SUICIDE-BEREAVED CHILDREN:
A CONTROLLED LONGITUDINAL EXAMINATION

A Thesis
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ABSTRACT

Little is known about the emotional and behavioral sequelae in children who have experienced parental suicide. The current study examined the reactions of children to parental death by suicide by completing a secondary analysis of data from the Grief Research Study, a longitudinal study of bereavement in children. Twenty-six suicide-bereaved (SB) children and adolescents, ages 5-17, were compared with 332 children bereaved from parental death not caused by suicide (NSB). Children and their surviving parents were assessed 1, 6, 13, and 25 months after the death. The children's emotional reactions to the death, family environment, psychiatric symptomatology, and family history of psychopathology were determined.

In general, fewer differences were found between groups than hypothesized. Differences in phenomenology were minimal suggesting that the bereavement experience, per se, is relatively unaffected by type of death, including death by suicide. This may be due in part to the decreased stigmatization of mental illness and suicidal behaviors that has occurred in the past decades. However, some differences were noted in rates of psychopathology between SB and NSB children in the first two years post-parental death. These differences were most notable for disruptive behavior disorders and generalized anxiety disorder. Interestingly, indices of depression and suicidality differed minimally between the two groups.

It should be noted that these cohorts have not yet passed through the age of risk; thus, the lack of robust findings in the area of psychopathology might not be due to a genuine lack of differences between these groups. As SB children generally come from families with a history of mental illness and high rates of family disruption, SB children need to be followed longitudinally as they pass through the age of risk to determine the specific impact parental suicide has on a young person's development and the emergence of psychopathology.
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INTRODUCTION

Suicide is a leading cause of death in America, accounting for over 31,000 deaths a year (Bureau of the Census, 1985). For women and men in Ohio, ages 26-45, the age group most likely to have children in the home, suicide is in the top five leading causes of death (Ohio Department of Health, 1992). In the United States, 7,000 to 12,000 children experience parental suicide each year (Small & Small, 1984).

The impact of suicide on survivors is substantial. Differences may exist between bereavement due to suicide and bereavement due to other types of death, but few controlled studies have examined the exact result of the suicide of a loved one (Ness & Pfeffer, 1990). Many individuals who commit suicide leave children, who must then make sense of their parent's decision to end their own lives and deal with the stigma surrounding suicide, which quite likely complicates the bereavement they experience simply from their parent's death. For this reason, bereavement might be substantially different for children who survive the suicide of a parent than for children who survive parental death brought about by causes other than suicide.

By the time they reach the age of 15, four percent of children in America will have experienced the death of a parent (Bureau of the Census, 1985). While research on adult bereavement provides models for examinations of childhood bereavement, children's unique social, behavioral, cognitive and physical development demand that children's reaction be studied directly (Weiler, Weller, Fristad, & Bowes, 1991). Following the death of a parent from causes other than suicide or homicide, Weller et al. found that one-third of these children met DSM-III-R criteria for a major depressive disorder. Despite experiencing depression, parent-bereaved children from stable families experienced few differences in psychosocial
functioning, i.e. school performance and peer relationships, when compared to non-bereaved community controls (Fristad, Jedel, Weller, & Weller, 1993). Other authors have found an increase in psychopathology in bereaved children, specifically increased depressive symptoms in adolescents (Reinherz et al., 1989).

While far fewer children experience the stress of parental death due to suicide, clinical lore suggests that parental death due to suicide may contribute to serious psychological impairment as these children grow. Two types of research about survivors of suicide exist: (1) comparisons of reactions to suicide with reactions to other causes of death; and, (2) reactions of specific types of survivors, i.e. widows, or children. Because of the paucity of research directly focusing on the results of childhood bereavement due to suicide, I first review research about survivors of suicide, then discuss literature devoted solely to childhood bereavement following suicide. This is followed by a discussion of potential mediating variables in any examination of suicide bereaved individuals.

Survivors of Suicide: Comparisons to Other Types of Death

Comparing individuals bereaved from suicide to individuals bereaved from other forms of death has yielded conflicting results. One review of the literature concludes that a difference in feelings of preoccupation with the bereaved and higher incidence of suicide attempts exists in suicide survivors (Ness, 1990). On the contrary, in a study of 174 college students who had survived the suicidal, accidental, or natural death of a family member or close friend, McIntosh & Kelly (1992) found no significant differences in suicidality, time required to return to “normal functioning”, and grief feelings between survivors of different types of death. Average elapsed time from the death until assessment was almost six years. These authors also found few differences between the reactions of family or non-family survivors. However, they did not control for the closeness of relationship with the deceased and found that participants rated their relationships, on average, as only moderately close with the deceased.

Cleiren (1994), however, examined spouses, parents, siblings, and adult children bereaved from suicide and other forms of death and found that the kinship relationship was the most important predictor of post-death functioning, i.e., surviving parents, widowers, and sisters showed less adaptive functioning following a suicide than adult children, widows and brothers of the deceased. This study did not examine
minor children bereaved from parental suicide. C'zirenn did show that early adaptation, as measured four months after the loss, was highly predictive of functioning fourteen months after the death. Additionally, survivors of both suicide and long-term illness reported some sense of relief from not having to deal with the worry and fear of what was going to happen to their troubled relative, as well as an end to their relative's suffering.

In mail-back questionnaire studies of adult survivors identified from medical examiner records, decreased detachment from the family and increased self-esteem were shown to be more important than mode of death in establishing healthy outcomes in survivors of suicide and accidental death (Reed, 1993; 1991). Reed also showed that, contrary to expectations, emotional distress was greater in survivors of accidental death than suicide. This might be due to the pre-existing family dysfunction in families where a suicide occurred and relief resulting from no longer having to struggle with severe stressors associated with the deceased.

Survivors of Suicide: By Type of Survivor

I now turn to an examination of specific types of survivors. Several studies have examined people's reactions to the suicide of someone close to them. Using questionnaires mailed to survivors of the suicides of children, spouses, parents (both adult and children), and siblings, McIntosh & Wrobleski (1988) found few outcome differences in personal symptoms based on relationship to the deceased. Other authors have examined the specific reactions of spouses and children to suicide.

Widows and widowers. A study of the widows of suicide completers showed that outcome response depended on family functioning before the death (Barraclough & Bunch, 1974). In this study, marital separation, alcoholism, or history of serious mental illness was associated with better post-death outcome, perhaps because the burden of living with an individual with a serious long-term problem had been removed.

Another study of widows and widowers of suicide completers specifically examined the grief reactions of suicide survivors and compared these reactions to those of bereaved spouses from other types of death including accident, unanticipated natural death, and expected natural death (Barrett & Scott,
1990). No significant differences were found on overall grief reactions between the four types of spousal death showing that the "course and quality" of the grief reaction are not different for these different types of survivors. Suicide survivors and survivors of sudden death both suffered shock and pain and a feeling of blame. Unique to suicide survivors in this study were feelings of embarrassment, anger, and wonder about the spouse's decision to end his/her life.

Child survivors of suicide. Children who have experienced the suicide of someone close to them may be particularly vulnerable to development of psychopathology, especially depression. Brent et al. (1993) examined 146 adolescent participants bereaved from the death of a friend or acquaintance. They found that 29% developed a depressive episode following the suicide of their peer.

Few studies have focused on children whose parents commit suicide, and studies which have been conducted are limited for various reasons. Several authors have studied children seeking psychiatric help. Cain and Fast (1966) examined outpatient charts of 45 children who had experienced a parental suicide. These children showed a pattern of either sad, guilt-laden, or withdrawn responses or angry, hostile, and defiant responses. Evaluation occurred, on average, four years after the death. Also of note in this study, a quarter of these children witnessed the suicide, yet their surviving parent often convinced them that the death was due to an accident or illness. Pfeffer (1980) interviewed five children who were receiving inpatient psychiatric treatment within two years of parental suicide. These children came from families with chronic family turmoil, including parental separation or divorce and/or frequent psychiatric hospitalization. Pfeffer indicates that these children's post-death reaction mirrored the reaction of their surviving parent. In both of these studies, participants were identified from children who were already receiving treatment. Therefore, they might not be representative of all children whose parents commit suicide.

Shepherd and Barraclough's (1976) landmark study of 36 children who had experienced the suicide of a parent found that immediately after the death, one third of these children showed behavioral problems including persistent anxiety, aggression, or withdrawal. The families in this study showed higher rate of disruption in the home before the suicide than randomly selected non-bereaved controls for stressors
such as marital separation and trouble with the law. This study is the only comprehensive examination of non-referred suicide-bereaved children. Of note, these findings are based solely on reports from the surviving parent because the children were never interviewed directly. Children were not interviewed because the researchers thought their questions might be harmful to these children, many of whom were not told the cause of their parent’s death given the severe stigma associated with suicide at that time. In addition, these researchers felt that parents would be ideal informants for reporting all of their children’s problems. Current research indicates that in children and adolescents, particularly those with psychiatric disturbances, parents are frequently unaware of important symptoms that the children themselves report; these include guilt, anxiety, sleep disturbance and suicidal thoughts (Weissman, Ovaschel, & Padian, 1980).

In a more recent study of suicide-bereaved children, Peffer and colleagues (1997) examined 22 children from 16 families in which a parent or child had committed suicide. Children and their surviving parent completed self-report instruments and semi-structured clinical interviews. Children ranged in age from 5.3 years to 14.3 years. These children, recruited from school and clinical referrals, were evaluated from one month to three years post-parental death. These children were compared to the normative sample of the Child Behavior Checklist and showed more internalizing symptoms and poorer school adjustment than the standard community sample. Approximately 40% of these children experienced symptoms of post-traumatic stress from the suicide. Self-report scores indicated that 25% of families contained children who experienced clinically significant depression after the death.

Mediating Variables

Family dysfunction. Several issues are relevant to the relationship between family dysfunction, family history of psychopathology and bereavement due to suicide. Pre-existing chronic family stress is evidenced in the majority of families in which an adult suicide occurs (Rich, Fowler, Rogarty, & Young, 1988; Shepherd & Barraclough, 1976). This stress results from psychiatric illness, physical illness, monetary troubles, or trouble with the law and may be associated with poorer post-death outcomes for survivors. Comprehensive studies indicate that almost 98% of individuals who kill themselves are
suffering from a mental illness, most notably depression, alcohol abuse, or comorbidity of affective disorder and substance abuse (Rich et al., 1988). Assortative mating research indicates that spouses are similar in measures of psychological distress and well-being (du Fort, Kovess, & Boivin, 1994). More specifically, men with bipolar disorder have been shown to be more likely to have affectively ill wives than men without bipolar disorder (Columbo, Cox, & Dunner, 1990). Post-death adjustment of the surviving spouse of a suicide victim may be confounded by the probability of their pre-existing psychiatric illness.

This psychopathology in a parent may have implications for psychopathology in a child survivor. In child psychiatric outpatients, increased numbers of psychiatric diagnoses has been associated with increased rates of psychopathology in the mother and extended family (Fristad & Clayton, 1991). In addition, this parental psychopathology may result in decreased care of the bereaved child (Harris, Brown & Bifulco, 1986). Results from a large community survey shows that adult suicide attempters are more likely to have a family history of suicide, especially of parental suicide attempt (Sorensen, 1991). For this reason, it is important to examine children who have survived the suicide of a family member, especially a parent.

**Social support.** The amount and type of support any bereaved individual receives has an impact on their grief reaction. For survivors of suicide, social support may be reduced due to the stigma associated with suicide, either by causing the bereaved individual to withdraw into him or herself or by preventing helpful responses by other people. Feelings of guilt, blame, shame or anger may cause the bereaved individual to retreat even from other family members, causing a sense of disconnectedness from the person who has died, family members and the community (Alexander, 1991).

A review of the literature on social reactions to suicide survivors shows that expectations about how to react seem to follow different, more constrained, “rules” than how to react with survivors from other causes of death (Calhoun & Allen, 1991). Community members often appear more unsure of how to treat individuals bereaved from suicide (Calhoun & Allen, 1991). Calhoun & Allen indicate that people who have experienced bereavement from suicidal death are likely to feel less support and more rejection from the community.
In a study of undergraduates which compared the suicide-bereaved to bereaved individuals from other types of death, survivors of suicide reported the most variability in the social support they received (Thompson & Range, 1992). Suicide-bereaved individuals apparently were able to "compensate" for this variability in social support and reported the same amount of blame, anxiety, and depression as individuals bereaved from other types of death.

Interviews with funeral directors about how the cause of death produces different responses in the bereaved and their social support networks showed that members of the community seem to have more difficulty expressing sympathy to suicide-bereaved individuals and show greater discomfort when interacting with the family (Calhoun, Selby, Steeiman, 1988). Suicide-bereaved individuals were seen by funeral directors as having a lack of social support and a sense of rejection, and were easily made uncomfortable by people attending the funeral (Calhoun et al., 1988). These differences in social support may play a role in the bereavement experienced by individuals who have experienced the suicide of a family member.

Summary

Thus, no study has clearly documented the emotional and behavioral sequelae in children who have experienced parental suicide. Because of the degree of disruption in homes in which a suicide takes place, and characteristics such as stigma which may be particular to suicide, differences may exist between bereavement following suicide of a parent and bereavement following non-suicidal deaths. By comparing suicide-bereaved children to children who have experienced other forms of parental death, the specific impact of suicide and not merely parental death can be examined. The use of a nonreferred sample allows an examination of the reactions of a wider sample of suicide bereaved children, not just those who have experienced significant impairment. The current study attempts to examine the reactions of children to parental death by suicide by completing a secondary analysis of data from the Grief Research Study.

Hypotheses

The proposed study attempts to describe the adjustment of children who have experienced parental suicide as well as to compare these children with children who have experienced parental death by
means other than suicide. Suicide bereaved children will be referred to as SB children and non-suicide bereaved will be referred to as NSB children. This study will also attempt to identify the risk and protective factors associated with mental health and adaptive functioning in suicide-bereaved children. Research questions for this study cover four areas: I. phenomenology of the grief reaction; II. psychopathology of the child and his/her surviving parent; III. psychosocial functioning of the child and his/her family; and IV. risk/protective factors which influence good and poor coping after the death in terms of both psychopathology and grief reactions. Hypotheses to be tested appear below.

I. Phenomenology

A. The grief reaction in SB and NSB children will show few overall differences.

B. When compared with NSB children, SB children will exhibit the following feelings about the death:

1. more guilt;
2. more anger;
3. less acceptance;
4. increased symptoms of post-traumatic stress disorder.

C. Because of the stigma associated with suicide, SB children will also show:

1. more shame;
2. decreased social support;
3. a change in religious practices.

II. Psychopathology

A. SB children will be more impaired than NSB children both prior to and in the two years following parental death, as evidenced on the following variables:

1. suicidal ideation and attempt;
2. behavior, anxiety, mood, and other (i.e. elimination and eating disorders) symptomatology;
3. severity of depressive symptomatology.
B. Parents in SB families will also show increased distress.

1. Surviving parent in SB families will show increased distress pre- and post- death, as evidenced by:
   a. increased overall psychiatric symptomatology;
   b. increased depression.

2. The deceased parent in SB families will exhibit increased psychopathology, especially substance abuse and mood disorders.

III. Psychosocial Functioning

A. Homes in which a parental suicide takes place will be less stable than homes in which a non-suicidal parental death takes place. SB homes will show:

1. increases in marital separation and divorce;
2. increases in previous psychiatric treatment of family members;
3. less close and more conflictual familial relationships;
4. more psychosocial stressors.

B. Due to this familial instability, SB families will be more likely to enter the grief study later than NSB families.

C. Due, in part, to instability in SB families, SB children will exhibit more problems than NSB children with:

1. school behavior;
2. interest in school;
3. peer involvement;
4. self-esteem.

