Affects of Parental Death on Intimate Relationships for Surviving Children: A Literature Review

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Abstract

The loss of a parent may be devastating at any age. One might assume that it may be easier to cope and move on with life if the deceased parent was of substantially older age and the adult children have had ample time to enjoy their parents as well as prepare for changes and brace themselves for the time when they would indeed lose their parents. It may be fair to assume that in turn losing a parent at a much younger age may be detrimental in that the preparation process may have been shortened and there was not as much time to nurture and enjoy an adult relationship with the parents. This paper explores the implications of parental death on young adult bereaved children between the ages of twenty and thirty-five years old and their ability to obtain and maintain healthy romantic relationships of their own. Reviewing numerous articles on the topics of grief and loss, this writer investigates reasons for or against a correlation between healthy relationships and unhealthy relationships related to early parental death. The results elusively did not offer direct correlation relating parental death to commitment levels in the adult bereaved child’s relationships. However, there is evidence suggesting an indirect correlation given that the research linked parental death to increased emotional reactions and grief process, which in turn was linked to commitment levels in romantic relationships.
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Affects of Parental Death on Intimate Relationships for Surviving Children

Grieving the loss of a loved one is often very difficult and may present many challenges. Grieving and moving forward after a loss may be especially difficult if the loss is of a parent and the bereaved child is a young adult. According to Erik Erickson’s theory on the stages of development, it is the sixth stage which comprises young adulthood with the age range from eighteen to thirty five years old. It is within this stage that people tend to seek romantic companionship and love. In this stage, people often commit to partnership and begin procreation. If this does not happen, a person may find him/herself isolating and distancing from others (Erikson, 1963). It is part of healthy human nature to socialize and seek companionship through intimacy. Connecting with others and partnering to lessen the burdens of daily life are part of what Alfred Adler called social interest. Adler describes humans as social beings, and that we as humans are able to survive and thrive only with communal living (Adler, 1927). Therefore, a loss within the primary network of community, especially immediate family, alters the family system and requires adaptation to change.

Trying to identify potential romantic interests and pursuing dating opportunities in search of true love and compatible lifestyles and personalities often presents as a very challenging task. Having parents to support romantic decisions as well as to model a healthy relationship is critical for children and young adults in their learning and development as they mature and grow. Therefore, it is important to ask the question of how do children and young adults learn how to have a healthy relationship if it is not role modeled for them? Is it even possible? What is the correlation between parental modeling and their children mimicking behaviors? What piece does nature play, and what piece does nurture play?
This paper compiles information from publications addressing the death of a parent, the grief process, and commitment issues in relationships. This review explores the significance among these three topics regarding influence and outcome in relationships for adult bereaved children who lost a parent when the adult child was between twenty and thirty-five years old.

The researcher’s hypothesis is that parental death affects the level of commitment that the bereaved adult child carries into his or her own romantic relationships. In this review, the term “commitment” is identified as three specific levels of dedication: commitment phobia, codependency and healthy commitment levels. As Barner and Rosenblatt (2008) state, there is an “obligation to give and feel indebted to the deceased [which] is cemented within the surviving offspring’s sense of self and awareness of, or growth within, her or his intimate relationships” (p. 320). It is suggested there is at least an emotional duty to feel indebted to the deceased person.

This research does not include the following aspects: whether or not the parents were married at the time of death, alcohol abuse, cause of death, whether there was an illness involved, or identification levels between the child and the deceased and/or living parent(s). Additionally, this research is limited to heterosexual parental relationships. Although grief and the grief process as a whole are included in this research, the focus of this review is specific on correlation between parental death and commitment levels.

The researcher discusses different theories around the topics of death and relationships. Starting in the first section, social exchange theory and how it relates to bereavement is discussed in relation to family dynamics. Cultural components as well as end of life preparation and care are discussed. The concept of anticipatory grief is also covered. Additionally, the historical perspective of views around death including theories by Burton, Rush, Darwin, Shand, Freud, and Kübler-Ross, amongst newer models on the stages of bereavement and how the stages are
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experienced. Additionally, one of the most current models in the grief field is that of J. William Worden’s four tasks of mourning, including accepting the reality of the loss, working through and experiencing the pain of the grief, adjusting to the world without the deceased person, and withdrawing emotionally from the deceased and moving on (Worden, 2009). This review begins with the overarching topic of death of a parent.

Death of a Parent

The purpose of researching the topic “death of a parent” is to identify research that has been conducted on the impact that parental death has on surviving adult bereaved children. Overwhelmingly, the theme that resonates throughout the current research is that losing a parent to death is a major life transition that inevitably changes partner dynamics and interactions. Grieving a parental death can lead to both increased and decreased intimacy, and the bereaved can incur a vast array of emotional experiences, including but not limited to devastation and/or a sense of relief. If an illness is involved, there can be a sense of peace and relief when the ailing parent dies. If the death was unexpected or tragic, there may be a much greater sense of shock and denial for the bereaved individuals. The grieving process then instigates ebb and flow within couples’ relationships, and that “closeness and intimacy may increase or diminish with grieving” (Barner & Rosenblatt, 2008, p. 324).

The bereaved offspring may relate to the life of the deceased or to others in new ways out of a sense of obligation to the deceased or, resultant from the death, rely upon their spouse and partner for resources in greater or lesser degree than before. However, by incurring the debt themselves, some partners of people grieving a parent death reported feeling a greater (emotional, interactional, or psychological) loss than may have been immediately recognized by the bereaved offspring, hindering communication and
emotional exchange…. Changes in communication exchange resulting from a parent’s death can have significant and tangible effects on the couple dyad. (Barner & Rosenblatt, 2008, p. 326)

Two additional points that affect the grieving process of bereaved adult children are the emotional impact and the sense of indebtedness that one partner may feel to not only the other partner, but also to the deceased or surviving parent(s). This indebtedness can stem from a variety of sources, primarily from receiving emotional or financial support or taking more than giving in the relationship. Anytime a trigger throws a balanced system off, there is a resulting overcompensation to maintain some sort of equilibrium.

Given the possible intensity of emotion that may come with grieving the loss of a parent, disruptions in the previously held equilibrium between partners in a couple may occur. These disruptions may result in shifts within the dyadic power dynamic and, as Molm et al. (2001) state, “produce corresponding inequalities in exchange benefits” (p. 161). For example, in a couple grieving the death of a parent, one partner may require an increase in resources (i.e., more closeness or support), leading to a greater sense of indebtedness resulting from the parent death. (Barner & Rosenblatt, 2008, p. 319)

In addition to feelings of indebtedness, many other questions present themselves after the death of a parent. These questions often regard important topics such as faith, God and identifying individual and collective purpose for living. As Marshall (2004) notes, parental death “raises a need for answers to existential questions of being concerning ‘the basic parameters of human life,’ including existence, identity, finitude, and otherness” (p. 354). Many of these topics may come up in discussion with the bereaved adult child and his/her partner. Active listening is reported as a necessity in feeling a close connection with one’s
partner, and lack of reciprocal listening is linked to feeling distance in the partnership. Having the ability to discuss such deep topics often leads to an increased level of trust and investment and therefore a greater sense of intimacy and connectedness with one’s partner.

In Cait’s (2005) reflection of a study that was conducted on adolescent girls who lost a parent to death and were interviewed years later, it was found that most had clear dynamic shifts in the family structure which affected the young women’s roles in the family, often taking on a new role as care giver for the surviving parent. “Often, this care-giving aspect was integrated into their identities. They became the caregiver for their friends or partners and for some, after a period of time they chose friends or intimate partners who could provide care and nurturing for them” (Cait, 2005, p. 93). This concept of role changing is important in that it affects the views of self, contribution to one’s family and to society and may even carry forward with a woman into adulthood.

