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Spiritual Practices among Northern Plains Tribal Members as a Protective Factor in the Relationship between Unexpected Deaths and Traumatic Grief

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SPIRITUAL PRACTICES AMONG NORTHERN PLAINS TRIBAL MEMBERS AS A PROTECTIVE FACTOR IN THE RELATIONSHIP BETWEEN UNEXPECTED DEATHS AND TRAUMATIC GRIEF

By

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Background: Grief is an important and potentially misunderstood construct in Indian country. Past research has shown that the experience of unexpected deaths has been associated with intense and maladaptive grief responses. Active participation in religion or spirituality has been shown to buffer against the negative effects of bereavement. Given the well-documented premature mortality rates and generally lowered life expectancy in American Indian communities, this study examined the relationships between spirituality, unexpected deaths, and traumatic grief, as measured by the Inventory of Traumatic Grief – Revised (ITG-R). *Method*: A secondary multiple regression analysis was used to test the hypothesis that higher numbers of unexpected deaths, experienced by the participants, will predict more traumatic grief symptoms. In addition this analysis investigated the role of active participation in traditional spiritual practices as a moderator in the aforementioned relationship. *Participants:* The sample consisted of 87 (43 females, and 44 males) Native American adults ranging in age from 18 to 81 years (M = 43.74, SD = 14.74). *Results*: A statistically significant main effect was found for unexpected deaths (p = .045) and for the interaction term (unexpected deaths x spirituality) (p = .050) in predicting symptoms of traumatic grief. Bivariate analyses supported the hypothesized directionality of the moderating relationship (i.e., active participation in traditional spiritual practices acted as a buffer in the relationship between unexpected deaths and symptoms of traumatic grief). In addition, post-hoc independent samples t-tests found that participants who endorsed active participation in traditional spiritual practices reported, on average, significantly more total deaths, expected deaths, and unexpected deaths than the group who did not endorse active participation in traditional spiritual practices. Chi-square test for independence found significant group differences in endorsement of participation in a formal religion and the time since the death. More specifically, the group that endorsed active participation in traditional spiritual practices had significantly more individuals who also endorsed participation in a formal religion and who experienced more deaths that were less than six months prior to the grief retreat. *Conclusions*: Given the high observed mortality rate in Indian country, these preliminary results suggest that active participation in traditional spiritual practices may protect against maladaptive traumatic grief responses in relation to unexpected deaths.

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CHAPTER 1

Spiritual Practices among Northern Plains Tribal Members as a Protective Factor in the Relationship between Unexpected Deaths and Traumatic Grief

Spirituality

Spiritual life is of great importance among American Indian[1] (AI) people. The Swinomish Tribal Mental Health Project (1991) described spirituality as a "fundamental reality of all life and all people, inseparable, connected to physical reality, bodily events, interpersonal relations, individual destiny, mental processes and emotional well-being" (p. 127). With this understanding, spirituality is not conceptualized as separate from any other element of life; therefore, American Indian spirituality informs all aspects of life including ways of knowing, illness, healing, and ways of dealing with grief. AI spirituality encompasses relationships to family, living, dead, and unborn, as well as the spiritual relationships with the entire world of living and spiritual beings. This complex network of relationships informs beliefs and guides a lifestyle that is in balance with these connections.

American Indian spiritual practices have withstood governmental prohibition and early Christianizing efforts employed by various churches. These efforts were employed to extinguish traditional practices and assimilate American Indians into the majority culture. Henry Teller, the Secretary of the Interior, put forth the Indian Religious Crimes act in 1883. This policy forbade Medicine wo/men from engaging in healing practices and prohibited all Indian persons from participating in any type of ceremonial dance. Convictions for these crimes were punishable by imprisonment (Irwin, 1997). Further governmental policies led to the oppressive, religion-based indoctrination of American Indian children into Christian residential boarding schools. The

[1] The terms American Indian and Native American will be used interchangeably throughout this paper.

forced removal of American Indian children from their homes and parents represented a sustained federal policy to interrupt the transmission of traditional spiritual values to the younger generation and to "reconstruct Native religions in conformity with dominant Protestant majority values" (Irwin, 1997, p. 36). Despite these influences, traditional spiritual practices have survived and remain as a key factor for understanding and conceptualizing the American Indian worldview.

Spirituality is an important component of American Indian life and culture. The Swinomish Tribal Mental Health Project (1991) acknowledged the importance of maintaining harmony, honoring, and deeply respecting all other beings, as it is considered dangerous to be in a state of conflict or disharmony with spiritual forces. It is also important to note that within many tribes, spirituality is not limited to one place or one set of beliefs. Tribal communities have been accepting of multiple interpretations including organized religions. For example, it is not uncommon for Native people to participate in both formal religious practices and traditional spiritual practices.

It is also important to note, however, that there is a large degree of heterogeneity in customs, family structures, religions, languages, and social relationships within this population (Fleming, 1992). With 566 federally recognized tribes and over 200 active indigenous languages (Bureau of Indian Affairs, 2012), it is especially difficult to generalize the complex construct of spirituality to all American Indian tribes.

Increasingly, programs have approached healing and recovery holistically, integrating elements of spirituality to aid in the healing process of Indigenous people. More specifically, programs have utilized the Medicine Wheel (Absolon, 1993; Gilgun, 2002; Johnson, 2006; Lavelle, 2008) as a model and have emphasized the integral role of traditional healers as co-

facilitators (Skye, 2002; Yazzie, 2000). The Aboriginal Healing Foundation (2006) identified and described promising healing practices for Indigenous people that included ceremonies, healers, and talking circles as core elements for positive change. These culturally-based healing programs have been beneficial for persons undergoing treatment for addictive behaviors (Dickerson, 2012) and have been shown to improve well-being (Schiff & Moore, 2006). The Aboriginal Healing Foundation (2007) also noted that participation in traditional practices and ceremonies has promoted healing through the development and maintenance of positive relationships. Cross (2003) and Bigfoot and Dunlap (2006) identified stories and storytelling as an effective healing tool for American Indians.

Research in the areas of spirituality and grief in Native American populations has been limited; however, Whitbeck, McMorris, Hoyt, Stubben, and Lafromboise (2002) found that regular engagement in traditional spiritual practices buffered the negative effects of discrimination in a sample of 287 American Indian adults. Another study addressed the relationship between spirituality and suicide among American Indians. In this study, Garroutte, Goldberg, Beals, Herrell, & Manson (2002) found that a high level of cultural spirituality orientation was significantly associated with a reduction in suicide attempts. Similarly, Schiff and Moore (2006) found that participation in the sweat lodge ceremony was associated with improved well-being in spiritual and emotional domains in a sample of Indigenous and non-Indigenous Canadians.

A salient aspect of spirituality among many American Indian tribes regarding grief, that has been anecdotally referred to, is the continuation of the relationship after the person is deceased. Benore and Park (2004) asserted that maintaining an attachment with the deceased person may have a positive impact on bereavement coping outcomes. For example, they suggest

that people who engage in "continued attachment" with their deceased loved one may experience less avoidance of thoughts and emotions related to the deceased, which may facilitate an adaptive appraisal of the death. Benore and Park (2004) also proposed that continued attachments may provide a source of meaning to the bereaved person's life and may offer an alternative perception of a permanent loss. They suggested that the "bereaved who strongly believe in CA do not need to reconcile a loss of the person, but rather a change in the relationship" (Benore & Park, 2004, p. 12). Several other researchers have referred to what Benore and Park (2004), labeled "continued attachment" as an "inner representation of the deceased" (Marwit & Klass, 1994), "ongoing attachment" (Hogan & DeSantis, 1996), and "continuing bonds" (Stroebe et al., 1992). Normand, Nickman and Silverman (1996) noted that participants who endorsed higher levels of continued attachment with the deceased also reported less post-bereavement helplessness. In addition, they related this finding to the lack of isolation for participants who continued communication and relationship with the deceased. Klass, Silverman, and Nickman (1996) related the protective role of a continued attachment with the deceased person to the tendency of survivors, who endorse a continued bond, to develop a new sense of self that is integrated with the deceased, in that, the deceased person has become "an eternal part" of the survivor. These authors also noted that the continued bond may contribute to the commonly held perception of the deceased person as a continuing source of guidance that supports or protects the survivor (e.g., s/he is looking over me, s/he is my guardian angel).

Mortality

The age adjusted mortality rate for all causes of death for American Indians and Alaska Natives (AIs and ANs) was 1.2 times greater than the mortality of all U.S. races (Indian Health Service, 2009); AIANs die earlier and more often than their US counterparts. The two leading

causes of death for AIANs in 2002-2004 were heart disease and cancer (malignant neoplasm). However, leading causes of death differed among genders. The two leading causes of death for females were heart disease and cancer, while the leading causes of death for males were heart disease and unintentional injuries (IHS, 2009).

American Indian and Alaska Natives die at higher rates than other Americans from tuberculosis (750% higher), chronic liver disease and cirrhosis (420% higher), diabetes (193% higher), and pneumonia and influenza (47% higher) (IHS, 2009). Lower health status and decreased life expectancy for AIANs has been well documented; however, this has proved especially true for Native populations in Montana and Wyoming. Andersen, Belcourt, and Langwell (2005) found that on average, the life expectancy for all AIAN people was 71.1 years, but within Montana and Wyoming the life expectancy for AIs was only 67.2 years. This stands in sharp contrast to the average U.S. life expectancy for all races of 78.5 years. The Indian Health Service (2009) suggested that lower life expectancy and the disproportionate disease burden exists as a consequence of higher rates of poverty, discrimination, lower levels of education, and cultural differences. Clearly, the social determinates of health that are rooted in poverty contribute to these mental and physical health disparities.

In addition, unintentional injuries sustained from vehicle accidents, drowning, falls, and other accidents, are the leading cause of death among AIANs between the ages of 1-44 years (IHS, 2013). In 2009, suicide was the second leading cause of death for AIANs between the ages of 10-34 years (Kochanek, Xu, Murphy, Miniño, & Ching, 2011). Moreover, the suicide rate for AIANs is 190% higher than the general population (Indian Health Service, 2011). AIs and ANs also experience homicide rates that are 180% higher and injuries that are 340% higher than the general population (IHS, 2011). The Indian Health Service (2009) suggested that

disproportionately higher injury rates among AIANs may be a reflection of the greater proportion of young adults within the AIAN population, lack of traffic safety regulations, living in rural environments, and a greater number of alcohol-related deaths.

