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The Effects of Parental Loss on Children: Disturbance to Resilience

Nawal S. Aboul-Hosn.

THE EFFECTS OF PARENTAL LOSS ON CHILDREN: DISTURBANCE TO RESILIENCE

DISSERTATION

Presented in Partial Fulfillment of the Requirements for

the Degree of Doctor of Philosophy in

Counseling in

the Adrian Dominican School of Education of

Barry University

by

Nawal S. Aboul-Hosn, LMHC, NCC

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ABSTRACT

THE EFFECTS OF PARENTAL LOSS ON CHILDREN:

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Nawal S. Aboul-Hosn, LMHC, NCC

Barry University, 2009

Dissertation Chairperson: Dr. Catharina M. Eeltink

Purpose

This study sought to synthesize and extend bereavement research relating to attachment and resilience by focusing on three constructs that may be related to resiliency and adaptive functioning. The primary purpose of this study was to investigate the relationship between family attachment, family hardiness, and family social support to resiliency and behavioral functioning of children who have lost a parent. A secondary purpose was to investigate the interrelationship between the three variables of family attachment, family hardiness, and family social support in families who have lost a parent.

Method

The research design chosen for this study was causal-comparative. The 55 participants in this study were parents raising children between the ages of eighteen months to eighteen years who had lost a parent within the past four years, and who were receiving mental health services or support. The participants completed the following questionnaires: The Family Attachment and Changeability Index (McCubbin, Thompson,

& Elver, 1995), the Family Hardiness Index (McCubbin, Patterson, & Glynn, 1996), the Social Support Index (Mc Cubbin, Mc Cubbin, & Thompson, 1996), the Child Resiliency Scale (Eisenberg, 2004), and the Child Behavior Checklist (Achenbach, 1991). The predictor variables in this study were: parent-child attachment, family hardiness, and family social support. The criterion variables in this study were the children's resiliency and the children's behavioral functioning.

Major Findings.

Of the nine hypotheses, the results found support for seven. Significant positive correlational relationships were found between child resiliency and the variables of family attachment, changeability, family hardiness, and family social support. Significant negative correlations were found between problematic behaviors as measured by the Child Behavior Checklist and family attachment, changeability, and family hardiness. Family hardiness correlated positively with family attachment and family social support, and the correlations were significant.

The results of this study indicate that family attachment, changeability, family hardiness, and social support are associated with increased resilience and decreased behavioral problems in children. These variables may be mediating factors that explain why family coherence is related to better adjustment after the loss of a parent. The findings suggest that counselors who work with families who have lost a parent should focus on increasing family attachment, family hardiness, and family social support, in addition to providing grief counseling.

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DEDICATION

I dedicate my dissertation to the memory of my grandfather who

instilled in me the passion for higher education…

taught me to give myself the permission to dream…

the courage to pursue my dreams,

and the possibility to go after my dreams...

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER I

THE PROBLEM

Introduction

A client's grief over the death of a parent presents one of the most challenging issues mental health counselors face with their clients. Death of a loved one is possibly the most penetrating loss individuals experience; it is a physical, emotional, and spiritual loss (James & Friedman, 1998). In the mental health field there has been an increased focus on the effects of grief and bereavement on individuals and families. Grief is the reaction of the human being to loss; it is universal, as it is the reaction to an event that every human will encounter, yet it is as personal and individual as our fingerprints. Grief is customized with a complicated combination of phenomena that govern our psychological makeup, which makes it difficult to predict and define. The interaction of biology, history, culture, health, age, gender, and the person's mental health all affect the specific reaction to the loss of a loved one. The grief reaction is also impacted by the family system, where love and nurture can provide a rich soil for healthy development. Love and nurture - the foundation for attachment - by the parent or parent figure to the child mold the emotional reaction to loss: healthy, complicated, or pathological. It is believed that the strength of this connection holds the key for understanding the reactions displayed by children to loss, and particularly to the loss of a parent (Hill, 2002).

Grief continues to be a developing area of research as new concepts emerge. The grief reaction is dependent on unique factors within each individual, which generates multiple angles to explore. Close attention has been given to grief in an effort to understand its dimensions, considering the different outcomes in people. Grief has been

classified as healthy, complicated, or pathological, depending on the emotional, cognitive, and behavioral states of the person suffering the loss (Bretherton, 1992).

Research (Bonano, Moskowitz, Papa, & Folkman, 2005; Brennan, Clark, & Shaver, 1998; Cook & Oltjenbruns, 1998) has shown that grief is a multidimensional combination of emotions that can affect the body, cognition, behavior, mental and physical health of a person. The intensity of grief is judged by the interference of these components with the daily functioning of the grieving person. The majority of bereaved people experience mild to moderate reactions to grief and return to before the loss function within a year (Bonano, 2004; Bonano et al., 2005; Bonano et al., 2002), but approximately 10% - 15% suffer more complicated grief reactions (Bonano & Kaltman, 2001). Complicated grief is a prolonged pining and yearning for the deceased with symptoms recognized as grief responses, such as depression and anxiety (Jacobs, Mazure, & Prigerson, 2000; Lichtenthal & Gruess, 2004).

Grief by itself is not a clinical pathology and most individuals learn to adjust satisfactorily without professional help. In fact, many will come through a bereavement much stronger (Klein & Alexander, 2003). The reactions to the pain caused by grief vary from pathological with long lasting effects to normal with healthy outcomes facilitated by resilience. The duration and intensity of the mental, physical, or behavioral disturbances distinguish complicated or “pathological” grief, from normal or “healthy” grief. Research on parentally bereaved children has focused primarily on the deficits that the parent’s death brings. Death of a parent does bring with it deprivation of love, nurture, and protection for the child in most cases (Elizur & Kaffman, 1982). It is a traumatic event and it may affect the child’s emotional stability and may exacerbate behavior problems in

school. The loss of a parent may affect a child emotionally, mentally, physically or behaviorally, depending on the child and the embracing factors post loss (Hill, 2002; Stroebe, Schut, & Stroebe, 2005).

Background

Consensus about how children deal with the loss of a parent has been difficult to reach. Early research (Furman, 1974) painted vivid portraits of the inner pain and confusion experienced by a young child when a parent dies. These studies yielded findings that supported the view of the vulnerability of children to this stressful event (Bonano, 2004) . This point of view has been called into question by several authors who contend that these earlier findings were based on non representative groups of children and did not use objective, standardized assessment measures (Kranzler, Shaffer, Wasserman, & Davies, 1990; Van Eerdewegh, Bierei, Prilla, & Clayton, 1982; Weller, Weller, Fristad, & Bowes, 1991; Worden, 1996).

Later studies (Fristad, Jedel, Weller, & Weller, 1993; Kranzler et al., 1990; Weller et al., 1991; Worden, 1996) have shown varying results regarding the bereavement exhibited by children when non-patient samples and standardized instruments were used. These studies compared bereaved children to control groups in terms of depression, anxiety, school performance, withdrawal, and bed wetting. Results from these studies suggested that children may exhibit different immediate effects upon the death of a parent. Children exhibited symptoms such as depression, anxiety, anger, somatic complaints, behavior problems up to one year after the loss, and these effects were classified as mild and short lived (Van Eerdewegh et al., 1982). The non-referred children (i.e., those not preselected on the basis of psychopathology or mourning

complications), exhibited considerable resilience one year after the bereavement as judged by commonly used indicators (Siegel, Karus, & Ravies, 1996).

One particular study measured depression levels in parentally bereaved children and children who were admitted to a psychiatric clinic for depression. Thirty-seven percent of the bereaved children met the criteria for major depressive disorder. Bereaved children and depressed children shared high level of suicidal ideation, 69%, and 81% respectively. None of the bereaved children attempted suicide, while 42% of the depressed children did make attempts (Weller et al., 1991).

Sanchez et al. (1994) compared bereaved children with a normal control group and found that none of the bereaved children met the DSM-III-R criteria for separation anxiety disorder, over anxious disorder, obsessive compulsive disorder, or phobia disorder. When these children were compared with a control group matched for age, the mean number of symptoms endorsed by the bereaved children was not significantly different from that of the clinical sample. Other analyses of data from these samples found that rates of somatic complaints expressed by the bereaved children did not differ from those of the “normal sample” (Sood, Weller, Weller, Fristad, & Bowes, 1992).

Silverman and Worden (1992) studied bereaved children ages 6 - 12 four months after the loss of a parent. They found that 62% of children were no longer crying frequently, 74% were sleeping well, 74% reported experiencing headaches, and 19% reported concentration problem at school. The reports from the children revealed that 22% thought that their school performance had worsened, while 18% thought that their performance has improved. The investigators concluded that 83% of children were coping effectively in the early months of their bereavement. Siegel et al., (1992) found

that children who lost a parent to death appeared relatively symptom free and were indistinguishable from non-bereaved children.

Discrepancies in the results of studies of children's reactions to parental loss shifted the focus from clinical pathology toward healthy adjustment. This approach has led a new approach for exploring grief without discarding the old one. The new lens followed the resilience in children who suffered the loss of a parent.

Observations of how individuals respond to the loss of a close relative show that over the course of weeks and months their responses usually move through a succession of phases (Bowlby, 1973). These phases are not clear cut and an individual may vacillate for a time back and forth between any two of them. Conditions affecting the course of mourning are classified under five variables: the identity and role of the person lost, the age and sex of the person bereaved, the causes and circumstances of the loss, the social and psychological circumstances affecting the bereaved at the time of the loss and afterwards, and the personality of the bereaved with special reference to his/her capacities for making love relationships and for responding to stressful situations (Bowlby, 1980). Emotional disturbance in many cases are traced back to the losses suffered during the course of life (Bowlby, 1980).

It is no surprise that studies conducted about grief in children have focused mostly on negative outcomes in an attempt to explain the disturbances displayed by children. When the problems were the focus, positive outcomes displayed by other children who suffered losses, were overlooked. In the last decade, the focus has shifted and positive outcomes of grief have been noticed and studied with the hope to prevent negative outcomes (Hawley & Dehaan, 1996).

Loss of a parent is a very sensitive event for the entire family. The surviving parent at this stage may go through a roller coaster of emotions. The more distressed the bereaved parent is, the less effective their parenting skills. It could be also that as children become aware of the surviving parent's inner pain, it affects them, and managing the bereavement tasks becomes more difficult for both the children and their surviving parent. Children perceive from the change in the situation with the surviving parent that something very serious has happened, and their ultimate fear becomes abandonment by their surviving parent. If no acceptable emotional outlet is available, fears and confusion can evolve into guilt and hostility, expressed through behavioral or emotional problems (Kalter et al., 2002; Norris-Shortle, Young, & Williams, 1993). Although it may be easier on the surviving parent to gloss over the loss initially, such action obscures the child's loss and the significant impact of the parent's grief on the child. Either of these processes could influence the parent-child relationship (Kalter et al., 2002).

Loss of a parent has been identified as a risk factor which implies that bereaved children are "at risk" for possible negative outcomes. Biological and environmental factors may increase the potential for negative outcomes (Honig, 1984). Biology and environment are not independent; and in the case of parental loss, both of these factors are tied by the loss of one of the attachment relations. Biological factors, emotional factors, and physical factors affect the surviving caregiver which can in turn impact the child biological well being. Environmental conditions disrupt the care giving process as the surviving parent become less available to provide the structure and the love that are important to the development of self esteem in children (Boss, 1991).

Theoretical Framework

This study has its theoretical framework in Attachment Theory and Resilience Theory. Attachment theory provides a framework for understanding individual differences in grief following the death of a close person (Bowlby, 1980). Resilience theory emerged about 35 years ago and it has led clinicians to promote and recognize the potential for positive outcomes for children facing adversity (Zandonella, 2006).

Attachment theory

Attachment theory is the joint work of John Bowlby and Mary Ainsworth (Ainsworth & Bowlby, 1991). The emergence of attachment theory after World War II was based on studies sponsored by the World Health Organization of homeless children in postwar Europe, as described in Bowlby's writings about affectionless children. The research focus was on the emotions exhibited by the children following the loss of a close caregiver (Bretherton, 1992).

According to Bowlby and grounded in the available empirical evidence, to grow up mentally healthy, the child needs to experience a warm, intimate, and continuous relationship with the mother or permanent mother substitute. In addition, they both find satisfaction and enjoyment within the relationship. Bowlby emphasized the importance for caregivers of children to ensure that the children's basic needs were met in order to help them build a sound attachment with their parents. Attachment theory states that when attachment behaviors are nurtured by the caregiver, the child develops a sense of security from which exploration of the world and internalization of positive self can proceed. Rejecting or ambivalent caregivers, on the other hand, provoke insecurity in the child (Bowlby, 1973, 1980).

Infants demonstrate attachment behaviors such as seeking and maintaining proximity to the mother when they are distressed or threatened. Secure attachment is evidenced in the mother's ability to calm her child down and to diminish the threat of external stimuli by her presence. Secure attachment allows the child the secure base to leave the attachment figure and explore the environment knowing that the secure base will be available should that environment becomes threatening (Bowlby, 1980).

Attachment security has particular relevance to the domain of close relationships and especially to the emotions and behaviors following the ending of a relationship by a death. Attachment theory is after all a theory about separation anxiety. The attachment behavioral system comes into play particularly in situations where proximity to the loved person is severed either temporarily or permanently, as in bereavement. Anxiety, hostility, depression, self-consciousness, impulsivity, and vulnerability have been shown to correlate highly with insecure dimensions of attachment than any of the other traits (Wijngaards-de Mej et al., 2007)

Bowlby argued that when the child is separated from the attachment figure, the intimate emotional bond and the associated sense of security are strained, and this may lead to deviation from normal personality development. The disruption of the attachment system through death, and the resulting depression and mourning may have even more serious consequences in relation to personality development. Insecurity of attachment is related to poor adjustment to bereavement (Stroebe et al., 2005), and unpleasant and disturbing emotions are related to poor adjustment after bereavement (Meuser & Marwit, 2000). There is considerable evidence that bereaved children's mental health problems are related to lower levels of acceptance, warmth, and support by the surviving parent

(Elizur & Kaffman, 1982). Also, there is evidence that the children's inhibition from expressing their negative emotions relates positively to mental health problems (Ayers, Sandler, Haine, & Wolchik, 2000).

Resilience Theory

Current research (Beardslee & Podorefsky, 1988; Bonano et al., 2002) suggests the majority of at risk children do not experience drastic outcomes, and many exhibit protective factors that buffer them from negative consequences. Studies (Boss, 1991); Elizur & Kaffman, 1982; have identified several personality, familial, and environmental variables that promote resiliency in youths at risk. Resilience is associated with an orientation toward psychological health. Resilience refers to the ability to get back to the original form, rise above adversity, and overcome the stress after being psychologically bent, compressed or stretched (McCubbin, McCubbin, & Thompson, 1996). Resilience is the ability to practice social competence and self confidence in a time of stress through mastery and appropriate responsibility. It results in successful adaptation despite risk and adversity.

Healthy adjustment is related to resiliency. Recognizing resilience in children following the pain of loss opened the door to study the process and the factors that lead to resilience. Individual resilience, the ability to thrive, mature, and increase competence in the face of adverse circumstances despite environmental obstacles draws on many resources: biological, psychological, and environmental (Garmezy, 1981; Garmezy, Masten, & Tellegen, 1984).

Research on childhood stressors such as the death of a parent has moved beyond its association with problem outcomes to focus on processes that lead to healthy

adjustment (Ayers & Sandler, 2003). Information on such processes may help clinicians design useful interventions to promote successful adaptation. Theoretical models of stress and resilience suggest that while major stressors, such as the death of loved one in the family, can increase mental health problems, the networking and support the family has been shown to decrease such problems (Ayers & Sandler, 2003; Wyman, Sandler, Wolchik, & Nelson, 2000), and increase the resilience for dealing with a traumatic event. One of the primary resilience factors that contribute to healthy adaptation of parentally bereaved children is positive parenting which has been linked in several studies to secure parental attachment style (Ravies, Siegel, & Karus, 1998; West, Sandler, Pillow, Baca, & Gerstonm, 1991). Positive parenting includes warmth and support (responsiveness, understanding, and positive affect) and consistency (clear expectations, following through). Other factors such as family cohesion, social support, and personal characteristics have also been found to influence the adjustment from psychopathology to resilience.

Statement of the Problem

Much of the focus of the literature on children dealing with grief has been on the psychogenesis of the later problems children may experience. Such studies are based on the illness model and have helped in identifying children who are having problems (Carl & Lewis, 1996). The counseling profession has long emphasized a model built more on health than illness, and recent studies seek to understand the impact of parental loss through salutogenesis or the origins of health (Hauser, Vieyra, Jacobson, & Wertreib, 1985). This approach looks at how children who are subjected to risk factors, such as parental loss, develop satisfactorily.

The construct of risk has been common in the medical field but it has only recently entered the language of education (Jens & Gordon, 1991) and is frequently misunderstood. While risk implies the potential for negative outcome, it also and importantly so, suggests that negative outcomes may be able to be avoided. Studying the different variables that influence the adjustment of bereaved children to the loss of one of their parents may help to explain the difference in grief outcome: healthy, complicated, or pathological.

Purpose and Significance of the Study

This study sought to synthesize and extend bereavement research relating to attachment and resilience by focusing on three constructs that may be related to resiliency and adaptive functioning. The primary purpose of this study was to investigate the relationship between family attachment, family hardiness, and family social support to resiliency and behavioral functioning of children who had lost a parent. A secondary purpose was to investigate the interrelationship between the three variables of family attachment, family hardiness, and family social support in families who had lost a parent.

Responses of children to grief has been increasingly studied in the last decade, in particular with the growing number of the losses caused by traumatic events such as natural disasters, terrorism, or war that have left a number of parentless children. The paradigmatic shift in clinical research from problem focus to strength based focus has gained status in the grief field. The focus has shifted from treating the problem to understanding the underlying causes of the problem. Bereavement research in the last decades has been carefully examining the underlying causes of resilience displayed versus problem exacerbated in bereaved children. This new direction reinforces further

investigation of the positive factors that bring about a positive outcome when facing a painful loss, and may be helpful in finding ways to promote prevention and reduce the need for interventions.

Research Questions

This research seeks the answer to the following questions:

1. What is the relationship between family attachment and resiliency of children who have lost a parent?
2. What is the relationship between family attachment and behavioral functioning of children who have lost a parent?
3. What is the relationship between family hardiness and resiliency of children who have lost a parent?
4. What is the relationship between family hardiness and behavioral functioning of children who have lost a parent?
5. What is the relationship between family social support and resiliency of children who have lost a parent?
6. What is the relationship between family social support and behavioral functioning of children who have lost a parent?
7. What is the relationship between family attachment and family hardiness in families who have lost a parent?
8. What is the relationship between family attachment and family social support in families who have lost a parent?
9. What is the relationship between family hardiness and family social support in families who have lost a parent?

Definition of Terms

Attachment behavior: seeking and maintaining proximity to another individual (Bowlby, 1973).

Bereavement: the internal process of having lost a significant other. The state of having lost something, whether it significant other, things or own sense of will (Goldman, 2002).

Grief: a normal internalized reaction to the loss of a loved person thing, or idea (Goldman, 2002). It has been defined as a painful but time limited process of reacting to a significant loss. It is the process of experiencing emotional, psychological, behavioral, social, and physical reactions to the perception of loss (Rando, 1993).

Mourning: taking the internal experience of grief and expressing it outside ourselves. It may include yearning, crying, screaming, wearing certain colors, and participating in certain rituals. It is the cultural expression of grief (Goldman, 2002).

Pathogenic: the deficit oriented approach (Hawley, 2000).

Psychogenesis: the origins of mental illness

Resilience: the ability to bounce back, returning to an original form after being bent, compressed or stretched. It refers to successful adaptation despite adversity (Hawley & Dehaan, 1996; Walsh, 1998).

Salutogenesis: the origins of health, emphasizes strengths rather than deficits of individuals and families (Hawley, 2000).

Organization of the Study

The intent of Chapter one is to present an overview, background, theoretical framework, and purpose of the study. Chapter II reviews the related literature on

attachment theory and resilience theory. Chapter III includes the methodology, participants, procedures, and method of data analysis. The results of this investigation will be reported in Chapter IV. Conclusions, implications, and recommendations for further studies will be discussed in Chapter V.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

Loss of a loved person can be one of the most intense and painful experiences any person will suffer. Not only is loss painful to experience, but it is also painful to witness, if only because we are so impotent to help (Bowlby, 1980). Many families will face the death of an immediate family member that shakes its foundation and leaves no member unaffected whether the death is anticipated or sudden (Jordan, Krauss, & Ware, 1993; Walsh, 1998). The experience of loss in the death of a family member constitutes both an individual and a family crisis (Cook & Oltjenbruns, 1998). Parental death is a major stressful event for children fueled by the corresponding stress of their surviving parent. An estimated 3.5% of youths in the United States under age 18 have lost one of their parents (Census, 1990; *U. S. Bureau of the census*, 2000). The death of a parent affects the child's self- concept, health, social, and economic circumstances (Kirwin & Hamrin, 2005). The need for understanding loss and grief is a critical aspect in the mental health field, especially with the growing number of bereaved children who experience loss of a parent under traumatic circumstances such as terrorism and wars.

Empirical data from children's bereavement studies have explored the different variables affecting bereavement such as developmental stage, age, gender, family circumstances, and death mode, emphasizing their pathological effect. The focus has shifted historically from diagnostic to strength based, and theoretically from pathology to resilience (Hawley, 2000). Sometimes creative energies are unleashed and loss through death serves as a significant stimulus for living. Parental death seemed to key ambitions

of notable figures such as Franklin Roosevelt, Lincoln, Lenin, and Darwin, leading them onward to greatness (Kearl, 1989). Other times parental death may lead to coping difficulties. According to Kearl, death can spawn depression and social withdrawal, or it can invigorate and stimulate individuals to pursue new heights in their many performances. Not only this is a logical assumption for children's behavior, the similar principle should apply to all the surviving individuals who are impacted with the loss. In this chapter, the variables that relate to a grief response in children are explored with a focus on the attachment style and tenacity to the lost parent as well as to the surviving parent or parent figure. Resiliency is also discussed as it relates to coping with loss.

Background

Guided by the deficit oriented approach that has been dominant in the mental health field, the literature regarding the links between the loss of a parent in childhood and psychopathology has been mainly explored by focusing on its negative implications (Janosick & Green, 1992). Early research found that the death of a parent was associated with emotional and behavioral disturbance and psychiatric disorders, in part as a result of the social adjustment difficulties faced by the surviving parent in the family (Ayers & Sandler, 2003)

A paradigmatic shift in research on childhood stressors such as losing a parent has taken place from theorizing about what caused the problems, to looking at why some children are less susceptible than others to being affected under the same circumstances. Studying the healthy recovery in parentally bereaved children may potentially lead to effective interventions for prevention and treatment.

Historically, detachment and "letting go" of the lost loved one was encouraged to achieve closure. Such emphasis was reinforced by the medical model that compared the bereavement to a wound that would heal leaving scar tissue, and once it healed the pain would be forgotten. This may have encouraged parents to protect their children from the pain of the wound by shielding them from talking about it as a protective factor (Davies, 1999). Recently, alternative views have been developed. For example, grief is seen as work and active coping (Attig, 2001; Worden, 2004). There has been a shift from emotional disengagement to learning how to cope with the loss (Attig, 2001). Research findings have supported the experience of an ongoing connection with the deceased (Klass, Silverman, and Nickman, 1996). In addition, it is now widely accepted that, despite the permanent physical separation, emotional engagement is never totally lost, and the current bereavement literature has focused on the continuing bond with the deceased as a coping mechanism (Field, Nicholas, Holen & Horowitz, 1999; Field and Friedrichs, 2004; Field, Gao, & Paderna, 2005; Klass & Walter, 2001; Klass et al., 1996; Stroebe, Stroebe, Gergen, Gergen, & Stroebe, 1991).

Investigations on children's adjustment following the death of a parent have yielded mixed results. Some have reported that children exhibit considerable psychological pain, and may exhibit symptoms including depression, anxiety, anger, aggression, academic underachievement, physical disturbance, and loss of developmental achievement (Christ, Siegel, & Sperber, 1994; Christ et al., 1993; Kaffman & Elizur, 1984; Kranzler et al., 1990; Osterweis, Solomon, & Green, 1984; Thompson et al., 1998). Others have found that children who lose a parent to death are largely indistinguishable from the non-bereaved children (Fristad et al., 1993; Siegel et al., 1996; Silverman &

Worden, 1992). These results reflect a lack of consensus regarding children's adjustment in the face of a parent's death. There has been a shift in understanding grief and loss, and a focus on healthy grief versus pathological grief. Healthy grief has a number of features that were thought to be pathological in the past and lacks others that were considered normal.

Mourning is the external expression of loss (Steen, 1998). Factors believed to influence the course of mourning in different individuals determine whether the outcome is healthy or pathological. These factors include a set of interrelated variables active prior to the loss. These variables include parental attachment style, personal characteristics that have been postulated by psychoanalyst theorists such as the personality of the bereaved child prior to the loss, the child's gender, and the child's emotional and developmental age (Elizur & Kaffman, 1982; Elizur & Kaffman, 1983). The change in the situational and environmental family circumstances associated with the loss, and the change in the structure of the family are also important variables, as well as the suddenness of the death. Another relevant variable is the bond that ties the bereaved child to the deceased parent, to the surviving parent or any significant other, all of which affect on the course of mourning (Hope & Hodge, 2006). As suggested by Bowlby (1961), there are reasons for the way individuals react to grief. During healthy child development, instinctive attachments are developed, first between the child and parent, and later to other adults. The underlying goal of attachment behaviors is to maintain a homeostatic relationship with the loved ones (Rando, 1984). Parental death disrupts this relationship. This disruption elicits actions to try to preserve the existing relationship as the goal of attachment is to maintain the affective bond (Bowlby, 1980).

Parental Attachment Styles

Attachment theory provides a coherent framework to understand interpersonal adaptation, coping styles, and psychological adjustment to loss (Cooper, Shaver, & Collins, 1998). Attachment theorists have suggested that the formation of an attachment relationship between infant and caregiver is the base for the physical and psychological development of the child (Hazan & Shaver, 1987). The early coordinated relationship between the child and the primary caregiver becomes internalized as a mental model that includes representations of self and representation of relationships with others. These working models conceptualize one's social world, and contribute to the differential experience of emotion, coping style, and psychological adjustment (Cooper et al., 1998). Individual differences in parent attachment styles may hamper or facilitate negotiation of life changes such as separation and loss. In a series of studies it has been found that each attachment style is associated with a unique pattern of caregiving. Grounded in empirical research there are four attachment styles: secure, anxious-ambivalent, avoidant, and preoccupied (Ainsworth, Blehar, Waters, & Wall, 1978). In well functioning adult relationships, partners provide one another with a secure base from which they can explore, and a safe haven to which they can retreat when distressed. Caregiving appears to be an ongoing process. Individuals with a secure attachment style report relatively low levels of compulsive, over involved, and controlling caregiving, and they report high levels of proximity (physical comfort) and sensitivity. Preoccupied, anxious parents report high levels of proximity, compulsive caregiving, but relatively low levels of sensitivity and cooperation. Dismissing avoidant caregivers report the lowest levels of compulsive caregiving, proximity, and sensitivity (Rholes & Simpson, 2004).

