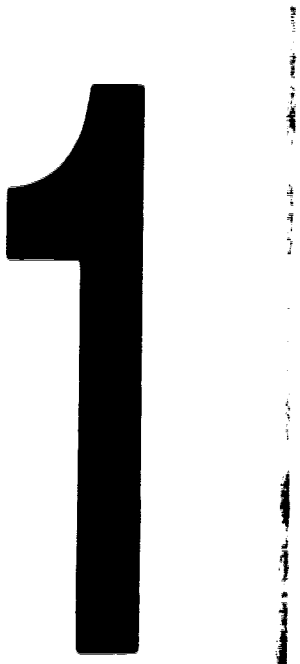

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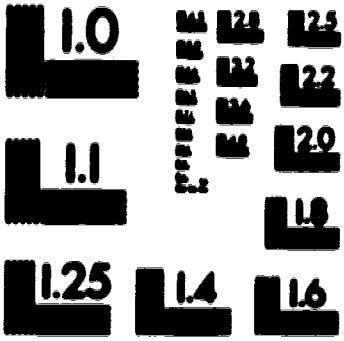

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PARENTAL GRIEF AND ADAPTATION FOLLOWING THE DEATH OF A CHILD BY AN IMPAIRED DRIVER

BY

SHERYL M. KINDRACHUK

A THESIS

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The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled PARENTAL GRIEF AND ADAPTATION FOLLOWING THE DEATH OF A CHILD BY AN IMPAIRED DRIVER submitted by SHERYL M. KINDRACHUK in partial fulfillment of the requirements for the degree of Master of Education in School Psychology.

Charles Norman, PhD

John Paterson, EdD

Lorene Everett-Turner, PhD

DATE: November 15, 1993

DEDICATION

To all of the victims of impaired drivers and their families, and to my parents, with much appreciation for their unconditional love and perpetual belief in me.

ABSTRACT

The loss of a child is a devastating trage[illegible] [illegible] most difficult of all losses to resolve, particularly where the death is [illegible] unexpected. The purpose of this study is to examine the grief and adaptation of parents whose child was killed by an impaired driver. For such individuals, the grieving process is frequently complicated by the perceived senselessness of a crime that could easily have been prevented. Moreover, frustration with a criminal justice system which continues to regard drinking and driving as a social problem rather than crime and considers crashes as "accidents" merely adds to the burden of loss. Thirteen parents (10 mothers and 3 fathers) of 10 children killed by an impaired driver participated in this research investigation.

Data were collected with both the use of an objective, standardized measure, the Grief Experience Inventory (Sanders, Mauger, & Strong, 1985) and a survey based on the Interview Questionnaire utilized by Knapp (1987). Results are consistent with many of the findings of previous research, and reveal intense levels of despair, anger/hostility, guilt, social isolation, loss of control, rumination, depersonalization, somatization, and death anxiety among most parents during the first year. However, extreme anger in the form of rage toward the offender and even hatred to the point of wishing he (in these cases all were men) would "drop dead" was found to persist despite years having elapsed since the child's death. Added to the fierce drive for revenge via the courts in which more often than not justice is perceived not to prevail according to the parents, the results of this study seem to indicate that grief following impaired driving crashes is not unlike that in which a child is murdered. The need to treat such incidents in a similar fashion is therefore proposed.

ACKNOWLEDGEMENTS

The author wishes to express warmest gratitude to the parents who participated in this study, without whom this research would not have been possible. May their strength and courage be an inspiration to those who may also find themselves contending with such a devastating loss.

Special thanks and appreciation is also extended to Dr. Charles Norman for his support and expertise in guidance and leadership and to Drs. John Paterson and Lorene Everett-Turner for their contributions to this thesis.

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I. INTRODUCTION

Alcohol misuse continues to challenge both policymakers and concerned citizens, particularly with respect to individuals who after "a couple" of drinks attempt to take charge of a motor vehicle. It has been estimated that an impaired driving collision occurs once every five minutes in Canada and that nationwide, drunk drivers kill thousands of people every year and seriously injure tens of thousands more. In 1990, drunk drivers were responsible for 112 deaths in Alberta alone (Alberta Solicitor General, 1992). Of all the drivers involved in the 357 fatal traffic collisions reported in the province in 1990, 22.1% had consumed alcohol before the crash, although it is believed that over 50% of traffic collisions actually involve drinking drivers (PAID brochure, 1990; Janzen, Paterson & Blashko, 1989a). Clearly, the considerable number of deaths and injuries resulting from alcohol-related accidents constitutes a public health problem deserving of the attention of all.

In attempting to reduce the incidence of impaired driving in our society, previous research was focused on the demographic, social, cultural, medical and personal characteristics of the drunk drivers themselves and the effects of current penalties and/or rehabilitation programs in deterring the degree of drinking and driving by these individuals. Recent research interest is centered on preventation, whereby efforts are directed toward educating and promoting awareness among the public, particularly among teenagers and young adults, of the serious legal, social and economic impact of impaired driving. Virtually neglected in the literature on impaired driving, however, are those left seriously injured and/or deprived of a loved one as a result of a drunk-driving crash.

The purpose of this project is to contribute to both the impaired driving and bereavement literature by documenting, in particular, the experience of parents whose child was killed by an impaired driver.

To date, the principal and most effective measure applied against drinking and driving is the implementation of laws limiting the amount of alcohol which can be legally consumed by a person who subsequently operates a motor vehicle on a public road. In Canada, the maximum legal limit for blood alcohol concentration (BAC) in drivers of motor vehicles is 80 milligrams of alcohol per 100 millilitres of blood (0.08%), with the risk of being in a crash increasing very rapidly at concentrations above this level. Given that the chances of being caught are a mere one in over 1000, however, many are free to motor the streets and highways while impaired despite the efforts of the renowned *Checkstop* and other enforcement programs. Assisting the legislative body in reducing the incidence of impaired driving in Alberta and preventing the tremendous cost to human life, is a group of individuals whose lives have been irrevocably altered as a result of an impaired driver. Fighting for changes to laws and attitudes about impaired driving as well as lobbying for tougher laws and stiffer penalties against the offender, PAID (People Against Impaired Drivers) members have banned together in an effort to spare others the pain and suffering they have personally endured as a result another's drinking and driving. For a further discussion of social support the reader is referred to Appendix A.

PAID (1992) suggests two changes in terminology be used in all written and verbal communications, which are also observed and acknowledged in this research:

> (1) An impaired driving crash is not an accident; it is a preventable "collision," "crash," or "incident"; and (2) "impaired" is preferable to "drunk." "Impaired" refers to operating a motor vehicle (car, truck, boat, airplane, ATV, etc.) while under the influence of alcohol at nearly all levels, legal and illegal drugs, fatigue, some medical conditions, etc. (p. 5).

All 13 parents (ie. 10 mothers; 3 fathers) who participated in this study, the majority of whom had lost their child to an alcohol-impaired driver, were recruited through PAID.

For those injured as a result of a "drunk driving crash," months or even years are frequently spent coping with ongoing pain, medical treatment, and financial insecurity, as well as battling depression and fatigue (Lord, 1987). When a loved one has been killed, however, available research on bereavement and loss suggests that the sudden and unexpected nature of traffic fatalities may pose particular difficulties for the recovery of those left behind. Such individuals may be at risk for experiencing prolonged distress and/or subsequent adjustment difficulties (Canadian Multidisciplinary Road Safety Conference V, 1987). In the case of fatalities involving impaired drivers, not only is the death sudden and unanticipated, but it is frequently violent, and in surviving family's point of view, senseless, in that the impaired driver had made a poor choice and could easily have prevented the crash. Moreover, families also experience frustration with the criminal justice system which continues to regard drinking and driving as a social problem rather than crime and considers crashes as accidents. Furthermore, when the victim is a child, parents must also confront the untimeliness of the death. Besides

feeling an overwhelming sense of pain and loss, families of impaired driving victims are thus encumbered with numerous other difficulties which impinge upon and frequently tax otherwise adaptive coping mechanisms. Consequently, the lack of empirical investigation into this form of victimization is difficult to comprehend. Not only may more effective assistance to this select group of individuals be provided, but perhaps such research may lead to changes in public attitudes and/or the creation of new laws preventing such tragedies from happening in the first place.

Lord (1987) conducted the only known investigation of "survivor grief" following impaired driving crashes by assessing the various parameters of grief symptomatology. Although responses were obtained both from individuals who had lost a loved one and those who had been seriously injured, the purpose of the present study is to examine specifically the grief and adaptation of parents whose child was killed by an impaired driver. Moreover, this study expands upon Lord's (1987) efforts not only by investigating the impact of the loss upon the respondent emotionally, as measured by the Grief Experience Inventory (GEI), but also in terms of a descriptive survey exploring the effect on marriage and family life as well. Following this brief introductory presentation, a review of the literature pertaining to parental grief and adaptation following the loss of a child is presented with an emphasis on the impact of sudden, unanticipated death. The research design and methodology is subsequently offered, including a description of the research instruments and the procedures utilized for data collection. The research findings and results are followed by a discussion section in which a summation and generalizability of the findings and limitations of the study is considered. To ensure that

the richest possible understanding of the victim's experience is obtained, the survey was conducted in interview format and in the comfort and privacy of the participants' homes.

II. REVIEW OF THE LITERATURE

Introduction

Perhaps our earliest experience with loss occurs at birth, when the comfort and security of the womb is lost. As we grow and mature, we learn that the pain of loss is as much a part of human existence as the joy often found in love. "In nature, loss is an essential element of creation--the rose blossoms, the bud is lost; the plant sprouts, the seed is lost; the day begins, the night is lost" (Colgrove, Bloomfield & McWilliams, 1991, p. 2). Loss is pervasive, inevitable, and experienced by everyone and "sets the stage for further creation or, more accurately re-creation" (Colgrove et al., 1991, p. 2).

The purpose of this review is to examine existing literature and research relevant to the bereavement experience following the loss of a loved one. After a brief discussion of loss and grief, an overview of the parental experience of, and adaptation to, bereavement following the loss of a child is presented with particular emphasis on the impact of sudden, unanticipated death.

Loss

Recently, there appears to be a general consensus among researchers of the importance of viewing loss in the larger perspective. Jansen (1985), for instance, contends that "we all grieve for the loss of a loved one, either via death or via the loss of an aborted love relationship" but that "we also grieve for other lost opportunities such as failing health, traumatic disabling conditions, and deteriorating physical and mental capacities" (p. 15). Similarly, Rupie (1985) challenges the limited conception of grief in our society, claiming that "it focuses only on the emotional reaction following the

death of a significant person, yet grief encompasses a broad range of life experiences and is the emotional response to the loss of anything one values" (p. 10).

Colgrove et al. (1991) has categorized the several types of losses one can expect to experience in life. Examples of obvious losses include death of a loved one, break-up of an affair, separation, divorce, job loss, robbery, loss of money, and sexual assault or other violent crime, whereas not-so-obvious losses involve moving, illness (loss of health), changing teachers/schools, success (the loss of striving), loss of a cherished ideal and/or long-term goal. Losses related to age are comprised of such events inherent in the developmental stages of life as childhood dreams, puppy love, crushes, adolescent romances, leaving school (dropping out or graduating), leaving home, loss of youth/beauty, loss of hair or teeth, loss of sexual drive, menopause and/or retirement. Included in the category of limbo losses are such situations in which one ponders, "'Is it on? Is it off? Is it a gain? Is it a loss?'" (p. 3) such as awaiting medical tests or reports on their outcome, a couple on the brink of divorce for the *n* th time, a lover's quarrel, selling the family home, or the outcome of a business transaction or lawsuit. Although the outcome of temporary losses is eventually favorable, such as a lover on vacation, a spouse in the service, a son or daughter away at school or financial setbacks, Colgrove et al. (1991) includes them as "losses nonetheless" (p. 8).

Grief/Bereavement

Be it large or small, obvious or not, any significant loss creates "an emotional wound, an injury to the organism" (Colgrove et al., 1991, p. 8). Following is a myriad of emotional and physical reactions commonly referred to as *grief*. *Grief* may be defined

as "a collection of biologically derived physiological reactions to loss" (Jeter, 1983, p. 219) and as a biological process, grief may be viewed as a universal human response to loss. In contrast, *bereavement* refers to the individual physiological and psychological response displayed by any one person facing a loss and is as unique as is each human being. Despite the distinction between these two terms, however, most investigators in the literature appear to use *grief* and *bereavement* interchangeably. Consequently, the two terms will continue to be used reciprocally for the purposes of this paper as well.

According to Carter (1989), the bereavement experience of those who have experienced the death of a loved one may be characterized by five main themes: *being stopped, hurting, missing, holding,* and *seeking*. *Being stopped* refers to the "interruption of life's usual flow following the death of a loved one and is characterized by varying types and degrees of inability, frequently stated in terms of 'I can't'" (p. 355). *Hurting* is composed of a variety of extremely painful emotions including sorrow and sadness and is revealed in such expressions as having been hit, wounded, stabbed, shattered, or crushed. *Missing*, which consists of a yearning or wishing for the deceased's presence despite the irreversible and permanent nature of the absence, is the bereavement theme that represents the acute awareness of everything that has been lost. *Holding*, or "a theme of selective preservation encompassing the bereaved one's desire to maintain all, particularly that which was good, from the loved one's lost existence" (p. 356). The fifth core theme of bereavement, *seeking*, describes a search for help that often takes the form of seeking comfort (often through religion) and meaning (from finding others who truly understand).

Grief Model

Although a variety of models conceptualizing grief from a host of divergent theoretical perspectives currently abound in the research, stage theories depicting the phases of normal grieving continue to persist in popularity. Despite differences of opinion regarding the number of stages, as well as the rate at which the grieving individual will traverse them, it is clear that progression through a recognized process is essential in the successful resolution of loss.

Assuming Lord's (1987) contention that ". . . grief resulting from a drunk-driving crash is not unlike that in which a family member is murdered" (p. 415), for the purposes of this review, the grief process offered by Sprang, McNeil & Wright, Jr. (1989) in their study of survivors of significant others who died violently will be presented. Since survivors of homicidal deaths were found to differ greatly in their reaction to death from those who grieved the nonviolent loss of a loved one, Sprang et al. (1989) proposed the following five stage representation of the grief process: (1) shock, denial, and isolation in which the individual attempts to limit his/her awareness of the reality of the event; (2) emotional release, characterized by the presence of psychological and/or physiological symptoms, including changes in sleeping and/or eating habits, sudden increases or decreases in weight, depression, and/or feelings of helplessness, disorientation and/or fear of "going crazy"; (3) guilt, anger, and resentment; (4) depression, with difficulty returning to daily activities and/or interacting within the larger society; and, (5) acceptance, resolution, and adaptation whereby full understanding of the loss has been reached such that the individual is able to return to

some form of normal life and experiences an overall sense of renewed hope for the future.

However, people who have suffered a severe loss often do not become their "old selves" after experiencing grief. They do not return to the personal identity and emotional organization they maintained before the loss (Weiss, 1988). The grief process following the death of another person will undoubtedly have an everlasting effect upon the survivor. For some, positive change may emerge as a result of dealing with the loss of a loved one. Calhoun & Tedeschi (1990) found that particularly with respect to self-perception, respondents described themselves as "more mature, more independent, better able to face other crises, and changed into a stronger or wiser person" (p. 269). For others, however, grieving may become a pathological process in which the grief becomes overwhelming and intolerable to the extent that the individual feels incompetent in handling the loss.

According to Sanders (1988), several variables may be responsible for promoting elevated health risks and contributing to generally poorer bereavement outcomes. These include being of younger age at bereavement, experiencing a sudden, unexpected death (eg. suicide, murder, AIDS), being a mother or widower, and/or possessing dependent or ambivalent personality characteristics. Experiencing multiple losses or tandem deaths, losing a child, having generally poorer physical and emotional health prior to bereavement and/or a perceived lack of social support were also identified by Sanders (1988) as contributing factors.

While the communication and support afforded by friends and family are, according to Feezel & Shepherd (1987), "a major interpersonal factor in coping with losses" (p. 324) results from bereaved respondents revealed that others often say and do things that are unhelpful (Range & Niss, 1990). Lehman, Ellard, & Wortman (1986) found that the common support tactics of giving advice, encouraging recovery, minimizing/forced cheerfulness, and identification with feelings (eg. "I know how you feel") frequently leave the grieving individual feeling misunderstood, isolated, and alone.

