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Running head: SURVIVOR'S PROGRESS IN BEREAVEMENT

A STUDY OF SURVIVOR'S PROGRESS IN BEREAVEMENT
THROUGH PRE-DEATH WORK

A Thesis Submitted to the Graduate School
in Partial Fulfillment of the Requirements
for the Degree of
Master of Science in Nursing

Helen Kathleen Brophy McHale

PITTSBURG STATE UNIVERSITY

Pittsburg, Kansas

2001

Acknowledgments

Twenty-five years ago I discovered Elizabeth Kübler-Ross. I honor her for her dedication to peaceful dying. I cherish Judy Pecher, my colleague and friend, who has devoted her life to this work. With Judy as guide, we spent the last decade together, working with individuals and families in the final phase of the human experience.

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developed by Ruth Huber, Ph.D. (1990). This hypothetical, zero to ten visual analogue scale created a self-reflection, which is believed to be the best indicator of progress.

Data were examined using a triangulation of qualitative and quantitative procedures. Data were statistically analyzed using percentile, measures of central tendency, and dispersion. Differences between variables were explored and examined for significance. Once relationships among variables were discovered they were investigated to determine direction and strength.

Although this investigator originally believed hospice care would make a significance difference in survivor's progress in bereavement, it did not. It did make a difference although not statistically significant. The mean change score revealed a .75 difference; those who had hospice reported traveling farther on the 10-Mile Mourning Bridge.

Those who had a longer time with knowledge of the impending death reported they were farther in bereavement, both at the time their spouses died, and about twelve weeks later at the interview. Participants whose spouses died at home reported being farther in bereavement at the time of death. Finally, there were strong (.49 & .53) to very strong (.90) relationships found between length of time with knowledge of the impending death and Mourning Bridge Scores.

Participants, who knew longer, that their spouse would die, reported being farther in bereavement. This discovery is worthy of future research. Healthcare professionals can analysis their own discussion of death and dying. It is imperative that we examine telling, (who, what, when, where, why, and sometimes how we tell) patients and families, about predictable impending death from life-limiting chronic illness. We need to tell and they need to hear. Knowledge and truth offer hope in the final phase of the human experience.

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A STUDY OF SURVIVOR'S PROGRESS IN BEREAVEMENT THROUGH PRE-DEATH WORK

An Abstract of the Thesis by
Helen K. McHale

Bereavement, a journey traveled while grieving, can be full of growth and self-discovery or darkened with loneliness and pain. This is especially true in Western Society where the discussion of death and grief are often avoided. This descriptive correlational research study was designed to determine whether hospice intervention assisted individuals who lost their spouses to a predictable death from a terminal illness, with progress in bereavement. Relationships between bereavement progress, support received prior to death, and other variables were examined for 16 participants.

An interactive theoretical approach was incorporated into the study framework. Carl Rogers and Joyce Travelbee's models of the interactive process were used. Effective communication is central to an interactive approach. Rogers (1961) and Travelbee (1966) emphasized the importance of personal interaction between individuals in therapeutic relationships. This investigator used the interactive process to interview participants. Half of the participants had hospice services and half did not. It had been an average of 12 weeks since participants lost their spouses. Some of participants' spouses died at home and some died in a hospital. The participants had various types of support prior to the death. These and other variable were gathered and measured.

Each participant answered questions from the Pre-Interview Questions form. They also measured their progress in bereavement using the 10-Mile Mourning Bridge

Chapter I

Introduction

This descriptive correlational research study was designed to explore personal progress in bereavement and associated phenomena of participants who lost their spouses to a predictable death. Relationships between bereavement progress, the support participants received prior to the death, and other variables, were examined using triangulation of qualitative and quantitative procedures. Practitioners with knowledge about the prognosis of a life-limiting illness often avoided discussion about the inevitable death rather than create an uncomfortable situation with patient and family. The discussion of death and grief offered healing and hope despite the avoidance of it.

This chapter explains the background and significance of the problem and its significance for nursing. The theoretical framework, problem statement, and study purpose are described. The research questions, research variables, demographic variables, and extraneous variables are identified. Also presented are the identification of study limitations, definition of relevant terms, and the general and theoretical assumptions.

Background and Significance

Death and grief are topics many adults find difficult to discuss. The National Hospice Organization (NHO) reported that Americans who were uncomfortable talking about death would more likely discuss safe sex and drugs with their children than talk with their terminally ill parents about end-of-life choices. Twenty-five percent of Americans over the age of 45 said they would not talk to their parents about death “even if the parent had a terminal illness and less than six months to live” (National, 1999a).

Our society withdraws from individuals in mourning to avoid emotional pain, “the assistance they do offer is superficial and full of platitudes” (Silverman, 1974, p. 320). The medical community is no more therapeutic than the public when they deal with death and grief. If a medical treatment will not cure a patient (and could cause harm, especially late in the disease) it may continue to be offered under the guise of hope.

Advanced medical technology, such as pharmaceuticals that mask unpleasant manifestations of disease provide patients with incurable illness a longer fuller life. Symptoms are often hidden, which allows patients and families to disregard the disease progression. According to Bales (1997) improved end-of-life care is needed to assist the public as they plan their futures and make crucial choices.

This investigator interviewed the family of a gentleman who had Parkinson’s disease for twenty years. He was admitted to the hospital because he choked on his food. His family was stunned and surprised when told he was in the final phase of the disease. “How could this be? He’s been just fine.” Those years of religiously taking medications concealed the signs of the inevitable. Further discussion with his family revealed there had been symptoms they unintentionally overlooked. The patient had been getting weaker, had trouble swallowing, and “coughed when he ate.” Although the disease grew worse each year it was not discussed. Amid new emotional turmoil, crucial adjustments had to be made. The patient had unfinished business. His frail wife was burdened with difficult decisions related to end-of-life care. She reviewed finances and decided where he would spend his final days. Her bereavement journey was strenuous. She suffered from loneliness and depression. It was difficult to leave home to participate in activities. Her fragile physical condition deteriorated as she struggled to recover from grief.

Individuals who suffer the loss of a loved one often experience physical and emotional illness after the death. Bereaved feel waves of ill-defined distress accompanied by feelings of emptiness or emotional distance from others. They experience decreased muscle power, insomnia, hopelessness, or depression (Blank, 1969; Lindemann, 1944/1994). Support that eases the journey through bereavement, and lessens or prevents grief's suffering, is priceless.

Erich Lindemann (1944/1994) coined the term anticipatory grief to describe the preliminary pain experienced by an individual, before an actual loss occurred. Norris and Murrell (1987) suggested, "the adaptational requirements of bereavement begin well before the death event" (p. 611). Grief work should be started when the physical, psychological, or spiritual impact of the impending death is first felt. While the individual prepares for the loss, the reality is gradually absorbed. Grief experienced before the death of a loved one hastens healing from that loss (Huber & Gibson, 1990). Anticipatory grief work, preparation before the loss occurs, empowers the bereaved to face the loss in a more constructive way (Speck, 1978). An interactive approach to care one that intimately involves the patient and family provides a process for either anticipatory grief work or communication during bereavement.

Significance to Nursing

Grief has far-reaching effects. Unrecognized and unresolved grief has forced a significant number of patients to the primary care setting afflicted with somatic symptoms. The roles and responsibilities of advanced practice nurses are enhanced through awareness of grief's effects and recognition of preventative solutions. Nurse

practitioners who choose to treat individuals with an interactive approach form a caring relationship that facilitated healing and health.

As primary practitioners, advanced practice nurses have treated acute as well as chronic conditions. Patients with congestive heart failure or cancer initially saw a cardiac or oncology specialist. Later, as care changed from curative to palliative, patients were referred to primary practitioners. Nurse practitioners have provided care for “the full range of human experiences and responses to health and illness without restriction to a problem-focused orientation” (Hamric, Spross & Hanson, 1996, p. 43). Practitioners assisted patients and families who faced a terminal illness with referral to hospice programs specializing in end-of-life care. Practitioners provided support “by becoming a resource for information, a specialized educator, an empowering collaborator, and an advocate for the hospice movement” (McHale, 1998, p.1). Nurses and other professionals uneasy with a dying population would benefit from training in principles of end-of-life care. There is an urgent need for additional nursing education in pain assessment and management (Ferrell, 1999b). Nurse practitioners who were available in a consultative, educative, and supportive way would assist with this training (Karrer, 1996).

Practitioners who recognize an evolving paradigm consider the family system the unit of healthcare. “In so doing, they will be reclaiming some aspects of nursing that have been given to other health professionals” (Wright & Leahey, 1994, pp. viii & ix). According to these authors an interactive approach is vital as nurse practitioners modify clinical practice and involve families. They engage and assess the patient and family and intervened effectively through communication facilitated by an interactive approach. This preventive work lessens grief’s somatic symptoms and related depression, which has

been treated by practitioners. Through the use of a preventative approach, nursing becomes instrumental in more frugal use of healthcare dollars.

Theoretical Framework

The study's theoretical framework was based on a process of personal interaction practiced by Carl Rogers (1961) and Joyce Travelbee (1966). This process was psychological in nature. Psychology's discipline contained broadly researched scientific works, which were invaluable resources. A 1986 review found theoretical works from psychology provided 49% of frameworks for nursing research (Burns & Grove, 1993).

Carl Rogers, psychotherapist, was selected as theorist for this study because he dedicated years to an interactive approach, which had a lasting influence across disciplines. His theory was modeled as a Person-to-Person Relationship based on understanding and accepting "the client's private world" (Torres, 1986, p. 168). Carl Rogers was founder of person-centered therapy. He may have been the most influential psychologist and psychotherapist in America, during the twentieth century. The nursing theorist chosen for this study was Joyce Travelbee. She, like Rogers, based her Human-to-Human Relationship Model on the interactive process. Rogers (1961) and Travelbee (1966) emphasized the importance of personal interaction between individuals in a therapeutic relationship. Interaction between client and therapist moved individuals to a place of comfort where therapeutic communication could occur (Torres). This intimacy and sense of comfort also enhanced conversations surrounding death and grief.

The interactive process stressed that effective communication was key to a positive outcome. Rogers identified the central characteristic of a therapeutic relationship as "the therapist's ability to participate completely in the patient's communication" (Torres,

1986, p.168), while Travelbee maintained, to achieve a therapeutic relationship “effective communication must take place” (Torres, p.192). Rogers and Travelbee emphasized that effective communication had value and significance for all healthcare practitioners.

These models of the interactive process, contained essential variables that formed steps or phases, which occurred before therapeutic communication took place. Rogers’ Person-to-Person Relationship contained emotional warmth, respect, empathy, and acceptance, these led to a place of safety (Torres, 1986). Travelbee’s Human-to-Human Relationship contained similar phases, described as the original encounter, emerging identities, empathy, and sympathy, which led to rapport (Meleis, 1997). Once an individual arrived at a place of safety or rapport, therapeutic communication began (Torres). Interaction between a research investigator and participant, which relied on the interactive process, facilitated comfortable, open communication.

This investigator used the interactive process to interview participants. Just as with Rogers and Travelbee’s models, the process consisted of four steps. The first step was this investigator’s introduction and explanation of the study to the participant. Receipt of the participant’s agreement was the second step. The third step required that the participant answer demographic and situational questions. The fourth step involved self-assessment. Participants measured where they were in their personal bereavement journey. The journey was measured using a self-reporting, zero to ten visual analog scale, the 10-Mile Mourning Bridge (A, p. 135) (Huber & Gibson, 1990). This investigator received permission to use and adapt “The 10-Mile Mourning Bridge” from Ruth Huber, Ph.D., University of Louisville (Appendix B, p. 137). This process led to a place of comfort for the participant where communication could take place.

A map of the steps for the interactive framework, as described by Rogers, Travelbee, and this investigator, was presented in Figure 1. The map also compared these steps to Joyce Travelbee's (1966) explanation of this process. Effective communication, the vehicle through which therapeutic relationships were established and maintained, took place only when the client or patient felt at ease and comfortable sharing their innermost feelings (Rogers, 1980). Using the interactive process to interview study participants facilitated a feeling of comfort during the interview.