The “sense of being owed an opportunity to give a verbal account of the grief was linked to the bereaved offspring’s internalization or taking upon herself or himself the full and direct emotional impact of the death (Moss & Moss, 2007) and being owed (or being allowed to give) these aspects to the partner and expecting the partner to reciprocate the giving in the exchange by listening” (Barner & Rosenblatt, 2008, p. 325). This is an example of the concept of exchange theory, described in more detail below, and is critical in the processing period of grieving.

Social exchange theory is the primary theory found associated with the death of a parent, which aligns the basic premises of economics with human behavior. Exchange theory is more or less a framework with which to observe couple interactions as a means to making sense of the bereavement following parental death (Gillies & Neimeyer, 2006).
In the study of couple dynamics, exchange theory has brought a language that can prove extremely useful in articulating commonalities across couples in behaviors and actions. The illustrations show that the death of a parent may represent significant changes in couple exchange. However, rather than simply being a “loss” for the couple, the parent death may offer significant costs and benefits to each partner, and these must be actively managed within the couple dynamics. (Barner & Rosenblatt, 2008, p. 331)

Exchange theory addresses ways in which emotions play a role in affecting changes in basic trade relations. Additionally, this theory is able to assess resources for individuals, couples and families. Costs and benefits are able to be identified, negotiated, agreed upon and managed for each partner as well as the family unit at large.

This seems an important focal point for looking at how a phenomenon like the death of a parent could necessitate changes in ongoing interpersonal exchange. Given that an individual’s feelings around the loss may vary considerably, there are a number of ways in which exchange may be affected by emotions stemming from the loss itself, or from changes in individual perspective with relation to social role and functioning, level of financial responsibility, or personal values. (Barner & Rosenblatt, 2008, p. 321)

Financial responsibilities as well as dealing with material possessions may temporarily heighten pragmatic behavior in order to deal with the business aspect of death, but predictably at some point there will be an emotional reaction or response in some form. Depending on how well prepared the deceased parent was for his/her imminent death often reflects how long it takes to deal with the logistical and business aspects of death. If clear direction was given, preferably in a legal manner with a healthcare directive and a living will, it may be reasonable to assume that the business aspect would be legally easier to execute. Although it is important to note that
this does not take into account emotional involvement and pain or the lifestyle of the deceased. For example, if the deceased parent hoarded material possessions, it may require substantial physical work to sieve through and clean out the deceased person’s belongings. Additionally, without legal documentation, discrepancies within the family may occur as to how to deal with things including material possessions, land, as well as traditional and cultural responsibilities. Given that cultures handle view and handle death differently, it is important to address the importance cultural components may play around the topic of grief, loss, and death at large.

**Cultural Component**

Another critical component is that of cultural differences with preparation for and acceptance of death. An example of this is observable with the notion of preparation for death. The Chinese, traditionally, believe that thinking and talking about death can attract evil spirits, bring bad luck, and even cause early or pre-mature death, so there is a general denial of death and many do not speak of it (Chow & Chan, 2006). Additionally, it is important for the Chinese who believe in an afterlife and practice ancestor worship to ensure that funeral arrangements are planned for and solidified for their parents’ death, because the death marks the crossover from being a mortal to becoming an ancestor (Chan & Yau, 2010). It may be considered disrespectful of the surviving children if those arrangements are not in place to honor their deceased parents. Furthermore, Chan and Yau state that “in the United States and Germany, early death preparation is gaining acceptance. An overwhelming majority of participants polled in a national survey of physicians, healthcare providers, seriously ill patients, and recently bereaved family members felt that it was important to make funeral arrangements before death” (p. 226). This is important both for the dying as well as the surviving family members because early preparation has been linked to lower stress levels for the sick and dying as well as inducing anticipatory grief for the
family members. Additionally, this may be especially important with the terminally ill in that “early death preparation can be equated with re-examination of values and completion of unfinished tasks. Participation in these personally-initiated and self-directed preparation tasks can lead to personal satisfaction in individuals and result in a sense of integrity and closure in life” (Chan & Yau, 2010, p. 226). Closure, in turn, often leads to a peaceful and prepared for departure.

Compared to Chinese traditions, a completely different view towards death is had in many Latino cultures. For example, death in many Mexican cultures is held in high regard as a valued and revered transition into afterlife. There is even a day of celebration, “Day of the Dead,” dedicated to the deceased. As Mendoza-Morteo (2011) stated, “the Day of the Dead celebration has deep roots in our country and it is an act of love, affection, respect and faith of people to their faithful departed. It involves talking, asking advice, finding peace and comfort, think[ing] about life problems and meet[ing] up with [the deceased] through faith” (p. 251). In Mexican traditions, death is honored and anticipated, not feared.

The implication that culture has on both open discussion and acceptance of death is relevant for understanding differences and remembering, in Adlerian terms, that things can always be different. From person to person, family to family, community to community, circumstance to circumstance, and culture to culture, there is a vast array of views and comfort levels around the topic of death and dying.

**Anticipatory Grief**

Anticipatory grief, although debatable in formal definition, identifies the grief process that happens while anticipating and leading up to an expected death but prior to the actual death. Anticipatory grief contains the three primary components of cognitive, emotional and social
elements. The cognitive component includes the realization of imminent death, whereas the emotional component includes the family’s need for reassurance that their loved one is comfortable and being provided adequate care. The social component consists of the forethought that social relationships and roles may change after the anticipated death (Coombs, 2010). This anticipatory grief is crucial in helping to soften the future bereavement process (Chan & Yau, 2010). Often, in a situation where death is imminent and the dying process is excessively long and awaited, the mourning period pre-death may be more emotional than that of post-death mourning. This may be especially true with disease progression of terminal illness, such as dementia, and the surviving family’s response to cognitive and behavioral changes in their loved one. It is common to mourn the loss of the person and the changes in his/her personality while they are still alive.

A Swedish widowhood study revealed that four out of ten widows regarded the pre-loss period more stressful than the post-loss. The present investigation of close relatives to patients dying from cancer (using interviews and the Anticipatory Grief Scale) found that preparatory grief involves much emotional stress, as intense preoccupation with the dying, longing for his/her former personality, loneliness, tearfulness, cognitive dysfunction, irritability, anger and social withdrawal, and a need to talk. (Johansson, 2012, abstract)

Dementia, Alzheimer’s, cancer, Lou Gehrig’s disease and congestive heart failure are all examples of terminal illnesses with disease progression that can take years of continued debilitation before imminent death. From the demands of providing full care, dealing with the doctors, hospitals, and medications to trying to retain a comfortable standard of living for the loved one, being a care giver for someone with such a diagnosis may become overwhelming and
exhausting. It is common for caregivers, whether a well spouse or able bodied adult child, to become burned out and require a break from their loved one and the 24 hour care often necessary. At some point in time, typically when the disease progression has gotten to a place where the family feels as though they can no longer care for their loved one without assistance, additional services may be solicited. These types of terminal diseases often lead to palliative care and hospice eligibility for end of life comfort care.