Loss of a Child

Certainly few would argue that the death of a significant person may well be "the most devastating crisis an individual may encounter in his or her lifetime" (Caryk, 1985, p. 1), producing intense psychological suffering and distress. Whether one loses a parent, sibling, spouse, child, relative, close friend, or other important person in his or her life, the death of a loved one launches the bereaved into such intense emotional turmoil that previous coping mechanisms are often rendered ineffective in dealing with the tremendous outpouring of grief and anguish such a loss frequently elicits. Although all are relationships involving some form of emotional attachment, the bereavement experience following the loss of a primary family member appears to present a more dismal portrayal for those left behind.

Zisook & Lyons (1988) found that while conjugal bereavement has been "well recognized as one of the most devastating of all life events" (p. 141-142), in their study, "the most difficult relatives to lose turned out to be children" (p. 141). Moreover, these researchers discovered that the loss of either sons or daughters was associated with

greater unresolved grief than the loss of any other relative (Zisook & Lyons, 1988, 1990). Similarly, Owen, Fulton & Markusen (1982) noted that the death of an elderly parent was "less disruptive, less emotionally debilitating and generally less significant for surviving adult children in terms of the continuity and stability of established behavioral patterns" (p. 191) than was either spousal or child loss. Although noting the tendency for investigators studying the impact of loss on the family to conceptually combine spousal with child loss, Lieberman (1989) asserts that the loss of a child is generally more severe, with studies demonstrating significant improvement in widows and widowers after one year, whereas parents continued to be symptomatic and display major problems in psychological and social functioning. It is virtually unanimous among researchers that of all the possible losses individuals may experience, the death of a child is likely the most traumatic and stressful event that can strike any family (Owen, Fulton & Markusen, 1982-1983; Miles, 1985; Miles & Perry, 1985; Rando, 1985; Dyregrov & Matthiesen, 1987; Knapp, 1987; Johansen, 1988; Zisook & Lyons, 1988; Bernstein, Duncan, Gavin, Lindahl & Osonoff, 1989; Florian, 1989; Gilbert, 1989; Jost & Hanse, 1989; Schwab, 1990) and the most difficult to resolve.

Despite the preponderance of findings demonstrating "consistent patterns of negative health and adaptive consequences for parents" (Murphy, Aroian & Baugher, 1989, p. 321), the loss of certain children are apparently grieved for more intensely than others. Littlefield & Rushton (1986) revealed that not only were healthy children grieved for more than unhealthy children, and girls less so than boys, but sex and health of the child interacted unequally in grief intensity such that healthy males were grieved for

significantly more intensely than both unhealthy male children and the two groups of female children (ie. healthy and unhealthy). No differences in grief intensity were observed among unhealthy males, healthy females, and unhealthy females. Although support was not provided for their prediction that older children would be grieved for more intensely than younger ones, children who were physically similar to their parents were grieved for more than were dissimilar children. Moreover, differences in the manner in which mothers and fathers coped with the death of their child also revealed some interesting trends. Not only have husbands been found to report generally lower levels of grief than their wives (Bohannon, 1990), but Cook (1981) found that whereas fathers tended to explain the loss as a void or feeling of something missing, mothers were more apt to describe it in more personal terms and frequently linked it to feelings of loneliness. In addition, Cook (1981) revealed that although both parents experienced difficulty with holidays, first birthdays and anniversaries appeared to be particularly troublesome for mothers.

Irrespective of the cause of a child's death, however, available research suggests that "the bereavement response is complex and often polarized with respect to social cohesion and disruption of bonds" (Lehman, Wortman & Sorensen, 1989, p. 360). This was found to be particularly true of the marital relationship. Lehman et al. (1989) found that while for some parents the child's death had strengthened the marriage and generally brought them closer together, for others, the death was "a stressor sufficient to disrupt the relationship" (p.360) with the couple subsequently separating or divorcing. Of the bereaved couples studied who remained together, despite feeling more upset, stressed and

somewhat tense in their marital role, Lehman et al. (1989) noted that many parents did not report feeling less content with their spouse or their children. On the contrary, they found that the majority generally felt closer to their remaining offspring and expressed an improvement in the parent-child relationship following the death. However, parental reports revealed that the death of a sibling was "overwhelmingly negative for children" (Lehman et al., 1989, p. 361), often resulting in prolonged periods of anguish characterized by feelings of anger and confusion.

Parental Grief

Researchers within the field of parental bereavement have generally employed the use of individually constructed surveys or questionnaires as their primary data gathering instrument. These are administered primarily in interview format, which permits a greater depth of understanding to be obtained. Moreover, the face-to-face interaction is apparently the preferred choice when investigation centers upon such a highly sensitive subject matter. The measurement of grief symptomatology has generally employed the use of standardized instrumentation.

When compared with nonbereaved controls, bereaved parents have been found to differ significantly in terms of both overall and specific grief symptomatology. Miles (1985) revealed that based on the Hopkins Symptom Checklist (HSCL), bereaved parents generally experienced more depression, anxiety, somatization, obsession-compulsion and interpersonal sensitivity than nonbereaved parents. Moreover, "it appears that time does little to alleviate the risk of emotional symptoms through the first 30 months after the child's death" (Miles, 1985, p. 80). Martinson, Davies & McClowry (1991) claim that

based on data obtained from the Symptoms Check List (SCL-90) bereaved parents may remain vulnerable to or at high risk for depression several years following the child's death. Bereaved parents from lower socioeconomic backgrounds as well as those with higher concurrent life stresses appeared to be at greater risk for developing emotional symptomatology.

Based on his survey data, Knapp (1987) revealed that following a child's death, bereaved parents tended to share five common features: (1) a desire never to forget the deceased child; (2) contemplation of suicide as a means of legitimizing the loss; (3) an eventual turning to religion for answers and/or comfort which according to Cook & Wimberley (1983) consist of one or more of the following theodicities: (a) the promise of reunion with the deceased child in an afterlife; (b) the death was intended by God to serve a noble purpose; and/or (c) the death served as a punishment for their wrong-doing; (4) significant changes in values such that attachments to traditional values and goals of success and personal achievement, for instance, tended to be replaced with new commitments to more intangible values; (5) a tendency towards becoming "more tolerant of other people and more sensitive to and understanding of the problems and suffering of others" (p. 67); and (6) the presence of grief that is "never totally resolved," referred to as "shadow grief."

Florian (1989) found evidence that bereaved mothers and fathers frequently succumb to the feeling of less meaning and purpose in life, adding that "this sense of overwhelming life .meaninglessness gained expression in most aspects of the bereaved parents' life" (p. 100), including the areas of work, coping with stress, and family and

social relations, with little improvement over time. Similarly, McClowry, Davies, May, Kulenkamp & Martinson (1987) revealed that despite the overt appearance of living seemingly functional, meaningful lives, parents tend to experience a sense of emptiness or an "empty space" even after 7-9 years.

Issues in Parental Grief

For the couple whose child has died, several psychological and sociological factors unique to parental bereavement have been identified that contribute in making it particularly difficult to resolve. Aside from contending with the unexpected and unnaturalness of a child's death, as well as associated issues of guilt and responsibility, bereaved parents frequently experience increased social stigmatization in which feelings of abandonment, helplessness, and frustration (Rando, 1985) often ensue. According to Rando (1985), bereaved parents are frequently avoided, rarely receive social invitations and may "find themselves the object of anger when their premorbid levels of activity and humor do not return quickly enough" (p. 20). When confronted with seeing other children, especially those of the same sex and/or age as their child, feelings of jealousy and resentment may emerge as parents are reminded of their deceased child's unfulfilled potential (Cook, 1981).

Particularly difficult is the loss of the primary support figure, "as the person to whom one would normally turn for support is also deeply involved in his or her grief" (Rando, 1985, p. 20). Moreover, incompatible grieving styles, the common tendencies to displace blame or feelings of anger on one another and/or misinterpret the manifestations of a spouse's grief as hostile or uncaring may contribute to discordant

coping strategies and subsequent difficulties in marital adjustment. Feeley & Gottlieb (1988) found that where the coping patterns of spouses were discordant, higher levels of conflict and hostility appeared within the couple's communication levels. Even where similar styles of grieving have been demonstrated, however, "spouses are often forced to accommodate to a lack of synchronicity" in their mood cycles (Rando, 1985, p. 21). The result may be subsequent estrangement thereby blocking communication or aggravating preexisting marital problems, particularly those found in their intimate union (Rando, 1985). Although the comfort of, and need for, sexual contact is frequently experienced by only one spouse, the partner's lack of interest and/or depressive symptomatology may interfere in the couple's sex life resulting in abstinence for as long as two years following the loss of the child (Rando, 1985).

Further intensifying strain on the marital relationship is "the fact that many couples are geographically isolated from their extended families" (Bernstein, Duncan, Gavin, Lindahl & Osonoff, 1989, p. 228) and "at the same time . . . other support networks . . . evaporate in the face of the tragedy" (p. 228). Finally, faced with the double burden of tending to the needs of their present children while at the same time doing the work of mourning the deceased child and confronting associated issues, Rubin (1986) notes that parents are frequently hampered in their ability to assist their remaining children, "who often are neglected in time of intense parental grief" (Brody, 1983 as cited in Johansen, 1988, p. 151).

Coping Strategies

In attempting to deal with the tremendous stress brought about by the traumatic and intensely painful loss of a child, parents have been found to utilize a variety of coping strategies, the most adaptive of which according to Videka-Sherman (1982) are active and externally directed. She contends that replacement of the child either with another child (pregnancy or adopting) or with another meaningful role (eg. a new job, returning to school) and altruistic involvement in active membership groups resulted in less depression among her sample of bereaved parents who utilized such strategies. Moreover, Videka-Sherman (1982) surmised that these tactics "afford the opportunity for the parent to reinvest energy and love in another valued pursuit" (p. 696). Escape (eg. trying not to think about it, alcohol and/or drug use) and preoccupation with the loss were found to be the least adaptive mechanisms of coping, however.

Schwab (1990) also observed the tendency of parents to become preoccupied with their loss, and to attempt to divert their attention toward external events. However, he noted that "although avoidance/diversion is generally considered to be an unconstructive coping strategy, avoiding painful thoughts and feelings through such strategies was a necessity for survival for many parents" (p. 420). The five major coping mechanisms utilized by the parents in his sample consisted of: (1) seeking the release of tension by talking, crying, exercising, and/or writing; (2) avoiding painful thoughts and feelings by keeping busy and/or trying not to think about their loss; (3) making use of a cognitive framework to assist in understanding and dealing with the loss experience through reading materials on loss and grief, and in trying to accept the reality of the situation,

accentuate the positive aspects and happy memories they had had with the child; (4) assisting others and/or contributing to a particular cause which not only directed their attention away from their grief but contributed to the belief that their child's death had resulted in something worthwhile; and (5) relying on religious beliefs for strength and maintenance of hope.

Gender differences identified through Schwab's (1990) interview and qualitative data revealed that not only did mothers use a greater variety of coping strategies than did fathers, and to a greater extent, but females relied more heavily on their religious faith, on helping others and on staying alone than did their male counterparts. In addition, mothers more often attempted to relieve their emotional tension through crying, and utilized writing and reading on loss and grief as their primary mechanisms of coping with the death of their child. In their study of maternal and paternal coping, Feeley & Gottlieb (1988) revealed that overall, mothers and fathers differed in only three of the fourteen strategies they examined, with mothers seeking social support, using preoccupation, and employing escape-avoidance tactics to a significantly greater extent than did fathers, suggesting perhaps more concordance than discordance in parental management of grief.

Marital Impact

With individual coping abilities frequently strained to the breaking point, the threat of marital disruption and divorce looms heavily over grieving couples. Findings from divorced couples, parents who divorce after the child's death, and those who remained married revealed two central themes: (1) the paradox of a new tie established

between the spouses despite the great deal of estrangement ensued by their separate grief experiences; and (2) "a strong sense of reordered priorities and sense of the self as a center of strength within the decision to face directly the issues given in the new world of parental bereavement" (Klass, 1986, p. 237). For parents who remained married, Klass (1986) found that although difficult for some, in the end, the loss appeared to be a positive factor in the marriage. Similarly, Dyregrov & Matthiesen (1987) discovered that for most of the parents they studied, the death had eventually brought them closer together.

Among the members who were divorced after the child died, it was observed that "the new tie between the couple may be a simple truce declared between them during the dying process but more often it is a sympathetic understanding that transcends the recent interpersonal strife" (Dyregrov & Matthiesen, 1987, p. 241-242). Parents who divorced within a few years after after the child's death claimed that the death was not necessarily a central factor in the divorce itself but that prior problems were no longer worth fighting about.

From couples who have successfully weathered the crisis period and/or experienced very little conflict in their marriage, suggestions may be obtained from an analysis of their interactions. Gilbert (1989) revealed several characteristics of such couples, claiming that stability may be reintroduced into the marital relationship through "open and honest verbal and nonverbal communication, perception of a shared experience, sensitivity to each other's needs, flexibility to accept differences and adapt

to the needs of their spouse, and a positive outlook on their relationship and themselves" (p. 625).

Sudden & Unexpected Death

Although hundreds of thousands of families must cope with the sudden and unexpected death of a family member each year (Lehman et al., 1989), this type of loss has been considered to cause "great psychic trauma" (Lundin, 1987, p. 109) in the survivors. Whether an individual has died as a result of an accident, self-inflicted (ie. suicide) or other-inflicted (ie. homicide), these sudden deaths are particularly traumatic for families because of the lack of time to psychologically prepare for such a loss (Miles & Perry, 1985; Lundin, 1987). In particular, "the grief process of parents in the case of the sudden death of a child may be intense because of the type of death, the suddenness of the loss, the resultant guilt feelings, and the shattered expectations of a long and healthy life for the child who died" (Miles, 1985, p.77). However, researchers have noted that relatively little is known about the impact of sudden loss upon surviving family members and how they cope with the loss of a loved one when no forewarning is possible (Lehman et al., 1987; Lehman et al., 1989).

Grief Symptomatology

Following the sudden and unexpected death of a relative, survivors have been found to develop an anxiety grief associated with "either pronounced symptoms or life-restricting effects" (Lundin, 1987, p. 109). Based partially on the Texas Grief Inventory, a questionnaire was designed by Singh, Mishra, Sharma, Gill & Kaur (1989) which identified eight symptoms considered to be universal manifestations of acute grief.

These include: (1) depressed mood (ie. sadness); (2) sleep disturbances; (3) loss of appetite; (4) feelings of exhaustion and/or tiredness; (5) frequent sighing; (6) overt weeping; (7) mental dullness and/or slowing of psychomotor activity; (8) disinterest in work and/or social activities. Consequently, Singh et al. (1989) suggest that "the process of grief and mourning is not a simple adjustment reaction with anxiety and depressive symptoms but is a major stressful event which sets in motion various adaptive processes at the biological, psychological and social spheres" and that "although the prominent symptoms of grief all seem to subside by 6 months . . . certain symptoms like an inner sadness or despair along with an idealized image of the lost person and the tendency to retain articles which remind one of the lost person tends to persist for a much longer time along with the development of psychosomatic symptoms that did not exist before and are probably long term consequences of having undergone a severe traumatic event" (p. 193).

Accidental Death

When a child has been mortally wounded in an accident, not only must parents face and cope with the situation at hand, but they also often have the responsibility of contacting other family members, making decisions about aspects of care before and after the death, and helping other members of the family adjust to the loss (Miles & Perry, 1985, p. 73). Moreover, parents frequently must interact with emergency room and/or critical care personnel and contend with such dilemmas as whether to view the body and if an autopsy should be done.

Miles & Perry (1985) identified additional situational variables that may also contribute to producing heightened feelings of helplessness and an overall intensification of grief symptomatology. These include being deprived of the chance to see the child either before or after the death or to complete ongoing activities or settle "unfinished business," as well as the lingering memories of mutilation and/or disfigurement of the child's body as a reminder of how much the child may have suffered. Kovarsky discovered that "the loss of a child from an accidental death places a parent at high risk for disturbed grief and loneliness" (p. 86). An increase in health complaints as well as increased drug have also been observed in parents following the accidental death of a child (Demi & Miles, 1988).

