base and of mental representations known as 'internal working models'.

A Secure Base

From the moment of birth the infant is in an unknown and potentially highly threatening environment. In that environment there needs to be someone with whom the infant can feel safe. The infant needs to feel that there is someone secure that she can depend upon, that she can return to whenever she is frightened and that she can leave when she is ready to explore again. The infant internalises this person as a 'secure base' (Bowlby 1988). It is usually the primary caregiver who is internalised in this way. Initially the caregiver must be visible whilst the child explores the environment but as the child grows she/he can be in another room, another house, another town etc. The child has an internal

representation of the caregiver. At times of insecurity such as illness or danger she will want the caregiver to become visible again but at other times the security provided by him/her can remain within the mind.

Internal Working Models

Our predictions about the self, the world and others are stored within our mind as 'internal working models' (IWMs). These are our blueprints for how we expect important others to behave and how the self might feel, think and behave in response. As infants they account for what children need to maintain proximity to their caregivers, predict the caregiver's behaviour and so ensure survival (Bowlby 1969). They develop initially out of repeated patterns of experience between infant and primary caregiver and they provide a subjective representation of the self and the caregiver (Magai & McFadden 1995). Both cognitive and emotional processes are involved. These mental representations are perceived as organised structures and although resistant to change are also open to modification over the course of development.

The fact that IWMs develop out of our experience with caregivers means that the quality of early care is important. A child who receives love from a dependable, consistently available caregiver and who is both protected and also given chances for freedom and exploration appropriately, will grow up with a secure sense of attachment. The child will have a truly secure base and her internal working models will be based on ideas of trust and an expectation that her needs will be met. However if a child receives care that is neither dependable nor constant, that is perhaps unpredictable and is not nurturing she

will grow up with a rather insecure sense of attachment. Her IWMs will be based on ideas that people are not dependable, cannot be trusted and may desert her in times of difficulty.

Attachment and Loss

Research into attachment in adult relationships began in the early 1970s with studies of adult bereavement (Bowlby & Parkes 1970, Parkes 1972). An inherent aspect of Attachment Theory is that of separation and loss. In essence, to be attached to somebody means to have to cope when that person is lost for an hour, a week or forever. 'Separation anxiety' is the term given to the reaction to such a loss in young children (Bowlby 1960). Bowlby (1980) argued that the psychological mechanisms that underpin brief separations also underpin permanent separations such as bereavement.

Mary Ainsworth was the first researcher to look at the reactions of infants to brief separation in the late 1960s with an experiment called the 'Strange Situation'. From her initial work three main attachment styles were observed. These were 'secure', 'anxious-ambivalent' and 'avoidant'. The 'Strange Situation' (Ainsworth et al 1978) is a twenty minute experiment in which the primary caregiver and one year old child enter a novel playroom with an experimenter. The caregiver leaves for three minutes whilst the experimenter remains. After the caregiver returns and reunites with the child the latter is left completely alone in the room for another three minutes. The aim of the experiment is to elicit the infants' individual responses to coping with the stress of separation and reunion. The 'secure' infant is usually distressed at separation but accepts comfort on

reunion with the caregiver and returns to play in an uninhibited way. The 'avoidant' infant shows few signs of distress on separation and ignores the caregiver when she returns. The infant plays in an inhibited fashion. The 'anxious-ambivalent' infant is very distressed by the separation and does not calm down upon reunion. The infant alternates between clinging to the caregiver and being angry with her. The infant again plays in an inhibited fashion.

Bereavement is the ultimate separation and Attachment Theory argues that a form of separation anxiety ensues as a response to loss in an important relationship i.e. parent-child, adult-spouse or adult-companion where love, support and caring are involved (Mikulincer & Florian 1996). "The possession of an accurate internal model of the world is a major source of confidence and self esteem. Major losses render a large section of that model obsolete, the sufferer feels lost in a world that looks familiar but feels unfamiliar" (Parkes 1992, p.47). Attachment Theory offers a plausible explanation of how insecure attachment styles can lead to difficulty dealing with a death. "It seems logical to suppose that those who relate poorly to the living are probably going to relate poorly to the dead" (Middleton et al 1993, p.58). Anxious ambivalent individuals have experienced a general lack of responsiveness from attachment figures and thus chronically anticipate rejection and loss. They are more likely to experience chronic grief. They are unlikely to resolve their grief because their attachment systems are primed to continue yearning and searching for the missing attachment figures. Avoidant individuals, who do not show any attachment-related feelings, are more likely to experience delayed or absent mourning. These forms of mourning can run on a

continuum ranging from 'chronic mourning' to 'prolonged absence of conscious grieving'. Attachment Theory suggests that secure individuals will experience grief that is somewhere in the middle of this continuum. However some researchers suggest that this may be an oversimplified view. Parkes (1990) suggests that the presence of other factors could lead people with secure attachments to also develop complicated grief. These other factors might be things like multiple or unexpected and untimely losses of people on whom one depends or who depended on the survivor, lack of security or support.

Measurement of Attachment

There are a variety of qualitative and quantitative measurements that attempt to assess attachment in adults. The most notable attachment measure is the Adult Attachment Interview (George et al 1985). It is an hour-long qualitative interview that measures both attachment experiences that have probably taken place in the past and the way in which these experiences are represented in the mind. The focus therefore, is on internal working models as opposed to actual attachment styles. Administration of the AAI requires extensive training and each interview needs to be transcribed and coded. The time consuming nature of the AAI means that in many studies it is impractical to use.

The Adult Attachment Styles questionnaire (AAS) (Hazan and Shaver 1987) is a measure which asks people to self rate their attachment style with respect to their feelings about themselves in romantic relationships. It is a three-item questionnaire that parallels the three attachment styles delineated by Ainsworth et al (1978). Many studies have found

that people rate themselves in one of the insecure categories (see Batholomew and Shaver 1998 for a review). This suggests that people are not biased when completing the AAS and do not automatically choose the secure option despite its suggested attractiveness.

Other measures have attempted to capture specific aspects of attachment such as memories of parenting. For example, Andersson and Stevens (1993) used the Parental Bonding Index (Parker et al 1979) to study the impact of experience with parents on the well being of elderly persons. They argue that the PBI is well suited for research in which internal working models of the self and others are important because it focuses on the recalled responses of parents to the individual's behaviour as a child in terms of care and overprotection. Andersson and Stevens (1993) found that the effect of recalled parental quality was stronger among those older people who lacked a current attachment figure in the form of an intimate partner. Their study offers some support for the notion that early experiences with parents will have an effect on the response to loss of a significant other.

There are no attachment measures currently available that have been developed with older people. Despite the many measures of attachment it is not yet clear whether the patterns of security detected in adulthood derive directly from the attachment styles developed in early life. Studies of attachment in adulthood show that insecure and secure patterns are detectable (Feeney & Noller 1990, Shaver & Hazan 1987) but not that they are necessarily the same as those detected in childhood. In a longitudinal study, Grossman and Grossman (1991) found that attachment patterns in the first ten years of life show 80% stability suggesting that there is at least some longitudinal pattern.

However it is not until samples like that of the Grossmans' study can be followed through to old age will the real answer be known.

Attachment and Old Age

It seems that even in adulthood, individuals appear to have a fundamental need to belong and to have unique and multiple attachments with others throughout the life span (Holmes 1993). Bowlby (1979) suggests "Whilst especially evident during early childhood, attachment behaviour is held to characterise human beings from the cradle to the grave".

Some researchers have suggested that older people cope better with the loss of a loved one because it happens during a stage of the life cycle in which it is expected (Neugarten 1979). However there is other research that suggests that this is not the case. Wortman & Silver (1990) emphasised the importance of a life course perspective. "The pain and anguish that spousal bereavement brings attests to the place of attachment in the lives of us all, not only when we are young, but throughout the life cycle" (Sable 1991, p.139). If people have experienced an attachment to one person for many decades and shared many intimate moments then why is it to be believed that there comes a point when people emotionally accept that the time is right for attachments to end? It may never feel that it is the right time to lose this affectional bond (Bowlby 1979) and it may never be readily accepted (Stoddard & Henry 1985). Important relationships provide a sense of security because of their stability or continuity and when these are lost forever that security is shattered temporarily or permanently.

Marris (1974,1978-79,1982) perceived bereavement as a crisis that upsets the meaning of life because we structure the meaning by our special attachment relationships. He feels elderly adults may be in particular jeopardy because of their tendency to view their lives retrospectively. The loss of a spouse may affect the nature of their remaining years, making them feel their life is over. Furthermore if it is later in life, it occurs at a time when attachment behaviour is prone to intensify rather than diminish (Bowlby 1988). Sable (1991) interviewed 81 women between the ages of twenty six and eighty two who had been widowed for between one and three years. She found that the older women grieved more intensely at the interview, reported more feelings of anxiety and depression and did not tolerate or adapt to bereavement more successfully than the younger women.

Those that are able to form new attachments may find it easier to cope with the death of a loved one. Lund et al (1993) found that remarriage was moderately related to better well being. Unfortunately older people, especially older women (Maddison & Raphael 1975) are more likely to lack an opportunity to replace the missing relationship with one of comparable intimacy.

Prigerson et al (1997) suggest that it is not simply that insecure attachment style leads to complicated grief but that of equal importance is the type of relationship that existed prior to the death. This is echoed in theories of grief resolution (Stroebe & Stroebe 1987). Parkes and Weiss (1983) found that widows who reported fewer disagreements with their spouse experienced less anxiety, depression, guilt and yearning for the deceased. Zisook et al (1987) found that conflictual relationships lead to greater depression levels post

bereavement. However in these studies marital quality information was collected after the death of the spouse and therefore could have been subject to retrospective bias. A study which collected information on marital quality prior to the death of a terminally spouse was completed by Van Doorn and colleagues (1998). They studied people aged over fifty before and after the death of their terminally ill spouses. Prior to the loss they used the Relationships Style Questionnaire (Pilkonis et al 1994) to measure current attachment style to non-specific other people and the marital domain of the Self-Evaluation and Social Support record (Brown and Harris 1986). They also administered the Inventory of Complicated Grief after the death. They found that people with insecure attachment styles who reported their spousal relationship as supportive, confiding and characterised by positive interactions were more likely to have higher complicated grief symptoms.

Attachment Theory offers an important conceptualisation of the link between early childhood experiences and psychological difficulties following the loss of a loved one. Studies also highlight the attachment function of spousal relationships and the effect that this can have on subsequent grief. Although there are few studies looking at attachment style over a long period of time there is certainly some evidence that recalled quality of parenting is related to psychological well-being in old age.

1.4 Risk Factors Following a Loss

Within the field of bereavement studies there are two main research methods that have been used to study risk factors and outcome (Parkes 1990). One method is retrospective studies of bereaved individuals. These allow us to study people with specific grief outcomes. They often lack control groups. The second method is prospective studies of people who are interviewed before or shortly after bereavement. These are usually carried out in the community. They are often longitudinal in design so that over time they can discover who does well and who does not.

The number of retrospective and prospective studies looking at the bereavement reaction of older people, is limited. The majority of studies that exist, focus on spousal loss and thus little is known about other types of loss. What is more although many of these studies describe their participants as 'older people' the sample often includes people under the age of sixty-five (an age generally regarded in England as the beginning of 'old age'). There are no studies of grief in older people that use a standard measure of complicated grief. There appears to be only one study looking at grief reactions in older people attending a clinical setting specifically because of their grief (Parkes 1991). Finally, despite the important contribution of Attachment Theory to our understanding of grief and mourning (Stroebe et al 1988) there are only two studies that investigate the link in older people (Parkes 1991 and Sable 1991). Overall the literature is unclear about the effects of bereavement or the particular factors that affect an older individual's adjustment (Sable 1991).

Sanders (1993) suggests that a number of methodological concerns cloud the interpretation of available data on bereavement research. There is a selection bias in many studies in that many of the participants in bereavement research are women. This may be because samples are taken from mental health sources and more women attend than men for bereavement difficulties (Parkes 1991), or women are more likely to reply to adverts or more women suffer bereavements. It is certainly true that husbands are more likely to die before their wives. The elderly population is predominantly female. The average woman is at home with her husband for five and a half years after he retires. On average, she then lives for a further five and a half years (Parkes 1992). Therefore it is women who are more likely to lose their partner. A further problem is that only participants who volunteer are included and therefore other forms of grief might be experienced which do not get studied. Studies do not always include non-bereaved matched group. Finally, there are few reliable measures for assessing the symptoms of bereavement. Whilst reviewing current literature it is useful to keep all of the above in mind.

In order to illustrate the diversity in grief research in older people four studies will be presented. The first two studies presented are landmarks in the field of bereavement research in older people. They were borne out of the growing recognition in the 1970s that research on bereavement in older people was lacking. They are both longitudinal in design and indicate some of the risk factors for bereavement difficulties. However both studies include people aged under sixty-five although the researchers regard them as 'older people'. The second two studies are cross-sectional and are the only two studies to

include measures of attachment in looking at grief in older people. One study is specifically with a clinical sample of bereaved people. The other is with a community sample of women only. Both studies include people aged over sixty-five.

The final part of this section is a summary of all risk factors for complicated grief that have been identified in a number of review studies. These are not necessarily specific to the older population. It is necessary to widen the literature search to these other studies due to the paucity of information on risk factors in older people. This information will act as a reference point for the current study.

Prospective Studies – study 1

Dale Lund and colleagues carried out a number of landmark longitudinal studies in the USA during the late 1970s and 1980s looking specifically at bereavement in older people. His book (Lund 1989) included the results of nine major studies. One of these studies was a two year longitudinal study of one hundred and thirty eight people aged over fifty who had recently lost their spouse (Lund et al 1985-86). 78% of the participants were female. Of those people who were asked to take part, 61% refused. This could have been due to the fact that the researchers contacted people within weeks of the death. This study did not include a control group. The researchers developed a scale that combined perceived stress, coping and depression and found that 18% of their sample were having difficulties after two years. The participants also completed questionnaires on bereavement-related feelings and behaviours, life satisfaction, social supports, religious activity and self-esteem. They found that the factors of an intense wish to die, confusion, low intensity of

feeling proud, crying frequently and not trying to keep busy in the early stages of bereavement were important predictors of having difficulty coping at two years. They found that social support did not have an impact on the level of coping.

Prospective Studies – study 2

The second study was by Gallagher-Thompson et al (1993) who carried out a thirty-month longitudinal study of the mental and physical health of older people following the death of a spouse. They evaluated a number of risk factors that included personality and ego strength, social support, religiosity, marital quality, anticipation of loss, and cumulative losses/stressors. The study compared two hundred and twelve recently widowed males and females aged over fifty-five with one hundred and sixty two people who had not lost a spouse within the last five years. There were almost equal numbers of men and women in the two groups. The bereaved participants were identified through the examination of death certificates and invited to take part. 30% of those approached replied and 28% of those were followed up (9% of the sample population).

The two groups were studied at two, six, twelve and thirty months. Participants completed a structured interview and several self-report measures. Grief was measured with the Texas Revised Inventory of Grief (Faschingbauer et al 1987) and depression was measured with the Beck Depression Inventory (BDI - Beck et al 1961). They found that more than 30% of the bereaved were experiencing mild depression or greater at 2 months following the loss and 18% were still experiencing it at 30 months after the loss. They found that grief behaviours stayed elevated (Thompson et al 1991) even when depression

scores decreased. Older women reported greater distress than older men. This is a regular finding in the reporting of depression in men and women (Nolen-Hoeksema 1987). In conclusion they found that the loss of one's spouse late in life may be followed by a period of considerable mental and physical distress. This general distress, unlike grief itself, diminished to roughly "normal" levels by 30 months following the loss. They made a similar finding to Lund et al (1985-86) that those who are more psychologically distressed at the outset have a more difficult adjustment over time.

As with most studies there are a number of aspects to these two studies that can be called in to question. Although both studies are helpful in understanding grief in the community there are three points which make it difficult to generalise. Firstly although in clinical practice, older people are usually regarded as being aged over sixty five, both studies included younger participants. One study classified older people as being aged over fifty and one classed them as being over fifty five. The experiences of people aged over sixty-five may be very different to those under that age and grouping them together may lead to the loss of important information about older people. Certainly within the field of loneliness research it has been found that there are differences in prevalence depending on age (e.g. Dean 1962). People over seventy-five are more likely to be living on their own.

Secondly, there may be an extremely strong selection bias in these studies. Although it is understandable that many newly bereaved people are unlikely to want to take part in research focusing on their grief it means that it can be difficult to generalise results.

Those people who do agree to take part in such research may be the ones who are experiencing fewer bereavement-related difficulties. Only 39% agreed to take part in the first study (Lund et al 1985-86) and only 30% in the second (Gallagher-Thompson et al 1993) and only 9% of the sample were actually included in this second study.

Thirdly, although the second study included equal numbers of male and female, only 22% of the sample was male in the first study. The experience of grief may be very different for the two sexes.

The conclusion of Lund's book (1989) which reviewed nine major studies, was in agreement with the findings of Gallagher-Thompson et al (1993). He concluded that "the overall impact of bereavement on the physical and mental health of many older spouses is not as devastating as expected. This point is acknowledged with considerable reluctance because it might be interpreted by some to imply that these people are not at risk for serious life difficulties and do not need any intervention services". However it is important to keep in mind the percentage of people interviewed. As noted above it is possible that those most deeply affected were those that decided not to take part. Coping with the death of a loved one is extremely stressful and possibly the most stressful experience that an individual can go through. Lund et al (1993) found that 72% of their sample of people aged over fifty reported the death of their spouses to be the most stressful event they had ever experienced. For those people who do have more serious difficulty, retrospective studies allow us to look more closely at their experiences.

Retrospective Studies – study 1

Parkes (1991) studied the case-notes of fifty-four people referred to him, over a five-year period, for the treatment of psychiatric disorders that had developed after a bereavement. The study included older people but was not specifically about them. The ages ranged from fourteen to eighty with a mean age of forty-eight. The majority (91%) were women. The majority of people were mourning the loss of a spouse (44%) but other relationships were included (e.g. parent or child).

Parkes used a 120 item checklist which he developed himself and which included variables on parents & parenting, the patient's personality, recent life circumstances and events, current symptoms and problems. He himself acknowledged that the measure might not be reliable or valid and that collecting data from notes meant that it was only as good as the notes from which they derived. However he concluded that the findings made logical sense based on his experience as a clinician. He drew a number of conclusions from the data. People who experienced multiple, sudden, unexpected or untimely deaths were at risk regardless of any other vulnerability. People who had not suffered one of the above bereavements but displayed psychiatric problems usually showed previous evidence of vulnerability.

Parkes also made a number of links between attachment and bereavement response. Anxious and conflicted parents predispose their children to become insecure adults and to react to bereavement with anxiety. Absent and rejecting parents predispose their children to depression after bereavement in adult life. Relationships in which one partner relies on

another for reassurance or independence and strength may give rise to 'chronic grief' when that partner dies.

Retrospective Studies – study 2

The second retrospective study was by Sable (1991). Her sample was community based and the study examined attachment, loss of spouse and grief in older women. Sable interviewed eighty-one widowed women between the ages of twenty-six and eighty-two. Eighty eight percent of the women were aged over fifty. Sable hypothesised that some women would have greater difficulty in adjusting, and that these women would reflect certain experiences that distinguished them from those with less difficulty.

The risk factors that were investigated were age, causes and circumstances of loss, social support during bereavement, socioeconomic status, and attachment, separation and loss experiences both currently and in the past. The level of grief was measured using the Texas Inventory of Grief (TIG, Zisook et al 1982). A semi-structured face to face interview was also conducted that explored general functioning and feelings since the loss, relationship with the spouse, social support systems, and details of the loss such as how the person died. The interview questions were derived from bereavement studies done by Marris (1958) and by Parkes & Weiss (1983) and also included parts of the Attachment History Questionnaire (DeLozier 1982). Sable found that older women who had lost their spouses were more distressed throughout the first three years of bereavement than younger women. Sable (1989) also found that women who described

more secure early attachments seemed to be handling bereavement better. They showed less distress on the TIG and less anxiety and depression.

As with the prospective studies there are a number of aspects that can be called in to question. Firstly, the age above which people were regarded as old was again set at fifty in the Sable (1991) study. This makes it difficult to generalise to clinical settings for older people.

Secondly, although both studies included measures of attachment neither had established reliability and validity. This makes it difficult to be sure that the studies actually measured attachment style as described by Bowlby (1963, 1979, 1980)

Thirdly, the studies were biased towards women (Sable's sample being exclusively female) again making it difficult to generalise any findings to the grief experience of men.