Personal Characteristics

As emphasized by attachment theory, human infants are born with a repertoire of behaviors aimed at attaining and maintaining proximity to attachment figures. Attachment research confirmed that a sense of attachment security contributes to subjective well-being, self-esteem, positive perceptions of others, and adjustment enhancing interpersonal cognitions and behaviors (Collins, 1996). Security enhancing interactions with an attachment figure are an important source of information about the figure's intentions and responses and are an important foundation of a secure self with positive views of others. During these interactions a person construes the attachment figure (one or both parents, or any other caregiver) as sensitive, empathic, responsive, and caring. Moreover, the person learns about the particular supportive, comforting, and soothing qualities and behaviors of this relationship. On the other hand, interactions with significant others who are unresponsive to one's attachment needs arouse insecurity about this other's good will and doubts about the proximity seeking. During such interactions secure attachment is not attained, negative models of the self and others are formed and secondary attachment strategies are formed (Main, 1990). Hyperactivation of the attachment system is characterized by recurrent attempts to minimize the distance from the attachment figure and to ensure their support through the use of angry and controlling responses. Deactivation of the attachment system consists of attempts to maximize the distance from the attachment figure and adoption of a self-reliant attitude (Cassidy & Cobak, 1988). Individual differences in the sense of attachment security are manifested in the modes of affect regulation (Magai, 1999; Mikulincer & Shaver, 2003; Shaver & Mikulincer, 2002). Repeated interactions with security enhancing attachment

figures fosters security enhancing strategies and a “broaden and build” cycle of attachment security based on Fredrickson’s theory of positive emotions (Fredrickson, 2001).

Developmental Stage, Age, and Gender

The impact of parental death is a universal fear producing experience. The fear of a parent’s death ranked among the highest of several stressors in a cross cultural study in six countries for school age children, and the degree of this potential stressor was not affected by gender (Yamamoto, Soliman, Parsons, & Davis, 1987). Although grief from losing a parent is a universal experience, personality traits make it an individual and personal experience. This complicates the understanding of grief in children. The child’s developmental stage affects his/her grief reaction (Nickman, Silverman, & Normand, 1998). Amato and Keith (1994) suggest that age at disruption influences the outcomes that are observed in children (Amato & Keith, 1994). Turbulent emotions are displayed by children at different stages of development as early as infancy if they are separated from their mothers. Bowlby and Robertson’s (1952) observations of children separated from their mothers initiated a new paradigm in understanding parental loss. Children grieve the loss of an attachment figure. The idea that grief in children is short lived was refuted by Bowlby and Robertson, and the longing for the absent mother, or mother figure was found to be persistent, but expressed differently at the different stages.

Age and gender of the bereaved child have been the focus of many studies and researchers have found varying results showing how these factors relate to children’s adjustment to grief (Elizur & Kaffman, 1982; Ravies, Siegel, & Daniel, 1999; Worden, 1996). In these studies, depression was found to be significantly correlated with the

child's gender, and anxiety was significantly correlated to the age of the child. Bereaved girls showed higher levels of depression than boys, and younger children showed higher levels of anxiety. Research exploring the impact of gender on bereavement adjustment has documented that girls display adverse consequences (depression, sexual acting out, pregnancy, drug use) that vary with their developmental stage and with the elapsed time since the death of the parent (Amato & Keith, 1994; Birtchnell, 1972a, 1972b; Kaffman & Elizur, 1984; Van Eerdewegh et al., 1982), while boys display behaviors such as aggression and anxiety (Fristad et al., 1993). Yet, other research reported no gender differences (Birtchnell, 1972; Fristad et al., 1993; Kaffman & Elizur, 1984; Van Eerdewegh et al., 1982). These inconsistent findings may be explained partly by the results from other investigations that have documented that factors such as the gender of the deceased parent is believed to interact with the effects of grief as related to age and gender of the child (Mack, 2001). Gender match of bereaved child with deceased parent for young (below age 11) girls and adolescent boys were found to identify children at increased risk for complicated bereavement (Arthur & Kemme, 1964; Rutter, 1979; Van Eerdewegh et al., 1982). Worden (1996) noted that the above noted pattern did not hold true across all situations.

Family Circumstances

The intrusion of death in a family leaves the surviving parent distraught and at times incapable of seeing the coping mechanisms children practice to comprehend the mystery of death. It often imposes a cascade of new stressors on the nuclear family such as change in the household roles, economic issues, change in the life situation, and even geographic displacement (Ravies et al., 1998). The change in the family structure due to

the loss of a parent calls for reorganization of the hierarchy of the family and change in the roles as the rules become blurry. As Bowlby believed that the specific way a child comes to regulate his or her attachment behavior is highly influenced by interpersonal experiences, and for the system to function appropriately in a specific caregiving environment it needs to be calibrated to that environment. For that, Bowlby alleged that early experiences within the family, especially those concerned of separation or threats of loss, were particularly influential in shaping the way the attachment system would become organized for an individual. Life disruptions such as death, "activate the attachment system" to use Bowlby's phrase, and reveal the strength of attachment style. Loss may reactivate earlier unresolved separations from the attachment figure, leading to a flood of feelings.

From an examination of the evidence drawn from many disciplines, it has been found that certain combinations of life circumstances such as parents' marital relationship, relation of the child to the deceased parent, and adjustment of the surviving parent to the death affect the grief in children. Clinical disorders and disturbances in parental marriage lead to certain forms of disturbance, and affect not only the individual, but almost invariably the entire family, especially in a time of loss (Bowlby, 1980). Relationship to the deceased person affects the dimensions of a child's grief (Norris-Shortle et al., 1993). In the case of secure attachment, loss, or threat of loss, activates the attachment system which heightens the accessibility of internal representation of security enhancing attachment figures and promotes seeking proximity and support from external attachment figures reinforced by the optimistic belief about the availability and responsiveness of the attachment figures. The external and internalized attachment

figures will have a soothing effect that facilitates effective coping and mood repair. Finally, the alleviation of distress contributes to the activation of other behavioral systems such as exploration and affiliation which broaden the individual's capacities and perspectives. On the other hand, attachment insecurities keep people from relying on external or internalized attachment figures which reduces the soothing, regulatory impact these figures might otherwise have (Mikulincer & Shaver, 2003).

The caretaker's reaction to death may impede or facilitate the children's healing grief. The emotional adjustment of the surviving parent to the loss is a factor that has been researched to study its influence on the bereaved child. The research has been fairly conclusive that positive adjustment of the surviving parent correlates to positive adjustment of the child. The definition of adjustment studied included looking at the emotional, physical and mental state of the surviving parent (Stoppelbein & Greening, 2000), and the degree of open communication with the bereaved child regarding the death (Ravies et al., 1998). Results regarding adjustment emphasized the importance of having an emotionally stable environment. Inconsistencies in the daily routine in the family and lack of open communication about the new changes create feelings of unpredictability and exacerbate adjustment difficulties (Furman, 1974; Osterweiss, Solomon, & Green, 1984; Rutter, 1983a). The child's perception of the surviving parent's open communication about death and the resulting changes is positively correlated with healthy adjustment (Ravies et al., 1998). Also, in regard to life circumstances, research has shown that parental education provides the family with the ability to utilize knowledge and problem solving skills effectively (Heath & Orthner, 1999).

Mode of Death

A factor that researchers have drawn contradictory conclusions about involves the circumstances surrounding the parental death. In one study (Saldinger, Cain, Kalter, & Lohnes, 1999) researchers compared children who lost their loved one due to suicide, and other sudden death, to children who had lost a parent due to an anticipated death. In this study, the lengthiest anticipation of death revealed the worst adjustment post death. The authors hypothesized that the stress of waiting is more emotionally and cognitively draining than a sudden loss. In contrast, a study conducted by Cerel, Fristad, and Weller (2000) noted elevated level of psychopathology in children who lost a parent to suicide as compared to parentally bereaved children due to other circumstance. When the death is sudden and unexpected and there is no opportunity to prepare the child for the death, adjustment can be problematic (Furman, 1974). Other studies found similarities in the post death adjustment in both groups, which lead them to hypothesize that the circumstance of the death might have less impact than other factors (Cerel, Fristad, & Weller, 2000; Fristad et al., 1993; Siegel et al., 1996; Silverman & Worden, 1992; Van Eerdewegh et al., 1982).

Children's whose parents die from socially taboo causes such as suicide, Aids, or murder, often experience complicated grief where the natural grieving process is inhibited because the child is unable to express what happened. The feelings are suppressed and they can become destructive as they are projected outwardly in the form of anger and rage, or inwardly, creating self-hatred, depression or anxiety (Goldman, 2002).

Parental Relationships

Bowlby (1977) declared that there is a strong relationship between an individual's experiences with caregivers and the later ability to make affectional bonds and to deal with emotional traumas. Once an attachment pattern is formed, this may become the foundation from which the later relationships are viewed. According to Solchany and Barnard (2001), the essence of a child's mental health lies within the parent-child attachment relationship. Such relationships operate throughout the life span although they change in form, becoming more reciprocal as the individual matures. Longitudinal studies have indicated that children with histories of secure attachment are more confident, competent, and socially skilled (Elicker, Englund, & Sroufe, 1992). The child's first relationships with his/her parents act as a template as they permanently mold the individual's capacity to enter into later relationships. These relationships shape the development of the child's personality, its adaptive capacities, as well as vulnerability to and resistance against particular forms of pathology (Schore, 2001). Human relationships are the building blocks of a healthy development that help in dealing with events faced in life. Intimate and caring relationships are the fundamental mediators of successful human adaptation (Shorekoff & Phillips, 2000). Actively satisfying and secure relationships with the parents create the basis of self- control, a sense of identity, self-esteem, and appreciation for self and others.

There is consensus in the literature on the positive relationship between the adjustment of the remaining caregiver and the adjustment of the child. Parental adjustment is defined as being emotionally available, capable of open parental communication and expression of feelings, and providing a healthy grief role model for

the child (Nickman et al., 1998; Ravies et al., 1999; Worden, 1996). The death of a parent impacts all existing relationships which lead to an increase of secondary stressors. Secondary stressors create secondary losses. While secondary losses such as moving away from family and friends, changing schools make adjustment more difficult (Mahon, 1999), familial adjustment depends on the surviving parent being able to be in control and relied on, and being able to strike a balance between supporting the grieving child while dealing with their own grief (Hope & Hodge, 2006). Resiliency correlates positively with emotional stability and minimal secondary stressors (Hope & Hodge, 2006). The relationship with the deceased parent, and the memory of that relationship dispensed by the surviving parent has a major effect of the child's reaction to loss.

Children's histories and memories of their relationship with the deceased parent will affect the dimensions of their grief (Norris-Shortle et al., 1993). It has been found that children maintain an inner construction of the deceased parent when the remaining parent engages them in memorializing activities such as visiting the grave, or making a collage about the deceased parent (Nickman et al., 1998).The more frequent and positive the contact to the deceased was, the more aware the children will be of the loss. This content is impacted by the relationship with the surviving parent, the family, and the support system within the child's environment. This support system is the essential link to the memory of the deceased parent. The bereaved children's reaction to the parental death reflects their surroundings. The interpretations of the reactions exhibited are complicated to understand as they depend on the child's personality, the environment, the family experiences. Security, open communication, and understanding in the parent child relationship are related to positive outcomes (Man, 1991).

Secure parental relation, the product of secure attachment (Ainsworth & Bowlby, 1991) is a protective factor that promotes security, confidence and adaptability; the stronger it is, the smoother and safer embarking to the unknown is. If the first few years of life take place within a secure attachment with the parents, then the child grows up appreciating self and others and grows to have psychological resiliency to fall back upon time of stress. It is very important to highlight this fact as it helps in understanding the results of the research done regarding loss in children. The early coordinated relationship between the child and the caregiver becomes internalized as a mental model to include representations of the self and representations of relationships with others. These representations create a world for each individual with his unique different experiences of emotions, psychological adjustment, and coping styles (Cooper et al., 1998). Differences in parental attachment styles and relationships can complicate or facilitate dealing with major life changes such as loss and separation (Ainsworth et al., 1978).

Attachment Theory

Attachment is believed to influence the course of grief and mourning in different individuals and to affect whether the final outcome is healthy or pathological. Bowlby claimed that grief and mourning processes in children and adults appear whenever attachment behaviors are activated, but the attachment figure continues to be unavailable. The experiences that a bereaved person has had with an attachment figure during the course of life, and especially during infancy, childhood and adolescence, account for a large proportion of the variance observed in the course taken by mourning (Bowlby, 1980). The first two to three years set their stamp on all that comes after. This can be a positive experience from which the child gains resilience for later stressful events, or a

negative experience if the child's early care has left basic fault (Balint, 1968). Schore (2001) emphasizes the link between attachment and the development of self-regulation. He believes that exposure to the primary caregiver's regulatory capacities facilitate the infant ability to approach, tolerate and incorporate new experiences. The attachment system provides the framework within which the child can explore and manage potentially stressful new experiences. He argues that when severe difficulties arise in the attachment relationship, the brain becomes inefficient in regulating affective states and coping with stress. Stress arises with asynchrony between caregiver and infant and sustained stress compromises development. Fonagy (2003) adds another dimension. He argues that attachment provides the context for the infant to develop a sensitivity to self-state that facilitates the development of the reflective function. He argues that it is by experiencing the primary caregivers' empathic expression, which depends a great deal on the attachment style of the parent, the infant acquires internal state understanding. Through the process of psychological feedback, functional connections are established to allow the infant to infer the emotional state of another, and to link emotional states with actions. At the final level of awareness the individual is able to reflect on internal states without the direct link to action. Fonagy maintains that this facilitates the development of the interpersonal interpretive mechanism essential to the ability to function in close interpersonal relationships.

Attachment theory has provided a framework for studies on both the short term and the long term effects of early relationship experiences on the developing child. Attachment theory integrates the inner psychological world with the outer world of behavior to demonstrate that the pattern of attachment relations during childhood are

associated with characteristics of emotional regulation, social relations, memory, and the development of the narrative, the story constructed about the self (Siegel, 1999). Attachment styles shape the personal expectations about love and ultimately lead to particular sorts of relationships (Mikulincer & Erev, 1991) Attachment theory emerged in 1948 with the intensive work of Bowlby and Robertson on hospitalized children who were separated from their parents. Mary Ainsworth joined Bowlby in his research in the late 1950's. Bowlby collaborated with remarkable professionals from different fields to develop his theory. He built this theory from concepts acquired from psychoanalysis, ethology, learning theory, and developmental theory.

Attachment theory is built on the concept of attachment behavior, which conceptualized as any form of behavior that result in a person attaining proximity to another differentiated and preferred person. Bowlby noted that two different sets of stimuli elicit fear in children, the presence of unlearned culturally acquired clues to danger, and the absence of an attachment figure. Although escape from the situation and escape to an attachment figure commonly occur together, the two classes of behavior are governed by separate control systems as observed when a ferocious dog come between a young child and his mother (Bretherton, 1992). Attachment is classified as a behavior with its own dynamic. Human infants direct their proximity-promoting signals initially indiscriminately to all primary caregivers, but the attachment gets stronger to those who respond to their needs and who are involved in their social interactions (Schaffer & Emerson, 1964). During the course of healthy development attachment behavior leads to the development of affectional bonds or attachment, initially between child and parent and later between adult and adult. The forms of behavior and the bonds to which they

lead are present and active throughout the life cycle. Attachment behavior is mediated by behavioral systems which early in development become goal directed. The goal of attachment behavior is to maintain a certain degree of proximity to, or communication with, the discriminated attachment figure. An attachment figure endures, but the various forms of attachment behavior associated with it are activated only when required. The systems mediating attachment behavior are activated only by certain conditions such as fatigue, fright, and unresponsiveness and are restored only under certain conditions such as a familiar environment and the ready availability and responsiveness of the attachment figure. Many intense emotions arise during the formation, maintenance, disruption, and renewal of the attachment relationship. The formation of a bond is described as falling in love, the maintenance as loving someone, and the disruption as grieving the loss of the loved one. A threat of loss arouses anxiety, actual loss leads to sorrow, and both are likely to arouse anger (Bowlby, 1973).

Bowlby (1980) analyzed normal infant attachment and the consequence when normal attachment is disrupted by a severe loss such as death from the primary caregiver. He emphasized that separation anxiety has an immediate relation to grief and described a three step sequence to grieving behavior experienced by the child. The first is protest, which is the anguish and anger over the loss. The second is despair when the realization of the loss settles and the child looses hope of finding the caregiver. The third is detachment when the child separates from people in general. Bowlby continued by explaining that because of the child's inability to reason at the time of such a trauma, the consequences could be 1) loss of trust in bonding with others, 2) over attachment to material things (such as food, toys) or 3) the progressive loss of the will to live and grow

as in failure to thrive illness. The three phases of separation responses were identified as follows: protest related to separation anxiety, despair related to grief and mourning, and denial or detachment related to defense mechanisms especially repression (Robertson & Bowlby, 1952).

Ainsworth contributed the concept of the attachment figure as a secure base from which an infant can explore the world. She formulated the concept of maternal sensitivity to infant signals and its role in the development of the infant-mother attachment patterns. The internal attachment system of the child is activated in times of danger, stress and novelty, and results in the gaining and maintaining of proximity to and contact with the attachment figure. The attachment figure encourages attachment by being responsive, available, comforting, and protective when a threat or a stressor arises. It is the availability, responsiveness and active support from the caregiver that allows the child to explore the environment confidently under ordinary circumstances and create a sense of security that the attachment figure will be available when the need arises (Crowell & Treboux, 1995).

Attachment theory states that infants differ in how they emotionally attach to their primary caregiver. It is through this emotional attachment that a child's perceptions of self, others, and the resources for emotional autonomy in times of crises are developed (Bowlby, 1980). These emotional working models of self and others are believed to influence the child's reaction and perception of his/her relationship with others. These working models will influence the individual throughout his life span (Bowlby, 1973, 1980). The unchallenged maintenance of a bond is experienced as a source of security, and the renewal bond a source of joy. Because such emotions are usually a reflection of

the state of the person's affectional bonds, the psychology and psychopathology of emotions are found to be in large part the psychology and psychopathology of affectional bonds (Sroufe, 1988).

Disturbed patterns of attachment behavior can be present at any age. Attachment behavior is a characteristic of survival that keeps the individual in touch with the caregiver. Principal determinants of the pattern of the attachment behavior are the experiences an individual has with the attachment figures during the years of immaturity, infancy, childhood, and adolescence. The way in which an individual's attachment behavior becomes organized with his personality influences the pattern of affectional bonds he/she makes during life. This framework determines what effect loss will have and the states of stress that result from the loss. The goal of attachment is to maintain an affectional bond, and any situation that seems to be endangering the bond elicits action designed to preserve it. The greater the danger of loss appears, the more intense and varied are the actions elicited to prevent it. In such circumstances all the most powerful sources of attachment behaviors become activated, such as clinging, crying, and angry coercion. This is the phase of acute physiological stress and emotional distress. When these actions are successful the attachment bond is restored, the activities cease, and the states of stress and distress are alleviated. When the effort to restore the bond is unsuccessful, sooner or later the effort wanes, but does not cease. Evidence also shows that when the effort to restore the bond is renewed, the pangs of grief and perhaps an urge to search are experienced afresh. The condition of the organism is then one of chronic stress (Bowlby, 1973, 1980; Bretherton, 1992).

Responses when Conditions are Favorable

Children at all developmental stages are capable of retaining memories and images of the dead person and can sustain repeated recurrences of yearning and sadness. By using their ability to keep their memories of the lost relationship and the intense feelings linked to it distinct from the present, they are like adults in similar circumstances, able to make the best of whatever new relationship may be offered to them. Infants respond to the grief of their survivors caregivers. They sense the grief through the tension carried by the surviving caregiver, through the changes in their schedule, and the disruption in the home. Toddlers and preschoolers will alternate between grieving behavior and playing behavior (Johnson, 1999). At this stage, children can display regressed behaviors during mourning. The children have short attention spans at this stage and they cannot deal with intense emotions for a long period of times. They use play activities to cope with such strong feelings, which may lead adult family members to conclude that they are not grieving (Geis, Whittlesey, Mc Donald, Smith, & Pfefferbaum, 1998). Johnson (1999) stated that six to nine year old children begin to understand that death is final, but they might not want to acknowledge that. The older school age children may fear being abandoned, fear the death of others and their own death. They may worry more about the surviving family members. They may seem withdrawn and distant. At this stage, the youths have a strong perception of what is right and what is wrong. Death may be perceived as a punishment (Johnson, 1999). The teenagers may feel guilty because while establishing their autonomy, tension and fights possibly had occurred with the deceased parent. The adolescents' changing bodies make

them appear more adult like, and the adults may assume that adolescent age children are emotionally mature enough to handle their feelings of grief (Johnson, 1999).

Responses when Conditions are Unfavorable

If after a loss a child is subjected to strong pressure to forget his/her grief and instead to become interested in whatever the caregiver thinks may distract him/her, the pain of loss is repressed and the grief will affect behaviors and feelings without being connected to the loss. In such cases expression of the loss oscillates from quiet resignation to overt yearning expressed more or less strongly depending on the circumstances (Bowlby, 1980). Separation anxiety can be at times excessively low or even altogether absent which could be interpreted as maturity. Bowlby referred to this action as pseudo-independence. Bowlby claims that a well loved child is quite likely to protest separation from parents but will later develop more self-reliance. These ideas reemerged in the work of Ainsworth's classifications of ambivalent, avoidant, and secure patterns of child-mother attachment (Ainsworth et al., 1978).

According to attachment theory, grief and mourning processes in children as well as in adults appear whenever attachment behaviors are activated but the attachment figure is unavailable, and an inability to form deep relationships with others may result when the succession of the substitute attachment figures is too frequent. Humans are motivated to maintain a dynamic balance between familiarity preserving, stress reducing behaviors represented by attachment to protective individuals and to exploratory and information seeking behaviors. If the attachment figure has acknowledged the infant's needs for comfort and protection while simultaneously respecting the infant's needs for independent exploration of the environment, and the child is likely to develop an

internalization of self as worthy and confident. Conversely if the attachment figure has frequently rejected the infant's requests for comfort it is likely that the child constructs an internal working model of self as unworthy, and/or incompetent.

The internal working models are far more than cognitive maps; they incorporate the capacity of self regulation, the ability to identify and reflect on internal states of self and others, mental representations of self and others, and strategies for managing relationship experiences based on those mental relationships. Depending on the attachment experience these individual capacities vary, and the degree to which they are integrated within the individual also varies (Atwool, 2006). The working models allow children to predict the attachment figure behaviors and plan their own responses, and this construct is therefore of a great consequence (Mack, 2001). Bowlby talked about the role of these internal working models in the intergenerational transmission of attachment patterns. Individuals who grow up to become stable and self reliant normally have parents who are supportive but who also encourage autonomy. Such parents tend not only to engage in communication with their own working models of self, the child and others, but they also indicate to the child that these working models are open to questioning and revision.

Ainsworth's categories of attachment represent the internal working models. The secure pattern provides the context for optimal development. The consistent responsiveness of the primary attachment caregiver facilitates the development of an internal working model where the self is perceived as worthy, others are perceived as reliable and available, and the environment is perceived as challenging but manageable with support. The attachment figure provides a stable base that facilitates the exploration

of the environment so crucial to early brain development. When faced with threat the infant is able to respond with both affect and cognition to be able to elicit a supportive and timely response. Neural integration is promoted allowing flexible and complex networks to develop. The child achieves balance, and mastery is the primary strategy when confronted with new situations. The secure child acquires an understanding of the mind and the capacity to reflect on the internal state of self and others. Adolescents with history of secure attachment present as confident and able to access support when needed (Allen & Land, 1999).

Adults with a secure internal working model have been characterized as secure and autonomous (Hesse, 1999). The adequacy of internal working models can be seriously undermined when defensive exclusion of information from awareness interferes with their updating in response to developmental and environmental change. Defensive exclusion protects the individual from experiencing unbearable mental pain, confusion, and conflict, but it interferes with the accommodation of internal working models to external reality. Bowlby surmises that severe psychic conflicts may arise when there is a difference in the actual experience lived and the communication received from others. Building on the basic tenets of the attachment theory, research has deepened and expanded, moving from the individual to the family (Belsky & Isabella, 1988) and from the family to cross-cultural and universal perspectives (Grossman, Grossman, Spangler, Suess, & Unzner, 1985). Attachment theory may provide the underpinnings of a general theory of personality organization and relationship development which may be the base for clinical interventions (Bretherton, 1992).

Resilience Theory

The resilience theory put forth in 1970 led researchers into studying the capacity of children to develop resilience in the face of adversity (Zandonella, 2006). By studying these children, researchers have uncovered resilience enhancing factors within the child, in caregivers, and the social environment. Awareness of these factors informs the design of interventions aimed at enhancing coping skills early in the children's lives rather than repairing disorders later. Resilience theory is associated with the orientation toward psychological health. It has been used to study children who show an ability to rise above adversity and to overcome stress. Resilience is associated with preloss acceptance and belief in a just world (Bonano et al., 2002). Family resilience theory emphasizes the family characteristics and behavior patterns, that cushion the impact of the stressful life events and enable bouncing back from stress (McCubbin, McCubbin et al., 1996). Resilience in children facing the loss of a parent depends on their individual characteristics as well as on the family processes. Resilience theory tries to understand how some individuals are able to manage some insurmountable tragedies as manageable challenges, and to identify the factors that enable them to adjust successfully despite the loss.

The resiliency model of family adjustment tries to explain why faced with the same tragedies and crises under the same circumstances, some families are able to recover while others deteriorate. This theory believes that the meaning given to a crisis such as the loss of a family member is fundamental for resilience. This meaning is the product of multiple factors including close, open communication with a high sense of understanding and caring. Several studies (Greef & Human, 2004; Kwok et al., 2005;

Mack, 2001) have measured family adjustment as it relates to the children's adjustment when dealing with the loss of a parent. These studies explored several avenues including the level of openness in parental communication and the parents' attachment styles. They found a higher level of open communication by the surviving parent to be significantly related to lower levels of depression and anxiety in bereaved children. These results demonstrate that children are more likely to adjust successfully to parental death if the family relationships are characterized by open sharing of information and feelings (Ravies et al., 1998). Nickman, Silverman, and Normand (1998) examined the ways in which surviving parents contributed to their children's memories and feelings about the deceased parent and how this influenced the children's adjustment. They found that parents who talked openly about the deceased parent with the child, gave the child memories of the deceased parent, and showed the child their respect for the deceased, had children who were better able to form an inner construction of the deceased parent and to adjust better to the loss (Hope & Hodge, 2006). Parents with a secure adult attachment style experience positive parental interactions, such as greater familial cohesion (Vareschi & Bursik, 2005).