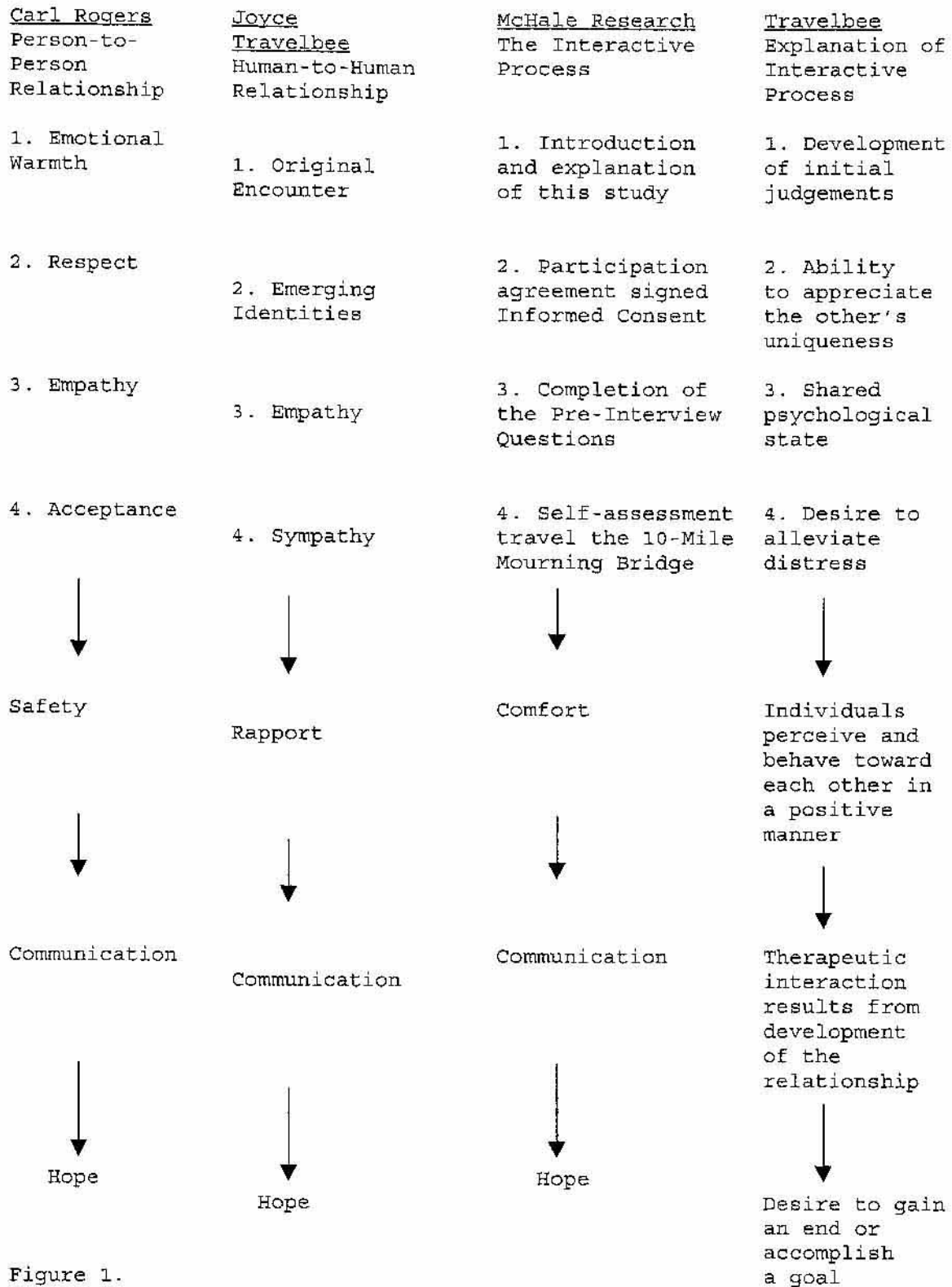


Figure 1.
Map of the Interactive Framework

Problem Statement

Western society's inability to accept and address death and grief caused a longer more complicated journey through bereavement. Many healthcare professionals believed by avoiding the discussion of death and dying, they spared individuals emotional pain, but they really robbed them of the chance to grieve in anticipation of the coming loss. These patients were denied precious time they needed to prepare for death as well as a chance to interact in a new light with family and friends. A longer grieving process also adversely affected their family physically, emotionally and financially, while it taxed our society. Greater use of anticipatory grief techniques could have provided benefits for patients, families, practitioners, and the healthcare community.

Study Purpose

The purpose of this study was to determine whether hospice intervention assisted individuals who lost their spouses to a predictable death from a terminal illness, with progress in bereavement. Progress was measured by travel along 10 imaginary miles on the 10-Mile Mourning Bridge, to resolution, an ability to go on with the rest of their life.

Research Questions

The questions addressed in this study were:

1. Does hospice care make a difference in a survivor's progress in bereavement as measured on the 10-Mile Mourning Bridge?
2. Do differences exist between participants' scores on the 10-Mile Mourning Bridge, who had a longer time with knowledge of their spouses' impending death, and those who had a shorter time with that same knowledge?
3. Do differences exist between those participants' scores on the 10-Mile Mourning

Bridge whose spouses died at home and those who died in the hospital?

4. Do relationships exist between participants' progress in bereavement as measured by the 10-Mile Mourning Bridge scores; at the time of death, at the time of the interview, and the measured differences between these two scores; when they are compared with length of time with knowledge of the impending death?

Research Variables

The study proposed to investigate the relationship between hospice support and survivor's progress in bereavement. Relationships between variables in the participants' situations had to be established. Each survivor's progress in bereavement had to be determined. Participant scores on the 10-Mile Mourning Bridge measured this research variable. Support survivors had available prior to the death of their loved was identified. Which support they found most helpful was established. This information was collected on the Pre-Interview Questions form (Appendix C, p. 139).

The following research variables were operationalized through development of the conceptual and operational definitions listed below:

1. Conceptual Definition of Survivor's Progress in Bereavement

Survivor's Progress in Bereavement was the participant's experience of traveling a personal journey through grief. The journey involved their entire grief experience. It began when the participant first learned their spouse would die. They felt empty and emotionally drained. They completed their journey once they felt whole and could hope again. With grief resolution came an ability to reinvest emotional energy into new interests or relationships and get on with the rest of their life (Huber & Gibson, 1990).

2. Operational Definition of Survivor's Progress in Bereavement

In this study the 10-Mile Mourning Bridge was a self-reporting, zero to ten visual analogue scale, used to measure the participant's perception of their progress on a personal bereavement journey.

3. Conceptual Definition of Support Available Prior to Death

Support available prior to death was the encouragement or assistance participant's received from any source, while their spouse was alive. The support involved any of the following physical, emotional, psychological, spiritual, psychosocial, or any other as defined by the participant. The support could have been provided either voluntarily or for payment. Participants defined the value derived from the various types of support.

4. Operational Definition of Support Available Prior to Death

During this study the Pre-Interview Questions form was used to collect information about support available to participants prior to the death of their spouses. Hospice support was among the ten types listed on the form. There was also a place to list other support.

Demographic Variables

The responses provided by participants on the Pre-Interview Questions form described the study sample. This investigator created the form. The form contained spaces for the participant to provide their age, birthdate and gender, as well as their relationship to the deceased, and the length of that relationship. It also contained spaces for the deceased's age, birthdate and gender, and the cause and place of the patient's death. There was a space to write the date they learned the illness was terminal, and one for the date of death. One space addressed whether participant and spouse discussed the impending death.

Extraneous Variables

This investigator's affiliation with a hospice organization was recognized as an extraneous variable. By limiting information provided about the investigator this was controlled. Participants were told the investigator was a Registered Nurse performing research to complete her thesis for a Master's Degree in Nursing. Work setting was never mentioned. The study setting was an environmental variable. Participants were encouraged to choose between a face to face or a telephone interview. The intent was to study the subjects in the environment where they were most comfortable.

Identification of Limitations

Limitations of this study can be found in the following list:

1. Neither the age of study participants, nor the length of their relationship, were considerations for study inclusion.
2. The 16 participants were a relatively small study sample.
3. Several demographic variables not considered in this study were level of education, income, religion, and ethnicity.
4. A portion of the assessment was made in retrospect as the death of each participant's spouse occurred weeks before the interview.
5. The research study design was limited in that it was not longitudinal.
6. This was not a controlled study; therefore it cannot offer any cause-and-effect explanation for relationships.

These limitations were considered while compiling and interpreting study data. It was envisioned that enlightening literary discoveries and significant study findings would create curiosity about the value of an interactive process for anticipatory grief work.

Definition of Relevant Terms

Acceptance: Acceptance meant to receive approval or satisfaction (McKechnie, 1973).

Acceptance was the fourth step in Carl Rogers' (1961) interactive process. Rogers believed the client must feel acceptance before therapeutic communication could take place. The terms that correlated with Rogers' acceptance were Joyce Travelbee's (1966) sympathy, and use of the Mourning Bridge for self-assessment in this study.

Anticipatory Grief: Anticipatory grief was the experience or expression of grief before the actual loss. Erich Lindemann (1944/1994) coined the term. This grief generally had positive effects as it decreased the pain experienced when the loss did occur (Byock, 1997; Costello, 1996; Huber & Gibson, 1990; Kübler-Ross, 1969; Levy, 1991; Lindemann, 1944/1994; Norris & Murrell, 1987; Speck, 1978; Wheeler, 1996).

Bereavement: Bereavement was a state of being deprived, particularly by the loss of a friend through death. It also referred to the period a person was in mourning and experiencing grief (McKechnie, 1973). The personal journey traveled while grieving was described as a person's time of bereavement or bereavement journey.

Congruence: Congruence meant agreement or harmony (McKechnie, 1973). Carl Rogers (1961) used congruence interchangeably with genuineness. "Congruence or genuineness is the most fundamental of the attitudinal conditions that promote therapeutic growth. [It describes] an accurate match of experience and awareness" (Rogers, 1961, p. 339). Rogers believed congruence was dependent upon the therapist's capacity to maintain a high level of self-awareness (Thorne, 1992).

Emerging Identities: Joyce Travelbee (1966) described emerging identities as the recognition of one another's specific position as a person (Torres, 1986). It was the

second phase in Joyce Travelbee's model of the interactive process and allowed individuals to begin to know one another so effective communication developed. The steps that correlated with Travelbee's emerging identities were Rogers' respect, and use of the Informed Consent (Appendix D, p. 141) for participant agreement in this study.

Emotional Warmth: Emotional warmth might have been the result of accepting someone, as they were (Torres, 1986). Emotional warmth was the first step in Rogers' (1961) Person-to-Person Model of the interactive process. This began the interactive process, which led to therapeutic communication. The phase and step that correlated with Rogers' emotional warmth were Joyce Travelbee's (1966) original encounter, and the introduction and explanation of this study to participants.

Empathy: Empathy was the projection of one's own personality into the personality of another in order to understand him better (McKechnie, 1973). For both Rogers (1961) and Travelbee (1966) empathy was the third step or phase of the interactive process. They believed that without empathy effective communication could not take place between a therapist and client. The step, in this study, that correlated with Rogers and Travelbee's empathy was participant completion of the Pre-Interview Questions.

Genuineness: Genuineness meant something was actually what it seemed or claimed to be. To be genuine was to be without pretense; sincere; frank (McKechnie, 1973). Carl Rogers (1961) used congruence interchangeably with genuineness. "Congruence or genuineness is the most fundamental of the attitudinal conditions that promote therapeutic growth. [It describes] an accurate match of experience and awareness" (Rogers, 1961, p. 339). Rogers believed congruence was dependent upon the therapist's capacity to maintain a high level of self-awareness (Thorne, 1992).

Grief: Grief was an intense emotional suffering caused by loss, misfortune, injury, or evils of any kind; sorrow; regret; as, we experienced grief when we lost a friend (McKechnie, 1973). Study participants felt the pain of grief as they experienced life without a spouse.

Hope: Hope was a desire for some good, accompanied by either a slight expectation of obtaining it or a belief that it was obtainable. Rogers (1961) and Travelbee (1966) believed therapeutic interaction through communication allowed individuals to hope.

Hospice: A hospice was originally a place of refuge for travelers, a home for the sick or poor (Como, 1990). "Hospice is a system of family-centered care designed to assist the terminally ill person to be comfortable and to maintain a satisfactory life style through the phases of dying" (McHale, 1998, p. 1). Many hospice families believed preparatory work, done during hospice care, helped them during their bereavement journey.

Human-to-Human Relationship: Joyce Travelbee (1966) used the term Human-to-Human Relationship to define her impression of an interactive process used to assist ill individuals. The model emphasized the importance of the therapist truly being with the human he or she was attempting to help before effective communication could take place.

Interactive Process: The interactive process was a type of therapy that utilized open, trusting relationship between client and therapist (Worchel & Shebilske, 1992). Carl Rogers (1961) and Joyce Travelbee (1966) utilized the theory of the interactive process in their models of care. They believed it was essential if therapeutic communication was to take place. The interactive process was used during this research study interview

Length of Time with Knowledge of Impending Death: This term described the span

of time between the date the participant and spouse first learned the illness would cause death, and the date of death. This length of time was measured in weeks.

Mourning: Mourning included actions or feelings of sorrowing, expressing grief, lamentation; sorrow; specifically, an expression of grief over a death (McKechnie, 1973).

Mourning Bridge Score: The Mourning Bridge score referred to a number between zero and ten, which described where study participants believed they were, in their bereavement journey. The participant traveled visually on a hypothetical 10-Mile Mourning Bridge. Zero represented just learning their spouse would die and the beginning of their bereavement journey. A score of 10 represented resolution, an ability to reinvest emotional energy and get on with the rest of their life, without a spouse.

Original Encounter: Joyce Travelbee (1966) defined original encounter as the point where individuals developed initial judgements of one another (Torres, 1986). Original encounter was the first phase of Travelbee's Human-to-Human Model of the interactive process. This first phase began the interaction, which led to therapeutic communication. The steps that correlated with Travelbee's original encounter were Rogers' (1961) emotional warmth, and the introduction and explanation of this study to participants.

Palliative Care: Palliative Care is the active total care provided to patients living with advanced incurable illness and their families. The focus of care shifts to quality of life and alleviation of distressing symptoms versus aggressive bio-medical interventions. The goal of Palliative Care is neither to hasten nor postpone death. It provides relief from pain and other distressing symptoms and integrates the psychological and spiritual aspects of care. Furthermore, it offers a support system to help relatives and friends cope during the patient's illness and bereavement. (McHale, in press)

Person-to-Person Relationship: Carl Rogers' (1961) used the term Person-to-Person Relationship to describe the interactive process as an approach to helping individuals. Rogers explained that therapeutic communication could occur within his caring model of the interactive process (Torres, 1986).

Rapport: Rapport was a relationship, especially a close or sympathetic relationship. Rapport could also signify agreement or harmony (McKechnie, 1973). According to Torres (1986) Joyce Travelbee defined rapport as a place in the interactive process where therapeutic communication could occur. The steps that correlated with Travelbee's rapport were Rogers' (1961) safety, and a place of comfort in this study.

Respect: Respect meant to notice someone with special attention; to regard; to heed; to consider (McKechnie, 1973). Rogers described respect as the second step in the interactive process (Torres, 1986). Rogers (1961) believed the therapist must respect a client before he is able to communicate with and help him. The phase and step that correlated with Rogers' respect were Travelbee's (1966) emerging identities, and use of the Informed Consent for participant agreement in this study.