Manson, Beals, Klein, and Croy (2005), examined the prevalence of trauma among two large American Indian communities. They found that approximately 62% of American Indian males and about 66% of American Indian females reported experiencing at least one significant trauma in their lifetime, with the majority of the reported traumas relating to the death of a loved one.

Grief and Bereavement Research

Grief is defined as the emotional or affective reaction resulting from loss (Stroebe, Hansen, Stroebe, & Schut, 2001). Although it has been most commonly conceptualized in relation to the death of a loved one, any perceived loss could result in a grief reaction. The terms grief, mourning, and bereavement have often been used interchangeably; however, most researchers in the field have agreed that bereavement is the objective event of losing a significant person through death, while mourning refers to the social expression of grief that is influenced by personal, familial, cultural, religious, and societal customs (Stroebe, Hansen, Stroebe, & Schut, 2001). Considering the variety of influences on grief, researchers have yet to agree on a clear classification of the processes of grief and its manifestations. The Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM-IV-TR; 2000) described grief, the response to the death of a loved one, as a normative and predictable consequence for this kind of loss. It further categorized this type of bereavement as a V-code (other conditions that may be a focus of clinical attention) to avoid pathologizing normal grief reactions. Recent revisions to the DSM-IV-TR as included in the DSM-5, have attempted to address maladaptive grief responses. The

bereavement exclusion in the diagnosis of Major Depressive Disorder was removed and proposed criteria for Persistent Complex Bereavement Disorder were added in Section Three, Conditions for Further Study (American Psychiatric Association, 2013).

Most individuals who have grieved the death of a loved one, may have initially experienced intense distress, but likely went on to adjust to the loss over time. However, for a small subset of bereaved individuals, the grief process may have been prolonged or intensified, preventing them from healing or adapting to the loss (Horowitz, Bonanno, & Holen, 1993). For these individuals, maladaptive grief is associated with health concerns such as cancer, heart disease, high blood pressure, suicidal ideation, and changes in eating habits (Prigerson et al., 1997). Bereavement theorists (Boelen, van den Bout & Keijser, 2003; Horowitz et al., 1997; Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 1995; Prigerson et. al., 1999; Prigerson et al., 2009) have asserted that the DSM-IV-TR has failed to accommodate those who are suffering from maladaptive grief and have argued for the necessity of its own diagnostic category.

Traumatic grief. The conceptualization of maladaptive grief has shifted over time and largely remains in flux. For example, early psychoanalytically-oriented theorists posited that a bereaved individual must "cut ties" with the deceased person in order to heal or adapt to the loss (e.g., Bowlby, 1969; Parkes & Weiss, 1983). More recently, Benore Park (2004) and Fisher (2001) have suggested that "continuing bonds" with the deceased person facilitates healthy adjustment. Over the past 20 years researchers have tried to draw a more distinct line between normal and pathological grief. This task has presented a unique challenge due to the array of differences in individual and cultural norms, as well as differing beliefs regarding death and grieving. Despite these difficulties, research (Boelen, van den Bout & Keijser, 2003; Horowitz

et al., 1997; Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 1995; Prigerson et al., 1999; Prigerson et al., 2009) has provided evidence to suggest that traumatic grief, formerly known as complicated grief, and more recently redefined as prolonged grief, is a separate clinical entity from other related disorders such as MDD, post-traumatic stress disorder (PTSD), anxiety disorders, and adjustment disorders. Researchers (Prigerson et al., 1995a; Prigerson et al., 1995b) have described traumatic grief as a stress-response disorder characterized by both traumatic and separation distress symptoms that load onto a single factor characterizing symptoms of traumatic grief. Although some symptoms of traumatic grief overlap with symptoms of other related disorders (such as MDD, PTSD, and Adjustment Disorder), research has established distinct differences in symptomology, etiology, treatment response, and other predictive qualities for traumatic grief. For example, a history of childhood separation anxiety (Vanderwerker, Jacobs, Parkes, & Prigerson, 2006), a close kinship relationship to the deceased (Cleiren, Diekstra, Kerkhof, van der Wal, & 1994), the nature of the death (Boelen, Van Den Bout, & De Keijser, 2003; Holland & Neimeyer, 2011), and lack of preparation for the death (Barry, Kasl, & Prigerson, 2002; Boelen, van den Bout, & de Keijser, 2003; Winokuer, 2000) have been shown to be risk factors for the development of traumatic grief.

The development of criteria for traumatic grief as a distinct clinical entity. Prigerson and colleagues (1995a) tested a sample of 82 widowed, elderly subjects to obtain baseline data using the Hamilton Depression Scale, Brief Symptom Inventory, Grief Measurement Scale and Texas Revised Inventory of Grief in order to investigate traumatic grief symptom differences in bereavement-related depression. Principal-component analysis revealed a complicated grief factor and a bereavement-depression factor. Complicated grief was characterized by seven symptoms including: (a) searching, (b) yearning, (c) preoccupation with thoughts of the

deceased, (c) crying, (d) disbelief regarding the death, (e) feeling stunned by the death, and (f) lack of acceptance of the death. Prigerson et al. (1995a) also found that baseline scores of complicated grief were associated with enduring functional impairment at 18-months follow-up. Guided by these seven symptoms, Prigerson and colleagues (1995b) developed and tested the Inventory of Complicated Grief (ICG) to measure maladaptive symptoms of loss. Exploratory factor analyses indicated that the ICG measured a single construct of complicated grief, distinct from bereavement-related depression and anxiety symptoms, and demonstrated high internal consistency and reliability. Results also showed that participants with traumatic grief (as indicated by scores above 25 on the ICG) endorsed significantly more social, mental, and physical impairments. Prigerson and colleagues (1997) later extended and replicated their findings from their previous study on a community sample of 150 widowed individuals (mean age 62.4 years) using a modified version of the Grief Measurement Scale. They found that traumatic grief symptoms at 6 months post-loss were significantly correlated with adverse health consequences and excess morbidity.

In consideration of the adverse mental and physical health outcomes for an important minority of bereaved persons, Prigerson and colleagues (1999) empirically tested criteria for a traumatic grief diagnosis. Receiver Operating Characteristic (ROC) analysis suggested that a reliable diagnosis (.93 specificity and sensitivity) of traumatic grief was comprised of the following two criteria: at least three of the four separation distress symptoms (i.e., preoccupation, yearning, searching, and loneliness) reported as *sometimes true* to *always true*; endorsement of at least four of the eight traumatic distress symptoms, namely, (a) purposelessness, (b) numbness, (c) difficulty acknowledging the death, (d) feeling that life is meaningless, (e) feeling that part of oneself has died, (f) a shattered worldview, (g) assuming harmful behaviors relative

to the deceased, and (h) excessive anger or bitterness related to the death experienced as at least *mostly true* for a duration of at least two months.

Prigerson and colleagues' (1995a; 1995b) initial findings gave way to Horowitz and colleagues' (1997) conceptualization of complicated grief. In a 1997 study, Horowitz and colleagues assessed 70 bereaved individuals using the Structured Clinical Interview for DSM-III Non-patient Edition at 6 months post-loss and 14 months post-loss to investigate possible combinations of symptoms that would comprise a reliable traumatic grief (formerly complicated grief) diagnosis. Their results found seven symptoms that predicted a diagnosis of traumatic grief, which were strikingly similar to those proposed by Prigerson and colleagues (1999). More specifically, Horowitz and colleagues (1997) proposed that complicated grief was comprised of intrusive symptoms and signs of avoidance. Intrusive symptoms included: yearning for the deceased, intrusive unbidden memories or fantasies and memories related to the lost relationship, and pangs of severe emotion related to the loss. Signs of avoidance included: feeling empty, excessive avoidance of people, places and activities related to the deceased, unusual levels of sleep interference, and loss of interest in work, social, caretaking, or recreation to a maladaptive degree. Duration of criterion symptoms lasting at least 14 months was used to avoid over-pathologizing grief reactions on the anniversary of the death (Horowitz et al., 1997). Of the subjects who met criteria for a traumatic grief diagnosis (41% of subjects) at 14 months post-loss, only 20% also met criteria for MDD (Horowitz et al., 1997). These findings supported traumatic grief as a distinct clinical entity and suggested consensus for a traumatic grief diagnosis, as both sets of criteria were independently derived yet shared considerable overlap.

Boelen, van den Bout and Keijser (2003) used The Dutch Version of the Inventory of Traumatic Grief (ITG) on a sample of 103 Dutch outpatients seeking grief treatment. Factor

analysis revealed three factors (traumatic grief, bereavement-related anxiety, and bereavement-related depression), which replicated Prigerson's findings in the United States, as well as provided some support for cross-cultural generalizability. Investigation of the psychometric properties of the Inventory of Traumatic Grief demonstrated high internal consistency (Cronbach's $\alpha = .94$) and high temporal stability (test-retest correlation of .92). Receiver Operating Characteristic (ROC) analysis determined a cut-off score of greater than or equal to 90 (out of 150) for an individual to be classified as experiencing clinically significant traumatic grief symptoms.

Proposed diagnostic criteria for traumatic grief. Prigerson et al. (1999) proposed criteria for Traumatic Grief disorder that included four core criteria.

Table 1.

Proposed Criteria for Traumatic Grief Disorder (Prigerson et al., 1999)

Criterion A. Separation distress	Requires that the person has experienced the death of a significant other, and the response included at least 3 of the 4 following symptoms *at least once every day*:
	1. Intrusive preoccupation with the deceased
	2. Yearning for the deceased
	3. Searching for the deceased
	4. Loneliness as a result of the death
Criterion B. Traumatic distress	In response to the death the individual must experience at least 4 of the 8 following symptoms as *at least once every day*:
	1. Purposelessness or feelings of futility about the future
	2. Subjective sense of numbness, detachment or absence of emotional responsiveness
	3. Difficulty acknowledging the death
	4. Feeling that life is empty or meaningless
	5. Feeling that part of oneself has died
	6. Shattered worldview (lost sense of security, trust, control)
	7. Assumes symptoms or harmful behaviors of, or related to deceased person
	8. Excessive irritability, bitterness or anger related to the death.
Criterion C.	The disturbance is at least 2 months in duration
Criterion D.	The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning

The duration criterion of 2 months was established to be consistent with duration criterion for MDD and to facilitate treatment by providing clinicians with a diagnosis that could be reimbursed by insurance companies.