D. SB children will show more stress-related health problems than NSB children.
IV. Risk/Protective Factors

The impact of child variables, family/environmental variables and type of bereavement (SB or NSB) will be determined on psychopathology. The role of the following variables, all cited as potential contributors to post-death functioning, will be examined:

A. Child Variables

1. functioning pre-death (poor functioning pre-death will be associated with poor functioning post-death)

2. functioning one month post-death (poor functioning 1 month post-death will be associated with poor functioning 6, 13 and 25 months post-death)

3. attributional style (negative attributional style will be associated with increased psychopathology)

4. self-esteem (low self-esteem will be associated with increased psychopathology)

5. age (younger children will be expected to have increased psychopathology post-death)

6. gender (no gender differences are expected)

B. Family and Environmental Variables

1. parental functioning (poor parental functioning will be associated with poor post-death functioning for the child)

2. SES (lower SES will be associated with poorer functioning for the child)

3. family attrition from study/late entry (attrition/late entry will be associated with more problems)

4. social support (decreased social support will be associated with poorer functioning)

5. post-death psychosocial stressors (increased stressors will be associated with poorer functioning)

6. family history of psychopathology in second degree relatives (increased family history will be associated with increased child psychopathology)
Method

Participants

Participants were recruited as part of the Grief Research Study, a longitudinal study of the process of bereavement in children. Over 360 children who are bereaved from parental death of all types have completed at least one interview for the Grief Study. These children and their families were recruited into the study through daily examinations of the obituaries in local papers, and contact with local funeral homes in order to determine if the deceased had children in the appropriate age range. The family was then contacted by phone and asked to participate. Approximately one-third of eligible families chose to participate in the study. None of these children had experienced the death of a sibling ever in their lives, and all had experienced the death of only one parent. In addition, the child and deceased parent had regular contact over the last two years.

Suicide bereaved (SB). The sample of 26 suicide bereaved children includes 13 females and 13 males from 15 families. Children range in age from 5 to 17 years with a mean age of 11.7 years (SD=3.4). Socioeconomic status (SES) for these families ranged from Upper (I) 20%; Upper Middle (II) 13%; Middle (III) 13%; Lower Middle (IV) 40%; to Lower (V) 13% on the Hollingshead scale M±SD= 3.1 ± 1.4 (Hollingshead & Redlich, 1958). For 22 (85%) of these children, the father is deceased. This is consistent with an overall gender difference in suicide completers; men are far more likely than women to kill themselves (Rich et al., 1988).

Non-suicide bereaved (NSB). SB children were compared with NSB participants, i.e., children whose parents died from reasons other than suicide. Originally, SB children were to be matched to NSB participants to control for any extraneous variance that might arise from differences in the child’s gender, age (± 2 years), SES (± 1 level), and gender of informant (living) parent. Gender of informant parent was thought to be important because research suggests mothers are more likely than fathers to report psychiatric symptoms in their children (Ivens & Rehn, 1988). However, upon comparing the SB group with the entire NSB group, there were no significant differences in any of the above-mentioned variables between the two groups of children (see Table 1). Therefore, SB children were compared with the grief project’s entire
sample of non-suicide bereaved children (n=332) except those children who experienced homicidal death or questionable suicidal death (n=10). This significantly increases the statistical power available to detect differences between groups.

**Measures**

1. **Phenomenology**

   The Grief Interview is a series of open-ended, semi-structured questions about the individual’s grief experience (Weller et al., 1984). The grief interview includes queries about the child’s emotional and behavioral reactions immediately following the death and in the following month (for initial interviews), at the time of the interview (for all follow-up interviews) and at the anniversaries of the death (for 13 and 25 month follow-up interviews). Specific feelings such as sadness, anger, guilt, and shame in response to the death are directly asked about. The Grief Interview also includes questions about the following: who the child is talking to about the death, post-traumatic stress disorder symptoms specifically resulting from the parental death, the child’s perceptions about the surviving parent’s current emotional state, and current support systems for the surviving parent and family. The parent version of this instrument asks the parents the same questions about his or her children in a third-person format (See Appendix A).

2. **Psychopathology**

   **Measures about the child.** Four instruments relevant to psychopathology were administered to each child and their surviving parent. They represent three methods of obtaining clinically relevant data, namely structured interviews, semi-structured clinical rating scales and self-report measures. These measures, while similar, provide a more complete picture of symptomatology than any one of the measures alone can obtain. For example, in a recent examination of structured interviews, Hodges (1993) stressed the importance of obtaining information on severity as well as presence of symptoms. Because structured interviews are not always used to their fullest potential, Hodges (1993) argues that psychometrically reliable scales of the information obtained need to be created.

   For that reason, the Grief Study has created the “BAMO” scale, a continuous scale which sums up behavioral, anxiety, and mood symptoms, as obtained on the DICA-R and DICA (described below). This
scale covers symptoms of behavior disorders (e.g. ADHD, Conduct Disorder, and Oppositional Defiant Disorder), anxiety disorders (e.g. Overanxious Disorder, Separation Anxiety, Phobias, and Obsessive Compulsive Disorder), mood disorders (e.g., Major Depression), and other types of disorders (e.g., elimination disorders, and Somatization Disorder). These are the most common diagnoses observed in children. For each diagnosis, a subject scores between 0 and 1; a score of 0 reflects no symptoms endorsed for that diagnosis while a score of 1 indicates the subject endorsed all possible symptoms for that diagnosis. To obtain the score for each diagnosis, the number of symptoms endorsed is divided by the number of possible symptoms. The BAMO treats all diagnoses equally with the exception of cigarette smoking, enuresis, encopresis and phobia, problems that would be given too much weight if treated equally to the other disorders. These four disorders are given half weight in the final summation. A subject's scores are summed up for each diagnosis. Scores can range from 0 to 18, two less than the number of disorders included in the DICA.

The Diagnostic Interview for Children and Adolescents- Revised (DICA-R) is a structured interview designed to assess presence or absence of DSM-III-R symptomatology in children (Reich & Welner, 1988). It accounts for symptoms across the whole range of childhood psychological disorders. The DICA has been demonstrated to have high test-retest reliability and moderate correlations with chart diagnoses (Welner, Reich, Herjanic, Jung, & Amando, 1988). This instrument is used to determine the psychiatric symptoms and diagnoses endorsed by the parent-bereaved children at any point since the last interview (SL1) and in the last two weeks (CUR). The initial interview assesses lifetime and pre-death symptomatology in addition to symptomatology experienced post-death. (All measures that are commonly available do not appear in Appendices to this thesis).

The Diagnostic Interview for Depression in Children and Adolescents (DIDCA) is a structured interview to assess depressive symptoms in children and adolescents (Weller & Weller, 1979). Multiple questions are asked for each of the nine symptoms of depression. If one or more questions within a diagnostic section is endorsed, the symptom is considered to be present. The DIDCA has excellent sensitivity and specificity (Fristad et al., 1995). The DIDCA is used to determine if participants have
experienced symptoms of depression since the last interview (SLI) and in the two weeks preceding the interview (CUR). It is used as the measure of depression for this project and will also be used to examine suicidal ideation and intent (See Appendix B).

The Children’s Depression Inventory (CDI) is a 27-item self-report scale to assess depressive symptomatology in children and adolescents (Kovacs, 1992). The CDI also has an equivalent measure for the parent to complete about his or her child (Weller & Weller, 1979). The child (parent) is asked to select the sentence in each item which best indicates how he or she (his or her child) has been feeling in the past two weeks. Each item is scored from 0 to 2 in the direction of increasing severity of depressive symptoms; total scores on the CDI range from 0 to 54. Test-retest reliability, concurrent validity, and the CDI’s sensitivity to severity of depressive illness have been demonstrated (Kovacs, 1992).

The Children’s Depression Rating Scale- Revised (CDRS-R) is a 21-item rating scale to assess current severity of depressive symptomatology in children and adolescents (Poznaski, Grossman, Buchsbaum et al., 1984). This scale has been shown to have good interrater reliability and test-retest reliability over a 4 week interval (Poznaski et al., 1984). Ratings are completed by the interviewer based on a semi-structured interview. Total scores range from 17 to 113 with increasing scores indicating increasing severity of depressive symptomatology.

Three items of the CDRS-R are observational in nature. Because some children participated in the study by phone or only their parents participated, observational ratings were not made and some CDRS-R scores were below the minimum of 17. Because of this, CDRS-R scores were pro-rated so that if the score was less than 17, the average score of the items completed was used to complete missing items. CDRS-Rs were administered to incorporate current symptomatology at each interview, 1, 6, 13, and 25 months.

Measures about the parents. Parental psychopathology and family history of psychopathology were obtained from the surviving parent with the Hamilton Rating Scale for Depression (Ham-D), the Family History-Research Diagnostic Criteria (FH-RDC) Interview and the Psychiatric Diagnostic Interview (PDI).
The Hamilton Rating Scale for Depression (Ham-D) is a severity rating scale used to assess depressive symptomatology in adults (Hamilton, 1967). Scores on the Ham-D are a sum of ratings for 17 items and can range from 0 to 50. The Ham-D has been shown to have high interrater reliability and adequate validity (Hedlund & Vieweg, 1979). The Ham-D was administered at each interview to the surviving parent to assess the severity of his or her depressive symptoms during the two weeks prior to the interview (See Appendix C).

The Family History-Research Diagnostic Criteria (FH-RDC) Interview is a semi-structured interview designed to assess symptoms of psychopathology in first-degree relatives of the informant (Endicott et al., 1978). The FH-RDC has adequate reliability and validity (Thompson et al., 1982), but tends to underestimate psychopathology (Andreason et al., 1986). The FH-RDC was administered to the surviving parent at each interview and was the instrument used to assess psychiatric symptomatology in the deceased parent pre-death and in all second-degree relatives of the participants pre-death and in the two years post-death.

The Psychiatric Diagnostic Interview (PDI) is a structured diagnostic interview to assess 17 psychiatric diagnoses in adults (Othmer et al., 1989). The PDI has acceptable reliability and validity (Othmer et al, 1989). In this study, the PDI was used to assess pre- and post-death psychiatric symptomatology in the surviving parents.

III Psychosocial Functioning

The Home Environment Interview- Abbreviated Version- Child and Parent Forms is a semi-structured interview designed to gain information regarding the quality and quantity of familial and nonfamilial interactions prior to and following the death (Robbins, 1983). The Home Environment has displayed high interrater reliability (Weller, Weller, & Fristad, 1989) (See Appendix D).
When consent was obtained, the Child Behavior Checklist-Teacher's Report Form (TRF) was sent to one of the child's teachers (Achenbach & Edelbrock, 1980). This instrument provides a measure of the child's behavior problems and adaptive functioning by obtaining information regarding the child's behavior in school. Standard scores are obtained for internalizing and externalizing behaviors reported by the teacher.

The Conners Revised Teacher Rating Scale was also sent to each child’s teacher (Conners, 1973). The Conners is a 28 item self-report designed to identify problem behavior in children, including conduct, anxiety, and learning problems. Adaptive functioning can also be determined using the raw score. The factors of the Conners have well established reliability (Glow, Glow, & Rump, 1982).

The Health/Sickness Questionnaire, School and Physician Rating Forms were used to gather information about the child's physical health (Fristad et al, 1991). On the school form, the number of days missed due to illness, number of visits to the school nurse and number of somatic symptoms are recorded. The physician form includes information about the number of office visits, physical symptoms reported and other pertinent health information (See Appendix E).

IV Risk/Protective Factors

In addition to information obtained on the above instruments, children were asked to fill out several relevant self-report measures.

The Children's Attributional Style Questionnaire (KASTAN) was used to measure attributional style in adolescents (Kaslows et al., 1984). The KASTAN, often called the CASQ, is the instrument usually used to measure attributional style in children and adolescents. The instrument contains 48 multiple-choice items, half of which contain negative outcome situations and half of which contain positive outcomes. The child picks the outcome from two choices of possible attributions for the given situation. Six subscales are grouped together to form composite scores for positive and negative events across the dimensions of internal, stable, and global styles. An overall score is computed by subtracting the negative event score from the positive. The overall score can range from -24 to +24. Reliability over a 6 month period has been shown to be acceptable (Seligman et al., 1984).
The Piers-Harris Self-Concept Scale is an 80-item self-report inventory designed to assess the child’s overall self-concept and self-esteem in six content areas: behavior, intellectual and school status, physical attributes, anxiety, popularity, and happiness and satisfaction (Piers, 1979). The Piers-Harris shows reliability generally higher than .70 for intervals up to five months, and even higher for shorter intervals (Piers, 1976). The Piers-Harris was used as a gauge of self-esteem in the interval since the last interview.

Procedure

Children and their surviving parents were evaluated separately approximately one month after the death of one of their parents (spouse). These face-to-face interviews were conducted simultaneously by different interviewers. The initial interview assessed symptoms which occurred since the death and also included assessment of premorbid functioning in the month prior to the death and over the child’s lifetime. The families were re-contacted and interviewed again at 6, 13, and 25 months after the death. The semi-structured interviews assessed psychiatric symptoms which occurred at any time since the last interview (SLI) as well as currently, within the two weeks prior to the interview (CUR).

These interviews took place either at the Grief Research Study offices at Ohio State University or in the participants’ homes. Each interview took approximately one to three hours. Interviewers were highly trained staff, graduate students and undergraduate students who were required to have interrater reliability measures of greater than .80 before they could conduct interviews independently.

Following each family’s interview, interviewers prepared written reports which were reviewed independently by two of the principal investigators. In addition, interviewers completed symptom and diagnostic summary sheets. On the symptom summary sheet, interviewers checked whether each symptom of depression was present or absent according to the child and according to the parent (two ratings). On the diagnosis summary sheet, interviewers decide if a child (by child and parent report) had no symptoms, symptoms but not enough for a diagnosis, or a diagnosis for each disorder covered in the DICA. These symptom and diagnosis summary sheets were reviewed in conjunction with the reports. From this, “Consensus Conference” ratings were made for each depressive symptom and for each of 24 disorders.
Data Analysis

Data were analyzed using the SAS Version 6 statistical computer program (1989). All tests are two-tailed tests. Degrees of freedom reported as non-whole numbers resulted from the Satterthwaite (1946) correction for unequal variance.

I. Phenomenology Hypotheses

A. The grief reaction in suicide-bereaved children was measured using the Grief interview. Chi-square analyses measured differences between SB and NSB children on overall grief responses of sadness, anxiety, and jealousy.

B. Chi-square analyses examined differences between SB and NSB children on guilt, anger and acceptance. Symptoms of post-traumatic stress disorder were summed and groups were compared with t-tests.

C. T-tests were used to examine differences in overall social support as an indirect measure of stigma. In addition, chi-square analyses were used to indirectly measure stigma as evidenced by shame and changes in religious practices.

II. Psychopathology Hypotheses

A. Measures about the Child

Child and parent report were obtained and reported separately. Additionally, symptoms reported by either the parent or the child were combined to create a more sensitive measure of the child’s functioning. If either the child or the parent reports a symptom, it was included in the Either summation. If child or parent has not participated at a certain interview, Either contains the available report.

1. Suicidality in each group was examined using the DIDCA. A scale was created which sums up ideation, intent, plans, and actual attempts. T-tests were used to compare SB and NSB children on this suicidality scale. Chi-square analysis was used to examine suicidality reported on the CDI.

2. T-tests were used to measure BAMO differences between SB and NSB children at each time post-death (1, 6, 13, 25 months). Chi-square analyses were used to analyze between-group differences in symptom summary sheet diagnoses of depression and other disorders.
3. Severity of depressive symptoms, as measured by the CDI and CDRS-R, were compared for SB and NSB children at each time period using t-tests.

B. Measures about the Parent

1. T-tests were used to compare SB and NSB parents at each time period on HAM-D scores. Parent report of psychiatric problems reported on the PDI and FH-RDC were examined using chi-square analyses for each of the major groups of disorders (i.e., mood, anxiety, substance abuse, sociopathy).

2. Chi-square analyses were used to compare differences for SB and NSB parents regarding the presence of psychiatric diagnoses and symptoms reported for the deceased parent prior to his or her death.

III. Psychosocial Hypotheses

A. Stability in homes in which a suicide takes place was compared to NSB homes. T-tests and chi-square analyses were used to examine differences in marital stability, previous psychiatric treatment of family members, and numbers of psychosocial stressors. Family relationships were measured using a scale created from the home environment interview. Differences on this scale were measured with t-tests.

B. Attritional differences between groups was compared using chi-square analyses.

C. Adaptive Functioning

1. School behavior was examined using TRF information. Internalizing, externalizing, overall behavior and adaptive functioning were compared using t-tests. Information obtained on the Conner's was also compared using t-tests.

2. Interest in school was compared between groups using t-tests on a scale of school interest compiled from the Home Environment interview. Chi-square analyses examined the CDI question regarding school interest.

