MARJA KAUNONEN

Support for a Family in Grief

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Support for a Family in Grief

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ACADEMIC DISSERTATION

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ACADEMIC DISSERTATION

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the Faculty of Medicine of the University of Tampere,
for public discussion in the auditorium of Building B,
Medical School of the University of Tampere, Medisiinarinkatu 3,
on Friday 17 March 2000 at 12 o'clock.

University of Tampere
Tampere 2000

Dedicated to Antti, Anssi, and Anna

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List of original publications

This thesis is based on the following papers, which are referred to in the text by their Roman numerals. In addition, some previously unpublished data are presented.

I Hyrkäs K, Kaunonen M and Paunonen M: Recovering from the death of a spouse. Journal of Advanced Nursing 1997, **25**, 775-779.

II Kaunonen M, Åstedt-Kurki P, Paunonen M and Erjanti H: Death in the Finnish family: experience of spousal bereavement. In press: International Journal of Nursing Practice.

III Kaunonen M, Tarkka M-T, Paunonen M and Laippala P: Grief and social support after the death of a spouse. Journal of Advanced Nursing, 1999, **30**, 1304-1311.

IV Kaunonen M, Aalto P, Tarkka M-T and Paunonen M: Oncology ward nurses' perspectives of family grief and supportive telephone call after the death of a significant other. In press: Cancer Nursing.

V Kaunonen M, Tarkka M-T, Laippala P and Paunonen M: The impact of supportive telephone call intervention on the grief after the death of a family member. Submitted for publication in Cancer Nursing.

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1 Introduction

Grief is described as one of the most universal human reactions occurring across all age groups and cultures as an adaptational response to different kinds of acute life crises or series of crises (Cowles and Rodgers 1991a; 1991b; Curry and Stone 1992; Jacob 1993). It is a reaction to a loss. In this study the loss has been narrowed down to the death of a family member or significant other. Experiential theory of grief (Hogan et al 1996) and Hogan's (1988; 1999b) six dimensions of grief have been used as the framework of grief. Grief experienced by bereaved families is defined to be more than a reaction to the loss. Loss of a family member is integrated into the changed persons the bereaved individuals have become (McClowry et al 1989).

Death of a family member is one of the most stressful events in a person's life. Social support has been shown to be widely beneficial in moderating the effects of both chronic and acute stress. Social support was defined in terms of existence or quantity of social relationships in general, in terms of the structure of a person's social relationships, and in terms of the functional content of relationships (Kahn 1979; Kahn and Antonucci 1980; House 1981; House and Kahn 1985). Social support can be divided into perceived support and actual support (Levy and Derby 1992; Kanacki et al 1996). Perceived helpful social support has been found to have a positive relationship with the grieving person's health (Gass 1987; Stroebe and Stroebe 1993) and coping after the death (Hogan and DeSantis 1994; Robinson 1995; Thuen 1995). It has also been suggested that negatively perceived social support hinders coping (Hogan and DeSantis 1994) and places widows at risk of morbidity (Gass 1987).

Several studies have been published also in Finland concerning the death and dying (See Linkola 1981; Peräkylä 1990; Hakanen 1991; Nissilä 1992; Ollikainen 1994; Molander 1999; Utriainen 1999). Family grief has been a topic only in Väisänen's (1996) study of family grief and recovery process after a baby's death and in Harmanen's (1996; 1997) studies of bereavement support groups organized by the Lutheran Church of Finland. In nursing science Kuuppelomäki (1996a; 1996b) studied incurable cancer patient's suffering experience and coping. Eriksson (1996) studied the help received by cancer patients' relatives in their adjustment and Mikkola-Salo and others (1998) the nursing care of a dying patient. This far the knowledge of grief and bereavement in nursing has been built on conceptualizations of grief from other disciplines, such as sociology, psychology, and medicine (Jacob 1993).

The ability of nurses to give effective and appropriate support is dependent upon understanding grief and recovery process after the death of a loved one. Then interventions can be targeted more accurately to facilitate surviving family members in their progression through grief recovery (Cowles and Rodgers 1991a; Hogan and Greenfield 1991; Curry and Stone

1992; Hogan and DeSantis 1994). The basis of this development is in the education of new nurses. In the curriculum of nurse education about half of the education is practical training and the teachers' primary responsibility in practical training is the integration of practice and theory (Munnukka 1998). In spite of that, Stenfors's (1999) recent study findings showed that almost half of the nurse students indicated lack of practicality in their education. Students reported that nurse education had least of all provided them with a preparedness to face death and to manage human relations problems (Mölsä 1992; Solantie and Leino-Kilpi 1998), although they recognized the need to deal with difficult situations, such as the patient's death or the care of a seriously ill patient and associated feelings (Karttunen 1999). Five years after graduation nurses evaluated that their nursing education failed to provide them with enough theoretical knowledge of terminal care or interactional skills for working with dying patients (Solantie and Leino-Kilpi 1998). Many nurses felt (61%) that their knowledge of matters concerning the support to a dying patient's family was inadequate (Mäkinen et al 1999).

In hospice care programs, the unit of care is not the patient, but the patient and his family (Zimmerman 1981). Since the first hospices opened in late 1960's, for example St. Christopher's Hospice in England in 1967, there has been a general change of attitudes to a more analytical and positive approach to the needs of a dying patient and also of the grieving family (Saunders and Baines 1986). Saunders and Baines already indicated that an increasing number of units and teams in the Hospice Movement have initiated a bereavement follow-up programme. The first Hospice in Scandinavia, Pirkanmaan Hoitokoti in Finland, was opened in 1987 (Häihälä 1997). Currently there are four hospices in Finland, which means that most people are dying at health centers, district, central or university hospitals, and nurses work with dying patients and their families.

Bereaved families are offered professional and peer support typically in support groups (Hopmeyer and Werk 1994; Thuen 1995; Williams and Frangesch 1995; Tunnicliffe and Briggs 1997; Beem et al 1998). Jackson (1996) and Nesbit and colleagues (1997) introduced a individual bereavement follow-up service. In Finland the Evangelical Lutheran Church of Finland has been active in organizing bereavement support groups. Finland is divided into 598 parishes, 58% of which have arranged grief counseling in groups. Despite this, only 4% of the bereaved family members participate in those groups (Harmanen 1997). The goal of interventions has been described to be the provision of supportive caring link with the survivor by listening, providing crisis intervention, grief symptom normalization and community service referral (Williams and Frangesch 1995; Tunnicliffe and Briggs 1997). The advantage of support groups is participants' opportunity to meet people with similar life situations (Trunnell et al 1992; Hopmeyer and Werk 1994; Beem et al 1998). The problem with many bereavement support groups is that they have been designed to help all of the participants (Aquilera 1994), or especially grieving women (Potocky 1993), and are unable to pay attention to each

participant's individual way to grieve. Earlier experiences of individual support, such as of supportive telephone calls made by nurses, have been mainly positive (Jackson 1996; Kojlak et al 1998). Considering the earlier study findings, the researcher concluded the importance of individual support and supported the decision to develop an individual supportive intervention to become part of family nursing and care of a dying patient and his or her family. In this study a nursing intervention for bereaved families was developed for one university hospital.

This study is part of an international grief research collaboration between Tampere University, Department of Nursing Science and the Department of Nursing Science at the University of Miami, USA (see e.g Kaunonen et al 1996; Hautamäki 1997; Kaunonen and Paunonen 1998; Rask 1998; Erjanti 1999). The purpose of this co-operation is to study grief in different cultures. The purpose of this study was to examine grief after the death of a family member and the impact of social support on grief. As a means of social support for nursing the researcher developed an individual supportive intervention. The supportive bereavement intervention constituted a follow-up telephone call, which was made by nurses as part of their nursing practice. Methodological and data triangulation was used in data collection in order to get a more complete view of a complex phenomenon.

2 Review of the literature

2.1 Defining grief

2.1.1 Definition of the concept of grief

Grief is a complex multidimensional process in response to a loss of a person to whom one has an emotional bond (Parkes 1986; Demi and Gilbert 1987; Rognlie 1989; Cowles and Rodgers 1991a; 1991b; Robinson and McKenna 1998). It is a normal, dynamic, pervasive, highly individualized process with a strong normative component (Cowles and Rodgers 1991a; 1991b; Jacob 1993). Grief has two major tasks, which are: to accept the death as real and to cope with the emotional and social problems that are created as a result of the loss (Rognlie 1989); a former definition included a third aspect, that is, emancipation from the bondage of the deceased (Rando 1984). Grief does not present a rigid, linear progression in behaviors, emotions or thoughts. It is a highly variable phenomenon among individuals according to different factors. Variables having an effect on grief are the type of death, the relationship to the dead person, significance of the relationship, age of the bereaved, past coping strategies, social support systems, and physical and mental health status of the person experiencing grief. Grief affects potentially every aspect of individual's existence: physical, social, cognitive, affective, behavioral, and spiritual. (Cowles and Rodgers 1991a; 1991b; Hogan and Greenfield 1992; Jacob 1993; Lund et al 1993; Martin and Elder 1993; Shuchter and Zisook 1993; Cowles 1996).

Normal, dynamic, pervasive and unique grief

Grief is a *normal* reaction to the loss (Silverman 1985; Beem et al 1998). Normal grieving time varies depending on the study and researcher from few weeks to several years. After two years most widowed people have coped with their grief (Stroebe 1992), but there is no clear end-point to grief (Martin and Elder 1993; Parkes 1997). Some researchers define that when the grief does not diminish over time it can change to chronic sorrow, which is not considered normal (Silverman 1985; Cowles and Rodgers 1991a; 1991b; Lindgren et al 1992). However, it has been defined normal that certain events, such as holidays, anniversary of the loss, and confrontation with reminders of the loss, renew aspects of grief recurrently for several years (McClowry et al 1987; Lund et al 1993; Shuchter and Zisook 1993; Stroebe et al 1993). Grief for the death of a baby or child has been found to continue at some lever for ever, although it is not pathological or complicated (Väisänen 1996; Sormanti and August 1997).

Grief is not stable, but a *dynamic* process changing over time. Grief process is not characterized as a linear shift from one phase to another, as for example Kübler-Ross (1969), Parkes (1986) and O´Nians (1993) see it, but as a wave-like oscillatory process in which the bereaved can experience both positive and negative feelings and emotions simultaneously and where more and less intense grief varies (Rigdon et al 1987; Cowles and Rodgers 1991a; 1991b; Curry and Stone 1992; Trunnell et al 1992; Jacob 1993; Martin and Elder 1993; Andersson and Dimond 1995; Hogan et al 1996).

Pervasiveness of grief denotes its potential to affect every aspect of the grieving person's life, that is physical, emotional, social, cognitive, and spiritual (Cowles and Rodgers 1991a; 1991b; Jacob 1993; Cowles 1996). The more personally significant the loss, the more people experience grief in all parts of themselves (Martin and Elder 1993). Examples of physical impacts of grief are nausea, loss of appetite and crying, social such as detachment or difficulty to tie new relationships. An emotional effect of grief is depression and cognitive disability to take care of normal tasks. Thinking of religion and after-death questions is an example of an impact on the spiritual dimension. (Cowles and Rodgers 1991a; 1991b) A feeling of meaninglessness, that neither oneself nor the universe has permanence or purpose, is also a form of spiritual aspect of grief (Saunders and Baines 1986) as are feelings of connection with the deceased (Sormanti and August 1997).

Although a variety of symptoms and manifestations are typical of grief, it is considered to be *unique* varying greatly between individuals according to for example an individual's life experience, age, previous experiences with loss, and cultural and religious background (Bowlby 1980; Jacob 1993; Shuchter and Zisook 1993). Grief as an individualized experience has been often used as a synonym for uniqueness of grief (see e.g Cowles and Rodgers 1991a; 1991b; Cowles 1996).

A bereaved individual has to work on his or her grief, and this 'work', such as accepting the reality of the loss, working through the pain of grief, adjusting to an environment in which the deceased is missing, and emotionally relocating the deceased and moving on with life, essentially form the 'tasks' of mourning (Stroebe 1992; Copp 1998). However, Stroebe also recognized that at some times, for some people, in some situations, working through grief may neither be necessary nor better than non-confrontational or even avoidance strategies.

2.1.2 Variables related to grief

An individual's grief response is unique and dependent upon many variables including cause and circumstances of death, such as anticipatory grief time (Bowlby 1980; Herth 1990), centrality of the relationship with the deceased (Bowlby 1980; Martin and Elder 1993; Hogan and DeSantis 1994), concomitant stressors (Bowlby 1980), availability of social support (Gass

1987; Stroebe and Stroebe 1993; Parkes 1997), age of the survivor (Bowlby 1980; Sanders 1980; Grimby 1993; Parkes 1997), gender of the survivor (Bowlby 1980; Silverman 1985; Brabant et al 1992; Farberow et al 1992; Anderson and Dimond 1995; Moriarty et al 1996) and personality of the bereaved (Bowlby 1980). These variables are believed to influence the course taken by grieving in different individuals, especially those that play a part in determining whether the outcome is healthy or pathological.

Gender of the survivor

Comparison of the grief of different genders after the death of a spouse has not been the focus of research. Dyregrov and Matthiesen (1987) and Moriarty and colleagues (1996) suggest that gender is an important source of variance in parental bereavement responses. There are also descriptions of the similarities and differences between widows' and widowers' grief (see Table 1 in Paper II).

The death of a spouse has been found to be one of the most stressful events of ones life (Lund et al 1993). When questioning the differences or similarities in spousal grief of different genders, comparable levels of grief emerged. Both widows and widowers have the same emotional involvement. There were no differences in the level of hope, coping style or grief resolution (Herth 1990; Brabant et al 1992; Gallagher-Thompson et al 1993). Also the outcome of grief is the same (Stroebe and Stroebe 1993).

In contrast, Silverman (1985) described grief reactions differing by gender. Widows felt greater degree of helplessness and worried about the tasks their husbands used to take care of, and they also saw their husband in a protective role (Anderson and Dimond 1995). Some researchers also found greater distress, more apprehension and greater fearfulness amongst widows (Brabant et al 1992; Farberow et al 1992).

In addition to the loss of a spouse widowers experienced the loss of social support (Stroebe and Stroebe 1993). They appeared to be more vulnerable on the decline of cognitive abilities and also at greater risk of death (Gallagher-Thompson et al 1993; Grimby 1995). Men also showed less acceptance of the death, but became sooner involved in romantic relationships (Shuchter and Zisook 1993). Those men who sought distraction in order to avoid confronting the loss showed less improvement in adjustment (Stroebe 1992), but those who participated in bereavement support group improved more than women (Levy et al 1993).

Age of the survivor

This study is limited to the grief of an adult delimiting the special features of the grief of a child or an adolescent out of the study. Sanders's study (1980) indicated that younger widowed people cope with their grief time passing when in older survivors' grief got more intense only after some time after the death of a spouse. Older survivors described hallucinations or a strong sense of the presence of the dead person to be typical (Grimby 1993; Parkes 1997). Disengagement and loneliness were commoner in the elderly (Parkes 1997).

Personality of the bereaved

Personal variables have been defined (Bowlby 1980; Sanders 1993; Stoebe and Stroebe 1993) to be amongst the most important determinants of adjustment to loss. Lund and colleagues (1993) recognized the critical roles of internal coping resources, self-esteem and competencies in making successful adjustments to the death of a spouse, on the other hand Stroebe and Stroebe (1993) discussed the role of emotional stability and locus of control.

Social support

Perceived helpful social support has been found to have a positive relationship with the grieving person's health (Gass 1987; Stroebe and Stroebe 1993) and coping after the death (Hogan and DeSantis 1994; Robinson 1995; Thuen 1995). Impoverished social network is linked with the mortality of elderly bereaved males (Gallagher-Thomson et al 1993) or with depression (Kanacki et al 1996). Nieminen and colleagues (1998) studied new patients in psychiatric out-patient care, who needed care after the death of a relative. Their results indicated that the patients did not receive social support from their network. The patients perceived their relatives as hindering rather than helping their grief. Hogan and DeSantis (1994) and Parkes (1997) suggested that widows who viewed their families as unhelpful were at greater risk after bereavement than those who viewed their families as helpful. Gass (1987) and House et al (1988) even suggested that unhelpful social support placed widowed people at risk of morbidity.

Relationship to the deceased

Significance of the relationship between the deceased and the survivor has an impact on how the grief is experienced (Martin and Elder 1993; Hogan and DeSantis 1994). Bowlby (1980) wrote that attachment provided the foundation for understanding of grief. An ambivalent or dependent relationship is linked with higher distress (Sheldon 1998). Gamino's and colleagues' (1998) study results showed that the presence of a problematic relationship between decedent and survivor was predictive of higher levels of grief. Death of spouse has been ranked to be the most important stressor in Holmes and Rahe (1967) Social Readjustment Scale. The scale can be criticized for not considering the death of a child one of the stressors, because studies indicate it to be the most difficult death for survivors to experience (see e.g Back 1991; Johnson et al 1993; Harmanen 1997).

Anticipatory grief

How much forewarning a bereaved person is given is found to be related to a considerable degree both to the capacity of the bereaved to recover from the loss and also to the form recovery takes (Bowlby 1980). Herth (1990) reported a longer illness (more than 6 months) of

the spouse to be related to more positive grief resolution and level of hope. On the other hand Hogan and colleagues (1996) indicated that study participants, whose family member had died following a chronic illness, did not miss their loved one less after death because they had anticipated the death.

Concomitant crises

Sanders (1993) reported that during bereavement, the existence of additional debilitating stressors may result in an overwhelming situation. Study findings of Gass (1987) suggest that other losses at the time of bereavement and prior history of poor mental-emotional health were related to lower psychosocial dysfunction. Parkes (1997) has listed risk factors associated with poor outcome after bereavement. He includes poor physical and mental health, low self-esteem and multiple losses to be amongst those risk factors.

2.1.3 Outcomes of grief

Depression

The most typical cause of depression amongst women was related to losses and the way women perceive the grief after the loss (Silverman 1985). In Finland Kokko (1999) suggested that one of the most important causes for depression is loss. When comparing recently bereaved elders to comparison participants, Breckenridge and colleagues' (1986) findings indicated that certain depressive symptoms characterized the bereaved group, that is, sadness, tearfulness, dissatisfaction with self, insomnia, appetite loss, and weight loss. Mendes de Leon and others (1994) indicated that conjugal bereavement resulted in a 75% increase in depressive symptoms, but for most older adults (65 to 99 years), depression scores returned to baseline levels by the second year of bereavement. Farberow and colleagues' (1992) study, on the other hand, indicated that bereaved suicide survivors and other bereaved widows had higher levels of severe depression and psychotism than a nonbereaved control group even 2½ years after the death. Martinson and colleagues' (1991) study of depression in grieving mothers and fathers suggests that bereaved parents are vulnerable to or at high risk of depression even several years after the death of their child. Depression of those parents did not appear to change between the second and seventh years. Society does not tolerate the visibility of grief in an endless way, which according to Moules (1998) may cause withdrawal and depression amongst survivors.

Increased mortality and morbidity

Increased mortality and morbidity rates have been found especially in elderly widowed persons (Tamminen 1996). Mendes de Leon and others (1994) found some evidence of an increased

mortality risk in the first 6 months of widowhood, particularly among young-old (65 to 74 years old) widows. Sheldon (1998) stated that bereavement is associated with high mortality and that up to a third of bereaved people develop a depressive illness, although he fails to support his statement with study findings. Gass (1987) suggests that appraisal of bereavement as having other anticipated threats, unhelpful social supports, limited use of death and mourning rituals, other losses at the time of bereavement, and a prior history of poor mental-emotional health are among factors that may place widows at risk of morbidity following bereavement.

Personal growth

Personal growth occurs to some degree across all phases of the bereavement process but is most evident as the survivor is emerging from the acute pain of grief (Cowles and Rodgers 1991a; 1991b; Hogan et al 1996). Major loss of the loved one will change the griever's personality (Rando 1984; Silverman and Klass 1996; Parkes 1998). Personal growth is engaged in a search for meaning and purpose and is associated with believing that grieving persons had grown less judgmental and more caring, tolerant, and compassionate. It includes a sense that the family had grown closer (Hogan et al 1996; Hogan and DeSantis 1996).