Motor Vehicle Accidents

Currently the leading cause of death of the young is motor vehicle accidents, which represent a major public health and safety problem (Prasean, Pinn, Jansen, Paterson & Strickler-Wilson, 1992). Moreover, "the sudden and unexpected nature of traffic fatalities may make it difficult for surviving loved ones to recover from the loss" (Ellard, Lehman & Wortman, 1987, p. 57).

While little empirical investigation into the psychological and/or emotional impact of traffic accidents currently exists, available evidence suggests that "prolonged distress and adjustment difficulties" (Ellard et al., 1987, p. 57) may be sustained in those left behind. Shanfield & Swain (1984) found that despite months and years having elapsed, the parents in their study continued to grieve intensely for the loss of their young adult children. Results obtained from the Symptom Checklist 90 (SCL-90) and the Beck

Depression Inventory (BDI), revealed elevated levels of psychiatric symptoms, especially depression, as well as increased health complaints. Moreover, "Those with unstable families who had ambivalent relationships with their children and whose children were perceived to have had problems at the time of the accident, had more guilt and increased psychiatric symptoms" (p. 533). Furthermore, "being a mother, losing a daughter, losing children who live at home, losing children born earlier in the birth order, and losing children in single car, single driver accidents seem to portend a more difficult bereavement" (p. 533).

In their literature survey, Hart & Linklater (1981) concluded that "traffic crashes represent a serious problem in terms of the psychological and social losses" (p. 1) experienced not only by the vehicle occupants but their families as well. According to these authors, unlike other crisis experiences, "In a crash, stresses from bereavement, injury, terror and guilt may be compounded with medical, legal and judicial procedures" (p. 2). Consequently, losses may result in increased mortality and morbidity, disrupted relationships, altered lifestyles, and a wide range of psychopathological syndromes" (p. 1). In addition, Hart & Linklater (1981) noted that "There are indications that victims of traffic crashes may experience stresses that remain hidden or unresolved for some time, later perhaps to be manifested in personality changes, disrupted relationships, or suddenly to come to the surface in outbursts of aggressive or bizarre behavior" (p. 2). Parents may be expected to be particularly susceptible to such negative outcomes.

Over the long-term, Lehman et al. (1987) revealed significant differences between bereaved and control parents in terms of social functioning in which those who had lost

a child reported being unable to discuss their feelings with relatives and generally felt "more bothered, tense, and neglected with thinking of their daily life with their spouse or partner" (p. 225). Furthermore, parental bereavement was associated with such negative outcomes as an increase in mortality, a decrease in financial status, a higher divorce rate, and persistent rumination about the accident and/or what could have been done to prevent it.

Homicide

While an individual who drives while impaired and subsequently kills a child is generally not guilty of committing murder, this act closely parallels that of an homicide. Both acts are sudden and violent in nature, and parental reactions in the aftermath show striking similarities. Given the extreme paucity of research currently available on those bereaved by the loss of a loved one in an impaired driving crash, a review of the literature pertaining to the experience of families of homicide victims appears to be contributory and is therefore presented.

Homicide is generally considered to be "the ultimate violation that one individual can impose on one another" (Sprang et al., 1989, p. 162). Although a much less common cause of death in children than accidents, the murder of a child is perhaps the most difficult with which families must cope. Aside from contending with the sudden and unexpected nature of a homicidal death, "the cruelty of this act adds to both the depth and extent of grieving" (Sprang et al., 1989, p. 162). According to Sprang et al. (1989), the grief process for families of murder victims is "more profound, more lingering, and more complex than normal grief" (p. 159).

Applebaum & Burns (1991) revealed the presence of Post-Traumatic Stress Disorder in surviving parents and children which Rinear (1988) found to persist as long as two years following a child's death. The mourning process is further complicated by a drive for revenge and associated feelings of anger and resentment and is frequently characterized by unresolved grief until completion of appropriate legal processes (Peach & Klass, 1987). Where interactions with the criminal justice system were necessary, Rinear (1988) found that stress occurred as a result of an exacerbation of post-traumatic stress symptomatology during legal proceedings. Moreover, delays and/or continuances in scheduled court appearances, a lack of information regarding the structural and/or operational aspects of the legal system, a fear of retaliation from the offender, the loss of time from work to attend court proceedings, associated financial matters, "poor treatment" from attorneys and/or public defenders, a lack of suitable waiting rooms (ie. apart from the offender and his or her family/friends) and/or failure to receive proper notification of scheduled sentencing and/or parole hearing dates were cited as additional sources of distress.

For those who have suffered the loss of a loved one at the hands of an impaired driver, frustration also results from attempts to obtain justice within a legal/court system that apparently continues to regard impaired driving as accidents rather than crimes. Surviving family members often experience considerable pain and suffering as a result of hearing their loved one depicted as either partially or wholly responsible for the crime or being excluded from observing the trial on the grounds that their presence may prejudice the jury. These individuals are also frequently dissatisfied with the verdict or

sentence and are repeatedly denied the opportunity to provide input into sentencing decisions. Moreover, intense grieving arises from the sudden and unanticipated nature of the death which is usually violent (and in the case of children, untimely) as well as from the senselessness of the event. A poor choice was made by the offender who could have prevented the crash. Consequently, one researcher concluded that the resultant grief for these survivors "is not unlike that in which a family member is murdered" (Lord, 1987, p. 415). Similarly, Rynearson (1986) observed that victimization, while common in individuals bereaved through homicide, is also prevalent in the case of alcohol-related car accidents as well, "where the bereaved perceives the dying as an unpardonable transgression" (p. 274).

In the only known investigation of the "victim experience" following a drunk driving crash, Lord (1987) reported on the responses of adults who had lost a primary family member, or who had a primary family member seriously injured, by addressing parameters of grief symptomatology over six time intervals: on the day of the crash, the day of the funeral, one week after the crash, one month after the crash, during the criminal trial, and at the time the questionnaire was completed. In addition, this researcher reported on what individuals had found helpful and unhelpful as they progressed through their grieving process.

According to Lord (1987), the unanticipated nature and violence of a vehicular homicide frequently lends itself to a longer period of shock, numbness and disbelief. Due to the helplessness often experienced by family members who are frequently unable and/or unwilling to discuss such practical matters as insurance, she claims that "it is clear

that the presence of loved ones to join them in their grieving is needed" (Lord, 1987, p. 419) Moreover, professionals (eg. police, physicians, nurses, etc.) who interact with the family at this time must do so in an empathetic, understanding, and honest manner in order to be of assistance.

While the numbness usually began to subside by the day of the funeral, Lord (1987) also observed a significant reduction in confusion among her subjects, which was followed by a decrease in such shock symptoms as physical pain, loss of appetite, insomnia, uncontrollable crying, and physical weakness. However, difficulties with concentration remained, accompanied by an increase in feelings of sadness, helplessness and a need to withdraw. Anger toward the offender was also present depending on whether data proving intoxication levels had been made available by this time. Acceptance of the emotions expressed by the victim's family is critical at this time but apparently by only a small group of supporters to whom they feel especially close. "Too many people, especially if their goal is to discuss practical matters or try to explain away the tragic nature of the loss, are not helpful" (Lord, 1987, p. 422) as are attempts to diminish the nature of the grief by explaining the death as "God's will."

Despite reporting a general decrease in frequency, many of Lord's (1987) subjects still felt numb a week after the crash, although sadness tended to predominate. Moreover, all symptoms of depression had increased, including a lack of ability to concentrate, insomnia, confusion, and physical weakness. Anger toward the defendant and a sense of helpless rage were also frequently experienced at this time, perhaps as a result of more being known of the circumstances surrounding the crash. Particularly

painful for the victim's family was the withdrawal of friends and relatives by the end of the week who may have erroneously concluded that they are no longer needed. While expressing an interest in obtaining information relevant to the crash from the police or district attorney, the family was frequently either put off or informed that charges they felt were inadequate had already been filed.

Although tending to decrease in frequency, the clinical symptoms of depression (sadness, loss of ability to concentrate, insomnia, uncontrollable crying, hopelessness, and physical weakness) were found to be present in one-quarter to one-half of the individuals surveyed by Lord (1987) a month after the crash. Although numbness was still experienced by one-fourth of the respondents at this time, hopelessness continued to increase in frequency, perhaps indicative of an acceptance of the reality of the loss. Anger toward the defendant also increased as did frustration with the courts. Although contacts often decreased after a month, appreciation was frequently expressed toward supporters who listened and empathized rather than attempted to provide advice or unrealistic expectations that grieving should cease and victims should "get on with life." As much of their attention remained focused on their tragedy, survivors frequently experienced a need to talk about their misfortune and often found themselves frustrated when friends or relatives avoided discussing the victim or crash for fear of causing undue upset. Lord contends that in fact, "they rarely think of anything else, so talking about it does not create new stress" (p. 426).

Despite ongoing frustration with the legal/court system, anger toward the defendant (who may have been seen for the first time at the trial), confusion, and sadness

were frequently experienced during the court proceedings. Regardless of the amount of time that had elapsed since the crash, however, frustration with the courts remained significantly high, followed in decreasing frequency by sadness and anger toward the defendant.

Summary

On the whole, it appears that each loss - immediate or cumulative, sudden or eventual, obvious or not, creates stress upon the individual and subsequently gives rise to feelings of pain, depression and sadness. Helplessness, fearfulness, emptiness, despair, pessimism, irritability, anger, guilt, and/or resentfulness, loss of concentration, energy, hope, and/or motivation, as well as changes in appetite, sleep patterns and/or sexual drive are also common following loss. The recovery process generally occurs in three distinct yet overlapping stages, all of which must be experienced for appropriate healing to take place: (1) shock/denial/numbness; (2) fear/anger/depression; and (3) understanding/acceptance/moving on (Colgrove et al., 1991).

The loss of a child appears to be the most stressful of all human loss experiences, and perhaps the most tragic. The rarity, unnaturalness and untimeliness of a child's death frequently leaves parents ill-prepared in dealing with the tremendous grief and anguish such a loss frequently elicits. Mothers in particular appear to experience higher levels of grief and greater difficulty coping with the death of their child. Incompatible grieving styles and/or discordant coping patterns often contribute to disruptions within the couple's marital relationship. Both partners have been found to experience a grief

that is never completely resolved and a reduction in overall life satisfaction following the death of their child.

Particularly traumatic for parents is the sudden, unanticipated death of a child, whether it be accidental or homicidal. While no person is generally to blame in the case where a child has died in an accident, a specified individual(s) is frequently at fault in an homicide. Although the accused are often appropriately punished by the courts for their wrongdoing, such is rarely the case where an impaired driver has killed a child. Numerous parallels between these two causes of death have been identified which are helpful in further understanding the reactions of bereaved parents.

The inability to psychologically prepare for acute, unexpected loss poses particular difficulties in the grief of these parents. Especially for parents whose child was killed in a motor vehicle accident, intense grieving was found to persist despite months and even years having elapsed. Although car accidents are a relatively common cause of death among the young, when alcohol has been a contributing factor in the crash, some have been inclined to call it murder. For families of impaired driving victims, "grieving the death of a loved one is lengthy and painful when the death is sudden, violent, and senseless" (Lord, 1987, p. 433). Moreover, the difficult grieving cycle is often compounded by frustration with a criminal justice system that apparently continues to regard impaired driving fatalities as accidents rather than the crimes they appear to be.

III. METHODOLOGY

Introduction

This research was designed to investigate the long-term adaptation of parents whose child was killed by an impaired driver. Specifically, the purpose of this study is to examine parental grief responses and perceptions regarding death, religion, memories, remembrances, issues of responsibility, as well as problems encountered. The impact of the loss on the marital relationship and remaining or subsequent children is also examined.

Sample

A total of 13 parents (10 mothers and 3 fathers of 10 deceased children) participated in this study. Alcohol impaired drivers were responsible for 8 of the children's deaths whereas 2 children were killed by a drug impaired driver who was "high" on cocaine. Clearly, the main reason behind the parents' willingness to participate in such a deeply painful study was their desire to provide information that may be helpful to other parents and their families who may be faced with a similar situation in the future. Brief descriptions of each participant are provided below.

Subject 1

Subject 1 is a 45-55 year-old mother. Her first-born child, a daughter, who was 20-30 at the time of death, was killed over ten years ago. After thirty years of marriage, she is recently divorced from her husband.

Subject 2

Subject 2 is a 50-60 year-old mother. Her first-born, a daughter also aged 20-30 at the time of death, was killed over five years ago. Subject 2 is currently married to her husband of nearly thirty years.

Subject 3

Subject 3 is a 45-55 year-old mother. Her daughter, a middle child, died a few years ago at the age of 10-20. Subject 3 has been married for nearly twenty years.

Subjects 4&5

Subjects 4&5 are a father and mother, respectively. Their youngest son was killed over five years ago at the age of 10-20. Subject 4 is currently 60-70 years old and Subject 5 is 50-60 years of age. The couple has been married for over twenty years.

Subjects 6&7

Subjects 6&7 are a father and mother respectively who have been married for over thirty years. Their youngest child, a daughter, was killed nearly two years ago at the age of 20-30. Subject 6 is 55-65 years old and Subject 7 is 50-60 years of age.

Subject 8

Subject 8 is a 40-50 year-old mother. Her youngest child, a 10-20 year-old daughter was killed nearly three years ago. Subject 8 is also married.

Subject 9

Subject 9 is a 40-50 year-old mother. Her younger of two sons was killed at the age of 20-30 nearly two years ago. She has been married for nearly thirty years but is currently separated from her husband.

Subject 10

Subject 10 is a 40-50 year-old mother. Her first-born child, a daughter, was killed almost twenty years ago and was of toddler age. She has been married for twenty-five years.

Subject 11

Subject 11 is a 40-50 year-old mother. Her daughter, the eldest, was killed six years ago at the age of 10-20. After nearly fifteen years of marriage, she is currently divorced from her husband.

Subjects 12&13

Subjects 12 and 13 are a married couple of 30 years. Their youngest son was killed four years ago at the age of 20-30. Subjects 12&13 are both 55-65 years of age.

Instrumentation

The instrumentation for this study consisted of a standardized test instrument, the Grief Experience Inventory (GEI), as well as a structured Interview Questionnaire.

The Grief Experience Inventory

An objective profile of grief symptomatology was obtained from the Grief Experience Inventory (GEI). Currently the only instrument of its kind within the field of bereavement research, the GEI is a self-report, 135-item true or false questionnaire designed to assess attitudes and experiences related to a subject's grief. Developed by Sanders, Mauger and Strong (1985), the instrument is also used in the training of bereavement counsellors (Sweetland & Keyser, 1991). The GEI contains both somatic and emotional content and includes three validity scales (Denial, Atypical Responses, and

Social Desirability) which assess test-taking attitudes, and nine symptom scales (Despair, Anger/Hostility, Guilt, Social Isolation, Loss of Control, Rumination, Depersonalization, Somatization, and Death Anxiety) that sample the multidimensional domain of the bereavement experience.

Respondents' raw scores were subsequently converted to T-scores which have a mean of 50 and a standard deviation of 10. Larger T-scores are reflective of greater intensity of behavior measured by the scale. Normed on various populations, including a sample of parents whose children died of a multitude of causes (Rando, 1983), Sanders, Mauger & Strong (1985) report scale reliability values ranging from 0.52 to 0.87 for a sample of 22 college students. Lower test- retest coefficients obtained from a group of 79 bereaved individuals, which varied between 0.18 and 0.69, are according to the authors, "most likely the result of the many real changes in the experience of grief during the 18 month period between the test administrations." Nevertheless, "The reliability data suggest that the Grief Experience Inventory scales are suitable for research use."

For the purposes of this study, the GEI was edited slightly. Due to the extreme variability among respondents in time elapsed since the children's deaths, clarification was required in determining one's "period of bereavement." Consequently, parents were asked to complete the questionnaire according to their experiences during "the first year after the crash," a period whereby emotional symptomatology is presumably greatest. In addition, subjects were asked to put either a "T" or "F" beside each relevant statement as opposed to marking their responses directly on the answer sheets. The principal

investigator subsequently transferred each subject's responses to the appropriate answer sheets for scoring, thus minimizing the possibility of respondent error.