3. T-test compared peer involvement between groups using a scale compiled from the Home Environment interview. In addition, t-tests examined differences obtained on the Piers-Harris popularity scale.
4. Self-esteem, measured with the Piers-Harris and scored against the normative sample, was compared between groups using t-tests.

D. Health problems were examined using the Physician and School rating forms and comparing numbers of visits to the doctor and days of school missed using t-tests. In addition, symptoms of illness checked by physicians or school nurses was summed to create a scale. This was compared between groups using t-tests.

IV. Risk/Protective Hypotheses

As the role of all the variables cited is thought to be a factor in psychopathology and phenomenology outcome, blocks of child and family/environmental variables were entered into a regression equation hierarchically. In addition, group status (SB, NSB) was used to predict outcome.

Results

Phenomenology Hypotheses

Grief Emotions

Time periods. Chi-square tests were conducted to assess if a greater proportion of SB children reported sadness, anger, guilt, shame, jealousy, anxiety, relief or acceptance about the death than NSB children. At the initial interview, children were asked if they experienced the emotion immediately (yes or no) after the death. At initial, 6 month, 13 month and 25 month interviews, children were asked if they experienced each emotion at the time of the interview (yes or no). At the 13 and 25 month interviews, the child was also asked if he or she experienced the emotion at the anniversary of the death (yes or no). If the child experienced the emotion at the anniversary, they were asked if the emotion was more intense at the anniversary or at its usual level. Parents were asked parallel questions about their children’s emotions. Emotions are reported from most to least experienced. Increased intensity at the anniversary is not included in the figures (See Figures 1-3).

Sadness. A non-significant trend indicated that at one month, SB children were less likely than NSB children to have experienced sadness ($\chi^2 = 3.45, df=1, p=.07$). A non-significant trend indicated that
parents reported that SB children experienced more intense sadness at the one year anniversary (t=1.93, df=18.5, p=.07). No significant differences between SB and NSB children by child or parent report were found for sadness experienced at any other time period (See Figure 1).

**Anxiety.** No significant differences in percentage of children who reported anxiety (i.e., about the death or for their surviving parent) were detected at any time period after the death. Significantly more SB children, by their parents’ report, experienced anxiety immediately after the death ($\chi^2=9.56, df=1, p=.005$) and at the one month time frame ($\chi^2=4.94, df=1, p=.03$). At the six month interview, a non-significant trend revealed a greater proportion of SB parents reported anxiety for their child ($\chi^2=3.74, df=1, p=.06$) (See Figure 1).

**Anger.** At six months, SB children reported significantly more anger than NSB children ($\chi^2=5.95, df=1, p=.02$). A non-significant trend indicated that parents reported that SB children experienced more intense anger at the one year anniversary ($t=1.86, df=17.6, p=.08$). No significant differences in child or parental report of anger were detected at other time periods (See Figure 1).

**Jealousy.** Chi-square tests revealed no significant differences in jealousy (i.e., that other people have both parents) between SB children and NSB children by their or their parents’ reports at any time period (See Figure 2).

**Guilt.** No significant differences at any time period for child or parent report were found between SB children and NSB children in guilt about the death (See Figure 2).

**Shame.** A non-significant trend indicated that SB children experienced more intense shame at the one year anniversary ($t=2.03, df=17, p=.06$). No significant differences were found in child report of shame at any time period. A significantly greater percentage of SB parents than NSB parents reported their children were ashamed about the death at the six month interview ($\chi^2=8.57, df=1, p=.005$) and at the one year anniversary of the death ($\chi^2=30.80, df=1, p=.001$). No significant differences were found in parent report at any other time period (See Figure 2).

**Acceptance.** No differences were detected in the proportion of children who reported acceptance about their parent’s death at any time period. Significantly less SB parents than NSB parents
reported acceptance for their children at six months ($\chi^2 = 11.64, df=1, p=.001$) and thirteen months after the death ($\chi^2 = 4.59, df=1, p=.04$) as well as at the one-year anniversary of the death ($\chi^2 = 4.16, df=1, p=.05$) (See Figure 3).

**Relief.** Chi-square test were conducted to see if bereavement to suicide was associated with greater relief (i.e., because of preexisting stress in families in which a suicide often takes place). Significantly fewer SB children than NSB children reported relief immediately after the death ($\chi^2 = 4.32, df=1, p=.04$). No differences were detected in parent report of relief at any time period after the death (See Figure 3).

**Summary of grief emotions.** SB and NSB children showed few differences in their grief reactions to the death. SB children reported significantly more anger at six months, while NSB children experienced significantly more relief immediately after the death. SB parents reported more anxiety for their children immediately and one month post-death and more shame for their children at the one year anniversary and thirteen month interview. More NSB parents reported acceptance in their children at six months, one year, and thirteen months post-death. One possible explanation for the few differences between groups is that the NSB group includes both children who clearly anticipated their parent’s death and children who experienced a completely unanticipated parental death. This could lead to differences in some grief emotions, most notably relief and acceptance.

**Comparisons of SB to NSB-anticipated & NSB-unanticipated**

Because the NSB sample includes children who are bereaved from anticipated parental death such as cancer as well as children bereaved from non-anticipated parental death such as auto accident, separate analyses were conducted to assess if SB children differed in relief and acceptance from anticipated or non-anticipated NSB children. This was done because many of the SB children anticipated the suicide but the anticipation seemed to be more uncertain than NSB children anticipating the death of a parent with a
terminal illness. It was hypothesized that SB children’s relief and acceptance would be less than NSB-anticipated but more than NSB-unanticipated. Chi-square tests were conducted between SB and NSB-anticipated and between SB and NSB-unanticipated to assess these differences. No direct comparisons were made between NSB-anticipated and NSB-unanticipated.

Acceptance. No significant differences were found between SB and NSB-anticipated in children’s report of their acceptance. Parental report of acceptance revealed that immediately after the death ($\chi^2 = 7.78, df=1, p=.005$), six months after the death ($\chi^2 = 12.82, df=1, p=.001$), and thirteen months after the death ($\chi^2 = 5.50, df=1, p=.02$), SB children were significantly less likely than NSB-anticipated children to report acceptance (See Figure 4).

No significant differences were found between SB and NSB-unanticipated in children’s report of their acceptance. At six months, SB parents reported less acceptance for their children than NSB-unanticipated parents ($\chi^2 = 7.45, df=1, p=.007$) (See Figure 4).

Relief. Fewer SB children than NSB-anticipated children reported relief at all time periods after the death (immediate: $\chi^2 = 13.21, df=1, p=.001$; 1 month $\chi^2 = 5.16, df=1, p=.05$; 6 months: $\chi^2 = 4.56, df=1, p=.05$; 13 months: $\chi^2 = 5.17, df=1, p=.05$; 25 months: $\chi^2 = 3.93, df=1, p=.05$). NSB-anticipated parents reported significantly more relief in their children six months after the death ($\chi^2 = 4.33, df=1, p=.04$). A non-significant trend also indicates that NSB-anticipated parents reported more relief in their children one month after the death ($\chi^2 = 3.21, df=1, p=.07$) (See Figure 4).

SB and NSB-unanticipated children did not differ in their reports of relief at any time period. Based on parent report, SB children experienced significantly more relief than NSB-unanticipated children immediately after the death ($\chi^2 = 11.22, df=1, p=.001$) and 25 months later ($\chi^2 = 4.02, df=1, p=.05$) (See Figure 4).

Summary. No differences in children’s report of acceptance were found when SB children were separately compared with NSB-unanticipated and NSB-anticipated. SB parents were less likely than NSB-anticipated parent to report acceptance immediately, six months post-death, and thirteen months post-death. SB parents were also less likely than NSB-unanticipated parents to report acceptance at six months post-
death. SB children were less likely than NSB-anticipated children to report relief at all time periods. SB parents reported less relief than NSB-anticipated parents at six months post-death, while more SB parents were likely to report relief than NSB-unanticipated parents immediately after the death and at twenty-five months. An examination of SB children compared to NSB children of unanticipated and anticipated status shows more differences in the emotions of acceptance and relief than comparisons to the entire group of NSB children.

**Post-Traumatic Stress Disorder Symptoms**

Because the experience of losing a parent is a traumatic event, and the experience of losing a parent to suicide is thought to be a more traumatic event, analyses were conducted to assess differences between SB and NSB children in post-traumatic stress symptoms. First, independent groups t-tests were conducted to assess significant differences between groups in overall post-traumatic stress disorder (PTSD) symptoms in regard to the death. SB and NSB children’s report of total PTSD symptoms did not differ at any time period. Parents’ report of their children’s PTSD symptoms differed significantly on overall PTSD symptoms only at the 25 month interview, with SB parents reporting fewer PTSD symptoms ($t=2.03$, $df=23$, $p=.05$) (see Table 2).

Because traumatic stress might be associated with type of death, overall PTSD symptoms were compared between SB children and NSB-anticipated and unanticipated. NSB children who experienced anticipated parental death did not differ from SB children on PTSD symptoms. Children who experienced unanticipated parental death experienced significantly more PTSD symptoms than SB children only by parental report at 25 months ($t=2.07$, $df=34.3$, $p=.05$).

Next, chi-square tests were conducted to test if SB children experienced significantly more of each of the major symptoms of post-traumatic stress disorder, Reexperiencing, Avoidance, and Increased Arousal. No significant differences between groups were detected for the post-traumatic symptoms of Reexperiencing, Avoidance, or Increased Arousal by the child’s report at 1, 6, 13, or 25 months. A non-significant trend was detected for the proportion of SB children experiencing more Avoidance at 13 months than NSB children ($\chi^2=3.32$, $df=1$, $p=.07$). By parental report, SB children were more likely than
NSB children to endorse Reexperiencing at 6 months post-death ($\chi^2 = 4.70, df=1, p=.05$). Non-significant trends were found showing decreased percentages of SB parents than NSB parents reporting Avoidance in their children at 25 months after the death ($\chi^2 = 3.18, df=1, p=.08$) (See Figure 5).

**Summary.** Few differences were detected in children’s experiences of PTSD symptoms in regard to the death. Parents reported that SB children experienced less overall PTSD symptoms at 25 months after the death, with NSB-unanticipated accounting for this difference. SB parents reported more reexperiencing of the death for their children at six months post-death but did not report differences in reexperiencing at other time periods or in avoidance or increased arousal at any time period. To further examine the issue of traumatic response to a suicidal death, the degree of trauma experienced by the SB children was determined as described below.

**Trauma of Death**

Suicide is a traumatic event. However, the degree of exposure survivors experience can vary widely. One might expect that increased exposure might lead to increased PTSD symptoms during bereavement. Thus, a trauma of death rating was created to assess the extent of exposure to this traumatic event experienced by SB children. A five-point scale was created which rated the trauma of the parent’s suicide. A score of 5 represents the most traumatic death possible, i.e., the child was the first person on the scene of their parent’s suicide. A score of 1 was given if the child did not see their parent commit suicide, did not have any idea that their parent was planning on killing him/herself and did not see the body after the death (until the visitation/funeral). The mean trauma rating for the SB children was $1.8\pm SD=1.3$. Over half (55.3%) received a score of 1, 23% received a 2, 0% received a score of 3, 12.5% received a 4 and 6.2% received a trauma score of 5. Thus, the majority of the SB children did not have any contact with the deceased parent at the time of the death or immediately thereafter. Correlations were completed to examine the relationship between trauma of death ratings and overall parent or child report of PTSD symptoms. At 25 months, parent rating of overall child PTSD symptoms was positively correlated with
trauma of death rating (r= .50, df=16, p= .05). The relationship at other time periods was not significant.

Given the small sample size and the limited range of trauma around the death, further analyses were not completed.

**Change In Social Support and Religious Activities**

Due to the stigma associated with suicide, SB children might be less inclined to seek out social support, might receive less social support from others, and might be inclined to change religious practices due to perceived stigma surrounding the parent’s suicidal death. Chi-square tests were conducted to determine if these differences occurred in our sample. Over half of all children reported talking to at least one person regarding their feelings about the death. No significant differences were found in either child or parent report between the percentages of SB and NSB children who reported talking about their feelings about the death with anyone else. Non-significant trends indicated that at six months, a greater proportion of SB children were likely to talk about their feelings ($\chi^2=3.24, \ df=1, \ p=.08$) while at 25 months, a greater proportion of NSB children were likely to talk about their feelings ($\chi^2=2.89, \ df=1, \ p=.09$). Chi-square tests did not reveal significant differences at any time period between the proportion of SB children or NSB children, by child or parent report, who thought that people had been helpful and supportive to their family. Over three quarters of all children and parents reported that people had been helpful and supportive to their family since the death (See Figure 6).

Chi-square tests were conducted to appraise if SB children experienced more changes, either increases or decreases, in religious practices after the death. Less than 30% of all of the children in the study reported that they increased or decreased religious participation after the death. No significant differences were detected based on child report. A significantly greater proportion of NSB parents reported religious change at the six month interview ($\chi^2=4.21, \ df=1, \ p=.04$). No other differences were detected in parental report of religious change (See Figure 6).
Summary. While shame and stigma associated with suicide were hypothesized to be associated with decreases in social support for SB children, no significant differences were found in either child or parent report in perception of social support at any time period. SB parents were less likely to report religious change at six months but religious change did not differ at any other time period.

Psychopathology Hypotheses

Measures About the Child

Suicidality. Suicidality in each group was examined using a scale created from the DIDCA which sums endorsements of suicidal ideation, intent, plans, and actual attempts. \( t \)-tests were used to compare SB and NSB children on this 4-point suicidality scale. Child, parent, and either report was examined for each time period pre- and post-death. No significant differences were found in suicidality (see Table 3).

No significant differences were found between groups at any time period when \( t \)-tests were used to examine if SB children or their parents answered the CDI question concerning suicidal ideation differently than NSB children (see Table 4).

Overall symptomatology: BAMO. Behavior, Anxiety, Mood and Other symptoms were combined to create the BAMO scale. \( t \)-tests were used to measure differences on the BAMO scale between SB and NSB children at lifetime, one month pre-death, one month post-death, SL1 until 6 months, 6 months, SL1 until 13 months, 13 months, SL1 until 25 months and at 25 months.

By child report, SB children experienced significantly greater BAMO scores at lifetime \((t=2.23, df=26.7, p=.03)\) and at 6 months SL1 \((t=2.56, df=302, p=.02)\) and a non-significant trend at 6 months current \((t=1.76, df=302, p=.08)\) (See Figure 7).

Parent report of BAMO differed significantly between groups, with SB children experiencing more symptoms for the children’s lifetime \((t=2.37, df=26.1, p=.03)\), and non-significant trends towards more symptoms at 6 months current \((t=1.85, df=302, p=.07)\), 13 months SL1 \((t=2.01, df=17.4, p=.07)\), and 13 months current \((t=1.90, df=17.4, p=.08)\) (See Figure 7).
By either report, SB children experienced significantly more BAMO psychopathology at lifetime \((t=2.48, \text{df}=26.1, p=.02)\), 6 months SLI \((t=2.38, \text{df}=22.7, p=.03)\), 6 months current \((t=2.15, \text{df}=302, p=.04)\), 13 months SLI \((t=2.36, \text{df}=17.6, p=.03)\), and a non-significant trend at 13 months current \((t=2.08, \text{df}=17.6, p=.06)\) (See Figure 7).

**Diagnosis of psychiatric disorders by team consensus.** Chi-square analyses were conducted to assess differences between SB and NSB children in diagnoses or symptoms of behavior, anxiety, mood, and other disorders by team consensus. First, between-group differences were detected for rates of diagnoses (versus symptoms or no endorsements) for each disorder at each time period. Thus, a total of 207 comparisons were made (23 disorders X 9 time periods). Of the 54 behavior disorder comparisons completed, SB children were more likely to experience diagnoses of behavior disorders than NSB children in six instances. SB children were more likely to be diagnosed with: **Oppositional Defiant Disorder** at 13 months SLI \((\text{SB: 27.8\%}; \text{NSB: 8.5\%}; \chi^2=4.48, \text{df}=1, p=.03)\) and 13 months current \((\text{SB: 27.8\%}; \text{NSB: 8.5\%}; \chi^2=4.48, \text{df}=1, p=.03)\); **Conduct Disorder** at 6 months SLI \((\text{SB: 13.6\%}; \text{NSB: 2.5\%}; \chi^2=5.82, \text{df}=1, p=.05)\) and 13 months current \((\text{SB: 11.1\%}; \text{NSB: 0.7\%}; \chi^2=5.05, \text{df}=1, p=.03)\); **cigarette usage** \((\text{SB: 36.4\%}; \text{NSB: 13.8\%})\) at 6 months SLI \((\chi^2=5.64, \text{df}=1, p=.02)\) and lifetime \((\text{SB: 11.5\%}; \text{NSB: 2.2\%}; \chi^2=3.67, \text{df}=1, p=.06)\).

