



LUNDS
UNIVERSITET

DEPARTMENT of PSYCHOLOGY

***An Assessment of Grief and Psychological Distress
among Jamaicans***

Jodi-Ann Johnson

Master's Thesis (30 hp)
Spring 2019

Supervisor: Per Johnsson

Abstract

Studies of grief have linked the experience of loss to multiple emotional, cognitive and physiological impairments but its behaviour across different cultures is insufficiently investigated. In this study, symptoms of grief and their relationship to negative psychological outcome among bereaved Jamaicans were assessed. A sample of ($N=58$) participants completed measures of grief and psychological distress in an online questionnaire. Findings showed that grief was strongly related to symptoms of post-traumatic stress, depression and anxiety. The cognitive response, “threatening interpretations of grief,” was also related to higher levels of distressing grief behaviour. The primary symptoms of grief identified were disbelief (difficulty accepting the loss) and longing and yearning for the deceased. There was no evidence of a diagnosable case of complicated grief (CG). Overall these findings indicate that for some bereaved Jamaican adults, the loss of a significant attachment figure negatively impacts mental health, and the expression of such a loss also parallels existing models of grieving.

Key words: grief, loss, depression, post-traumatic stress, anxiety, cognitive, distressing, mental health, culture

An Assessment of Grief and Psychological Distress among Jamaicans

It may be said that human differentiation is an abiding phenomenon that defines our existence. No two individuals are alike be it phenotypically or genetically, yet, this piece of epistemology arguably loses traction in the face of death, this being an inevitable and universal experience common to all (Prigerson et al., 2009; Bui, 2018). Throughout the life course an individual may encounter many types of losses. One may suffer impacting losses such as the loss of a home, the loss of a career, migration, and incapacitation and so on (Parkes, 1998; Jordan & Litz, 2014; Zisook et al., 2014). Notwithstanding their overall gravity, contemporary research has described the major loss of a loved one or significant attachment figure as one of the most emotionally distressing, and psychologically disruptive events that an individual may encounter (Zisook et al., 2014; Enez, 2018; Bowlby, 1980). With bereavement conceptualized as an inevitable occurrence across human lifespan, how does this reality represent a problem for social scientific inquiry or at best, qualify as a meaningful research focus?

Exploring the significance of grief is powered by the myriad of physical, emotional and cognitive decrements with which it is associated (Kersting, Braehler, Glaesmer & Wagner, 2011). Several studies have presented findings in support of these negative associations. Loss of a loved one is associated with declining health indices such as weight loss, functional impairment and increased rates of illness (Shear, Ghesquire, Glickman, 2013). In addition to being associated with poor physiological outcomes for particular age groups such as older adults, clear and distinct psychiatric comorbidities are often linked to the sustainment and development of disordered grieving (Shear et al., 2011). The prevalence of this occurrence following major bereavement is 6.7 %. Additionally, studies have shown that approximately 40% of grieving individuals meet a criteria for major Depressive Disorder (MDD) in the first two months post-loss while almost 20% a year after (Enez, 2018). On a similar note, the prevalence of posttraumatic stress disorder among bereaved persons is approximately 10%, depending on the characteristics of the loss (Enez, 2018).

The socioemotional sequelae are no less empirically grounded. Bereavement is shown to be associated with social and emotional factors such as lowered satisfaction and well-being

and increased loneliness and social withdrawal (Shear, Ghesquire and Glickman, 2013). An example of these findings is that of Arbuckle and De Vries's (1995), who investigated life satisfaction and hopefulness in elder adults, 2 to 15 years after off-spring bereavement (Shear, Ghesquire and Glickman, 2013). They found that bereaved elders experienced reduced satisfaction and hopefulness but greater self-efficacy than non-bereaved controls.

The foregoing evidence points to an undeniable need for grief to be further elucidated. However, throughout the discourse it becomes clear that the subject lacks a systematic cross-cultural approach. Therefore, the primary objective of the thesis is to examine the symptomatology of grief in Jamaica. Findings will potentially push the discipline a step further towards a much needed diagnostic consensus on problematic grief, as well as increase local public awareness of the issue. These objectives are guided by three research questions: What are the symptoms and patterns of grief among bereaved Jamaicans? Is there a relationship between grief and psychopathology bereaved Jamaicans? Has grief affected quality of life or influenced posttraumatic growth?

Defining Grief and Bereavement

In contemporary terms, human interpersonal loss or the loss of a loved one in death, is objectively defined as bereavement, a painful but unfortunately common human experience with an inherent capacity to create profound emotional impact with significant psychosocial, behavioural, physical and economic consequences (Bonnano & Kaltman, 2001; Bui, 2018).

Observed reactions and psychobiological responses to any form of loss converge primarily on the broader psychological construct of grief and are shown to be culturally determined (Smid, Groen, de la rie, Kooper & Boelen, 2018; Enez, 2018). Therefore, grief is conceptualized as the continuum of an individual's emotional, cognitive and psychobiological responses to bereavement (Zisook & Shear, 2009). In analysis then, grief is generally treated as the subjective processing of loss, while bereavement is the objective experience of losing a loved one to death and not the response itself (Shear, Ghesquire, & Glickman, 2013, Zisook & Shear, 2009). Further, studies have differentiated grief from the concomitant concept of mourning, although both concepts are sometimes used interchangeably throughout the literature. However, by way of majority theoretical consensus, mourning has been mostly portrayed as encompassing behavioural manifestations of grief that are influenced by existing cultural norms and practices, typical of the coping and adjustment period following loss (Rosenblatt, 2008).

For current study purposes, focus is exclusively given to human loss by bereavement or death. As such, throughout the ensuing discourse, the construct will be used interchangeably with the construct of loss, and interpersonal loss, representing only the loss of a loved one or significant attachment figure. In the proceeding sections a critical review of the relevant literature will be simultaneously discussed in relation to applicable theories and the study-specific premises outlined above.

The Universality and Individualization of Grief- The Normal Course of Grief

The literature explores the universal experience of grief within a broader context that examines the normal and abnormal course of grief. In line with this differentiation, researchers have for decades attempted to demarcate a universal, expected, normative set of reactions to the loss of a an attachment figure, from reactions that are considered atypical, abnormal, and disproportionate to prevailing societal and cultural norms of grieving (Bui, 2018; Zisook & Shear, 2009; Moayedoddin, 2015). This theoretical divide taps cultural and clinical domains. Accordingly, neither the Diagnostic and Statistical Manual Fifth Edition (DSM-V) nor the International Classification of Diseases (ICD-10) currently offers a differential diagnosis for pathological variants of grieving or Complicated Grief (CG; to be discussed later) but has instead classified this process under disorders requiring further study (Bui, 2018).

The role of culture is evident in that, by specifying a diagnostic criteria for CG, the DSM-5 stipulates that such a diagnosis should only be rendered when severe bereavement reactions exceed cultural parameters (as indicated above) and are not attributable to culturally specific mourning rituals (Smid, Groen, de la Rie, Kooper & Boelen, 2018). Clinical considerations are then brought to the fore of the ongoing debate. Of central concern is whether or not grief in itself should be pathologized - seen as a disease- or instead be treated as an instinctual stress induced response to profound loss (Bonanno & Kaltman, 2001; Bui, 2018). The former stance is endorsed by most clinically oriented bereavement theorists, while the latter mainly reflects the views of clinicians. Further endorsements are seen by some researchers who note that grief, however expressed, is not a psychological disorder hence clinical designations of this nature must be cautiously applied (Rosner, Pfoh, & Kotoucova, 2011).

In this light, the predominant aim of current grief care is to identify and treat distressing bereavement-related behaviours that pose a clinical risk rather than focusing on non-threatening manifestations (e.g., Currier, Neimeyer, & Berman, 2008). This position has been met with minor opposition, with defenders of normative grief counselling arguing that

such interventions have not been shown to be problematic (cf. Larson & Hoyt, 2007, p. 352; Moayedoddin, 2015). In a similar vein, Zisook & Shear (2009), expressed that intervening in a normal process could function to increase clinician sensitization to dysfunctional grief indicators that may potentially lead to CG, as well as better inform their ability to carefully distinguish between normal and pathological variants of grief.

Overall, the literature demonstrates that the task of defining the ‘normal course of grief’ has proven to be historically difficult on two main grounds. These are individual, and as mentioned before, cultural factors that often mitigate the unpredictability of the grief spectrum (Rosner et al., 2011; Zisook & Shear, 2009; Smid, Groen, de la ríe, Kooper & Boelen, 2018). Importantly, the notions of individualization and culture function bi-directionally in the sequelae of grief. The individual is likely to interpret and process his or her loss in a culturally conversant manner, while the sheer notion of culture influences and shapes idioms of grief that are endorsed by the bereaved individual (Rosenblatt, 2008). Resulting from this interplay is the general observation throughout the literature that while bereavement is universal, objectively occurring for everyone, different individuals and cultures grieve uniquely (e.g., Wikan, 1988; Rosenblatt, 2008; Smid et al., 2018; Stroebe & Schut, 1998; Li, Wang, Zhou, Ren, Gao, 2018; Hsu, Kahn, & Hsu, 2002; Rosenblatt & Nkosi, 2007).

Individualization precludes the irrefutability of a normal conceptualization of grief. Research has consistently shown marked individual differences in grief reactions exhibited, particularly in the ways bereaved persons cope, the duration and intensity of their reactions, and the different outcomes seen (Zisook et al., 2014). In illustration of individual variability in coping and outcome, some studies reported the manifestation of responses corroborating a typical grief symptomatology, or a descending pattern of grief intensity, which were accompanied by negative affect in the majority of their samples, (e.g., Lindemann, 1944; Bonanno et al., 2002; Bonanno, Wortman & Nesse, 2004; Kim et al., 2017; Tseng, Cheng, Chen, Yang, & Cheng, 2017). But extended scrutiny of these findings reveals more individualized trajectories. One of these being Bonanno et al’s (2002) study of depressive symptoms in spousally bereaved individuals at pre, and 6 to 18 months post loss. Among the authors’ main findings was evidence of two types of reactions: chronic grief and chronic depression, which essentially supported existing assumptions of intense emotionality after loss. However, equally significant was the observation that 45% of the same sample was characterized by a steady progression of low depressive symptoms throughout the study, and low levels of other generalized symptoms (e.g., yearning). These findings highlight differentiated outcomes which challenge the predominant assumption of normal bereavement

that emotions tend to be elevated in the initial aftermath of loss, and are abated with time (cf. Jordan and Litz, 2014; Zisook et al., 2014; Zisook & Shear, 2009; Shear et al., 2013). The authors also pointed out that these characteristics were indicative of patterns of resilience in some adults in the presence of loss.

Similarly, Tseng et al. (2017) investigated prospectively, the grief reactions of couples to perinatal loss and reported findings that also supported a normal course of grief. On the whole, parents' levels of grief were found to significantly decline from baseline to 3 and 6 months following perinatal loss. These changes in grief were however significantly attenuated over time by individual differences in such variables as gender, reproductive ability, social support, religious beliefs. For example, women reported higher levels of grief than men; infertility was associated with more grief severity; and support from husband's parents and religious beliefs predicted lower levels of grief. These associations demonstrated that a common or normal grief profile was substantially interspersed and influenced by individual variability in grief reactions. Furthermore, they underscore the continual difficulty in establishing a generalized spectrum for grief as bereavement situations are indeed uniquely characterized (see also Bonanno & Kaltman, 2001).

On the matter of grief intensity and duration, what has become increasingly evident throughout the literature is that some individuals grieve openly and for relatively short periods and eventually accept their loss (e.g., Lindemann, 1944; Bonanno et al., 2002; Bonanno, Wortman & Nesse, 2004; Bonanno & Keltner, 1997; Tseng et al., 2017), while others do so more protractedly and intensely, later developing psychogenic and somatic complications (Kim et al, 2017; Schwartz, Howell & Jamison, 2018; Hinton et al., 2013; Johannesson et al., 2009; Shah et al., 2013; Mostofsky, 2012). Mainly, these overt grief behaviours and responses are consonant with surviving traditional assumptions that grief must be expressed or articulated as part of the normal instinctual course of bereavement (Lindemann, 1944; Freud, 1917/1957; Bowlby, 1980). Nevertheless, a key antithesis may be found embedded within this hypothesis, inadvertently lending support to the individualization postulate. Accordingly, many scholars maintain that for some persons, a manifestation of grief can sometimes be absent, delayed, masked or inhibited at the initial stages of mourning (Bowlby, 1980). Historically, such covert responses are commonly interpreted as being symptomatic of a latent pathology which predisposes or places the bereaved at risk of developing more chronic complications (Lindeman, 1944; Bowlby, 1980; Freud, 1917/1957). On the contrary, both early and contemporary inquiries have frequently highlighted the limited empirical validation for a delayed course of grief (Bonanno & Kaltman, 2001; Zisook & Shear, 2009) and in some

cases, have refuted assumptions of later grief chronicity (Keltner, Moffitt & Stouthamer-Loeber, 1995; Bonanno et al, 2004a & 2002b).

In sum, the intensity and duration of grief has been shown to be variable in the same individual overtime and for different groups of people (Zisook & Shear, 2009). Relatedly, the role of culture in the individualization of grief develops from the bi-directionality explained earlier. Therefore, individual differences in grief reactions should not be viewed independently of their cultural contexts, as they are inextricably related. Cross-cultural theorists note that the ways in which one handles the impact of loss is influenced by the norms of his or her cultural identity (Smid et al., 2018) and in further endorsement of this stance, Rosenblatt (2008) commented that “no knowledge about grief is culture free” (p. 207).