Interview Questionnaire

The second instrument selected for this study was based on the descriptive survey utilized by Knapp (1987) in his investigation of 155 mothers and fathers who had lost children varying in age from 1 to 28. Losses via long-term, terminal illness, suicide, murder, and sudden, unanticipated death were represented, with time elapsed since these deaths ranging anywhere from three months to five years. Modified slightly, the revised Interview Questionnaire (Appendix B) employed in the present study also consisted of both open and closed-ended questions and was carried out in structured interview format.

Section I (Preliminary Data Collection) consists of the collection of demographics and family history-taking. This section serves the purpose of acquiring basic information while simultaneously allowing the respondent(s) to settle into the interview.

The purpose of Section II (The Loss Experience & Grief Responses) is to supplement data collected by the GEI. Questions pertaining to grief symptomatology as well as how respondents handled their grief, and what was helpful/unhelpful during the grieving process comprised this portion of the interview.

Section III (Memories/Thinking About) is devoted to exploring subjects' thoughts and feelings of the child's death and the types of memories currently held.

Section IV (Some Problems) explores parental reactions regarding the various difficulties often encountered in attempting to "get back into life." Potential stressors investigated include social events (or lack thereof), birthdays, the death certificate,

finances, the child's possessions, his or her room or school, same-age mates, and death anniversaries.

The purpose of Section V (Husband/Wife Relationship) is to examine the effect of the child's death upon the marriage and subsequent communication between the spouses.

Issues of Responsibility comprised Section VI. Towards whom or what feelings of guilt, and anger, and hostility were directed, as well as blaming tendencies are explored.

Section VII consists of questions pertaining to Remembrances as well as respondents' Religious Reactions & Attitudes About Death.

Section VIII (Subsequent Child) explores the possibility of subsequent children following the death of a child. Parental perceptions regarding sibling reactions are obtained in Section IX (Siblings).

The purpose of Section X (Just A Few Last Questions . . .) is to obtain some personal information with respect to changes (if any) in personal habits, drug and/or alcohol use, prolonged psychosomatic complaints, and "getting back to normal."

Procedure

Initial contact was made with an individual familiar with families who had lost loved ones in impaired driving crashes. Through this person, the investigator and purpose of her study were introduced to prospective participants. Attendance by the principal investigator at various informal meetings resulted in initial contacts being made with the majority of subjects. Prior to determination of the entire sample, however, this

contact person moved out-of-province and a subsequent replacement was found to provide the necessary assistance.

Subjects unfamiliar with the investigator were initialiy contacted by letter describing the purpose of the study (Appendix C). Although composed by the researcher, the signature of the contact person appeared at the base reference of the letter to ensure familiarity. The individual recognized the importance of ensuring credibility with a name respondents would recognize and accept as legitimate. Bereaved respondents were informed that the study would focus on the consequences of impaired driving accidents with the intended purpose of increasing our understanding of how such tragedies affect people's lives as well as assisting those who may be affected in the future. A reply form was also enclosed with the letter which was to be completed and returned in the self-addressed stamped envelope provided. Respondents willing to participate in the study as indicated by a "Yes, I/We agree to participate in the study" were asked to provide a current telephone number and were subsequently contacted to set up a date and time for the interview which was conducted in the privacy of their own homes. Respondents familiar with the investigator were merely contacted by telephone to arrange for interview appointments. All respondents were informed that a copy of the GEI questionnaire would be received in the near future and was to be completed by each participant prior to the scheduled interview.

Interviews were conducted by the principal investigator of this thesis and generally lasted from one to four hours. Before the interview began, the completed GEI form(s) was collected, and the appropriate Consent Form (Appendix D) reviewed. Two

copies of this document were signed, one of which was returned to the researcher and the other kept by the respondent(s). Confidentiality of responses was assured as well as anonymity of personal identity. Respondents were asked to provide only as much information as personally deemed appropriate and informed that if at any time they wished to terminate the interview or withdraw from the study they could do so without incurring ill will. Permission to tape-record was obtained from all subjects and at the conclusion of the interview, appreciation was expressed to respondents for their participation. All interviews were subsequently transcribed to facilitate analysis of the data which were examined for frequency and patterns of responses.

Limitations to Generalizability

While an attempt was made to ensure as much control as possible, certain aspects of the study were beyond the command of the researcher. These included: (1) the small population of impaired driving victims from which the subjects were drawn; and, (2) due to the restricted sample size, uncontrollable variations among parents in terms of the amount of time that had elapsed since the child's death. A third element concerns the limitation of all self-report instruments in which distortions of true perceptions, feelings, or attitudes may be reported as a result of subject's preference to respond in a more socially desirable or acceptable manner. An unwillingness or inability of several participants to provide in-depth information, thereby offering more "Yes" or "No" responses was noted.

A final factor which must be recognized concerns ethical considerations, which took precedence over strict adherence to principles of design. The highly sensitive and

traumatic nature of the subject matter necessitated concern for interviewee comfort and emotional stability. Consequently, the need for spousal support during data collection was acknowledged and considered a requisite. Where couples were interviewed together, however, more comprehensive data could possibly have been obtained by conducting the interviews separately.

IV. RESULTS

Demographics

All of the 13 parents who participated in this study are white and 10 are female. All three males were currently married; and among the 10 women participants, seven were married (three to the three males), two had divorced and one was separated from her husband. Ten deceased children were represented among the 13 parents in this sample. The age range for the parents was from 41 to 63 years and is displayed in Table 1. Nine of the parents had completed high school, with 5 of the parents having gone on to training or education past the high school level. All but one (who was unemployed due to illness) were currently employed outside the home.

Table 1

Parent's Current Age, Child's Age at Time of Death & Time Elapsed Since Death*

Parent's Age (yrs)	Child's Age at Death (yrs)	Time Since Death (yrs)
41	3	1.25
41	11	1.25
43	14	1.25
44	15	2
47	17	4
51	20	4
53	21	4
53	2	6
55	1	6
57	23	6
58	24	6
59		11
63		18
$\bar{X}$ 51	17	6

*Indicates no horizontal relationship between subjects' scores on the three age variables.

The amount of time that had elapsed since the children's deaths ranged from 15 months to 18 years and is presented in Table 1. The age of the child at time of death varied from 3 to 24 years (see Table 1). Among the 10 deceased children, half were youngest in the birth order, 4 were first-born and one was a middle child. Ten parents had at least one remaining child over 18 years of age and four had at least one remaining child under the age of 18 at the time of the loss of their child to the impaired driver. Seven of the respondents lived in urban settings while the remainder lived in outlying rural or suburban areas.

At the time of the interview, six of the parents classified their family life as happy and satisfactory. Two (a married couple) described their present family situation as "satisfactory but not happy." Three parents reported dissatisfaction with the status of their current family life and for the remaining two respondents, the question was not applicable given their present focus on adjustment to retirement issues. Although all of the parents indicated that they were generally a close-knit family prior to, as well as after, their children's death, two reported diminished closeness among immediate family members following the death. Five of the 13 parents reported having many friends and an active social life. Also noting the presence of "quite a few" friends was one mother who reported feeling "very uncomfortable outside of the home," however. The remaining seven parents reported having a few friends and a preference for "doing things alone." One couple claimed to have lost a lot of friends after their child was killed. Six parents had immediate family living close by.

Grief Symptomatology/Grief Responses

The Grief Experience Inventory profiles of the parents comprising the present sample generally reveal a picture of intense grief during the first year after the child's death. Respondents were asked to complete the GEI according to their recollections within this first year time frame for two reasons: (1) to determine as precisely as possible the grief experience in which symptomatology is presumably greatest; and (2) to control for the extreme diversity among the subjects in terms of time elapsed since the child's death, thereby reducing variance between individual respondents, and ensuring more consistent responses. The nine GEI scales which sampled the symptomatology most commonly associated with the grief experience are listed as follows: *Despair, Anger/Hostility, Guilt, Social Isolation, Loss of Control, Rumination, Depersonalization, Somatization, and Death Anxiety.* T-scores above 50 were indicative of significantly high levels of subjective distress. Only one individual displayed consistently mild grief symptomatology (as reflected by T-scores below 50 on all GEI bereavement scales).

Although the individual subscales were also used as organizers to facilitate presentation of the data, supplemental information obtained from the Interview Questionnaire was also incorporated to highlight the various domains measured by each of the nine GEI scales. While data were also collected from the interview based on subjects' experiences during the first year, questions probing respondents' current physiological and psychological well-being were included both for ethical considerations and debriefing purposes. The deeply personal and extremely traumatic subject matter

investigated by the study necessitated concern for the emotional stability of the parents following termination of the interview.

Despair

Ten of the 13 parents experienced significantly intense levels of despair. According to Sanders et al. (1985), this measure of an individual's overall mood state is characterized by a pessimistic outlook on life, feelings of hopelessness and/or worthlessness, a slowing of thoughts and/or actions, and diminished self-esteem and is "the most pervasive psychological expression of grief" (p. 8). While depression may be the unfortunate result of the death of a child, along with associated considerations of suicide, the long-term effects of despair are often manifested by the relative ease at which various "triggers" evoke painful emotions despite years having elapsed since the occurrence of the loss.

Feelings of sadness or despair are often of such severity that the hurt felt by parents was primarily referred to as pain. This was described by one mother as "a very deep pain; very deep, very empty, very hollow," and for another, synonymous to the "terrible agony" of a broken heart. Another mother responded with the term "devastated" to describe her sorrow. One mother indicated that her pain was associated with missing her child:

> My heart hurt . . . I just felt like I was in terrible pain all the time. I was so sad . . . my arms felt empty. I wanted to hold her and she wasn't there to be held . . . and there were so many things that would start it up again too, especially if I was out.

Although the intensity of such feelings eventually subsided, painful periods of acute, piercing grief were indeed common. Such unexpected attacks were reported by

virtually all parents, and were, as the following mother describes, quite immobilizing:

> I would be going along the day and for a couple of hours not think about her. All of a sudden, the pain, the physical pain would hit me and I would burst into tears and sometimes even drop to my knees on the floor . . . it was physical pain and very overwhelming.

Eight subjects reported that these attacks of intense pain generally came in waves or often occurred in cycles, thereby requiring considerable individual effort in maintaining an ability to function, as one father observed while at work:

> I'd be good for sometimes for a whole week or something like that . . . I'd go along probably for maybe four or five days and never even think about it. Things would roll right along, it would pass by me, and everything all of a sudden, it would seem one day would be a real downer. I would have to work exceptionally hard to keep my concentration.

Fortunately, many claimed that eventually the periods of intense pain became farther and farther apart, or as one mother noted, "the times just got longer between the times I'd feel terrible." One father explained his experience in the following manner:

> For the first month, every two hours or so it was on your mind. If it wasn't on your mind it would flash by every two hours or so, no matter what you were doing and gradually that time space got greater and greater and greater.

Despite a reduction in both the intensity and frequency of despairing affect, respondents indicated various "triggers" which tended to re-activate painful feelings and contribute to subsequent adjustment difficulties. Often, "The simplest things: a scene in a movie, a song, geese flying south in the fall, a child's dress in a store window - will trigger sadness" (PAID, 1991, p. 9). Special events that frequently caused pain included holidays, particularly the first Christmas following the child's death. As one mother recalled:

> Christmas was very difficult. It was just so gloomy . . . we went through it . . . we really tried to enjoy it and at times it wasn't terrible. We had a nice dinner and the kids had a good time opening their presents . . . but it was difficult.

Upon looking back, another mother noted:

> Maybe the first Christmas, if that was to happen again, I would not be at home. To me that was too difficult. You need someplace different so the [child's] absence is not so intense.

Birthdays and death anniversaries were also problematic for parents, although the former were generally reported as more difficult than the latter:

> The first couple of years . . . the anniversary was a real hard time for me and I spent some time out at the cemetery . . . but the last couple of years the day of her death has had less of an impact on me and her birthday has had more of an impact. Her birthday is a very difficult time.

While many parents often reminisced about the child's past or unseen future during these times, such thoughts frequently evoked considerable anguish and distress, as one mother recalled of her recent difficulty with what would have been her daughter's 16th birthday:

> . . . I handled it very badly . . . I allowed myself to think about _____; about the day she was born and when she was little and the day she died and how much I missed her and I fell apart. It hadn't been like that last year. It was sad but not that bad. She would have been 16 this year and maybe that had something to do with it. It's a milestone and so much older than when she was [age] . . . a young woman . . . I continue to see some of her friends from time to time and they're all mature . . . they have boyfriends and they're driving and none of them are little kids anymore. And that's what _____ would have been.

Indeed, years later, intense feelings of despair were often reported as another mother indicated:

> I find her birthday still bad. I keep thinking back to the day she was born . . . and every year I think of the day before. At about ten thirty, I'd think the contractions started. I almost relive the day . . . I find her birthday more painful than the anniversary of the crash.

In contrast to the former mother, the following mother indicated how she handles this special occasion: ". . . I think about it and go through it and then have a good cry. That's it."

Television shows, movies and/or songs were also cited as eliciting painful thoughts and/or feelings and due to their vast prevalence in everyday living, were often a source of continued lapses in emotional functioning. One father recalled:

> I was driving down the road and all of a sudden the tears start running down my eyes because I think of something or something is said on the radio or I drive by his grave.

One mother found seeing young children difficult:

> It bothered me . . . when I saw little children, the toddlers. Toddlers really got to me because I think I had such a clear picture of _____ when she was at that age.

Although few parents were bothered by the child's death certificate, the mother above added that:

> . . . any official form where you had to talk about how many children you have now, I found very painful . . . one of the questions [on the last census] was 'How many children do you have?' and I saw that question and I just tensed . . . any form where I could not acknowledge _____ bothered me.

While all of the parents kept remembrances of their child, certain objects were selected as particularly significant and saved. These included photographs, specific articles of clothing (eg. the child's jacket), favorite toys/dolls, jewelry, books, written compositions, artwork, awards and/or trophies. Such items frequently evoked feelings of discomfort, however. As one mother commented, "It's comforting and it's painful. I don't want to let go. I don't want to put them back. It's a weird feeling."

Consequently, many parents indicated that they did not look at such articles very often:

> Sad, painful at first. Afterwards it's a type of comfort to be able to touch this stuff and reflect then put it away. Yet I've only done it a couple of times.

Such items served as a painful reminder of their children, "their presence, their personalities, their company, the memories that we would have had" and/or "what they had ahead for them" that was "wasted." For some, a sense of failure in their parental role ensued, as one mother explained:

> I remember thinking mothers are supposed to take care of their kids and I wasn't . . . if I had taken better care of her this wouldn't have happened.

She also expressed subsequent anxiety in caring for their remaining children and often feared for their safety:

> I remember I worried . . . I didn't want to drive. I didn't want them to go out of the house. Everytime they went I'd be terrified till they got back home again. And that neither one of them drank, neither one of them got in a car with someone who had been drinking.

Ten of 12 parents (one did not respond) experienced depression, the most disastrous form of despair which one mother described as "wanting to curl up into a little ball" and another claimed was because "just so much joy is taken from your life." Five of the subjects subsequently entertained thoughts of suicide as an escape from the unbearable pain, as the following mother admitted:

> A number of times I wished for death. I'm too chicken to take my own life, but there are times when an actual physical pain like somebody is squeezing the living breath out of you that I never would have imagined. I would hope that God would squeeze that last breath out and I would give up right there.

Another mother also expressed thoughts of suicide as well as a desire to trade her life for her daughter's that was so short-lived:

> I think there were times when I said I'd like to be with her. I often wish that it was me instead of her because I'd lived so much longer than she did and seen so many more things . . . in the beginning I used to think I'd certainly be better off dead because I wouldn't be suffering this much.

While suicidal urges were generally momentary retreats from the unbearable pain of loss, despair was a considerably more long-lasting, continuous emotional state. Though generally reducing in intensity and frequency, numerous stimuli often provoked a resurgence of the "old" pain despite years having gone by. Consequently, parents were frequently left "scarred for life."

Anger/Hostility

High intensities of anger/hostility were exhibited by 9 of the 13 respondents. Indicative of an individual's level of irritation, anger, and feelings of injustice, these emotions were directed towards numerous persons and/or objects. Although anger is a common response to loss (Janzen et al., 1989b), fervent anger to the point of hatred or resentment often occurred as parents sought to place blame for their imposed affliction. Profound feelings of rage were directed primarily at the impaired driver, although chronic frustration with the criminal justice system was also prevalent, and served to further intensify parental hostility. While attempts to avenge the loved one's death via the court system were frequently met with little success, loss of faith and resultant bitterness often ensued.