Prigerson and colleagues (1999) described the combination of symptoms in Criterion A as Separation Distress, and the combination of symptoms in Criterion B as Traumatic Distress.

Traumatic grief distinctions from major depressive disorder and adjustment disorder. Proposed criteria for traumatic grief included some symptoms that have been associated with MDD. According to the DSM-IV-TR (2000) a MDD diagnosis consists of two or more major depressive episodes which are characterized by depressed mood, loss of interest or pleasure, significant weight loss, sleep interruption, psychomotor agitation or retardation, fatigue, feelings of worthlessness, diminished ability to think or concentrate, and/or recurrent thoughts of death for at least two months (American Psychiatric Association, 2000). There have been clear similarities in presentation of MDD and traumatic grief symptoms, especially when the symptoms co-occur; however, research has demonstrated differences in phenomenology and prognosis of treatment (Horowitz et al., 1997; Prigerson et al., 1995a; Prigerson et al., 1995b; Shear, Frank, Houck & Reynolds III, 2005). As previously noted, Horowitz et al. (1997) and Prigerson et al. (1995) found that criterion items related to grief and depression loaded separately on two different factors, hence representing two different constructs. These findings have since been replicated in other studies, suggesting that even though these symptoms may co-occur the disorders are clinically distinct (Boelen, Van den Bout, & De Keijser, 2003; Chen et al., 1999; Prigerson et al., 1996)

An Adjustment Disorder is characterized by the onset of distressful emotions in response to and within three months of an identifiable stressor (APA, 2000). This description could meet

the criteria for traumatic grief symptoms; however, the DSM-IV-TR (2000) clarifies that symptoms of adjustment disorder cannot result from bereavement. The diagnosis of adjustment disorder is also limited to a 6-month period in which the symptoms must dissipate or fit with another diagnosis. This may be problematic, as some traumatic grief symptoms have been found to have an onset later than 3 months after a loss and can last for years (Pivar & Prigerson 2004; Prigerson et al., 1995a).

Traumatic grief distinct from PTSD. There has been some confusion in the field of traumatic grief in relation to the differentiation between symptoms of traumatic grief and symptoms of PTSD. Research has shown that although traumatic grief may be a type of a stress response syndrome, there are differences in symptomology, course and treatment (Prigerson et al., 1999; Silverman, Johnson & Prigerson, 2001). Arguably, the most important difference lies in the nature of the trauma. Prigerson et al (1999) asserted that the traumatic distress symptoms are characterized by the trauma of the separation, regardless of whether or not the death was violent or traumatic. Prigerson et al. (1999) added that symptoms of separation distress (preoccupation, yearning, searching, and loneliness) are unique to the traumatic grief diagnosis and not included in the diagnosis of PTSD. Overlap of these disorders, however, is likely to occur, especially if the death of a loved one was violent or traumatic. This overlap or co-morbidity may contribute to the confusion about the differences between the two disorders. Researchers have shown that the nature of the symptoms in traumatic grief and PTSD are likely to differ. For example, an individual with PTSD is more likely to experience hypervigilence about the threat of a trauma in which his/her safety is at risk; whereas a bereaved individual may experience hypervigilence in the form of searching for the deceased person (Prigerson et al., 1995; Prigerson et al., 1999). It has also been shown that intrusive symptoms of PTSD seem to

be experienced as negative or anxiety provoking. In contrast, bereaved individuals experience intrusive thoughts about the deceased in the form of comforting and happy memories, followed by sadness about the reality of the loss (Stroebe, Schut, & Finkenauer, 2001). In addition, individuals who reported PTSD symptoms responded well to a treatment that habituated fear/arousal responses to stimuli associated with the trauma, while bereaved individuals showed improvement of some symptoms, but overall, they did not seem to benefit from exposure or flooding approaches (Silverman, Johnson, & Prigerson, 2001).

Cross-cultural views of death and grief.

The majority of bereavement research has largely focused on the bereavement resulting from the death of an immediate family member (spouse or child) in the context of mainstream American cultural values regarding death and grief. The DSM-IV-TR (2000) described culture-bound syndromes such as Ghost sickness, which is conceptualized as a preoccupation with death and the deceased among "many American Indian tribes" (p. 900). Symptoms may include: "bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation" (p. 900). However, it is important to consider vast differences that exist among different tribes. For example, the Apsáalooke and the Diné have prescribed periods for mourning and do not speak of the deceased after that time allowed for mourning (Nagel, 1988).

Stone (1998) examined the beliefs surrounding death and grief within the Lakota tribe, and found that his participants placed a high value on ceremonies that integrated "the bereaved, the family, the community, and the tribe into a group working to resolve grief" (p. 121).

Shunkamolah's (2009) qualitative study explored the coping strategies used by a sample of bereaved American Indians. This study identified three major factors that significantly

influenced the grief experience of American Indians: whether the death was sudden or anticipated, the proximity of the participant from the deceased, and the generation of which the deceased belonged. He found that American Indian participants' coping behaviors in response to a death were largely relational (i.e., spiritual, family, physical/psychological health, place, work/school, and community) and were components of, what he termed, "cultural coping." He found that the bereaved participants relied heavily on cultural coping, which included accessing cultural resources, traditional tribal people, and places of cultural significance. In addition, "the participants described their view of grief as ever evolving" as opposed to resolving (Shunkamolah, 2012, p. 8).

Recent revisions to the DSM-IV-TR, resulted in a broader interpretation of "culture-bound syndromes" by reconceptualizing the cultural formulations into three concepts: cultural syndromes, idioms, and explanations. The authors argue that the new formulation acknowledges that important cultural explanations and experiences of distress are locally-shaped, but may not be completely culturally distinct configurations of symptoms (APA, 2013).

Current revisions of traumatic grief and the DSM-5

Criterion A, B, and C for traumatic grief has recently been revised (see Prigerson, et al., 2009). Criterion A is now limited to one symptom (yearning or searching for the deceased). Criterion B (traumatic distress) was refined to include symptoms of identity confusion, avoidance of reminders, difficulty moving on, and feeling stunned, dazed or shocked by the loss. Criterion C was extended from 2 months to 6 months to avoid pathologizing disturbances in a normal grief response (Prigerson et al., 2009).

The revised criteria were empirically derived using Item Response Theory (IRT) and incorporated questions from the Inventory of Complicated Grief – Revised (Prigerson et al.,

1995). The revised criteria also aligned with many proposed symptoms from Prigerson et al. (1999) criteria, as well as many from Horowitz et al.'s (1997) proposed criteria. The empirically derived symptoms require the subject to experience separation distress, characterized by symptoms of yearning or searching, and at least five of the nine cognitive, emotional, and behavioral symptoms: (a) identity confusion, (b) difficulty accepting the loss, (c) avoidance of reminders, (d) inability to trust, (e) bitterness or anger, (f) difficulty moving on, (g) numbness, (h) feeling like life is meaningless, and (i) feeling stunned, dazed or shocked by the loss. The name of the diagnosis was also changed to prolonged grief disorder as to avoid confusion with trauma symptoms experienced in relation to PTSD; however for the purposes of this study, the term traumatic grief will be used in accordance with Prigerson and colleagues' (1999) criteria for traumatic grief and in conjunction with the Inventory of Traumatic Grief (Prigerson & Jacobs, 2001).

Despite Prigerson and collegues' (2009) efforts toward inclusion of the empirically-derived symptoms into the new DSM-5, the DSM-5 taskforce did not adopt the proposed criteria as a diagnosis. They did, however, include a similair set of criteria under the section labled: conditions for further study. Two major changes were made to the DSM-5 as an attempt to address the minority of beareved individuals who experienece maladaptive grief responses after a death of a loved one. The first modification was the removal of the "bereavement exclusion" from the MDD diagnosis, allowing bereaved individuals to seek treatment for MDD after two weeks of symptoms (APA, 2013). This amendment has caused some controversy within the bereavement research field, as past research has shown that traumatic grief symptoms are clinically distinct from MDD. Shear (2012) made a distinction between the word depression that is used with a "small d" to describe a state of feeling sad, and the word depression as it exists

within the diagnosis of Major Deppresive Disorder (MDD). She argued that "undoutebly, small d depression" is a core feature of grief, however, "it is not the same as the psychaitiric diagnosis of depression" (Shear, 2012, p. 462).

The second change to the DSM-5 included the addition of proposed criteria for Persistent Complex Bereavement Disorder (PCBD) under conditions for futher study. Current proposed criterion are shown in Appendix A (APA, 2013).

Expected vs. Unexpected Death

Stress theorists have asserted that the unexpectedness of a death should predict poorer health outcomes due to the abruptness of change and the lack of time the individual is given to adjust to the change. However, the empirical evidence is mixed in this area (Stroebe & Schut, 2001). Some studies have found that unexpected deaths predict negative health outcomes (Sanders, 1983; Stroebe, Stroebe, & Domittner, 1988), while other researchers found no differences in health outcomes in studies that compared bereavement due to suicide with other forms of losses (Barret & Scott, 1990; Sherkat & Reed, 1992). However, Silverman, Range, and Overholser (1994) found that bereavement from suicide was associated with more intense grief reactions and argued that bereavement due to suicide includes added difficulties in comparison to bereavement due to natural causes, accidental death, and/or homicide. Methodological issues such as, how the death was categorized (self-report vs. medical record), and limited or lack of maladaptive grief scales may also contribute to these discrepancies within the research. For example, in a study investigating traumatic grief, Boelen and colleagues (2003) found participants who experienced a death of a loved one that was due to "natural causes" reported less traumatic grief reactions, as measured by the Dutch Version of the Inventory of Traumatic Grief, than participants who experienced the death of a loved one due to "unnatural causes." In a

separate study, Barry, Kasl, and Prigerson (2002) found that lack of preparedness was significantly associated with traumatic grief symptoms at 4-months and 9-months post loss. In addition, Holland and Neimeyer (2011) found that within a sample of 947 recently bereaved young adults, separation distress was predicted by the closeness of relationship to the deceased. They also found that participants whose loved ones died by violent means exhibited significantly more symptoms of traumatic distress than participants whose loved ones died of natural causes.