Safety: Safety was a quality or condition of being safe, free from danger, injury, or damage. Safety was security (McKechnie, 1973). Rogers defined safety as a place in the interactive process where therapeutic communication could occur (Torres, 1986). The correlating step or phase were Travelbee's (1966) rapport, and comfort in this study.

Self-Awareness: Self referred to one's own person. Aware meant knowing, realizing, or being conscious (McKechnie, 1973). Carl Rogers (1961) and Joyce Travelbee (1966) described this personal quality as being invaluable to the therapist using the interactive process. The therapist who was self-aware was fully available to the client, while they

put their own opinions and experiences aside (Torres, 1986).

Sympathy: Sympathy is a sameness of feeling as someone else. It described an affinity between persons and one person for the other (McKechnie, 1973). Sympathy, the fourth phase of Travelbee's interactive model, was essential for effective communication (Torres, 1986). Steps correlating with Travelbee's sympathy were Rogers' (1961) acceptance, and use of the Mourning Bridge for self-assessment in this study.

10-Mile Mourning Bridge: Ruth Huber (1990) developed "The 10-Mile Mourning Bridge", a zero to ten hypothetical visual analogue scale, to represent a bereavement journey. Study participants used it as a self-reporting tool. Huber and Bryant (1996) demonstrated the validity and reliability of "The 10-Mile Mourning Bridge". Study participants visually traveled their own bereavement journey on the Mourning Bridge. Zero represented just learning their spouse would die and the beginning of the journey. Bereaved individuals successfully crossed the Mourning Bridge (traveled 10 miles) when they were able to reinvest emotional energy into new interests and relationships. After crossing the Mourning Bridge, participants experienced resolution, ability to get on with the rest of their life without their spouse (Huber & Gibson, 1990).

Tension: Tension was any stretched condition. It could have represented mental strain (McKechnie, 1973). Carl Rogers (1961) used the term tension to denote a condition of inner conflict or turmoil experienced by clients that caused them to seek therapy.

Therapeutic Use of Self: Therapeutic use of self was an ability to use one's personality consciously, and in full awareness, to establish relatedness and structure intervention (Rangel, Hobbie, Lansinger, Magers, & McKee, 1998). Rogers (1961) and Travelbee (1966) believed that therapeutic use of self was essential for effective interaction.

General Assumptions

- Assumptions made about this study can be found in the following list:
1. Providing an explanation of the study might prevent hesitation in answering.
 2. The participants would understand the informed consent agreement.
 3. The participants would be willing to accurately answer the demographic data and pre-interview portions of the questionnaire.
 4. The participants would be able to understand and answer questions related to travel on the 10-Mile Mourning Bridge.
 5. Some of the participants would want to describe the story of their loved one's illness and the events surrounding the death.
 6. The private nature of the thoughts and feelings of the survivor might pose difficulties, and possibly produce incomplete or misinterpreted responses.
 7. Research on the grief process was difficult because grieving people presented with a myriad of physical, emotional, and spiritual complexities, none of which could be controlled to the extent required by perfect research designs.
 8. This investigator was particularly interested in any correlation found between the utilization of hospice services and survivor travel on the Mourning Bridge.
 9. For the measurement of feelings, communication based on a simple visual analogue scale seemed appropriate.
 10. Differences found to be statistically significant related to study concepts.

Theoretical Assumptions

The following common assumptions were drawn from the interaction theories:

1. In dealing with individuals in an interactive way, concepts such as self-awareness

and tension, although abstract, were useful as a focus.

2. The individual's internal frame of reference was the focus of both verbal and nonverbal communication.
3. Relationships between client or patient and therapist or nurse significantly impacted the ability to deal with needs and cope.
4. The therapist or nurse acted as a facilitator of human development.

Interaction theories focused on the characteristics of human beings and the role of the counselor or nurse, as they helped individuals with some sort of psychological tension (Torres, 1986, p. 204). Individuals, who experienced grief from the loss of a loved one, as well as those who anticipated such a loss, would benefit from the practitioner's use of these theories, which facilitated meaningful communication.

Summary

The general public as well as medical and nursing professionals have avoided the discussion of death and grief in our society. Studies have shown that discussing death before the loss benefited both the patient and family. They met death in a more constructive way (Speck, p. 15). Huber and Gibson (1990) stressed the importance of early grief work, while the findings of Norris and Murrell (1987) suggested support offered after bereavement was ill timed. Erich Lindemann's (1944/1994) term, anticipatory grief, described the preliminary pain experienced by an individual, before an actual loss occurred. Anticipatory grief facilitated facing the loss and later decreased the pain from grief. The loved one and family felt a great peace at the time of death because they experienced grief through anticipation (Kübler-Ross, 1969). These

scholarly works illustrated that the interaction principles as practiced by Rogers and Travlebee were useful when employed by professionals to help patients and families with end-of-life care. Communication facilitated by the interaction process also allowed individuals to get in touch with and share their feelings during this research study.

This chapter was an introduction to the research study, "Survivor's Progress in Bereavement Through Pre-Death Work." This chapter explained the background and significance of the problem and its significance to nursing. The theoretical framework, problem statement, and study purpose were described. The research questions, research variables, demographic variables, and extraneous variables were identified. Limitations were identified, relevant terms were defined, and the general and theoretical assumptions were presented.

Chapter II contains the review of literature, theoretical framework, and assumptions for this study. Classic works as well as recent literature related to grief, bereavement, and anticipatory grief are reviewed. Additionally, stage theories and implications of the grief process for individuals are presented.

Chapter II

Review of Literature

Chapter II contains the review of literature, theoretical framework, and assumptions for this study. Classic works as well as recent literature related to grief, bereavement, anticipatory grief, stage theories, and implications for the grief process were reviewed.

An in-depth review of literature revealed that although Erich Lindemann coined the term and published the benefits of anticipatory grief in 1944, to date, few practitioners have used this practice. During the late 1960's and early 1970's Elizabeth Kübler-Ross struggled with an unprepared healthcare system as she turned her attention to people's fear of death. She recognized that this fear of death was prevalent among physicians, nurses, and other healthcare professionals, as well as terminally ill patients and families. Research revealed that grief work should begin when an illness was deemed terminal. In fact, assistance provided to the bereaved after the death of their loved one, should have been started much earlier (Huber & Gibson, 1990; Norris & Murrell, 1987).

Survivors' progress in bereavement was studied using a descriptive correlational design. A triangulation of methods was used to examine relationships between survivors' progress in bereavement, support they received before their spouses' death, and other variables. Participants answered Pre-Interview Questions (Appendix C, p. 139) which provided qualitative data. They used a self-reporting visual analogue scale, "The 10-Mile Mourning Bridge" (Appendix A, p. 135) (Huber & Gibson, 1990), to describe their bereavement journey. This investigator received permission to use and adapt "The 10-Mile Mourning Bridge" (Huber & Gibson, 1990) from Ruth Huber, Ph.D., University of Louisville (Appendix B, p. 137).

The validity and reliability of "The 10-Mile Mourning Bridge" was demonstrated (Huber & Bryant, 1996). Report social behaviors as mathematical figures have no more limits than true words (Aiken, 1969). Joint use of qualitative and quantitative measures improved the understanding of study results (Abdellah & Levine, 1994). Burns and Grove (1993) describe this type of design as one that helped identify "many interrelationships in a situation in a short period of time" (p. 302). The Mourning Bridge facilitated self-reflection, believed to be the best indicator of progress.

This study integrated a theoretical framework based on the interactive process as practiced by Carl Rogers, a psychotherapist, and Joyce Travelbee, a nurse. These theorists emphasized the importance of interaction between the therapist and client or the nurse and patient. They each developed a model of this interactive process. Using this process helped an individual move to a place of comfort (safety or rapport) where therapeutic communication took place (Torres, 1986). Grieving individuals found healing and hope through communication facilitated by the interactive process.

Theoretical Framework

Introduction. Interaction theories had, as their major focus, the relationship between helping practitioner and the individual in need. Theories foundational to the interactive approach were principally psychological in nature. Emphasis was on interaction and the results. This concept of interaction was emphasized by Carl Rogers' belief in a Person-to-Person Relationship for helping individuals, and Joyce Travelbee's faith in a Human-to-Human Relationship, which helped those who were suffering.

Development of the interactive process. Carl Rogers, who lived from 1902 to 1987, was the founder of person-centered therapy and was perhaps the most influential

American psychologist and psychotherapist of this century (Thorne, 1992). His work provided the basis for many interactive nursing theories (Torres, 1986). Rogers' impact was felt through his voluminous writings, the counseling and psychotherapy school he founded, and the indirect influence his work had on professional activity "where the quality of human relationships is central. Carl Rogers enabled countless people throughout the world to be themselves with confidence" (Thorne, preface).

The Person-to-Person Relationship involved growth and maturational development, demonstrated by the accomplishments of the individual (Torres, 1986). In his book, On Becoming a Person (1961), Carl Rogers' approach was described as nondirective, incorporating the counselor's understanding and acceptance of the client's private world. The relationship included emotional warmth, respect, empathy, acceptance, and safety. Rogers (1961) believed the therapist acted as a separate person, and kept his or her own interpretation of reality, which might be distorted, out of the interactive process. "The better adjusted and more competent counselor can interact with a client through many interviews without interfering with the freedom of the client to develop a personality quite separate from that of his therapist" (p. 53). The result was a greater understanding of the client. This approach freed the client to find new meaning and form new goals while they explored their life and experiences in depth. Rogers believed, philosophically, that humans were trustworthy organisms, capable of evaluating their inner and outer situations, able to make constructive choices, and act on those choices. He believed both client and counselor had much to gain by this nondirective, client-centered, interpersonal process (Rogers, 1961; Torres, 1986). Carl Rogers and Joyce Travelbee's models of the interactive process were similar.

Joyce Travelbee lived from 1926 to 1973. She was recognized as a nursing theorist, psychiatric nurse practitioner, an educator, and a writer. Development of her nursing theory was influenced by her experiences in Catholic Charity institutions and her early nursing education practice (Rangel, Hobbie, Lansinger, Magers, & McKee, 1998). In contrast with others of her time, Travelbee believed the ill individual should be involved in the planning and decision making of their own care. Travelbee (1971) described the role and function of the professional nurse practitioner as one that utilized an interpersonal process to assist individuals, families, or communities with the experience of illness and suffering. Travelbee expected the interactive process to facilitate development of coping skills and prevention of additional suffering. She also hoped it would assist individuals as they searched for meaning in their own experience of illness and suffering.

Travelbee's model of the interactive process was based on a Human-to-Human Relation between nurse and patient. She believed the model allowed patients to recognize and reach goals. Travelbee (1971) alleged several factors were essential to nursing practice: (a) a theoretical basis concerned with the nature of human beings; (b) an understanding of the meaning of illness, suffering, and health; and (c) communication skills. Travelbee (1966) believed the nurse's use of self, required: (a) insight; (b) self-understanding; (c) an understanding of human behavior; and (d) an ability to intervene effectively. Intuition played an important role in nursing practice, but the "Use of intuition or hit-or-miss methods of care are inappropriate. Compassion and empathy are appropriate emotions when the nurse also has insight" (Torres, 1986, p. 192).

Recent study results related to caring behaviors in nurses “support the NP’s emphasis on the interpersonal principles of the advanced practice nursing model” (Brunton and Beaman, 2000, p. 454). Through empathy and support the nurse helped the patient and family find meaning in their suffering and consequently hope (Urquhart, 1999). Nurse practitioners caring for patients and families facing end-of-life issues provided effective palliative care by using an interactive model.

Rogers’ Person-to-Person Model. Carl Rogers listed three core conditions necessary for his theory: (1) First there was congruence or genuineness which meant the therapist “is what he *is*, when in the relationship with his client he is genuine and without ‘front’ or facade” (Rogers, 1961, p. 61). He must be “without any attempt to assume or hide behind a professional role” (Thorne, 1992, p. 37). (2) The second condition was acceptance, which Rogers considered, “‘unconditional positive regard’, an elaboration [that] implies a caring by the therapist which is totally uncontaminated by judgements or evaluations of the thoughts, feelings or behaviour of the client” (Thorne, 1992, pp.37-38). “It means he prizes the client in a total rather than a conditional way” (Rogers, 1961, p. 62). (3) The last of the conditions for Rogers’ theory was empathy. Of this he wrote:

It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living in his/her life, moving about in it delicately without making judgements, sensing meaning of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensings of his/her world as you look with fresh and unfrightened eyes at elements of

which the individual is fearful. It means frequently checking with him/her as to the accuracy of your sensings, and being guided by the responses you receive. You are a confident companion to the person in his/her inner world. (1980, p. 142)

Therapists who used Carl Rogers' model were able to recognize, understand, and accept the client's world, without considering their own attitudes or values (Torres, 1986). To help the client explore their personal experience, the interaction focused on the client's perception of himself and his world. The therapist maintained a high level of awareness of what was being felt at a visceral level (Thorne, 1992). According to Carl Rogers (1961), his Person-to-Person Relationship model of the interactive process required several conditions. The conditions that must exist were (a) emotional warmth, (b) respect, (c) empathy, and (d) acceptance, which lead to a place of (d) safety, where therapeutic communication began. Through practitioner's therapeutic use of empathy and support, which involved compassion and self-awareness, patients were offered strength and hope (Urquhart, 1999). Various disciplines used Rogers' model to establish and maintain therapeutic communication.

Travelbee's Human-to-Human Model. Joyce Travelbee (1966) described her model of the interactive process as a Human-to-Human Relationship. The model was based on and incorporated the following ideas. Travelbee (1966) understood that **all** human beings engaged in interpersonal process. She believed nursing involved a disciplined intellectual approach and therapeutic use of self, to assist human being as they experienced illness and suffering. Travelbee used her model to reach a goal of rapport. Here therapeutic communication began between the therapist and the client. The interactive process was

interpersonal and involved change. It empowered patients to prevent, cope with, and find meaning in their illness and suffering (Torres, 1986).