Resilience is viewed as the interaction of two distinct but related family processes. First, adjustment relies on the protective factors possessed by the individual and the family that facilitate maintaining the integrity and functioning of the family to fulfill the developmental tasks in the face of risk factors. Second, adaptation involves the recovery factors that promote the family's ability to bounce back and adapt in family crisis situations by altering relationships to restore the harmony and balance of the family (McCubbin, McCubbin et al., 1996). Family resilience requires the ability to be flexible

enough to counterbalance stability and change as family members go through challenges and crises. A flexible balance between stability and change maintains a stable family structure while allowing for change and adaptation in response to life challenges (Beavers & Hampson, 1993; Walsh, 1998)

Research has identified many protective factors that promote resiliency in children. These include personal temperament that elicits positive responses from family members as well as from strangers, a close bond with the caregiver during the first years of life, and an active engagement in acts of helpfulness in middle childhood and adolescence (Werner, 1984). Rutter stated that many children do not succumb to deprivation, and it is important to determine why this is so, and what it is that protects them from the hazards they face. He formulated that family and social support modify the impact of the stressors and lead to less damaging results (Rutter, 1979, 1983a).

Personal Characteristics of Resilient Children

Results of many longitudinal studies (Garmezy et al., 1984; Rutter, 1979, 1983a, 1983b; Werner, 1984; Werner & Smith, 1992) have provided perspectives on the critical developmental personality factors that characterize resilient children. An active, evocative approach toward problem solving that enables them to negotiate an array of emotionally hazardous experience is characteristic of resilient children (Greef & Ritman, 2005). These children are able to attract other's positive attention from infancy, maintain an optimistic view of life even in the midst of suffering, and maintain a positive vision of a meaningful life. They are alert and autonomous, they seek novel experiences, and they have a proactive perspective. It should be noted also that the majority of the resilient children were firstborn, they recovered from childhood illnesses more quickly than their

peers, and they were remembered by their mothers as having been active and good-natured children (Werner, 1986).

Self Concept Factors

The capacity to understand self and self-boundaries in relation to long term family stressors, to enhance positive self-esteem as a result of adaptive life competencies, and to steel oneself of stress are self concept factors that act as protective factors. The central component in the lives of resilient children that contribute to their effective coping appears to be the feeling of confidence or faith that things will work out as well as can be reasonably expected, and that the odds can be surmounted.

Rak and Patterson (1996) found that at some point in their young lives resilient children were required to carry out socially desirable tasks to prevent others in the family or community from experiencing distress or discomfort. The authors concluded that may such acts of required helpfulness may lead to enduring and positive changes, including resiliency.

Family Conditions that Promote Resiliency

Along with the above cited personality factors, researchers have found that some family conditions buffer the impact of stressors. The age of the opposite sex parent was found to be correlated with resiliency as follows: resilient males tended to have younger mothers, while resilient females tended to have older fathers. Other factors that have been found to be of great importance in promoting resiliency in children include 1) having four or fewer children in the family spaced more than two years apart; 2) having an abundance of nurture and love versus minimal separation from the caregiver during the first years of life; 3) the presence of alternative caretakers (grandparents, siblings,

neighbors) to help when the parent was not available; 4) the existence of a network of individuals who share similar values and beliefs and who serve as a support group; 5) having a younger sibling or a friend that the child could trust; and 6) having consistency of rules and structure in the household (Rak & Patterson, 1996).

Support in the Environment

Resilient children often have a number of mentors outside the family throughout their development. Resilient children through their environment are taught to reject rejection. They pursue help from others in their environment even if they do not get a sense of welcoming the first time.

The resiliency model holds that the interaction of family problem solving and coping, family resistance resources, family support, and the coherence of the family restore and stabilize the family in the face of crisis. Coherence in the family fosters confidence in the family which helps to deal with crisis. Coherence fosters the view of a crisis as ordered, predictable, comprehensible, and manageable. This view allows the family to adapt to events that affect family and social structures (Patterson & Garwick, 1994). A high sense of coherence in the family promotes health and stability which helps families to reach higher levels of organization and adjustment after a crisis (Antonovsky & Sourani, 1988).

Achieving coherence in a family is a process that starts with communication which helps the family to comprehend the crisis. Talking about and sharing the experience of loss facilitates adaptation for family members which promotes strength for the family unit (Walsh, 1998). Open and honest communication is an essential element for grief resolution (Gilbert & Smart, 1992; Jordan et al., 1993), especially the

transitional difficulties of the immediate aftermath of the loss (Walsh, 1998). The loss of one of the caregivers in the nuclear family changes its structure. Ambiguity may surface in messages about distorted roles and rules in the family which fosters depression and anxiety and blocks the mastery of challenging situations (Boss, 1991). Clear, open and direct communication between family members, tolerance of conflicts, and the readiness to tackle the differences are essential for resilience when dealing with loss in the family (Bloch, Hafner, Harari, & Szmukler, 1994). Children who experience open communication after the loss of a parent report less depression and anxiety symptoms (Ravies et al., 1998).

The family's ability to be flexible enough to reorganize after a death while maintaining stability is the ticket for healthy adjustment. Allowing too much change may be chaotic, while resisting any change invites confusion (Walsh, 1998). Through healthy adjustment the family adapts to new routines to compensate for the loss of the familiar and comfortable. Rituals such as funeral and anniversary to mark the loss of a loved one can bind the family together by sharing grief and receiving comfort in the supportive network of the community of survivors (Imber-Black, Roberts, & Whiting, 1988).

Making meaning of the loss through linking it to their social world, their culture, their religious belief system, their multigenerational past, and their hopes and dreams for the future is constructive (Walsh, 1998). Families develop belief systems that are connected to their cultural values and are influenced by their position and experiences in their social world over time (Falcov, 1995). These belief systems organize the experience to make sense of the crisis situations and to come up with coping mechanisms

accordingly. A family belief system is powerful; it can emphasize problems and restrict options or promote growth and healing (Wright, Watson, & Bell, 1996).

Religious and spiritual values influence the family belief system. During times of loss, religion may help bind together the fragments of one's life, restoring some sense of coherence and meaning (Parrot, 1999). Spirituality can provide an inner wholeness and connection with others. It is a fundamental factor of resilience as it provides the individual with the ability to understand and overcome stressful situations (Angell, Dennis, & Dumain, 1998). Studies have found that religious and spiritual beliefs are significantly related to positive coping and future outlook (Angell et al., 1998), less distress, and reduced depression (Park & Cohen, 1992). Attendance at religious activities enhances a person's social integration, and thereby increases his/her self-esteem (Brubaker, 1990).

Economic resources can buffer the family's experiences of loss and influence their adaptation especially in cases when the finances have been drained by costly medical bills. Research shows that bereaved children in families with higher income experience less difficulty in concentration, fewer learning problems, and fewer sleeping disturbances than children from lower income families (Ravies et al., 1998).

It is reasonable to conclude that resilience in children in the face of a parental loss is a permutation of the family's ability to recover and adapt when facing a crisis. It is the degree to which the child accepts the loss and shows an ability to live a fulfilling and productive life. Resilience in children depends on the degree of the family's successful adaptation in the face of a crisis, its internal strengths, ability to collaborate, open communication, and external support from society, religion, and spirituality. Resilience

on the family level is the degree of strength in the family relations, the ability to adjust to new roles, and the ability to use of internal and external resources. The degree to which the family succeeds will be reflected on the well being of the individual and the family as a whole (Greef & Human, 2004).

Research on resilience has been carried out most frequently using the longitudinal methods to study the outcomes of exposure to risk factors over the years of living (Werner, 1992). Rutter (1979) found that a single stressor did not have a significant impact, but the combination of two or more stressors diminished the likelihood of positive outcomes, and increased number of stressors increased the impact of all other stressors. Studies of resiliency have revealed that protective factors in the histories of the participants (personal characteristics, supports in the environment, self concept factors) diminished the negative impact of the risk factors (Rak & Patterson, 1996).

The emerging understanding about the relationship between risk factors and childhood vulnerability and resiliency has changed the research focus from looking at the correlation between risk factors and vulnerability to looking at the relationship between risk factors and resilience. Empirical evidence indicates that 1) children face numerous stressors due to a loss; 2) many of these stressors are associated with an increased potential for psychological problems; 3) children themselves report that they feel disturbance; and 4) children can function competently after the loss of a parent (Haggerty, Sherrod, Garmezi, & Rutter, 1994). Garmezy (1984) identified three stages in the search for understanding resilience in children: 1) identification of children at risk who have good coping abilities; 2) the search for individual, familial and extra familial correlates for these abilities; and 3) identifying the mediating processes underlying

resiliency. Given the interrelated importance of these three components Garmezy et al. (1984) postulated three models to evaluate the relationship between risk and resiliency: compensatory, challenge, and conditional.

The Compensatory Model

The compensatory model weighs environmental risk and protective factors in combination to predict outcomes for the child after the loss of a parent. If several protective factors are present such as involvement with an extended family and a supportive school environment, the negative impact of additional stressors such as moving, financial difficulties, and the surviving parent's depression, may be reduced.

The Challenge Model

The challenge model depicts that while a negative relationship exists between risk factors and competence, risk factors could be potential enhancers of competence provided there are only few. However multiple risk factors greatly increased the probability of adverse outcomes for the child and a child may become overwhelmed by risk factors that occur within a short time period.

The Conditional Model

The conditional model postulates that personal attributes such as optimism about future possibilities, and a tendency to seek new experiences work to modulate (dampen or amplify) the impact of risk factors. For example a child who is attractive to others because of his personality, and who is open to new experiences may be better able to cope with the loss of a parent.

Research about at-risk children in the mental health field currently outweighs research about resiliency in children. As the understanding of risk factors, protective or

buffering factors, and resilience versus vulnerability becomes clearer, it is incumbent to incorporate assessment and intervention strategies that will help identify and amplify resiliency in children. Protective factors, such as the temperament of the child, unexpected support in the family and community, and self-esteem, lead a majority of at risk children to succeed in life.

Implications for Treatment Decisions

Because risk factors do not always predispose children to negative outcomes, decisions regarding counseling may result in the following errors: 1) false positives, which means the at risk children who are not vulnerable because of the loss will be provided services; or 2) false negatives, in which children at risk, who are vulnerable due to the loss, are not served (Jens & Gordon, 1991). A diagnostic process that correctly identifies the vulnerable children versus the resilient children will be of great benefit to help target the needed support services more effectively. This approach can help identify the roots of resiliency in children by carefully evaluating the life history of children's relationships and their interactions with significant others (Sullivan, 1953). This approach is about understanding these patterns of interactions, and the complex relationship between specific life events, a person's constitutional factors, and his/her relationships to others (Rak & Patterson, 1996). This diagnostic approach may help counselors promote resiliency in children at risk, look for the strengths in children who have experienced parental loss, and specify possible protective factors experience by those children (Rak & Patterson, 1996).

Summary

The death of a parent is one of the most disturbing events that affect a child; it can trigger a cascade of significant life changes for the bereaved child. In the past, research focused on the pathological outcomes of grief. In the last few decades, studies have been exploring the predictors of adjustment of the children to the loss. A variety of factors have been identified to exacerbate the effect of parental death on children: Parental attachment style, personal characteristics, age and gender, family circumstances, mode of death and the parental relationships.

Data suggests that children who lose a parent exhibit different levels of effects from pathological to healthy adjustment. These effects are examined under two theories in this paper: attachment theory and resilience theory. Attachment theory claims that grief and mourning processes in children and adults appear whenever attachment behaviors are activated and the attachment figure continues to be unavailable. It also claims that a well loved child is quite likely to protest separation from parents, but will later develop more self-reliance. The death of a parent impacts all existing relationships. Through attachment, a child develops emotional working models of self and others; these working models are believed to influence the child's reaction and perception of his/her relationship with others throughout his life span and to affect whether the final outcome is pathological or healthy. Healthy attachment styles nurtured with love, acceptance, and trust can facilitate the development of a secure base to help children throughout the pain of a loss, and may result in resilience.

Resilience theory is associated with the orientation toward psychological health. It has been used to study children who show an ability to rise above adversity and to

overcome stress. Research has identified many protective factors that promote the resiliency in children. These include personal temperament that elicits positive responses from family members as well as from strangers, a close bond with the caregiver during the first years of life, and an active engagement in acts of helpfulness in middle childhood and adolescence. Awareness of these factors informs the design of interventions aimed at enhancing coping skills early in the children's lives rather than repairing disorders later. The goal is to focus on how to develop healthy attachment styles with love, acceptance, and trust to aim at a secure base to help throughout the pain of a loss.

CHAPTER III

METHODOLOGY

Introduction

The goal of this study was to investigate the relationship between parental/family attachment, family hardiness, and social support on children's behavior and resiliency in families who have lost a parent. Chapter III includes a description of the research design and discusses the rationale for the approach. The sample population, research procedures, participant selection, and instrumentation are also described. Issues of internal validity, external validity, data analysis, and limitations are also addressed.

Research Design and Rationale

The research design chosen for this study was causal-comparative research. Isaac and Michael (1997) describe the purpose of this type of research as an investigation of possible cause and effect relationships made possible by observing some existing consequences and searching back through the data for plausible causal factors. Causal-comparative research is "ex post facto" (Latin for "after the fact") since both the effect and the alleged cause have already occurred and must be studied in retrospect which means the data are collected after the events of interest have occurred. Such research starts with an effect and looks for the causes; the researcher attempts to determine the cause or the reason for the preexisting differences among individuals or groups. The investigator takes one or more effects which are the dependent variables and examine the data by going back through time, seeking out causes of relationships and their meanings. The causal-comparative design is the design of choice when it is not possible to select, control, and manipulate the facts necessary to study cause and effect relations directly.

The causal-comparative method observes a result that already exists and searches back through several possible causes that are related to the event. It yields useful information concerning the nature of the phenomena, what goes with what under what conditions, sequences and patterns. The individuals in causal-comparative studies are not randomly assigned to treatment groups because they were already selected into groups before the research began. The groups are already formed and are already different on the independent variable. The independent variable cannot be manipulated for ethical and practical reasons. Considering the fact that the death of a parent or a parent figure stamps the child's life with health or sickness, and searching for the reasons why certain children bounce back while others are compressed, causal-comparative design is the approach selected to study these variables.

Predictor and Criterion Variables

The predictor variables in this study were: parent-child attachment, family hardiness, and family social support. Parent-child attachment was measured using the Family Attachment and Changeability Index FACI8 (McCubbin et al., 1995) . The Family Hardiness Index(McCubbin, Patterson et al., 1996) was used to measure family hardiness. The Family Hardiness Index consists of four subscales: 1) co-oriented commitment, 2) confidence, 3) challenge, and 4) hardiness. Family social support was assessed using the Social Support Index, a scale that measures the degree to which families find support in their communities.

The criterion variables in this study were the children's behavioral functioning as measured by the Child Behavior Checklist (Achenbach, 1991), and the children's resiliency as measured by the Child Resiliency Scale (Eisenberg, 2004).

Instrumentation

Family Attachment and Changeability Index

The Family Attachment and Changeability Index (FACI8) was adapted by McCubbin, Thompson, and Elver (1995a) to study youths and their families. Youths and their families create for themselves specific and predictable styles of functioning which can be measured and identified. These patterns have predictable power in explaining which youths are most likely to succeed in life. This instrument was adapted from FACES IIA (McCubbin et al., 1995) which was adapted from the Family Adaptability and Cohesion Scales (Olsen, Portner, & Bell, 1982) which was adapted from the Family Adaptability and Cohesion Scales II (Olsen, Sprenkle, & Russell, 1979). The Family Attachment and Changeability Index 8 was used to measure family functioning as an indication adaptation after becoming a single parent family. The FACI8 consists of a six point Likert scale of how often the event occurs ranging from Never to Always, with 6 being Not Applicable. The items ask the respondent to describe how often each item is happening now. The FACI8 consists of two subscales Attachment and Changeability.

Attachment. An 8-item scale designed to determine the strength of family members' attachment to each others. Examples of items in the attachment scale are: In our family everyone goes his or her own way; and we have difficulty to think of things to do as a family.

Changeability. An 8-item scale designed to determine how flexible the family members are in their relationships with each other. Some example items in the Changeability scale: each family member has input in major family decisions; and our family tries new ways of dealing with problems. These scales may be used separately or

in combination. These two subscales have a low intercorrelation of .13 and are not assumed to be curvilinear variables.

Designed to be administered to both youths and parents the internal reliability (Cronbach's alpha) for the youth's Attachment scale is .73. The internal validity for the parent's Attachment scale is .75. The internal reliability for the youth's Changeability scale is .80. The internal validity for the parent's Changeability scale is .78.

Validity of the instrument was established by conducting chi-square analysis to determine the FACI8's relationship to the treatment program's successful outcome. Two criterion indices of success were adapted for this investigation: 1) program completion, and 2) post-treatment living situation (6-12 moths). Program completion is operationalized as a classification given to youths who finish the treatment program, or who in the staff judgment met the staff expectations for progress and achieved an expected level of improvement to be released earlier than normal. post-treatment living situation is defined and operationalized as a classification given to youths who complete the program and who upon follow up (3 and/or 12 months later) were found to be in a less restrictive living situation (e.g. living with a family member, foster home, independent living situation). Failure is defined as the youth is living in a more restrictive situation (e.g. jail, mental health facility, shelter).

The test-retest reliabilities for the FACI8 when administered over 6-12 months is statistically significant and varies with a low of .26 to a high of .48 indicating the validity of the use of this index to assess program effects and change. The test-retest reliability of the Changeability scale for youth is .26, and for youth attachment scale is

.32. The test-retest reliability of the Changeability scale for parents is .48, and for parent attachment scale is also .48.

Subscales scores are obtained by summing the number circled by the respondent (i.e., Never = 1, Sometimes = 2, Half the time = 3, More than half the time = 4, Always= 5) for the items in each subscale. There is a list that helps determine which items belong to each subscale for both of the subscale sets. Items in the Attachment scale require reversal (i.e., Never = 5, Sometimes = 4, Half the time = 3, More than half the time = 2, Always = 1) before summing and are marked with an asterisk in the right hand column. This ensures that all items are scored in a positive direction for analysis and interpretation.

Subscale 1: Attachment 2*, 5*, 7*, 9*, 12*, 13*, 15*, 16*

Subscale 2: Changeability 1, 3, 4, 6, 8, 10, 11, 14,

The FACI8 instrument is currently being tested within the Family Stress, Coping and Health project and by other investigators. The few studies that included this scale have been cited in the validity of the scale and are included in the references.

.Family Hardiness Index

The Family Hardiness Index was developed to measure the characteristics of hardiness as stress resistance and adaptation resources in families, which are thought to function as a mediating factors in mitigating the effects of stressors and demands, and assist in facilitating family adjustment and adaptation over time. Hardiness refers to the internal strength and durability of the family and their sense of control over outcome of life events and hardships. The Family Hardiness Index was initially used to investigate family traditions, routines, and celebrations in a research of the Family Stress Coping and

Health Project at the University of Wisconsin-Madison. This test was developed to adapt the concept of individual hardiness to the family unit. The items were constructed to fit three components: commitment, challenge, and control and to reflect a “we” rather than an “I” criterion.

The Family Hardiness Index takes about five minutes to complete. It is a 20 item instrument consisting of four subscales (Co-oriented Commitment, Confidence, Challenge, and Control) which calls for the respondent to assess the degree (False, Mostly False, True, Mostly True) to which each statement describes their current family situation. The co-oriented commitment subscale measures the family’s sense of internal strengths, dependability, and ability to work together. The Confidence subscale measures the family’s sense to plan ahead, the ability to endure hardships and experiences with interest and meaningfulness. The Challenge subscale measures the family’s endeavor to be innovative. The Control subscale measures the family’s sense of being in control of family life rather than being shaped by outside events and circumstances. An earlier individual hardiness scale developed by existential therapist Kobassa (1979), was based on the concept that personal characteristic with both cognitive and behavioral components act as stress resistance and offset the illness producing effects of stress. This concept was applied to families to measure the dimension of hardiness and is closely linked to the concept of family schema where the degree of strength in the family determines the management of crises and transitions. Research on the Family Hardiness scale has revealed that Family Hardiness is at its lowest point at the single and couple stages of the lifecycle. It is at highest at the preschool and school age, a noticed increase in scores in adolescent and launching, empty nest and retirement stages. The internal

reliability as measured by Cronbach's alpha for the Family Hardiness Index is .82 (Mc Cubbin et al., 1996).

Social Support Index

The Social Support Index (SSI) was developed as a part of several national studies aiming at recording the degree to which families find support in their communities. Community based social support is viewed as an important dimension and factor in family resilience: it is a buffer against family crisis, a factor in promoting family recovery, and a mediator in family distress. The Social Support Index is a 17- item instrument that takes about five minutes to complete. It uses a five point Likert scale ranging from Strongly Disagree to Strongly Agree to record the degree to which families are integrated in to their community, which is viewed as a source that can provide emotional and network support. The internal reliability (Cronbach's alpha) of the Social Support Index is .82. The Social Support Index was found to have a validity coefficient of .40 with the criterion of family well being, and it was found that community/social support varied across stages of the family life cycle: the lowest point was at School Age Stage and the highest point at the Empty Nest Stage (Mc Cubbin et al., 1996).

Using the Social Support Index in a study of families faced with the threat of war, it was found that community/social support was positively correlated with the family's sense of fit – relating to successful adaptation in the environment-within a foreign community. When family life cycle stage was taken into consideration, community social support was positively correlated to family adaptation at the couple and adolescent stage of the family life cycle. When applied to the study of families with

different backgrounds, community/social support was negatively correlated with family distress (Mc Cubbin et al., 1996).

Child Behavior Checklist (CBCL)

The Child Behavior Checklist (Achenbach, 1991) is a behavior assessment scale for children between age two and eighteen years that is administered individually or in groups to parents or other informants to assess the competencies and problems of children and adolescents through the use of ratings and reports. The time needed to administer the Child Behavior Checklist is approximately fifteen minutes.

The Child Behavior Checklist combines a 113-item behavior problems checklist with a seven part social competency checklist. Parental responses to the checklist provide an accurate and comprehensive description of their children's behaviors that help the clinicians to distinguish between typical children and those children who have significant behavioral disturbances. Items on the behavior problems checklist are clustered into behavioral syndromes that are similar to the diagnostic categories of the Diagnostic and Statistical Manual of the American Psychiatric Association fourth- Edition (DSM- IV). The checklists are part of a larger effort by Achenbach (1993) to create an empirical taxonomy of behavioral disturbance in which syndromes describe features of behavior that co-occur in children, and profiles represent combinations of symptoms that occur at greater than chance levels. The Child Behavior Checklist 4-18 is a revision of the 1983 version of the Child Behavior Checklist and improves upon it in several respects: the checklist was renormed on a nationally representative sample, the norms were extended to include 17 and 18 year olds, the wording of some items was slightly modified to be inclusive of subjects as old as 18, and the behavioral syndromes were reformulated to be

uniform across gender and age. The titles of the syndromes were rephrased to be less provocative.

The behavior problems checklist is the Child Behavior Checklist strongest feature. Its items use simple unambiguous words to describe the behavior problems that most concern parents and mental health professionals. Items were only included on the behavior problems checklists if they significantly discriminated between referred and typical children. A higher behavior problem score signifies that a child has more behavior in common with referred children and thus is more likely to be behaviorally disordered. This is counterintuitive to most users' expectations that higher score signify a more severe case of the disorder and that confusion leads to frequent misinterpretations of the scores. Behavioral syndromes were derived from a principal components analysis of the behavioral problems from referred children, and syndrome titles were assigned based on each syndrome's item content. The 1991 titles are more carefully phrased that were the 1983 syndrome *titles* (e.g. hostile withdrawal has been renamed simply withdrawn). The Child Behavior Checklist is essentially an empirically derived research instrument that has become recognized as an important clinical tool (Doll, 1998).

Child Resiliency Scale

Children's resourceful adaptation to changing circumstances and contingencies were assessed using the 11-item questionnaire derived from Block and Block's (1969, 1980) Q–sort. Items represent the constructs of resiliency as identified by Block and Block. In the development of the questionnaire items representing specific social skills or problem behaviors were dropped (Eisenberg et al., 2004). The items are scored on a scale from 1 (highly undescriptive) to 9 (Highly Descriptive). A few items were simplified

slightly with phrases from Caspi et al. (1992). When the longer (23 items) version of this measure was used, Alphas ranged from .87 to .90 for teachers and from .73 to .87 for parents. As evidence of validity and stability across contexts, parent's and teacher's reports in different settings are significantly correlated, $r = +.39$ and $r = .21$ for boys and girls respectively, $p < .001$ (Eisenberg et al., 1996). Positive associations between resiliency scores and parent's and teacher's reports of the children's social status and socially appropriate behaviors are indicative of predictive validity as are negative associations between resiliency and parent's and teacher's reports of negative emotionality (Eisenberg, Fabes, Guthrie, & Reiser, 2000; Eisenberg et al., 1997). Both parent's and teacher's reports of resiliency have been also associated with low levels of problem behaviors (Eisenberg et al., 1996; Eisenberg et al., 2000). Because many items on the long version (23 items) overlapped with other constructs, a "purer" version of the resiliency scale has been developed that takes about five minutes to complete. Five faculty and five students with relevant expertise rated the 23 resiliency items as to how much they reflected resiliency. Resiliency was defined as flexible, adaptable behavior. Even though some of the items were reversed, reflecting low resiliency, instructions were to rate each item based on how well it tapped resiliency regardless of valence of the item. These items were rated on a scale from 1-9 with 1 indicating not at all descriptive of resiliency and 9 reflecting most descriptive of resiliency. The items that obtained a mean score of greater than an absolute value (if reversed) of 7 or above were retained and used in the shorter version of the scale (e.g., "can bounce back or recover after a stressful; or bad experience"). The alphas for the 7-item version of ego-resiliency were .65 and .82 for parents and teachers, respectively (Cumberland, Eisenberg, & Reiser, 2004). In another

larger sample of children the correlation between the short version and the longer versions of the resiliency scale was .87 for teachers and .75 for parents. Alphas for teachers and parents for this version in recent analyses ranged from .70 to .87 in two data sets (three assessments) for elementary school children and adolescents in grades 6-9 (Spinrad et al., in press), and .72 for parents and caregivers reports for the 30 month assessment in the current sample. The shortened resiliency scale has been associated with measures of children agreeableness (Cumberland et al., 2004), popularity (Spinrad et al., in press), and low levels of internalizing problems (Eisenberg et al., 2004).

Demographic Questionnaire

A demographic information form (Appendix G) was also completed. This data was used to describe the characteristics of the participants as a group.

Organizations Background

Tragedy Assistance Program for Survivors

The Tragedy Assistance Program for Survivors is a nonprofit organization founded out of tragedy in 1994. The Tragedy Assistance Program is a front line resource for families and loved ones of the United States military. It provides 24 hours a day, seven days a week, comfort and care through comprehensive services and programs including peer based emotional support, good grief camps, case work assistance, crisis intervention, and grief and trauma resources. TAPS encourages and facilitates TAPS Care Groups around the country to help military families during their grief process. The mission of the Tragedy Assistance Program is to provide ongoing emotional help, hope, and healing to all who grieve death of a loved one in military service of America. The Tragedy Assistance Program is committed to providing compassionate care to all military

survivors regardless of their relationship to the deceased or the circumstances or geography of the death. TAPS volunteers and employees must pass background check, fingerprints and they must attend the ongoing grief training regarding therapeutic support after the loss of a loved one. The researcher is a volunteer for TAPS, but was not involved in collecting data from the participants. The designated staff members assigned for the research are TAPS volunteers who agreed to help with the research.

