AN EXPLORATION OF BEREAVEMENT INTERVENTION

In

PALLIATIVE/HOSPICE CARE PROGRAMMING

By

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ABSTRACT

Bereavement intervention is subsumed within palliative programme philosophy which encompasses the family as the unit of care and provides a continuum of care that extends beyond the death of a family member. There is no available research on the effect of post-bereavement intervention within palliative programming, and very limited research exists that evaluates the effect of intervention on bereavement outcome. This exploratory study endeavors to differentiate bereavement outcome between two populations having palliative/hospice program support but only one choosing to participate in bereavement follow-up. A mixed strategy of quantitative and grounded theory approaches provided an expanded analysis through which meaning structures and time/process parameters for grieving individuals were explored. The study extended from idiosyncratic data into the realm of larger systemic interactions. An important finding was that the amount of time for preparation for the death of a family member is crucial. Other mitigating factors influencing the grief outcome were social support, network viability, and age.
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CHAPTER 1
INTRODUCTION TO THE STUDY

Background

"We are all vulnerable to the profound feelings that accompany loss ... whether that be our own impending death or loss of health; the death or loss of health of someone we love; the loss of relationships, of function, of dreams; the loss of possessions" (Ajemian and Mount, 1980, p.422).

The past twenty years have seen a phenomenal shift in awareness of issues surrounding death and dying in Western society. The result has been a proliferation of popular literature and self-help organizations; the establishment of professional studies, specializations, journals; and the development of palliative care/hospice organizations and treatment centres throughout North America. Governments have established policies and procedures covering standards of care and resulting funding parameters (Hospice Development and Technical Assistance Group, Bethesda MD. 1978; Government of Canada, Minister of National Health and Welfare, 1982).

Vachon (1988) notes that "a basic tenet of
hospice/palliative care is the provision of emotional support for the patient/family unit ... [and] that this care will continue into the bereavement process" (Medicare Reimbursement Policies in the United States, Vachon, 1988, p.36).

Research related to grief and bereavement increased significantly with the inception of hospice care and with St. Christopher's Hospice in 1965 in England. Studies by Hinton (1967) and Parkes (1972) indicated need for helping and supporting bereaved individuals, and demonstrated relationships between bereavement difficulties and decreased job performance and/or increased physical/mental health problems. Redefinition of "normal" bereavement, of what constitutes "at risk populations" and efficacy of amelioration lend vitality -- and challenge -- to an ever changing, ever growing area of inquiry (Rando 1984, 1986; Raphael, 1980, 1982; Schoenberg, 1975; Vachon 1982, 1988; Worden, 1982). These studies contain a desire for knowledge that can be directly applied to alleviate the pain and suffering of dying individuals and their families -- to turn the potentially most painful life experience into a period of growth and change. It is felt that Palliative Care reduces bereavement risk through its incorporation of the
family as the unit of care.

**Basic Social Process (BSP)**

Glaser (1978) describes a BSP as a process containing "two or more clear emergent stages, requires that the stages should differentiate and account for the problematic pattern of behaviour. ... A process is something which occurs over time and involves change over time" (p.97).

Consideration of change over time is forced upon an explication of bereavement programming as it is subsumed within the evolution of hospice/palliative care that reflects societal change in priorities. Reference is made on the previous page to "an ever changing, ever growing area of inquiry". With bereavement care, a consideration of the BSP would look at multiple linkages between the individual and societal structures and the multiple levels in which this is played out. There are two levels of analysis therefore -- the basic social psychological process (BSPP) that "refers to social psychological processes such as becoming, highlighting, personalizing, health optimizing, awe inspiring and so forth", and the basic social structural process (BSSP) that would include "bureaucratization,
centralization, organizational growth". ... "Usually one requires a BSPP to understand the focus on a BSSP" (Glaser, p.102).

When considering the structure of health distribution through programming of palliative care, health prevention through bereavement support, and availability and access through government funding priorities, the focus is on social structural process. This also includes societal norms that may change over time thus impinging upon role definition and social expectations of bereaved individuals. At this level of analysis, the social structures are "conditions that affect the nature" of the social psychological processes (Ibid, p.103).

"The value systems and normative milieus of the larger social structure typically influence the behaviours of individuals through transmission and enforcement ... mediated through individual human action. This involves, first, social-psychological theory, which deals with the individual's response to a 'given' social situation, and, second, theory at the structural level, which deals with the determination of that given social situation by characteristics of the larger social system" (Lazarsfeld et al, 1972, p.291).
It is not possible to divorce the observed processes of change for bereaved individuals from the dynamics of societal change. As individuals seek redefinition, reformulation and reintegration of meaning and self, they do so within a dynamic society under-going continuous infra-structural change. For grieving individuals, the process of change may appear to be in phases or stages, which can, particularly in retrospect, be seen as turning points within the process. These are viewed as

"critical junctures ... when the occurrence or non-occurrence of a particular critical event (or whatever) will determine whether a new stage has been entered; ... or may not be as clear ...[but] may be obvious later after a short period of time, through gradual occurrence and clarity of a set of indicators" (Glaser, 1978, pp.99-100).

Turning points can also apply to societal change. The major influence on current Palliative Care development can be traced back to the 1960s, when a booming economy accommodated broad social diversity. Combined with societal introspection, this produced a multiplicity of social movement expressions which spoke to alienation, materialism, technological advances and dehumanizing structures. These
were incorporated within a paradigm shift which restructured Cartesian "thoughts, perceptions and values that formed a particular vision of reality" (Capra, 1982, p.30) Capra places this shift in a broad perspective of cultural revolution encompassing a movement from the scientific method to a reformative evolution of "most social relationships and forms of social organizations" (Ibid, p.31). This is expressed in holistic terms of ethical values and human "standards of justice, truth and beauty" (Ibid).

The late 1970s and early 1980s saw tremendous social change influenced by the downturn of the economy -- high unemployment, high interest rates, increased pressure on government spending, increased technological advance with inherent cost increase, thus placing additional pressures on health care dollars. The shift in government policies and health care funding parameters toward cost saving preventive and health promotion programming, benefitted the implementation of Palliative Care and community based support structures. The need to incorporate a sense of social justice in this process is also apparent.

"In a time when health care expenditures are increasingly scrutinized to maximize the benefits for
the community at large, the needs of the bereaved should be given a high priority in an attempt to reduce their potential long-term burden on the health care system" (Bereza, 1988, p.1097).

Within the medical model, the impact of holism is slowly eroding entrenched power structures -- particularly in Palliative Care programming -- supporting and validating individuals through personal empowerment. It is also affecting medical training, course content and physician specialty choices -- with a larger number of new doctors opting for holistic family medicine (St. Louis University School of Medicine, 1984; DeBellis et al. 1988).

The roles and societal expectations of women have changed dramatically, which in itself impacts role redefinition and meaning during the bereavement process. Capra considers the feminist movement as "one of the strongest cultural currents of our time ... having a profound effect on our further evolution" (Capra, 1982, p.30) Feminist values of cooperation, collaboration and consensus, have been assimilated into environmental movements, holistic health and healthy community movements, and community planning and social organization models. It is within this context that individuals have matured,
developed attachment bonds, relationship differentiation and role behaviour strategies in the home and community. With the death of a family member, the bereaved are bereft of relational roles and self definition. For some, depending upon the life cycle stage, there is little or no understanding of role expectations in society, resulting in a feeling of discontinuity.

Therefore, while focus may be on the individual grieving process and its amelioration through bereavement support programming, we are in fact incorporating the grieving process of a variety of individuals encountered in a variety of milieux; "these milieux, in turn, are located in larger historical and social structures" (Mills, 1961, p.129). This suggests that as grief and bereavement concepts are embedded within complex systems, we need to "move toward a complex, mutually causal, and self-transcending [understanding of the] structure of change ... that knits together those apparently disparate aspects of our emergent maps of reality" (Schwartz and Ogilvy, p.57) In this way Schwartz and Ogilvy suggest that while process may have rules -- phases or stages -- "they are rules for engagement rather than for objectifying", that will be innovative -- "heterarchical, decentralized and many-
dimensional", and will consider multiple sources and mutuality of experience. Glaser would identify a Basic Social Structural Process as the social structure within which the social-psychological processes are facilitated (Glaser, 1978, p.102).

The social psychological processes of grief and bereavement are bounded by the culture of the society, and meaning is derived from the connections of personal with social processes. Parkes (1971) maintains that an individual's "assumptive world" model incorporates both the idealized world and the actual, perceived world. When the affectional bonds are severed through grief, the initial response is resistance to change. Lack of fit requires individuals to change their map of reality, giving up one self-view and the assumptive world-view, while building up new assumptions about the world and self.

One way in which to frame the death event and to reframe living in the new configuration is through ritual acts and behaviours contained within mourning customs of a society. Of major concern in our society is the loss of ritual surrounding death and bereavement. As religiosity declines, so too do the wakes, the funeral processions, the black arm bands, the "shivah" -- the opportunities for the
community to draw together to support the bereaved. While cultures use ritual to legitimize social arrangements -- for example the current trend to elaborate wedding rites -- a reflection of our death-denying society is found in its lack of legitimation of the death.

**Grief as an Illness**

Since World War II, care for the terminally ill has been progressively focussed in the hospital setting thus defining this component of care. Modern hospice/palliative care was first put forth by physicians -- Drs. Cecily Saunders in England and Elizabeth Kubler-Ross in the United States -- who spoke to the need for better care of the terminally ill and their families. It was presented as "a new and challenging opportunity to refocus on the patient as a human being, to include him in dialogues, to learn from him the strengths and weaknesses of our hospital management of the patient" (Kubler-Ross, 1969, Preface).

Recognition was given to the role of the family in the patient's perception of and reaction to illness, and to the concomitant family changes/disruptions that occur in response to the illness trajectory. Grief was acknowledged
as a disorienting process, and subsequently thought to be something that required professional intervention in order to minimize or avoid certain reactions.

"Implicit in this approach are the notions that (1) a spontaneous healing process will occur if the mourner has sufficient psychological health, (2) the mourner should grieve in a certain way, and (3) the mourner should seek professional person’s privileged knowledge about how to grieve" (Silverman, 1986, p.6).

As a result, ‘grief’ was incorporated into medical nomenclature, with certain aspects labelled a "functional psychiatric disorder" (Parkes, 1972, p.6), and couched in terms of ‘healing’ or ‘recovery’ with an implied ‘cure’. The delineation of risk variables inherent in the bereavement process, and their potentiality for expression, has occurred within a medical paradigm. Manifestation of "symptoms" or pain has been considered pathological, hence grief treated as an illness. Expertise was located in the physician or psychoanalyst and the individual required intervention in order to give up, or "decathect" the deceased. With these parameters, it is difficult for grieving individuals to realize that the pain and discomfort associated with grief and bereavement is normal, not
pathological, that it is a process, a transitional period while the individual/family adjusts and adapts to life without the deceased. The objectification of 'grief' as illness created a metaphor in which symptoms equate pathology and individuals "take up residence in the kingdom of the ill prejudiced by the lurid metaphors with which it has been landscaped" (Sontag, 1977, p.4).

While the impetus for change in caring for the terminally ill and their families arose within the medical community, it was noted earlier that the social community of the 1960s engaged in extensive self-appraisal and discerned a need for empowerment and experiential validation. Subsequent societal transformations enabled the expression of the pervasive fear, isolation and impotency of terminal illness and the need for support of the bereaved. This resulted in an almost evangelical attachment to values inherent in a Palliative Care paradigm perceived to be based upon a holistic philosophy of care. Holism appears to be contradictory to the medical paradigm, yet is contained within it. This creates a source of tension for professionals and clients alike. Shifting of attitudes within the hospital and health care systems is reflective of changing attitudes and priorities within the larger society.
Paradigm Shift in the Medical Model

A Cartesian conceptual framework upon which the scientific reductionist method is based has been applied to the concepts of health, illness and pathology. In this view, the body is a machine which can be analyzed in its component parts. Thus 'grief', as we have observed, has been framed in symptomatology based upon concerns about risk, recovery and time-boundedness.

It is important to recognize the culture of the reductionist approach which structures the operational paradigm of medical caregivers/researchers throughout their education and practice. Under this condition, it is natural to delineate bereavement risks in a symptomatic manner. However, cross-disciplinary conflicts can arise from a lack of value congruence. Roberts (1989) maintains that social work and medical value differences "can catalyze successful collaboration between the two professions, which will ultimately benefit patients [and clients] who receive care" (p.211). Rossman (1977), however, cautions that professional intransigence is not easily overcome and that entrenched funding priorities and cure motivation precludes funding for "compassion and empathy" (p.192). He asserts that hospices are in "hostile territory" competing for
limited resources, and offering nothing but anecdotal evidence of success. There are reasons therefore, for amassing a body of knowledge that should not escape practitioners of any discipline. Legitimation precludes marginalization -- an occurrence prevalent with alternate health care (ie. homeopathy, naturopathy) -- and ensures incorporation/acceptance into the medical community. Another impetus for data formulation is legitimizing claims for funding which would conceivably save health dollars. Lamers (1988) cites lack of hospice/palliative care funding as a constraint on hospice research but emphasizes that the value of research cannot be underestimated as benefits to patients and families and dissemination of knowledge legitimizes concerns and needs. Dush (1988) notes that while there is an increase of articles (approximately 2000 in the period 1980 - 1985) pertaining to the hospice concept, death and dying theory, pain and symptom control, only seven per cent (7%) cited grief as the primary area of focus, and none cited bereavement. He feels large gaps are to be found in the areas of prevention, hospice family psychology, "specificity in defining measurable aspects of what we are trying to accomplish by our efforts", and program research (Dush, 1988, p.26). Yalom and Vinogradov
(1988) found "only four empirical studies in the professional literature which attempt to examine the efficacy of bereavement groups" (p.420).

Consideration may also be given to the need for renewed direction in a medical community that has avoided the issue of death and has subliminally promoted death denial in its all out war on disease.

"The medicalization of society has brought about the epoch of natural death to an end. Western man has lost the right to preside at his act of dying. Health, or autonomous power to cope, has been expropriated down to the last breath. Technical death has won its victory over dying. Mechanical death has conquered and destroyed all other deaths" (Illich, 1976, p.210).

Paradigms are perceived to be "a pattern of metaphors which leads to an internalization of a "map" of reality or a belief system" (Schwartz and Ogilvy, 1979, p.2). A paradigm shift within the medical model results in some subtle, yet pervasive changes in the focus of care throughout the system. A 'shift' requires introspection and acknowledgement of a different world view. The Cartesian model is based upon an objective world having neutral instrumentality. Shannon (1989) asserts that the biomedical
model of disease is becoming obsolete. "Increased focus on promotion and illness prevention have created new demands ... [in which] boundaries between health care providers and patients will undergo dramatic change" (p.32). Patients now have acknowledged rights within the health care system -- however pervasive the pressures of loyalty and obligation to a physician may be. Patient-centered care is becoming a catch phrase. But the shift is greater than "cosmetic" changes. The model itself shifts in Palliative Care -- and with it has shifts the power of the professional (including the physician) to the patient and the family/significant other. With this shift has come the realization that while grief exhibits many of the 'symptoms', grief is not an illness in itself, but rather a process of transition, of change. Recognition is also made of societal factors that "have an impact on the circumstances of death and the course of bereavement" which may necessitate intervention to "facilitate the grieving process [to] prevent or alleviate detrimental consequences of bereavement" (Osterweiss, 1984, p.240).

Incorporating the holistic health paradigm therefore requires a total restructuring of values, in which recognition is given to "individual potential and quality of
life through patient and family participation in the
decision-making and care processes" (Reidy, Levesque, and
Payette, 1987, p.131). The holistic values of self-
determination are far-reaching and complex, and "cannot help
but have an impact on the institutional system, and even
perhaps on the global health system" (Ibid, p.146).

Research Questions

It is hypothesized that Palliative Care reduces
bereavement risk through its incorporation of the family as
the unit of care. In this way the family unit is empowered
and gains control over treatment and intervention issues.
It is noted in the literature that while many family members
with palliative care experience choose not participate in
bereavement support groups, other families do (Vachon, 1988;
O’Toole, 1987; Roy and Sumpter, 1983). This observation
begs the questions:
• "for whom is bereavement care effective?" (Osterweiss,
  1988),
• what needs are met for those who participate?
• why do some individuals choose not to participate?
• what personal/social barriers exist to participation in
  bereavement support activities?
Research Objectives

The exploration into the efficacy of bereavement follow-up began with a modified replication of a quantitative study carried out by Cameron and Brings, at the Royal Victoria Hospital Palliative Care Unit in 1976. Realizing that there are limitations in replication, a further explication of the grieving process incorporating a qualitative analysis utilizing William Worden's "tasks of grieving" was also included in the exploratory design. This qualitative framework clarified meaning structures and the bereavement process over time, which enabled evaluation of the effect of bereavement intervention and provided support for its utility as a preventive health intervention.

The original Cameron study was carried out in 1976 -- in the infancy of palliative care in both Canada and the United States. While personal loss and grief response does not change, the structures within which it is framed, hence the personal framing, have done so. Palliative Care programming, which encompasses a bereavement follow-up component within its mandate for continuity of care, now has its own history, its own tradition, and its own culture. It was defined within the medical model, however it subscribes to values, goals and objectives that impose a paradigm shift
toward holistic patient-directed care. The evolution of palliative care has created a subtle shift in the approach to total care which is mirrored by expectations of the people within the process -- both clients and professionals.

Through the modified replication of the Cameron-Brings study and, more importantly, the further analysis through application of Worden's Four Tasks of Grieving, this thesis will endeavour to clarify the efficacy of bereavement intervention by exploring:

• the need for bereavement intervention,
• implications for practice which will address family resource evaluation through contextual analysis, and will speak to social structures which impinge upon or ameliorate the grieving process,
• policy implications for provision of bereavement intervention programming.

Summary
This chapter has provided an introduction to this research project by addressing:
the historical development of bereavement care through the palliative care movement,
values inherent in social structural changes which may affect bereavement outcome,
the lack of research in the specific area of bereavement intervention.

Encompassed within an analysis of bereavement resolution is an interwoven tapestry of time and interpretation with which individuals frame their grieving experience and their perceived need for bereavement support. The covert shadow of structural change (both in society and in the medical model itself) has led to a broader analysis of bereavement care and process. A greater strength of the full inquiry is found in the elucidation of conceptual and philosophical growth, which has broader implications for Palliative Care and client empowerment.
CHAPTER 2
THEORETICAL FRAMEWORK

This chapter provides a substantive inventory of bereavement risk factors, the definition of grief, and factors which ameliorate the bereavement process. Rationale is explored for provision of bereavement intervention from three perspectives: social cost, informal and formal support networks.

Introduction

It is known that bereavement is a powerful stressor that can result in family breakdown, ill health (mental and physical), inability to work or to cope with school, and suicide. This is exacerbated by disruption of social ties and coincident isolation and loneliness, and occurs concurrently with changing roles, establishing a new identity, and finding meaning in life (Vachon, 1982). The process can take up to four years or longer and depends upon many factors, among which are: the age of the deceased, the quality of the relationship with the deceased and within the
family network, and the strength of the support network. It will particularly effect children and those with dependent children, young marrieds, elderly men over seventy years of age, and individuals in poor physical or mental health. Symptoms of grief include: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, impaired judgement, and appearance of traits of the deceased (Lindemann, 1944; Vachon, 1982). Separation and individuation -- the movement from acknowledging the loss to reinvesting energy into life and living -- is the long-term process of grief (Worden, 1982; Kivowitz, 1988).

Grieving is a highly individual process and its resolution assumes various characteristics which encompass individual effectiveness in meeting personal needs, perceived on-going social network support over time, readily available professional assistance, and a repertoire of coping skills. Bereavement support is perceived as a means of enhancing social networks and decreasing personal distress. Anticipatory bereavement, the opportunity to contemplate the loss of a loved one in the supportive and caring environment of a Palliative Care Program, can also


augment the bereavement process (Rando, 1986; Schoenberg, 1974; Wasow and Coons, 1988). It is felt that Palliative Care reduces bereavement risk through its incorporation of the family as the unit of care.

**Grief Defined**

Grief is defined as the personal experience of the loss, and grieving -- or mourning -- as the process of adaptation to the loss (Worden, 1982, p.31). While much is written about the needs of the bereaved, little is known about the meaning of the death event to the bereaved and how it structures their mourning. There does not seem to be agreement on the definition of the grieving process. It has been defined variously as "a process of psychological reintegration" (Marris, 1986, vii), "a process of 'realization' by means of which affectional bonds are severed and old models of the world and self given up" (Parkes, 1971, p.101), "a period of transition... the process of going from one situation to another" (Silverman, 1986, p.8), a "disequilibrating" event that results in role change over time (Ibid).

Worden (1982) suggests that "uncomplicated grief
encompasses a broad range of feelings and behaviours" that fall into four general categories (p.19). These categories are groupings of data derived from years of research stimulated by Lindemann's watershed study of 1944. One manifestation encompasses physical sensations that are most commonly reported by grieving individuals:

1. Hollowness in the stomach
2. Tightness in the chest and/or throat
3. Oversensitivity to noise
4. A sense of depersonalization
5. Breathlessness, shortness of breath
6. Muscles weakness and/or lack of energy

For simplification, Table 1 outlines the remaining three of Worden's four categories of grief manifestation which include the feelings, cognitions and behaviours observed in various uncomplicated grief reactions.
Table 1: Manifestations of Normal Grief (Worden, 1982).

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Cognitions</th>
<th>Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>sadness</td>
<td>disbelief</td>
<td>sleep disturbance</td>
</tr>
<tr>
<td>anger</td>
<td>confusion</td>
<td>appetite</td>
</tr>
<tr>
<td>guilt</td>
<td>preoccupation</td>
<td>disturbance</td>
</tr>
<tr>
<td>anxiety</td>
<td>sense of</td>
<td>absent-mindedness</td>
</tr>
<tr>
<td>loneliness</td>
<td>presence</td>
<td>social withdrawal</td>
</tr>
<tr>
<td>fatigue</td>
<td>hallucinations</td>
<td>dreams of the deceased</td>
</tr>
<tr>
<td>helplessness</td>
<td>shock</td>
<td>avoiding reminders</td>
</tr>
<tr>
<td></td>
<td>yearning</td>
<td>searching</td>
</tr>
<tr>
<td></td>
<td>emancipation</td>
<td>restlessness</td>
</tr>
<tr>
<td></td>
<td>relief</td>
<td>crying</td>
</tr>
<tr>
<td></td>
<td>numbness</td>
<td>visiting places</td>
</tr>
<tr>
<td></td>
<td></td>
<td>treasuring objects</td>
</tr>
</tbody>
</table>

As bereavement denotes a profound loss, it is suggested that reconciling the loss involves various tasks of resolution and phases of adaptation (Worden, 1982; Rando, 1984). Worden posits four tasks of resolution implicit within the grieving process — accepting the reality of the loss, experiencing the pain of grief, adjusting to the loss of the individual and reinvesting energy in new relationships and activities (Worden, 1982, pp. 11-15). This process is exacerbated by the "unique, individualistic perception of loss by the griever", and is further compounded by the social and cultural structures within
which the individual structures meaning (Rando, 1984, p.15),
thus influencing the perception of need for supportive
intervention.

The Meaning of Grief

Grief has been summarily defined above. Whatever the
definition, the ultimate meaning for the bereaved individual
is embodied within the relationship between feelings,
purpose and action, and their conceptual organization.
Bereavement undermines the trust in attachment and results
in ambivalence or disruption of meaning. Throughout an
individual's growth and development, the melding of
attachment and experience leads to the formation of
behavioral strategies. Through these schemata,
relationships are developed that entail the structuring of
meaning. Bowlby (cited in Marris, 1986) suggests that
bereavement is a process of psychological reintegration
whereby 'meaning' is related to conceptual reorganization,
through emotional and purposive organization of
relationships. The assessment of bereavement intervention
relies upon recognizing the individual's framing of the
death event and the ability to evaluate the behavioural strategies embodied within their particular bereavement process.

Obershaw (1977) describes grief as an all encompassing "psychological, physiological and sociological reaction to loss" (p.72) -- Figure 1. The process incorporates: protest -- numbness and disbelief; despair -- confirmation of loss and catalyst for grief expression; detachment -- pulling back from the deceased person; and, reorganization -- decreased emotional upheaval when discussing the deceased. When this process is ameliorated or aggravated by social support networks, family structure, flexibility and resources, the meaning of the grief process becomes more apparent.
"Meaning [is seen] as a crucial organizing principle of human behaviour [as it] relates purposes to expectations so as to organize actions, [with] the compelling reasons to act constituting the trauma of loss" (Marris, 1986, vii).

The critical interaction of cognitive, emotional and evaluative framing is incumbent upon the meanings derived by the individual from on-going attachments and support. As can be seen in Figure 1, Obershaw presented the grief process in basically a linear progression. It should be noted however that a process occurs over time, and is not
linear. Fiefel (1987) contends that "the route of grief appears to be one of tangled and complex pathways, with trails looping back and forth" (p.15). The Obershaw model could therefore be adapted to reflect this non-linear progression in the following manner:

Figure 2: Non-linear Representation of the Bereavement Process

Thus the evaluative framing over time indicates there are two major components to grief resolution — meaning and time.

Adaptation to Loss

Grief Process Throughout the literature there is discussion regarding bereavement resolution and the mourning
processes by which this is achieved. Considerations of phases, stages, sequences and tasks structure this process delineation. Much of the discussion relates to Freud and his concept of "grief work" in which the "bereaved gradually undoes the psychological bonds that bound him to the deceased" (Raphael, 1982, p.33). Under these conditions the multidimensional layers of the relationship with the deceased that were built up and internalized over the years, are slowly reviewed and sorted through. As we have discussed previously, this is a painful process encompassing not only the physical reactions to the loss, but also the process of undoing the intricate webs of bonding that went into building the relationship. This process is aided and abetted by the quality of that relationship, and in normal grieving -- where there is little/no ambivalence toward the relationship -- it is common to find feelings of anger and guilt, sadness, crying and despair, relief and emancipation. In his conceptualization of the grieving process in 1944, Lindemann reiterated Freud's reference to "grief work" in his approach to grief resolution, in which the individual:

• reviews the relationship with the deceased;
• becomes aware of the alterations in his environment without the deceased;
• expresses his loss and sorrow; and,
• seeks new relationships/activities from which he can acquire new patterns of conduct (Lindemann, 1944, p.9).

While this process may appear to be step-wise, in actuality it is cyclical and goes forward, then back and then forward again as it gradually changes in shape and complexity over time.

**Stages/Phases/Sequences**  
Sequencing (or stages) contains an inherent structural process -- with various researchers outlining four to twelve stages. This type of approach implies an invariant, or sequential, movement through grieving, and passive participation in the grief resolution by the bereaved. It can also lead to caregivers fitting individuals to the stages rather than seeking a better understanding of the individual and their interpretation of the process.

Rando (1984) identified investigators who have incorporated phases/stages/sequencing in their approach to
mourning. Bowlby (1961) outlined three phases which entail: "the urge to recover the lost object; disorganization and despair; and reorganization". Parkes (1974) expanded these into four phases by adding "the phase of numbness" at the beginning. Engel (1964) expressed six sequences: shock and disbelief, developing awareness, restitution, resolving the loss, idealization, and outcome. Kubler-Ross’s (1967) five stages of dying are also applied to the grieving process: denial and isolation, anger, bargaining, depression, and acceptance. Rando (1984) suggests three reactions, rather than phases, which facilitate movement of the grieving individual back and forth among them: avoidance, confrontation and re-establishment.

Stage or phase analysis of the grieving process is consistent with viewing grief as an illness, where an individual exhibits certain 'symptoms' depending upon how well they are coping/adjusting to the death of their family member. Grieving individuals are thus seen to passively proceed through a phase or stage 'process' until the symptoms dissipate.

Tasks of Grieving    Worden’s approach is task oriented
and involves active engagement of an individual in certain tasks or behaviours to facilitate his/her grief resolution.

This active versus passive participation in the process -- where one is "doing" rather than having something "done to", thus enhancing personal control and competency -- is the rationale behind incorporating task-oriented analysis in this study.

Mourning is the work of grief. Task delineation implies work that needs to be done, that specific "things" need to be accomplished in order to move through the grieving process. An explication of tasks by Parkes and Weiss (1983) outlined three activities needing to be resolved in the recovery process: intellectual recognition and explanation of the loss, emotional acceptance of the loss, assumption of a new identity (Rando, 1984). William Worden combined the tasks of Parkes and Weiss with those of Lindemann (from which they were derived) to elucidate the four tasks of mourning briefly outlined above -- accepting the reality of the loss, experiencing the pain of the grief, adjusting to the loss of the individual and reinvesting energy in new relationships and activities (Worden, 1982) --
- which are further incorporated into a schema for grief counselling (see Chapter 6). "The tasks approach gives the mourner some sense of leverage and hope that there is something that he or she can actively do" (Ibid, p.32) which alleviates feelings of helplessness and provides a means for assessment and intervention in bereavement resolution. It is felt that grieving is not complete until all the tasks have been accomplished, which indicates an end point -- but not total closure, as

"we find a place for what we lose. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else" (Freud, cited in Worden, p.16).

Worden maintains that while there is not a step-wise progression through the tasks, all the tasks require completion in order to facilitate further growth and development. This approach is reminiscent of child development framing by Piaget (1954) where incompletion of a task at a certain level will impair the ability to master tasks at higher levels. Unfinished tasks of grieving are likened to unhealed wounds.
Bereavement Intervention

Rationale

"There is a traditional Jewish proverb that 'to grieve alone is to suffer most'. Grief may be silent for some but it asks for community. We are becoming aware that suppressing or minimizing grief and failure to comprehend its healing power are maladaptive not just for the individual and immediate family but for the larger community" (Fiefel cited in Morgan, 1987, p.17).