Despite these criticisms these studies suggest that there is a need for further exploration of attachment and ageing and not just in those people who have lost a spouse. Parkes' clinical group showed that people seek psychological help after the loss of other loved ones. In attachment terms it is easy to see how the loss of a spouse can lead to difficulties. It is the loss of a relationship that has been a central part of the individual's life for many years. This loss comes at a time of life when it is compounded by the stresses of ageing

and can thus be doubly stressful. However little is known about the relationship between attachment, old age and loss of other significant relationships.

Other Risk Factors

As shown above the information about older people and risk factors for low psychological well-being is very scarce. Thus it is necessary to look at the wider research which focuses on adults under the age of sixty-five. A number of researchers have described the general risk factors that have been identified following difficult bereavement reactions (e.g. Sanders 1993, Parkes 1990, McKiernan 1996). Sanders (1993) divides the factors into four groups: (1) biographical/ demographic, (2) individual, (3) mode of death and (4) circumstances following the loss. These terms are adopted below:

Biographical / Demographic Factors

Age of bereaved person

Parkes (1970) found that women under sixty-five consulted their GPs for emotional problems more frequently during the first six months of bereavement than older widows, and they also took more medication. Sanders (1981) found that initially younger spouses had higher intensity of grief but two years later they showed a significant improvement. The older widows initially showed a lower intensity of grief but after two years they experienced a great deal of anxiety and loneliness. In contrast, Sable (1991) found that older women showed more intense grief than younger women at interview and were more anxious and depressed. However the interview was anywhere between one and three

years after the loss of spouse. Lund et al (1986) found that age did not predict adjustment in their sample of fifty to ninety three year olds.

Gender of bereaved person

There is little consensus on the effects of gender on grief experience. Lund et al (1986) found that older males and females differed in their lack of specific skills of daily living but they were similar in their emotional, psychological, social and health adjustments. Women seem to show more distress than men but this may simply be related to the general finding that women report more depression than men (Nolen-Hoeksema 1987). Men are at greater risk of dying after a bereavement (e.g. Jones & Goldblatt 1987). This may be one of the reasons why most bereavement studies include more women than men.

Relationship to the deceased

The relationship to the person who died has also been found to be important. The majority of studies have looked at spousal bereavement (e.g. Lund et al 1985-86, Sable 1991) and certainly the death of a spouse can have devastating effects for about 20% of older people (e.g. Prigerson et al 1995a). However the death of a child, the death of a parent and the death of other people can also have devastating effects.

Leshner & Bergey (1988) studied the emotional changes that occurred in eighteen elderly mothers (mean age of 86.6) after the death of an adult child and found a high level of psychological distress (as measured by the Geriatric Depression Scale and the TRIG). Rando (1985) suggests that there may be a sense of 'survival guilt' in that parents do not

expect that their child will die before them. Edelstein (1984) suggested that the death of a child at any age leads to three losses: the loss of part of oneself, the loss of a link to the future, and the loss of illusions regarding life and death. Some researchers argue that this type of death may be the most difficult death to resolve because there is a mourning for the self as well as the child who died (Sanders 1980). The intensity of grief may be of longer duration than other types of bereavement.

Research on loss of a parent seems to mainly have focused on children and adolescents. There does not seem to be any research that has looked at loss of a parent in old age.

Individual Factors

Health of bereaved person before bereavement

It is likely that if an individual has suffered mental health difficulties prior to a loss, the stress of grief will exaggerate that condition during bereavement. Parkes (1975) reported a link between poor bereavement outcome and premorbid mental illness. Nuss and Zubenko (1992) found that a prior history of mental illness was associated with increased risk after a bereavement. Hays et al (1994) also found that a past history of a criterion based psychiatric disorder did increase vulnerability to distress after a bereavement. Their findings also suggested that a past history of sub-syndromal affective symptomatology also increased the risk of distress following a bereavement. They suggest that the relationship between a past history of a short period of low mood and complicated grief should be investigated.

Mode of death

Sudden unexpected death

Several studies confirm the traumatic effects of sudden, unexpected deaths (Lundin 1984, Duke 1980, Shanfield et al 1987). However, Clayton et al (1971) showed no such associations. Her studies included an older population. Parkes (1990) suggested that her findings might indicate that a sudden death is not unduly traumatic for older people because they are expecting death to occur.

Sudden unexpected death has been shown to have a debilitating effect on the bereaved in that shock acts to prolong grief as well as to produce excessive physical and emotional trauma (Lundin 1984, Sanders 1989). If a death is expected people have an opportunity to experience 'anticipatory grief' i.e. symptoms of grief prior to the death. It is argued that experiencing anticipatory grief reduces the grief reaction following the death (e.g. Averill 1968, Ball 1977). Some studies have assumed that anticipatory grief occurs if the illness prior to death is more than five days (e.g. Ball 1977) whilst others have used measures of anticipatory grief (e.g. Levy 1992). If, as research suggests, experiencing anticipatory grief is beneficial for the long-term grief reaction it seems inappropriate to always assume that it occurs during prolonged illness. Kramer (1996-97) studied women whose husbands were terminally ill. She found that not all women experienced anticipatory grief. She found that those women who were able to be open and honest with themselves (and if possible, their spouses) about the death were able to experience better post-death adjustment. Thus the death may come as a sudden shock for those people who, for

whatever reason, cannot be open and honest about the impending death no matter how long their loved one has been ill.

Parkes (1975) noted that the mode of death was one of the primary predictors for bereavement outcome after spousal loss. Parkes described it as the 'unexpected loss syndrome'. This was confirmed by his case-note analysis (see page 35) (Parkes 1991). Lundin (1984) also found respondents who experienced the sudden death of a relative had significantly more somatic and psychiatric complaints compared to those who'd anticipated the death. They had higher levels of unresolved loss as measured with the Texas Inventory of Grief (Zisook et al 1982). Lehman, Wortman & Williams (1987) found that four to seven years after a car crash in which a spouse or child died, bereaved people showed significantly greater distress than did matched controls. The unexpected deaths seemed to leave survivors with feelings of loss of control and loss of trust.

Suicide

Some researchers have argued that reactions to deaths by suicide are more extreme and last longer than reactions to other deaths (Cain 1972, Demi 1978). Gallagher-Thompson et al (1993) studied one hundred and eight people over the age of fifty-five whose spouses had committed suicide. They compared them to two hundred and twelve older people who had lost a spouse through natural death. They found that initially there was no difference in distress between the two groups. However, over the course of thirty months they found that the level of psychological distress remained more intense and

lasted longer in the suicide survivors group. It seems that people who have survived suicide are at risk of intense and prolonged grief reactions.

Homicide

Rynearson and McCreary (1993) studied eighteen people who had suffered a bereavement by homicide. The majority of deaths were of children (66%). The mean interval since the murder was two and a half years. They used the TRIG (Faschingbauer et al 1987) to measure grief and the Impact of Events Scale (Horowitz 1981) to measure trauma. They found that the group showed extremely high measures of grief and severe trauma. They suggest that the mode of dying and that the indirect exposure to homicide creates acute and sometimes chronic signs and symptoms of posttraumatic stress phenomena.

Number of deaths

In a review of available evidence, Stroebe and Stroebe (1987) found that bereavement in adult life may help in coping with a bereavement in old age (e.g. Vachon, 1976). However, experiencing multiple bereavements may increase the risks of suffering psychological distress (e.g. Kastenbaum 1969). Clegg (1988) found that 31% of people admitted to a psycho-geriatric ward had suffered more than one bereavement. Parkes (1992) also included multiple losses as a risk factor in his article on the psychological well-being of older people following a bereavement. The time frame within which to count multiple losses, is not clear from the research.

Circumstances Following the Loss

Social Support

It is generally believed that the presence of emotional or instrumental social support assists in adjustment to the loss of a loved one (Stroebe & Stroebe 1987). Many bereavement studies have included measures of social support. Bowling and Cartwright (1982) found that the widowed in their study obtained social support from a network of friends and relatives, and frequent contact with someone close did seem to alleviate feelings of loneliness. Social support early, rather than later, in the process of recovery has been associated with better mental health (Schuster & Butler 1989). One conclusion that has emerged from research on depression is that it is the quality of social support that is more important than simply the quantity or number of individuals in the network (e.g. Henderson et al 1981). Lam and Power (1991) found that emotional and practical support (measured with the Significant Others Scale, Power et al 1988) were negatively correlated with depression as measured on the Geriatric Depression Scale-30 (Yesevage et al 1983) in a sample of older people. They also found that 14% of the variance on the GDS-30 was explained by the SOS.

Duran et al (1989) found that stable social support was a buffer of stress two years after the death. The qualitative aspects of social support (e.g. perceived closeness, self-expression, contact, shared confidence, and mutual helping) were important in leading to lower depression and more positive ratings of coping, health and life satisfaction (Dimond et al 1987). Raphael (1979) found that widows who viewed their families as unhelpful were at greater risk after bereavement than those with helpful families.

Gallagher (1986) states that bereaved elders who are lonely and without adequate social support tend to be at risk for developing serious adjustment problems.

Commentary

People can have difficulty coping after the loss of any significant relationship. Although the literature has focused mainly on spousal loss it seems that other losses can also be devastating. The mode of death seems particularly important. If a person dies suddenly or unexpectedly or is murdered or commits suicide then the bereaved person is at greater risk of low psychological well-being. If multiple deaths occur within a short time span there is also greater risk of low psychological well-being for the bereaved person. Attachment style is another important risk factor. People with an insecure attachment style, perhaps especially an insecure-ambivalent/dependent one, may be more likely to have difficulty coping than people who have a secure attachment style. Another risk factor for low psychological well-being is the presence of prior mental health difficulties. Lack of social support seems to have some impact on the grief experience but results are contradictory. From the available literature it seems that the majority of older people who are bereaved do not experience long-term difficulties. There is a small amount of evidence that being an older woman is a risk factor for complications in grief (i.e. Sable 1991).

1.5 Current study

There are no studies to date that have looked at risk factors for low psychological well-being in males and females aged over sixty-five who have suffered the loss of a significant other. What is more there are no studies that have included valid and reliable measures of both attachment styles and complicated grief. The current retrospective study is a first step towards filling these gaps in the literature. It is a preliminary investigation of the risk factors for low psychological well-being for people aged over sixty-five. The inclusion criteria for the study will be anyone who is aged over sixty-five and who has suffered the loss of someone that they consider to be significant (e.g. spouse, child, sibling). People will not be included if they have suffered a loss within the previous six months. There will be no exclusions on the nature of the death or the length of time since death.

The participants will complete valid and reliable measures of complicated grief, depression, loneliness, attachment style and social support. Information will also be collected from participants about past medical and psychiatric history.

Research Question

The over-arching research question is **‘What are the risk factors for low psychological well-being in bereaved people aged over sixty-five?’**

Research suggests that following the death of a loved one many people experience loneliness and depression. There is also a sizeable minority who experience complicated

grief. These three mental health effects can be put together under the umbrella term 'psychological well-being'.

Research into Attachment Theory provides good evidence that there is a relationship between quality of parenting received in childhood and psychological problems in adulthood. In relation to bereavement, Attachment Theory suggests that these psychological problems may predispose a person to complicated grief following a significant loss. Attachment Style is classified as an 'individual factor' in the literature on risk factors.

Research into risk factors for low psychological well-being suggests that there are three other areas of risk. These are biographical factors (i.e. the relationship to the deceased), circumstances following the loss (i.e. social support) and mode of death (i.e. sudden or unexpected death and number of deaths experienced around the time of the most significant death). These all affect the psychological well-being of a person following the loss of a loved one. The suggested model of the interaction of the four areas of risk is illustrated in Figure 1.1.

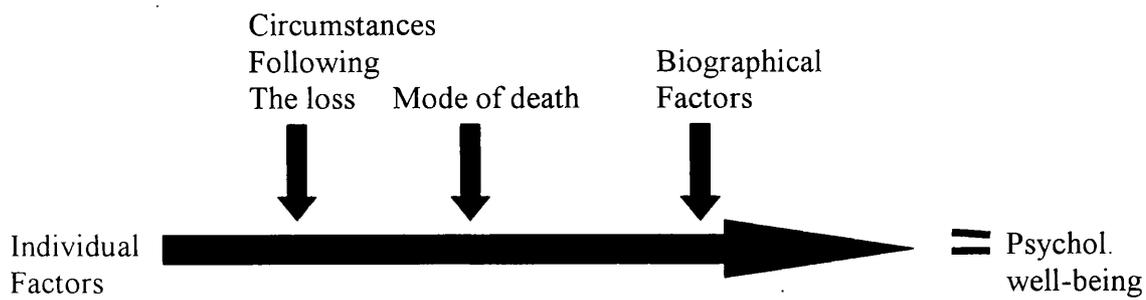


Figure 1.1: Conceptual model of the relationship between individual factors, circumstances following the loss, mode of death, biographical factors and psychological well-being.

This model is further elaborated in Figure 1.2.

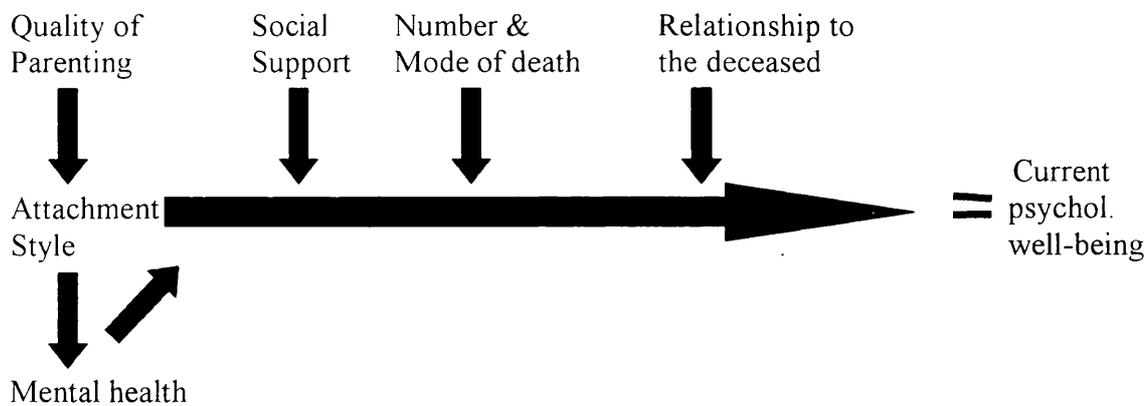


Figure 1.2: Conceptual model of the relationship between quality of parenting, attachment style, mental health, social support, mode of death, number of deaths and psychological well-being after the death.

The two main hypotheses for the current study are:

Hypothesis 1: Attachment style will be related to psychological well-being.

Hypothesis 2: The effect of attachment style on psychological well-being will be moderated by previous mental health, social support, number and mode of deaths and relationship to the deceased.

Chapter 2: Method

2.1 Design

This is a retrospective, non-experimental, non-randomised, post-test only study. The participants were people who were aged over sixty-five and who had suffered the death of a significant other (e.g. spouse, child, sibling) more than six months before the interview.

2.2 Recruitment

People seeing a psychologist

The researcher approached eleven Psychology Services for older people in the then North Thames region. Psychologists were asked if they ever saw clients with bereavement difficulties and if they would be willing to assist in the research. Eight departments said that they would be able to help. Three departments said that they did not see people with bereavement difficulties.

A memo indicating the study criteria (Appendix 1) was sent to participating departments. Psychologists were asked to approach their clients and ask if the researcher could send an information sheet to them. The psychologists then contacted the researcher and provided address details for the clients. They were sent an introductory letter (Appendix 2), the information sheet (Appendix 3), a reply slip and a stamped addressed envelope. Ethical approval required that clients were only contacted once. Eleven people agreed for the researcher to send details and all were subsequently interviewed. The researcher was told

about another eleven possible participants but their details were not subsequently provided. These people had decided not to receive an information sheet.

Recruitment through Psychology Services was low and consequently other bereavement resources were contacted.

People attending a bereavement support group

The co-ordinators of two bereavement support groups in Essex were contacted by the researcher and asked if they might be able to help in recruitment. The researcher was invited to talk to the groups about the project. In total, thirty information sheets (Appendix 4) and reply slips were sent to the co-ordinators who handed them out within one of their meetings. The co-ordinators collected the replies together and sent them back to the researcher. Twenty-three replies were received and thirteen people agreed to take part in the research.

People who had attended a bereavement counselling service

The co-ordinator of a bereavement counselling charity in East London was contacted and asked if she would be willing to help in recruitment. The trustees of the charity agreed that the researcher could contact clients who had completed their counselling. Introductory letters (Appendix 5), information sheets (Appendix 6), reply slips and SAEs were sent to thirty one people. Twelve replies were received and six people agreed to be interviewed. Two replies stated that the person had recently died.

People in the community

Members of the bereavement support group suggested two people who were not attending/had attended any bereavement resource. These people were sent an introductory letter (Appendix 7), an information sheet (Appendix 8), a reply slip and a stamped addressed envelope. Both people agreed to be interviewed.

Potential biases in recruitment

The majority of participants in this study had been in touch with or were in touch with a psychologist, counsellor or support group specifically in relation to the death of a loved one. There may be a qualitative difference between people who seek some form of professional or voluntary support for their grief and those that don't. The motives for agreeing to take part may also be specifically related to symptom level. For example, it is possible that people who were more lonely agreed to take part as it provided them with some short relief from their loneliness.

2.3 Ethical Considerations

Approval for the study was sought and obtained from North West Multi-Centre Research Ethics Committee (MREC) (Appendix 9). This approval was then forwarded to the LRECs for each of the eight participating Psychology Services. Some of the LRECs provided ethics approval for more than one Psychology Service. Approval was subsequently granted by Enfield and Haringey LREC (Appendix 10), The Royal Free Hospital and Medical School LREC (Appendix 10), The Redbridge and Waltham Forest LREC (Appendix 10), The Camden and Islington LREC (Appendix 10), East London and

City LREC (Appendix 10), and the West Essex LREC (Appendix 10). Approval was also granted by the Joint UCL/UCH Committees on the Ethics of Human Research (Appendix 11) to cover people who were not seeing a psychologist or counsellor.

An information sheet was sent to all potential participants. The information sheet was altered slightly to reflect the different organisations to which they were affiliated. The information sheet was designed to help people to decide if they wanted to take part in the study. The researcher subsequently met with all those who agreed to take part. The Ethics Committees regarded the information sheet and a brief introduction from the researcher as sufficient to allow participants to give informed consent. The researcher and participant signed the consent forms (Appendices 12 & 13) before the initial interview commenced.

It was recognised that the nature of the interview might cause some distress to participants. They were asked to make contact with the researcher if they felt that they needed subsequent help. No participants contacted the researcher for this reason. Twelve people completed a second interview that focused more specifically on relationships and losses. The researcher telephoned these people a week after the interview to check that they were not experiencing prolonged distress. No participants reported experiencing severe distress following the interview.

2.4 Participants

Due to the recruitment procedures, it is not possible to give an exact figure of people who were approached about the study. Seventy-four information packs were sent out and the researcher knows of a further eleven who were told about the study by their psychologist. It is possible, however, that psychologists also spoke about the research to other clients and the researcher was not told because they immediately declined to take part. Two people who had received support from the counselling service are known to have died and it is possible that some of the other thirty-one from that resource had moved or died. They therefore would not have received their information pack.

In total thirty-two people (43% of number of packs sent out) agreed to be interviewed by the researcher. Thirty-one people completed the full interview. One person did not complete the Parental Bonding Instrument or Adult Attachment Styles questionnaire. These were the final two questionnaires of the interview. Having completed the other questionnaires the participant felt that the response items were too restricting. She didn't feel that they were adequate for the responses that she wanted to give. She therefore decided not to continue with the final two questionnaires. Twelve people (37.5% of total) also completed an audio-taped interview adapted from the loss section of the Adult Attachment Interview (George et al 1985).

2.5 Measures

Inventory of Complicated Grief (ICG) (Prigerson et al 1995a, Appendix 14)

This questionnaire was chosen as a measure of complicated grief. It assesses symptoms of loss which are associated with long term functional impairments. It consists of 19 items that measure a single underlying construct of complicated grief. The complicated grief construct has been found to be clearly distinguishable from the symptoms of depression and anxiety. The scale was developed using data collected from 97 people aged over 65 who had been bereaved and were initially involved in a sleep and bereavement study. The mean length of time since bereavement was 2.83 (experimental group) and 15.25 (control group) years.

The questionnaire asks respondents to think about how they currently feel, think and behave and give their ratings on a five point Likert scale (ranging from 'never' (0) to 'always' (4)). The total score ranges from 0 to 76.