While Rogers used four conditions to reach a place of safety, where therapeutic communication could occur, Travelbee's used four interlocking phases. These phases involved: (a) an original encounter, where there was recognition of the uniqueness of the ill person; (b) emerging identities, which established a bond based on the uniqueness of the human beings; (c) empathy, that is felt on a conscious level; and (d) sympathy, a sincere desire to alleviate distress (Meleis, 1997). Travelbee's goal was to reach a place of rapport. Once rapport was achieved therapeutic communication began. Application of this process meant being involved and comprehending another's distress. It meant feeling compassion. It relieved others from feeling alone (Torres, 1986). "The major emphasis of this theory is on human relationships" (Torres, p. 195). Both Rogers and Travelbee emphasized that commitment and confirmation of professional responsibility were essential during this client-centered process.

Concept of person. Rogers described human nature, "In my experience I have discovered man to have characteristics which seem inherent in his species" (Thorne, 1992, p. 200). He described these characteristics as positive, forward moving, constructive, realistic, and trustworthy (Thorne, 1992). He preferred to address persons as individuals. He built theory on concepts and propositions that focused on individuals' characteristics and behaviors. Major concepts of his theory were; change, perception, organized whole, self-enhancement needs, conflict/tension, interaction, and symbolism.

These proposition statements characterized Rogers' view of individuals:

1. The individual's perceived world is his reality.

2. Individuals have the tendency to actualize, maintain, and enhance themselves in a changing environment.
3. An individual reacts as an organized whole to satisfy his perceived needs.
4. Individuals experience life through symbolism related to their self-concept.
5. Individuals interact with the environment with differing intensity of emotion depending on significance of the event to self-maintenance and enhancement.
6. Tension/conflict is created when a discrepancy exists between an individual's world and the symbolic world of others who are perceived as well adjusted (Torres, 1986, p. 168).

The client's perception of his world was the focus of interaction during therapy. To better understand the client the therapist separated himself from his personal world. Rogers believed individuals had a basic human need for positive regard. Thorne (1992) presented this as being "universal in human beings and to be pervasive and persistent, has been poorly met in many person's who present themselves for therapy" (p. 37). Rogers (1961) determined that individuals who were treated with positive regard learned to accept themselves and were "ready to move forward in the process of becoming" (p. 63).

Joyce Travelbee (1966) described each human being as a "unique thinking, biologic, and social organism, an irreplaceable individual who is unlike any other person" (p. 26). She thought individuals were influenced by their world, but she also believed they made progressive changes and positive choices.

Travelbee (1966) developed her theory to guide nurses caring for individuals, families, and communities. Her goal was effective treatment of illness and promotion of health.

These statements from Torres (1986) described Travelbee's philosophical assumptions and characterized her view of persons as human beings:

1. Human beings are irreplaceable and unique.
2. As biological organisms, they are affected, influenced, and changed by heredity, environment, culture, and life experiences.
3. Individuals can go beyond the material aspects of their world, which is both limited and unlimited.
4. Human beings experience conflict and make choices.
5. Human beings are capable of rational, logical thinking, and maturity.
6. Individuals possess an elusive sense of aloneness, but they also possess an ability to feel understood.
7. As social beings, they can know, love, and respond to others uniqueness.
8. Human beings strive to rise above their limitations and above such human conditions as loneliness, restlessness, and dissatisfaction.
9. Human beings recognize that they will die, and death remains abstract.
10. Humans have the capacity to evolve and change over time (p.190).

Travelbee believed that to understand human beings one must search out their uniqueness (Doona, 1979). Previous choices, environment, their relationships with others, as well as their own understanding of death affected human beings. "It is only when the stereotypes of nurse and patient are dissolved that professional nursing care can be provided" (Doona, p. 149). Each person perceived the other as a unique human being, before a relationship was established and maintained.

Interaction theorists have similar beliefs about the concept of person. Individual people affect their own destiny. As they live, individuals naturally search for meaning in their experiences. Each person is an individual with personal needs. Individuals are interacting beings, able to validate one another's needs (Meleis, 1997).

Concept of environment. Interaction theorists believe environment affects individuals. Incomplete development, temporary or permanent disability, or restrictions in environment create unmet needs. Unmet needs also result from an adverse reaction to an inadequate environment. The therapists, through quality of presence, attempt to assist the client accept their humanness and find meaning in their experience (Rogers, 1961; Travelbee, 1971; Thorne, 1992).

According to Carl Rogers (1961) the environment affects individuals physically and emotionally. This is the client's perceived reality. Rogers believed individuals could adapt, maintain, and enrich themselves "in a changing environment [and that] individuals interact with the environment with differing intensity of emotion" (Torres, 1986, p.168). The intensity is regulated by the significance of the event to self-maintenance and life enhancement. Carl Rogers focused his work on creating an environment where therapeutic communication was achieved through a therapist's use of self.

Doona (1979) published Joyce Travelbee's theory as a guideline for interventions in psychiatric nursing. "Beyond this publication, no published evidence was found that directly develops, implements or refines Travelbee's ideas" (Meleis, 1997, p. 368). Joyce Travelbee's time for further development of her theoretical model was limited. She died in 1973, before she was 50 years old. Meleis shared that Travelbee did not develop a conceptual definition for the domain of environment. Torres (1986) noted "that the

concept of the *environment* is very limited and relates mostly to the hospital, where the ill individual is found" (p. 190).

Regardless, Joyce Travelbee's theory has potential for use in practice and need not be in a particular environment. Alleviating suffering, redefining the situation, and finding meaning in the experience, results in improved self-esteem, better problem solving, and a more supportive environment (Travelbee, 1971). Individuals discover "that a new system is providing them with greater autonomy and more challenging roles" (Meleis, 1997, p.368). Travelbee believed her patients were in an environment of suffering. Urquhart's (1999) discussion of suffering contained this quote by Frankl "Man is not destroyed by suffering, he is destroyed by suffering without meaning" (p. 39). Travelbee fostered an environment which helped human beings find meaning in their suffering, "meanings that are of particular importance to them" (Meleis, p. 361). Travelbee theorized this occurred in an environment that established a therapeutic relationship using the interactive process.

Concept of health. With interaction theories "concepts of the *environment* and *health* and their meanings to interpersonal process are limited" (Torres, 1986, p. 204). The focus is on human characteristics and the role of the therapist. The orientation is illness and disease (Meleis, 1997). The person either has a need or is in distress. The purpose of the interactive relationship is to prevent or deal with this need or distress.

Carl Rogers (1980) had a nondirective approach to helping individuals with some sort of psychological tension. Illness was described as a tension or conflict that occurred when there was a "discrepancy between an individual's world and the symbolic world of others who are perceived as well adjusted" (Torres, 1986, p. 168). Rogers viewed the therapeutic relationship as a process that allowed a problem to be adequately dealt with.

In contrast, Travelbee (1966) defined health using the World Health Organization (WHO) definition: "Health is a state of complete physical, mental, and social well-being [sic] and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political, economic, or social condition" (p.7).

Rogers' (1980) goal was health for the individual, which he viewed as changed behavior and improved adjustment. Rogers described success with his approach as decreased psychological tension, increased tolerance for frustration, and client behavior that moved from relatively immature to mature in nature. Clients had increased awareness of their behaviors and were less defensive. They discussed plans and behavioral steps needed to reach identified outcomes. Clients treated by Rogers' method, demonstrated improvement in life tasks, such as job performance (Torres, 1986)

Travelbee (1966) understood and treated psychological illness, as Rogers did, through communication. Her theory, which addressed interaction as a major concept in nursing, was limited to interaction involving illness, specifically suffering and pain. Travelbee (1966) developed assumptions about illness, which she believed must be viewed from the personal perspective of the individual. She also believed environment, choices, relationships, and their own understanding of death affected individuals.

Travelbee's (1971) health assumptions were; (a) during illness one rearranged one's priorities, (b) illness reminded one of how frail human beings actually were, and (c) to be ill was to be lonely and realize how minimally others grasped the meaning of illness. She established that fear of the known and unknown, was profound in terms of one's ability to cope during illness. She recognized that illness created worries about economics,

dependents, ability to adapt, pain, and fatigue. Illness also increased a sense of loneliness and helplessness, and a fear of death. Torres (1986) shared that Travelbee acknowledged the physical realm of illness. Illness changed one's ability to sleep and handle frustration created by pain. Illness also altered the ability to manage small events.

Suffering, related to and experienced during illness, involved discomfort and anguish. Travelbee (1972) understood suffering was associated with feelings of intense physical and emotional pain. It included a long wait in the hospital for someone to visit. Suffering involved learning a loved one had a fatal illness and knowing there was no one to talk to. Suffering also involved feelings of overwhelming stress or tiredness.

Travelbee (1966) believed there was a degree effect with suffering. She proposed that the more a person cared and was attached to an object, "the more the person suffers when that object or person is lost" (p. 72). Travelbee understood that illness and suffering were encountered physically by human beings. She thought they were encountered emotionally and spiritually as well. She believed communication was the way a nurse-patient relationship was established that aided those who were suffering.

Travelbee believed, as Rogers did, that illness was an individual experience, understood only through the patient's perception. Through a therapeutic relationship, healing and self-actualization occurred as individuals "found meaning in illness, suffering, and pain experiences" (Meleis, 1997, p. 363). Travelbee (1971) believed the nurse's use of self was the intervention that assisted the patient deal, on all levels, with illness. Travelbee defined health as subjective, as defined by the person, but also "involving the absence of disease or disability as assessed by a spiritual director or psychological counselor" (Torres, 1986, p. 191). Travelbee and Rogers addressed the

patient's psychiatric health, but as a nurse Travelbee differed. She also supported the value of physical health promotion and disability prevention.

Concept of nursing. Carl Rogers, although not a nurse but a therapist, provided a framework used by nursing theorists. Much nursing research is psychological in nature. "Nursing theories are supportive of Carl Rogers' nondirective approach to helping individuals with some sort of psychological tension" (Torres, 1986, p. 204). The focus of interactive theories is the dignity of human beings, humanity, uniqueness, autonomy, and accepting the values of others (Meleis, 1997). Those who use interactive processes for therapeutic communication were essentially counseling and nursing the individual.

Carl Rogers believed what mattered to any individual was not some concept of objective reality, but "the way in which a given person perceives reality" (Thorne, 1992, p. 24). Rogers (1980) thought to understand another person or his behavior, one must understand the person's perception or awareness of himself and his world. With this approach "a person's subjective experience is worthy of the deepest respect even if to others it may appear bizarre or misguided" (Thorne, p. 24). The foundation of the therapist's role is also their purpose, aid clients to explore and discover their inner resources: "not to impose, however gently, external solutions, strategies, interpretations or explanations" (Thorne, p. 25). The therapist has the capacity to grasp and maintain an awareness of the client's reality, at the present moment, in order to remain therapeutic.

Joyce Travelbee (1966) described her view of nursing as "An interpersonal process whereby the professional nurse practitioner assists an individual or family to prevent or cope with the experience of illness and suffering" (p. 5). The focus of her nursing was on interpersonal relationships. Her goal was, to find meaning in the suffering experience

while coping with the illness situation. For those who found meaning in suffering, the experience promoted growth and increased individual potential.

Travelbee described ““Lack of support in the nurse-patient relationship”” (Meleis, 1997, p. 191) as a nursing problem faced by interaction theorists. Nurses of Travelbee’s time began the movement whereby the patient became a partner in the nursing process. During the interactive theorist’s assessment, the patient’s perceptions and his or her individuality, were respected and perceived as important to the future of their care.

Travelbee (1966) believed the nurse patient relationship was essential to the purpose of nursing. She also felt that “communication is the process that can enable the nurse to establish a nurse-patient relationship” (p. 94). Communication provided the patient with the ability to interact and heal. Travelbee also understood that nurses were human beings that needed to self-reflect and review their own values. Nurses who recognize this function as a “human being who cares, gives care, establishes connections, and helps patients relieve their distress” (Meleis, 1997, p. 192). Therapeutic interaction with the patient and family involve caring which is a “combination of what the nurse does and what the nurse is like as a person” (Bruton and Beaman, 2000, p. 452). Nurses who practiced the interactive process in Travelbee’s time “reintroduced the significance of the nurses’ intuition and subjectivity in the nursing act” (Meleis, p. 192). These theorists provided nursing with a new perspective:

1. There is a reciprocal assessment process.
2. Patient perspective is significant in health care.
3. Situation determines need and care.
4. Patients are helpless and suffer due to illness (Meleis, 1997, pp. 192-3).

The interaction theorists identified central concepts that remain significant components of interaction in nursing today. These components consist of; sensing, perceiving, validating, being aware of existential transactions, as well as promoting goal oriented interaction, and the self-development of nurses (Meleis, 1997).

Carl Rogers' described the counselor's role; through empathic understanding the counselor assumes the client's internal frame of reference. "Behavior must be understood from the internal frame of reference of the individual himself" (Torres, 1986, p. 203). Joyce Travelbee described the nurse's role as a disciplined intellectual approach where one "uses the self therapeutically in relation to illness and suffering and their meaning to the patient" (Torres, p. 203). Rogers and Travelbee emphasized the patient or client's viewpoint must be the first consideration when using the interactive process.

Assumptions of interaction theories. Joyce Travelbee and Carl Rogers had similar beliefs about the meaning of the interactive process. It involved a nondirective approach to helping individuals who experienced psychological tension (Torres, 1986). According to Torres four common assumptions were drawn from the interaction theories:

1. Client therapist relationship significantly impacts the client's ability to cope.

Travelbee tried to assist human beings cope with illness; to learn, find meaning, and grow from the experience (Meleis, 1997). Individuals faced with life-limiting illness and grief benefit from a therapeutic relationship developed through an interactive process. Carl Rogers' (1961) interactive process was based on insightful experience with human beings. Individuals develop trustworthiness once they felt their personal experience was respected and understood. Once a client believed the therapist understood his world, "then almost invariably the client would begin to behave in ways which were positive and

forward moving” (Thorne, 1992, p.26). Vulnerable clients who suffer the ravages of grief need a trusting relationship where their deepest feelings can be exposed.