2.1.4 Bereavement, mourning, and sorrow and their relation with grief

Bereavement

Bereavement denotes both the period of time following the death, during which grief occurs, and also the state of experiencing grief (Rosenblatt et al 1976; Copp 1998; Cutcliffe 1998). Bereavement process is often mentioned as a synonym for grief process, which is a process that follows the death of a person to whom the survivor has been and continues to be meaningfully attached (Hogan and DeSantis 1994; Sormati and August 1997). Tyson-Rawson (1996) defined bereavement resolution as coming to terms with the death in the sense of its having meaning, an increased individual ability to function effectively, and a sense of acceptance of the loss as part of one's life history.

Mourning

Mourning denotes the culturally defined acts that are usually performed when death occurs and that are frequently prescribed by religious and cultural beliefs, that are carried out as a public display of the grief response (Rosenblatt et al 1976; Kastenbaum 1986; Cowles and Rodgers 1991a; 1991b; Hogan 1995). Mourning rituals provide for the individual a structured way to recall the lost loved one and to make some statements about one's feelings (Rando 1984; Mulhall 1996). Fear of death and unresolved grief can cause anxiety, depression and physical

disease. Traditional mourning rituals can be seen as helpful in overcoming the fear of death (O'Gorman 1998). Haberecht and Prior (1997) stated that an important way to deal with the chaos of grief is to sample it in small amounts through ritual. Mourning customs have been the focus of extensive writings of social anthropologist, who have been interested in the variety of rituals in different cultures instead of the emotional responses of the bereaved (see e.g Stroebe 1992; Klass 1996; Kenny 1998). Nenola's (1994) study of Finnish mourning customs revealed that there are only few collective mourning rituals. Väisänen's (1996) findings confirmed, that after the death of a baby rituals are few. Bowlby (1980) describes, that according to the anthropological literature cultural patterns differ enormously. Almost in all societies rules and rituals of at least three kind obtain: those for determining how a continuing relationship with the dead person should be concluded, those that prescribe how blame should allocated and anger expressed, and those that lay down how long mourning should last. Cowles's (1996) study of cultural perspectives of grief indicated, that while each of the cultural groups described unique mourning rituals, no particular differences in the intrapersonal experience of grief could be attributed to cultural heritage or ethnicity alone.

Sorrow

Moules (1998) defined sorrow to be overwhelming sadness, which is contained within grief, when grief is as much the celebration of the lost person as it is the relinquishing or sorrowing of the loss. A related concept of prolonged grief is chronic sorrow. Prolonged grief is a long-term reaction to one loss, and chronic sorrow is the reaction to multiple losses over time (Lindgren et al 1992). Later, Eakes and colleagues (1998) in their middle-range theory of chronic sorrow have expanded the concept of chronic sorrow to describe also those who have experienced a single loss, bringing their definition close to grief. Critical attributes of chronic sorrow are: a perception of sorrow or sadness over time in a situation that has no predictable end. The sadness or sorrow is cyclic or recurrent. It is triggered either internally or externally and brings to mind the person's losses, disappointments or fears. The sadness or sorrow is progressive and can intensify even years after the initial sense of disappointment, loss or fear (Lindgren et al 1992; Eakes et al 1998).

2.2 Theoretical perspectives of grief

2.2.1 Development of grief studies

Freud has been given the credit for being among the first to conceptualize the grief (see e.g Rigdon et al 1987; Hogan et al 1996). In his writing Mourning and melancholia, which originates from 1917, Freud defines mourning to be "a regular reaction to the loss of a loved

person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, and ideal, and so on" (p. 243). The original German word Freud used "Trauer", which can mean both the affect of grief and its outward manifestation, has been translated as mourning. Mourning is not regarded as a pathological condition. It passes off after a certain time has elapsed, when the grieving person's ego has succeeded in freeing its libido from the lost object. Withdrawal of the libido takes time, but Freud is considering whether it begins simultaneously at several points or follows a fixed sequence. The mourning elapses without leaving traces of any gross changes (Freud 1978). Lindemann (1944) in his study defines grief work to be emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. Common to persons in acute grief is sensations of somatic distress, for example tendency of sighing respiration or loss of appetite, feelings of guilt, preoccupation with the image of the deceased, hostile reactions, and loss of patterns of conduct. Both Freud's and Lindemann's theories were based on a clinical diagnosis with specific somatic symptoms.

Kübler-Ross (1969) outlined her five stage theory of coping with imminent death, but her stages have also been used to identify the grief of individuals after a loss (Rando 1984). The five stages of coping are: denial and isolation, anger, bargaining, depression, and acceptance. Parkes (1998) describes the course of grief to be numbness, pining, disorganization and despair, and reorganization. Reorganization includes letting go attachment to the lost person, and moving on to review and revise one's basic assumptions of the world.

Bowlby's (1980) attachment theory incorporates much psychoanalytic thinking, but differs from the traditional one in adopting principles derived from ethology and control theory. Observations of how individuals respond to the loss of a close relative showed their responses usually moving through succession of phases. These phases are not clear cut, and any one individual may oscillate for a time back and forth between any of the two. The four phases are: (1) Phase of numbing that usually lasts from a few hours to a week and may be interrupted by outbursts of extremely intense distress and / or anger. (2) Phase of yearning and searching for the lost figure lasting some months and sometimes for years. (3) Phase of disorganization and despair. (4) Phase of greater or lesser degree of reorganization. It is necessary to discard old patterns of thinking, feeling and acting before new ones can be fashioned. That includes a redefinition of oneself as well as the situation, which means relinquishing finally all hope that the lost person can be recovered and the old situation re-established. (Bowlby 1980) Tie-breaking customs separate one from the reminders of a deceased person. They include discarding or temporarily putting out of sight personal property of the deceased, practicing a taboo on the name of the deceased and changing residence. (Rosenblatt et al 1976; Bowlby 1980)

Rando (1984) defined three tasks of grief, which she suggested are necessary to know in order to completely understand the experience of grief. Those tasks are emancipation from the bondage of the deceased, readjustment to the environment in which the deceased is missing, and formation of new relationships. She used the psychoanalytic term decathexis about the detachment and modification of emotional ties between the deceased and the survivor. However, she added that even though the death separates the deceased and the survivor, it does not constitute the end of their relationship. The new relationship is based largely on recollection, memory, and past experience.

Martin and Elder's (1993) Model of pathways through grief is build upon Bowlby's work on attachment completed with Lamers' addition of recovery to it. They visualize their model as the shape of number eight. It reflected the continual process of dealing with attachments and losses throughout life. The model is divided into the inward path and the outward path. The inward path includes protest, despair and detach. The outward path on the other hand includes explore, hope and invest. In the cross section of paths is meaning which the authors see as an integral part of the healing process in grief experience. The model states that other people play a significant role in the grief process and calls it the circle of influence. It is important that the bereaved understand the potential power of this influence. It is also important that they have a choice as to how they will let others affect their need to grieve.

Hogan and colleagues introduced their experiential theory of bereavement in 1996. It was developed with non-clinical grieving persons based on grounded theory approach. The theory states that regardless of the cause of death, the timeliness of the person's death, or the relationship of the survivor to the deceased, the bereavement follows a consistent overall pattern (See Table 1).

Table 1. Processes of Surviving a Death

Entry Points	**Processes**
Acute/Chronic illness	1. Getting the news
* *Cancer*	Getting the diagnosis
	Shock
	Calculating the odds
	Dedicating resources
	Being there for them
	Accommodating care
	Negotiating treatment
	Fighting for life
	Enduring stress
	Shutting it out
	Maintaining hope
	Losing the battle
	Seeing the obvious
	Ending the suffering

Table 1 continues

Table 1 continues

Sudden death	2. Finding out Responding the news 3. Facing realities Going through the motions 4. Becoming engulfed with suffering Missing, longing, and yearning Enduring hopelessness Existing in the present Reliving the past Making sense Aching with physical pain Getting through the day 5. Emerging from the suffering Embracing hope 6. Getting on with life 7. Experiencing personal growth Becoming

Adapted from Hogan et al 1996, 48.

In contrast to the stage theories they suggest that although the components may appear to occur linearly, many of the phases overlap and recur (see also Trunnell et al 1992). The model also presumes that grief may linger indefinitely, but its intensity lessens over time. Throughout the grief process cycles of grief occur either associated with special occasions related to the deceased person, such as birthday or family celebrations, or grief occurs without notice, triggered by music, sound, or something else familiar. Personal growth is encompassed as a vital component of the grieving process occurring to some degree across all phases of the bereavement process.

The most recent definition of grief in terms of stages or tasks agrees that those stages are overlapping phases of a mixture of emotions and responses. Sheldon divides grief into four stages, which are (1) Initial shock, (2) Pangs of grief, (3) Despair, and (4) Adjustment. Each stage has its own task to accomplish, such as to accept the reality of loss during the initial shock. (Sheldon 1998). Moules (1996) in her writing proposed that stage models obscure unique experiences and narrowly focus on psychological responses overlooking the social, spiritual, familial, and physical domains of the experience. Table 2 (page 23) presents the chronological development of grief studies from Freud's (1917/1967) and Lindemann's (1944) classical psychoanalytics and to Klass and others' (1996) postmodernity.

Table 2. Grief studies with their theoretical background

Researcher/s (publishing year)	**Theoretical background**	**Definition of grief**
Freud (1917)	Psychoanalytics	Mourning is a regular reaction to the loss of a loved person. Mourning elapses without leaving traces of any gross change
Lindemann (1944)	Psychoanalytics	Grief work is needed to the emancipation from the bondage to the deceased
Kübler-Ross (1979)	Psychiatry	Five stages of coping with grief include denial and isolation, anger, bargaining, depression, and acceptance
Bowlby (1980)	Psychoanalytic-cognitive (Attachment theory)	Four phases of grief: numbing, yearning and searching for the lost one, disorganization and despair, and reorganization. Grief is a form of separation anxiety
Rando (1984)	Attachment theory	Three tasks of grief necessary to understand the experience of grief are emancipation from the bondage, readjustment, and formation of new relationships
Martin &Elder (1993)	Nursing	Pathways through grief model reflects that part of grieving is the reaction to lost meaning and part of healing is developing new relationships with others and with oneself
Hogan, Morse & Tasón (1996)	Nursing	Bereavement is defined as the response to the dying and death of another as well as the subsequent grief response. Process of bereavement follows a consistent overall pattern. The duration of grief varies, it may linger indefinitely, but over time its intensity lessens.
Klass, Silverman & Nickman (1996)	Postmodernity	New model of grief: resolution of grief involves continuing bonds that survivor maintains with the deceased, can be healthy part of the survivor's ongoing life.

2.2.2 Grief in family nursing theories

Symbolic interactionism, systems, developmental, and social exchange theories have been defined as the frameworks for family nursing theories (McShane 1991; Boyd 1996; Paunonen and Vehviläinen-Julkunen 1999). In spite of the way family nursing is conceptualized (see Wright and Leahey 1990; Hakulinen and Paunonen 1994; Nolan et al 1995; Hakulinen et al 1999; Paunonen and Vehviläinen-Julkunen 1999; Smith and Friedemann 1999), family nurses need to recognize the family also after the death of a family member. According to Artinian (1996) a health care professional's contact with the family concerning death or dying has an significant impact on the family's grief reaction, however she fails to clarify her statement in more detail. McClowry (1989) and colleagues defined the grief experienced by bereaved families to be more than a reaction to the loss of a family member. The process involves familial and extrafamilial role alignment and reorganization and can result in either positive or negative outcomes. They also acknowledged that for many individuals even after successful adaptation, pain continues, and the loss of the family member is integrated into the changed person that the bereaved individual has become. It is not unusual for the family to grieve for different reasons over time. The process of grief does not limit the bereaved to one particular emotion at a time. They recognized that many people find it difficult to listen to those who have experienced the death of someone they love and therefore the bereaved frequently lack the opportunity to express the pain. The remaining support system may also be bereaved and consequently, poorly prepared to provide needed support (Hansson et al 1993). Friedemann (1995) saw that through death the family and individual system change. She also recognized that grief can be a necessary constituent of a human being's personal growth.

Friedman and McCown (1998) recognized also family members' psychological need for support to be greater during the period when the family member is dying and after the death. Both the informal and formal social support system of the family can play an important role in supporting grieving families. They suggest that the affective need of family members during the time of major loss is to be able to grieve for the loss. Constructive grief work depends on the ability of the social support network to be permissive of feelings, positively accepting and supportive. Family members' energies should be directed to the actual loss as experienced collectively and individually. When feelings are shared there needs to be an open stage for discussing, recalling, memory associating, and reliving of past events. When the family is grieving, conflicts in the family often become overt and the affective needs of family members are usually not acknowledged. On the other hand, functional families pull together during this period and try to share their grief and support each other (Friedemann 1995; Friedman and McCown 1998).

When death becomes imminent and talk of cure is replaced by a primary concern for comfort, family needs for support and assistance require the specialized skills of professional nurses (McClowry et al 1989). The definition fails to explain what those specialized skills are. There is a paucity of investigation about family health following the death of a member (Denham 1999). Gilbert and Smart (1992) and Friedman and McCown (1998) see the role of the family nurse when assisting grieving families to be as follows: encouraging open communication; assisting the family to assume new roles; facilitating the expressions of emotions; supporting the family members in their grief; assuring that the family members' feelings are normal; assisting the family to understand and absorb knowledge about the course of illness and treatment; and encouraging family cohesiveness. Friedemann (1995) states that nursing care of grieving families involves understanding the very special way the family moves in its life process and guiding the individuals in their search for new congruence. She also recognized the importance of nurses in noticing the signs indicating that the family members are distancing themselves instead of pulling together.

2.2.3 The role of social support in grief

Social support has been defined as interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid. Affect is seen as expressions of liking, admiration, respect, or love. Affirmation means expressions of agreement or acknowledgement of the appropriateness or rightness of some act or statement of another person. Aid includes direct aid or assistance, such as money, information, time, and entitlements. (Kahn and Antonucci 1980)

Social support can be seen in terms of existence or quantity of social relationships in general, in terms of the structure of a person's social relationships, and in terms of the functional content of relationships (House and Kahn 1985; House et al 1988). The structural and functional characteristics of a social network influence the potential availability of support (Stylianos and Vachon 1993). The major individuals or groups that may provide social support range from informal sources, that is family and friends, to persons connected with major life roles such as work, to professional and semi-professional persons and groups who provide specific services, including forms of support. (Kahn 1979; Kahn and Antonucci 1980; House 1981; Gamino et al 1998; Kojlak et al 1998)

Social support can be divided into perceived support and actual support (Levy and Derby 1992; Kanacki et al 1996). Perceived helpful social support has been found to have a positive relationship with the grieving person's health (Gass 1987; Stroebe and Stroebe 1993) and coping after the death (Hogan and DeSantis 1994; Robinson 1995; Thuen 1995; Duke 1998;

Persson et al 1998). It has been suggested that impoverished social network is linked with the mortality of elderly bereaved males (Gallagher-Thompson et al 1993) and with depression (Kanacki et al 1996). It has also been suggested that social support perceived to be unhelpful hinders coping (Hogan and DeSantis 1994) and places survivors at risk of morbidity (Gass 1987; House et al 1988).

Older adults grieving over the death of their spouse have grown closer to their own families, but lost membership in the social network of married couples to which they had belonged (Anderson and Dimond 1995). Loss of a partner has been found to result in a decrease of social support for widowers but not for widows (Stroebe and Stroebe 1993). Lopata, who has divided social support into economic, service, social, and emotional support, suggested that grandchildren did not contribute as often to the emotional support as expected and also friends appeared relatively infrequently in the emotional support system (Lopata 1993). In a study of the relationship between social support and depression, there was no significant relationship between the amount of contact the elderly widows had with their children and the perceived amount of social support they received (Kanacki et al 1996). Appendix 3 presents an overview of the studies concerning the role of social support in grief.

In this study social support was defined in terms of existence or quantity of social relationships in general, in terms of the structure of a person's social relationships, and in terms of the functional content of relationships. Social support was either positive or negative and not only positive as Tarkka (1996), Tarkka and Paunonen (1996a; 1996b) or Tarkka and others (1999) defined social support in their studies of the role of social support in motherhood. The providers of social support were either informal sources, that is family and friends, or persons connected with major life roles (see eg Kahn 1979; Kahn and Antonucci 1980; House 1981), which meant that professional support was not differentiated as Eriksson (1996) did. Social support was studied as the grieving persons perceived and expressed it.

Support interventions after the death

Bereavement support includes professional individual support, professional group support, non-professional individual support, and non-professional group support (Rognlie 1989; Trunnell et al 1992; Levy et al 1993; Lieberman 1993; Hopmeyer and Werk 1994; Dyregrov 1995; Caserta and Lund 1996; Beem et al 1998). Beem and colleagues (1998) have also used workshops as a form of bereavement support. Appendix 4 presents the studies of different forms of bereavement support. Professional support is given by psychotherapists, social workers, psychiatrists, nurses with additional training (Beem et al 1998), and church workers (Harmanen 1996; 1997). Non-professionals are volunteers and people who have suffered a loss themselves. In some groups they have had special training (Levy and Derby 1992; Levy et al 1993). In Finland, bereaved families are offered bereavement support if the family member has died at a

hospice. “Family hours“ which are part of the life at a hospice have been found helpful in giving answers to family members’ questions. (Sinnemäki and Simonen 1995). Even though 58% of Evangelical Lutheran Parishes of Finland offer bereavement support groups (Harmanen 1997) and 85.6% of Finns belong to the Evangelical Lutheran Church (Statistical 1998), only 16.7% of the widowed people in the study of Hyrkäs et al (1997) had attended a support group.

Positive coping strategies should be strengthened and supported. Interventions which demonstrate of an empathetic presence and a caring professional have been found most helpful (Eakes et al 1998). Raphael and colleagues (1993) have described counseling and therapy of the bereaved, but also recognized that counseling is not necessary for normal grief, but simply support and understanding. Support groups seemed to highlight the value of interpersonal support in coping with the loss of a loved one (Gamino et al 1998). Eakes and colleagues (1998) suggested that interventions should include taking time to listen, offering support and reassurance, recognizing and focusing on feelings, and appreciating the uniqueness of each individual and family.

After the death grieving spouses did not any longer receive as much support as they did during the illness leaving them to loneliness and emptiness. Interventions need to be available early in bereavement and continue over long periods of time. (Jacob 1996) In her meta-analysis of previous research Cooley (1992) suggested the timing of intervention to be 1-2 weeks after the funeral allowing for rituals to be concluded, and for the social support that often accompanies the funeral rites to have faded.

Only few studies report the results of individual or family support. Nurses have used supportive telephone call as a means of bereavement follow-up (Williams and Frangesch 1995; Jackson 1996, 1998; Tunnicliffe and Briggs 1997; Kojlak et al 1998). The purpose of the telephone intervention has been described as to provide a supportive caring link with the survivor in which listening, crisis intervention, grief symptom normalization and community referral were provided (Williams and Frangesch 1995; McClain and Shaefer 1996; Wesson 1997) by using nurses as the key experts of the service (Tunnicliffe and Briggs 1997). Another purpose has been to provide skill training to enhance parenting effectiveness and to normalize the parenting experiences (Glazer and Clark 1997). Referral to available support groups has been made, because groups were found to be both useful and efficient for most of the grieving people and particularly valuable for those who experience high levels of grief and psychological strain due to the loss (Thuen 1995). Family members were generally pleased with the idea of a follow-up telephone call and were appreciative of the interest and concern expressed by the interviewer (Jackson 1998; Kojlak et al 1998). Many took the opportunity, within the interview session, to discuss further their own loss, their personal reactions to the loss, and their current status in the bereavement process. Furthermore, about one half of the

participants expressed an interest in knowing more about community support groups. (Kojlak et al 1998).

The main difference between individual support, such as telephone calls, and bereavement support groups is the participant's opportunity to meet people with similar life situations (see e.g Rognlie 1989; Trunnell et al 1992; Hopmeyer and Werk 1994; Harmanen 1997; Beem et al 1998). As a result of a telephone-based intervention, caregivers of dementia patients have shown a significant increase in their use of social support, a decrease in depressive symptoms, and an increase in life satisfaction (Davis 1998). The problem with many bereavement support groups is that they have been designed to help all of the participants (Aquilera 1994), or specially grieving women (Potocky 1993), and can not take into consideration each participant's individual way to grieve.

