

# Couples at Risk Following the Death of Their Child: Predictors of Grief Versus Depression

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This longitudinal study examined the relative impact of major variables for predicting adjustment (in terms of both grief and depression) among bereaved parents following the death of their child. Couples ( $N = 219$ ) participated 6, 13, and 20 months postloss. Use of multilevel regression analyses enabled assessment of the impact of several predictors and facilitated analysis of factors that were either shared by parents or individual. Grief was predicted mainly by shared parent factors: child's age, cause and unexpectedness of death, and number of remaining children. By contrast, depression was predicted by individual parent factors: gender, religious affiliation, and professional help seeking. Theoretical implications of these findings are discussed.

*Keywords:* parental bereavement, predictors, death of child, depression, grief

Bereavement is known to increase the risk of mental and physical illness and even mortality (W. Stroebe & Stroebe, 1987). There are reasons to believe that parents whose child has died are particularly vulnerable to these health detriments (Nolen-Hoeksema & Larson, 1999), yet, the identification of risk according to "loss of a child" per se may not be a sufficient indicator of the need for professional help. Prior research on the efficacy of intervention for bereaved parents has frequently failed to find benefits (e.g., Lake, Johnson, Murphy, & Knuppel, 1987; Videka-Sherman & Lieberman, 1985; for a review, see Schut, Stroebe, van den Bout, & Terheggen, 2001). There are good reasons to argue that further differentiation between parents who are at relatively more versus less risk is needed (Murphy et al., 1998): Secondary preventive interventions (i.e., those programs that identify highly vulnerable individuals) have been shown to be more effective (for the bereaved in general) than those not targeting high-risk persons (Schut et al., 2001). In sum, it is important to identify predictive factors to facilitate early identification of parents who might indeed be in need of professional help.

There has been surprisingly little sound empirical research investigating which subgroups among bereaved parents are at particularly high risk of suffering extreme negative consequences. With the notable exception of a study by Dyregrov, Nordanger, and Dyregrov (2003), most of these investigations have been restricted to the examination of one or two factors, such as the cause of death (e.g., Boyle, Vance, Najman, & Thearle, 1996; Murphy, Johnson, Wu, Fan, & Lohan, 2003) or the gender of the

parents (e.g., Sidmore, 1999). This limitation has an important consequence: Spurious results may be reported due to the confounding effects of other variables. Even in the study of Dyregrov et al. it is unclear whether the elevated risk for psychological problems is due to the unexpected nature of these losses, to other specific aspects related to violent deaths, to age differences, or to other relevant factors.

Another serious shortcoming is the way the *dependency* of the couples has been handled in analyses (so-called nested data). The loss of a child is unique, in the sense that some aspects are automatically shared by the parents as a couple (e.g., child's age) whereas others are individual (e.g., parent's gender). Parents within a couple lose the same child and have therefore more in common than two independent parents who lose different children. Some of the variables that have been studied vary only between the children, and therefore between the couples (e.g., gender of the child), whereas others vary between all of the individuals (e.g., age of the parent). Consequently, the psychological adjustment of the parents within a couple might be influenced by the fact that they share numerous factors and their adjustment is therefore not independent. This leads to the following statistical problem: When each parent is treated as an individual case in analysis, data from a number of couples are inappropriately expanded into values for a number of individuals that is twice as large (Hox, 2002). Standard statistical tests lean heavily on the assumption of independence of observations. If this assumption is violated, the estimates of the standard errors of statistical tests are too small, resulting in spurious "significant" results (Hox, 2002).

Finally, researchers need to consider the selection of dependent measures more carefully. Depression has frequently been used as the indicator of grief reactions. However, symptoms of grieving (e.g., yearning, anger) form a separate cluster from those associated with depression (Prigerson, Frank, et al., 1995). Are generic measures such as depression scales adequate, or is it essential to include grief-specific measures?