2. The individual’s internal frame of reference is the focus of both verbal and nonverbal communication. Travelbee (1971) described communication as a process that enabled the nurse to establish a nurse-patient relationship. Assessment with Travelbee’s model emphasized that systematic observations should be validated with the ill individual. The nurse viewed the individual as a unique person (Torres, 1986). Travelbee stressed that the nurse must focus on the patient’s perception and avoid “‘using oneself as a yardstick’ by which to evaluate others” (Meleis, 1997, p. 362). Carl Rogers (1961) said the therapist remained a distinct person. He separated his understanding of reality, which might have been different than the client’s, from the interactive process. This resulted in a greater understanding of the client. Rogers (1961) believed that during the counseling session the conversation and thought followed that of the client. Every detail, even the counselor’s tone of voice, conveys a complete ability to share the client’s feelings. This facilitates human development (Rogers, 1980).

3. Therapists act as facilitators of human development. Travelbee (1971) believed rapport established in a nurse-patient relationship, and meaning found in suffering lead to development of hope in the patient. Change occurs while nursing assists individuals, families, and the community. The change entails disability prevention and health promotion (Torres, 1986). Carl Rogers’ (1961) stressed that client-centered therapy, involved success for the individual. He believed the therapist helps the individual reach his potential as a human being. The goal is progress, which involves improved adjustment by the client to the world he lives in.

4. In dealing with individuals in an interactive way, concepts such as self-awareness and tension, although abstract, are useful as a focus. Travelbee (1966) described nurse's therapeutic use of self as action, which requires self-understanding and insight. The nurse intervenes effectively and understands human behavior. Travelbee (1966) believed reliance solely on intuition or random methods of care was inappropriate. Compassion and empathy were fitting emotions when used with insight. She also alleged that nurses have an ability "to empathize with patients who are similar to themselves" (p. 142). Carl Rogers (1961) suggested congruence or genuineness was the most fundamental attitude that promoted therapeutic growth. The effective therapist "when in the relationship with his client he is genuine and without 'front' or facade" (Rogers, 1961, p. 61). There was never "any attempt to assume or hide behind a professional role" (Thorne, 1992, p. 37). Rogers (1961) knew the client presented to the therapist when he had reached a high level of inner tension and needed assistance. His research proposed that, when a client received benefits from the interactive process "tension of all types is reduced – physiological tension, psychological discomfort, anxiety" (Rogers, 1961, p. 65). Decreased tension is evidenced in communication (Torres, 1986). Therapists who preserve a high level of self-awareness provide clients with empathy and compassion, and reduce inner tension.

Use of the interactive process. Carl Rogers (1961) identified characteristics of an ideal client-counselor relationship. The most important was the therapist's ability to participate completely in the patient's communication. Joyce Travelbee (1966) also based her model of the interactive process on this premise. Torres (1986) discussed and compared their descriptions of the interactive process. The characteristics that Rogers (1961) identified, the steps of the interactive process that Travelbee (1966) explained, and the interactive

process as practiced during this study were compared in Table 1. An interactive approach was used to facilitate communication during interaction and interviewing of participants.

What Rogers (1961) discovered in early years of clinical practice was, when he pledged himself to understanding his client's subjective world, and the client perceived this, the client behaved in positive ways. He found that when individuals believed their experience was respected and understood, they became increasingly trustworthy. Rogers believed that being genuine was fundamental to the promotion of therapeutic growth. To describe this condition of genuineness, Rogers (1961) "coined the term 'congruence'. By this we mean that the feelings the therapist is experiencing are available to him, available to his awareness, and he is able to live these feelings, be them, and is able to communicate them" (p.61). Congruence, as a characteristic of an effective therapist, was an accurate match of experience, awareness, and communication (Rogers, 1961).

Table 1

Comparison of Interactive ApproachesRogers' Characteristics of an Ideal Client-Counselor Relationship

1. The counselor reinforces the client's perception of reality in such a way that the client acknowledges accuracy of the comments.
2. The client is a co-worker on a common problem. The client is respected as part of the therapeutic process, not merely as receiver of the counselor's input.
3. The counselor treats the client as equal. This facilitates understanding and enhances communication.
4. The client's feelings are understood. The entire focus is on the client's feelings, which the counselor accepts as his perception.
5. The line of thought is the client's. Again the emphasis is completely client centered.
6. Tone of voice conveys an ability to share feelings. This facilitates a nonjudgmental attitude about what the client says and feels. (Rogers, 1961; Travelbee, 1966; Torres, 1986).

Travelbee's Explanation of the Interactive Process Steps

1. Development of initial judgements. Therapeutic use of self and an awareness of the client's reality begins the process.
2. Ability to appreciate the other's uniqueness. Individuals play a respected role as they discover one another.
3. Shared psychological state. The client is as crucial as the therapist is. They can empathize with each other.
4. Desire to alleviate distress. The client's description of his situation is accepted as reality and sympathized with.
5. Individuals perceive and behave toward each other in a positive manner. The client feels a sense of being in a safe, comfortable place.
6. Therapeutic interaction contributes to development of the relationship. The client is able to communicate. (Rogers, 1961; Travelbee, 1966; Torres, 1986).

The Interactive Process Practiced During McHale Research Study

1. Introduction and explanation of study. The study procedure and purpose were explained allowing the investigator to sense the participant's reality.
2. Receiving participation agreement. Voluntary participation facilitated participant's involvement and ownership of the process.
3. Completion of the Pre-Interview Questions. The investigator treated the participant as equally important to the process while remaining sensitive but available to assist.
4. Self-Assessment: The 10-Mile Mourning Bridge. The investigator treated the participant's recollection and examination of their grief journey with quiet respect and understanding.
5. Feeling a sense of comfort. The investigator allowed the participant the time they desired to review feelings related to their bereavement journey.
6. Discussion and sharing personal experience. The investigator's therapeutic use of self, open ended questions, and normalization of emotional feelings, allowed the participant a safe place to share their inner most thoughts.

Death and Loss

Saunders (1981) stated “The death of a loved one has been recognized universally as unequalled in its capacity to give rise to personal pain and suffering” (p. 319). Although death was described as a stressful event, two of its characteristics converted the event to a crisis situation. First, the loss was so final; the human being was lost forever. They could not be replaced; one could only adjust to the loss. Additionally, death did not happen often. An individual had little experience and was forced to create new personal solutions to deal with the death (Goldberg, 1973).

Professionals in the field of psychiatry studied death and grief for many years. Classic works continued to be studied and referred to, while new theories were investigated and developed. Doctor Erich Lindemann’s work on grief was published in 1944 and republished in 1994. He reflected that as long ago as 1917, Freud described feelings and behaviors associated with grief in his Mourning and Melancholia. Lindemann, as Instructor of Psychiatry, at Harvard Medical School, coined the term anticipatory grief in his 1944 presentation, “Symptomatology and Management of Acute Grief.”

Lindemann (1944/1994) described physical symptoms often experienced by those who suffered from grief. Individuals were overcome by waves of distress lasting up to an hour. They experienced difficulty with swallowing or breathing, a feeling of emptiness in their abdomen, or weakness in their muscles. Some grieving individuals encountered a distress they described as tension. Others reported a slight sense of unreality, a feeling of increased emotional distance from other people (they appear shadowy or small). Many experienced an intense preoccupation with the image of the deceased. Blank (1969) also described physical symptoms experienced after the loss of a loved one. He considered

this initial response a normal manifestation of the grief reaction. They felt depression “characterized by dejection, tearfulness, restlessness or retardation, insomnia, and the expression of feelings of hopelessness, helplessness, emptiness and guilt” (Blank, p. 204).

Even after the initial grief reaction, bereaved individuals continued to feel tearful, empty, or upset. How did one move beyond this great burden and pain? Traditionally, psychiatrists helped individuals who struggled to recovery from grief, but not all psychiatrists specialized in grief work. Although it has been over 50 years since Lindemann developed the concept of anticipatory grief, the focus today continues to be assistance after the death event. In this society that strives to escape pain, the discussion of death is avoided. Not only is the discussion of impending death avoided, but also they are not comfortable talking about death, after it happens, either. Individuals in mourning share that they felt abandoned, even by friends and family. Much of the support they do receive is “superficial and full of platitudes, and without any real comprehension of what is needed for successful coping” (Silverman, 1974, p. 320).

Norris and Murrell (1987) disclosed, “Our findings strongly suggest that the adaptational requirements of bereavement begin well before the death event” (p. 611). Huber and Gibson (1990) agreed and explained that at the first sign of any physical, psychological, or spiritual effect from the impending death, grief work should have begun. Individuals who expressed feelings of loss before an expected death, gradually absorbed the reality of the loss over time, finished unfinished business, and began to change their assumptions about life and their own identity. Huber and Gibson’s study suggested grief experienced prior to death accelerated the recovery. Their study further supported Lindemann’s (1944/1994) idea of the importance of anticipatory grief work.

Funeral directors often described the spouse and family of a deceased hospice patient as “having it all together” during the funeral preparation and services. These individuals were able to focus on tasks, however difficult, and make sound decisions without the influence of unreliable emotions. They were prepared for these events, which surround death, by thoughtful guided discussion, in anticipation of the coming loss. Hospice has helped millions of patients and families experience a dignified death for over 20 years (National, 1999b). Although these families undoubtedly suffered from the loss of their loved one, they were better prepared to face the stark reality.

It is difficult to make a distinction between the terms grief and bereavement. Saunders (1981) described grief as a psychological process, which included emotions and memories experienced in response to a loss. This process included the bereaved’s affect and surrounding intrapsychic dynamics. Saunders described bereavement as “the broad, umbrella term that cushioned and gave context to mourning and grief” (p. 319).

Youll and Wilson (1996) referred to grief as an individual response. It could be a reaction to losing a person, an object, or any highly valued concept. Valente and McIntyre (1996) described bereavement as simply the experience that followed the death of a loved one. Based on these definitions it is safe to say that grief is the lived experience while bereavement is the personal journey. Although grief and bereavement were defined separately in this study, they often appeared together in literature where authors used them interchangeably. An author’s description could differ from the study definition, but material was presented as it appeared, without attempts at clarification.

Grief. Grief is a powerful emotional condition. It affects every part of your life. “It can make a stone of your heart” (Youll & Wilson, 1996, p. 40). Grief can destroy you

physically and mentally. A normal grief reaction includes crying, or feeling empty, or having a preoccupation with the deceased. Grief frequently involves social withdrawal (Stoudemire & Blazer, 1985). Dramatic words used to describe grief, such as “‘loss’ and ‘blow’ had real physical connotations” (Hasler, 1996, p. 52). Just as physical wounds need to heal, so does grief. Any complicated healing delays restoration of the body. Delayed healing causes further injury and reopening of the original wound. Complete healing results in new vigor and wisdom, a desired outcome for grief. McKissock and McKissock (1996) contend “There is no shortcut to the resolution of grief. People learn to live around the painful memories rather than eliminate them” (p. 31).

Most individuals experienced grief during their lifetime. Does this make grief a normal part of being human that does not require specialized attention? It is essential that those who worked in the psychosocial and spiritual realms of grief understand what Kleyman (1996) alleged. He believed that grief was not a disease but an emotion. Grief was as natural a reaction as eating when hungry, drinking when thirsty, or sleeping when tired. “Grief is nature’s way of healing a broken heart. Grief is love not wanting to let go” (p.8). Jacob (1996) acknowledged that other authors considered grief a normal experience, “Recent conceptualizations of grief reflect the tendency to view grief as a normal, dynamic, pervasive, individualized experience” (p. 280). In contrast, Engel’s (1961) classic work reflected otherwise:

Grief is the characteristic response to the loss of a valued object. Certainly it involves suffering and an impairment of the capacity to function, which may last for days, weeks, and even months. We can identify a consistent etiologic factor, namely, real, threatened, or even fantasized object loss. It fulfills all the criteria of a discrete

syndrome, with relatively predictable symptomatology and course. The grieving person is often manifestly distressed and disabled to a degree quite evident to an observer. The skeptic quickly raises some pointed questions: *Is not grief a natural reaction to a life experience? How can one put it into the same category as the pathological states we call disease?* To this we answer that it is 'natural' or 'normal' in the same sense that a wound or a burn are the natural or normal responses to physical trauma. The designation 'pathological' refers to the changed state and not to the fact of the response. Or it may be said: *Everyone experiences grief - it's part of life.* But that only emphasizes the ubiquity in life of the significant etiologic factor and the universal vulnerability of human beings to this particular stressful experience. The same may be said of other disease states to which man is prone – measles, for example. Actually, the statement is not entirely correct. With a short life or under exceptionally favorable circumstances, one may escape both measles and grief.

(pp. 18-19)

Death takes away. It takes away loved ones and causes the terrible pain called grief. But grief also has the ability to give back. The pain experienced does not just erode the grieving individual. Through the pain of grief one becomes strong, more able to help others, more able to help themselves. "Grief is powerful alchemy. It plunges us into sorrow and forces us to face the finiteness of life, the mightiness of death, and the meaning of our existence on this earth" (Quigley & Schatz, 1999, p. 78).

Avoidance. We are uncomfortable with the prospect of death. Findings from a study of over 9,000 patients in 1995 stunned and shocked researchers. Researchers uncovered a "pattern of depersonalized care near the end of life and poor communication among

patients, families, and doctors (Harper, 2000, p. 23). The Robert Wood Johnson Foundation funded the study, which shed light on the problem, hence “the term *end-of-life issues* came into full vogue” (Harper, p. 23). These results were serious for healthcare professionals and facilities that provided end-of-life care. Care as well as communication related to the dying trajectory was reevaluated to identify inadequacies for patients, families, healthcare professionals, and the community.