It is known that various populations are at great risk for abnormal grieving or prolonged grief reactions. These populations include:

- the elderly, particularly men over seventy years of age,
- young married individuals,
- children, siblings and adolescents,
- those with prior history of mental or extensive physical illness,
- individuals with multiple, and possibly unresolved, losses (Rando, 1984).
The risks include:

- a 15% risk of psychiatric admission for bereaved individuals (Barnes, 1987; McHorney and Mor, 1988),
- high rates of family breakdown with a death of a child, some cite an incidence of 50% - 80% possibility of divorce for bereaved parents (Lauer et al, 1988; Rando, 1986),
- increased morbidity of the elderly in the first year of bereavement:
  - indicated by an increase of six visits to a doctor,
  - resulting in three times the rate of hospitalizations than the normal population,
  - a 40% mortality risk for elderly men within the first six months post bereavement, (Conway, 1988; Frederick and Frederick, 1985; Gass and Chang, 1989; McHorney and Mor, 1988; VandeCreek, 1988; Walton, 1987; Wasow and Coons, 1987),
- 4% of all children will lose a parent prior to the age of eighteen (Masterman and Reams, 1988).
These children are at risk of

- a three year delayed reaction for elementary school-aged children with a 2:1 ratio of admission to child psychiatric programs,
- increased depression in the first year followed by decreased depression and increased behaviour problems (Sandler et al, 1988), and
- drug and alcohol abuse, and suicide if the children are adolescents (Ney, 1987).

The literature substantiates these and many other risks to bereaved populations. In health care costs alone, consideration can be given to the numbers of bereavement-related physician visits which add to the health care burden in terms of physician utilization as well as a threefold hospitalization potential. Other costs include legal considerations of family breakdown, school counselling needs for children, increase in the support requirement from Family Service Agencies and the Ministry of Social Services and Housing, Child Welfare.

Thus preventive implications of bereavement intervention
for survivors must not be underestimated -- risk factors, as mentioned above, can lead to multiple grief expression, some having detrimental effect. Bereavement follow-up has long-term significance and can circumvent these tragic events and their concomitant anguish. The Palliative Care focus on total family care ensures the continuity of care throughout bereavement.

It is recognized that bereavement patterns are systemic, effecting the total family-community health and support network. It was noted previously in the Rationale above, that there are many risks associated with the grieving process. These are generally related to individuals having low social support networks -- elderly males, children, single parents. Social support networks can therefore be seen as protective mechanisms.

**Social Support** Social support provides the means by which individuals receive affirmation of their pain and sustenance during the grieving process. This is reflected in various definitions:

an experience in human solidarity which strengthens bonds between and among people (Wasserman and Danforth,
"enduring patterns or intermittent ties that play a significant part in maintaining psychological/physical integrity over time" (Caplan cited in Wasserman and Danforth, 1988), and, affirmation that an individual is cared for, loved, esteemed and a member of a network of reciprocal mutual obligations (Cobb cited in Wasserman and Danforth, 1988).

Wasserman and Danforth contend that through social support networks, "one's own and other peoples' pain become moral reference points to human connection" (Ibid, x).

There are significant components or dimensions to social support networks that are critical contributors to positive bereavement support and outcome. Caplan suggests that social support provides others who mobilize psychological resources, share tasks; and provide material, skills, or tool resources, and cognitive guidance (cited in Wasserman and Danforth, 1988, p.7). Bloom, (cited in Wasserman and Danforth, 1988, p.9) delineates five dimensions of social support that are echoed by Gottlieb
These are presented below in Table 2.

Table 2: Dimensions of Social Support

<table>
<thead>
<tr>
<th>Bloom</th>
<th>Gottlieb</th>
</tr>
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<tbody>
<tr>
<td>• maintain social identity</td>
<td>• sustains individual emotionally</td>
</tr>
<tr>
<td>• macro - degree integrated into larger society</td>
<td></td>
</tr>
<tr>
<td>• micro - social ties give social identity feedback</td>
<td></td>
</tr>
<tr>
<td>• emotional support</td>
<td></td>
</tr>
<tr>
<td>• loved and valued as a person</td>
<td></td>
</tr>
<tr>
<td>• environmental support - allows expression of anxiety, concerns, problems in an accepting, non-threatening environment</td>
<td></td>
</tr>
<tr>
<td>• information and new ideas enhance personal problem solving capability</td>
<td></td>
</tr>
<tr>
<td>• social affiliation</td>
<td>• unconditional access or available network members who can provide advocacy</td>
</tr>
<tr>
<td>• need for attachment, connection, and bonding.</td>
<td></td>
</tr>
</tbody>
</table>

The importance of these components of social support should not be underestimated in maintaining both physical and
mental well-being of bereaved individuals. The types of support outlined above would alleviate the impact of life stresses, decrease dependency on chemical substances, liquor and tobacco, and assist with recovery through enhancing coping skills.

There appears to be two types of support networks -- informal and formal. However, upon closer scrutiny it seems there is a continuum that extends from 'most informal' (kith and kin) to 'most formal' (government social programmes) with a broad range of 'semi-formal' support configurations in between. This informal/semi-formal sector is the focus for "self-care" and "mutual aid" initiatives by governments (Epp, 1986; Fykes et al, 1988) which result in much of the programming found along the continuum. These support groups are representative of personal initiatives that may or may not have professional impetus and guidance but generally come together at specific times and locations and involve particular populations -- Compassionate Friends (bereaved parents), Widow-to-Widow, etc. Funding may be through personal contribution, government grants (ie. New Horizons for outreach programming), government grants to voluntary
agencies or through formalized arrangements with non-profit organizations (hospitals) or government departments (ie. Community Health).

Informal support networks Informal support generally defines assistance provided by family, friends, neighbours and volunteers, and dominates the non-institutional support of dependent individuals - aged, physically or mentally disabled individuals and children -- as well as the spontaneous or community support for bereaved individuals.

The literature frequently mentions that response to life stresses is less critical for those who have good social supports (Parkes, 1972; Rando, 1984; Mitchell, 1986). Vachon has found that "the best form of intervention with the bereaved is that supplied by family and friends who will let them talk about the deceased" (Vachon, 1982, p.73). These informal networks of kith and kin are supplemented by a number of other helpers -- those considered "natural helpers" and "self-help" groups. Natural helpers can be those found along everyday pathways -- neighbours, the beauty parlour, bars. However, lay relationships can also be supportive in harmful ways by encouraging harmful
processes. Kurtz and Powell (1987) suggest that
"these natural networks may enable the deviant to
become more involved in the problem (protect him from
consequences), stigmatize him for having the problem,
or provide faulty guidance" (p.71).

Self-help groups -- bridging informal and formal
networks. Self-help bereavement groups are generally
included under informal support networks but have evolved
with varying degrees of formality. Pancoast et al. (1983)
define two models of self-help, both which encompass the
support needs of bereaved individuals:
"a clinical model of self help is a means of
individuals and small groups dealing with their own
problems, struggling to survive. ... a structural model
presents self-help as a natural and healthy way for
communities to organize themselves... against loss of
control and self-awareness" (p.12).

That self-help is linked with informal support networks is
open to discussion. However, Pancoast et al. suggest that
it is through the local social networks, the webs of friends
and family, that self-help groups emerge, and that effective interventions take advantage of these existing networks. Societal and demographic changes intensify the lack of informal support networks -- thus forging the need for linkage with self-help support groups.

Demographic changes indicate smaller and more dispersed families thus lack of familial support networks. Increased mobility within society results in lack of social support networks; Movement toward death-in-hospital versus death-in-home/community increases the invisibility of death, hence invisibility of the bereaved, which in turn exacerbates discomfort with death and others' pain; Increased social isolation is a result of decreased social support.

Self-help bereavement groups are organized around bereavement issues, and can be general in approach or specific to sex/age/life cycle factors. There may be little or no involvement by professionals, and emphasis is on helping one another through an environment that "creates community, enhances personal locus of control, and
emphasizes interaction and growth" — all conducive to sharing and healing (Klass and Shinners, 1982, p.38).

Generally this informal caregiving results from people who have experienced their own losses in the past, and are actively motivated to reciprocate assistance they previously received from others. Hoehne (1986) indicates that social support groups comprise 39.8% of the self-help organizations in Canada in 1986, with groups for widow/ers accounting for 6% of this number. These groups enhance the informal networks of individuals but are not the only source of support. Churches, seniors groups, and voluntary agencies also fill this gap.

Difficulties occur, however, in the voluntary aspect of self-help as leadership waxes and wanes over time with individuals moving in and out of the groups, or groups becoming maladaptive as individuals get "stuck" and becoming territorial. Without a professional component, continuity of support can be lacking, individuals requiring greater assistance may not be referred or find their needs not being met, and pathological grieving can develop.

Another concern with self-help is the personal effort
involved in connecting with a support group at a time when focusing energy beyond survival can be insurmountable.

Self-help is also not a panacea -- it is not for everyone and in some cases, as alluded to above, can produce iatrogenic effects. Fisher et al. (cited in Gottlieb, 1988) suggest that individuals will cope on their own:

"to the extent that they do not perceive a particular condition as problematic; or

to the extent that they believe the benefits of seeking or accepting assistance are outweighed by the costs"

(p.269).

This puts the onus upon an grieving individual to seek assistance at a time when self esteem may be lowest and vulnerability highest. Psychological and social costs result if there is a stigma attached to being perceived as weak and unable to cope with the stresses of bereavement, or if the values of the person's reference group do not subscribe to 'outsiders' help. Under these circumstances an individual will not access needed support.

**Formal Support Networks** The formal support sector is made up of both nonprofit organizations -- voluntary
organizations, charities and hospitals -- and the private-for-profit industries, as well as direct government programmes. This latter support is generally seen as a vast array of social programmes and benefits available to members of a society and would encompass survivors' benefits and pensions. Some fall within the realm of provincial jurisdiction and are available through the Ministry of Social Services and Housing, under which GAIN for Seniors is administered; and the Ministry of Health, responsible for Seniors and Community Health issues. Unfortunately government policies, or lack thereof, do not encourage the development of creative bereavement support networks through schools, community agencies and neighbourhood houses. While basic benefits come to be accepted as entitlement, the residual nature and poor quality of many services function to create a void into which self-help becomes a remedial compensator (Pancoast et al. 1983).

Substitute support systems Historically, social workers were given the responsibility to develop expertise in implementing strategies for finding and sustaining adequate, life-giving, substitute placements or activities
that will support individuals in the community. These have been seen in the development of foster care, adult day centres, and volunteer networks. However, very little is available outside hospice/palliative programming to complement or enhance the grief recovery process. Even palliative programs are receiving limited funding which results in less intervention with bereaved individuals, a particularly dangerous situation for those at risk.

Temporary support systems The hospital or hospice bereavement programmes that exist tend to offer support only to individuals who are family members involved in their specific programming. These supports tend to be temporary. Generally this support is offered in four to eight biweekly meetings after which individuals may be very much on their own. Only one program, the bereavement program of Lions Gate Hospital, offers an on-going, unbounded program to which any bereaved individual is welcome. There are pros and cons to both approaches which will be discussed further in Chapter 6.
Summary

This chapter has presented information that delineates risk factors and theoretical framing of the bereavement process. Rationale for bereavement intervention was presented, as well as a summary of informal and formal support systems, with discussion of self-help activities which "represent a continuum of arrangements for engaging in mutual aid" (Pancoast et al. p.19, 1983).
CHAPTER 3
QUANTITATIVE ANALYSIS AND FINDINGS

This chapter provides a description of the quantitative methodology followed in this study. The quantitative analysis was undertaken in an attempt to replicate a study by Cameron and Brings (1980)/Cameron and Parkes (1983), to test the efficacy of bereavement intervention, and was carried out according to the Cameron and Brings, (1980)/Cameron and Parkes (1983) protocols. The findings of the analysis are also presented.

Rationale for the Quantitative Analysis

There is a dearth of information pertaining to the assessment of bereavement intervention in palliative care programming. Existing research has compared groups having palliative care experience and bereavement follow-up with groups who have neither intervention (Cameron and Brings, 1980; Cameron and Parkes, 1983). The current study compares two groups of individuals, both having palliative care experience, but only one group having bereavement
intervention as well. Osterweiss (1988) suggests that "assessing the effects and effectiveness of hospice bereavement components is complicated by the fact that bereavement support permeates all of hospice" (p. 79).

The perceived gap in the literature and a strong indication of need for verifiable (i.e., replicable) studies with which to substantiate knowledge provided the impetus for replicating the Cameron study. A complementary replication of a study carried out by Cameron and Brings at the Royal Victoria Hospital in Montreal, published in 1980, and republished under Cameron and Parkes in 1983, is presented in this chapter.

"The aim of the study was to evaluate the effect of bereavement follow-up provided by the Palliative Care Unit (PCU) upon the surviving relatives of patients who had died thereby comparing them with a matched group of relatives of patients who had died in other wards of the same hospital" (Cameron and Parkes, 1983, pp. 73).

The purpose of the quantitative analysis in the current study is to ascertain whether bereavement outcome differs between those individuals with bereavement intervention and
those without bereavement intervention. While all of the subjects have Palliative Care Programme involvement, only some choose to participate in bereavement follow-up.

As part of the Palliative Programme under investigation, all programme families are personally invited and encouraged to access bereavement follow-up support. Roy and Sumpter (1983) have determined that only 25% respond -- a statistic borne out by the annual response rate of the study Palliative Programme. Questions have been raised about the efficacy of providing such programming, with the suggestion that a palliative programme itself may provide sufficient anticipatory bereavement and support thus ameliorating the grieving process.

Methodology

The original study by Cameron and Brings was carried out twelve months and two weeks after the patient’s death. The timing was chosen so that it would be after the anniversary date of the family member’s death and thus attempt to avoid influence of "anniversary depression", yet memories of the illness and activities of early bereavement
would still be clear. There were sixty-eight (68) relatives contacted, of which fifty-nine (59) agreed to be interviewed. The questionnaires were administered over the telephone and the results were examined to provide two matched groups of twenty (20) each, for further analysis.

To quantitatively assess the effect of bereavement group intervention in the current study, two groups of subjects with Palliative Care experience were identified -- those with the bereavement group participation, and those without. To accommodate the analysis, the base protocols developed by Cameron and Brings -- procedures, questionnaire, grief and adjustment inventories -- were incorporated into a modified complementary replication. Both populations in the study had the Palliative Care Programme support prior to the death of the family member. In the Cameron design only one group had the Palliative Care Programme and bereavement follow-up experience, and the other had neither.

**Sample Selection**  A desired sample size was fifteen (15) for each group. The total number of the Bereavement Group participants was sampled as there were only ten (10) individuals in this group. The response rate was 80% with
eight (8) out of ten (10) responses.

The sample of those without bereavement intervention (a population of 34) was selected through disproportionate stratified random sampling based upon the age and sex stratification of the group with bereavement intervention, to facilitate a matching between the two samples (Appendix I). This method of sampling increases "precision in estimating population value and improves adequacy of the size of each sample strata for the analysis" (Eckhardt and Ermann, 1977, p.193). From the derived sample of fifteen (15) individuals, there was seven (7) responses for a 47% response rate.

This portion of the study was not without complications -- many of which are reflected in a current evolution of structural change and commitment to Palliative Care within the study hospital. At the outset, the replication of the Cameron study included a third population -- one with neither the Palliative Care nor bereavement support experience. A lack of individuals in this population was found and appears to be a reflection of the changes which have occurred within the hospital. Since the
inception of its palliative care program ten years ago, essentially all physicians refer terminally ill individuals and their families to the programme. The result was a limited population/samples of ten (10) family members, six of whom were adult children, not spouses. The response rate from this population precluded the use of a sample from this group. Only two responses -- both spouses -- were received, and another spouse's letter was returned with no forwarding address. Of the two responses, one spouse referred himself immediately for bereavement counselling and was therefore not part of the study. The other spouse had extensive knowledge of palliative care, but his wife had adamantly refused to participate in the programme or to accept any outside help in the home. Without this population the focus of the quantitative analysis changed to the one presented in this Chapter.

Thus the final study sample was fifteen individuals of whom twelve could be paired for the quantitative analysis. The pairing was based upon the criteria established by the Cameron and Brings study -- age, sex and relationship to the deceased. Data derived from all fifteen subjects were
incorporated into the qualitative analysis (Chapter 4).

Data Collection Procedures

All subjects were involved with the Palliative Care Programme at a tertiary care hospital in British Columbia. The samples for each group were derived from the Palliative Care Programme lists. The study covered a time period of three months. All individuals were contacted thirteen months post-bereavement. An introductory letter from the Palliative Programme Social Worker accompanied the researcher's request for the subjects' participation in the study. Upon receipt of the returned consent form, a telephone call was placed to make an appointment for a telephone interview. The telephone interview generally took from 45 to 60 minutes.

The interviews were conducted in a conversational style using the Cameron and Brings Questionnaire which was utilized as an interview guide (Appendix II). This allowed for eliciting basic information from all respondents, but also permitted probing and exploring information that illuminated the subject matter (Patton, 1989). Open-ended
questions were added to encourage further clarification of certain areas not covered in the original document (i.e. cremation).

The general issues addressed in the interview were:

1. Bereaved Individual -- age, sex, relationship to the deceased, quality of that relationship, time of illness/preparation for the death.

2. Family Relationships -- number of children, relationship changes, changes in living arrangements.

3. Social Support -- neighbours/friends, activities and hobbies, social clubs/groups.

4. Financial Concerns -- impact of the loss on employment, pension income, housing change, new employment, estate/will.

5. Personal Health Issues -- prior/post bereavement history, use of tranquillizers, alcohol, tobacco.

6. Anticipatory Bereavement -- the Palliative Care Experience, time for preparation for the death.

7. Religion, Ritual, Bereavement Anniversary -- religiosity, funeral/memorial service, burial/cremation, visits to grave/other location.
The Cameron and Brings Questionnaire  All study subjects participated in a telephone interview which incorporated a modified Cameron and Brings Questionnaire (Appendix II). Changes were made to the Questionnaire when it was found that the it contained assumptions and biases that required rewording to preclude imposing symptoms onto the respondents. For example under "Health Since Bereavement", a question asked the respondent if,

"compared to the time immediately after the death, do you feel ... "more depressed ___ less depressed ___ about the same ___"."

Exception was taken to the term "depressed" by the second respondent. This term was changed to "sad or depressed" thus allowing the respondents to choose the best fit for their experience, where upon ten chose "sad", and four replied "depressed". While "sad" is also naming the feeling, it is the feeling label suggested by the respondent
and is a known bereavement reaction (Worden, 1982). It is also less value laden than "depressed", which had very specific connotation for the respondents. Those who replied "depressed" used both terms in different contexts which indicates discrimination of meaning.

To account for changes in funeral and burial practice, the section on "Cemetery" required additional probing that would elicit ritual behaviour other than "visiting the grave". Here a question was added asking if there was "a special place that reminds you of (your family member) that you visit?". The responses were appropriate for the number of individuals whose family member was cremated (70% of the sample), and for some, given the degree of grief resolution, quite creative.

Respondent: "I can always go and stand in my closet... (laughter)... you see, I didn’t know what to do with him for the longest time, so I kept him in my closet!"

Respondent: "The Parks Board wouldn’t allow me to
inter the ashes at the tennis courts in Stanley Park, but I cheated and took a pinch [of ashes] over, and now I can go and watch a good game of tennis with him!"

Respondent: "My front room is full of plants given to me when my husband was dying. Now they are blooming and doing wonderfully. This, in a way, keeps him alive for me. Being in that room makes me feel close to him."

The Therapeutic Interview Consideration was also given to the dynamics of the interview, as it has been established that the interview itself effects responses. While the therapeutic interview is generally defined in the clinical sense, having some identifiable outcome, the information interview can also be interpreted in this vein.

Basic to grief resolution is developing an understanding of the death event itself. The bereaved individual generally accomplishes this through numerous reiterations of the death event, the illness trajectory and
other pertinent experiences in which the event is framed. Thus, "during the course of an interview, information-seeking questions and therapeutic consequences often coexist" (Fuchs Ebaugh, 1988, p.213). Two respondents were very specific about the interview process -- one emphatically stating "I have to do this", and the other sharing that

"This form of interview [telephone] has been most helpful as I am very shy and would never have been able to share this information in a group or face-to-face setting" (Respondent).

Both individuals had never fully told their stories; the former felt 'driven' to do so.

When dealing with potentially stressful areas of investigation, the investigator must be sensitive to the respondent’s need for information and control. This may entail "explicit negotiation of [the] research relationship" (Sutton and Schurman, 1988, p.345). Respondents to the current study were generally open in expressing their grieving experiences. Many commented that the opportunity to share their story had been therapeutic. However, prior
to interview commencement, it had been clearly established that they could withdraw from the study at any time or could refuse to answer any of the questions. The purpose of the study was clearly explained, and any further questions were answered openly by the researcher. This, in effect, established not only a trust between the interview participants, but also a shift of control to the respondent, allowing their full direction within the parameters of the interview. The primary concern was the respondent's interpretation of the death and grieving events and issues, not the investigator's. This had resulted as mentioned above, with the Questionnaire being "opened up", and the respondents encouraged to respond in their own words and to share their stories with a minimum of imposed structure. While the questionnaire was used as a guide to facilitate covering a range of grieving experience, the individual "story" was fostered through empowerment.

Quantitative Data Analysis

Cameron and Brings Grief and Adjustment Inventories Each subject participated in a telephone
interview and the results were assessed using two inventories developed by Cameron and Brings, 1980 (Appendix III). A value of 'one' was assigned each time a classified item occurred in the subject's profile. The classified items corresponded to symptoms of grief which include: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, impaired judgement, and appearance of traits of the deceased (Lindemann, 1944; Vachon, 1982). These values were added up and resulted in two scores for each respondent — a Grief Score and an Adjustment Score. The Grief Score reflected the presence of grief symptoms, some described as 'maladaptive', while the Adjustment Scores reflected the absence of the grief symptoms.

Interview Coding  When coding the respondent's replies, a value of one was assigned each time a classified item occurred in the subject's profile. These items were contained in two coding frames — the Cameron-Brings Anniversary Grief Inventory and Adjustment Inventory (Appendix III) — and presented difficulties of confounding variables, cultural bias, and hyperbole. For example:
"Undesirable weight change still persists" and "Has not recovered lost appetite" can each be broken down to three confounding variables:

"Undesirable / weight change / still persists"

"Has not/ recovered/ lost appetite"

Words like "haunted" and "intolerable" together in a sentence not only exaggerates the variable "memory of the death" but also has serious cultural connotations for individuals with prescribed religious ritual on the anniversary of the death. Modifications made to the coding frame allowed for consistency in scoring. This permitted quantifiability and replication of the statistical analyses used in the Cameron and Parkes study.

A final concern related to the coding frames was the underlying premise of personal responsibility for grieving resolution and outcome. While the questionnaire elicited information relating to social and family supports, financial and living arrangements, this information was not utilized in the inventories, and the individual, by inference, was "blamed" for social isolation, not engaging in new activities or relationships (friendships). These
factors can be highly dependent upon age, sex, and accessibility -- both financial and physical -- as well as support network strengths.

Both the interviews and the coding were carried out by the investigator thus imposing consistency into the approach and analyses.

**The Wilcoxon Matched-Pairs Signed-Ranked Test**

Following the Cameron and Brins (1980)/ Cameron and Parkes (1983) analysis protocol, the Wilcoxon Matched-Pairs Signed-Ranked Test was administered. The assumptions inherent in using this test were:

1. that the samples were from the same population and were therefore related -- all the subjects were matched on relevant variables -- age, sex and relationship to the deceased -- thereby achieving control through matching;

2. a group which had undergone a treatment was being compared to one which had not -- those with bereavement intervention were compared to those without;

3. the scores of the two groups may or may not be
distributed normally in the population from which
the sample was drawn, therefore a distribution
free test was desired; and,

4. the level of measurement is ordinal (Siegel,
1956).

In terms of the Wilcoxon Test, the null hypothesis
would find no difference in grief outcome between the two
groups, thus the Grief and Adjustment Scores of the groups
will differ only by chance. With the alternate hypothesis,
the sum of the positive ranks would significantly differ
from the sum of the negative ranks for each scoring.

**Fisher's Exact Test** The Fisher's Exact Test is carried
out when cross-tabulating small samples and replaces the $X^2$
test administered in the original studies (which had a
larger sample size). It is a probability test which
analyzes discrete data, and is helpful in ascertaining
whether independent variables fall into one of two mutually
exclusive classes.

**Description of Method of Quantitative Analysis**

The respondents -- eight from the "bereavement" group,
and seven from the "non-bereavement" group -- were matched into six (6) pairs. Following the original protocol, the pairs were matched for age, sex, and relationship to the deceased. The pairs were comprised of two daughters, four widowers and six widows, ranging in age from twenty-eight to seventy-nine.

Grief and Adjustment Scores were derived from the Cameron Inventories. Cross-tabulations were carried out to ascertain variable relationships that may have contributed to the Grief and Adjustment Scores. The Scores were compared using the Wilcoxon Matched-Pairs Signed-Ranks Test which indicates both direction and magnitude of differences.

Findings of the Quantitative Analysis

The complementary replication of the Cameron-Brings study was carried out with mixed results. As previously mentioned, the samples were matched according to the criteria established by Cameron and Brings -- age, sex and relationship to the deceased. These were characteristics that were available to the investigator prior to the interviews and analysis and were implemented in the sampling
of the group without bereavement intervention. A difficulty arose however when it was found that the two samples were in fact not comparable. This was found when the Fisher's Exact Test was carried out and it became apparent that there was a difference in the amount of time for preparation for the death which influenced the decision to participate in the bereavement intervention.

Cross-tabulations All of the study respondents had been participants in a Palliative Programme. Cross-tabulations were carried out to see what variable relationships may have contributed to the differences observed in the Grief and Adjustment Scores. It was thought that poor health, religious belief and practice, and social support may have contributed in some way to participation in the bereavement support group. Almost the total population indicated some health-related grieving difficulties and only 30% indicated that the health issue was resolved. However a cross-tabulation of health and bereavement group participation showed no significant relationship between these variables. As well, religious practice did not differentiate between those responding to the bereavement
support and those who didn't. Age and sex were equally nonpredictive. Those with perceived low social support were divided equally between the two groups. Cross-tabulations were run on the variables of "prep" -- months ill before death, and "BG" -- bereavement group, with some startling results. It was speculated that some of those who participated in the bereavement group may have had little time to prepare for the death of their family member.

**Fisher's Exact Test** Table 3 shows the cross-tabulation of 'bereavement group participation' with 'time for preparation' and the Fisher's Exact Test results. The contingency table shows that there is a division between those who participated in the bereavement group and those who did not.

A direct relationship was found between the time individuals had to prepare for the death and participation in the bereavement group. Those who had nine (9) or less months to prepare for the death were ALL in the bereavement group. One individual had eleven (11) months to prepare but also had no familial or social network support and was a male over seventy years of age. The range of preparation
time for the Bereavement Intervention group was 3 - 11 months; while the range for the others was 11 - 72 months.

Table 3  Cross-tabulation of Preparation Time and Bereavement Group Participation.

<table>
<thead>
<tr>
<th>Bereavement Group Participation</th>
<th>Yes</th>
<th>No</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation Time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( &lt; 10 months)</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>100.0</td>
<td>83.3</td>
<td>41.7</td>
<td></td>
</tr>
<tr>
<td>(&gt; 10 months)</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>16.7</td>
<td>83.3</td>
<td>58.3</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>58.3</td>
<td>41.6</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Statistic  One Tail  Two Tail
Fisher's Exact Test 0.00408  0.00466

Statistic  Symmetric  Dependent  Dependent
Lambda  0.83333  0.83333  0.83333  

Both the one-tail and two-tail probabilities were less than p = .005, thus indicating significant results in
these comparisons. The Lambda statistic indicated that there is an 83% reduction of error when using 'time for preparation' to predict 'bereavement group participation' and vice versa and is thus deemed symmetrical.

From these data two observations can be made:
1. family members who have little time for preparation for the death appear to perceive a need for bereavement follow-up; and,
2. a careful assessment is required of those with longer preparation periods -- especially if combined with low social support. Greater effort should be made to involve them in some form of bereavement follow-up as some may require additional support (given the Grief and Adjustment Scores for the group without bereavement intervention).

The finding concerning the time for preparation benefits from clarification. All the deceased died of cancer. Cancer is a generic term for a group of diseases that generally have a discontinuous disease trajectory over time. In the literature it is termed "episodic" and relates to the characteristics of alternating stable
periods of varying length -- normally referred to as "remission" -- followed by exacerbation (Rolland, 1989). This effects family system adaptation to disease in many ways, primarily in the manner in which role reallocation and crisis response are incorporated into family functioning. Given a longer disease trajectory, an anticipatory bereavement process may be supported through the palliative program. Also, the integration of time with personal interpretation and meaning of the death event may allow for greater resolution of some of the grieving issues.

It has been suggested that the time for preparation substantially impacts family functioning and adaptation - - shorter period of preparation time results in greater disintegration and risk (Adams and Lindemann, 1974; Rolland, 1989). As is observed in this study, the bereavement group is entirely composed of individuals who had comparatively little time to prepare for the death of their family member.

Wilcoxon Matched-Pairs Signed-Ranks Test The Wilcoxon Test was carried out and the results illustrated
the difficulty of small sample size compounded by lack of comparability of the two samples due to the variable of 'time for preparation'. While there was a variation in the Grief and Adjustment Scores between the samples, the differences were not significant and could not lead to any conclusions about the efficacy of bereavement intervention. The statistical analyses of the Grief and Adjustment Scores have been included for information.

Table 4: Differences in Grief Scores between those With and Without Bereavement Intervention using the Wilcoxon Matched-Pairs Signed-Ranks Test.