Forms of Grief - Acute Grief and Integrated Grief

Studies endorsing the assumption of normal grief processes have revealed a trajectory of grief responses that primarily unfold in two forms: acute grief and integrated grief (Zisook et al., 2014; Zisook & Shear, 2009). In general, these investigations highlight that following significant loss, some persons inevitably adjust with time and progress along a normal, non-pathological course of grief, characterized by moderate disruptions in cognitive, emotional, physical and interpersonal functioning that require no intervention. Conversely, a clinically significant minority fail to cope or adapt to the loss event and continue to suffer prolonged periods of chronic loss-related impairment that undermine normal functioning (O'Connor & McConnell, 2018; Shear et al., 2013; Bonanno & Kaltman, 2001). Supporters of “normative” grief argue that because a disordered course of grief is consistently proven to be associated with a smaller percentage of bereaved persons, this infers that a continuum beginning with intense emotional responses appearing in the early aftermath of loss is expected and hence considered to be normal (Bui, 2018; Zisook & Shear, 2009). Introduced here is the grief trajectory which arguably begins with a “normal”, uncomplicated initial reaction to loss or the phase of acute grief.

Although emotional and behavioural disruptions during acute grief tend to be heightened, they usually fluctuate or are abated over time as one adjusts to the loss event and gradually regains interest in the pleasurable aspects of life (Bui, 2018; O'Connor and McConnell, 2018; Shear et al., 2013; Jordan & Litz, 2014). The most commonly cited reactions that are empirically associated with this form of grief are frequent thoughts and pre-occupation with the deceased as well as states of intense yearning and longing accompanied by

dysphoric feelings of sadness, anger, guilt and shame (Bui, 2018; Bowlby, 1980; Rosner et al., 2011; Bui, 2018; Zisook & Shear 2009; Zisook et al., 2014; Bonanno & Kaltman, 2001).

As stated earlier, most bereaved individuals will eventually adjust to their loss overtime and return to normal pre-loss functioning as the intensity of grief subsides (Shear et al., 2013). This potential course of adjustment or adaptation embodies the second suggested phase along the grief trajectory from which acute grief evolves- integrated or abiding grief (Zisook & Shear, 2009). Here the reality of the loss experience is gradually processed, re-appraised and assimilated into one's ongoing existence, leading to a gradual decrease of the emotional and behavioural disruptions that were heightened during the acute phase (Zisook & Shear, 2009; Shear et al., 2013). Although loss reactions are found to be less salient during this period, when successfully integrated, grief at this stage is not cured but evolves and endures across the lifespan in latent forms which may be triggered by for example, death anniversaries, family or celebratory events, birthday of the deceased, and so on (Zisook et al., 2014).

Some contemporary researchers challenge claims to a normal symptomatology of grief. By way of illustration, in one study that coded common emotion themes during conjugal bereavement, the investigators found that although negative emotional themes such as anger, sadness, distress, anxiety and contempt were present, these emotions were also surrounded by positive appraisal themes such as pride in the deceased, love, affection, and happiness (Bonanno & Mihalecz, 1999). These positive themes were also correlated with reduced grief at 14 months post-loss. The authors demonstrated that contrary to most of the literature linking bereavement to a negative symptomatology, there are also positive aspects of bereavement. Nevertheless, in the interest of balance, one should bear in mind that the experience of positive affect has also been shown to evoke cognitions of guilt and shame in the bereaved (Zisook & Shear, 2009).

Similarly, yet on a more cultural note, Kim et al., (2017) recently examined early and prolonged grief behaviours among 49 Nepali widows immediately following death and identified a number of grief responses which were in some dimensions, inconsistent with findings on traditional grief manifestations. Specifically, even though the most commonly endorsed responses were crying, memory and appetite loss, others which were strongly profiled included sleep disturbances, fainting and domestic-related stress.

In an attempt to highlight grief duration, some studies on acute and integrated grief have been conducted prospectively (Maciejewski et al., 2007; Bonanno et al., 2002; Kim et al., 2017; Hinton et al., 2013). The literature discusses the stage theory of grief as a key postulate on which these are based. Accordingly, this perspective entails the notion that a

normal psychological response to loss progresses through distinct stages after bereavement and has over the years acquired mainstream theoretical and clinical acceptance (Maciejewski et al., 2007). Beginning with the seminal four-stage hypothesis of Bowlby and Parkes which outlined shock-numbness, yearning-searching, disorganization-despair, and reorganization, (Maciejewski, et al., 2007), normal grieving has traditionally evolved across five stages: denial, anger, bargaining, depression, and acceptance (Johannesson et al., 2009; Shear et al., 2006; van Doorn et al., 1998; Bonanno et al, 2002; Wiese et al., 2010). However, Maciejewski and colleagues tested the stage theory on a bereaved sample at 1 to 24 months post-loss and found that counter to the model's assumptions, yearning as opposed to disbelief was the dominant initial response to bereavement. Although frequency of grief indicators within the stage model was not obtained, the authors note that they peaked in the sequence hypothesized, with yearning, anger and depression resolving in four, five, and six months respectively. It should be noted that presently, the stage theory is poorly evidenced by research and fails to consistently account for the wide spectrum and phenomenology of loss (cf. Holland & Neimeyer, 2010).

While there is no definitive timeline for the duration of normal grief, the literature largely suggests that most disruptions following bereavement are usually resolved within six months (Zisook et al., 2014; Bui, 2018; Maciejewski et al., 2007). This consensus is mainly rationalized according to existing criteria for pathological or maladaptive responses which specify a symptom persistence of 6-12 months (Prigerson et al., 2009; Bui, 2018).

Abnormal Course of Grief (Complicated Grief)

The grief process becomes problematic when a significant minority of persons fail in their cognitive-emotional transition from acute grief to integrated grief, resulting in a protracted period of unresolved loss-related distress (Jordan & Litz, 2014; Shear et al, 2013). This group of individuals is described by theorists as having evolved into the third phase of grief, more specifically a type of outcome that is generally conceptualized throughout the bereavement literature and within clinical parameters as complicated grief (CG), 'abnormal' grief, or pathological grief. Complicated grief is a psychological syndrome which entails a prolonged and debilitating form of acute grief which results when different complications and factors such as maladaptive thoughts, feelings or behaviours work to undermine and derail the initial acute mourning process and as a result impede a healthy transition to integrated grief (Zisook et al., 2014). This trajectory was best analogized by Engel (as cited in Shear & Ghesquire, 2013) who commented that CG takes form when similar to a wound,

complications adversely interfere with the healing process. Note, that whereas during periods of acute grief related symptoms tend to be intense but transient, when CG emerges, the symptoms remain and are often times amplified and intensified (Zisook & Shear, 2009). Consequently, the bereaved typically undergoes increased emotional and psychological separation distress as well as traumatic distress. Characteristic manifestations include pre-occupation with the deceased (insistent memories and thoughts) and circumstances of the death; excessive negative affect (e.g., guilt, anger), intense sorrow and emotional pain, and persistent yearning and longing (Hospice Support Fund, 2017; Zisook & Shear, 2009; Prigerson et al., 2009).

According to the DSM-V, before a diagnosis of CG is made, these reactions or complications must be considered relative to their frequency and intensity of presentation by the bereaved; level of interference with social, occupational and other important areas of functioning; and importantly, the degree to which they are dissonant with cultural, religious and age-appropriate norms of grieving and mourning (Smid et al., 2018; Bonano & Kaltman, 2001). At present, there is no definitional consensus on abnormal grief (Rosner et al., 2011, Bonano & Kaltman, 2001; Bui, 2018; Enez, 2018; Smid et al., 2018). As such, in an attempt to establish a discrete clinical framework for the phenomenon, CG has overtime acquired a number of synonymous designations to capture the variety of proposed diagnostic criteria throughout the literature (Enez, 2018; Shear & Ghesquire, 2013; Bui, 2018). The common designations with which it is often interchangeably used are complicated grief disorder (CGD), prolonged grief (PG), prolonged grief disorder (PGD) and most recently persistent complex bereavement disorder (PCBD; Enez, 2018). Despite their syntactic differences, conceptually, these constructs altogether proffer diagnostic frameworks for disordered and potentially harmful patterns of grieving. Except for arguably minor differences among the proposed diagnostic criteria for each construct, the historical period in which each criteria set was developed, and the main proponents of each set of criteria, there are markedly common features among the categories which constitute existing core symptoms of CG (Shear et al., 2011).

Acute, integrated, and complicated grief processes, presage the current lack of definitional consensus in the bereavement literature concerning the putative demarcation of normal and abnormal grief. While on one hand many bereavement theorists have proposed discrete diagnostic conceptualizations for complicated grief, on the other hand, standard clinical oversight maintains that complicated grief characterizations are normal stressor-specific behaviours which can be captured by other diagnostic categories. Therefore, grief

should not be viewed as a pathological condition warranting psychiatric intervention (Rosner et al., 2011; Bui, 2018; Bonanno & Kaltman, 2001; Shear et al., 2011). Consequently, clinicians are implored to be cautious in their application of disordered grief designations (Zisook & Shear, 2009). However, the danger with this circumscription is that in an effort to avoid the misdiagnosis or over-diagnosis of disordered grief, clinicians may also fail to render patients presenting with valid CG symptoms the requisite category of care (Shear, Ghesquire; Bui, 2018; Zisook & Shear).

The former stance was best articulated by Freud (1917/1957) who posited that:

Although mourning involves grave departures from the normal attitude toward life, it never occurs to us to regard it as a pathological condition and to refer it to a medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful (p. 243).

Even so, many studies have countered this normative postulate to show that CG is a unique pathological entity that is clearly distinguishable from other psychiatric diagnoses such as Major Depressive Disorder (MDD), Post-traumatic Stress Disorder (PTSD), and Generalized Anxiety Disorder (GAD) on grounds of clinical phenomenology, etiology and treatment response (Enez, 2018; Shear et al., 2011). In this light, persons presenting with symptoms of CG should be evaluated accordingly and given required clinical support.

Cultural Assessment of Grief

In acknowledgement of the significant variance in grief behaviours that may be accounted for by cultural divergence, bereavement research has now increased its focus on delineating grief cross-culturally. As an inevitable life event across the lifespan, bereavement is experienced by all. However, in an increasingly pluralistic world where cultural norms and traditions heavily shape and dictate existing behaviour, studies have shown that patterns of grieving across various cultures are completely different (Stroebe & Schut, 1998). Therefore, in order to provide an informed and balanced understanding of the subject, grief has been explored in the literature within non-Western emic dimensions (see Klass & Goss, 2003; Marshall & Sutherland, 2008; Rosenblatt, 2008; Smid et al., 2018; Kim et al., 2017; Hinton et al., 2013; Li, Wang, Zhou, Ren, Gao, 2018). The guiding assumption behind the emerging

culturally sensitive literature is that culture “creates, influences, shapes, limits and defines grieving, sometimes profoundly,” (Rosenblatt, 2008, p. 208). Therefore, a deeply rooted cross-cultural perspective acknowledges the reality of human plasticity in grieving; that it is affected by the fluidity of culture; and demonstrates how ethnocentric interpretations of grief limit insights into our own grief and that of other cultures (Rosenblatt, 2008; Stroebe & Schut, 1998; Klass, 1999).

With reference to the changing bereavement discourse, Curren (as cited in Rosenblatt, 2008), asserted that in as much as the bereavement field like other fields continues to insufficiently represent culture in its growing literature, it has also made significant progress in exploring grief and culture. This suggests that the inclusion of cultural dynamics into mainstream bereavement research is in a nascent state and there might not be a unified premise on which it is being done. What then, if any, are the major moot points raised in the literature regarding the increasing need for a cross-cultural assessment of grief? Researchers have mainly pursued an answer to this question by comparing the major tenets of bereavement scholarship with existing cultural variations. The underlying assumption being that the current edifice of grief is a ubiquity of Western, ethnocentric limitations (Rosenblatt, 2008; Stroebe & Schut, 2008). Accordingly, a cross-cultural examination of relevant conceptual, methodological and theoretical issues in the field is outlined below.

Conceptual issues in cultural perspective. From a conceptual standpoint, grief and mourning, the “normal” course of grief, and complicated or pathological grief, are some of the main tenets of common bereavement parlance. With reference to grief and mourning, researchers frequently define these separately, the former capturing more of an individualized reaction to loss, and the latter representing culturally sanctioned ways of grieving (Stroebe, Hansson, Schut & Stroebe, 2008). It has been reasoned that the concepts are arguably artificial as they may be viewed differently in other cultures, in some instances representing a single process (Rosenblatt, 2008). Evidence supporting this cross-cultural overlap is seen in a study by Hsu, Kahn, & Hsu (2003) on the grief reactions of Taiwanese widows to the loss of their husbands. The authors documented that crying was prohibited in front of the deceased and only permitted at a later time. In this context, it may be argued that at the time that crying was openly displayed it could have been seen as both an act of grief and an act of mourning. This stands in contrast to current Western definitions. Nevertheless, it should be noted that some researchers of the psychoanalytic tradition use both concepts interchangeably, although done as a matter of perspective rather than cultural sensitivity (Stroebe et al., 2008).

Subsequent to grief and mourning, is the notion of a normal course of grief, which is also ubiquitous in extant literature. The course of grief is described as assuming two normative or ordinary forms- acute grief and integrated grief- of varied durations, which in a significant minority of cases, develop into a case of complicated or pathological grief (Zisook et al., 2014; Shear et al., 2013; Zisook & Shear, 2009). Each form of grief is characterized by a series of symptoms (crying, loneliness, preoccupation with thoughts of the deceased, feelings of hopelessness, intense yearning etc.). But, are these so-called manifestations of normal or pathological grief universal to all cultures? In assessing this knowledge claim, Stroebe and Schut (1998) reasoned that although crying is possibly the most overt reaction that is common to all bereavement scenarios, it is not necessarily symptomatic of grief. Furthermore, studies indicate that in some cultures, reacting to the loss of a loved one is associated with more somatic than cognitive-emotional symptoms (e.g. Fabrega & Nutini, 1994). These findings contrast popular Western constructions of grief symptomatology, revealing that the course of grief presents differently across cultures and happens to be as normal as culture dictates. In endorsing this stance, Barley, (as cited in Klass, 1999) stated that “there is no such thing as grief, except as a Western cultural construct,” (p.161).