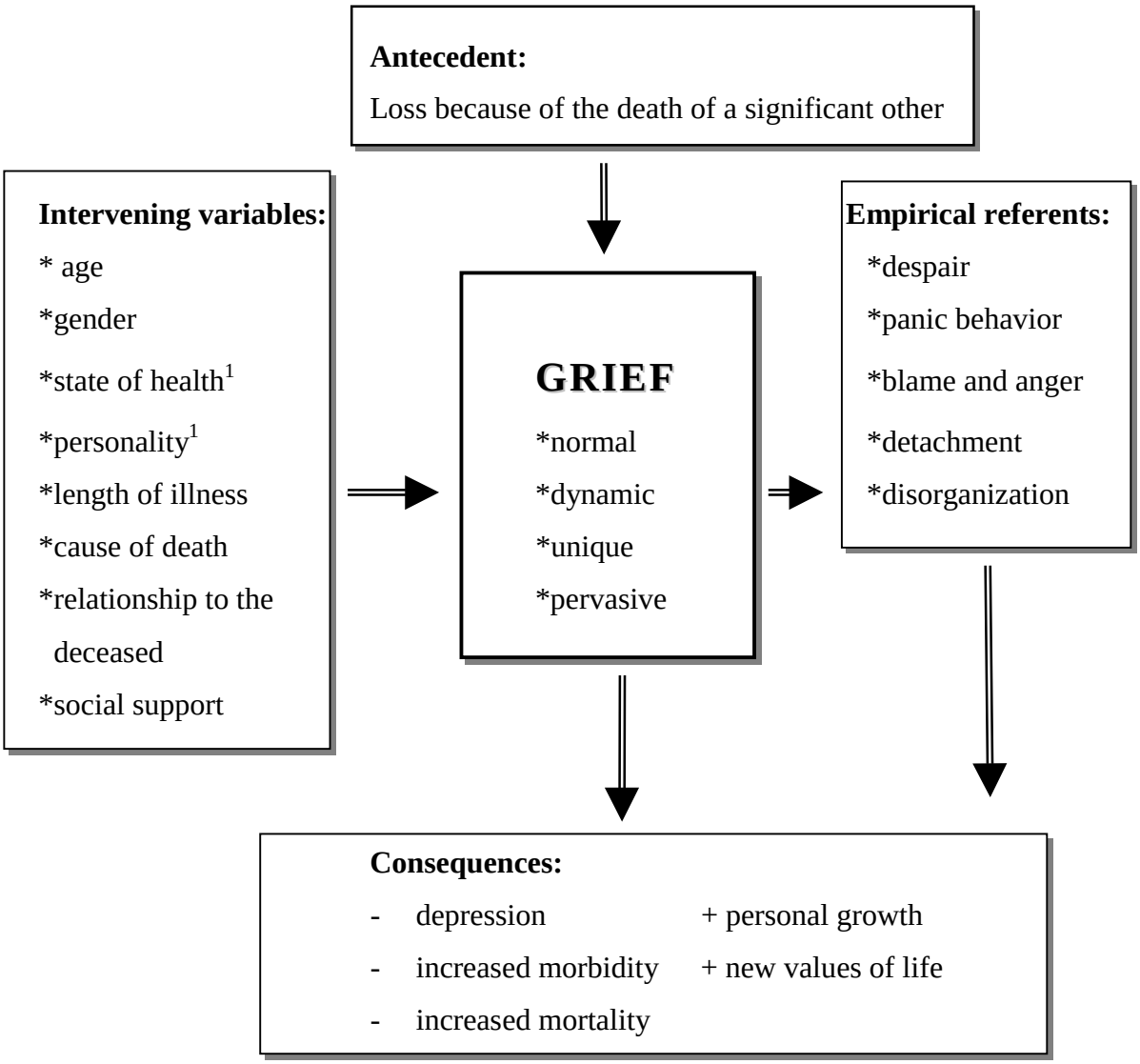
2.3 Summary of the literature

Concept of grief in this study

In this study grief is defined as a normal, dynamic, unique, multidimensional process after the death of spouse (e.g Jacob 1993; 1996; Cowles 1996; Hyrkäs et al 1997). The principal antecedent of grief is a loss in some form, in this study the loss has been defined to be the death of a significant other. The dimensions of grief are defined correspondingly to Hogan's theory (1988; 1999a) as despair, panic behavior, blame and anger, detachment, disorganization, and personal growth. Despair defines the sorrow and suffering that characterizes grief. Blame and anger is an emotional facet and panic behavior a physiological factor. Detachment describes the need to detach oneself emotionally from others during the healing process. Disorganization is a cognitive component of grief, which disrupts the bereft individual's ability to accomplish activities of daily living. Personal growth is defined as a new conceptualization of the bereavement process. (Hogan 1999b). Grief process is not characterized as a linear shift from one phase to another, as for example in Kübler-Ross (1969) indicated, but as an oscillatory process in which the bereaved can experience both positive and negative feelings and emotions simultaneously (Hogan et al 1996).

Grief is defined as a reaction to the loss, which in this study has been narrowed down to the loss of a significant other or family member. Figure 1 (page 29) presents a summary of how grief is conceptualized in this study. Grief is a normal, dynamic, pervasive, and unique process with a strong normative component. The intensity of grief reactions were measured using Hogan Grief Reactions Checklist (Hogan 1988). Study hypotheses were that gender of the grieving person and the deceased, age of the grieving person and the deceased, anticipatory grief time, cause of death, type of death, relationship between the grieving and the deceased, and perceived social support

have an impact on the grief. State of health of the participants or their temperament was not measured in this study. Possible consequences of the bereavement are increased morbidity, mortality and depression, but also personal growth and new values of life, appreciation of family, friendship and life. The importance of anticipatory grief time was recognized as a possibility for nurses to help families to prepare for the coming death by finishing unfinished business with the dying. The relationship between the nurse and the family laid the ground for the nurses' bereavement follow-up intervention.



[1] not measured in this study

Figure 1. Grief concept as understood in this study

Support intervention in this study

The support intervention in this study was a telephone program (Williams and Frangesch 1995; Jackson 1996, 1998; Tunnicliffe and Briggs 1997; Kojlak et al 1998). It was an interactive program involving information exchange between the grieving family member and the nurse from the oncology ward through a telephone call initiated by the nurse four weeks after the death of a significant other on the ward. The program was focused on meeting the needs of the grieving survivor at the time of death notification and for a period of one month after the death. The program was designed to assist participants to gain knowledge of grief reactions, available bereavement support, and the illness and death of the significant other. An additional purpose was to provide a supportive caring link with the survivor in which listening and answers to the possible questions were provided; however, the purpose was not to continue the relationship as Tunnicliffe and Bryggs (1997) described but to complete the relationship.

The objectives of the call were to (1) provide supportive environment to discuss one's feelings; (2) allow the significant others to make questions about things bothering their mind; (3) provide information about the grief experience; (4) provide information about the possible support group in the area; and (5) serve as a finishing point of the relationship between nurse and family. Figure 1 in Paper IV illustrates the idea of the supportive telephone call as a finishing point of family nursing as compared to average nursing care, where the relationship between nurse and family end at the death of the patient.

The role of nurses was to empower participants to act on their own behalf by providing information, suggesting alternatives and providing support in the acceptance of the death of a significant other and integration of new knowledge. It was emphasized that the nurses should realize their limitations, they were not counselors and they should not become overly involved with the relatives but advise of help available (see e.g Jackson 1996; Carmack 1997).

3 Aims of the study

The purpose of this study was to examine grief after the death of a family member and the impact of social support to the grief. As a means of social support in nursing a supportive bereavement intervention, that is a supportive telephone call, was developed in the university hospital. More specifically, the aims of the study were:

1) to assess the presence and intensity of grief after the death of a family member (Paper I, IV, V)
2) to compare the grief between widows and widowers (Paper I, II)
3) to assess the role of social support in grief (Paper III, IV, V)
4) to describe the impact of the supportive telephone call in grief (Paper V).

4 Methods

4.1 Methodological basis

4.1.1 Methodological assumptions of the study

The complexity of the phenomenon under study and the aims of this study guided the researcher when planning the study design. The HGRC has been developed by using qualitative grounded theory method (Hogan 1988). In this study the purpose was to test the instrument in Finnish data. The qualitative data were used as a means of validating the study. Using triangulation approach assumes that the researcher 1) values qualitative and quantitative methods equally for their ability to explain human nature and ground therapeutic nursing conditions and 2) has drawn no a priori conclusions about each method's relative contribution to the study (Foster 1997); both statements were acknowledged by the researcher. Careful comparison of quantitative and qualitative data adds support for the variables in the research; comparison also shows new dimensions about the topic and thereby contributes a more complete understanding of the topic. Researchers are able to make non-substantive suggestions such as rewording of items of quantitative instruments. (see e.g Tripp-Reimer 1985; Connelly et al 1997)

4.1.2 Triangulation

Originally triangulation has been a technical term used in surveying and navigation to describe a technique whereby two known or visible points are used to plot the location of a third point (Knafl and Breitmayer 1991). In research triangulation refers to the use of multiple methods or perspectives to collect and interpret data about some phenomenon, in order to converge on an accurate representation of reality (Denzin 1978; Mitchell 1986; Knafl and Breitmayer 1991; Dootson 1995; Begley 1996a; 1996b; Polit and Hungler 1997).

A single perspective limits the study of many phenomena important to nurse scientist because many of the topics of interest cut across the traditional disciplines (Mitchell 1986). When studying all dissertation theses in nursing science in Finland, it was noticed that during the last years the use of triangulation in those studies has become more common. Vehviläinen-Julkunen (1990) and

Munnukka (1993) were the first ones to define the use of triangulation in their studies. Vehviläinen-Julkunen (1990) used investigator triangulation as a means of guaranteeing reliability and validity of her study. Munnukka (1993) used multiple triangulation, that is investigator, data, and methodological triangulation in order to increase the validity and reliability of the study. Routasalo (1997), Koponen (1997), and Paavilainen (1997) have defined the use of methodological triangulation in their studies, whereas Tarkka (1996), Lindvall (1997) and Aalto (1997) have used data triangulation. Lepola (1997) and Taival (1998) have used both methodological and data triangulation. Several researchers have used a combination of methods (Hentinen 1984; Krause 1987; Paunonen 1989; Lindström 1992; Aavarinne 1993; Kuuppelomäki 1996a; Välimäki 1998) or a combination of data sources (Meriläinen 1986; Liukkonen 1990; Nojonen 1990; Raatikainen 1992; Åstedt-Kurki 1992; Janhonen 1992; Eriksson 1996; Kaila-Behm 1997; Pelttari 1997), but have not defined it as triangulation.

In this study the use of multiple triangulation was justified with the complexity of grief phenomenon that was the object of study. Triangulation was seen as an attempt to improve validity by combining various techniques in the study (Dootson 1995), to increase the information obtained from participants, and to provide a more holistic view of their world (also Foster 1997). It was seen as a possibility to increase the depth and quality of the results as well and to understand more fully the world of the people studied (Mitchell 1986; Begley 1996b) and to develop substantive theory through the use of multiple methodology (Hogan and DeSantis 1991). The purpose of multiple methods in a study design is to overcome the deficiencies and biases that stem from any single method (Mitchell 1986). The aim of triangulation is to achieve results in which the variance that is obtained reflects the trait being studied rather than reflecting the method being used to measure (Mitchell 1986).

Multiple triangulation in this study meant the use of data, investigator, theoretical, and methodological, but no unit of analysis triangulation (Mitchell 1986; Denzin 1989; Knafl and and Breitmayer 1991; Begley 1996a; Burns, Grove 1997). Table 3 (page 34) presents the framework of multiple triangulation in this study modified from Shih (1998). Data triangulation denoted using multiple data sources, grieving family members and nurses, all with similar focus, to obtain differing views about the grief in order to validate the findings; time, space and person (see Denzin 1989; Knafl and Breitmayer 1991) or use of a variety of sampling strategies (Boyd 1993). In investigator triangulation two researchers examined the data (see Begley 1996a). Theoretical triangulation in this study denoted the combination of theories of grief and social support as the framework for study (see Kimchi et al 1991; Begley 1996a; Bennett 1997). It was used in theory testing in order to generate a new model of grief and social support. In theory generating studies, theoretical triangulation typically occurs at the conclusion rather than at the outset of the study (Knafl and Breitmayer 1991).

Table 3. Framework for evaluating the completeness of the study using multiple triangulation (modified from Shih 1998)

Type of Triangulation	**Approach**	**Purpose/goal**
Investigator	Research team	*substantive, theoretical and methodological diversity
Data source	Family members	*represents individual's perspectives
	Nurses	*represents providers' perspectives
Theory	Experiential theory of grief	*conceptualize family grief and the role of social support in coping with grief
	Social support	
Methodology	Hogan Grief Reactions Checklist - Quantitative	*collect more in-depth data regarding family grief and coping with grief and the role of support in coping
	Open-ended questions Nurses' diaries - Qualitative	
Unit of analysis	Individual	*focus individual level of grief and coping with grief experiences
Analysis	Descriptive statistical analysis	*obtain the completeness of the phenomenon
	Content analysis	

As a means of methodological triangulation both qualitative and quantitative methods were used in the study. It occurred at the level of data collection and design to address the same research problem (Morse 1991). The triangulation occurred simultaneously between methods. (Morse 1991; Boyd 1993; Begley 1996a; Friedemann and Smith 1997). Table 4 (page 35) presents the limitations and resolutions for each type of methodological triangulation. There was no unit of analysis triangulation in this study even though it has been defined useful in studies of families, organized groups, and communities. (Knafl and Breitmayer 1991; Boyd 1993; Begley 1996a)

Triangulation process in the study progressed by conducting qualitative and quantitative research true to the paradigmatic assumptions of each method (e.g Dootson 1995). Pertinent results within each method were distinguished. Confidence in the results was examined. Next the criteria for inclusion of results in the conceptual model was defined, and the conceptual model was constructed. Integration across the methods occurs only after qualitative and quantitative results have been achieved and examined within the method. (Foster 1997)

Table 4. Limitations and Resolutions for each Type of Methodological Triangulation (Morse 1991, 122)

Approach	Type	Purpose	Limitations	Resolution
QUAL[1]+quan[2]	Simultaneous	enrich description of sample	Qualitative sample	Utilize normative data for comparison of results
QUAL→quan	Sequential	test emerging H_0; determine distribution of phenomena in population	Qualitative sample	Draw adequate random sample from same population
QUAN+qual	Simultaneous	to describe part of phenomena that cannot be quantified	Quantitative sample	Select appropriate theoretical sample from random sample
QUAN→qual	Sequential	to examine unexpected results	Quantitative sample	Select appropriate theoretical sample from random sample

[1] Qualitative

[2] Quantitative

4.2 Samples and data collection

4.2.1 Sample of the phase I of the study

The target population of the first phase of this study consisted of widowed spouses in Southern Finland. The criteria for inclusion were as follows: 1) had a spouse died more than six months but less than four years (1990's) prior to the data collection; 2) age of the deceased was 25-65

years (working age); and 3) the spouse died at the hospital. The study was carried out in one university hospital and in one district hospital.

A convenience sample of all widowed spouses meeting the criteria set out for the study was collected in 1994 (N=897). All participants were inquired their informed consent to take part in the study with a covering letter following the questionnaire. A total of 464 (52%) widowed spouses returned the questionnaire. The number of incompletely filled or totally empty forms was 146 and they were omitted from the analysis. The final sample thus consisted of 318 widowed spouses. (Papers I-III)

4.2.2 Sample of the phase II of the study

Nurse sample

All nursing staff on the oncology wards that served as the intervention group were asked to participate in the study. The total population consisted of 37 nurses and practical nurses. The number of nursing staff who made the supportive telephone calls was 26 (70%). The number of calls each nurse made varied from one to eleven. There were 94 diaries that the nurses wrote after a supportive telephone call to the grieving family. (Paper IV)

Grieving family samples

In the second phase of the study the target populations consisted of an intervention group and a control group (Paper V). The phase I study served as a pilot study for the phase II. The criteria for inclusion in the intervention group were as follows: 1) a family member died in the oncology ward; 2) named to be the closest relative in the patient records; and 3) the age of majority, and 4) ability to answer the questionnaire.

A convenience sample of all families meeting the criteria set out for the intervention group was collected during the intervention period from May 1st, 1997 to December 31st, 1998. Nurses reported a total of 128 deaths in the oncology wards during the intervention. Some of the families were excluded from the study because of the patient's short stay on the ward or because the nurses' evaluated the family member not to be competent to participate due to his or her age or illness. One family was excluded from the data collection because of their unknown address. A total of 108 families (84%) agreed to take part in the intervention. A total of 70 (65%) family members between September 1997 and April 15th, 1999 responded to the postal questionnaire.

The criteria for inclusion in the control group were as follows: 1) a family member died in the medical clinic or neuro-surgical clinic of the university hospital; 2) named to be the closest relative in the patient records; 3) the age of majority; and 4) contact address was in the patient record.

A convenience sample of the grieving families meeting the criteria set out for the control group was collected during the intervention period from May 1st, 1997 onwards to October 31st, 1998, until the number of 150 questionnaires were reached for the analysis. A total of 385 questionnaires were mailed. Altogether 162 (42%) of the questionnaires were returned. Four of them were returned because of an unknown address and three were omitted from the analysis because of missing data. The analyzed data consist of 155 family members in the control group. Figure 2 describes the sample of the whole study, missing data and in study population of each paper.

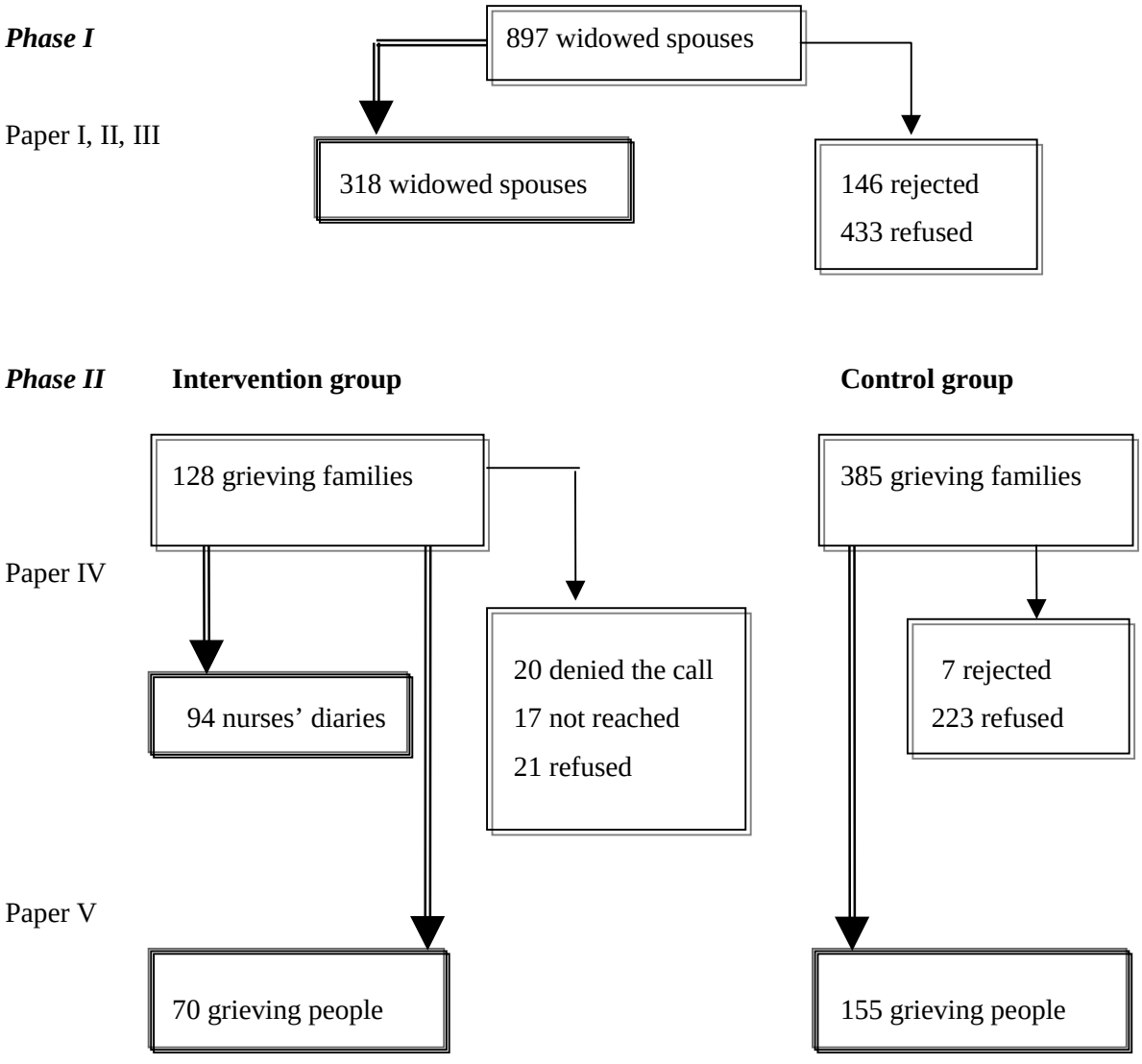


Figure 2. Study samples

4.2.3 Data collection

Phase I

The data were collected using a self-report questionnaire including structured questions and open-ended questions. The questionnaire is presented in Appendix 1. The structured questions consisted of demographic data and of the Hogan Grief Reactions Checklist (HGRC)(Hogan 1988). The open-ended questions inquired what helped and hindered the widowed spouses cope with their grief and whether there was something that the widowed spouse would like to tell or ask the deceased spouse. All widowed spouses received information about the study together with the questionnaire. The variables of the questionnaire are presented in chapter 4.3.