<table>
<thead>
<tr>
<th>Pair #</th>
<th>Without Intervention</th>
<th>With Intervention</th>
<th>d</th>
<th>Sign Direction</th>
<th>Wilcoxon Rank</th>
<th>Rank with less frequent sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
<td>2</td>
<td>-4</td>
<td>-</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>9</td>
<td>-5</td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>11</td>
<td>+4</td>
<td>+</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>7</td>
<td>+7</td>
<td>+</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>5</td>
<td>-15</td>
<td>-</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>2</td>
<td>-2</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

T = 6.5

Grief Scores: The least desirable score for the Grief Inventory is 33, with the most desirable is 0. The range of scores achieved for both samples was 20 to 0. There
is no information about 'expected range' in the original studies (Cameron and Brings, 1980/Cameron and Parkes, 1983) and the Scores listed in Table 4 can only indicate if one group has done/not done as well as the other, thus are relative and not definitive.

Table 5: Computer Analysis of Grief Scores using the Wilcoxon Matched-Pairs Signed-Ranks Test.

<table>
<thead>
<tr>
<th>mean rank</th>
<th>cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.00</td>
<td>4  - ranks (with &lt; without)</td>
</tr>
<tr>
<td>4.50</td>
<td>2  + ranks (with &gt; without)</td>
</tr>
<tr>
<td>0</td>
<td>0  ties</td>
</tr>
<tr>
<td>6</td>
<td>6  total</td>
</tr>
</tbody>
</table>

\[ z = -0.3145 \quad 2\text{-tailed } p = 0.7532 \]

"Without Intervention" Grief Scores  The range of scores for those without bereavement follow-up was 20 to 0, with the mean equalling 8.167, and the median being 5. Both the maximal and minimal attainable scores were represented in this sample indicating a wide range in grief resolution during the thirteen month period -- some doing very well, others doing relatively poorly. Two individuals were each found to have a 'maladaptive' grief score (See Appendix III).
"With Intervention" Grief Scores  The range of scores for those with bereavement follow-up was 11 to 01. The mean was 5.75, the median was 6 indicating fairly even grief resolution.

Adjustment Scores  The most desirable Adjustment Score is 14, the least desirable being 0. The range of scores for both samples was 01 to 14.

Table 6: Differences in Adjustment Scores between those With and Without Bereavement Intervention using the Wilcoxon Matched-Pairs Signed-Ranks Test.

<table>
<thead>
<tr>
<th>Pair #</th>
<th>Without # Intervention</th>
<th>With # Intervention</th>
<th>Δ</th>
<th>Sign</th>
<th>Wilcoxon Rank</th>
<th>Rank with less frequent sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>12</td>
<td>+2</td>
<td>+</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>12</td>
<td>+7</td>
<td>+</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>9</td>
<td>+3</td>
<td>+</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>14</td>
<td>5</td>
<td>-9</td>
<td>-</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>10</td>
<td>+9</td>
<td>+</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>14</td>
<td>12</td>
<td>-2</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

T = 6.5
Table 7: Computer Analysis of Adjustment Scores using the Wilcoxon Matched-Pairs Signed-Ranks Test.

<table>
<thead>
<tr>
<th>mean rank</th>
<th>cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.50</td>
<td>2 - ranks (with &lt; without)</td>
</tr>
<tr>
<td>3.50</td>
<td>4 + ranks (with &gt; without)</td>
</tr>
<tr>
<td></td>
<td>0 ties</td>
</tr>
<tr>
<td></td>
<td>6 total</td>
</tr>
<tr>
<td>z = - .7338</td>
<td>2-tailed p = .4631</td>
</tr>
</tbody>
</table>

"Without Intervention" Adjustment Scores

The scores of this group encompass the lowest and highest adjustment scores, with the range for the group without bereavement intervention being 01 - 14, the mean being 6 and the median being 5.5.

As previously mentioned, two scores of 14 were found in the 'without intervention' group. These were also the individuals with the lowest Grief Scores for this group thus bearing out assertions that bereavement follow-up is not necessary for all bereaved individuals. These scores were achieved by individuals who had cared extensively, over time, for their ill family member at home, and one included a home death. There had been time to integrate internal role reorganization as well as drawing upon the palliative programme resources to facilitate this
process.

The least desirable scores -- even though ascribed to individuals having "years" for adaptation -- seem to have resulted from a disease trajectory of remission/exacerbation in combination with chronicity. This can result in caregiver exhaustion and/or in complicated grieving due to caregiver depletion and feelings of apathy, helplessness and resignation that develop as "defense mechanisms against overwhelming threat and loss" (Wasow and Coons, 1988, p.25; Rando, 1986, p.6).

"With Intervention" Adjustment Scores The bereavement group range is 05 - 13, with a mean of 10.5 and a median of 11.5. This suggests that the group with the bereavement follow-up has a greater overall adjustment than those without the intervention. It can be observed however that one individual in this group had what appears to be a relatively low score of 5. The scoring for this individual pointed out a weakness in the Grief and Adjustment Inventories (Appendix III). There was little difference between the Grief Score and
Adjustment Score for this individual. However the coding could not discriminate how well the individual was managing relative to the experience of the loss -- in this instance multiple losses.

Comparability with the Cameron-Brings /Cameron-Parkes Studies

Few of the current findings are consistent with those of the original study published by Cameron and Brings, 1980 and by Cameron and Parkes, 1983, in which individuals having Palliative Care and Bereavement Support were compared with individuals having neither supportive intervention. In the original study, patients were not randomly assigned to the Palliative Programme and tended to be younger individuals than those in the general hospital population. The patients, hence the families, in the current study were representative of all ages as virtually all terminally ill individuals and their families were referred to the Palliative Program in the study hospital. Age characteristics of the study population reflected this age range. The twelve matched
study respondents were comprised of two daughters, four widowers and six widows, and ranged in age from twenty-eight to seventy-nine. The number of years married ranged from 13 to 53 with a mean of 36.6 years and a median of 37 years.

Age Similarities between the studies were noted with those over 65 having greater difficulties with persistent grief -- as indicated by the Grief and Adjustment Scores. However, where Cameron and Parkes found high use of sedatives and psychiatric symptoms in their population over 65, the current study found only two individuals over 65 using sedatives moderately and no one under 65. The current study samples were all non-smokers and only one indicated higher alcohol consumption than prior to the death. In fact, as an indication of the times, exercise was the 'drug of choice' by half of the current study sample -- for all ages.

Additional information found in the current study was related to difficulties encountered by surviving daughters in their 20s -- these observations of seven young women (daughters or siblings) were made by
respondents. They related observed difficulties that included: dropping out of university, occupational disruption, breaking up long term relationships, moving home and in one case, seeking the support of a therapist.

**Major concerns** Pain and suffering were major concerns with the original investigation. Only one mention was made of pain and suffering by the current study respondents which may well be a direct result of improved pharmacopeia as well as the maturation of palliative caring. While Cameron and Parkes do mention that "it takes time to break bad news and to give support that is necessary if it is to be digested and to give rise to appropriate 'worry work'", delineation of 'time' was in "days" rather than months and was related to "warning of death" rather than "time for preparation for the death" (Cameron and Parkes, p.77). This again is a reflection of program maturation as individuals currently enter the program when the decision is made to end active, curative procedures. The emphasis is on quality time, at home, with families, thus "months" rather than "days" becomes the measurement.
Support Networks  Loneliness was referred to by twenty of the PCU sample and ten of the controls in the original study. In the current study, the concept of 'aloneness' as well as loneliness was cited many times (twelve out of fifteen) and was related to being "uncoupled" or "singled". In fact, the original study noted 1) pain and 2) loneliness as the "hardest things" whereas the current group indicated 1) the loss, 2) the funeral/burial procedures and 3) loneliness as the "hardest things".

Other Findings

The size of families, their accessibility, and religious affiliation are also indicators of support networks noted in the current study.

Children  The number of children averaged 1.75, with 75% having two children. Of the twelve respondents only four had children at home - two with either one and two children under the age of 12; another who had a twenty year old daughter move home; and another's fifty-year old daughter had always lived in the home.
Family and social support  Family and social support were judged average to high by 76% of the respondents -- but those with highest Grief Scores and Lowest Adjustment Scores were also among those with lowest social and family support. All the grown children, except three, live within an hour drive and contact with them is high. Only one respondent indicated that his children were out of province -- he also had little or no social support.  

Finances  Only one spouse and one daughter noted that finances were more difficult now than before the death of the family member -- the wife had a 40% drop in pension income and moved to a cheaper apartment; the daughter also moved to cheaper accommodation. All the other respondents owned their own homes and only one widow worked part-time because "she enjoyed it and had always done some work outside the home".

Religiosity  The area of religiosity was most interesting with 25% noting church attendance -- only two individuals indicated that religion and the church community were integral to their lives. Over 70% of the
respondents had their family member cremated, while 60% of these (nearly half the total sample) did not have a funeral or memorial service. This finding relates directly to the difficulties surrounding funeral and burial procedures encountered in this study.

Bereavement group participation Participation in the bereavement follow-up group related directly to the amount of time of preparation for the death as discussed above, and varied from two months to currently active (a year after commencement), with an even split between the four continuing at least sporadically and the four who participated for a short period of time. Those who discontinued earlier felt that their needs -- primarily for information -- had been met. Others indicated that with time they 'outgrew' the need for the group focus on bereavement and needed to look more at issues related to 'being single'. Three of the four who continued, noted that they could not "have made it" without the support of the group and the social worker. The young children, noted above, were included in Art Therapy sessions for bereaved children.
Summary

A complementary replication was attempted but small sample size and lack of comparability between the two groups greatly limited the power of the analysis.

It was found that the amount of time for preparation of the death of a family member was a critical factor in participating in the bereavement follow-up. Age factors were also a concern in the current study with men over seventy years of age and young women in their twenties found to be at greatest risk.

It is known that grief resolution can be effected by a number of variables which are related to social support networks, aspects of family structure, flexibility and resources, combined with the disease trajectory and its concomitant symptom control and hospital or home-based care. Many of these variables relate specifically to personal support networks. The quantitative analysis did not address these factors, even though the Cameron and Brings Questionnaire included this area of inquiry. The findings outlined above and those included in the comparability to the Cameron and Brings (1980)/Cameron...
and Parkes, 1983 studies, indicate these factors are important to bereavement resolution.

Grief and Adjustment Scores for two individuals indicate that bereavement intervention is not required by everyone.

Lack of comparability of the current study with the original Cameron studies is seen to be a result of palliative programme maturation, changes in medical recognition of need for palliative care and progress in pain management.
CHAPTER 4
QUALITATIVE ANALYSIS AND FINDINGS

This chapter outlines the qualitative methodology, analysis and findings of the research. A qualitative, grounded theory approach was used in an attempt to build substantive theory relating to the efficacy of bereavement intervention. This involved arranging data derived from the interviews into broad categories or themes. From these data, two core categories were modelled, their dimensions substructed and analyzed utilizing Worden’s Tasks of Grieving. Respondents’ quotes were included verbatim from the interviews for illustrative purposes. Edited quotes were used in matrices to present concise representations of the responses.

The information contained in this chapter pertains directly to the respondents and their personal experiencing of the grief process.

Rationale for the Qualitative Analysis

It has been noted by Yalom and Vinogradov (1988) and Osterweiss (1988) that there is little information available about the efficacy of bereavement intervention. Therefore,
very little can be gleaned from the literature which applies to the efficacy of bereavement support programmes — especially within the parameters of palliative care programming. One study by Roy and Sumpter (1983) presented an outline of their palliative care bereavement program but no comparisons were made between those who did or did not participate in the bereavement group. There was no indication of why certain individuals attended, why others didn’t, or whether there was a discernable difference in their bereavement outcomes. Vachon (1988) offers an overview of counselling and psychotherapy in palliative/hospice care in which the following results are presented:

- Fryer (cited in Vachon, 1988) infers that continuity of care and sharing supportive information about the deceased with family members may be helpful in the bereavement process.
- Vachon (cited in Vachon, 1988) writes that assessment of intervention in the palliative program is difficult because the program as a whole is generally evaluated, not components of care.
- Parkes (cited in Vachon, 1988) found it difficult to separate psychosocial bereavement care for survivors
from the effects of symptom control, but suggested that hospice itself tended to ameliorate survivor anxiety. de St. Aubin and Lund (cited in Vachon, 1988) found a high number of palliative program survivors accessed a bereavement support group but attendance was sporadic, averaging 2.1 bereavement contacts. None of these studies advanced knowledge about bereavement outcome associated with the palliative care programming, and indicated a general lack of research in this area.

It was noted in Chapter 2 that bereavement is an all encompassing process which includes psychological, physiological and sociological dimensions. The beginning point for research is to determine how individuals frame this process. From this personal framing, a grounded understanding may be established about what constitutes the bereavement process and what strategies for intervention are needed and most appropriate. As noted above, there is no differentiation between the effect of hospice intervention and the effect of, and/or need for bereavement intervention. As grieving pervades all realms of personal functioning, the best sources of information are bereaved individuals themselves. From this information a researcher can formulate hypotheses concerning service objectives and modes
of intervention.

A conceptual approach seeking to explore the full range of "thoughts, feelings, experiences and intuitions" in an experiential and dialectic exploration with subjects would be highly suited to explicating the various dimensions of grief (Rowan in Mitroff and Kilman, 1982, p. 84). This approach would validate the respondents' experiences through an interview process with the resultant data being rich in depth and detail. A qualitative grounded theory approach lends its flexibility and creativity to this endeavour.

**Qualitative Analysis Methodology**

As an adjunct to the quantitative analysis which is one measurement in time, the qualitative approach sought to incorporate all subjects and responses to the Cameron and Brings Questionnaire, to evolve an analysis that would assist in understanding bereavement resolution as a process over time.

**Sample Selection** The samples were derived to accommodate the quantitative analysis of the data as discussed in Chapter 3. Responses from all fifteen subjects are included in the qualitative analysis. To facilitate a grounded theory approach only, all subjects
could have been sampled through purposive sampling for specific characteristics — for example, males over seventy years of age, daughters in their twenties, individuals married a certain number of years, single parents of both sexes with dependent children — depending upon the investigation (i.e., grief resolution of elderly males). This form of sampling is highly suited to grounded theory as it is flexible, maximizes prospects for useful comparison, and can be utilized as data collection proceed and various indicators become visible. Patton suggests that

"naturalistic inquiry becomes a mixed strategy as the investigator moves back and forth between ... inductive, open-ended and phenomenological encounters with research settings to more hypothetical deductive attempts to verify "hypotheses" or solidify ideas" (Patton, 1989, p.110).

This is congruent with Glaser’s theoretical sampling from which extensive comparisons are made in order to elicit codes, emergent patterns and indicators, and to clarify the "theoretical possibilities and probabilities" (Glaser, 1978, p.42). This does not rely upon comparability of groups but rather upon variables which are considered valuable to each group. The sampling evolves with on-going analysis
suggesting the direction for further inquiry through which to substantiate an emerging theory (Ibid).

**Data Collection Procedures**

Data derived from the interviews were incorporated into the qualitative analysis. As the interview focus had been on providing a therapeutic milieu as well as that of information gathering, the responses were rich in diversity and depth.

**Coding Paradigm** Responses to the questionnaire were first assessed by considering the seven general areas covered by the inquiry: characteristics of the bereaved individual, family relationships, social support, financial concerns, personal health issues, anticipatory bereavement, and religiosity, ritual and the bereavement anniversary; and broken down into themes. The comments included within the themes were specifically scrutinized for:

- conditions that may be in place ("He died because of the treatments", "His job killed him -- the stress caused him to become ill");
- interactions between or among actors ("I’m pleased to see my daughter turning the corner", "I feel I don’t fit anywhere", "It helped me to feel I was needed");
strategies or tactics ("I participated in the Bereavement Group", "I sought personal counselling", "I saw a psychic", "I meditate and use creative visualization", "I keep in fighting trim"); and, consequences ("It made me feel needed", "It’s hard living alone). These are all elements of the coding paradigm inherent in grounded theory coding and analysis (Strauss, 1987). "It functions as a reminder to code data for relevance to whatever phenomena are referenced by a given category" (Ibid, p.25). Inclusion of the four criteria subsumed within the coding paradigm assures the researcher that the coding is valid. While the focus at this level of investigation is the personal experience of the bereaved individuals, broader social issues pertaining to services and support networks for these individuals are incorporated into the analyses of Chapters 5 and 6. The coding and theme analyses are presented under Grounded Theory Approach below.

Frame for Bereavement Analysis. The responses were then abstracted utilizing a frame which consisted of the Four Tasks of Grieving as elucidated by Worden (1982) which include: accepting the loss, experiencing the pain of the loss, adjusting to living with the loss, and reinvesting
energy in new activities or relationships; and are discussed in greater detail below. Each of the respondents' comments were considered indicators of a level of grief resolution and were assigned to the appropriate Worden Task. These Four Tasks also meet the coding paradigm criteria -- involving conditions, interactions among actors, strategies and tactics, and consequences. The raw data contained in the Worden abstracting are to be found in Appendix V.

"Time" and "cognitive biases" are other elements that are implicit in the personal experiencing of the grief event and the subsequent bereavement process. These are subsumed within the comments that frame the event and the subsequent resolution.

**Time as a Study Parameter: Retrospective Analyses**

The current study was undertaken thirteen months post-bereavement and lacks a baseline assessment of family dynamics, possible risk factors, and individual resources and coping strategies. It has been suggested that intervening factors may distort outcome analyses when conducting retrospective studies. However, for the purpose of a qualitative analysis, these intervening factors are merely added dimensions to the analysis and will be reflected in the language as well as the resolution
Simmon (in Berg and Smith, 1988) noted that with the passage of time, a warm relationship tended to "expand" in meaning, whereas less important relationships were subject to "shrinkage". Meaning is reflected in expressed emotions -- tears, laughter, apathy -- and is dependent upon the intervening factors. Encoded memories are influenced by original distortions of the death event -- the image of the deceased, the extent of suffering, the last words spoken, denial -- as well as the preceding illness experience. The current memories are responses to intervening events -- the actual experiences of grieving (i.e. loneliness, the 'firsts', the extent of role disruption and family
congruence). Current memories may reflect selective forgetting or avoidance of circumstances surrounding the death and the ensuing bereavement process may be enhanced by the strategies that had been developed within the relationship to cope with the preceding disease process and thus current bereavement amelioration. All are reflections of integrating and assimilating the interpretation of the event in the individuals' lives.

**Cognitive Biases**  
Bowlby (1985) cautions that there are also cognitive biases that will affect response to loss, hence will colour the "story" of that loss experience. These cognitive biases include:

- "how the bereaved construes the part played in the loss by the dead person himself" (Bowlby, 1985, p.233) — was there some form of 'blame' for the individual not seeking medical support early enough?; had the deceased tried everything they could to fight the disease? — "We fought the good fight" (Respondent).

- "how he construes his own part in the loss, and the way the deceased might regard it" (Bowlby, 1985, p.233) — was enough done, did I fail in some way? — "She kept asking me to take her away
from all this, ...to a safe place somewhere" (Respondent).

"what expectations he has of the way that anyone who might proffer assistance would treat him" (Bowlby, 1985, p.233) -- will the individual feel patronized or pitied? --"No one's going to feel sorry for me; no one's going to be able to say 'Poor old E.'" (Respondent)

"how aware he is of the constructions he puts on past events and of their pervasive influence on the expectations he has in the present" (Bowlby, 1985, p.233) -- "I had an extremely hard childhood and was never loved before I knew her, she has been my life [...now she'd gone and I am again unloved and will not be loved again] (Respondent)

"the extent to which whatever constructions and expectations he may have are open to new information and so to revision, or else are closed" (Bowlby, 1985, p.233) -- "I hadn't anticipated the pluses of being single"; "There has been nothing positive about this past year, it's as hard now as it was at the beginning [and I can't see it getting any better]" (Respondents).
However, it has been noted by Sutton and Schurman (in Berg and Smith, 1988) that retrospective studies are most appropriate when dealing with "hot" (emotionally laden) topics. This investigator agrees with the above authors, and submits that interviewing bereaved individuals prior to the anniversary date in any other circumstance than an intervention milieu may be deemed unethical.

While cognitive biases may be related to either original distortions or intervening events that have effected the framing of the event, the most salient feature is the respondent's interpretation of the experience. The respondent's interpretation is his/her reality from which meaning is derived, hence is a valid observation.

Grounded Theory Approach

The data were analyzed utilizing the researcher's knowledge base and general understanding of the variables involved in the grieving process. This allowed a sensitivity to information as it evolved from the data that could be conceptualized utilizing the grounded theory approach elucidated by Glaser and Strauss (1967), Glaser (1978), Strauss (1987) and illustrated by the techniques of Miles and Huberman (1984). Underlying the relationship
between data and theory is "a set of empirical indicators within the data" which conceptualizes relationships between categories and their properties (Glaser, 1978, p.55). In this way, the richness and diversity of the respondents' experiences and unique expressions of their mourning processes were capitalized upon through an "emergent fit between the data and a pre-existent category" as well as an on-going process of "refitting" the categories to the data as they emerged (Ibid, p.4). This process in itself lent vigour to the exercise.

Analysis and organization occurred through rigorous reworking of the data using guidelines set out by Glaser (1978) and Strauss (1987). Qualitative analysis techniques as discussed by Miles and Huberman (1984) were also incorporated.

Open coding was used to identify topics, issues and emergent themes. The coding paradigm of conditions, interactions, strategies and consequences were incorporated into this analysis to maintain focus and to evolve themes (discussed below). Respondents' comments were first scanned, then grouped and analyzed word by word and/or line by line to elicit
commonalities or relationships between these themes that may reflect a specific subject or concept grouping. By repeating this process, three major categories were identified through clustering of the emergent bereavement themes -- process, place, person. (Glaser, 1978; Strauss, 1987)

Axial coding is a further analysis of each major category to elucidate inherent dimensions and characteristics (discussed below). Subcategories were evolved and tentative relationships were hypothesized by the researcher. Axial codes relating to the open codes of process, place and person include stage/phase, transition, ritual, tradition, culture, role language and experience. All these open and related axial codes evolved from the data and relate directly to the individual bereavement experience, the structures within which the individuals are grieving, and were reflected both in their responses to the questionnaire and the structural parameters of the study itself. Together, with the open codes, the axial codes form the "clusters of analysis" that are related to the core categories (Strauss, 1987, p.70).

Core categories were the central themes incorporating
the analytic clusters that conceptually bound them together. The two core categories "meaning" and "time" were found to be highly integrative, and are integral to developing theoretical codes which "conceptualize how the substantive codes may related to each other as hypotheses to be integrated into theory" (Glaser, 1978, p.72).

"Meaning" is implicit in the language, in emotional expression (anger, fear, sadness, guilt), in cultural and traditional expression (ritual, funerals, roles), in experiential connotation (time, positive/negative, growth) as well as indicative of the process itself.

"Time" has been found to be a critical component of the grieving process. It has become almost axiomatic that "time heals" and was reflected in the experiential framing of the past year by the respondents. Time is a component part of this study having been administered thirteen months post-bereavement. Bereaved individuals are embedded within social structures that are constantly changing imposing differential stresses. "Time" is deeply intertwined with the expressions of meaning, yet is its own entity with its own dimensions. "Time" is the second core category.
Thus, how an individual perceives the meaning of the loss is integral to the task resolutions. How the individual has interpreted the meaning and dimension of time is integral to the structuring of each individual's grieving process. By considering both categories together, it is then possible to further explicate outcome and the efficacy of bereavement intervention.

- **Memo writing** was used throughout the process as a separate activity which helped to guide the evolution of the core categories. The 'memos' were written whenever 'something' occurred to the researcher that involved insights, questions or hypotheses.

- **Integrative Diagrams and Charts** were used to conceptualize relationships/interrelationships, to model theoretical codes and as analytical tools from which observations could be made.

- **Report and Thesis Writing** is the last stage of the research process. A summary of the findings is presented and is illustrated throughout with anecdotal support from respondents' information. Conclusions in the form of hypotheses and substantive theory provide the basis for ascertaining the efficacy of bereavement intervention, as well as relating formal and informal
support systems to bereavement outcome.

**Themes**

Following are examples of themes that evolved from respondents' comments.

**Grief:**

Grief is being cast out into the middle of the ocean without a life jacket.

Grief is a deep abyss out of which you must crawl.

**Finality:**

He's not coming back, this is the way things have to be.

Things and places get built into your life.

There's no one to share with, no companionship.

**Denial:**

We didn't want to know.

She was very frightened, would not talk about it, didn't consider she would die until the last week.

We didn't talk about it, and I still don't. I can't remember.

He was a positive thinker, denied that he would die.

**Social:**

Men seem to find someone else very quickly.

Men seem to need to be taken care of.

Dating is rehearsing for the time when I will want to remarry.

My friends don't want to hear the real things.

We used to eat out a lot -- it's hard to do that by myself.

An acquaintance came up to me and said "Good to
see you're getting over it" six weeks after the death.

Philosophy:
He’s not in the grave, he’s everywhere.

There’s more to life than worrying about dying.

He will always be part of my life.

The ocean is a connection with life rather than with place. It frees you to be anywhere. The ocean is always there.

I took time out for forty days of mourning.

I engage in meditation and creative visualization.

Growth: I have more freedom now. There are some benefits to being alone.

My son tries to boss me but I can handle it.

I’ve never gardened before, now I love it.

I have new friends, my friends, and I’m doing things I’ve never done before.

Ritual: We went bowling on the anniversary. It was great fun -- we’ll do it again every year.

We eat dinner together every day. It’s important to reinforce that time of coming together.

I’m compiling a book that will provide the children with a sense of who that person was.

We’ve dedicated a bench in his memory.

We planted his favourite shrub on the anniversary.

We didn’t have a funeral -- it was nobody else’s damn business.
Anger: She wasn’t "right" for two years and when she finally did see the doctors it was too late.

Why did she have to die, she’s the only love I’ve ever had in my life. It’s not fair.

The doctor was brutal when he told us -- my husband fainted.

It was terrible. We went all the way across town and the hospital turned us away and we had to go home.

He procrastinated and didn’t see the doctor until too late.

The themes were analyzed according to the coding paradigm to ensure that they were conceptually complete. Examples are given below in Table 8.
Table 8: Examples of Theme Assessment utilizing the Coding Paradigm
Components of Condition, Interaction, Strategies and Consequences.

<table>
<thead>
<tr>
<th>THEME</th>
<th>Condition</th>
<th>Interaction</th>
<th>Strategies</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief</td>
<td>no control</td>
<td>alone</td>
<td>sink/swim</td>
<td>no guides</td>
</tr>
<tr>
<td></td>
<td>-cast out</td>
<td>-without</td>
<td>-ocean</td>
<td>-middle</td>
</tr>
<tr>
<td></td>
<td>despair</td>
<td>self-driven</td>
<td>start again</td>
<td>slow process</td>
</tr>
<tr>
<td></td>
<td>-deep abyss</td>
<td>-you must</td>
<td>-crawl out</td>
<td>-out of which</td>
</tr>
<tr>
<td>Finality</td>
<td>its over</td>
<td>he's gone</td>
<td>accept</td>
<td>no choice</td>
</tr>
<tr>
<td></td>
<td>-not coming back</td>
<td></td>
<td>-have to</td>
<td>-this way</td>
</tr>
<tr>
<td></td>
<td>habits</td>
<td>memories</td>
<td>incorporated</td>
<td>little change</td>
</tr>
<tr>
<td></td>
<td>-things and places</td>
<td></td>
<td>-built into your life</td>
<td></td>
</tr>
<tr>
<td>Ritual</td>
<td>routine</td>
<td>family</td>
<td>event</td>
<td>tradition</td>
</tr>
<tr>
<td></td>
<td>-every day</td>
<td>-together</td>
<td>-eat</td>
<td>-dinner</td>
</tr>
<tr>
<td></td>
<td>honouring</td>
<td>together</td>
<td>tangible</td>
<td>memorial</td>
</tr>
<tr>
<td></td>
<td>-anniversary</td>
<td>-we</td>
<td>-planted</td>
<td>-shrub</td>
</tr>
</tbody>
</table>

It was found that there were common relationships or concepts for some of the themes, thus resulting in grouping, or clustering them together.

grief - finality - anger - denial (Process)

ritual - philosophy - tradition (Place)

growth - philosophy - social - role (Person)
These clusters were seen to reflect various aspects of the grieving process that the individual incorporated into resolution and reorganization. These became the open codes of "Process, Place, and Person".

Axial coding around these open codes then took place incorporating the themes, defining them stringently, and evolving linkages between them:

**Process** When considering "process", the frame of "transition" encompasses the changes which may denote stages or phases of bereavement resolution which occur over time. As in Obershaw's system (See Chapter 2, Figures 1 and 2), this process may be identified by certain behaviours or reactions, indicating reintegration and/or reorganization.

**Place** "Place" incorporates the rich diversity of ritual, tradition and culture which denote rootedness in history. Linked with "process" by ritual, new traditions are created that are consolidated into the family culture.

**Person** As the "person" proceeds through the bereavement process, role redefinition is enhanced or limited by experience of support and understanding, and is expressed in the language of
reformulation which reflects "the change from focus on limits and probabilities to potential and the possible" (Schneider, 1984, p.225).

Figure 4  Dimensional Analysis of "Meaning" in the Bereavement Process

The suggested relationships in Figure 4 are not mutually exclusive but attempt to conceptualize the multiple layers of organization that an individual brings to an experience, and the manner in which meaning is expressed through metaphor. Process, place and person are the open codes through which meaning is ascribed to the process of bereavement. Metaphors best illustrate the connotations inherent in each of these meaning
components.