A total of 54 comparisons were made for anxiety disorders. In five cases, SB children were more likely than NSB children to receive diagnoses. SB children were more likely than NSB children to receive diagnoses of **Overanxious Disorder** at Lifetime \((\text{SB: 15.4\%}; \text{NSB: 3.2\%}; \chi^2=5.00, \text{df}=1, p=.03)\), Pre-death \((\text{SB: 15.4\%}; \text{NSB: 1.6\%}; \chi^2=9.51, \text{df}=1, p=.002)\), and Post-death \((\text{SB: 15.4\%}; \text{NSB: 2.7\%}; \chi^2=6.14, \text{df}=1, p=.02)\). A non-significant trend revealed that a greater percentage of SB children were diagnosed with Overanxious Disorder at 13 months SLI \((\text{SB: 11.1\%}; \text{NSB: 1.3\%}; \chi^2=3.16, \text{df}=1, p=.08)\). A non-significant trend also indicated that SB children \((44.4\%)) were more likely to receive a **phobia** diagnosis than NSB children \((21.6\%)) at 13 months SLI \((\chi^2=3.55, \text{df}=1, p=.07)\).
While 36 mood disorder comparisons were made, only one indicated a significant difference. At 13 months current, SB children were more likely than NSB children to be given a diagnosis of Major Depressive Disorder by team consensus (SB: 27.8%, NSB: 8.5%; $\chi^2 = 4.4.8$, df=1, $p=.04$).

**Symptoms of psychiatric disorders by team consensus.** Next, chi-square analyses were conducted to determine whether differences existed between SB children and NSB children on rates of endorsed diagnoses and/or symptoms (versus no symptoms at all for that disorder). Of 207 analyses conducted, 29 significant differences and three non-significant trends emerged between groups with SB children experiencing more diagnoses or symptoms in all of these. Nearly half (15/32) of these differences were in the area of behavior disorders. Eight were in anxiety disorders, three in mood disorders, and five in “Other” disorders (see Table 5).

**Depressive Disorder.** Chi-square analyses were conducted to assess if the proportion of children who met criteria for depression based on the DIDCA differed between SB and NSB children. Child, parent and either reports were examined. No significant differences were detected bychild report. A non-significant trend indicated that in their lifetime, more SB children than NSB children experienced symptoms equivalent to a depressive episode ($\chi^2 = 3.14$, df=1, $p=.08$). SB parents reported significantly more depressive episodes for their children in the 13 month SL1 time period than did NSB parents ($\chi^2 = 4.36$, df=1, $p=.04$). By either report, SB children experienced significantly more depressive episodes in their lifetime ($\chi^2 = 4.29$, df=1, $p=.04$) (See Figure 8).

**Depressive symptoms.** T-tests were used to determine if the number of depressive symptoms at each time period differed between groups. SB children reported more depressive symptoms over their lifetime than NSB children ($t=3.00$, df=329, $p=.003$) and at 6 months SL1 ($t=2.26$, df=292, $p=.03$). No differences in depressive symptoms were detected by parent report at any time period. Either report detected significant differences, with SB children experiencing more depressive symptoms at lifetime ($t=2.52$, df=345, $p=.02$) and 6 months SL1 ($t=2.44$, df=301, $p=.02$) (See Figure 8).
Depressive symptom severity: CDRS-R. T-tests were used to compare CDRS-R depression severity scores for SB and NSB children. Child report as well as “combined” child and parent report were examined. No significant differences between groups were detected in CDRS-R child or combined scores at any time period. A non-significant trend at 25 months indicated that NSB children scored higher on the CDRS-R (t=1.91, df=33.7, p=.07) (See Figure 9).

Self-Report: CDI. T-test were used to compare CDI self-reports of depression. Child and parent reports were examined. No differences were found in CDI total scores at any time period (See Figure 9).

Summary. No differences were detected between groups in suicidality. Overall symptomatology, operationalized in the BAMO scale, showed differences between groups with SB children experiencing more symptoms at lifetime, 6 months SLI, 6 months current and 13 months SLI. When team consensus conference diagnoses were examined, SB children experienced more Oppositional Defiant Disorder, Conduct Disorder and Overanxious Disorder than NSB children at more than one time period. When consensus conference ratings of symptoms and/or diagnoses were compared between groups, a pattern of SB children experiencing significantly more behavioral disruption and somewhat more anxiety than NSB children emerged. When rates of depressive endorsements were specifically compared, SB children experienced higher rates of symptoms and/or diagnoses endorsement at lifetime, 6 months SLI and 13 months. However, no differences were detected in self-report of depression or depressive symptom severity.

Measures about the Parents

It was hypothesized that surviving and deceased parents from the SB group would experience significantly more psychopathology than parents from the NSB group before the death. Surviving parents from the SB group were further hypothesized to experience significantly more psychopathology than surviving parents from the NSB group in the two years after the death. FH-RDC and PDI information were examined but PDI results are not reported here because they were redundant. Depressive symptom severity was evaluated with the Ham-D. Parental psychiatric problems reported on the FH-RDC were compared between groups using 2 X 2 chi-square tables. Analyses compared reports of symptoms and/or
diagnoses versus no endorsements for each of the major groups of disorders (i.e., behavior, anxiety, mood, and other). If a significant difference emerged between groups, 3 X 2 Fisher’s Exact tests were conducted on individual disorders in that category (e.g., GAD in anxiety) to ascertain if differences existed between groups between reports of diagnoses, symptoms but no diagnosis, and absence of symptoms for each disorder. At the initial interview, surviving parents were evaluated for the time periods prior to the death and in the one month after the death. At the one year and two-year interviews, they were evaluated for problems that had occurred in the past year.

**Depressive symptom severity in the surviving parent.** T-tests were used to compare differences between SB and NSB parents at each interview on HAM-D scores. On average, surviving parents in both groups experienced impairment after the death; one month after the death, the average Ham-D score was 11, indicating mild depression. No significant differences were detected at any time period for the 17-item or 24-item Ham-D (See Figure 10).

**Psychiatric disorders in the surviving parent.** Surviving SB parents did not significantly differ from surviving NSB parents in their report of psychopathology at any time period. At the initial interview, greater than 50% of all parents had experienced symptoms of psychiatric illness. In the period between the initial interview and the 25 month interview, about 40% of all parents experienced symptoms of mental illness. A non-significant trend indicated that surviving SB parents were more likely than surviving NSB parent to have experienced symptoms and/or diagnoses of Other (e.g., somatization, eating disorders) disorders in their lives prior to the initial interview ($\chi^2 = 3.11, df=1, p=.08$).

**Psychiatric disorders in the deceased parent.** Chi-square tests were used to compare differences between the SB and NSB groups regarding the presence of psychiatric diagnoses and symptoms reported for the deceased parent prior to his or her death. Eighty-five percent of deceased SB parents had experienced symptoms and/or a diagnosis of one or more mental illnesses prior to his or her death compared to 35% of NSB parents. Deceased SB parents were significantly more likely than deceased NSB parents to have experienced symptoms or diagnoses of mood disorders and behavior disorders (see Table 6). Rates of anxiety and other diagnoses did not differ between groups. Within the category of mood

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disorders, a greater percentage of deceased SB parents than NSB parents experienced major depressive disorder and bipolar disorder. In the behavior category, SB parents were more likely to experience symptoms or diagnoses of the following: alcohol abuse, drug abuse, and antisocial personality disorder.

**Summary of measures about the parents.** Contrary to expectations, surviving SB parents were no more likely than NSB parents to experience symptoms or diagnoses of mental illness. Additionally, surviving SB parents did not experience more severe depressive symptoms than NSB parents. Overall, the experience of losing a spouse was associated with increased levels of depressive symptomatology. However, as expected, suicide completers experienced significantly more psychopathology prior to their death than did parents deceased for reasons other than suicide. Specifically, suicide completers were more likely to have experienced mood disorders including major depressive disorder and bipolar disorder and behavior disorders including alcohol abuse, drug abuse, and antisocial personality disorder than parents deceased from causes other than suicide.

**Psychosocial Hypotheses**

**Family Stability**

**Marital stability.** SB families (46.7%) were significantly more likely than NSB families (5.9%) to experience marital divorce or separation prior to the death ($\chi^2 = 23.50$, df=1, $p=.001$).

**Previous psychiatric treatment of family members.** SB families were significantly more likely than NSB families to include a family member who had received mental health assistance prior to the death (SB: 85%, NSB: 12%; $\chi^2 = 90.4$, df=1, $p=.001$).

**Psychosocial stressors.** A scale was created for each time period which summed the 11 psychosocial stressors assessed on the DICA. These stressors include arguing or abuse, divorce or separation of relatives, financial problems, death or serious illness of a close friend or relative, problems with the law, or substance abuse in the family. Parents reported that SB children experienced fewer psychosocial stressors in the month after the death ($M_{±SD} = 0.2±0.4$) than did NSB children ($M_{±SD} = 0.7±1.0$) ($t=4.54$, df=33.2, $p=.001$). A non-significant trend indicated that parents of SB children
(M±SD=3.2±2.4) reported more stressors for their children in their lifetime than did parents of NSB children (M±SD=2.2±1.6) (t=1.95, df=22.0, p=.06). No differences were detected in child or parent report of psychosocial stressors at any other time period before or after the death.

**Family relationships.** Family relationships were measured using a scale created from the Home Environment Interview. Children and their surviving parents were asked about the types of activities that the child participated in with each parent prior to the death and with the surviving parent at all time periods after the death. The scale summed five types of activities with parents, which included: going places together; doing fun activities at home; doing work at home; talking or arguing; and other activities. Scores ranged from 0 to 5; t-tests were used to detect differences between groups in this scale. In addition, children and surviving parents were asked if they thought each of the parents “does a lot of things” with the child. Chi-square analysis were used to assess differences between groups on this question. Parents were also asked what kinds of activities the family as a whole does together, with activities coded similarly to those above. These activities were added to create another 0 to 5 point scale.

Surviving SB parents reported that their children participated in significantly fewer activities (M±SD=2.9±1.5) with the deceased parent than NSB parents reported (M±SD=3.7±1.2) (t=2.69, df=259.0, p=.007). Far fewer SB parents (31.8%) than NSB parents (75.6%) reported their children did “a lot” with the deceased (χ²= 17.50, df=1, p=.001).

No differences were detected between groups based on child or parent report regarding the quantity of activities the surviving parent engaged in with the child pre-death or at any other time period. SB parents (pre-death: M±SD=2.4±1.4; 6 mo: M±SD=3.0±0.7; 13 mo: M±SD=3.1±0.6) reported significantly fewer family activities than NSB parents (pre-death: M±SD=3.6±0.9; 6 mo: M±SD=3.6±0.8; 13 mo: M±SD=3.6±1.0) prior to the death (t=3.34, df=17.1, p=.004) and at six (t=3.42, df=239.0, p=.001) and thirteen months (t=2.89, df=21.4, p=.01).

**Family dysfunction.** A five-point scale was created to rate the degree of dysfunction in each family in which a suicide took place. A score of 5 represents a completely chaotic family while a score of 1 represents a family which appears entirely stable. On average, SB families scored 3.3 (S.D.=1.2) for family
dysfunction. Over half (56.3%) of the SB families received scores in the 4-5 range. Due to the small sample size of 15 SB families and the restricted range of these scores, further analyses were not able to be completed to determine the impact of family dysfunction on child’s outcome. However, a qualitative examination of the data did not suggest major differences in outcome based on family dysfunction pre-death.

**Summary of family stability.** SB families showed a higher degree of disruption on several measures than NSB families. SB parents were more likely to have divorced or separated prior to the death than NSB families. SB families were more likely than NSB families to have experienced the mental health treatment of at least one family member prior to the death. SB families tended to experience more psychosocial stressors than NSB families until the month immediately before the death. However, contrary to expectations, SB families did not experience an increased incidence of psychosocial stressors after the death. In fact, NSB parents reported more psychosocial stressors than SB parents in the month after the death. While surviving SB and NSB parents did not differ in their reports of activities they participated in with their children, deceased SB parents were far less likely, by parent report, to have participated in a range of activities with their children prior to the death. While this lack of activities might be attributed to the increased rate of divorce in SB families, it suggest less positive dyadic interactions between the parent and the child in the period prior to that parent’s death. The parent’s psychopathology might have played a role in creating the problems in this relationship. SB families also participated in fewer activities than NSB families before the death and six and thirteen months later.

**Attributional Differences**

Attributional differences between groups were compared using chi-square analysis. SB children (27%) were significantly more likely than NSB children (9%) to enter the study at the six month interview ($\chi^2 = 7.96, df=1, p=.01$). However, once SB children were in the study, they were no more likely than NSB children to drop out (SB: 42.3%, NSB: 32.5%).

**Adaptive Functioning**

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Behavior at school. School behavior was examined using TRF and Conner’s information. Internalizing, externalizing, overall behavior and adaptive functioning from the TRF and total problems reported on the Conners were compared using t-tests. Adaptive functioning questions include the teacher’s assessment of academic performance and effort, appropriate behavior, and overall happiness. A total of 20 comparisons were made (5 indices X 4 time periods). No differences were found in overall behavior or adaptive functioning on the TRF or total scores on the Conner’s teacher ratings at any time period. At six months, SB children were rated as showing significantly more internalizing behavior ($M_{\pm}SD=60.7\pm11.1$) than NSB children ($M_{\pm}SD=54.0\pm9.0$) ($t=2.21$, $df=143.0$, $p=.03$). A non-significant trend at the initial interview indicated that SB children scored higher on the externalizing scale ($M_{\pm}SD=54.7\pm5.7$) than NSB children ($M_{\pm}SD=50.7\pm8.3$) ($t=1.79$, $df=182.0$, $p=.08$).

Interest in school. T-tests were used to also examine the CDI question assessing interest in school. No significant differences were detected in child or parent CDI. A non-significant trend indicated at six months, SB children reported less interest in school ($M_{\pm}SD=0.6\pm0.8$) than NSB children ($M_{\pm}SD=0.3\pm0.6$) ($t=1.82$, $df=282.0$, $p=.07$). As previously reported, the TRF adaptive functioning scale provides an indication of academic performance and interest. No differences were detected between groups on this measure.

Popularity. Children’s self-perception of popularity was assessed using the Piers-Harris popularity scale and the CDI friendship question. No significant differences were detected between groups at any time period on either of these measures. Teacher ratings of popularity were assessed by examining Scale 4 of the TRF, the Social Problems scale. By teacher report at initial interview, SB children had significantly more problems with social interactions than did NSB children (SB: $M_{\pm}SD=57.57\pm3.20$; NSB: $M_{\pm}SD=55.28\pm6.10$) ($t=2.34$, $df=21.8$, $p=.02$). No differences in teacher perception of popularity were detected at other time periods.

Self-esteem. Self-esteem was assessed using the Piers-Harris total score. At six months, SB children ($M_{\pm}SD=56.7\pm11.5$) reported significantly lower self-esteem than NSB children.
(M±SD= 63.5±10.2) (t=2.88, df=983.0, p=.005). A non-significant trend indicated at initial interview, SB children (M±SD= 56.8±6.7) reported lower overall self-esteem than NSB children (M±SD= 61.2±9.5) (t=1.77, df=293.0, p=.08).

**Summary of adaptive functioning.** Of 36 analyses conducted on adaptive functioning, SB children differed from NSB children 6 times. These differences all occurred immediately or by six months post-parental death. By teacher report, SB children differed from NSB children only in their internalizing behavior six months after the death. Teachers did indicate that SB children experienced more social problems in the month after the death. No between-group differences were detected in children's report of interest in school or popularity. SB children reported lower self-esteem initially and at six months post-death, but their self-esteem was almost identical to NSB children at later time periods.