Rationale

In light of the evidence presented for traumatic grief as a distinct clinical entity separate from PTSD, and its potential for long term negative effects on functioning and physical morbidity (Prigerson et al., 1997), it is clear that inclusion of the proposed diagnosis into future versions of the DSM is greatly needed. This may prove to be especially relevant in populations that experience higher rates of deaths.

In an informal survey by a Northern Plains tribal community liaison, grief was identified as a significant health disparity. University researchers Holkup and Swaney, PhD, collaborated with a Northern Plains tribal community in an effort to address the "relentless and layered" grief that the community was experiencing. The Research team identified two major goals of the project; to pilot a culturally-anchored grief recovery intervention, and to evaluate the effectiveness of the grief intervention by collecting quantitative and qualitative data (Swaney, et al., 2011).

Ray Daw (Navajo Behavioral Health), Maria Yellow Horse Brave Heart (University of New Mexico), and two Northern Plains tribal community professionals trained by the National Grief Recovery Institute developed a three and one-half day long Grief Retreat intervention (Hansen et al., 2012). In total, six culturally-anchored Grief Retreats were offered to the tribal

community, and pre-, post-, 1-month, and 3-month follow-up measures were collected. The present study is a secondary analysis of the data that was collected in the previously-mentioned, larger study. Only pre-intervention data will be included; more specifically, the demographic questionnaire, the Grief History, and the Inventory of Traumatic Grief – Revised. The purpose of this secondary analysis is to assess the relationship between unexpected deaths and symptoms of traumatic grief, and to explore the influence of active participation in traditional spiritual practices on the aforementioned relationship.

Hypotheses

This study will investigate the relationship between the number of unexpected deaths experienced within the last five years and symptoms of traumatic grief within a sample of Northern Plains Tribal community members. It is hypothesized that:

1) Participants who report high numbers of unexpected deaths within the last five years will endorse more symptoms of traumatic grief, as measured by the Inventory of Traumatic Grief (Prigerson & Jacobs, 2001) and
2) Active participation in traditional spiritual practices will moderate the relationship between numbers of unexpected deaths and symptoms of traumatic grief (e.g., participants with high numbers of unexpected deaths who endorse being spiritually active will endorse fewer symptoms of traumatic grief).

CHAPTER 2

Method

Participants

The archival data used in this study was collected as part of a larger study that used a community-based participatory research approach to explore and address grief within a Northern

Plains tribal community. The community is geographically isolated and is designated as one of eight federally recognized tribal reservations, categorized by the Indian Health Service (IHS), that make up the Billings Regional Area. The Billings Area IHS health clinic provides comprehensive services to over 70,000 American Indian and Alaska Native people in Montana and Wyoming. As stated previously, the average life expectancy for American Indians living in Montana and Wyoming was found to be more than 11 years less than the U.S. life expectancy for all races and approximately 4 years shorter than the average life expectancy for all American Indian and Alaska Native people (Anderson, Belcourt, & Langwell, 2005).

Data from the 2010 US census suggested that the Northern Plains tribal community was comprised of approximately 49% males and 51% females. In addition, 25.7% of the sample was under the age of 19 years, while 31% were between the ages of 20 and 39 years, and 36.8% of the population was over the age of 40 years. The 2010 US census also estimated 36% of the sample was living at the federal poverty rate, which fluctuated throughout the year due to seasonal employment. Haynes and Haraldson (2010) reported that 80% of the children living in the Northern Plains Tribal community qualified for free or reduced school lunch, which was higher than the combined average for all reservations in the state. Additionally, educational attainment estimates for community members over the age of 25 years was reported as 6.5% of the population achieved less than 9^{th} grade, 15.4% achieved 9^{th} – 12^{th} grade, but did not receive a diploma, 24.8% received a high school diploma or GED, and 27.2% received an associates, bachelors, or graduate degree (US census, 2010).

Adult members of a Northern Plains tribal community were recruited through an initial Historical Trauma conference to participate in one of six culturally-anchored Grief Retreats, held over the course of 18 months, as part of the larger study (June 2010 – September 2011).

Initially, 91 participants were identified from the original data set who were administered the Grief History questionnaires, the demographic information and the Inventory of Traumatic grief. However, four cases were excluded from the analyses due to missing data. Two of the participants did not complete the Grief History questionnaire, and two participants completely rejected the ITG-R. The sample consisted of 87 (43 females, and 44 males) Native American adults ranging in age from 18 to 81 years (M = 43.74, SD = 14.74). In addition, 6.6% (n = 6) of the sample had partial high school education or less, 23.3% (n = 25) obtained a high school diploma or a GED, 38.4% (n = 33) had some college training, and 31.4% (n = 27) of the sample completed college or had graduate school training. Furthermore, 19.5% (n = 17) lived alone and 43.7 % (n = 38) were employed.

The total number of deaths that were experienced by the participants within the previous five years ranged from 1 to 22 with an average of 5.3 deaths (SD = 3.7). Unexpected deaths experienced by participants within the previous five years ranged from 0 to 17 with an average of 1.9 unexpected deaths (SD = 2.48). Of the sample, 60.7% (n = 53) experienced a death less than 12 months prior (33.7% one to three months, 14.6% four to six months, 4.5% seven to nine months) and only 39.3% (n = 34) endorsed their most recent death as more than one year prior to the study.

Of the sample, 69% (n = 60) endorsed active participation in traditional spiritual practices, 59.8% (n = 52) endorsed active participation in an organized religion, and 80.5% (n = 70) endorsed active participation in both traditional spiritual practices and an organized religion.

Measures

All measures were randomized and administered on the first day of the Grief Retreat prior to the intervention. Three of the 10 measures from the larger study are included in this study. These measures are as follows:

Tell Us About You Questionnaire. A 7- item demographic questionnaire developed by the original research team inquired about personal and demographic information including: age, date of birth, sex, education, employment, whether the participant lived alone, and if the participant was active in traditional spiritual practices and/or active in organized religion. See Appendix B.

The Gunning Fog Index uses a formula to measures the readability of English writing. The Gunning Fog readability score for the Tell Us About You Questionnaire was 3.835, which suggested that the test can be read and understood by individuals who left full-time formal education after 3.8 years.

Grief History. The Grief History questionnaire was developed by the research team and asked participants about: how many months since last death experienced, the number of deaths experienced within the last five years, cause of death, and their relationship to the deceased. See Appendix C. This questionnaire was revised by the research team in between Grief Retreats 4 and 5 to help simplify the process for participants.

The Grief History Questionnaire – Revised asked the participants: how many months it had been since the last death they had experienced, their relationship to the deceased, their age at the time of the death, the cause of death, and how old the person was when s/he died. Participants were asked to note whether the death was expected or unexpected, if it was violence related, and if the death was addiction related. See Appendix D.

The Gunning Fog readability score for the Grief History Questionnaires was 11.75, which suggested that the test can be read and understood by individuals who left full-time formal education after 11.75 years. The score was elevated as a consequence of the examples given for causes of death (e.g., obstructive pulmonary, pneumonia, non-Hodgkin's lymphoma).

Inventory of Traumatic Grief. The Inventory of Traumatic Grief (ITG) is a 30-item self-report questionnaire developed by Prigerson and Jacobs (2001) intended to identify and measure maladaptive grief symptoms in response to bereavement. The ITG contains a five-point scale (1 = *less than once a month, no sense,* or *no change*; and 5 = *several times a day, an overwhelming sense,* or *extreme/extremely disturbed*) that measures two factors: separation distress and traumatic distress. Separation distress is characterized by symptoms of preoccupation, yearning, searching, and loneliness and is indicated by high scores on items such as "I think about the deceased so much that it can be hard for me to do the things I normally do," "I feel myself longing and aching for the deceased," and "I feel drawn to places and things associated with the deceased" (Prigerson & Jacobs, 2001). Traumatic distress includes: feelings of purposelessness, numbness, difficulty acknowledging the death, feeling that life is meaningless, feeling that part of oneself has died, a shattered worldview, harmful behaviors related to the deceased person, and excessive anger or bitterness related to the death (Prigerson et al., 1999). Traumatic distress is indicated by high scores on items such as, "I feel that I have trouble accepting the death," "I can't help feeling angry about the death," "I feel disbelief over the death," and "I go out of my way to avoid reminders that the deceased is gone" (Prigerson & Jacobs, 2001). Previous studies have shown high internal consistency for the ITG (Cronbach's α = .94) (Boelen, Den Bout, De Keijser, & Hoijtink, 2003). See Appendix E.

The Gunning Fog readability score for the Inventory of Traumatic Grief was 8.869, which suggested that the test can be read and understood by individuals who left full-time formal education after 8.8 years.

Please See Appendix F for scoring criteria. The scores range from 30-150 with a suggested cut-off score of 90 to constitute a diagnosis of traumatic grief (Boelen, Den Bout, De Keijser, & Hoijtink, 2003).

Culturally Vetting the Inventory of Traumatic Grief. Similar to many scales in the field of bereavement, the Inventory of Traumatic Grief was developed from a Western scientific worldview based on data from predominantly elderly European-American samples. Although the ITG has since been used in other countries such Pakistan, Norway, Egypt, Chile, and Belgium (Haynes, Richard, & Kubany, 1995; Knafl, et al., 2007; Polit, Beck, & Owen, 2007; Vogt, King, & King, 2004), the applicability of the ITG with a Native American sample was unknown. To address this issue the original research team set up a Focus Group consisting of five professionals from the tribal community to discuss the relevance and appropriateness of each item on the Inventory of Traumatic Grief. Of the five members, two were fluent speakers of the tribal language, two were tribal traditionalists, and all of them were working in the mental health field with either a M.A. or a Ph.D. Prior to the meeting each Focus Group participant was sent a packet of information including a copy of the ITG, a chapter describing the development of the ITG, and a cover letter addressing the goals and purpose of the meeting. Each member was asked to consider the following five questions:

1) What is your overall impression of the inventory?
2) Do the items on this inventory reflect grief in your tribal community?
3) What's missing?