The construct of complicated or pathological grief is also culturally attenuated in the same way that normal grief is. Described as an aberrant way of grieving by Western definitions, indices of complicated grief (prolonged, intense, absence, delayed, exaggerated; Bonanno & Kaltman, 2001) appear to be coded differently in other cultures. By way of illustration Wikan (1990), in a comparative study on two Muslim societies, reported that a Balinese who grieved openly was viewed as vulnerable and significantly distressed and was instead encouraged to smile when faced with bereavement. On similar premises, although the literature maintains that complicated grief generally lasts for an extended period (Prigerson et al., 2009), there is evidence of abbreviated and protracted phases in other cultures that do not necessarily lead to maladaptive grief behaviours (Stroebe & Schut, 1998). One such example were the native American Navajo Indians who according to tribal norms were restricted to grieve for four days during which they were allowed to express their emotions but not excessively. Following this period, a return to normal life was mandatory and reflection on the loss event prohibited (Miller & Schoenfeld, 1973). These findings contradict Western formulations of disordered grief, particularly as they relate to the absence of grief and protracted (prolonged) grief as indicative of psychological dysfunction (Freud, 1917/1957; Bowlby, 1980). In conclusion, the foregoing assessment demonstrates that the application of

concepts of grief pathology from one culture, to another in which grief is conceptualized differently, is cross-culturally unsound (Rosenblatt, 2008).

Methodological issues in cultural perspective. As with all other phenomena, in order to effectively assess the process of grief optimal methodologies must be engaged. The objective of current evidence-based practice in Psychology is to develop established measures that are useful for diagnostic and therapeutic purposes, and of equal importance to this task are the attendant empirical or non-empirical tools used (Neimeyer, Hogan, & Laurie, 2008). The bereavement field currently relies on several established measures of grief, most of these targeting noted grief-related symptomatology such as separation distress, interpersonal disruption and impaired functioning (Neimeyer et al., 2008). In light of the extensive impact of cultural norms and practices on the overall experience of grief, it is important that culturally attuned research is also represented on a methodological level, avoiding Universalist assumptions of generalizability, as well as content that is culturally biased or reductive (Rosenblatt, 2008).

Based on extant literature, a lack of cultural sensitivity in bereavement methods could hinder the research process on a number of levels. To begin, some established tools that are widely used in Western populations may not be equally apt for grief assessment across cultural and sub-cultural settings (Smid et al., 2018; Neimeyer et al., 2008; Rosenblatt, 2008). For example, employing the use of interviews among grieving Taiwanese widows following stillbirth made it difficult for the researchers to access the study population as most informants' feared participation would bring ill-luck and that they would be committing a social offence. Due to this, recruitment of participants took over two years (Hsu, Tseng, Banks & Kuo, 2004). Similar constraints were noted in a study among Zulu widows by Rosenblatt & Nkosi (2007). Chiefly, because interaction norms dictated conversation etiquette, the interviewer being younger than the women she was interviewing, could not have questioned the participants directly. There is limited data to infer that interviews are not effective data collection methods for cross-cultural research but this is not the aim. Moreover, multiple other cross-cultural researches have employed this method and continue to do so (e.g., Kim et al., 2017; Hsu et al, 2003; Fabrega & Nutini, 1994). The key extract, is that all cultural variables should be considered when investigating indigenous groups, particularly the cultural context of the investigation.

Beyond these limitations, while most prominent grief measures are psychometrically merited and some also tested cross-culturally, not all are sensitive to unique cultural variables that may be central to the grief realities of different groups (see Neimeyer et al., 2008). This is as a result of a number of prominent scales (e.g., Texas Revised Inventory of Grief- TRIG) being developed on Western samples (Ting Li et al., 2018). In this instance Ting Li and colleagues tested a Chinese version of the TRIG and found in contrast to previous studies, a one factor structure which differed from the original and follow-up validation studies. Discordant findings were attributed to items on the original instrument targeting more Western patterns of grief phenomena. Similarly, when existing measures were paired with additional items assessing culturally-specific variables of loss among a mixed sample of bereaved Caucasians and African Americans, distinct racial differences emerged (Neimeyer, et al., 2008, p. 155). Once more, the need for culturally sensitive measures is seemingly warranted, however there were marked sample disparities between the original and Chinese study which should be kept in mind when interpreting these results. Therefore findings may not have been culturally significant.

In conclusion, the literature highlights clearly, the value of culturally adapted research methods to bereavement research however, the stance is critically viewed. This is especially reflected in the DSM-V's Cultural Formulation Interview (CFI), developed for routine patient assessment, but critiqued for lacking an explicit focus on cultural aspects (Smid et al., 2018). Nevertheless, the importance of cultural factors when investigating grief phenomena is indeed recognized at one of the highest clinical levels. Additionally, some scholars argue that in spite of cultural differences, grief reactions can still be reliably detected by standardized instruments such as the TRIG or Inventory of Complicated Grief (ICG), implying that the case for culturally sensitive methodologies may be exaggerated (Enez, 2018). On the whole, because the bereaved are the central entities of the grief context, are of diverse cultural backgrounds, and may seek mental health care following significant interpersonal loss, cultural assessment may help both the clinician to offer informed care, and the patient to construct expectations of care (Smid et al., 2018).

Theoretical Issues in Cultural Perspective. With reference to theory, the bereavement literature highlights: opposing views on the extent to which cross-cultural differences should guide the conceptualization of grief (Parkes, 2001; Bowlby, 1980; Stroebe & Schut, 1998; Enez, 2018); primary misinterpretations of grief-specific cross-cultural research (Klass, 1999); and theoretical weaknesses that challenge the universal conceptualization of grief (Rothbaum, Weisz, Miyake, Morelli, 2000; Parkes, 2001). These

areas of discrepancy presage a number of challenges to constructing a cross-cultural model of grief. First, some bereavement theorists oscillate between the need to address the cross-cultural deficit in grief theorizing and understanding on one hand, and corroborating or expanding existing Westernized assumptions on the other (Bowlby, 1980; Parkes, 2001). As a result, some scholars, even while acknowledging that grief is a multifaceted process attenuated by individual as well as cultural differences, also reason that it is more or less universally defined for everyone (see Bowlby, 1980; Enez, 2018;). For example, despite having examined a number of anthropological works on mourning rituals across different cultures, Bowlby (1980) stated that “social custom differs enormously. Human response stays much the same,” (p. 126). Specifically, he later concluded that while cultures differ significantly in the kinds of grieving behaviours that are encouraged, proscribed and regulated, common to all are constituent rules that govern beliefs of continuity (continuing a relationship with the deceased), appropriate affect (attributing blame and expressing anger), and the duration of mourning (p. 131).

Similarly, Enez (2018) while acknowledging that the manifestations of grief are influenced by sociocultural factors, also suggested that despite marked variations in the experience of loss, individuals express common patterns of emotional distress (see also, Bonanno & Kaltman, 2001). In the past, others have even further suggested that Western contemporary models of grief have acquired reasonable theoretical authority (Klass, 1999). Consistent with this stance, in a classic cross-cultural comparison of grief and mourning in 78 societies studied earlier by anthropologists, Rosenblatt, Walsh and Jackson (as cited in Parkes, 2001), acknowledged the existence of strong cultural variations in the behavioural responses and emotional expresses accompanying grief. Nevertheless, they would later determine that American idioms of grieving were relatively adequate grounds on which to “generalize about the species,” (1976, p. 124).

Second to this, the cross-cultural literature is at times erroneously conflated with that of multiculturalism (Klass, 1999). The ambivalence demonstrated in these assumptions may be partially explained by the latter, which Klass, (1999) describes as the view that various cultural forms exist as an amalgamated entity derived from other cultures. In this context, the reality of cultural diversity does not translate to differences. Rather, grief, is indeed universally patterned merely occurring within varied cultural environments. Conversely, the author critiques multiculturalism with that of cross-culturalism, which he presents as a more applicable antithesis of the multicultural agenda of grief. Essentially, a cross-cultural model of grief unlike a multicultural model of grief, would do more than subserve pluralistic notions of

grieving by offering a relativist, fine-grained account of the ways in which different cultures respond to death (p. 154). Coming from an axiomatic angle, Rosenblatt (2008), (in contrast to his own earlier formulations on cultural differences; cf. Parkes, 2001) supports this view, conceding that an understanding of the interrelationship between grieving and culture serves as a crucial preliminary to the establishment of an effective cross-cultural theorizing (p. 208).

Thirdly, a large part of referent literature has always drawn attention to the reality of loss in Western or developed contexts, resulting in fewer studies that explore the cross-cultural correlates of grief (Hinton et al., 2013). By the same token, some of the most prominent theoretical frameworks and praxis to which the field subscribes are of predominantly Euro-American origins orientations (Rosenblatt, 2008), suggesting that the bereavement literature in its current state may be fundamentally flawed. The popular point of contention underlying these ruling assumptions is the “universal hypothesis” of grief. In general terms, grief is conceptualized as a universally experienced process of biological and evolutionary origins, spanning human history and cultures (see earlier discussion; Bowlby, 1980; Stroebe & Schut, 1998; Archer, 2008; Klass, 1999). In specific terms, grief as a universal reaction to bereavement, means that in spite of cultural differences, it is possible to identify a spectrum of responses that are common to, and shared by all individuals in the face of emotional loss (Klass, 1999; Rosenblatt, 2008). Please note, this definition is not to be confused with the objective and equally universal occurrence of bereavement (as discussed earlier). Two models of relevance are often used to illustrate the universality of grief.

The first is that of attachment theory. Fundamentally, Bowlby (1980), from a Darwinian perspective, endorsed the survival value and biological basis of human attachment, positing that attachment behaviours (e.g., crying, hugging, clinging) are prolonged evolutionary systems of relatedness in all species that promote child-mother proximity. Grief then represents the negative consequence that occurs when emotional bonds are permanently severed, leading to the experience of *separation distress* (Bowlby, 1980).

Ample empirical evidence supporting the universal nature of grief from an attachment perspective is documented in findings from both human and animal studies, the latter case showing grief-life reactions to the loss of a companion or mate (van IJzendoorn & Sagi, 1999; Averill, 1968). In this light, the model is often defended by attachment theorists as being cross-culturally sensitive (Bowlby, 1980; van IJzendoorn & Sagi, 1999). However, in drawing cross-cultural comparisons with the attachment systems of collectivist societies such as Japan, some of its major hypotheses (viz., sensitivity hypothesis, competence hypothesis, and secure base hypothesis) have been critiqued by some as being ethnocentric and heavily influenced by

established Western ideologies (Stroebe & Schut, 1998; Klass & Goss, 2003; Rosenblatt, 2008; Rothbaum Weisz, Miyake, Morelli, 2000). Furthermore, some researchers note that while the model acknowledges that attachment parameters are indeed attenuated by culture, it maintains that the overall system of attachment is constant in all cultures (Rothbaum et al., 2000).

The second framework which is relevant to the universality of grief is that of the “grief work hypothesis” (Freud, 1917/1957). It also stands as one of the most influential perspectives in the history of bereavement research, also informing Bowlby’s attachment model (Klass, 1999; Stroebe & Stroebe, 1991). The core argument of “grief work” is that post-loss recovery depends on the extent to which the bereaved cognitively confronts the reality of loss and emotionally detaches one’s self from the deceased (Stroebe & Stroebe, 1991). Working through one’s grief is hypothesized by some bereavement theorists as the most effective method for grief resolution and coping and is central to the structure of Western clinical grief interventions (Stroebe & Stroebe, 2001; Stroebe & Schut, 1998). On this premise, “grief work” represents the universal benchmark for coping successfully after bereavement. However, is this style of coping applicable to all cultures?

Few studies have investigated and confirmed the construct of “grief work” within cross-cultural contexts (e.g., Miller & Schoenfeld, 1973; Pennebaker & O’Heeron, 1984) while others have produced findings that are not cross-cultural in nature, but nonetheless challenge its main assumptions (e.g. Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002; Stroebe & Stroebe, 2001). The availability of few cross-cultural studies suggests that the model is not always assessed indigenously and cannot be generalized to all cultural groups. Also, since grief work postulates that grief resolution is achieved through cognitive confrontation of the loss event, it would be expected that grief would be expressed rather than internalized. On the contrary, the notion of grief expression is discouraged in some non-Western societies such as China (Ting Li et al., 2018).

Overall, it would appear that the literature highlights the need for grief to be cross-culturally assessed. However, the full-scale incorporation of a cross-cultural model has been met with much apprehension. Two major junctures are highlighted. In the first place, researchers are divided on the degree to which grief arguably occurs universally across various peoples and cultures, or universally, relative to cultures. And in the second place, it may be said that following a critical look at existing frameworks of grief, the process emerges as an ethnocentric construct lacking strong cross-cultural indices (Stroebe & Schut, 1998). These arguments form a major context of justification for a cultural overhaul of bereavement

research. This would result in a refined research tradition that is informed by cross-cultural perspectives and free from ethnocentrism (Rosenblatt, 2008).