Survivors of the crash in which the child perished often evoked intense feelings of anger (eg. "I was really angry at his girlfriend because she survived") and for the following mother, persisted several years later in the form of eventual resentment:

> I still resent her friend that was in the vehicle that survived. And I tried to avoid her, and I shouldn't because it wasn't her fault, but I still resent her.

Another mother expressed resentment towards other mothers in addition to her daughter's peers:

> I used to feel resentful for a long time . . . seeing mothers and daughters together. I used to go to church and I'd see Mrs. _____ and her daughter and I would sit there and I would say, 'that's so unfair, how come you've got yours and I don't have mine!' And her friends, when I'd see them, oh! I'd feel really resentful! I thought that was awful that they should be around enjoying themselves and _____ was gone.

Such visualizations of surviving children and/or intact families served as particularly painful reminders of the loss of future hopes, dreams, and expectations for the deceased child, with anger often fuelled as a result of the parents' inability to change their devastating reality.

However, feelings of profound anger/hostility were expressed primarily towards the impaired driver who was viewed as the sole cause of the child's untimely death and the source of their tremendous suffering. Burning anger toward the offender resulted in a literal wish for the death of this individual by the following mother:

> I still absolutely hate the man and I'd be happier if he was dead. And that took me a while to realize . . . people would say, 'well, what would make you happy?' and I would say, 'I don't know.' But now I know. If this man dropped dead I'd be happy.

One mother commented that her immense anger necessitated adjustment to the fact that she "hated" another human being and thus an irrevocable change in personality occurred:

> Six years later I really have anger in me. I hate [the offender] and I've had to deal with the person I hate. And I'm not usually a hateful person. So I had to deal with accepting that I hated somebody. I resent the fact that he's gone on with his life. He'll still finish his education, get married, have children or whatever way he's going in his life. He gets to go on and my child is finished. I resent that and I always will.

Only one parent claimed that her ability to forgive the impaired driver who killed her daughter was necessary to the successful resolution of her anger:

> I think the faith helps you to be able to forgive him after a while and you have to be able to do that before you can to on. It was tough, very tough, but after I did it I could put it behind me and I really noticed a difference because I didn't have to deal with that anymore.

However, anger and resultant bitterness was also expressed by many parents toward the handling of impaired driving, particularly by the legal/judicial system which was described as a "rude awakening" and "a failure." Many felt that such cases are simply not treated properly by the courts. One father revealed that:

> The whole court system is a game. For example, the defense lawyer decided we would have judge and jury. The day that court was going to be had he sees which judge it is so he decides, (because he knows the judicial system), it would be better to have judge only and not the jury. The jury people had been already paid and they were there and they were told to go home. Ridiculous. They played games.

He also observed that "Everything was sticking up for the drunk driver. Nobody to stick up for [my son]." Another parent pointed to the fact that:

> We can't sue this guy because there's no survivors, meaning if there would have been a child or something like this we could sue him. And so the law says she's only worth $3,000. That's all you can collect from

> your insurance. Not that the money part--don't get me wrong--but it's just that the first four years of her life we spent $3,000 on glasses alone never mind anything else. I mean nothing ever repays you for raising a child, you know, but it's the unfairness of the law.

Many parents expressed dissatisfaction with the lack of appropriate financial compensation for their child which served to further aggravate feelings of injustice. Moreover, grievances associated with the media reporting of the case were also common:

> There were lots of things that I argued about, but it was the way the newspaper reported it. I believe the headline said something like 'Two Young People Killed in Head-On Crash' and it made me so mad because the other guy was driving down the wrong side of the divided highway! And I know they can't say everything but they could have totally changed the context of the headline.

While parents cited numerous sources for their feelings of anger/hostility, including crash survivors and scenes of intact families, dissatisfaction was also expressed towards the media for sensationalism of the situation as well as the lack of appropriate monetary compensation for the child. However, the impaired driver was the primary target for the extreme reactions of hatred and rage. Perceived as the sole determinant of their unbearable pain, this individual was also held responsible for irrevocable personality changes in many parents. Given that such individuals rarely received what the parents felt was appropriate punishment by the criminal/judicial system, a further exacerbation of parental fury and fervent drive for revenge was often the unfortunate consequence.

Guilt

The feeling of being responsible somehow for the death, or in some way to blame or guilty from having survived the deceased was present above the 55th percentile in 11

of the 13 parents. Numerous sources of parental guilt reactions were apparent, including guilt resulting from the status of the parent-child relationship at the time of death as well as from past performance in the parental role. Moreover, a "time-and-relationship guilt" (Johansen, 1988) was also observed among parents in terms of what was not done for the child while he or she was alive. Guilt from not spending enough time with the child while he or she was alive was a common response:

> . . . I had guilt feelings about not visiting her as much as I should have. And why didn't I get her a big present for the last Christmas she was here. . . and we didn't have as much money when she was growing up as we did when the other two children were young, so they got more than she ever did and I never felt guilty about it when she was alive because we often talked about it. But when she was gone, it made me feel guilty about it.

Having been a "bad" parent at times was also commonly associated with guilty feelings and, as another mother reported, emphasized the guilt that often occurred as a result of perceived ineffectiveness in past performance in the parental role:

> I remember she didn't want to have afternoon naps--this was maybe four or five months before. And yet I always made her lie down. And I think 'oh if I would have spent that time with her instead of making her lie down.' All these kinds of things are the things you think of then. You feel guilty.

While such feelings were generally short-lived, guilt continued to cause distress for some parents as the following mother noted of her regret in supporting her son's interest in music:

> I think if I hadn't supported [him] and he hadn't gone to [music school], he never would have been going to see that girl and he wouldn't have been where he was.

The irrational aspect of these guilt feelings is characteristic of the "if" or "second-guess syndrome" (Johansen, 1988) common during the initial period of mourning. One father indicated that:

> I felt guilty because I bought a little part for the car that he needed and I thought that, well, if I hadn't bought it that it [the crash] wouldn't have happened.

Although many parents eventually recognized the irrationality of their guilt feelings, others continued to view themselves as partially responsible for the child's death. Many experienced difficulty resuming normal activity and enjoying themselves, often experiencing guilt when having fun:

> I often felt very guilty when I found myself laughing at something and having a good time. It's a hard thing to explain. I didn't have an opportunity to trade my life for hers, to save her with my life, but I often wondered if I would have, because after the first few months I think I was glad that I was alive; I enjoyed life and just after a year or two, I started to look forward to the future. But I'd stop myself and wonder why I was laughing so hard after such a horrible thing had happened.

One mother reported feeling guilty when attempting to take pleasure in the sexual aspect of her intimate relationship with her husband:

> I remember the first time that my husband wanted to make love . . . it didn't happen for weeks and weeks and weeks . . . I felt so guilty . . . I think it was the first time since she'd been killed that I felt any kind of happy feelings and I felt so guilty for it. I said, 'why should I be enjoying something and she's not?' . . . that was a tough one.

In most cases, the passage of time enabled parents to identify the causes of their guilt as well as to recognize the irrational components of such thoughts. While guilt was generally experienced as a result of perceived ineffectiveness in terms of parents' past performance in the parental role (ie. not having done enough for the child while he or

she was alive), attempts at resuming the pleasures of living often effected such feelings. However, most parents eventually learned to forgive themselves, realizing that their guilt was unjustified, and the circumstances of the death beyond their control.

Social Isolation

Withdrawal from social contacts and/or responsibilities was found to exist in 9 of the 13 subjects. As the loss of the child was often perceived as a type of emptiness, bereaved parents were often left with a sense of deprivation or desolation, frequently resulting in loneliness and feelings of aloneness. While parents often required the presence of others to join them in their grieving, many found that the clearly overt avoidance, insensitive comments, and/or exclusion from social events served to exacerbate their perceived isolation. Consequently, as one mother noted:

> I kind of shied away from people. I hated to meet people for the first time after . . . not strangers, but people you knew for the first time because they don't know what to say; and you don't know what to say. So you talk around the subject so it was almost easier not to go anywhere.

While many parents experienced a need for social contact, feelings of isolation were often the result of discomfort in the role of bereaved parent and an inability to "fit in":

> I didn't like to be alone, so I would go to a friend's house. I'd phone and say 'I'm coming for coffee' and I'd spend ten minutes and I'd be uneasy there. I'd have to get out of there. I'd go to the mall, then ten minutes there and I had to get out of there. Just unsettled . . . but I didn't want to be in the house alone, but still didn't know where I wanted to be. I didn't fit in anywhere.

Indeed, Sanders et al. (1985) claimed that "people withdraw not only by their own choosing but by their feelings of isolation by others" (p. 9). Johansen (1988) claimed that friends and neighbors are frequently too uncomfortable or embarrassed to be of

much assistance to parents and often stay away or do nothing as a result of involvement in their own deep grief over the child's death and/or their perceived inability to help. However, the lack of support afforded by such individuals served to merely intensify parental feelings of abandonment:

> . . . like everybody wants to go away from it and ignore it, whether they don't want to say it because it will upset you or they are tired of hearing about it, I don't know. But you need to talk about it over and over and over.

Another respondent (a father) observed the effects of social stigmatization as well and claimed that, "I did find it strange to go to town. Some people would talk to you, some people would avoid you, absolutely avoid you."

The "taboo" nature of the child's death often resulted in usual support systems being severed (Peach & Klass, 1987) and parents being excluded from social activities. The reasoning that "I thought it would hurt you too much" was found to be particularly distressing by the following mother:

> It hurt me more not being invited . . . because I want to know that life's still going on and people are still marrying and having kids . . . and that hurts that we were left out . . . but it wasn't just the weddings; people just didn't invite us places.

However, many parents experienced feelings of self-consciousness when in social or public gatherings, as one couple noted:

> It was hard . . . the first, you might say, public appearance since the funeral . . . we had got the tickets and made the plans and we did a lot . . . the hardest thing [we] had to do was walk across that street to go to watch them play ball and to go and help with the hamburgers.

While attempting to re-integrate with the larger society, many respondents encountered comments from others that were frequently insensitive and unhelpful:

> When people told me to forgive . . . anything that would have me be generous towards [the offender] made me wild. Anybody who told me that I *ought* to do something upset me . . . that I *ought* to go to church . . . or *ought* to talk to anybody or *ought* to join a group. I hated that.

Many previous friendships were reportedly terminated as a result of seemingly thoughtless actions or uncaring attitudes of others. Parents claimed to have received such "horrible platitudes" or "unthinking remarks" as, "I know how you feel," "be happy she's in heaven," "it's God's Will," "it's time now to go on with your life," or as one mother explained, "people asking if I'm over it. You're never over it. You always have a hole in your heart."

While parents turned to both family and friends for support, thoughts and feelings were also shared with ministers or pastors as well. In some cases, isolation and estrangement from immediate family members were experienced, as the following mother reported:

> My family, especially with my family. They want to go on with their lives and I'm not ready yet. It's hard. I feel like I'm crying alone. I can't even talk to my mother. She wants me to be the happy-go-lucky person I once was and that always jokes around. It's hard on me. I feel betrayed, deserted. I feel like I'm on an island by myself . . . I can talk to [my husband] a little bit, but not that much.

Within the marital pair, only half of the parents indicated that their current spouses were generally supportive and sensitive to their needs. As the following father noted, "We had support and we had each other to lean on. When one was weak the other was strong."

Two (from the same couple) reported "going separate ways for a while," citing incompatible grieving styles as a contributing factor:

> . . . he had just different needs and responses from what mine were . . . I had to see _____ 's body . . . where [he] didn't need that . . . and [he] handled it more alone than I did.

Four respondents, all of whom were female, received little support from their spouses (or in one instance, ex-spouse) as one mother claimed:

> Initially, I felt he didn't understand because he obviously wasn't hurting as much as I was because he wasn't showing it. And he didn't care about my suffering because he didn't give me what I wanted . . . he's not someone that talks about it; how he's feeling. And sometimes I feel when I go to talk he'll say 'look, if you just forget about it, don't even worry about it' and that's his answer . . . whereas I'm the other way. I have to talk about things and talk them over.

Among those reportedly being able to talk freely about their child's death with their partner, many found discussions of deep inner feelings difficult:

> I never have talked to him very much about her. We couldn't talk to each other. I would try to and I would get this lump in my throat and not be able to get the words out and it was the same for him. We're just physically unable to talk to each other about her. We talk about her but not in depth.

Consequently, most respondents felt more comfortable discussing their child with friends and claimed that involvement with People Against Impaired Drivers (PAID) and the relationships cultivated as a result were quite helpful:

> We've gone to a lot of different things and we're finding different people with the same experience and the same feelings and thoughts . . . being involved in PAID, we're not alone in this. Everybody's gone through this experience and the frustrations.

Due to its substantial membership and specialized focus, the organization not only provided parents with an invaluable support network but also a channel in which the hurt, anger and frustration may be put toward a positive outcome. Thus, one mother noted that in effect:

> It's an avenue for us to try to maybe do something that will help somebody else not to have to go through this. Or just public awareness, it gives us a purpose I guess which we all need.

While support is generally given during the initial stage when friends and family assemble for the funeral, parents generally experienced loneliness and isolation while grieving. An intensification of such feelings was often exhibited as a result of the naive or callous conduct of others. Exclusion from social events as well as receiving insensitive comments were particularly hurtful and often resulted in further abandonment and aloneness. While immediate family members were often called upon to provide necessary support and guidance at this time, spouses were especially hindered in their ability to do so as a result of absorption in their own grief as well as incompatibilities in grieving styles. Therefore, many turned to PAID seeking support, guidance and companionship among those who truly understood.

Loss of Control

Ten respondents experienced an inability to control overt emotional expressions. The most common expression reported (by all parents) was crying:

> My eyes would weep. I wouldn't be sobbing, but I just couldn't stop the tears from coming. And they would just come all the time! I'd be talking to somebody and my face would be wet and my eyes would be just pouring tears, although I wasn't sobbing.

However, such reactions were generally physiological in nature. While the vast majority of these "unemotional" grief responses simply happened without any apparent stimulation, some were triggered by such emotions as anger. One mother also admitted to kicking furniture and throwing things around at times. In any event, the frequency

of such uncontrollable outbursts eventually diminished as time advanced and the recovery process progressed.

Rumination

Observed in 10 of the 13 parents during the first year, this is a measure of the amount of time spent with thoughts concerning the deceased or of a preoccupation with thoughts of the deceased. Although pervasive initially, frequently eliciting feelings of sadness and despair as well as anger, these reflections were generally momentary and eventually became of the "unemotional type." Triggered by various stimuli, pleasant, wistful recollections of the child as they were or would have been were often remembered. However, many parents recalled particularly disturbing "intrusive thoughts" (Dyregrov & Matthiesen, 1987) of the circumstances surrounding the child's death and were often concerned with the extent of suffering associated with the death, haunted by the memory of the child as he or she appeared at death. Consequently, difficulty concentrating was relatively common among many respondents, particularly for those who returned to work shortly after, as one father explained:

> That's what I found the hardest--when I went back to work--was to concentrate. But I knew that I had to be doing something. If I could be working all the time, I would forget.

While many things reminded parents of the child, thoughts were often triggered by the child's same-age peers, as one recently bereaved mother commented:

> I still 24 hours a day think of her. What she would have been doing in school, especially when I see one of her friends. You hear about a teenager doing this or a sixteen-year-old doing that. And I think to myself, well, _____ would have done it this way or [she] would have done it that way. I often stop and wonder what she'd look like now.

Although few parents reported dreaming about their child, many wished they could have viewed their child in a dream, as one mother revealed:

> I used to wish all the time that I would dream about her. I really wanted to dream about her. I still figure I'd be grateful if I could dream about her. I felt so bereft all the time that I didn't dream about her.

She also reported (as did five other respondents) eventually feeling her child's presence, which was revealed as quite comforting:

> It was a big relief to me, actually, when I first started feeling her around . . . and I didn't for a long time . . . and I felt very bereft that I didn't have her presence, but I did at some point realize that I was feeling her around me . . . I feel _____ with me all the time. She encourages me and loves me.

Preoccupation with thoughts about the circumstances surrounding the child's death itself were also common but as one father explained, quite unsettling:

> How he rode that motorcycle. The police report said he did everything properly. He applied the brakes at the right time; he laid the bike down properly.