Bereaved try to avoid uncomfortable feelings associated with the emotional expression of grief. According to Lindemann (1944/1994), people learn that, visits from family and friends, mention of the deceased, and receipt of sympathy precipitates waves of discomfort. “There is a tendency to avoid the syndrome at any cost, to keep deliberately from thought all references to the deceased” (pp. 155-156). This explains some of the isolation preferred by many bereaved individuals.

A chance meeting with the spouse of a former, but deceased patient, generated conversation but, it took a statement such as; “I bet you really miss Jim now that the kids have gone back to college.” to produce any meaningful conversation. Talking and crying in public were uncomfortable, but the bereaved departed enriched by the interaction. Experience demonstrated that it was healthier to express grief through talking and tears, than it was to suppress the pain. Sharing “facilitates the mastery of these feelings” (Blank, 1969, p. 204). Bereaved individuals only complete their grief work by traveling through the pain. “Anything that continually allows the person to avoid or suppress the pain can be expected to prolong the course of mourning. [One must] allow bereaved people to experience the full, unmitigated grief of the loss; anything that detracts from this will have to be dealt with later” (Hasler, 1996, p. 53).

Illness. Professionals involved in grief work recognized a relationship between suffering a loss and subsequent illness. The bereaved suffered an exacerbation of symptoms from a chronic illness or they developed an entirely new disease. Increased incidence of mental illness from unfinished grief was reported in research studies. Valente and McIntyre (1996) believed that as many as "10 percent to 15 percent of those who seek treatment at mental health clinics have underlying unresolved grief" (p.11). Fenner and Manchershaw (1993) described a clinic in London where a nurse practitioner recognized that a number of clients, bereaved for one to two years, lingered after visits and regularly seemed to want to talk about their loss. These same patients frequently presented with a series of minor physical ailments. Parkes (1988) reported that patients "showed a significant depression of lymphocyte (T-cell) function during the early weeks after bereavement" (p. 367). Norris and Murrell (1987) also reported about the physical effects of grief, "grief following the loss alters immunologic effectiveness and leaves the bereaved less resistant to infection and pathological organisms" (p. 606).

A known case involved a 74-year-old gentleman who lost his wife of 39 years to ovarian cancer. Although he had 10 children who loved and supported him, he was unable to talk about his wife's death. For several weeks he was not even able to say her name. A month later he shared "I dream about her but I don't see her face." He was distraught but unable to share his pain. He described flu-like symptoms, was taken to his physician, and was diagnosed with Guillain-Barré syndrome. He avoided his painful grief, but Guillain-Barré, an autoimmune disease, caused numbness and instability in his legs and feet. He continued to suffer the effects until his death, 13 years later.

Just the knowledge of the death did not seem helpful to some individuals. They “detach themselves from the experience, or their loved one, to try and avoid the pain of loss and grief” (Wheeler, 1996, p. 26). These individuals, seen later by physicians, had physical symptoms resulting from failure to work through their grief and guilt. “If they had been helped before the death of their partner to bridge the gulf between themselves and the dying one, half the battle would have been won” (Kübler-Ross, 1969, p. 162).

Individuals may feel uncomfortable and at a loss for ways to help their loved one who is dying. Practitioners assist these family members by their relaxed caring example. Small tasks such as wiping the patient’s perspiring brow, offering ice chips, holding the patient’s hand, reading out loud, or just being there to listen, offer family members a chance for communication and connection with their loved one.

Assistance. Understandably, individuals need help during this difficult time. Even those who deal with death on a regular basis are not prepared to meet the needs of the grieving. But with inappropriate or no help these individuals “may spend long, agonizing months working through their pain and suffering alone” (Greifzu, 1996, p. 22). It is imperative that professionals involved in the care of patients and families observe family interaction, especially the type of support the caregiver receives from other family members. This may be a predictor of the support they will need after the death. While studying Australian widows, Parkes (1988) found, “the strongest single predictor of a poor health outcome was the bereaved person’s perception of his family as unhelpful or lacking in understanding. Also interesting is Raphael’s finding that this is also the group who benefit most from counseling” (p. 370).

While some individuals ask for assistance with grief, others do not. Requesting assistance can not be trusted as an indicator of who truly needs it. "Duke found that 'shyness to ask for help' predicts poor outcome, and this suggests that those who do ask for help may have less need of it than those who are too frightened or depressed to ask" (Parkes, 1988, p. 371). According to Lloyd-Richards and Rees (1996), individuals who possess knowledge and understanding of the grief process, should begin working with the bereaved as soon as imminent death is known, "the sooner that bereavement is initiated the easier the process will be to manage" (p. 109). Therapeutic communication helps individuals. They become comfortable with expressing feelings, which facilitates healing.

Programs that contact bereaved individuals, either in person or by telephone, periodically after the death of a loved one, have the best chance of identifying and helping those in need. Bereavement contact often produced a spouse who cried as they verbally reviewed events surrounding the death. Despite this expression of sadness it was not unusual for the bereaved to share "I'm so glad you called, I feel so much better".

Bereavement. Parkes (1988) reviewed a great deal of bereavement research. Among those reviewed was a survey of research that contained over four hundred published works done by Raphael in 1983. As a result of this review Parkes recognized the "Results suggest that we cannot over-simplify the problem of bereavement" (p. 365). Individuals who suffered in bereavement were often regarded as being ill. Somatic symptoms were a part of normal grieving. The bereaved also suffered from loss of sleep and appetite. Bereavement transition required that individuals relinquish "many of their old assumptions, and then construct a whole new set of assumptions which will enable them to cope with their changed world without their loved one" (Huber & Gibson, 1990, p.52).

According to Valente and McIntyre (1996) the bereavement process is dynamic, but normal. Individuals, families, generations, and cultures have their own “unique style of grieving. Grief does not occur in a rigid, linear, or uniform pattern. Symptoms of grief wax and wane over time” (p. 10). Personalities, diverse relationships, and individual circumstances, affect how humans cope with the death of a loved one (Doka, 2000b).

When an individual suffers the loss of someone close, they feel and accept the pain experience. “Comfort alone does not provide adequate assistance in the patient’s grief work. He will have to express his sorrow and sense of loss” (Lindemann, 1944/1994, p. 159). Supportive environment guides bereaved individuals to complete the two major tasks of grief. Rognlie (1989) described these tasks as, accepted the death as real and cope with problems, both emotional and social, which are created by the loss. According to Wheeler (1996) the bereaved are assisted with grief by frank communication. “When discussing the loved one with family members, use words like ‘dying,’ ‘dead,’ and ‘died’ rather than ‘lost’ or ‘gone’ to help them accept reality” (p. 29). These terms are also helpful when they are used openly in the healthcare community. Hearing the terms used makes it easier for others do the same. Anticipating the loss prepares loved ones, but the reality of the actual death usually remains a shock.

Mourning. Openness and flexibility related to the duration of mourning permits bereaved individuals more time to adjust to their loss. Appropriate time for grieving may be influenced by an individual’s culture. The amount of time tolerated for readjustment to a loss is often related to the “value we place on the lost object, person, or function, and this may differ widely from the value the bereaved attaches to that which is lost” (Speck, 1978, p. 146). The length of time spent in mourning appears to depend upon successful

“*grief work*, namely, emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and formation of new relationships” (Lindemann, 1944/1994, p. 156).

Length and intensity of a grief response depends on diverse dynamics including age, religion, coping capability, availability of support systems, and how the individual “perceives the loss and changes in his life” (Wheeler, 1996, p.26). Blank (1969) said to “avoid blundering in giving advice to the bereaved, or avoid making unrealistic demands on him, it would be safe to assume one year to be the minimum duration of mourning,” (p. 204) with one to two years quite typical. Some psychologists and sociologists believe it takes years to work through a loss as great as that of a spouse. The bereaved continue to experience low spots as long as several years after the loss (Doka, 2000a).

Survivors take on characteristics of their deceased loved one. They develop symptoms similar to those suffered by the deceased. They experience feelings of remorse or guilt about their relationship. They can feel angry with God, physicians, or even the deceased (for leaving them behind). Usually symptoms begin to diminish after one year of mourning. The lost loved one “is psychologically relinquished, and new adaptations are made. Symptoms may recur on significant anniversaries, such as birthdays, holidays, or date of death” (Stoudemire & Blazer, 1985, p. 574). In a supportive, permissive, healing, environment, the bereaved recovers outwardly in as short as one to two years. “Inwardly, the process often takes much longer and it may be around two to five years before the bereaved person experiences life with something like the sense of meaning and purpose that existed before the death” (McKissock & McKissock, 1996, p. 30).

Practitioners, who are aware of unrealistic expectations for bereaved individuals, to

get over it and get on with their lives, offer help. When the patient and family are prepared for death, the bereavement process is discussed. If this was not possible, shortly after death a statement is offered. It helped the bereaved and family to hear, "It's not unusual for a year or more to pass before you feel healing from a loss such as yours."

Grief stages. Elisabeth Kübler-Ross (1969), pioneer in the field of death and dying in the United States, developed her own model of the grieving process, which remains foundational today. Kübler-Ross's stages of grief were (a) denial (isolation), (b) anger, (c) bargaining, (d) depression, and (e) acceptance (Hasler, 1996). Robinson and Pickett (1996) described Parkes' definition of the grief process as "characterized by four phases: (1) numbness, (2) yearning and protest, (3) disorganization, and (4) recovery" (p. 4).

Stage theories enhance the understanding of bereavement (Huber & Gibson, 1990; Lloyd-Richards & Rees, 1996). Bereaved individuals gain control over their grief if they complete several steps. They have to (a) accept the reality of death, (b) experience the pain of grief, (c) change their environment and adjust to the missing deceased, and (d) reinvest their emotional energy into living their life and planning their future.

Engel (1961) alleged grief followed a predictable pattern of three phases until resolution occurred. Uncomplicated grief runs a consistent course:

1. An initial phase consists of shock, disbelief, and developing awareness. The individual tries to insulate themselves by denying the loss.
2. During the second phase the painful effects of sadness, guilt, shame, helplessness, or hopelessness mark an awareness of the loss. The bereaved experiences crying, emptiness, insomnia, unexplained discomfort, lost interest in activities, and impaired work performance.

3. Finally, there is a prolonged phase of restitution and recovery where mourning is accomplished. Individuals return to health as they overcome the trauma of loss.

Unlike some previous findings, recent research suggests that the first task is to accept the reality of the death. Worchel and Shebilske (1992) cite Huber and Gibson (1990) when they explained, "this task can be facilitated by working in advance with spouses of terminally ill patients" (p. 375).

Professionals involved in grief work are familiar with the stages and tasks necessary to process grief and complete the bereavement journey. Clinicians should be flexible in their approach. A grieving individual might move between stages "he or she can also experience what seem on the surface to be conflicting emotions" (Hasler, 1996, p. 52). As with other stage theories, although individuals do not have to process these in order, what is essential is that they complete each one.

Friends and family members of dying or bereaved individuals often ask about the stages of death and dying. It is more important for them to support the individual where they are in the process, than it is to identify what stage they are in. Friends and family often need as much assistance and support as the bereaved individual does.

Anticipatory grief. When a loved one is lost, an expected period of grief follows. In contrast, anticipatory grief is experienced before the actual loss occurs. Families of patients with a life-limiting illness, poor prognosis, and a predictable death, have an opportunity to grieve in anticipation of their loss. As the patient and family openly address their coming loss they begin to grieve. Feelings of "helplessness, guilt, anger, denial, fear, confusion, and rage can be as intense as the emotions a person experiences after his loved one actually dies" (Wheeler, 1996, p. 26). If the principle of anticipatory

grief is applied, preparing the person in anticipation of the loss, "then they may be enabled to meet the loss in a more constructive way" (Speck, 1978, p. 15).

This anticipatory guidance, is a preventive measure, which helps individuals while they attempt to adjust to a loss. The goal of this guidance is to help the person cope by discussing the details of the crisis before it occurs. The individual and those sharing the loss (family or healthcare professional) benefit from anticipatory guidance. This guidance facilitates early mobilization of strength, which allows the actual loss to be met more constructively. Discussing what to expect lowers anxiety so the individual is prepared with a healthy reaction to the loss. Full preparation for a coming loss can never occur, but anticipation makes the event less traumatic (Speck, 1978).

Elisabeth Kübler-Ross (1969) explained that patients who were allowed to experience anticipatory grief were helped. By facing the issues surrounding death, which others including professionals avoided, they lived more fully in the time they had left.

We have several patients who were depressed and morbidly uncommunicative until we spoke with them about the terminal stage of their illness. Their spirits were lightened, they began to eat again, and a few of them were discharged once more, much to the surprise of their families and the medical staff. I am convinced that we do more harm by avoiding the issue than by using time and timing to sit, listen, and share. If, we, as members of the helping profession, can help the patient and his family to get 'in tune' to each others needs and come to an acceptance of an unavoidable reality together, we can help to avoid much unnecessary agony and suffering on the part of the dying and even more so on the part of the family that is left behind. (p. 142)

Honest discussion about imminent death allows patients to complete unfinished business and address unresolved issues. Part of the nurse's role is to suggest that "it's never too late to bring closure to an unresolved issue" (Wheeler, 1996, p.27). In Dying Well. The Prospect for Growth at the End of Life, Ira Byock (1997) offered a formula to facilitate this closure. Byock suggested that individuals consider "'the five things of relationship completion' --- saying 'I forgive you'; 'Forgive me'; 'Thank you'; 'I love you'; and 'Goodbye'. [These give the patient] a kind of script with which to greet his final days with courage and determination" (p. 140).