The Jamaican Landscape

Grief originates from bereavement but the phenomenon is shown to be nested. As a psychobiological response to a significant or meaningful loss event, it is instantiated only by the context and concomitant sociocultural correlates of the precipitating bereavement experience. Therefore, an investigation into the ways in which grief presents in a cross-cultural context is best supplemented by an understanding of the discriminants of that society. On this basis, the Jamaican landscape is briefly discussed below.

The bereavement literature underscores some key components of grief. These are: human loss as one of its primary progenitors (Parkes, 1998); it is culturally defined (see Rosenblatt, 2008); it most often follows an individualized trajectory (Zisook et al., 2009); it is clinically significant (Zisook & Shear, 2009) and it is a stress-induced response (Archer, 2008). The extent to which these are represented in Jamaica varies according to its historical and sociological background.

Firstly, the Jamaican context is ripe for a cross-cultural delineation of grief. As a Caribbean nation, it is heavily shaped by religious practices and traditions that have been passed on through slavery and colonialism, an inheritance that is reflected in its existing religious beliefs and customs (Marshall & Sutherland, 2008). As a result, the society's construct and articulation of grief is deeply rooted in the cultural assimilation and syncretization of British, West-African, Indian, Chinese and European influences (Marshall & Sutherland, 2008). Similar to other non-Western environments, in Jamaica grief is expressed in a culturally unique way which at times contrasts traditional assumptions. To illustrate, at a point in time following bereavement, friends and family of the bereaved gather for a proverbial "send-off" for the deceased, which tends to assume the appearance of a celebratory event as opposed to a sad and somber occasion (Mandy, 2014). Despite the interpretation of an outsider, this particular mourning practice allows the bereaved to grieve openly with both family and the community and possibly functions as an adaptive aspect of the grieving experience.

Secondly, grief is heavily discussed as a stress induced response but less explored in the context of sociocultural stressors both pre and post-loss. It is said that grief occurring in

stressful socioeconomic contexts is potentiated and sometimes obstructs the coping process (Kim et al., 2017). Writing in 1998, Parkes noted that of 200 consultations with clinicians a third were psychological in origin while 27 % were loss-related, and most frequently caused by death. Also, in some societies, individuals contend with mass political violence that increases the likelihood of interpersonal loss (Kim et al., 2017). In Jamaica, similar antecedent factors to bereavement may be encountered. It was reported in 2016 that the country had the world's highest violent death rate for females and the sixth highest in total (McEvoy & Hideg, 2017). This statistic stands in stark contrast to the island's relatively small population of 2.7 million (STATIN, 2017). Also salient, are health and economic issues, including increasing non-communicable diseases, a shortage of health service personnel and growing rates of poverty. For example, despite economic growth, between 2007 and 2010 poverty levels had steadily increased to 17.6% while youth unemployment leads to the emergence of criminal behaviour (PAHO, 2012). These figures highlight a predisposition for premature death, and the compounding social circumstances that are likely to accompany such event.

Lastly, the clinical significance of grief although bolstered throughout bereavement research, is less promoted in Jamaica due to broader cultural and economic factors surrounding mental health in general (Thompson, 2017). In a study on stigma and mental attitudes towards mental illness in Jamaica, Hickling, Hickling, Robinson & Abel (2010) found that mental disorders were negatively perceived and in turn influenced a pattern of ambivalent emotional support towards patients with mental illnesses. Apart from being heavily stigmatized, mental health care in Jamaica also lacks an optimal infrastructure. According to a 2009 WHO report, there was a shortage of trained psychiatric staff and a dearth of local quantitative and clinical research (WHO, 2009). Unfortunately, as the subject currently stands, the problem is yet to be addressed.

Present Study

A growing body of literature has pursued the emergence and maintenance of explanatory models and paradigms for the understanding, diagnosis and evaluation of grief ontologies (e.g., Freud, 1917/1957; Bowlby, 1980; Lindemann, 1944; Stroebe et al., 2008; Stroebe & Schut, 2001; Parkes, 2001). However, while the role of culture in these analyses is acknowledged, the cross-cultural and sociocultural parameters of grief are insufficiently expounded. Some inquiries are more concerned with mourning behaviour and by this orientation offer more peripheral than central insights into the phenomenon (Klass, 1999). Grief cannot be understood independently of its cultural context yet there is minimal

availability of culturally-specific models that robustly satisfy a cross-cultural criterion (Rosenblatt, 2008; Klass, 1999). Also, risk factors associated with maladaptive or disordered variants of grief are commonly explored within post-loss-specific dynamics rather than within the broader sociocultural context of the bereaved (Stroebe & Schut, 1998). Also, a substantial part of the bereavement literature analyzes grief processes within stressor-specific, spousal, and clinical sub-groups (e.g., Prigerson et al., 2009) but based on extant findings, grief assessment is also valuable for deriving clinically useful information from other bereaved groups.

As a preliminary step towards addressing these deficits in the literature, the present study aims to assess patterns of within a small group of bereaved Jamaican adults. More specifically, the study will assess existing patterns of grief reactions across different reported periods of time since loss. This orientation of the study may allow for a comparison with traditional assumptions of grieving behaviours. Secondly, the relationship of grief with the development of other forms of psychopathology following loss will be examined in order to assess the potential magnitude of loss among non-disorder-specific grievers. And lastly, outcome following the experience of loss will be relationally assessed. Overall, this dissertation promises an initial small-scale overview of the country's grief status quo that may be useful for making reasonable theoretical comparisons and informing future research directions on a more representative level.

Method

Sample and Participant Selection

The current study is a cross-sectional correlational design which utilized a purposive snowballing sampling technique. Owing to time allotted for completion of study and proximity of access to overseas-based population, this method was deemed most optimal. The study's inclusion criteria were Jamaican adults, 18 years or older who had experienced a past or recent bereavement. Persons were recruited through contacts of the researcher who had knowledge of bereaved individuals, and through participants who also knew of persons who were bereaved. To increase sample heterogeneity, there was no exclusion criteria. However, as a show of respect, persons bereaved under one month were not recruited but were allowed to participate only if willing. Participants were not at the time of the study receiving any form of grief-related care. The sample size was not fixed but was based on the methods of similar designs whereby an adequate number of participants were recruited from bereaved populations

of interest (e.g., Ginzberg, Geron, Solomon, 2002; Tomarken et al., 2012). A total of 60 individuals provided responses and 2 declined consent. The final sample therefore consisted of (N = 58) participants, most of whom were between 35-45 years ($n = 20$, 34.5 %) with the majority being females ($n = 41$, 70.7%).

Procedure

Following a joint evaluation of the University's ethics criteria by both the researcher and the supervisor, it was determined that the study did not require ethical approval. All persons satisfying the inclusion criteria were then directed to an online questionnaire hosted by Google Forms. The questionnaire was preceded by an information sheet about the study and details of informed consent. Contained was a battery of standardized measures including self-constructed items to assess particular factors. On average, completion of the questionnaire took twenty to twenty five minutes. Those indicating their consent were allowed to proceed to the study. Data was collected between March and April, 2019.

Materials and Measures

Sociodemographic, loss-related characteristics. Items were included to ascertain sociodemographic characteristics (i.e., age group, gender, level of education, marital status, income group) and loss-related characteristics (i.e., cause of death, kinship to deceased, time since loss, grief support, quality of relationship to deceased). A number of other items were also adapted based on previous studies, to also assess (religiosity, perceived social support, perception of suffering, perception of nature of death) commonly cited factors in the literature often linked to CG or negative psychosocial outcome after bereavement (Lobb et al., 2010; Hibberd, Elwood, Galovski, 2010; Hospice Support Fund, 2017). The omission of items from previously used scales was largely due to the administrative constraint of accommodating longer measures considered more central to the investigation.

Quality of relationship with deceased. Assessing this variable was done with the use of a single item asking participants to indicate which statement best described the quality of their relationship held with the deceased. Responses included for example, "*warm and loving*", "*we shared and talked about everything*," and "*our relationship was neither good nor bad*." The content of the responses was guided by extant literature on pre-bereavement factors that affect poor adjustment to loss (Hospice Support Fund, 2017).

Perceived social support. The Multidimensional Scale of Perceived Social Support (MSPSS) is a 12-item self-report measure assessing subjectively perceived social support on

three subscales: friends, family and significant other (Zimet, Dahlem, Zimet & Farley, 1988). The instrument has been validated across multiple cross-cultural samples with reported Cronbach's α of .93 to .96 (Hannan, Alce & Astros, 2016) and .83 (Nakigudde, Mussi, Ehnvall, Airaksinen, Agren, 2009). In the present study 3 items, 1 from each subscale, were selected from items corresponding to highest factor loadings in a validity study by Zimet, et al. (1988). Participants rated the items on a 7-point Likert scale ranging from "very strongly disagree" to "very strongly agree." Items utilized in the study were, "There is someone with whom I can share my joys and sorrows," "I get the support I need from my family" and "I have a friend with whom I can share my joys and sorrows." The reliability of these items in the present study was Cronbach's α .91.

Religiosity. In view of the cross-cultural context of the study, levels of religiosity were assessed. Drawing on the approach of Bonanno et al. (2002), religiosity was assessed on two separate dimensions measuring personal religious devotion and religious conservatism. Using a 5-point Likert-type scale where 1 = "never" and 5 = "always," participants were asked two questions: "When you have decisions to make in your daily life, how often do you ask yourself what God would want you to do?" (Personal devotion) and "Do you ever try to encourage people to believe in Jesus and to accept Him as their Savior?" (Religious conservatism). Items on each dimension were totaled to form a single score of overall religiosity and further trichotomized into the categories low religiosity, moderate religiosity and high religiosity according to the lower, middle and upper quartiles of the range of scores obtained. The dimensions of religiosity used in the subscales were based on the empirical validations of Kendler, Gardner & Prescott (1997). The items showed good reliability on each dimension in previous studies ranging from Cronbach's α .65 (personal devotion) to Cronbach's α .83 (religious conservatism; Bonanno et al., 2002). Their reliability in the present study was acceptable (.65) and most likely due to the small number of items used but were deemed culturally suitable for the present sample. Items selected also corresponded with the highest factor loadings reported in another study by Miller, Davies, Greenwald, (2000).

Perceived circumstances of nature of death and suffering. In adaptation of the method of Barry, Kasl & Prigerson, (2002), these variables were assessed with the use of two separate items measuring the dimensions, "perception of the nature of the death" and "perception of suffering." Persons were asked "How peaceful or violent did you view the passing of the deceased?" (i.e., nature of death) and "to what extent do you think your loved one suffered in dying?" (i.e., suffering). Responses were given on a 7-point Likert-type scale ranging from "peaceful" to "violent" and "not at all" to "extremely." Due to conceptual

overlap in response options, scores were trichotomized into more optimal categories, “peaceful,” “neutral,” and “violent.” Similar to the variable religiosity, this was done according to the lower, middle and upper quartiles of the range of scores. The items were not totaled to form a single score as the dimensions are distinct.

Symptom Measures

Complicated grief symptoms. The Prolonged Grief Questionnaire (PG-13) is the most recent scale that has been distilled from the Inventory of Complicated Grief Revised (ICG-R) measure and is one of the most widely validated measures of complicated grief (CG; Jordan & Litz, 2014; Enez, 2018). It contains 13 items on grief related thoughts and behaviours that are rated on a 5-point Likert scale ranging from “*not at all*” to “*several times a day*” (items 1 to 5) and “*not at all*” to “*overwhelmingly*” (items 6 to 12). The advantage of the PG-13 is that it satisfies the most recent DSM proposed symptom criteria for CG or Prolonged Grief Disorder (PGD; Thomas, Hudson, Trauer, Remedios, Clarke, 2013). It also represents a collection of the most unbiased and informative items from its parent scale (i.e., ICG; Jordan & Litz, 2014). Good psychometric properties for the ICG were reported across diverse samples with Cronbach’s α ranging from .94 - .96 (Eisma et. al, 2015; Boelen et al., 2010; Golden et al., 2007). In light of these strengths, the PG-13 was used in the current study to measure the symptom severity of CG by categorizing participants meeting a criteria for CG (Thomas et al., 2013). Prigerson et al’s (2009) diagnostic algorithm as well as a cut-off score were both used to assess a “caseness of CG and symptom severity as previously done by Tomarken, et al. (2012). Cronbach’s α in the sample was .89. In the interest of consistency, throughout the analysis, grief severity will be referred to as CG (complicated grief) for semantic correspondence to its measure (PG-13).

Depressive symptoms. The Patient Health Questionnaire-9 (PHQ-9) is a brief self-administered 9-item depression module of the full PHQ, designed to detect and measure symptoms of depression and severity in medical and clinical settings (Smarr & Keefer, 2011). It holds merit as one of three instruments (Beck Depression Inventory-II [BDI-II], Hospital Anxiety and Depression Scale, PHQ-9) endorsed by the National Institute for Health and Clinical Excellence (Smarr & Keefer, 2011) and items are based on the Diagnostic and Statistical Manual Fourth Edition (DSM-IV) criteria for depression diagnoses. Good convergent validity has also been established with strong correlations of $r = 0.73$ and 0.70 with the Beck Depression Inventory (BDI) and Short Form Health Survey (SF-20) respectively (Smarr & Keefer, 2011). Cronbach’s α in the present sample was .92.