Central Community Mental Health Services

Central Community Mental Health Services are non-profit organizations that have been serving the needs of at-risk and dependent children and their families in Central Florida since 1994. The Central Community Mental Health Services deliver a variety of services including behavior analysis, and in home, school, and community counseling services. They are involved with foster care, adaption services; independent living assessment and training; transitional housing; mentoring; substance abuse services; psychiatric services; services for the developmentally disabled; and mental health services for Juvenile Justice Facilities. The Central Mental Health Community Services provide services to all families whether they are in crisis or at risk. The services are available in the community under different agencies that work together such as the Community Based Care of Brevard (CBCB); Devereux; Intervention Services; Children Home Society (CHS); Department of Children and Families (DCF), Child Care Association; Bright Star; and North Star, to ensure a wide variety of available services for different needs from crisis interventions to preventive interventions. The researcher is an employee in one of the agencies in the Central Community Mental Health Services, but was not be involved in collecting data. The designated staff members assigned for the

research were volunteers who agreed to help with the research. The designated staff had a background in mental health, as they worked at one of the affiliated organizations.

Participants

The participants in this study were recruited from the following organizations: Tragedy Assistance Program for Survivors (TAPS), and the Central Community Mental Health Services in Brevard County. The participants recruited for this study from both resources were receiving mental health support. TAPS participants were active members in Good Grief Camps and the Central Community Mental Health Services participants were receiving therapeutic services provided by the mental health practitioners within the Central Community Mental Health Services organization. The families selected for this study included one or more children between the ages of 1.5 and 18 who had lost one of their parents to death. The surviving parents were the active respondents to the scales used in the study. Families participating in the study met the following selection requirements: 1) one of the parents was deceased); 2) at least one child between the ages of eighteen months and eighteen was living in the home with the surviving parent; and 3) the parental death was within the last seven years.

Procedures

The participants in this study were parents raising children between the ages of eighteen months to eighteen years who had lost a parent, and who were receiving mental health services or support, individual or with the family. These services were provided by mental health therapists, social workers, or volunteers (trained and certified) facilitating grief for parentally bereaved children. The parents were volunteers who were asked to complete a series of questionnaires about their child or children to investigate the

relationship between parental attachment, family hardiness, and social support on children's behavior and resiliency in families who have lost a parent. Participants were recruited through the Tragedy Assistance Program for Survivors, and the Central Community Mental Health Services. Written permission to conduct the study was obtained by this researcher from these organizations. Participants from the Tragedy Assistance Program for Survivors were recruited through the inclusion of a cover letter (Appendix A) in their admission packages for their child's yearly group camp and by a flyer (Appendix E) that was posted on their website, in their newsletter, or on site during the camps. Participants from the Central Community Mental Health Services were recruited by posting flyers (Appendix C) at these sites.

Tragedy Assistance Program for Survivors (TAPS)

Participants from TAPS responded to a cover letter (Appendix A) and the corresponding flyer (Appendix E) inserted in the admission package from the group camp. The TAPS flyer (Appendix E) was posted on TAPS website www.taps.org, in their newsletter, or on site throughout Good Grief Camps. The cover letter (Appendix A) provided general information about the research, it indicated the name, the phone number and the email address of the trained staff member designated as the point of contact as well as their affiliation with the corresponding organization. It provided the contact information for the researcher, the Barry University Chairperson, and the institutional Review Board point of contact. The flyer (Appendix E) also provided contact information for all parties involved in the research, the designated staff information, and affiliation with the corresponding organization, and provided brief description of the scales used in the study. The designated staff member within TAPS organization were volunteers

trained and certified in facilitating grief support. The staff members were given instructions on how to distribute and collect the packets (Appendix N). They also signed a 3rd party confidentiality agreement (Appendix M). After completing the above procedure, the designated staff member was able to answer any questions the participants had. Participants who were interested in participating contacted the designated staff member. The designated staff member gave the participants packets along with the choice to complete the questionnaires in a quiet, comfortable room with a table and chair or to mail the packet back in the provided stamped envelope. The participants were given instructions (Appendix F) regarding completion of the research packet. Each packet was given a number that was marked on each form and test. Each participant completed one packet for a child in their household. If the parent wished to complete questionnaires for more than one child, they were given additional packets. After completion of the questionnaires, the participants placed them in the provided envelope, sealed it, and wrote the researcher's name on the back of the sealed envelope. The participants gave their packets to the designated staff member who placed the packets in the lock box provided by the researcher to ensure privacy. The researcher picked up the packets in person. The participants were also given the option to mail the packets to the researcher in an addressed, stamped envelope provided by the researcher. Detailed information about the designated staff members for both organizations was available (Appendix O).

Central Community Mental Health Services

Participants from Central Community Mental Health Services were recruited through flyers (Appendix C). The purpose of the study, the eligibility requirements for the potential participants, and the study procedures were identified on the flyer. The flyer

indicated the phone number and the email address of the trained staff members designated as the point of contact (Appendix C). The designated staff involved in the data collection had a background in mental health and they were affiliated with the organization, employed or contracted. The designated staff members signed a 3rd party confidentiality agreement (Appendix M). The staff members were given instructions on how to distribute and collect the packets (Appendix N). The designated staff members answered any questions the participants had. The flyers were posted on the bulletin boards at each of the sites. After the participant contacted the staff member, a convenient time and place were found for the staff member to meet with the prospective participant. The location was a private neutral room with a chair and a table and a lock box to drop the completed packets. At this meeting the staff member answered questions about the study. The participants completed the questionnaires in the packet. If the parent wished to complete questionnaires for more than one child, they were given additional packets. After completion of the questionnaires, the participants placed them in the provided envelope, sealed it, and wrote the researcher's name on the back of the sealed envelope. The participants gave their packet to the designated staff member who placed the packets in the lock box provided by the researcher to ensure privacy. The researcher picked up the packets in person. The participants were also given the option to mail the packets to the researcher in an addressed, stamped envelope provided by the researcher.

Confidentiality

All participants were told that participation was strictly voluntary and they could drop out at any time during the study with no adverse effects whatsoever. They were told that, as a research participant, the information they provided would be kept confidential,

that is, no names or other identifiers were collected on any of the instruments used. Data results would only be reported in aggregate form, with no reference to any specific participant. All data and questionnaires would be kept in a locked file in the researcher's office. All raw data, including Demographic Information Forms would be destroyed after five (5) years in accordance with Florida laws and university policies and procedures. All designated staff members signed a third party confidentiality form (Appendix M).

Risks

The participants were made aware that risks involved in participating were minimal, but should they experience any emotional distress they could contact this researcher who would refer them to a clinician within the organization in which they were already receiving services. All of the participating organizations had clinicians available who could see the participants. If there was a charge, the researcher would pay for one counseling session.

Data Collection

Volunteers who agreed to participate in this study completed a research packet containing 1) a cover letter (Appendix A); 2) a demographic information form (Appendix G; 5 minutes; this data was used to describe the characteristics of the participants as a group); 3) the Family Attachment and Changeability Index (Appendix H; 5-10 minutes); 4) the Family Hardiness Index (Appendix I; 5-10 minutes); 5) the Social Support Index (Appendix J; 5 -10 minutes); 7) the Child Behavior Checklist (Appendix K1 1/2 to five years old & Appendix K2 6-18 ; 15-20 minutes); and 8) the Child Resiliency Scale (Appendix L; 5 -10 minutes). A quiet, comfortable room, private with a table and chair was provided for the participants to sit while they completed the questionnaires. A

locked box was provided in that room to drop the completed packets. It took 45-60 minutes to complete the questionnaires. If a participant withdrew, the data was not used and the information was destroyed.

Ethical Considerations

The voluntary nature of the study was stressed and the participants were informed that they may cease to participate in the study at any time without any negative repercussions. They were informed that they could stop the process of completing the tests at anytime without penalty. To ensure confidentiality no personal identifiers were attached to the surveys.

Research Questions and Hypotheses

Research Questions

The research questions and hypothesis guiding this study were as follows:

1. What is the relationship between family attachment and resiliency of children who have lost a parent?
2. What is the relationship between family attachment and behavioral functioning of children who have lost a parent?
3. What is the relationship between family hardiness and resiliency of children who have lost a parent?
4. What is the relationship between family hardiness and behavioral functioning of children who have lost a parent?
5. What is the relationship between family social support and resiliency of children who have lost a parent?

6. What is the relationship between family social support and behavioral functioning of children who have lost a parent?
7. What is the relationship between family attachment and family hardiness in families who have lost a parent?
8. What is the relationship between family attachment and family social support in families who have lost a parent?
9. What is the relationship between family hardiness and family social support in families who have lost a parent?

Hypotheses

1. Family attachment is positively correlated with resiliency in children.
2. Family attachment is positively related to behavioral functioning of the children.
3. Family hardiness and resilience in children are positively correlated.
4. Family hardiness and behavioral problems in children are negatively correlated.
5. Family social support and resilience in children are positively correlated.
6. Family social support and behavioral functioning in children are negatively correlated.
7. Family attachment is associated with increased family hardiness.
8. Family attachment is associated with increased social support.
9. Family hardiness and family social support in families who have lost a parent are positively correlated.

Limitations

There are some limitations in this study. The participants were limited to a few select organizations which limited the generalizability of the study. Another limitation

was that some of the participants were from different backgrounds (military, diverse ethnicity) where cultural differences could have reduced the reliability and validity of the test instruments used in the study.

Delimitations

The study was limited to volunteers from specific organizations or groups that were accessible to the researcher. The participants in this study were from families who had lost a parent.

Assumptions

For the purposes of this study, it was assumed that the participants were truthful on their disclosure while answering the test questions. It was assumed that the parents were able to evaluate their children's behaviors, and that they were able to understand the content of the questions in the tests.

Data Analysis

The Statistical Package for the Social Sciences software was used to analyze the results (SPSS, Chicago, III). Correlational analyses were conducted on the data collected.

Summary

The goal of this study was to investigate the relationship between family attachment, family hardiness, and social support on children's behavior and resiliency in families who have lost a parent. A correlational approach was used to examine the relationships between these variables as measured by the Family Attachment and Changeability Index, the Family Hardiness Index, the Social Support Index, Child Behavior Checklist, and the Child resiliency scale. This Chapter describes the research design, the independent and dependent variables, instrumentation, and the study

participants and procedures. Assumptions, delimitations, and limitations affecting the study were also discussed. Chapter IV presents the results of the study and Chapter V contains the summary, conclusions, and recommendations for further research.

CHAPTER IV

RESULTS

Introduction

This chapter provides a comprehensive analysis of the data obtained from the study. Descriptive statistics and inferential statistics are presented in this chapter. The first section provides demographic details for the participants and descriptive statistics for the data. The statistical analysis was conducted using the Statistical Package for the Social Science for Windows, SPSS Version 11.0 software. The data was collected using five self-administered scales: The Family Attachment and Changeability Index (FACI8), the Family Hardiness Index (FHI), the Social Support Index (SSI), the Child Behavior Checklist (CBCL), and the Child Resiliency Scale. The data was analyzed using correlations with a significance level of 95% in order to assess the relationship between the variables of interest.

This study was conducted with families who had at least one child who lost a parent to death. The study aimed to explore the relationship of family attachment, family hardiness, and family social support to resiliency and behavioral functioning of children who lost a parent. The research questions were:

1. What is the relationship between family attachment and resiliency of children who have lost a parent?
2. What is the relationship between family attachment and behavioral functioning of children who have lost a parent?
3. What is the relationship between family hardiness and resiliency of children who have lost a parent?

4. What is the relationship between family hardiness and behavioral functioning of children who have lost a parent?
5. What is the relationship between family social support and resiliency of children who have lost a parent?
6. What is the relationship between family social support and behavioral functioning of children who have lost a parent?
7. What is the relationship between family attachment and family hardiness in families who have lost a parent?
8. What is the relationship between family attachment and family social support in families who have lost a parent?
9. What is the relationship between family hardiness and family social support in families who have lost a parent?

The predictor variables in this study were parent-child attachment, family hardiness, and family social support. The criterion variables in this study were the children's behavioral functioning and resiliency.

The hypotheses tested were:

1. Family attachment is positively correlated with resiliency in children.
2. Family attachment and behavioral functioning of the children are negatively correlated.
3. Family hardiness and resilience in children are positively correlated.
4. Family hardiness and behavioral problems in children are negatively correlated.
5. Family social support and resilience in children are positively correlated.

6. Family social support and behavioral functioning in children are negatively correlated.
7. Family attachment is associated with increased family hardiness.
8. Family attachment is associated with increased social support.
9. Family hardiness and family social support in families who have lost a parent are positively correlated

These hypotheses were examined by recruiting volunteer participants from two groups, the Tragedy Assistance Program for survivors (TAPS), a resource for families of the United States military, and the Central Community Mental Health Services in Brevard County. Participants in both groups were members receiving mental health services provided by the groups. The TAPS group completed their packets in Washington, D.C. during the Good Grief Camp Memorial weekend that takes place once a year for participants from all over the states. The Central Community Mental Health Services participants were receiving therapeutic services provided by the mental health practitioners within the Central Community Mental Health Services organization. Both groups, TAPS and Central Community Mental Health Services, received the same tests materials and followed the same procedures.

Descriptive Statistics

For this study the researcher used a causal-comparative approach. A total of 100 packets were distributed for both groups, 66 packets were returned. A total of eleven participants from both groups were dropped from the research due to incomplete materials in their returned packets. Data was analyzed on 55 participants from both

groups. Descriptive statistics were computed for the demographic variables of groups, number, age, gender, marital status, ethnicity, and education.

Participant Groups

The participants were recruited from two groups, the Tragedy Assistance Program for survivors (TAPS) and the Central Community Mental Health Services in Brevard County. The total number of participants to complete the study was 55 participants, with 20 Participants from the TAPS program (36%) and 35 participants from the Central Community Mental Health Services (64%). The distribution is presented visually in Figures 1 & 2.

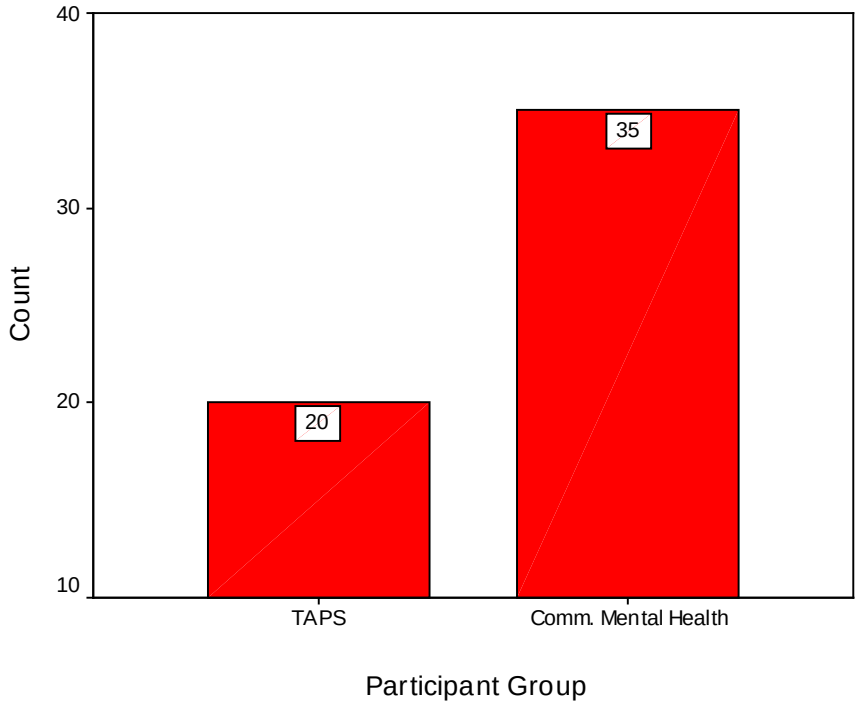

Figure 1. Number of participants in each group.

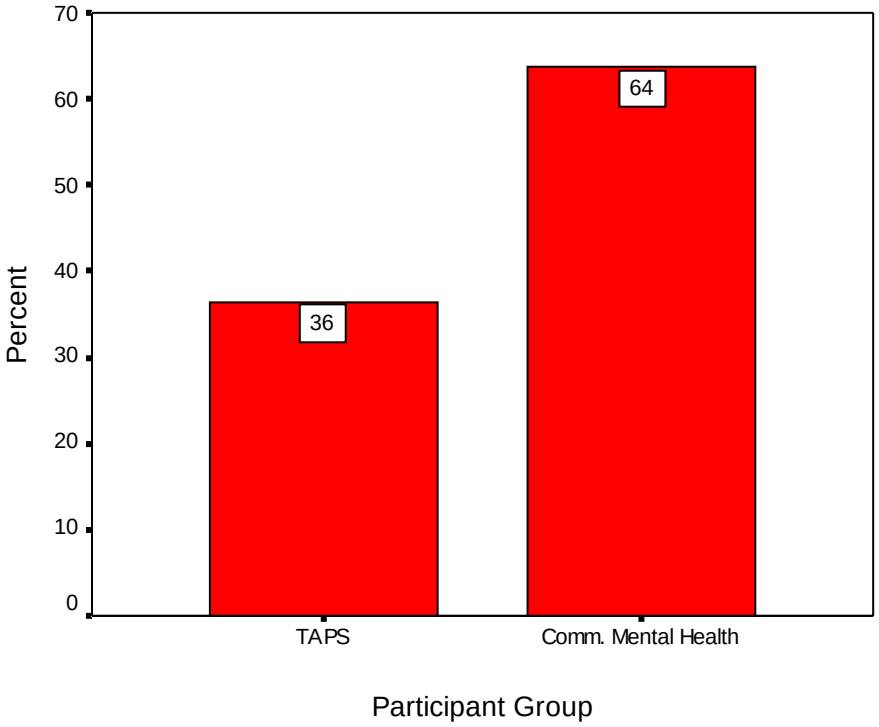

Figure 2. Percentage of participants in each group.

Age of Participant Parents

The participant parents ranged in age from 30 to 56 in the TAPS group, with a mean of 41.40 and a standard deviation of 8.83. In the Central Community Mental Health Services group the ages ranged 23 to 68 with a mean of 40.50 and a standard deviation of 9.85. The age histograms for the two groups are presented in Figures 3 and 4.

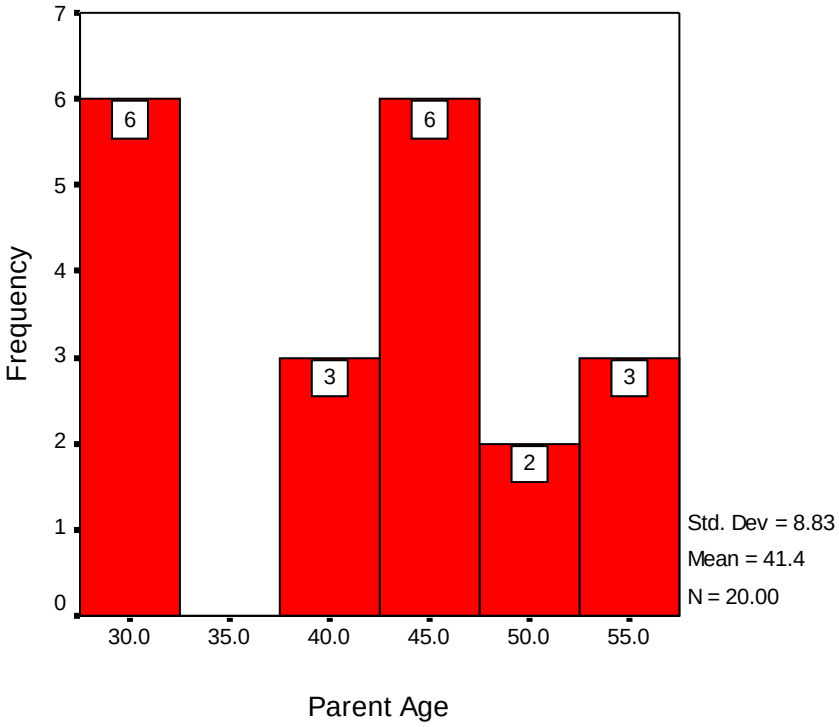

Figure 3. TAPS participant parents' age.

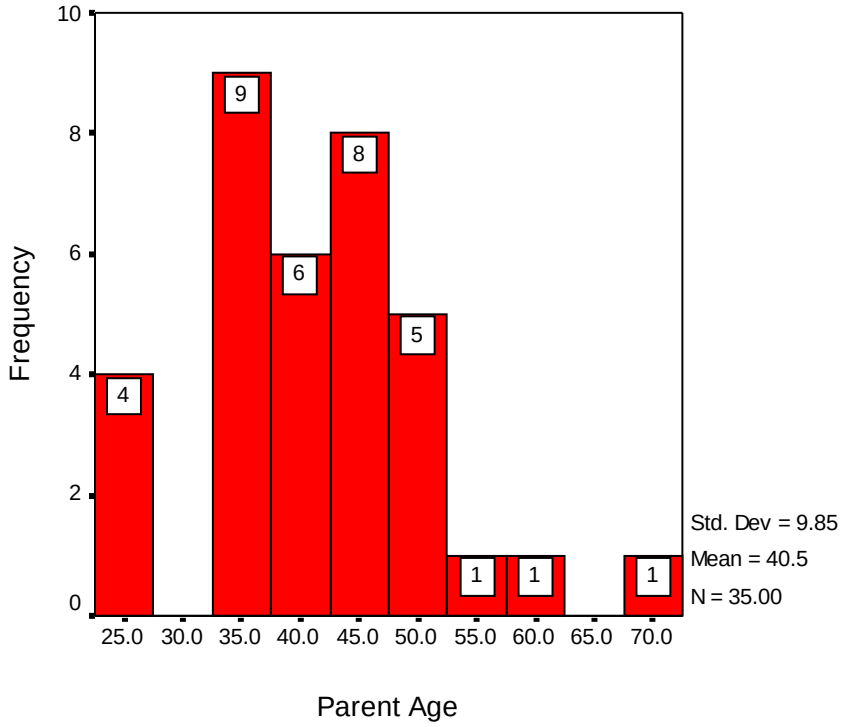

Figure 4. Community Mental Health Services participant parents' age.

Gender of Participant Parents

There were a total of 49 females (TAPS 20; Community Mental Health Services 29) and 6 males (Taps 0; Community Mental Health Services 6) in the study. The distribution of the genders is presented in Figure 5.

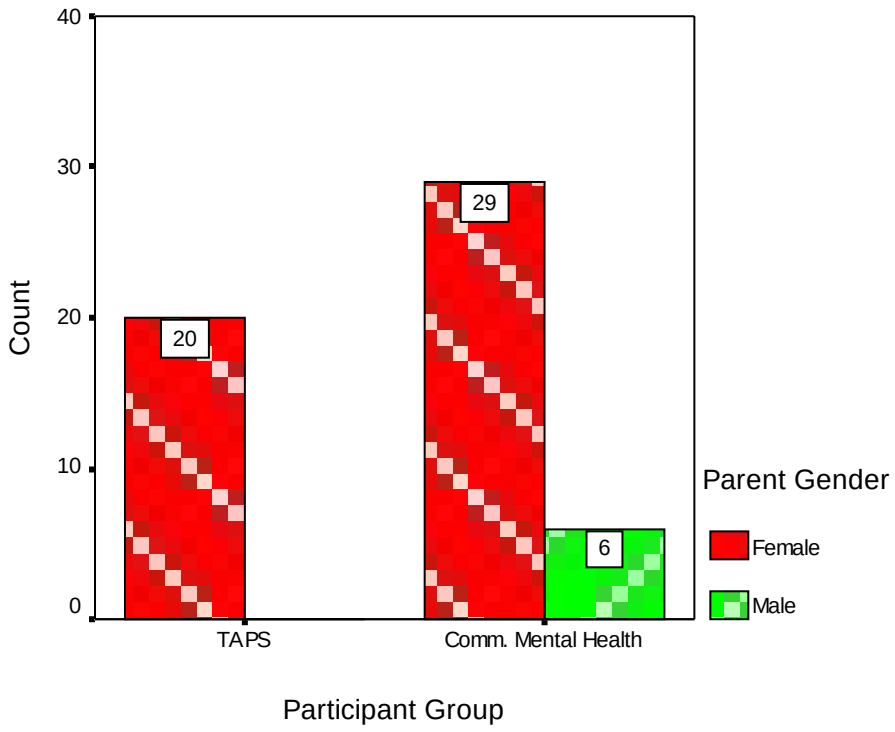

Figure 5. Gender of participant parents in each group.

Year of Loss and the Parent Lost

The year of loss of the parent in both groups ranged from 2002 through 2009. In the TAPS group 18 children lost their fathers and 2 lost their mothers; in the Central Community Mental Health Services group, 24 children lost their fathers and 11 lost their mothers. The data are presented graphically Figure 6.

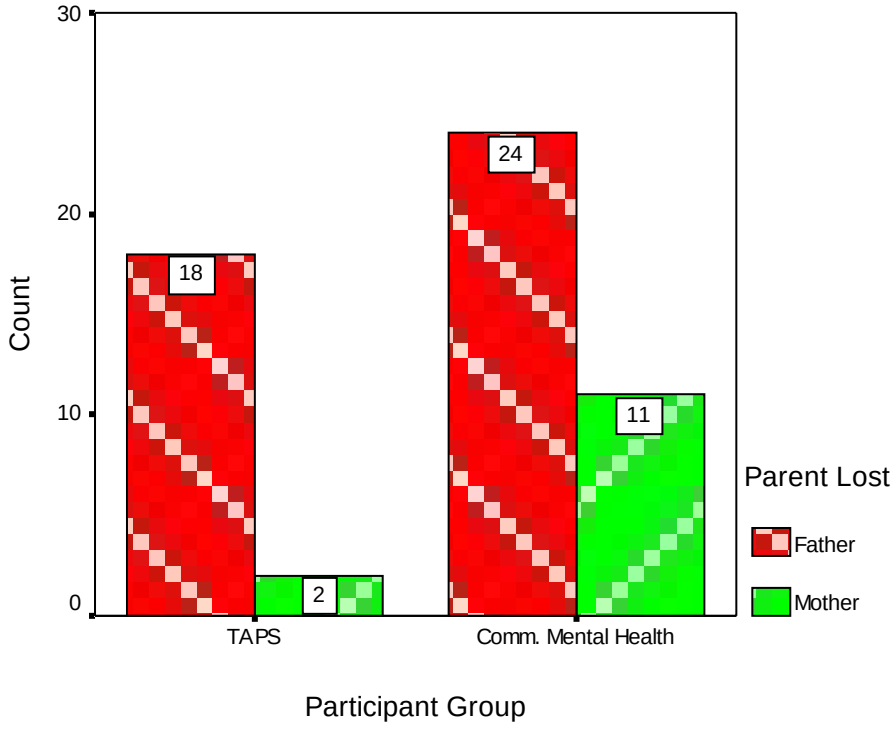

Figure 6. Gender of parent lost.

Cause of Death of the Parent

The most common cause of death for the TAPS group was combat, and for Central Community Mental Health Services it was accident. The results are presented in Figure 7.