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In sum, it is important to approach the investigation of risk factors among parents by examining potentially influential factors simultaneously, by distinguishing between those factors that are shared by the couple and those that are individual characteristics of the parent, and by including a grief-specific as well as generic measure of parental adjustment.

To overcome the difficulties identified above, in the current study we included six factors shared by the parents, six individual factors, and time simultaneously in one multivariate analysis. The relationship between each factor and symptoms was also checked in univariate analysis, to highlight the possibility of spurious results due to confounding factors. To take the dependency of the parents into account, we analyzed the data in multilevel regression models that were especially designed to analyze variables from different levels simultaneously, using a statistical model that includes the various dependencies (Hox, 2002). Finally, we included measures of both depression and grief symptoms as dependent variables to gain more insight into the patterns associated with these different constructs.

We selected specific individual factors and factors shared by parents that had been identified in the previous research literature as important (for a review, see Rubin & Malkinson, 2001) but had never been investigated in a single, simultaneous analysis. Shared parent factors were child-related factors (age and gender), circumstances surrounding the death of the child (cause of death and its [un]expectedness), and family situation factors (the number of remaining children and a subsequent pregnancy). Tentatively, given the shortcomings noted above in existing studies, we expected older age of the child (cf. Rubin, 1990), traumatic or unexpected death (cf. Murphy et al., 2003), and absence of other children (cf. Dyregrov et al., 2003) to be associated with higher symptomatology. Individual factors were age and gender of the parent, education, employment, religious affiliation, and professional (psychological) help seeking. We expected mothers to report more symptoms than fathers (cf. Sidmore, 1999). In general, we expected symptomatology to decrease over time. Given the longitudinal design, we were also able to explore the association between the risk factors and the course of grief and depression across the duration of our study. Potentially, this enables identification of subgroups that adjust differentially over time.

## Method

In total, 463 Dutch couples who had lost a child were contacted via obituary notices in local and national newspapers. Bereaved grandparents (i.e., those parents whose deceased child was a parent him- or herself) were not included in this investigation, given that they are likely to experience additional difficulties. Single parents were also not included, because the study was designed to compare individual predictors with shared parent predictors. In total, 219 parent couples (47%) agreed to participate. Informed consent procedures were utilized. The deceased children of the nonrespondents turned out to be older than the children of the parents participating in the study,  $t(378) = -5.29, p < .001$ .<sup>1</sup> The parents who participated ranged in age from 26 to 68 years ( $M = 42.2, SD = 9.1$ ), and their deceased child was under 30 years of age ( $M = 10.2, SD = 9.8$ ). Of the deceased children, 68.7% were boys. The causes of death varied from neonatal death or stillbirth (16.3%), through illness or disorder (47.7%), to accident, sudden infant death syndrome (SIDS), suicide, or homicide (36.1%).

The design of the study was longitudinal, consisting of three points of measurement, at 6, 13, and 20 months after the death of the child. The

attrition rate was 17.8% over this 14-month period. Parents completed the questionnaires separately. Biographical data about the parents, the child, and circumstances surrounding the loss were gathered during an interview with the couple at the first measurement point after their loss.

## Dependent Variables

Grief reactions were measured with the Inventory of Complicated Grief (ICG; Prigerson, Maciejewski, et al., 1995; Dutch version by Dijkstra, 2000). The ICG consists of 19 items covering psychological aspects of grief, for example, "I find it difficult to accept the death of our child" and "I feel that it is unfair that I should live when our child died." The answers are given on a 5-point scale ranging from *never* (1) through *sometimes* (3) to *always* (5). In our study, Cronbach's alpha was .90 to .92, and test-retest coefficients varied from .81 to .88.

Depression was measured using the subscale of the Symptom Checklist-90 (Derogatis, 1977; Dutch version by Arrindell & Ettema, 1986). The subscale Depressive Symptomatology consists of 16 items. Answers are given on a 5-point scale, ranging from *not at all* (1) to *very much* (5). In our study, Cronbach's alpha was .94 and test-retest reliability was .86.