Post-traumatic stress symptoms. Symptom severity of post-traumatic stress (PTS) was measured with the administration of the Posttraumatic Stress Checklist-Civilian Version (PCL-C). This measure was used as it is a comparatively brief standardized self-report measure consisting of 17 items relating to key PTSD symptoms rated on a 5-point Likert scale from 1= “not at all” to 5= “*extremely*” (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Of merit, the PCL-C may be applied to any traumatic event and so was suitable for the assessment of bereavement in the present study. The instrument has also been found to be reliable in both clinical and non-clinical samples with a reported Cronbach’s α of .89 and .94 respectively (Weathers, Litz, Herman, Huska, & Keane, 1993; Conybeare, Behar, Solomon, Newman, & Borkovec, 2012). In support of its convergent validity, the PCL-C has been found to correlate strongly with the Traumatic Symptoms Checklist (TSC; $r = .61$; Conybeare et al., 2012) and the Clinician Administered PTSD Scale (CAPS; $r = .92$; Weathers et al., 1993). The instrument demonstrated excellent reliability in the present sample ($\alpha = .93$).

Anxiety Symptoms. The Clinically Useful Anxiety Outcome Scale (CUXOS) is a brief and accurate self-report measure used to evaluate levels of anxiety (Zimmerman, Kiefer, Kerr, Balling, 2019). It comprises 20 items on a 5-point Likert scale ranging from 0 = “*not at all true*” to 5 = “*almost always true*.” It takes into account the respondent’s past using the prompt, “how well it describes you in the past”. Although relatively recent, the CUXOS has been validated in other studies (Jeon et al., 2017) and was chosen for its strong psychometric properties and accuracy in measuring depressive symptoms. In its validity study a Cronbach α .95 was reported. The scale demonstrated excellent reliability in the present sample ($\alpha = .95$).

Outcome Measures

Posttraumatic growth. Posttraumatic growth was measured with the Posttraumatic Growth Inventory–Short Form (PTGI-SF) questionnaire. This tool is a brief version of the original PTGI and consists of 10 items on a 5-point Likert scale that assess perceptions of positive changes in life as a consequence of stressful life events (Cann, Calhoun, Tedeschi, Taku, Vishnevsky, Triplett, & Danhauer, 2010). As previously done by Bellet, Jones, Neimeyer & McNally, (2018), in the present study, participants were asked to respond in reference to their loss. Items ranged from, (0 = “*I did not experience this change as a result of my loss*”) to 5 = (“*I experienced this change to a very great degree as a result of my loss*”). The PTGI-SF has displayed strong psychometric credibility across various studies and is found to be as robust as the original instrument in assessing post-bereavement outcome (Bellet et al.,

2018). As per standard criteria, higher scores represented greater growth. Internal consistency in the present sample was excellent ($\alpha = .91$).

Quality of Life. The Quality of Life Scale (QOLS) was utilized to capture quality of life outcomes within the research sample. This is a self-administered 16-item tool that has been adapted and expanded since its original development to assess perceptions of quality of life among a number of chronically ill groups as well as healthy populations (Burckhardt & Anderson, 2003). It spans the domains of material & physical well-being, relationships with other people, social community and civic activities and personal development (Burckhardt & Anderson, 2003). It was first developed for use in US English-speaking populations and is merited for its keen attention to background diversity and individual perspective (Burckhardt & Anderson, 2003). In line with standard use, higher scores on the instrument corresponded to better quality of life. The QOLS has displayed significant convergent and discriminant validity with similar measures such as the Life Satisfaction Index-Z (LSI-Z; $r = 0.67$ to 0.75) and the Arthritis Impact Measurement Scales (AIMS) ($r = 0.28$ to 0.44), respectively (Burckhardt & Anderson, 2003). Excellent reliability was shown in the present sample ($\alpha = .95$).

Negative Cognitions. The Grief Cognitions Questionnaire (GCQ), is a 38-item measure of bereavement-related cognitions developed across 9 sub-scales to represent negative grief-related cognitions specific to “self,” “world,” “life,” “future,” “self-blame,” “others,” “appropriateness of grief” “cherish grief” and “threatening interpretation of grief” (Boelen & Lensvelt-Mulders, 2005). The present study included 6 items from the subscales: self, world, life, future, appropriateness of grief and threatening interpretations of grief. These subscales corresponded with the highest factor loadings shown from its development study and were identified as the most commonly identified types of grief cognitions (Boelen, den Hout, den Bout, 2006). Participants were asked to rate their engagement with these behaviours on a scale of (0 = *never* to 100 = *always*). High reliability for the GCQ was indicated in psychometric findings with Cronbach’s alpha of the total scale ($\alpha = 0.96$; Boelen & Lensvelt-Mulders, 2005). In support of its validity, the instrument also correlated significantly with other symptom measures such as the ITG (Inventory of Traumatic Grief; $r = .80$) and SCL-90 (Symptom Checklist) depression and anxiety sub-scales ($r = .67 - .78$; Boelen & Lensvelt-Mulders, 2005).

Plan of Analysis

Statistical analyses for the study were conducted using the Statistical Software Package for the Social Science (SPSS; version 24). Upon examination of the study data and

execution of relevant tests of normality, standard assumptions were not met. Therefore, in accordance with established statistical protocol, data was instead analyzed non-parametrically. In order to provide a meaningful overview of the data, analysis commenced with preliminary descriptive statistics of the entire sample ($N = 58$), followed by descriptive results for participants not meeting a criteria participants who satisfied a cut-off criteria for high levels of CG ($n = 11$; CG sub-category). Following this initial step, in an aim to assess relationships and associations of the study's categorical background, loss-related and cognitive variables (e.g., level of education, marital status, income group, cumulative loss, and kinship to deceased, GCQ subscale items) with symptom severity, a series of Spearman's rank order correlations and Kruskal-Wallis H tests were done. Firstly, relationships between background variables and symptom severity were assessed, followed by an assessment of the relationship between loss related characteristics and symptom severity. A third series of correlations were done to examine relationships between symptom severity and grief cognitions measured with the subscales of the GCQ; and between other symptom measures.

Descriptive Statistics

The number of married participants in the study were 23 (39.7%), whereas 22 were single (37.9%), 10 (17.2%) in a relationship but not living together, and 3 (5.2%) in a common-law union. The majority of participants ($n = 46$, 79%) received higher level education, whereas 8 received secondary education (13.8%) and 4 indicated other (6.9%). The highest level of income indicated was greater than JMD \$150,000 ($n = 26$, 44.8%), followed by JMD \$50,000 to \$150,000 ($n = 24$, 41.4%), less than JMD \$50,000 ($n = 5$, 8.6%) and other ($n = 3$, 5.2 %).

With reference to the loss characteristics of the sample, the main reported cause of death was prolonged illness ($n = 21$, 36.2%), followed by brief illness ($n = 14$, 24.1%) and then traumatic causes ($n = 10$, 17.2%). The lowest reported causes of death were sudden illness ($n = 7$, 12.1%) and unexpected medical cause ($n = 6$, 10.3%). Most participants reported that they had lost a parent ($n = 17$, 29.3%) or a grandparent ($n = 12$, 22.4%), followed by other kinship not specified ($n = 9$, 15.5 %). The remainder of the sample had lost a sibling (7, 12.1 %) while other reported kinships were partner or spouse ($n = 4$, 6.9%), child ($n = 5$, 8.6 %), and friend ($n = 3$, 5.2%). Participants were also asked to indicate the quality of their relationship to the deceased. Most appraised the relationship as warm and loving ($n = 42$, 72.4) whereas the second most endorsed quality was other or unspecified ($n = 9$, 15.5%). Less persons indicated that the relationship was distant ($n = 5$, 8.6%) while the least amount of

participants indicated that it was neither good nor bad ($n = 2, 3.4$). At the time of the study, a majority of participants ($n = 21, 36.2$) had experienced their loss over 60 months while 19.1% ($n = 11$) each had lost someone within 7 to 12 months and 12 to 24 months. Also, only 8 persons (13.8%) had been bereaved within 6 months and 7 persons (12.1%) between 36 to 60 months. Perceived circumstances of the nature of the death and perceived circumstances of the suffering of the deceased were also asked of participants. With the former, the majority perceived the death as peaceful (48.3%, $n = 28$), 36.2% ($n = 21$) as violent, and 15.5% ($n = 9$) as neutral (neither violent nor peaceful). As for perceived suffering, over half of the sample (51.7%, $n = 30$) endorsed that the deceased had greatly suffered, while less than half endorsed that the person had suffered somewhat (37.9%, $n = 22$). Perception of suffering as moderate was endorsed by the lowest amount of participants (10.3%, $n = 6$). Similar loss (cumulative loss) had also been previously experienced by participants once or more than once. Those having experienced a loss once before or after the bereavement in question were 27 (46.6%) while 15 (25.9%) participants had experienced a loss twice. Seeking support for grief was not popular among the sample. An amount of 4 (6.9%) participants reported that they sought help after their loss while 42 (72.4%) felt that they did not require help. Three participants (5.2%) responded that they did not seek help and 9 (15.5%) responded other or unspecified. Level of perceived social support was high among participants as indicated by (51.7%, $n = 30$). Fewer indicated medium support (29.3%, $n = 17$) and 19% ($n = 11$) low support. Finally, 50% ($n = 29$) of participants reported being very religious, 43.1% ($n = 25$), moderately religious and slightly religious 6.9% ($n = 4$). These sample characteristics are summarized in table 1.

CG Sub-Group

According to the diagnostic algorithm a “caseness” of CG was not confirmed. To further examine clinically relevant levels of CG symptoms, it was revealed that 24.1% of the sample ($n = 14$) showed a cut-off score above 26, consequently satisfying a criteria for high levels of distress (Tomarken, 2012; Thomas et al., 2014). Of this sub-category, the majority were females ($n = 11$). Those having experienced multiple losses represented a majority of participants in this sub-group ($n = 8$). Further, half (50%, $n = 7$) of the group indicated that the most common cause of death was due to “prolonged illness” while also reporting that the nature of death and suffering of the deceased were perceived as “violent and great,” respectively. Similarly, 50% of persons reported high levels of social support and religiosity while endorsing that following their loss they did not feel that they required professional help. Most described their relationship with the deceased as having been *warm and loving* ($n = 11$,

78.6%). The number of persons seen within each category of time since loss was not disproportionate. A total of 7 persons combined had experienced a loss less than 6 months to 1 year while the remainder had lost someone over 1 year. Higher levels of CG were reported for participants experiencing a loss less than 5 years.

Grief Patterns

The five most common symptoms of grief indicated in the total sample were: trouble accepting the loss, ($M = 2.71$, $SD = 1.14$); longing or yearning ($M = 2.55$, $SD = 1.15$); emotional pain ($M = 2.31$, $SD = 1.15$); feeling confused about life ($M = 1.98$, $SD = 2$) and feeling shocked or dazed ($M = 1.95$, $SD = 2$). Compared to the CG sub-category, higher mean scores were indicated: trouble accepting the loss ($M = 3.86$, $SD = .77$); yearning ($M = 3.86$, $SD = 1.02$); emotional pain ($M = 3.64$, $SD = 1.21$); and feeling shocked or dazed and confused about life ($M = 3.43$, $SD = .122$). These results mean that the grief symptoms indicated were more intense for participants experiencing higher levels of complicated grief. To obtain insights into patterns of “normal” and complicated grief within the sample, the most common symptoms of grief identified above were analyzed across each period of time since loss. Symptom scores were highest for the category “7 to 12 months” since loss and lowest for the category “over 5 years.” Results from Kruskal-Wallis analysis of variance showed a statistically significant difference in scores for the item “feeling shocked or dazed” between categories of time since loss ($H(4) = 10.42$, $p = .03$). The groups across which this item differed the most were those 7 to 12 years with a mean rank of 40.45 and those over 5 years with a mean rank of 40.52.

Symptom Severity- Non-CG Category and CG Sub-Category

Based on existing scoring criteria and recommendations for the relevant instruments used, moderate to high symptom levels of psychological distress were displayed in the total sample. In total, the highest rates of psychological distress among all participants were shown for PTS with 27.6% indicating moderate levels of symptoms compared with 10.3% who showed high symptom levels. Results from the Mann-Whitney U test did not show significant differences between the symptom scores of males and females. Moderate levels of depression were reported by 15.5% of participants compared to 12.1% who reported high levels of symptoms. Anxiety symptoms were the least exhibited and were displayed at moderate levels by 10.3% of participants. Within the CG sub-category the highest symptom levels shown were that of PTS and CG with mean scores of: 36 (9.44) and 32.57 (6.63) respectively. Levels of

anxiety and depression were not shown to be elevated with respective means of 18.43 (14.76) and 9.29 (5.71) representing minimal symptoms of anxiety and mild symptoms of depression. Symptoms of PTS were shown to be moderate to moderately high for males ($M = 40$) and females ($M = 34.91$) combined, but were slightly higher for males. Similar to the CG sub-category, within the non-CG sub-category, the most common symptoms indicated were those of PTS ($M = 36$, $SD = 9.44$) and CG ($M = 32.57$, $SD = 6.63$). Symptom levels along with the mean scores and standard deviations on all symptom measures are summarized in table 2.

Relationship between Loss and Background Variables and Symptom Severity

There were significant differences in the symptom levels of CG ($H(4) = 10.86$, $p = .02$) and PTS ($H(4) = 13.39$, $p = .01$) between the different age groups. Differences in CG symptoms across age groups had mean ranks of: 46.50 (18 to 25 years); 34.24 (26 to 34 years); 22.48 (35 to 45 years); 27.65 (46 to 60 years) and 28.31 (> 60 years). As for PTS the mean ranks were: 38.50 (18 to 25 years); 41.21 (26 to 34 years); 22.75 (35 to 45 years); 22.95 (46 to 60 years) and 27.31 (> 60 years). Highest ranked means for CG did not represent highest symptom scores. This means that levels of CG symptoms differed for participants in different age groups but they were not representative of higher severity. Meanwhile the highest ranked means for PTS corresponded with higher symptom levels; this mean that symptoms of PTS among participants varied across the different age groups and represented moderate to moderately high levels of severity. Other symptom measures were not significantly different by age group ($p > .05$) nor other background and loss characteristics ($p > .05$).