**Worden’s Four Tasks of Grieving**

Incorporated into the analysis were the Tasks of Grieving as developed by William Worden (1982). These Tasks were utilized as assessment tools and were applied to dimensions of the core categories to conceptualize bereavement outcome from which to draw certain conclusions. William Worden outlined a process of grieving that encompassed completion of certain "tasks", or actions that can be taken to ameliorate the grief process. These tasks suggest a perception of control by the grieving individual which can be seen as 'movement' through the process -- the answer to "will it ever end?" -- as well as turning points, or critical junctures. Briefly the tasks are:

**Task I** -- To accept the reality of the loss.

Behaviours that can circumvent accepting the loss include: denial of the loss through minimizing the meaning of the loss, selective forgetting, or by denying the irreversibility of death or distorting the loss through continuing on as though the individual is
alive.

Task II -- To experience the pain of grief.

Working through the pain is important or it will manifest in some other way -- generally through somatic illness. Unfortunately there is a social conspiracy for individuals to "get over it" thus reinforcing stoicism. Negation of the pain results in cutting off feelings, avoiding painful thoughts and idealizing the deceased.

Task III -- To adjust to the environment without the deceased.

This task is highly dependent upon the relationship with the deceased individual and the roles ascribed to that individual. The work encompassed in this task is the critical juncture for the grieving individual. Withdrawing into helplessness is an example of not adapting to the loss.

Task IV -- To withdraw emotional energy from the deceased and to reinvest it in another relationship and/or activities.

This is not to be understood as forgetting or
dishonouring the deceased in some way, but indicates an outward orientation, looking beyond 'what was' and 'what is' to 'what could be'. Incompletion of this task is seen as holding on to the past attachment.

Summary of Methodology

The data derived from the fifteen respondents was incorporated into a rigorous process of coding, memoing, and recoding. Core categories were evolved from the axial and open coding. The data was then analyzed by applying Worden's Four Tasks of Grieving in order to assess grief resolution. Respondents' comments were related to the task definitions and indicated where individuals may have not addressed certain issues, thus creating cause for concern about unresolved grief. Differences were related to bereavement follow-up to ascertain efficacy of the intervention.

Findings of the Qualitative Analysis

The richness and diversity of the respondents' experiences, their unique framing of the mourning process was capitalized upon. It became evident that their words
reflected both surface expression of the bereavement period and multiple layers of meaning that related to the essence of the bereavement process -- to their identity, to their sense of belonging, and to their expressions of change and possible growth. These expressions in turn related to a deeper explication of needs that were associated with broader concepts of "pathology prevention versus the enhancement of well-being, and an individual focus versus a social environmental focus" (Zautra and Sandler, 1983, p.36). This section will be primarily devoted to clarifying the personal connotations of meaning as they are evaluated utilizing Worden's framework as discussed above. The broader conceptual implications will be explored extensively in the next chapter.

For the grieving individual the relationship of time and meaning are translated into metaphors which connote process, place and person as well as psychological and sociological structures with which the bereaved must contend.

**Metaphor as an Expression of Meaning**

When framing a new experience, meaning is lost when
termed as something old or familiar. To enable understanding, analogy may well supercede precise statements. This analogous expression is termed "metaphor" and incorporates interaction which has implications for selecting, emphasizing and organizing relationships.

The interaction of metaphors can be understood in a systemic delineation of meta-messages: each message having both primary and secondary interpretations. The primary message is the observable language description, while the secondary message is reflective of the referent condition, empirical and linguistic ideas, and associated ideas. Weyant (1979) considers metaphors as bridges between cognition and perception having both internal and external referents and intersubjectivity (Hanen, Osier and Weyant, 1979).

While the concept of 'time' cannot be separated from metaphor, 'meaning' and 'metaphor' are of primary concern in this part of the discussion with the 'time' dimension to be addressed below.

Relationship of Metaphor to Worden’s Tasks

Metaphors of Process Process metaphors are highly
emotive and illustrate the transition from despair to resolution. These are found throughout the literature and in the self-expressions of the study respondents. An overall transition metaphor would be "It [grief] is a mental wound, which heals slowly and leaves scars" (Marris, p.27). Examples of early grief metaphors connote external control, ostracism and disintegration: "It feels like I have been cast into the middle of the ocean without a life jacket" (Respondent); "It is a deep abyss out of which you must crawl" (Respondent); "I move through life as if I am a robot, programmed by someone or something" (Vachon, 1982, p.77); "A door slammed in your face and a sound of bolting and double bolting on the inside" (Lewis, 1961, p.9). Metaphors of later, or mid, transition show tentative resolution: "Things seem to be going fairly well - but I'm waiting for the other shoe to drop" (Respondent). Next, the aspect of "time" is used metaphorically as a turning point, as an awareness (cognition) of duration and moving on. "I used to smell the clothes. Then I found in December the scent was gone -- it was time to let go" (Respondent). Still later, a future orientation is noted: "The ashes were scattered in the ocean. This gives the children a
connection with life rather than place -- freeing them to
move on in their lives -- the ocean is always there"
(Respondent).

A simple delineation of Process Metaphors with
Worden's four tasks of grieving, related to bereavement
group participation, follows. Tasks III and IV have been
combined as Task III is seen by Worden as the critical
juncture in the grieving process. Task IV is the hardest
task to complete, and the respondents' comments indicated
that some were venturing into reconciling this task,
while many were still working through Task III. It
should be remembered that the tasks are not necessarily
step-wise and in many instances overlap each other.
Therefore, it is possible to incorporate some of Tasks
III and IV while still working on issues related to
Task II. However when avoidance is involved in Task II,
it is not necessarily healthy to engage in remarriage,
selling-out, travelling extensively until the pain of the
loss has been addressed.
Table 9: Matrix of Process Metaphors with Worden’s Four Tasks of Grieving related to Bereavement Group Participation.

<table>
<thead>
<tr>
<th>Group</th>
<th>Task I</th>
<th>Task II</th>
<th>Task III/IV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accepting the Loss</td>
<td>Experiencing the Pain</td>
<td>Adjusting to loss</td>
</tr>
<tr>
<td></td>
<td>Gut wrenching</td>
<td>Things don’t build build up</td>
<td>Time to let go</td>
</tr>
<tr>
<td></td>
<td>Incredible pain</td>
<td>Scent gone</td>
<td>&quot;Uncoupled&quot;</td>
</tr>
<tr>
<td></td>
<td>Terrible numbness</td>
<td>Ambushed</td>
<td>Free to move on</td>
</tr>
<tr>
<td>YES</td>
<td>&quot;Security sweater&quot;</td>
<td>Memory hard</td>
<td>Always there</td>
</tr>
<tr>
<td></td>
<td>&quot;Uncoupled&quot;</td>
<td>connection with life</td>
<td>Good days/bad days</td>
</tr>
<tr>
<td></td>
<td>castle out</td>
<td>waiting</td>
<td>Life goes on</td>
</tr>
<tr>
<td></td>
<td>No life jacket</td>
<td>good days/bad days</td>
<td>Painful at first</td>
</tr>
<tr>
<td></td>
<td>Deep abyss</td>
<td>no self-pity</td>
<td>Nothing positive</td>
</tr>
<tr>
<td>NO</td>
<td>Crawl out</td>
<td>harder now</td>
<td>unfinished business</td>
</tr>
<tr>
<td></td>
<td>Door slammed</td>
<td>I miss the calls</td>
<td>no longer a couple</td>
</tr>
<tr>
<td></td>
<td>Can’t remember</td>
<td>It isn’t time yet</td>
<td>turned corner</td>
</tr>
<tr>
<td></td>
<td>Played the game</td>
<td>It’ll be another year</td>
<td>positives to being single</td>
</tr>
<tr>
<td></td>
<td>He isn’t dead</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abandoned</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Analysis of Table 9

"Yes Group"

- Task I -- tend to be physical referents

- Task II -- shows engagement in the process of experiencing the pain

- Task III/IV -- positive forward focus noted.
As there are few psychologically painful referents noted in this groups' comments, it suggests that the bereavement intervention promoted self-expression of the painful experience and efforts toward resolution.

"No Group"

- Task I -- highly emotive, psychologically oriented statements with multiple layers of meaning observed.

- Task II -- little process engagement indicated; there seems to be an avoidance of the pain so well elucidated in Task I.

- Task III/IV -- The positive engagement noted applies to two individuals who had high grief resolution scores in the Cameron analysis (Chapter 3, p.19). Others either did not have remarks that fell into Task III category or had negative connotation.

The lack of engagement in Task II is remarkable. This is illustrated by one individual who had the highest Grief Scores and lowest Adjustment Scores moving into the tasks in Task IV while still exhibiting
profound grief reactions and avoiding Task II engagement.

There was ambivalence noted in both groups with regard to being "uncoupled" while finding benefits to being single. This is a natural occurrence as the individuals were not "singled" by choice, but are finding strengths and self-expression that are positively reinforcing.

**Metaphors of Place**

Lack of funeral and burial ritual were remarked upon in both the Population Characteristics above and will be expanded upon in Chapter 5. These rituals are significant reinforcers of socially ascribed values and supports within our society, as well as within some personal meaning structures. This discussion will focus on aspects of our lives that may not be perceived as ritualistic but have extensive meaning to us.

Ritual is a fertile domain of metaphor. It is ubiquitous in our daily lives -- where one sits at the table, who carves the turkey, the "Saturday" routine -- and lends itself to drawing upon family strengths and resources to facilitate grieving, as well as creatively formulating new traditions for the family configuration.
Rituals can be accessed for therapeutic intervention as they naturally reinforce membership, healing, identity, belief expression, negotiation and celebration within a family unit.

"Ritual is probably the most potent socialization mechanism available to kin and other groupings for preparing individual members to understand the group's meanings, carry on its traditions and perform those social roles considered essential to its continuation" (Imber-Black, Roberts and Whiting, 1988, p.333).

By engaging in rituals the family can redefine the frame for a particular event. For example, the anniversary date of the death can be a very difficult time for the family. One respondent spoke of how the suggestion of "bowling" from an eleven year old grandson broke the sadness and tension associated with a day of remembrance. It was deemed so successful that "we'll do it again each year -- his grandfather would have enjoyed knowing that we're together in a happy sharing way rather than sad". This in turn makes planning the ritual as important as the event itself. Ritual does not have to be reserved for difficult special occasions. The symbolism inherent
in ritual also has functional purpose in daily life routines. As a part of everyday family life, ritual frames interactional habits, maintenance procedures and role/identity definition -- it prepares us to meet each day, makes life more manageable, coordinates schedules. "We make a point of having dinner together everyday -- I do the cooking and we all tidy up after -- it's important to have the time together" (Respondent). Creative grieving can incorporate new rituals thus creating new traditions -- for example, what do you do with the 'empty chair'? "I bought a round table"; "I sat in the chair" (Respondents). New roles, identities and ways of experiencing the new family configuration can assist with reintegration and reconnection of grieving individuals in the family and in the community. Decreased religiosity -- not to be confused with spirituality -- has led to loss of association between religion and family rites and the ultimate loss of bonding between family and religious community/group. However ritual entails symbolism that is not only religious, it is "one of the most efficient ways for identifications to be made. I wear certain clothing, I say an oath, I sing a song, I fast on a certain day, I wear a
certain headdress, I address people with a certain term, and by doing so I consider myself and am considered by others to belong to a certain group" (Kertzer, 1989, p.24).

Table 10  Matrix of Place Metaphors with Worden's Four Tasks of Grieving related to Bereavement Group Participation.

<table>
<thead>
<tr>
<th>Group</th>
<th>Task I</th>
<th>Task II</th>
<th>Task III/IV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accepting the Loss</td>
<td>Experiencing the Pain</td>
<td>Adjusting to Loss Investing energy Outward</td>
</tr>
<tr>
<td>YES</td>
<td>Presence everywhere</td>
<td>The group was a safe refuge</td>
<td>Things and places get built into your life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The smell of cologne/perfume</td>
<td>A book of memories</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sailing</td>
<td>Dinner together each day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eating by self</td>
<td>Presence everywhere</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ritual mourning period</td>
<td>Dedicated a bench</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visiting grave</td>
<td>Planted favourite shrub</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revisiting special places</td>
<td>Bowling on anniversary</td>
</tr>
</tbody>
</table>

| NO     | Cut adrift  | Visit grave  |
|        | Presence everywhere | Lonely |
|        | Played the game | No daily phonecall |
|        | I have no place | Alone |
|        | No one else's business | |

Analysis of Table 10:

"Yes Group"

- Tasks II, III/IV predominate this group with a high
propensity for creative grieving indicated. Many individuals demonstrated new ways of doing things, incorporating symbolic meaning in creating new activities/roles.

"No Group"

- Task I, II predominate which follows directly from the finding in the Process Metaphor Matrix (Table 9). It seems difficult to create new ritual/tradition or roles when the death event and associated pain have not been reconciled. Creativity requires energy. Energy in some members of this group is being consumed in avoidance strategies of Task II engagement.

Metaphor of Person The greatest challenge facing a bereaved individual is that of redefinition. When a family member dies, the whole family configuration changes in accordance with the role the deceased had within the family, the relationship to that individual and the value of that relationship. The death of a father may result in a son taking on the father’s prerogative of ‘advising’ the mother -- "My son tries to boss me but I can handle it" (Respondent) -- or a daughter -- "My daughter is bolder with me, tries to tell me what to do, just like her mother" (Respondent). Black would see this as a metaphorical
transfer which shifts meaning in the family system of the principle metaphor of 'role' (Hanen et al. 1979). This is not reflective of the primary message of "bossing" or "telling me what to do", but rather the secondary message of role redefinition and its embeddedness within family systems.

The meaning is also defined through experience and reflected in language. The experience of grief is all consuming, it is the loss of identity and the loss of attachment/relatedness. While devastating, it can also be a growth experience -- many times reflective of the quality of the relationship with the deceased individual. "My husband was my closest and best friend. But all of our friends were really his friends. Now I have my own friends and I'm doing things I never did before" (Respondent). "I have more freedom now -- there are some benefits to being alone that I hadn't anticipated" (Respondent). "Our old dog died just before my husband died. I have a new dog now. She's my dog" (Respondent). Here the principle/primary meaning of death and being alone is related to the secondary meaning of self-determination/expression.

Language also expresses the quality of the experience and the reformulated meaning. Schneider (1984) sees this as
the result of internal processing that occurs with evolving role redefinition and reintegration. For example "pain" becomes "hurt", "anxiety (diffused)" become "scared (focussed)", "problems" become "challenges", "symptoms" become "reminders" and the "search for meaningful existence" becomes "search for wholeness" (p.224). This is illustrated by the difference inherent in the change of "crying" to "teariness" which occurs during transition in grieving.
Table 11: Matrix of Person Metaphors with Worden’s Four Tasks of Grieving related to Bereavement Group Participation.

<table>
<thead>
<tr>
<th>Group</th>
<th>Task I Accepting the Loss</th>
<th>Task II Experiencing the Pain</th>
<th>Task III/IV Adjusting to Loss Investing Energy Outward</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>no &quot;poor me&quot;</td>
<td>get on with it</td>
<td>I’ve made it!</td>
</tr>
<tr>
<td></td>
<td></td>
<td>scared</td>
<td>resilience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>uncoupled</td>
<td>new roles/duties</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lonely</td>
<td>rehearsing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>periodic sadness</td>
<td>control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>nostalgic</td>
<td>self confidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>anticipating future</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>reaching out</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>softer - less</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>hardnosed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>independence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>positive attitude</td>
</tr>
<tr>
<td>NO</td>
<td>too old</td>
<td>don’t need crutch</td>
<td>have done well</td>
</tr>
<tr>
<td></td>
<td>abandoned</td>
<td>lonely</td>
<td>challenge</td>
</tr>
<tr>
<td></td>
<td>desolate</td>
<td>uncoupled</td>
<td>independence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>role loss</td>
<td>positive attitude</td>
</tr>
<tr>
<td></td>
<td></td>
<td>driven</td>
<td>adventurous</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ambiguous</td>
<td>no &quot;poor me&quot;</td>
</tr>
</tbody>
</table>

Analysis of Table 11:

The difference between the two groups is found in the self-image related referents, continuing expressions of grief, and a sense of redefinition. These are evidenced in a general focus on the future as indicated in the Task III and IV engagement which are indicative of adjusting to the environment without the deceased and investing energy in new
activities or relationships. Both groups are engaged to some extent with these Tasks.

Differences appear between the groups primarily in the Task I expressions of grief which are still evident in the group without bereavement intervention. This group also had the highest grief scores and lowest adjustment scores -- which are again reflected in the self-image related to the relationship with the deceased and engagement in the earlier tasks.

Engagement with Task II is not unusual. When the loss is interpreted as loss of self, developing new self-image requires time. Differences are observed when the language/expressions are compared. Both groups again noted the sense of being incomplete, not being a couple (as in Table 9 Analysis). However, the group with bereavement intervention illustrates Schneider's (1984) internal processing and have incorporated many of the transitions inherent in role redefinition and reintegration. The group without bereavement intervention still evidence lack of reorganization.

Metaphor is basic to our structure of meaning -- our connectedness, our bonds of attachment -- where "a complexity of relationships and interrelatedness" stretch
like webs and nets of tension and movement implying "opposing capacities for snaring or entrapment or rescuing and safety" (Belenky et al, 1986, p.178). Conceptual framing of grieving will vary accordingly.

Relationship of Time to Worden's Tasks

As has been previously established, the grieving process is one that occurs over time. In this sense it is not time-bounded but rather related to the amount of time it takes to complete the grieving tasks. This can take up to four years or more -- and again, is dependent upon the relationship with the deceased and role redefinition. Not only is time part of the process, part of the study parameter, but it is also a construct used by all of the respondents to refer to their grieving process. It was noted that direct reference to time or time frames was frequently made, as well as comments that included time-delineated concepts. It was therefore important to substruct the variable of time to grasp inherent dimensions of meaning and to make observations.
Table 12: Matrix of Preparation Time with Bereavement Group Participation.

<table>
<thead>
<tr>
<th>Bereavement Group Participation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preparation Time</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 10 months</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>3 mos.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4 mos.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>6 mos.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7 mos.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8 mos.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9 mos.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>&gt; 10 months</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>11 mos.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>13 mos.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>24 mos.</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>+72 mos.</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

It was found that time for preparation for the death of the family member was a factor in participating in the bereavement group. All participants in the bereavement support group had eleven or fewer months to prepare, whereas those who did not choose to participate had eleven to over seventy-two months in which to prepare.

Only one individual in the bereavement intervention group had a longer period than ten months, and this
individual was a male over seventy with no family or social support networks. "I was totally alone" (Respondent). It is interesting that there was self-perceived risk for this group. All individuals were invited to participate, and for the most part, those with more than ten months preparation time felt they didn't require assistance at the time of invitation.

It was found earlier that the time for preparation for the death of the family member delineated one sample from the other. It was also interesting to find that when the variable of "time" was substructed, there was still another division between those having the bereavement intervention and those without.

The respondents' references to time were listed for each group and were analyzed. From this analysis, four dimensions of time were found: time line, occasion, conditional, and turning point. (See Appendix VI)

Before analyzing these results, it is important to be clear on the definitions incorporated in these terms. Both the Random House Dictionary (1980) and the New Webster Encyclopedic Dictionary (1980) were utilized in the definitional delineation.
Four Dimensions of Time

Time Line Time line is the term applied to a concept used by the respondents to denote or allude to a time frame, a period of time. Even within this dimension there were four themes:

4 -- no quality time; no time to discuss -- regrets
3 -- a release; it'll work out -- time heals
2 -- positive; a gift -- quality
3 -- time to prepare -- reconciliation

Occasion This dimension denotes the time of a certain experience, occurrence or event and many times includes a specific referent. "The hardest time was my birthday"; "The illness of two years was the same as his retirement of two years"; We could go to the hospital any time"; "There was two years of suffering for us both"; "I looked after her for more than six years, now there's nothing"

These two time dimensions occurred fairly evenly across the two populations as was observed in Table 13 below. An expanded matrix, Table 14 below, illustrates the differences between the two sample groups and the remaining two time dimensions: conditional and turning point. These are found to relate directly to three of Worden's Tasks.

Conditional Conditional time denotes the choice or
perception of a proper moment in the future.

**Turning Point** Turning point is seen to be a right moment in time or an aspect of timing that occurred in the past and is observed in retrospect. Fuchs Ebaugh (1988) found that turning points may be gradual or abrupt but tend to be specific events that crystallize role ambivalence and are generally reached after a gradual build-up occurs which culminates in a decision being made. The death event itself is a major challenge to an individual's life goals and reorganization evolves slowly with few or many turning points.

There were fifteen respondents noting time dimensionality. All fifteen referred to a time line, or time frame. Essentially equal numbers made reference to an occasion -- duration of certain experiences.

<table>
<thead>
<tr>
<th>Time Dimension</th>
<th>Bereavement Group Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Time Line</td>
<td>8</td>
</tr>
<tr>
<td>Occasion</td>
<td>3</td>
</tr>
<tr>
<td>Conditional</td>
<td>0</td>
</tr>
<tr>
<td>Turning Point</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 13: Matrix of Four Dimensions of Time with Bereavement Group Participation
The most pertinent delineation occurs with the conditional and turning point referents -- Table 14 below. Not only do these occurrences differentiate between the two groups, but also relate directly to Worden's tasks and to the Cameron Grief and Adjustment Scores in Chapter 3.

Table 14: Matrix of Two Dimensions of Time with Bereavement Group Participation related to Worden's Tasks of Grief Resolution.

<table>
<thead>
<tr>
<th>Time Dimension</th>
<th>Bereavement</th>
<th>Intervention</th>
<th>Worden's Task Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditional</td>
<td>Yes 0</td>
<td>No 5</td>
<td>I &amp; II</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 -- Not time yet</td>
<td>Avoidance of pain/issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 -- Another year</td>
<td>He's not dead yet</td>
</tr>
<tr>
<td>Turning Point</td>
<td>5</td>
<td>1*</td>
<td>III/IV</td>
</tr>
<tr>
<td></td>
<td>3--there's a time</td>
<td>1--turned corner</td>
<td>Moving forward, adjusting to loss</td>
</tr>
<tr>
<td></td>
<td>1--it was time</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1--year was over</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* This individual was one of two whose Grief and Adjustment Scores indicated high grief resolution.

It can be observed in this matrix that the time dimensions are highly related to the Process Metaphors.
It was found in the Process Metaphor Analysis, that most of the "No Intervention Group" had not fully resolved issues pertaining to Task II -- experiencing the pain of the loss. This is again seen in this matrix -- with added observations. Those who have not addressed the pain associated with death event will not reach "turning points/critical junctures". Their framing will encompass conditional time -- "It's not time yet". Likewise, those who have dealt with experiencing the pain have not avoided or put off addressing these issues and can look back and perceive that "moment in time" from which things changed.
Table 5: Context Matrix of Temporal Dimensions in the Bereavement Process

BEREAVEMENT

MEANING

METAPHOR

PERSON — PLACE — PROCESS

TIME

time line
occasion
conditional
turning point

Figure 5 is a conceptualization of the relationship between time and meaning, illustrating the connection between the time dimensions and the process metaphors.

Summary

The core categories of "meaning" and "time" were both substructed and analyzed by applying Worden's Tasks of Grieving. It was noted that these categories are both interrelated and separate entities. They indicate both an individual's meaning structure of his/her grieving experience as well as progression through the process.
It can be observed that bereavement resolution is progressing very well for those who have participated in the bereavement intervention. While there still may be some issues surrounding Task II resolution (Experiencing the Pain) when considering Person Metaphors, this group is well engaged with Tasks III (Adjusting to the Loss) and IV (Investing Energy Outward) when the other dimensions of meaning and metaphor are considered.

Comparatively, the group without bereavement intervention is not doing as well with many avoiding painful issues associated with grief resolution, thus becoming "stuck" at this level (Task II). It should not be forgotten, however, that two individuals in this group have shown excellent progress and are well engaged in Tasks III and IV issues. This finding substantiates speculations that not all individuals require bereavement intervention.

It was again observed that time for preparation for the death of the family member is the major motivator for bereavement intervention participation. First discussed in the Quantitative Analysis, it was found that the six individuals with bereavement intervention were seen to have eleven months or less of preparation. This finding
holds when the total sample of eight with bereavement intervention is considered.
CHAPTER 5
INTERPRETATION OF FINDINGS

This chapter will concentrate on the findings of the research project as they relate to the thesis objectives iterated in the Introduction.

The primary objectives were to identify:
- the need for bereavement intervention;
- implications for practice which will address family resource evaluation through contextual analysis, and will speak to social structures which impinge upon the grieving process;
- policy implications for provision of bereavement intervention programming.

For the purposes of this discussion, the need for bereavement intervention will be addressed, with consideration of practice and policy implications to be undertaken in Chapter 6.

The investigation was organized around two methodologies -- a quantitative replication of a study based on symptomatology, and a qualitative analysis of meaning structures which frame the grieving process -- to measure the effect of bereavement intervention on grief resolution.
Two populations were sampled -- individuals with bereavement intervention, and those without. Both groups had participated in a Palliative Care Programme. The strength of the study is to be found in the mixed strategy of the investigation.

The data in Chapters 3 and 4 were addressed from the personal level of experience incorporating anecdotal information and individual scoring on Grief and Adjustment indices. This chapter will endeavour to expand upon the personal information as well as incorporate a broader analysis of the data in order to clarify the need for bereavement intervention.

An expanded analysis takes the exploration beyond that of individual experience, and incorporates consensual data of the aggregate -- data that has been derived from multiple studies to ascertain symptomatology, as well as social trends which impinge upon individual grieving processes. This exploration will illustrate the meaning structures and time/process parameters for grieving individuals from a different perspective. It extends the idiosyncratic data into the realm of larger systemic interactions as well as age-related, generational, socialization differences. In this way, the person-in-transition is also considered from
the person-in-environment perspective which integrates the personal with the social dimension. This is related to the concept of Basic Social Process, discussed in the Introduction, which considers the multiple linkages between the individual and societal structures and the levels of enactment over time.

**Interpretation of the Quantitative Findings**

The quantitative analysis is a modified replication of a study carried out in 1975-76 (Cameron and Brings, 1980). Protocols developed in the original study -- questionnaire, grief and bereavement coding inventories, matching criteria of age, sex and relationship to the deceased -- are incorporated into the current study design. The Wilcoxon Matched-Pairs Signed-Ranks and the Fisher's Exact Tests are also the statistical analyses incorporated into both the original and current studies. However, the findings of the current study are inconclusive for various reasons. At the structural level these include:

- structural changes in the incorporation and expansion of palliative care into the healthcare system,
- attitudinal changes toward care for the terminally ill and their families,
medical advances in pain management, and
perceived changes in family size and support networks. These factors, in combination, resulted in an inability to acquire a sample from a limited population of individuals not having palliative care experience nor bereavement intervention experience at the study hospital. The major stressors of the bereavement experience are also seen to change over the years. The individuals in the Cameron and Brings (1980) study cited pain and suffering of the deceased as the hardest thing to bear, with 75% mentioning loneliness. The current study samples cites funeral/burial experiences as the most difficult, with 80% noting loneliness -- but in most instances as a product of social ostracism. Suffering of the deceased family member is not an issue.

At the level of analysis factors are:
- the lack of significant difference between the two samples' grief and adjustment scores as indicated by the Wilcoxon Tests (Tables 4, 5, 6, and 7)
- the lack of comparability between the two samples due to the amount of preparation time for the death of the family member illustrated in the Fisher's Exact Test (Table 3), and
Findings also indicate that bereavement intervention is not necessary for all individuals and that support networks are integral to bereavement resolution.

Two observations are drawn from the data analysis:

- family members who have little time for preparation for the death appear to self perceive the need for bereavement intervention, and
- a careful assessment is required of those with longer preparation periods -- those over 24 months.

It can be seen, therefore, that while the results may have been inconclusive, there are findings of value in the quantitative portion of the analysis.

It has been mentioned previously that the interview questionnaire included questions about family and social support factors that were not addressed in the Grief and Bereavement Inventories that formed the basis of the comparative analysis. Indications from the study, and from the Cameron and Parkes (1983) discussion, are that these factors are important in bereavement resolution. The Grief and Bereavement Inventories are worth exploring further.

Review of Grief and Adjustment Scores The Grief and Adjustment Inventories derived by Cameron and Brings were
evolved from consensual data in the literature regarding bereavement risk. When the Grief and Adjustment Scores are related to social factors, both their value and shortcomings as assessment tools become apparent.

The Scores are discussed extensively in the Chapter 3. Of note in this discussion are the scores of the outliers -- all of whom appear in the group without bereavement intervention. Two individuals indicate high grief resolution, while two individuals have the poorest scores and thus indicate some distress thirteen months post-bereavement. It is also observed that one individual with bereavement intervention has relatively poor scores which are similar to those observed in the other group. This appears to indicate that the intervention has not been of benefit to this person. Unfortunately this is where an inventory of symptoms does not explain other mitigating factors. Thus while the Grief and Adjustment Scores are deemed indicators of possible risk, they must be considered with other intervening variables.

To show the differences between these individuals, Table 15 relates the Scores and perceived risk to religiosity, family support, social support and health. Clients #1 and #2 represent the greatest degree of
resolution noted, clients #3 and #4 the least, and are therefore outliers — all found in the group without bereavement intervention. Scores of Client #5 (without intervention) and Client #6 (with intervention) indicate possible bereavement difficulties.

Table 15: Relationship of Grief and Adjustment Scores to Variables of Health, Support Networks, and Religious Belief/Practice.