## Independent Variables (the Predictors)

*Shared parent factors* were child's age, gender, cause of death, unexpectedness of the loss (measured on a 5-point scale),<sup>2</sup> number of remaining children, and subsequent pregnancy and/or baby 20 months after the death. Cause of death was categorized in three groups: stillbirth or neonatal death (0), illness or disorder (1), or traumatic death (SIDS, accident, suicide, homicide) (2). *Individual factors* were gender, age, education (measured on a 6-point scale), employment (in hours), religious affiliation (nonreligious vs. religious), and professional help seeking.

## Analysis

To deal with the complications associated with having multiple predictors in a dependent structure, we analyzed the data with multilevel regression analysis (Hox, 2002). A unique feature of multilevel analysis is that it works with a specific statistical model designed for nested data. In our data there is a nested structure captured by a three-level hierarchy. The three measurement moments in time are nested in one person, the father or mother. The measurements of the father and mother are dependent and are thereby nested in a couple. Therefore, time since death is the lowest level (first level), which is nested in the individual, the parent (second level), and the parents are nested in a couple (third level). Each independent variable varies only at one specific level. Time since the loss of the child varies only at the lowest level, the time level (first level). The individual factors of the parent differ at the individual level (second level). The remaining factors are the same for the parents in a couple, but these factors do vary between the couples at the shared parent level (third level).

## Statistical Procedure

First, intraclass correlations were calculated to indicate the proportion of variance at one specific level. For each of the two dependent variables

<sup>1</sup> Unfortunately, additional information on nonrespondents was not available to investigate further selection effects. It is unlikely that participation was related to financial resources enabling placement of an obituary, because it costs very little to do this in local newspapers in the Netherlands.

<sup>2</sup> Because of the very high correlation ( $r = .93$ ) between the parents in assessing (un)expectedness, the mean of the two variables was calculated and taken as the measure of unexpectedness for the couple.

(grief and depression) a multilevel regression analysis was done with MLwiN (Rasbash et al., 2000). All independent variables were put in the multilevel regression model. The part of the variance that was explained at the three specific levels in the definite model for each dependent variable was calculated. In addition, for each dependent variable, univariate regression analyses were calculated. Significance of continuous or dichotomous variables was checked by *t* tests. The variable "cause of death" consists of two dichotomous variables and was checked using a chi-square test.<sup>3</sup> The dependent variables were all transformed to a scale of 0–100 to facilitate comparison between the predictors and the comparison between the predictive value for depression and grief.

It is possible that the regression coefficient for time (which reflects the association between time and the dependent variable) differs for the units at one specific level. This possibility was checked for the dependent variables (depression and grief), while the time factor was made random at the individual and the shared parent levels. If this were the case, the trend of grief symptoms through time would differ for individuals (at the second level) and/or for couples (at the third level). To identify which factors were responsible for particular trends, we conducted exploratory interactions between time and the predictors (at the specified level).

Multilevel analysis has advantages with respect to dealing with missing data. Problems associated with panel attrition (i.e., individuals who, after one or more measurement occasions, drop out of the study) are of relevance here. According to Hox (2002) multilevel analysis leads to unbiased estimates when the panel attrition follows a pattern defined as missing at random (for more information, see Hox, 2002; Little, Schnabel, & Baumert, 2000).

## Results

### Testing the Adequacy of a Three-Level Model

For the dependent variables (grief and depression) the total variance was divided into three parts referring to the three subsequent levels (see Table 1). The amount of variance at each level was assessed by constructing an intercept-only model. A total of 14% to 18% of the variance occurs at the time level for the dependent variables. The major part of the variance in grief (50%) was found at the shared parent level, and another 36% was found at the individual level. These results show that the differences in grief between the individuals were smaller than the differences between the couples of parents (36% vs. 50%). By contrast, the essential part of the variance of depression (62%) was found at the individual level. The shared parent level played only a minor role, accounting for 21% of the variance. Differences in depression were therefore larger between the individual parents than between the couples of parents (62% vs. 21%). In sum, there is relatively

more resemblance in grief symptoms between the two parents in the couple than in their depression symptoms.