4) Because this inventory focuses on only one death, how can it be used for individuals who experience multiple or layered (one death after another, after another) deaths?

During the meeting, the Focus Group participants added a sentence to the instructions that asked the participants to answer the questions regarding the most recent death they had experienced and to answer all of the questions with that person in mind. In addition, the Focus Group participants believed that it was too much to ask of the responders to remember the scale where almost never = *less than once a month*, rarely = *once a month or less or less than one week*, sometimes = *once a week or more or less than once a day*, often = *once every day and* always = *several times a day*. Therefore, they changed the 5-point scale by Prigerson and Jacobs (2001) (i.e., 1 = *almost never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, 5 = *always*) to the recommended equivalent (i.e., 1 = *less than once a month*, 2 = *once a month or more/ less than once a week*, 3 = *once a week or more/ less than once a day*, 4 = *once every day*, 5 = *several times a day*).

All five Focus Group participants reviewed the Inventory of Traumatic Grief, item by item, to rate whether the item was offensive (i.e., Yes or No) and how relevant the item was to the tribal beliefs regarding grief (i.e., 1 = *not relevant*, 2 = *somewhat relevant*, 3 = *quite relevant*, and 4 = *highly relevant*). All five Focus Group members rated the ITG items for offensiveness and relevance, however, one participant responded from an individual perspective (e.g., how relevant is this item to me? Is this item offensive to me?) as opposed to responding in a manner consistent with tribal beliefs about grief. For this reason, this member's responses will be excluded from analysis. A summary of the responses included in the analyses are presented below.

Table 2.

Summary of Focus Group member's responses

	Offensive? yes	Number of omitted Offensive ratings	Relevant? (1-4) Average score	Number of omitted Relevance ratings
Member #1	#12, #16,	2	3.5	4
Member #2	none	0	3.81	1
Member #3	#12 (maybe)	0	3.35	3
Member #4	#15	0	3.4	14

Three items were rated as offensive and thus led to discussion regarding potential changes. Items that were rated as offensive included feelings of anger, hearing the voice or seeing the deceased, and feeling physical pain in the same area of the body that the deceased person experienced. The participants rated the items as being quite relevant or highly relevant (M = 3.35 – 3.81).

Intra-class correlation coefficient (ICC) has been shown to be an appropriate measure of agreement for multiple raters with ordinal ratings (Fleiss & Cohen, 1973) and was used to measure the percentage of agreement among raters for item relevance. Missing data was replaced with average scores for each rater. The intra-class correlation coefficient was .612 indicating that, on average, raters agreed 61% of the time. This statistic is lower than the desirable percentage of agreement of .7 to .8; however, it is important to recall that this composite score of agreement contains both intra-observer and inter-observer variability. Therefore, systematic variability between the raters (e.g., one rater consistently rated 3's) will reduce the composite agreement score. This may be the case for member # 4 who omitted 14 item relevance items, which were then replaced with this member's mean score (3.4), thus reducing the variability in agreement.

The Fleiss Kappa statistic (an extension of Cohen's Kappa), which is used to calculate the degree of agreement over that which would be expected by chance for multiple raters, was used to measure the agreement among raters on offensiveness ratings. It can be interpreted as expressing the extent to which the observed amount of agreement among raters exceeds what would be expected if all raters made their ratings completely randomly. Generally, a Fleiss Kappa of < 0.2 is considered poor agreement, 0.21-0.4 fair, 0.41-0.6 moderate, 0.61-0.8 strong, and more than 0.8 near complete agreement. Results showed a Fleiss Kappa statistic of 0.741, which suggested strong agreement.

Other recommended changes from Focus Group participants included: adding blanks to question number 12, 24, and 25, for clarity and ease of understanding, in places where the question referred to the deceased person. The word "not" was underlined in question number 20 for emphasis. The word "troublesome" was added to questions numbered 31and 32 to qualify "these feelings."

The group discussed each item and made changes to the wording of the following 7 questions depicted in the table below:

Table 2.

Summary of changes to individual items on the ITG.

Item #	**Original Question**	**Revised Question**	**Focus Group Rationale**
5.	I feel myself longing and *yearning* for _____.	I feel myself longing and ***aching*** for _____.	The word "yearning" is rarely used by the tribal community members
16.	I see _____ *stand before me*.	I see ***or feel*** _____.	The words "or feel" were added and the words "stand before me" were deleted to more accurately reflect the tribal cultural beliefs regarding the deceased.

19.	I am *bitter* over _____'s death.	I am ***resentful*** over _____'s death	Focus Group members think that "resentful" is more commonly used and the most synonymous word to bitter.
23.	I feel unable to imagine life being *fulfilling* without _____.	I feel unable to imagine life being ***satisfying*** without _____.	Focus Group participants believe that the term "satisfying" was a more commonly used and a more appropriate word.
26.	I have lost my sense of *security* or safety since the death of _____.	I have lost my sense of ***wellbeing*** or safety since the death of _____.	The term "wellbeing" is more commonly used and a more appropriate word to capture the essence of the question for the community.
33.	Have there been times when you did not have *pangs* of grief and then these feelings began to bother you again?	Have there been times when you did not have ***feelings*** of grief and then these ***troublesome*** feelings began to bother you again?	The word "pangs" was replaced with "feelings" due to the infrequency of the use of the word "pangs" within the community. The word "troublesome" was added to denote a negative experience.
34.	*Can you* describe how your feelings of grief have changed over time?	***Please*** describe how your feelings of grief have changed ***from their death until now.***	This question was restated to specify a time frame and the word "please" replaced the words "can you" to make the question more polite.

Procedure

A coding scheme was developed to categorize modes of death indicated by participants in Groups 1 – 4 as expected or unexpected. Participants in Groups 1 – 4 were asked to indicate how many deaths were due to illness, suicide, car accident, other accident, homicide, alcohol and/or drug related, and other. Suicide, car accident, other accident, homicide, and alcohol and/or drug related deaths were coded as unexpected. Many participants, however, did not indicate the total number of deaths by writing the numeric value; instead they simply checked (√) next to the modes of death. In order to maintain a conservative coding scheme the checkmarks were counted as "one" death. Fortunately, Groups 5 and 6 completed a revised version of the grief history questionnaire that required participants to list each death and to indicate the mode of death as

well as if the death was expected or unexpected. In Groups 5 and 6 unexpected deaths were coded by the participants' responses (yes or no). Two participants from the original sample of 91 were excluded from analyses due to missing data from the Grief History questionnaire. An additional two participants, who completely rejected the ITG-R by marking "n/a" on all items, were excluded from the analysis as well. However, it was decided that participants who rejected individual items on the ITG-R were included; therefore, missing values were coded as zero on the measure. This allowed an alternative interpretation of the ITG –R with possible scores ranging from 1 to 150. Responses were entered into SPSS for analysis.

CHAPTER 3

Results

Assumptions of normality, linearity, and homogeneity of variance were met. A summary of intercorrelations and descriptive statistics for the measured variables are presented in Table 3. A simultaneous multiple regression analysis was performed using IBM SPSS Statistics version 21 to test the hypothesis that participants who experienced higher numbers of unexpected deaths within the previous five years will report more symptoms of traumatic grief, as measured by the ITG – R, while controlling for gender, age, and the time since the last death. The overall model was not statistically significant (R^2 = .086), however, multiple regression results found a significant main effect for unexpected deaths (p = .045), which provided support for the first hypothesis.

Table 3

Summary of Intercorrelations, Means, and Standard Deviation of the Grief History, a Demographic Variable, and the ITG-R.

	Unexpected Deaths	Active Participation in Traditional Spiritual Practices	ITG-R Total	*M*	*SD*
Unexpected Deaths	—	.281*	.027	1.885	2.485

Active Participation in Traditional Spiritual Practices	—	-.001		
ITG-R Total		—	57.943	25.639

*$p < .05$ (2-tailed).

A moderation analysis was used to test the second hypothesis that active participation in traditional spiritual practices would act as a moderator in the aforementioned relationship. A significant main effect ($p = .050$) for the interaction variable (Unexpected Deaths x Spirituality) was found suggesting moderation (Baron & Kenny, 1986). The interaction term in the model accounted for 21.9 % of the variance in ITG-R scores.

Table 4.

Regression Analysis Summary for Factors Predicting Symptoms of Traumatic Grief.

Model

	B	***SEB***	***β***	***p***	***R²***
Age	.001	.200	.001	.995	.001
Months since last death	1.916	1.785	.133	.286	.120
Gender	-8.599	5.530	-.169	.124	-.172
Unexpected Deaths	10.341	5.078	1.006*	.045	.223
Active Participation in Traditional Spiritual Practices	10.109	8.297	.182	.227	.136
Unexpected Deaths x Spirituality	-10.283	5.162	-1.032*	.050	-.219

*$p \leq .05$.

A bivariate analysis was used to tease apart the moderation effect, due to the nature of the variables included in the model. The independent variable was continuous and the moderator was input as a categorical variable (yes versus no), therefore; a correlational method was used to test the differences between unexpected deaths and scores of traumatic grief for non-spiritual participants and unexpected deaths and scores of traumatic grief for spiritual participants (Baron

& Kenny, 1986). The bivariate correlation between unexpected deaths and scores on the ITG-R for participants who did not endorse active participation in traditional spiritual practices was positive and approached significance (r = .347, p = .076). See Figure 1 for the visual representation of this relationship.