**Hospice and End of Life Care**

Death can be expected or unexpected, traumatic or peaceful, and the dying process can be sudden or anticipated based on disease prognosis, disease progression, access to care, and an array of other variables. Hospice, which has only been in the United States since the early 1970s, is a philosophy of promoting comfort care to patients at the end of their life. Initially founded by Cicely Saunders in the United Kingdom in the late 1960s, hospice has since become a household name providing holistic care both in the home setting and in nursing care facilities to meet the physical, social, emotional, psychological and spiritual needs of the patient (Richmond, 2005). The purpose of hospice care is to support the patient and family with a peaceful and comfortable death. According to the United States Department of Health and Human Services (USDHS), the Centers for Medicare and Medicaid have strict guidelines for hospice requirements. In order to qualify for hospice care, the patient must have a terminal illness with a prognosis of six months or less to live as well as a commitment for comfort cares only, and that the patient is not seeking aggressive treatment for their hospice diagnosis (USDHS, 2011). According to the National Hospice and Palliative Care Organization’s (NHPCO, 2011) Facts and Figures, over one third, approximately 35.3%, of hospice patients died or discharged within seven days of admission to a hospice program. An additional 27% died or were discharged
within their first month of hospice care (p. 5). Although the majority, 82.7%, of hospice patients, are over 65 years of age, approximately 17% of hospice patients are between the ages of 25 and 64 years old (p. 6). Therefore, at least one in six patients in hospice may have young adult children between twenty and thirty five years old anticipating the death of their parent. These figures are profound in that it is often perceived that hospice care is strictly for substantially older adults. These numbers act as a reminder that no one is exempt from death, and it is often unknown as to when one’s time on earth will come to an end.

Additionally, bereavement support has been deemed critical for the family members of the patient in hospice. Bereavement support is persistently adhered to in varying degrees in most, if not all, hospice programs.

There is continued commitment to bereavement services for both family members of hospice patients and for the community at large. For a minimum of one year following their loved one’s death, grieving families of hospice patients can access bereavement education and support. In 2010, for each patient’s death, an average of two family members received bereavement support from their hospice. This support included follow-up phone calls, visits, and mailings throughout the post-death year. (NHPCO, 2011, p. 12)

This type of bereavement support is important given that as a society we do very little to honor significant losses or recognize that the healing process takes time. Employers often will only give a few days of bereavement leave to employees, and it is typically for immediate family deaths. With hospice support, there is an outlet for the bereaved with people to talk to and affirm feelings related to grief and loss. This is very important in normalizing emotions and feelings that may stir up after the loss of a loved one.
Summary

In summary, the death of a parent may change the life of a bereaved adult child and his/her partner in many influential ways. Sometimes the bereaved adult child wants closeness and support and sometimes distance from his/her partner or from anyone. Sometimes there is an increased sense of indebtedness to the deceased and/or living parent as well as to the partner. Cultural background and practice is important in understanding the expectations around the acceptance of and preparation for death. Anticipatory grief may be helpful in starting the grieving process, especially when the parent is in a hospice program nearing the end of life. If the parent was enrolled in a hospice program, there may have been more preparation for death as well as availability and accessibility towards bereavement education and support.

Inevitably, there are numerous life questions around purpose and meaning that arise and instigate emotional responses. As Rosenblatt and Barner (2006) state, “reactions and fundamental changes of a bereaved adult offspring have the potential to effect a partner and the couple relationship” (p. 278). And therefore, the couple interactions around intimacy are affected. “Closeness and distance involve matters of emotion, physical closeness, extent of mutual self-disclosure, and amount of time spent together and apart” (Rosenblatt & Barner, 2006, p. 278). “The dance of couple intimacy and distance is key to the chemistry of a relationship and to the dynamics of relationship change and stability” (Rosenblatt & Barner, 2006, p. 279). Although this dance is ongoing throughout a relationship, major life changes such as death magnify emotions. Emotions may ebb and flow considerably throughout the process of grieving.
Grief Process

In order to understand the terminology relating to the process of grieving, the words grief, mourning and bereavement must be clearly defined as they relate to this review.

Grief describes an individual’s personal response to loss and has emotional, physical, behavioral, cognitive, social and spiritual dimensions. Mourning is the outward and active expression of that grief. It is through the process of mourning that grief is resolved. Bereavement refers to the period after loss during which grief and mourning occur. It is the state of having experienced a loss. Bereavement is a form of depression, which usually resolves spontaneously over time. (Buglass, 2010, p. 44)

Therefore, grief is a personal response to loss, mourning is the expression of grief and bereavement is the time period after which the loss has occurred. There are many models and theories that have been developed and expanded upon over the years that address the process of grieving. However, these theories have evolved over time, and one common process currently adhered to by many in the grief counseling field are the grief tasks, discovered by J. William Worden in the early 1990s. Yet, it is important to explore the origins of numerous theories, as well as the initial approach to grief from both a societal and individual perspective. Through understanding the historical perspective we are able to see the evolution in thinking and patterns within using words to describe the grief process.

Historical Perspective

According to Granek, the conceptualization of grief has been discussed for hundreds of years. Robert Burton wrote *The Anatomy of Melancholy*, which was published in 1651. Burton discussed the concepts of bereavement and melancholy, and the notion that everyone is affected at some point in their life with both.
Burton argued that grief is a kind of transitory melancholy that affects everyone at some point in their lives. While Burton referred to grief as a “cruel torture of the soul” (p. 259), he also emphasized the distinction between melancholy as a disease, and melancholy as a normal reaction to everyday events such as death of a loved one. He proposed that melancholy could either be found in disposition or in habit, the former referring to context specific melancholy, and the latter referring to a person who is habitually melancholic in character. “In disposition, is that transitory melancholy which goes and comes upon every small occasion of sorrow, need, sickness, trouble, fear, grief, passion or perturbation of mind . . . and from these melancholy dispositions, no man living is free” (p. 143). (Granek, 2010, p. 49)

Benjamin Rush also discussed grief and bereavement in his book *The Diseases of the Mind*, published in 1812. Although Rush did not believe that grieving people were sick, he did describe numerous emotional and physical symptomatic responses common to those grieving. Some of these include “aphasia, fever, sighing, loss of memory, and the development of gray hair. Rush offered a variety of remedies to “heal grief” that included using opium, crying, and in intense cases, bloodletting and purges” (Granek, 2010, p. 50).


[Darwin] described in detail the expressions of depression and grief, including the mechanical aspects of crying and the accompanying facial expressions. Darwin also made a distinction between an active, frantic form of grief, and a passive, more depressive form, which he claimed had different etiologies. In addition to describing the physical
characteristic of grief in people, Darwin noted that animals such as monkeys and apes also display and experience grief. (Granek, 2010, p. 50)

Therefore, it may be assumed that Darwin’s correlation between humans and primates suggests that feelings and emotions are both at the root of grief and mourning. Even a domesticated dog whose owner dies may experience a bout with depression just as people do. Many animals are capable of attaching with others as well as feeling, and are able to feel the sorrow in the loss when their connection dies.

According to Granek, it was Alexander Shand who wrote the first thorough study of the psychology of grief in his book on instincts and emotions titled *Foundations of Character*, published in 1914. Shand described grief reactions in four different types.

[Shand] referred to grief as “the laws of sorrow” (Shand, 1914/1920). He described four types of grief reactions: the first was active and directed aggressively to the outside world; the second was depressive and lacking in energy; the third suppressed through self-control; and the fourth involved frenzied and frantic activity. Shand (1914/ 1920) also spoke about other aspects of grief, including the need for social support, the continued relationship with the deceased, and the trauma associated with sudden death. (Granek, 2010, p. 50)

Yet it was Freud who had the most impact with contemporary grief research. Freud wrote *Totem and Taboo*, published in 1912, and then *Mourning and Melancholia* in 1917. Freud conceptualized normal and abnormal behaviors on a continuum, which was profound in that it recognizes that everyone falls somewhere within the continuum. Freud’s work has often been interpreted as suggesting that if a bereaved person does not do their personal grief work that the risk of developing a psychiatric illness from pathological grieving is possible (Granek, 2010, p.
However, Freud also believed that grief is not a pathological state, although it may often feel that way.