Phase II

The supportive telephone program was implemented by the nursing staff of oncology wards 1.5.1997-31.12.1998. Before the beginning of the intervention several seminar sessions were held on both wards to inform the staff of the purpose and format of the proposed bereavement support service. In addition, the researcher collected a "grief-study" folder for each ward with the information concerning the education and intervention. Also a telephone survey was made in each Lutheran Parish of the University Hospital Area in order to enable the nurses to give accurate information about the bereavement support in municipalities. During the research period, regular feedback meetings were held separately on each ward together with the staff, the director of nursing, and the researcher. At the time of death nurses paid special attention to the family. Family was supported in undertaking and arranging funeral and memorial rituals by giving them advice where to turn and by giving them written material for bereaved families. When it was possible the primary nurse accompanied the family, when they came to collect the body of the deceased with the funeral director. A telephone call was initiated by the nurse four weeks after the death of a significant other on the ward. The participant was named as the patient's closest family member in the hospital documents. The program was focused on meeting the needs of the grieving survivor at the time of death notification and for a period of one month after the death. The program was designed to assist participants to gain knowledge of grief reactions, available bereavement support, and the illness and death of the significant other. An additional purpose was to provide a supportive caring link with the survivor in which listening and answers to the possible questions were provided.

In the second phase of the study nurses in participant oncology wards were provided semi-structured diaries (see Appendix 2). When the patient had died the nurses filled in the background data. They were instructed to continue the diary after the supportive telephone call and describe their experience of the call.

Both family members in intervention group and control group used a self-report questionnaire. (See Appendix 1) After Phase I the Hogan Grief Reactions Checklist (Hogan 1988) was modified for the study only by revising one item (item 33) in the Finnish translation of the HGRC and correcting one misprint (item 45). One open-ended question was added for the control group inquiring how the family member would like to develop the care of the dying. The questionnaire of the intervention group included additional questions about the participant's perception of the supportive telephone call.

4.3 Instruments

The data for this study were collected during phase one by structured questionnaires, which were chosen in order to facilitate the international research project in Finland and in the United States. During phase two the structured questionnaires were modified only slightly in order to obtain comparable data. For the intervention group the researcher developed an instrument inquiring the experiences of supportive telephone call.

Grief: Hogan Grief Reactions Checklist (HGRC)(Hogan 1988) was used as an instrument to measure the intensity of grief (see Appendix 5). HGRC is a 61-item self-report instrument. Each item is rated on a five point Likert scale ranging from (0) "does not describe me", to (4) "describes me well". Some of the items were negatively worded in the HGRC and were reverse coded before the data analysis. The HGRC is scored to obtain six dimensions of grief, that are: despair (13 items), panic behavior (14 items), personal growth (11 items), blame and anger (7 items), detachment (8 items), and disorganization (8 items). The translation into Finnish of the HGRC has been made by back translation method. The internal consistency of the scale on the basis of Cronbach's alpha values in different dimensions of grief was 0.65 to 0.83 (phase I) and 0.57 to 0.85 (phase II), suggesting that the scale was reliable.

Social Support: We sought a measure of social support to test our hypothesis that a perceived lack of social support can complicate grieving. To that end, participants were asked, "What helped your coping with the loss?" and "What hindered your coping with the loss?" From these data, any mention of positive interpersonal support or contact was coded as positive support, and any mention of negative interpersonal support or contact was coded as negative support, while the absence of such references was also coded.

Unexpectedness: The anticipated grief time has an effect to coping with grief (see Hogan et al 1996). The participants were asked the amount of time they expected or anticipated the death with a structured question. The answers were recoded into two classes: unexpected death and anticipated the death at least one week.

Supportive telephone call: The scale used in the study of intervention group was developed and tested specifically for this purpose by the researchers. The scale consisted of structured questions about the participants perception of the call, including an opinion whether the intervention was worth continuing, timing of the call and content of the call (6 items).

Demographic characteristics included gender and age of the participant and the deceased, time of death, relationship to the deceased and participation in a bereavement support group. In addition the control group was inquired about the cause of the death.

Table 5 presents the list of theoretical concepts of the study, variables used to describe those concepts in each phase of the study and the level of measurement of each variable.

Table 5. Phases of the study, theoretical concepts, variables and level of measurement in the questionnaires and diaries

Phase of the study Theoretical concepts	**Variables used in the study**	**Levels of measurement**
Phase I		
Demographic variables	Gender of the survivor	Nominal scale
	Age of the survivor	Ratio scale
	Relationship to the deceased	Nominal scale
	Gender of the deceased	Nominal scale
	Age of the deceased	Ratio scale
	Date of death	Interval scale
	Cause of death	Nominal scale
	Other death experiences	Nominal scale
Social support	Existence of social support	Nominal scale
	Type of social support	Nominal scale
	Support group participation	Nominal scale
Unexpectedness	Anticipatory grief time	Interval scale
Grief experience	Despair (sum of 13 items)	Interval scale
	Panic behavior (sum of 14 items)	Interval scale
	Personal growth (sum of 10 items)	Interval scale
	Blame and anger (sum of 7 items)	Interval scale
	Detachment (sum of 8 items)	Interval scale
	Disorganization (sum of 8 items)	Interval scale
Phase II Intervention group		
Demographic variables	Gender of the survivor	Nominal scale
	Age of the survivor	Ratio scale
	Relationship to the deceased	Nominal scale
	Gender of the deceased	Nominal scale
	Age of the deceased	Ratio scale
	Date of death	Interval scale
Social support	Existence of social support	Nominal scale
	Type of social support	Nominal scale

Table 5 continues

Table 5 continues

	Support group participation (3 items)	Nominal scale
Unexpectedness	Anticipatory grief time	Interval scale
Grief experience	Despair (sum of 13 items)	Interval scale
	Panic behavior (sum of 14 items)	Interval scale
	Personal growth (sum of 11 items)	Interval scale
	Blame and anger (sum of 7 items)	Interval scale
	Detachment (sum of 8 items)	Interval scale
	Disorganization (sum of 8 items)	Interval scale
Supportive telephone call	Usefulness of the call	Nominal scale
	Knowing the calling nurse	Nominal scale
	Timing of the call	Nominal/Ratio
	Experience of the call (6 items)	Interval scale
Phase II Control group		
Demographic variables	Gender of the survivor	Nominal scale
	Age of the survivor	Ratio scale
	Relationship to the deceased	Nominal scale
	Gender of the deceased	Nominal scale
	Age of the deceased	Ratio scale
	Date of death	Interval scale
	Cause of death	Nominal scale
Social support	Existence of social support	Nominal scale
	Type of social support	Nominal scale
	Support group participation (3 items)	Nominal scale
Unexpectedness	Anticipatory grief time	Interval scale
Grief experience	Despair (sum of 13 items)	Interval scale
	Panic behavior (sum of 14 items)	Interval scale
	Personal growth (sum of 11 items)	Interval scale
	Blame and anger (sum of 7 items)	Interval scale
	Detachment (sum of 8 items)	Interval scale
	Disorganization (sum of 8 items)	Interval scale
Phase II Nurses' diaries		
Demographic variables	Gender of the survivor	Nominal scale
	Relationship to the deceased	Nominal scale
	Gender of the deceased	Nominal scale
	Age of the deceased	Ratio scale
	Date of death	Interval scale
	Patient's primary nurse	Nominal scale
	Nurse at the time of death	Nominal scale
	Caller	Nominal scale
Supportive telephone call	Date of call	Interval scale
	Length of call	Ratio scale
	Call experience	Nominal scale

4.4 Data analysis

4.4.1 Statistical analysis

The statistical analysis was carried out using SPSS/ Win 7.0 Programme (Agresti 1996; Argyrous 1997; Norušis 1997). The analysis begun by forming frequency distributions in order to identify possible coding errors and to examine the distributions of each variable (Argyrous 1997). To examine baseline differences between the intervention group and the control group for the control variables, t-test for continuous variables and chi-square test for categorical variables were used. Measurement levels of the variables (Hicks 1990; Burns and Grove 1995; Argyrous 1997) are presented in Table 5.

The associations between categorical demographic data and grief were examined by cross-tabulations and chi-square tests in order to determine whether the variables were independent. Differences between means were studied by using independent sample t-tests. The level of significance was set at ≤ .05.

Non-parametrical one sample Kolmogorov-Smirnov estimation procedure was used as a basis for the analysis of whether social support was related to coping with grief or not. Social support was studied as the grieving widowed persons perceived and expressed it. The criterion for selecting each item for further analysis was that the item was supposed to have a significant difference between the grief answers in the level of 99.9% ($p \leq .001$) in both groups of the social support variable. (Neter et al 1988; Siegel and Castellan 1988; Ranta et al 1997) (see Paper III).

Stepwise logistic regression analysis (Agresti 1996; Agresti and Finlay 1997; Norušis 1997) was made to find out the significant differences in grief reactions between the control subjects and the intervention subjects, using group as dependent variable (phase II, Paper V). The best models were selected so that adding an extra independent variable did not increase the fit of the model significantly, unlike deleting any independent variable decreased the fit significantly. The interpretation of the model was based on odds ratio (OR) and on 95 percent confidence intervals (95%CI) (Agresti 1996). The analyses were conducted firstly for dimensions of grief, and secondly for dimensions of grief and separately for each group of background variables. The groups were variables describing the survivor, variables describing the deceased, and variables describing the death. The third analysis was made by using dimensions of grief and background variables as follows: gender and age of the survivor and deceased, relationship between the survivor and deceased, anticipatory grief time and perceived social support.

HGRC (Hogan 1988) instrument's validity and reliability were assessed by means of correlation coefficients and Cronbach's alpha coefficient (Burns and Grove 1995; Polit and

Hungler 1999). Cronbach's alpha coefficients were calculated for both phases of the study (Appendix 6).

4.4.2 Content analysis

The written answers to open-ended questions in the questionnaires (phase I and phase II) as well as the nurses' diaries were analyzed using content analysis. This common method of analyzing data in qualitative research studies was chosen, because it may also be used in quantitative studies and can cope with large volumes of data. It is applicable to people's written or oral communication and can be used for example with diaries. Most commonly content analysis is used to describe the content of the message rather than its process or paralingual aspects. (Krippendorf 1984; Waltz et al 1991; Nieswiadomy 1993; Burns and Grove 1997; Polit and Hungler 1999) It involves creating categories of data and developing rules for coding data into categories (Waltz et al 1991, Dey 1993; Germain 1993; Nieswiadomy 1993; Kyngäs and Vanhanen 1999; Polit and Hungler 1999). The researcher applies consistently the specified criteria in selecting and processing the content to be analyzed (Waltz et al 1991).

Content analysis was used to describe both inductive, theory-building techniques wherein categories for describing data evolved during the analysis (Paper I, II, IV), and deductive, theory-testing techniques wherein theory-based categorical schemes were developed using Kahn's theory of social support (1979) before conducting the analysis (Paper III) (see Waltz et al 1991). However, qualitative researchers resist imposing an a priori theoretical schema on the data (Germain 1993).

Content analysis procedure in this study was that modified from Waltz and colleagues (1991). The quantification of the data was done after inferences were obtained (see e.g Krippendorf 1984; Burns and Grove 1997; Kyngäs and Vanhanen 1999). The researcher started the analysis by carefully reading the data and transcribing them to verbatim. The unit of analysis was chosen to be a theme describing for example the content of the supportive telephone call (paper IV). Next the data were organized into themes (see Table 1 in Paper IV: Example of the content analysis process of the main category). The content of data in each theme was classified as subcategories (e.g was satisfied with the patient care => good patient care). The subcategories were combined into categories (e.g satisfaction with the ward) and further into main categories (e.g family's care experience). After the analysis was completed another researcher in the field of the investigation evaluated the relevance, clarity, and completeness of the scheme. The categories were discussed until an agreement on the analysis was reached. When the data were quantified the analysis was continued by coding each theme in order to be able to combine it with the statistical data.

4.5 Ethical considerations

The study plans both in phase I and phase II were scrutinized and approved by the Ethical committees of the hospitals in question. Permission to use and to translate HGRC instrument was obtained from the author. The nature of the study and vulnerability of the study subjects caused the researcher to carefully consider the ethical issues throughout the study process (see e.g Cowles 1988; Lee 1993; Husted and Husted 1994; Parkes 1995; Ethical guidelines 1996; Paavilainen et al 1996; Vehviläinen-Julkunen 1997; Polit and Hungler 1999). It has been discussed whether questioning of relatives during grieving process for the purpose of collecting data is justified. De Raeve (1994) and James and Platzer (1999) emphasized the grieving people's vulnerability, weakness and inability to take part in decision-making. On the other hand, Parkes (1995) argues that there is an infringement of rights if people are denied the freedom of choice to take part in research. The studies of Bowlby (1980), Cowles (1988), Parkes (1995) and Robertson and colleagues (1997) encouraged this study's researcher to continue the study, since grieving family members had expressed positive comments about being able to participate. As both Holloway and Wheeler (1995) and Parkes (1995) stated, research interventions can be therapeutic, although therapy is not their purpose, so participation in this study and the possibility to express one's feelings can be a very therapeutic experience.

Family members in the intervention group were informed about the study in writing when visiting the ward after the death as well as orally by the nurses. This included a brief explanation of the study and an invitation to take part. A statement that the participant has the opportunity to ask questions and that the participation is voluntary and the participant is free to withdraw at any time was also included. Participant's privacy, anonymity and confidentiality during the study was emphasized. Family members expressed orally their informed consent. Family members, who were willing to cooperate, were telephoned by the nurse about one month after the death. It was decided that the nurses would make three attempts to call. At the beginning of the call, the family member was asked his or her willingness to discuss. The length of the call and its topics were primarily dictated by the respondent. Four months after the death the questionnaire was mailed to the family members. An information sheet was included in the questionnaire explaining the study briefly and inviting to participate. No follow-up letters were mailed, because it was considered ethically right not to pursue family members further.

Oncology nurses' participation in the intervention was voluntary. Before the beginning of the study several seminars were held in order to reinforce the nurses' capability to meet the grieving families. A folder was left on both wards containing seminar material and instructions for the call. Head nurses of the wards as well as the director of nursing supported the study. During the study meetings were held regularly to discuss the feelings and experiences of the intervention. Possibility of supervision was offered for the nurses. Diaries served as a means to

work through the situation. The anonymity of the nurses was protected by using codes when analyzing and reporting the data.

Participation in research could have stimulated powerful emotional responses for the grieving family members both during and after the data collection activities. Although there were no possibilities of therapeutic interventions, the nurses informed during the calls about available bereavement support groups and other sources of support. When reporting the study results the researcher ensured that anonymity of the participants and confidentiality were strictly honored.

Ethics of research including ethical questions concerning the researcher were considered carefully prior to the beginning of the study. Nursing education, working experience with dying patients as well as personal experiences of grief were helpful when beginning the study and during the study. Membership in the grief study group, discussions with participant nurses and colleagues at the University, as well as the researcher's diary helped the researcher if problems occurred during the study. Although strong moral grounds exist for objecting to research in the field of palliative care, but, as de Raeve 1994 stated, if the arguments are sound, it does not have to follow that no such research should take place. Using bereaved family members as the data source was necessarily required for the research purposes of this study (see Robertson et al 1997).

5 Results

5.1 Participants of the study

Phase I

The group of 318 widowed spouses participating in the study consisted of 242 (76%) widows and 76 (24%) widowers. Their age ranged from 30 to 77 years (mean = 56.3 years, SD=9.29). The youngest of the deceased was 25 years of age and the oldest 68 years (mean = 54.7 years, SD=9.07). The cause of death was natural in 158 (50%), accident in 15 (5%), suicide in 13 (4%), and something else in 131 (41%) cases. Participants explained natural causes of death including deaths after long illness. Something else they explained to be sudden deaths for example due to cardiac arrest or stroke. Most of the spouses died at hospital (n=271, 85%). One third of the deaths came as a surprise for the spouse (n=101, 32%), while every fifth of the widowed spouses had known more than six months about the possibility of the death (n=72, 23%). A total of 53 (17%) of the widowed spouses had participated in a bereavement support group. Nine of each ten support groups (n=50, 91%) were organized by the parish. Most often the support group was attended one to three times (n=29, 55%) or four to seven times (n=12, 23%). Characteristics of the study participants are presented in Table 6.

The total number of the bereaved spouses, who met the study criteria, was 897, altogether 69% of whom were female and 31% male. The mean age of the deceased spouses was 54.8, ranging from 25 years to 70 years. When the total sample was compared with the study population, widowers were underrepresented in the sample (31% vs. 24%). The distribution of mean ages of the deceased spouses was equal (54.8 years vs. 54.7 years).

Phase II

The intervention group consisted of the surviving family members on the oncology wards. During the time of the study (deaths between 1.5.1997-31.12.1998) nurses reported a total of 128 deaths on the oncology wards, 58% of the deceased were male. The majority of family members were female (n=80, 63%)**.** Altogether 16% (n=20) of the families did not participate in the study, either because the family denied their participation or the family did not meet the criteria of participation. The response rate of the questionnaire was 65%. The 70 family members of the intervention group, who returned the questionnaire, consisted of 50 (71%) women and 19 (27%) men (see Table 6). The background data were missing from one

questionnaire. The age of the participants ranged from 26 years to 86 years (mean = 57.3 years, SD=13.44). Mean age of the deceased was 62.3 years, ranging from 22 years to 86 years. When comparing the age of all the deceased and the participants, t-test of the mean age of the deceased and chi square- test of the gender of the deceased or family member failed to reveal any statistically significant differences between the groups.

The control group was defined to be the surviving family members in other in-patient wards of the same university hospital. The wards were chosen to be those where cancer patients were also cared for, such as neuro-surgical and medical wards. The control data collection started May 1st, 1997 and it was continued until 150 participants were reached (deaths between 1.5.1997 – 31.10.1998). The number of mailed questionnaires was 385. A total of seven questionnaires were omitted from analysis because they were returned empty due to an incorrect address. The analyzed data consisted of the answers of 155 study subjects, indicating a response rate of 41%. Altogether, 28% (n=43) of the participants were male and 72% (n=112) female (see Table 6). Their age ranged from 32 to 78 years (mean = 58.7, SD=12.8). The mean age of the deceased in control group was 68.9 years (range 17 to 95 years).