The original study found high validity and reliability. Internal consistency was 0.94. Test-retest reliability was measured at 6 months with 28 people and found to be 0.80. Concurrent validity was assessed with the Beck Depression Inventory (Beck et al 1961) total score ($r=0.67$, $p<0.001$), the Texas Revised Inventory of Grief (Faschingbauer et al 1987) total score ($r=0.87$, $p<0.001$) and the Grief Measurement Scale (Jacobs et al 1987) total score ($r=0.70$, $p<0.001$). The ICG appeared to have good face validity with 85% of respondents preferring it to the TRIG.

Quality of life measures were also completed (Medical Outcomes Study (MOS) short form general health survey, Stewart et al 1988). This was used to determine a threshold ICG score above which the respondent would have a significantly more compromised quality of life. People who scored >25 on the ICG were significantly more impaired than those who scored ≤ 25 . The differences found were in general health ($t = 2.51$, $df = 28$, $p < 0.02$), mental health ($t = 4.92$, $df = 28$, $p < 0.0001$), physical health ($t = 3.70$, $df = 28$, $p < 0.0009$), social functioning ($t = 2.49$, $df = 9$, $p < 0.04$) and bodily pain measures ($t = -20.57$, $df = 28$, $p < 0.02$). A second study (Prigerson et al 1995b) focused on people over 65 who had been bereaved for between 0 – 6 months. They suggested that six months was the earliest time point, after a death, to identify symptoms of complicated grief that would indicate long term impairments. People who scored above the threshold of 25 at six months post loss were the ones who were likely to have long-term impairments. The mean score for the sample of bereaved participants was 17.74 with 20% scoring above the cut off.

Studies using the ICG have tended to use the cut off score to define those who have long term impairments from their grief symptoms. People who score higher are more likely to have longer term difficulties. In the current study the complicated grief score will be analysed on a continuum. People's experience of grief is not categorical and taking a continuum approach reflects that. Grief is an experience of greater or lesser intensity. The ICG will be used as a measure of grief that has been found to measure a distinct construct in older people and not as a measure of categorical complicated grief. It will be taken that a higher score on the scale increases the chances of concomitant difficulties.

Adult Attachment Styles (AAS) (Hazan & Shaver 1987, Appendix 15)

This questionnaire was chosen as a short measure of attachment style. It was chosen to assess the impact of attachment on psychological well-being and level of grief.

The AAS is a three item questionnaire based on descriptions of romantic love attitudes that parallels the three attachment styles delineated by Ainsworth et al (1978). The Secure position describes feeling comfortable with dependency, finding it easy to get close to someone and having low anxiety about the possibility of loss. The Avoidant position describes feeling uncomfortable with dependency and lacking in trust. The Anxious-Ambivalent position describes wanting to be closer to others than most people do and having anxiety about rejection. The questionnaire includes two parts that ask the respondent to focus on romantic relationships. The first part requires the respondent to rate each item on a 7 item Likert scale (ranging from 'disagree strongly' (1) to 'agree strongly' (7)). The second part requires respondents to choose the single alternative which best describes how they feel in close adult relationships.

In the original study, securely attached people described their most important love experience as happy, friendly and trusting. They were able to accept and support their partner despite his/her faults. In terms of attachment history, they reported warmer relationships with both parents and between their two parents. Avoidant people characterised their most important love experience by fear of intimacy, emotional highs and lows, and jealousy. In terms of attachment history they described their mothers as cold and rejecting. The anxious/ambivalent individuals experienced love as involving

obsession, desire for reciprocation and union, emotional highs and lows, and extreme sexual attraction and jealousy. Anxious/ambivalent individuals experienced their fathers as unfair.

Kirkpatrick and Hazan (1994) found that 70% of people identified the same attachment style after four years. Although the secure group was most stable, if they broke up with a partner they were more likely to later rate themselves as insecure.

Given the nature and age of the sample in the current study the majority had experienced only one major relationship that had often lasted for more than thirty years. Many of the participants were now widowed and had not had a relationship since the death. For these reasons participants initially found it difficult to complete the AAS which focuses on feelings in romantic relationships. In discussion with a supervisor it was agreed that participants should be directed to think about the time when they were “courting” in their “younger days” and to think about how they felt at that time.

Parental Bonding Instrument (PBI) (Parker et al 1979, Appendix 16)

The PBI is a 25-item questionnaire that asks about parental behaviours and attitudes. The same questions are answered separately for both parents. It examines the contribution made by both parents to the parent-child bond. This questionnaire was chosen to assess the potential contribution that parental behaviour made to attachment status and level of psychological well-being and grief.

Responses are recorded using a 4 point Likert scale (ranging from 'very like' to 'very unlike'). Questions are worded both negatively and positively thus reducing the likelihood of acquiescence. The PBI measures two factors: 'care' and overprotection'. The 'care' factor comprises 12 items which focus on the affective nature of the parent in respect to the respondent. These 12 items allow a maximum score of 36. The 'overprotection' factor includes 13 items that focus on the level of control the parent used towards the child. A maximum score of 39 can be obtained. Several studies have suggested that 'care' and 'overprotection' are the two factors that are most important in parental contributions to bonding (Roe and Siegelman 1963, Parker et al 1979). However, see Murphy et al (1997) for further discussion on this topic. The PBI has been used with many clinical and non-clinical populations (Parker 1993).

In the original study a mean score of 24.9 (maternal – 26.8, paternal – 22.9) was obtained for the 'care' scale and 13.3 (maternal – 14.7, paternal - 11.9) for the 'overprotection' scale. The total sample involved 150 people ranging in age from 17 – 40 years. Reliability and validity were found to be acceptable. Test retest reliability was found to be 0.76 ($p < 0.001$) for the 'care' scale and 0.63 ($p < 0.001$) for the 'overprotection' scale. Split half reliability was found to be 0.88 ($p < 0.001$) for the 'care' scale and 0.74 ($p < 0.001$) for the 'overprotection' scale. Concurrent validity was measured using a Pearson correlation. The two 'care' measures were 0.77 and 0.78 (both $p < 0.001$) and the two 'overprotection' measures were 0.48 and 0.50 (both $p < 0.001$).

In a further sample of 410 primary care patients, 25 were aged between sixty-one and seventy-four. The means found were maternal care - 26.3, paternal care - 24.9, maternal overprotection - 11.6, paternal overprotection - 11.3 (Parker et al 1979). No significant effects of age on ratings were found. However in a study which included depressed people aged up to 83 years, Parker et al (1987) found that older age was associated with reporting higher care and lower overprotection for both parents. These differences were significant. There are several reasons why this may be. This may be as a result of changes in parenting styles. These could be a cohort effect. It may be due to processes that occur in old age. For example, a frequent aspect of growing older is to review one's life. It could be that those people who positively review their lives tend to over estimate the level of parental care that they received. It may also be that older people show less willingness to talk about their parents unfavourably.

Heiss et al (1996) compared the PBI with four other parental attachment scales to see whether they were indeed measuring the construct of attachment. The respondents were college students with a mean age of 19.7 years. They found that the PBI (as well as the four other measures) did assess constructs related to attachment and at least grossly differentiated healthy from pathological bonding with parents.

Significant Others Scale (SOS) (Power et al 1988, Appendix 17)

This measure was chosen as a short measure of social support. It measures the quality of support provided by significant others in the social network. The measure focuses on the perceived adequacy of social support as opposed to the size of the social network. The

measure includes 8 items. Four items ask about the actual level of emotional and practical support that people receive and four ask about the ideal level of support that people would like to receive. The questions are asked separately for up to six significant people (partner, closest child, second closest child, sibling, best friend and important other). Ratings are made on a 5 point Likert scale (ranging from 'never' (1) to 'always' (5)).

The SOS has been found to have good reliability and validity. Test retest reliability was found to be between 0.73 to 0.83 over a six month period. The measure was also found to have good criterion validity.

Lam and Power (1991) carried out a postal survey of people aged 65 to 84 with the SOS. Two thirds of the sample were satisfied with the support they received. Only 6% of a younger adult population were satisfied to the same extent (Power et al 1988). Their tentative interpretation is that older people are more satisfied with their relationships. This may be that they are more realistic or resigned in their expectations for support from close relationships i.e. whatever level of support they receive they do not expect any more or less. They have an understanding that they are receiving as much support as they are going to get from significant others.

The revised UCLA Loneliness Scale (Russell et al 1980, Appendix 18)

Although many researchers agree that loneliness is made up of two elements (social and emotional, Weiss 1973) there are no valid and reliable measures of this (Russell 1982). The revised UCLA loneliness scale measures loneliness as a single phenomenon.

However it has been used in a study of Weiss's typology (Russell et al 1984). It was found that certain items (items not indicated) on the scale differentiated between these two forms of loneliness. The revised UCLA loneliness scale was used in the current study as one of the measures of psychological well-being. Separate measures of social and emotional loneliness could not be provided

The scale consists of 20 items worded both positively and negatively. Respondents indicate how often they experience each item using a 4-point Likert scale (ranging from 'never' (1) to 'often' (4)). The scores range from 20 (low level of loneliness) to 80 (high level of loneliness).

The original study was based on a sample of 237 college undergraduates. The mean score for students who were dating or married was 32.7 whilst it was 43.1 for those who did not have an intimate relationship. The scale was found to have high internal consistency (coefficient α 0.94) and good discriminant and concurrent validity (correlations not given). Test retest reliability was 0.73 over 2 months and 0.62 over 7 months. These correlations indicate some stability in loneliness scores, but also indicate that variations do occur over time.

Perlman and colleagues (1978) used an 11 item version of the scale (items not indicated) with older people. They found that the loneliness scores (means not given) were highly related to experiencing anxiety, depression, unhappiness and dissatisfaction. They did not

find a significant relationship between marital status and loneliness although widowed people had higher loneliness scores. The current study used the full version of the scale.

Geriatric Depression Scale (GDS-15) (Yesavage 1988, Appendix 19)

The GDS-15 is a screening questionnaire for depression specifically designed for an elderly population. It was chosen for this specific reason. There are a number of differences that need to be taken into account when developing a screening scale specifically for older people. Firstly, biological symptoms which are key in the diagnosis of depression in younger people are less useful in older people. Non-depressed older people often suffer aches and pains as a result of physical illnesses, their sexual interest is often decreased and they may suffer from sleep and appetite disturbances (Coleman et al 1981). Secondly, older people with depression often complain of more subjective experiences of memory loss and cognitive impairment (Kahn et al 1975) than younger people. Thirdly, some questions routinely asked of younger people may not seem appropriate to an older cohort. For example, asking if the person is hopeful about the future may have a very different meaning for a person nearing the end of their life span. The GDS-15 has been designed to avoid all of these difficulties.

The GDS-15 consists of fifteen questions with a yes/no response format. This format was chosen to make it as simple and easily understood as possible. Questions are worded both negatively and positively thus reducing the likelihood of acquiescence. The possible score ranges from 0-15 with a cut-off of 5.

The GDS-15 was originally developed as a 30-item measure (Yesavage et al 1983). Test of reliability showed that the scale was a consistent measure. Internal consistency was high (alpha coefficient 0.94 and split-half reliability 0.94). Test-retest reliability was evaluated by having twenty participants complete the questionnaire at two time points, one week apart. The correlation was 0.85 ($p < 0.001$) which suggests that at least within a one week time frame, the GDS-30 reflects stable individual differences. The GDS-15 has also been validated.

Test of validity showed that the GDS-30 did seem to be measuring depression in an older population. Convergent validity between the GDS and Zung Self Rating Depression Scale (Zung 1965) was 0.84 ($p < 0.001$) and between the GDS and Hamilton Rating Scale for Depression (Hamilton 1960) was 0.80 ($p < 0.001$). The GDS was also compared to the classification of participants using research diagnostic criteria (RDC) for depression derived from a clinical interview. T-tests showed that there was a linear relationship between RDC classification (normal, mild, severe depression) and scores on the GDS. The differences were all significant at the $p < 0.001$ level.

Brink et al (1982) found that a cut-off score of 11 on the GDS-30 yielded 84% sensitivity (number of people correctly classified as depressed) and 95% specificity (number of non-depressed people correctly classified). Almeida and Almeida (1999) found that with a cut-off score of 5, the GDS-15 was a good screening instrument for Major Depressive Episode as defined by DSM-IV.

Adult Attachment Interview – (George et al 1985, Appendix 20).

The Adult Attachment Interview enables researchers to assess attachment representations in adolescence and adulthood. The Adult Attachment Interview provides a basis for reliable and valid inferences about peoples internal working models and their methods of dealing with distress (Steele & Steele 1994). Respondents are asked to reflect on their childhood attachment experiences and evaluate possible impacts of these experiences on their own personality and behaviour. Respondents are asked about their parents in terms of closeness, rejection and threatening behaviour. They are asked about their own views on how these experiences may have shaped their personality. They are also asked about major losses.

For the purposes of this study it was decided that a third of participants would be interviewed with the loss section of the AAI. The time consuming nature of the full AAI (interview, translating and scoring) meant that it was impractical to use it. However it was thought that focusing on the loss section with a small proportion could assist in understanding the complex relationship between earlier attachments and more recent losses. The AAI manual stipulates that people are not seen at home. However the interviews for the current study were completed in participants' own homes. This decision was agreed with a supervisor as there was no other practicable option.

The scale for unresolved loss in the Adult Attachment Interview assesses disorganisation and/or disorientation in thinking or discourse resulting from the death of a significant figure. The final rating is given after an assessment of the transcript for the continuing

presence of three types of disorganised responses to the loss (Main & Hesse 1990). These three types are lapses in the monitoring of reasoning, lapses in the monitoring of discourse and reports of extreme behavioural reactions. Within each category are a number of specific types of lapses or behaviours (Appendix 21).

Although usually the AAI is transcribed it was agreed with a supervisor that interviews would not be transcribed. This decision was made because only the loss section was being rated and it was felt that a rating could be made by assessors as the recordings would be of a reasonable length. The plan was to give the tapes to a qualified clinical psychologist to rate. The psychologist would be blind to participants' complicated grief score. However having completed the interviews it became clear that the principles of the AAI were not being adhered to and it would be difficult to make an accurate rating. Each interview took between 45 minutes and ninety minutes. The whole AAI normally takes between half an hour and an hour to complete. This may have been due to the interview taking place in each participant's home but also it may have been due to the nature of the study. People were taking part in a study about bereavement and may have felt sanctioned to talk at length. Although a loss rating was not made the tapes were analysed for lapses and these are presented in Appendix 22. The remaining content of the tapes will be discussed elsewhere. However if any of the interview material serves to illustrate a point it will be included in the relevant section.

Biographical questions about the bereavement

Seven questions were asked about the person who had died (Appendix 23). These were to establish the relationship to the deceased, time since death, nature of the death and number of other deaths two years before or after the main death.

Medical and psychiatric history

Participants were asked to give brief details about their physical and mental health histories before the key death and afterwards (Appendix 24). These were to establish what changes in health had occurred since the death.

2.6 Procedure

The researcher contacted every person who returned their reply slip and who indicated that they would like to take part in the research. The researcher visited each person at their home. At the start of the interview the researcher explained the study again and answered any questions. Participants signed two consent forms (one to keep as a personal copy). The consent forms were separated from the score sheets so that individual data was not identifiable. The score sheets were numbered and the codes kept separately. All information collected from participants was kept in a locked filing cabinet.

The majority of the questionnaires were self-report. Given that participants were being asked to complete a number of questionnaires and that the topic was grief, it was felt that it was unfair to ask people to go through the process on their own. It was decided that the questionnaires should be made easier for them to complete. For each questionnaire each

response option was written on an individual A5 envelope (Appendix 25). Each questionnaire item was then written in 14 point on an individual piece of paper. For each questionnaire the researcher placed the response option envelopes in front of the participant, checked that they could read the items and then passed them the first questionnaire item. The participant placed the item on the response envelope that seemed most applicable. This continued until all the items for that questionnaire had been completed. The researcher placed the items in their respective envelopes to be coded after the interview.

Following completion of the study a short summary of the findings and a letter of thanks was sent to every participant.

Chapter 3: Results

Overview

The results of the data analysis are divided into three sections. The aim of the study was to investigate the psychological well-being of older people following the death of a loved one and in particular, the factors that might represent an increased risk of low psychological well-being. The first section of this chapter will describe the current study sample. The second section will focus on the results from relevant literature and compare them to the current sample. The final section will focus specifically on the psychological well-being of the sample and address the hypotheses of the study. Where appropriate quotes from the tape recorded interviews will be included.

3.1 Characteristics of the group

Source

Thirty two people were interviewed for the current study. The participants came from four sources. Eleven (34%) were seeing a psychologist, thirteen (41%) were attending support groups for people following bereavement, six (19%) had received bereavement counselling up to two years before the research interview and two (6%) were not in contact with any voluntary or statutory bereavement organisation. The latter group was excluded from group comparisons as it included only two people.

The participants came from various parts of inner London and a large new town in Essex. All the participants were white except one who was from Tanzania. He had lived in this country for nearly forty years.

Age of participants

All participants were aged over sixty-five. The mean age of the whole group was seventy-four (range 66-87) and seventy three (range 66-86) without the two community participants. A one way ANOVA showed that there was no significant difference between the three source groups in age (Table 3.1).

Table 3.1 A comparison of age statistics by participant source

<u>Participant Source</u>	<i>Mean, SD, range and group statistics</i>				<i>F-value</i>	<i>p-value</i>
	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>Range</i>		
Psychologist	11	73.2	5.4	66-82	0.129 ¹	0.880
Support Group	13	72.9	4.5	66-82		
Counsellor	6	74.2	6.7	66-86		
Community	2	85.5	2.1	84-87	<i>not included in one way ANOVA</i>	

Gender of participants

There were 26 females and 6 males in the total group. The community group was composed of one male and one female. Having removed the community participants from the analysis, a Chi ² test showed that there were no differences between the three source groups in gender (Table 3.2).

Table 3.2. A comparison of gender by participant source (frequencies, percentages and group statistics)

<u>Participant Source</u>	<i>Male Female</i>		<i>χ²</i>	<i>p-value</i>
	<i>N</i>	<i>%</i>		
Psychologist	0/11	0 / 36.7	3.785 ²	0.151
Support Group	3/10	10 / 33.3		
Counsellor	2/4	6.7/ 13.3		

¹ Degrees of freedom = 2,27

² Degrees of freedom = 2.

Marital status of participants

In the whole group, there were only three people (9%) who were still married. Twenty-eight people (88%) were widowed and one person was divorced. The community group was composed of two widowed participants. Having removed the community participants from the analysis, a Chi² test showed that there were no differences between the three source groups in marital status ($\chi^2 = 5.491$, df 4, $p = .241$).

Years attending school

The mean length of time at school was 10.3 years. The most common ages for schooling were from five to fourteen years (56%). One person rarely attended school. The remainder (12) attended for between ten and sixteen years (38%). There were no differences in length of time spent at school for the three source groups ($F(2,27) = .280$, $p = 0.758$).

Main occupation of participant prior to retirement

Occupation prior to retirement was classified using the nine major groups classification as outlined in Standard Occupational Classification (Office for National Statistics 2000). The majority were employed in administrative occupations (22%), machine operative occupations (19%) or customer service occupations (13%). Having removed the community participants from the analysis, a Chi² test showed there were no differences in occupation for the three source groups ($\chi^2 = 18.914$, df 18, $p = 0.397$).

Relationship to person who died

Although the study was open to people who had lost anybody that was significant to them, the majority of participants had suffered the death of their spouse or partner (88%). Three people (9%) had lost an adult child. Two of these had been widowed prior to their child's death. One person (3%) had lost a brother in law. The four people who had lost someone other than a partner were all seeing a psychologist.

Time since person died

On average the significant person had died seven years prior to the research interview. The range was from nine months to thirty years. There was a significant difference ($F(2,27) = 9.225, p = .001$) between the three participant source groups for length of time since loved one had died. The mean length of time since a death for the members of the support group was 13.5 years. It was 2.2 years for those seeing a psychologist and 2.5 years for those who saw a counsellor. The mean length of time since death for the two community group participants was 6.2 years. People obviously continued to attend bereavement support groups for many years after a death.

Age when person died

The mean age of the person who died was sixty-six years (SD 14.4). The youngest age was thirty-two (an adult child) and the oldest was eighty-eight years. There were no differences in age at death between the three participant source groups ($F(2,27) = 1.557, p = .229$).

Main occupation of partner prior to retirement

The main occupations for partners prior to retirement were as skilled trades people (28%), professional occupations (16%) or in management (13%). There were no differences in partners' occupation for the three source groups ($\chi^2 = 19.860$, df 16, $p = 0.227$).