[Freud] focused on how, initially, loss and grief deplete us, empty us out. In his view, mourning often feels like dejection and exhaustion. A part of this exhaustion occurs because when a person dies, the mourner naturally withdraws his or her energy from the outside world while focusing on the person who has died. The mourner is preoccupied with the memories of the person who died and is caught between holding onto and letting go the object of his/her loss. (Berzoff, 2011, p. 263)

Bradbury (2001) stated the importance of the fact that Freud’s book Mourning and Melancholia was written in the midst of World War I, with two of Freud’s sons both fighting on the front lines. Freud was in the midst of daily uncertainty about the whereabouts and livelihood of his sons. Additionally, Bradbury discussed the central topic of Freud’s paper in this quote:

One could argue that the central topic of Freud’s paper is actually the crucial mechanism of what he called ‘identification’. Melancholia (depression) was used as the illustrative example, while mourning, in contrast, was used as an example of the norm. Freud provided somewhat brief descriptions of normal and pathological mourning. Yet, these thumbnail sketches of grief and mourning were to prove to be brilliant and profound. (Bradbury, 2001, p. 212)

Shifting to more contemporary models within the 20th century, Buglass (2010) states, “the dual process model is based on the principle that when people are grieving, the manner of coping is a two-way process: ‘The person moves between grieving and trying to come to terms with the loss’ (Dunne, 2004)” (p. 44). Stroebe and Schut (1999) developed the Dual Process Model in 1999, which identified these two types of stressors in the grief process – loss and
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restoration. There is another key component that plays a role, which is the idea of regulatory coping, known as “dosage” grief, which allows for vacillation between confronting and avoiding the tasks of grieving (Stroebe & Schut, 1999, abstract). These both encourage the active grieving process yet allow for the body to take breaks and actively heal.

Lindemann’s theory developed in 1944 states that there are five distinct phases, including somatic disturbances (tightness in the throat, shortness of breath, choking); a preoccupation with the image of the deceased; feelings of guilt; feelings of hostility or anger; and difficulty in carrying out everyday routines (Buglass, 2010). Conceivably these five phases are still relevant, although discussed in a more fluid and circular structure rather than in a linear fashion.

Perhaps most famously and in the 1960s, Elisabeth Kübler-Ross identified the five stages of grief, primarily the stages of dying, as denial, anger, bargaining, depression and acceptance (1969, p. 265). This theory was adhered to for decades as the most accurate representation of the grief process. However, “one limitation of stage or phase models is that they follow a fairly set pattern whereas, in reality the stages or phases often overlap or occur non-sequentially” (Buglass, 2010, p. 45). Conversely, it was later discovered that the five stages of grief may be more applicable to the dying process rather than post-death grief. Therefore, Kübler-Ross’s model is still very applicable to anticipatory grief and the emotional journey that takes place in the mind with processing and preparing for a diagnosis or prognosis.

Similar to Kübler-Ross, Bowlby’s Attachment Theory developed in the 1970s “emphasizes the importance of human attachments and bonds that are developed early in life. Grief evolves through a sequence of four overlapping, flexible phases. These are: 1) Shock; 2) Yearning & protest; 3) Despair; and 4) Recovery” (Buglass, 2010, p. 45). This theory provides an explanation for the common human need to form strong affectionate bonds with other
humans. When these bonds are severed, there is an emotional distress response at the loss of attachment (Buglass, 2010). Perhaps attachment theory explains a lot about the impact that parental death plays on bereaved children, regardless of age. It is, after all, human nature to attach, bond, and nurture relationships with parents, family and society.

Comparable to both Kübler-Ross and Bowlby, Parkes’ theory developed in 1972 identifies the four phases of bereavement as shock; yearning & pining; disorganization and despair; and recovery (Buglass, 2010, p. 45). “Parkes suggested that grief is not a state, but a process that does not involve symptoms that begin after a death and then fade away, but rather a succession of phases that merge into and replace each other” (Buglass, 2010, p. 46).

Worden’s model, developed in 1991, emphasizes a shift from the passive phases of grief to active tasks of mourning, and includes four primary tasks. These include: task one – to accept the reality of loss; task two – to work through and experience the pain of grief; task three – to adjust to a world without the deceased person, and task four – to withdraw emotionally from or relocate the deceased and move on.

Mourning – adaptation to loss – may be seen as involving [Worden’s] four basic tasks…It is essential that the grieving person address the issue of these tasks in order to adapt to the loss. Bereaved individuals make varied adaptations to the loss of a loved one. Some make a better adaptation, and some a less good one….Grief is a cognitive process involving confrontation with and restructuring of thoughts about the deceased, the loss experience, and the changed world within which the bereaved must now live (Stroebe, 1992). Some would call this grief work. (Worden, 2009, p. 39)

Buglass (2010) links Worden’s model as being in line with Freud’s Grief Work Psychoanalytic Theory, which states that there is a struggle to sever ties and detach energy
invested in the deceased person. Some of the perceived “shortcomings of Freud’s theory are that one has to confront the experience of bereavement to come to terms with death and avoid detrimental health consequences, such as sleep disturbance, loss of appetite, absent mindedness and social withdrawal” (p. 45). Yet, as discussed earlier, it was Freud’s work that really started the trend with grief work being recognized and accepted as a true psychological issue.

The Adlerian perspective towards grief appears to have been studied minimally. In Hartshorne’s synopsis of grief and loss from an Adlerian perspective, he states that grief, like every emotion and behavior, serves a purpose. Hartshorne likes the Adlerian model to the psychoanalytic, attachment, and other major models. However, he goes on to state that lifestyle is the largest predictor of how a bereaved person will respond to the death of a loved one.

Lifestyle reflects movement, and grief should be viewed in this context. The extent to which social interest and the life tasks are developed predicts some of the difficulty and complication experienced with grief. Grief, like other forms of behavior, always has a purpose, and understanding the purpose helps us to understand the way the individual is managing their grief. (Hartshorne, 2003, p. 151)

Hartshorne’s link of adaptability to lifestyle is highly poignant. Lifestyle represents the style of living that someone has created for him/herself based on numerous factors, including family atmosphere and values, birth order, genetic and environmental influences, family constellation, gender and gender guiding lines, role models, goals and mistaken goals, and teleology (Powers & Griffith, 1987). These components mold a person’s personality and their responses to life problems. Additionally, there may be different reactions to death based on who died, the relationship that the adult child had with their deceased parent, as well as what the circumstances were surrounding the death.
A mother’s death tends to have a stronger influence than [a] father’s death, and male offspring are somewhat more vulnerable than female offspring. Elevations in mortality risks are primarily found in minor children. Adult offspring experience a reduced mortality risk recently after parent’s death, which over time approaches, and in some instances even exceeds, that of the general population. Time does not consequently heal all wounds, as long term grief and regret at the loss of the parent might outweigh the short-term relief from burdens and worries. (Rostila & Saarela, 2011, p. 245)

Traditionally, mothers are often the parental figure that keeps the home running smoothly. They often have been the ones to manage the child rearing, cook, clean, purchase groceries, do laundry, help children with homework, and more recently have also maintained full time careers outside of the home. Mothers tend to be nurturing, and the bond between a mother and child, if healthfully established in infancy, may be one of the strongest bonds a person can have, and it may remain strong forever. Although the impact that parental death has on adult offspring may lessen over time, there remains a component of abandonment and feeling left behind to deal with things that the person may never have experienced doing alone before.

Alexander Levy wrote eloquently about the experience of losing both of his parents in his book *The Orphaned Adult*. Levy (1999) stated, “there is no experience quite as stunning as when there is nothing where something has always been. To try and imagine the absence of something is to imagine the thing itself, not the hole left behind” (p. 7). Levy goes on to state, “Especially when that thing has the first face you probably ever saw, spoke the first words you ever heard, and whose touch has comforted and guided and corrected and made you safe since the beginning of time” (p. 7). Parents generally are, after all, a constant in the lives of their children. They are the guiding force, role models, and the initial bond for the child. Levy educates readers stating
that nearly 5 percent of the adult population loses a parent each year. Of this 5 percent, accompanying feelings are often identified as “surprisingly intense” and that many of these adults feel as though they have to mourn in secrecy because losing a parent is part of the natural order within universal dynamics (1999, p. 9). However, despite natural order, there remains real emotional and physical loss associated with the death of a parent.