### Explained Variance

The part of the variation in, for example, grief symptoms that can be predicted by the factors in the model is known as explained variance. As shown in Table 1, of the variance that was estimated to be at the shared parent level in *grief* (50%), a sum of 21% was explained by these predictors on the shared parent level: age of the child, cause and unexpectedness of the death, and number of remaining children. Seven percent of the initial 36% at the individual level was explained by individual predictors (gender, education, and work), resulting in a total of 28% of the total variance of grief being explained by our model.

In *depression*, 30% of the initial 62% at the individual level was explained by the predictors gender, religiosity, and help seeking. No variance was explained at the shared parent level. For both dependent factors, no variance was explained at the time level because no predictors were included that varied between the time measurements.

### Shared Parent Explanatory Variables (Third Level)

For *grief*, four factors shared by the parents were significant: the age of the child, the cause of death, the unexpectedness of the loss, and the number of remaining children (see Table 2). There was a curvilinear relationship between grief and the age of the child (up to the age of 17 the grief increases; after the age of 17 the grief decreases). Parents who lost their child to a traumatic death had the most grief symptoms, followed by those who lost their child to an illness or a disorder. Parents who experienced a stillbirth or a neonatal death had the lowest levels, comparatively, of grief symptoms. Furthermore, the more the parents expected the loss, the less grief they experienced. The fourth factor related to grief, which was the only factor related to *depression*, was the number of remaining children: Parents grieved less and had less depression when there were other children in the family.

### Individual Explanatory Factors (Second Level)

The effect of age of the parent was not significant for either dependent variable. One variable was significant for both: Women reported higher levels of grief and depression than men. For grief symptoms, the number of hours the parent worked was significant; if they worked more hours, they reported fewer grief symptoms. Respondents with higher education reported less grief than those with lower education. For depression, religious affiliation and professional help seeking of the parent mattered; nonreligious parents reported being less depressed than religious parents, and non-help-seekers reported less than help-seekers.

Table 1  
Estimated Variance and Explained Variance at Three Levels

Level	Grief		Depression	
	Variance	Explained	Variance	Explained
Shared parent (3rd)	.50	.21	.21	.00
Individual (2nd)	.36	.07	.62	.30
Time (1st)	.14	.00	.17	.00
Total explained variance		.28		.30

Note. *n* = 219 couples.

<sup>3</sup> The two dichotomous variables were constructed as follows: Variable 1, illness or disorder, score = 1; died from other causes, score = 0. Variable 2, traumatic death, score = 1; died from other causes, score = 0. The third category, stillbirth and neonatal, was scored as 0 on both variables.

Table 2  
*Predictors of Grief and Depression in Univariate and Multivariate Analysis*