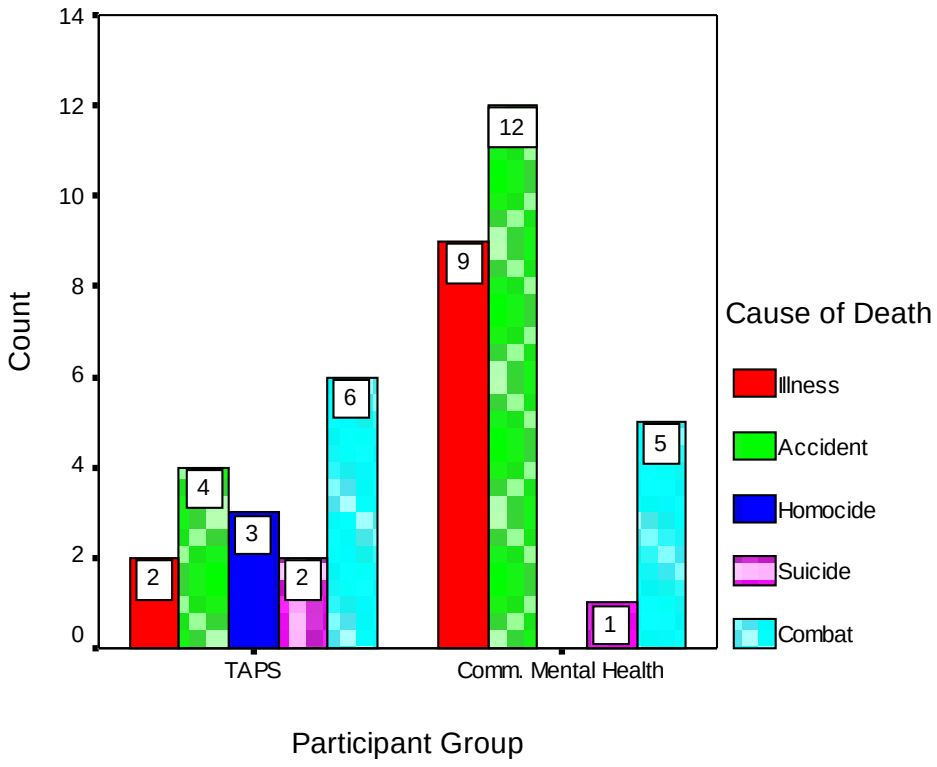

Figure 7. Cause of death.

Marital Status of the Participant Parents

Details about the marital status of the participants are presented in Figure 8. The majority of the participants in both groups were widowed.

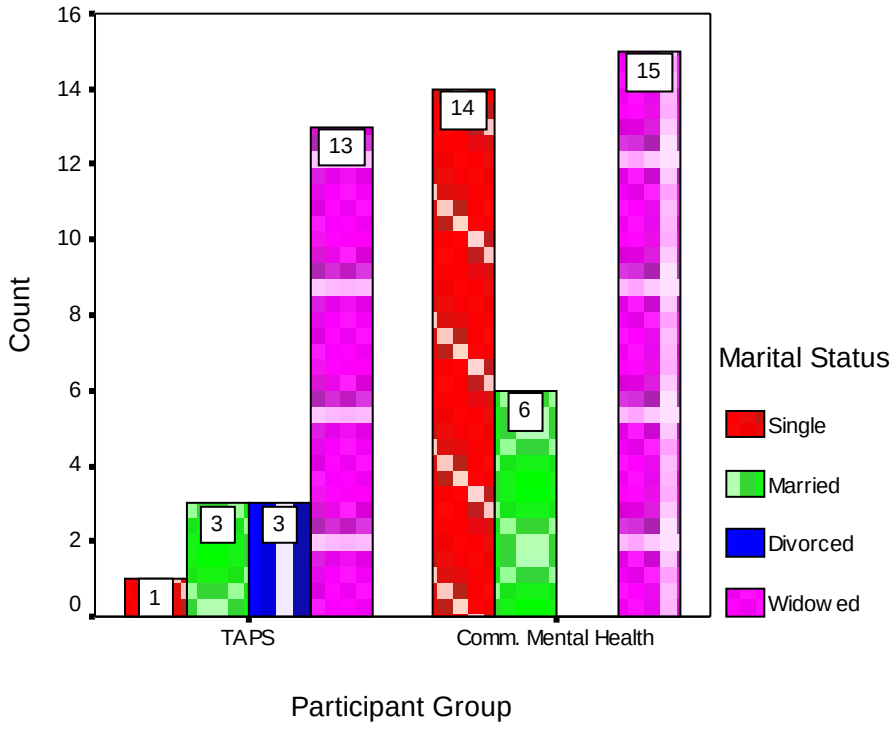

Figure 8. Marital status.

Participant Parents' Work Status

The majority of the Central Community Mental Health Services participants' work status was never employed, while never employed was the least likely status for the TAPS participants. Figure 9 presents the results graphically.

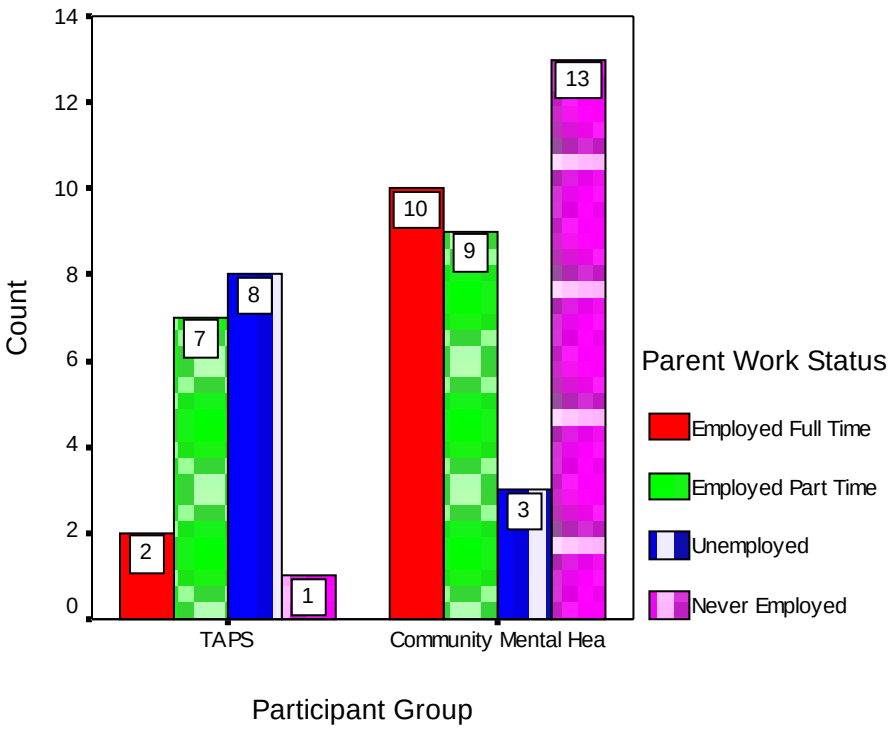

Figure 9. Work status.

Participant Parents' Educational Level

The majority of the participants in the Central Community Mental Health Services group had less than a high school degree. The TAPS Group had somewhat more formal education, as only two had not completed high school. Educational level is illustrated in Figure 10.

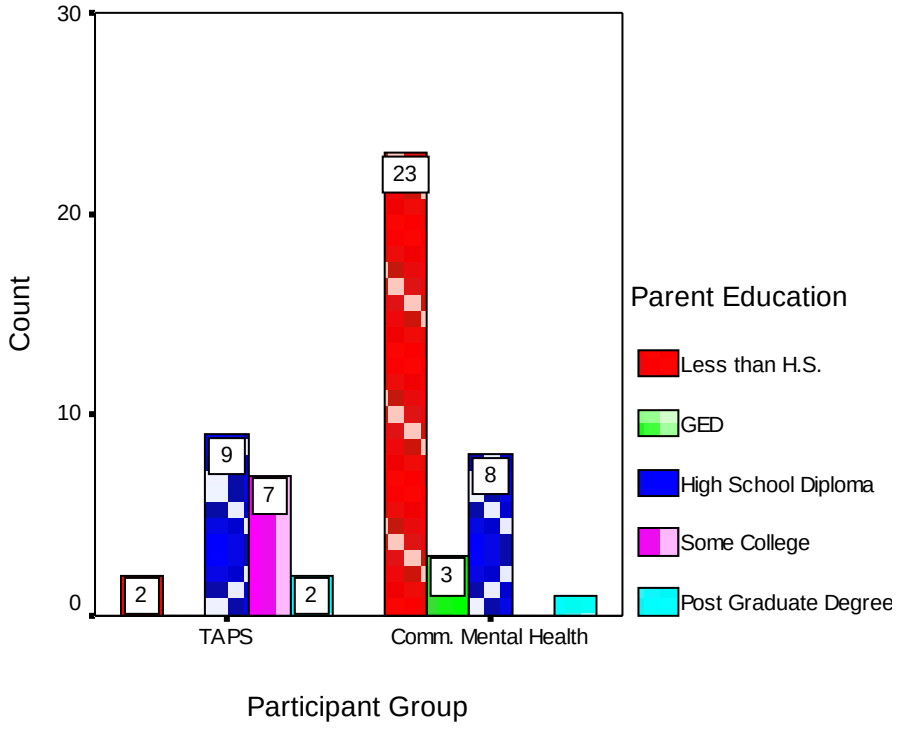

Figure 10. Educational level.

Participant Parents' Income Level

The annual income level as presented in Figure 11 shows that the majority of the participants in the Community Mental Health Services group had under $10,000 annual income. The TAPS group had somewhat higher overall annual income.

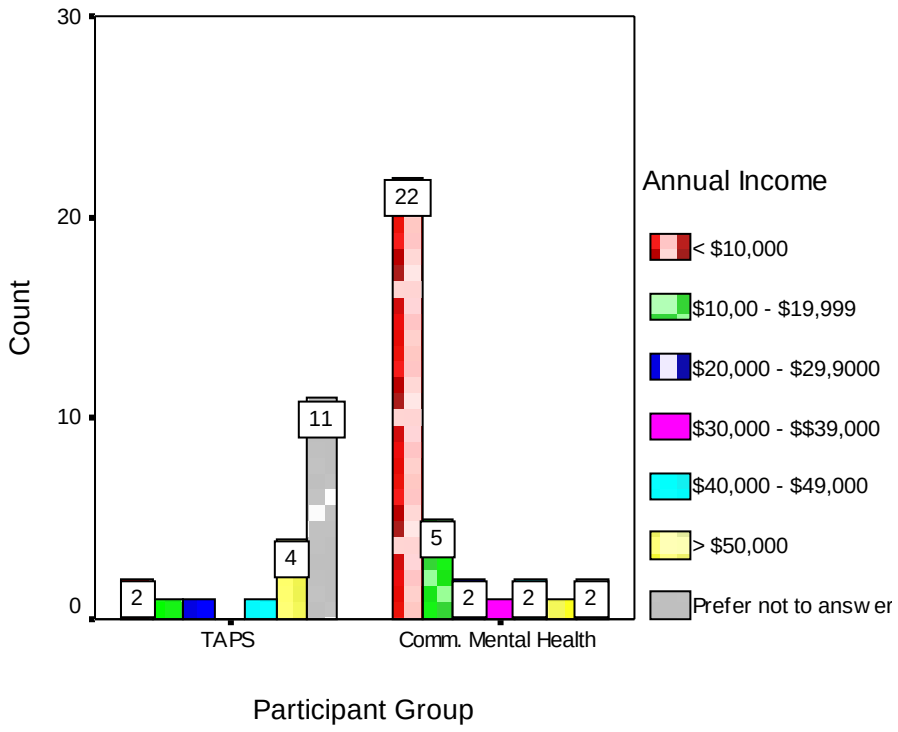

Figure 11. Annual income.

Race/ Ethnicity

There were twelve Caucasians, three Hispanics, and no African-American participants in the TAPS group. The Central Community Mental Health Services group was more diverse, with eleven identifying themselves as Caucasian, seven African-American, seven Asian, five Hispanic, and two Lebanese. The details are presented in Figure 12.

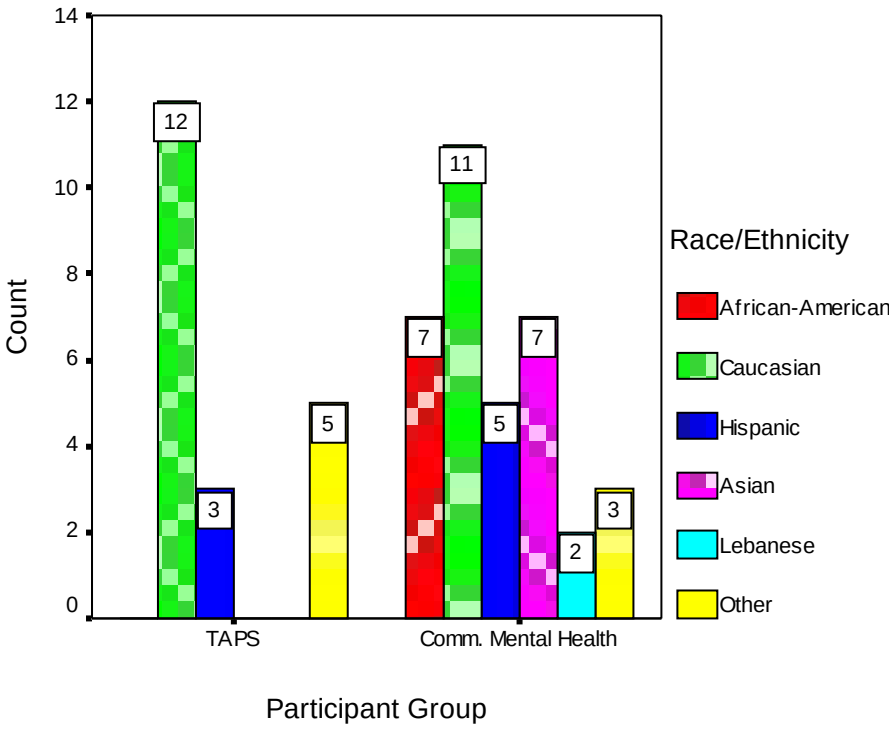

Figure 12. Race/Ethnicity.

Child Age and Gender

The ages of the children ranged from 3 to 18 years with the mean of 9.20 and standard deviation of 4.30 for the TAPS group, and ranged from 1.5 to 18 years with a mean of 10.40 and standard deviation of 4.62 for the Central Community Mental Health Services group. The ages are presented graphically in Figures 13 and 14.

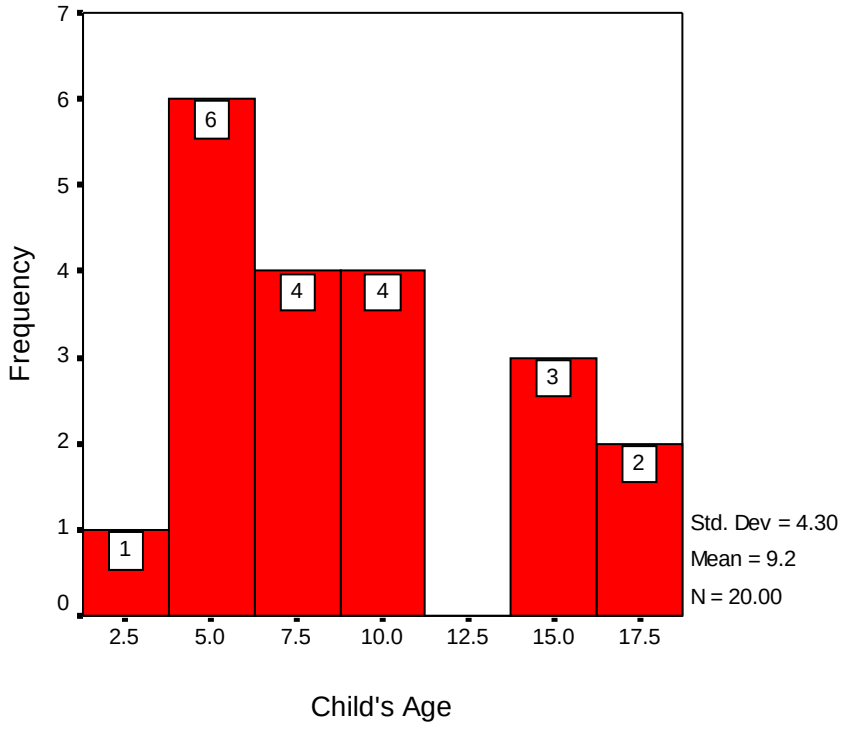

Figure 13. TAPS children's ages.

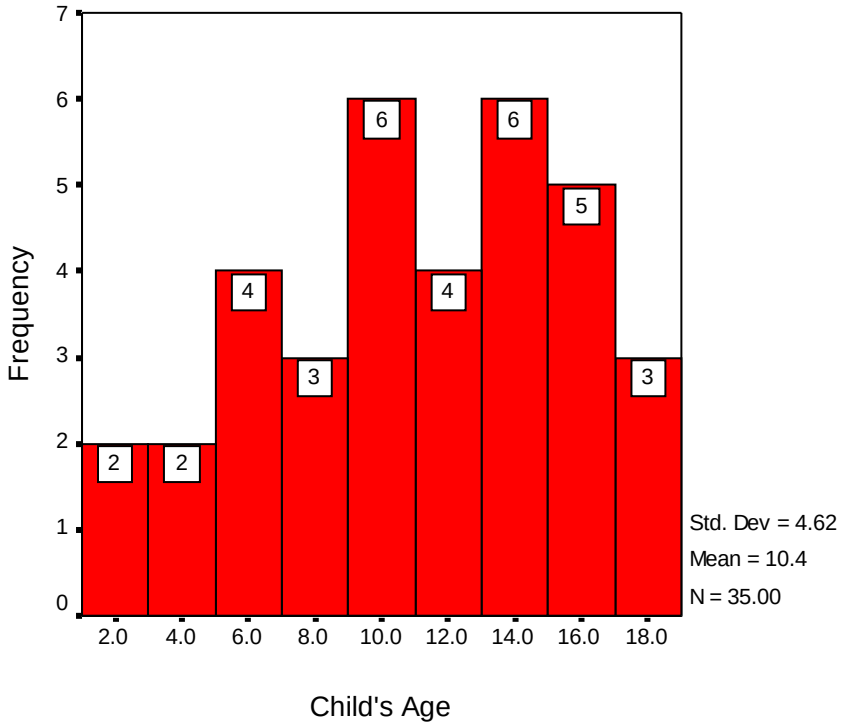

Figure 14. Community Mental Health Services children's ages.

Children's Gender

There were more male children than female children in the TAPS group, while the opposite was true for the Central Community Mental Health Services group.

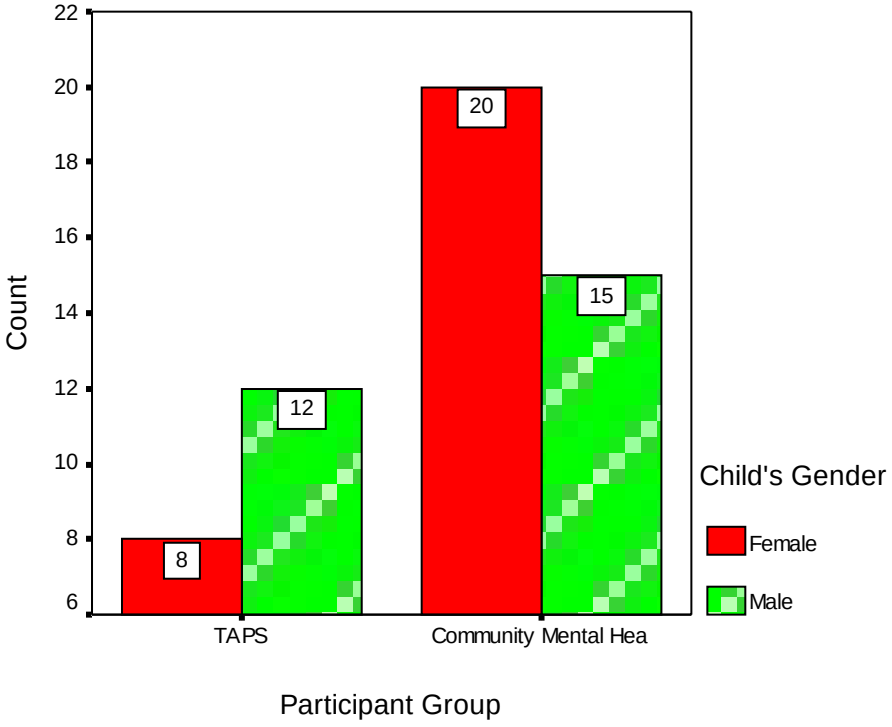

Figure 15. Children's gender

Number of Number of Siblings for Children in the Study

The majority of the children in the TAPS group had one sibling. The Central Community Mental Health Services group had more siblings, with nine having three siblings, fifteen having two siblings, and eight having one sibling.

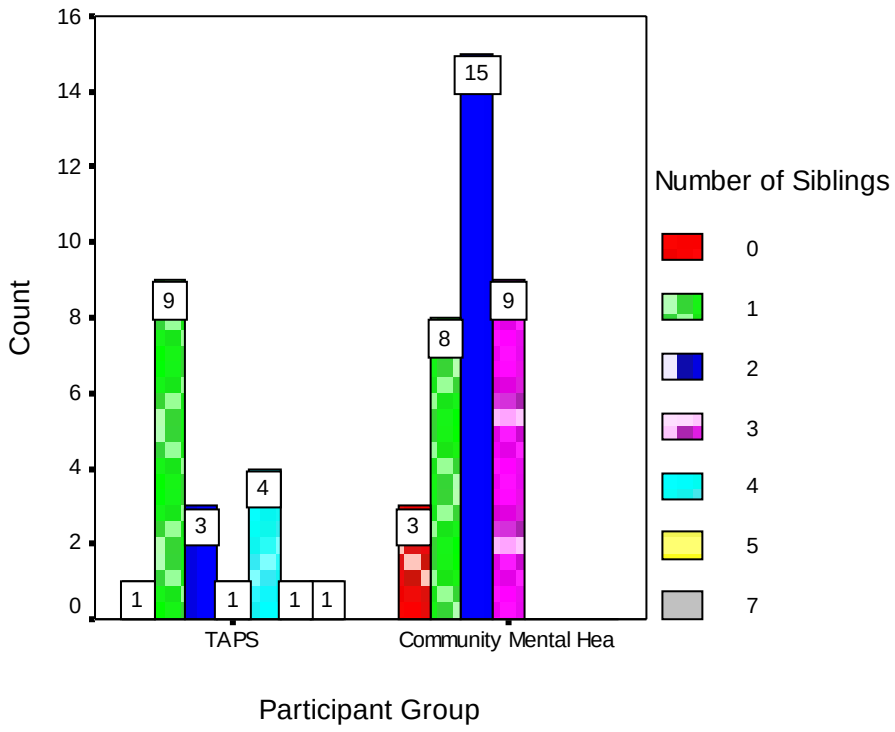

Figure 16. Number of siblings of the children

Summary

The participants from the TAPS and the Community Mental Health Services group were similar in terms of age, gender, parent lost, and marital status. The TAPS group had somewhat more education, higher income levels, and fewer children than the Central Community Mental Health Services group. For the purposes of analyzing the data, all the participants were combined into one group. The following are the descriptive statistics for all 55 participants.

Descriptive Statistics: All Participants

Participant Parents' Age

The parents participating in the study ranged in age from 23 to 68 years with a mean of 40.8 and a standard deviation of 9.42. The data is presented graphically in Figure 17.

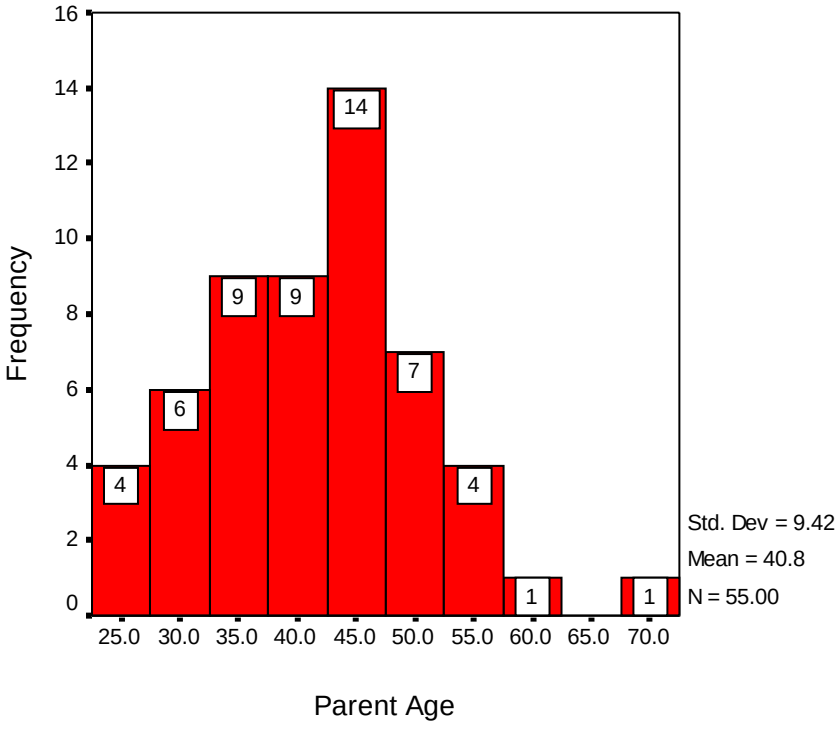

Figure 17. Participant parents' age.

Parents' Gender

There were a total number of 49 females (89%) and 6 males (11%) who participated in the study. The data is presented graphically in Figure 18 and 19.

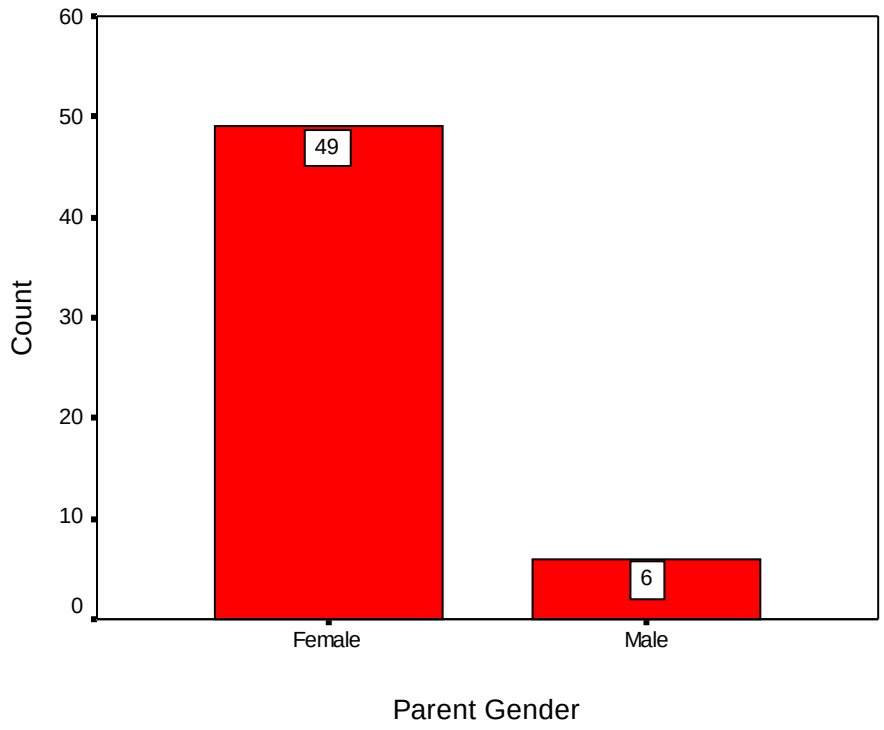

Figure 18. Participant parents' gender (count).