Table 1

Background and Loss Characteristics of Sample

Characteristic		<i>N</i> = 58	
		n	%
Gender	Male	17	29.3
	Female	41	70.7
Age group (years)	18-25	6	10.3
	26-34	14	24.1
	35-45	20	34.5
	46-60	10	17.2
	>60	8	13.8
	Level of education	Secondary	8
	Tertiary	46	79.3

	Other	4	6.9
Marital Status	Married	23	39.7
	Common-law relationship	3	5.2
	Single	22	37.9
	Relationship living apart	10	17.2
Income group (monthly)	<\$50000	5	8.6
	\$50000<\$150000	24	41.4
	>\$150000	26	44.8
	Other	3	5.2
Cause of death	Sudden illness	7	12.1
	Prolonged illness	21	36.2
	Brief illness	14	24.1
	Unexpected (e.g., medical cause)	6	10.3
	Traumatic (e.g., homicide)	10	17.2
Kinship to deceased	Parent	17	29.3
	Partner or spouse	4	6.9
	Child	5	8.6
	Sibling	7	12.1
	Grandparent	13	22.4
	Other	9	15.5
	Friend	3	5.2
Time since loss (months)	0-6	8	13.8
	7-12	11	19
	12-24	11	19
	36-60	7	12.1
	>60	21	36.2
Cumulative Loss	Once	27	46.6
	More than once	15	25.9
Attitude to grief support	Sought help	4	6.9
	Did not seek help	3	5.2
	Did not require help	42	72.4
	Other	9	15.5
Quality of Relationship with deceased	Warm and loving	42	72.4
	Distant, barely communicated	5	8.6
	Neither good nor bad	2	3.4
	Other	9	15.5
Religiosity	Slightly	4	6.9
	Moderately	25	43.1
	Very	29	50
Circumstances of death (nature of death)	peaceful	28	48.3
	Neutral	9	15.5

	Violent	21	36.2
Circumstances of death (suffering)	Suffered somewhat	22	37.9
	Moderately suffered	6	10.3
	Greatly suffered	30	51.7
Perceived social support	Low	11	19
	Medium	17	29.3
	High	30	51.7

Table 2
Mean Scores, Standard Deviations and Symptom Levels of
Psychological Measures

Measures	(N=58)		Level %		
	M	SD	Moderate	High	Extremely high
PCL-C	27.58	11.17	27.6	10.3	
PG-13	20.96	7.97		24.1	
PHQ9	4.41	5.54	15.5	12.1	
CUXOS	9.53	12.11	10.3		
GCQ	8.36	3.85	3.4	5.2	
PTGI	22.41	15.13	3.4	12.1	
QOL	85.48	18.05		34.5	58.6
MSPSS	4.73	1.98			

Note. PCLC = Post Traumatic Checklist; PG-13 = Prolonged Grief; PHQ9 = Patient Health Questionnaire; CUXOS = Clinically Useful Anxiety Outcome Scale; GCQ = Grief Cognitions Questionnaire; PTGI-SF = Post Traumatic Growth Inventory Short Form; QOL = Quality of Life Scale; MSPSS = Multidimensional Scale of Perceived Social Support.

Relationship between PG-13 and Symptom Measures

Correlations between the PG-13 and all symptom measures were first examined and found to be significant. These results are seen in table 3. Significant relationships were also found between the subscales of the PG-13 and symptom measures. The separation distress subscale was found to be significantly positively correlated with the PCLC ($r_s = .40, p = < .01$) and the PHQ-9 ($r_s = .45, p = < .01$) while correlations with the GCQ and CUXOS were not significant, ($p = > .05$). The significant relationship is interpreted as: symptoms of yearning, longing and pre-occupation with the deceased (separation distress) were likely to be associated with increased symptoms of depression and greater negative grief cognitions. A significant positive relationship was also found between the cognitive-behavioural emotional subscale and all symptoms measures. As seen in table 3, this means that emotional symptoms such as pain, sorrow, avoidance of reminders of the deceased etcetera, were likely to be

associated with increased levels of depression, post-traumatic stress, anxiety and negative grief cognitions.

Relationship between Cognitive Variables and Symptom Severity

Correlations between the cognitive subscales of the GCQ (self, world, life, future, appropriateness of grief, and threatening interpretations of grief) and symptom severity were calculated. Some variables were significantly more correlated with some symptom measures than others. The subscale threatening interpretations of grief was significantly positively correlated with all symptom measures: CG ($r_s = .43, p < .01$); PCL-C ($r_s = .38, p < .01$); PHQ9 ($r_s = .31, p < .01$); CUXOS ($r_s = .27, p < .04$). This statistic means that participants engaging more in thoughts of threatening interpretations of grief were likely to experience an increase in the severity of symptom levels reported. Other significant relationships found are presented in table 4.

Quality of Life and Post-traumatic Growth

Intercorrelations for the total sample with respect to outcome levels in quality of life and post-traumatic growth are reported in table 5. The mean score for quality of life in the total sample was $M = 85.48$ ($SD = 18.05$) representing extremely high quality of life, while the mean score for post-traumatic growth was 22.41 ($SD = 15.13$) representing moderate to high growth. Post-traumatic growth was not related to CG symptom severity in the total sample and its relationship to symptoms of anxiety was not significant ($p > .01$). Within the CG sub-category, it was shown to be negatively correlated with CG but this was also not significant ($p > .05$). Positive correlations were shown with all other measures but these were not at a significant level ($p > .05$). In both the total sample and CG sub-category, quality of life was significantly negatively correlated with all symptom measures meaning that increased levels of psychological distress were related to lower quality of life.

Table 3

Correlations between PG-13 and other symptom measures

Measure	PG-13	CUXOS	GCQ	PHQ9	PCLC
PG-13	–	.30*	.41**	.54**	.56**
CUXOS	.30*	–	.15	.63**	.66**
GCQ	.41**	0.15	–	.25	.38**
PHQ9	.54**	.63**	.25	–	.72**
PCLC	.56**	.66**	.38**	.72**	–

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table 4

Correlations between cognitive variables and symptom measures

Measure	CUXOS	PCLC	PHQ9	PG-13	Threatening	Self	World	Life	Future	Inappropriateness
CUXOS	–	.66**	.63**	.30*	.27*	.02	.07	.107	.18	.14
PCLC	.66**	–	.720**	.56**	.38**	.10	.30*	.25	.29*	.301
PHQ9	.63**	.72**	–	.54**	.31*	0.19	.20	.29*	.21	.26*
PG-13	.30*	.56**	.547**	–	.43**	.12	.31*	.21	.16	.33*
Threatening	.270	.38**	.31*	.43**	–	.41**	.42**	.49**	.61**	.61**
Self	.02	.10	.19	0.12	.41**	–	.52**	.75**	.51**	.49**
World	.07	.30*	0.20	.31*	.42**	.52*	–	.68**	.41**	.57**
Life	.10	.25	.296*	.21	.49**	.75**	.68**	–	.58**	.57**
Future	.18	.29*	.21	.16	.61**	.51**	.41**	.58**	–	.45**
Inappropriateness	.14	.30*	.263*	.33*	.61**	.49**	.57**	.57**	.45**	–

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 5

Intercorrelations on outcome and symptom measures as a function of total sample and CG sub-category

Measure	PTGI	QOL	GCQ	PG-13	CUXOS	PHQ-9	PCL-C
PTGI	–	-.62	.26	-.36	.52	.15	.48
QOL	-.14	–	-.36	.59*	-.67**	-.52	-.71**
GCQ	.11	-.33*	–	-.33	.08	.2	.15
PG-13	.07	-.30*	.41**	–	-.29	-.34	-.56*
CUXOS	-.10	-.56**	.15	.30*	–	.5	.52*
PHQ9	-.04	-.58**	.25	.54**	.63**	–	.47
PCLC	-.03	-.53**	.38**	.56**	.66**	.72**	–

Note. Intercorrelations for PG sub-category ($n = 14$) are presented above the diagonal and intercorrelations for total sample ($n = 58$) are presented below the diagonal. PTGI = Post Traumatic Growth Inventory; QOL = Quality of Life scale; GCQ = Grief Cognitions Questionnaire; PG-13 = Prolonged Grief; CUXOS = Clinically Useful Anxiety Outcome Scale; PHQ9 = Patient Health; PCLC = Post Traumatic Checklist.

* $p < .05$, two tailed. ** $p < .01$, two tailed.

Discussion

The present study investigated grief symptomatology, sequelae, and outcome, among a group of Jamaicans who have suffered significant loss. As a multifaceted process which is differentiated across individuals and cultures, the research aims were informed and guided by the ever-present need for paradigms of grief to be expanded cross-culturally. To this end the investigation pursued answers to three main questions: What are the symptoms and patterns of grief among bereaved Jamaicans? Is there a relationship between grief and psychopathology among bereaved Jamaicans? Has grief affected quality of life or influenced post-traumatic growth? Findings supported an established symptomatology of grief with disbelief (difficulty accepting loss) and yearning emerging as the two most endorsed grief indicators among participants which appeared to abate with time. A caseness of CG was not found. Secondly, grief severity was significantly related to post-traumatic stress, depression, anxiety and threatening interpretations of grief. Lastly, grief was negatively correlated with quality of life while there was no evidence of post-traumatic growth.

In assessing the emerging patterns of grief among Jamaicans, mainly, while some bereaved persons demonstrated elevated levels of grief severity, in line with standard diagnostic guidelines, a case of complicated grief was not found. Grieving appeared symptomatic rather than critical and may have been mitigated by protective factors such as religion or social support. These factors were seen to a great degree within the CG sub-category of participants who even while identifying with combined negative predictors such as multiple losses and perceiving the death of the deceased as violent, simultaneously reported high social support and religious involvement. These are systems which function as a communal safety net for persons who are psychologically distressed or emotionally vulnerable and have been linked to positive psychological outcomes following bereavement and trauma (Bonanno et al., 2002; Hibberd et al, 2010). Therefore, the possibility exists that maladaptive adjustment may have been significantly buffered by these agents.

The five most common grief indicators identified were trouble accepting the loss (disbelief), yearning and longing for the deceased, emotional pain, feeling confused about life and feeling stunned or shocked. Also, based on a cross-sectional examination of the different periods of time since loss with which participants identified, these symptoms appeared to diminish with time. The study raises important points. Firstly, these findings accord with existing models of grief symptomatology which propose a set of mandatory symptoms that accompany the course of bereavement (Prigerson, et al., 2009; Shear et al., 2011). In essence, there is a majority consensus among clinician-oriented researchers that yearning or longing for the deceased is constant in all cases of significant loss (Prigerson, et al., 2009; Shear et al.,

2011). Additionally, this and other symptoms are expected to last for at least six months after which their intensity is expected to decline (Zisook et al, 2014). In the study, longing and yearning was not foremost but was the second most endorsed symptom, across all time periods post-loss. This suggests that as far as arguments for the universality of a common experience of grief go, there was some amount of evidence present.

Secondly, as stated earlier, symptoms appeared to follow a staged progression although there is no certainty as to how fluid or fixed this movement was. Results indicated that symptoms were highest at the outset within the first six months of bereavement or up to a year following loss, but were lowest at over five years post-loss. At a glance this is consistent with the stage theory of grief whereby grief progresses and resolves over different stages as it moves from acute manifestations to integrated grief (Maciejewski et al., 2007). Nevertheless, it was also noteworthy that symptoms were highest for persons 7 to 12 months post-loss instead of those less than 6 months, also emphasizing that although arguably a universal stressor, the duration of grief varies for everyone. This behaviour also speaks to the individualization of grief and is further illuminated by the fact that yearning and disbelief were also still present at over 5 years post-loss. In light of these patterns, symptoms and patterns of grief among bereaved Jamaicans to an extent parallel ruling assumptions of grief but are shaped by individual factors.

Findings on the second research question reveal that symptoms of grief are strongly related to the occurrence of anxiety, depression, post-traumatic stress and negative cognitions. The cognitive factor, threatening interpretations of grief, was found to be strongly related to CG and other psychological symptoms while the strongest co-occurrence was linked to post-traumatic stress and depression. Findings are supportive of existing literature on the comorbidity of complicated grief and other psychological disorders (Shear et al., 2011; Enez, 2018). It is comprehensible that some individuals when confronted by a loss, transition to vulnerable psychological states as they negotiate the reality of what has occurred. Research shows that approximately 40% of persons who are bereaved meet a criteria for MDD two months after the loss event while 20% do so a year later (Enez, 2018). A symptomatic overlap often occurs between the two wherein disturbances in sleep, appetite, and interpersonal functioning tend to develop. In the case of persons with CG, the emotional focus is on the deceased, while for persons with MDD, negative emotionality is often directed towards the self (Enez, 2018). These findings may be further interpreted in line with cognitive-behavioural conceptualizations of grief which maintain that global negative beliefs toward the self, world,

life, future, others, and interpretations of grief frequently occur after bereavement (Boelen et al., 2003).

Another key finding in the study was that a high level of quality of life was found to be related with symptoms of grief, whereas a relationship with post-traumatic growth was not found. Bereavement has been associated with a number of negative consequences including reduced quality of life (Shear et al., 2013). According to the study's findings, participants' evaluation of their quality of life was a function of their level of psychological distress. There are several ways in which this could be interpreted. First the literature emphasizes that quality of life is often tied to an evaluation of one's subjective well-being therefore the relationship identified is supportive of the literature (Burckhardt, 2003). Simply put, perceptions of happiness and material comfort are significantly individualized. Considering most participants in the study had received a higher education and identified with an upper income group, an increased quality of life would be expected. Second, 36.2% of participants were bereaved in excess of five years which increases the likelihood that grief may have already been resolved or integrated. Alternately, there's also the question of whether persons reporting greater quality are more resilient in the face of loss, as well as the likelihood that participants' bonds to their deceased were uniquely characterized (Hibberd, et al., 2010).