Variable	Grief				Depression			
	Univariate		Multivariate		Univariate		Multivariate	
	<i>B</i>	<i>SE</i>	<i>B</i>	<i>SE</i>	<i>B</i>	<i>SE</i>	<i>B</i>	<i>SE</i>
Shared parent factors								
Age child (in years)	0.201	0.030***	0.715	0.167***	0.232	0.036***	0.292	0.169
Age child square	-0.042	0.014**	-0.042	0.015**	-0.028	0.014*	-0.019	0.015
Gender child (0 = boy)	2.437	2.349	1.386	2.013	0.515	2.106	1.600	2.037
Cause of death (0 = death at birth) <sup>a</sup>								
Illness	7.538	2.818***	4.748	3.121*	3.584	2.573***	0.774	3.242
Traumatic	15.809	2.912***	6.377	3.326*	10.179	2.669***	5.441	3.354
(Un)expectedness (5-point scale)	-1.868	0.794**	-3.593	0.956***	-0.441	0.714	-0.196	0.769
No. of children	-0.725	0.708	-1.917	0.620**	-0.569	0.628	-1.338	0.627*
New pregnancy (0 = not)	-9.539	2.360***	2.137	3.120	-7.672	2.087***	0.963	3.080
Individual level								
Gender parent (0 = father)	8.133	1.065***	5.099	1.620***	12.170	1.276***	11.228	1.790***
Age parent	0.338	0.105**	-0.046	0.166	0.232	0.099*	0.007	0.173
Education	-2.741	0.509***	-2.062	0.491***	-1.823	0.552***	-0.981	0.522
Work (in hours)	-0.216	0.030***	-0.097	0.043*	-0.249	0.036***	-0.015	0.047
Religiosity (0 = not)	2.569	2.015	1.771	1.767	5.002	1.958**	5.161	1.838**
Professional help-seeking	3.536	2.992	2.422	2.690	8.468	2.993**	6.494	2.859*
Time level								
Time	-2.195	0.274***	-2.504 <sup>b</sup>	0.607***	-1.650	0.301***	-0.830 <sup>c</sup>	0.411*
Time × Unexpectedness <sup>d</sup>	—	—	0.489	0.210*	—	—	—	—
Time × New Pregnancy <sup>d</sup>	—	—	-1.915	0.718**	—	—	-2.638	0.750***

Note. *n* = 219 couples.

<sup>a</sup> Cause of death (death at birth, illness, and accident) is tested with chi-square test. <sup>b</sup> Random at 3rd level. <sup>c</sup> Random at 2nd and 3rd level. <sup>d</sup> Only significant interactions are included.

\* *p* < .05. \*\* *p* < .01. \*\*\* *p* < .001.

### Factor Time and Time Interactions (First Level)

As time goes by, grief symptoms and depression decrease (for means, see Table 3).<sup>4</sup> The decrease in grief through time varied only between the couples of parents (third level), whereas the decrease in depression varied between individual parents (second level) as well as between couples. Two factors were identified that explained differences across time. An unexpected death was associated with higher levels of grief than was an expected death, 6 months after the death. The difference between the expecting couples and the not-expecting couples became smaller as time went by (*p* < .01). As time proceeded the depression and grief of parents who became pregnant again decreased more rapidly than that of parents who did not become pregnant (*p* < .01). The other interactions between time and the predictors were not significant.

### Univariate Analyses Versus Multivariate Analysis

The results show differences between magnitude and significance of the contribution of several predictors when results of the multivariate analyses are compared with results of the univariate analyses (see Table 2). A number of factors (e.g., age of the parent for both grief and depression reactions) were significant predictors in a univariate analysis (*p* < .001) but not when studied simultaneously with the other predictors in the multivariate model. By contrast, the predictor *number of remaining children* had a significant contribution in predicting grief in the multivariate model (*p* < .01), which was not found in univariate analysis.

### Discussion

Our study provided information about predictors of adjustment of parents to the loss of their child. Moreover, the results show important differences in grief versus depression as a result of the more sophisticated statistical analyses. Depression is predicted by individual factors, whereas grief is mainly predicted by bereavement-specific factors, the factors the parents share. It stands to reason that the grief-specific measure should account for more variance at the shared parent than at the individual level, because most of the factors at the shared parent level reflect characteristics of the loss, assumed to affect the intensity of parents' grief reactions. In contrast, factors at the individual level are demographic (or population) characteristics, which are likely to be associated with other life stressors in addition to bereavement. Although not affecting the extent of grief, these other stressors might influence the level of depressive symptoms. Thus, although depression and grief are strongly associated, the two concepts appear to be different, at least for a substantial part. This endorses the notion that depression and grief are two different concepts,

<sup>4</sup> Our bereaved parents appear to be at elevated risk compared with other bereaved groups. For example, if one transforms the means of Prigerson, Maciejewski, et al. (1995) to a scale of 0–100 in order to enable comparison with ours, their mean score for widows and widowers on the ICG is 25.3 (*SD* = 17.4). Our means are much higher, indicating high vulnerability among the bereaved parents.