The significant others (N=385) consisted of 134 (35%) male and 251 (65%) female survivors. Altogether 215 (56%) of the deceased were male. The mean age of the significant others was 59.4 years ranging from 26 to 87 years with a standard deviation of 12.8. The largest groups of survivors were spouses 216 (56%) or children 130 (34%). The age of the deceased ranged from 17 to 98 years (mean = 69.6; SD=14.4). When comparing the total control group with the participant control group survivors, both t-tests of the mean age of the survivors and the deceased failed to reveal a significant difference. Neither were there statistically significant gender differences in comparison of the chi-square–tests between the gender of the participant or non-participant survivors or between the gender of the deceased in participant or non-participant groups. A total of 56% (n=216) of the deceased were spouses in the control group, when the proportion was 52% (n=81) in the participant group, however this difference was not statistically significant.

During the study period (1.5.1997-31.12.1998) 26 nurses and practical nurses, which wrote diaries about the intervention, made supportive telephone calls to 92 families. The number of calls each participant nurse made varied from one to eleven. In 54 cases the caller was the patient's primary nurse, 11 of whom were present at the time of death. In 20 cases the caller was another nurse who was at present when the patient died. Altogether 19 of the callers were nurses who were neither the primary nurse nor present at the time of death, but had been responsible for the care of the patient. On average the call lasted for 19.5 minutes (Range 3-45 min). Nurses described 95% of the calls as positive.

Table 6. Characteristics of the participants of the study (N=543)

	Phase I		Intervention group		Control group	
Variable	**n**	**%**	**n**	**%**	**n**	**%**
Gender						
* male	76	24	19	27	43	28
* female	242	76	50	71	112	72
Relation to the deceased						
* spouse	318	100	49	71	83	54
* child			10	15	61	40
* parent			2	3	7	5
* other			7	10	4	3
Gender of the deceased						
* male	242	76	43	61	84	54
* female	76	24	26	37	71	46
Cause of death						
* natural causes	158	50			93	60
* accident	15	5			9	6
* suicide	13	4			1	1
* illness	131	41	70	100	51	33
Amount of notice of the coming death						
* sudden death	101	32	7	10	32	21
* few hours	41	13	11	16	43	28
* week	21	7	11	16	35	23
* few weeks	38	12	11	16	16	10
* few months	40	13	14	20	7	5
* more than six months	72	23	15	21	21	14
Participation in a bereavement support group						
* yes	53	17	4	6	12	8
* no	265	83	64	91	141	91

	Mean	Range	Mean	Range	Mean	Range
Age of the participant	56.3	30-77	57.3	26-86	58.6	32-78
Age of the deceased	54.7	25-68	62.3	22-86	68.9	17-95

5.2 Grief after the death of the significant other

5.2.1 Assessment of grief by Hogan Grief Reactions Checklist

Grief of the family member was investigated using HGRC both during study phase I and phase II. Frequency and percentage distributions of each separate item are presented in Appendix 7. When the intensity of grief was analyzed by the time from the death (Paper I), the results indicated that despair and disorganization diminished significantly over time. Widows indicated higher intensity in despair, panic behavior, personal growth, blame and anger, and detachment, although the difference was statistically significant only in panic behavior (Paper II). When the time from death was more than eight months but less than two years there were no significant differences in grief reactions between widows and widowers. But when the time from death exceeded two years, the widowers displayed blame and anger more strongly than widows. Widowers perceived themselves less disorganized than the widows. Mean values of grief dimensions in different time points suggested that grief was most intense eight months to two years after the death. Personal growth was expressed most over two years after the death indicating coping with death. Low values in the dimension of blame and anger were anticipated because the cause of death was mainly illness and natural causes. The mean values of dimensions of grief are presented in Table 7.

Table 7. Intensity of grief 4 months (n=225), from 8 months to 2 years (n=84) and over 2 years (n=228) after the death of a significant other

	Time from death					
	4 months after death		8 months to 2 years		Over 2 years after death	
Grief dimension	Mean	SD	Mean	SD	Mean	SD
Despair	1.40	.72	1.52	.67	1.35	.66
Panic behavior	1.24	.66	1.36	.63	1.32	.73
Personal growth	1.96	.57	1.99	.54	2.03	.57
Blame and anger	.84	.39	.81	.48	.81	.49
Detachment	1.21	.61	1.36	.60	1.25	.68
Disorganization	1.38	.72	1.50	.56	1.44	.74

Graphical presentation of percentage distribution of dimensions of grief for the phase I and phase II separately for intervention and control group are presented in Appendix 8. There are no major differences between the study groups or between the dimensions of grief in shapes of the curves. The presentations reveal that in other dimensions of grief than personal growth the majority of the participants' answers belong to the level "not quite describes me". In all groups more than half of the participants' answered personal growth "fairly well" as describing them. The percentage is highest in phase I participants and in addition one fifth of them describe personal growth as describing their grief "well". Blame and anger is perceived as describing participants' grief the least, about one in five participants in each group answered the dimension as not describing their grief at all.

5.2.2 Family member's expressions of grief and coping with grief

Family members described their grief in their answers to the following open-ended questions "What helped your coping with grief?" and "What hindered your coping with grief?". These descriptions were analyzed using content analysis and the results are presented in Paper II. After the death of their spouse widows worried most about how to survive, about things concerning illness and death, and about their loneliness. Widows' worry of surviving included taking care of daily tasks and decision-making and almost equally economic survival. Things concerning illness and death included suddenness of the husband's death, illness and agony during the illness, foreverness of the loss, and incomprehensibility of the death. Loneliness was described by being left alone, avoidance of friends and emptiness of the home. Widows described their grief as follows:

> "And then came the worry, how do I manage to take care of everything alone, especially economically"
>
> "My husband's fight against cancer was a difficult and hard experience that lasted about one year."
>
> "Loneliness, emptiness. Our friends disappeared."

Widowers' grief focused on survival, loneliness, and the loss of a long life together. When worrying about their survival, widowers found taking care of different tasks alone to be the most difficult thing, worrying about economics was not as important for them as it was for widows. Feeling that they were left alone was an important part of widowers' grief. Loss of long life together was described by one widower as follows:

> "Our marriage lasted for over 40 years without any major disagreements – the familiar habits of our life disappeared. All our future plans for retirement are gone. I am lonely."

Widowed spouses indicated that support from other people was the most important way of surviving. Families and friends were found to be the most important source of support. The role of social support in grief is described more detailed in Chapter 5.3. Work was an important strategy to cope, structuring the day, taking the thoughts from the loss, and giving the

possibility to meet colleagues. Grieving spouses turned to religion, they read the Bible, prayed, participated in church activities, and discussed with ministers or other church workers.

5.3 The role of social support in grief

5.3.1 Helpful social support after the death of a spouse

The role of social support in grief was investigated using participants' answers to open-ended questions (Paper II and Paper III). Seeking and getting support from other people was the most important way of surviving. Widowed spouses described an average of 1.8 relationships per each respondent. Only less than one in six widowed spouses did not have a supportive social network. The most important support persons were close family members and friends. Extended family and relatives were mentioned less often. Only one of each ten widowed spouses (n=31) described professionals, such as nurses, doctors or ministers, as helpful in their coping. Functional content of the support was aid (n=100), that is time, concrete help, or the fact that one is needed. Affect (n=97) included ability to express oneself, empathy, sense of duty to others, sense of love and respect, and feeling of continuity of life. Affirmation was described less frequently (n=64). Social support was not only receiving support, but also being the one who supported others, or experiencing the true reciprocal support. People who joined bereavement support groups did not differ significantly as to their perceived social support when compared to those who did not join a group.

5.3.2 Social support network and its relation to grief reactions

Relationship between the existence of social support and the grief was studied (Paper III). A statistically significant difference was found only in the dimension of disorganization (χ^2=11.0, df=2, p= .004). Those without a supportive social network were less disorganized. Widowed spouses with a supportive network had the possibility to grieve, while those without it, had to cope alone and 45.5% of them belonged to the lower quartile in disorganization. The study results suggest the same with regard to the dimension of panic behavior. If a person had a supportive social network when grieving, he or she was not required to operate rationally, but had the possibility to grieve. Those who did not have social support had to continue their normal duties, they could not allow themselves panic although they felt they were functioning like zombies. They avoided tenderness and had feelings of revenge and desire to harm others.

5.4 Impact of support intervention on grief

5.4.1 Nurses' experience of the supportive telephone call

Oncology ward nurses' perspectives of the supportive telephone call after the death of a significant other was studied (Paper IV). Almost all nurses perceived the call positively (95%). Analysis of the diaries revealed nurses' description of a family member's grief and the description of supportive telephone call after the death of a family member. Nurses expressed the multidimensionality and uniqueness of the grief when describing the family member's grief and coping with grief. Descriptions of mourning revealed the importance of funeral and memorial service to a grieving Finnish family. From the viewpoint of nurses the supportive telephone call as a finishing point of family nursing served as a means of evaluation of the nursing process of each patient and family. During the call nurses received feedback from the family about the patient care. They were able to evaluate the family member's coping and support him or her to seek help when needed. Families perceived the continuity of the nursing relationship after the death confirming the individuality of the deceased family member's care until the death.

5.4.2 Family members' experience of the supportive telephone call

Family members' experiences of the supportive telephone call were described in Paper V. Family members' experience of the supportive call was mainly positive (89%). The call was perceived positive, because it offered a possibility to discuss the death, the deceased or the grief. The family member received answers to his or her questions. He or she perceived the call as emotional support or informational social support. Negative experiences included disappointment when the call was never received and length of the call was short or timing of the call soon after the death.

A total of 98% of the family members in the intervention group supported the continuation of the call, although only 53% of them knew the nurse who called. Most of the participants (93%) found the timing of the call, one month after the death, suitable, however the opinion of the best possible timing ranged from "immediately after the death" to eight weeks after the death. The frequency and percentage distribution of the perception of the call is presented in Table 8. The nurse's call was recognized to have an impact on how the family members perceived the death in 72 percent of the answers. The possibility to talk was perceived quite

much or very much helpful by 80 percent of the family members, nurses expertise and support and the topics of the discussion were helpful for two thirds of the survivors.

5.4.3 Impact of supportive telephone call on grief (HGRC)

Family members in both intervention group and control group grieved over their family member's death. According to t-tests of the HGRC (Hogan 1988), the results indicated significantly higher ($p<0.05$) mean values of grief in intervention group in despair, detachment and disorganization, whereas personal growth was higher in control group. Stepwise logistic regression analysis revealed, when only the grief dimensions were included in the analysis, a model where the group had an association with despair. Dimensions of grief and background

Table 8. Frequency and percentage distribution of the participant family member's perception of the supportive telephone call (N=70)

	Perception of the supportive call											
	Did not help		Uncertain		Helped a little		Helped quite much		Helped very much		Total	
Variable	f	%	f	%	f	%	f	%	f	%	f	%
Perception of the call	-	-	3	6	18	33	18	33	15	28	54	100
Knowledge of grief experiences	4	8	10	21	15	31	16	33	3	6	48	100
Nurse's knowledge and support	-	-	2	4	15	29	18	35	17	33	52	100
Possibility to talk about the deceased	1	2	1	2	8	16	20	39	21	41	51	100
Topics of the telephone discussion	-	-	4	8	14	28	18	36	14	28	50	100
Call had an impact on my experience of the death	6	12	8	16	13	27	16	33	6	12	49	100

variables were included in the final analysis (see Paper V). This analysis revealed a model where personal growth was the most important factor related to the use of this method (OR 2.23; 95%CI 1.04-4.77). Anticipatory grief, age of the deceased and perceived negative social support emerged also as significant in the model.

5.5 Summary of the results

All survivors (n=543) indicated that they were grieving over the death of their family member. Grief did not have an endpoint, although time passing the intensity of the grief diminished. Study results suggest that gender of the grieving person had a relationship to the grief.

The results showed that Finnish widowed persons receive social support most often from their own family and friends. They perceive most helpful the support that they receive but also the support that they can give to other grieving family members. Social support was related to coping with grief, that is, those survivors who did have social support were able to grieve by expressing their feelings and forgetting the demands of normal life, whereas those without support had to continue their duties even when they felt they were functioning like zombies.

The impact of the supportive telephone call on grief was perceived positively by both surviving family members (89%) and the nurses (95%). Survivors described their positive experience of the call as satisfaction, perceived social support, possibility for discussion and answers to questions, mutuality of the experience, caring for the family member, respect for the deceased, and characteristics of the nurse. In the dimensions of grief despair was found to be more intense in intervention group indicating the impact of the supportive telephone call in alleviating the grief. Nurses indicated the call positive because they were able to get feedback from patient care and to evaluate their work and finish the relationship with patient and patient's family.

Supportive telephone call model

These study findings suggest, that the supportive telephone call after the death of a family member is a suitable intervention for nursing after the death of a patient. Theoretical model of grief that guided this research (Figure 1, page 29) and assumptions of grief intervention (see Paper IV, V) were supported partly. Figure 3 presents a summary of the study results indicating the impact of positively perceived social support on grief after the death of a family member. The results of the study suggest that social support perceived negatively has a negative impact on grief. The goal of this intervention is to have a positive impact on family member's grief and coping with grief.

The prerequisite for successful action is support from nursing management. Nurses' participation in the intervention should be based of voluntarity, but their commitment is also important. Before beginning the intervention, seminars discussing the topic of grief and grief intervention are needed. A possibility for discussion or supervision before beginning and during the implementation of the intervention is suggested. The study results indicated that the model of the call in this study was satisfactory. Timing four weeks after the death was found to be suitable. Length of the call varied from few minutes to 45 minutes, but it was emphasized that the family member made the decision concerning the length of the discussion as well as the topics of the discussion. During the study family members were informed about the telephone call both orally and by using a covering letter. It is important to give the information concerning the intervention as well as other important information in writing, because the study results indicated that some family members forgot what had been said.

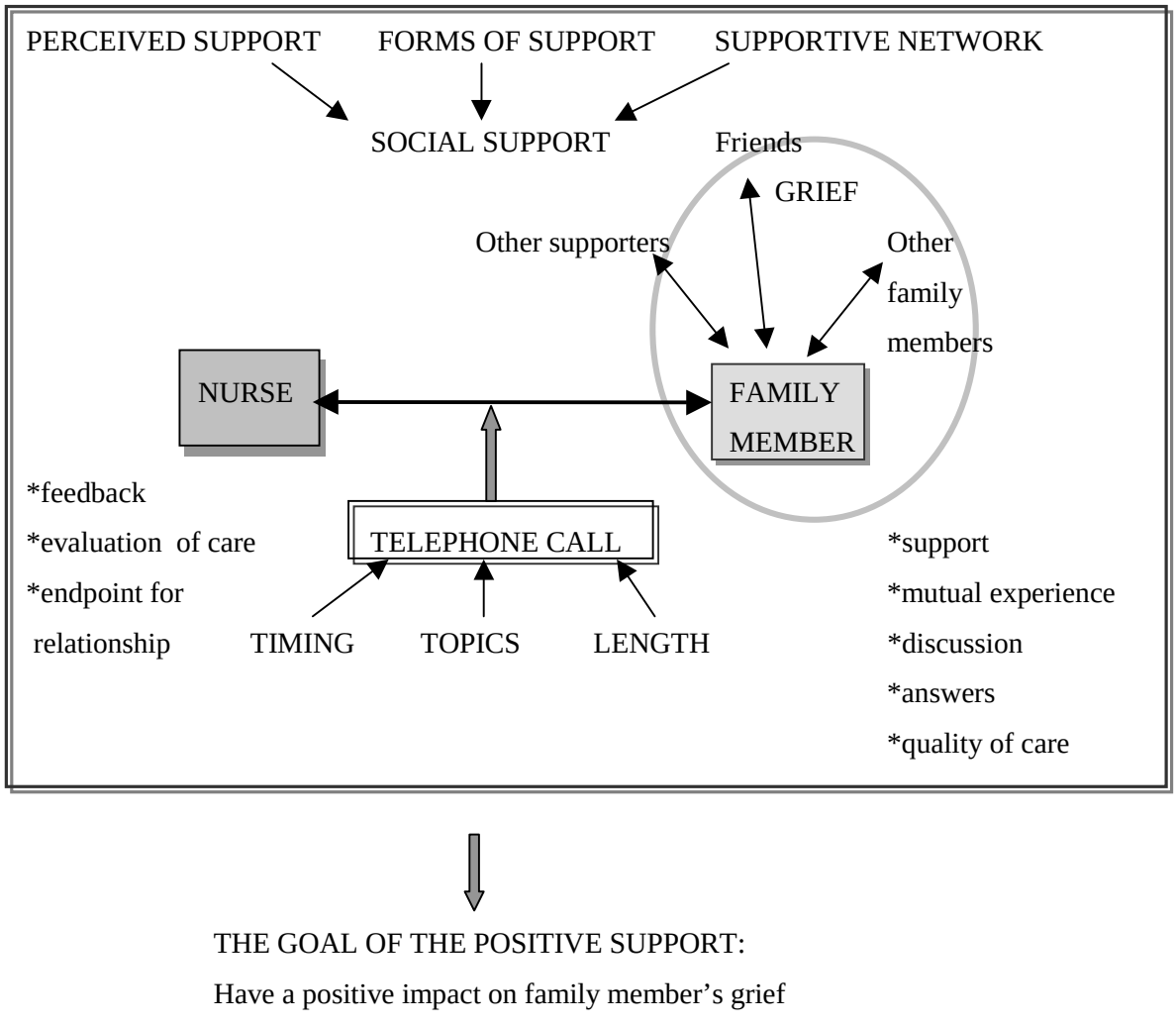


Figure 3. Nursing support for a family in grief

6 Discussion

6.1 Validity and reliability of the study

The complexity of the phenomenon under investigation was the basis for using triangulation in this study (Patton 1990). The aims of this study as well as the study being part of a large research project led the researcher to use the combination of both quantitative and qualitative research methods and that of data collection method. Validity and reliability of this study have been discussed separately for quantitative and qualitative study parts.

Validity and reliability of *quantitative research* concern those of the instruments used, sampling and data. The basic attributes which have been used in this study to assure that the research instruments will provide dependable measurements of the variables under investigation are validity, reliability, and usability (Dempsey and Dempsey 1992). The HGRC instrument has been developed from empirical data using grounded theory method (Hogan 1988; 1996). Since the instrument has been developed in the United States, its suitability to Finnish culture can be questioned. One of the purposes of this study was to test and develop the Finnish version of the HGRC. Careful back-translation of the instrument guaranteed against the loss of the original meaning of the items. After the phase I of the study minor corrections were made in the HGRC, which were: the missing item of personal growth was added to the HGRC and the Finnish translation of the item "Function like a zombie" was changed (see Appendix 1).

In this study the internal consistency of the instrument, as measured by Cronbach's alpha, varied in phase I from 0.65 to 0.83 and in phase II from 0.57 to 0.85, which can be considered good (Burns and Grove 1995; Peirce 1995)(Appendix 6). It was anticipated that the Cronbach's alpha values would be lower in the dimension of blame and anger, because it is a typical grief reaction for those who have survived a homicide or suicide (Hogan 1999b), and this study population consisted of deaths caused by illness or natural causes. The analysis revealed that reverse coded items lowered the internal consistency of some dimensions of grief to under 0.70, which has been used as a standard for reliable instrument (Peirce 1995). Because unpublished findings of the National Family Bereavement Study are consistent with these study findings, there are plans to change the wording of those items (Hogan 1999c).

Usability refers to the practical aspects while using the instrument. The HGRC (Hogan 1988) is a 61-item Likert scale instrument, which was not found too difficult to complete, when considering the small number of questionnaires returned empty during phase II. Technically the text could be larger in size, because some older participants indicated having difficulties to

follow the line of answer possibilities of the items. Their answers may have skipped to a wrong line. The instrument was perceived so well by the participants that the researcher suggests that it could be used as a tool for recognizing grief reactions in bereavement support groups, although some changes are recommendable in the Finnish wording of some items.

In this study total sampling was used. Response rate for the questionnaire was 52% in phase I, 65% in phase II intervention group and 42% in control group, which can be regarded as good when considering the data collection with postal questionnaires and the study topic (Stroebe and Stroebe 1993; Polit and Hungler 1999). The possibility of sample bias was studied by comparing the total sample with the participants separately in phase I and phase II intervention and control groups. Comparison revealed that the only significant difference was in phase I study, where the percentage of widowers in missing data was larger than expected.