**Resilience**

“Resilience to loss is defined as bereaved persons showing a stable pattern of low distress over time and has been distinguished from maladaptive grief or the more traditional trajectory of recovery (Bonanno, 2004). The percentage of individuals showing a resilient trajectory after natural, expected deaths is substantial (Bonanno et al., 2002)” (Kristensen, Weisaeth & Heir, 2012, p. 85). However, Neimeyer and Currier (2009) argue that “although most people respond to loss in a resilient fashion, experiencing only transitory distress…longitudinal research documents substantial and sustained bereavement-related difficulties for many people (Bonanno, Wortman, & Nesse, 2004). Most worrisome is recent evidence that 10 to 15% of the bereaved struggle to adapt to their loss over a period of many months or years” (p. 352).

The concept of resilience is important and controversial amongst grief and loss experts. George Bonanno is one of the most famous psychologists to recently conduct numerous research efforts on the topic of resilience. “The human capacity for resilience, highlighted by Bonanno, is natural and normal, part and parcel of the innate health built into all human beings” (Kelley, 2005, p. 265). Therefore, this theory suggests that humans are naturally resilient and able to adapt to change and loss. “Bonanno’s (2004) research suggests a psychological counterpart, an innate psychological immune capacity that, when unhampered, produces well-being and wisdom even during extremely aversive events and facilitated psychological healing from the inside out”
Humans are essentially equipped to deal with transitions, loss and change.

There are differing opinions on the notion of resilience as well as recovery as they relate to grief. According to Shapiro (2008), “recovery is defined as the restoration of adaptive stability permitting flexible responsiveness to evolving challenges of interdependent development...[and that] recovery is evaluated multi-dimensionally while linked to individual, relational, and cultural expectations for restoring stability of everyday activities while moving forward toward redefined life goals” (p. 56). However, it has also been argued that there is no such thing as full and complete recovery from grief, and that grief never goes away, it evolves. Thomson (2010) states “research in death studies seems to indicate that successful grieving does not mean “recovery” (Paletti, 2008), because many individuals never “recover” to a pre-loss sense of “self” and “self-in-the-world (Arnold & Buschman Gemma, 2008)” (p. 893-894).

Köhler (2011) sums up the concept of resilience in his article stating “you probably already have what you need to get through this on your own. If after six months or a year you find you’re still having trouble, you should probably seek professional help” (p. 3). Although most bereaved are able to adjust to life without their loved one without long lasting difficulties, there is a small percentage of bereaved that are prone to chronic grief responses (Van Der Houwen, et al., 2010, p. 195). In turn it may be helpful for many individuals, even those considered healthfully grieving, to have someone to talk to through their grief process. However, it is especially critical for the population with chronic grief responses to get psychological assistance to help deal with their grief. Grief that is unresolved may present itself in the future in vague ways.
Additionally, there is a type of grief that comes with an unidentifiable event and may be less definite or even uncertain. For example, a deployed soldier where the soldier’s family does not know if s/he is still alive. Or, a family member who has developed Alzheimer’s disease, and the loved ones have said their goodbyes to the person and their cognitive functioning, but in fact their body is still alive. This type of grief is very real, and is known as ambiguous loss.

**Ambiguous Loss**

The concept of ambiguous loss was identified and explored by Pauline Boss, and written about extensively in her book *Ambiguous Loss: Learning to Live with Unresolved Grief* (1999). Boss has also written at length about soldiers at war who are missing in action as well as the grief experienced by the terror attacks on the United States on September 11, 2001. Turner, Wieling and Boss (2002) discuss the terror threats and the type of “frozen grief” that accompanied many after the attacks.

In the wake of the recent terrorist acts, ambiguous loss is also felt by many who fear they have lost a terror-free way of life, even if they did not directly lose a loved one. Sometimes ambiguity erodes the cognitive and emotional processes that allow us to grieve fully and eventually begin coping. The result is ‘frozen grief.’ Without a chance to participate in the rituals that normally bring comfort to the bereaved individuals and families, people get emotionally stuck in the sadness and find it impossible to go on with their lives. They may become depressed or unable to make decisions, go to work, or perform daily tasks. (Turner, Wieling & Boss, 2002, abstract)

According to Boss, there are two primary types of ambiguous loss. “The first is physical absence with psychological presence. A loved one is missing physically - lost, kidnapped, disappeared, but kept present psychologically because they might reappear. Examples can be
catastrophic (e.g., lost at sea with no body to bury) or more common (divorce, adoption, migration, immigration). An example of this, which was the news headlines for weeks, was when Jacob Wetterling was abducted in Minnesota in 1989. Wetterling’s family, friends, and community rallied together to keep the search going for him. To date, that search has not ended and many people continue to hope and pray that Wetterling is still alive.

Boss continues to educate her readers stating that “the second type of ambiguous loss…is physical presence with psychological absence. A loved one is physically present, but missing psychologically. Catastrophic examples are Alzheimer’s disease, Pick’s disease and others that lead to dementia, traumatic brain injury, stroke, coma, chronic mental illness, depression, autism and addiction” (Boss, 2010, p. 139). This is especially common in end of life care, where family members sometimes have an opportunity to actively feel their anticipatory grief in preparation for their loved one’s imminent death. However, with dementia cases, sometimes the person can live years beyond a point where they have little to no recollection of people in their life. There can also be behavior and personality changes in the person. This can all be very difficult for family members to understand and process.

Ambiguous loss consists of loss that is unclear and unresolved. This can take many shapes or forms, and is often its own entity of grief. Although it is obvious that ambiguous loss is often common with cognitive impairments such as dementia, it is less known that it may also accompany ordinary grief. Some significant losses, including parental loss, with the realization that along with the loss of the person was a loss of dreams, may readily be accompanied with thoughts and feelings associated with ambiguous loss. Ambiguous loss and loss of dreams may often coincide and happen simultaneously.
A feeling of the loss of dreams often occurs in addition to the physical loss of a loved one. This is associated with the loss of the roles the lost loved one played as well as emotional support from the deceased. For example, if the adult bereaved child marries and wishes her father were alive to walk her down the aisle at her wedding, is considered a loss of dreams. Or, if the bereaved births a baby and wishes that her mother was alive to guide the young new mother in her child rearing of her new baby as well as wishing the infant child had a living maternal grandmother is another example of loss of dreams. The loss of a dream is the psychosocial loss that often accompanies a separation or physical loss (Bowman, 1994). These losses of dreams are very real and are often mourned in ways similar to that of mourning the deceased loved one. These losses may occur over many years, as different situations and circumstances present themselves at different times. A situation may arise with a clear role that should have been filled by the deceased parent (i.e. walking a daughter down the aisle at her wedding…).

Healing from ambiguous loss and shattered dreams requires hope. Hope is derived from re-writing one’s story. The importance of strength based counseling, according to Bowman, is that it gives the client a sense of hope (1999). Hope, which builds personal strength, is critical for the bereaved to see that there is a future, and allow for the ability to identify things to look forward to and to live for. Re-writing stories is also a technique often used within Adlerian therapy, with lifestyle assessments and identifying the meaning and feelings associated with early recollections and memories. Specifically, Robert Willhite expanded on the concept of collecting early recollections by describing a process whereby clients are creatively given permission to and asked to change the pieces of their early recollections from points they did not like to stories they are comfortable with (Mosak & Di Pietro, 2006, p. 308). Although the use of
early recollections are not limited to those experiencing grief and loss, and may be used with a variety of struggles, this is an example of the power and healing that grief counseling and grief therapy can have on a grieving client. In line with the golden rule of Adler’s individual psychology, “everything can be different” (Ansbacher & Ansbacher, 1956, p. 363).