One rewarding hospice case involved a couple who had been married over 50 years. For years they had coexisted but lived separately, as many couples do. She was a teacher he was a mechanic. Information indicated that the wife had lung cancer and only a short time to live. This created many problems. The husband struggled with tasks he had never done before. He was unsure in the kitchen and felt the same about laundry, shopping, and helping his wife with personal care. The family and couple had doubts about their ability to avoid nursing home care. She was very weak. He had signs of Parkinson's disease.

With assistance from the hospice staff they talked openly about the illness. They were not afraid to discuss death. With patience, minimal assistance, and gentle guidance, this couple worked out creative ways to keep the patient home for her entire illness and death. He learned to administer and record a complicated medication schedule. She learned to accept his way of making meals and his clumsy but loving personal care. This open approach to the illness and the loving care allowed the patient to live longer than anyone predicted. During a conversation toward the end of the patient's life, the couple shared that this special time together had rekindled long lost love and allowed them to know

each other in ways never before possible. They were encouraged to grieve in anticipation together. The husband was prepared. He was able to reinvest his emotional energy into his champion dogs not long after the loss of his wife. The outcome could have been very different with a more traditional, in and out of the hospital, approach to care.

Denial. Leon H. Levy (1991) described different findings about anticipatory grief. He suggested that neither knowing about a coming loss nor having an opportunity to grieve beforehand equaled anticipatory grief. "It would seem self-evident that simply having the opportunity to experience anticipatory grief does not ensure that one will. To believe otherwise would be to ignore all that we know about the operation of denial in the face of threat" (p. 4). George L. Engel (1961) discussed denial in his classic work, "Yet the human mind, that wonderful instrument of discovery, has a disconcerting capacity to use denial, to turn away from that which is not easily comprehended or which has awesome implications" (p. 22).

Levy (1991) reported that although widows of a group of cancer patients were told their husbands had a poor prognosis, only 66% reported they were told their husbands were dying. Levy suggested that an individual's usual level of emotional adjustment and ability to cope with stress influenced the outcome of anticipatory grief work. "It is important for those working with the families of dying patients to exercise caution in attempting to facilitate anticipatory grief" (p. 26).

One patient cared for by this investigator, used denial to remain in control of his short life. He was weak and each breath was a struggle. During the first home nursing visit he loudly proclaimed that he wasn't sick. He insisted on doing things without his family's help and he refused to use the much-needed oxygen. The significance of his denial and

his need for control was quietly explained to his family. After his family left the room, he was asked to wear the oxygen for a short trial period, he complied. The benefits he might feel from the oxygen were explained. It was clarified that wearing the oxygen in the future was entirely up to him. This nurse told him that he had her permission to take off the tubing, and throw it across the room, anytime he wanted to. When his family returned he loudly told them wearing oxygen was up to him and not them. This gentleman remained in denial about his illness until he died a few days later, but he also remained in control. He never removed his oxygen. Losing control can be a very frightening experience. "Loss of control results in a deep inner pain which can be linked to loss of hope" (Urquhart, 1999, p. 36). Adapting to his personal needs; to be able to deny his illness, to regain his self-esteem, and to have an internal locus of control, permitted this patient to die a comfortable dignified death, in his home.

Anticipatory grief as unhelpful. Although Erich Lindemann reported positive results from the practice of anticipatory grief, he also shared, in certain circumstances it could have a negative impact. Lindemann (1944/1994) described grief work done too effectively, by a woman worried about the potential death of her husband, away at war. "She goes through all the phases of grief - depression, heightened preoccupation with the departed, a review of all the forms of death which might befall him, and anticipation of the modes of readjustment which might be necessitated by it" (p. 160). This might have been helpful if the wife received sudden notice of her husband's death, but what of their eventual reunion? Several cases were brought to Lindemann's attention; husbands who returned from the battlefield complaining their wives no longer loved them, they demanded an immediate divorce. In these situations "apparently the grief work had been

done so effectively that the patient has emancipated herself and the readjustment must now be directed towards new interaction” (Lindemann, 1944/1994, p.160).

“Anticipatory grief, ‘cannot and does not exempt survivors from all sadness in advance, but it does provide a means of setting in motion a unique process of relinquishing a key person and then filling a void’” (Costello, 1996, p. 174). For the most part, “the principle that emerges from these studies is that before any crisis or loss occurs it helps if people can worry” (Speck, 1978, p. 20).

Palliative care. Palliative Care is the active total care provided to patients living with advanced incurable illness and their families. The focus of care shifts to quality of life and the alleviation of distressing symptoms versus aggressive bio-medical interventions. The goal of Palliative Care is neither to hasten nor postpone death. It provides relief from pain and other distressing symptoms and integrates the psychological and spiritual aspects of care. Furthermore, it offers a support system to help relatives and friends cope during the patient’s illness and bereavement.(McHale, in press)

“The World Health Organization’s definition of palliative care includes the offer of a support system to help the family cope during the patient’s illness and during the bereavement” (Bromberg & Higginson, 1996, p. 12).

Palliative care specialists manage pain and symptoms. Nurse practitioners utilize advanced skills to make certain, patients and families receive quality end-of-life care. Advanced practitioners are able to “assure that patients receive the highest quality of pain control possible with the most efficient use of resources” (Cronin & Ladd, 1997, p. 47). This insures that pain does not interfere with the time patients and families spend

together. According to pain guidelines, the patient's pain is best controlled with an interdisciplinary approach that utilizes collaboration. Planning patient's care involves collaboration from family members and addresses their worries and concerns. Interdisciplinary management is vital to successful anticipatory grief work. Palliative care practitioners assist patients and families to complete their end-of-life tasks.

Elizabeth Kübler-Ross (1969) eloquently described fear of death:

Death is still a fearful, frightening happening, and the fear is a universal fear even if we think we have mastered it on many levels. It might be more helpful if people would talk about death and dying as an intrinsic part of life just as they do not hesitate to mention when someone is expecting a baby. (pp. 5 & 141)

Discussion of death and dying reveals it is not death people fear but rather the dying process. "How their loved ones will die is a major source of anxiety and presents a major challenge for professional carers" (Costello, 1996, p. 173). People are afraid of being alone and suffering unrelieved symptoms such as pain or choking. Speck (1978) discovered "patients wanted to know what would happen to them and the sensations they might experience" (p. 20). Palliative care nurses can usually provide such information.

Watching a loved one die in pain negatively affects the grieving process. Genuine reassurance provided by a confident palliative care team relieves anxiety, panic, and uncertainty experienced by the patient and family. Cameron and Parkes (1983) explained "relatives of patients who have suffered severe, unrelieved pain before death, are left with intense feelings of anger which disturb their sleep and impair the process of grieving" (p. 76). Symptom control and emotional support help a patient feel "cared for, safe, and more open to expressing his true feelings and emotions" (Wheeler, 1996, p. 29).

Making sure terminally ill patients and their families' experience a peaceful death is an extraordinary, fundamental, responsibility facing the nursing profession. Nurses have an excellent chance to impact end-of-life care (Ferrell, 1999a). Nurses strive to assure that pain and symptoms are controlled, but they need education. Nursing educators are challenged to improve end-of-life education as they incorporate a palliative approach into the nursing curriculum (Ferrell, 1999b). Nurses, who facilitate anticipatory grief work, remain open and honest while they discuss death, dying, and the future. These nurses help patients and families complete end-of-life tasks. End-of-life care is a collaborative effort and is based on medical and nursing research findings (Steele, 1990).

The Impact of Grief

Relationships. According to Speck (1978) when we grieve part of our world is lost. He defined grief as a "“deep or violent sorrow caused by loss or trouble’ Sorrow is seen as an essential ingredient of grief with an implied pining for the world which is lost, rather than the object itself” (p. 8). “Grief places us outside of our existing social roles while we reclaim and reestablish our place in the social world” (Shapiro, 1996, p. 317).

Professionals are sensitive to those who experience the death of someone who was part of their life, even if that relationship was less than perfect. It is difficult for the bereaved to understand their feelings of sadness for someone who did not treat them with love and respect. They need guidance and acceptance to understand these confusing feelings.

Life, as it was, is lost and significantly changed. The individual grieves the loss of their world, as they knew it. The focus of grief work in our society is on “individuals rather than relationships and denies the enduring nature of our important attachments.

Grief literature typically addresses individual experience rather than family process” (Shapiro, 1996, p. 314).

A lost loved one is not replaceable. Parkes (1988) explained, “Each love relationship is unique, and theoretical models which assume that libido can be withdrawn from one object in order to become invested in another similar object, fail to recognize this uniqueness” (p. 366). The person who died represented a key element in a social system. Death disintegrated this system. It altered the bereaved’s living arrangements and social structure. “The bereaved is surprised to find out how large a part of his customary activity was done in some meaningful relationship to the deceased and [this activity] has now lost its significance” (Lindemann, 1944/1994, pp. 156 & 159). Individuals, who lost a spouse and were in an abusive relationship, need assistance understanding their feelings, which are confusing. “Painful deeds do not magically evaporate because the person is no longer alive. Death does not abruptly resolve hurtful actions” (Grollman, 2000a, p. 3). It is best to use an honest but direct approach with these issues.

Culture. A patient and family who face death have viewpoints determined by ethnic, racial, religious, or economical influences. These influences also determine the challenges they experience. Various groups have their own diverse strengths and weaknesses although “they may or may not be relevant to all people from a specific cultural group” (Habel, 2001, p. 29).

It is common for African Americans to care for their sick and dying relatives, in their own homes. Friends and family come from various parts of the country and relieve each other. They freely share their thoughts and ideas. The in-home services offered by a hospice or other end-of-life provider, may provide them with no more than they are

already doing for themselves (Harper, 2000). Many of these individuals are comfortable with an open, outward expression of grief. Healthcare professionals recognize that loud wailing and lamenting, even in public, is normal for some people.

Rituals, customs, and beliefs facilitate the grieving process, but they can also complicate the process. The pain of grief is eased by a belief that a loved one is in heaven or at peace (Doka, 2000b). Many older adults experience a deep sense of spirituality. Their beliefs help them face illness, suffering, and loss. Religion is often mentioned as a way of coping with a difficult event like death (Maddox, 2001). Grollman (2000b) revealed that very religious individuals sometimes become angry with God over the loss of a loved one. These individuals feel torn because they were taught that feelings of rage or anger toward God are sinful. Being told these feelings are normal, and an important part of the need to express grief, helps them recover.

Memories that families take into bereavement were created while end-of-life care was provided. Individuals from various cultures understand and express pain differently. In some cultures “people are socialized to be stoic in the face of pain” (Habel, 2001, p. 29). While in other cultures, openly displaying pain and frequently requesting pain medication is common. Some individuals view suffering as deserved, representing their past misdeeds. Suffering is viewed as occurring because of divine will. In contrast, others use suffering as a way to control their circumstances and to manipulate others. (Urquhart, 1999). In Western culture, some patients are encouraged to talk about their terminal illness, but this is inappropriate for patients from a Muslim culture (Habel). Other factors, which affect grieving, are the use of touch, eye contact, and facial expression. The gender of the nurse who provides care to the patient should also be reviewed for acceptability.

Sacred items or symbols such as religious beads or dream catchers may need to stay close to the patient. Many cultures have rituals that should happen at the time of death. These rituals may involve allowing the patient's spirit to leave by taking the body outside, opening a window, or lighting candles (Habel, 2001). To support a patient and family's best use of resources, they are trusted and respected as the authority of their own cultural assessment and coping. This assists them with their grief experience (Shapiro, 1996). To understand the influence culture has on end-of-life issues and grief, consultation with a transcultural nurse is helpful. The interpersonal process is used within the correct cultural context, once the patient and family's needs are understood.

Families. We serve the patient, family, and society best when we treat the patient and family as a unit. Wright and Leahey (1994) believe comprehensive care that involves families requires an interactive approach. Anticipating family needs while developing open communication, prevents future problems caused by grief. Caregivers' needs are also anticipated to "reduce some of the difficulties which occur at a later date, to the benefit of both the carer and health and social services" (Chesson & Todd, 1996, p.18).

As a patient moved into the terminal phase of an illness, he became detached and less able or willing to communicate. This detachment was heart breaking for family and friends who wanted to interact and say their good-byes. This was explained as a normal part of the separation process a patient experiences as he gradually leaves this life. Practitioners anticipate when to share this information by becoming familiar with the pathophysiology of terminal illness. Patients, who suffer from end-stage kidney and liver disease, as well as brain tumors, often demonstrate this withdrawing and inability to communicate earlier than patients who suffer from other terminal illnesses do.

Elisabeth Kübler-Ross (1969) discussed family needs and referred to preparatory grief. She believed family members were more comfortable if they were helped to express emotions before their loved one died. "When anger, resentment, and guilt can be worked through, the family will then go through a phase of preparatory grief, just as the dying person does." (Kübler-Ross, p.169). Couldrick (1992) agreed, "Communication with the family is essential if the patient is also to share the responsibility for the management of his illness and his death" (p. 1522). Grief expressed before death is more bearable. Confronting a loss before it occurs helps make sense of it.

Although everyone does not treat the knowledge of an impending death the same way, nursing interventions attempt to assist the family with coping. "We cannot help the terminally ill patient in a really meaningful way if we do not include his family" (Kübler-Ross, 1969, p. 157). Nurses help family members understand that it is normal to have thoughts that are hard to control and feelings that fluctuate. Families who had problems functioning during an early phase of the patient's illness continue to have problems during bereavement. They need additional follow-up and support (Kristjanson, Sloan, Dudgeon, & Adaskin, 1996).

Individuals, who attempt to protect themselves from the reality of an impending death, by detaching from the patient, needed to be encouraged by professionals to interact with their loved one. It may help them if they attempt to talk and visit often, share family pictures, and recall past memories. It is important that these family members understand that avoiding interaction may "make the dying patient feel isolated and alone" (Wheeler, 1996, p. 28). Later, many bereaved individuals regret not spending more time with their loved one.