<table>
<thead>
<tr>
<th>Client #</th>
<th>Grief Adjustment Scores</th>
<th>Social Family Support</th>
<th>Religious Belief</th>
<th>Health Status</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
<td>1</td>
<td>Nil</td>
<td>Some</td>
<td>Personal</td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>5</td>
<td>Nil</td>
<td>Nil</td>
<td>Unknown</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>14</td>
<td>Some</td>
<td>High</td>
<td>Church</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>14</td>
<td>High</td>
<td>Some</td>
<td>Personal</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>6</td>
<td>Some</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>5</td>
<td>Some</td>
<td>High</td>
<td>Church</td>
</tr>
</tbody>
</table>

When observing Table 15, it seems that the Scores justify the risk evaluation — except for clients #5 and #6, where other variables must be considered. The Scores for clients #1 and #2 appear to be in agreement with the risk assessment, as do those for Clients #3 and #4. Client #5, while not having an overly high Grief Score (undesired score), also does not have a high Adjustment Score (desired score), and is deemed at high risk because of a combination
of the low Adjustment Score with poor health, low social and family support networks, and no religious belief or practice.

Client #6 is not assessed as having a high risk even though the Grief and Adjustment Scores do not appear to be as good as those of Client #5. The differences may appear in the high family support and church activity however, very poor health complicates the picture. The health of this client, coupled with the death of the family member may have brought the family closer together but all are involved in the grieving process while concerned with the very poor health of the Client. Why then is the risk assessment not greater?

This is where the Grief and Adjustment Scores must be taken under advisement, and where other variables require consideration. The major differences between Clients #5 and #6 is the participation in the bereavement intervention by Client #6 and the degree of Task resolution found when the Worden assessment was carried out. Client #6, while still grieving loss of family member and poor personal health is moving well into Tasks III and IV issues and is exhibiting increased self-image and independence. Client #5 is still dealing with Task II issues and presents
low self-image and little desire or initiative to address Task III issues.

It is known that grieving can take up to four years (or longer) and is highly dependent upon the relationship to the deceased, the quality of that relationship, and personal coping strategies. One respondent noted that it would be "another year" before grieving issues could be addressed. This is the personal assessment for that individual and will in most likelihood be accurate. The Worden Task analyses assist in clarifying the inherent risk assessments. It is important therefore to incorporate both assessment tools when considering need for intervention. Thus the analysis is strengthened through the mixed strategy of both quantitative and qualitative analyses.

Interpretation of the Qualitative Analysis Findings

A grounded theory approach is used in the qualitative analysis to conceptualize the grieving process enunciated by the study respondents. Initially, the comments underwent a rigorous process of theme delineation and coding in order to achieve an emergent fit between the data and the concept of the bereavement process. The core categories were then analyzed by an application of Worden’s Four Tasks of
Grieving (1982).

The findings presented in Chapter 4 outline various dimensions of the core categories of "meaning" and "time" (Figures 4 and 5). "Meaning" was framed in metaphorical codes inferred by the respondents' bereavement experience descriptors, and "time" is expressed both metaphorically and dimensionally. From these analyses it is possible to assess need for preventive intervention at certain levels of task engagement as well as from the environmental and individual contexts -- which relate to support systems and life experiences as well as individual coping styles. The data presented in Chapter 4 is idiosyncratic in nature, pertaining to individual grief trajectories and unique expressions of the process. To explore these findings in greater depth, a recap of the Worden Task analysis is presented.

Review of the Relationship of Metaphor to Worden's Tasks

Process Metaphor (Chapter 4, Table 9) The analysis found that the group with bereavement intervention had few psychologically painful referents and are well
engaged in Tasks III and IV (adjusting to the environment without the deceased and investing energy in new activities and relationships).

Some individuals without bereavement intervention referred to the death event in emotionally laden terms and most of this group avoided Task II -- engaging in experiencing the pain of the loss. This was thought to be a remarkable occurrence and was further illuminated when the dimensions of time were substructed and it was observed that the majority of this group had not reached a turning point. They were, in fact, placing conditions upon the grieving process, rather than addressing painful issues -- "it’s not time yet".

**Place Metaphors** (Chapter 4, Table 10) Again a difference is observed between the two groups, with those having bereavement intervention being highly creative in their grieving process. Ritual and symbolic meaning are expressed by a number of this group. This is also true for two individuals without bereavement intervention, and is indicative of engagement with Tasks III and IV in defining new possibilities while engaging in the transition out of old relationships and roles (Imber-Black et al. 1988).

**Person Metaphors** (Chapter 4, Table 11) These
expressions of self-image and a sense of redefinition are the least definitive of the metaphors in discriminating between the two groups. Some individuals without bereavement intervention expressed low self-image referents that related to Task I and the reality of the loss. An interesting finding is the lack of person metaphors for this group. Even those with high resolution do not allude to self-identity issues -- perhaps because these are non-issues for the two individuals, in the sense that they are resolved and energies are being put into other personal and family needs.

By and large, those with bereavement intervention are more expressive and able to relate their experiences without constraint. This reflects a more positive self-image and a greater sense of control and outward focus.

Discussion

The Process Metaphors and Turning Points are the most dramatic indicators of need for intervention at early stages of bereavement. All those participating in the bereavement intervention were involved in the group within three months post-bereavement. Through this involvement they had acknowledged the reality of the loss, had engaged in
experiencing the pain of the loss and are moving well into
Tasks III and IV of the process -- Task III being considered
a critical juncture by Worden hence a turning point (Worden,
1982).

It could be suggested that the Bereavement Intervention
with its emphasis on encouraging individual sharing of
his/her story -- actualizing the loss; assisting with
identifying and expressing feelings that may be deemed
socially unacceptable (for example, anger at the deceased or
relief that the person has died); as well as interpreting
and acknowledging "normative" behaviours and individual
grieving styles -- particularly facilitates engagement with
Tasks I and II.

During the interviews it became apparent that few of
those without bereavement intervention had had the
opportunity to express themselves -- to tell their stories,
to voice their anger and despair -- and to be affirmed
through this expression. When one interview became
noticeably painful for the respondent, the investigator
reiterated permission to withdraw at any time, whereupon the
response was "No, I have to do this, I have to get it out".
Another respondent did withdraw stating "I can't talk about
it yet ... to me he's not dead yet".
Worden (1982) describes principles of grief counselling that include: actualizing the loss, identifying and expressing feelings, living without the deceased, facilitating reinvesting energy in activities and other relationships, providing time to grieve, interpreting "normal" grieving behaviour, allowing for individual differences, providing continuing support, and examining defenses and coping styles. Through these procedures, grieving individuals' experiences are affirmed and engagement in the task resolution is enhanced. The results of the metaphor and time dimensions analyses indicate that these activities were beneficial to those who participated in the bereavement intervention.

Bereavement Intervention -- Conceptualizing the Need

The results of the findings reviewed above indicate that while the time for preparation for the death of a family member may be the prime motivator for participation in bereavement intervention, the participants have better bereavement resolution than do the majority of those without intervention. Most of those without intervention are still dealing with (or avoiding) Task II issues which relate to experiencing the pain of the loss.
It can also be observed in the findings that the group with intervention are focussing on different issues than are many of the other group. The hurdle of pain has been crossed and issues of redefinition and independence are more cogent. There are areas of concern that affect both groups and that are implicated in conceptualizing need for intervention. These are at both the individual and societal levels and include: social support networks, ritual and tradition, and the social psychological processes of role redefinition.

It has been found that the stress response to the death event increases vulnerability to disease (Lindemann, 1944; Parkes, 1975; Zautra and Sandler, 1983; Frederick and Frederick, 1985) and has resulted in a broad spectrum of risk variables as discussed previously. As well, the social environment is known to enhance or delimit bereavement outcome through availability of family and/or social support networks as well as community resources and perceived social expectations.

Social Support Chapter 2 discussed the value of social support systems as protective mechanisms. The data supports this assumption.

Informal Support Societal trends in family
configuration enhance or jeopardize the change process — the size, the mobility, the resource repertoire of families, the prevalence of single parent families — hence the availability of informal support networks. The data in Chapter 3, Other Findings, indicate that the size of the families averages 1.78 children, with two of the respondents having dependent children at home. Table 16 outlines comparative personal variables of the two groups — those with intervention and those without.
Table 16: Personal Variable Comparison between Individuals With and Without Bereavement Intervention.

<table>
<thead>
<tr>
<th>Variable</th>
<th>With Intervention</th>
<th>Without Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Children:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Health:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Poor health since bereavement, resolved</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Poor health since bereavement, unresolved</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Poor health prior to bereavement, continuing</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Poor health and other losses</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Religion:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Spiritual belief</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Personal belief, no church</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Church</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>(Church and belief integral to self)</td>
<td>(2)</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Family Support:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Some</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td><strong>Social Support:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Some</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

It was noted earlier in both the quantitative and qualitative analyses that the time of preparation for the
death of the family member was the definer of participation in the bereavement group (Chapter 3, Table 3; Chapter 4, Table 12). This factor brought about the lack of comparability of the samples. This was not known at the time of sample selection which was based upon Cameron and Brings (1980) criteria for matching described above (Chapter 3; Appendix I). It is of interest to note in Table 16 how well matched the samples otherwise appear to be.

There is difference observed in the variables of family and social support. Six of the eight individuals with bereavement intervention indicate high family support, with one having none. Conversely, this group notes very low social support networks. The death event (and the preceding illness) appears to have drawn the family closer together, but this does not confer an ability to offer one another the emotional support required during the grieving process. All of these eight individuals participated in the bereavement intervention. All had little time to prepare for the death of the family member and it can be surmised that they perceived a need for support for themselves -- as well as support in meeting the needs of their families.

Most of the group without bereavement intervention indicate "some" to "no" family or social support -- these
individuals were found to be avoiding engagement with Task II issues and to have the most critical to mediocre Grief and Adjustment Scores. Only two individuals have a high combination of family and social support -- the two whose Scores indicate high grief resolution.

It is notable that five individuals of the fifteen respondents indicated a "special friend who will listen and listen and accept". All five were observed to be well engaged in Tasks III and IV, and had corresponding low Grief and high Adjustment Scores. This tends to follow Vachon's contention that "the best form of intervention ... is supplied by family and friends who will let them talk about the deceased" (Vachon, 1982).

"Semi-formal" Support  Five individuals in the bereavement intervention group and one individual in the group without bereavement intervention utilized various strategies of self-help, during the illness of the deceased family member and post-bereavement. Five respondents mentioned a particular book by name and author -- O. Carl Simonton, Getting Well Again -- which assisted them during the illness of the deceased family member with thinking positively and living fully, one day at a time. Three of them had also accessed self-help groups prior to their
bereavement -- Bosom Buddies (mastectomy support group); HOPE (creative living with cancer); Cansurmount (support for individuals with cancer and their families). While these groups may not have bereavement intervention as a prime focus, they do offer shared experience and strategies for coping with disease and loss, and accepting environments.

Formal Support Eight individuals accessed the bereavement intervention sponsored by the palliative care program of the study hospital. The program is not bounded by time and bereaved persons can come and go as they feel they require support and information.

One person without bereavement intervention sought private counselling. This individual indicated that it was for a short period of time and that while there was an ongoing need to address some unresolved issues, "it wasn’t time yet".

The bereavement group participants expressed needs being met that included: social support, openness and acceptance, the normalcy of the bereavement expression (ie. not going crazy), sharing and validation of experience, perception of growth in others and self, permission to talk about the death and about self, availability of information from which to define own guidelines for grieving, and the
provision of a refuge and support. These directly relate to findings expressed by Zautra and Sandler (1983) which include "six types of social support: cognitive guidance, emotional support, positive feedback, social participation, task assistance, and advice and information" (p.42) and to other research findings noted in Chapter 2.

Upon analysis, these individuals are also found to be thoroughly engaged in Worden's Tasks III and IV.

**Ritual and Tradition**

As mentioned in Chapters 1 and 4, a major concern for bereaved individuals in our society is the loss of ritual surrounding death and bereavement. Ritual acts and behaviours contained within mourning customs of a society marks the transition "but also makes a transition at the same time" (Imber-Black, 1988, p.14). While ritual "marks" and "makes" the transition, cultural meaning is also embedded within the process and assists people in constructing their maps of reality. Yalom (1989) found that "rituals of a funeral or scheduled services proved helpful by providing structure and identifiable norms of behaviour during the first painful weeks of bereavement" (p.440). However, the lack of funeral/burial rituals is remarkable in the current study. Loss of traditional funeral ritual is supported by the
number of cremations in the study sample (70%), with 60% of these having no memorial/funeral service. Cremation can be entered into as a way to escape the grief process as rapidly as possible and thus can have adverse effects on the bereavement process. It was found that in response to "what was the hardest thing to bear this year?", a large number of responses pertained to funeral or burial procedures -- many of these respondents had not participated in a funeral or memorial service.

Avoidance of ritual is substantiated by Parkes (1972), Cassem (1976) and Keith (1981) as a reflection of "'the [North] American way of not dying' [in which] mourners are deprived of the social context best suited for the integration of loss" (Cassem, 1976, p.393). Roy and Sumpter (1983) note ambivalence about visiting the grave and Rando (1984) associates the changes in funerary procedures with the way in which families relate to society with fewer social ties, increased alienation from each other and "nuclearization" of the family. "My wife didn't want a funeral, it's no one else's business but ours" (Respondent), well illustrates this contention.

The provision of social structure and support helps to frame the event and to allow expression of loss. This lack
of social sanction is evident in lack of understanding of the grieving process that pervades current society. The loss of structure is reflected in occupational "compassionate leave" of three days; in comments from an acquaintance six weeks post-bereavement "I'm glad to see you're getting over it"; and in the general sense of 'friends' "not wanting to hear about it".

The need for validation, for open discussion of the death and the process are important aspects of grief resolution that were not being met outside the bereavement group. The concept of 'aloneness' was cited many times (twelve out of fifteen) and was related to being "uncoupled" or "singled", a self-defined feeling of ostracism from society. It was expressed that when there is a death the focus is on the dying person, but seldom on the "self" -- this loss of focus results in the loss of "self in action -- in life". "People would call and ask how he's getting along, but never how are you doing" (Respondent). People (society) do not want to witness another's pain. It is easiest to avoid or impersonalize the process, thus allowing objectification -- keeping "it" at arms length. "The group allowed me to speak about things that my friends didn't want to hear -- [they indicated that ] I should be 'past that by
As we try to remove ourselves from the pain and awareness of death, we become personally more vulnerable to it and less supportive of others who are bereaved. Schneidman (1976) critiqued current perspectives of death which treated death as a social disease. He commented upon a stigma of death with its resultant outcast status for the survivors. "Being a widow is like having a contagious disease" (Silverman, 1986, p.16). Aries (in Schneidman, 1976) further developed this theme by observing that "mourning is no longer a necessary period imposed by society; it has become a 'morbid state' which must be treated, shortened, erased by the "doctors of grief" [morticians] (p.80). With regard to traditional wakes or community support for the bereaved, he states that "sadness and mourning have been banished from this calming reunion" (p.81), thus perpetuating the objectification of the death event and minimalizing its meaning for the bereaved family members.

To compensate for lack of community support, individuals are found to have created their own meaning for their experience. The "place metaphors" indicate creative grieving by individuals who are engaged in Task III issues.
This ingenuity encompasses creative visualization and meditation techniques, holistic philosophies of life and positive thinking, symbolic mourning periods, and projects which reflect the meaning and value of the deceased family member to family and community.

**Discussion** When the aggregate bereavement outcome is reviewed, the group with bereavement intervention shows evidence of better grief resolution thirteen months post-bereavement than do those without bereavement intervention. Tasks I and II are well resolved for the former group. Many of the latter group are found to be groping with these Tasks, and it would seem, could benefit from intervention at this level.

One of the research questions is — "why do some individuals chose not to participate?". When asked that question, the responses are that they didn’t feel they needed it at the time of the invitation. This has implications for programme implementation.

There are also other issues. Five of the eight individuals with bereavement intervention actively sought information and support prior to the death of their family member. Was this indicative of the short period for preparation for the death or was it due to an information-
seeking approach to life/problems which was incorporated into their personal control and mastery issues? There is little in the literature identifying help-seeking behaviour.

Fisher et al. (in Gottlieb, 1988) relate help-seeking behaviour to many dimensions of self-esteem and self-assessment. These encompass: the perception of the difficulty as problematic and the values of the individual's reference group, a sense of vulnerability and consistency of the self-worth evaluation, the ego-centrality of the task (importance to self-definition), embarrassment, whether the need to seek help is due to external or internal causes, and the perceived opportunity to reciprocate.

These variables were not measured in this study but may be subsumed within the reasoning not to participate in the bereavement intervention.

**Role Redefinition**  It is important to address the issue of roles and redefinition as they are integral to restructuring one's life post-bereavement. When a family member dies, the multiple and reciprocal roles which involved that individual also die. "I am no longer a wife or lover or best friend", "I am no longer a daughter", "He was the worrier -- I was the doer. Now I have no one to worry about what I do", "He was my security", "She was my soul-
mate" (Respondents). Wrapped up in these relationships are a multitude of nuances that do not become reality until after the death event. These are reflective of the layers of attachment and trust developed in childhood and extended into the adult relationship over the years. Marris (1986) expands upon Bowlby’s theory of attachment — that childhood bonds provide the experience from which individuals will approach all relationships in which security is sought — and sees this as the basis for meaning structures encompassing "emotions and purpose" (p.viii). This "attachment becomes embedded in principles which guide and interpret our later discoveries of order and relevance, effectiveness and helplessness" (Ibid). Bereavement disrupts this attachment and the ability to organize our worlds.

Relationships provide an integral source of value and reward, self-esteem or self-worth. With bereavement, this resource is cut off, disrupting interaction patterns, thus presenting a need to establish new patterns of attachment and meaning structures. This entails changing self-concept through a dual process of forfeiting previously held views about oneself as well as integrating some of the past into the new. (Parkes, 1971; Thom and Wright, 1979; Wynne, 1984; Silverman, 1986; Moos, 1986).
Worden's Tasks I and II are integral processes in developing schema for framing the new identity. Some roles must be assumed for reasons of survival, however realigning self-identity/self-worth is a difficult shift, especially if societal role prescriptions are ill-defined. Silverman (1986) has found in her work with widows that the role of widow is socially marginalized when compared to the honourable/desirable role of wife (p.15). Widows' comments about feeling "outcast", about inequities -- "men are able to find someone easier than women", increases isolation and the sense of rejection -- "My friends don't want to hear about it", "They were his friends, not mine", "It's not the same, they are all couples and don't understand" (Respondents).

Much of the social framing of grief and bereavement follows from lack of ritual and avoidance of pain in our society, is discussed above. However, the social framing also frames the individual's experience and the new meaning structures that are developed. "I'm surprised at my resiliency", "I'm much more independent", "I do things my way now" (Respondents).
Social Psychological Process

Individuals who are in the process of reframing their identities and integrating meaning with self-image, are doing so within a society which places certain expectations upon them. This basic social process is also undergoing change and thus clouds the clarity of social expectations and role definitions which, in turn, impinge upon the healing, the redefining, the modifying of frames that the bereaved must address.

Idiosyncratic considerations Individual cognitive styles, past experiences which have led to a successful integration of personal belief about oneself, affect the worldview of the individual and whether or not an event is perceived as a failure or a challenge. Personal appraisal of the event's threat to self is the key to whether an intervention is aimed at prevention or growth enhancement. It was noted in the Worden analysis of the Process and Person Metaphors that those with lowest self-image and the most emotionally laden referents were avoiding engagement with Task II. These individuals would not benefit from a growth enhancement intervention as their interaction with their environment was not appraised as having a positive component. "Nothing was positive about this year"
(Respondent). Positive appraisal indicates healing and suggests increased competency which could be related to the successful adjustment, through Task engagement, to the loss of the family member. "Positive affects associated with (stressful) events are signals that events are occurring that are congruent with a person's interests" (Zautra and Sandler, 1983, p.49).

**Aggregate consideration**  "The structure and climate of social exchange can also facilitate or actively interfere with integration of mastery experiences" (Ibid, p.48). The lack of societal understanding and support, and the loss of ritual which brings community together has been discussed above. Zautra and Sandler (1983) suggest that "event-event correlations would be useful to gauge specific person-environment responses" to experiences. (p.49).

The linkages between the person and environment are also reflective of different socialization and therefore, expectations inherent in social process. These social changes are reflected most eloquently in subtle shadings of meaning found in responses to the question of "remarriage", which reflect changing social norms and role expectations over time. Widows in their 60s represent a longer period of marriage and a role/identity socialization that began prior
to World War II. This age group spoke of maintaining identity and ways of doing things which reflected values and habits derived from their marriages and did not consider remarriage an option. Mastery of tasks and increased independence was assessed through reference to the deceased husband -- "My husband would be proud of me". The women in their fifties express openness toward change and the possibility of remarriage "sometime" but qualify it by stating that there are unanticipated advantages to being alone, to being able to do whatever, whenever they wish.

This group was in their twenties during the 1960s and seem to have a greater outward focus and resiliency in their approach to bereavement and life. All of them indicate active involvement with assisting daughters in their twenties through their bereavement. Younger respondents in their forties, are different still -- incorporating more of a holistic approach, with death being viewed as part of life and expressing hopes of making the grief experience one of growth with positive outcome. Remarriage is not as important to them at this point as is a successful, positive experience for both themselves and their children. The most interesting aspect of the responses is the generational change in the philosophical and psychological framing of
their bereavement experiences.

All of the above individuals are well engaged in Tasks III and IV with inferred new role definition and activities. Most have achieved this point by being involved in the bereavement intervention during the early stages of bereavement, when preventive intervention is most indicated. Having had that experience, these respondents now note a need to "move on", to address other issues — "issues related to being single", to find other means of interaction and community.

Models of Assessment for Bereavement Intervention

It is important to ascertain those most at risk and to target them for bereavement intervention strategies. It is noted in the study that elderly men and young women in their twenties seem to be particularly at risk. It is also noted that those with little time for preparation for the death of the family member self-perceived need for assistance and chose to participate in the bereavement intervention. Their progress with their bereavement resolution indicates that the intervention provided a supportive milieu while preventing grief related difficulties from arising. As time went by, these individuals moved toward personal
redefinition rather than experiencing acute grief issues. This reflects differing needs that are found in two models of assessment for intervention -- prevention and growth -- developed by Zautra and Sandler (1983). They posit two complementary models for "guiding needs assessment efforts for prevention programs", one of which addresses prevention of pathology, the other enhancement of personal development (p.35). While these models may appear to have differing focus, for the purposes of bereavement intervention both are applicable and adaptable.

Both the dynamics of social support networks and community resources availability are important in assessing the need for bereavement intervention and to mediate appropriately for an individual and his/her family. Through interpreting the findings presented in Chapter 4, it is observed that specific task resolution, hence progress through the grieving process, assists in delineating the intervention needs and relevant intervention strategy -- that of prevention or personal growth enhancement.

Psychological Distress Model This model is based upon the assessment of the impact of a stressful event upon an individual. It is a preventive intervention model which
focusses needs assessment efforts on symptoms and ways in which to alleviate their harmful effects. Collectively -- across populations -- it has been shown that certain risk factors may predispose individuals to difficult grieving trajectories. Thus certain populations are deemed "at risk". An idiosyncratic interpretation of distress would be the meaning ascribed to the event by the individual -- the individual’s personal appraisal. Even though the death event may have profound consequences for an individual, the personal appraisal may not necessarily be negative, or one of requiring active intervention. "Our time together before her death was highly positive and close ... we fought the good fight" (Respondent).

The Grief and Adjustment Scores are indicators of possible difficulties that may require a preventive intervention. The difficulties are confirmed when the Worden Task analyses are undertaken -- as well as pinpointing the level of intervention (Task I or II).

Psychological Growth Model Zautra and Sandler (1983) indicate that "evidence of personal development begins with the assessment of events that signify either successful transactions with the environment or opportunities for success" (p.45). In the bereavement process, this model
relates directly to Task III engagement which Worden (1982) deems to be the turning point in grieving resolution. The growth model applies directly to those individuals who have engaged successfully in Tasks I and II and are seen to be engaging in activities/behaviours that are self-enhancing. These are revealed in the Place and Person Metaphors and relate to self-image, role redefinition and a positive interaction with the environment (which may also have undergone redefinition).

Death of a loved one is a definitive event. Certain characteristics of palliative care programming provide underlying support for grief amelioration and the possibility of an eventual positive affect associated with having experienced the loss. By incorporating the family as the unit of care and encouraging personal involvement in decisions and caring, mastery and a sense of control, coping strategies and personal efficacy, are enhanced. "I hadn’t realized there were benefits to being single", "I feel much more self-confident and I’m doing things that I’ve never done before" (Respondents). These comments are indicative of positive growth responses found within bereavement resolution. It is important to note however that the transformation of the pain of grief into the energy required
for creativity and growth only seems possible after Tasks I and II have been experienced fully.

Discussion Individuals who would benefit from the Psychological Growth Model tend to be those who approached life problems with positive attitudes and who were either not deemed at risk or had successfully engaged with Tasks I and II. Those who participated in the intervention have progressed beyond a Psychological Distress Model of intervention. This illustrates the success of the bereavement intervention in ameliorating the bereavement process. While support may still be required by some of this group (those with the lower Grief and Adjustment scores), the intervention itself may need reassessment and a change in focus to concentrate on growth issues.

Assessment While assessment of need may address two models of intervention, the assessment for the actual bereavement intervention requires two levels of analysis — the community and the individual/family.

Community assessment A knowledge base of services available in the community, at both the formal and informal support levels is necessary. There also needs to be an awareness of barriers to programming which may appear in the guise of policies or funding parameters, and the
availability of trained personnel. Target intercepts can be identified and may include: churches, neighbourhood houses, service clubs, community services, wellness groups, schools and various agencies through which programming and/or other types of supports may be made available. There may also be need for public education and thus an assessment of media availability, speakers, and the degree of receptivity which would ultimately define content and target populations. With this broad range of community based resource, a full complement of both preventive and growth oriented interventions could be evolved in a network of support structures.

**Individual/family assessment** There are four major routes through which an assessment of individual/family needs can be made in the palliative programming prior to the death of the family member.

- Psycho-social assessments of the individual/family coping repertoires, support networks, health factors and other intervening variables (ie. financial) are common areas of assessment for social workers in health care settings. As well, known bereavement risk factors can be identified -- conflicted relationship with the dying individual, problem areas in family functioning,
men over age seventy, poor health, no support networks, etc. With this information an assessment of appropriate targets for intervention, and levels of intervention (prevention/growth) can be assessed. For example, children will respond to various strategies -- play therapy, art/music therapy -- given their level of development. Adolescents respond well to music/group therapies.

The personal story of the illness experience reveals coping mechanisms, areas of strained resources and concern, strengths and worldview/philosophy, as well as the quality of the relationship between the patient and the individual/family. It has been found through personal experience of the investigator that newly admitted patients and/or their family members appreciate the opportunity to tell their stories and to express their concerns -- many of which focus on the welfare of the family post-bereavement.

The advantage of a palliative care programme is the interdisciplinary nature of the care and the ability of each team member to share their concerns and observations about the well-being of individuals and/or family members.
Dush (1988) outlines a health concern checklist that very simply elicits patients' concerns about their health status and "takes about five minutes to complete. ...It appears that a checklist such as this helps some patients to surface concerns that they would otherwise be reluctant to bring up -- such as 'sexual difficulties'" (p.23). An adaptation of this type of checklist may be of assistance in assessing individual/family concerns and survival needs, and may be filled out retrospectively by the social worker as a resource tool, or directly by the individuals concerned thus enhancing their control over information and interventive care.

It is important to remember that bereavement intervention is not a treatment but the provision of professional intervention in a caring and supportive environment, through which "the greatest gift we can offer the bereaved is to be with them" (Fiefel in Moos, 1986, p.255) -- to truly be with them in whatever manner is required.

Planning Intervention It is important therefore for bereavement programs to recognize the societal and
family structures that impinge upon an individual's bereavement expression. Myths of "family" and "social network support" must not interfere with an assessment of actual need. When a family member dies, the total family system is involved individually in reconciling that loss. Thus intervention requires flexibility and ingenuity in order to meet the various needs of age groups and life stages. While programmes for adults tend to encompass all age groups, some individuals may relate better to sex and/or age differentiation -- young singled fathers, raising children and assuming caregiving and domestic roles may have difficulties relating to the needs of elderly men with grown families and vice versa. Teens and children require their own cohorts to enable freedom of expression.

The types of programmes developed therefore depend a great deal upon the needs of the bereaved being met.

Summary

The search for meaning is seen as a key factor in the grief process. A descriptive analysis of findings from a bereavement intervention study which incorporated two methodologies has been presented to provide insight into the
structures of meaning which occur during the grieving process. Coding for a quantitative analysis of the data derived indices which provide measurement of the degree of bereavement resolution by the study respondents at one point in time, thirteen months post-bereavement. Core categories were evolved and analyzed qualitatively to ascertain how individuals frame the grieving process over time and to what extent this process has been ameliorated by bereavement intervention.

The core categories are those of "time" and "meaning", unify the numerous themes presented in the data and relate to the objectives of the study on both the personal and societal constructs under consideration.

William Worden's Four Tasks of Grieving (1982) have been utilized to assess the degree of bereavement resolution of the two groups, hence the need for intervention. Two models of intervention have been suggested -- preventive and growth enhancing -- at two levels of application -- individual/informal and formal support networks. The roles of support networks, ritual, role redefinition, and social psychological processes have been discussed.

The data indicates that individuals with the bereavement intervention have better grief resolution than
do the majority of individuals without the intervention.
Chapter 5 dealt with the first of the three primary objectives:

- the need for bereavement intervention.

Based upon data derived from the study, this chapter will address the remaining two objectives of the thesis:

- implications for practice incorporating family resource evaluation through contextual analysis, and through identifying social structures which impinge upon the grieving process:

- policy implications for provision of bereavement intervention programming and for the overall welfare of bereaved individuals.

The discussion will be presented in two sections:

SECTION I will encompass a systems approach to intervention and will be followed by implications for integrative practice. Intervention for a family unit begins upon entry into the Palliative Care Programming with a thorough assessment of patient/family needs.
Social workers, as members of the Palliative Multi-Disciplinary Teams, with their knowledge of family systems and dynamics, are intrinsic elements in the psycho-social dimensions of care for the family unit. They are also mediators for family/staff/support services interactions.