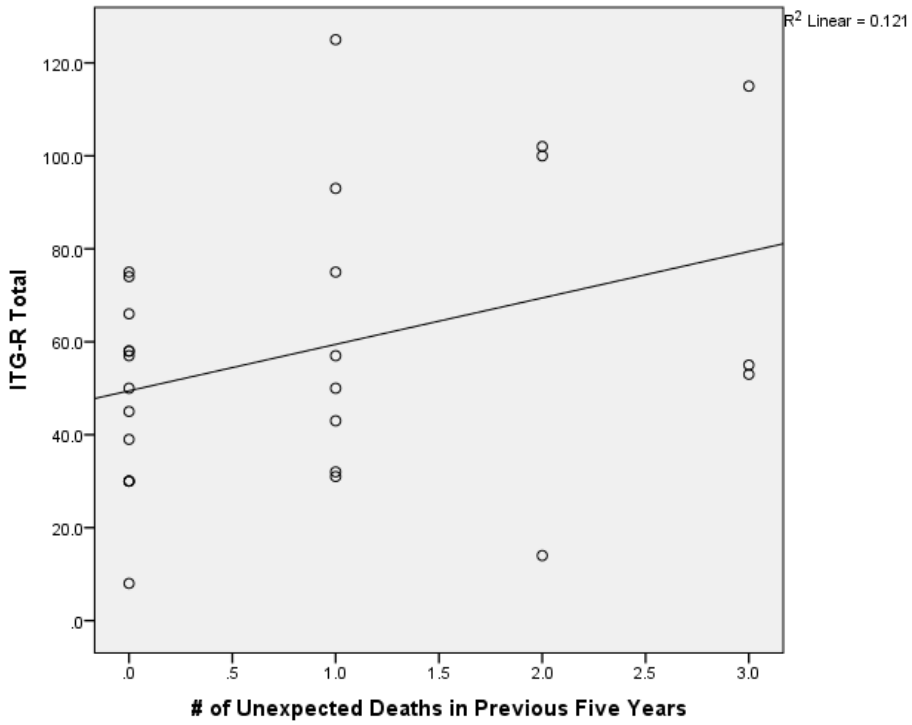

Figure 1. Scatterplot of the Number of Reported Unexpected Deaths in Relation to ITG-R Scores for participants who report not being active in Traditional Spiritual Practices. Pearson's r = .347, p = .076.

The bivariate correlation between unexpected deaths and scores on the ITG-R for participants who endorsed active participation in traditional spiritual practices is slightly negative (r = -.031, p = .814). See Figure 2 for the visual representation of this relationship. This suggests that, for participants who are spiritually active in traditional practices, increased numbers of unexpected deaths are not associated with increased symptoms of traumatic grief.

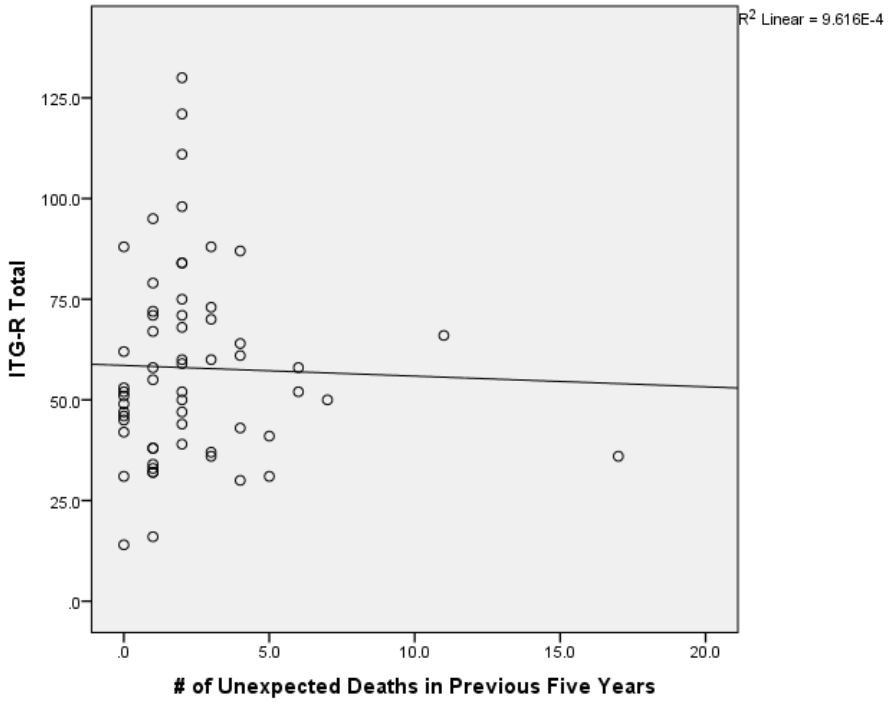

Figure 2. Scatterplot of the Reported Unexpected Deaths in Relation to ITG-R Scores of Participants who report being active in Traditional Spiritual Practices. Pearson's r = -.031, p = .814.

Results from the moderation analysis prompted further investigation into potential differences between the two levels (not active in traditional spiritual practices vs. active in traditional spiritual practices) that represented the moderator variable. Independent t-tests were performed to investigate mean differences between the two groups on age, ITG-R scores, total deaths, unexpected deaths, and expected deaths. Results showed that on average, the group who endorsed active participation in traditional spiritual practices experienced significantly more total deaths, expected deaths, and unexpected deaths than the group who did not endorse active participation in traditional spiritual practices. The two groups did not show significant mean differences in age and total ITG-R scores. A summary of descriptive scores for the two groups are presented in the table below.

Table 5.

Summary of Descriptive Statistics for Levels of the Moderator Variable

	Active Participation in Traditional Spiritual Practices	N	*M*	*SD*
Total Deaths	no	27	3.370**	2.3063
	yes	60	6.150**	3.9049
Unexpected Deaths	no	27	.852*	1.0267
	yes	60	2.350*	2.7972
Expected Deaths	no	27	2.519*	2.2765
	yes	60	3.800*	3.1071
ITG-R Total	no	27	57.963	29.5303
	yes	60	57.933	23.9554
Age	no	26	41.00	16.410
	yes	60	44.93	13.934

*$p < .05$ (2-tailed), ** $p < .001$ (2-tailed).

Chi-square tests were performed on categorical variables to explore potential group differences in gender, education, employment, living status (alone vs. not alone), endorsement of participation in a formal religion, group status (groups 1-4 vs. groups 5-6)[2], and time since the death (less than six months vs six months or more). Significant group differences in endorsement of participation in a formal religion and the time since the death. More specifically, the group that endorsed active participation in traditional spiritual practices had significantly more individuals who also endorsed participation in a formal religion. In addition, the group that endorsed active participation in traditional spiritual practices also experienced more deaths that were less than six months prior to the grief retreat. A Fisher's exact test, which is a statistical

[2] Group status was determined based on the two versions of the Grief History Questionnaire. Groups 1-4 filled out the first version with categorical variables and groups 5-6 were administered the second version that allowed continuous responses. This variable was investigated to consider methodological issues as a potential confound.

significance test used in the analysis of contingency tables where expected numbers are less than five, was used to test whether there were significant group differences in the amount of participants who met the suggested cut-off point for a traumatic grief diagnosis. No significant group differences were found. See Table 6.

Table 6.

Summary of Chi-square and Fisher's Exact Test for Independence for Participants who endorsed Active Participation in Traditional Spiritual Practices and those who did not.

	Value	df	Pearson Chi-Square Asymptote Significance (2-sided)	Fisher's Exact test Significance (2-sided)
Religion	8.414	1	.004*	
Gender	.389	1	.533	
Group	.318	1	.573	
Time since the last death	10.643	1	.001**	
Live alone	.451	1	.502	
Employed	1.384	1	.239	
Education	2.560	1	.110	
Traumatic Grief				.274

*$p < .05$ (2-tailed), ** $p < .001$ (2-tailed).

Lastly, reliability analysis found high internal consistency for the items on the Inventory of Traumatic Grief-Revised (Cronbach's $\alpha = .96$). Results also showed that removal of any individual item did not increase the internal consistency.

CHAPTER 4

Discussion

This study used a western psychological measure of grief, the Inventory of Traumatic Grief, intended to measure symptoms of traumatic grief, and was developed on a sample of older European-American widow/widowers who experienced a single death. This measure was used in a study that assessed grief in a Native American population who ranged in age from 18-81 (M = 43.74), and who experienced, on average, 5.3 deaths in the previous five years. Consequently the applicability of this measure with an American Indian sample was unknown prior to this study. Overall, the model accounted for only 8.6% (R^2 = .086) of the total variance in the ITG-R scores. Low sample size and methodological limitations may have contributed to, but cannot fully explain, this low value; thus, suggesting that a large majority of the variance in traumatic grief scores was unaccounted for by this model. In light of the overall low predictive power of the model, these results should be interpreted as preliminary data to inform future research. In addition, the assumption of construct validity in the dependent variable, traumatic grief, should be further assessed within American Indian populations.

However, despite the limitations of this project, these preliminary results offer insight into a growing area of research. As predicted, a main effect for unexpected deaths (p = .045) was found in the hypothesized direction; increased reported numbers of unexpected deaths were positively associated with increased reported symptoms of traumatic grief. This effect suggested that overall, as unexpected deaths increase; there is a tendency for traumatic grief scores to increase as well. More specifically, this effect suggests that on average, for every standard unit increase in traumatic grief scores, there is a 1.006 increase in unexpected deaths, after controlling for the effects of gender, age, and time since the death. This finding supports previous research

that identified the lack of preparation for a death as a risk factor for the development of traumatic grief and other negative psychological symptoms associated with bereavement (Barry, Kasl, & Prigerson, 2002; Boelen, van den Bout, & de Keijser, 2003; Winokuer, 2000).

A significant interaction effect was also found (Unexpected Deaths x Spirituality), which indicated a moderation effect. This finding supported the second hypothesis that active participation in traditional spiritual practices acts as a protective factor against the development of traumatic grief. Results suggested that for every standard unit increase in traumatic grief scores, there is, on average, a 1.032 decrease in the slope for the interaction term (Unexpected Deaths x Spirituality), after controlling for the effects of gender, age, and time since the death. Otherwise stated, unexpected deaths predicted increases in symptoms of traumatic grief, but this relationship varied across whether or not the participants were active in traditional spiritual practices.

Bivariate analysis of traumatic grief scores and unexpected deaths for each level of the moderator (spirituality) supported directionality of the second hypothesis. In other words, higher reported numbers of unexpected deaths were associated ($r = .347$, $p = .076$) with increased traumatic grief scores for individuals who are not active in traditional spiritual practices at a level that approached statistical significance. However, for the participants who reported being active in traditional spiritual practices, higher numbers of reported unexpected deaths were not associated ($r = -.031$, $p = .814$) with increased symptoms of traumatic grief, suggesting that being spiritually active in traditional practices may act as a protective factor against the development of traumatic grief. This finding was especially evident for the participants who experienced a higher than average number of unexpected deaths. For example, Spiritually active participants who reported the highest numbers of unexpected deaths (ranging from 6-17 deaths)

in the previous five years, scored under the suggested clinical cut-off point of 90 for a traumatic grief diagnosis (Boelen, Van Den Bout, & De Keijser, 2003) . In fact, they all reported scores that were equal to or less than 68 on the ITG-R.