**Health Problems**

Health problems were examined using the Physician and School rating forms. Forms were mailed to the child's physician and teacher. Unfortunately, less than half of both teacher and physician forms were returned at each time period. T-tests were used to compare SB and NSB children at each time period on numbers of visits to the physician and school nurse, and days of school missed. In addition, symptoms of illness checked by physicians or school nurses were summed to create Physician Report and School Report Health Problems Scales. Physician Report Health Problems Scale could range from 0 to 16 and School Report Health Problems Scale could range from 0 to 30. Thus, a total of 20 comparisons were made (5 ratings x 4 time periods).

**Physicians.** Overall, children in this sample were healthy; scores obtained on the Physician Report Health Problems Scale ranged from 0 to 10. Physicians reported that SB children had significantly fewer doctor visits than NSB children at 13 months (SB: M±SD=0.7±1.1; NSB: M±SD= 2.0±3.3; t=2.71, df=24.5, p=.02) and at 25 months (SB: M±SD=1.8±2.7; NSB: M±SD= 6.0±8.5; t=3.50, df=18.4, p=.005). No other differences in health care usage based on physician report were detected.
Teacher. Scores obtained on the School Report Health Problems Scale ranged from 0 to 14. At 25 months, school nurses reported that SB (M±SD= 0.8±0.8) children missed significantly fewer days of school than NSB (M±SD= 2.8±3.8) children (t=2.78, df=10.1, p=.02). A non-significant trend revealed that SB children (M±SD= 0.8±1.1) experienced fewer health problems by school nurse report than NSB children (M±SD= 1.4±2.3) at one month (t=1.86, df=23.0, p=.08).

Summary. Contrary to expectations, SB children experienced fewer physician visits than NSB children at 13 and 25 months and missed significantly fewer days of school than NSB children at 25 months. Because no significant differences in socioeconomic status existed between groups, SB and NSB children should have been just as likely to be insured and have access to health care. Thus, this does not seem to be an issue of access to care. Potentially, NSB children might be reporting increased somatic concerns due to the nature of their parent’s death (e.g. a child who lived through their parent’s long fight with cancer might be more likely to complain of aches and pains in the area of the tumor), or their parents might show increased concern for their health and take them to the physician more often (e.g. having a parent died from a heart attack might lead the surviving parent to take the child to the physician more often for blood pressure and cholesterol checks.) Presumably, some types of death, unable to be differentiated in the anticipated/unanticipated split would be more likely to lead to increased somatic complaints. By this logic, suicide would not be associated with increased somatic concerns.

Risk/Protective Hypotheses

Multiple regressions were performed to determine if group status (SB, NSB), child and/or family/environment variables pre-death and at one month after the death predicted psychopathology (BAMO) at 6, 13, and 25 months. The either computation of BAMO was used in all regressions. Because BAMO was not normally distributed in this sample, it was transformed and the square root of BAMO was used as the predicted variable.
Child Variables

First, hierarchical regression was performed. Attributional style was not used in this analysis due to the amount of missing data on this variable. Variables included in this analysis were: BAMO Life, BAMO Pre, Piers-Harris Total Score, child’s age, and child’s gender. Subsequent to these analyses, stepwise regressions were performed for each time period to determine which specific child variables made contributions to the predicted square root of BAMO.

Six month outcome. For the six month square root of BAMO, the regression equation resulted in an adjusted $R^2$ of .40, $F(7,738)=23.92, p=.001$. When the equation was recomputed without group type in the equation, the adjusted $R^2$ was .40, $F(6,739)=27.90, p=.001$. As can be seen, the $R^2$ did not differ whatsoever when group type was taken out of the equation; thus group type did not contribute to this equation. The following variables made contributions to the equation: BAMO post-death score ($p=.001$), BAMO lifetime score ($p=.01$), and child’s gender ($p=.07$).

Thirteen month outcome. At 13 months, a similar pattern occurred. The full equation with group type resulted in an adjusted $R^2$ of .34, $F(7,729)=17.3, p=.001$. The equation without group type resulted in adjusted $R^2=.35, F(6,721)=20.33, p=.001$. Thus, group type provided no meaningful incremental gain. When stepwise regression was computed, the following variables made significant contributions to the prediction of the 13 month square root of BAMO: BAMO post-death score ($p=.001$), self-esteem ($p=.001$), lower self-esteem at one month post-death was associated with poorer functioning at 13 months), and BAMO lifetime score ($p=.005$).

Twenty-five month outcome. Again at 25 months, type of death did not contribute to the equation. When the full equation was computed, adjusted $R^2=.23, F(7,171)=8.54, p=.001$. The equation without group type resulted in adjusted $R^2=.23, F(6,172)=10.02, p=.001$. Thus, group type led to no incremental gain in $R^2$. When stepwise regression was computed, the following variables were predictors: BAMO post-death score ($p=.001$), self-esteem ($p=.05$), child’s gender ($p=.08$).
Summary. Of note, the specific experience of having a parent commit suicide is not a predictor of psychiatric outcome in the presence of other child-specific variables. However, the child’s functioning in the month after the death does predict outcome at 6, 13, and 25 months post-loss. In addition, the child’s lifetime psychiatric functioning and self-esteem play important roles in the prediction of child’s psychiatric functioning throughout the first two years post-parental death.

Family and Environmental Variables

Hierarchical regression was also used to assess if type of death contributed to child’s psychiatric functioning at 6, 13, and 25 months over and above the contribution of family/environmental variables. Familial attrition could not be used in this analysis. Variables included in the analysis were: Ham-D total score; any psychiatric symptom or diagnosis in the deceased parent; any psychiatric symptom or diagnosis in the living parent; Hollingshead level; perception of social support; and child and parent report of pre and post death psychosocial stressors.

Six month outcome. For the six month square root of BAMO, the regression equation resulted in an adjusted $R^2$ of $.11$, $F(12,172)=2.97$, $p=.001$. Then, the equation was recomputed without the type of death variable in the equation. This resulted in an adjusted $R^2$ of $.04$, $F(11,173)=1.70$, $p=.08$. The $R^2$ was significantly different, indicating that type of death contributes to the square root of overall psychiatric symptoms over and above parent/environmental variables. When stepwise regression was computed, the following variables contributed to the variance accounted for by the relationship: type of death ($p=.001$), child report of psychosocial stressors after the death ($p=.001$), and parent report of stressors prior to the death ($p=.05$).

Thirteen month outcome. Again at 13 months, the full equation was a significant predictor of the square root of BAMO, [adjusted $R^2=.11$, $F(12,149)=2.68$, $p=.005$] but the reduced equation was not [adjusted $R^2=.05$, $F(11,150)=1.84$, $p=.06$]. This difference was a significant one indicating that type of death makes a significant contribution to the linear combination of family/environmental variables predicting the square root of child’s psychiatric functioning at 13 months post-death. When stepwise
regression was computed, the following variables made contributions to the predicted square root of BAMO: type of death (p=.001), parent report of psychosocial stressors prior to the death (p=.01), and quality of the relationship with the deceased parent prior to the death (p=.07).

**Twenty-five month outcome.** At 25 months, however, the block of family/environmental variables did not make a significant contribution to the prediction of the square root of BAMO with [adjusted $R^2=.04$, $F(12,118)=1.43$, $p=.20$] or without type of death [adjusted $R^2=.05$, $F(11,119)=1.61$, $p=.10$]. When stepwise regression was computed, the presence of symptoms of psychopathology in the deceased prior to his or her death (p=.01), and the child’s report of psychosocial stressors in the month after the death (p=.03) contributed to the relationship.

**Summary.** Family and environmental variables prior to and in the month after the death in conjunction with type of death contribute a small amount to the square root of BAMO at 6 and 13 months. In the presence of family/environmental variables, the specific experience of having a parent commit suicide is a predictor of psychiatric outcome. Beyond type of death, psychosocial stressors prior to and after the death, and the quality of the relationship with the deceased contribute to the prediction on psychiatric outcome at 6 and 13 months.

**Discussion**

Perhaps, despite clinical lore, the grief experience of losing a parent to suicide is no different from the grief experience of losing a parent to other causes. SB and NSB children did not differ in their experience of sadness, jealousy, or guilt. Some differences were found in anger, shame, acceptance, and relief. While these emotions were hypothesized to differ between groups, the differences were not as great or pervasive as expected. This might be related to the small sample size and lack of available statistical power to detect results. However, this might indicate that surviving the suicide of a parent is not necessarily a qualitatively different event than surviving the death of a parent from any other cause. Initially, almost all children report sadness and almost 40% of all children remain sad about the death two years later. Overall, the similarities between SB and NSB children in regard to their grief reaction might reflect a societal trend towards decreased stigma about mental illness as well as suicide. Over the last
decades, mental illness and suicide have become topics which are more openly discussed, even in the nightly news, and are no longer tightly kept as family secrets. This openness and decrease in stigmatization might have served to normalize the grief process for SB families, making their experience closer to the kind of grief experienced whenever a parent dies.

Differences in acceptance and relief seemed to be mediated by if the non-suicidal death was anticipated or unanticipated. On the variables of relief and acceptance, SB children's relief and acceptance were generally less than that of NSB-anticipated children but greater than that of NSB-unanticipated children. While a few of the suicides in this sample took the family completely by surprise, many of the suicides were in some way anticipated by the family due to the parent's previous psychiatric history. However, even when families were aware of the risk of suicide in the parent, the child did not feel as much relief as if their parent had suffered from a long physical illness.

Post-traumatic stress symptoms as a result of the death did not differ between groups at most time periods. When symptoms did differ, NSB-unanticipated seemed to account for this difference. The NSB-unanticipated deaths include accidents in which the child was involved or sudden heart attacks or aneurysms witnessed by the child. SB children, for the most part, were not directly exposed to the trauma of the suicide. Only at the 25 month parent report did the traumatic nature of the death seem to be related to SB children's post-traumatic stress symptomatology.

No significant differences were detected between SB and NSB children's experience of social support, and religious change was only greater for SB children by parent's report at one time period. Stigma was thought to play a role in both of these in that perception of stigma could have made SB children less likely to seek out social support or more likely to change their religious beliefs. Similarly, the suicide could also have led other people to stigmatize the SB children, leading to decreased available support or a feeling of unacceptance at their place of worship. Because this did not seem to occur at a greater rate for SB than for NSB children, the current role of stigma in suicide needs to be reexamined. Suicide has become less of a stigmatized event in the last 20 years, and survivors have been increasingly
allowed to grieve openly and to carry out usual religious ceremonies (Kelleher, Andrews, Danziger, & Campbell, 1997). The lack of difference in perception of social support among the children in this sample might be due in part to these societal changes.

No differences were detected between SB children and NSB children in suicidality. SB children did show more symptoms of psychopathology than NSB children at their lifetime, six and thirteen months after the death. This pattern was also evident for symptoms and/or diagnoses of depression. By two years after the death, they experienced just as much psychiatric symptomatology as NSB children. SB children experienced more diagnoses and symptoms of behavior disorders and overanxious disorder. No differences were detected in self-report or severity of depression. SB children appeared more behaviorally deregulated than NSB children, perhaps, in part, due to the disruption they experienced at home prior to the death. The lack of differences in depression and other psychiatric symptoms in the month after the death seems to indicate that the experience of losing a parent is initially equally difficult, regardless of the type of death. For SB children, the impact of the death still seems to be problematic six months after the death.

The rates of depression experienced by SB children in this study were equivalent to those seen in other studies. In Pfeffer's (1997) referred sample of suicide-bereaved children, approximately 25% of children experienced clinically significant depression. In the sample presented here, 37% of children experienced symptoms equivalent to a depressive episode at one month, and 31% experienced these clinically significant symptoms at six months. The semi-structured interview technique used in the present study is a more sensitive measure of depression than the self-reports such as the CDI used in Pfeffer's study and thus resulted in increased rates of depression in our sample of non-referred SB children. In addition, previous studies showed elevated rates of psychopathology in SB children as compared to community controls and did not directly compare SB and NSB children on measures of psychiatric symptomatology. By comparing SB children with bereaved children who had experienced parental death by causes other than suicide, this study was able to directly examine the unique contribution of suicide.
As expected, suicide completers experienced significantly more behavior and mood disorders than did parents deceased for reasons other than suicide. Surviving SB parents did not experience different rates of psychopathology than surviving NSB parents prior to or after the death. Because mental illness occurred in surviving SB parents at the same rate as surviving NSB parents, SB parents were no less able to be effective parents after the death.

Also as expected, SB families showed a higher degree of family disruption than NSB families. This includes increased rates of divorce, mental health treatment, and psychosocial stressors prior to the death in the SB group. The Grief Study initially attempted to recruit only families in which divorce, mental health treatment, and other psychosocial stressors, such as serious illness or other death in the family, did not complicate the bereavement process. Because these problems were so prevalent in bereaved families, the Grief Project began accepting into the study families who experienced one or more of these events. This initial recruitment strategy might have led to a magnification of these differences in family stability between the SB families and the NSB families and might underrepresent the extent of these problems in the overall population of bereaved families. However, the differences between groups found in this area seem to be robust and reflect genuine differences between families in which a suicide takes place and families which experience other types of parental death.

In addition, SB families entered the study later than NSB families, probably due to the turmoil within the family. SB children’s relationship with the deceased parent seemed to have been compromised. SB parents reported significantly fewer activities in which the child participated with the deceased parent than did NSB parents. The divorce rate in these families coupled with the lack of quality of the relationship with the deceased parent seems to suggest that the suicide completor, perhaps because of his or her illness and perhaps due to the divorce which might also be related to the illness, was not able to maintain a quality relationship with his or her child. The divorce itself might also have reduced the impact of the parent’s psychopathology on the children in that they had less exposure to their parent’s problems and subsequently to the parent’s decision to end his or her own life.
The quantity and quality of activities in which surviving SB parents participated with their children did not differ from the quantity and quality of activities reported in NSB families. SB families did less together prior and one month after the death. Of note, the quality of the child's relationship with the deceased parent contributed a small yet significant proportion of the variance in BAMS at one time period. Nevertheless, having experienced the suicide of a spouse or ex-spouse, SB parents seem able to be competent parents even though their families have experienced significant turmoil. This diminished relationship with the deceased, coupled with a sufficient relationship with the surviving parent, might have served as a buffer for SB children.

Few differences between groups were detected in the area of adaptive functioning. Teachers reported slightly more internalizing and social problems in SB children within the first six months post-death. In addition, SB children reported lower self-esteem in the first six months post-death. Contrary to hypotheses, SB children showed fewer physician visits and days of school missed than NSB children.

The child's functioning in the month after the death was the strongest predictor of the child's psychiatric functioning 6, 13, and 25 months later. Type of death did not contribute to this prediction over and above child variables. This implies that bereaved children, regardless of the type of parental death, should be closely monitored in the month after the death. This is especially true for children who experienced psychiatric problems prior to the death and who have low self-esteem. Close monitoring could lead to early intervention in these children and could potentially reduce their likelihood of experiencing subsequent psychiatric problems in the two years after the death.

Contrary to expectations, parent and family variables before and immediately after the death contributed little to the prediction of subsequent psychopathology in bereaved children. In this set of analyses, type of death played the largest role, indicating that the experience of losing a parent to suicide is a more important predictor than specific family or parent variables. This might be because SB families are, on the whole, more disrupted than NSB families.

The children examined in this study have not yet reached the age of risk for development of severe psychopathology. While few differences are evident between SB and NSB children in psychiatric
symptomatology in the first two years post-parental death, SB children are more likely to have a family history of mental illness, more behavioral dysregulation prior to and six months after the death, and less close family relationships. As these children enter adulthood, they might be at increased risk for mental illness and suicidality. The long-term impact of parent suicide is still not known.

This study included a relatively small sample of suicide-bereaved children. However, it is the largest study to date to interview both SB children and their parents about their experiences pre and post-death. This small sample size could have decreased the statistical power to detect results and led to less differences between groups than actually exist. Another relevant issue is whether this sample is representative of the population of SB children. While it is never possible to determine who did not participate, the current study recruited directly from the community by daily examination of obituaries. Most other studies in the area used referred samples. Therefore, the current study is expected to be the most representative examination of SB children available.