**Grief Counseling**

With significant loss, the intention of grief counseling is not to get over the loss. The goal is to aid the healing process that takes place. Healing may become visible when the grief is not so fully consuming anymore, and not absolutely devastating and debilitating. The triggers that cause a grief response are fewer and farther between. When the unpredictability of grief responses lessens, and the ability to function resumes to a place of healthy homeostasis, healing is taking place.

Alan Wolfelt developed the Companioning Model of Bereavement where he describes the role of grief counselors as companions. “Bereavement caregivers help people to integrate life’s losses by being present to them and observing them – companioning” (Carpinello, 2004, p. 1). Wolfelt elaborates on his idea of companioning by stating that companioning is about honoring the spirit, curiosity, learning from others, walking alongside, being still, discovering the gifts of sacred silence, listening with the heart, bearing witness to the struggles of others, being present to another person’s pain, respecting disorder and confusion, and going to the wilderness of the soul with another human being (Carpinello, 2004, p. 1-2). Being fully present and non-judgmental towards the bereaved are huge gifts that can be very comforting and normalizing for the bereaved individual.

Carpinello (2004) also describes the concept of grief counseling, according to Ken Doka, as validation (p. 2). “Grieving individuals need reassurance that what they are experiencing is
normal” (Carpinello, p. 2). This validation affirms feelings and normalizes the bereaved person’s responses to their grief. Additionally, Doka stated the importance of ritualization as a way to give extraordinary meaning and honor in a symbolic fashion to their loved one. Doka identified four functions of rituals as rituals in continuity, rituals in transition, rituals in affirmation, and rituals in intensification. He states that “rituals must fit the story. They must be planned ahead and thoroughly processed after completion” (Carpinello, 2004, p. 13). Rituals can vary greatly, but some common rituals may include washing a body post death, a memorial service or funeral, lighting candles, reading a poem, going through pictures, speaking of memories, and intentionally reflecting on the deceased person, their life, and their contributions to their family, community, workplace and world at large.

Sometimes it is difficult to make sense out of death. Especially when death occurs earlier than anticipated or in a tragic occurrence. Regarding the concept of meaning reconstruction, including sense-making, benefit-finding, and progressive identity change after a loss, research results show that “although the objective circumstances of the loss carry weight, the survivor’s subjective interpretation of the loss is more influential in explaining ensuing grief responses and that sense-making is a more critical pathway to [compound grief] than the objective cause of death” (Lobb, et al., 2010, p. 685). Therefore, it is most important to ask the bereaved individual where s/he is at emotionally, what their interpretation is of the situation, and how best to be of support.

Köhler (2011) quoted Nancy Moules, a pediatric oncology nurse that spoke of a grieving mother and the dichotomous emotional responses from society. There are “sometimes paradoxical relationship[s] many of us have with the emotions accompanying a loved one’s death. ‘There [are] all these cultural expectations of grief that are contradictory,’ she says."
is, get over it, you should be over it by now! And the other is, what’s wrong with you that you aren’t continuing to feel it? Didn’t you love the person? And we turn all those judgments inward” (p. 2). This example sets a tone for the various responses that bereaved individuals receive in society. Given the unpredictability with personal support networks, the option for grief counseling may be a very appropriate option for support. According to results from a 2009 study on grief counseling, “when high growth [potential] participants sought counseling, they seemed to focus on growth-oriented dimensions rather than mere symptom relief. Of the 11 participants who sought grief counseling for their loss, 10 (91%), found the experience to be helpful” (Gamino, et al., 2009, abstract). Yet Kristensen et al. (2012) state from their research that “overall, grief counseling or therapy seems be most effective when the bereaved shows clear symptoms of [prolonged grief disorder] or other mental health problems secondary to loss (Currier, Neimeyer et al., 2008)” (p. 87). With this said, it is clear that there is a discrepancy in opinion about who is most appropriate for grief counseling and where and when it should be available.

**Summary**

In summary, there are numerous theories and models addressing the grief process. The historical perspective and evolution of the different theories is insightful in understanding societal and individual responses to grief. Many famous theorists have contributed to grief work including Freud, Bowlby, Kübler-Ross, Boss, Bowman and Worden. However, the variance between some of these theories is slight, primarily with semantics. Yet, they all built on each other and have played a crucial role in getting us as a society to a greater understanding and acceptance of grief and loss work. To generalize, all of the theories address different emotional stages and all of the theories are subject to sway from the lineation and a bereaved person may
identify with any of the stages at any time. This idea is in line with Worden’s current theory, the grief wheel, suggesting that shock, protest, disorganization and reorganization may take place in order for healing to occur. The key idea is that when healing takes place, the emotional ruts become less pronounced, and the extreme emotional charges felt in and between the stages dissipate over time. After all, the grief process is rarely static (Buglass, 2010).

Additionally, the idea of resilience is crucial in ensuring hope for the bereaved. Innately we as humans have the ability to allow ourselves to actively mourn significant losses and heal to a capacity where functionality is resumed. As Bowman (1999) states, “promotion of resiliency, bouncing back from adversity, requires hope (Werner & Smith, 1992). Hope, to be real, includes a future story (Lester, 1995)” (p. 179). That is usually possible by engaging in intentional grief work and allowing the growth process to occur.

An overarching theme across all of the identified theories includes the need for support when going through the grief process. “The most common sources of support [for bereaved persons are] other family members (particularly adult children [supporting a bereaved parent who has lost a spouse]), followed by friends and then siblings” (Smoski & Thompson, 2009, p. 4). Without such support, the grief process can be completely overwhelming, and the bereaved individual may incur many other psychological, emotional, spiritual and physical problems if there is no empathetic outlet. Additionally, Smoski and Thompson (2009) state that “bereaved elderly individuals with poor self-esteem and/or inadequate coping skills are at a greater risk for difficult bereavement” (p. 3). Another form of support is that of grief counseling. It is an important resource for bereaved individuals and families as they process the loss of their loved one.
Often, the person most entrusted to act as a primary support through a major life transition such as parental death is a life partner. It is a partner that is often viewed as the most confided in and highly revered support system. This support and empathy are both necessary for healthy grieving, which leads to the concept of commitment levels within intimate relationships.

**Commitment**

The concept of commitment is critical, as the primary question that started this research is based on commitment levels in intimate relationships. The researcher’s hypothesis is that parental death affects the level of commitment that the bereaved adult child carries into his or her own romantic relationships. In this research, the term “commitment” is identified with three specific levels of dedication: commitment phobia, codependency and healthy commitment levels. “Commitment consistently predicts relationship stability and longevity” (Birnie, McClure, Lydon & Holmberg, 2009, p. 82). As Barner and Rosenblatt (2008) state, there is an “obligation to give and feel indebted to the deceased [which] is cemented within the surviving offspring’s sense of self and awareness of, or growth within, her or his intimate relationships” (p. 320). Overall commitment is the desire to stay in a relationship, willing to negotiate and dialogue to compromise and make things work.