Previous physical health problems of participants

Two of the sample (6%) described having long term health problems since childhood. They described multiple operations and hospital stays. One participant stayed in hospital for a year with a tuberculosis related health problem. Thirteen people (41%, including one of the community group) had been in hospital once for a discrete illness e.g. hip replacement, hysterectomy, skin cancer. Four (13%) had had a discrete illness but not been an inpatient e.g. pneumonia. These latter two groups did not have any other health problems. Six people (19%, including one of the community group) said that they had never had any major health problems. Having removed the community participants from the analysis, a Chi² test showed there were no differences between the three source groups ($\chi^2 = 7.389$, df 8, $p = 0.495$).

Previous mental health problems of participants

Seventeen of the sample (53% including one of the community group) said that they had not had any previous problems with their mental health. Seven (22% including one of the community group) had experienced long term anxiety or depression without the need for a hospital admission. Five people (15%) described a discrete episode of anxiety or

depression, e.g. worry about ill health in a child or about family problems. Three people (9%) had been in hospital at least once, for mental health difficulties, prior to the death of a significant other. All three were seeing psychologists at the time of the current study. There were no significant differences between the three participant source groups for previous mental health difficulties ($\chi^2 = 13.776$, df 12, $p = 0.315$).

Physical health problems since the death

Eleven of the sample (34%) felt that they had developed new physical health problems since the death of a significant other. These were problems such as arthritis, stroke, heart attack, gallstones and cataracts. It is not known whether the death had any causal relationship with the physical health problems.

Perceived mental health problems since the death

Fourteen of the sample (44%) described new mental health problems since the death. Six (43%) of these had not experienced any previous mental health difficulties. Three (9%) had been admitted to a psychiatric ward following the death of a significant other. Two of these had already experienced an admission prior to the death. They experienced the loss of an adult child and a brother-in-law. The other person had experienced a discrete episode of anxiety in the past. She was admitted following the loss of her husband. One had been admitted for a month, one for six months and one for longer than six months. The latter participant was still in hospital at the time of the current study.

Four (13%) had been admitted to a mental health day hospital following the death. Three were still attending at the time of the current study. The shortest attendance was for

sixteen months whilst the longest was for three years. All four people were also seeing a psychologist. A recording was not made as to whether they attended the day hospital before they began to see a psychologist or visa versa.

Formal psychological intervention

Thirteen (41%) had not sought any formal psychological intervention since the death of a significant other. Eleven people (34%) were seeing a psychologist and eight people (25%) had seen a counsellor. This latter group included two people from the support groups who had received formal bereavement counselling.

Complicated Grief Scores

A measurement of complicated grief was made using the Inventory of Complicated Grief (Prigerson et al 1995a). The mean score of the three source groups was 33.53 (SD 15.56) and the range was 3 – 65. A one way ANOVA showed that there was a significant difference between the three groups ($F(2,27) = 4.252, p = .025$). Table 3.3 shows the mean scores for each of the groups. Those people seeing a psychologist had much higher scores on the ICG than any other group.

Table 3.3: Group statistics of scores on the Inventory of Complicated Grief

<u>Participant Source</u>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>Range</i>
Psychologist	11	43.36	17.95	3-65
Support Group	13	27.54	11.81	12-50
Counselling	6	28.50	9.46	19-45
Community	2	23.00	12.73	14-32

Depression Scores

The sample was screened for depression using the Geriatric Depression Scale-15 (Yesavage 1988). The mean score for the three source groups was 6.60 (SD 3.96). A score of 5 or above suggests probable Major Depressive Episode (DSM-IV) (Almeida and Almeida 1999). The range was 0 - 14 and eighteen (60%) scored on or above the cut off. A one way ANOVA showed that there was a significant difference between the three groups ($F(2,27) = 8.800, p = .001$). Table 3.4 shows the mean scores for all four groups. People who were seeing a psychologist scored higher on the GDS-15.

Table 3.4: Group statistics of scores on the Geriatric Depression Scale-15

<u>Participant Source</u>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>Range</i>
Psychologist	11	9.64	3.38	4-14
Support Group	13	4.15	3.16	0-12
Counselling	6	6.33	2.88	2-10
Community	2	2.50	3.54	0-5

Loneliness Scores

A measurement of loneliness was made using the Revised UCLA Loneliness Scale (Russell et al 1980). The mean score of the three source groups was 40.83 (SD 11.82). The range was 21-64. A one way ANOVA showed that there were no significant differences between the three groups ($F(2,27) = 0.672, p = .519$). Table 3.5 shows the means of all four groups.

Table 3.5: Group statistics of scores on the Revised UCLA Loneliness Scale

<u>Participant Source</u>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>Range</i>
Psychologist	11	43.91	13.62	24-63
Support Group	13	38.23	12.27	21-64
Counselling	6	40.83	6.27	31-49
Community	2	42.50	10.61	35-50

Summary of characteristics of the group

The majority of the sample were female and their average age was 74. The majority had lost a spouse and the average age of the person who had died was sixty-six. The average length of time since the death was seven years. Most of the people in the sample had experienced some physical health problems and just under half had also experienced mental health difficulties during their lives. A small number of people described mental health difficulties for the first time after the bereavement. People who were seeing psychologists scored significantly higher on measures of complicated grief and depression. However their level of loneliness was equal to people from the other groups.

3.2 Comparisons with relevant literature

Time length of grief

There were no participants who scored '0' on the Inventory of Complicated Grief suggesting that grief as measured on the scale had not ended for any of the current sample. The lowest score was '3' and that participant indicated that she often felt envious of those who had not lost anybody, suggesting that the impact of losing her spouse had affected her outlook towards others. Thompson et al (1991) found that people were still grieving at 30 months after the loss. Wortman and Silver (1989) suggested that it was probably even longer. In the current study people had been bereaved for up to thirty years and yet still showed signs of grief as measured on the ICG. Thus the results of the current study are more in accordance with those of Meuser et al (1994-95) who suggest that people may never 'get over' their grief.

Some of the quotes from the tape recorded interviews are printed below. These indicate how many of the participants did not feel that they had 'got over' the death:

"I'm finding it's getting worse. As time goes on it's reality. It's a different grief now than when you first lose them"

(Case 18, ICG = 50, 1 year since husband's death)

"There's no way you can get over 48 years"

(Case 18, ICG = 50, 1 year since husband's death)

"I don't think you ever get over it"

(Case 9, ICG = 17, 2½ years since husband's death)

“Even now I’m sort of numb when I think. I just miss him terribly and I always will”

(Case 9, ICG = 17, 2½ years since husband’s death)

“No I still feel very bereft at not having him here. I take life more as it comes now. I don’t look forward”

(Case 16, ICG = 34, 7 years since husband’s death)

“I just feel there is no point going on but you do”

(Case 11, ICG = 40, 1½ years since husband’s death)

Complicated Grief

Complicated grief and bereavement related depression have been found to be significantly correlated (Prigerson et al 1995b). In the current study, Pearson correlations were performed between scores of complicated grief (ICG) and depression (GDS-15).

The results are presented in Table 3.6 below:

Table 3.6: Pearson correlations between scores on the Inventory of Complicated Grief and Geriatric Depression Scale-15.

	Inventory of Complicated Grief
Geriatric Depression Scale-15	.781**

**p<0.01(two tailed)

A significant correlation was found between complicated grief and depression. The results are in accordance with those found by Prigerson et al (1995b).

Rosenzweig et al (1997) found that complicated grief and bereavement related depression became less related over time. Complicated grief was found to persist whilst bereavement

related depression reduced except in those who scored above the cut off on the ICG. In this group both depression and complicated grief remained stable after six months. In the current study a partial correlation was performed between complicated grief and depression whilst controlling for the length of time since the death. The sample was split in to two groups (those above (21) and those below (11) the cut off as used by Rosenzweig et al 1997) and a correlation performed on each. The results are presented in Table 3.7.

Table 3.7: Partial correlation between scores on the Inventory of Complicated Grief and Geriatric Depression Scale-15 whilst controlling for time since death.

	Inventory of Complicated Grief	
	Above cut-off sample	Below cut-off sample
Geriatric Depression Scale-15	.6051**	.1861

**p<0.01(two tailed)

The findings suggest that even when time since death is controlled for there is a significant positive relationship between complicated grief and depression in those who score above the ICG cut-off. There is no significant relationship in those who score below the cut-off when time since death is controlled. The findings are in accordance with those of Rosenzweig et al (1997).

Loneliness

Lund et al (1993) found that people who had remarried had lower levels of loneliness. Only one person in the sample had remarried and the spouse was still alive. A small

number of people (five) had new intimate partners. The mean for people without a partner was 41.92 and 37.43 for those with a partner. Thus people rated themselves as slightly less lonely if they had a partner. However the differences were not significant ($t(30) = .903, p = .374$).

Dean (1962) and Tunstall (1967) found that people aged over eighty were significantly more lonely than younger old people. In this study there were only six people aged over 80. There was no difference in loneliness scores for this group ($t(30) = -.014, p = .989$). Thus for this sample there were no differences in loneliness for those who had a new partner or those who were aged over eighty.

Depression

Mendes de Leon et al (1994) found that depression scores remained high among 65-74 year olds well after the first year of bereavement. There were nineteen people who fitted this category, in the current sample. The mean GDS-15 score of the 65-74 year olds was 6.89 and it was 5.54 for those who were 75 and over. Thus both groups on average scored above the cut off for depression. Thus in this sample depression remained high for all ages after the first year of bereavement.

Age

Lund et al (1986) found that age did not predict adjustment after bereavement in a sample of fifty to ninety three year olds. Pearson correlations were performed on the current sample, between age of participant and scores of complicated grief (ICG), depression

(GDS-15) and loneliness (UCLA). There were no significant relationships between age and the three dependent variables ($r = -.108$ ($p = .557$), $r = -.152$ ($p = .406$), $r = .185$ ($p = .310$) respectively). The results are in accordance with those of Lund et al (1986) in that age is not related to adjustment.

Gender

The current study is like many others in that recruitment of male bereaved participants was low. Lund et al (1986) found that males and females were similar in their ability to adjust after a bereavement. In the current sample there were only six males. A point biserial correlation (Pearson's r) was performed between gender and scores of complicated grief (ICG) and depression (GDS-15) and loneliness (UCLA). The results are printed in table 3.8.

Table 3.8: Point biserial correlations between gender of participant and scores on the Inventory of Complicated Grief, Geriatric Depression Scale-15 and Revised UCLA Loneliness Scale.

	Gender
Inventory of Complicated Grief	-.280
Geriatric Depression Scale-15	-.366*
Revised UCLA Loneliness Scale	-.068

* $p < 0.05$ (two tailed)

Gender is negatively correlated with scores on the GDS-15 ($p < 0.05$). The means show that the average score for women was 7 on the GDS-15 (SD 4) whereas the average for men was 3 (SD 2). Thus although the numbers of males was small, in this sample, on average, women scored higher than the men suggesting that they were more depressed.

Thus the results showed that in this sample there was a gender difference for depression but not for complicated grief or loneliness.

Relationship to the deceased

Leshner & Bergey (1988) found a high level of grief and depression in older women who had lost their adult children. Sanders (1980) suggested that this type of death might be the most difficult to cope with. In the current study, three women had suffered the death of an adult child. Although the numbers were small a t test was calculated for scores on the ICG, GDS-15 and UCLA for those who had lost a spouse and those who had lost a child. Howell (1997) emphasises the robustness of parametric t tests. Equality of variance was shown to be acceptable. There was found to be a difference of less than one point between the groups on the Revised UCLA Loneliness Scale ($t(29) = -.101, p = .920$) The means and t tests for the ICG and GDS-15 are presented in Table 3.9 and 3.10:

Table 3.9: Independent Samples t-tests and group statistics comparing people who'd lost an adult child with those who'd lost a spouse on the Inventory of Complicated Grief

	<i>t</i>	<i>df</i>	<i>Sig</i>	<i>Mean</i>	<i>SD</i>
Adult Child	-2.410	29	.023	50.67	13.20
Spouse				30.14	14.08

Table 3.10: Independent Samples t-tests and group statistics comparing people who'd lost an adult child with those who'd lost a spouse on the Geriatric Depression Scale-15

	<i>t</i>	<i>df</i>	<i>Sig</i>	<i>Mean</i>	<i>SD</i>
Adult Child	-1.599	29	.121	9.67	5.13
Spouse				5.86	3.82

There was found to be a significant difference on scores of complicated grief for those people who had lost an adult child. Although on average they also scored higher on the GDS-15 the differences were not significant.

One of the women who lost an adult child was interviewed using the modified AAI and spoke of how the loss of her son had affected her deeply:

“Before then I didn’t really feel old. But now I really feel old and I feel I’m not living I’m just existing. I haven’t really lived since he went (14 sec silence) We were so close”

“I shall never get over it I know I won’t”

(Case 1, ICG = 65, 3 years since son’s death)

Thus the results of the current sample are in line with those of Leshner and Bergey (1988) and Sanders (1980) that the death of an adult child is possibly the most difficult death to cope with.

Conclusion of the comparisons with relevant literature

The findings of the current study are in accordance with the majority of findings reported by other relevant literature. The current study showed that there is evidence that people never get over the death of a significant other. It also found that age does not predict outcome in people aged over 65 and that gender only significantly affected depression scores. There is also some evidence that the loss of an adult child leads to greater levels of complicated grief than the loss of a spouse.

3.3 Research Hypotheses

Data Preparation

Case Selection

The data were complete except for two instances in which some or all of the attachment variables were missing. One person did not have a father figure present during childhood. He could not complete the paternal Parental Bonding Instrument section. This person was omitted from the analysis of paternal care and complicated grief, depression and loneliness. One other person did not complete the Adult Attachment Styles questionnaire or Parental Bonding Instrument. This person was omitted from all analysis for hypothesis one.

Data Inspection

A number of tests were carried out prior to analysis to ensure that outliers were removed and all variables showed normal distribution.

Firstly all dependent variables used interval data and therefore normality was tested by eye, by inspection of skewness and kurtosis calculations and with Kolmogorov-Smirnov tests. All dependent variable distributions were found to be normal.

Secondly, linear regression assumes *homogeneity of variance in arrays*. In order to ensure the validity of this assumption for the regression analysis, the predicted values were plotted against the standardised residuals. The residuals were normally distributed.

Finally, Cook's D distance values (Cook & Weisberg 1982) were calculated for each regression analysis. Cook's D assesses change in regression when a case is deleted. Cases with scores larger than 1.0 are suspected of being outliers (Tabachnick & Fidell 1996) and should be removed. There were no values found to be larger than 1.0.

Adult Attachment Styles

The Adult Attachment Styles questionnaire provides brief descriptions of the three attachment styles. These are secure, insecure-anxious ambivalent and insecure-avoidant. Only three people (9%) were categorised as anxious ambivalent (Table 3.11). It was decided that the two insecure categories would be combined. Other studies of attachment and adult psychological difficulties have compared insecure and secure (e.g. Sadowski et al 1999) and thus the current study is consistent with these.

Table 3.11: Frequencies and percentages of attachment style as measured by the Adult Attachment Style questionnaire

<i>Attachment Style</i>	<i>N</i>	<i>%</i>
Secure	17	53%
Avoidant	11	35%
Anxious ambivalent	3	9%
Not known	1	3%

Exploratory Analyses

There are three measures of psychological well-being used in the current study. The scales used were the Inventory of Complicated Grief (ICG), the Geriatric Depression

Scale-15 (GDS-15) and UCLA (Revised UCLA Loneliness Scale). Table 3.12 shows that the three variables were highly positively correlated suggesting a strong relationship between them.

Table 3.12: Inter correlations between scores on the Inventory of Complicated Grief, Geriatric Depression Scale-15 and the Revised UCLA Loneliness Scale and their means and standard deviations

	1	2	3	Mean	SD
1. Inventory of Complicated Grief		.781**	.489**	32.88	15.44
2. Geriatric Depression Scale-15			.634**	6.34	4.01
3. Revised UCLA Loneliness Scale				40.94	11.60

**p<0.01(two tailed)

Hypothesis 1: Attachment style will be related to psychological well-being.

To test this hypothesis, three analyses were done. Firstly exploring the relationship between quality of parenting and attachment style, secondly exploring the relationship between quality of parenting and psychological well-being and thirdly, exploring the relationship between attachment style and psychological well being.

Quality of parenting and attachment style

Attachment Theory suggests that quality of care received during childhood is important in the development of an attachment style. People who receive consistently dependable care and are not over-controlled are more likely to develop a secure attachment style

(Bowlby 1969,1973,1980). The conceptual model of the study includes the assumption that quality of parenting is related to attachment style (table 3.13).

Table 3.13: Independent Samples t-tests, means and standard deviations comparing people with insecure versus secure attachment styles on the four parenting scores (maternal and paternal care and overprotection)

	<i>t</i>	<i>df</i>	<i>Sig</i>	<i>Insecure</i>		<i>Secure</i>	
				<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>
Maternal care	-1.254	18	.226	24.43	14.8	29.88	7.5
Maternal overprotection	1.675	29	.105	14.29	10.2	8.94	7.6
Paternal care	-.190	28	.850	23.85	12.2	24.59	9.2
Paternal overprotection	-.227	28	.822	9.62	10.1	10.47	10.3

Levene's Test for equality of variance indicated that the homogeneity of variance assumption for maternal care had been violated ($p < 0.05$). For this variable, equal variance was not assumed and the *t* value, *df* and *p* level were taken from the 'equal variance not assumed' row.

The results in table 3.13 show that there was no significant difference in parental care and overprotection for people with a secure or insecure attachment style. Thus in this sample, using the Parental Bonding Instrument and Adult Attachment Styles questionnaires, no relationship was found between quality of parenting and attachment style.

Quality of parenting and psychological well-being

Although a relationship was not found between attachment style and quality of parenting it is possible that the latter has a more direct relationship with psychological well-being.

This was tested by performing Pearson correlations between the four parental scores and the three dependent variables (table 3.14).

Table 3.14: Pearson correlations between maternal and paternal care and overprotection scores and the Inventory of Complicated Grief, Geriatric Depression Scale-15 and the Revised UCLA Loneliness Scale

	4	5	6	7
1. Inventory of Complicated Grief	.071	.175	.025	.137
2. Geriatric Depression Scale-15	-.029	.263	-.060	.333
3. Revised UCLA Loneliness Scale	-.111	-.121	-.302	.104
4. Maternal care				
5. Maternal overprotection				
6. Paternal care				
7. Paternal overprotection				

The results in Table 3.14 show that there were no significant relationships between quality of parenting and psychological well-being.

Attachment style and psychological well being

Although in this sample, quality of parenting (as rated on the PBI) was not related to attachment style or psychological well-being, it is hypothesised that the latter two variables will be related. Attachment Theory suggests that those people with an insecure attachment style will be more likely to experience mental health difficulties following the loss of a significant other.

In order to test the hypothesis that attachment style will be related to psychological well-being in bereaved older people, an independent samples t-test was calculated. Table 3.15

shows that there were no significant findings. However the means showed that people with an insecure attachment style tended to have higher scores on all three dependent variables (i.e. less psychological well-being).

Table 3.15: Independent Samples t-tests, means and standard deviations comparing people with insecure versus secure attachment styles on the three variables of psychological well-being (ICG, GDS-15, UCLA)

	<i>t</i>	<i>df</i>	<i>Sig</i>	<i>Insecure</i>		<i>Secure</i>	
				<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>
Inventory of Complicated Grief	1.451	29	.157	36.57	16.6	28.71	13.6
Geriatric Depression Scale-15	1.407	29	.170	7.29	4.2	5.29	3.7
Revised UCLA Loneliness Scale	1.501	29	.144	44.57	7.7	38.4	13.8

Thus in conclusion to the analysis for hypothesis 1, for this sample of older bereaved people there was a relationship (but not a significant one) between attachment style and psychological well-being.

Hypothesis 2: The effect of attachment style on psychological well-being will be moderated by previous mental health, social support, number and mode of deaths and relationship to the deceased.

The results of hypothesis 1 indicated that attachment style was not significantly related to psychological well-being. Therefore hypothesis 2 as written above was no longer viable. However given that research suggested that the other variables were all risk factors for low psychological well-being after a significant death, the hypothesis was rewritten as:

Hypothesis 2: Psychological well-being after a significant death will be moderated by previous mental health, social support, number and mode of deaths and relationship to the deceased.

The literature on risk factors for low psychological well-being after a death suggests that there are four groups of factors which increase risk. To test hypothesis 2, three analyses were carried out. The first two explored the relationship between each individual risk factor and the psychological well-being. The final analysis explored the combined relationship of these factors with psychological well-being.