External validity refers to the generalizability of the research findings to other settings or samples (Hicks 1990; Dempsey and Dempsey 1992). From a very narrow perspective one cannot really generalize the sample on which the study has been done, any other sample is likely to be different in some way (Burns and Grove 1995; Polit and Hungler 1999). The limited generalizability of these study findings is acknowledged due to the complex nature of the grief phenomenon and the relatively small sample of the intervention group. Internal validity is defined to refer to the extent to which it is possible to make an inference that the independent variable is truly influencing the dependent variable and that the relationship is not spurious (Polit and Hungler 1999). The intervention and control group design was used to control the threat to external events affecting the dependent variables of interest. It was not possible to control selection bias by using random selection of data, but in the beginning of the data analysis in phase II the chi square- and t-tests were made to compare the background variables of the data. No significant difference was found between the groups in gender of neither the participants nor the deceased. The mean age of the participants did not differ between the groups, but within the control group the mean age of the participants was significantly higher than the mean age of the total sample ($t=-3.19$, $p=.002$). In the intervention group the surviving spouses were overrepresented, when comparison was made between participants and non-participants.

Maturation did not cause bias in phase II, where all participants were mailed the questionnaires four months after the death of the family member. It may explain some of the missing data in phase I. Testing or instrumentation biases were not applicable in this study, because the participants completed the questionnaire only once and the same instrument was used in both phase I and phase II. During phase II subject mortality was not a real threat since the length of time between the death and data collection was only four months. (Burns and Grove 1995)

Reliability in *qualitative research* has two specific concerns: firstly that the information gathered from the informants is accurate, and secondly, reliability of the data collector (Dempsey and Dempsey 1992). In order to gather accurate information the informants of this study were either grieving significant others (Paper II, III, V) or nurses, who participated in the intervention (Paper IV). Self-report measurements were used to gather the data, surviving family members answered the open-ended questions and nurses wrote their diaries. The study attempted to reach all of those people in a certain area that filled the criteria. The researcher's genuine attempt was to establish a sense of trust both between the researcher and the participating nurses and between the researcher and the grieving family members, the importance of which has been emphasized (Lee 1993). It was also remarkable that after every telephone call nurses made notes in their diaries.

The researcher acknowledged that participation in a study with a sensitive topic could stimulate powerful emotional responses during the study process (Cowles 1988; Paavilainen and colleagues 1996). The information letter included the researcher's contact information to give the participants the possibility to call the researcher. Intervention group also received information about their local bereavement support groups and sometimes nurses encouraged them to contact their family doctor. Regular feedback conversations were held in the intervention wards. During the conversations, nurses revealed some negative experiences of the calls and the researcher got the impression that those calls still bothered them more than the diaries indicated. This might indicate that nurses have not described their own negative experiences of the call, but it might also indicate that after discussion with their colleagues and the researcher those negative experiences were not perceived as negative any more.

Strauss and Corbin (1990) stated that a qualitative study could be evaluated accurately only if its procedures are sufficiently explicit so that readers of the resulting publication can assess their appropriateness. *Content analysis* process has been described in Chapter 4.4.2 and in Paper IV, table 1. Both unitizing reliability, which means consistency in identifying the units to be categorized, and interpretive reliability, which means consistency in assigning units to categories, are important in content analysis (Waltz et al 1991). Using intrarater technique assessed stability reliability and reproductibility was assessed by interrater technique, which required clear delineation of the units to be categorized and the rules for assigning them to categories. The content categories of the open-ended answers were constructed as they emerged from the data (Paper II, IV). A priori framework of social support by Kahn (1979) and Kahn and Antonucci (1980) was used (Paper III, V) as a means to organize the data in order to put the data into a more usable form (Patton 1990; Sandelowski 1995). Krippendorf (1980) and Waltz and colleagues (1991) distinguished a set of criteria for validating content analysis. The data-related validity assesses how well the data analysis method represents the information inherent in or associated with available data, and is divided into semantical and sampling

validity. Semantical validity assesses the degree to which a method is sensitive to the symbolic meanings that are relevant within the given context. Kahn's theory was well suited for this study's analysis. The researchers were able to include all statements in classes in accordance with the theory. An attempt was made to achieve correspondence between data language and the language of the participants and it was clarified by using data examples in text (Paper II, IV, V, thesis). Sampling validity that assesses the degree to which available data constitute an unbiased sample for a universe of interest, was attempted by using total samples both in phase I as well as in phase II, which meant large study samples for content analysis. Pragmatical or product-oriented validity assesses how well a method works under a variety of circumstances, which in this study meant choosing content analysis due to the possibility of using both inductive and deductive analysis. Correlational validity is the degree to which findings obtained by one method correlate with findings obtained by another, which in this study was pursued by using multiple triangulation. The limitation of this study is the shortness of comparison of the qualitative and quantitative study results, which needs to be done in future analysis. Predictive validity is the degree to which predictions obtained by one method agree with directly observed facts. Process-oriented or construct validity assesses the degree to which an analytical procedure models, mimics, or functionally represents relations in the context of the data and was attempted by using discussions after independent content analysis done by two researchers. Nursing education and working experience with dying patients has added to the researcher's understanding of grief and the validity of the study.

6.2 Interpretation of the findings

1. All participants grieved the death of their family member. Grief reactions showed gradual improvement over time supporting the findings of Lund and colleagues (1993), Grimby (1995) and Hogan and colleagues (1996). However, there could not be seen an end in the grief reactions, although the time from death ranged from four months to four years. These findings are consistent with the suggestions of several previous researchers, such as Martin and Elder (1993), Hogan and colleagues (1996) and Klass and colleagues (1996), that there is no endpoint in grief**.** Study participants indicated that during the early bereavement preoccupation with thoughts of the lost person were combined often with the sense of his or her actual presence as well as vivid dreams of the person still alive and well, which was reported in earlier studies of Bowlby (1980) and Grimby (1995). It appears that all grieving family members recognized change because of their grief. The intensity of personal growth dimensions was highest when comparing different dimensions of grief. Participant described their personal growth already four months after the death. These study findings supported Hogan’s (1999b) results indicating

that in order to be able to have personal growth, a person must have felt despair. The results indicated that despair and disorganization described negative grief reactions most intensively. Several variables contributed to the grief experience. Anticipatory grief, age of the deceased, perceived negative support were variables describing personal growth in logistic regression model as well as gender of the grieving person and time from death or social support. These findings were congruent with the theoretical framework of the study and with past research (Cowles and Rodgers 1991a; 1991b; Jacob 1993). However, more research is needed to investigate the phenomena, because of the complexity and individualized nature of grief.

2. Grieving widows in this study reported their grief stronger than widowers in the HGRC supporting the earlier findings of Farberow and others (1992), Gallagher-Thompson and others (1993) or Shuchter and Zisook (1993). When the time from death of a spouse (phase I) was less than two years, no significant differences between the gender of the widowed spouse was found, but when the time exceeded two years widowers were less disorganized than widows, but felt more blame and anger than widows. Widows' worry of survival included taking care of daily tasks, decision-making without spouse's support, and worry of family's economic situation. Widowers were worried about their ability to maintain housekeeping. Widowers described their loneliness more often than widows, which result may reflect the lack of bereavement support for men and poor preparation of friends to provide needed support for a grieving widower, as Hansson and others (1993) have suggested.

3. After the death of a spouse both widows and widowers described seeking and getting support from other people to be the most important way of surviving. Only less than one in six widowed spouses in phase I did not have a supportive social network. Widowed spouses found their families and friends to be the most important source of support. This finding is consistent with earlier findings that the family recovery process mostly takes place through dialogue between the family members (Väisänen 1996) or that grieving persons grew closer to their own families (Anderson and Dimond 1995), but it is inconsistent with Lopata's (1993) findings about the role of grandchildren or friends as emotional support. Functional content of the social support was as often aid and affect and a little less often affirmation. These results agree with the earlier study findings of Hogan and DeSantis (1996) or Väisänen (1996), that being present, comforting and listening are the most important ways of support from family and friends.

Social support after the death of a spouse was found helpful when the grieving spouse received support, which was an expected finding, but in addition to that, supporting others as well as both receiving and giving support was also found helpful. The study results suggest that one aspect in adjusting to grief is the need to feel to be needed and have a meaning in life. Anderson and Dimond (1995) described widowed people keeping themselves busy as one of the coping strategies. It may also suggest a cultural aspect that the Finnish culture encourages

grieving persons not to detach from others and concentrate on one's own grief, but also to support other grieving family members.

Social support was related to coping with grief: those survivors who did receive social support were able to grieve by expressing their feelings and forgetting the demands of normal life, whereas those without support had to continue their duties even when they felt they were functioning like zombies. These findings are consistent with the earlier findings of Hogan and DeSantis (1994), Duke (1998), and Robinson and McKenna (1998) that social support makes overwhelming experiences tolerable.

4. Findings of this study are consistent with the suggestions of previous research, such as Williams and Frangesch (1995), Jackson (1996; 1998) and Warren (1997), that a supportive telephone call after the death of a family member is a suitable intervention for nursing after the death of a patient. In the intervention group the response rate was significantly higher than in phase I or in control group. It is also remarkable that in the intervention group men participated more actively than in other groups. This result suggests that men are left alone in their grief and need individual support in their grief. For grieving women participation in a bereavement support group is easier than for grieving men. (see Harmanen 1997). The small number of bereavement support group participants indicates the importance of individual support in grief. Harmanen (1997) stated in her study that only four percent of the bereaved family members participate in a bereavement support group organized by the parish. Three fourth of the participants had lost a family member during the previous six months. In our study the percentages were 17 (phase I), 6 (phase II intervention group) and 8 (phase II control group). The result that people who joined bereavement support groups (in phase I) did not differ significantly as to their perceived social support when compared to those who did not join a group confirmed that of Levy and Derby (1992).

Grieving family members indicated their satisfaction of the call. Despite that, the results showed significantly higher mean values in the intervention group in despair, detachment and disorganization but in personal growth the value was higher in the control group. This may be an indication of the successful impact of the telephone call on alleviating grief. Results may suggest that since family members knew about the call and while they anticipated it was coming they spent time thinking about the questions and what to talk with the nurse. The intervention facilitated their grief. Grief was not delayed, which may lead to a conclusion that those grieving family members also were able to adjust to the situation and begin to see the future sooner, agreeing with Robertson and others (1997).

6.3 Nursing implications

Nurses are often left to deal with the patients' and the families' grief and anger and therefore it is critical that they are conversant with the contemporary parallel issues of death and dying and health and healing (O'Gorman 1998). Nurses' need of specific education about bereavement assessment is recognized (Walshe 1997; Mikkola-Salo et al 1998). These study results add to the knowledge of the area of nursing education in which both nursing students (Mölsä 1992; Solantie and Leino-Kilpi 1998; Karttunen 1999) and nurses (Solantie and Leino-Kilpi 1998; Mäkinen et al 1999) indicated lack of sufficient theoretical knowledge and interactional skills.

Attention should be paid to the whole family during the grief process, which starts when the family is informed of a family member's terminal illness. Even though the social support from the professionals was found helpful only in ten percent of phase I findings (Paper III), it was remarkable that its importance was expressed before and immediately after the death of a spouse, thus supporting the results of Mikkola-Salo and others (1998) or Denham (1999). The support may have been only a few words, a gentle gesture, or giving some time, but the grieving spouses remembered it. After the death of a family member, the family should be given time and met humanely. Nurses should pay attention to the differences in the grief reactions of widows and widowers when meeting the grieving family members. Already during the terminal illness of the spouse the importance of family and friends as a source of support for the grieving person should be recognized. Widows need more emotional support and affirmation that they can manage themselves, whereas widowers need either advice as to where to get help or concrete help on how to manage daily housework. Both needed support in reducing their loneliness, which they were worried about (Paper II). Study results support keeping contact with the family, for example by telephone, thus showing nurses' willingness to support the family.

The supportive telephone call intervention is an alternative and additional form of family support. Its advantage is that it can be included in regular nursing care, it does not need a new organization or meeting place, most of the family members can be reached by phone, and it does not require transportation. There is a possibility for application also in other care contexts, for example in public health care. The study results demonstrated that nurses need to recognize the importance of keeping their promises to families. Participant family members very clearly expressed their disappointment when they did not receive the call although it had been agreed upon.

6.4 Research implications

Grief after the death of a family member is a complex phenomenon that needs further research. A longitudinal study would be needed to confirm these results and also to permit greater generalization about the intensity of grief after the death of a family member. It would be an interesting challenge to extend this quasi-experimental study to a longitudinal one and continue data collection two or three years after the death of a family member. The study results suggest that the supportive call was perceived as very important also by family members of those deceased whose hospitalization was very short (Paper V). It would be interesting to study the impact of this kind of supportive intervention after a sudden death, when there is no debriefing involved.

Data collection by interviewing the participant family members and nurses would be an alternative way to collect data. Many participant family members indicated their willingness to talk at the end of the questionnaire by writing down their name and address. The difficulty with an interview short time after the death would be how to keep the interview from turning to a therapy session. The advantage of interviewing participants is that it could help us reach a deeper understanding of the experience of grief and the impact of social support for grieving family. During the discussions nurses evaluated their difficulties in calling the grieving family member, they explained how they carefully selected the time of call and went to a peaceful office to make the call. Data collection by interviewing the nurses would describe their experiences of the call. In this study it remains unclear which were the strong and weak points of the intervention, although we know that the majority of participant nurses perceived them positively. Another issue would be to examine why some nurses failed to participate in the intervention and in the study.

7 Conclusions

1. All significant others grieved the death of their family member. The intensity of grief diminishes as the time from death passes, but no endpoint of the grief could be found.
2. Grieving people receive social support most often from their own family and friends.
3. Social support is related to coping with grief: those survivors who did receive social support were able to grieve by expressing their feelings and forgetting the demands of normal life.
4. Grieving people perceive receiving support as helpful, but also benefit when they can support other people.
5. Gender differences in grief indicate that grieving women and men benefit from different types of support. Women need more emotional support and affirmation, whereas men need advice or concrete help.
6. Positive results indicate that a supportive telephone call can be an alternative and additional form of nursing support for a grieving family.

8 Summary

The purposes of this study were to examine family members' grief after the death of one family member, to produce information that could help to develop nursing care, and to produce information about an instrument used in the assessment of grief. In addition, the aim was to develop a nursing intervention to support grieving families.

The sample of the study consisted of 543 grieving family members, of whom 318 were widowed spouses and took part in the first phase of the study. Altogether 242 (76%) of the participants were female. The response rate was 52%. The second phase of the study consisted of an intervention group and a control group. The 70 family members who took part in the intervention group consisted of 50 (71%) females. The response rate was 65%. In the control group 155 family members participated in the study, including 112 (72%) females. The response rate was 41 %. The number of nursing staff (both nurses and practical nurses) on the wards involved in the intervention was 26 (70%). The data were collected by questionnaires during 1994 (phase I) and during the years 1997-1998 (phase II) and by nurses' diaries written after the supportive telephone call. The structured self-report questionnaire for family members consisted of demographic data, Hogan Grief Reactions Checklist (Hogan 1998), and several open-ended questions. In addition, the perception of the supportive telephone call was measured with 10 items developed by the researcher. The validity and reliability of the instruments were found to be acceptable but to require further improvement. The data analysis consisted of statistical analysis and content analysis.

The results showed that all participants grieved the death of their family member. Despair and disorganization described negative grief reactions most intensively. Participant described their personal growth already four months after the death. There were gender differences in the expressions of grief. Women expressed their grief more intense than men and were more worried about new tasks, such as financial affairs of the family. Men were more worried about loneliness. Social support had an impact on the grief experience. Family members and friends are the most important sources of support. Social support after the death of a spouse was found helpful when the grieving spouse received support, as was expected, but in addition to that, supporting others as well as both receiving and giving support was also found helpful.

The study results indicated that a supportive telephone call after the death of a family member is a suitable nursing intervention after the death of a patient, because the supportive call was perceived as very important also by family members of those deceased whose hospitalization was very short. Nurses are in a special position to meet the grieving family member with whom they have shared the experience of terminal illness and the death of the patient. Nurses have indicated their need of additional education regarding bereavement

assessment. Therefore it is recommended that a specific educational program be implemented prior to the beginning of the supportive intervention.

9 Tiivistelmä

Tutkimuksen tavoitteena oli saada tietoa perheen surusta perheenjäsenen kuoleman jälkeen, tuottaa tietoa hoitotyön kehittämiseksi ja tuottaa tietoa perheen surun tutkimisessa käytetystä mittarista. Lisäksi tavoitteena oli kehittää hoitotyöhön tukitoimintamalli surevien perheiden tukemiseen.

Tutkimuksen kohdejoukko koostui 543 surevasta perheenjäsenestä. Heistä tutkimuksen ensimmäiseen vaiheeseen osallistui 318 aviopuolisonsa menettänyttä, joista 242 (76%) oli naisia. Osallistumisprosentti oli 52. Tutkimuksen toinen vaihe muodostui koe- ja kontrollisryhmistä. Koeryhmän 70 surevasta perheenjäsenestä oli 50 (71%) naisia. Osallistumisprosentti oli 65. Kontrolliryhmään kuului 155 surevaa perheenjäsentä. Heistä naisia oli 71%. Kontrolliryhmässä vastausprosentti oli 41. Tutkimukseen kuuluvia tukipuheluita soitti koeryhmän vuodeosastoilla 26 sairaan- ja perushoitajaa. Tutkimusaineisto kerättiin vuosina 1994 (vaihe I) ja vuosina 1997-1998 (vaihe II) tehtyinä postikyselyinä. Lisäksi tukitoimintaan osallistuneet sairaan- ja perushoitajat kirjoittivat päiväkirjaa soitettuaan tukipuhelun. Sureville perheenjäsenille lähetetty kyselylomake sisälsi taustamuuttujia, surua mittaavan, Hogan Grief Reactions Checklist -mittarin (Hogan 1998) sekä useita avoimia kysymyksiä. Lisäksi tutkija kehitti kymmenen osiota sisältävän mittarin, jolla koeryhmältä kysyttiin tukipuheluista. Tutkittaessa käytettyjen mittareiden validiteettia ja reliabiliteettia, ne havaittiin luotettaviksi, mutta niiden todettiin kaipaavan jatkokehittelyä. Tutkimusaineisto analysoitiin käyttämällä tilastollisia analyysimenetelmiä ja sisällön analyysia.

Tulokset osoittivat kaikkien osallistujien surevan perheenjäsenensä kuolemaa. Surun ulottuvuuksista epätoivo ja epäjärjestys kuvasivat surureaktioita voimakkaimmin. Osallistujat kuvailivat persoonallista kasvuaan jo neljä kuukautta läheisen kuoleman jälkeen. Surun ilmaisemisessa oli naisten ja miesten välillä eroja. Naiset kuvasivat suruaan voimakkaampana kuin miehet sekä olivat enemmän huolissaan uusista tehtävistään, kuten perheen talousasioista huolehtimisesta. Miehiä huolestutti yksinäisyys enemmän kuin naisia. Sosiaalisella tuella oli yhteyttä surun kokemukseen. Perheenjäsenet ja ystävät olivat tärkeimmät tuen antajat. Ennakko-oletuksen mukaan sosiaalinen tuki koettiin auttavana puolison kuoleman jälkeen, mutta sen lisäksi puolison kuolemaa surevia auttoi mahdollisuus olla tukena toisille. Lisäksi tilanne, jossa sekä antoi tukea että sai sitä, koettiin auttavana.

Tutkimuksen tulokset osoittavat, että tukipuhelu perheenjäsenen kuoleman jälkeen on potilaan kuoleman jälkeiseen hoitotyöhön sopiva tukimuoto. Myös lyhyen sairaalassaolon jälkeen kuolleiden potilaiden perheenjäsenet arvioivat puhelut tärkeiksi. Yhteiset kokemukset perheenjäsenen kuolemaan johtaneen sairauden ajalta sekä potilaan kuolemasta ajalta antaa hoitohenkilökunnalle erityisaseman surevan perheen tukemiseen. Toisaalta hoitohenkilökunta

on ilmaissut tarvitsevansa lisää koulutusta surevan ihmisen kohtaamiseen. Siksi voidaan suositella, että ennen tukitoiminnan aloittamista siihen osallistuvalle hoitohenkilökunnalle järjestetään aiheeseen liittyvää koulutusta.