The sample of SB children examined here was somewhat heterogeneous. While the majority of parents were suffering from major mental illness which clearly impacted the family, one parent made the decision to end her life after a debilitating accident. Two parents committed suicide with no clear psychopathology evident before the death. This heterogeneity speaks to the diversity of families in which suicide takes place but makes generalization from the results somewhat difficult.

Studies need to replicate the kind of long-term controlled study presented here. Future research should try to increase the sample size of suicide-bereaved children and make special attempts to reduce attrition over the two year period. Larger sample sizes would increase the available statistical power and would make within-group comparisons as well as longitudinal analyses possible. In addition, these suicide-bereaved children should be followed up longer than two years. Perhaps the impact of suicide is felt as the child grows up.
LIST OF REFERENCES


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<th>% NSB (n=332 children, 191 families)</th>
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<th>df</th>
<th>p&lt;</th>
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Table 1

A Comparison of Demographics Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Families and Children
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<th>p&lt;</th>
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<tr>
<td></td>
<td>M (±SD)</td>
<td>M (±SD)</td>
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Note: Potential range of scores: 0-12.
²Satterthwaite Correction (1946) for unequal variance used

Table 2
Overall Post-Traumatic Stress Disorder Symptoms: Differences Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Children at 1, 6, 13, 25 Months Post-Parental Death
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Table 3

Suicidality: Comparisons between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Children Prior to the Death and at 1, 6, 13, 25 Months Post-PARENTAL Death
Table 3 (continued)

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Note: Scores can range from 0-4.
\*Satterthwaite correction (1946) for unequal variance used.
\*SLI= “Since Last Interview”, the period of time from the last interview until 2 weeks before the current one.
\*CUR= “Current”, the two weeks immediately preceding the interview.
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Note: Scores can range from 0-2
*Satterthwaite correction (1946) for unequal variance used

Table 4

**Differences Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Children on Children’s Depressive Inventory (CDI) Self-report of Suicidality at 1, 6, 13, 25 Months Post-Parental Death**
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Table 5

Percentage of Suicide-Bereaved (SB) versus Non-Suicide-Bereaved (NSB) Children Receiving Consensus Conference Endorsement Diagnoses and/or Symptoms Prior to the Death and 1, 6, 13, and 25 Months Post-Parental Death
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Note: Only significant differences reported

*** p<.005 ** p<.01 * p<.05 +p<.08

* 25mo Cur includes no significant results.
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<td>1.07</td>
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*Fisher's exact test used when chi-square not reported. 
Mood includes any symptom or diagnosis of major depressive disorder, or bipolar disorder. 
Sx=symptom, if any symptom of a disorder, less than full diagnostic criteria, is endorsed. 
Dx=diagnosis, if diagnostic criteria is met for a disorder. Symptom and diagnosis are exclusive categories. 
Anxiety includes any symptom or diagnosis of panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, or generalized anxiety disorder. 
Behavior includes any symptom or diagnosis of alcohol abuse, drug abuse or antisocial personality. 
Other includes any symptom or diagnosis of organic brain damage, schizophrenia, psychosis, somatization disorder, eating disorder, or mental retardation.

Table 6
Psychiatric Symptomatology in Decedent Parent from the Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Groups
Figure 1
A Comparison Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Child and Parent Report of Child’s Sadness, Anxiety, and Anger in Response to Parental Death Immediately After the Death and at 1, 6, 13, and 25 Months Post-Death
Figure 2
A Comparison Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Child and Parent Report of Child's Jealousy, Guilt, and Shame in Response to Parental Death Immediately After the Death and at 1, 6, 13, and 25 Months Post-Death
Figure 3
A Comparison Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Child and Parent Report of Child’s Acceptance and Relief in Response to Parental Death Immediately After the Death and at 1, 6, 13, and 25 Months Post-Death
Note: All comparisons are SB to NSB-A and SB to NSB-U. No direct comparisons were made between NSB-A and NSB-U.

Figure 4
A Comparison Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved-Anticipated (NSB-A) and Suicide-Bereaved and Non-Suicide-Bereaved-Unanticipated (NSB-U) Child and Parent Report of Child's Acceptance and Relief in Response to Parental Death Immediately After the Death and at 1, 6, 13, and 25 Months Post-Death
Figure 5
A Comparison Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Child and Parent Report of Child's Post-Traumatic Stress Disorder Symptoms of Reexperiencing, Increased Arousal, and Avoidance in Response to Parental Death at 1, 6, 13, and 25 Months Post-Death
Figure 6
A Comparison Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Child and Parent Report of Perception of Social Support and Religious Changes Subsequent to Parental Death
Figure 7
Overall Behavior, Anxiety, Mood, and Other (BAMO) Symptoms: Differences Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Children Prior to the Death and at 6, 13, and 25 Months Post-Death by Child, Parent, and Either Report

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Figure 8
Diagnosis and Symptoms of Depression: Differences Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Children Prior to the Death and at 1, 6, 13, 25 Months Post-Parental Death by Child, Parent, and Either Report

67
Figure 9

Depression Symptom Severity and Self-Report: Differences Between Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Children Prior to the Death and at 1, 6, 13, 25 Months Post-Parental Death on the Children’s Depressive Rating Scale-Revised (CDRS-R) and Children’s Depressive Inventory (CDI)
Figure 10
A Comparison of Suicide-Bereaved (SB) and Non-Suicide-Bereaved (NSB) Parents at 1, 6, 13, 25 Months Post-Parental Death on the Hamilton Rating Scale for Depression (Ham-D)
Appendix A

13 MONTH FOLLOW-UP CHILD GRIEF INTERVIEW

CODE EVERY BLANK: 0 = NO, 1 = YES, 2 = DO NOT KNOW, 9 = NOT APPLICABLE (ENTERED ON COMPUTER AS ".") 
unless otherwise specified

COMPLETE PRE-INTERVIEW: ONE YEAR ANNIVERSARY DATE WAS: __________

1. PROMPT: (A) FIRST, ASK: "Sometimes when someone we love dies, we feel... How are you feeling NOW (in the past two weeks) about your Mom/Dad's death?"

(B) SECOND, ASK: "Some children have different or stronger feelings at the ANNIVERSARY of their parent's death (e.g., like the day, week, when your Mom/Dad died), around that time did you feel... and if so did you feel... more strongly than how you feel now?

CODE: (A) As usual (as specified above)
(B) 0 = NO, 1 = YES, 2 = DO NOT KNOW, OR 3 = INTENSIFIED (**Six present, but more intense/severe at anniversary than now)

<table>
<thead>
<tr>
<th>Gefühl</th>
<th>(A) NOW</th>
<th>(B) ANNTY.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAD</td>
<td></td>
<td></td>
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<td>ANGRY OR MAD</td>
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<tr>
<td>(at Mom/Dad for dying, at living parent, or because it was't time for him/her to go yet)</td>
<td>(6) (7)</td>
<td>(8) (9)</td>
</tr>
<tr>
<td>GUILTY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(for something said/done)</td>
<td>(10) (11)</td>
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</tr>
<tr>
<td>ASHAMED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(for hurting his/her feelings; for wishing he/she would die because being sick was so hard on everyone)</td>
<td>(12) (13)</td>
<td></td>
</tr>
<tr>
<td>JEALOUS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(that other kids have 2 parents &amp; I only 1)</td>
<td>(14) (15)</td>
<td></td>
</tr>
<tr>
<td>ANXIOUS OR SCARED</td>
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<td></td>
</tr>
<tr>
<td>(my other parent, aibs, will die)</td>
<td>(16) (17)</td>
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<td>ACCEPTING</td>
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<tr>
<td>(it is too bad that Mom/Dad dies, I will always think of him/her, but it's time to go on with my life)</td>
<td>(18) (19)</td>
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<td>RELIEVED</td>
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<td>(misery is over - less tension in the house)</td>
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<tr>
<td>24</td>
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<td>(25)</td>
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</table>
2. A. Are you talking to anyone about these feelings? (26)

IF NO, skip to Q. 3. IF YES, ask:

B. With whom did you talk? (circle choices where applicable)
   parent (27)
   sister (older/younger) (28)
   brother (older/younger) (29)
   self (30)
   grandparent (31)
   other relatives (32)
   teacher (33)
   counselor (34)
   friend (peer/adult) (35)
   neighbor (36)
   other: (37)

C. What kind of things do you talk about?
   ask where parent has gone (38)
   ask why parent died (39)
   ask when you will see parent again (40)
   ask if other parent/siblings will die too (41)
   other: (42)

3. Do you ever find yourself:
   thinking your Mom/Dad is still alive (43)
   thinking you will see him/her again (44)
   talking about your Mom/Dad a lot (45)
   not wanting to talk about your Mom/Dad at all (46)
   feeling like your Mom/Dad was "perfect" (47)
   getting angry over things that never used to bother you (48)
   crying a lot (49)
   daydreaming a lot (50)
   feeling like you want to be younger again (51)
   feeling like you want to be lots older (52)
   getting into more arguments (53)
   getting into more fights (54)

continued...
3. Continued

- taking care of your brothers/sisters ___ (55)
- taking care of your Mom/Dad ___ (56)
- wanting to be around your Mom/Dad all the time ___ (57)
- wanting to have your own way all the time ___ (59)
- getting sick more often ___ (59)
- having more accidents/getting hurt more often ___ (60)
- feeling you should have more responsibility ___ (61)
- feeling you have too much responsibility ___ (62)

4. Are you doing any of these things?
   **CODE**: 0=NO, 1=ONCE OR TWICE, 2=INFREQUENTLY, 3=OFTEN

- wanting to talk a lot with parent/brother/sister about the death ___ (63)
- looking at pictures of Mom/Dad ___ (64)
- visiting the cemetery ___ (65)
- talking/thinking a lot about experiences with the deceased parent ___ (66)
- wanting to get/keep things that belonged to the deceased parent ___ (67)
- other: ___________________________ (68)

5. A. Have you thought that you heard/saw/touched/smelled your Mom/Dad since he/she died?

   **CODE**: 0 = NO
   1 = YES, HYMNPOMPICT ONLY (when first wake up)
   2 = YES, HYMNOCCIC ONLY (before fall asleep)
   3 = YES, DAYTIME ONLY
   4 = YES, OTHER: ___________________________

- heard ___ (69)
- saw ___ (70)
- touched ___ (71)
- smelled ___ (72)

continued . . .
5. CONTINUED

IF NO, skip to Q. 6. IF YES, ask:

B. Did he/she:

know you were there
do or say things that he/she always used to

talk to you
other: ____________________________

C. When this happened did you feel:

frightened/upset
comforted
confused
sad
other: ____________________________

Is there anything else about the experience you want to tell me? "_________"

PROMPT Q. 6 - 8:

"Sometimes when people go through something really difficult, they experience things in many different ways. In these next questions please tell me if you have felt this way or had these experiences."

6. REEXPERIENCING:

A. Are you often bothered by memories of your Mom/Dad's death, ______ (15)
funeral, or burial? (in young children ask for repetitive play
in which aspects of the death, funeral, or burial are expressed).

B. Do you often have bad dreams or nightmares about your Mom/Dad's ______ (16)
Mom/Dad's death, funeral, or burial?

C. Do you find yourself suddenly acting or feeling like you are ______ (17)
living through his/her death, funeral, or burial all over again
(e.g., as if you are actually going through it for the first time)?

continued . . .
6. **REEXPERIENCING CONTINUED**

D. Do you find that you feel much worse when you are reminded of the death, funeral, or burial? 

(Note: feeling should be of intense psychological distress) 

E. If child answers **YES** to at least **ONE** of A - D in reexperiencing **ASK:**

How long has _______ been going on? 

**CODE** in weeks: 

0 = < 1 wk., 1 = 1 wk., 2 = 2 wks., 3 = 3 wks., 4 = 4-12 wks.)

7. **AVOIDANCE:**

A. Do you try to avoid thoughts or feelings that remind you of your Mom/Dad's death, funeral, or burial? ____________

B. Have you found yourself going out of your way to stay away from activities that remind you of the death, funeral, or burial (e.g., like not playing games you used to play with your Mom/Dad, not going places you used to go especially with him/her)? ____________

C. Do you "draw a blank" or have trouble remembering what happened at your Mom/Dad's death, funeral, or burial? ____________

D. Has it seemed like you haven't felt as many feelings as you usually do since the death (e.g., like normally you would feel happy, sad, angry, or scared, and now you only feel sad or angry)? ____________

E. Do you ever feel now like you won't have a long life yourself? ____________

F. If child answers **YES** to at least **THREE** of A - E in avoidance **ASK:**

How long has _______ been going on? ____________

**CODE** in weeks: 

0 = < 1 wk., 1 = 1 wk., 2 = 2 wks., 3 = 3 wks., 4 = 4-12 wks.)

8. **INCREASED AROUSAL:**

A. Do you feel like you are on "super-alert", for example, to make sure your Mom/Dad, brother/sister, you, won't be harmed/die? ____________

continued . . .
INCREASED AROUSAL CONTINUED

B. Have you found yourself "startling" at the mention of your Mom/Dad's name or when you think of him/her (e.g., like you actually jerk or jump when you hear his/her name or think of him/her)?

C. Do you find that you actually break out in a "cold sweat", that your heart starts to race, or you get dizzy or shaky when you are reminded of your Mom/Dad's death (e.g., going past the cemetery, funeral home, or church)?

D. If child answers YES to at least TWO of A - C in arousal ASK:
   How long has _______ been going on?
   (CODE in weeks:
    0 = < 1 wks., 1 = 1 wks., 2 = 2 wks., 3 = 3 wks., 4 = 4 wks.)

9. Has anyone sort of filled in or taken your Mom/Dad's place for you? ______ (30)
   IF NO, skip to Q. 10. IF YES, ask:

   B. Who is it?
      relative: ________ (31)
      family friend ________ (32)
      teacher, scout leader, etc. ________ (33)
      parent's new boy/girlfriend ________ (34)
      other: ________ (35)

   C. CODE: whether the person is the same sex as the deceased parent. ______ (36)
      0 = DIFFERENT SEX, 1 = SAME SEX
10. A. How is/was your Mom/Dad (surviving parent) feeling now/at-anniversary?  ASK, CODE, & PROMPT EACH ITEM AS BEFORE IN Q. 1.

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<td>(42)</td>
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<td>jealous</td>
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<td>(46)</td>
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<tr>
<td>anxious or scared</td>
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<td>just like normal</td>
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<tr>
<td>other:</td>
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11.

A. Is your Mom/Dad talking to anyone about these feelings?  ____ (57)

IF NO, skip to Q. 12.  IF YES, ask:

B. With whom is he/she talking?

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<td>other:</td>
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</tbody>
</table>
12. 
A. Are people being helpful and supportive to your family since your Mom/Dad died? 

IF NO, skip to Q. 13. IF YES, ask:

B. How?

- giving family money/food/clothing, etc. 
- taking care of children 
- helping with house/yard upkeep 
- other: ____________________

PROMPT Q. 11 - 16
"These next questions are open-ended. You might need to think a little before you answer them, so take a minute to think if you’d like.

13. Do you notice any differences in your Mom/Dad since the last interview?

If so, how is he/she different? (record verbatim) ________________
__________________________

14. Do you notice any differences in yourself since the last interview?

If so, how are you different? (record verbatim) ________________
__________________________

15. What has been the hardest thing about the whole experience?

(record verbatim) ________________
__________________________

16. What has been the best thing in helping you to cope with the whole experience?

(record verbatim) ________________
__________________________

NOTE TO INTERVIEWERS: BEFORE THIS FORM IS RETURNED FOR DATA ENTRY YOU MUST HAVE PUT A CODE IN EVERY BLANK (OR A WORD RESPONSE WHERE APPROPRIATE)
Appendix B
DIDCA - C (IG)

DIAGNOSTIC INTERVIEW FOR DEPRESSION IN CHILDREN AND ADOLESCENTS
FORM: CHILD REPORT, INITIAL GRIEF EVALUATION

The DIDCA is a semi-structured interview developed for the assessment of depressive symptomatology associated with the DSM-III-R diagnosis of Major Depressive Episode in children and adolescents ages 6 - 18. It is administered in face-to-face interviews with the child (DIDCA-C) or the primary caretaker of the child (DIDCA-P). Developed by Elizabeth Weller, M.D., and Ronald Weller, M.D., The Ohio State University, Department of Psychiatry, 473 West 12th Street, Columbus, Ohio 43210. NOT TO BE USED, QUOTED, OR REPRODUCED WITHOUT PERMISSION.