Previous mental health, relationship to the deceased and psychological well-being

Several researchers have pointed to a link between pre morbid mental health and psychological adjustment after a bereavement (e.g. Parkes 1975, Nuss and Zubenko 1992). Hays et al (1994) found a possible link between sub syndromal affective symptomatology and poor outcome following a bereavement. They suggested that this be investigated further. Research has also shown that psychological well-being following a death may also be affected by the relationship to the deceased (e.g. Leshner and Bergey 1988).

Independent samples t-tests were used to study the relationship between previous mental health and relationship to the deceased with complicated grief (ICG), depression (GDS-15) and loneliness (UCLA). Table 3.9, 3.10 and 3.16 show the results of these analyses.

Table 3.16: Independent Samples t-tests, means and standard deviations comparing people with/without previous mental health difficulties on the three variables of psychological well-being (ICG, GDS-15, UCLA)

	<i>t</i>	<i>df</i>	<i>Sig</i>	<i>Without</i>		<i>With</i>	
				<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>
Inventory of Complicated Grief	-2.943	30	.006**	26.12	12.1	40.53	15.6
Geriatric Depression Scale-15	-3.204	30	.003**	4.47	3.5	8.47	3.6
Revised UCLA Loneliness Scale	-1.006	30	.322	39.00	12.4	43.13	10.6

** $p < 0.01$ (two tailed)

Previous mental health difficulties was scored as 'yes' for anyone who said that they had 'experienced problems with their nerves' prior to the death. This included some people who had been hospitalised for mental health reasons as well as those who described a discrete non-hospitalised episode. A significant relationship was found between prior mental health difficulties and scores on the Inventory of Complicated Grief and Geriatric Depression Scale-15. A look at the means of the scores shows that those who experienced previous mental health difficulties had higher scores compared to those who had no previous problems. There were no significant relationships with the Revised UCLA Loneliness Scale.

Tables 3.9 and 3.10 indicate that losing an adult child leads to higher scores on both the Inventory of Complicated Grief and the Geriatric Depression Scale-15. However the difference is only significant on the ICG (table 3.9). There is no difference in levels of loneliness between those who'd lost a child and those who'd lost a spouse (page 83).

Nature of death and psychological well-being

Several researchers have documented the traumatic effects of sudden, unexpected deaths (Duke 1980, Lundin 1984, Shanfield et al 1987). This variable was rated as an expected death after a long illness, an expected death after a short illness and a sudden, out of the blue death. The rating was based on the perception of the participant and not the researcher. A one way ANOVA (table 3.17) was performed to study the relationship between nature of death and psychological well-being.

Table 3.17: One way ANOVA, means and standard deviations comparing the nature of death (sudden, long illness, short illness) on the three variables of psychological well-being (Inventory of Complicated Grief - ICG, Geriatric Depression Scale - GDS-15, Revised UCLA Loneliness Scale - UCLA)

	<i>F</i>	<i>df</i>	<i>Sig</i>	<i>Sudden</i>		<i>Long illness</i>		<i>Short illness</i>	
				<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>
ICG	4.482	2,29	.020*	45.63	14.4	29.21	13.5	27.80	14.3
GDS-15	1.597	2,29	.220	8.38	4.0	6.07	4.34	5.10	3.3
UCLA	0.074	2,29	.929	41.88	11.7	41.21	11.7	39.8	12.5

* $p < 0.05$ (two tailed)

The nature of the death was only significantly related to the complicated grief (ICG) score. The results suggest that there is a relationship between experiencing a more sudden, unexpected death and going through a more difficult grief reaction. The nature of the death was not significantly related to the depression or loneliness scores.

Number of deaths, number of social supports, satisfaction with support and psychological well-being

It has been found that multiple deaths are more likely to increase psychological distress (e.g. Kastenbaum 1969). In terms of social support the research suggests several relationships. Bowling and Cartwright (1982) found that frequent contact with someone close alleviated loneliness. Power et al (1988) also found that more social support was negatively correlated with depression. Henderson et al (1981) suggested that the quality of the social support is more important than the quantity.

Pearson correlations were calculated to study the relationship between number of deaths, number of social supports and overall satisfaction with support and complicated grief (ICG), depression (GDS-15) and loneliness (UCLA). Table 3.18 shows the results of these analyses.

Table 3.18: Pearson correlations between number of deaths, number of social supports, overall satisfaction with support and scores on the Inventory of Complicated Grief, Geriatric Depression Scale-15 and the Revised UCLA Loneliness Scale

	4	5	6
1. Inventory of Complicated Grief	.573**	-.079	-.257
2. Geriatric Depression Scale-15	.502**	-.274	-.232
3. Revised UCLA Loneliness Scale	.289	-.531**	-.471**
4. Number of deaths		-.145	-.224
5. Number of supports			.307
6. Satisfaction with support			

**p<0.01(two tailed)

Table 3.18 indicates a number of significant relationships. There is no indication of the time frame for counting other deaths as important. For the purposes of the current study it was decided that a four-year time limit would be imposed. The number of other deaths was significantly positively correlated with the ICG ($p < 0.01$) and GDS-15 ($p < 0.01$). This suggests that the more deaths a person has to cope with in the two years before or after the main significant death, the higher their levels of complicated grief and depression. There was no relationship between level of loneliness and the number of deaths experienced. It makes logical sense that there would not be a relationship between the two variables unless the deaths that had occurred were the main social contacts for the participant.

The number of social supports was significantly negatively correlated with the loneliness variable. The SOS gives people the opportunity to identify up to six social supports. The results in table 3.18 suggest that the more of those social supports that can be identified the lower the levels of loneliness.

Overall satisfaction with support was also negatively correlated with the loneliness variable. The SOS provides a discrepancy score between actual support and ideal support. Scoring zero or above would indicate satisfaction with support received. The results in Table 3.18 suggest that the more satisfied a person is with their social support the lower their levels of loneliness.

The results shown in Tables 3.9, 3.10, 3.16, 3.17 and 3.18 suggest that different risk factors are important for each dependent variable:

1. Level of complicated grief (as measured by the Inventory of Complicated Grief) is significantly related to previous mental health difficulties ($p < 0.01$), nature of the death ($p < 0.05$), number of deaths ($p < 0.01$) and relationship to the deceased ($p < 0.05$).
2. Level of depression (as screened by the Geriatric Depression Scale-15) is significantly related to previous mental health difficulties ($p < 0.01$) and number of deaths ($p < 0.01$).
3. Level of loneliness (as measured by the Revised UCLA Loneliness Scale) is significantly related to the number of social supports available ($p < 0.01$) and satisfaction with social support ($p < 0.01$).

All risk factors and psychological well-being

The above findings will be used in carrying out a multiple regression analysis to test hypothesis 2. A multiple regression analysis was performed for each of the dependent variables (tables 3.19, 3.20 and 3.21). The independent variables included in each analysis were those that had been found to have a significant relationship with each dependent variable (see points 1-3 above). Gender was also entered in to the analysis for GDS-15 as these variables were found to be significantly correlated (Table 3.2).

Table 3.19: Multiple regression summary statistics for complicated grief and previous mental health difficulties, nature of the death, number of deaths and relationship to the deceased

	<i>Beta</i>	<i>t</i>	<i>sig t</i>	<i>partial²</i>	<i>R²</i>
Previous mental health	-.046	-.237	.815	.002	.418
Nature of the death	.149	.913	.370	.001	
Number of other deaths	.517	3.192	.004	.273	
Relationship to deceased	-.281	-1.727	.096	.099	

Table 3.19 shows that the four factors jointly accounted for 41% of the variance on the Inventory of Complicated Grief ($F(4,27) = 4.846, P = .004$). Only the number of deaths experienced was found to have an independent effect ($p = .004$). This was found to account for 27% of the variance. Relationship to the deceased accounted for about 9% of the variance.

Table 3.20: Multiple regression summary statistics for depression (GDS-15) and number of deaths, previous mental health difficulties and gender.

	<i>Beta</i>	<i>t</i>	<i>sig t</i>	<i>partial²</i>	<i>R²</i>
Previous mental health	.315	2.012	.054	.126	.431
Number of other deaths	.372	2.466	.020	.178	
Gender of participant	-.232	-1.557	.131	-.079	

Table 3.20 shows that the three factors (previous mental health, number of deaths, gender of participant) jointly accounted for 43% of the variance on scores of the Geriatric Depression Scale-15. The number of deaths ($p = .020$) and previous mental health ($p = .054$) were found to have independent effects. Previous mental health was found to account for 13% of the variance. The number of deaths accounted for 18% of the variance and 8% was accounted for by the gender of the participant.

Table 3.21: Multiple regression summary statistics for loneliness (Revised UCLA Loneliness scale) and number of social supports and overall satisfaction with support

	<i>Beta</i>	<i>t</i>	<i>sig t</i>	<i>partial²</i>	<i>R²</i>
Number of supports	-.427	-2.792	.009	-.211	.387
Satisfaction with support	-.341	-2.230	.034	-.146	

Table 3.21 shows that the two factors (number of supports and satisfaction with support) jointly account for 38% of the variance. Both factors have independent effects ($p = .009$ and $p = .034$). The number of supports accounts for 21% of the variance on scores of loneliness. Satisfaction with support accounts for 15% of the variance.

The results from the three multiple regression analyses suggest that hypothesis 2 can be accepted. Psychological well-being is significantly moderated by the nature of the death, number of deaths, previous mental health difficulties, relationship to the deceased,

number of social supports and overall satisfaction with social support. The risk factors that were important were different for each measure of psychological well-being.

Chapter 4: Discussion

Overview

This study was a preliminary investigation into the psychological well-being of older people following the death of a significant other. The major aim of the study was to identify the factors that would indicate those most at risk of low psychological well-being.

The model proposed that psychological well-being after the death of a significant other would be moderated by a number of risk factors.

The study used a retrospective, non-randomised design looking at a group of older people who had all experienced the death of a significant other more than six months prior to the research interview. Data was collected in person with the interviewer assisting the participant through a number of self-report questionnaires. Each interview lasted between one and one and a half hours. The nature of the study topic imposed some constraints on the amount and type of information collected. The retrospective nature of the data collection meant that there could be some response biases and difficulties in interpretation of the findings. The non-randomised nature of the study meant that the sample might be different to the wider population of bereaved older people.

Twelve participants were also interviewed using the unresolved loss section of the Adult Attachment Interview (George et al 1985) as an interview guide. In accordance with the interview manual these interviews should have taken between twenty and thirty minutes.

However they were often three or four times as long. Due to their age, the current participants had at least three people to discuss (significant other and parents) and some had four or five. They also seemed immersed in the details of their stories. The possible reasons for this have been discussed in the methods section (page 66). Thus it was decided that the tapes contained too much information to be able to include in the current study. The data from these interviews will be presented elsewhere.

This chapter is split in to four sections. Firstly the main findings are presented and subsequently discussed with reference to the relevant literature. Secondly, the limitations of the current study are discussed. Thirdly, the clinical implications that can be drawn from the main findings are discussed. Finally, the conclusions of the study and recommendations for future research are presented.

4.1 Main Findings

Characteristics of the group

The current study sample was drawn from four sources. These four groups were compared on a number of variables. The numbers within each group were fairly small as the total sample included only thirty-two people. The main differences between the groups were in the length of time since the death of a significant other and in their scores of psychological well-being. Those people who attended support groups had been bereaved for 13.5 years on average. Those who saw a psychologist or had seen a counsellor had been bereaved for just over two years, on average.

On average, people who were seeing a psychologist scored higher on measures of complicated grief, depression and loneliness than people who saw a counsellor, who attended a support group or were not in touch with any bereavement services. The difference was significant only for the scores of complicated grief.

Comparisons with the relevant literature

Results from the current study were found to be in accordance with relevant literature. The key point that came out of the comparisons was that people did not seem to 'get over' the death no matter how long they had been bereaved.

Research hypotheses

The main effects of bereavement on mental health have been found to be in terms of grief, depression and loneliness (page 7). In the current study psychological well-being was measured by three self report questionnaires each assessing one of the above individual constructs.

Independent samples t-tests were used to test the first research hypothesis regarding the relationship of quality of parenting to attachment style and to current psychological well-being. No significant relationships were found between quality of parenting and attachment style, quality of parenting and current psychological well-being or attachment style and current psychological well-being.

Multiple regression analyses were used to test the second hypothesis that psychological well-being would be moderated by previous mental health, relationship to the deceased, social support and number and mode of deaths. A more sudden death, the death of an adult child, experiencing several deaths within a four-year time frame and having previous mental health difficulties were all predictive of higher complicated grief scores. Experiencing several deaths within a four-year time frame, previous mental health difficulties and being female was predictive of higher depression scores. Having fewer social supports and being dissatisfied with that support was predictive of higher loneliness scores.

4.2 Interpretation of the main findings

Characteristics of the group

Time since death

Within the current sample there were significant differences in the length of time people had been bereaved. People who attended the support group had been bereaved for 13.5 years on average whereas those that saw a psychologist or counsellor had been bereaved for about two years on average. It seems likely that those people who seek specific psychological support do so within the first few years after a death. However as nothing is known about the people who decided not to take part it could also be that people seeing a psychologist who agree to take part in bereavement research are those that have attended in the first few years after the death. Support groups are unhindered by the time constraints by which statutory services have to abide. From the conversations with participants it was apparent that many of the support group attendees had been members

for many years. It seems that people who go to a bereavement support group continue to attend for a very long time. Many participants said that they preferred to attend the group because they were with people who had also lost somebody and who therefore showed greater understanding. Many people said that they had been surprised at how old acquaintances had often stopped talking to them once they had lost a spouse. They suggested that other people felt awkward if they were not widowed themselves.

Complicated Grief

The results of the current study suggest that the level of complicated grief was higher than those reported in the study in which the Inventory of Complicated Grief was validated (Prigerson et al 1995a,b). The mean score was 32.8 in the current study whilst it was 17.74 in the original. Both studies used people aged over sixty-five. Although a cut-off score was not used in the current study if it was applied to the current sample, 65% of the sample would score over 25. In the original study only 20% scored above the cut-off. Within the current sample there was also a significant difference in complicated grief scores depending on their source. Those people who were seeing a psychologist scored significantly higher on the Inventory of Complicated Grief than any of the other three source groups.

The difference between the current sample and the Prigerson et al studies (1995 a,b) as well as the differences within the current sample are probably best understood as a reflection of the sample sources and the length of bereavement. The sample in Prigerson et al's studies (1995a,b) were taken from the community and were not in touch with

specific bereavement services. In the current sample the majority of people were drawn from specific bereavement related sources. It seems that people who seek psychological help or on-going support for their loss report lower levels of psychological well-being as measured on a questionnaire of complicated grief.

There are three points that can be made about these findings. Firstly, the evidence tentatively suggests that those people who feel greater levels of grief seek out support. Secondly, it seems that people who see a psychologist are experiencing the highest level of grief. Thirdly, it is possible that levels of grief are maintained or increased by receiving psychological or on-going support around bereavement difficulties. These points are discussed below.

The two people who were included in the study, from the community are not a representative sample of people who do not seek support. The fact that they were only two and that they were referred by people in the support group makes them unrepresentative. Given that the study did not include a representative sample of bereaved people who did not seek help it is not possible to know what levels of grief those people are experiencing. Although it would be hoped that those who are in most distress seek support this cannot be confirmed by the current study. However the findings of Prigerson et al (1995a,b) can allow for a tentative suggestion that people who seek support appear to have higher levels of distress. The community samples in those studies had much lower scores on the ICG.

The length of time since the loss needs to be taken into consideration when considering the differences between the groups. On average, people who saw a psychologist had only been bereaved for 2.2 years. There was a significant negative relationship between length of time since the person had died and scores on the Inventory of Complicated Grief ($r = -.469, p < 0.01$) indicating that people score higher the shorter the time since the death. Thus it is not surprising that people who saw a psychologist experienced the highest levels of complicated grief. However the finding that levels of grief decrease over time does not necessarily mean that psychologists are seeing people who will improve on their own with the passage of time. Lund et al (1985-86) and Gallagher-Thompson et al (1993) both found that experiencing greater levels of distress in the early months after the loss indicate longer-term coping difficulties. Thus the sample that were seeing a psychologist may actually be those people with the greatest level of long term difficulty. On average this group of people had been bereaved for 2.2 years. Prigerson et al (1995b) had found that people who scored above 25 on the ICG at six months after the loss were those likely to have physical, psychological, functional and social impairment at eighteen months. In the current study the mean of the psychology sample was above 25 and they had already been bereaved for more than eighteen months.

Finally, it is possible that the experiences of focusing on the feelings of grief and the loss serve to maintain the distress. A common therapeutic approach with bereaved people is termed "grief work". Some researchers have suggested that it is not always an appropriate intervention. The concept of 'grief work' incorporates the idea that it is beneficial for the client to review the life and death of their loved one. Wortman and

Silver (1989) found that a number of people who did grief work had poorer outcomes. Stroebe (1992-93) also found contradictory results in a review of the evidence. Rosenblatt et al (1976) and Stroebe and Schut (1999) argue that some distancing from unpleasant emotion is important. However, the current study did not include a formal evaluation of the interventions provided by the psychologists, counsellors and support groups and therefore cannot make conclusions about the type of therapeutic work that was involved.

Depression

The findings from the Geriatric Depression Scale-15 are in line with the literature on the experience of depression after a bereavement. Futterman et al (1990) found that about 30-40% of adults could be classified as clinically depressed in the first few months after a bereavement. Mendes de Leon et al (1994) found that it was worse for older people and that it could remain high well after the first year of widowhood. In the current sample 59% of the sample were on or above the cut off score for probable clinical depression and the majority of them had been widowed for longer than a year. There are a number of reasons why the rate of depression may be so high in this sample.

Much of the discussion about the scores of complicated grief (above) can be also applied to this section. Again there was a difference between the four source groups and their level of depression. Although the differences were not significant, the statistics in Table 3.4 show that the highest means were for those people who were seeing a psychologist. Both this group and those people who had seen a counsellor had means above the cut off

for clinical depression. As with the scores of complicated grief it may be that the difference in means is due to the length of time that the person has been bereaved. Nine out of the thirteen people who scored below the cut-off were attending the support group and it was this group that had been bereaved for the longest length of time. Thus it may be that with time people's level of depression decreases naturally. It may also be that receiving a specific psychological intervention following a bereavement serves to maintain the depression. However another possibility is that psychologists are seeing those people with the highest levels of psychological distress and they are those people who are more likely to have long-term difficulties.

Loneliness

The findings from the current study suggest that the level of loneliness in the current sample is roughly equal to that of other groups that have been studied. Russell et al (1980) reported that the mean of students without an intimate partner was 43.1 and 32.7 for those who had a partner. The current study falls between these two groups with a mean of 40.94. Thus the current study findings seem in accordance with those of Peplau et al (1982) who found that older people are not more lonely than other people.

Within the current sample people who attended a support group reported the lowest levels of loneliness (mean 38.23). Bowling & Cartwright (1982) found that the widowed in their study obtained social support from a network of friends and relatives, and frequent contact with someone close did seem to alleviate feelings of loneliness.

In the current study people within the support groups had often been attending for many years. Thus they had built up friendships with people who had also been bereaved. During many of the interviews people indicated that they preferred being with other bereaved people as they could share a sense of understanding as well as a sense of not being different. One of the questions on the Inventory of Complicated Grief asks about feelings of envy of people who have not lost somebody. Many people did say that they felt envious. Thus being with other bereaved people meant that people did not have to feel envious. People who attended support groups may have been less lonely because they belonged to a group, they belonged to a network of people with similar experiences and they felt secure within the group as they had been attending for years.

Loneliness scores did show a decreasing trend as time since the death increased although the correlation was not significant. Thus it is possible that people in the support group were least lonely because they had been bereaved for the longest length of time. However this idea can be combined with those presented above. If people seek support from a group, as time goes on the strength of those relationships increases. People are more likely to become friends and may also begin to meet individually. This certainly seemed to be the case with the people in the current study. So not only is the time since the death increasing but also the length of time of having new supportive friends.

Comparisons with the relevant literature

Time length of grief

For most of the last century the resolution of grief was regarded as meaning that the person disengaged from the deceased (e.g. Rando 1986, Raphael 1983, Sanders 1989). More recently researchers have begun to acknowledge that resolution may not mean disengagement. It may be that people never actually get over the death of a significant other but that they find a way to incorporate the dead person into their own on-going life i.e. they experience continuing bonds (Klass et al 1996). Stroebe et al (1993) suggest that recovery should no longer be understood as someone returning to their baseline levels of functioning. Weiss (1993) suggest terms such as 'accommodation' or 'adaptation' might be better than 'recovery'. Meuser et al (1994-95) suggest that older widows/widowers may just learn to live with their emotions. Research has shown that older people continue to experience psychological symptomatology over a long period of time (e.g. Thompson et al 1991, Meuser et al 1994-95).