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Marja Kaunonen

Appendix 2. Diary instructions for the participant nurses about the supportive telephone call

Name of the patient

Date of birth

Date of death

Name of the family member, relationship to the deceased

Address and telephone number of the family member

Primary nurse (initials)

Nurse at the time of death (initials)

Nurse when family came to get the body (initials)

Nurse who made the telephone call (initials)

Date of the telephone call

Duration of the telephone call

Nurse's perception of the call: positive or negative

Nurse's written diary about the experiences of the call

Or if the telephone discussion did not occur the cause for that:

for example family member was not reached; family member denied the call

Topics of the discussion

Memorizing the deceased; Family adjusting after the death; Grief experience; Things that helped in the grief

Participation in the bereavement support group/ did family member know about the support group

Atmosphere of the telephone call

Family member was surprised when called

Discussion was easy/ difficult

Nurse's feelings after the call

Telephone call was as anticipated

How family member will survive worried the caller

Notice! These themes are as examples and you can describe your experiences freely. Diaries are important as a source during group discussions. The researcher can also use them as data for the study.

Your diaries are confidential!

Researcher	Publ year	Sample	Data collection	Instrument	Social support theory	Results
Gass	1987	Older widows (N=100), spouse died 1-12 months earlier	A structured home interview	Appraisal of bereavement, Ways of coping, Assessmental Resource, Sickness Impact Profile	Lazarus and Folkman (1984)	No significant differences in seeking social support among different appraisal groups; higher amounts of helpful social supports were related to lower psychosocial dysfunction; more social support and no other losses were related to less health dysfunction in widows; suggest that unhelpful social supports may place widows at risk for morbidity following bereavement
Levy & Derby	1992	Widows who joined BSG (n=40) and widows who did not join BSG (n=96)	Longitudinal study (6, 13, and 18 months postmortem) structural interviews, self-report measures	Social Support Evaluation Scale, CED-S. POMS-A, POMS-T, Impact of Event Scale (IES)	Fleming et al (1982) Cohen et al (1985) Cohen (1988)	Joiners and nonjoiners did not differ significantly in their perceived social support
Gallagher-Thomson et al	1993	Recently widowed elders (n=212), people who had not lost a spouse within last 5 years (n= 162), survivors of suicides (n=108)	Longitudinal study (2,6,12,30 months postmortem) Structured home interview with self-report measures	Beck Depression Inventory, Brief Symptom Inventory, Texas Inventory of Grief - Revised		Interaction between the mode of death and the nature of social support network. Bereaved males who died during the study reported more often than survivors that their wife was their main confidante; less involvement in fewer socially oriented activities, and had a much smaller social network

Lopata	1993	Widows (N=82.078)	Home interviews	Questions focused on the support systems of widows		Only 12% of the widows received economic support; the widowers saw themselves as recipients of service supports much more often than as givers; most socially active were the middle and upper class widows; grandchildren did not contribute as often to the emotional supports as expected and also friends appeared relative infrequently in the emotional support system
Stroebe & Stroebe	1993	Widowed (n=60) and married (n=60) under the age of retirement	Interviews with questionnaire at 4-7 months, 14 months and 2 years after bereavement	Deficit Model of Partner Loss 1. perceived social support 2. received social support	French& Kahn (1962) Lazarus (1966) Lazarus& Folkman (1984)	Loss of a partner resulted in a decrease of social support for widowers but not for widows; a significant positive relationship between the availability of social support and health; individuals with a greater number of supportive relationships suffered from fewer depressive symptoms and somatic complaints than those with less social support; failure to find a buffering effect in social support since social support. had similarly positive effects on married and widowed individuals
Hogan & DeSantis	1994	Bereaved adolescents (n=157), aged of 13-18, had a sibling die within 5 years	Semi-structured questionnaire	Written responses to: 1. What helped you cope with your sibling's death? 2. What made it harder to cope with your sibling's death?		Social support were viewed both helping and hindering the coping process. Helpful support was perceived as people "being there for me". Family, friends and social system provided support of an interpersonal nature. Adolescents identified peers as the persons most able to provide unconditional support. Parents, other family members were able to give positive support despite their own grief, but also were too preoccupied with their own grief or spousal discord to be present and available when needed

Robinson	1995	Widows (N=65) age 45- 84, spouse died 13-24 months earlier	Correlational cross-sectional design	Norbeck Social Support Questionnaire, Robinson Bereavement Questionnaire, Jalowiec Coping Scale, Grief Experience Inventory	Kahn (1979)	A moderate positive significant relationship between social support and total combined coping, and between social network and total combined coping; social support had moderate positive direct effects on total combined coping and was inversely and weakly related to total grief response
Thuen	1995	Participants (n=164) of Norwegian Bereavement Care Project	Questionnaire	Global measure of perceived social support; sources of support; perceived outcome	Cobb (1976) Pinneau (1976)	Respondents most frequently claimed to receive emotional support, to some extent also informational support, whereas the instrumental support was negligible. Social support offered by the groups appeared to be of considerable importance to the respondents' evaluation of the groups and it explains a considerable proportion of perceived outcome
Kanacki, Jones, Galbrait	1996	Widows (n=31) and widowers (n=35) over 55 years old, widowed up to 6 months	Questionnaire	Personal Resource Questionnaire-85, Beck Depression Index, demographic questionnaire	Weiss (1974)	Negative relationship between the amount of perceived social support and depression; not related to size of social network; for the widowers less social contact appeared to provide equal social support

Source	Support Intervention	Focal group	Other participants	Purpose	Timing	Size of the group	Results
Rognlie (1989)	Bereavement support group	Grieving families	Two trained bereavement workers	Help members accomplish the task of mourning; education and support rather than therapy	8-10 weeks	6-11 participants	Subjects reported benefits including increased emotional, mental and physical stability after their participation; Better acceptance and coping with loss
Jackson (1992, 1996)	Individual support	Bereaved families of intensive therapy unit	Primary nurse	Help people to regain control and power whilst giving them the freedom to face and express the pain of death	Immediately after death (letter) and 2-4 weeks after the telephone call	No group	Nurse-run service is inexpensive; it had a positive effect on both the nurse care-givers and bereaved survivors
Levy, Derby (1992)	Bereavement support group	Widowed spouses	Professional or trained volunteer	Concern with the welfare of the bereaved	At entry to BSG, 6 and 13 months after the death	Not defined	Comparison support group joiners with non-joiners indicated no differences were found for perceived levels of social support, joiners reported experiencing more stressful events and higher levels of depression, anger, anxiety, and subjective stress.
Levy et al (1993)	Bereavement support group	Widows, widowers	Specially trained volunteers or staff	Provide social support	From 1 months to 18 months after the death	Not defined	Neither group membership nor level of group involvement was associated with significant greater improvement in adaptation over the 18 months

Hopmeyer, Werk (1994)	Comparison of 3 support groups	Widows/ Suicide survivors/ Cancer death survivors	Peer group leader/ professional leader/ combination of both	Help participants develop and strengthen informal support networks; become less lonely and isolated; give a sense of belonging	Twice a week/ weekly meetings 6-8 times	4-13 participants	Members benefited from the shared experience with others and could be helped to regain hope for their own futures when they saw others had survived
Bisson, Deahl (1994); Dyregrov (1995)	Psychological Debriefing groups	Survivors Families Help workers	Psychology or other expert with crisis therapy education	Promote the emotional processing of traumatic events through the ventilation and normalization of reactions and preparation for possible future experiences	24-72 hours from the crisis; possible a follow-up 3-4 weeks later	10-15 or less	No research results: the hypothesis that PD decreases psychological sequelae has not been adequately tested
Williams, Frangesch (1995)	Telephone follow-up	Grieving families of emergency department patients	Nursing staff with the help of physicians and pastoral staff	Listening, crisis intervention, grief symptom normalization, and community referral	Three calls over a period of 2 months	No group	Positive survivor feedback in the surveys has convinced the grief program's positive impact. Nurses had different levels of willingness and ability to do grief interaction.
Glazer, Clark (1997)	Support group	Grieving parents	Leader	To enhance parenting effectiveness; to provide a supportive environment for discussion; to normalize the parenting experiences	5-week class	9 parents	Support and skills for parents to support their grieving child

Harmanen (1997)	Support group	Grieving people	Theology or diacony	Progress the grief work during the sessions; dwelling on grief and memories; aiming to personal growth and coping	5-8 times during 3-4 months	In average 7 participants and 1-2 leaders	According to group leaders the grief was most alleviated by talking, by experiencing fellowship, by finding a place for grief and by sharing knowledge of the stages of grief.
Nesbit et al (1997)	Bereavement education pathway	Grieving families with a sudden or unexpected death	Multidiscip-linary team	To ensure ongoing support for families who are at risk for profound feelings of sadness, despair, and isolation	Continues the first year after a child's death	No group	Participated families revealed positive support for the follow-up contact with nursing staff, would have liked more contact with the physicians. Follow-up calls and letter appeared difficult for nursing staff to complete
Tunnicliffe, Briggs (1997)	Bereavement programme	Bereaved relatives in ICU	Nurse	To support bereaved relatives by offering information and advice, refer to support services, be aware of the family's reactions to bereavement, continue the relationship and use nurse as the key expert	Identifying a named nurse; a sympathy card; contact by phone in seven to ten days time	No group	Not systematic evaluation this point; relied on informal feedback from staff and relatives
Beem et al (1998)	Workshop	Grieving people	Two counselors for every 12 participants	Give information and insight what one can expect in bereavement and available support facilities; opportunity to meet fellow bereaved; ample space for emotional release	Two-day workshop	20-35 participants	Workshop is not suitable for people who seek therapy, but those who need a little extra support

Field (1998)	Bereavement follow-up	Grieving families	General practitioners District nurses	Continuity of the contact, symptom control and provision of psychosocial support to patients and relatives	GP visited the bereaved home shortly after death, possible a second visit	No group	GP's experienced sometimes bereavement visits difficult, but they contributed to job satisfaction; improved the family nursing
Jackson (1998)	Bereavement follow-up programme	Grieving relatives of ITU patients	Named nurse	Enquiry how family is coping following the death, give opportunity to ask questions and offer advice about possible needed help	Provision of named nurse; a letter of condolence; a telephone call	No group	92% of participants expressed positive feelings about the service, the continuance of the contact and the thought that somebody continued to care
Kojlak et al (1998)	Individual telephone follow-up	Grieving families of CCU patients	Social worker, charge nurse, nurse coordinator	Assessment of the bereavement needs of families of patients dying in critical care unit (CCU)		No group	Generally pleased with the idea of follow-up telephone call, appreciated information about community resources
McCorkle et al (1998)	Supportive intervention after death	Grieving spouses	Specially educated nurse	Effects of different types of nursing care on spousal outcomes (intervention group in oncology home care)		No group	Bereavement course can be positively influenced based on the model guiding nursing care during terminal illness and after the death

Appendix 5. Dimensions of grief and variables of Hogan Grief Reactions Checklist (Hogan 1988)

Dimension of grief	**Variable**
Despair	Shattered hopes
	Aching with loneliness
	Agony
	Feeling hopeless
	I should have died and she should have lived
	I believe one day I will be happy again
	Little control over my sadness
	I seldom cry
	Function like a zombie*
	Heaviness in heart
	I have no difficulty accepting the permanence of the death
	Shock
Panic behavior	Fast heartbeats
	Muscle tension
	Rarely feel frightened
	Shortness of breath
	Panic attacks over nothing
	Rarely fatigued
	Feel shaky
	Seldom have headaches
	Sick more often
	Startle easily
	Back pain
	Burning in my stomach
	Excessive worrying
	Dizziness
Personal growth	Learned to cope better with life
	Became a better person
	Better outlook on life
	Have less compassion for others
	Stronger because of the grief
	More forgiving person

Appendix 5 continues

	Less tolerant of myself
	More tolerant of others
	Hope for the future**
	Reached a turning point where I begin to let go some of the grief
	Am having more good days than bad
Blame and anger	I rarely feel bitter
	Resentment
	Feeling revengeful
	I rarely feel anger
	Feelings of hostility
	Wanting to blame others
	Desire to harm others
Detachment	Preoccupation with being worthless
	I feel confident
	Confusion about who I am
	Feeling unable to cope
	Do not know myself
	I do not fear that I will lose control
	Feeling detached from others
	Avoidance of tenderness
Disorganization	Remember new information easily
	Forget easily i.e. names, telephone numbers
	No difficulty concentrating
	Impaired long term memory
	Difficulty learning new things
	Difficulty with abstract thinking
	Tasks seem insurmountable
	Difficulty remembering things from the past

* Finnish translation of the variable was changed after the phase I study

** Variable missing from phase I questionnaire

Appendix 6. Cronbach's alpha coefficients for Hogan Grief Reactions Checklist

Dimension of grief	Phase I Cronbach's alpha	Phase II Cronbach's alpha
Despair	.81	.85
Panic behavior	.83	.83
Personal growth	.75	.74
Blame and anger	.65	.57
Detachment	.68	.68
Disorganization	.79	.81

Example of the correlation matrix of Blame and anger (Phase II)

	K8	K15	K37	K42	K48
K8	1.0000				
K15	.2926	1.0000			
K37	.5288	.3042	1.0000		
K42	.4164	.3576	.3993	1.0000	
K48	.1750	.1371	.2210	.2687	1.0000
K5R	.0748	.0625	.1266	.0722	.0431
K58R	.1006	.0681	.1772	.0845	.2328

	K5R	K58R
K5R	1.0000	
K58R	.1929	1.0000
N of Cases =	209.0	

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Alpha if Item Deleted
K8	5.3301	7.7703	.4207	.3364	.4886
K15	5.6938	9.2904	.3158	.1677	.5430
K37	5.1914	7.1940	.4828	.3497	.4567
K42	5.5455	8.6722	.4067	.2874	.5129
K48	5.7512	9.7166	.2927	.1263	.5569
K5R	3.6938	7.5789	.1798	.0474	.6169
K58R	3.8469	7.6591	.2424	.1002	.5692

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

Reliability Coefficients 7 items

Alpha = .5740 Standardized item alpha = .6456

Item	Does not describe me at all (%)	Does not quite describe me %)	Describes me fairly well (%)	Describes me well (%)	Describes me very well (%)	Missing answers (%)
Shattered hopes	56 (17.6)	70 (22.0)	72 (22.6)	61 (19.2)	50 (15.7)	9 (2.8)
Learned to cope better with life	52 (16.4)	109 (34.3)	87 (27.4)	49 (12.6)	23 (7.2)	7 (2.2)
Little control over my sadness	98 (30.8)	132 (41.5)	45 (14.2)	26 (8.2)	7 (2.2)	10 (3.1)
Excessive worrying	70 (22.0)	97 (30.5)	80 (25.2)	36 (11.3)	23 (7.2)	12 (3.8)
I rarely feel bitter (k)	40 (12.6)	92 (28.9)	70 (22.0)	56 (17.6)	49 (15.4)	11 (3.5)
Shock	187 (58.8)	53 (16.7)	28 (8.8)	20 (6.3)	18 (5.7)	12 (3.8)
Fast heartbeats	120 (37.7)	82 (25.8)	56 (17.6)	34 (10.7)	20 (6.3)	6 (1.9)
Resentment	204 (64.2)	71 (22.3)	20 (6.3)	6 (1.9)	8 (2.5)	9 (2.8)
Preoccupation with being worthless	109 (34.3)	70 (22.0)	64 (20.1)	39 (12.3)	29 (9.1)	7 (2.2)
Became a better person	115 (36.2)	95 (29.9)	51 (16.0)	35 (11.0)	13 (4.1)	9 (2.8)
I should have died and he/she should have lived	149 (46.9)	77 (24.2)	31 (9.7)	19 (6.0)	30 (9.4)	12 (3.8)
Better outlook of life	101 (31.8)	88 (27.7)	61 (19.2)	38 (11.9)	21 (6.6)	9 (2.8)
I seldom have headaches (k)	61 (19.2)	79 (22.0)	42 (13.2)	54 (17.0)	84 (26.4)	7 (2.2)
Heaviness in my heart	57 (17.9)	91 (28.6)	83 (26.1)	47 (14.8)	35 (11.0)	5 (1.6)
Feeling revengeful	271 (85.2)	27 (8.5)	3 (.9)	1 (.3)	4 (1.3)	12 (3.8)
Burning in my stomach	193 (60.7)	50 (15.7)	41 (12.9)	12 (3.8)	11 (3.5)	11 (3.5)
Want to die to be with him	186 (58.5)	87 (27.4)	16 (5.0)	9 (2.8)	11 (3.5)	9 (2.8)
Muscle tension	98 (30.8)	65 (20.4)	88 (27.7)	28 (8.8)	29 (9.1)	10 (3.1)
Have less compassion for others (k)	193 (60.7)	62 (19.5)	34 (10.7)	14 (4.4)	4 (1.3)	11 (3.5)
Forget easily names, telephone numbers	69 (21.7)	71 (22.3)	92 (28.9)	43 (13.5)	38 (11.9)	5 (1.6)
Feel shaky	106 (33.3)	104 (32.7)	58 (18.2)	30 (9.4)	14 (4.4)	6 (1.9)
Confusion about who I am	200 (62.9)	67 (21.1)	29 (9.1)	13 (4.1)	4 (1.3)	5 (1.6)
I feel confident (k)	66 (20.8)	84 (26.4)	82 (25.8)	43 (13.5)	29 (9.1)	14 (4.4)
Stronger because of grief	83 (26.1)	81 (25.5)	71 (22.3)	45 (14.2)	29 (9.1)	9 (2.8)
I believe one day I will be happy again (k)	45 (14.2)	79 (24.8)	74 (23.3)	57 (17.9)	56 (17.6)	7 (2.2)
Impaired long term memory	134 (42.1)	97 (30.5)	50 (15.7)	23 (7.2)	9 (2.8)	5 (1.6)
Rarely feel frightened (k)	54 (17.0)	96 (30.2)	74 (23.3)	51 (16.0)	39 (12.3)	4 (1.3)
Feeling unable to cope	140 (44.0)	103 (32.4)	37 (11.6)	24 (7.5)	12 (3.8)	2 (.6)
Agony	167 (52.5)	79 (24.8)	37 (11.6)	20 (6.3)	8 (2.5)	7 (2.2)
More forgiving person	41 (12.9)	57 (17.9)	107 (33.6)	62 (19.5)	44 (13.8)	7 (2.2)
Panic attacks over nothing	185 (58.2)	73 (23.0)	31 (9.7)	10 (3.1)	14 (4.4)	5 (1.6)
I don’t have difficulty concentrating (k)	54 (17.0)	115 (36.2)	77 (24.2)	42 (13.2)	24 (7.5)	6 (1.9)
Function like a zombie	233 (73.3)	69 (18.9)	10 (3.1)	4 (1.3)	1 (0.3)	10 (3.1)
Shortness of breath	166 (52.2)	80 (25.2)	39 (12.3)	11 (3.5)	12 (3.8)	10 (3.1)
Avoidance of tenderness	156 (49.1)	91 (28.6)	37 (11.6)	18 (5.7)	9 (2.8)	7 (2.2)