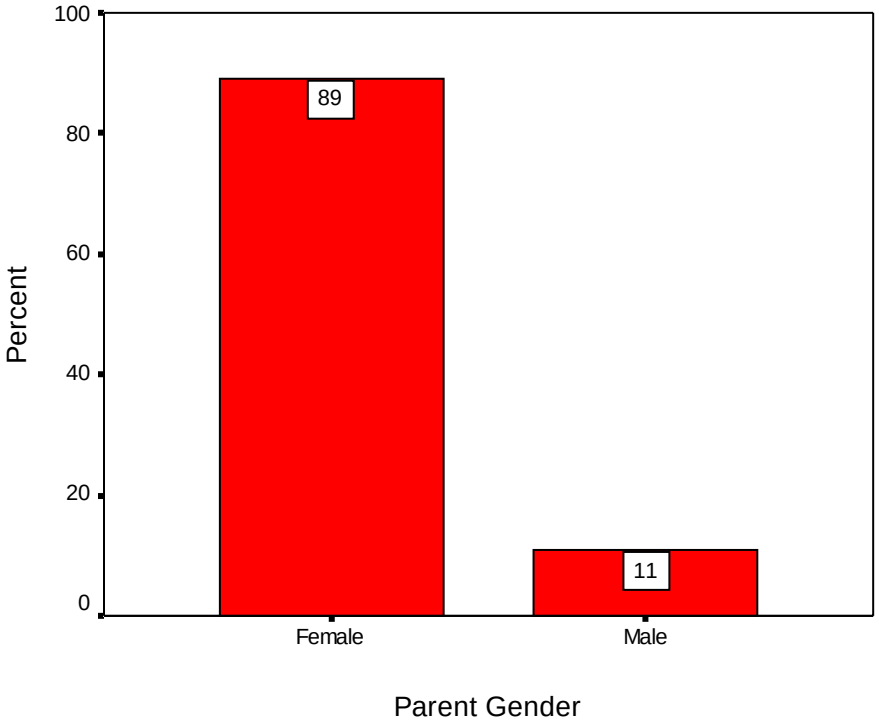

Figure 19. Participant parents' gender (percentage).

Year of Loss

The year of the loss of the deceased parents ranged from 2002 through 2009, with the highest number in 2007. The data is presented graphically in Figure 20.

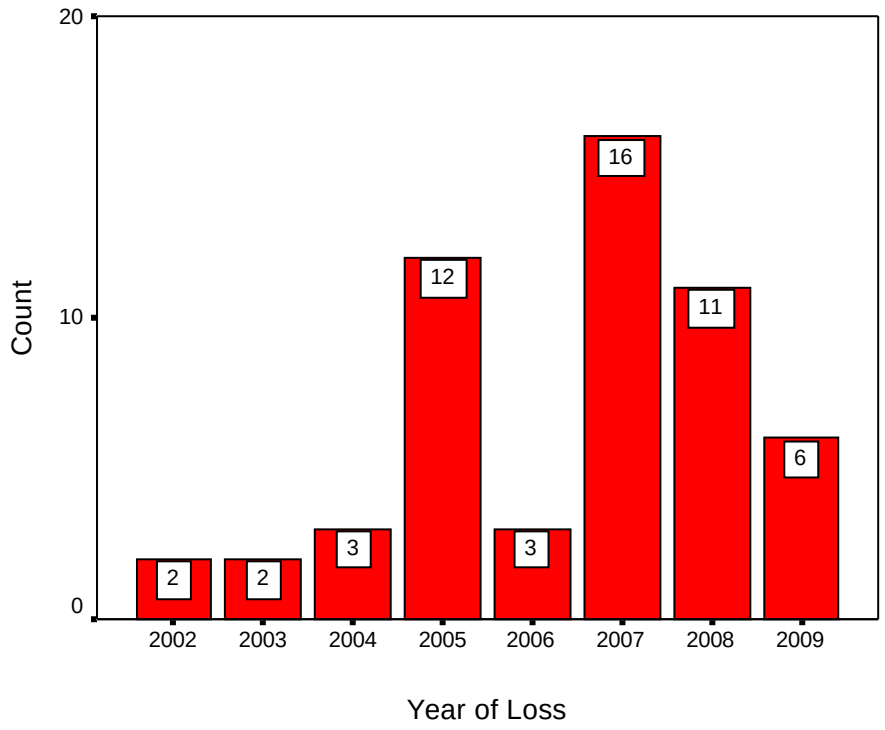

Figure 20. Year of loss.

Gender of the Parent Lost

Among the children in this study, 42 children lost their fathers (76%) and 13 children lost their mothers (24%) as shown in Figures 21 and 22.

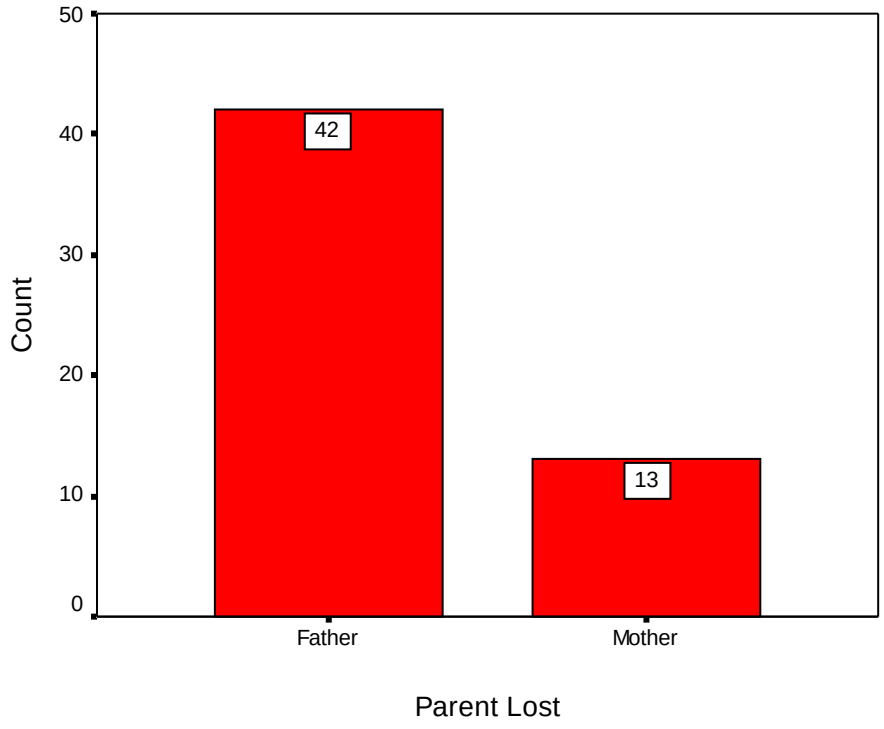

Figure 21. Gender of the parent lost (count).

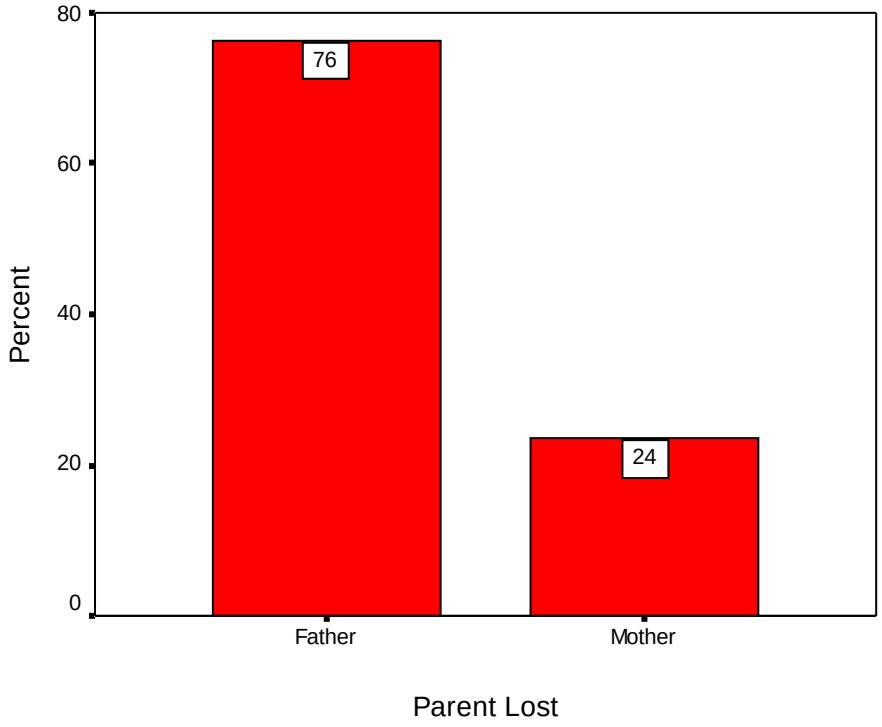

Figure 22. Gender of the parent lost (percentage).

Cause of Death

The highest percentage for cause of death reported was due to accident (40%). The number reported for illness and combat was 29% and 20%, respectively, and the number reported for loss due to homicide and suicide was evenly distributed at 5%. The results are shown in Figure 23.

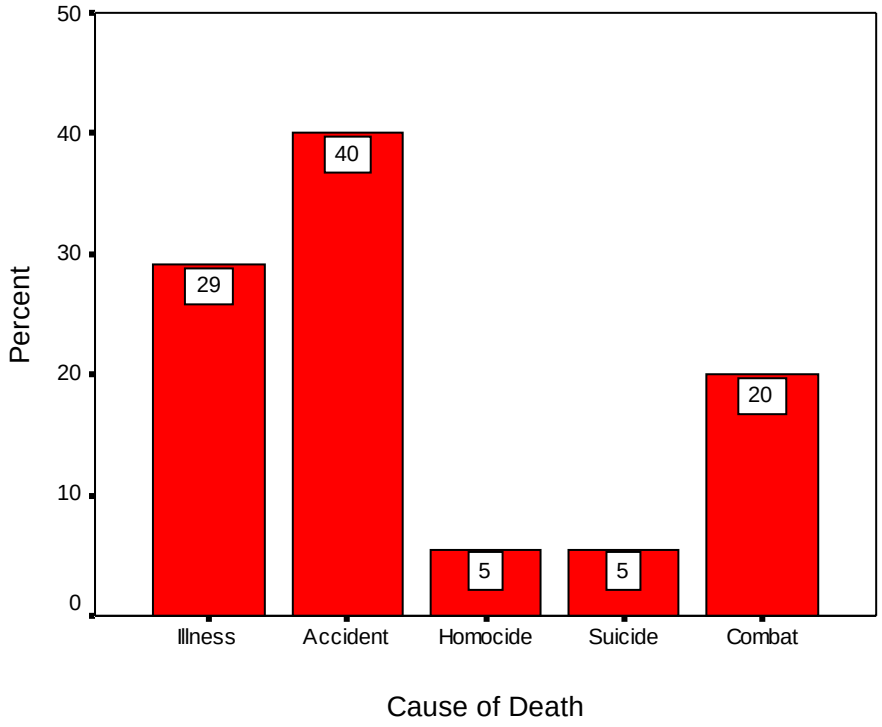

Figure 23. Cause of death.

Participant Parents' Marital Status

Fifty-one percent of the participants in the study were widowed, 27% were single, 16% were married, and 5% were divorced. The results are shown in Figure 24.

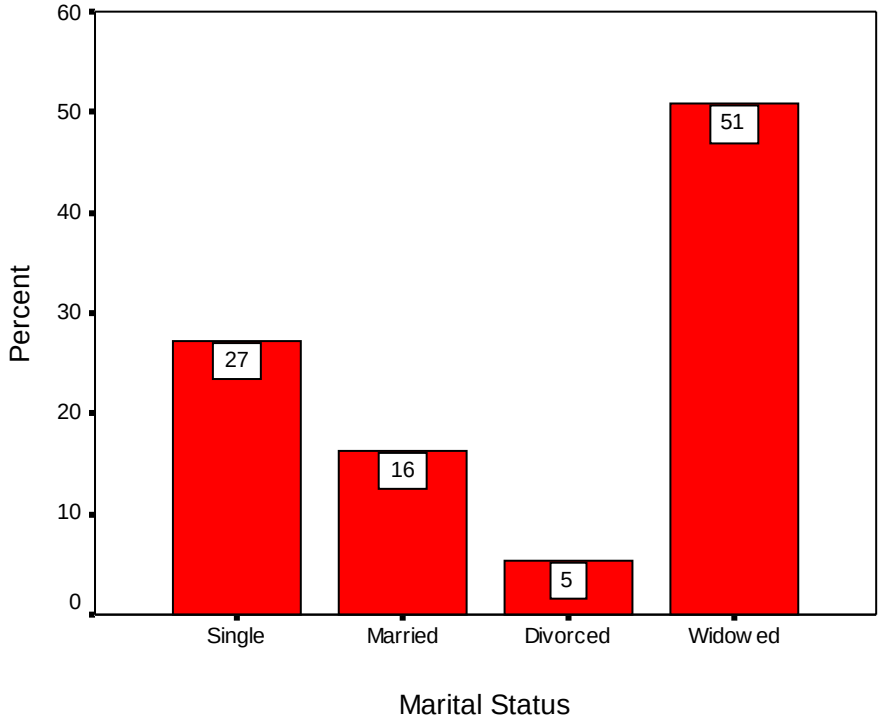

Figure 24. Participant parents' marital status.

Participant Parents' Work Status

Thirty percent of the participants were employed part time 26% were never employed, 23% were employed full time, and 21% were unemployed at the time of the study. The results are presented in Figure 25.

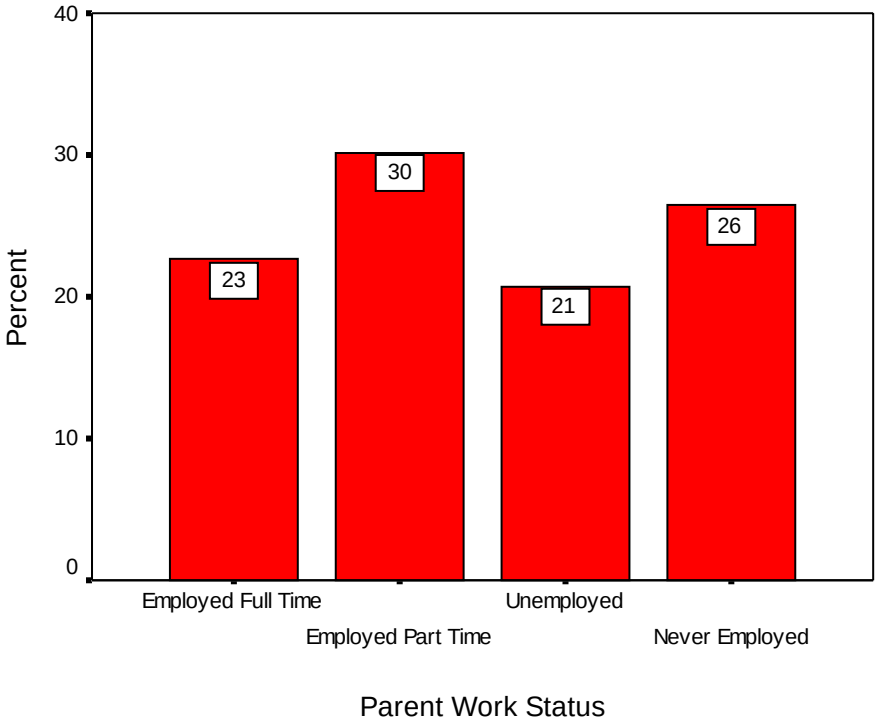

Figure 25. Participant parents' work status.

Participant Parents' Educational Level

Forty-five percent of the participants had less than a high school degree, 5% had a high school diploma, 31% had some college education, 13% had a GED, and 5% had a postgraduate degree. The results are represented in Figure 26.

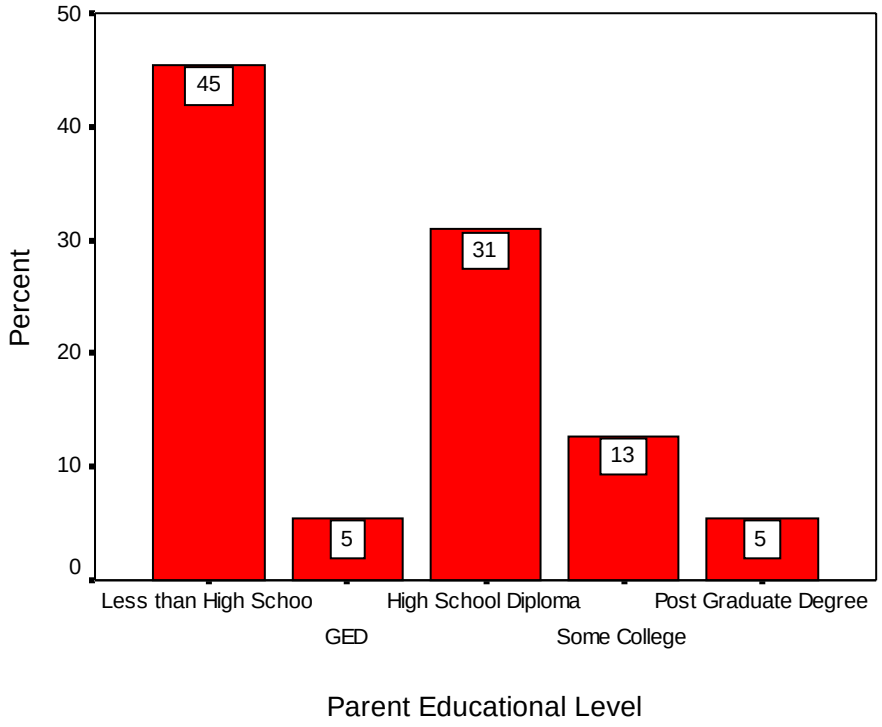

Figure 26. Educational level.

Participant Parents' Annual Income Level

The highest percentage (44%) of the participants' income level was less than $10,000. The income levels are shown in Figure 27.

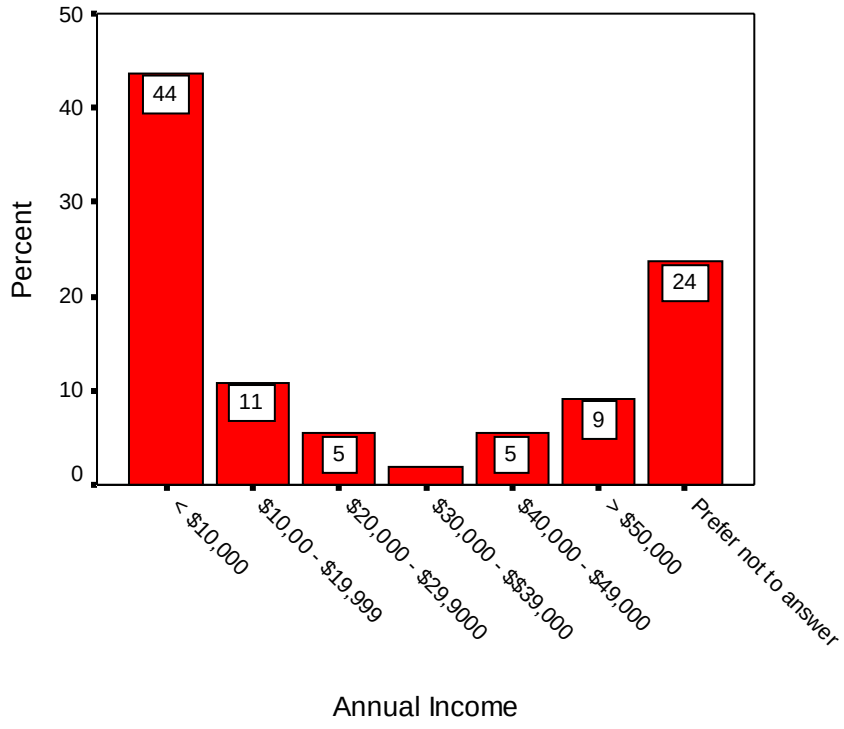

Figure 27. Income level.

Participant Parents' Race/Ethnicity

The majority of the participants were Caucasian (42%). Hispanic and Other were at 15% each, African-American and Asian was 13% each, and there were 4% Lebanese participants. The results are presented in Figure 28.

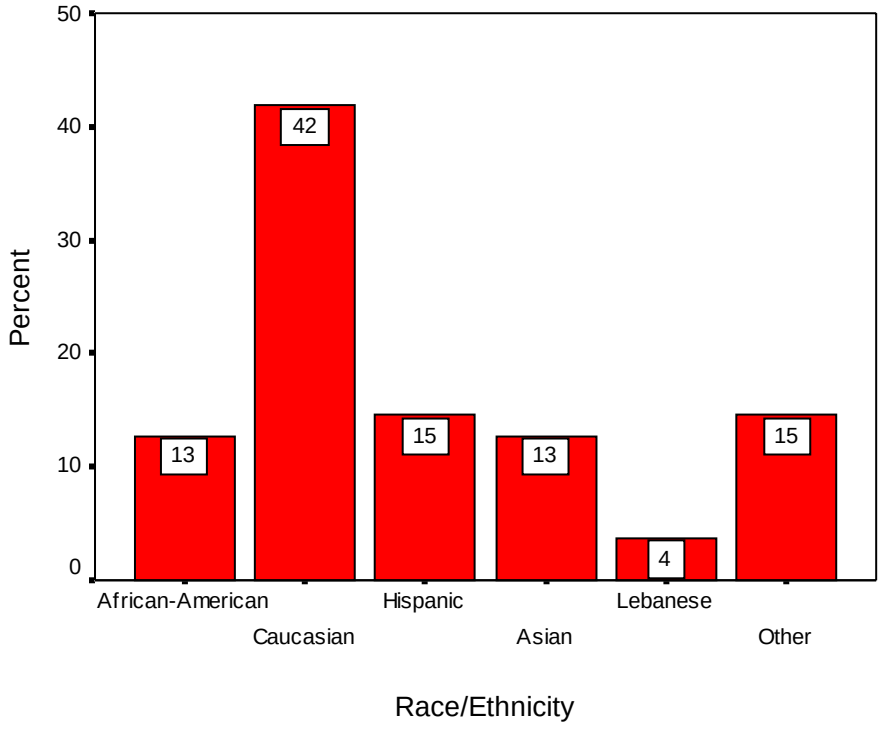

Figure 28. Ethnicity of the participant parents.

Child's Gender

The gender of the children in the study was almost evenly distributed with 51% males and 49% females as shown in Figure 29.

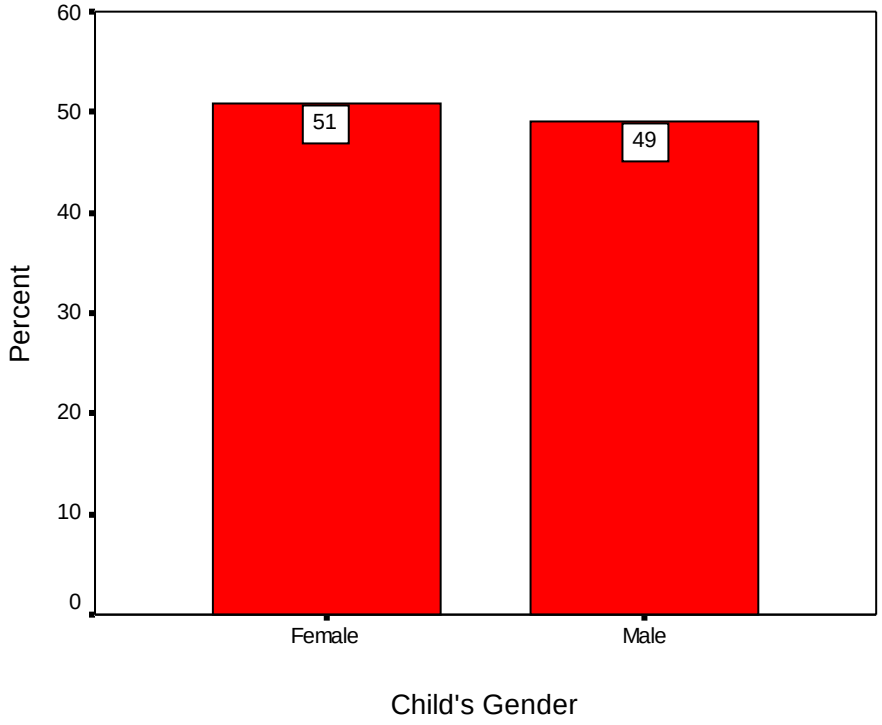

Figure 29. Gender of the children.

Child's Age

The children of the participants in the study ranged in age from 1.5 to 18 years old, with the mean 10.0 and standard deviation of 4.50. The results are presented in Figure 30.

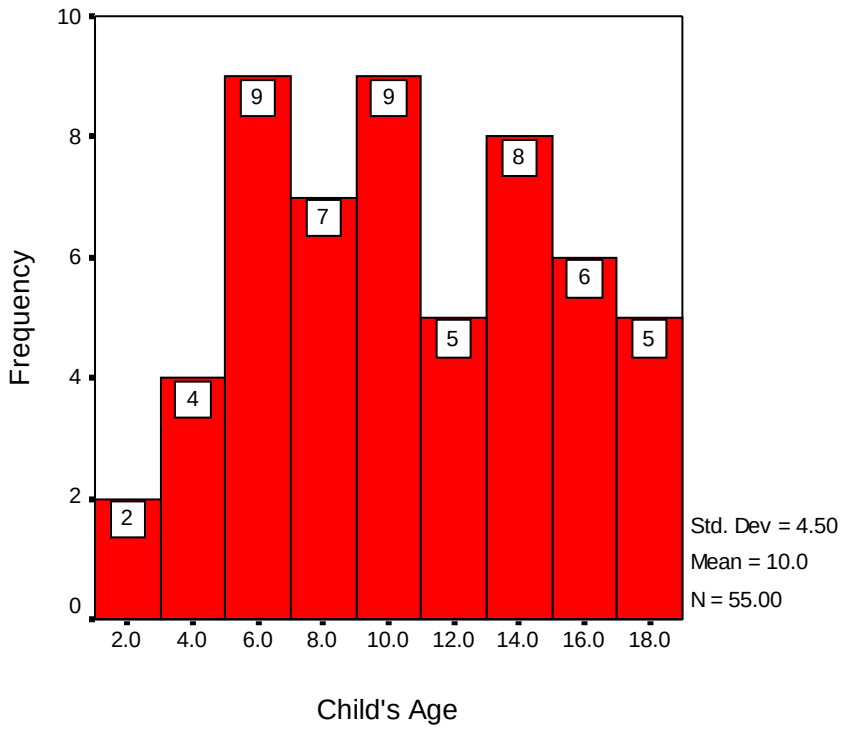

Figure 30. Ages of the children.