SECTION II will cover policy and programming development. Subsumed within this area of discussion are government policies and programmes which have consequences for bereaved individuals, government and hospital policies that define programming and funding parameters, and implications for programme development for both community and individual stakeholders.

The role of the Social Worker as practitioner and policy initiator will be discussed

SECTION I

To enable bereavement risk assessment and intervention it is incumbent upon "those caring for family members during bereavement to have basic understanding of human behaviour, family
dynamics, and the psychology of grief and bereavement in order to identify needs" (Ajemian and Mount, 1980, p.426).

Family resources and transactional patterns -- the creative capacity of the family system to promote coping and survival, to effect healing, to generate new knowledge; and the family’s capacity to interact with the outside world in a manner that is conducive to enhancing and preserving family integrity -- critically impact bereavement outcome (Karpel, 1986; Kirschner and Kirschner, 1986). The challenge is to ameliorate crises such that the continuity and consistency of the family’s integrity are maintained.

Every role, responsibility and function fulfilled by the dying member is ... irreplaceably lost to the family system. Every member of the family is being effected uniquely and differently at many interacting levels (Brenner, 1985, p.15).

Knowledge of family systems, of interrelated external and internal relationships and responses, and of family life cycle dynamics, is necessary to mediate the experience of grief and bereavement -- not only for the family but also for the staff with whom the family interacts (Jenkins, 1989).
The loss of a family member results in a major disruption in family configuration and role delineation. From a systemic perspective, concerns are related to identifying facilitating elements that will ameliorate the transition and engender feelings of security and competence. This life stage is brought about by the critical event of the death of a significant other, and results in the loss of established pathways and familiar interactional patterns. Coping capacities are stretched as the bereaved attempt to incorporate meaning and purpose into this new experience. The extent of the grief reaction is effected by the interpretation of the illness experience by the individual, and is further influenced by the relationship to the deceased, by the strength of that relationship and by the coping strategies developed over the relationship time span. (Raphael, 1982).

**Implications for Practice**

The systems approach of analysis is chosen as the means to understand context of family, social support network, and community/societal network -- their component parts, structure and dynamism, and to focus intervention efforts. It became apparent in Chapter 5 that individuals do not
grieve in isolation but are part of larger systems which include both informal and formal support networks which are also embedded within societal values and norms.

**Intervention Strategies**

The family systems paradigm provides a framework for an analysis of supportive networks, allowing integration of various systemic designs while incorporating analysis of family within the larger network. This will require a merging and conceptualizing of these issues in a manner conducive to clarifying the process and dynamics of the family in personal and social contexts. "Family therapy [has] evolved out of a continuing search for a useful paradigm to understand human systems and to work with human problems" (Anderson et al, 1986, p.3).

When considering the death event from the systems perspective, it is important to remember concepts that would apply to Family Systems and to the grieving process. These concepts include the consideration of the overall interrelatedness and inter-dependencies of the component parts, and the ways in which they interact. The interactions are perceived at different levels—environmental (abstract), familial subsystems (intermediate) and family resources
(concrete)—and are bounded. These boundaries confine the particular actors within the system and may, or may not, be permeable or open to movement in/out (Yelaja, 1985).

Death of a family member results in a transformation of the family unit. Initially, there is a loss of family homeostasis, a move away from stability toward uncertainty (Goldsmith in Walsh, 1982; Irving and Benjamin in Yelaja, 1985; Kirschner and Kirschner, 1986). Various elements are involved in this change and include both individual and systematic coping mechanisms which promote the survival of the family unit. Karpel (1986) has found that the response of these resources to a perceived hostile environment will depend upon the magnitude of the threat, the extent of the coping repertoire, and the ability of a family member to assume a leadership role while maintaining self-integrity. Family characteristics of protection, self-respect, hope, tolerance, affection and humour further enhance family survival. In addition, family attributes of: permanence, system linkages, legacies, entitlement and trustworthiness are part of the resource repertoire accessed for family redefinition.

Various family therapy designs can be utilized in practice, depending upon the network characteristics that
one wishes to emphasize, and can be combined with an approach encompassing family resources. The following theories are included in the study as they have salient characteristics which pertain to the needs of bereaved individuals. Integrative family therapy provides the focus of context -- the patterned behaviour responses and precipitating events -- which reinforces communication patterns and clarifies the impact on the bereaved person-in-the-system encompassed within network transactions. Interactional therapy incorporates the concept of rules and integrity. Problem-determined system analysis emphasizes the embeddedness of systems and the communication between and within system levels which determine focus and functioning attributes. The sociocultural approach embodies the notion of "culture shock" and the consequences of disintegration and disruption which may be associated with the loss of a significant other.

**Integrative family therapy.** Integrative family therapy is based upon values of life's sacredness, the right to information and to self-determination. Reality is structured by the individual resulting in perception-based vulnerabilities/defenses, communication styles, cognitions and responsive patterns. "The assessment of the problem
depends on assessing the stress, the discrepancy between image and experience, imaged solution and actuality, deviance and resource" (Duhl and Duhl, 1981, p.495). The meaning, or person specific point-of-view, the communication and transactions among individuals, and the impact of the social and/or family system on the individual and vice versa are necessary considerations. Problem determination includes assessing both situational and experiential components -- coping styles, internal resources, and the repertoire of automatic patterned behaviours -- in the context of the behaviours. Precipitating events and the degree of the distress response are related to the flexibility of the network/system.

The context of the death of a family member encompasses interactional, complementary and independency patterns established over the years of the relationship and an incongruence of established family roles and habits with the new situation. In order to place the loss of the family member in perspective, it is necessary to look at complementarity within the family unit, the sub-systems/boundaries and the transactional patterns that were established over the years. Who assumed the leadership role for the family; who set the parameters for the location of
functioning; who maintained the family executive functions; who carried the family vision that enabled family continuity?

Interactional therapy. Interactional therapy is closely aligned with integrative theory and is helpful in delineating the development of family dynamics and in perceiving unrealistic expectations which effect the survivor's transition through the grieving process. These include the notions of "expectability" and predictability; the balance of separateness and togetherness -- autonomy incorporating mutuality, reciprocity and connectedness; the rules and meta-rules through which the family assured stability and change (Bodin, 1981, p.276). The ability to adapt and to cope with the new family configuration can initially become overtaxed and the resiliency required to survive is stressed. This inability to fill the gaps left by unfulfilled expectations and loss of value orientation results in a lack of mastery of the environment, and an inability to incorporate the new 'life space'. The realization is painful as it is perceived as a threat to personal identity and integrity.

This analysis also applies to society's "expectations" of newly bereaved individuals/families; the "rules" of the
network and their impact on the bereaved. What does a "three day bereavement leave" signify?

**Problem-determined system analysis.** In this approach "helping agents and clients ... must be understood within the entire context of the larger system" (Levin, et al, 1986, p.66). The contextual components are inclusive of the values and meaning systems of the bereaved individuals and the social structures with which they interact. The problem definition lies in the shared communication of "all individuals actively involved in communicative interaction ... [who] form the ecology of ideas that define the membership of the communicating system" (Anderson et al, 1986, p.8). The membership of this network is derived from the observed communications between family members, helping agencies and families, community and families. This includes the assessment for community intervention outlined in Chapter 5.

Evan Imber-Black (1986) suggests that family therapy should be considered in a much broader context than that of the nuclear constellation, noting that "the family is embedded in larger systems, which are, in turn, embedded in a wider social and economic context" (p.30), and cautions that intervention must be at the appropriate level.
Communication patterns must be related to content in order to understand the realities facing bereaved individuals/families. Normal analyses of reciprocity and circularity tend not to consider issues of power. Lack of access to resources that ensure self-determination (through loss or inability to access power) "represents a distortion of the systemic paradigm" and highlights possible bereaved/social communications as mentioned above. The concept of triads also takes on a new twist when considered as interactions between three systems -- the individual/family, the community support network, the palliative program or healthcare system -- and the possible impact on support given the differing focus on needs.

Sociocultural approach Another way of analyzing the formal support network is a sociocultural approach which is concerned with "the behaviour of individuals within the impersonal institutions of society" (De Hoyos et al, 1986, p.62). The authors combine integrative and interactional approaches with a third stage -- sociocultural intervention. While this approach has been developed to counsel ethnic minorities, there is direct application for bereaved individuals and access to formal support. The concept of discrimination could be understood in the context of pension
availability and/or survivors' benefits, access (referral) to community support networks through medical gatekeepers, and policies/funding that structure program availability. Cultural dissonance applies to the contrast between social roles (and acceptance) before and after the bereavement. Consequences to those deemed at risk in this analysis are extensive and result from the combined effect of:

- social dislocation - denial of "access to conditionally rewarding roles" [ie. no longer parent, spouse, child ...];
- cultural dislocation - from loss of ascribed meaning of mourning traditions and community support;
- sociocultural dislocation - "values and social structures are far removed from and at variance with the ...[network]... values and social structure" [ie. no longer a couple; 'abandoned' after death of only parent; 'cast-out'.] (Ibid, p.64)

**Discussion** The foregoing discussion has outlined four family systems therapy approaches for assisting the person-in-transition-in-environment and are not mutually exclusive, as an analysis can incorporate many systems frameworks of family therapy in mediating the grieving process. Aspects
of Salvador Minuchin's structural analysis can be incorporated into analyzing sub-system boundaries, the shifts of relationships and interactions between and within the sub-systems, and the restructuring that occurs with the family redefinition (cited in Kirschner and Kirschner, 1986). Psycho-dynamic concepts of J. Rice and D. Rice (1986) includes the concepts family legacies and role models. Through Kirschner and Kirschner (1986), an understanding of unrealistic expectations and unmet needs assists with clarifying the relationship and negating idealizing tendencies. The emphasis on family resources further expands the realm of psychotherapeutic intervention to include context, transition and process (Karpel, 1986).

Paul and Miller (in Karpel, 1986) caution that "intellectual knowledge withers in the face of the challenge of using these notions experientially" (p.439).

Implications for Integrated Practice

The data show that there are multifarious combinations and permutations of coping capacities and skills, as well as differential grief resolution among members of the two study groups. These are related to support networks, ritual, role redefinition, and social psychological processes that may
have positive or negative influence upon individual grieving and present the challenge for integrated practice.

"Social network is viewed ... as a shifting configuration of structures and processes taking place within conceptually bounded sets of individuals" (Erickson, 1984, p.187).

Referential frameworks of bereaved individuals shift in structure and process. The complex interactional patterns that structure the individual's social and physical environments undergo subtle shadings of change from that of discrete family unit with spouse/parent alive to family without spouse/parent. The compatibility of changed prior family 'rule systems' with the new identity complicates transition. This may be augmented by the degree of personal differentiation or constrained by past role ascription or may be exacerbated by the degree of anomie from the values of the social network.

With the focus of analysis expanding to the support network, the individual/family system is subsumed into the larger environment and into the multiple layers of interactions and feedback with which the individual must contend. It is here that network functioning is deemed either supportive or inhibitive in its effect upon the
discrete system and in its ability to absorb the systemic needs of the bereaved individuals. The individual’s network, which may still include the family, now shrinks as friends, roles and expectations change and/or disappear -- and as decreased income/mobility infringe upon ability to maintain activities/connections.

This implies a system of response reactions/patterns to environmental cues and realities that define the context and strength/support of the environment. It is therefore, important to ascertain the various indicators of positive support and enabling mechanisms within the structure of the network system and to indicate ways in which social workers can mediate the process for the bereaved. Network intervention considers missing structures of past (and possible future) truncated social systems and attempts to incorporate new structure through providing linkages to opportunities for shared experience and information. The individual is [re]connected with a social network which may include volunteer support, bereavement group participation, mutual aid/self help organizations, professional counselling, telephone buddy systems, wellness programs, art/music therapy for children/teens.

Conflict and disharmony is generally the signaler of a
broader base of problems within the family systems itself, as well as reflective of difficulties with network transactions. Bowen (Kerr, 1982) suggests that:

"In this sense, symptoms reflect a failure of adaptation by the system and are exaggerations of normal processes. Thinking of symptoms as pathological can obscure this view of the underlying system forces" (p.235).

Intervention in the family and family/network transactions, with a focus on the changing patterns and forms of both system levels may be indicated.

Social networks function as powerful determinants of a person's access to information, assistance, social support, opportunities to gain competence and to influence decisions affecting well-being. Network processes also function "to reinforce norms and values regulating behaviour" (McIntyre, 1986, p.422).

Following is an exploration of some network components where change strategies may be targeted. Each grouping of components is not meant to be mutually exclusive. In fact, all are highly interrelated. The groupings are simply ways of delineating areas or concepts for easier elucidation. It is also helpful in ascertaining where the access to
information may lie, how opportunities for competency and well-being are encouraged -- or not, as the case may be. Processes that reinforce patterns of behaviour responses are noted and reflect the culture of the network.

**Contextual Realities and Relational Processes** The response of individuals to pressures placed upon their integrity will depend a great deal upon the meaning of the death event to the individual. Parkes (1971) relates life transition competency to the number of other change events that have occurred in the individual's life. This is brought to bear on the individual grief experience and may necessitate a total restructuring of the individual's assumptive world. Ascertaining the bereaved individual's construction of reality -- the meaning of loss and the implications on adaptability and adjustment to the system configuration -- is one way the social worker can enable redefinition. This meaning also requires delineation in terms of secondary gains which will impede grief resolution. For example, a role of disability and illness may intensify family attention and reinforce helplessness/hopelessness rather than developing compensatory adaptation abilities. Duhl and Duhl (1981) incorporate the concept of "vulnerabilities" or "defenses" as ways in which family
patterns are "played" in "the quasi-simultaneous, the ricochet-like release of automatic behaviours ... as one person's defense triggers another's vulnerability" (p.502).

Enabling redefinition draws upon the need for empathic validation. Encouraging the telling of the story, sharing the "ins" and "outs" of the experience is critical. Extreme patience and empathic understanding are bonuses in this process. Initially, the most one may expect is developing a sense of safety and trust. "Safety is the feeling experienced when you know that one's boundaries will be respected, that you are regarded by others with caring" (Ibid, p.506). As alluded to above, it is also necessary to ascertain ways in which the network colludes to maintain avoidance behaviours rather than intervening to facilitate the psycho-social transition. The concept of multiple realities of problem definition and problem solution -- where everything is connected to everything else -- lends itself to maintaining a status quo unless there are ways to work through what may be a therapeutic impasse.

When an individual is involved in the emotional transition of adjusting to a new situation, the ability to maintain separate emotional and intellectual system functioning is impaired. "When these two systems are not
functionally separate, man loses that choice and behaviour and thinking are more emotionally determined" (Kerr, 1981, p.237). The emotional overload experienced by most newly bereaved individuals results in withdrawal from the very thing that is needed most - the interaction and support of others. When the system is non-responsive, or is 'stuck' in its approach, it overlooks the fact that withdrawal is as much an indication of need for others as is overt emotional dependence.

The demands or exigencies of the specific grief context are necessarily defined by the individual's and/or family's coping repertoire. The effectiveness of this coping must be conceptualized when analyzing particular interventions. The relationship between the supportive environment and the bereaved requires careful consideration in order to fully understand the multiple realities that exist and the ways in which the 'message' is imparted (see metacommunications, below). To this end, Gunderson (1985) suggests five hierarchical therapeutic functions that meet various needs. The first, found in early grief, is "containment", and relates directly to Maslow's first hierarchical need -- that of security. This is the assurance of physical well-being and safety for the bereaved and may be as simple as who will
be in the house, who will prepare the meals, or as complicated as who will pay the bills. Secondly is "support" -- which consists of deliberate attempts to decrease anxiety and distress. "Structure" results after the first month and includes the organization of the support environment such that the integrity is preserved through meeting basic needs. Over time two further components would be "involvement" -- the gradual enhancement of ego functioning through support activities designed to reinforce competence -- and, "validation" -- enhancing the uniqueness and personal value of the individual.

**Boundaries, System Flexibility and Morphostasis**

Family and support network characteristics can either facilitate or hinder the transition into the new configuration. The actual boundaries of the system -- the degree of exchange within and permeation from without that has been tolerated -- and the conceptual boundaries -- the assumptive world meaning ascribed to the death event and the related stresses -- are attributes to be considered. The openness of the family system, its creative response and growth enhancement ability, the multiplicity of emotional needs and concerns, and its capacity for adaptation, are other properties inherent in easing the transition.
An awareness of client/family systems in need of help and support, and reorganization of the family roles, is necessary. The particular interrelational and transactional patterns within the family system define that system. Rigidity of function, double binds, negations are indicative of relationship roles in a closed system. A family system incorporating these qualities would suggest hierarchical power bases or complementarity. Preference for maintaining status quo system functioning, rather than changing pseudo-mutuality, reinforces old roles and expectations which may not be conducive to grief resolution. Patterns of interaction that have become routinized and impersonal are indicative of a closed system with inflexible relationship rules.

A happy medium would embody the ability of a system to maintain an equilibrium and stability within a framework of growth and integration. This would be indicative of having achieved a balance between morphogenesis and morphostasis -- the consolidation of innovation and change with stability -- thus providing an even referential point for the bereaved having predictable structure while allowing for creative response to their multifaceted needs. Rituals, symbolism and creative grieving strategies illustrate this balance. A
creative response can also be a product of mutual exploration by the individual/family and social worker -- an interpretation of environmental stress and/or individual validation needs .. "I have my own friends now". From the sociocultural perspective, the social worker can work across the "cultures" of the support network and the family environment to deal "simultaneously with the clients’ emotional adjustment, interpersonal relations with support systems [formal and informal], and adjustment to societal structures" (De Hoyos et al, 1986, p. 66). "My friends don’t want to hear these things"; "It doesn’t seem to take men long to find someone else" (Respondents).

**Communication**  As discussed previously in Chapter 4, communication is never straightforward, being comprised of the transactions and linkages within the family/social system -- and generally contains messages within messages (metaphorical levels of meaning) (Hanen et al. 1979). This is further defined by the context in which the message occurs -- the time, place, with whom. How the bereaved perceives the support network/family configuration is very much a product of perception of "analogs" or rules which define the relationship of family members to each other and to support system. In systems theory, communication is
defined in information-processing terms which incorporate all the above dynamics and relate its flow—directionality, energy and content characteristics—to the boundary permeability and the openness of the system.

Communication assumes many purposes. Boundaries between family and network or between family members may be sustained for reasons of separateness. It may also be an expression of a need for continuation of a life-long control of roles and relationships. It may be expressed as active withdrawal. Different family members may be perceived as part of the power system. Lack of response/participation may not merely be the exercising of an individual's prerogative of choice, but may be a strong disapproval of the imposition of irrelevant expectations. It is worth assessing who is involved and who is uninvolved when evaluating the efficacy of coping strategies.

A major concern in family therapy is the metacommunication contained at the subliminal level that structures the relationships, rules, reciprocity, and complementarity found within the system. This communication is the meaning behind messages like "We didn't have a funeral. It was nobody's business but our own." and is more than boundary rigidity. It is reflective of "the nature of
interdependence between parts; and ... the degree to which uncertainties affect the behaviour of the system" as well as the complexity of the interactions (Ricci and Selvini-Palazzoli, 1984, p.169). The complexity is heightened by the number of players, the relationships of relationships and the linkages between these relationship territories. "I'm closer to the in-laws, my family always try to tell me what to do". To illustrate the nature of complexity, Ricci and Selvini-Palazzoli (1984) move beyond dyadic communication to a higher level that incorporates the metacommunication meaning: "the game itself, and not the various players, should be considered the "real" receiver of the sender's communication" (p.171). They present a graphic illustration of this schema which is evident at all levels of communication -- personal, interpersonal, and societal:

"1. I (sender)
2. am saying something (message)
3. to you (apparent receiver)
   inevitably and concomitantly
4. to him/them
5. in this situation (context) " (Ibid).

Stanton (1984) relates communication to:
- spatial "maintenance of self-other clarity" (personal
space) -- "My son tries to tell me what to do, but I can handle it" (Respondent);

- gradations that are incorporated in "closeness-intimacy or distance-strangeness" -- "[with new friends...] my son has the killer instinct, he always goes for the jugular" (Respondent).

These dynamics must be considered in light of the impact on the bereaved -- considered in light of the ambience of the family system -- and the "culture" of the supportive environment.

**Discussion** The family systems therapies and implications for integrative practice discussed above sensitize the therapist/social worker to the many levels of intervention that maybe required to mediate the grieving process for an individual/family.

It is also possible to delineate general therapeutic strategies which will ameliorate the grieving experience:

- supporting and allowing the grief process, and accepting the permanence of the change;
- assistance by the therapist with practical and immediate consequences of the multiple losses inherent in the death of the family member;
- achieving a deeper understanding of transactional
patterns that limit/assist the transition;
letting go--both symbolically and actually--the fantasies of the lost relationship. In this way the stage is set for rebuilding self-esteem, for a renewed belief in the future and in a personal ability to form it.

As Judy Tatlebaum (1980) so aptly writes in the close of her book _The Courage to Grieve_, "As we journey through these painful experiences of living, we must never forget that we have an amazing resilience and capacity to survive. ... just as spring follows winter, so it's nature's way, that through it all, whatever we suffer, we can keep growing. It takes courage to believe we can survive, that we will grow. It takes courage, too, to live now and not postpone living until some vague tomorrow" (p.160).

SECTION II

_**Characteristics of the Sampled Bereavement Programme**_

Currently two hundred patients/families per year are cared for through the Palliative Care Programme at study hospital. The program is dedicated to providing comfort and emotional support for the patient and family members, both
in the hospital and at home. Extensive intervention and amelioration are carried out prior to the death of the family member by the Palliative Care Team, through coordination by the Social Worker, Head Nurse and Medical Director. Volunteer support is provided by trained volunteers, both on the Palliative Care Unit and in the community under the direction of a Volunteer Coordinator (B.S.W.) and the program Social Worker.

Bereavement counselling is provided before, during and after death. The Social Worker provides 1:1 bereavement counselling and directs on-going, bi-weekly bereavement groups of up to twenty-five (25) persons. The first meeting of each month is dedicated to information about grief and bereavement and to resolving participant issues. The second meeting is primarily concerned with building social support amongst the participants. New participants are asked to start with the first monthly meeting which is structured, rather than the second which is more informal. Volunteers are integral components of these sessions and also carry out 1:1 support under the direction of the Social Worker. Individuals are free to participate for any length of time — given their personal needs, and can also drop-out and return at any time should they so wish.
All families in the Palliative Programme receive an invitation to participate in Bereavement Follow-up through a letter and a telephone call one month post bereavement -- from the Social Worker with volunteer assistance. Family members are encouraged to attend individually, with other family members, or with a close friend.

Of the family members participating in the Palliative Programme, only twenty-five per cent (25%) feel they need further support and choose to participate in Bereavement Follow-up. (This is consistent with hospice study findings in the United States (Roy and Sumpter, 1983; O'Toole, 1987)). Eighty five per cent (85%) of the Bereavement Group participants are self-referred from the community at large and represents individuals whose family member died at a different hospital. This translates to approximately fifty (50) survivors enrolled from the Palliative Services, and one hundred-seventy five (175) self-referred individuals participating per year.

Implications Concerning Bereavement Intervention from the Findings

The study bereavement group is an open-ended, on-going group and is therefore not time-bounded as are most
programmes outlined in the literature (Yalom, 1989; Silverman, 1986; Osterweiss et al. 1984). There are advantages to both approaches which accounts for inclusion of both types in Program Components (below).

Respondents to the study noted the beneficial effects of group, volunteer and social worker support and information. Some indicated that they found it difficult to connect with people consistently -- because of the flexible in-and-out nature of the programme -- thus missed developing a support network/group with whom they could interact outside the group environment. Even though some participants were able to do this, there was concern voiced about the different levels of grieving within the bereavement group and therefore differing needs. Participants also mentioned that they wished for issues to change as they changed and to address aspects of being single and the social constraints they felt old friends, business associates and the community in general placed on them. Most felt that their grieving needs had been met but that their social needs had not been.

Most of those who did not participate in the group indicated that they did not feel they required assistance when first contacted. This is valid as not all individuals
require bereavement intervention. Outcome analysis however, found that five of the seven individuals without bereavement intervention would have benefitted from assistance -- and that one had sought private counselling six months post-bereavement. The implication from this group and from the literature (Silverman, 1986, Vachon, 1988) is that a one-month post-bereavement follow-up may be too soon as the support network may still be engaged at that time. Disengagement of friends and distant family members may not occur until after the one month period, thus giving the bereaved individual false sense of well-being. The implication is that a one-month contact is indicated to "touch base" and a three-month contact regarding bereavement group participation may be more realistic. For those who refuse participation, a regular three-month contact is suggested for the first year. While the individual who withdrew from the study stated that another year was needed, an on-going contact would make it easier for this individual to reach out for help or for group intervention when the time is right.

The palliative care programme itself was sufficient support for two people in the study. Programme support for the patient/family and for anticipatory bereavement issues,
life-long habits of meeting adversity as challenges, the quality of the relationship with the deceased, and personal health, strengths, sex and age combined to assist these individuals through their grieving process.

Time-bounded programmes tend to run for eight sessions -- either one per week for two months, or biweekly for four months -- during which time a natural progression from engaging in the reality of the loss and experiencing the pain through to disengagement from the group and an outward focus on meeting needs from community and informal support networks is encouraged. "Homework" and/or grieving exercises may be undertaken during these sessions but Yalom and Vinogradov (1988) caution that the use of techniques and formulae are not always appropriate for the individuals in the group or for group dynamics that may develop during a specific session. Thus if this approach is to be utilized, group facilitators must be judicious and flexible in their use.

The advantage of these groups is the ability to focus on specific issues which encourages preparedness by participants, and enhancement of group cohesion and the informal support that rapidly develops during the programme which has a tendency to spin off into outside activities.
The disadvantages are found in the time-boundness — in the lack of opportunity to opt back into the bereavement intervention should difficulties need addressing, and in the maximum four-month period inherent in the programme designs. Some programmes have incorporated flexibility in allowing an individual to attend two consecutive bereavement interventions if necessary, as well as developing a professionally supervised, volunteer run social support group for those who have completed the initial eight sessions. Another advantage lies in a concern for limited resources and trained personnel. Lack of both delimit the availability of on-going programming, thus providing an incentive for time-bound programmes.

Bereavement Intervention Programme Development

Programme development is related to meeting the challenge of "providing the most appropriate care, in the most appropriate place, at the most appropriate time" (Fyke, Pallan and Juzwishin, 1988).

In delineating standards for palliative/hospice care, the International Work Group in Death, Dying and Bereavement (1978) elucidated assumptions, principles and standards which relate to bereavement care and are outlined in Table
17 below. Many standards which pertain to hospice/palliative care philosophy, team, links to the community, and psychosocial needs of patients and families are applicable to this discussion but are not included as space would not permit. These assumptions and principles present essential underlying standards for palliative services establishing bereavement intervention programmes. They do not address content nor target populations of programming but may act as guidelines from which to address bereavement needs of survivors.
Table 17: Assumptions, Standards and Principles pertaining to Bereavement Intervention

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivors are at risk emotionally and physically during bereavement</td>
<td>The provision of appropriate care for survivors is the responsibility of the team who gave care and support to the deceased.</td>
</tr>
<tr>
<td></td>
<td>Hospice care provides continuity of care.</td>
</tr>
<tr>
<td></td>
<td>Continuity of care (services and personnel) reduces the patient’s and the family’s sense of alienation and fragmentation.</td>
</tr>
<tr>
<td>Hospice care for the family extends into the bereavement period</td>
<td>Family needs continue after the death of one of their members.</td>
</tr>
<tr>
<td>Hospice care is provided by an interdisciplinary team.</td>
<td>No one individual or profession can meet all the needs of terminally ill patients and families all the time.</td>
</tr>
</tbody>
</table>

(Rando, 1984, pp.293-300)

Ajemian and Mount (1980) supplemented these efforts by outlining forty-one assumptions and principles specifically designed to "assist in the development of care programs to assist the grieving and bereaved" (Ajemian and Mount, 1980, pp. 422-428). These general assumptions and principles are organized into four major areas of concern: family, caregivers, bereavement programmes and community, and research in bereavement. Many of these are implicit in the following programme delineation.
Philosophy    Encompassed within the Palliative Care philosophy, bereavement intervention is subsumed within continuity of care and enables survivors to find quality and meaning from life and death experiences. It is provided to assist individuals with adjusting to the loss of a loved one. Grief is considered a natural, highly personal response to this loss which is manifested in a variety of physical and emotional distresses and is a life transition through which some individuals require compassionate support. Bereavement care provides a nurturing environment which facilitates safe passage for the person-in-transition.

Goals    The goals of bereavement intervention are to facilitate the grieving process through the prevention or alleviation of detrimental consequences of grieving, and to enhance the integrity of the person and the family unit.

Objectives    The objectives of bereavement intervention are:

- to provide family members with information about the normal grief process;
- to provide opportunities to review and reflect upon the loss experience;
- to assess and monitor individual coping abilities, stress levels and available support;
to encourage families to utilize existing support systems or to seek and create additional sources of support.

Programme Components Not everyone requires extensive intervention and support during the bereavement process, but most appreciate information and validation of their pain and sorrow. Certain populations are at greater risk for prolonged, and possibly pathological, grief reactions. In order to respond to the broad range of need, programme components need to be flexible in terms of content, time of day, and age/time of life specificity. A broad range of programmes -- all encompassing professional supervision and volunteer involvement -- are therefore suggested:

- In-hospital monthly memorial service to which friends and families bereaved in the prior month are invited; staff are also encouraged to attend.

- Four week follow-up group -- 1 meeting per week -- offered to all who attend the memorial service, during which practical issues regarding finances, income tax, pensions, grief process will be discussed. Attendees requesting further assistance or indicating greater need will be referred to an appropriate intervention group or to 1:1 counselling.
- Bi-weekly evening group — 2 per month — on-going drop-in for mutual support and for information/issue resolution.