						2(6)
Less tolerant of myself	6 (1.9)	20 (6.3)	60 (18.9)	117 (36.8)	106 (33.3)	9 (2.8)
Feelings of hostility	192 (60.4)	63 (19.8)	33 (10.4)	11 (3.5)	8 (2.5)	11 (3.5)
Dizziness	169 (53.1)	72 (22.6)	38 (11.9)	23 (7.2)	6 (1.9)	10 (3.1)
Difficulty learning new things	96 (30.2)	98 (30.8)	78 (24.5)	25 (7.9)	11 (3.5)	10 (3.1)
I have no difficulty accepting the permanence of the death (k)	48 (15.1)	111 (34.9)	70 (22.0)	34 (10.7)	45 (14.2)	10 (3.1)
More tolerant toward others	29 (9.1)	59 (18.6)	136 (42.8)	59 (18.6)	30 (9.4)	5 (1.6)
Wanting to blame others	245 (77.0)	42 (13.2)	14 (4.4)	5 (1.6)	2 (0.6)	10 (3.1)
Don’t know myself	173 (54..4)	70 (22.0)	39 (12.3)	15 (4.7)	6 (1.9)	15 (4.7)
Rarely fatigue (k)	74 (23.3)	132 (41.5)	64 (20.1)	26 (8.2)	15 (4.7)	7 (2.2)
Hope for the future	---	---	---	---	---	---
Difficulty with abstract thinking	121 (38.1)	116 (36.5)	47 (14.8)	11 (3.5)	6 (1.9)	17 (5.3)
Feeling hopeless	110 (34.6)	99 (31.1)	53 (16.7)	27 (8.5)	22 (6.9)	7 (2.2)
Desire to harm others	292 (91.8)	14 (4.4)	1 (0.3)	3 (0.9)	2 (0.6)	6 (1.9)
Remember new information easily (k)	40 (12.6)	146 (45.9)	81 (25.5)	30 (9.4)	12 (3.8)	9 (2.8)
Sick more often	154 (48.4)	86 (27.0)	41 (12.9)	17 (5.3)	11 (3.5)	9 (2.8)
Reached a turning point where I began to let go of some of the grief	19 (6.0)	52 (16.4)	103 (32.4)	79 (24.8)	61 (19.2)	4 (1.3)
Back pain	125 (39.3)	69 (21.7)	55 (17.3)	33 (10.4)	26 (8.2)	10 (3.1)
I don’t fear that I will lose control (k)	46 (14.5)	73 (23.0)	79 (24.8)	70 (22.0)	41 (12.9)	9 (2.8)
Feeling detached from others	107 (33.6)	86 (27.0)	63 (19.8)	34 (10.7)	21 (6.6)	7 (2.2)
I seldom cry (k)	83 (26.1)	91 (28.6)	74 (23.3)	44 (13.8)	20 (6.3)	6 (1.9)
Startle easily	110 (34.6)	83 (26.1)	65 (20.4)	30 (9.4)	21 (6.6)	9 (2.8)
Tasks seem insurmountable	102 (32.1)	140 (44.0)	41 (12.9)	14 (4.4)	8 (2.5)	13 (4.1)
I rarely get angry (k)	33 (10.4)	77 (24.2)	81 (25.5)	66 (20.8)	51 (16.0)	10 (3.1)
Aching with loneliness	78 (24.5)	85 (26.7)	55 (17.3)	37 (11.6)	56 (17.6)	7 (2.2)
Am having more good days than bad	19 (6.0)	49 (15.4)	89 (28.0)	90 (28.3)	63 (19.8)	8 (2.5)
Difficulty remembering things from the past	134 (42.1)	120 (37.7)	40 (12.6)	11 (3.5)	8 (2.5)	5 (1.6)

(k) reverse coded item

Frequency and percentage distribution of answers in HGRC in Phase II Intervention group

Item	Does not describe me at all (%)	Does not quite describe me %)	Describes me fairly well (%)	Describes me well (%)	Describes me very well (%)	Missing answers (%)
Shattered hopes	11 (15.7)	16 (22.9)	11(15.7)	11 (15.7)	17 (24.3)	4 (5.7)
Learned to cope better with life	14 (20.0)	14 (20.0)	27 (38.6)	6 (8.6)	0	9 (12.9)
Little control over my sadness	16 (22.9)	26 (37.1)	19 (27.1)	3 (4.3)	2 (2.9)	4 (5.7)
Excessive worrying	12 (17.1)	22 (31.4)	16 (22.9)	11(15.7)	5 (7.1)	4 (5.7)
I rarely feel bitter	14 (20.0)	17 (24.3)	10 (14.3)	10 (14.3)	13 (18.6)	6 (8.6)
Shock	31 (44.3)	22 (31.4)	6 (8.6)	2 (2.9)	4 (5.7)	5 (7.1)
Fast heartbeats	23 (32.9)	16 (22.9)	14 (20.0)	7 (10.0)	5 (7.1)	5 (7.1)
Resentment	40 (57.1)	17 (24.3)	6 (8.6)	2 (2.9)	1 (1.4)	4 (5.7)
Preoccupation with being worthless	22 (31.4)	19 (27.1)	11 (15.7)	12 (17.1)	4 (5.7)	2 (2.9)
Became a better person	26 (37.1)	26 (37.1)	4 (5.7)	7 (10.0)	1 (1.4)	6 (8.6)
I should have died and he/she should have lived	27 (38.6)	22 (31.4)	9 (12.9)	5 (7.1)	3 (4.3)	4 (5.7)
Better outlook of life	20 (28.6)	27 (38.6)	15 (21.4)	3 (4.3)	1 (1.4)	4 (5.7)
I seldom have headaches	16 (22.9)	10 (14.3)	7 (10.0)	18 (25.7)	18 (25.7)	1 (1.4)
Heaviness in my heart	9 (12.9)	14 (20.0)	15 (21.4)	14 (20.0)	14 (20.0)	4 (5.7)
Feeling revengeful	56 (80.0)	6 (8.6)	3 (4.3)	0	1 (1.4)	4 (5.7)
Burning in my stomach	39 (55.7)	13 (18.6)	7 (10.0)	4 (5.7)	4 (5.7)	3 (4.3)
Want to die to be with him	38 (54.3)	17 (24.3)	6 (8.6)	3 (4.3)	2 (2.9)	4 (5.7)
Muscle tension	16 (22.9)	13 (18.6)	19 (27.1)	9 (12.9)	9 (12.9)	4 (5.7)
Have less compassion for others	42 (60.0)	16 (22.9)	3 (4.3)	4 (5.7)	2 (2.9)	3 (4.3)
Forget easily names, telephone numbers	12 (17.1)	23 (32.9)	10 (14.3)	12 (17.1)	11 (15.7)	2 (2.9)
Feel shaky	13 (18.6)	25 (35.7)	11 (15.7)	9 (12.9)	8 (11.4)	4 (5.7)
Confusion about who I am	32 (45.7)	23 (32.9)	5 (7.1)	4 (5.7)	2 (2.9)	4 (5.7)
I feel confident	19 (27.1)	23 (32.9)	14 (20.0)	9 (12.9)	1 (1.4)	4 (5.7)
Stronger because of grief	17 (24.3)	22 (31.4)	17 (24.3)	8 (11.4)	1 (1.4)	5 (7.1)
I believe one day I will be happy again	8 (11.4)	22 (31.4)	16 (22.9)	16 (22.9)	5 (7.1)	3 (4.3)
Impaired long term memory	25 (35.7)	25 (35.7)	11 (15.7)	4 (5.7)	1 (1.4)	4 (5.7)
Rarely feel frightened	9 (12.9)	21 (30.0)	15 (21.4)	12 (17.1)	9 (12.9)	4 (5.7)
Feeling unable to cope	30 (42.9)	24 (34.3)	8 (11.4)	4 (5.7)	1 (1.4)	3 (4.3)
Agony	18 (25.7)	25 (35.7)	15 (21.4)	5 (7.1)	3 (4.3)	4 (5.7)
More forgiving person	5 (7.1)	18 (25.7)	27 (38.6)	10 (14.3)	4 (5.7)	6 (8.6)
Panic attacks over nothing	35 (50.0)	19 (27.1)	8 (11.4)	1 (1.4)	1 (1.4)	6 (8.6)
I don’t have difficulty concentrating	15 (21.4)	22 (31.4)	11 (15.7)	12 (17.1)	5 (7.1)	5 (7.1)
Function like a zombie	26 (37.1)	13 (18.6)	18 (25.7)	4 (5.7)	2 (2.9)	7 (10.0)
Shortness of breath	28 (40.0)	20 (28.6)	7 (10.0)	4 (5.7)	6 (8.6)	5 (7.1)
Avoidance of tenderness	35 (50.0)	13 (18.6)	10 (14.3)	4 (5.7)	2 (2.9)	6 (8.6)

Less tolerant of myself	15 (21.4)	27 (38.6)	12 (17.1)	7 (10.0)	4 (5.7)	5 (7.1)
Feelings of hostility	34 (48.6)	15 (21.4)	11 (15.7)	1 (1.4)	4 (5.7)	5 (7.1)
Dizziness	32 (45.7)	12 (17.1)	15 (21.4)	4 (5.7)	2 (2.9)	5 (7.1)
Difficulty learning new things	16 (22.9)	25 (35.7)	11 (15.7)	9 (12.9)	2 (2.9)	7 (10.0)
I have no difficulty accepting the permanence of the death	16 (22.9)	17 (24.3)	13 (18.6)	10 (14.3)	10 (14.3)	4 (5.7)
More tolerant toward others	7 (10.0)	19 (27.1)	27 (38.6)	6 (8.6)	6 (8.6)	5 (7.1)
Wanting to blame others	48 (68.6)	14 (20.0)	1 (1.4)	2 (2.9)	0	5 (7.1)
Don’t know myself	35 (50.0)	22 (31.4)	4 (5.7)	3 (4.3)	1 (1.4)	5 (7.1)
Rarely fatigue	16 (22.9)	26 (37.1)	11 (15.7)	8 (11.4)	3 (4.3)	6 (8.6)
Hope for the future	9 (12.9)	13 (18.6)	22 (31.4)	14 (20.0)	5 (7.1)	7 (10.0)
Difficulty with abstract thinking	21 (30.0)	26 (37.1)	11 (15.7)	6 (8.6)	0	6 (8.6)
Feeling hopeless	20 (28.6)	18 (25.7)	15 (21.4)	7 (10.0)	5 (7.1)	5 (7.1)
Desire to harm others	58 (82.9)	4 (5.7)	1 (1.4)	1 (1.4)	0	6 (8.6)
Remember new information easily	17 (24.3)	23 (32.9)	21 (30.0)	4 (5.7)	0	5 (7.1)
Sick more often	26 (37.1)	19 (27.1)	11 (15.7)	5 (7.1)	3 (4.3)	6 (8.6)
Reached a turning point where I began to let go of some of the grief	9 (12.9)	21 (30.0)	24 (34.3)	10 (14.3)	4 (5.7)	2 (2.9)
Back pain	27 (38.6)	14 (20.0)	11 (15.7)	4 (5.7)	8 (11.4)	6 (8.6)
I don’t fear that I will lose control	8 (11.4)	16 (22.9)	18 (25.7)	17 (24.3)	5 (7.1)	6 (8.6)
Feeling detached from others	22 (31.4)	17 (24.3)	17 (24.3)	6 (8.6)	5 (7.1)	3 (4.3)
I seldom cry	22 (31.4)	22 (31.4)	11 (15.7)	8 (11.4)	3 (4.3)	4 (5.7)
Startle easily	19 (27.1)	23 (32.9)	11 (15.7)	6 (8.6)	7 (10.0)	4 (5.7)
Tasks seem insurmountable	25 (35.7)	18 (25.7)	12 (17.1)	8 (11.4)	4 (5.7)	3 (4.3)
I rarely get angry	8 (11.4)	16 (22.9)	20 (28.6)	14 (20.0)	10 (14.3)	2 (2.9)
Aching with loneliness	11 (15.7)	16 (22.9)	19 (27.1)	12 (17.1)	7 (10.0)	5 (7.1)
Am having more good days than bad	7 (10.0)	11 (15.7)	24 (34.3)	18 (25.7)	7 (10.0)	3 (4.3)
Difficulty remembering things from the past	27 (38.6)	30 (42.9)	6 (8.6)	1 (1.4)	2 (2.9)	4 (5.7)

Frequency and percentage distribution of answers in HGRC in Phase II Control group

Item	Does not describe me at all (%)	Does not quite describe me %)	Describes me fairly well (%)	Describes me well (%)	Describes me very well (%)	Missing answers (%)
Shattered hopes	39 (25.2)	48 (31.0)	31 (20.0)	18 (11.6)	16 (10.3)	3 (1.9)
Learned to cope better with life	37 (23.9)	45 (29.0)	34 (21.9)	30 (19.4)	5 (3.2)	4 (2.6)
Little control over my sadness	49 (31.6)	67 (43.2)	23 (14.8)	4 (2.6)	10 (6.5)	2 (1.3)
Excessive worrying	48 (31.0)	43 (27.7)	34 (21.9)	17 (11.0)	9 (5.8)	4 (2.6)
I rarely feel bitter	22 (14.2)	43 (27.7)	39 (25.2)	33 (21.3)	16 (10.3)	2 (1.3)
Shock	84 (54.2)	37 (23.9)	12 (7.7)	9 (5.8)	11 (7.1)	2 (1.3)
Fast heartbeats	59 (38.1)	41 (26.5)	30 (19.4)	17 (11.0)	7 (4.5)	1 (.6)
Resentment	107 (69.0)	29 (18.7)	11 (7.1)	3 (1.9)	2 (1.3)	3 (1.9)
Preoccupation with being worthless	64 (41.3)	36 (23.2)	27 (17.4)	19 (12.3)	8 (5.2)	1 (.6)
Became a better person	63 (40.6)	46 (29.7)	22 (14.2)	16 (10.3)	6 (3.9)	2 (1.3)
I should have died and he/she should have lived	101 (65.2)	23 (14.8)	6 (3.9)	12 (7.7)	12 (7.7)	1 (.6)
Better outlook of life	43 (27.7)	47 (30.3)	34 (21.9)	20 (12.9)	8 (5.2)	3 (1.9)
I seldom have headaches	25 (16.1)	23 (14.8)	28 (18.1)	31 (20.0)	46 (29.7)	2 (1.3)
Heaviness in my heart	30 (19.4)	36 (23.2)	40 (25.8)	28 (18.1)	20 (12.9)	1 (.6)
Feeling revengeful	141 (91.0)	7 (4.5)	4 (2.6)	0	0	3 (1.9)
Burning in my stomach	92 (59.4)	34 (21.9)	14 (9.0)	7 (4.5)	6 (3.9)	2 (1.3)
Want to die to be with him	111 (71.6)	20 (12.9)	8 (5.2)	6 (3.9)	9 (5.8)	1 (.6)
Muscle tension	58 (37.4)	36 (23.2)	30 (19.4)	15 (9.7)	12 (7.7)	4 (2.6)
Have less compassion for others	108 (69.7)	29 (18.7)	11 (7.1)	2 (1.3)	2 (1.3)	3 (1.9)
Forget easily names, telephone numbers	53 (34.2)	35 (22.6)	31 (20.0)	19 (12.3)	16 (10.3)	1 (.6)
Feel shaky	56 (36.1)	41 (26.5)	30 (19.4)	14 (9.0)	13 (8.4)	1 (.6)
Confusion about who I am	99 (63.9)	29 (18.7)	15 (9.7)	8 (5.2)	1 (.6)	3 (1.9)
I feel confident	22 (14.2)	49 (31.6)	51 (32.9)	20 (12.9)	11 (7.1)	2 (1.3)
Stronger because of grief	39 (25.2)	41 (26.5)	31 (20.0)	28 (18.1)	12 (7.7)	4 (2.6)
I believe one day I will be happy again	28 (18.1)	29 (18.7)	46 (29.7)	25 (16.1)	24 (15.5)	3 (1.9)
Impaired long term memory	61 (39.4)	55 (35.5)	23 (14.8)	7 (4.5)	5 (3.2)	4 (2.6)
Rarely feel frightened	26 (16.8)	37 (23.9)	33 (21.3)	36 (23.2)	21 (13.5)	2 (1.3)
Feeling unable to cope	84 (54.2)	43 (27.7)	14 (9.0)	5 (3.2)	7 (4.5)	2 (1.3)
Agony	69 (44.5)	50 (32.3)	22 (14.2)	9 (5.8)	1 (.6)	4 (2.6)
More forgiving person	15 (9.7)	39 (25.2)	58 (37.4)	28 (18.1)	12 (7.7)	3 (1.9)
Panic attacks over nothing	97 (62.6)	34 (21.9)	11 (7.1)	9 (5.8)	1 (.6)	3 (1.9)
I don’t have difficulty concentrating	24 (15.5)	44 (28.4)	43 (27.7)	29 (18.7)	13 (8.4)	2 (1.3)
Function like a zombie	101 (65.2)	24 (15.5)	14 (9.0)	7 (4.5)	6 (3.9)	3 (1.9)
Shortness of breath	92 (59.4)	37 (23.9)	10 (6.5)	6 (3.9)	8 (5.2)	2 (1.3)
Avoidance of tenderness	80 (51.6)	39 (25.2)	24 (15.5)	5 (3.2)	3 (1.9)	4 (2.6)

Less tolerant of myself	51 (32.9)	60 (38.7)	26 (16.8)	10 (6.5)	3 (1.9)	5 (3.2)
Feelings of hostility	96 (61.9)	36 (23.2)	16 (10.3)	5 (3.2)	0	2 (1.3)
Dizziness	104 (67.1)	25 (16.1)	9 (5.8)	7 (4.5)	7 (4.5)	3 (1.9)
Difficulty learning new things	57 (36.8)	55 (35.5)	21 (13.5)	12 (7.7)	6 (3.9)	4 (2.6)
I have no difficulty accepting the permanence of the death	33 (21.3)	37 (23.9)	26 (16.8)	30 (19.4)	27 (17.4)	2 (1.3)
More tolerant toward others	12 (7.7)	42 (27.1)	62 (40.0)	28 (18.1)	8 (5.2)	3 (1.9)
Wanting to blame others	119 (76.8)	23 (14.8)	7 (4.5)	2 (1.3)	1 (.6)	3 (1.9)
Don't know myself	91 (58.7)	41 (26.5)	16 (10.3)	4 (2.6)	1 (.6)	2 (1.3)
Rarely fatigue	31 (20.0)	70 (45.2)	26 (16.8)	23 (14.8)	3 (1.9)	2 (1.3)
Hope for the future	25 (16.1)	29 (18.7)	51 (32.9)	31 (20.0)	14 (9.0)	5 (3.2)
Difficulty with abstract thinking	65 (41.9)	40 (25.8)	32 (20.6)	8 (5.2)	3 (1.9)	7 (4.5)
Feeling hopeless	64 (41.3)	40 (25.8)	30 (19.4)	11 (7.1)	8 (5.2)	2 (1.3)
Desire to harm others	142 (91.6)	8 (5.2)	1 (.6)	0	0	4 (2.6)
Remember new information easily	22 (14.2)	52 (33.5)	47 (30.3)	24 (15.5)	8 (5.2)	2 (1.3)
Sick more often	80 (51.6)	33 (21.3)	20 (12.9)	11 (7.1)	7 (4.5)	4 (2.6)
Reached a turning point where I began to let go of some of the grief	12 (7.7)	34 (21.9)	46 (29.7)	46 (29.7)	14 (9.0)	3 (1.9)
Back pain	73 (47.1)	21 (13.5)	25 (16.1)	19 (12.3)	15 (9.7)	2 (1.3)
I don't fear that I will lose control	25 (16.1)	28 (18.1)	34 (21.9)	41 (26.5)	25 (16.1)	2 (1.3)
Feeling detached from others	66 (42.6)	35 (22.6)	21 (13.5)	19 (12.3)	10 (6.5)	4 (2.6)
I seldom cry	33 (21.3)	51 (32.9)	37 (23.9)	16 (10.3)	15 (9.7)	3 (1.9)
Startle easily	56 (36.1)	58 (37.4)	23 (14.8)	9 (5.8)	7 (4.5)	2 (1.3)
Tasks seem insurmountable	67 (43.2)	53 (34.2)	19 (12.3)	11 (7.1)	2 (1.3)	3 (1.9)
I rarely get angry	14 (9.0)	35 (22.6)	55 (35.5)	32 (20.6)	15 (9.7)	4 (2.6)
Aching with loneliness	51 (32.9)	42 (27.1)	23 (14.8)	12 (7.7)	24 (15.5)	3 (1.9)
Am having more good days than bad	7 (4.5)	28 (18.1)	43 (27.7)	44 (28.4)	313 (20.0)	2 (1.3)
Difficulty remembering things from the past	73 (47.1)	47 (30.3)	22 (14.2)	5 (3.2)	6 (3.9)	2 (1.3)