Number of Siblings

Thirty-one percent of the children had one sibling, 33% had two siblings, 18% had three siblings, 11% had 4 or more siblings, and 7% were the only child in the family. Figure 31 presents the results graphically.

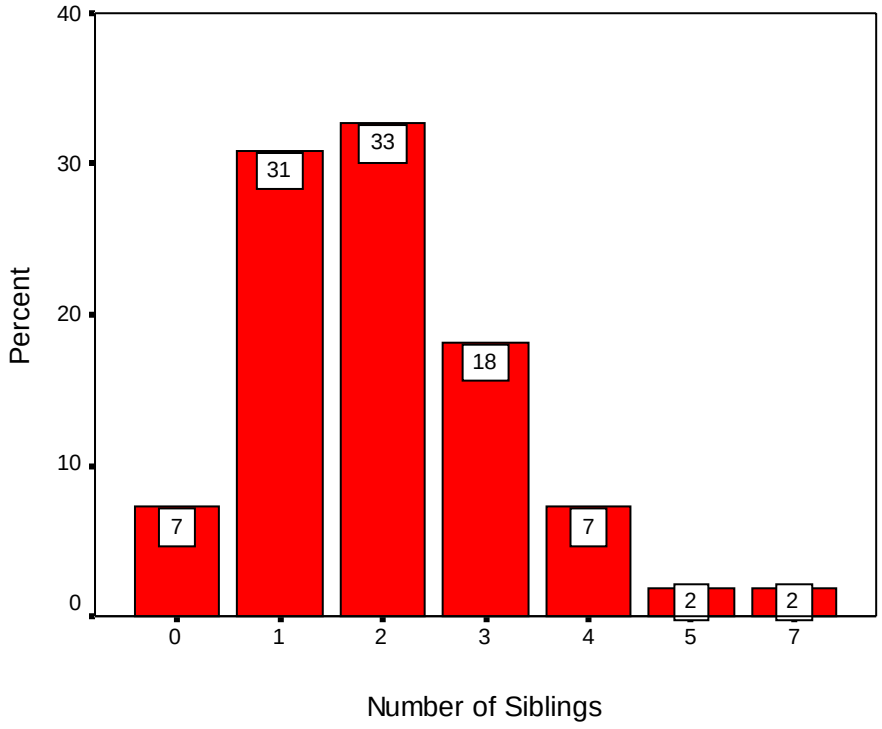

Figure 31. Number of siblings.

Grade Level of the Child

The children in the study ranged from not being in school to being in grade 12. The results are presented in Figure 32.

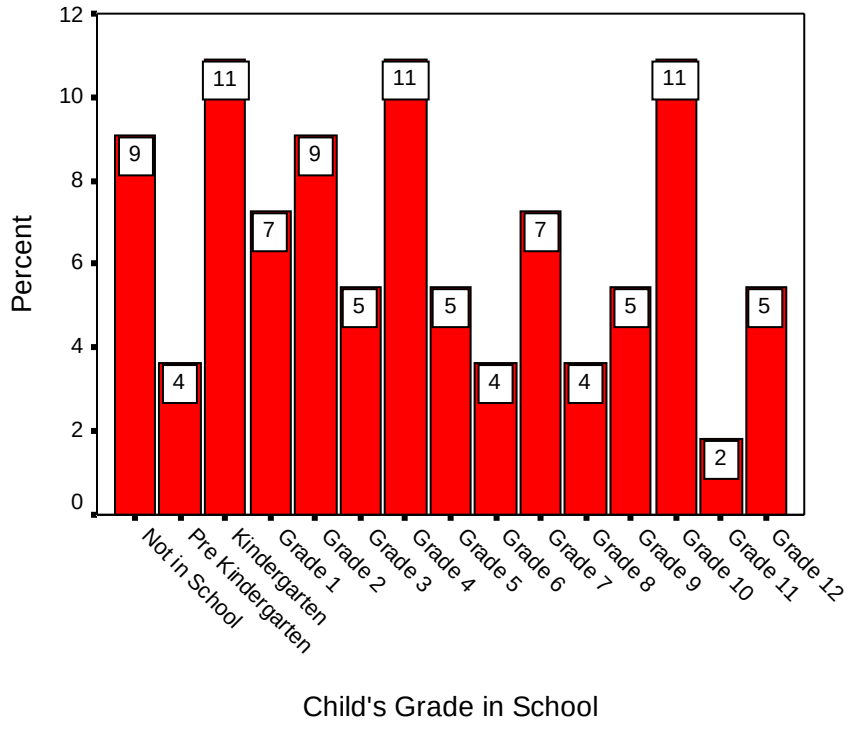

Figure 32. Grade level of the children.

Inferential Statistics

The Family Attachment and Changeability scale (FACI8), is a self administered questionnaire that consists of two subscales, Attachment and Changeability. Attachment is an 8-item scale designed to determine the strength of family members' attachment to each others. Changeability is an 8-item scale designed to determine how flexible the family members are in their relationships with each other.

Pearson correlation coefficients were computed to determine if any significant relationships existed between Resiliency in Children and the two subscales of the FACI8, Attachment and Changeability. In order to control the overall Type I error, the level of significance was set to .05 for the correlational analyses.

Research Question 1: What is the relationship between family attachment and resiliency of children who have lost a parent?

Hypothesis 1: Family attachment is positively correlated with resiliency in children.

The correlation between the family attachment subscale and child resiliency was significant ($r\ (55) = .308$, $p < .05$). The coefficient of determination (R^2) was .094, indicating that 9% of the variance in child resiliency was accounted for by family attachment. Therefore, the first hypothesis was accepted. The results are presented in Table 1.

Table 1.

Family Attachment and Resiliency Correlation

Correlations

		Child Resiliency
Family Attachment	Pearson Correlation	.308*
	Sig. (1-tailed)	.011
	N	55

*. Correlation is significant at the 0.05 level (1-tailed).

The correlation between the changeability subscale and child resiliency was significant ($r(55) = .233$, $p < .05$). The coefficient of determination (R^2) was .054, indicating that 5% of the variance in child resiliency was accounted for by changeability. The results are presented in Table 2.

Table 2.

Changeability and Resiliency Correlation

Correlations

		Child Resiliency
Changeability	Pearson Correlation	.233*
	Sig. (1-tailed)	.043
	N	55

*. Correlation is significant at the 0.05 level (1-tailed).

Research Question 2: What is the relationship between family attachment and behavioral functioning of children who have lost a parent?

Hypothesis 2: Family attachment and behavioral functioning of the children are negatively correlated.

The correlation between the family attachment subscale and externalizing behavior problems on the Child Behavior Checklist was significant ($r (55) = -.239$, $p < .05$). The coefficient of determination (R^2) was .097, indicating that 10% of the variance in total behavior problems was accounted for by family attachment. The correlation between the family attachment subscale and total behavior problems on the child behavior checklist was also significant ($r (55) = -.313$, $p < .05$). The coefficient of determination (R^2) was .057, indicating that 6% of the variance in total behavior problems was accounted for by family attachment. Therefore, the second hypothesis was accepted. The results are presented in Table 3.

Table 3.

Family Attachment and Child Behavior Checklist Correlations

Correlations

		Internalizing Problems	Externalizing Problems	Total Problems
Family Attachment	Pearson Correlation	-.184	-.239*	-.313*
	Sig. (1-tailed)	.090	.039	.010
	N	55	55	55

*. Correlation is significant at the 0.05 level (1-tailed).

The correlation between the changeability subscale and externalizing behavior problems on the child behavior checklist was significant ($r (55) = -.251$, $p < .05$). The

coefficient of determination (R^2) was .063, indicating that 6% of the variance in total behavior problems was accounted for by changeability. The correlation between the changeability subscale and total behavior problems on the child behavior checklist was significant ($r(55) = -.296$, $p < .05$). The coefficient of determination (R^2) was .087, indicating that 9% of the variance in total behavior problems was accounted for by changeability. The results are presented in Table 4.

Table 4

Changeability and Child Behavior Checklist Correlations

Correlations

		Internalizing Problems	Externalizing Problems	Total Problems
Changeability	Pearson Correlation	-.109	-.251*	-.296*
	Sig. (1-tailed)	.215	.032	.014
	N	55	55	55

*. Correlation is significant at the 0.05 level (1-tailed).

Research Question 3: What is the relationship between family hardiness and resiliency of children who have lost a parent?

Hypothesis 3: Family hardiness and resilience in children are positively correlated.

The correlation between the family hardiness and child resiliency was significant ($r (55) = .435$, $p < .01$). The coefficient of determination (R^2) was .19, indicating that 19% of the variance in child resiliency was accounted for by family hardiness. Therefore, the third hypothesis was accepted. The results are presented in Table 5.

Table 5.

Family Hardiness and Child Resiliency Correlation

Correlations

		Child Resiliency
Family Hardiness	Pearson Correlation	.435**
	Sig. (1-tailed)	.001
	N	55

**. Correlation is significant at the 0.01 level (1-tailed).

Research Question 4: What is the relationship between family hardiness and behavioral functioning of children who have lost a parent?

Hypothesis 4: Family hardiness and behavioral problems in children are negatively correlated.

The correlation between family hardiness and internalizing behavior problems on the child behavior checklist was significant ($r(55) = -.281$, $p < .05$). The coefficient of determination (R^2) was .079, indicating that 8% of the variance in total behavior problems was accounted for by family hardiness. The correlation between family hardiness and total behavior problems on the child behavior checklist was significant ($r(55) = -.314$, $p < .01$). The coefficient of determination (R^2) was .099, indicating that 10% of the variance in total behavior problems was accounted for by family hardiness. Therefore, the fourth hypothesis was accepted. The results are presented in Table 6.

Table 6.

Family Hardiness and Child Behavior Checklist Correlations

Correlations

		Internalizing Problems	Externalizing Problems	Total Problems
Family Hardiness	Pearson Correlation	-.281*	-.189	-.314**
	Sig. (1-tailed)	.019	.083	.010
	N	55	55	55

*. Correlation is significant at the 0.05 level (1-tailed).

**. Correlation is significant at the 0.01 level (1-tailed).

Research Question 5: What is the relationship between family social support and resiliency of children who have lost a parent?

Hypothesis 5: Family social support and resilience in children are positively correlated.

The correlation between social support and child resiliency was significant ($r(55) = .363$, $p < .01$). The coefficient of determination (R^2) was .131, indicating that 13% of the variance in child resiliency was accounted for by family social support. Therefore, the fifth hypothesis was accepted. The results are presented in Table 7.

Table 7.

Family Social Support and Child Resiliency Correlation

Correlations

		Child Resiliency
Social Support	Pearson Correlation	.363**
	Sig. (1-tailed)	.003
	N	55

**. Correlation is significant at the 0.01 level (1-tailed).

Research Question 6: What is the relationship between family social support and behavioral functioning of children who have lost a parent?

Hypothesis 6: Family social support and behavioral functioning in children are negatively correlated

Family social support did not correlate significantly with child problematic behaviors as measured by the Child Behavior Checklist. Therefore, the sixth hypothesis was not accepted. The results are presented in Table 8.

Table 8.

Family Social Support and Child Behavior Checklist Correlations

Correlations

		Internalizing Problems	Externalizing Problems	Total Problems
Social Support	Pearson Correlation	-.143	-.078	-.095
	Sig. (1-tailed)	.149	.285	.244
	N	55	55	55

Research Question 7: What is the relationship between family attachment and family hardiness in families who have lost a parent?

Hypothesis 7: Family attachment is associated with increased family hardiness.

The correlation between the family attachment subscale and family hardiness was significant ($r (55) = -.391$, $p < .01$). The coefficient of determination (R^2) was .152, indicating that 15% of the variance in family hardiness was accounted for by family attachment. Therefore, the seventh hypothesis was accepted. The results are presented in Table 9.

Table 9.

Family Attachment and Family Hardiness Correlation

Correlations

		Family Hardiness
Family Attachment	Pearson Correlation	.391**
	Sig. (1-tailed)	.002
	N	55

**. Correlation is significant at the 0.01 level (1-tailed).

The correlation between the changeability subscale and family hardiness was significant ($r (55) = -.451$, $p < .01$). The coefficient of determination (R^2) was .203, indicating that 20% of the variance in family hardiness was accounted for by family attachment. The results are presented in Table 10.

Table 10.

Changeability and Family Hardiness Correlation

Correlations

		Family Hardiness
Changeability	Pearson Correlation	.451**
	Sig. (1-tailed)	.001
	N	55

**. Correlation is significant at the 0.01 level (1-tailed).

Research Question 8: What is the relationship between family attachment and family social support in families who have lost a parent?

Hypothesis 8: Family attachment is associated with increased social support.

Family attachment did not correlate significantly with family social support, (r (55) = -.040 p = .387). Therefore, the eighth hypothesis was not accepted. The results are presented in Table 11.

Table 11.

Family Attachment and Social Support Correlation

Correlations

		Social Support
Family Attachment	Pearson Correlation	.040
	Sig. (1-tailed)	.387
	N	55

Changeability did not correlate significantly with family social support, (R (55) = -.090 p = .256). Table 12 presents the results.

Table 12.

Changeability and Social Support Correlation

Correlations

		Social Support
Changeability	Pearson Correlation	-.090
	Sig. (1-tailed)	.256
	N	55

Research Question 9: What is the relationship between family hardiness and family social support in families who have lost a parent?

Hypothesis 9: Family hardiness and family social support in families who have lost a parent are positively correlated.

The correlation between the family hardiness and family social support was significant ($r(55) = -.660$, $p < .01$). The coefficient of determination (R^2) was .435, indicating that 43% of the variance in family social support was accounted for by family hardiness. Therefore, the ninth hypothesis was accepted. Table 13 presents the results.

Table 13.

Family Hardiness and Social Support Correlation

Correlations

		Social Support
Family Hardiness	Pearson Correlation	.660**
	Sig. (1-tailed)	.001
	N	55

**. Correlation is significant at the 0.01 level (1-tailed).

Summary

The primary purpose of this study was to investigate the relationship between family attachment, family hardiness, and family social support to resiliency and behavioral functioning of children who have lost a parent. A secondary purpose was to investigate the interrelationship between the three variables of family attachment, family hardiness, and family social support in families who have lost a parent. Of the nine hypotheses, the results found support for seven.

Significant positive correlational relationships were found between child resiliency and the variables of family attachment, changeability, family hardiness, and family social support. A non-significant positive correlation was found between child resilience and social support.

Significant negative correlations were found between problematic behaviors as measured by the Child Behavior Checklist and family attachment, changeability, and family hardiness. Social support correlated negatively with problem behaviors but the correlation was not significant. Family hardiness correlated positively with family attachment and family social support, and the correlations were significant. Family attachment and changeability correlated positively with social support, but the correlations were not significant. Findings are discussed in Chapter 5.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Parental death is considered one of the most significant and stressful events for children and their families. When a parent dies it affects each member of the family and the family as a whole. The death of a parent affects a child's self-concept, health, social, and economic circumstances. How the surviving parent copes with the loss of their partner affects the way their children work with the tasks of grieving (Steen, 1998). The need for mental health providers to understand the grief process has been on the rise since the tragic incident on September 11, 2001. Thousands of civilians, military personnel, and rescue people have been killed through acts of terrorism, crimes, and natural deaths. Many of them left behind children who are now grieving the loss of their caregiver, mother, father, or both parents.

Several studies have been exploring the grieving process in children who have suffered parental death. Consensus about how children deal with the loss of a parent has been difficult to reach. Salver and Skoinick (1992) looked at adults who in their childhood experienced the death of a parent. In their study, they explored the quality of parenting by the surviving parent and the type of environment that was present after the parent's death. They also examined the subjects' perceptions of their relationships with the surviving parent and the nature of the family environment. Early research (Furman, 1974) painted vivid portraits of the inner pain and confusion experienced by a young child when a parent dies. These studies yielded findings that supported the view of the vulnerability of children to this stressful event (Bonano, 2004). This point of view has been called into question by several authors who contend that these earlier findings were

based on non representative groups of children and did not use objective, standardized assessment measures (Kranzler et al., 1990; Van Eerdewegh et al., 1982; Weller et al., 1991; Worden, 1996). Later studies have shown that parentally bereaved children exhibited considerable resilience one year after the bereavement as judged by commonly used indicators (Siegel et al., 1996). Discrepancies in the results of studies of children's reactions to parental loss have led a new approach for exploring the resilience of children who suffer the loss of a parent. The focus has shifted from treating the problem to understanding the underlying causes of the problem.

Bereavement research in the last decades has been carefully examining the underlying causes of resilience displayed, versus problem exacerbated, in bereaved children (Antonovski & Sourani, 1998; Boss, 1991; Elizur & Kaffman, 1982; Hope & Hodge, 2006). The goal of this study was to increase understanding of the importance of the positive factors: parental attachment, family hardiness, and social support, in time of loss, to predict resilience in children and avoid internalized and externalized behavior problems.

Restatement of the Methodology

The research for this study was causal-comparative research, an investigation of possible cause and effect relationships made possible by observing some existing consequences and searching back through the data for plausible causal factors (Isaac & Michael, 1997). The participants in this study were recruited from the following organizations: Tragedy Assistance Program for Survivors (TAPS), and the Central Community Mental Health Services in Brevard County. The participants recruited for this study from both resources were receiving mental health support. TAPS participants were

active members in Good Grief Camps and the Central Community Mental Health Services participants were receiving therapeutic services provided by the mental health practitioners within the Central Community Mental Health Services organization. The families selected for this study included one or more children between the ages of 1.5 and 18 years who had lost one of their parents to death; the parental death was within the last seven years.

The data was collected using five self-administered scales: The Family Attachment and Changeability Index (FACI8), the Family Hardiness Index (FHI), the Social Support Index (SSI), the Child Behavior Checklist (CBCL), and the Child Resiliency Scale. A total of 100 packets were distributed for both groups, 66 packets were returned (66% return rate). The data from eleven participants from both groups were not used due to incomplete materials in their returned packets. Data was analyzed on 55 participants from both groups. Descriptive statistics were computed for the demographic variables of parent age, parent gender, year of loss, parent lost, cause of death, marital status, parent educational level, parent work status, annual income, race/ethnicity, child's age, child's gender, number of siblings, and child's grade in school. Pearson correlation coefficients were computed to determine if any significant relationships existed between family attachment, family hardiness, and family social support, and resiliency and behavioral functioning of children who had lost a parent. In order to control the overall Type I error, the level of significance was set to .05 for the correlational analyses.

Discussion

There were nine research questions guiding this study. Research Question 1: What is the relationship between family attachment and resiliency of children who have

lost a parent? Hypothesis 1: Family attachment is positively correlated with resiliency in children. The correlational analysis between the family attachment and changeability scale and resiliency in children was positive and significant; Hypothesis 1 was accepted. The correlation revealed that 9% of the child resiliency was accounted for by family members' attachment to each other, and 5% was accounted for by family members' flexibility in their relationships with each other when facing a problem.

Research Question 2: What is the relationship between family attachment and behavioral functioning of children who have lost a parent? Hypothesis 2: Family attachment and behavioral functioning of the children are negatively correlated. The results were significant and Hypothesis 2 was accepted. This correlation indicated that 10% of the externalized behaviors exhibited by children were accounted for by family attachment and 9% were accounted for the ability families' ability to be flexible when facing problems in life such the death of a loved one.

These results reveal that in time of loss, families with healthy attachment and flexibility in dealing with problems have children who are resilient and exhibit fewer behavioral problems. These results are in accordance with previous research (Rutter, 1987; Walsh, 1998) that found the degree of family security (attachment and changeability) positively correlated with resiliency in children and successful coping with a crisis. Family attachment and flexibility in facing problems within such families draws from the strengths that unite them together-their attachment to each other, their flexibility in facing problems–and helps them to deal with the loss of the loved one with whom they share a bond. The results of this study suggest that in a time of loss these assets help families stay together and remain connected, allowing the focus to be on the children,

who absorb the positive attention, and reciprocate with positive behaviors and increased resilience. The results of this study corroborate previous studies that have found a positive relationship between insecurity of attachment and internalizing and externalizing behavior problems (Goldberg, Gotowiec, & Simmons, 1995).

Research Question 3: What is the relationship between family hardiness and resiliency of children who have lost a parent? Hypothesis 3: Family hardiness and resilience in children are positively correlated. The correlation was significant, thus Hypothesis 3 was accepted.

Research Question 4: What is the relationship between family hardiness and behavioral functioning of children who have lost a parent? Hypothesis 4: Family hardiness and behavioral problems in children are negatively correlated. This correlation was significant, and Hypothesis 4 was accepted. Nineteen percent of the resiliency in children was accounted for by family hardiness, and ten percent of the children's behavior problems were accounted for by family hardiness.

Family hardiness measures the internal strength and durability of the family and sense of control over the outcome of life events and hardship. Family hardiness consists of characteristics a family possesses to resist stress and adapt resources that are believed to assist in facilitating family adjustment and adaptation over time. These characteristics are the measure of the degree of commitment, confidence, challenge, and control the family unit has developed over the years. This explicates the finding of a positive effect of hardiness in a family in the development of resilience in children. On the other hand, the lack of the family hardiness accounts for the increase in behavioral issues in the

children as the family constellation is charged with fear, and lack of security in the family's ability to preserve the foundation built before facing stressful events.

Research Question 5: What is the relationship between family social support and resiliency of children who have lost a parent? Hypothesis 5: Family social support and resilience in children are positively correlated. The correlation between social support and resiliency in children was positive and significant; therefore the fifth hypothesis was accepted. Thirteen percent of the resiliency in children was accounted for by social support. Social support is viewed as an important factor for family resilience (McCubbin, Patterson et al., 1996). Previous studies have emphasized the importance of social support as a buffer against family crisis and as a factor in promoting family recovery (Reed & Sherkat, 1992).

Research Question 6: What is the relationship between family social support and behavioral functioning of children who have lost a parent? Hypothesis 6: Family social support and behavioral functioning in children are negatively correlated. Family social support did not correlate significantly with child problematic behaviors as measured by the Child Behavior Checklist. Therefore, the sixth hypothesis was not accepted. Examined closely, these results imply that social support enhances the resiliency in children but the lack of it does not exacerbate the behavioral problems in children.

Research Question 7: What is the relationship between family attachment and family hardiness in families who have lost a parent? Hypothesis 7: Family attachment is associated with increased family hardiness. The correlation between the family attachment and changeability scale and family hardiness was significant indicating that 15% of the variance in family hardiness was accounted for by family attachment and 20%

was accounted for by changeability. Therefore, the seventh hypothesis was accepted.

Attachment and support between the family members creates a safeguard against the aftermath of a loss, and facilitates the adaptation and adjustment of the family. Such affirmation is supported by previous research (Olsen et al., 1982) as well as by the results obtained from this study.

Research Question 8: What is the relationship between family attachment and family social support in families who have lost a parent? Hypothesis 8: Family attachment is associated with increased social support. The correlation between family attachment and social support was not significant, and therefore Hypothesis 8 was not accepted. In this study, the sample tested was receiving supportive therapeutic interventions which means the negative results in relation to this question need to be interpreted tentatively. The lack of correspondence between family attachment and social support in this study may be due to other factors. It could be that in this specific sample, the support they were receiving by being in counseling or receiving other support services superseded the need for social support from their community. It could also be that family social support does not have a significant relationship to family attachment if family attachment is dependent on established parenting styles and family members' personalities, rather than outside influences.

Research Question 9: What is the relationship between family hardiness and family social support in families who have lost a parent? Hypothesis 9: Family hardiness and family social support in families who have lost a parent are positively correlated. This correlation was significant, with 43% of the variance in family support being accounted for by family hardiness. This large R^2 value indicates a strong relationship

between these two variables. It may be that social support increases family hardiness, that families with internal strength and durability and a sense of control over outcomes of life events and hardships are better able to obtain community support, or these variables may have a synergistic effect on each other.

Conclusion

The aim of this study was to identify and explore factors that have the potential to assist families to adapt and adjust to the loss of one of the caregivers. Previous researchers have found that families with a strong sense of coherence adjust better after a crisis (Lin, Sandler, Ayers, Wolchick, & Luecken, 2004). The results of this study indicate that family attachment, changeability, family hardiness, and social support are associated with increased resilience and decreased behavioral problems in children. These variables may be mediating factors that explain why family coherence is related to better adjustment after the loss of a parent.

Implications for Family Therapy

The family therapist can contribute on several levels. On the individual level, interventions should focus on the loss and the bereavement of the individual family members. An indication of success will be the degree to which the child increasingly accepts the loss and shows the ability to live a fulfilling and productive life. On the family level, the therapeutic goals would be the strengthening of family relations, adjustment, and utilization of internal and external resources in order to foster resiliency. The degree to which a family succeeds will likely be reflected in their personal and family well-being. The assessment of the families dealing with loss will be a critical component. The assessment of the three constructs used in this study will help reveal the

degree of the parent-child attachment, the family hardiness, and the family social support. Such assessment will provide the base to explore the parent-child attachment style to include the attachment to the deceased parent and the attachment to the surviving parent, the strengths the family has, as well as valuable information about the values and belief system of the family. The information collected will help customize the interventions to be used on the individual level as well as the family. In terms of prevention, family therapists could provide services to families who are at risk of losing a parent, for example, those who have a family member in the military, law enforcement, or emergency services, or families who are dealing with a parent diagnosed with a terminal illness.

Recommendations for Future Research

While this research data supported the position that there is a relationship between family attachment, family hardiness, family social support, and child resiliency and behavior problems, it is important to remember that there may be long term consequences of the loss or symptoms that manifest themselves later in the bereavement process. For example delayed grief responses (i.e., complicated mourning) have been observed in adults 2 or 3 years after the loss of a loved one (Worden, 1991). In addition, studies of adults who suffered the loss of a parent in childhood suggest they may evidence poorer adult adjustment than those who did not experience such a loss (Osterweiss et al., 1984). Thus, children studied in this research may appear resilient and healthy functioning in the short term but they may remain at risk for later emotional problems. This possibility suggests the importance of longitudinal research and long time follow up on bereaved children. Future studies should also explore the parental death effect in relation to child

gender, age, and birth order. Finally, the social support effect should be explored further in more specific facets such as values, belief, and religion since they are prime factors in the construct of the family attachment and family relationships.

As a correlational study, this study cannot clearly determine cause and effect. Future studies are needed to assess what counseling techniques facilitate the development of family attachment, family hardiness, and family social support. Then, the findings of these studies should be investigated in an experimental study that looks at two or more groups and measures the effectiveness of these techniques in fostering child resiliency and reducing behavior problems for children who have lost a parent.

Summary

The death of a parent is one of the most serious stressors that can occur to children. In addition to the traumatic loss of a parent, the bereaved child often experiences changes in multiple other domains of their lives: changes in caregiver, family, school, and friends (Thompson et al., 1998). A number of studies provide evidence of elevated mental health problems in bereaved children (Dowdney, 2000; Lutzke, Ayers, Sandler, & Barr, 1997); however, other studies have not found a relation between parentally bereaved children and mental health problems (Chase-Lansdale, Mott, Brooks-Gunn, & Phillips, 1991). Rather, they found children under such traumatic circumstances showed positive outcomes in the face of adversity.