- Widow-to-widow — can be carried out in conjunction with a church or a community resource, under professional supervision.

- Men's Group — may be age-specific given population needs and may cover issues of single parenting, child-care as well as grief-specific needs and other life skills; may also be carried out in conjunction with a community group or agency, again, under professional supervision.

- Special groups and 1:1 for adolescents — contracted out to a specialist working with teens.

- Art Therapy/Music Therapy and groups for children to age 12 and families, both separately and in combination. Portions contracted out.

- Adult family groups — recognizing the individual response to death and gaining some understanding of how each family member is working through specific grief issues.

- 1:1 counselling for high risk individuals.

- On-going contact with bereaved individuals who do not
participate in Bereavement Intervention, at three month intervals (or more frequently as indicated), by telephone.

- A Bereavement Anniversary Card sent from the Palliative Care Staff and Volunteers on the anniversary of the death of the family member.

**Economic Considerations** Currently the government is investing monies in expensive health care facilities and doctors fees in order to provide excellent medical care for its citizens. It is important to consider how the money is spent and what benefits accrue. As monies are being expended, maximum benefit should be attained for minimum investment. The social costs inherent in unresolved bereavement need to be addressed as these costs reflect opportunities foregone. In a market economy, people are free to choose options that bring them the highest personal gain. When markets fail, restrictions are placed on the ability to choose. Bereavement support is only available to a limited number of individuals involved with palliative programmes and seldom are services available for children or adolescents in the community other than on an ad hoc basis. The inception of broad based bereavement intervention
comprised of both hospital and community agency/service club/school cooperation (coordinated by the Palliative Programme Social Worker) would amount to a per capita cost of less than one dollar ($1.00) per person in the study catchment area. As everyone will experience grief and bereavement, this is a utility cost that is redeemable merely through providing less-cost options for the population. In effect, this intervention would represent an absolute advantage over medical intervention when considering limited resource allocation.

Bereavement intervention also embodies government philosophy inherent in guiding principles established for cooperative health/community ventures. It incorporates responsive programming, with community-based integration of services through centrally coordinated program planning that are appropriate and cost-effective; and sponsors outreach and community agency/school involvement in meeting the broad range of needs of bereaved of all ages. This enables necessary referral and the flexibility to tailor programmes to changing population characteristics.

Other implications are related to benefits accrued by the individual through awareness and accessibility of supportive, social resources; through changes in worldview
and self-view which evolve from understanding and accepting environment; and the redefinition of bereavement as a life transition rather than an illness. The end results are less traumatic resolutions and growth in personal competency through acquiring new strategies and role redefinition.

Policy Implications

Palliative Care/Hospice Care Policy Bereavement Care is encompassed within guidelines for Hospice Care programming which were formalized in the United States within Medicare Reimbursements in the Tax Equity and Fiscal Responsibility Act, 1982, following years of development and discussion:

- in the United States Congress, House of Representatives, 1976;
- from Hospice Standards developed by the National Hospice Association, 1978;
- from various National Hospice Symposia; and,
- through State efforts to standardize care for terminally ill individuals and bereaved families (Hudson, 1988; O'Toole, 1987; Hospice Development and Technical Assistance Group, 1978).

"Hospices are mandated by federal and state regulations and
by accreditation agencies to provide bereavement care to family members" (O'Toole, 1987, p.185). Canadian guidelines were first established in 1981/82 but are not legislated (Government of Canada, National Health and Welfare, 1981, 1982).

All of these standards/guidelines outline comprehensive bereavement support services for the families as part of the hospice/palliative care mandate.

The outlined purposes of the bereavement care are to:

- "maintain continuity of care of the family from hospice admission to resolution of grief;
- decrease bereavement-related illness and death among those affected, with a resulting reduction in health care costs" (Hospice Development and Technical Assistance Group, 1978, p.59).

This includes pre-death care and assessment, with active bereavement follow-up by the social worker being deemed imperative for high risk individuals (Ibid).

As a necessary component of Palliative Care Services, the Canadian Guidelines include "the development, implementation and evaluation of effective bereavement services" (Government of Canada, National Health and Welfare, 1981, p.8), with the delivery of the personal
health care and welfare services being a provincial responsibility. However, there is no existing policy on Palliative Care/Hospice Care at either the federal or provincial levels. Practice in British Columbia has evolved from the British Columbia Hospice/Palliative Care Association's adoption of components for palliative care from English and American sources. Included within these programmes is the Bereavement Component:

"Qualified bereavement counsellors supervise volunteer support to family and friends after the death of a patient. In addition, the counsellors are able to identify individuals at risk of pathological grieving" (Steering Committee, Ministry of Health, 1987, p.4).

While no decision has been made with regard to implementing policy -- or rather a decision has been made to not make one -- latterly funded programs (St. Paul's Hospital, Vancouver and St. Mary's Hospital, New Westminster) have included this program component. Incorporation of bereavement intervention can be impeded by lack of community resources and networks through which bereaved individuals and their families are actively supported.

Inclusion of bereavement services in the hospice/palliative programming resulted from constant effort
on the part of health care professionals who emphasized the importance of this component of care. Unfortunately, while this continuity of care has been included in American statutes, the funding required to ensure bereavement programme delivery and training of staff has not. O'Toole (1987) indicates that this has resulted in "conflict between mandate and hospice philosophy on the one hand and lack of funds and adequately trained staff on the other ... [thus] creating conflict between responsibility and ability" (p.185).

Funding for programmes in Canada has historically been "hospital global budgets and voluntary donations" (Hudson, 1988, p.40). This has resulted in problems with dedicating required staffing levels and positions exclusively to the Palliative Services, especially at times of limited government funding and pressure on hospital bed utilization. While the impetus for palliative care includes a cost-containment component -- palliative care being deemed less expensive than acute care intervention -- hospitals will staff on pro-rated bases rather than fully dedicate staff. This has affected nursing levels as well as other staffing -- social work, rehabilitation services. Because it is difficult to assess effective outcome, it has not been
possible to document and prove the need for extra staffing and services (Lamers, 1988; Dush 1988).

Recently approved palliative programmes have benefitted from a provincial impetus toward community-based care which increases home care while decreasing hospital bed utilization. Palliative Care programmes emphasize symptom alleviation, quality of life issues, and maintaining terminally ill individuals in the home with full support for as long as possible. This support combines hospital and community efforts and includes home care nursing, volunteers and social work intervention.

Inherent within the lack of policy and government position are funding difficulties which continue to plague globally funded hospital programmes due to changing priorities, lack of training programmes and low levels of community-based support.

Myths surround the concept of community-based care which delude policy-makers into believing that it will provide a magic wand of health care cost-containment as well as empower those requiring the system’s support. It is assumed that community-based care is cheaper than large institutional settings and involves non-paid family and voluntary community support. It is also seen as involving
joint financing between government ministries (health and social services), therefore circumventing future need to commit resources to other services. However, Shannon (1989) has noted that while escalating health care costs have encouraged the reduction of hospital-based care, the popularity of accessible community/neighbourhood health centres has resulted in "radical cost containment policies" for these centres (p.34). This illustrates that merely shifting dollars will not meet the needs of the populace. Social support systems and voluntary efforts are also mythologized and not as readily available as wished. Therefore, successful community-based programming becomes contingent upon increasing staffing at the community level. The other problem inherent in funding cuts is that the risk variables outlined in Chapter 2 represent actual health care opportunity costs resulting from lack of response to the needs of bereaved individuals through the appropriate level of intervention. Successful bereavement intervention also requires dedicated funding and staffing to ensure programme development and intervention, and liaison with the community support network.

Policy dedicated to Bereavement Intervention as a component of Palliative Care Services could be addressed
through the following option. The Ministry of Health through the Department of Community and Family Health could totally fund and provide Bereavement Intervention Services as a direct program addition to Palliative Care Services. The programmes would be delivered and coordinated through the Palliative Programme Social Worker in conjunction with community agencies and volunteers.

**Advantages**

- Bereavement care would be formally recognized as an integral component of preventive health programming in the health care system.
- Dedicated funding and administration of the Bereavement Intervention would take place within existing structures.
- Funds now being used to care for bereaved individuals in acute and psychiatric care settings, and through the Ministry of Social Services and Housing, would be redirected to more appropriate, economical bereavement support services.
- Community energy and commitment would be developed and maintained through volunteer support component and through community resources participation.

**Disadvantages**
Additional funds would be required to meet the most basic criteria for comprehensive Bereavement Intervention.

Finances As well as funding and resource allocation inherent in programme policy, finances are also a critical area of concern for bereaved individuals. Income affects our total well-being -- our access to food, clothing, housing, transportation and amenities of life. While only three of the fifteen respondents mentioned loss of income, with two noting detrimental effects, this is not the norm and is reflective of the upper middle class catchment area of the study hospital.

A large number of individuals in Canada who live in poverty are elderly women and female heads of households with dependent children. Factors which contribute to old age poverty are education and ethnicity, sex, and the length of time in the labour force. Hence "to be old and female is the best combination to ensure being poor in Canada" (Delude, 1978, p.38). Louise Delude (1978) in Women and Aging adds "that to be old and a widow is an even better combination" and many are seen to be "living in financial circumstances that the word "poor" is too weak to describe" (Ibid). The Health and Welfare Canada Monthly Statistics:
Income Security Programs, August, 1988, indicates:

1,352,395 pensioners receive OAS/GIS and that 47% of this number are single women.

The National Council of Welfare (NCW), based on 1987 figures, found that the poverty rate for unattached elderly females was 46.1 per cent (NCW, April 1988, p.7).

The plight of retired, widowed women is exacerbated by a history of low employment participation (less than 50% of employable women in the 70s), only 25% covered by pensions which in turn were limited by low wages, periodic work histories and a large amount of part-time employment (Retirement without Tears: Senate Committee Report on Retirement, 1979). Poor survivor's benefits add to the disadvantaged position. Very few private pensions carry over to the widowed spouse.

While some of these data may appear to be dated, the situation has changed very little for today's bereaved elderly woman, many of whom have never worked -- or for younger women who are forced to work post-bereavement. It still remains a fact that women in the workforce earn 64% of male earnings for comparable employment and the availability of quality daycare and after school care is a grave concern. Guest (1985) has found that pension risk is heightened by
"sexist bias of social security programmes [which] discriminate against women" (p. 173). This is further exacerbated by a federal government proposal to curtail Canada Assistance Plan payments to wealthy provinces (which includes British Columbia) thus placing pension supplements, healthcare and low cost housing programming in jeopardy.

Issues raised in the House of Parliament in 1975 with regard to the Omnibus Bill on the Status of Women, Bill C-16, are still pertinent fifteen years later and directly effect women of all ages. These issues include:

- the numbers of women concentrated in low paying, low status jobs, perceived as a reserve pool of labour, are therefore the least secure and most affected by lay-offs;
- lip service to equality in the workforce maintaining the "ghettoization" of working women with equal pay laws lack enforcement and penalties;
- the continuing need for day care;
- pension plans containing sex based differential payments and benefits; and,
- inequities of survivors benefits in pension plans.

For the woman under age 65 and widow of a pensioner, there is a survivor's pension of 60 per cent of the deceased
spouse's pension (CPP) - which is based upon the spouse's work history and income. The picture with Old Age Security and Guaranteed Income Supplement is no less bleak - for both men and women. For a single, elderly person, maximum pension benefits from OAS($343)/GIS($407) amounted to $750 per month in June, 1990.

GAIN for Seniors, provides supplementary income to individuals on OAS/GIS and also provides income assistance to seniors aged 60 - 64. The program is administered by the Ministry of Social Services and Housing in British Columbia and is part of a federal/provincial cost sharing program under the Canada Assistance Plan (Health and Welfare Canada, March 1987, p.1). The supplementary benefits (GFSS) are usually paid only to persons in receipt of the GIS and as of April 1, 1987 the GFSS was set at $49.30 for a single person, whereas each of a couple received $60.25. Again, while these figures may seem dated, the financial position for bereaved individuals has not changed, and increasing housing costs creates even greater risk.

The above discussion does not include immigrant men and women. A new Canadian must live here forty years before qualifying for full OAS pension. While the rationale behind extending the qualification time was to enable
"totalization" of pensions with reciprocal agreement countries, many of our new Canadians come from countries that don't have pension plans or social security systems. This places an added burden on the bereaved -- young and old -- of these populations - many of whom will have lower education, a history of low paying jobs, and English as a second language.

Changes may occur over time with added pressure from women's groups concerned with pay equity and day care issues, and from seniors groups concerned with quality of life issues that include pension reform and increased community support for terminally ill individuals. The recently published report *Toward a Better Age* outlines seniors' involvement with these issues (Province of British Columbia, 1990). Two new Ministry of Health programmes -- the Victoria Health Project and the Hospital/Community Partnership Program -- are seen by seniors to be a starting point for coordinating services (Ibid). A bridge will be required from this type of programming to encompass all-aged bereaved and their respective needs.

**Discussion** It is difficult to ascertain where fiscal policy issues leave off and health prevention/promotion policy issues begin. Policy and programming that is of
benefit to bereaved individuals — whether direct personal intervention or indirect intervention through pension/survivor’s benefits reform, pay equity issues, day care, low cost housing — are directly related to allocation of resources. Therefore, it is apparent that multilevel intervention is necessary.

Social workers are well aware of the relationship between unresolved grief issues and the development of illness, disruption of personal and family equilibrium, maladaptive coping strategies, and death. Economic considerations are paramount to the survival of bereaved individuals and their families. Social welfare and health welfare are indivisible. Policy needs to address these issues through implementing comprehensive, preventive programming, thus decreasing waste of scarce health care resources.

"The spectrum of public policy creates, sustains, alters or damages the social, economic, physical, and natural environments that sustain or fail to nurture people’s health (Milio, cited in Shannon, 1989, p.33).

Role of the Social Worker in Bereavement Intervention

The role of the social worker is all encompassing. It
entails both the "foregrounds and backgrounds of the client" which includes the background of

"social, psychological, economic, cultural and environmental factors which contribute to the etiology of disease and the process of recovery. ...[and the foreground of] the observable feelings and needs which might be overlooked by those focusing solely on the diagnosis and curing of disease" (Ontario Association of Professional Social Workers, 1986, p 1).

Social Worker in Family Practice As mentioned in Section I, the social worker must have a firm foundation in family systems analyses -- but also must have an ecological framing. This encompasses understanding of network variables that effect bereavement outcome -- societal expectations, availability of informal/formal social supports, availability of programmes and personnel to whom individuals may be referred. It also requires an ability to integrate these variables.

Coupled with this knowledge base must be an understanding of the bereavement process and how it reflects the multiple dynamics of personal, family and social expectations of outcome.

Roles include assessment and intervention, group and
individual counselling, referral and liaising which all combine to meet criteria of 1) intervention, based upon 2) psychosocial assessment, toward 3) clarification of problems and goals, and 4) identification of a mutually acceptable plan of action, leading to 5) attainment of goals (Ibid).

Social Worker as Professional  On-going research and quality assurance are critical to social work practice, as is continuing education. Adherence to Canadian Association of Social Workers' professional ethics is implicit in all areas of practice.

Teaching, developing assessment tools and intervention strategies, training and supervision of other professionals and volunteers, coordinating programmes and other administrative roles, may all be subsumed within professional expectations of the social worker. Policy initiation and advocating on behalf of grieving constituents is a critical dimension of professional involvement. Active participation in professional associations which address policy issues and "strengthen the profession's role and improves quality of service" are important aspects of practice (Ontario Association of Professional Social Workers, 1986).

Social Worker as Team Member  Recognizing that
interdisciplinary teams can be cumbersome and that negotiation is hard work, social workers can be particularly effective in the team setting. Not only do they interpret the psychosocial needs and requirements for certain supportive activities, but they are facilitators of communication within the team, helping to focus and integrate team efforts. Perceived social worker roles on the team include: client advocacy, coordinators of action, negotiators, conflict diffusers and group leaders. "Social work team members are more likely than other members to take active roles in helping teams function effectively" (Toseland, et al, 1986, p.48). The greatest plus the social worker brings to the team is the ecological approach which incorporates concern for the individual, the situation and the helping relationship. This can be utilized for client benefit or for team benefit.

An additional role is that of addressing grief issues of team members themselves which result from prolonged caring for dying individuals and their families.

**Social Worker as an Individual** In order to be an effective palliative care team member and grief counsellor, it is important that the social worker resolve personal issues surrounding death and dying prior to involvement in
this area of practice. While it may not be necessary for the social worker to have personally experienced the death of a close family member, other life experiences will provide an experiential base from which to draw knowledge, understanding and compassion for grieving individuals. It is this richness of experience and compassion that underlies the social worker's effectiveness with the clients.

At the same time, it is important to remember that every loss experience is different for every individual, and that the expert in a specific loss situation is the individual involved in that loss.

Summary

This chapter addresses two thesis objectives.

Implications for practice, presented in Section I, addresses issues raised by the data from a family systems theory perspective. This perspective provides the framework for assessment and intervention, for understanding both family and social tensions which impinge upon the grieving process of an individual, and for ameliorating that process.
Section II addresses issues of bereavement intervention programme development, policy implications which impinge upon this development, and upon the general welfare of bereaved individuals. The multiple roles of the social worker through which effective practice is developed and maintained are discussed.
CHAPTER 7
SUMMARY AND CONCLUDING REMARKS

This chapter will present a summary of the study and conclusions drawn from the findings. Implications for further research are also addressed.

Summary

The purpose of the study was to determine if bereavement intervention had an effect on the bereavement outcome of individuals who had participated in a palliative care programme. Bereavement intervention is subsumed within palliative programme philosophy which encompasses the family as the unit of care and provides a continuum of care that extends beyond the death of the family member, through bereavement. There is no available research on the effect of post-bereavement intervention within palliative programming, and very limited research exists which compares a palliative population with a general population of bereaved individuals. Cameron and Brings (1980) studied the effect of bereavement intervention as a preventive health strategy for bereaved individuals whose family member died at the same hospital. One population had participated in
the palliative care programming and bereavement follow-up, the other population had neither intervention (Cameron and Brings, 1980; Cameron and Parkes, 1983). The results indicated that those with the palliative care and bereavement intervention had better grief resolution outcome than did those without intervention. A modified replication of the Cameron and Brings (1980) study was carried out to ascertain if bereavement intervention had an effect on the grief resolution of individuals all having the palliative care experience. Only one group had the bereavement intervention while the other group did not. An additional analysis of outcome was also included which utilized William Worden’s (1982) Four Tasks of Grieving through which meaning structures and the bereavement process over time were clarified.

The study encompassed the notion of structural change in society and in medical approaches to care for the terminally ill. This led to a broader analysis of bereavement care addressing sociological dimensions which effected the grieving process and included issues of funeral and burial procedures, support networks, policies, and social expectations of grieving individuals.

**Study Parameters** The study design included a mixed
strategy of methodology in the exploration of this question and was an ex post facto retrospective study, thirteen months post-bereavement. A quantitative methodology was utilized in an attempt to carry out a modified replication of the Cameron and Brings (1980) study. A qualitative, grounded theory approach was used to elucidate the meaning structures which frame the grieving process, and to provide support for its utility as a preventive health intervention.

**Quantitative Analysis** The quantitative analysis followed protocols established in the original study -- timing of the study, telephone interview, questionnaire, coding inventories, matching of samples through criteria of age, sex and relationship to the deceased, and statistical tests. Data were collected incorporating the original study questionnaire (see Appendix II), modified through the addition of clarifying open-ended questions, and used as a guide for an interview which was framed as therapeutic not merely information-seeking. The samples consisted of eight individuals with bereavement intervention and seven individuals without the intervention. All had participated with their deceased family member in the same palliative care programme. The initial sampling had incorporated a random disproportionate sampling technique based upon the
Cameron and Brings (1980) criteria of age, sex and relationship to the deceased (Appendix I). This was to facilitate matching of the samples resulting in six matched pairs. Data were coded using the Cameron and Brings Grief and Adjustment Inventories (Appendix III and IV), from which Grief and Adjustment scores were derived. The statistical measures of the Fisher's Exact Test and the Wilcoxon Signed-Ranks Matched-Pairs Test were applied to the scores.

Qualitative Analysis A qualitative grounded theory approach utilized data from all fifteen respondents. The data were analyzed using a method of scanning for thematic variables, clustering the themes, subjecting the themes to open and axial coding, memo writing, developing integrative matrices and diagrams, and, through emergent fit, evolving core categories which conceptually bound the codes together. Core categories of "meaning" and "time" were identified. "Meaning" was operationalized as "metaphor" which reflected the experiential framing of the respondents. "Time" was subsumed within the metaphorical framing, exhibited its own dimensionality, and was also a study parameter.

Williams Worden's Four Tasks of Grieving (1982) were used as a frame to delineate the bereavement process and grief
resolution (Appendix V).

Findings The overall findings of the quantitative analysis were inconclusive as an intervening variable of "time for preparation for the death of the family member" was found to be the prime motivator for bereavement intervention participation and rendered the two samples incomparable. Statistical analysis of the Grief and Adjustment scores found differences between the two samples in bereavement resolution but they were not significant. The replication was also unsuccessful due to small sample size, to maturation of palliative care and to improved pharmacopeia since the original study was carried out in 1975-76. Thus structural change and history impinged directly upon the replication of the original study.

The Worden Task analyses of the core categories of "meaning" and "time" indicated that the group with bereavement intervention had better grief resolution than did those without the intervention.

Consolidating the Worden Tasks analyses with the scores derived from the Cameron and Brings Grief and Adjustment Inventories resulted in a complementary assessment of grief resolution and individuals at risk of bereavement difficulties. This further substantiated, and lent strength
to, the Worden Task analyses findings that bereavement intervention had a positive effect on the bereavement resolution outcome.

**Interpretation of the Findings** The data indicated that individuals with bereavement intervention had better grief resolution than did the individuals without the intervention. There were general findings that apply to both sample groups and to both the individual/informal and community/formal contextual levels. These included lack of ritual, lack of social support networks, barriers to both informal and formal support, lack of social roles with regard to role redefinition, and limited bereavement programme availability.

The research questions posed in Chapter 1, Introduction, provide a framework for a synopsis of the study interpretation.

1) For whom is bereavement care effective? It was noted in Chapter 2, Theoretical Framework, that there were particular populations at risk for prolonged and/or difficult grief resolution. Broadly defined, the bereavement outcome was seen to depend upon the relationship to deceased, the quality of that relationship and the coping repertoire of the individual/family -- which included the
strength of support networks. Individuals specifically deemed at risk were: children, young marrieds and those with dependent children, men over seventy years of age, and individuals with poor physical or mental health and/or multiple losses.

The study samples were representative of all these risk groups. All respondents except two had limited family and social support networks. The risk factors observed in the groups were: age and sex, conflicted relationships with the deceased, poor health, children of the deceased, young widowed with dependent children, and individuals with multiple losses. The at-risk individuals having bereavement intervention achieved better grief resolution than at-risk individuals without bereavement intervention.

The study also corroborated other research findings that not all individuals require bereavement intervention. Two individuals in the group without intervention had combinations of high family and social support networks, did not have conflicted relationships with the deceased and had actively participated in the care of the deceased — with home death being possible for one of the deceased.

2) What needs are met for those who participate in bereavement intervention? The answer to this question
was eloquently addressed by the bereavement intervention participants and reflected many of the theoretical frameworks suggested in Chapter 2. These responses included:

- sharing and validation of the grieving experience,
- openness and acceptance,
- permission to talk about the death and one’s self,
- availability of information from which to define one’s own guidelines for grieving,
- perception of growth in others and self,
- provision of a refuge,
- affirmation of identity and assistance with role redefinition,
- social support and professional guidance.

3) Why do some individuals choose not to participate? and, 4) what personal/social barriers exist to participation in bereavement support activities? These two questions are intrinsically related and are therefore considered together. There are three contextual elements which frame the choice of participation in bereavement intervention -- individual/informal, community/formal, and ideological that provide perceived barriers and influence choice.
At the informal level there are various factors which impede participation:

- personal values and reluctance to seek help or to appear weak,
- concern about loss of control,
- personal response to social pressures -- being strong, getting over it quickly, being stoic,
- family conflict,
- financial/access concerns (i.e. no car, time of day),
- reluctance to admit limitations and emotional needs,
- support is not required because of sufficient family and social support networks and coping repertoires.

The formal context of community resources and socially sanctioned behaviours can restrict options through structural and social conventions which result in:

- lack of information and knowledge about grief and bereavement,
- lack of ritual or social framing of the death event,
- discomfort with and avoidance of other's pain,
- an expectation of early grief resolution,
- limited availability of programmes,
- limited access to programmes either through restriction to specific groups or to time and distance parameters,
lack of trained personnel,
programmes unsuited to specific needs,
timing of the invitation to participate.

The ideological contextual level encompasses policies and procedures, and funding priorities that provide barriers to programming and are disincentives to participation.

The philosophy of palliative care incorporates the family as the unit of care and provides for a continuum of care that includes post-bereavement support. However, unless palliative care programming is staffed and funded appropriately, bereavement intervention cannot be initiated with families prior to the death of the family member. Thus the philosophy becomes hollow and meaningless in its operationalization and at-risk family members feel cut adrift with the isolation of bereavement reinforced.

The timing of the referral of terminally ill patients to the palliative programme by physicians may also interfere with staff ability to assess and support families through their losses.

Bereavement related difficulties may be exhibited in somatic disease manifestation. Social costs and lost opportunities inherent in caring for bereavement-
related illness can be alleviated by appropriate, early intervention which also results in lower health care expenditures.

**Assessment** Two models of assessment -- preventive and growth enhancing -- at two levels of application -- individual/informal and formal support networks were suggested to enable intervention as indicated by the risk factors and population needs.

**Implications for Practice** Family systems therapies were suggested as interventive strategies for both family and support network systems. In this way, family resource evaluation was addressed through contextual analyses and social structures could be identified that impinged upon or ameliorated the grieving process. Engaging in family systems therapies and integrative practice sensitizes the therapist/social worker to the many levels of intervention that maybe required to mediate the grieving process for an individual/family.

A definitive exploration of bereavement intervention programme development was presented as a means by which bereavement needs of diverse populations could be addressed. Bereavement programming was outlined with policy and funding implications of palliative care and bereavement intervention
Finally, discussion of the role of the social worker in stressed intervention at both client and political levels with sensitivity to broader issues and advocacy on behalf of bereaved clients emphasized. It is necessary to remember that the development of protocol and programming occurs within social parameters and constraints that evolve from changing values and priorities. Therefore, inherent in restructuring family identity is active participation in the evolution of programming development, and awareness of policy implications.

Implication for Further Research

The exploration of the efficacy of bereavement intervention examined the effect of the intervention on bereavement outcome. It has also noted lack of research, programme availability, community resources and policies that define funding and staffing parameters. These present some of the possible areas of concern for further research. Specifically, some of these may be:

- Assessment of community resources and interested stakeholders through which to establish a community-wide bereavement support network.
Developing education packages to sensitize community groups, interested constituents, and schools, about the bereavement process, and needs of bereaved individuals.

Assess and develop bereavement intervention programmes designed for meeting specific age, life-stage needs as well as general all-aged programming.

Carry out content analyses of various bereavement programmes and bereavement outcome measurements to evaluate efficacy of various strategies.

Explore help-seeking behaviours to ascertain appropriate strategies for encouraging participation by those deemed most at-risk.

Actively engage in policy and programme development including funding and staffing components at both the departmental/institutional and municipal/provincial government levels.

While the idiosyncratic nature of the bereavement experience may make it difficult to rigourously design evaluative studies with uniform measures and methods, it is important to incorporate research into practice in order to expand knowledge and to legitimize claims for funding and programme development. Two other areas that require attention were briefly touched upon in this study. The place for ritual
and symbolism in today's world is an important consideration. As well, the whole aspect of "creative" grieving -- with creative intervention -- bears attention.

CONCLUSION

Grief affects all of us at one time or another. Some of us, because of factors in our lives — isolation, low social support networks, few or estranged family members, age, sex, poor health — will be at greater risk than others. While grieving is a natural process, some physical and mental disturbances are normal but may be unsettling and disruptive. Unsupported grief reactions can result in higher incidence of disease (heart disease, cancer, high blood pressure, anxiety and depression) and related visits to physicians, hospitalization, need for counselling assistance, or psychiatric intervention. Support, reassurance and knowledge will help deter development of pathological grieving complications.

The findings of the study imply that individuals with bereavement intervention have better grief resolution than do individuals without the intervention. They also substantiate contentions that not everyone requires
bereavement intervention.

The strength of the study is derived from the mixed strategy approach which involves the discipline of prior protocols as well as rigorous adherence to grounded theory principles.

Various risk factors are also described in the study that effect:

- elderly males,
- young women in their twenties, and
- risk for individuals with either too short or too long a preparation time for the death of a family member.

The timing of the invitation to the bereavement support group may also be a critical factor for consideration. The group without bereavement follow-up indicated that at the time of invitation they did not feel that the support group was necessary. When analyzing the grief resolution of this group, it is observed that their initial assessment of not requiring any further support may have been questionable for most of them. One individual had, in fact, sought private counselling but had not resolved some fairly major grief issues. Continued contact at three months intervals with those refusing to participate may circumvent bereavement related difficulties.
Preventive implications of bereavement intervention for survivors must not be underestimated — risk factors, as mentioned above, can lead to hospitalization. Not only can there be personal health implications but: possible income loss resulting from decreased productivity in the work place through absenteeism or inability to continue in a work role; the loss of family through breakdown; failure at school and behaviour problems with children; possible suicide. Effective bereavement follow-up has long-term significance and circumvents these tragic events and their concomitant anguish. It is important to consider the cost-effectiveness of intervention and to justify program dedicated staff and funding.