Further analysis of group differences (active in traditional spiritual practices vs. not active in traditional spiritual practices) showed that the participants who endorsed being active in traditional spiritual practices also experienced significantly more total deaths, unexpected deaths, and expected deaths than the group who endorsed that they were not active in traditional spiritual practices. This is an interesting finding that may provide further support to the hypothesis that active participation in traditional practices buffers the negative effects of experiencing multiple deaths. Chi-square analysis showed that the group that endorsed active participation in traditional spiritual practices had significantly more individuals who also endorsed active participation in a formal religion. This could potentially be a confounding variable, in that it may share variance or explain more variance in traumatic grief scores than active participation in traditional practices; however, it should be noted that only 19% of the participants endorsed not being active in either traditional spiritual practices or a formal religion. The majority of the participants (80.5%, $n = 60$) endorsed being active in at least one or both traditional practices or a formal religion. In fact 72% ($n = 43$) of those participants endorsed active participation in both traditional spiritual practices and a formal religion. Due to the low number of participants in each group (not active, active in traditional spiritual practices, and active in a formal religion), and the high rate of co-occurrence of endorsement in both traditional practices and a formal religion, endorsement in a formal religion was not included in the regression model. It would be important, however, for future research to investigate this overlap and assess whether the results of this study can also be attributed to specific religious beliefs.

Many Native American tribal belief systems are inclusive to other ways of practicing spirituality, including integration of formal religion. However, it would be necessary to consult with tribal elders about how best to conceptualize spirituality, the role of formal religion within spirituality, and how to understand the overlap of formal religion and traditional spiritual practices within the same construct.

Finally, chi-square analysis found significant group differences between the two groups in the time since the last death. Specifically, the group that endorsed active participation in traditional spiritual practices experienced significantly more deaths that were less than six months prior to the grief retreat.

It may seem counterintuitive to predict that experiencing higher numbers of unexpected deaths does not result in increased symptoms of traumatic grief for those who are active in traditional spiritual practices; however, this finding may reflect aspects of cultural resilience that already exists within the community. Shunkamolah (2009) found that Northern Plains American Indians relied largely on, what he referred to as, "cultural coping" after a death. Components of cultural coping included: accessing cultural resources, accessing traditional tribal leaders, visiting sacred places, and leaning on their relational foundations (i.e., spirituality, family, and community) for support. It may be the case that each time an individual experiences an unexpected death, s/he is more likely to call upon previously utilized coping resources, making them more accessible and readily available for future experienced deaths. In effect, this tendency may provide opportunity for the individuals to cope and grow in ways that would not have been otherwise available.

These results may also provide preliminary support for treatment approaches that integrate elements of traditional practices and spirituality. In addition, these results may also

support the commonly referred notion among American Indian people that "culture cures." Teri Cross (2003) of the National Indian Child Welfare Association discussed American Indian "Culture as a Resource for Mental Health." He illustrated his assertion of culture as a "key element in a strength-based approach," with a traditional healing story. He argued that "we can and must measure the value of such (culturally-based) interventions to demonstrate the value of cultural resources for mental wellness and for mental health treatment" (Cross, 2003, p. 358).

It may also be the case that within this project, endorsement of active participation in traditional spiritual practices reflects adherence to a tribally-specific protocol for grieving that has been successful, now and historically, in facilitating the healing process after a death. The Swinomish Tribal Mental Health Project (1991) noted that traditional grieving protocols at each stage of the grieving process, "guide the family toward an acceptance of the death and renewal of tribal social life… [these processes] reaffirm tribal relationships and help set things right" (p. 159). Further research is needed to confirm this hypothesis; however, if this is the case, clinical implications for the community could include increasing access and awareness of cultural resources and traditional tribal leaders who can guide the bereaved person in a tribally-specific grief protocol. As Cross (2003) pointed out, it may be helpful to thoroughly assess the value of active participation in traditional practices as it relates to culturally appropriate grieving in an American Indian sample. This approach may encourage the use of strength-based tribally-specific interventions and inform research that could establish these tribally-specific practices as efficacious.

A more general possibility is that endorsement of active participation in traditional spiritual practices may reflect adherence to a relational worldview and a belief in the spirit world that is protective and allows for a continued relationship with the deceased person that offers

continued support and guidance. In that sense, these findings may provide support for Benore and Park's (2004) conception of continued attachment with the deceased person as a protective factor for bereaved individuals. Research has shown that continued attachment with the deceased is associated with less helplessness and less isolation, which is facilitated by continued communication with the deceased person and others (Normand, Nickman, & Silverman, 1996). Active participation in traditional spiritual practices likely provides means for extra community and family support after an unexpected loss and thrusts the individual or family into a tribally-specific protocol for grieving the loss, which likely involves continued contact or communication with the deceased person. However, Benore and Park (2004) emphasized an important distinction between those who believe in continued attachment as part of their "global meaning-making system" or worldview, and those who utilize continued attachment as a coping skill. For example, Silverman and colleagues (1992) found that continued attachment dissipated over time for some bereaved individuals as they decided to "let go" of the attachment with the deceased person. This element of continued attachment may not be accurate (or even possible) from an American Indian worldview; therefore, it would be important to further investigate the role of continued attachment in bereavement from an American Indian and/or tribally specific worldview.

There are several potential implications for these results; however, it should be noted that given the limitations of this project, these results should be considered as preliminary data to help inform future research directions. In this study, it seems most important to gain a deeper understanding of the factors within traditional practice or spirituality that are specifically protective. A qualitative approach could facilitate understanding of the grieving and healing process for those who endorse active participation in traditional spiritual practices. On the other

hand, it seems equally important to gain a deeper understanding of traumatic grief as it is experienced individually and collectively within the community. Again, a qualitative approach could help illuminate the previous assumption that traumatic grief exists within the community and if it is accurately reflected and measured by the ITG-R.

Interestingly, reliability results suggested that the ITG-R has high internal consistency (Cronbach's $\alpha = .96$) within this sample; however, content validity was not investigated. A review of original data revealed that participant's responded to the ITG-R in relation to multiple deaths, despite the fact that the ITG-R instructed participants to think of "the most recent death." In addition, some participants rejected individual items on the ITG-R, while two others rejected the entire measure. The ITG was developed and normed on an elderly Euro-American sample who experienced a single death (usually the death of a spouse or significant other). Therefore; it may be the case that participants were responding consistently, as a group, but that the measure was not "capturing" the entirety of the experience of traumatic grief. It would be important to specifically investigate how multiple deaths or the relationship to the deceased may influence traumatic grief scores with ethnically-diverse and younger samples. Clinical interviews could be added to investigate the content validity of the ITG-R within an American Indian sample.

Limitations and Future Directions

Methodological limitations such as the use of categorical scales and the inconsistent format of the Grief History questionnaire may have reduced variation in our predictor variable (unexpected deaths), thus decreasing the ability of the model to explain variance in traumatic grief scores. Yet, despite the conservative coding scheme used to categorize the predictor variable in the first four groups, results found statistically significant effects. These results,

although somewhat preliminary, may suggest that active participation in traditional spiritual practices acts as a protective factor against potential negative effects of unexpected deaths.

Overall, the model accounted for only 8.6% (R^2 = .086) of the total variance in the ITG-R scores. Small sample size and methodological limitations may have contributed to, but cannot fully explain, this low value; thus, a large majority of the variance in traumatic grief scores was unaccounted for by this model. Future research should investigate other predictive factors (e.g., the closeness of the relationship to the deceased, history of childhood separation anxiety) and may need to consider, more generally, the individual's relationship with grief itself in order to address the complex and layered effects of multiple deaths within this sample. Methodological limitations and content validity of the measures could be better addressed by administering structured interviews using DSM 5 criteria for Persistent Complex Bereavement Related Disorder (APA, 2013), or other empirically supported measures of Prolonged grief such as the Prolonged Grief scale (PG-13) (Prigerson et al., 2009).

The construct of maladaptive grief, although not completely new to psychology, has been recently redefined as a focus of clinical attention. However, the evolution of this construct is still in flux within the majority culture. Considering the cultural differences in belief systems, worldviews, and customs, it seems fair to assert that maladaptive grief, as defined by American Indians, may be different than the symptoms represented on the Inventory of Traumatic Grief. For this reason it would be important to gain a deeper understanding of the phenomena of grief, as it is experienced individually and collectively, and whether or not the phenomena of maladaptive grief even exists within American Indian communities.

Efforts from the original research team and the Focus Group to assess the cultural validity of the ITG provided a foundation for future discussion of the applicability of Western

measures used within a Native American sample. This practice supports the empowerment of Indigenous communities to culturally-vet Western psychological measures for use as community-defined "tools" or to develop measures that originate from Indigenous knowledge systems that fit with the tribally-specific conceptualization of the problem. Agreement ratings that inquired about the relevance of each ITG question in relation to the tribal community's beliefs about grief were less than desirable (ICC = .612). This may suggest that although the items were deemed not offensive, that they are not particularly relevant to the experience of grief from the perspective of the tribal members. Therefore, for this reason and those stated above, the cultural validity of the ITG-R should be further investigated within a Native American sample.