In the current sample people had been bereaved for between nine months and thirty years. Although scores of complicated grief were found to reduce as the time between the death and the interview increased, there was no participant who scored at floor level on the ICG. People who attended the support group had been bereaved for the longest length of time and yet on average they scored 27.54 (above the cut-off for long term impairments) on the ICG. Thus the evidence from the current study suggests that for this sample of older people they were indeed living with their grief as opposed to recovering from it.

Research hypotheses

The relationship between attachment style and current psychological well-being.

The results indicate that attachment style and quality of parenting are not associated with current psychological well-being. This result is inconsistent with the findings of other studies. Sable (1991) found that older women who described more secure early attachments experienced less depression, anxiety and grief symptoms. Van Doorn et al (1998) found that insecure attachment styles were associated with complicated grief and depressive symptoms. The conclusion from Parkes' (1991) retrospective case note analysis was that there was strong evidence that the patterns of attachment in childhood coloured the bonds of adult life and in turn those influenced the pattern of bereavement. Andersson and Stevens (1993) found that quality of parental care (as measured with the PBI) did impact on psychological well-being of older people but that this relationship was less if a person had an intimate partner. They suggest that the presence of an intimate partner can prevent psychological distress but without that partner people who recall poor quality of parenting report less psychological well-being. There are a number of possible reasons why no significant findings were found. These are the nature of attachment across the life cycle, the measures used and the application of the measures.

The first possible explanation for the inconsistency of the findings in the current study is the nature of attachment across the life cycle. Research has not yet been able to show that patterns of attachment shown in adulthood are the same as those found in childhood. Grossman and Grossman (1991) found 80% stability of attachment styles over a ten year period. Kirkpatrick and Hazan (1994) found a 70% stability rate of attachment using the

AAS over a four-year period. However they also noted that secure people who separated from a partner were more likely to re-rate themselves as insecure. Thus attachment style measured at one time point may not remain stable. In the current study attachment style was measured in relation to romantic love relationships. The measurement at this time point may be very different to attachment style in childhood.

A second explanation is that the way attachment was measured lead to a non-significant result. In the current study attachment style was measured with the Adult Attachment Styles questionnaire (Hazan and Shaver 1987) and recalled quality of parenting was measured with the Parental Bonding Instrument (Parker et al 1979). One major possibility for the lack of a relationship between these two measures and psychological well-being is that they were not accurately measuring the construct of attachment. Although they have proved useful in other studies with older people (e.g. Andersson and Stevens 1993) they may not have been in the current study.

A third possible explanation lies in the way that the sample actually completed the Adult Attachment Styles questionnaire. The prompts for the AAS ask people to focus on all their experiences of intimate relationships. The sample for the current study were all aged over sixty-five and had been with their most recent intimate partner for many decades. Often they had only ever had one relationship. For many it was this one intimate partner who had died. For these reasons it was difficult for people to complete the questionnaire. Following discussion with a supervisor it was agreed that the participants would be directed to think specifically about their younger days when they were courting. One

difficulty with this is the retrospective nature of the question. They may not have accurately remembered the experience and rated them more favourably, especially if they were thinking about the person who had died. However in looking at the results it seems that 44% reported insecure attachment styles in relation to their romantic relationships. This suggests that people weren't biased towards making a more favourable rating. Despite this it is still not possible to be certain that people remembered their experiences accurately.

Relationship between risk factors and psychological well-being

The role of the nature of the death

It was found that the nature of the death predicted 4% of the variance in complicated grief scores. It seems that the more sudden a death the higher the complicated grief score. There was no relationship between sudden death and depression or loneliness. Other studies have found that sudden, unexpected deaths can have traumatic effects (e.g. Parkes 1975, Lundin 1984) although these studies have not usually included older people. In a sample that included older people, Clayton et al (1971) found no such relationship. Parkes (1990) suggested that the findings might indicate that older people were expecting death to occur and were therefore prepared. The results of the current study suggest that this is not the case. This is the first study to look at the experience of a sudden death in a sample of older people using a criterion-based measure of complicated grief. Studies such as that of Clayton et al (1971) may not have picked up the traumatic effects of experiencing the sudden death of a significant other because they were using measures of anxiety and depression only.

The role of the number of deaths

The number of deaths a person experiences within a four-year time frame was found to have independent effects on scores of complicated grief and depression. It accounted for about 20% of the variance on both measures.

In modern society the most likely time to suffer a significant loss is during old age (Parkes 1992, McKiernan 1996). As people get older they are likely to experience the deaths of more and more people that they know. A multiple comparison Bonferroni test showed that the significant effect of multiple deaths occurred when two or more deaths were experienced along with the key significant death. It is understandable that the more deaths a person experiences the harder it is for them to cope. Even though it seems that people never actually 'get over' the death of a significant other, most people are able to accept it and reorganise their thoughts and feelings accordingly. If this process is not completed before another death occurs, the bereaved person can begin to feel overwhelmed. Before completing the process for a first time they must start the process again.

The role of previous mental health difficulties

Following their own research into past personal history of dysphoria and conjugal bereavement, Hays et al (1994) posed the question 'what is the relationship between a past history of a short period of depressive mood and a classification of complicated grief?' In answer to this question the current study suggests that that there is a relationship between an indication of any experience of previous mental health

difficulties and level of complicated grief and depression. People who said that they had experienced previous mental health difficulties experienced higher levels of complicated grief and depression. Bereavement of a significant other is consistently described as being the most stressful life event that people can experience (e.g. Stroebe and Stroebe 1993). If people have experienced mental health difficulties after other stressors in their lives it seems more likely that they will experience them again after the death of someone close.

A second point can be made about the level of mental health difficulties. Research has shown that a large proportion of emotional distress goes undetected (e.g. Bridges & Goldberg 1985). In the current study, those people who said that they had experienced problems with their nerves experienced a level of distress that was high enough for them to remember it. It is possible that their level of distress would have been regarded as syndromal if it had been detected appropriately.

The role of the relationship to the deceased

Much of the research on bereavement in older people has focused on spousal loss. However Leshner & Bergey (1988) found a high level of psychological distress (as measured by the Geriatric Depression Scale and the TRIG) in elderly mothers after the death of an adult child. Edelstein (1984) suggested that the death of a child at any age leads to three losses: the loss of part of oneself, the loss of a link to the future, and the loss of illusions regarding life and death. Some researchers argue that this type of death

may be the most difficult death to resolve because there is a mourning for the self as well as the child who died (Sanders 1980).

Although there were only three people in the current sample who had experienced the death of an adult child they did show higher levels of complicated grief and depression. However two of the three women had also lost their husband more than two years before. Thus these women might have been experiencing grief which was compounded by the loss of two significant others.

The role of social support

The number of social supports and satisfaction with social support were both found to be predictive of lower loneliness scores. The finding that the number of social supports is related to the level of loneliness is consistent with findings in other studies. Lopata (1979) found that people who indicated loneliness associated it with the absence of a spouse, companion or social support.

Research in general suggests that social support assists in the adjustment to the loss of a loved one (Stroebe and Stroebe 1987). The current study can qualify this by suggesting that support only assists in adjustment to a bereavement in terms of loneliness. It seems that social support does not have any bearing on feelings of depression or complicated grief. Lund et al (1985-86) found that social support was not related to coping ability after a death. Lam and Power (1991) found that scores on the SOS were related to levels

of depression in a sample of people over sixty-five. However the current study found no such relationship.

Multiple risk factors

The findings on risk factors in the current study were in accordance with those of other studies. The current study was able to demonstrate the importance of measuring different forms of psychological well-being. Complicated grief has been shown to be different from bereavement related depression (Prigerson et al 1995a,b). The current study measured these two constructs along with a measure of loneliness. It was found that the pattern of risk factors differed depending on the construct being measured.

Although complicated grief and depression were found to remain related over time the important risk factors were found to be different. The general picture of a person with a high complicated grief score is one whose adult child has died, who has experienced previous mental health difficulties, whose significant other has died with little warning and who has experienced two or more deaths in the two years before or after the death of the significant other.

The general picture of a person with a high depression score is someone who is female, who has experienced previous mental health difficulties and who has experienced two or more deaths in the two years before or after the death of the significant other.

The general picture of a person with a high loneliness score is someone with few social supports and who indicates a negative discrepancy between the support they receive and the support they would like.

4.3 Limitations of the study

There are a number of limitations to the current study which need to be taken in to account. These are the design of the study and the method of data collection.

Study design

There are three problems with the study design. These lead to problems of internal and external validity.

The use of a non-randomised one group post test only design brings the internal validity of the study in to question (Barker et al 1994). It is difficult to infer causality in a study where participants were self-selected and there was no comparison group. However Cook and Campbell (1979) suggest that if enough contextual information is available then causality can be inferred to some extent. The independent variables measured in the current study were drawn from relevant research and had been shown quite clearly to be important in understanding people's reaction to the death of a significant other. The current study took those variables and applied them to a subset of the bereaved population i.e. older people.

The retrospective nature of the design also increases the difficulties in inferring causality. The first hypothesis of the study was that quality of parenting and attachment style would have an effect on psychological well-being following the death of a significant other. However all the participants were aged over sixty-five and they had obviously been through a lifetime of experiences. Any one of these experiences may have had a significant impact on their current psychological well-being. However there was no formal assessment of these other experiences. Thus it cannot be ruled out that factors other than those measured were more important in understanding the psychological well-being of bereaved older people.

External validity of the study can also be questioned. The majority of people (94%) who were included in the study were from bereavement related sources. These sources were approached because the major aim of the study was to look at risk factors for low psychological well-being. It was hypothesised that people who sought help following a bereavement were more likely to be experiencing lower psychological well-being. However it is possible that older people who do not seek help experience similar levels of distress. As this was not studied it is only possible to make conclusions about older people who do seek help.

Method of data collection

There are two problems with the data collection that may have impacted upon the results. These are the way the data was collected and some of the measures used.

Firstly, all the questionnaires were self-report. However given that the research was about the loss of a significant other it seemed inappropriate to ask people to complete the process on his/her own. In order to make the experience easier the researcher actively participated in the data collection (see page 67 for full explanation). It is possible that this method of data collection altered the results given by the participants. Some participants discussed the questionnaire items with the researcher either asking for an opinion, for clarification of an item's meaning or to present the reasons for their response choice. Although the researcher attempted not to sway their choices there were a number of times when participants reported that they were genuinely stuck. The researcher then had to use her own judgement having listened to the evidence. In order to check the reliability of this form of data collection an equivalent group would need to complete the same questionnaires in the usual self-report manner.

The current study found that neither attachment style nor parental care were related to psychological well-being. This is contrary to the findings of many studies and therefore it is necessary to question the validity of the measures used. As previously indicated the focus of the Adult Attachment Interview (George et al 1985) is on internal working models. Hesse (1996) suggests that the central task of the interview is to present and think about memories related to attachment and maintain a coherent discourse with the interviewer. The end result is a classification of the interviewee in to one of three main attachment categories that parallel those defined by Ainsworth et al (1978). Thus it measures attachment style in the present. It is the most well replicated measure of attachment. However in the current study, the Adult Attachment Styles questionnaire

(Hazan and Shaver 1987) was used as a short attachment measure because participants were being asked to complete many other measures. It seemed appropriate to use this measure as it asked about attachment in romantic love relationships. It was believed that this experience would be easy to think about.

The lack of significant results with the AAS may be due to two reasons. Either the responses were biased because of the retrospective questions or the measure was not valid for the current study. The difficulties with this measure also highlights the fact that there are no attachment measures which have been validated on an older sample. Thus currently it may be difficult to make an accurate rating of older people's attachment with any measure.

Shaver et al (2000) found that the AAS and AAI do share certain underlying constructs relevant to attachment theory although the association is fairly modest. De Haas et al (1994) compared the AAI and the AAS and concluded that compared to the AAI, the AAS seemed to measure a more general personality trait and that attachment experiences were not reflected in attachment style as measured by the AAS. Thus it seems that the AAI might have been a more appropriate measure to use. However there are also potential difficulties with using the AAI.

Firstly the interview is meant to move at a rapid pace and should take roughly one hour in total. As the taped interviews in the current study showed, the interviewees found it hard not to talk about losses in lengthy terms. They seemed to be absorbed in the details

leading up to the death and also had more deaths to discuss. It may be difficult to move older bereaved people quickly through the loss section. They may also consider it upsetting to be asked to do so.

A second problem with using the AAI is that it would still have been subject to retrospective bias. The death of a significant other may alter the way a person reflects on their attachment experiences and alter the way he/she interacts with the interviewer. The resolution of loss is of crucial clinical consideration when rating the AAI (Steele and Steele 2000). In order to test the impact of loss on AAI classification, a series of people from different age groups would need to be interviewed before and after the death of a significant other.

The second measure of early life experiences was the Parental Bonding Index (Parker et al 1979). The PBI has been found to be valid and reliable on a mainly younger sample, and seemed an appropriate measure of recalled parenting. This measure has been found to be able to differentiate depressed from non-depressed people (Parker et al 1987). However in the current study there was no relationship with depression scores. Again it seems that the AAI may have been a better measure as this incorporates questions on parents and parenting.

4.4 Clinical implications

The results of the study can be used to think about identifying those people who are at risk of low levels of psychological well-being after the death of a significant other, about the usefulness of support that is available for these people and about the use of a criterion based measure of complicated grief.

Risk Factors

The findings of the current study have implications for understanding the risks for developing high levels of distress following a bereavement. A number of factors have been identified which seem to have a bearing on levels of complicated grief, depression and loneliness. People with high levels of distress are most in need of help. The factors that have been found to be important are similar to those found to increase risk for younger age groups.

Firstly, the number of deaths that a person experiences in the two years before and after the key death is particularly important. This factor had an independent effect on complicated grief and depression scores and predicted about 20% of the variance. Having to cope with multiple losses seems to leave people emotionally vulnerable. Bowlby (1980) saw healthy mourning as an individual successfully accepting that a change has occurred in the external world, and that corresponding changes in the internal, representational world are also needed. People who experience several losses may not have time to complete this full process. Thus people who report the loss of a number of people in the few years around the key death should be targeted by clinicians. They may

be too overwhelmed to be able to accommodate each individual death within their own understanding and may need some specific support with that task in mind.

Secondly, the nature of the death is also an important risk factor. The stereotypical view of older people is that they are at a time in life when they expect death to occur. However the findings of the current study suggest that this is not the case. Older people find it just as hard to cope when they have little or no warning of the death of a significant other. The majority of people in the study had lost a spouse. Many had been married for four or five decades. These people found it difficult having to live in a world without their partner. One participant said “There’s no way you can get over 48 years”. Thus clinicians should target those people who report that the death of their significant other was sudden. These people may be in particular need of help.

Thirdly, people who say that they have had previous experiences of mental health difficulties are more likely to be at risk of higher complicated grief or depression scores. Ninety three percent of people who indicated that they had had previous experiences scored above the cut off (as suggested by Prigerson et al 1995a,b) suggesting that they were experiencing a high level of complicated grief. It is possible that those people who said that they had experienced prior mental health difficulties would have been experiencing syndromal levels but that they did not seek help or it was not recognised by health professionals. Thus these would be people who were more likely to develop high levels of psychological distress as a result of stressors.

Fourthly, number of supports and satisfaction with them, have been found to be important in the reduction of levels of loneliness. However support has no bearing on levels of depression or complicated grief. What is more the mean levels of loneliness in the current study group are similar to those found in other populations. Other researchers have called on the need to encourage older people to seek out new supports (e.g. Weiss 1982). However although a commendable idea it is not a simple process. This study offers some support that older bereaved people are no more lonely than anyone else. However again the self-selection of the sample and the methods of recruitment may mean that those who were most lonely were not included.

Help seeking

In the current study people received specific help about their bereavement difficulties from a psychologist, a counsellor or a support group. The three forms of help provide support in very different ways and therefore they cannot be considered as a similar group. People seek help in different ways and have different views about what is and isn't appropriate help for them. The current study did not investigate the pathways which people took to get to one of the three sources of help studied here. However the data from the current study does allow for some suggestions.

There are a number of findings from the current study that can be used to think about the process of help. If the marker of therapeutic success is the reduction in levels of psychological distress (and this is not clear with bereaved older people) then it seems that seeing a psychologist, a bereavement counsellor or being in a support group does not lead

to obvious reduction in distress. People had been seeing a psychologist for between 3 and 36 months and people had seen the counsellors for between 1 and 6 months. Many people had attended the support groups for years. The mean of both groups on the ICG and GDS-15 were above the recommended cut-offs. People who were attending support groups also had high means although below the cut-off on the GDS-15.

A number of hypotheses can be generated about these findings. Firstly it may be that older people's levels of distress do not decrease as time goes on, no matter what intervention is provided. This may be an aspect of them 'living with' their grief. Secondly, it may be that there is a time frame within which to begin the therapeutic work in order for psychological distress to decrease (e.g. within 6 months). People were unable to accurately say when they had first seen a psychologist or counsellor so it is not known the length of time between the death and receiving help. Thirdly, it may be that there is a form of intervention that will work but that is not widely used. There have been some findings that 'grief work' is not always helpful (e.g. Stroebe and Schut 1999). If this is the main therapeutic intervention taken with bereaved people then it may not be helping. Despite all the hypotheses that can be generated, the self-selection of the participants means that these can only remain tentative suggestions requiring further investigation.

Measure of complicated grief

The Inventory of Complicated Grief (Prigerson et al 1995a) has proved useful in the current study. It was developed as a criterion based measure of specific symptoms of grief that can have a long-term impact on the psychological well-being of older people.

Although it does correlate with the depression measure it also appears to measure a separate construct. Different risk factors were found to be relevant to the two different constructs. What is more the ICG does not seem to be gender specific whereas this has been a common finding with depression measures (Nolen-Hoeksema 1987). The original findings of the ICG (Prigerson et al 1995a,b) found that a high score at six months after the loss was an important indicator of later functional impairment. The current study found a sample of people who had high scores years after the loss. In thinking about the work of clinical psychologists with bereaved older people, the Inventory of Complicated Grief may be a useful tool to use within the session. It identifies thoughts and feelings around separation and distress and could be a simple way of identifying them. It may be that working on the relevant salient thoughts and feelings could be a useful therapeutic approach.

4.5 Conclusions and future research

This study was a preliminary investigation into the risk factors associated with low levels of psychological well-being in older people following the death of a significant other. It provides tentative evidence of the relevant importance of mode of death, number of deaths, relationship to the deceased, previous mental health difficulties and social support in the experience of psychological well-being. It also indicates that a high proportion of people who receive or are receiving some form of help for their difficulties are still suffering high levels of distress. However the possible biases of the study design and the self-selection of the participants means that the study requires replication before firm statements can be made.

The findings of the current study indicate the need for more longitudinal studies that focus on the grief experience of older people (i.e. over 65) over time. Further research should focus on three main areas. Firstly, in order to substantiate the claims of the current study, replication is required. This should include a carefully matched control group of people who have not sought help following the bereavement. It is possible that people who do not seek help are experiencing higher levels of grief, depression or loneliness. It may be that their levels of distress are such that they feel unable to seek help. Alternatively it may be that their distress is much less than those who seek help. Or it may be that they are just the same as those who do seek help. A carefully matched comparison group is needed to determine their levels of distress. However as has been shown in this study and many other bereavement studies, recruitment in to these studies is particularly difficult.

Secondly, the current study was unable to find a relationship between attachment style, parenting experiences and psychological well-being following the death of a significant other. It seems unlikely that this is an accurate finding. It may suggest however that the relationship is much more subtle than originally believed. The study should be repeated using a qualitative interview such as the Adult Attachment Interview. This would allow for an exploration of unconscious attachment that may provide very different results to measures of conscious attachment.

Thirdly, the findings of the study suggest that despite receiving some form of support many people still experienced high levels of psychological distress. This is testament to

the fact that the impact of the death of a significant other is long-standing and that little is known about interventions that might work. The people who were seeing psychologists had the highest levels of grief (ICG). They also had been bereaved for the shortest length of time. Other studies have found that experiencing high levels of distress soon after a loss is indicative of long term distress. It would be useful to investigate the content of intervention and support provided by different agencies. It may be that bereaved older people are not receiving the help that would be most useful to them. It may also be that different interventions are needed in order to improve the different forms of psychological well-being.

In conclusion, the death of a significant other is an experience that can lead to high levels of long-term psychological distress. The effects of bereavement on older people have been relatively neglected in the literature. The current study offers evidence for the usefulness of a criterion based measure of complicated grief and that the risk factors identified in younger people are also applicable to an older population.