It is incumbent upon programme initiators to fully dedicate staff to the palliative programming. As we have observed, societal changes influence family configuration and subsequent coping and problem solving strengths. To safeguard the integrity of the individual and the family unit, appropriate staff must be readily available to actively intercede when necessary. Full risk assessment and contact with all palliative patients and families requires extensive work on the part of the program social worker. Through consolidating risk assessment with active
intervention, the social worker can facilitate family strengthening through creative grieving in which family ritual and new traditions can be developed. Enhanced social support networks may be vital to the survival of the individual.

The impact of social change must not be underestimated. The population is aging due to lower birth rates combined with better housing, nutrition and health factors. Illness and disease are held in abeyance for longer and longer periods of time thus extending disease trajectory. Implications of large numbers of frail elderly cohorts, with aging and/or dispersed families, hampers the development of informal support networks.

Family size and mobility, and well as the increased numbers of single parent families also limits the family support network and threatens individual survival. The risk assessment must incorporate family/social/religious support structures, past history of crisis response and resultant repertoire of coping mechanisms; the social realm of community-based focus of health support services and availability of home caregivers and support networks; and, flexible, individually determined bereavement follow-up intervention.
"Family studies are critical... because the family focus is a definitive feature of hospice care" (Dush, 1988, p.17). Social work expertise and understanding of network strengths and needs, of family dynamics, of interpersonal stressors and coping abilities ameliorate the grieving process through appropriate intervention strategies. Bereavement support enhances social networks and legitimizes the grieving experience and experience of loss.

Characteristics of hospice/palliative care through integration of bereavement within the dying experience and active involvement of family and patient in determining intervention. The family is the "unit of care" both as a family configuration and as individual members with individual needs. Continuity of care is vital to facilitate on-going assessment of psycho-social client needs, to foster awareness of developing risk related problems, and to intercede and refer to other professional bodies when necessary. Government focus on community-based health promotion and prevention must consider that efforts toward individual self-sufficiency and independence are contingent upon resource allocation and enhancement of the professional support structures -- such that family and social structures can then be strengthened.
Thus, enhancing coping capacity translates into community-based services that would "provide the skills and the community support needed by people", and includes recognition of "the importance of ensuring that informal care-givers have access to the support they need" (Epp, 1986, p.4). A broad range of government, private and voluntary/nonprofit agency and volunteer programmes are seen as reinforcing individual integrity and autonomy. Demographic changes that may preclude this approach must be considered. By emphasizing financial aspects of health care services, "the maldistribution of tasks, responsibilities and contributions" are obscured, as are the direct consequences (McNiven, 1986, p.321).

Palliative care is a collaborative, sharing model of care that empowers the individual and family. A core component of this model of care, bereavement intervention, offers hope and "a respect for the healing resources within each person" (Katz and Seth, 1987, p.132). Bereavement intervention has been shown to influence positive grief resolution through the provision of social support, information, validation, caring concern and professional counselling.

Concerted effort must be made to interpret the language
and ideology of policies and the concomitant implications for implementation. In this way family integrity will be enhanced post-bereavement through fully funded and appropriately staffed palliative programming -- of which bereavement intervention is an integral part.
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APPENDIX I

Sampling Frame
APPENDIX I

Sampling Frame:
Disproportionate Stratified Random Sampling

The samples for the study were drawn from a population of forty-four (44) individuals having Palliative Care experience. It was hoped to derive two samples of fifteen that would be comparable within age and sex strata so that matching could be facilitated for paired tests. To this end the population was first divided into those having bereavement intervention and those not having bereavement intervention. The number of individuals having the bereavement intervention was ten (10), thus the total population was sampled.

The remaining population of thirty-four (34) individuals -- those not having bereavement intervention -- was then sampled through stratified random sampling using disproportionate sampling ratios. These ratios were based upon the stratification of the bereavement intervention sample.

In this manner, it was hoped to maintain homogeneity
within age strata by sex wherever possible, and resulted in differential sampling between the strata. Homogeneity between the strata was not a concern, however it should be noted that the characteristics of the total population (44) indicated a fairly homogeneous population.

Response Rate:

Five (5) males and ten (10) females, from which six pairs were matched for the quantitative analysis: two (2) daughters, four (4) widowers, and six (6) widows.
Stratification by Age and Sex for two populations -- those having bereavement intervention and those without:

<table>
<thead>
<tr>
<th>Age</th>
<th>Total</th>
<th>With Intervention</th>
<th>Without Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>&lt; 39</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>40 - 49</td>
<td>3</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>50 - 59</td>
<td>9</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>60 - 69</td>
<td>12</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>&gt; 70</td>
<td>16</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>44</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

Disproportionate sampling based upon the bereavement intervention sample characteristics:

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<thead>
<tr>
<th>Age</th>
<th>N=10 F</th>
<th>M</th>
<th>S=10</th>
<th>%</th>
<th>S=15</th>
<th>N=34 F</th>
<th>M</th>
<th>S=15</th>
<th>F</th>
<th>M</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 39</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>20</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1:1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 - 49</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>1-2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1:1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 - 59</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>20</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1:2</td>
<td></td>
</tr>
<tr>
<td>50 - 69</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>40</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>2:3</td>
<td></td>
</tr>
<tr>
<td>&gt; 70</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>1-2</td>
<td>6</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1:7</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>100</td>
<td>15</td>
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<td>10</td>
<td>5</td>
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</table>
APPENDIX II

Cameron and Brings Questionnaire and
Selected Questionnaire Excerpts
CAMERON AND BRINGS
BEREAVEMENT ANNIVERSARY QUESTIONNAIRE

Date of interview _______________  Group Control # ______

The first grouping of questions are very general questions about your deceased family member and your awareness of his/her illness process.

Name of patient ________________________________

Age ____  Length of Illness ____  Date of Death _____

Name of K.P _____________________________ Marital status __

Relationship to patient _____________________  Age ____

How many years married to patient? ______  First marriage? ____

Time lapse between your awareness of the impending death and the actual death? ______________

Did you discuss the impending death with the deceased person? ___

Had the patient made a will? ______  When? __________________

Had the wishes for funeral arrangements been discussed? ______

When? __________________
I would now like to ask you about your family and your current relationship with it.

Are there children? ______

Ages and sex ____________________________________________

Where do they live? _______________________________________

Who now lives with you? ___________________________________

Is this a new arrangement since the death? ______

Are your relations with other members of your household closer ___ unchanged ___ more distant ___

than before the death?

To whom do you feel closest now? _________________________

For K.P. other than spouse - is this different than from before the death? ______

How has this changed? ___________________________________

_____________________________________________________

Children / Family (when no children) / Friends (when no family)

Do your children/family/friends talk about (the dead person) to you _____ to each other ______

Do they do this more ____ or less ____ than they did during the first months?
Do you talk to your children/family/friends about (the dead person)? ________
Do you find yourself doing this more ___ or less ___ than in the first month?
Has their behaviour pattern changed since the death? ______
   In what way? __________________________________________
Has their schoolwork/occupation performance altered? ______
   In what way? __________________________________________
Do you feel closer to them than you did prior to the bereavement? ______
Is there anything else about your children/family/friends that you would like to share with me? ____________________________
   ____________________________
   ____________________________
   ____________________________

The next set of questions are concerned with your health status both prior to and since your bereavement.

Health Since Bereavement
During this year, has your health been better or worse than before your bereavement? ____________________________
During this year, have you sought professional help from a Doctor ____ Psychiatrist ____ Counsellor/Social Worker ____

How many times? ____________________________________________

Did you in the year prior to the death? ________________

Please explain ____________________________________________________________________________

________________________________________________________________________________________

Are you eating any better than you did immediately after the bereavement? ____ Are you sleeping better? ____

Do you take sleeping pills? ____ Tranquillisers? ____

Did you before the death? ____ For how long? ____

Compared to the time before the death, do you now:

Drink more ____ less ____ the same ____

Smoke more ____ less ____ the same ____

Have you gained weight ____ lost ____ stayed the same ____

Compared to the time immediately after the death, do you feel more depressed ____ less depressed ____ about the same ____

Would you now share with me any changes that have occurred in your life over the past year?
Living Arrangements
Have you changed your living arrangements this year? ________
   If so, when did you make the changes? ________________________
Do you now think this was a wise decision? ______________________

Finances
Has your income altered during the year? ______
Do you find it difficult to budget and manage finances? ______
Do you find it necessary to work in order to supplement your income? ______

Occupation
Did you work before the death? ______
Did you temporarily cease to work during the period of illness and death? ______ For how long? ______
Do you now work? ______ Do you enjoy your work? ______

Religion
Do you consider yourself a religious person? ______
Do you think that your faith has helped you during your bereavement? ______
Did your religious feeling or practice change at the time of the death? 

Have you returned to religion after being away for a time? ____

Have you returned to taking part in church activities? ______

Did you receive support and help from your own minister, priest, rabbi or whoever was appropriate? ____________________________

Cemetery

Do you ever visit the grave of (the dead person)? _____

Do you make frequent visits to the grave? ______

Does this help you? ____________________________

Anniversary

How did you spend the day? ____________________________

____________________________________________________

Did you visit the grave? ___ Did you feel very depressed? ___

What did you think about and remember? ____________________________

____________________________________________________

Were you alone? ____________________________
Palliative Care Unit (For those with P.C.U. experience only)

Have you returned to the P.C.U.? ______

If so, was it for a specific purpose or just to visit? ______

How many times have you been back during the year? ______

Did you feel comfortable? ______

Did you attend the December meeting? ______

If so, did you enjoy the evening? ______

Did it help you plan for the holiday season? ______

How many contacts have you had with the Palliative Care Staff during the year? ______

Were these self or staff initiated? ______

Bereavement Support

Did you/Do you belong to a bereavement support group? ______

Did someone ask you to join or was it self-initiated? ______

If you were asked to join a group and you chose not to, what were your reasons for not participating? ______

______________________________

______________________________

______________________________
Would you wish to participate in a group now? ____________

Who sponsored the group?

Hospital ________ Agency ________
Club ________ Church ________
Family Services ________ Other ________

Do you still attend the meetings? ____________

If no, how many months post bereavement did you attend? ____

How often did/do you attend these meetings? ____________

What has helped the most? ________________________________

In reflecting over the past year, what are your general impressions about the following:

Do you feel any closer to your friends since bereavement? _____

Have you made any new, close relationships this year? _______

What do you feel about the possibility of re-marriage? _______

Do you ever think about this? _____________________________

Do you find yourself grieving any less now than you did earlier?
Do you ever feel guilty because you are not worrying as much now? 

Do you feel that you have more understanding and sympathy for other people's problems since your bereavement? 

Have you begun to return to any former activities which you had abandoned for a time? 

Have you begun any new activities? 

Do you go out more than you did? 

Have you begun to make plans for the future? 

When did you dispose of personal belongings? 

Do you keep reminders such as photographs where you can see them? 

Have you experienced any other loss during the year? 

If yes, please explain 

If you had to try to single out any one thing, what would you say was the hardest thing to bear this year?
Were there some positive things that occurred during this year?

Do you now have a clearer image of (the dead person) in your mind than you did after the death?

Do you often find yourself tearful now?

If yes, is it different from when you were first bereaved?

In what way?

Who or what do you think has helped you the most during this year?

Is there anything else that you wish to share?
Do you wish to make an appointment to discuss this further, or do you wish to receive information about bereavement support groups?

Thankyou.
I. Cemetery

To account for changes in funeral and burial practice, the section on "Cemetery" required additional probing that would elicit ritual behaviour other than "visiting the grave". Here a question was added asking if there is "a special place that reminds you of (your family member) that you visit?". The responses were appropriate for the number of individuals whose family member was cremated (70% of the sample), and for some, the degree of grief resolution, quite creative.

---

Cemetery

Do you ever visit the grave of (the dead person)?

Yes - 4; No - 9; No answer - 1

If not, why?

Cremated, ashes scattered - 8

Interred in Manitoba - 1

No answer - 1

Do you make frequent visits to the grave?

Periodic - 3 Regularly - 1
**Respondent**: I have a very personal religious belief. My wife wished for cremation and no funeral. I couldn’t do that. I visit the grave often. It helps.

**Respondent**: "My daughter became hysterical at the thought of scattering the ashes in the ocean -- she said she felt like she was 'pushing him away'. I realized it was important to her to have him interred so we did. And we have planted a rhododendron at his site -- it was his favourite plant.

(If cremated and not interred) Is there a special place that reminds you of your family member that you visit?

Not really  -  2
Yes  -  6

Would you be willing to share this with me?

Examples of responses:

**Respondent**: "I can always go and stand in my closet... (laughter)... you see, I didn’t know what to do with him for the longest time, so I kept him in my closet!"
Respondent: "The Parks Board wouldn’t allow me to inter the ashes at the tennis courts in Stanley Park, but I cheated and took a pinch [of ashes] over, and now I can go and watch a good game of tennis with him!"

Respondent: "My front room is full of plants given to me when my husband was dying. Now they are blooming and doing wonderfully. This, in a way, keeps him alive for me. Being in that room makes me feel close to him."

Respondent: "Her ashes were scattered in the ocean. This gives the children a connection with life rather than place -- freeing them to move on in their lives -- the ocean is always there"

Respondent: "I like to go and sit on a bench overlooking the seawall where we walked. He liked to sit there when he was too weak to do the walk anymore. We’ve dedicated the bench in his name to the municipality. There’s a nice little garden there too."
II. Bereavement Support

Did you/Do you belong to a bereavement support group?

Yes - 8; No - 7

Did someone ask you to join or was it self-initiated?

Some asked me - 15

If you were asked to join a group and you chose not to, what were your reasons for not participating?

Not a joiner - 1
Didn’t need it - 4
Not ready - 1
Saw a therapist - 1

Would you wish to participate in a group now?

No - 7

For participants:

Who sponsored the group?

Hospital - 8

Do you still attend the meetings?

Yes - 4; No - 4

If no, how many months post bereavement did you attend?

< 3 months - 4; > 3 months - 4
How often did/do you attend these meetings?

Regularly - 6; Periodically - 2

What has helped the most?

The bereavement group participants expressed needs being met that included: social support, openness and acceptance, the normalcy of the bereavement expression (ie. not going crazy), sharing and validation of experience, perception of growth in others and self, permission to talk about the death and about self, availability of information from which to define own guidelines for grieving, and the provision of a refuge and support. "The bereavement group has been a source of my sanity".
III. General Impressions

If you had to try to single out any one thing, what would you say was the hardest thing to bear this year?

The death - 2

Respondent: "It feels like I have been cast into the middle of the ocean without a life jacket";

Respondent: "It is a deep abyss out of which you must crawl"

Other:

"I miss the phone calls -- she used to call everyday".

"Grief was so painful, I hadn't anticipated how much it would HURT".

"The "Firsts" were the hardest."

"This fall -- with the rain ... it was just like last fall before she died, ... wet and dreary. It brought it all back, ... all that pain".

"I miss HIM. I'm disappointed and angry that we couldn't do all the things we had planned to do when he retired".
"Going back to England and telling her family about her death — it kept the grief fresh".

"Father's Day"

"My birthday! I'd prepared myself for every other special occasion during the year and forgot about my birthday — and no one else knew 'cause I don't tell people when it is — and there I was alone! It really caught me off guard."

"I miss the sharing and companionship".

"The anniversary date of the death".

"At the beginning everything was hard ... mostly I guess, other than him, were all the plans we made for his retirement".

---

Were there some positive things that occurred during this year?

Nothing was positive — 3

For example: "I can't talk about this yet. For me he isn't dead yet".

Improved relationship/greater closeness with my children — 4
Increased independence - 4; Greater resilience - 3
Closer friends - 6; Good neighbours - 4
New pet - 1; New activities - 3
Return to Church roots - 1

Comments included:
"I’m managing really well I did the vegetable garden for the first time this year. It’s also better now that I see my daughter turning the corner" [resolving issues].

"I have a wonderful friend who has listened and listened -- she’s always there and always accepting".

"I had a new grandchild born in September -- it was a bittersweet experience -- wonderful for me, sad that my husband missed it".

"My neighbours have been so considerate and thoughtful."

"I’m doing things I’ve never done before. I never had close friends, now I have new friends that I do new things with".

"I hadn’t anticipated how much freedom there is to being alone -- freedom to do what I want, when I want. It
was a surprise".

"The sailing has brought the family closer together -- we share time and space together and are also close to my wife/their mother this way".

"It really helped me to see that I could help others (in the bereavement group)".

"I don't let little things build up anymore. The death helped that way -- time is too short".
APPENDIX III

Cameron and Brings

Grief and Adjustment Inventories
Group Control# 

Grief Inventory

1. Physical Health (as perceived by respondent)

Undesirable weight change ..........................1
Undesirable eating pattern change persists.........1
Undesirable sleep pattern change persists..........1
Uses sleeping pills (since bereavement/illness)...1
Uses tranquillizers (since bereavement/illness)...1
Feels health has deteriorated since bereavement ..1

Total

2. Psychological Health

a) Grief indices present after one year:

Pining and seeking .....................................1
Sense of presence .......................................1
Death wish or suicide ..................................1
Tearfulness ...............................................1
Anger .......................................................1
Guilt .......................................................1
Restlessness/tension ...................................1
Avoidance/blocking .....................................1

Sub-Total
b) Indices of poor adjustment:

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<td>Uncomfortable with reminders</td>
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<td>Visits to grave very distressing</td>
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<td>Haunted by intolerable death memories on bereavement anniversary</td>
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<td>Avoiding new activities/relationships</td>
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<td>Lacks concentration, ability to follow thru</td>
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<tr>
<td>Experiences panic attacks</td>
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Sub-Total __


c) Indices of maladaptive adjustment:

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<td>(Increased smoking, drinking etc.)</td>
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<td>Death wish</td>
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<td>More depressed now than earlier</td>
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<td>Isolation re: social withdrawal</td>
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<td>Marked sense of presence</td>
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<tr>
<td>Has symptoms of dead person</td>
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<tr>
<td>Failure to see Dr. re: deteriorating health</td>
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</table>

Sub-Total __

Total __

Grand Total (1+2a,b,c) __

Comments:
Adjustment Inventory

1. **Physical Health**

   Appetite normal .......................... 1
   Weight normal or desired .................. 1
   Sleeping habits normal .................... 1
   Health related to bereavement now resolved ... 1
   Has sought professional help with health related problems appropriately ............ 1

   **Total**

2a. **Psychological Health**

   Grieving less, no guilt ..................... 1
   Feels less depressed/saddened than at time of bereavement ........................... 1
   Comfortable with reminders of deceased ...... 1
   Memories of deceased happy/realistic ........ 1
   Clearer image of deceased person .......... 1

   **Sub-Total**

b. **Behavioural/Social Sphere**

   Resumed old activities..................... 1
   Engaging in new activities/relationships ..... 1
   Personal expression of independence ........ 1
   Planning ahead for the future ............. 1

   **Sub-Total**

   **Total**

   **Grand Total (1+2a,b)**

Comments:
APPENDIX IV

Code Book for SPSS:X Analysis
1-4 CID  Client Identification Number
5-6 AGE
7 SEX  1 = Male  2 = Female
8 REL  Relationship to Deceased
   1 = Spouse  2 = child
9 CHILD  Number of children/siblings
11-12 MAR  Number of years married
13-14 PREP  Number of Months Ill before Death
   (awareness of not getting better)
15 HEALTH  Health Risk
   1 = nil/low
   2 = poor health since death, resolved
   3 = poor health since death, unresolved
   4 = poor health prior, continuing
   5 = poor health and/or other
16 RELIG  Religiosity
   1 = nil
   2 = spiritual
   3 = personal, no church
   4 = church
17 FSUPP  Family Support
   1 = nil/lo
   2 = some/moderate
   3 = high
18 SSUPP  Social Support
   1 = nil/lo
   2 = some/moderate
   3 = high
20-21  GRIEF  Grief Score  
22-23  ADJUST  Adjustment Score  
25  BG  Bereavement Group  

1 = Yes;  0 = No  

To ensure confidentiality, identifiable personal information -- age, sex, relationship to the deceased, number of years married -- pertaining to the respondents has been removed from the Raw Data Matrix.

Raw Data Matrix

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APPENDIX V

Abstract of Comments

utilizing William Worden's Four Tasks of Grieving
Interview Abstract

using William Worden's Four Tasks of Grieving, 1982

Task I  Accepting the reality of the loss: (absence of: denial, searching, minimalizing, selective forgetting)

Cancer is stress-related, therefore you need to incorporate a healthy life style.

There was a misdiagnosis, there was no time.

I don’t know how long he was sick, I can’t remember.

We didn’t talk, we didn’t want to think that he wouldn’t get better.

The death was brought on and aggravated by the treatments.

The doctors didn’t give us enough information.

Death is "an act of God"

Grief was so painful. I hadn’t anticipated how much it would hurt. I was numb and very angry.

We trusted the doctors and the treatment was wrong. They gave us wrong advice.

I didn’t understand what was happening.

There was a terrible numbness that lasted for ages and ages and then one day it was over.

It was gut-wrenching and painful.

I travel extensively. Her image is still there, it is so empty.
There were good days and bad days.

The whole year was hard. It's harder now.

There was nothing positive about the year.

I didn't want to give up hope. I was shocked when he died.

Talking about him made me sad, so I didn't want to dwell on him.

His job killed him -- the stress caused him to become ill.

To me he's not dead yet.

It will be another year before I can talk about it.

The finality of it is the hardest.

Grief is a deep abyss out of which you must crawl.

I can't talk about it as I have a bad stomach and it makes me very sick.

It was like being cast out into the ocean without a life jacket.

His suffering is over. He suffered terribly.

I had to move. We built the house together, her presence was everywhere.

I lost part of myself.

The hardest thing was buying the coffin.

The memory of the death is hard -- it wasn't him.

I don't remember how long he was sick -- I've blocked
it out, it was so painful.

The treatments were so hard on him we didn’t have any quality time.

He died at home. He waited until everyone was there and then peacefully slipped away. It was a gift.

He knew the baby was being born. He waited until until she was born and he heard her cry on the phone. He said "That’s my grand-daughter" and then slipped into a coma and died three days later.

The time we had was precious – highly positive and close.
Task II  Experiencing the pain of grief: (absence of: negating feelings, avoiding painful thoughts, idealizing the dead, stoicism; concerns re: letting go of anger, fears, guilt, loss as part of self, avoidance, reliving/reworking the death event)

It's none of the doctors' damn business how my health is.

My friends asked me not to move away.

I don't need anything (alcohol, tranquillizers), I don't need any crutches.

My wife kept asking me to take her away from all this.

You have to move ahead. There's nothing you can do -- he's gone and you have to move on.

I thought I was doing so well and then I went to the dentist and he found I had seven cracked teeth -- all within the last year!

All those lost dreams and expectations that have to be worked through.

I used to visit the grave when I needed to work out a problem, it's less now.

I'm waiting for the other shoe to drop.

The boys follow Mom's lead -- they're managing well.

I feel too old.

It's nobody else's business.

My wife was so scared.
I gave the clothes away -- it made me feel needed.

There are some unresolved issues that need to be addressed. It's not time yet.

We played the game and kept up the pretense -- I deeply regret that.

I wished I could go too.

What right did she have to go and leave me?

She was my soul-mate.

Pain over time is different -- it becomes more like nostalgia.

I remember the image of him at the end -- it's hard.

The wrenching pain has now been replaced by periodic sadness.

I never wanted to be a "poor me person".

The children were able to cope. They must.

I needed to get on with it.

I observed a ritual mourning period just before the anniversary.

I needed to check out my emotions.

I haven't really cried yet -- I don't think I've allowed myself to feel it yet.

I exercise regularly -- I keep in fighting trim.

I haven't dismissed him from my life.

It's more natural and easy to speak of him now.
The nights are still very difficult.

I wear his sweater for security -- it smells of his aftershave.

Visiting the grave was painful at first, now it's okay.

It's hard to concentrate at times.

I was in stress overload (on the anniversary of the death) and can't remember anything we did.

The stiff upper lip thing -- it fits.

I won't wallow in self pity.

It doesn't take men long to find someone else.

Last fall was wet and dreary, just like when she was sick and dying. It brought it all back.

I don't have time to deal with it right now.

It's hard living alone -- it's definitely different without a mate.
Task III Adjusting to the Environment without Deceased:
(considerations of: role loss, developing new skills, loneliness and reaching out to others, self-confidence, taking initiative)

I used to walk everyday with my wife -- I still can't walk those pathways and have had to make new one's for myself.

I am collecting stories and vignettes about her from her friends and am compiling a book for our son -- my wife feared that he would forget her.

I meditate and use creative visualization.

I am proud of my resilience.

People expected me to "get over it" within two months.

My son tries to boss me but I can handle it.

He's not there, he's everywhere.

The bereavement group allows me to talk about myself -- to say things I could never say to my friends.

I don't like eating by myself.

My friends expect me to be "over it" by now.

Sitting at home isn't good. You have to make an effort to get out. It's easier now.

I have a new dog -- she's my dog. She's wonderful. She fills the hole and gets me out for my exercise.

He's not coming back. Things have to be this way.

I now have friends of my own.
I don’t fit anywhere — I’m not a couple, I’m not anything.

I miss the sharing.

I feel alone and scared.

I address issues now — there’s no time to let things build up.

I’ve learned not to be so uptight about things.

I’ve created my own guidelines to handle my bereavement.

I need to be whole for the children.

We make a point of eating together every day.

I’ve re-established a friendship with an old friend.

I grieve for the children’s loss.

I thought I would manage better. It’ll work out in time.

I have one very close friend.

I’m very shy — it’s hard for me to reach out to others, to speak up in a group.

The experience of the new grandchild is bittersweet — he’s not here to enjoy it.

My neighbours of many years provide me a sense of security.

Time heals. It takes time.

It’s lonely. My small dog keeps me company.
The anniversary was the end of the first year -- the end of all the "firsts"

I'm reverting back to my old independence and am becoming increasingly self directive.

I miss the sharing -- "wouldn't "M" have loved this"

The bereavement group is a refuge -- there I know I'm not going nutty.

I feel the experience has softened me -- I'm not so hardnosed.

My daughter is becoming bolder -- tries to boss me like her mother did.

I miss the phonecalls.

I'm able to reach out to more my friends now.

I feel so alone, not just lonely -- as though I don't fit.

It's hard alone.

I'm trying to venture out on my own now.

I've learned new skills at work and for the first time I've put in the vegetable garden -- my husband used to do that.

My problems are minor compared to others.

The "Firsts" are the hardest.

I had two years to learn how to do things.

He left me a wonderful letter -- it has been such a solace to me.
We planted his favourite shrub on the anniversary -- the rest of the day was very hard.

There has been nothing positive about the past year.

I turned the corner at Christmas.

I'm no longer part of a couple.

It's hard to meet new people, especially when old friends are all couples.

I'm lonely and alone.

I felt abandoned when everyone went away.

I've started going out more.

I miss him -- the person.

I'm not that old.

There are some advantages to being single.
Task IV  Withdrawal and reinvestment of energy in new activities/relationships: (concerns re: never marrying again, inability to love someone else, letting go, no painful memories)

The thought of remarriage scares me.

The thought of another family overwhelms me.

The smell was gone -- I used to smell the clothes and then I found the smell was gone -- it was time to let go.

We spread the ashes in the sea -- the sea signifies connection with life.

It's a beautiful world -- there's a lot to do and see and cherish.

I'm so proud of how well the children are doing.

I went to a psychic who predicted "lots of fun and dancing in the year to come" -- I'm looking forward to it.

I'm open to remarriage -- I'm not that old and there are advantages to being married.

Everyone is different -- there's no way to help everyone.

I'm too old to consider remarriage.

Remarriage would be a betrayal of her.

I have lots to do -- no time for remarriage right now.

I'm travelling and doing things I didn't get the chance to do with my husband.
I am still distressed over lack of resolution before the death.

If I remarried I would always compare the second with the first.

I've returned to my church and am making new friends.

The memories are still painful.

I'm planning to sell the house in a year or two and travel.

I have a wonderful close friend who will listen and listen.

I'm looking forward to the new baby.

I have new friends and new activities -- it's exciting.

Time was a real gift.

It was a relief, the year was over. I'd made it and now I can go on.

Things and places get built into your life.

There's a time to finish up things.

I have more freedom now.

There's more to life than worrying about dying.

I plan to remarry. I'm dating now -- "rehearsing".
APPENDIX VI

Abstract of Time Connotations
Time Connotations:

1 - time line, period of time, time frame
2 - occasion, duration of time relating to certain experiences
3 - conditional, choice of proper moment - future
4 - turning point, timing, at right moment - past

Without Bereavement Intervention

2 Two years of suffering for us both.
3 It’s not time yet - x3
1 No time to talk.
3 Don’t have time to deal with it right now.
1/2 Looked after [deceased] for over six years, now there’s nothing.
1/2 Illness of two years equalled the retirement of two years.
1 Had time to prepare, to learn the things I need to know.
2/3 It’ll be another year before I can talk about it.
1 Time is a release.
1 He had time to take care of things before he died.
1 There was no quality time.
3 He waited until everyone was there and then he died.
4 Christmas was a turning point for me.
With Bereavement Intervention

4 The year was over, now I can go on.
4 There's a time to leave.
3 He stayed alive until she was born.
1 Doesn't take men long before they find someone.
1 Time was a real gift.
1 My husband had time to take care of everything.
2 Hardest time was my birthday.
2 We could go to the hospital anytime to be with him.
2 We discuss things right away -- there's no time to let things build up.
1 There was no time to discuss things, to work through the fear and anger.
3 I'll have time to indulge myself after...
1 There may have been more time for us if there hadn't been a misdiagnosis.
4 Pain changed after that time.
1 Time heals.
1 I will work it out in time.
1 The time of her illness was very close.
4 The smell was gone, it was time.
4 The pain was gone.
4 It was time to start again.