--- FACE DATA SHEET ---

Interviewer’s name: ____________________________

Date of Interview: __/__/____ Total Time: __:__ (hrs.) (min.)

Type of Interviewer:  

<table>
<thead>
<tr>
<th>CODE</th>
<th>Research Assistant</th>
<th>Psychiatrist</th>
<th>Other Physician</th>
<th>Psychologist</th>
<th>Social Worker</th>
<th>Other</th>
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Child’s ID#: ____________

Sex: ____________  

<table>
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<th>CODE</th>
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<th>Female</th>
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Race: ____________  

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<th>Other</th>
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Type of Sample: ____________  

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<th>Psychiatric</th>
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<th>Psychiatric</th>
<th>Other</th>
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<thead>
<tr>
<th>CODE</th>
<th>Nonpatient</th>
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</table>
GUIDE TO ASSESSING DEPRESSIVE SYMPTOMS.

The purpose of the PIDCA is to assess depressive symptoms associated with the DSM-III-R diagnosis of Major Depressive Episode. Ten (10) symptoms are covered: (1) Sad/Dysphoric Mood; (2) Anhedonia/Loss of pleasure; (3) Appetite disturbances; (4) Sleep disturbances; (5) Fatigue/Energy loss; (6) Psychomotor Agitation; (7) Psychomotor Retardation; (8) Guilt/Low self-esteem/Hopelessness; (9) Concentration/Thinking problems (10) Suicidal Ideation/Thoughts of death. Within each symptoms heading, there are several sub-items to assess various components of the symptoms, as well as questions regarding previous (lifetime) evidence of the symptom.

Each item is rated for the last month (4 weeks). Additional time periods are rated for research purposes as specified on the various forms. Each item is rated as "Yes" or "No". Items are rated as "Yes" ONLY if they are of a severity to be clinically significant or clinically meaningful. The items rated as "No" should represent the absence of any evidence of the symptoms or that the symptom is not happening frequently enough, is not of a sufficient duration, or is not impairing the child's home, school, or social functioning. The following guidelines should be used to determine if a symptom is rated as a "Yes".

1. FREQUENCY: How often does the symptom happen? On a daily, weekly, monthly basis?

   ASK: How often is your son sad? All the time? Many times? Once in a while? Every day? Most days? Only once a month?

2. DURATION: How long does the symptom last? Minutes, hours, all day long?

   ASK: How long does the mood last? Does it go away quickly? Can it last as long as several hours?

3. REACTIVITY: How easy is it to get rid of the problem? If the parent of child can do something easy to get rid of the sadness, for example, it is not considered particularly significant.

   ASK: Is it easy to make it go away? Or, does it come back quickly? Does he forget about it once he gets involved in something else?

4. INTERFERENCE WITH CURRENT FUNCTIONING:
   Does the symptom get in the way of the child's functioning? At home, at school, with friends?

   ASK: Does sadness make his want to stay away from friends? Does sadness make his friends want to stay away from him? Does irritability make him very difficult to get along with at home or school? Do the sleeping problems make him tired at school so that he falls asleep in class?

Thus a "Yes" marked on any of the items must represent that the symptom is occurring to such an extent that it is a problem for the child in some way whether because it is happening very often, is lasting a long time, cannot be easily resolved, or is showing up as something that is interfering with the child's daily functioning.
PRE-INTERVIEW

1. What name do you like to be called? __________________

2. When is your birthday? ___/___/___
   (Mo.) (Day) (Yr.)

3. How old are you? ___

4. How tall are you? * ___ *
   "When possible measure actual ht. & wt.

5. How much do you weigh? ___

6. What grade are you in?
   CODE: present grade OR if summer = last grade completed OR if not in school = 00)

7. What is your religion?
   Protestant = 1
   Catholic = 2
   Jewish = 3
   Other = 4 (specify: ________)
   None = 5

8. What is/was your father's occupation? __________________

9. What is/was your mother's occupation? __________________

10. Are you on a special diet? __
    CODE: 0=No, 1=Yes
    If yes, describe __________________

11. Do you take any medications? __
    CODE: 0=No, 1=Yes
    If yes, describe __________________

12. How many people live at your house at present? ___ ___
    A. Who are they? (List by sex and age)
    Name ____________________________ Sex ______ Age ______ Relationship ______
    Codes (N,S,F,H,A)
    N=natural
    S=step
    F=foster
    H=half
    A=adopted

B. If child lives with one parent:
   Single Dead Separated Divorced
   Is your father? ___ ___ ___ ___
   Is your mother? ___ ___ ___ ___
   How old were you when you started living with only your mother/father? ___ ___

13. How many times have you moved since kindergarten? ___ ___
    How many times have you moved since last year? ___ ___
    How many different schools have you attended since kindergarten? ___ ___
    How many different schools have you attended since last year? ___ ___
## Child Depression Criteria

**CODE EVERY BLANK:** 0 = NO, 1 = YES, 2 = DO NOT KNOW, 9 = NOT APPLICABLE (ENTERED ON COMPUTER AS ".")

**unless otherwise specified**

<table>
<thead>
<tr>
<th>SUBJECT #</th>
<th>1-3</th>
<th>CARD #</th>
<th>4-5</th>
</tr>
</thead>
</table>

### 1. Depression

**RECENT**

Lately have you been having times when you feel depressed or sad and have felt:

<table>
<thead>
<tr>
<th></th>
<th>1 NO.</th>
<th>1 NO.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>PRE-DEATH</td>
<td>POST-DEATH</td>
</tr>
<tr>
<td>a. unhappy</td>
<td></td>
<td>(6)</td>
</tr>
<tr>
<td>b. discouraged</td>
<td></td>
<td>(8)</td>
</tr>
<tr>
<td>c. low</td>
<td></td>
<td>(10)</td>
</tr>
<tr>
<td>d. down in the dumps</td>
<td></td>
<td>(12)</td>
</tr>
<tr>
<td>e. worried</td>
<td></td>
<td>(14)</td>
</tr>
<tr>
<td>f. &quot;antsy&quot;</td>
<td></td>
<td>(16)</td>
</tr>
<tr>
<td>g. &quot;don't feel good&quot;</td>
<td></td>
<td>(18)</td>
</tr>
<tr>
<td>h. felt like crying</td>
<td></td>
<td>(20)</td>
</tr>
<tr>
<td>i. moody</td>
<td></td>
<td>(22)</td>
</tr>
<tr>
<td>j. other:</td>
<td></td>
<td>(24)</td>
</tr>
</tbody>
</table>

**IF YES, how long have you been feeling this way?**

<table>
<thead>
<tr>
<th></th>
<th>DAYS</th>
<th>DAYS</th>
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<tr>
<td></td>
<td>PRE:</td>
<td>POST:</td>
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</tbody>
</table>

**LIFETIME**

I've been asking you if you have recently felt (describe...e.g., sad, depressed, and/or like crying), now I would like to know about your whole lifetime.

Have you ever felt like this (describe) before? 

<p>| |</p>
<table>
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<tbody>
<tr>
<td>(30)</td>
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</table>

How old were you when you felt like this the first time?

<table>
<thead>
<tr>
<th></th>
<th>YEARS OLD</th>
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<tbody>
<tr>
<td></td>
<td>(31-32)</td>
</tr>
</tbody>
</table>

How long did it last?

<table>
<thead>
<tr>
<th></th>
<th>MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(33-34)</td>
</tr>
</tbody>
</table>
2. LOSS OF INTEREST

RECENT
Have you lost interest in your usual activities like:

a. going to school?
   ____(35)____   ____(36)____

b. don't like school anymore?
   ____(37)____   ____(38)____

c. don't like being with your friends?
   ____(39)____   ____(40)____

d. want to stay by yourself?
   ____(41)____   ____(42)____

e. haven't been careful about your looks; i.e., comb hair, wash face, brush teeth, keep clothes neat?
   ____(43)____   ____(44)____

LIFETIME (USE SAME PROMPT AS IN Q. #1)

Have you ever felt like this (describe) before?

   ____(45)____
   YEARS OLD
   ____(46-47)____
   MONTHS
   ____(48-49)____

3. APPETITE

RECENT
Have you noticed that you do not feel like eating much?
   ____(50)____   ____(51)____

Have you lost weight?
   ____(52)____   ____(53)____

How much?
   ____(54-55)____ LBS.   ____(56-57)____ LBS.

Have you noticed that you have been eating more than you usually do?
   ____(58)____   ____(59)____

Have you gained weight?
   ____(60)____   ____(61)____

How much?
   ____(62-63)____ LBS.   ____(64-65)____ LBS.

LIFETIME (USE SAME PROMPT AS IN Q. #1)

Have you ever felt like this (describe) before?

   ____(66)____
   YEARS OLD
   ____(67-68)____ MONTHS
   ____(69-70)____
   (71-72) BLANK
4. **Insomnia**

**Recent**

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Mo. Pre-death</th>
<th>1 Mo. Post-death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been having trouble sleeping?</td>
<td>(6)</td>
<td>(7)</td>
</tr>
<tr>
<td>Have you had trouble falling asleep?</td>
<td>(8)</td>
<td>(9)</td>
</tr>
<tr>
<td>Have you been waking in the middle of the night?</td>
<td>(10)</td>
<td>(11)</td>
</tr>
<tr>
<td>Do you wake up early in the morning and can't go back to sleep?</td>
<td>(12)</td>
<td>(13)</td>
</tr>
<tr>
<td>Have you been sleeping more than usual?</td>
<td>(14)</td>
<td>(15)</td>
</tr>
<tr>
<td>Do you feel like sleeping (taking naps) during the day and then cannot sleep at night?</td>
<td>(16)</td>
<td>(17)</td>
</tr>
<tr>
<td>Have you been having a lot of nightmares or bad dreams?</td>
<td>(18)</td>
<td>(19)</td>
</tr>
</tbody>
</table>

**Lifetime** (Use same prompt as in Q. 41)

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Mo. Pre-death</th>
<th>1 Mo. Post-death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever felt like this (describe) before?</td>
<td>(20)</td>
<td></td>
</tr>
<tr>
<td>How old were you then?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long did it last?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YEARS OLD</td>
<td>(21-22)</td>
<td></td>
</tr>
<tr>
<td>MONTHS</td>
<td>(23-24)</td>
<td></td>
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</tbody>
</table>

5. **Energy**

**Recent**

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Mo. Pre-death</th>
<th>1 Mo. Post-death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you felt like you don't have any energy?</td>
<td>(25)</td>
<td>(26)</td>
</tr>
<tr>
<td>Do you get tired quickly?</td>
<td>(27)</td>
<td>(28)</td>
</tr>
<tr>
<td>Do you feel like you don't have any pep?</td>
<td>(29)</td>
<td>(30)</td>
</tr>
<tr>
<td>Do you feel like you can't play very long?</td>
<td>(31)</td>
<td>(32)</td>
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</table>

**Lifetime** (Use same prompt as in Q. 41)

<table>
<thead>
<tr>
<th>Question</th>
<th>1 Mo. Pre-death</th>
<th>1 Mo. Post-death</th>
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</thead>
<tbody>
<tr>
<td>Have you ever felt like this (describe) before?</td>
<td>(33)</td>
<td></td>
</tr>
<tr>
<td>How old were you then?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long did it last?</td>
<td></td>
<td></td>
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<tr>
<td>YEARS OLD</td>
<td>(34-35)</td>
<td></td>
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<tr>
<td>MONTHS</td>
<td>(36-37)</td>
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6. PSYCHOMOTOR AGITATION

**RECENT**
- Have you been feeling more tense, anxious, irritable or fussy than is normal for you?  
  - Pre-Death: __ (38)  
  - Post-Death: __ (39)
- Have you been fidgety and cannot sit still (ants in your pants)?  
  - Pre-Death: __ (40)  
  - Post-Death: __ (41)
- Have you been in more fights than usual?  
  - Pre-Death: __ (42)  
  - Post-Death: __ (43)

**LIFETIME (USE SAME PROMPT AS IN Q. #1)**
- Have you ever felt like this (describe) before?  
  - __ (44)
- How old were you then?  
  - __ YEARS OLD (45-46)
- How long did it last?  
  - __ MONTHS (47-48)

7. PSYCHOMOTOR RETARDATION

**RECENT**
- Have you felt like you just couldn't do anything?  
  - Pre-Death: __ (49)  
  - Post-Death: __ (50)
- Do you sit around all the time?  
  - Pre-Death: __ (51)  
  - Post-Death: __ (52)
- Do you feel like not talking?  
  - Pre-Death: __ (53)  
  - Post-Death: __ (54)
- Do you feel like you do not want to move?  
  - Pre-Death: __ (55)  
  - Post-Death: __ (56)

**LIFETIME (USE SAME PROMPT AS IN Q. #1)**
- Have you ever felt like this (describe) before?  
  - __ (57)
- How old were you then?  
  - __ YEARS OLD (58-59)
- How long did it last?  
  - __ MONTHS (60-61)
  
  (62-72) BLANK
8. GUILT
RECENT

Have you had bad thoughts about yourself?  ___ (6)  ___ (7)
Do you blame yourself for bad things that happen?  ___ (8)  ___ (9)
Do you feel you are no good?  ___ (10)  ___ (11)
Do you hate yourself?  ___ (12)  ___ (13)
Do you feel you should be punished?  ___ (14)  ___ (15)
Do you feel dumb or stupid?  ___ (16)  ___ (17)
Do you feel there is no future?  ___ (18)  ___ (19)
Do you feel hopeless or helpless?  ___ (20)  ___ (21)

LIFETIME (USE SAME PROMPT AS IN Q. 41)

Have you ever felt like this (describe) before?  ___ (22)
How old were you then?  ___ (23-24) YEARS OLD
How long did it last?  ___ (25-26) MONTHS

9. TROUBLE THINKING
RECENT

Have you had trouble thinking?  ___ (27)  ___ (28)
Do you feel confused?  ___ (29)  ___ (30)
Do you feel you cannot complete your school assignments?  ___ (31)  ___ (32)
Do you feel you cannot make up your mind?  ___ (33)  ___ (34)
Do you feel you cannot concentrate?  ___ (35)  ___ (36)
Do you feel you cannot pay attention?  ___ (37)  ___ (38)

CONTINUED . . .
TRouble thinking. continued

Do you feel you have been daydreaming a lot? ______ (39) ______ (40)

Do you feel you are forgetting things you shouldn't? ______ (41) ______ (42)

Have your grades dropped? ______ (43) ______ (44)

LIFETIME (USE SAME P3ROMPT AS IN Q. #1)

Have you ever felt like this (describe) before? ______ (45)

How old were you then? ___ YEARS OLD (46-47)

How long did it last? ___ MONTHS (48-49)

<table>
<thead>
<tr>
<th>10. SUICIDE</th>
<th>1 NO.</th>
<th>1 NO.</th>
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<tbody>
<tr>
<td></td>
<td>PRE-DEATH</td>
<td>POST-DEATH</td>
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</tbody>
</table>

Have you had thoughts of death or have you been thinking about what it is like to be dead? ______ (50) ______ (51)

Have you wished you were dead? ______ (52) ______ (53)

Have you had thoughts of hurting yourself? ______ (54) ______ (55)

Have you had thoughts of killing yourself? ______ (56) ______ (57)

Have you made any plans for hurting yourself? ______ (58) ______ (59)

Have you made any plans for killing yourself? ______ (60) ______ (61)

Did you try to hurt yourself? ______ (62) ______ (63)

Did you try to kill yourself? ______ (64) ______ (65)

LIFETIME (USE SAME P3ROMPT AS IN Q. #1)

Have you ever felt like this (describe) before? ______ (66)

How old were you then? ___ YEARS OLD (67-68)

How long did it last? __ MONTHS (69-70)

(71-72) BLANK
Appendix C

ID # __ __ __ __ __ __ __ __ __ __ CARD # __ __

----------------------------------------
HAMILTON PSYCHIATRIC RATING SCALE FOR DEPRESSION
----------------------------------------

------------------------------------------------------------------------
FOR EACH ITEM SELECT THE CUE WHICH BEST CHARACTERIZES THE SUBJECT
CODE EVERY BLANK: WITH SELECTED CUE
------------------------------------------------------------------------