Table 3  
*Means and Standard Deviations for Depression and Grief at Three Measurement Moments*

Measurement time	Grief <sup>a</sup>		Depression <sup>a</sup>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
6 months ( <i>n</i> = 438 parents)	45.24	19.79	23.95	19.72
13 months ( <i>n</i> = 378 parents)	43.00	18.72	22.17	19.12
20 months ( <i>n</i> = 361 parents)	41.52	18.15	20.49	17.90

<sup>a</sup> The original scales are transformed to 0–100.

which prior research has suggested (e.g., Prigerson, Frank, et al., 1995). Conclusions about grief reactions based on data measured by depression scales should therefore be interpreted with caution.

Two major improvements from usage of multilevel regression analysis were the focus on multi- rather than univariate analyses and studying the data at different levels. First, the results clearly showed the importance of examining the association between symptoms and multiple predictive factors simultaneously: Differences were found in the magnitude and significance of the contribution of several predictors, indicating their confounding influences.

Second, the importance of studying at the individual and shared parent (as well as time) levels became evident from the fact that variance in symptoms occurred at all levels. So, in addition to the predictive factors that the parents (by definition) share, there was a resemblance in symptoms within the couples. For example, although parents did vary within a couple on grief, these differences were smaller than the differences between the couples of parents.

As with all research, there are limitations to our study. One limitation is our focus on grief and depression, leaving out other relevant dependent variables (e.g., anxiety symptoms, traumatic responses). Further investigation could extend the scope. Another limitation is that we narrowed our sample to couples of parents, excluding single parents. Although it is probable that the same factors play a role in bereaved single parents, caution is needed in generalizing these results. There are also limitations in the selection of variables in our study: Our identification of risk factors has concentrated on contextual factors (i.e., situational and circumstantial ones). Further research needs to extend investigation to the meaning of loss for parents, regulatory coping processes, and the manner in which bonds are continued or relinquished (cf. Bonanno & Kaltman, 1999).

What picture of parents at risk emerges from our findings? Age of the child is a predictor of grief, the youngest and oldest ages being associated with comparatively less grief. The number of children that remain in the family after the loss contributes to the prediction: The more children, the fewer grief symptoms parents report. Of the three major theoretical approaches to bereavement (i.e., attachment theory [e.g., Bowlby, 1969], cognitive stress theory [e.g., Lazarus & Folkman, 1984], and the evolutionary psychology approach [Archer, 1999]), evolutionary psychology offers the only theoretical approach to grief that can account for both of these findings. Because natural selection operates at the level of the genes, we care for our relatives to the extent to which they share our genes (inclusive fitness) and are likely to pass them on to future generations (i.e., reproductive value). According to

this theory, the curvilinear relationship between extent of grief and age of a child would be due to the fact “that children of different ages vary in terms of the times and effort put into rearing them and in terms of their potential for producing future offspring” (Archer, 1999, p. 151): A young adult has had a greater investment than a child at 1 year, and a young adult is also most likely to produce offspring. Parental investment then levels off, and reproductive value even decreases in later life. The inverse relationship between number of children and grief symptoms would be explained by the fact that parents with many children have more means of passing on their genes than parents with few children or parents who lost their only child. The problem with this type of evolutionary explanation is that it does not explain the *psychological* mechanisms that link the assumed determinants to the grief response.