Similarly, his wife also recalled experiencing such disturbing, intrusive thoughts:

> The moment of death . . . I've read that thing over and over and over again, the whole instant of the accident. Just visualizing the accident and going through that . . . the whole nightmare . . . that was what kept flashing first of all. That was wonderful when that quit.

Another mother reported a preoccupation with the events leading up to the crash that claimed the life of her daughter which interfered with her initial ability to function:

> I kept thinking of what must have happened that day. What _____ and _____ must have done from the moment they woke up and what [the impaired driver] must have done when he got up. I just ran it like a movie--and I couldn't stop it.

Many parents recalled "very vivid" and traumatic memories of their child's death, which served as a painful reminder of the violence involved:

> I went to the police station and picked up her purse and it was awful, all splattered with blood; the things inside were smashed. You'll never forget that.

Another mother described her trauma in preparing her daughter's body for the funeral:

> She looked awful . . . _____ and I spent nearly four hours working on her beautiful long hair--as we combed and brushed it, it came out in clumps. I held my baby in my arms while _____ worked on her. Her makeup took the longest. Her face was black and blue, and the more we tried to cover the bruises, the worse it looked. We had to mold in her eyes with makeup because she had given up her eyes.

While rumination about the horrific or gruesome aspects of the death were recalled by all, most parents reported eventually having fewer such thoughts and focused on the positive, happy memories of their child, particularly the "good things" about the child:

> In the beginning, _____ was perfect . . . I didn't remember the times she kicked over curfew or phoned at twelve and said, 'do I have to be home by twelve, can't I stay later?' and obviously not gonna make it home by twelve . . . I didn't remember any of that. I remembered only the good things.

While initially remembering only the positive aspects about the child, many parents reported later being able to find humor in the "bad things" as another mother indicated:

> I remember the happy times . . . we talk about some of the bad times . . . her sicknesses . . . and she got herself into a couple of jams . . . like she landed up in jail and we had to bail her out and pay her fines. But I can look on that as a funny incident in her life . . . there's some sad memories . . . but we have to look at the happy times, at least I feel, to keep our sanity.

However, most parents generally remembered their children "as they were" age-wise at the time of death:

> I remember her voice and I remember her smile and I remember different images . . . I have a strong memory of her sitting on that chair in my room. We were both sitting in the chair and she was telling me about
>
> school problems. I remember . . . words that she has said and the expression on her face and I remember the last few days of her life.

All stressed the extreme importance of each memory, treasuring every one of them. The mother above added that, "I dread getting Alzheimer's or something like that because . . . if I had that I might forget that I had her."

While two respondents expressed thoughts of changing their place of residence as a result of "too many memories," only one individual moved elsewhere because of overly painful memories. Few parents expressed a desire to "forget it all" and many did not feel that they could forget, often claiming as the following mother did that, "Forgetting it all would mean forgetting her and that would almost be a denial that she ever existed and she ever lived and was important."

Virtually every parent eventually experienced a need to share their thoughts and feelings about their tragedy with others. Some felt a "really great" need to talk about their child and in effect, keep his or her memory alive, as the following mother revealed:

> I was surprised. Because people would come and they would be scared to say anything. And I really needed to talk about _____ to everybody; to remember her.

Others did not experience an overwhelmingly great need to discuss their loss, but shared their feelings when asked, as this mother reported:

> It's not a compulsion. It was only if it came up . . . if people asked, then I would tell the truth. They would listen a bit, I'd talk a bit and then it was fine and I could carry on.

Although surviving parents frequently experienced recurrent and intrusive thoughts associated with the extent of trauma and suffering associated with their child's death, many also recalled pleasant memories that depicted the essence of the child as they were, or would have been. While persistent rumination causing anxiety and distress was common initially, such reflections did not appear to be indicative of a continuous emotional state. Rather, memories of the child were recalled with a sense of wistfulness and were relatively brief in duration.

Depersonalization

Numbness, shock, and confusion that according to Sanders et al. (1985) "is particularly evident when the death is unexpected or when severe feelings of loss of control of one's environment or universe ensue" (p. 10) was present in 11 of the 13 subjects. Such reactions frequently appear during the immediate phase of grief and often serve as temporary protection from the full realization of the enormous loss soon faced. Consequently, parents tended to perceive themselves as "zombies" or as if "in a fog," unable to think, eat, feel, sleep, or act. While parents expressed an inability to believe the reality of the death, most did not deny the fact as the following mother recalled:

> It was a terrible shock the way it happened. I don't remember getting dressed. I remember being in the car and going over [to the police station] and just praying, 'let it be someone else'--hoping, hoping it was a mistake. And yet you *know* it's not a mistake but you're praying that maybe it will be a mistake.

Shock also led to immobilization in which some parents were unable to function or participate in decision-making:

> I didn't even know where I was. They say people were here and I don't remember them being here. I remember sitting on the chesterfield and just not being able to focus on anybody.

Most parents experienced an overall emotional dullness and relatively vague recollections during this time as another mother recalled:

> I can remember being on the LRT and feeling like I couldn't breathe and I had to get off. The walls were just closing in on me. Or I just had to get out of there--like claustrophobia. Sitting in the classroom and everything, there would be a booming--it seemed like a hollow room. Deep pain wasn't for I'd say three days [after the crash].

While the shock, numbness, and sense of disbelief characteristic of this initial phase of grief usually disappeared after the first few days, rarely persisting beyond a week or so, many parents reported being particularly vulnerable and helpless, often unable to function adequately or participate in any significant decision-making. Consequently, the presence of friends and family to assist the bereaved was often necessary at this time.

Somatization

Significantly high levels of somatic distress were evident among 7 of the 13 respondents. According to Weiss (1987), current medical research has found support for the negative effects of intense grief upon the bereaved's bodily system. While the parents were generally free of serious illness, complaints included difficulty sleeping, loss of appetite, headaches (and in one instance, migraines), heart palpitations, minor gastrointestinal problems (eg. diarrhea) and aggravations of pre-existing ailments (eg. asthma). Physical exhaustion (experienced primarily after crying) and reduced vigor often characteristic of depression were frequent, as one mother claimed:

> Like, before I was lifting over a hundred pounds; now I'm lucky if I can lift the coffee pot. The emotional strength is totally gone. Like to do stuff that I would normally do like once a month move the fridge and stove and the couch out and vacuum and clean . . . just forget it.

Many parents expressed a decreased desire to perform previously enjoyable activities as the following mother indicated:

> I used to do a lot of exercises before _____ died and I didn't do anything after that. I didn't do the gardening which I always did quite well, and I didn't do the everyday cleaning. I didn't even think about cleaning the house.

One mother recalled extreme skin sensitivity, which "hurt like there were sores under it" and described her cardiovascular trouble as follows:

> My heart would start racing. It was like I couldn't breathe. Sometimes I would have real difficulty breathing. It was like a football was there. I was trying to get past this huge big lump and I couldn't swallow and then I'd find that's when my heart would start because I felt like I was smothering.

While few parents admitted use of tranquilizers, and in one case, alcohol, to assist with sleep, others reported little difficulty sleeping, including this mother who recalled:

> I had no trouble sleeping. I could fall asleep very, very easy. I'd just go to bed and fall asleep. And I loved going to sleep. I loved it. I loved being able to close my eyes and go to sleep because while I was asleep it wasn't hurting.

She also claimed an overall absence of physical ailments:

> It was amazing how healthy I was. I didn't get any colds, I didn't have any backaches--and I do have a bad back. I didn't have headaches, I didn't have any lines on my face . . . but I could see when I looked at myself that I looked, if anything, better than I used to. I felt like hell emotionally, but it wasn't translated physically.

Thus, some parents experienced few somatic complaints or a complete absence of any physical symptomatology, whereas others suffered from a variety of ailments and often required temporary medical assistance for the alleviation of such symptoms.

Death Anxiety

Nine of the 13 subjects experienced significantly heightened personal death awareness or death anxiety. While most studies generally indicated little or no effect of the death of a loved one upon survivors' feelings about their own impending mortality (Tokunaga, 1985), this finding appears not to have held true among the majority of the parents in the present study. However, those who had previously feared death indicated that they no longer did so following their child's death. For many of these parents, death promised subsequent reunion with the deceased child in an afterlife. As one mother aptly commented:

> If there's a chance that I'll see _____ again in an afterlife . . . if that's the reward for dying, then I don't mind it. I don't want to leave my children here either, but . . . when the time comes, I won't be sorry at all.

Summary

While variations in the intensity, frequency and duration of grief symptomatology was observed among parents during the first year following the death of their child, all experienced some form of despair, anger/hostility, guilt, social isolation, loss of control, rumination, depersonalization, somatization, and death anxiety. However, three themes remained prominent, and manifested among the vast majority of responses. These consisted of intense pain and despair first, anger and hostility second, and rumination third.

The tremendous pain and suffering reported at the loss of a child permeated virtually every aspect of parental experience during the first year, often being unexpectedly re-activated at any time by numerous triggers prevalent in the environment. Special days, remembrances, photographs, songs, movies, were capable of producing intense feelings of extreme, debilitating pain despite years having elapsed since the death. Burning anger toward the careless, lethal actions of the one responsible for the loss of an innocent life was also harbored many years later, and was merely compounded by the injustice of inappropriate punishments for perceived murder. Yet the memory of the beloved child remains in minds of all parents, thoughts of whom are treasured and often recalled on a daily basis.

Coping Strategies

Four parents reported difficulty returning to normal activity. Three reported simply "going through the motions" of carrying on with previously established goals or family plans. One mother reported marrying shortly after her child's death, another proceeded to continue with educational training, while others reluctantly went ahead with pre-arranged travel or holiday plans. Although the majority returned to their previous places of employment, one mother terminated her work following her child's death:

> I tried to go back to the university . . . I had these experiments and I tried to keep going but it only lasted about two weeks . . . I couldn't stand the people who were there . . . most of them were so incompetent in talking with me . . . so I just told my supervisor that I was just quitting . . . I had no interest anymore. It was too hard to concentrate.

Nevertheless, many parents found a "safe haven" in their work. As one mother noted, "My job is busy and I think it was probably one of my saving graces because I had to have my head clear."

Responses given to the "greatest need" recalled at the time of the child's death included the knowledge that the child did not suffer, "having someone who really understood," being with family, ensuring funeral preparations were "the way she would have wanted it done," or simply having the child back alive. One mother felt she had been deprived of "the right to grieve" and of sufficient time for healing. However, many needs were unfulfilled, as the following mother remembered:

> To hold her, to touch her, to kiss her. I didn't hold her in the hospital and I feel like I should have. And I wanted to go back and redo the hospital. I should never have left the room when they told me to.

When asked whether anything facilitated the grief process, the usual response given by parents was simply, "the passage of time." In attempting to deal with the death of their child, the parents in the present study employed a variety of coping strategies. One mother obtained professional help, another sought the support of a group called the Compassionate Friends, while the remainder indicated various other ways of handling their grief. One mother, for instance said that she "had to look for things to be thankful for" whereas another recalled "finding out" helped:

> I just kept looking for things that would keep me going . . . I really did want to do something . . . so I really tried to find out about things like how come this guy is still driving, what kind of record he had before . . . and I kept trying to find out . . . what are the laws, what can you do about it, all that stuff.

One mother revealed that having another child was helpful:

> It just gives you another interest . . . so you're not dwelling on it . . . not that it would replace . . . but it just gives you . . . another thing to work on . . . that makes you go on.

Only one other mother expressed a desire to have another child, but due to the mature ages of the majority of the parents, such an option was generally irrelevant. For a few parents, comfort was found in their religious beliefs which reportedly strengthened as a result of their tragedy:

> I found it a real comfort. I certainly never . . . blamed God . . . I wondered why did it have to be our family; why couldn't it have been the neighbor's family . . . but I think it almost strengthened our faith.

Others said that they were "very angry" with God for allowing the death of a child. While many attributed their child's death to "God's Will" or part of a "Divine Plan" of some sort, others turned toward religion seeking answers:

> I can't even say that I'm angry with Him. I just want Him to tell me why. And I guess then I would have answers . . . right now I haven't got those answers.

But as another mother commented, "I'm not sure if I will end up with 'that's the will of God'; maybe it's just there is no answer."

Although some parents found consolation and suitable explanations in their faiths, many did not feel that they had fully resolved their grief, nor did they anticipate a complete resolution in the future as one mother concluded:

> Not resolved it . . . I sure wouldn't describe it as that. I just learned to live with it . . . but if you mean get over it, I'll never get over it . . . it's unthinkable.

While the majority of the parents indicated that their grief reactions were essentially the same as for others who had experienced the loss of a child, albeit allowing for individual differences in response as well as variations in the time factor, most did not feel that others, including spouses, siblings, in-laws or parents necessarily shared grief in the same way. As one mother specified:

> We all reflect the loss of a person depending on what relationship they were to us. _____ lost a brother; I don't know what it's like to lose a brother. I can't comprehend where he would be in his type of grief . . . and he can't understand the parenting.

Many women assumed responsibility for managing the grief of other family members which often added to the burden of grieving:

> My mother had a terrible, terrible time with _____'s death. And I was trying to give to my mom when I didn't have anything to give. [my daughter] went through a terrible, terrible time too. It took so much out of me and I tried to give to her as well. The little bit I had I was giving away and there was nothing left for me.

Sibling Reaction

Parental reports generally indicated that remaining children also experienced grief following the loss of a sibling. Feelings of anger, bitterness and hostility were most often expressed, particularly by the males, although sadness and sometimes guilt were also observed. However, many parents reported being exceedingly consumed by their own grief such that difficulty was often encountered in recalling emotional upset among remaining offspring, or as the following mother noted about her daughter, "It's very hard for me to say definitively because I wasn't observing her all that much and who knew what was just her age."

Moreover, many children were no longer living in the parental home, which prevented parents from observing sibling reactions. However, among those who had children at home, school problems were common, as the following mother related:

> . . . the teachers were phoning all the time because she was hard to get along with. I don't know if I overspoiled her or she was just angry at the situation or she was a teenager and just . . . I don't know what to pinpoint at the time.

However, another mother claimed that aside from school problems, overt emotional upset was generally absent from her youngster:

> We watched . . . he looked after himself a lot that summer and went out with his friends and had a good time with them . . . but I don't think that they're [ie. young children] not feeling it . . . I think they really, really repress it.

Many parents also indicated that the children frequently did not talk about their feelings to any great extent, but stressed the importance of open, honest communication nonetheless:

> Encourage them to talk about the memories and how they are feeling. Because I think many times the children get left out and sort of disregarded.

Although most indicated that their children were generally psychologically healthy and had for the most part successfully dealt with the loss, three parents reported persisting adjustment problems among one or more of their remaining children.

Current Adaptive Functioning

Although very few parents evidenced prolonged psychosomatic symptoms attributable to their grief experience, many experienced an irrevocable personality change as a result of their child's death, as one mother described:

> I'm not very happy anymore . . . I don't feel that I'll ever be happy again, not the way I was. I was a very jolly, happy person. I . . . really enjoyed life. . . I don't have the same spirit anymore . . . I'm more serious now.

However, effective coping mechanisms were generally intact and employed. Such individuals indicated positive effects in both personal as well as family functioning. They had significantly reduced or completely eliminated their consumption of alcohol. Many also indicated increased awareness, particularly with respect to driving habits, and an appreciation for the fragility of life, as one father commented:

> We're a little more careful. I would say I am . . . I look both ways. We took a driver's course. We are more cautious about driving in a storm. We would stay home more I think if the roads were bad. I think my life is more precious now.

Many revealed an overall improvement in their relationships with previous or current spouses. Those who were married prior to the child's death had remained married and frequently mentioned that the tragedy had generally "strengthened" the marriage. One mother indicated that this was the result of being forewarned about the possibility of marital disruption by noting that, "It made it better and that was because we were warned . . . and I know I made a conscious decision to save the marriage."

The divorced and separated respondents also revealed similar positive effects as the divorced mother of two recalled:

> Actually we sort of came together . . . I was glad that he felt comfortable enough to be around at the time with my family . . . that he could be there for my other two kids . . . it was probably the best time we ever got along . . . because our needs were put aside like our anger. It was something that we had to deal with together in a different sense . . . we probably get along better now than then.