Chapter 5: References

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Appendix 1

A copy of the memo regarding study criteria which was sent to participating psychology departments

Memo

To:

From: Elin Downes-Grainger

Re: What are the risk factors for an outcome of complicated grief in the elderly following bereavement?

I am interested in contacting all of the clients who fit into any one of these categories and are aged over 65:

On the waiting list with a referral for bereavement difficulties.

Being seen by a psychologist and the main focus is bereavement difficulties.

Recently discharged by a psychologist and bereavement difficulties are known to still be a problem.

In order that I can carry out the study I need the following help from the psychologist:

- . Identify all clients that fit into any one of the above three categories.
- . Let them know that I would like to contact them.
- . Let me know if there are any people that I should not see in their own home.

Appendix 2

A copy of the introductory letter sent to prospective participants who were seeing a psychologist

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Date

Dear

I understand that NAME OF CLINICAL PSYCHOLOGIST recently spoke to you about a research project that you might be willing to take part in. I am carrying out the research and enclose an information sheet that explains what it is about and why I am doing it. When you have read the information sheet I would be grateful if you could complete the enclosed reply slip to let me know whether you would or would not like to take part. I also enclose a stamped addressed envelope to make this easy to do.

Whatever you decide to do, I wish you all the best and hope that you have found a way to cope with your loss in the best way possible for you.

Best wishes,

Lin Downes-Grainger
Clinical Psychologist in Training

Appendix 3

A copy of the information sheet sent to prospective participants who were seeing a psychologist

Research Project: Why do people grieve in different ways after the death of a loved one.

You are being invited to take part in the above research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with anyone that you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

I am carrying out this research as part of my postgraduate degree. I am a Clinical Psychologist in Training at University College London and my name is **Elin Downes-Grainger**.

The project is looking at what might lead people to grieve differently from one another after the death of a loved one. In particular I am interested in the relationship between you and the person who has died.

The first research interview takes about one hour and there are a number of questionnaires to be completed. These ask about the circumstances of the death, about how you are feeling at the moment in yourself and about the person who has died, about any support that you have and about your childhood relationship with your parents.

There is a second research interview which also takes about one hour. This interview is more like a conversation and will be more specifically about your loss. I will record it on audio-tape. If you would prefer you can agree to just complete the first interview and not take part in this second one.

There is no therapy involved in this study although I hope that talking about these things will be of some benefit to you. My main hope for the research is that it will help psychologists and other health professionals to understand what are the factors that might lead some people to need extra support after the death of a loved one. This could then assist them in giving the help where it is needed.

If you needed further support after taking part in this study I would be happy to talk to you and give you information on your local bereavement services. If you were still seeing a psychologist you could talk to him or her and if you were no longer seeing a psychologist you could be referred to them.

This study has been reviewed and approved by the North-West Multi Research Ethics Committee. My two supervisors are **Stephen Davies** (Consultant Clinical Psychologist, Essex and Herts Community NHS Trust) and **Howard Steele** (Senior Lecturer, University College London). I can be contacted on _____ if you wish to discuss the project.

You can keep this information sheet and a copy of the consent form for your reference.

Appendix 4

A copy of the information sheet given to prospective participants who were attending a support group

CONFIDENTIAL

Research Project: Why do people grieve in different ways after the death of a loved one.

You are being invited to take part in the above research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with anyone that you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

I am carrying out this research as part of my postgraduate degree. I am a Trainee Clinical Psychologist at University College London and my name is **Elin Downes-Grainger**.

The project is looking at what might lead people to grieve differently from one another after the death of a loved one. I am comparing people who have sought help from a psychologist to cope with their grief and people who have not. I am interested in the relationship between you and the person who has died.

The first research interview takes about one hour and there are a number of questionnaires to be completed. These ask about the circumstances of the death, about how you are feeling at the moment in yourself and about the person who has died, about any support that you have and about your childhood relationship with your parents.

There is a second research interview which takes about half an hour. This interview is more like a conversation and will be more specifically about your loss. I will record it on audio-tape. If you would prefer you can agree to just complete the first interview and not take part in this second one.

My main hope for the research is that it will help psychologists and other health professionals to understand what are the factors that might lead some people to need extra support after the death of a loved one. This could then assist them in giving the help where it is needed.

It is possible that some of the questions may cause some discomfort or distress. You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. If you needed further support after taking part in this study I would be happy to talk to you and give you information on your local bereavement services.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committee on the Ethics of Human Research. My two supervisors are **Stephen Davies** (Consultant Clinical Psychologist, Essex and Herts Community NHS Trust) and **Howard Steele** (Senior Lecturer, University College London). I can be contacted on _____ if you wish to discuss the project. You can keep this information sheet for your reference.

Appendix 5

A copy of the introductory letters sent to prospective participants who had attended a counselling service



The City and East London Bereavement Service

67 Philpot Street
Whitechapel
London
E1 2JH

Tel/Fax: 0207 247 1209

Dear

You may remember meeting with a bereavement counsellor from this service some time ago. It is very helpful for us to learn about how and why people grieve differently. This helps us to think about the service we offer. So we have agreed to help with a research project about bereavement by contacting all the people over sixty five who have seen a bereavement counsellor at this service over the last two years.

A trainee psychologist called Elin Downs-Grainger is carrying out this project about grief. I enclose a letter and information sheet from her about the project, as well as a reply slip and stamped addressed envelope.

If you would like to take part Elin would appreciate it if you would send back the slip so that she can contact you to arrange to visit. You are under no obligation at all to take part in this project.

If you have any questions about what the study involves Elin would be happy to speak to you. Her phone number is on the information sheet.

Best wishes

Yours sincerely

Mrs Jan Fish
Co Ordinator



Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

General Enquiries: 0171-380 7897
Clinical Tutor Team: 0171-391 1258
UCL: 0171-387 7050
Code from overseas: +44 171
Fax: 0171-916 1989

12th March 2001

Dear

I am carrying out a research project looking at the different ways that people grieve after the death of a loved one. The City and East London Bereavement Service have agreed to help me in finding people who might be able to help. They gave me your name and said that you might wish to help me.

I enclose an information sheet that explains the purpose and content of my research. I also enclose a reply slip and envelope. I hope that you will be able to help me but whatever you decide I wish you all the best in living with your loss.

Yours sincerely,

Elin Downes-Grainger
Trainee Clinical Psychologist

Appendix 6

A copy of the information sheet given to prospective participants who had attended a counselling service

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Research Project: Why do people grieve in different ways after the death of a loved one.

You are being invited to take part in the above research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with anyone that you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

I am carrying out this research as part of my postgraduate degree. I am a Clinical Psychologist in Training at University College London and my name is **Elin Downes-Grainger**.

The project is looking at what might lead people to grieve differently from one another after the death of a loved one. In particular I am interested in the relationship between you and the person who has died.

The first research interview takes about one hour and there are a number of questionnaires to be completed. These ask about the circumstances of the death, about how you are feeling at the moment in yourself and about the person who has died, about any support that you have and about your childhood relationship with your parents.

There is a second research interview which also takes about one hour. This interview is more like a conversation and will be more specifically about your loss. I will record it on audio-tape. If you would prefer you can agree to just complete the first interview and not take part in this second one.

There is no therapy involved in this study although I hope that talking about these things will be of some benefit to you. My main hope for the research is that it will help psychologists and other health professionals to understand what are the factors that might lead some people to need extra support after the death of a loved one. This could then assist them in giving the help where it is needed.

If you needed further support after taking part in this study I would be happy to talk to you and give you information on your local bereavement services.

This study has been reviewed and approved by the North-West Multi Research Ethics Committee. My two supervisors are **Stephen Davies** (Consultant Clinical Psychologist, Essex and Herts Community NHS Trust) and **Howard Steele** (Senior Lecturer, University College London). I can be contacted on _____ if you wish to discuss the project.

You can keep this information sheet and a copy of the consent form for your reference.

Appendix 7

A copy of the introductory letter sent to prospective participants who were in the community

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Date

Dear

I was given your address by your friend _____. He told me that it would be okay to write to you. I am a trainee clinical psychologist and am currently carrying out research looking at why people grieve in different ways. I have interviewed _____ and he said that you might also be interested in helping me.

I enclose an information sheet about my research and a reply slip and envelope. I would be grateful if you could let me know whether you would be happy for me to interview you.

Thank you very much for considering my research. I look forward to meeting you if you decide to take part. Best wishes whatever you decide to do.

Yours sincerely,

Elin Downes-Grainger
Trainee Clinical Psychologist

Appendix 8

A copy of the information sheet given to prospective participants who were
in the community

CONFIDENTIAL

Research Project: Why do people grieve in different ways after the death of a loved one.

You are being invited to take part in the above research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with anyone that you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

I am carrying out this research as part of my postgraduate degree. I am a Trainee Clinical Psychologist at University College London and my name is **Elin Downes-Grainger**.

The project is looking at what might lead people to grieve differently from one another after the death of a loved one. I am comparing people who have sought help from a psychologist to cope with their grief and people who have not. I am interested in the relationship between you and the person who has died.

The first research interview takes about one hour and there are a number of questionnaires to be completed. These ask about the circumstances of the death, about how you are feeling at the moment in yourself and about the person who has died, about any support that you have and about your childhood relationship with your parents.

There is a second research interview which takes about half an hour. This interview is more like a conversation and will be more specifically about your loss. I will record it on audio-tape. If you would prefer you can agree to just complete the first interview and not take part in this second one.

My main hope for the research is that it will help psychologists and other health professionals to understand what are the factors that might lead some people to need extra support after the death of a loved one. This could then assist them in giving the help where it is needed.

It is possible that some of the questions may cause some discomfort or distress. You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. If you needed further support after taking part in this study I would be happy to talk to you and give you information on your local bereavement services.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committee on the Ethics of Human Research. My two supervisors are **Stephen Davies** (Consultant Clinical Psychologist, Essex and Herts Community NHS Trust) and **Howard Steele** (Senior Lecturer, University College London). I can be contacted on _____ if you wish to discuss the project. You can keep this information sheet for your reference.

Appendix 9

A copy of the approval letter from the North West Multi Centre Research
Ethics Committee



Executive

North West

**MREC
Gateway House
Piccadilly South
Manchester
M60 7LP**

**Chairman
Mrs Jennifer Blunt OBE**

**Tel 0161 237 2394
Fax 0161 237 2383**

e-mail
alison.forbes@mchester-
ha.nwest.nhs.uk

Our ref: MREC 99/8/94
Your ref:

7th March 2000

**Ms E Downes-Grainger
37 Lorne Road
Forest Gate
London
E7 0LJ**

Dear Ms E Downes-Grainger

MREC 99/8/94

What are the risk factors for an outcome of complicated grief in the elderly following bereavement?

Protocol
Subject Information Sheet - version 2, 8th February 2000
Subject Consent Form - version 2, 8th February 2000
Letter of Invitation - version 2, 8th February 2000

The Chairman of the North West MREC has considered the amendments submitted in response to the Committee's earlier review of your application on the 12th January as set out in our Response Form of that date.

The Chairman, acting under delegated authority is satisfied that these accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study whose title and document references are given at the head of this letter. I am, therefore, happy to give you our approval: this is on the understanding that you will follow the protocol as agreed. Any comments the MREC wished to make are contained in the attached MREC Response Form. The project must be started within three years of the date on which MREC approval is given.

Please read the notes regarding notification of changes and completion of progress reports at the end of the Response Form carefully, as the MREC requires that they be followed. In addition approval is given subject to the conditions set out below:



INVESTOR IN PEOPLE

Conditions of Approval

- ◆ You follow the protocol agreed and advise the MREC of any changes made. Any changes to the protocol will require prior MREC approval.
- ◆ You complete the final report form sent to you at the end of your project and return it to the MREC Manager.
- ◆ You notify any serious unexpected adverse drug reactions to the MREC Manager, appropriate LRECs and your sponsor using the procedure set out in the General Guidance for Researchers.

You will no doubt realise that whilst the MREC has given approval for the study on ethical grounds, it is still necessary for you to obtain management approval from the relevant Clinical Directors and/or Chief Executive of the Trusts (or Health Boards/DHAs) in which the work will be done.

Local Submissions

It is also your responsibility to ensure that any local researcher seeks the approval of the relevant LREC before starting their research. To do this you should submit the appropriate number of copies of the following to the relevant LRECs:

- this letter
- the MREC Application form, (including copies of any questionnaires)
- the attached MREC response form
- Annex D of the Application form
- **one** copy of the protocol

It is important to check with the respective LRECs the precise numbers of copies required as this will vary and failure to supply sufficient copies could lead to a delay.

Local Sites

Whilst the MREC would like as much information as possible about local sites at the time you apply for ethical approval it is understood that this is not always possible. You are asked, however, to send a completed copy of Annex C for each local site as soon as a researcher has been recruited.

ICH GCP Compliance

MRECs are fully compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH) Guidelines for the Conduct of Trials Involving the Participation of Human Subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/ Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice adopted by the Commission of the European Union on the 17th January 1997. The Standing Orders and a Statement of Compliance were included on the computer disk containing the guidelines and application form and are available on request or on the Internet at <http://dSPACE.dial.pipex.com/mrec>

Yours sincerely



Alison Forbes
Manager, MREC North West

c.c.

Enclosures *MREC response form*
 Progress report form

Appendix 10

A copy of the approval letters from Enfield and Haringey LREC, the Royal Free Hospital and Medical School LREC, the Redbridge and Waltham Forest LREC, the Camden and Islington LREC, the East London and City LREC, and the West Essex LREC

11 May 2000

Dr Elin Downes-Grainger
Clinical Psychologist in Training
37 Lorne Road
Forest Gate
London
E7 0LJ

Dear Dr Downes-Grainger

772 – MREC 99/8/94 - What are the risk factors for an outcome of complicated grief in the elderly, following bereavement?

Acting under delegated authority, I write to inform you that the above study has been considered by the MREC sub-group of the Local Research Ethics Committee and has been approved.

The committee looks forward to receiving a copy of your interim report in six months time or at end of your study if this is sooner.

Yours sincerely,



Christine Hamilton
LREC Administrator
(on behalf of the LREC Chairman)



ROYAL FREE HOSPITAL
POND STREET
LONDON NW3 2QG
TELEPHONE 020 7794 0500
FAX 020 7830 2961



CHAIRMAN **JOHN CARRIER**

CHIEF EXECUTIVE **M T ELSE**

REPLY TO EXTENSION

5628

05 May 2000

Ms Elin Downes-Grainger
37 Lorne Road
Forest Gate
London E7 0LJ

Dear Ms Downes-Grainger

Re: **WHAT ARE THE RISK FACTORS FOR AN OUTCOME OF COMPLICATED
GRIEF IN THE ELDERLY FOLLOWING A BEREAVEMENT**

I am pleased to be able to inform you that your recent submission to the Royal Free Hospital & Medical School Local Research Ethics Committee has now received approval by Chairman's Action. This approval will be formally documented at the next meeting of the full committee.

This approval does not mean that the study may commence. The study may only begin following approval by the Trust through the office of the Director of Research & Development (please contact Sadaf Zaidi on extension 8304).

Please note the code number (**M103-2K**) that the submission has been given and quote this in all correspondence.

Yours sincerely

A handwritten signature in cursive script that reads 'Maureen Carroll'.

Maureen Carroll
Secretary
Royal Free Hospital & Medical School
Local Research Ethics Committee

cc Mr J Farrell, Head of Pharmaceutical Services
Ms S Zaidi, Research & Development



CLINICAL INFORMATION CENTRE

Royal Free Hampstead NHS Trust

The Royal Free Hospital, Pond Street, London NW3 2QG
Switchboard: 020 7794 0500 Ext. 8304 Fax: 020 7830 2233
Direct line: 020 7830 2816 e mail: rosemarybrown@rfh.nthames.nhs.uk

07/06/2000

Dear Ms E. Downes-Granger

Re: What are the risk factors for an outcome of complicated grief in the elderly following bereavement

R&D ID: 5036
Ethics ID: M103-2k

Following the approval of your ethics application and registration form your project has been fully registered with the R&D department. I would be grateful if you would inform me of any changes regarding funding, project status e.t.c

Should you have any queries please quote the ID number.

You may proceed with your project.

Sincerely

Rosemary Brown
Research & Development Assistant
Clinical Information Centre



Redbridge & Waltham Forest
Health Authority

Ms E. Downes-Grainger
37 Lawn Road
Forest Gate
E7 OLJ

Becketts House,
2-14 Ilford Hill,
Ilford, Essex IG1 2QX
Tel: 020 8478 5151
Fax: 020 8926 5001
ECR Fax: 020 8926 5002
Reg. Fax: 020 8926 5003

18th May 2000

Dear Ms Downes-Grainger,

Re: LREC (R&WF) 90 (SC)
What are the risk factors for an outcome of complicated grief in the elderly following bereavement

Thank you for forwarding details of the above mentioned study to the Redbridge and Waltham Forest Local Research Ethics Committee. I can confirm that the Committee considered this research application and was happy to approve the ethical aspects of this study involving Thorpe Coombe Hospital.

The Committee looks forward to receiving a final report of your research findings in due course.

Yours sincerely

N. Akhtar

DR. N. AKHTAR
Chairman of LREC

Telephone: 0171-288 5675 (24 hr service)
0171-288 5676
0171-288 5677
Fax Number: 0171-288 5674

Ms Elin Downs-Grainger
Clinical Psychologist in Training
37 Lorne road
Forest Gate
London E7 0LJ

Dear Ms Downs-Grainger

MREC 2000/205 What are the risk factors for an outcome of complicated grief in the elderly following bereavement

I refer to your submission of the above project to the Local Research and Ethics Committee on 2 August 2000. I am pleased to inform you that the above named project has been **approved**.

Approval is for two years from the date of this letter. Extension of this period will be dependent on the submission of a brief synopsis of the project together with an estimation of the time required for its ultimate completion.

The Ethics Committee will require an annual report on the progress of the study, and a copy of the completed study together with any consequent publication. In addition, the Committee must be informed, by the completion of the relevant form, of any untoward or adverse events that occur during the course of the study. The person who provided independent review of the original protocol should also be sent information regarding adverse events.

The Ethics Committee must be informed of, and approve, any proposed amendment to your initial application that has a bearing on the treatment or investigation of patients or volunteers.

A copy of the patient consent form and information sheet must be lodged in the clinical notes.

I am sure that every effort is already made to preserve the confidentiality of any patient information used in this study. Please ensure that the team of investigators are aware that everyone who has access to patient information appreciates the importance of maintaining confidentiality particularly in respect of the use of computers and the statutory regulations laid down in the Data Protection Act 1984

In terms of the managerial and financial implications associated with the study, where these relate to additional costs for the Trust, Mr Rob Hurd (Management Accountant, Finance Department, Whittington Hospital), will be in contact with you to discuss the Trust's schedule of charges for research projects. **Approval of these issues must be obtained from your general manager before the study commences.**

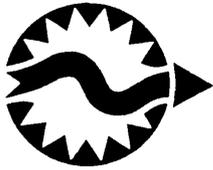
In any correspondence regarding the study please quote the above Ethics Committee reference number.

Yours sincerely



Mr John Farrell

Chairman - Local Research and Ethics Committee



Ms Elin Downes-Grainger
Clinical Psychologist in Training
37 Lorne Road
Forest Gate
London E7 OLJ

22nd May 2000

Our Ref: MS/SG/P/00/100m

Dear Ms Downes-Grainger

Re: P/00/100m - What the risk factors for an outcome of complicated grief in the elderly following bereavement?

I am happy to tell you that the above study was approved at the recent meeting of the Research Ethics Executive Committee.

Please note the following conditions to the approval:

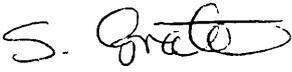
1. The Committee's approval is for the length of time specified in your application. If you expect your project to take longer to complete (i.e. collection of data), a letter from the principal investigator to the Chairman will be required to further extend the research. This will help the Committee to maintain comprehensive records.
2. Any changes to the protocol must be notified to the Committee. Such changes may not be implemented without the Committee or Chairman's approval.
3. The Committee should be notified immediately of any serious adverse events or if the study is terminated prematurely.
4. You are responsible for consulting with colleagues and/or other groups who may be involved or affected by the research, such as extra work for laboratories.
5. You must ensure that, where appropriate, nursing and other staff are made aware that research in progress on patients with whom they are concerned has been approved by the Committee.
6. The Committee should be sent one copy of any publication arising from your study, or a summary if there is to be no publication.

I should be grateful if you would inform all concerned with the study of the above decision.

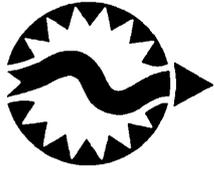
Your application has been approved on the understanding that you comply with Good Clinical Practice and that all raw data is retained and available for inspection for 15 years.