Strengths and Limitations

The study cites some theoretical and methodological limitations. From a theoretical point of view, the study was largely motivated by the need for more cross-cultural researches however, due to the limited time available, areas that are more central to this aspect of the literature could not have been pursued. This saw the study being conducted instead within more established theoretical parameters such as the universality of grief, or acute, integrated and complicated grief rather than within more culturally informative frameworks such as for example disenfranchised grief.

Another theoretical limitation is the absence of a more in-depth analysis of its context of study. One of the major draw-backs to emerging cross-cultural investigations in bereavement research is the lack of a clear elucidation of the grief process as opposed to an outline of cultural rituals and mourning practices. In reflection, perhaps what has always challenged this process is the absence of a cumulative body of work that could inform future research directions. Likewise, the present study was also limited by this gap and could only provide a partial perspective of the actual grief status-quo from a cross-cultural standpoint.

A few methodological limitations were also present. At the risk of sounding cliché, the study being of a correlational design, lacks the kind of robustness that a prospective longitudinal research could have otherwise offered. This also brings to the fore the reliance on self-report measures throughout the study. Additionally, although efficient, data for the study was collected electronically which means there is no guarantee of the validity of responses received. The researcher also notes that as a cross-culturally oriented investigation, the use of a broader grief scale tapping a wider variety of grief reactions as opposed to the PG-13 would have been more meaningful. It should also be noted that while the symptom measures were used to assess severity and not diagnose, most of these scales were developed in clinical populations. Therefore, responses obtained are not necessarily reflective of clinically relevant psychological distress. Lastly, due to the small sample size used, no generalizations can be drawn hence inferences are cautiously applied.

In spite of these weaknesses, a number of strengths were also noted. To begin, the primary strength of this investigation was the novelty of its context. Although the field of bereavement research is burgeoning, an assessment of grief among Jamaicans had never been carried out. Therefore, an empirical platform from which future inquiries into the subject may be done has been created. Secondly, by utilizing a wide range of measures electronically, there was an allowance for multiple variables of interest to be tapped simultaneously at no inconvenience to participants. Thirdly, the process of the investigation has also been kept open and honest thereby ensuring the potential for replicability, and does not make generalized knowledge claims that fall outside of its methodological scope. Finally, with the utilization of a non-clinical sample, insights into meaningful patterns of grief among “ordinary grievers” are provided.

Future Research

Future bereavement research within Jamaica should extend focus to two areas. First, similar to existing studies that have examined grief among a variety of bereavement sub-groups such as cancer care providers, or palliative care workers, future grief investigations could glean meaningful information by following this approach. However, this should be done with a focus on the experience of grief within disenfranchised communities where sociopolitical violence predisposes community members to the risk of increasing interpersonal loss. The second area of focus is related to the latter. In an effort to truly bridge the cultural divide, the development of a Jamaican-specific grief scale should first be developed as the use of Western-derived instruments in many cross-cultural contexts makes it difficult to trust

conclusions that are drawn. It also inherently contradicts the purpose of these kinds of researches. On a final note, there are still to date few epidemiological studies of grief. In future an evaluation of the prevalence of grief within Jamaica could help to raise public awareness of its vast sequelae.

Conclusion

The experience of grief also unfolds problematically for some Jamaicans suffering loss. While not representative of the bigger picture, findings indicate that grief is related to increased psychological distress and lower quality of life. The cognitive component of grieving has also emerged as highly influential in the emotional processing of loss demonstrating that for some individuals, negative constructions toward the self are more defining of their overall reaction to bereavement. Associations were not found between grief and more frequently related factors such as gender, age, and education and this may be indicative of latent pre-bereavement factors or psychological processes that regulate grief-related distress. The sample in question did not grieve uniquely however, the findings of any investigation are only as informative as what it set out to investigate. This reflection refers to the separate relationships seen between different subscales of the PG-13 when they were teased apart and different symptom measures. In looking at this finding, it is perhaps worthwhile to consider that participants who fell below the cut-off score used for distressing levels of CG may or may not have responded alternately if separate or even more extensive kinds of reactions were assessed. On the whole, it remains proven that interpersonal loss does indeed alter the human experience.

References

- Arbuckle, N. W., & De Vries, B. (1995). The long-term effects of later life spousal and parental bereavement on personal functioning. *The Gerontologist*, 35(5), 637-647.
- Archer, J. (2008). Theories of grief: Past, present, and future perspectives. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention*. (pp. 45–65). Washington, DC: American Psychological Association. <https://doi-org.ludwig.lub.lu.se/10.1037/14498-003>

- Arthur, C. M., Hickling, F. W., Robertson-Hickling, H., Haynes-Robinson, T., Abel, W., & Whitley, R. (2010). "Mad, sick, head nuh good": Mental illness stigma in Jamaican communities. *Transcultural psychiatry*, 47(2), 252-275
- Averill, J. R. (1968). Grief: Its nature and significance. *Psychological Bulletin*, 70(6, Pt.1), 721–748. <https://doi-org.ludwig.lub.lu.se/10.1037/h0026824>
- Bellet, B. W., Jones, P. J., Neimeyer, R. A., & McNally, R. J. (2018). Bereavement outcomes as causal systems: A network analysis of the co-occurrence of complicated grief and posttraumatic growth. *Clinical Psychological Science*, 6(6), 797-809.
- Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD checklist (PCL). *Behaviour Research and Therapy*, 34(8), 669-673.
- Boelen, P. A., van den Bout, J., & van den Hout, M. A. (2003). The role of cognitive variables in psychological functioning after the death of a first degree relative. *Behaviour Research and Therapy*, 41(10), 1123–1136. [https://doi.org/10.1016/S0005-7967\(02\)00259-0](https://doi.org/10.1016/S0005-7967(02)00259-0)
- Boelen, P. A., van den Bout, J., & van den Hout, M. A. (2006). Negative cognitions and avoidance in emotional problems after bereavement: A prospective study. *Behaviour Research and Therapy*, 44(11), 1657–1672. <https://doi.org/10.1016/j.brat.2005.12.006>
- Boelen, P. A., Huntjens, R. J., van Deursen, D. S., & van den Hout, M. A. (2010). Autobiographical memory specificity and symptoms of complicated grief, depression, and posttraumatic stress disorder following loss. *Journal of Behavior Therapy and Experimental Psychiatry*, 41(4), 331-337.
- Boelen, P. A., & Lensvelt-Mulders, G. J. L. M. (2005). Psychometric properties of the grief cognitions questionnaire (GCQ). *Journal of Psychopathology & Behavioral Assessment*, 27(4), 291–303. <https://doi.org/10.1007/s10862-005-2409-5>
- Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review*, 21(5), 705–734. [https://doi-org.ludwig.lub.lu.se/10.1016/S02727358\(00\)000623](https://doi-org.ludwig.lub.lu.se/10.1016/S02727358(00)000623)
- Bonanno, G. A., Mihalecz, M. C., & LeJeune, J. T. (1999). The core emotion themes of conjugal loss. *Motivation and Emotion*, 23(3), 175-201.
- Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., ... & Nesse, R. M. (2002a). Resilience to loss and chronic grief: a prospective study from

- preloss to 18-months postloss. *Journal of Personality and Social Psychology*, 83(5), 1150.
- Bonanno, G. A., Wortman, C. B., & Nesse, R. M. (2004b). Prospective patterns of resilience and Maladjustment during Widowhood. *Psychology and Aging*, 19(2), 260–271. <https://doi.org/10.1037/0882-7974.19.2.260>
- Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. London: Hogarth Press & Institute of Psychoanalysis. Retrieved from: <https://www.abebe.org.br/files/John-Bowlby-Loss-Sadness-And-Depression-Attachment-and-Loss-1982.pdf>.
- Bui, E. (2017). Grief: From normal to pathological reactions. In E. Bui (Ed.), *Clinical handbook of bereavement and grief reactions* (pp. 85-101). Retrieved from <https://ebookcentral.proquest.com/lib/lund/detail.action?docID=5150694#>
- Burckhardt, C. S., & Anderson, K. L. (2003). The quality of life scale (QOLS): reliability, validity, and utilization. *Health and Quality of Life Outcomes*, 1(1), 60.
- Cann, A., Calhoun, L. G., Tedeschi, R. G., Taku, K., Vishnevsky, T., Triplett, K. N., & Danhauer, S. C. (2010). A short form of the posttraumatic growth inventory. *Anxiety, Stress, and Coping*, 23(2), 127–137. <https://doi.org/10.1080/10615800903094273>
- Conybeare, D., Behar, E., Solomon, A., Newman, M. G., & Borkovec, T. D. (2012). The PTSD Checklist—Civilian Version: Reliability, validity, and factor structure in a nonclinical sample. *Journal of Clinical Psychology*, 68(6), 699-713.
- Currier, J. M., Neimeyer, R. A., & Berman, J. S. (2008). The effectiveness of psychotherapeutic interventions for bereaved persons: a comprehensive quantitative review. *Psychological Bulletin*, 134(5), 648.
- van Doorn, C., Kasl, S. V., Beery, L. C., Jacobs, S. C., & Prigerson, H. G. (1998). The influence of marital quality and attachment styles on traumatic grief and depressive symptoms. *Journal of Nervous & Mental Disorders*, 186(9), 566-573.
- Eisma, M. C., Schut, H. A., Stroebe, M. S., Voerman, K., van den Bout, J., Stroebe, W., & Boelen, P. A. (2015). Psychopathology symptoms, rumination and autobiographical memory specificity: Do associations hold after bereavement? *Applied Cognitive Psychology*, 29(3), 478-484.
- Enez, Ö. (2018). Complicated Grief: Epidemiology, Clinical Features, Assessment and Diagnosis. *Current Approaches in Psychiatry/Psikiyatride Guncel Yaklasimlar*, 10(3).
- Fabrega, H., Jr, & Nutini, H. (1994). Tlaxcalan constructions of acute grief. *Culture, Medicine and Psychiatry*, 18(4), 405–431. Retrieved from

<http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=7712778&site=eds-live&scope=site>

- Freud, S. (1957). Mourning and melancholia. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 239-260). London: Hogarth Press & Institute of Psychoanalysis. (Original work published 1917).
- Ginzburg, K., Geron, Y., & Solomon, Z. (2002). Patterns of complicated grief among bereaved Parents. *Omega: Journal of Death & Dying*, 45(2), 119. <https://doi-org.ludwig.lub.lu.se/10.2190/XUW5-QGQ9-KCB8-K6WW>
- Golden, A. M., Dagleish, T., & Mackintosh, B. (2007). Levels of specificity of autobiographical memories and of biographical memories of the deceased in bereaved individuals with and without complicated grief. *Journal of Abnormal Psychology*, 116(4), 786.
- Hannan, J., Alce, M., & Astros, A. (2016). Psychometric properties of the newly translated creole multidimensional scale of perceived social support (MSPSS) and perceived adequacy of resource scale (PARS) and the relationship between perceived social support and resources in Haitian mothers in the US. *BMC Psychology*, 4(1), 7.
- Hibberd, R., Elwood, L., & Galovski, T. (2010). Risk and protective factors for posttraumatic stress disorder, prolonged grief, and depression in survivors of the violent death of a loved one. *Journal of Loss & Trauma*, 15(5), 426–447. <https://doi.org/10.1080/15325024.2010.507660>
- Hinton, D. E., Peou, S., Joshi, S., Nickerson, A., & Simon, N. M. (2013). Normal grief and complicated bereavement among traumatized Cambodian refugees: Cultural context and the central role of dreams of the dead. *Culture, Medicine, and Psychiatry*, 37(3), 427-464.
- Holland, J. M., & Neimeyer, R. A. (2010). An examination of stage theory of grief among individuals bereaved by natural and violent causes: A meaning-oriented contribution. *OMEGA- Journal of death and dying*, 61(2), 103-120.
- Hospice Support Fund (2017) Complicated Grief. Merrifield, VA, The Hospice Support Fund. Retrieved from <http://www.hospicesupportfund.org/documents/Complicated%20Grief%20Report.pdf>
- Hoyt, W. T., & Larson, D. G. (2010). What have we learned from research on grief counselling? *Bereavement Care*, 29(1), 10–13. <https://doi-org.ludwig.lub.lu.se/10.1080/02682620903560841>