Many also indicated themselves as generally more understanding, compassionate, and sympathetic with people, and often utilized these talents for the benefit of community organizations such as PAID or other victim service agencies. However, "anything to do with drinking and driving," particularly "the stupidity of it" or the fact that "it was so unnecessary" lingers on:

> I feel a real sense of . . . how unnecessary it was . . . if she'd died of cancer or gotten AIDS or anything, like there was a reason for it . . . because she was sick . . . there was something wrong with her heart . . . but to lose her in that way I think was such a stupid way to go . . . it was so unnecessary. Such a simple thing could have prevented it.

Regardless of the amount of time elapsed since the death of the child, three reactions remained prominent. The first and most frequent was frustration with the courts, second was sadness, and third was anger toward the defendant.

V. DISCUSSION AND CONCLUSION

Introduction

While there appears to be general consensus among researchers of the importance of viewing grief in the broader perspective, thereby encompassing a variety of losses one may experience in life, the death of a loved one retains its place as the most devastating of all life crises. The extreme emotional suffering elicited by such a loss remains unmatched in intensity by any other grief-provoking event. When the death is of an innocent child, grieving becomes a life-long process of adaptation to such an unexpected, unnatural occurrence. Further, the tremendous pain and anguish is exacerbated by the discovery that the careless actions of an individual who, while aware of the lethal consequences of drinking and driving, nevertheless chose to do so anyway, instantly terminating the life of the helpless child. Added to the rage at the defendant for his horrific crime is the baffling meagreness of punishment imparted by a criminal justice system which apparently continues to regard impaired driving crashes as accidents.

The purpose of this study was to investigate parental grief and adaptation following the death of a child by an impaired driver. It is the sole research of its kind within the field of parental bereavement, and only the second documented case of the "victim experience" (Lord, 1987) following an impaired driving incident. Specifically, parental grief responses within nine symptom areas (despair, anger/hostility, guilt, social isolation, loss of control, rumination, depersonalization, somatization, death anxiety) as well as the impact of the loss on the marital relationship and remaining/subsequent

children were studied. A description of the findings within each of these areas is reviewed and discussed.

Discussion

Despair

Few would argue the prevalence of painful feelings of sadness and sorrow following significant loss. The finding that the majority of parents (10 of 13) experienced tremendous hurt and marked distress along with the associated symptoms of hopelessness, helplessness, exhaustion or tiredness, and lowered self-esteem characteristic of depression, closely resembled those of acute grief discovered by Singh et al. (1989) in their investigation of parents who lost children in a tragic boat accident. Moreover, data supporting the persistence of such feelings of inner sadness and despair was also reviewed by the present research.

The study by Demi & Miles (1988) found elevated levels of emotional distress in parents whose children died by suicide as well as in parents whose children died of accidents and chronic disease (ie. non-suicide). Similarly high levels of emotional distress reported by the parents in this study and suggested that method of death alone is not related to the heightened levels of despair experienced by bereaved parents.

The findings of this study also coincide with those of Martinson et al. (1991, who studied surving parents of cancer victims. These investigators found such parents vulnerable to or at high risk of depression even years later. While the majority of parents whose child was killed by an impaired driver also reported depressed feelings,

they subsequently appeared to lead generally functional, meaningful lives. However, such individuals may also be at similar risk for depression several years later.

Anger/Hostility

This study found exceedingly high intensities of anger/hostility among the vast majority of subjects. These findings are consistent with those of Lehman et al. (1987) who also discovered levels of hostility in bereaved parents to be as high as those of psychiatric outpatients. The detection of intense feelings, especially against the impaired driver and the legal system, found in this study was also supported by the findings of Lord (1987) in her examination of survivor grief following a drunk-driving crash. The finding that most respondents in this study displayed anger and hostile feelings that did not diminish despite years having elapsed was in contrast to those of Singh et al. (1989), however, who found hostility in 80% of the subjects during the second month following the child's death and in only 38% of the same subjects after one year.

Guilt

Guilty feelings were present in the majority of respondents in this study. This finding is consistent with that of Sprang et al. (1989) who found that the closer the bereaved's relationship was with the deceased, the more likely guilt will play a predominant role in the grieving process. The parent-child relationship has no equal in closeness. Moreover, Rando (1985) claimed that because the basic function of parenthood to protect the child has been destroyed, the guilt experienced by a bereaved parent will consequently be more intense than the usual guilt experienced by mourners. However, the findings of this study were in contrast to those of Singh et al. (1989) who

revealed that guilt feelings were present in only 15-18% of respondents. Perhaps religious or cultural differences of the subjects in the two studies account for the diversity observed in percentages of guilt in surviving parents.

Social Isolation

In the present study it was found that 9 of 13 subjects felt uncomfortable with and preferred to withdraw from social contacts. Rinear (1987) also found that parents surviving the death of a child by homicide reported feelings of detachment, estrangement, or alienation from others. Parents in Rinear's (1987) study cited comments such as, "I feel removed from my friends and co-workers because they have no concept of such a cruel experience" (p. 310) which reflected the isolation encountered by respondents in the present study.

Present findings were again consistent with those of Peach & Klass (1987). These researchers claimed that the parent of a murdered child is a novel and relatively unknown social role and as such, individuals must search for a way to cope and survive without the benefit of appropriate role models. Moreover, support was also found in Carter's (1989) study of adults who had experienced the death of a loved one, in which the bereaved is frequently left with a sense of desolation, deprivation or abandonment, sometimes described as utter loneliness or aloneness.

Jansen, Peterson & Blashko (1991) stated that loneliness is a serious outcome of depression. The worried, "down in the dumps" mood frequently poses difficulties for others who attempt to interact with such individuals. Moreover, the negative, complaining attitude also tends to drive other people away. Additionally, sleep, sexual,

and physical problems disturb normal relationships. Finally, depressed individuals are often unable to perform routine duties and family members frequently find it difficult to be around them. The majority of subjects in this study described symptoms very similar to the above.

Loss of Control

Most subjects in this study experienced difficulty controlling overt emotional outbursts. While most cried considerably, only a few displayed more aggressive conduct. Miles & Perry (1985) found that such behaviours as hysteria, crying, wailing, or physical acting out may result when parents learn of a child's death. A similar loss of control was observed by the bereaved individuals studied by Carter (1989), one of whom reportedly noted, "The strongest feeling is that I'm not in control of my life."

Rumination

Most parents in the present investigation experienced persistent intrusive thoughts and images pertaining to the deceased child. This was similar to the findings of Rinear (1988), who noted surviving parents frequently reported recurrent and intrusive thoughts of their child's murder, which generally reflected concern with the extent of brutality or suffering associated with the death. Dyregrov & Matthiesen (1987) also showed that 96% of bereaved parents experienced intrusive thoughts regarding the deceased child.

All parents in the present study held positive, healthy memories of their child, however. This finding was consistent with that of Carter (1989), who noted that among her subjects, certain objects were selected as particularly significant, collected and saved. Happy, "good" memories were recalled and related while painful memories were often

"pushed back." Most parents in this study also reported having fewer disturbing thoughts with the progression of time.

Depersonalization

According to Miles & Perry (1985), the most common reactions of the bereaved during the immediate phase of grief are attitudes of shock, numbness and disbelief. In the present study, 90% of the subjects experienced similar feelings. In both studies, parents described this period as if "in a fog," a time whereby the sense of reality was stunted and only certain details were remembered.

Lord's (1987) study demonstrated that numbness was present in 83% of the respondents on the day of the crash. However, she found that one month after the crash, a mere 25% continued to experience such numb emotions. Most respondents in this study indicated that such feelings persisted for only a week or so. However, the lengthy time frame since the death may account for the shorter period observed in the present study. Nevertheless, the relatively short duration of depersonalization discovered is also unlike that found by Sprang et al. (1989) who stated that when a murder occurs, the period of shock and denial is considerably more intense, requiring months for the survivor to comprehend what has occurred. Perhaps the brutality of murder is greater than that of an impaired driving crash. This could explain the shorter period of shock found in the present study.

Somatization

According to this study, slightly more than half of the subjects complained of some somatic distress. Demi & Miles (1988) also investigated the physical health

outcomes among suicide and non-suicide bereaved parents, claiming no differences were found between the two groups. However, the researchers did reveal that over half reported new or exacerbated health problems. Difficulty sleeping as well as changes in appetite were the most commonly reported health changes in both studies. Similarly, Weiss (1987) stated that medical scientists are beginning to accumulate evidence of the capability of intense grief in weakening the griever's immune system, thereby increasing the individual's susceptibility to various illnesses. Findings of this study also showed that respondents displayed a variety of physical symptoms.

Death Anxiety

The present study found that most of the parents interviewed experienced high intensities of personal death awareness. Similarly, Tokunaga (1985) stated the presence of little doubt that the death of another person has an immediate and everlasting effect upon the survivor. In addition, Cattell (1974) as cited in Tokunaga (1985) commented that "the loss of a loved person suddenly and violently alters one's views of the world and more importantly, provides drastic alterations in one's view of himself" (p. 267-268). The parents in this study who indicated a previous fear of death, but no longer did so following their child's death, provide support for Cattel's (1974) contention.

Progression of Grief

The findings of the present study generally support the five stage model ([1] shock, denial, and isolation; [2] emotional release; [3] guilt, anger, and resentment; [4] depression; and, [5] acceptance, resolution, and adaptation) of the grief process proposed by Sprang et al. (1989) with a few slight variations. Although parents initially

experienced shock, numbness and disbelief following receipt of the news of their child's death, few attempted to deny the reality of the occurrence. Isolation was also experienced followed by the phase of emotional release in which a wide variety of psychological and/or physiological symptoms were identified. In addition, all reported feelings of guilt, anger and resentment, although the latter two were more prominent than the former. Depression was also common among most respondents during the fourth stage, with associated difficulty encountered resuming daily activities and/or interacting within the larger society. While many parents eventually accepted and adapted to their loss, subsequently finding a renewed sense of interest and hope for the future, very few indicated ever achieving complete resolution of the loss.

Effect of Child's Death on Marital Relationship

The majority of respondents in this study indicated an overall improvement in the quality of relationship between themselves and their spouses. Lehman et al. (1989) found that the number of marriages that had improved relations nevertheless equalled the number that had deteriorated. This finding regarding improved spousal contentment differs from prior research investigations of the effect of accidental death of a child marital breakup. However, as Lehman et al. (1989) concluded, "Ultimately, it will be important to distinguish the circumstances that either strengthen or destroy bereaved couples, leading some to social and affective withdrawal and others to enhanced social bonds" (p. 360).

Effect of Sibling Death on Remaining Children

Findings with respect to sibling reactions following the loss of a brother or sister were generally similar to previous studies documenting the ill-effects of death upon children. In her review of the literature, Bernstein (1989) noted numerous negative impacts of sibling loss on surviving children based on parental report. Lehman et al. (1989) also found that the majority of the parents indicated that their children suffered negative effects of sudden bereavement. However, "The fact that the child simultaneously loses the sibling and the parents' availability appears to be particularly salient" (Bernstein, 1989, p. 228). Brody (1983), as cited in Johansen (1988), also found that remaining children were often ignored by parents. Since many respondents in the present study were the informants, it cannot be certain that their reports were objective observations of the children's reactions. Therefore, these results are of questionable merit.

Special Issues & Applications

While generally perceived as accidents, the responses and reactions observed among parents whose child was killed by an impaired driver show a striking resemblance to those following murder. Parents who have lost their children at the hands of an impaired driver experienced an intensity of anger and hostility few could even begin to comprehend as well as a drive for revenge that is seen only among victims who have suffered as a result of another's relentless, brutal actions. The hostility and quiet rage that lingers within as a result of the many injustices endured, threatens the vitality of the spirit and tears apart the fabric of much that was good and positive in their lives.

Parents have been ruthlessly robbed of their power to protect their child from harm. In an attempt to reassert control over their helplessness, and thereby diminish the power of the killer (ie. the impaired driver), many attempted to seek vengeance through the criminal justice system. Although the revenge and justice sought in the name of the child was entrusted to the courts, such attempts were often met with disillusionment and further disappointment. The legal system was found to be a procedural labyrinth that not only compounded the tremendous burden of grief but was fraught with perceived injustice. Chronic frustration in trying to obtain justice within a system that considers drinking and driving as merely a social problem and crashes as accidents was an unfortunate reality. Extreme anger was subsequently fuelled to the ultimate degree of hatred for the defendant and for some, a wish this individual would literally "drop dead." It is therefore virtually impossible in the eyes of most respondents to envision successful resolution of this grief in which the child's life is instantly and irrevocably terminated while the perpetrator often remains free to walk the streets.

From a personal standpoint, the current thesis project has afforded the investigator with considerable opportunity for learning. The findings of this study have provided the investigator both with an awareness of the uniqueness of the parental bereavement experience and of the various issues pertaining specifically to the death of a child as a result of an impaired driver. This information has particular significance to grief counsellors and their educators.

In addition to the normal courses of clinical therapy, the author suggests several specific recommendations when treating this group of bereaved parents:

1. Encourage parents to develop and understanding of how their child was killed (eg. who was driving and at what speed, his or her prior activities and/or destination, where the child was, etc.), so that they no longer continue to perplex about it. Obtaining traffic crash reports, the autopsy report, as well as speaking directly to prosecuting attorneys and others involved in the case and requesting copies any court documents to which they may be entitled, may be helpful in this regard.
2. Prepare parents for the court ordeal ahead, and explain to them that they may be additionally victimized by the criminal justice system which may serve to prolong their grief resolution.
3. Explain to parents that during the course of their bereavement, they will likely experience upsurges of grief at specific times, such as holidays, birthdays, when the child would have graduated, etc.
4. Help parents to recognize that they also must grieve for the lost hopes, dreams, and expectations they once held for their child. Parents must grieve for what was lost individually, as a couple, and as a family.
5. Help parents realize that they could not have protected their child from every adversity.
6. Assist couples in understanding that there are differences in their individual grieving styles and in findings ways to respect those. Identify problem areas and define solutions.

7. Work with the couple to show them that the effect on a relationship is very profound, and inform them of the normal tendency to place blame. Work on keeping the lines of communication open.

8. Teach men that grieving openly (eg. crying) is permissible, and that even as family protector, they cannot "fix" everything. Suggest physical activity as a method for releasing feelings of anger and frustration.

9. Women should be encouraged to express their feelings of anger, which have traditionally been repressed.

10. Encourage parents to enjoy their other children and explain to them that this is not a betrayal of the deceased child.

11. Reassure parents that they will never forget, that the pain can diminish, and that they will not be the same, but can survive.

12. Refer parents to the nearest PAID self-help group. Through mutual sharing, support, and modelling, they learn that their feelings and reactions are normal. Membership in such a group is especially helpful for bereaved parents who find the emotional and social support necessary in coping effectively with their grief.

While the trauma that bereaved parents must endure following the death of a child in an impaired driving crash is frequently diverse in composition, intensity, and duration, it is imperative for clinicians faced with the task of assisting such individuals to possess a clear understanding of the specific variables that will necessarily affect successful resolution of this form of parental grief. If therapeutic intervention is to be effective, use of appropriate techniques derived from a precise understanding of the unique stresses and

special dynamics of this form of parental bereavement is of utmost importance.

Directions for Future Research

The present study has attempted to expand on the work of Lord (1987) by focussing specifically on the parental experience of grief following an impaired driving crash. While most previous findings were supported in the present study, others emerged with particular prominence. As Lord (1987) notes, such symptoms/reactions that showed high frequencies (eg. frustration with the criminal justice system, physical pain, helplessness) should be scaled in order to obtain more in-depth and qualitative review. While the GEI was employed as an objective measure, other standardized test instruments could also provide supplemental data.

While suggestions for future research have been presented elsewhere in this chapter, other avenues might consist of the following:

1. Replication of the study with a larger, more representative sample of bereaved parents, perhaps with the utilization of a control group.
2. Longitudinal examination of the long-term resolution process. Parents may be studied in the immediate post-crash period, as well as at regular, selected intervals during the first two or more years following the death.
3. Further investigation into the grief process and its impact on surviving siblings.
4. Delineation of parental personality characteristics which contributed to successful and/or unsuccessful adjustment to this form of child loss.
5. Examination of parental attributions specific to impaired driving and the effect of such explanations upon subsequent post-crash adjustment.