Please quote the above study number in any future related correspondence.

Yours sincerely

A handwritten signature in black ink, appearing to read 'S. Swash', with a stylized flourish at the end.

PROFESSOR M SWASH MD FRCP FRCPath
Chairman
ELCHA Research Ethics Committee



East London and The City **HEALTH AUTHORITY**

Ms Elin Downes-Grainger
Clinical Psychologist in Training
37 Lorne Road
Forest Gate
London E7 OLJ

5 September 2000

Our Ref: MS/SG/P/00/100m

Dear Ms Downes-Grainger

Re: P/00/100m - What the risk factors for an outcome of complicated grief in the elderly following bereavement?

Thank you for your letter of 19 July 2000. Approval has been granted to conduct your study at the Homerton Hospital and the Annex D form will be placed on file.

Yours sincerely

PROFESSOR M SWASH MD FRCP FRCPath
Chairman
ELCHA Research Ethics Committee

Chief Executive: Carolyn Regan
Chairman: Professor Elaine Murphy
Aneurin Bevan House 81 Commercial Road · London E1 1RD
Tel: 020 7655 6600 · Fax: 020 7655 6666

NHS

Aneurin Bevan House
81 Commercial Road
London E1 1RD

Ms Elin Downes-Grainger
Clinical Psychologist in Training
37 Lorne Road
Forest Gate
London E7 OLJ

Tel: 020 7655 6600
Fax: 020 7655 6666

27th March 2001

Our Ref: MS/RI/P/00/100m

Dear Ms Downes-Grainger

Re: P/00/100m - What are the risk factors for an outcome of complicated grief in the elderly following bereavement?

Thank you for your letter dated 12th March 2001.

I acknowledge that you have received approval from the North West MREC for some slight changes to your study in September 2000.

I also acknowledge the letter of approval from the East London and City Bereavement Service. As in our telephone conversation on 7th March, this letter does suffice as evidence for the committee and the changes are approved, noting the conditions of the North West MREC.

The information has been noted and added to our records.

Yours sincerely



P.p. Senior Administrator
PROFESSOR M SWASH MD FRCP FRCPATH
Chairman
ELCHA Research Ethics Committee

**WEST ESSEX
LOCAL RESEARCH ETHICS COMMITTEE**

**Parndon Hall , The Princess Alexandra Hospital NHS Trust, Hamstel Road, Harlow,
ESSEX, CM20 1QX**

Tel: 01279 827082

Fax: 01279 429371

Our ref: JT/sj

2 June 1999

Ms Elin Downes-Grainger
37 Lorne Road
Forest Gate
London E7 OLJ

Dear Ms Downes-Grainger

**1269 WHAT ARE THE RISK FACTORS FOR AN OUTCOME OF
COMPLICATED GRIEF IN THE ELDERLY FOLLOWING A
BEREAVEMENT (Elin Downes-Grainger)**

I write to confirm receipt of your letter dated 27 May 1999 together with the amended invitation letter and patient information sheet. I note that you have also agreed not to show the titles on the questionnaire to participants.

This project has been given unconditional approval by way of Chairman's Action.

Please note that I may be contacting you from time to time for information on the progress of the project. I would also be grateful if you would notify me when the project is completed, or if it is terminated for any reason prior to completion, and if there are any material changes to the protocol for the project perhaps you will advise me accordingly. May I take this opportunity to wish you every success with the project.

Please ensure that the above reference number is quoted on all correspondence regarding this project.

Yours sincerely,



**Jane Thomas
Secretary to the West Essex Local Research Ethics Committee**

PP

Appendix 11

A copy of the approval letter from the Joint UCL/UCH Committees on the
Ethics of Human Research



The University College London Hospitals

The Joint UCL/UCLH Committees on the Ethics of Human Research

Committee Alpha Chairman: Professor André McLean

Please address all correspondence to:
Iwona Nowicka
Research & Development Directorate
UCLH NHS Trust
1st Floor, Vezey Strong Wing
112 Hampstead Road, London NW1 2LT
Tel. 020 7-380 9579 Fax 020 7-380 9937
e-mail: iwona.nowicka@uclh.org

Dr H Steele
Senior Lecturer in Psychology
Sub-department of Clinical Health Psychology
UCL
Gower Street

November 8, 2000

Dear Dr Steele

Study No: 00/0250 *(Please quote in all correspondence)*
Title: The effects of attachment style, social support, loneliness and nature of the death on the expression of grief in older people

Thank you very much for letting us see the above application which was agreed b Chairman's Action. The study can go ahead.

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

pp
Professor André McLean, BM BCh PhD FRC Path
Chairman

cc. Elin Downes-Grainger ✓

Appendix 12

A copy of the consent form approved by the Joint UCL/UCH Committees on
the Ethics of Human Research

CONFIDENTIAL

Research Project: Why do people grieve in different ways after the death of a loved one.

CONSENT OF PARTICIPANT:

- ❖ Has Elin Downes-Grainger spoken to you about this study? Y/N
- ❖ Have you read the information sheet about this study? Y/N
- ❖ Have you had an opportunity to ask questions and discuss this study? Y/N
- ❖ Have you received satisfactory answers to all your questions? Y/N
- ❖ Have you received enough information about this study? Y/N
- ❖ Do you understand that you can withdraw from the study at any time and without giving a reason. Y/N
- ❖ Do you agree to take part in this study? Y/N

DELETE AS APPROPRIATE

- ❖ I agree to take part in the first interview only OR
- ❖ I agree to take part in both interviews and I understand interview two, will be tape-recorded.

Signed _____ Printed Name _____

Dated _____

RESEARCHER:

confirm that I have fully explained the purpose and nature of the investigation. The participant has read the information sheet and is satisfied with all aspects of the study. The participant has agreed to take part voluntarily.

Signed _____ Dated _____

Printed Name: ELIN DOWNES-GRAINGER

Appendix 13

A copy of the consent form approved by the North West Multi Centre
Research Ethics Committee

Research Project: Why do people grieve in different ways after the death of a loved one.

CONSENT OF PARTICIPANT:

I agree to take part in the above research study. I agree to the following:

- ❖ I have read the information sheet and have discussed the study with Elin Downes-Grainger. I am satisfied with the nature, purpose and effects of the study.
- ❖ I agree to take part in the study voluntarily.
- ❖ I understand that I can withdraw from the study at any time without giving a reason. I understand that this will not affect my health care in any way.

DELETE AS APPROPRIATE

- ❖ I agree to take part in the first interview only OR
- ❖ I agree to take part in both interviews and I understand interview two, will be tape-recorded.

Signed _____ Printed Name _____

Dated _____

RESEARCHER:

I confirm that I have fully explained the purpose and nature of the investigation. The participant has read the information sheet and is satisfied with all aspects of the study. The participant has agreed to take part voluntarily.

Signed _____

Printed Name: ELIN DOWNES-GRAINGER

Dated _____

Appendix 14

A copy of the Inventory of Complicated Grief

Inventory of Complicated Grief

Please answer each question choosing one of the responses from the response card.

1. I think about this person so much that it's hard for me to do the things I normally do.
2. Memories of the person who died upset me.
3. I feel I cannot accept the death of the person who died.
4. I feel myself longing for the person who died.
5. I feel drawn to places and things associated with the person who died.
6. I can't help feeling angry about his/her death.
7. I feel disbelief over what happened.
8. I feel stunned or dazed over what happened.
9. Ever since s/he died it is hard for me to trust people.
10. Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about.
11. I have pain in the same area of the body or have some of the same symptoms as the person who died.
12. I go out of my way to avoid reminders of the person who died.
13. I feel that life is empty without the person who died.
14. I hear the voice of the person who died, speak to me.
15. I see the person who died stand before me.
16. I feel that it is unfair that I should live when the person died.
17. I feel bitter over this person's death.
18. I feel envious of others who have not lost someone close.
19. I feel lonely a great deal of the time ever since s/he died

From:

Holly Prigerson, Mark Miller, Charles F Reynolds, Ellen Frank. Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research* 1995, vol 59, 65-79.

Inventory of Complicated Grief

Response Card

Never

Rarely

Sometimes

Often

Always

0

1

2

3

4

Appendix 15

A copy of the Adult Attachment Styles questionnaire

Adult Attachment Styles

The following questionnaire, in two brief parts, is concerned with your experiences in romantic love relationships. Take a moment to think about all of the most important romantic relationships you've been involved in. For each relationship think about:

- How happy or unhappy you were, and how your moods fluctuated.
- How much you trusted or distrusted each other.
- Whether you felt you were too close emotionally or not close enough.
- The amount of jealousy you felt.
- How much time you spent thinking about your partner.
- How attracted you were to the person.
- How the relationship might have been better.
- How it ended.

Thinking about these good and bad memories of various relationships will help you answer the following questions accurately.

Part 1:

Read each of these three self-descriptions below and then rate how much you agree or disagree that each one describes the way you generally are in love relationships. Choose one of the responses from the separate response card for each self-description. (Note: The term 'close' and 'intimate' refer to psychological or emotional closeness, not necessarily to sexual intimacy).

1. I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being. (Choose one response)
2. I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to get very close to my partner, and this sometimes scares people away. (Choose one response)
3. I find it relatively easy to get close to others and am comfortable depending on them. I don't often worry about being abandoned or about someone getting too close to me. (Choose one response)

Part 2:

Below, the three options from the previous page are printed again. Please say which is the single alternative that best describes how you feel in romantic love relationships.

1. I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being.
2. I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to get very close to my partner, and this sometimes scares people away.
3. I find it relatively easy to get close to others and am comfortable depending on them. I don't often worry about being abandoned or about someone getting too close to me.

From:

C.Hazan & P.Shaver. Romantic Love conceptualised as an attachment process. Journal of Personality and Social Psychology, 1987, Vol 52, 3, 511-524.

Adult Attachment Styles

Response Card

**Disagree
Strongly**

1

**Disagree
Moderately**

2

**Disagree
Slightly**

3

**Mixed
Not sure**

4

**Agree
Slightly**

5

**Agree
Moderately**

6

**Agree
Strongly**

7

Appendix 16

A copy of the Parental Bonding Instrument

Parental Bonding Index

This questionnaire lists various attitudes and behaviours of parents. As you remember your own **MOTHER** in your first sixteen years would you choose a response from the response card for each question.

1. Spoke to me with a warm and friendly voice.
2. Did not help me as much as I needed.
3. Let me do things I liked doing.
4. Seemed emotionally cold to me.
5. Appeared to understand my problems and worries.
6. Was affectionate to me.
7. Liked me to make my own decisions.
8. Did not want me to grow up.
9. Tried to control everything I did.
10. Invaded my privacy.
11. Enjoyed talking things over with me.
12. Frequently smiled at me.
13. Tended to baby me.
14. Did not seem to understand what I needed or wanted.
15. Let me decide things for myself.
16. Made me feel I wasn't wanted.
17. Could make me feel better when I was upset.
18. Did not talk with me very much.
19. Tried to make me dependent on her.
20. Felt I could not look after myself unless she was around.
21. Gave me as much freedom as I wanted.
22. Let me go out as often as I wanted.
23. Was overprotective of me.
24. Did not praise me.
25. Let me dress in anyway I please.

This questionnaire lists various attitudes and behaviours of parents. As you remember your own **FATHER** in your first sixteen years would you choose a response from the response card for each question.

26. Spoke to me with a warm and friendly voice.
27. Did not help me as much as I needed.
28. Let me do things I liked doing.
29. Seemed emotionally cold to me.
30. Appeared to understand my problems and worries.
31. Was affectionate to me.
32. Liked me to make my own decisions.
33. Did not want me to grow up.
34. Tried to control everything I did.
35. Invaded my privacy.
36. Enjoyed talking things over with me.
37. Frequently smiled at me.
38. Tended to baby me.
39. Did not seem to understand what I needed or wanted.
40. Let me decide things for myself.
41. Made me feel I wasn't wanted.
42. Could make me feel better when I was upset.
43. Did not talk with me very much.
44. Tried to make me dependent on her.
45. Felt I could not look after myself unless she was around.
46. Gave me as much freedom as I wanted.
47. Let me go out as often as I wanted.
48. Was overprotective of me.
49. Did not praise me.
50. Let me dress in anyway I please.

From:

G Parker, L Kiloh, L Hayward. Parental representations of neurotic and endogenous depressives. *Journal of Affective Disorders* 1987, vol 13, 75-82.

Parental Bonding Index

Response Card

Very like

Moderately like

Moderately unlike

Very unlike

Appendix 17

A copy of the Significant Others Scale

Significant Others Scale (ERG)

1. Can you trust, talk to frankly and share your feelings with your spouse?
2. Ideally, how often would you like this to be?

3. Can you lean on and turn to your spouse/partner in times of difficulty?
4. Ideally, how often would you like this to be?

5. Does he/she give you practical help?
6. Ideally, how often would you like this to be?

7. Can you spend time with him/her socially?
8. Ideally, how often would you like this to be?

Please answer the above eight questions for each of the six sections below. If any section does not apply to you, go on to the next section. Use the responses provided on the response card.

Section 1: SPOUSE (HUSBAND/WIFE) OR PARTNER

Section 2: CLOSEST SON OR DAUGHTER

Section 3: A SECOND CLOSEST SON OR DAUGHTER

Section 4: BROTHER OR SISTER

Section 5: BEST FRIEND

Section 6: ANOTHER IMPORTANT PERSON (please state who?)

From:

DH Lam & MJ Power. Social support in a general practice elderly sample. *International Journal of Geriatric Psychiatry*, 1991, vol 6, 89-93.

Significant Others Scale

Response Card

Never

Seldom

Sometimes

Often

Always

1

2

3

4

5

Appendix 18

A copy of the Revised UCLA Loneliness Scale

The Revised UCLA Loneliness Scale

Indicate how often you feel the way described in each of the following statements.

1. **I feel in tune with the people around me.**
2. I lack companionship.
3. There is no one I can turn to.
4. **I do not feel alone.**
5. **I feel part of a group of friends.**
6. **I have a lot in common with the people around me.**
7. I am no longer close to anyone.
8. My interests and ideas are not shared by those around me.
9. **I am an outgoing person.**
10. **There are people I feel close to.**
11. I feel left out.
12. My social relationships are superficial.
13. No one really knows me well.
14. I feel isolated from others.
15. **I can find companionship when I want it.**
16. **There are people who really understand me.**
17. I am unhappy being so withdrawn.
18. People are around me but not with me.
19. **There are people I can talk to.**
20. **There are people I can turn to.**

From: D Russell, LA Peplau, CE Cutrona. The revised UCLA Loneliness Scale: Concurrent and discriminant validity evidence. *Journal of Personality and Social Psychology* 1980; 39:472-480.

Response Card

Never

Rarely

Sometimes

Often

1

2

3

4

Appendix 19

A copy of the Geriatric Depression Scale-15

Geriatric Depression Scale

Please answer each question using the choices on the response card.

1. Are you basically satisfied with your life?
2. Have you dropped any of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel that you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

From:

JA Yesavage. Geriatric Depression Scale. *Psychopharmacology Bulletin* 1988, vol 24, 709-710.

Geriatric Depression Scale

Response Card

Yes

No

Appendix 20

A copy of the modified version of the Adult Attachment Interview

Adapted Adult Attachment Interview

This interview is about the important relationships that you have had in your life. I want to interview you about some of your childhood experiences and then about your experiences as an adult.

1. **Could we first start by you telling me briefly about who was in your family when you were a child, where you lived, what your family did and so on. Did you see your grandparents when you were little?**
2. **Thinking about your childhood relationships with your parents, I'd like you to try to describe your relationship with them as a young child?**
3. **When you were a child did you lose any loved ones such as a parent or a close family member? (probe in detail e.g. sudden or expected? How did you feel when you first heard? Did you attend the funeral? Have your feelings changed over time? Has the loss affected who you are today, and how you related to your own children?)**
4. **Did you lose any other important people during your childhood? (same probes as above)**
5. **Could you tell me about the loss of KEY PERSON ? (probe in detail e.g. sudden or expected? How did you feel when you first heard? Did you attend the funeral? Have your feelings changed over time? Has the loss affected who you are now? What did the person mean to you?)**
6. **Have you lost any other loved ones as an adult? (same probes as above)**

From:

C George, N Kaplan, M Main. An Adult Attachment Interview: Interview protocol. Unpublished manuscript, University of California, Berkeley, Department of Psychology 1985.

Appendix 21

A copy of the types of lapses scored in the unresolved loss section of the
Adult Attachment Interview

Indices of disorganized/disoriented responses to loss in the AAI context

1. Lapses in the monitoring of reasoning during discussion of a loss	
Indications of disbelief that the person is dead	
Sense of being causal in a death where no material cause was present	
Indications of confusion between the dead person and the self	
Disorientation with respect to time	
Disorientation with respect to space	
Psychologically confused statements	
2. Lapses in the monitoring of discourse during discussion of a loss	
Unusual attention to detail	
Poetic phrasing with a memory quality (often, eulogistic speech)	
Prolonged silences	
Unfinished sentences (weaker indices)	
Sudden changes of topic or moves away from the topic	
Invasions into other topics of information regarding a death	
3. Extreme behavioural reactions: reports very disorganized or disoriented behavioural responses to a loss (lapses in the monitoring of behaviour)	
Reports of re-direction of distress following bereavement	
Reports of extreme responses at the time of bereavement	

Appendix 22

Examples of AAI unresolved loss lapses found in the taped interviews

Lapses in the monitoring of reasoning

Indications of disbelief that person is dead:

If I wanna do something I make sure she will agree to it (Case 14 talking about wife who died, ICG = 40)

I can sit down and talk to her. Do you think I'm doing this right? (Case 14, ICG = 40)

Although it's a year gone I say to myself I wonder if he's up there (hospital) wondering why I'm not visiting him (Case 18, ICG = 50)

Indications of confusion between the dead person and self:

It was a terrible shock for me because I must have been dying when I went to see him the last time (Case 3, talking about death of father twenty years ago, ICG = 50)

Psychologically confused statements:

Wasn't a very good childhood. My father was very strict. My stepmother used to tell tales to him about me.

Later in interview: As I say I was upset when they died both of them so they couldn't have been bad I spose. Perhaps it was me (Case 7. ICG = 48)

When my son was alive I would never think of doing anything like that (Case 7, talking about attempting suicide when son was alive with terminal illness, ICG = 48)

A part of me died with him and still has really (Case 3, ICG = 50)

Lapses in the monitoring of discourse

Poetic phrasing

It was like a little step, a gateway to heaven really. He was so cared for (Case 9, talking about husband going in to a hospice, ICG = 17)

Sudden changes of topic or moves away from the topic

Q: Could you tell me about when your mother died?

My mother had a lovely place to end the few years of her life but she was critical, very. She criticised the food, she pushed the plates away. They had a lovely dining room because it used to be a sort of country house, lovely furn. , flowers everywhere. (continued on to talking about how mother treated her. After 4 minutes said 'And then she died') (Case 3, ICG = 50)

Reports of extreme behavioural reactions

Since I've been ill, since I've had this breakdown I haven't cried. I feel well in myself but it's just the shaking and the first thing I complained of was a sore underneath. It's three years I've had that. They say it's nerves but I can't see it. (Case 10, ICG = 3)

There are many little things which I have forgotten. It's not like ordinary forgetfulness it's like it never happened. I don't know whether it was the shock of John or my own illness (Case 13, ICG = 28)

I had a breakdown. I ended up in Barnet (psychiatric hospital) (Case 7 – talking about when husband died, ICG = 48)

I tried to commit suicide. Didn't want him to go before me. (Case 7 – talking about when son was terminally ill, ICG = 48)

Appendix 23

A copy of the questions about the bereavement

Appendix 24

A copy of the biographical questions

Biographical Questionnaire

Name _____ Gender _____

Date of birth _____ Marital Status _____ (M,S,W,D)

Main occupation prior to retirement _____

Main occupation of partner _____

Age when started school _____ Age when left school _____

Have you had any significant physical problems in your life? _____

Can you give details? Any hospital admissions?

Have you had any significant problems with your nerves in your life?

Can you give details? Any hospital admissions?

What contact have you had with medical services since the death of your loved one?
Physical problems? Nerves problems? What dept? Where? How often?

Appendix 25

A diagrammatic representation of the questionnaire completion procedure

Presentation of Questionnaires

Example question taken from Geriatric Depression Scale-15 (Yesavage 1988)

Each question is presented on a single piece of paper (as below). Each response item is written on an envelope (as below, not to size). The participant places the single question item on the response (envelope) of their choice.

1. Are you basically satisfied with your life?

Yes

No