The next two bereavement-specific factors related to grief were the cause and the unexpectedness of the loss. These factors and the age of the child are partly overlapping concepts. For example, only infants can die of SIDS, and an accident or suicide is probably unexpected. Because all these factors have a significant relationship with grief when analyzed simultaneously, they each have a unique contribution to grief intensity. The concept of low parental investment could explain that parents who experienced a stillbirth or a neonatal death had lower levels of grief than parents who lost their child at a later stage and to other causes. However, this finding would also be consistent with attachment theory (Bowlby, 1969). Because the development of attachment involves exposure learning derived from mutually satisfying interactions, one would expect the strength or parental attachment to increase with the age of a child at least for the first few years. Attachment theory would also offer an explanation for the greater impact of unexpected losses on grief, a finding that could not be explained by evolutionary psychology. According to attachment theory, the sudden and unexpected loss of a child might destroy the parents’ feeling of safety and security. For the person who has experienced loss without forewarning, there is no situation that feels safe—loss can come again out of the blue. Death after a long illness should also be less stressful than adjustment to a sudden change of the same magnitude, because adjustments to change take place over time (Lazarus & Folkman, 1984). Because individuals are likely to adjust over time, stress theory would also offer a plausible explanation for the fact that the difference between the two groups decreased over time.

The finding that grief and depression decreased more rapidly among parents for whom a new pregnancy occurred than among those for whom this was not the case is ambiguous with regard to the cause–effect relationship. It could be an example of the same evolutionary principle we evoked earlier to account for the inverse

relationship between number of surviving children and intensity of grief. Alternatively, it might merely reflect the fact that these parents already felt less grief and were less depressed before the new pregnancy.

The individual factors predicted the intensity of depressive symptoms, gender of the parent, religious affiliation, and professional help seeking. The difference between men and women could simply represent differences in psychological distress between the genders in the general population. However, there could also be loss-specific reasons: Mothers invest more resources, time, and effort into a fetus or a young child than do fathers. Both evolutionary and attachment theory would therefore predict that mothers should grow more attached to the young child and therefore experience higher levels of grief over the loss. However, both theories would also lead one to expect that this difference should become smaller at a later age, when the investment of the two parents should become more balanced. There was no support for this latter assumption. That we failed to find a positive relationship between age of parents and extent of their grief (at least, when other predictors were controlled for) is also inconsistent with evolutionary psychology. Because reproductive value declines throughout adult life, particularly for women, grief over the loss of a child should increase with increasing age of the parents.

Religious affiliation predicted depression: Religious parents had more depressive symptoms than nonreligious parents. Although this positive relationship has been found before, it contradicts the finding of many other studies (cf. M. S. Stroebe, 2004). It is noteworthy that religiosity was *not* related to grief symptoms, suggesting perhaps that it is not relevant as a specific coping strategy. Further research is needed in which the role of religiosity in bereavement is studied in depth; for example, factors such as perceived closeness to God, religious support, and religious and spiritual struggle need to be differentiated.

It is difficult to interpret the result that help seekers were more depressed. On the one hand it seems plausible that depression may lead to help seeking. On the other hand, it is also conceivable that—even if helpful in the long run—professional intervention may exacerbate symptoms of depression, for example, by focusing on difficulties (cf. Schut et al., 2001). Thus, the direction of causality remains unclear. Again, it is interesting to note that the relationship with help seeking held only for depression and not for grief. This may indicate that bereaved parents in our sample did not seek help for more intense grief symptoms.

The findings of our study have both theoretical and practical implications. On a theoretical level, we have to conclude that no single theory of bereavement is able to explain the whole pattern of our findings. Although many of our findings were consistent with the interpretation of grief in terms of evolutionary psychology (Archer, 1999), there were also inconsistencies. Furthermore, the fact that the impact of expectedness of the loss on grief, although not inconsistent with evolutionary psychology, cannot be explained by this theory but is consistent with stress and attachment theory reinforces our belief that any interpretation of bereavement research must be based on a multitheoretical approach including attachment and cognitive stress theory.

The results of our study also have important clinical implications insofar as they identify bereaved persons at high risk of poor psychological adjustment. As Schut et al. (2001) reported, selecting participants by screening for risk level raises the chances of the

intervention leading to positive results. The risk factors in our study can help identify people at high risk.

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