This study considered bereaved children who had experienced a major adversity and investigated the relationship of family attachment, family hardiness, and family social support to resiliency and behavioral functioning of these children. Of the nine hypotheses, the results found support for seven. Significant positive correlational

relationships were found between child resiliency and the variables of family attachment, changeability, family hardiness, and family social support. Significant negative correlations were found between problematic behaviors as measured by the Child Behavior Checklist and family attachment, changeability, and family hardiness. Family hardiness correlated positively with family attachment and family social support, and the correlations were significant. The findings suggest that counselors who work with families who have lost a parent should focus on increasing family attachment, family hardiness, and family social support, in addition to providing grief counseling.

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APPENDIX A

Barry University
Parent Cover Letter

Dear Parent,

I am a Ph.D. student at Barry University. As part of my doctoral dissertation, The Effects of Parental Loss on Children: Disturbance to Resilience, I am conducting a research on families who have a child who has lost a parent due to death. Your voluntary participation in this research project is requested.

The aim of the research is to see if factors such as parental attachment, the family's ability to handle stress, and family support in the community are related to children's behaviors and ability to cope with stress.

In accordance with these aims, the following procedures will be used: completion 6 questionnaires.

If you decide to participate in this research, you will be asked to complete the following, which will take approximately one hour:

- Completion of a Demographic Information Form (5 minutes)
- Completion of five questionnaires that take approximately 45-60 minutes in total to complete:
    - Family Attachment and Changeability Index (5-10 minutes) measures family attachment and functioning
    - Family Hardiness Index (5-10 minutes) measures the characteristics of hardiness as stress resistance and adaptation resources in families.
    - Social Support Index (5 -10 minutes) records the degree to which families find support in their communities.
    - Child Behavior Checklist (15-20 minutes) assesses the competencies and problems of children and adolescents through the use of ratings and reports. This test has two versions, please choose the version age-appropriate for your child and place the unused version back in the package.
    - Child Resiliency Scale (5-10minutes) assesses children's resourceful adaptation to changing circumstances and contingencies.

There will be 40 participants in this study. Participants will be recruited from TAPS Good Grief Camp, and from the Central Community Mental Health organization.

Your consent to be a research participant is strictly voluntary and should you choose to drop out at any time during the study, there will be no adverse effects whatsoever.

If you do not wish to participate this will not impact the services you are receiving in any way. You may skip any questions that you do not wish to answer. The data may still be used in the research.
There are no known risks to you, but if you experience any distress you will be referred to a counselor in your organization / community. Although there are no direct benefits to you, your participation in this study may help our understanding of what factors are associated with children's ability to cope with the loss of a parent.

As a research participant, information you provide will be kept anonymous, that is, no names or other identifiers will be collected on any of the instruments used. Data results will only be reported in aggregate form, with no reference to any specific participant. All data and questionnaires will be kept in locked files in the researcher's office. All data will be destroyed after 5 years in accordance with the Barry University Institutional Review Board guidelines.

If you are interested in participating, please see the designated staff member _____ for the packet of questionnaires. The flyer and the cover letter will indicate the phone number and the email address of the trained staff members designated as the point of contact. The designated staff involved in the data collection has a background in Mental Health and they are affiliated to the organization, employed or contracted.
The designated staff member will take you to a room where you can complete the questionnaires. The designated staff member will be able to answer any questions you may have.
When you are finished, please put all the forms back in the packet, seal the envelope and write the researcher's name **Nawal Aboulhosn** on back of flap where flap meets envelope. Please give the packet to the designated staff.
You can choose to mail the packet to the researcher in the included stamped envelope.

If you have any questions or concerns regarding the study, or your participation in the study, you may contact me, Nawal Aboul-Hosn at (321) 525-1556, The Barry University Chairperson, Dr. Catharina Eeltink, at (321) 235-8401, or the Institutional Review Board point of contact, Ms. Barbara Cook, at (305) 899-3020.

Thank you for your time.

Respectfully yours,

Nawal Aboul-Hosn, MA, LMHC

APPENDIX B

March 4, 2009

To the Central Community Mental Health

Dear Program Manager,

I am a licensed mental health therapist who is completing a doctoral thesis at Barry University to see if factors such as parental attachment, the family's ability to handle stress, and family support in the community are related to children's behaviors and ability to cope with stress.

I am soliciting parents who have a child between the ages of two and eighteen who has lost a parent to death. The parent will be asked to take several standardized tests about their child. This will take approximately 45 minutes.

Would you be willing to post the attached flyer in your school so that I may obtain participants for this study?

Could you let me know in writing that I have your permission to recruit participants for my study through your school in this manner? If you would like to talk to me about this project, I can be reached at 321 525-1556. My email is: supportivecsling@aol.com

Sincerely,

Nawal Aboul-Hosn, LMHC

APPENDIX C

Research Study Flyer

A doctoral research study is being conducted by Nawal S. Aboul-Hosn, MA., LMHC., a doctoral candidate at Barry University in the Adrian Dominican School of Education, investigating the relationship of the parental attachment, family hardiness , and social support to children's behavior and resilience.

If you are the surviving caregiver raising a child who lost a parent, and you are interested in participating in this study or would like more information, please call or email:

Samir Kerolos (Mental Health Counselor) keroloss@bellsouth.net (321) 427-3988

Barbara Johnson(Lisenced Social Worker) BdcsBr@aol.com (321) 626-3780

The designated staff has been working at this agency with children and families for the last 10 years

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Research Study Requirements: One hour of your time to complete the following:

- Completion of a Demographic Information Form (5 minutes)
- Completion of five questionnaires that take approximately 45-60 minutes in total to complete:
    - Family Attachment and Changeability Index (5-10 minutes) measures family attachment and functioning
    - Family Hardiness Index (5-10 minutes) measures the characteristics of hardiness as stress resistance and adaptation resources in families.
    - Social Support Index (5 -10 minutes) records the degree to which families find support in their communities.
    - Child Behavior Checklist (15-20 minutes) assesses the competencies and problems of children and adolescents through the use of ratings and reports. This test has two versions, please choose the version age-appropriate for your child and place the unused version back in the package.
    - Child Resiliency Scale (5-10minutes) assesses children's resourceful adaptation to changing circumstances and contingencies.

Eligibility Requirements:

- You are the surviving parent of a child between the ages of two and eighteen who has lost a parent
- Your child is living in your home with you
- The parental death was within the last four years
- Your participation in this research study is entirely voluntary and the confidentiality of the participants will be carefully protected
- You may drop out of the study at any time without any adverse effects

This is a research study and is not considered a therapeutic session. Confidentiality will be carefully protected.

Participation is entirely voluntary.

Supportive Counseling
931 Pelican Lane
Rockledge, Fl, 32955

APPENDIX D

March 4, 2009

Ms. Bonnie Caroll, TAPS CEO
Tragedy Assistance Program For Survivors
910 17th street, NW Suite 800
Washington, DC 20006

Dear Ms. Caroll,

I am a licensed mental health therapist who is completing a doctoral thesis at Barry University to see if factors such as parental attachment, the family's ability to handle stress, and family support in the community are related to children's behaviors and ability to cope with stress.

I am soliciting parents who have a child (children) between the ages of two and eighteen who has (have) lost a parent to death. The parent will be asked to take several standardized tests about their child. This will take approximately 45 minutes.

Would you be willing to post the attached flyer to your website so that I may obtain participants for this study?

I would also like permission to put a cover letter in the registration packet for each child's packet for the Summer Camp and if a parent is interested, a staff member will facilitate giving the packet to the parent on the registration day and see that a room will be provided for the parent to complete the questionnaire.

Could you let me know in writing that I have your permission to recruit participants for my study through the TAPS organization in this manner? If you would like to talk to me about this project, I can be reached at 321 525-1556. My email is: supportivecsling@aol.com

Sincerely,

Nawal Aboul-Hosn, LMHC

APPENDIX E

Research Study Flyer

A doctoral research study is being conducted by Nawal S. Aboul-Hosn, MA., LMHC., a doctoral candidate at Barry University in the Adrian Dominican School of Education, investigating the relationship of the parental attachment, family hardiness , and social support to children's behavior and resilience.

If you are the surviving caregiver raising a child who lost a parent, and you are interested in participating in this study or would like more information, please call or email:

Jon "Jay" Weidel (Group Leader TAPS) jonjwedel@yahoo.com(302) 697-3639

Judith Mathewson (Group Leader TAPS) jjmathewson@att.net (321) 243-3376

The designated staff has been working with TAPS children and families for the last 10 years

---

Research Study Requirements: One hour of your time to complete the following:

- Completion of a Demographic Information Form (5 minutes)
- Completion of five questionnaires that take approximately 45-60 minutes in total to complete:
  - Family Attachment and Changeability Index (5-10 minutes) measures family attachment and functioning
  - Family Hardiness Index (5-10 minutes) measures the characteristics of hardiness as stress resistance and adaptation resources in families.
  - Social Support Index (5 -10 minutes) records the degree to which families find support in their communities.
  - Child Behavior Checklist (15-20 minutes) assesses the competencies and problems of children and adolescents through the use of ratings and reports. This test has two versions, please choose the version age-appropriate for your child and place the unused version back in the package.
  - Child Resiliency Scale (5-10minutes) assesses children's resourceful adaptation to changing circumstances and contingencies.

Eligibility Requirements:

- You are the surviving parent of a child between the ages of two and eighteen who has lost a parent
- Your child is living in your home with you
- The parental death was within the last four years
- Your participation in this research study is entirely voluntary and the confidentiality of the participants will be carefully protected

- You may drop out of the study at any time without any adverse effects

This is a research study and is not considered a therapeutic session. Confidentiality will be carefully protected.

Participation is entirely voluntary.

APPENDIX F

Research Instruction Form

Dear Parent,

I am thankful that you have agreed to participate in this research!

For your convenience a quiet area is provided with designated staff members from the organization. The designated staff members are trained to answer any questions regarding the forms.

Please take your time to fill out the forms included in the provided packet, and feel free to ask any questions from the designated staff person. If you choose to include more than one child in the research, please ask for another packet.

The Child Behavior Checklist has two age levels. Please complete only your child's age scale disregard the other one, and please return to the packet.

I would like to remind you that you can quit at any time if you chose to, also you may skip any questions you are not comfortable to answer.

When you are finished, please put all the forms back in the packet, seal the envelope and write the researcher's name **Nawal Aboulhosn** on back of flap where flap meets envelope. Please give the packet to the designated staff.

You can choose to mail the packet to the researcher in the included stamped envelope.

If you have any questions or concerns regarding the study, or your participation in the study, you may contact me, Nawal Aboul-Hosn at (321) 525-1556, The Barry University Chairperson, Dr. Catharina Eeltink, at (321) 235-8401, or the Institutional Review Board point of contact, Ms. Barbara Cook, at (305) 899-3020.

Thank you for your time.

Respectfully yours,

Nawal Aboul-Hosn, MA, LMHC

APPENDIX G

Demographic Information Form

Please fill out this demographic survey so that we may obtain some general information about you.
Your responses are confidential.

Please write in (where appropriate) or circle the number of your response.

1. Your age: _____

2. Your gender:
    1. Female
    2. Male

3. Year of loss: _____
    1. Father
    2. Mother

4. Cause of death:
    1. Illness
    2. Accident
    3. Homicide
    4. Suicide
    5. Combat

5. Your marital status:
    1. Single
    2. Married
    3. Separated
    4. Divorced
    5. Widowed
    6. Cohabitating
    7. Domestic Partner

4. Your education level:
    1. Less than High School Diploma
    2. GED (General Education Diploma)
    3. High School Diploma
    4. College
    5. Undergraduate College Degree
    6. Graduate Degree (Master's Degree, Ph.D., J.D., M.D., etc)

5. Current work status:
    1. Employed/Self Employed Full Time
    2. Employed/Self Employed Part Time
    3. Unemployed
    4. Never employed

6. Income:
    1. Less than $10,000 per year
    2. $10,000 to $19,999
    3. $20,000 to $29,999
    4. $30,000 to $39,999
    5. $40,000 to $49,999
    6. $50,000 or more
    7. Prefer not to answer

7. Your race/ethnicity
    1. African-American
    2. Caucasian
    3. Hispanic
    4. Asian
    5. Lebanese
    6. Other (please write it) _____

8. Your child's age _____

9. Your child's gender
    1. Female
    2. Male

9. Number of siblings your child has _____

10. Your child's current grade in school _____

APPENDIX H

FACI8

Decide how well each statement describes what is happening in your family. In the column headed **Now**, circle the number which best describes how often each thing is happening right now. In the column headed **Like**, circle the number which best describes how often you would like each thing to happen in your family.

For example, if you felt that most of the time it is all right for the members of your family to talk about their feelings, you would circle 4 in the **Now** column. After you have finished all the items in the **Now** column, think about how often you would like these things to occur in your family in the future. For example, if you would like for the members of your family to be able to talk about their feelings all the time, you would circle 5 in the **Like** column.

						NOW			
LIKE									
In my family:	Never	Sometimes	Half the time	More than half	Always		Never	Sometimes	Half the time
1. In our family it is easy for everyone to express his/her opinion.	1	2	3	4	5		1	2	3
2. It is easier to discuss problems with people outside the family than with other family members.	1	2	3	4	5		1	2	3
3. Each family member has input in major family decisions.	1	2	3	4	5		1	2	3
4. Family members discuss problems and feel good about the solutions.	1	2	3	4	5		1	2	3
5. In our family everyone goes his/her own way.	1	2	3	4	5		1	2	3
6. Family members consult other family members on their decisions	1	2	3	4	5		1	2	3
7. We have difficulty thinking of things to do as a family.	1	2	3	4	5		1	2	3
8. Discipline is fair in our family.	1	2	3	4	5		1	2	3
9. Family members feel closer to people outside the	1	2	3	4	5		1	2	3

family than to other family members.									
10. Our family tries new ways of dealing with problems.	1	2	3	4	5		1	2	3
11. In our family, everyone shares responsibilities.	1	2	3	4	5		1	2	3
12. It is difficult to get a rule changed in our family.	1	2	3	4	5		1	2	3
13. Family members avoid each other at home.	1	2	3	4	5		1	2	3
14. When problems arise, we compromise.	1	2	3	4	5		1	2	3
15. Family members are afraid to say what is on their minds.	1	2	3	4	5		1	2	3
16. Family members pair up rather than do things as a family.	1	2	3	4	5		1	2	3

APPENDIX I

FAMILY HARDINESS INDEX

Directions: Please read each statement below and decide to what degree each describes your family. Is the statement False (0), Mostly False (1), Mostly True (2), or Totally True (3) about your family? Circle a number 0 to 3 to match your feelings about each statement. Please respond to each and every statement.

IN OUR FAMILY……..	False	False	Mostly True	Totally True	Not Applicable
1. Trouble results from mistakes we make	0	1	2	3	NA
2. It is not wise to plan ahead and hope because things do not turn out anyway	0	1	2	3	NA
3. Our work and efforts are not appreciated no matter how hard we try and work	0	1	2	3	NA
4. In the long run, the bad things that happen to us are balanced by the good things that happen	0	1	2	3	NA
5. We have a sense of being strong even when we face big problems	0	1	2	3	NA
6. Many times I feel I can trust that even in difficult times that things will work out	0	1	2	3	NA
7. While we don't always agree, we can count on each other to stand by us in times of need	0	1	2	3	NA
8. We do not feel we can survive if another problem hit us	0	1	2	3	NA
9. We believe that things will work out for the better if we work together as a family	0	1	2	3	NA

10. Life seems dull and meaningless	0	1	2	3	NA
11. We strive together and help each other no matter what	0	1	2	3	NA
12. When our family plans activities we try new and exciting things	0	1	2	3	NA
13. We listen to each others problems, hurts and fears	0	1	2	3	NA
14. We tend to do the same things over and over…it's boring	0	1	2	3	NA
15. We seem to encourage each other to try new things and experiences	0	1	2	3	NA
16. It is better to stay at home than go out and do things with others	0	1	2	3	NA
17. Being active and learning new things are encouraged	0	1	2	3	NA
18. We work together to solve problems	0	1	2	3	NA
19. Most of the unhappy things that happen are due to bad luck	0	1	2	3	NA
20. We realize our lives are controlled by accidents and luck	0	1	2	3	NA

APPENDIX J

Family Stress , Coping and Health Project
School of Human Ecology
1300 Linden Drive
University of Wisconsin-Madison
Madison, WI 53706

SOCIAL SUPPORT INDEX

Hamilton McCubbin Joan Patterson Thomas Glynn

Directions: Read the statements below and decide for your family whether you:
(1) **Strongly Disagree;** (2) **Disagree;** (3) **Neutral;** (4) **Agree;** or (5) **Strongly Agree** and circle that number.

Please indicate how much you agree or disagree with each of the following statements about your community and family.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Disagree
1. If I had an emergency, even people I do not know in this community would be willing to help.	0	1	2	3	4
2. I feel good about myself when I sacrifice and give time and energy to members of my family.	0	1	2	3	4
3. The things I do for members of my family and they do for me make me feel part of this very important group.	0	1	2	3	4
4. People here know they can get help from the community if they are in trouble.	0	1	2	3	4
5. I have friends who let me know they value who I am and what I can do.	0	1	2	3	4
6. People can depend on each other in this community.	0	1	2	3	4
7. Members of my family seldom listen to my problems or concerns; I usually feel criticized.	0	1	2	3	4
8. My friends in this community are a part of my everyday activities.	0	1	2	3	4
9. There are times when family members do things that make	0	1	2	3	4

other members unhappy.					
10. I need to be very careful how much I do for my friends because they take advantage of me.	0	1	2	3	4
11. Living in this community gives me a secure feeling.	0	1	2	3	4
12. The members of my family make an effort to show their love and affection for me.	0	1	2	3	4
13. There is a feeling in this community that people should not get too friendly with each other.	0	1	2	3	4
14. This is not a very good community to bring children up in.	0	1	2	3	4
15. I feel secure that I am as important to my friends as they are to me.	0	1	2	3	4
16. I have some very close friends outside the family who I know really care for me and love me.	0	1	2	3	4
17. Members of my family do not seem to understand me; I feel taken for granted.	0	1	2	3	4

Please print. Be sure to answer all items.

CHILD BEHAVIOR CHECKLIST FOR AGES 1½-5

For office use only
ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year _____

CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now. *Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.*

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

_____

Your relationship to child:

☐ Mother ☐ Father ☐ Other (specify):

Below is a list of items that describe children. For each item that describes the child ***now or within the past 2 months***, please circle the ***2*** if the item is ***very true or often true*** of the child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of the child. If the item is ***not true*** of the child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to the child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. Aches or pains (without medical cause; ***do not*** include stomach or headaches)
0 1 2 2. Acts too young for age
0 1 2 3. Afraid to try new things
0 1 2 4. Avoids looking others in the eye
0 1 2 5. Can't concentrate, can't pay attention for long
0 1 2 6. Can't sit still, restless, or hyperactive
0 1 2 7. Can't stand having things out of place
0 1 2 8. Can't stand waiting; wants everything now
0 1 2 9. Chews on things that aren't edible
0 1 2 10. Clings to adults or too dependent
0 1 2 11. Constantly seeks help
0 1 2 12. Constipated, doesn't move bowels (when not sick)
0 1 2 13. Cries a lot
0 1 2 14. Cruel to animals
0 1 2 15. Defiant
0 1 2 16. Demands must be met immediately
0 1 2 17. Destroys his/her own things
0 1 2 18. Destroys things belonging to his/her family or other children
0 1 2 19. Diarrhea or loose bowels (when not sick)
0 1 2 20. Disobedient
0 1 2 21. Disturbed by any change in routine
0 1 2 22. Doesn't want to sleep alone
0 1 2 23. Doesn't answer when people talk to him/her
0 1 2 24. Doesn't eat well (describe): _____
0 1 2 25. Doesn't get along with other children
0 1 2 26. Doesn't know how to have fun; acts like a little adult
0 1 2 27. Doesn't seem to feel guilty after misbehaving
0 1 2 28. Doesn't want to go out of home
0 1 2 29. Easily frustrated
0 1 2 30. Easily jealous
0 1 2 31. Eats or drinks things that are not food—***don't*** include sweets (describe): _____
0 1 2 32. Fears certain animals, situations, or places (describe): _____
0 1 2 33. Feelings are easily hurt
0 1 2 34. Gets hurt a lot, accident-prone
0 1 2 35. Gets in many fights
0 1 2 36. Gets into everything
0 1 2 37. Gets too upset when separated from parents
0 1 2 38. Has trouble getting to sleep
0 1 2 39. Headaches (without medical cause)
0 1 2 40. Hits others
0 1 2 41. Holds his/her breath
0 1 2 42. Hurts animals or people without meaning to
0 1 2 43. Looks unhappy without good reason
0 1 2 44. Angry moods
0 1 2 45. Nausea, feels sick (without medical cause)
0 1 2 46. Nervous movements or twitching (describe): _____
0 1 2 47. Nervous, highstrung, or tense
0 1 2 48. Nightmares
0 1 2 49. Overeating
0 1 2 50. Overtired
0 1 2 51. Shows panic for no good reason
0 1 2 52. Painful bowel movements (without medical cause)
0 1 2 53. Physically attacks people
0 1 2 54. Picks nose, skin, or other parts of body (describe): _____

Be sure you answered all items. Then see other side.

7-28-00 Edition

Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18**

For office use only ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl

CHILD'S AGE

CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ____

CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now.
(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

_____

Your gender: ☐ Male ☐ Female

Your relation to the child:

☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, computers, singing, etc. (Do *not* include listening to radio or TV.)

None ☐

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

None ☐

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

None ☐

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

APPENDIX L

Parent Report of Child Characteristics

Please rate how much each item describes your child. Please use this scale and write in the number to the left of the item:

1 = most undescriptive
2 = very undescriptive
3 = quite undescriptive
4 = somewhat undescriptive
5 = neither descriptive or undescriptive
6= somewhat descriptive
7 = quite descriptive
8 = very descriptive
9 = most descriptive

___ 1. Is resourceful in initiating activities (finds ways to make things happen and get things done).
___ 2. Freezes up when things are stressful, or else keeps doing the same thing over and over again.
___ 3. Is curious and exploring; he/she likes to learn and experience new things.
___ 4. Can bounce back or recover after a stressful or bad experience.
___ 5. When under stress, he/she gives up and backs off.
___ 6. Shows specific mannerisms or behavioral rituals (e.g., has specific habits or patterns of behavior—taps fingers, bites fingernails, or stutters or bites lips).
___ 7. Tends to get sick when things go wrong or when there is a lot of stress (for example, gets headaches, stomach aches, throws up).
___ 8. Tends to go to pieces under stress; becomes rattled and disorganized when things are stressful.
___ 9. Can talk about unpleasant things that have happened to him/her.
___ 10. Is creative in the way he/she looks at things; the way he/she thinks, works or plays is very creative.
___ 11. Uses and responds to reason (thinks things out and you can explain things to him/her like you can an adult).

APPENDIX M

Confidentiality Agreement

As a member of the research team investigating _____,
I understand that I will have access to confidential information about study participants. By signing this statement, I am indicating my understanding of my obligation to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about study participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information unless specifically authorized to do so by office protocol or by a supervisor acting in response to applicable protocol or court order, or public health or clinical need.
- I understand that I am not to read information and records concerning study participants, or any other confidential documents, nor ask questions of study participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I understand that a breach of confidentiality may be grounds for disciplinary action, and may include termination of employment.
- I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or situation which could potentially result in a breach, whether this be on my part or on the part of another person.

_____	_____	_____
Signature	Date	Printed Name
_____	_____	_____
Signature	Date	Printed Name

APPENDIX N

Script for the designated staff members

Hello, my name is Nawal Aboul-Hosn and I would like to thank you for volunteering your time and agreeing to help with this research study I am doing "The Effects of Parental Loss on Children: Disturbance to Resilience". I am a student at Barry University. Your participation is voluntary, and it will take place during the Good grief Camp week end. The process should take 45-60 minutes per participant to complete the questionnaires for this research.

The goal of this study is to investigate the relationship between parental attachment, family hardiness, and social support on children's behavior and resiliency in families who have lost a parent. The participants in this study will be parents who are raising a child between the ages of two and eighteen who has lost a parent and who are receiving mental health services or support, individual or with the family.

Please keep in mind that you do not ask any identifying questions to participants, to protect their privacy; at this time I would like to ask you to please read and sign the third party confidentiality form I am passing to you.

Once you are approached by participants, Please direct them to the designated room. Please give them the research package to complete the forms.

Please open the package provided to you at this time: Each packet has a number that will be marked on each form and test. Each participant will complete one packet for a child in their household. **If the parent would like to include more than one child in the research please provide additional packages as needed.** (Appendix A) cover letter for the participant; (Appendix F) instructions regarding completion of the research packet; (Appendix H) Family Attachment and Changeability Index (5-10 minutes) measures family attachment and functioning; (Appendix I) Family Hardiness Index (5-10 minutes) measures the characteristics of hardiness as stress resistance and adaptation resources in families; (Appendix J) Social Support Index (5 -10 minutes) records the degree to which families find support in their communities; (Appendix K) Child Behavior Checklist (15-20 minutes) assesses the competencies and problems of children and adolescents through the use of ratings and reports. **Please note that this test has two versions, make sure the parents choose their child age-appropriate version and place the unused version back in the package;** (Appendix L) Child Resiliency Scale (5-10minutes) assesses children's resourceful adaptation to changing circumstances and contingencies.

The participants will give their packet with the completed forms to a staff member who will give the packets to the researcher. At this time, I would like you to ask you to please sign this 3rd party confidentiality agreement.

Keep in mind that participants may withdraw at any time, and they have the right to skip any questions they choose to not answer.

When the participants return the packet to you, check that they have sealed the envelope and written the researcher's name on back of flap where flap meets envelope.

This Lock Box will be located in the room designated for the research, please drop the package in this lock box which only this researcher has the key for and I will pick it up as soon at the end of each day.

Please know that the participants have the choice to mail the packet (s) in the included stamped envelop if they choose to.
If you have any questions you can reach me at (321) 525-1556
supportivecsling@aol.com

Questions, Comments

Thank you for your time

APPENDIX O

Designated staff members Information

List of Designated Staff Members for the participating organizations in the research:

Tragedy Assistance Program for Survivors (TAPS)

Jon "Jay" Weidel (302) 697-3639 jonjwedel@yahoo.com

Mr. Weidel is a Group Leader that has worked with TAPS for the last 10 years in different group ages.

Judith Mathewson (321) 243-3376 jjmathewson@att.net

Mrs. Mathewson founded the Grief Camp for Children 10 years ago, and she is currently a Group Leader.

Central Community Mental Health

Samir Kerolos keroloss@bellsouth.net (321) 427-3988

Mr. Korolos is a Mental Health Counselor for Nine years; he is currently working at Devereux, and at Intervention Services.

Barbara Johnson BdcsBr@aol.com (321) 626-3780

Mrs. Johnson is a licensed Social worker with 22 years of experience, she collaborates with the Central Community Mental Health.