**Commitment Phobia**

“Commitment” is described broadly as the motivation to stay in a relationship and work toward its success (Birnie et al., 2009, p. 80). Therefore, commitment phobia can be defined as a fear, aversion or lack of motivation to stay in a long term relationship. “Avoidant individuals tend not to have satisfying or long-lasting close relationships…they report lower overall relationship satisfaction and less intimacy in their interactions with their partner” (Birnie et al., 2009, p. 80). Perhaps related to abandonment issues in childhood, commitment phobia is a real
situation for many. Individuals with commitment phobia may tend to have shorter term relationships, avoid their partner when the level of intimacy increases, and have either not been married or if married, struggled with fidelity in the marriage. Commitment phobia may not be limited to romantic relationships, but may also be pervasive in other areas of life for the individual, including school, work, and home life (Allen, 2012).

Commitment phobia is often detrimental in that it prevents an individual from being able to truly commit to another person or partnership. This impediment may prevent either individual from being able to sincerely feel unconditional love and acceptance. Perhaps this is attributed to the commitment phobic partner’s own attachment or abandonment in childhood.

Commitment phobia may also arise in individuals with counter-dependent personalities. Typical behaviors found in people with counter-dependency struggles include pushing others away, acting strong and invulnerable, cutting off from his/her feelings, acting self-centered, addicted to activities or substances, is armored against others attempts to get close, has a falsely inflated sense of self esteem, tries to look good, acts secure, has manic energy, blames others, avoids intimacy and closeness, tries to victimize others before they can victimize him or her, and is a people-controller (Weinhold & Weinhold, 2008). However, commitment phobia and counter-dependency do not necessarily partner in every situation, as an individual with commitment phobia may not exhibit any counter-dependency traits and someone with counter-dependency traits may seek out more surface relationships and potentially even a partner who exhibits codependent traits.

Individuals high in attachment avoidance are typically less committed to their partners than those who are low in avoidance, experiencing briefer relationships and a higher likelihood of divorce…[as] commitment develops as a result of partners becoming
increasingly dependent on each other…[and] one of the defining characteristics of attachment avoidance is a discomfort with dependence. (Birnie et al., 2009, p. 80)

Given that people often learn through trial and error, and tend to avoid things that have proven to not work well, it is natural to protect oneself from being hurt repeatedly. Yet the question arises as to whether or not the trial and error must be personally felt, or if it is as effective if it is observed in others opposed to the self. Let’s use the concept of divorce as an example. Perchance a child that grew up in a home where the parents divorced may be more likely to actively choose divorce for him/herself later in life because that was the modeled behavior. Or possibly it is attributed to observing the split in others, i.e. parental divorce, as having been interpreted as a type of rejection or abandonment felt by the child and is therefore a hindrance in breaking through the child’s coping mechanisms and allowing him/her to fully commit to another. Or yet another possibility is that the child may have observed and felt horrendous chaos and sadness surviving a divorce in their family of origin and is therefore committed to never experiencing that again for either themselves or for their future children.

Because of a history of others failing them, commitment should have negative associations for avoidantly attached individuals and this should lead them to adopt a pattern of commitment aversion, whereby they avoid engaging in behaviors that would facilitate commitment and instead engage in behaviors that undermine and short-circuit the development of commitment. (Birnie et al., 2009, p. 80)

Romantic relationships can create both feelings of vulnerability and safety. Therefore, it can be very difficult to stay in or leave a relationship depending on what is at stake to gain or lose by doing so. As Rhoades, Stanley and Markman (2010) state, “stability was not only a function of attraction, but the comparison level for alternatives…sometimes people remain in
relationships they might rather leave because the barriers to leaving are too great or the alternatives to staying are poor” (p. 543). That may tend to happen more often than commonly thought of, where despite being immersed in a relationship that is comfortably uncomfortable, it is easier to stay than to leave because the fear of the unknown is often perceived as scary and risky. Therefore, the perceived cost outweighs the assumed benefit. Either, or neither, may actually be an accurate representation of the reality of the situation. However, perceived reality is what actually matters, because perceived reality is the reality in the individual’s mind and deciphers how the individual views him/herself as well as others and the world at large.

Despite popular belief that men tend to exhibit more commitment phobia than women do and that women tend to confess love earlier in relationships than men do, the “ANOVA study results revealed that men reported thinking about confessing love approximately 42 days earlier than women did. And 61.5% of the relationships [portion] of this study reported that the man had confessed love first” (Ackerman, Griskevicius & Li, 2011, p. 4). Additionally, Ackerman et al. state that “although people generally believe that women are more associated with love and initial relationship commitment, it is in fact men who are more likely to express love and commitment first in romantic relationships” (p. 4-5). Not only were men found to confess love first, but also that they felt happier when receiving confessions. According to Ackerman et al., numerous studies have found that men are actually more likely than women to hold certain romantic beliefs, such as that one should marry for love of that love is everlasting (p. 2).

Early in relationships…individuals are beginning to form beliefs about their relationship and do not have any existing beliefs in place to guide their interpretation of behaviors. As a result, they are prone to pay close attention to their partners’ behaviors and to attribute meaning to them regardless of whether this meaning is accurate…. The need to
make [stay-leave] decisions creates an increased desire for answers, which motivate[s] individuals to exaggerate the degree to which they believe their partners’ behaviors are meaningful indicators of their feelings about the relationship. (Ogolsky, 2009, p. 101)

We tend to place meaning on other’s behavior and word choices, always purposefully, yet sometimes mistakenly. It is common to care deeply about how a partner, especially early in a relationship, will interpret and respond to intense situations.

**Codependency**

An unhealthy overcompensation to commitment phobia is the opposite behavior, codependency. Codependency is an extreme focus on relationships, often caused by a stressful family background. Considered an excessive preoccupation with the lives of others, “researchers agree that codependency involves relationship patterns, with two people meeting each other’s needs in dysfunctional ways” (Fuller & Warner, 2000, p. 5-6). There are many behaviors typical of an individual with codependency struggles. Some of these may include clinging to others, acting weak or vulnerable, being overwhelmed by feelings, being other-centered and addicted to people, having a low self esteem, acting incompetent, feeling insecure, feeling guilty, craving intimacy and closeness, and being a people pleaser (Weinhold & Weinhold, 2008). Primarily, a person exhibiting codependent traits often feels inferior of making their own decisions and relies heavily on the influence and approval of others.

Fuller and Warner (2000) state that “there may be a certain kind of person who is likely to become involved in codependent relationships” (p. 6). Often seen in individuals who were raised in codependent homes, these people learned a sense of helplessness and victimization by lacking initiating their own sense of control in situations. “Codependency involves a learning system in which family habits are passed down, one generation teaching those behaviors to the
next generation” (Fuller & Warner, 2000, p. 6). The danger in this results in unhealthy obsessions with partners and partnerships as opposed to creating and maintaining a healthy commitment, focused on balance with overall health and well-being as the primary goal.

Codependent relationships can continually evolve over time into increasingly unhealthy situations. This is often the case with alcoholic relationships, where a codependent spouse will enable the alcoholic little by little with smaller, but manageable, losses until it explodes with a major situation that unfolds. For example, a husband may make up lies or excuses to cover for his intoxicated wife, often to avoid embarrassment and shame, and to protect the alcoholic and the chaotic lifestyle from being found out or ridiculed. Yet at some point, the problem drinker may wind up in jail, having been arrested for driving while intoxicated. At this point, the problem has become public, and it may be much more difficult to cover up. Sometimes though, this type of major episode is necessary to instigate awareness and change.