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Appendix A

Proposed Criteria for Persistent Complex Bereavement Disorder

<table>
<tr><td>Criteria A.</td><td colspan="2">The Individual experienced the death of someone with whom he or she had a close relationship.</td></tr>
<tr><td rowspan="5">Criteria B.</td><td colspan="2">Since the death, at least one of the following six symptoms is experienced on more days than not and to a clinically significant degree and have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children.</td></tr>
<tr><td colspan="2">1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play behavior, including behaviors that reflect being seperated from and also reuniting with a caregiver or other attachment figure.</td></tr>
<tr><td colspan="2">2. Intense sorrow and emotional pain in response to the death.</td></tr>
<tr><td colspan="2">3. Preoccupation with the deceased.</td></tr>
<tr><td colspan="2">4. Preoccupation with the circumstances of the death. In children this preoccupation with the deceased may be expressed through themes of play and may extendt to preoccupation with possible death of others close to them.</td></tr>
<tr><td rowspan="8">Criteria C.</td><td colspan="2">Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree and have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children.</td></tr>
<tr><td>Reactive distress to the death</td><td>Social/Identity disruption</td></tr>
<tr><td>1. Marked difficulty accepting the death.</td><td>7. A desire to die in order to be with the deceased.</td></tr>
<tr><td>2. Disbelief or emtotional numbing</td><td>8. Difficulty trusting other individuals since the death.</td></tr>
<tr><td>3. Difficulty with positive reminiscing about the deceased.</td><td>9. Feeling alone or detached from other individuals since the death.</td></tr>
<tr><td>4. Bitterness or anger related to the loss</td><td>10. Feeling that life is meaningless or empty without the deceased.</td></tr>
<tr><td>5. Maladaptive appraisals about oneself in relation to the deceased (e.g., self-blame).</td><td>11. Confusion about ones role in life, or a diminished sense of one’s identity (e.g., feeling that a part of oneself died).</td></tr>
<tr><td>6. Excessive avoidance of reminders of the loss.</td><td>12. Difficulty or reluctance to pursue interests since the loss, or to plan for the future since the loss (e.g., friendships, activities).</td></tr>
<tr><td>Criteria D.</td><td colspan="2">The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.</td></tr>
<tr><td>Criteria E.</td><td colspan="2">The bereavment reaction is out of proportion to or inconsistent with cultural,

religious, or age-appropriate norms.</td></tr>
</table>

Appendix B

TELL US ABOUT YOU

For the questions below, please fill in the blank or circle the correct response. For example, for the question: "Are you male or female?" draw a CIRCLE around 1 if you are female, like this (1)

1. **How old are you?**

   Age: _____ years

   Date of birth: ____/____/_____
   mm dd year

2. **Are you male or female?**

   Female ……
   1

   Male ……
   2

3. **Do you live alone?**

   Yes ……
   1

   No ……
   2

4. **Are you employed?**

   Yes ……..
   1

   No ……
   2

5. **What is the highest grade in school that you completed?**

   Completed 6th grade or less
   …….1

   Junior high school (7th – 9th grade)
   ……2

   Partial high school (10th – 12th grade)
   ….. 3

   High school graduate or GED ……. 4

   Partial college training ……. 5

   Completed college …… 6

   Graduate professional training ……7

   Other _____ …… 8

6. **Are you spiritually active in an organized religion?**

   Yes …… 1

   No …… 2

7. **Are you spiritually active in traditional practices?**

   Yes …… 1
   No …… 2

Appendix C

GRIEF HISTORY

For the questions below, please circle the response that fits for you. For example: If the last death you experienced was 1 to 3 months ago, circle the 1 like this (1)

1. **How many months has it been since the last death you have experienced?**

   1 to 3 months …….. 1

   4 to 6 months …….. 2

   7 to 9 months …….. 3

   10 to 12 months …….. 4

   More than 12 months ……. 5

2. **How many deaths have you experienced in the last five years?**

   1 to 2 deaths ……...1

   3 to 4 deaths …….. 2

   5 to 6 deaths …….. 3

   7 to 8 deaths ……. 4

   More than 9 deaths …….. 5

3. **How many of the deaths were caused by:** (for example if 1 death was caused by cancer and 1 death was caused by diabetes; place a 2 next to illness)

Illness_____	Homicide_____
Suicide_____	Alcohol/
Car Accident_____	drug related_____
Other Accident_____	Other_____
Please Specify_____	Please Specify_____

4. **How were the people who died related to you?** Check as many as apply

Great-Grandparent _____	Child _____
Grandparent _____	Grandchild_____
Parent _____	Great-Grandchild_____
Aunt _____	Friend_____
Uncle _____	Community member_____
Sibling _____	Other_____

Cousin _____ Please Specify_____

Appendix D
GRIEF HISTORY Revised

1. **How many months has it been since the last death you have experienced**? _____(months)

2. **How many deaths have you experienced since 2006 or in the past 5 years?** For example,
    a. Father, I was 56, chronic obstructive pulmonary disease, he was 85
    b. Aunt, I was 57, I don't know what she died from, she was elderly, she was 89, expected
    c. Uncle, I was 58, non-Hodgkin's lymphoma, he was 70, expected
    d. Cousin, I was 55, suicide (he shot himself), he was 57, drinking at the time, Vietnam vet, unexpected
    e. Nephew, I was 55, car accident, he was 21, his 21st birthday, unexpected, drinking
    f. Grandniece, I was 58, pneumonia, she was 2, unexpected

    Be sure to consider all your relationships including family, friends, and community members. After you've listed the deaths you've experienced, please note whether or not the deaths were expected, unexpected, violence related or addiction related.

Relationship	**My Age** at the time of their death	**Cause of Death**	**Their Age** at the time of their death	**Expected** Yes/No	**Violence Related?** Yes/No	**Addiction Related?** Yes/No Alcohol, drugs
Example: Close friend	55	Lung cancer	57	Yes	No	Yes, tobacco

Appendix E
INVENTORY OF TRAUMATIC GRIEF – REVISED (ITG – R)

When answering the following questions, please think about the most recent death you have experienced and respond to the following questions with that person in mind.

Please mark the box next to the answer that best describes how you have been feeling over the **past month**. The blanks refer to the deceased person over whom you are grieving.

1. The death of _____ feels overwhelming or devastating.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

2. I think about _____so much that it can be hard for me to do the things I normal do.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

3. Memories of _____upset me.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

4. I feel that I have trouble accepting the death.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

5. I feel myself longing and aching for _____.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$

Several times every day [ ]$_5$

6. I feel drawn to places and things associated with _____.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

7. I can't help feeling angry about 's_____ death.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

8. I feel disbelief over _____’s death.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

9. I feel stunned, dazed, or shocked over _____'s death.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

10. Ever since _____ died it is hard for me to trust people.

No difficulty trusting others [ ]$_1$
A slight sense of difficulty [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

11. Ever since _____ died I feel like I have lost the ability to care about other people or I feel distant from people I care about.

No difficulty feeling close or connected to others [ ]$_1$
A slight sense of detachment [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

12. I have pain in the same area of my body as_____ had pain, I have some of the same symptoms as _____, or I have assumed some of the behaviors or characteristics of _____.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

13. I go out of my way to avoid reminders that _____ is gone.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

14. I feel that life is empty or meaningless without _____.

No sense of emptiness or meaninglessness [ ]$_1$
A slight sense of emptiness or meaninglessness [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

15. I hear the voice of _____speak to me.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

16. I see or feel_____ stand before me.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

17. I feel like I have become numb since the death of _____.

No sense of numbness [ ]$_1$
A slight sense of numbness [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

18. I feel that it is unfair that I should live when _____ died.

No sense of guilt over surviving the deceased [ ]$_1$
A slight sense of guilt [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

19. I am resentful over _____'s death.

No sense of resentfulness [ ]$_1$
A slight sense of resentfulness [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

20. I feel envious of others who have <u>not</u> lost someone close.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

21. I feel like the future holds no meaning or purpose without _____.

No sense that the future holds no purpose [ ]$_1$
A slight sense that the future holds no purpose [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

22. I feel lonely ever since _____ died.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

23. I feel unable to imagine life being satisfying without _____.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

24. I feel that a part of myself died along with _____.

Less than once a month [ ]$_1$
Once a month or more, less than once a week [ ]$_2$
Once a week or more, less than once a day [ ]$_3$
Once every day [ ]$_4$
Several times every day [ ]$_5$

25. I feel that _____'s death has changed my view of the world.

No sense of a changed world view [ ]$_1$
A slight sense of a changed world view [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

26. I have lost my sense of wellbeing or safety since the death of _____.

No change in feelings of wellbeing [ ]$_1$
A slight change in feelings of wellbeing [ ]$_2$
Some change [ ]$_3$
A marked change [ ]$_4$
An overwhelming change [ ]$_5$

27. I have lost my sense of control since the death of _____.

No change in feelings of being in control [ ]$_1$
A slight sense of being out of control [ ]$_2$
Some sense of being out of control [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

28. I believe that my grief has resulted in significant impairment in my social, occupational or other areas of functioning.

No functional impairment [ ]$_1$
Mild functional impairment [ ]$_2$
Moderate [ ]$_3$
Severe [ ]$_4$
Extreme [ ]$_5$

29. I have felt on edge, jumpy, or easily startled since the death.

No change in feelings of being on edge [ ]$_1$
A slight sense of feeling on edge [ ]$_2$
Some sense [ ]$_3$
A marked sense [ ]$_4$
An overwhelming sense [ ]$_5$

30. Since the death, my sleep has been . . .

Basically okay [ ]$_1$
Slightly disturbed [ ]$_2$
Moderately disturbed [ ]$_3$
Very disturbed [ ]$_4$
Extremely disturbed [ ]$_5$

31. How many months after your loss did these troublesome feelings begin?
_____ months (For example 0 = never, 1= 1month, 2= 2 months, 3 = 3 months, etc)

32. How many months have you been experiencing these troublesome feelings?
_____months
(For example 0 = never, 1= 1month, 2= 2 months, 3 = 3 months, etc)

33. Have there been times when you did not have feelings of grief and then these feelings began to bother you again?

Yes [ ]$_1$
No [ ]$_2$

34. Please describe how your feelings of grief have changed from their death until now?

Appendix F
SCORING CRITERIA FOR TRAUMATIC GRIEF

For Office Purposes Only

35. If interviewer-administered, does rater consider this respondent to have syndromal level Traumatic Grief?

yes□
No□

36. Does respondent meet the following criteria for Traumatic Grief?

Criterion Al

The death of a significant other is a prerequisite for completion of the ITG.

Criterion A2

Separation Distress: at least 3 of the 5 following symptoms must be greater than or equal to 4 ("once every day," "very," or "marked").

- Q2, Q3, Q5, Q6, Q22

Criterion B

Traumatic Distress: at least 6 of the 12 following symptoms must be greater than or equal to 4 ("once every day," "very," or "marked").

- Q4, Q7, Q8, Q9, all, Q13, Q14, Q17, Q19, Q21, Q23, Q26

Criterion C

- Q32 is greater than 2 months.

Criterion D

- Q28 is greater than or equal to 4 ("severe").

yes □
No □