6. An analysis and comparison of parents who sought membership in PAID or other related support groups with individuals who had not sought such affiliation(s).

According to Lord (1987), criminal justice advocacy is also a fruitful field for study, including such questions as: "Are some of the victim frustrations when interacting with the criminal justice system more significant than others in affecting emotional/mental outcomes?" and/or "Do victims who are allowed to give input into criminal justice decisions react more positively regardless of the outcome?" (p. 433).

Concluding Remarks

The study of parental grief subsequent to an impaired driving crash is an unchartered territory fertile for exploration. While few in number, willing participants are eager to cooperate and share their experiences for the benefit of all. It is with much hope that the efforts of this investigation will find utility in the hands of those surviving the loss of a loved one by an impaired driver. While proffering little comfort in easing the tremendous pain and suffering, perhaps the knowledge that others have endured the agony and emerged to share their accounts will suffice to encourage one to persevere in the face of their tragic adversity. Perhaps the "voice of the victim" (Lord, 1987) will be heard and lead the way toward the elimination of such needless human loss and end the formidably tragic suffering.

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APPENDIX A
Social Support

Membership in such parent support groups as People Against Impaired Drivers (PAID) for the first few years may facilitate movement toward recovery for these individuals. In serving the dual purposes of assisting those in need by providing individual psychological and/or emotional support to its members, as well as that of social advocacy by promoting social and policy changes in attitudes toward drinking and driving and the laws associated with drinking while impaired, such organizations may provide a "positive and appropriate setting" for the working through of such lingering issues as rage at the drunk driver (Kowaz, Roesch & Friesen, 1990, p. 69). Moreover, expression of anger and frustration toward the judicial system and/or its representatives may be vented by members who share this common experience. Fellowship, laughing and crying together, and supporting and befriending others may lead to a safe haven among those who truly understand.

Weiss (1987) claims that the use of a therapeutic manual may prove to be beneficial in facilitating movement toward recovery of those who have experienced traumatic death. He contends that in presenting material based on others' accounts, readers may be assured that their experiences are not unique, and by presentation of relevant issues the reader is likely to recognize that "the material demonstrates its right to be accepted as authoritative" (p. 432). If Weiss' (1987) resulting work is indeed "very likely to be helpful" as he purports it to be, perhaps the efforts of this thesis may also provide some measure of relief, however minimal, for the parents whose child was killed by an impaired driver.

APPENDIX B
Interview Questionnaire

INTRODUCTION

We are going to be talking about _____'s death, how you and your husband responded and dealt with this, generally what took place in your family that will help other parents who may be faced with adjusting to a similar situation in the future. I'm also interested in how you and your family interrelated with the larger community in the aftermath of this tragedy.

Now, this will be a painful experience for you to have to relive these events again. How do you feel about this?

If at any time you wish to stop, just say so and I assure you I will understand. . . .

I am willing to stay as long as you are willing to talk . . . . . .

I am going to have the tape-recorder running and I would like you to give me as much detail as you care to go into. . . . . .

I would like you to just relax, be comfortable, and tell me of your experiences in your own way.

IF YOU DO NOT FEEL COMFORTABLE IN ANSWERING ANY OF THESE QUESTIONS, PLEASE SAY SO AND WE'LL SKIP THAT ONE.

I. PRELIMINARY DATA COLLECTION

(This section consists of collection of demographics and family history-taking and serves the purpose of getting some basic information while letting the parent(s) settle in to the interview)

1. Demographics
   To get us started, I would like to know something about you and your family. . .
   a) Sex M F
   b) Age
   c) Occupation Husband _____
      Wife _____
   d) How long have you been married?
   e) Educational level (highest grade/year completed)?
   f) Membership in any parent support group? Yes No
      -- If yes, which one(s) and how often do you attend meetings?

2. Family
   a) Could you tell me something about your family life?
   b) How are you generally getting along?
   c) Would you classify your family life as happy and satisfactory?
   d) Were there other children in the family at the time?
   e) How many children do you have?
      Sexes
      Ages
      Grades
   f) Can you tell me something about your family's relationship to the outside world?
      -- Are you a close-knit family?
      -- Do you, as a family, have many 'friends'?
      -- Do you interact frequently with others?
      -- Do you entertain often, go on picnics, take vacations with others, etc.?
      -- Do you know your neighbors well?
      -- Do you have relatives living close by?
      OR
      -- Do you do things alone?
      -- 'Isolate' vs. 'integrated'

3. Information on Deceased Child
   a) Name of child
   b) Position of the child in the birth order (eg., first child, second child)?
   c) Child's age at death

d) How long has it been since death of child?

4. Information on the Crash
   a) When (what year/month) did the crash happen?
   b) How did you hear the news?
      -- Who told you?
      -- How were you told?
      -- Where were you?
   c) Is there anything about the way this was handled that you would like to change?
   d) Do you have any thought (having been through it) on how these things should be handled?

II. THE LOSS EXPERIENCE & GRIEF RESPONSES

I know you experienced great grief after your loss. . . . . .

1) How did you handle this?
2) Can you tell me something about this?
3) What kinds of symptoms did you experience and how severe were they?

Sadness?
Irritability?
Loss of Appetite?
Sleeping Problems?
Difficulty concentrating?
Preoccupation with thoughts?
Depression?
Fear of being alone in house?
Fear of dirt?
Bitterness?
Sense of failure as mother or a person?
Fear of death?
Anger?
Guilt?
Failure to accept reality?
Problems returning to normal activity?
Afraid of resp. of caring for other children?
Time confusion?
Repetitive dreams about _____?
Exhaustion?
Lack of Strength?
Somatic distresses?
-stomach problems
-headaches
-heart palpitations
-asthma
-colitis
-recurring allergies

4) Sometimes the phase of acute piercing grief does not hit until sometime later. Did you experience anything like this?
-- How did you interpret this?

5) Grief symptoms often come in waves, they occur in cycles, they come and go, Do you experience any of this?

6) Do you think that your reactions or behaviors are the same as for others who have had this experience or were yours different?

7) Was it possible to share your grief with anyone? Who?

8) How great was your need to talk about it?

9) Who would listen to you?
   a) Did it help to talk?
   b) Does it still help?

10) Who do you share your thoughts with the most now?

11) Did you feel that others (husband, siblings, in-laws, parents, etc.) shared grief in the same way you did?

12) What kinds of behaviors or experiences, looking back now, did you find most useful or comforting to you in the aftermath?

13) What kinds of relationships did you cultivate at the time or, looking back, might have cultivated that would have been helpful or comforting?

14) What types of things and reactions or behaviors from people definitely did not help?

15) What complicated your grief work? What made it easier?

16) Can you tell me, what was your *greatest need* at the time of _____ 's death and during the aftermath?

17) Do you think you have essentially resolved your grief?
-- If NO, Do you think you ever will?

18) What kind of advice, if you had to give it, could you give to others that might prove useful to them in dealing with this kind of tragedy?

III. MEMORIES/THINKING ABOUT

1) Is it important to you to have someone to share your feelings with now?

2) How do you remember _____ now? What kinds of thoughts tend to dominate your memories now?

3) What kinds of things or events stimulate you to think about these days?

4) How important to you are these memories?

5) Looking back on _____ 's death, What kinds of memories do you have now of what happened?

6) How do you feel now about what happened then? Can you share these feelings with me?

7) Would you ever like to simply forget it all?

8) Do you think you will ever stop thinking about it?

9) If you had to name one person with whom you are most comfortable talking about with _____, who would that be?

10) What kind of *mental image* of do you have now?
Can you explain that to me?
(Memorialization - Idealizing the child - lives beyond death)

11) Tell me, do you ever feel _____'s *presence* ? Is this comforting to you?

IV. SOME PROBLEMS

1) Did seeing or being around other children of the same age bother you at the time? (IF YES), in what way? -- What about now?

2) What did you do with _____'s things? (Possessions, toys, clothes, etc.)

3) What kind of feelings did you have about _____'s school? Teachers? Classmates? Playmates?

4) You received a death certificate. . . . Did you find this hard to deal with?

5) What about income-tax time? This ever a problem for you or your husband?

6) What about spending money? Ever find this to be helpful?

7) How did your social life change afterwards? Can you tell me something about this?

8) Ever suffer any feelings of self-consciousness when in a social or public gathering?

9) Did you ever think about changing your place of residence?

10) What about _____'s room? How did you deal with this?

11) What do anniversaries of _____'s death mean to you?

12) What about his/her birthday? How do you handle this?

13) How has your relationship with other family members changed?

V. HUSBAND/WIFE RELATIONSHIP

1) How do you believe _____ 's death affected your relationship with your husband/wife?

2) Was he/she supportive of you? Sensitive to your needs?

3) Were you able to talk deeply about this with your husband/wife?

4) Can you talk about this with him/her now?

5) How did your husband/wife respond to this? Tell me how you perceived his/her reactions and behavior?

6) Do you and your husband/wife still talk about _____ 's death?

7) Are there some things you and your spouse simply do not talk about regarding _____'s death?

8) Do you ever get the feeling that maybe he/she wants to forget?

9) Did your husband/wife grieve? How? Were you able to give him/her support?

10) Getting back to your relationship with your husband/wife, any changes noted in your sexual relationship?

11) Any problems prior to 's death that you would define as significant?

VI. RESPONSIBILITY

1) Did you ever get the feeling that authorities, or friends, or even family members held you or your husband responsible for _____'s death?

2) Can you tell me something about your experiences with the police?
   a) What kind of an experience was it?
   b) Did it impress you?

3) Was there ever any tendency on your part to attach blame for what happened?
   -- What about now?
   (IF YES), Directed toward whom? Can you elaborate?

4) What about 'displaced anger' or hostility?
   -- On spouse?
   -- On friends?
   -- On grandparents?
   -- On siblings?
   -- On friends?
   -- On other children, generally?
   -- On things (cars, bike, bed, machinery, etc.)?
   -- On legal/judicial system?
   -- On self (depression, guilt, suicidal urges, psychotic reaction, etc.)?

5) Guilt sometimes comes when we try to live a "normal" life again. Ever experience this?

6) Ever feel qualms of guilt when having fun?

VII.

A. REMEMBRANCES

1) Do you have any -- have you kept any -- remembrances of _____ ? (favorite toys, clothes, photos, etc.).
   (IF NO) Do you wish you had some now?
   (IF YES) Do you look at them often?
   How do you feel when you take them out?

2) Is this a painful experience for you? Or, do you find it comforting?

B. RELIGIOUS REACTION

1) Are you a religious person? Do you have a belief in God?

2) How did this tragedy affect your religious orientation?

3) Did you ever question why God allowed this to happen?
   a) How did you handle these feelings?
   b) How do you feel about this now?

4) Did you in any way feel that _____'s death might have been attributed to God's will or a part of a divine plan of some sort?

C. ATTITUDES ABOUT DEATH

1) Has this tragedy changed any of your ideas about death?

2) Did you ever fear death? What about now?

3) Did you ever want to die?

4) Do you think you are afraid of dying?

VII. SUBSEQUENT CHILD

1) Did anyone advise you to have another child (a 'special child') soon after _____'s death?
   (IF YES) Who made this suggestion?
   How soon after was this suggestion made?
   What did you think about this?

2) Did you want to have another child?
   (IF YES) Why?
   (IF NO) Did you take any steps to prevent another pregnancy?

3) Did you perceive any hesitancy on the part of your husband to have another child?

   (If had a child)
   a) Do you perceive any differences in your feelings toward this subsequent child compared to your feelings for the one you lost?
   b) Is he/she 'special'? How?
   c) Do you in any way feel over-protective of *this child*?
   d) Do you in any way feel over-protective of your other children?

IX. SIBLINGS

1) Did you explain the details about what happened to _____ to your other children?
   a) How did you do this?
   b) How did he/she/they respond?

2) Did you observe any signs of emotional upset among the siblings after the death of _____ ? (eg. bedwetting, school problems, moodiness, etc.)
   How did you handle this?

3) Did any sibling overtly express or reveal any feelings of *guilt* or *anxiety* or *depression*?

4) Any bitterness or anger or hostility expressed?

5) Do you think they have dealt with this successfully?

6) Do they ever talk about today?

7) Any suggestions you might give others on how to handle sibling reaction based upon what you have learned from this experience?

X. JUST A FEW LAST QUESTIONS OF A PERSONAL NATURE

1) Any evidence of prolonged psychsomatic symptoms (nervousness, insomnia, nightmares, headaches, heart palpitations, etc.) that might be present?

2) Any increase or decrease in drug or alcohol use since your experience?

3) Any significant changes in your personal habits?

4) Ever entertain thoughts of suicide?

5) How has your life, personally, *changed* as a result of _____'s death?

6) How has your family *changed* as a result of _____'s death?

7) Do you think you have come now to the full realization of what life will continue to be like without _____?

8) Tell me about getting back to normal. How does one accomplish this?

APPENDIX C
PAID Request for Participants

October 13, 1992

Dear ,

I am writing to introduce Sheryl Kindrachuk who is a graduate student at the University of Alberta. As part of the requirement for a Master's degree in Psychology, she is conducting a study of parents who have lost their child at the hands of an impaired driver. Such information will hopefully help other parents who may be faced with adjusting to a similar situation in the future.

Since the success of her research is dependent entirely upon the voluntary participation of individuals who have experienced this type of loss, I am assisting Sheryl in finding interested and willing participants. Your participation in this research project would involve between 2 to 3 hours of your time in which you would be asked to complete the Grief Experience Inventory and answer questions about how you and your family are doing at present, how you have been affected by the collision, and how you and your family interrelated with the larger community in the aftermath of your tragedy.

The interview will be tape recorded in order to allow for a more complete gathering of all factual information and thus a more comfortable conversation as well as for transcription of the interview. All data will be held in strict confidence with complete anonymity guaranteed. The cassette tape will not be heard by any other person other than Sheryl and the person assigned to transcribing the tape. The tape will be kept under lock-and-key until the thesis is completed, at which time it will be erased. If desired, you may examine the transcribed material to ensure its correctness and you may request any change in personal information that may identify you or your family.

If you are interested in participating in Sheryl's research project, please let her know either way by simply filling out the enclosed slip of paper and sending it in the self-addressed stamped envelope. If interested, Sheryl will contact you to set up a convenient time to conduct the interview in your own home. If you have any other questions or concerns, please do not hesitate to call Sheryl (434-0479 or 436-1339), Gladys (457-9826 between October 16-30 when I am away) myself (987-3530 after October 30) or Sheryl's Supervisor Dr. Charles Norman at the university (492-3802) and we will be happy to discuss them with you.

Sincerely,

Fern Palylyk

Please circle one and enclose your reply in the self-addressed stamped envelope provided.

YES I/We _____ agree to participate in the study. You may call us at _____ to arrange for an interview appointment.

NO I/We would prefer not to participate in the study

APPENDIX D
Consent Form

The purpose of the research being undertaken is to learn more about the long-term adaptation to losing a loved one in an alcohol-related motor vehicle accident. Although many people die each year in Alberta as a result of impaired driving, there has been very little study of family members who have lost a loved one in this manner.

The information gathered will be incorporated into a thesis written for a Master's degree in School Psychology. Such data will be used to assist other parents whose child has died as a result of an impaired driver.

Your participation in this research project is voluntary and will involve between 2 to 3 hours of your time. In order to aid in developing a deeper understanding of this problem, you will be asked to complete the *Grief Experience Inventory*. You will also be asked to answer questions about how you and your family are doing at present, how you have been affected by the accident, and how you and your family interrelated with the larger community in the aftermath of this tragedy. The interview will be tape recorded in order to allow for a more complete acquisition of all factual information and thus a more comfortable conference as well as for transcription of the interview. All data will be held in strict confidence with complete anonymity guaranteed. The cassette tape will not be heard by any other person other than the interviewer and the individual assigned to transcribing the tape. The tape will be kept under lock-and-key until the thesis is completed, at which time it will be erased. If desired, participants may examine the transcribed material to ensure its correctness and may request a change in any personal information that may identify them. If, at any time during the course of the interview you choose to withdraw any part or all of the information you have provided, you may do so without prejudice.

In order to ensure that I am operating with your understanding and consent, I would appreciate your cooperation in signing this form. Please sign two copies and keep one for yourself. Thank-you.

_____

Date

_____

Signature

END

28-08-96

FIN