1. Depressed mood (sadness, hopeless, helpless, worthless)
   0 Absent
   1 These feeling states indicated only on questioning
   2 These feeling states spontaneously reported verbally
   3 Communicates feeling states nonverbally - i.e., through
      expressions, posture, voice and tendency to weep
   4 Reports VIRTUALLY ONLY these feeling states in his/her
      spontaneous verbal and nonverbal communication

2. Feelings of guilt
   0 Absent
   1 Self-reproach, feels he/she has let people down
   2 Ideas of guilt or rumination over past errors or
      sinful deeds
   3 Present illness is a punishment. Delusions of guilt
   4 Hears accusatory or denunciatory voices and/or
      experiences threatening visual hallucinations

3. Suicide
   0 Absent
   1 Feels life is not worth living
   2 Wishes he/she were dead or any thoughts of possible harm
      to self
   3 Suicidal ideas or gestures
   4 Attempts at suicide (any serious attempt rates 4)

4. Insomnia (Early)
   0 No difficulty falling asleep
   1 Complains of occasional difficulty falling asleep - i.e., more
      than one half hour
   2 Complains of nightly difficulty falling asleep
5. **Insomnia (Middle)**
   0 No difficulty
   1 Complains of being restless and disturbed during the night
   2 Waking during the night - any getting out of bed rates 2
      (except for purposes of voiding)

6. **Insomnia (Late)**
   0 No difficulty
   1 Waking in the early hours of the morning but goes back to sleep
   2 Unable to fall asleep again if gets out of bed

---

6.a. **Hypersomnia**
*DOES NOT FIGURE IN TOTAL SCORE*

   0 None
   1 Occasionally or sometimes sleeps a couple extra
      hours per day or night
   2 Requires extra sleep almost on a daily basis, or has
      extreme difficulty getting out of bed

---

7. **Work and Activities**

   0 No difficulty
   1 Thoughts and feelings of incapacity, fatigue, or weakness
      related to activities, work, or hobbies
   2 Loss of interest in activities, work, or hobbies - either
      directly reported by patient, or indirect in listlessness,
      indecision, and vacillation (feels he/she has to push self to
      to work or activities)
   3 Decrease in actual time spent in activities or decrease in
      productivity
   4 Stopped working because of present illness

---

8. **Retardation**
(Slowness of thought and speech, impaired ability to
concentrate, decreased motor activity)

   0 Normal speech and thought
   1 Slight retardation at interview
   2 Interview difficult
   3 Complete stupor

---

9. **Agitation**

   0 None
   1 Playing with hands, hair, etc.
   2 Hand-wringing, nail biting, hair pulling, biting of lips
10. **Anxiety Phobic**

- 0 No difficulty
- 1 Subjective tension and irritability
- 2 Worrying about minor matters
- 3 Apprehensive attitude apparent in face or speech

11. **Anxiety Somatic**

Physiological concomitants of anxiety. eg:
- Gastrointestinal - dry mouth, wind, cramps
- Indigestion, diarrhea, belching
- Cardiovascular - palpitations, headaches
- Respiratory - hyperventilation, sighing
- Urinary frequency, Sweating
- Incapacitating

12. **Somatic Symptoms, gastrointestinal**

- 0 None
- 1 Loss of appetite, but eating. Heavy feeling in abdomen
- 2 Difficulty eating, uses laxatives or medication for bowels, or medication for g.i. symptoms

13. **Somatic Symptoms, general**

- 0 None
- 1 Heaviness in limbs, back, or head. Backaches, headaches, muscle aches, loss of energy, and fatigability
- 2 Any clear-cut symptom rates a 2

14. **Genital Symptoms**

- 0 Absent, not ascertained (circle which)
- 1 Mild Symptoms such as: loss of libido, menstrual disturbances
- 2 Severe

15. **Hypochondriasis**

- 0 Not present
- 1 Self-absorption (bodily)
- 2 Preoccupation with health
- 3 Frequent complaints, requests for help, etc
- 4 Hypochondriacal delusions

16. **Loss of Weight**

- 0 No weight loss
- 1 Probable weight loss associated with present illness
- 2 Definite weight loss according to patient
16a. **Hyperphagia** *DOES NOT FIGURE IN TOTAL SCORE*

0 None
1 Increased appetite but no significant change in eating habits
2 Increased appetite with weight gain

17. **Insight**

0 Acknowledges being depressed and ill
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

18. **Diurnal Variation**

Rate level of variation (absent, mild, severe)
A.M.  P.M.
0 0 Absent (circle code under column - A.M./P.M.
1 1 Mild for when symptoms are worse)
2 2 Severe

19. **Depersonalization or Derealization, (such as feelings of unreality nihilistic ideas)**

0 Absent
1 Mild
2 Moderate
3 Severe
4 Incapacitating

20. **Paranoid Symptoms**

0 None
1 Suspicious
2
3 Ideas of reference
4 Delusions of reference and persecution

21. **Obsessional and Compulsive Symptoms**

0 Absent
1 Mild
2 Severe
22. Helplessness

0 Not present
1 Subjective feelings which are elicited only by inquiry
2 Volunteers his/her helpless feelings
3 Requires urging, guidance, and reassurance to accomplish
tasks or personal hygiene
4 Requires physical assistance for dress, grooming, eating,
   bedside tasks, or personal hygiene

23. Hopelessness

0 Not present
1 Intermittently doubts that "things will improve" but can be
   reassured
2 Consistently feels "hopeless" but accepts reassurance
3 Expresses feelings of discouragement, despair, pessimism about
   future, which cannot be dispelled
4 Spontaneously and inappropriately perseverates, "I'll never get
   well" or its equivalent

24. Worthlessness

Ranges from mild loss of esteem, feelings of inferiority, self-
depreciation, to delusions of worthlessness

0 Not present
1 Indicates feeling of worthlessness (loss of self-esteem) only
   on questioning
2 Spontaneously indicates feelings of worthlessness (loss of self-
esteeem)
3 Different from #2 by degree: Volunteers that he/she is "no good"
   "inferior", etc.
4 Delusional notions of worthlessness - i.e., "I am a heap of
   garbage" or its equivalent

25. Seasonal Variations *DOES NOT FIGURE IN TOTAL SCORE

0 None
1 Mild seasonal change in mood
2 Moderate seasonal change in mood
3 Severe seasonal change in mood

25A. If seasonal changes occur, note whether they occur
in the fall/winter (code=1) or spring/summer (code=2).
If no seasonal changes, code = 0.

Total Score *DO NOT COUNT SHADED CODES
Add all other codes for total depression score
Appendix D

SUBJECT #: _____ CARD #: _____ Parent's I.D. #: _____
(1) (2) (3) (4) (5)

FOLLOW-UP PARENT HOME ENVIRONMENT INTERVIEW

CODE EVERY BLANK: 0 = NO, 1 = YES, 2 = DO NOT KNOW,
9 = NOT APPLICABLE (ENTERED ON COMPUTER AS ".")
unless otherwise specified

ECONOMIC STATUS

1. Have you moved since we talked with you last?

   (06) IF YES, is your new home:

   ___ (07) larger     ___ (10) smaller
   ___ (08) nicer      ___ (11) not as nice
   ___ (09) other: _______________________

BLANK (12-17)

2A. Has there been a significant shift in your family's income?

   (18) CODE:

   No, deceased spouse had not contributed
   significantly to family income...................1
   No, surviving spouse has compensated by
   increasing his/her earning; insurance
   policies have paid cash & mortgages, other
   reasons...........................................2
   Yes, family now has less income and/or more
   expenses...........................................3
   Yes, family now has more income and/or less
   expenses...........................................4
   Other:____________________________________5

B. IF change, indicate relevant factors:

   ___ (19) medical expenses     ___ (22) Social Security payments
   ___ (20) income brought home    ___ (23) charity/welfare received
   ___ (21) money management      ___ (24) other:_________________
3A. **Has there been a change in who lives in your home?**

**IF NO, SKIP TO Q. 4. IF YES, ASK:**

<table>
<thead>
<tr>
<th>CODE</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NO</td>
</tr>
<tr>
<td>1</td>
<td>YES</td>
</tr>
<tr>
<td>2</td>
<td>DO NOT KNOW</td>
</tr>
<tr>
<td>3</td>
<td>NOT APPLICABLE (ENTERED ON COMPUTER AS '.') UNLESS OTHERWISE SPECIFIED</td>
</tr>
</tbody>
</table>

B. **Who?**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Additional adults</td>
</tr>
<tr>
<td>26</td>
<td>Additional children</td>
</tr>
<tr>
<td>27</td>
<td>Fewer children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>relative</td>
</tr>
<tr>
<td>2</td>
<td>hoarder</td>
</tr>
<tr>
<td>3</td>
<td>live in caretaker</td>
</tr>
<tr>
<td>4</td>
<td>parent's boy/girl friend</td>
</tr>
<tr>
<td>5</td>
<td>new baby</td>
</tr>
<tr>
<td>6</td>
<td>step-children</td>
</tr>
<tr>
<td>7</td>
<td>moved away</td>
</tr>
<tr>
<td>8</td>
<td>sent away</td>
</tr>
<tr>
<td>9</td>
<td>Other/Combination:</td>
</tr>
</tbody>
</table>

C. **What was the child's reaction?**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>resentful of new person(s)</td>
</tr>
<tr>
<td>28</td>
<td>some &quot;replacement&quot; of deceased parent by new person</td>
</tr>
<tr>
<td>29</td>
<td>jealous of time given to new person</td>
</tr>
<tr>
<td>30</td>
<td>misses child who is gone</td>
</tr>
<tr>
<td>31</td>
<td>fears she/he too will be sent away</td>
</tr>
<tr>
<td>32</td>
<td>other:__________</td>
</tr>
</tbody>
</table>

---

**FAMILY INVOLVEMENT**

4. **Have you remarried or are you dating?**

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes (remarried)</td>
<td>Yes (dating)</td>
</tr>
<tr>
<td>2</td>
<td>Not yet, but will do so in near future</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Not yet, but will do so at a later date</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Unsure</td>
<td>Other:__________</td>
</tr>
</tbody>
</table>

**IF NO, GO TO Q. 9 AND ASK ONLY ABOUT SURVIVING PARENT. IF YES, CONT.**
A. ___(34) Did/do your children know ahead of time about your plans to remarry/date?

B. ___(35-36) If yes, how long did/have they known? (CODE: in weeks)

6. ___(37) Did/will you "consult" with them before making your decision?

7. What was their reaction when they found out?
   ___(38) ambivalent  ___(42) indifferent
   ___(39) happy  ___(43) jealous
   ___(40) resentful  ___(44) other: ______________________
   ___(41) angry

8. What kind of things do you and your spouse/boy or girlfriend do together?
   ___(45) A. Going out (e.g. to parties, movies, etc.)
   ___(46) B. Household chores
   ___(47) C. Watching TV, quiet time (e.g. reading, etc.)
   ___(48) D. Talking to each other
   ___(49) E. Arguing
   ___(50) F. Private intimate time together
   ___(51) G. Other: ________________________________
9. There are many different activities which parents and children may do together. What kind of things do you/your spouse and your child do together?

<table>
<thead>
<tr>
<th>SELF</th>
<th>SPOUSE/BOYFRIEND/GIRLFRIEND</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>(52) A. Go on outings, physical activities, sports</td>
</tr>
<tr>
<td>B</td>
<td>(53) B. Play games, watch TV, quiet time</td>
</tr>
<tr>
<td>C</td>
<td>(54) C. Household chores, homework</td>
</tr>
<tr>
<td>D</td>
<td>(55) D. Talking, arguing</td>
</tr>
<tr>
<td>E</td>
<td>(56) E. Other: ____________________</td>
</tr>
</tbody>
</table>

10. (62) (63) Overall, do you feel like you/your spouse (boyfriend or girlfriend) does a lot with your child?

11. What kinds of things does your family do together?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(64) A. Outings, physical activities, sports</td>
</tr>
<tr>
<td></td>
<td>(65) B. Play games, watch TV, quiet time</td>
</tr>
<tr>
<td></td>
<td>(66) C. Talking</td>
</tr>
<tr>
<td></td>
<td>(67) D. Going to church</td>
</tr>
<tr>
<td></td>
<td>(68) E. Other</td>
</tr>
</tbody>
</table>

12. (69) Has there been a change in the amount of time the family spend together in activities?

**CODE:**  No change = 0  Less = 1  More = 2
15. **A.** ____(16) Has there been a change in religious practices?**

**CODE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No. .........................................................................................</td>
</tr>
<tr>
<td>1</td>
<td>Yes, have discontinued (going to church, Sunday school)</td>
</tr>
<tr>
<td>2</td>
<td>Yes, still do (__________________) but less frequently....................</td>
</tr>
<tr>
<td>3</td>
<td>Yes, do (__________________) but more frequently..........................</td>
</tr>
<tr>
<td>4</td>
<td>Yes, previously did not (__________________) but do now...................</td>
</tr>
<tr>
<td></td>
<td>Other:________________________________________________________________</td>
</tr>
</tbody>
</table>

**B. If yes, (change in religious practices) indicate reasons for change:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Religious activities had been determined by deceased spouse</td>
</tr>
<tr>
<td>18</td>
<td>Religious beliefs have changed as a result of the death</td>
</tr>
<tr>
<td>19</td>
<td>Children have requested this change</td>
</tr>
<tr>
<td>20</td>
<td>New influential adult has requested this change</td>
</tr>
<tr>
<td>21</td>
<td>Other:________________________________________________________________</td>
</tr>
</tbody>
</table>

6. **A.** ____(22) Has there been any change in child care?**

**CODE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No. .........................................................................................</td>
</tr>
<tr>
<td>1</td>
<td>Yes, parent previously cared for child(ren), now outsider does...............</td>
</tr>
<tr>
<td>2</td>
<td>Yes, a different outsider now cares for child(ren)..............................</td>
</tr>
<tr>
<td>3</td>
<td>Yes, outsider previously cared for child(ren), now parent does...............</td>
</tr>
<tr>
<td></td>
<td>Other:________________________________________________________________</td>
</tr>
</tbody>
</table>

7. **A.** ____(23) Are there any other changes that have affected your family’s functioning?**

________________________________________________________________________
Appendix E

HEALTH SICKNESS QUESTIONNAIRE - SCHOOL FORM

FOLLOW-UP EVALUATION

child's Name: ________________________ Date __________

Informant's Name: ________________________

Position (please circle): Nurse, Teacher, Other (___________)

1. Please list the number of school days missed.
   from ________ to ________: # OF DAYS = ________
   (date) (date)

2. Please list the number of visits made to the school nurse in this time period:
   # OF VISITS = ________

3. Please "✓" how frequently you have noticed the following symptoms on days he/she has been in school.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>ALMOST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomachaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Looks run down&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma attacks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aches &amp; Pains</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>describe ________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your participation!
HEALTH/SICKNESS QUESTIONNAIRE - PHYSICIAN FORM
FOLLOW-UP EVALUATION

This questionnaire is designed to provide information regarding the physical health of _______ following the death of his/her parent. We greatly appreciate your taking the time to complete it.

Informant's Name: ____________ Date: ____________

Position (please circle): Nurse, Teacher, Other (___________)

1. Please list the number of visits to your office
   from ________ to _________: # OF VISITS = ___
   (date) (date)

   IF HE/SHE HAS NOT BEEN TO YOUR OFFICE IN THIS TIME PERIOD
   PLEASE STOP HERE.

2. Please "✓" the type of complaints ______ has had.

   YES NO

   Appetite loss/Weight loss: ___ ___
   Stomachaches: ___ ___
   Nausea/Vomiting: ___ ___
   Diarrhea: ___ ___
   Constipation: ___ ___
   Headaches: ___ ___
   "Looks run down": ___ ___
   Asthma attacks: ___ ___
   Dizziness: ___ ___
   Pains: ___ ___
   Hives: ___ ___
   Neuro-dermitis: ___ ___
   Sleep problems: ___ ___
   Enuresis/Encopresis: ___ ___
   General Aches & Pains: ___ ___
   Other (please describe ________): ___ ___

3. If there is any other information you feel would be helpful (e.g., lab results) in documenting _______ physical health over the time periods listed, please note below or attach documents.

________________________________________________________________________________________

Thank you for your participation!