- van IJzendoorn, M. H., & Sagi, A. (1999). Cross-cultural patterns of attachment: Universal and contextual dimensions. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, Research, and Clinical Applications* (pp. 713-734). New York: Guilford Press.
- Jeon, S. W., Han, C., Ko, Y.-H., Yoon, S., Pae, C.-U., Choi, J., ... Zimmerman, M. (2017). A Korean validation study of the Clinically Useful Anxiety Outcome Scale: Comorbidity and differentiation of anxiety and depressive disorders. *PLoS ONE*, 12(6), 1. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=123534697&site=eds-live&scope=sitehibberd>
- Johannesson, K. B., Lundin, T., Hultman, C. M., Lindam, A., Dyster-Aas, J., Arnberg, F., & Michel, P. O. (2009). The effect of traumatic bereavement on tsunami-exposed survivors. *Journal of Traumatic Stress*, 22(6), 497-504.
- Jordan, A. H., & Litz, B. T. (2014). Prolonged grief disorder: Diagnostic, assessment, and treatment considerations. *Professional Psychology: Research and Practice*, 45(3), 180.
- Kendler, K. S., Gardner, C. O., & Prescott, C. A. (1997). Religion, psychopathology, and substance use and abuse: A multimeasure, genetic-epidemiologic study. *The American Journal of Psychiatry*, 154(3), 322.
- Kersting, A., Brähler, E., Glaesmer, H., & Wagner, B. (2011). Prevalence of complicated grief in a representative population-based sample. *Journal of Affective Disorders*, 131(1-3), 339-343. <https://doi-org.ludwig.lub.lu.se/10.1016/j.jad.2010.11.032>
- Kim, J., Tol, W. A., Shrestha, A., Kafle, H. M., Rayamajhi, R., Luitel, N. P., ... & Surkan, P. J. (2017). Persistent complex bereavement disorder and culture: Early and prolonged grief in Nepali widows. *Psychiatry*, 80(1), 1-16.
- Klass, D. (1999). Developing a cross-cultural model of grief: The state of the field. *Omega: Journal of Death and Dying*, 39(3), 153-178. <https://doi-org.ludwig.lub.lu.se/10.2190/BDTX-CYE0-HL3U-NQQW>
- Klass, D., & Goss, R. (2003). The politics of grief and continuing bonds with the dead: The cases of Maoist China and Wahhabi Islam. *Death Studies*, 27(9), 787. Retrieved from <http://search.ebscohost.com.ludwig.lub.lu.se/login.aspx?direct=true&db=edb&AN=11093963&site=eds-live&scope=site>
- Keltner, D., Moffitt, T. E., & Stouthamer-Loeber, M. (1995). Facial expressions of emotion and psychopathology in adolescent boys. *Journal of Abnormal Psychology*, 104(4),

- 644–652. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=8530767&site=eds-live&scope=site>
- Li, T., Wang, S.-W., Zhou, J.-J., Ren, Q.-Z., & Gao, Y.-L. (2018). Assessment and predictors of grief reactions among bereaved Chinese adults. *Journal of Palliative Medicine*, 21(9), 1265–1271. <https://doi-org.ludwig.lub.lu.se/10.1089/jpm.2018.0001>.
- Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101, 1141-1148.
- Lobb, E. A., Kristjanson, L. J., Aoun, S. M., Monterosso, L., Halkett, G. K., & Davies, A. (2010). Predictors of complicated grief: A systematic review of empirical studies. *Death Studies*, 34(8), 673-698.
- Maciejewski, P. K., Zhang, B., Block, S. D., & Prigerson, H. G. (2007). An empirical examination of the stage theory of grief. *JAMA*, 297(7), 716-723.
- Mandy, T. (2014). Mourning on nine night a Jamaican way. Retrieved from <https://www.catholicsandcultures.org/jamaica/death-mourning-afterlife>
- Marshall, R., & Sutherland, P. (2008). The Social Relations of Bereavement in the Caribbean. *Omega: Journal of Death & Dying*, 57(1), 21–34. <https://doi-org.ludwig.lub.lu.se/10.2190/OM.57.1.b>.
- McEvoy, C. & Hideg, G. (2017). Global violent deaths: Time to decide (Small Arms Survey). Retrieved from <http://www.smallarmssurvey.org/fileadmin/docs/U-Reports/SAS-Report-GVD2017.pdf>
- Miller, L., Davies, M., & Greenwald, S. (2000). Religiosity and substance use and abuse among adolescents in the National Comorbidity Survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(9), 1190–1197. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=10986817&site=eds-live&scope=site>
- Miller, S. I., & Schoenfeld, L. (1973). Grief in the Navajo: Psychodynamics and culture. *International Journal of Social Psychiatry*, 19(3-4), 187-191.
- Min-Tao Hsu, David L. Kahn, & Mutsu Hsu. (2002). A Single Leaf Orchid: Meaning of a Husband's Death for Taiwanese Widows. *Ethos*, 30(4), 306. Retrieved from <http://search.ebscohost.com.ludwig.lub.lu.se/login.aspx?direct=true&db=edsjsr&AN=edsjsr.3651877&site=eds-live&scope=site>
- Min-Tao Hsu, Ying-Fen Tseng, Banks, J. M., & Ling-Lih Kuo. (2004). Interpretations of stillbirth. *Journal of Advanced Nursing (Wiley-Blackwell)*, 47 (4), 408–416. <https://doi.org/10.1111/j.1365-2648.2004.03119.x>

- Moayedoddin, B., & Markowitz, J. C. (2). (n.d.). Abnormal grief: Should we consider a more patient-centered approach? *American Journal of Psychotherapy*, 69(4), 361–378. Retrieved from <http://search.ebscohost.com.ludwig.lub.lu.se/login.aspx?direct=true&db=edselc&AN=edselc.2-52.0-84954533099&site=eds-live&scope=site>
- Mostofsky, E., Maclure, M., Sherwood, J. B., Tofler, G. H., Muller, J. E., & Mittleman, M. A. (2012). Risk of acute myocardial infarction after the death of a significant person in one's life: The determinants of myocardial infarction onset Study. *Circulation*, 125(3), 491–496. <https://doi.org.ludwig.lub.lu.se/10.1161/CIRCULATIONAHA.111.061770>
- Nakigudde, J., Musisi, S., Ehnvall, A., Airaksinen, E., & Agren, H. (2009). Adaptation of the multidimensional scale of perceived social support in a Ugandan setting. *African Health Sciences*, 9(2).
- Neimeyer, R. A., Hogan, N. S., & Laurie, A. (2008). The measurement of grief: Psychometric considerations in the assessment of reactions to bereavement. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of Bereavement Research and Practice: Advances in Theory and Intervention*. (pp. 133–161). Washington, DC: American Psychological Association. <https://doi-org.ludwig.lub.lu.se/10.1037/14498-007>
- O'Connor, M. F., & McConnell, M. H. (2018). Grief Reactions: A neurobiological approach. In *Clinical Handbook of Bereavement and Grief Reactions* (pp. 45-62). Humana Press, Cham.
- Pan American Health Organization, (2012). *Health in the Americas (PAHO)*. Retrieved from https://www.paho.org/hq/index.php?option=com_tabs&view=article&id=2151&Itemid=3632&lang=en
- Parkes, C. M. (1965). Bereavement and mental illness. *British Journal of Medical Psychology*, 38, 1- 26.
- Parkes, C. M. (1998). Bereavement in adult life. *BMJ (British Medical Journal)*, 316(7134), 856. Retrieved from <http://search.ebscohost.com.ludwig.lub.lu.se/login.aspx?direct=true&db=edo&AN=ejs10736027&site=eds-live&scope=site>
- Parkes, C. M. (2001). A historical overview of the scientific study of bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care*. (pp. 25–45). Washington, DC: American Psychological Association. <https://doi-org.ludwig.lub.lu.se/10.1037/10436-001>

- Pennebaker, J. W., & O'Heeron, R. C. (1984). Confiding in others and illness rate among spouses of suicide and accidental-death victims. *Journal of Abnormal Psychology*, *93*, 473, 76
- Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., ... & Bonanno, G. (2009). Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS Medicine*, *6*(8), e1000121.
- Rosenblatt, P. C. (2008). Grief across cultures: A review and research agenda. In *Handbook of bereavement research and practice: Advances in theory and intervention*. (pp. 207–222). Washington, DC: American Psychological Association. <https://doi-org.ludwig.lub.lu.se/10.1037/14498-010>
- Rosner, R., Pfoh, G., & Kotoučová, M. (2011). Treatment of complicated grief. *European Journal of Psychotraumatology*, *2* (1), 7995.
- Sang Won Jeon, Changsu Han, Young-Hoon Ko, Seoyoung Yoon, Chi-Un Pae, Joonho Choi, ... Mark Zimmerman. (n.d.). A Korean validation study of the Clinically Useful Anxiety Outcome Scale: Comorbidity and differentiation of anxiety and depressive disorders. *PLoS ONE*, (6), e0179247. <https://doi.org/10.1371/journal.pone.0179247>
- Schwartz, L. E., Howell, K. H., & Jamison, L. E. (n.d.). Effect of time since loss on grief, resilience, and depression among bereaved emerging adults. *Death Studies*, *42*(9), 537– 547. <https://doi-org.ludwig.lub.lu.se/10.1080/07481187.2018.1430082>
- Shah, S. M., Carey, I. M., Harris, T., Dewilde, S., Victor, C. R., & Cook, D. G. (2013). The effect of unexpected bereavement on mortality in older couples. *American Journal of Public Health*, *103*(6), 1140–1145. <https://doi.org/10.2105/AJPH.2012.301050>.
- Shear, M. K., Ghesquiere, A., & Glickman, K. (2013). Bereavement and complicated grief. *Current psychiatry reports*, *15*(11), 406.
- Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N.,... Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, *28*(2), 103–117. <https://doi-org.ludwig.lub.lu.se/10.1002/da.20780>
- Smarr, K. L., & Keefer, A. L. (2011). Measures of depression and depressive symptoms: Beck Depression Inventory-II (BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Geriatric Depression Scale (GDS), Hospital Anxiety and Depression Scale (HADS), and Patient Health Questionnaire-9 (PHQ-9). *Arthritis Care & Research*, *63*(S11), S454-S466.
- Smid, G. E., Groen, S., de la Rie, S. M., Kooper, S., & Boelen, P. A. (2018). Toward cultural assessment of grief and grief-related psychopathology. *Psychiatric Services*

- (Washington, D.C.), 69(10), 1050–1052. <https://doi-org.ludwig.lub.lu.se/10.1176/appi.ps.201700422>
- Statistical Institute of Jamaica. (n.d.). Retrieved from http://statinja.gov.jm/Demo_SocialStats/Health.aspx
- Stroebe, M. S., Hansson, R. O., Schut, H., & Stroebe, W. (2008). Bereavement research: Contemporary perspectives. In M. S. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention*. (pp. 3–25). Washington, DC: American Psychological Association. <https://doi-org.ludwig.lub.lu.se/10.1037/14498-001>
- Stroebe, M., & Schut, H. (1998). Culture and grief. *Bereavement Care*, 17(1), 7-11. Retrieved from https://www.researchgate.net/publication/239789673_Culture_and_grief
- Stroebe, M., & Stroebe, W. (1991). Does “grief work” work? *Journal of Consulting and Clinical Psychology*, 59(3), 479–482. <https://doi.org/10.1037/0022-006X.59.3.479>
- Stroebe, M., Stroebe, W., Schut, H., Zech, E., & van den Bout, J. (2002). Does disclosure of emotions facilitate recovery from bereavement? Evidence from two prospective studies. *Journal of Consulting and Clinical Psychology*. 70, 169-178.
- Thomas, K., Hudson, P., Trauer, T., Remedios, C., & Clarke, D. (2014). Risk factors for developing prolonged grief during bereavement in family carers of cancer patients in palliative Care: A Longitudinal Study. *Journal of Pain and Symptom Management*, 47(3), 531–541. <https://doi-org.ludwig.lub.lu.se/10.1016/j.jpainsymman.2013.05.022>
- Thompson, K., (2017, May). *Mental Illness Worry*. Retrieved from http://www.jamaicaobserver.com/front-page/mental-illness-worry-professionals-say-data-suggest-doubling-of-cases-in-10-years_99700
- Tomarken, A., Roth, A., Holland, J., Ganz, O., Schachter, S., Kose, G., ... Nelson, C. J. (2012). Examining the role of trauma, personality, and meaning in young prolonged grievers. *Psycho-Oncology*, 21(7), 771–777. <https://doi.org/10.1002/pon.1983>
- Tseng, Y., Cheng, H., Chen, Y., Yang, S., & Cheng, P. (2017). Grief reactions of couples to perinatal loss: A one-year prospective follow-up. *Journal of Clinical Nursing (John Wiley & Sons, Inc.)*, 26(23–24), 5133–5142. <https://doi-org.ludwig.lub.lu.se/10.1111/jocn.14059>
- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993, October). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. In *annual*

convention of the international society for traumatic stress studies, San Antonio, TX (Vol. 462).

Weisz, J. (1,2), Miyake, K. (3), Rothbaum, F. (4), Pott, M., & Morelli, G. (n.d.).

Attachment and culture: Security in the United States and Japan. *American Psychologist*, 55(10), 1093–1104. <https://doi-org.ludwig.lub.lu.se/10.1037/0003-066X.55.10.1093>

Wiese, C. H., Morgenthal, H. C., Bartels, U. E., Vossen-Wellmann, A., Graf, B. M., & Hanekop, G. G.(2010). Post-mortal bereavement of family caregivers in Germany: A prospective interview-based investigation. *Wien Klin Wochenschr*, 122(13-14), 384-389.

Wikan, U. (1988). Bereavement and loss in two Muslim communities: Egypt and Bali compared. *Social Science & Medicine*, 27(5), 451–460. [https://doi-org.ludwig.lub.lu.se/10.1016/0277-9536\(88\)90368-1](https://doi-org.ludwig.lub.lu.se/10.1016/0277-9536(88)90368-1)

World Health Organization (2009). *Report on mental health system in Jamaica*. (WHO-AIMS) Retrieved from https://www.who.int/mental_health/Jamaica_who_aims_report.pdf?ua=1

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment*, 52(1), 30-41.

Zimmerman, M., Kiefer, R., Kerr, S., & Balling, C. (2019). Reliability and validity of a self-report scale for daily assessments of the severity of anxiety symptoms. *Comprehensive Psychiatry*, 90, 37-42.

Zisook, S., Iglewicz, A., Avanzino, J., Maglione, J., Glorioso, D., Zetumer, S., ... & Pies, R. (2014). Bereavement: course, consequences, and care. *Current Psychiatry Reports*, 16(10), 482.

Zisook, S., & Shear, K. (2009). Grief and bereavement: what psychiatrists need to know. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 8(2), 67–74. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=19516922&site=eds-live&scope=site>