Codependency is typically a learned response at a young age, often for survival within a chaotic family unit. By the time an individual is aware of these behaviors, they may have lived decades with the codependent behaviors, and therefore do not know how to do things differently. Some well-known methods to aide individuals with codependency struggles in their healing and recovery process include attending a twelve step program, such as Al-Anon, and engaging in talk therapy with a counselor or psychotherapist. Both of these methods can provide tools, encouragement and support for the individual in making choices that promote detachment and personal growth. Detachment, in this sense, is the ability to let go of meaning and judgment placed on oneself or others. It is a type of mental awareness that allows an individual to maintain healthy boundaries without fear of others’ responses. “Detachment doesn’t come without hard work and a daily commitment to the effort, but the payoff is rewarding. Feeling good about
AFFECTS OF PARENTAL DEATH ON RELATIONSHIPS

Yourself and feeling free to live your life in whatever way is pleasing to you are two gifts that detachment promises” (Casey, 2008, p. 55). Detachment is crucial in order to truly have a healthy relationship, consisting of mutual respect, balance, trust and commitment to the partnership.

Healthy Relationships

Unhealthy relationships in the form of avoidant and codependent tendencies are often preventable and changeable. So then the question becomes, what constitutes a healthy relationship and how does one attain that? “Attachment and caregiving cognition, motivation, and behavior are aspects of evolutionary-based behavioral systems that produce strong emotion. In important romantic relationships, partners have attachment and caregiving bonds with each other” (Pistole, Roberts & Mosko, 2010, p. 147). The important piece to note is that yes, attachment and caregiving are important, but this research suggests there needs to be a balance with focus not solely on the partner or partnership, but also on individual health and well-being. This balance is what comprises a healthy base for relationships.

Commitment, which predicts relational persistence for both short and long relationships, is an individual’s long-term relational direction. Commitment is uniquely influenced by (a) satisfaction, or happiness with the relationship; (b) perceived alternatives, such as other attractive partners; and (c) investments that would be lost if the relationship ended. (Pistole et al., 2010, p. 146)

Therefore, if the incentive to stay is greater than that to leave, the partnership may occur.

“The fundamental guarantee of marriage, the meaning of marital happiness, is in the feeling that you are worthwhile, that you cannot be replaced, that your partner needs you, that you are acting well, and that you are a fellow man and true friend” (Carlson & Slavik, 1997, p. 401). Feeling
needed and wanted in any relationship is critical to feeling invested in and wanting to remain in a healthy exchange. However, it is most important that an individual is able to comprehend and value their own self worth in order to actively participate in a healthy partnership. Relying exclusively on others for affirmation of worth and importance is problematic. After all, we cannot love another unless we learn to love ourselves.

Summary

In summary, the theoretical systems of “interdependence theory and exchange theory are concerned with the forces that attract partners, and the personal, interpersonal, and social factors that influence the formation, development, and continuance of relationships” (Rhoades et al., 2010, p. 543). Rhoades et al. continue to state that “personal commitment is the sense that one wants to stay in the relationship, whereas moral commitment is a sense of obligation to stay and structural commitment refers to constraints or pressures that could make partners remain together” (p. 543-544). This brings up the notion that there can be different indicators that drive commitment. There are “four different facets of commitment: dedication, perceived constraint, felt constraint, and material constraints” (Rhoades et al., 2010, p. 545). Therefore, it is fair to assume that commitment levels within romantic relationships are often very complicated, with multiple angles contributing to behaviors as well as to the choice of whether to stay in or leave a relationship. Life is often not as clear cut with relationship decisions as other decisions. It is imminent that commitment, lack of commitment, commitment phobia, and codependency are all viable options and have been proven to the individual, sometimes mistakenly, that it is the choice that works and will keep the person safe.
Implications for Mental Health Practitioners

The research conducted for this review on the topics of the death of a parent, the grief process and commitment levels within romantic relationships of adult bereaved children suggests that parental death creates a major impact on the life of the adult bereaved child. Although the researcher did not find any sources directly relating the parental death to commitment levels in the adult bereaved child’s relationships, there is an indirect correlation given that the research linked parental death to increased emotional reactions and grief process, which in turn was linked to commitment levels in romantic relationships.

It may be insightful to understand the evolution of theories related to grief and the grieving process, but it is especially critical to recognize some of the frequently referenced names, such as Freud, Kübler-Ross, and Worden regarding current theories and applications around grief counseling and the grief process. Additionally, familiarizing with Boss and her concept of ambiguous loss as well as Bowman and his theory about the loss of dreams are highly critical in working with clients that will be, if not already, dealing with and working through grief, loss and transition in their lifetime. It may be helpful to look for signs of active mourning or denial in the client that is seeking grief counseling. By recognizing other mental health issues in addition to grief may allow for greater efficacy with treatment options and referrals. This is especially critical when working with a client experiencing chronic grief responses, and is struggling to move forward from their experience and may feel relatively stuck.

Human beings are survivors by nature, and despite the challenges and problems that occur in life, have the ability to learn coping mechanisms and approaches to allow functionality amidst chaos. Continually seeking success in the three life tasks that Adler eloquently described as the work task, the love task, and the community task, we are constantly striving towards our
goals in life. The basic goals, that everyone yearns for, are to belong, to feel significant, and to feel safe. When one or more of those goals is compromised, people may seek dire straits to re-attain their place in the world with meeting those three critically important goals. When self esteem is threatened, it may be a subconscious response to overcompensate and attempt superiority over the person that presents as threatening. According to Mosak and Maniacci (1999), people use safeguarding behaviors including making excuses, the use of aggression, seeking distance, anxiety and exclusion as ways to protect oneself against feelings of inadequacy (p. 84-88). Especially with grief and loss, the feelings of abandonment and sadness may be elevated, and the fear of being vulnerable may be heightened. It is imperative to be cognizant of this as a practitioner and to meet the client where s/he is at. Kübler-Ross taught us that our clients are our best teachers, as they are the experts in their own lives. “As bereavement workers, we must meet the grieving without expectations about what should happen or what they should be feeling. There are no experts in this work” (Carpinello, p. 1). It is critical that grief workers provide affirmations and normalizations through word choices as well as by being keenly present and actively listening as opposed to appearing disinterested, casting judgment or exclusively pushing the client toward instigating change. In line with any type of counseling, eye contact, facial expressions, body language, vocal tone, and active listening are all critical for the client to feel important and worthwhile in the counseling setting (Carpinello, p. 3). These skills show the client that the counselor is fully engaged and interested in the situation. In line with Adler’s expression of empathy, it is critical for the practitioner to exhibit social feeling, “to see with the eyes of another, to hear with the ears of another, to feel with the heart of another” (Ansbacher & Ansbacher, 1956, p. 135). By showing empathy, the practitioner therefore humanizes themselves as well as more likely to meet the client where the client is at emotionally.
**Conclusion**

Although the researcher was not able to find any articles that directly correlate parental death with commitment levels in the romantic relationships of the adult bereaved child, an indirect correlation was found relating parental death to grief process and from grief process to commitment levels. This was the expected outcome in that anytime there is significant change, including grief, loss and transition, the body learns to compensate for the altered and perhaps now unbalanced homeostasis.

Additionally, the topic of grief process is largely theoretical, yet critical in understanding the societal acceptance of grieving. Despite the fact that death has occurred since the beginning of time, it is amazing that we do not typically have an elevated level of acceptance for extended grief responses in American society. Yet, according to Bonanno’s theory, we as humans are innately able to work through our own grief with a heightened level of resilience.

Numerous questions arose throughout this research, and a wide array of aspects can be addressed in future research and studies. Some of these ideas include, but are not limited to, the connection between parental death and divorce rates for adult bereaved children, lack of support correlated with respective suicide rates for surviving family members of deceased persons, differences in grieving approaches, the meaning(s) that individuals, communities and workplace settings place on grieving, interpersonal conflict related to grieving, and cultural differences within the grieving process.

Significant grief and loss, especially of a close loved one, albeit imminent and unavoidable, are often very difficult experiences that require energy, time and attention. It is the intentional process of mourning that allows an individual to feel and heal and that enables feelings processing and future movement.
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AFFECTS OF PARENTAL DEATH ON RELATIONSHIPS