Although it is important for the patient and family to spend time together, for some a gradual detachment is necessary. "An important part of supporting someone who has experienced anticipatory grief is enabling them to detach emotionally" (Costello, 1996, pp. 173-74). This detachment requires interventions before the death such as offering respite care, providing social support, and communicating effectively with the family of the dying person.

The patient and family feel a great peace at the time of death when they experience grief through anticipation. This peace provides bereaved individuals with the strength they need to go on with the rest of their lives. The most significant help nurses provide which eased a relative's pain, is to encourage the communication of feelings, while allowing time to work on them. Kübler-Ross (1969) shared "Our goal should always be to help the patient and his family face the crisis together in order to achieve acceptance of this final reality simultaneously" (p. 180). Gabany (2000) speculated that, nurses who assist patients to plan their end-of-life wishes, while they are still able to, ensure satisfaction with those choices and ease the bereavement journey for their families.

Gender differences. Although we understand that men and women grieve differently, how these differences affect them during bereavement is not understood. According to Parkes (1988), it was a mystery that widowers were more likely to die after the death of their spouse, than widows were. He explained that among the Huli people of New Guinea, there was a higher rate of mortality among widowers than there was among widows. He attributed this "to the fact that in that society widows grieve but widowers do not. One wonders if Anglo-American society is very different" (Parkes, p. 369). In Western Culture the expression of grief is often restricted. This restriction may contribute

to pathological grief in our society. During grief and bereavement research Parkes studied women from Boston who were under age 45. During the first year of bereavement these widows all showed more signs of emotional disturbance than comparable young widowers did. Over the next two to four years, despite their initial emotional turmoil, these widows returned to an emotional level equal to married women about same age, yet the widowers appeared to continue grieving. According to Shapiro (1996), gender roles, predetermined by society, stipulate what is acceptable bereavement for men and women.

Despite bereavement specialists' experience that the grief exhibited by men was different from that exhibited by women, Quigley and Schantz's (1999) study of older adults revealed conflicting findings. The study discovered comparable emotional experiences for both genders. Both men and women reported similar levels of guilt, anger, despair, denial, sadness, and isolation when grieving the loss of a spouse. It may have been that as people aged they paid less attention to social expectations related to grieving. Various factors contributed to a tendency to both recognize and experience grief differently than they did when they were younger. This investigator has seen few men attend a bereavement group over a two-year period, but those that did were over 60 years old and were willing to share their experience, and expressed their inner most feelings.

The acute phase of grief is often inhibited by Western Society but should be encouraged by professionals. Succumbing to and expressing the pain of grief is viewed as "morbid, unhealthy, and demoralizing, and the proper action of a friend is to distract the mourner from his or her grief" (Hasler, 1996, p. 53). Inhibiting the expression of grief causes the bereaved to feel out of control, as if they are losing touch with reality. Subsequent anxiety may be reduced by discussing this inhibition as a problem and by

ventilating feelings (Jalowiec, Murphy, & Powers, 1984). Professionals support bereaved individuals by helping them to identify, express, and understand their emotions.

Spouses. The relationship between spouses involves a different history and level of investment than a relationship between siblings, offsprings, or friends does. The latter group do not care any less about the dying person, and they certainly experience a sense of sorrow and loss. But, for the dying person and spouse, who shared a household for years before death, “the disruption in daily routines, presence of momentos, and overall sense of loss would be far greater” (Ransford & Smith, 1991, p. 302). Kurtz, Kurtz, Given, and Given (1997) recognized that this phenomenon existed because the family structure was severely disturbed by the loss of a spouse which “often involves a loss of social or economic status, and may necessitate substantial reorganization of social roles” (p. 60). “When we lose a spouse we lose our present [life]” (Doka, 2000b, p. 1).

Ransford and Smith (1991) reviewed studies that compared the post-death time of bereaved that received hospice care with those who did not receive hospice care. One of those studies by “Mor et al. [12] found few significant differences in grief resolution of primary care persons between hospice and traditional oncological care settings” (p. 295). About half the bereaved were spouses, 45% were non-spouse relatives. Physicians, who refer patients to hospice during the last week of life, minimized the time available for preparatory physical, emotional, social, and spiritual services. This reduces the ability of the bereaved to adjust to the loss (Speer, Robinson, & Reed, 1995). A Veterans Administration (VA) Hospital study, done by “Kane et al. [11] found no significant difference between the bereaved of Hospice patients as compared to controls” (Ransford & Smith, p. 295). Noteworthy in these studies is that only 46% of the hospice and 43% of

the control were spouses. Ransford and Smith found that studies which did not differentiate between bereaved spouses and others, failed to recognize “that these two groups may experience some very different bereavement processes” (p. 302). If grief was more easily resolved among non-spouses than spouses, then hospice care may have been more valuable when the personal relationship was closer or more involved.

Older adults. Many people in our society consider death a tabooed topic. But many older individuals do not treat death as such a dreaded event. Older adults have usually encountered the deaths of several friends and family members. Some of these adults even consider that they are living on borrowed time. Various losses experienced during a lifetime prepare an individual, somewhat, for the only remaining loss, that of their own life. “Such deprivations may be described as *anticipatory losses*, or ‘little deaths’” (Speck, 1978, p. 7). Research studies of bereaved individuals often involved older adults. “This is the age group who are most commonly bereaved, and they are more vulnerable to poor health than their younger counterparts” (Parkes, 1988, p. 371). Although these adults expect death and may have experienced it before, experience does not protect them from the effects of grief and bereavement.

Jacob (1996) studied older widows who had been married about 50 years. The widows’ major complaint was loneliness. This loneliness caused them the greatest emotional suffering. Some felt that nothing could ever take the place of their spouse. One widow described feeling like she was only half there, half of her was gone. Losing a spouse is both an emotional loss and a social loss. These losses require significant changes in the individual’s role as well as their life style. Having such critical changes occur during the already stressful grieving process, can create illness.

In 1996 Jacob studied older wives who had provided care to their ill husbands. "The older women began to face reality when they became aware of the terminal diagnosis. However, it was not until the reality of the actual death that grieving could begin" (p.283). It is crucial to understand that those in long marriages suffer more intense grief. "Widowed individuals show higher rates of disabling illness and hospitalization, as well as higher rates of suicide and death from other causes. Death sometimes occurs soon after the loss of the spouse" (Potocky, 1993, p. 288).

To relinquish a familiar role, time as well as considerable emotional and cognitive work, are required. Therapists find that discussing death often touches just the surface and focuses only on social concerns. When given ample time to discuss feelings and concerns, in a safe environment, older individuals develop trust. As a result, subsequent discussions become more intimate and emotional (Davis-Berman, Berman, & Faris, 1995). Nurse practitioners are in a unique position to assist this population. They help older adults, as well as other healthcare professionals, by contributing to both protocols and planning for end-of-life care (Shuler, Huebscher, & Hallock, 2001). An intimate emotional discussion with an older individual facilitates uncomplicated travel through bereavement. This allows them to face their new reality, a changed life without a spouse.

Summary

In this chapter, the interactive process as practiced by Carl Rogers and Joyce Travelbee, was described through a review of literature. The study framework, an interactive process, was examined as a model of care that assisted individuals who were psychologically vulnerable from the pain of death and grief. Assumptions of the interactive process were reviewed. A comparison of the concepts of person, environment,

health, and nursing, as they were found in Rogers and Travelbee's theoretical models were presented. Literature, which examined the experiences of death, grief, bereavement, and anticipatory grief, was reviewed. Additional literature related to the impact grief had on relationships, families, gender, spouses, and older adults, was presented.

Chapter III contains the design of the study. This investigator used a descriptive correlational design, which incorporated triangulation of qualitative and quantitative procedures to explore study participants' progress in bereavement.

Chapter III

Design of the Study

Chapter III of this descriptive correlational research study contains the design utilized to explore personal progress in bereavement and associated phenomena of participants who lost their spouses to a predictable death. Relationships between bereavement progress, the support they received prior to death, and other variables, were examined with a triangulation of qualitative and quantitative procedures.

Patients and families often reported they received little information about the prognosis of a life-limiting illness. This occurred despite the availability of timelines for many terminal diseases, as long as they run their normal course. Professionals avoided discussion of death rather than create an uncomfortable situation with patient and family.

Two models of the interactive process emphasized the importance of a therapeutic relationship. They were used as the theoretical framework for this study. Each model contained variables that moved individuals to a place of comfort (safety and rapport), where therapeutic communication could take place (Torres, 1986). The steps of the interactive process as developed by Carl Rogers (1961), practiced by Joyce Travelbee (1966), and utilized during this study, were mapped in Figure 2. The interactive process facilitated therapeutic communication and provided an opportunity for healing and hope.

This chapter contains a description of the research design. It provides a description of the protection of human participants, identification of the population and sample, and the setting. The instrumentation, instrument validity and reliability, data collection, and data analysis are also presented.

Survivors Progress in Bereavement
Map of the Interactive Process

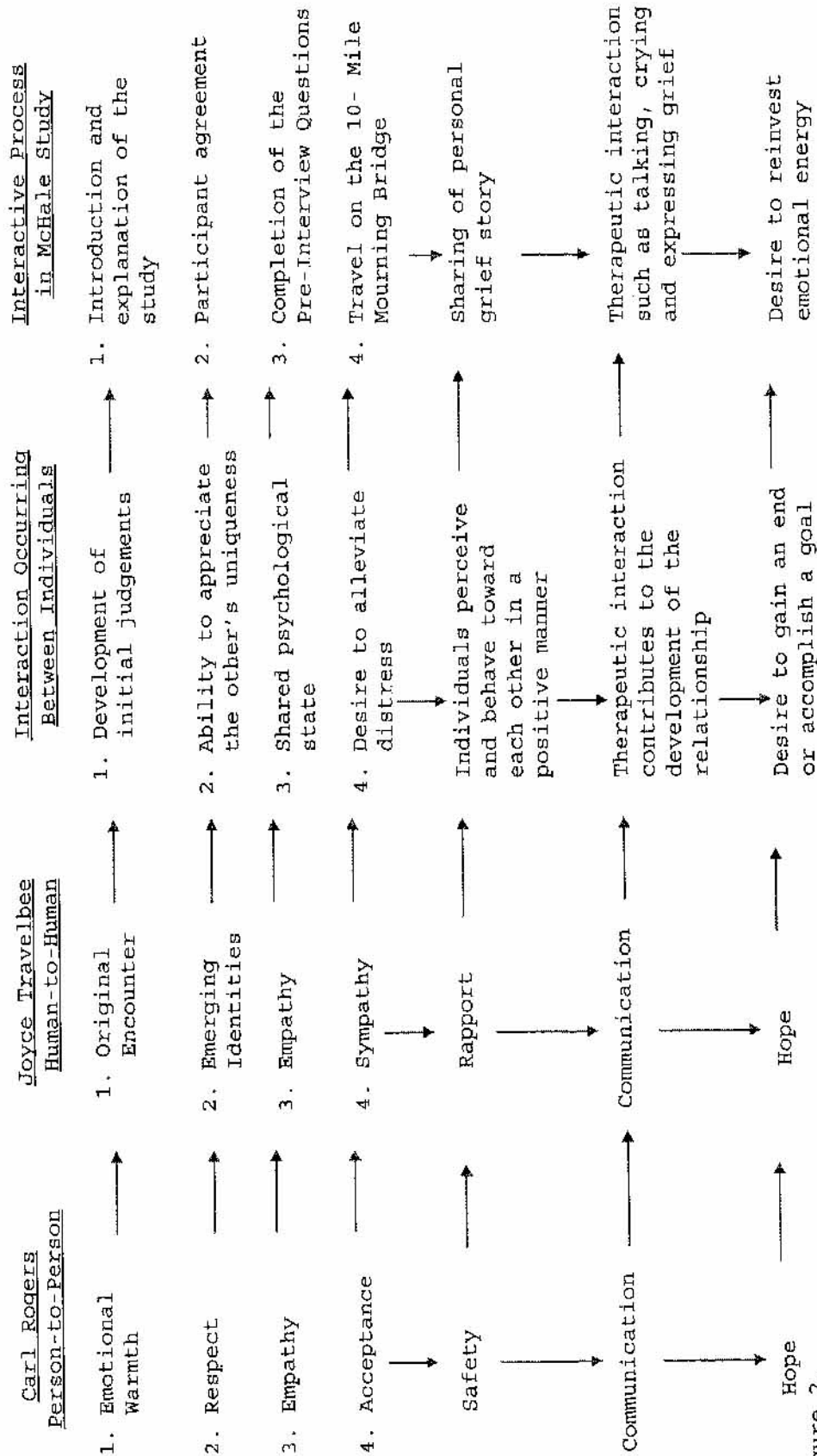


Figure 2.
Map of the Interactive Process

Description of Research Design

This research study utilized a descriptive correlational design to examine relationships between variables present prior to a survivor's bereavement journey and their scores on a visual analogue scale. The design facilitated "the identification of many interrelationships in a situation in a short period of time" (Burns & Grove, 1993, p. 302). The study included an interview, which consisted of answering questions and completing a self-reported visual analogue scale to examine a "Survivor's Progress in Bereavement Through Pre-Death Work".

The research combined a triangulation of qualitative and quantitative approaches to gather data. Data were gathered during the interview process from information provided as responses to the Pre-Interview Questions (Appendix C, p. 139) and self-measurement on the 10-Mile Mourning Bridge (Appendix A, p. 135). This investigator received permission to use and adapt "The 10-Mile Mourning Bridge" (Huber & Gibson, 1990) from Ruth Huber, Ph.D., University of Louisville (Appendix B, p. 137).

The Pre-Interview Questions provided information related to demographics, as well as support participants received prior to the death of their spouses. The 10-Mile Mourning Bridge represented the participant's personal bereavement journey. The Design of the Study was mapped and can be found in Figure 3. This map presented a review of the measurement, description, examination, and interpretation of variables.

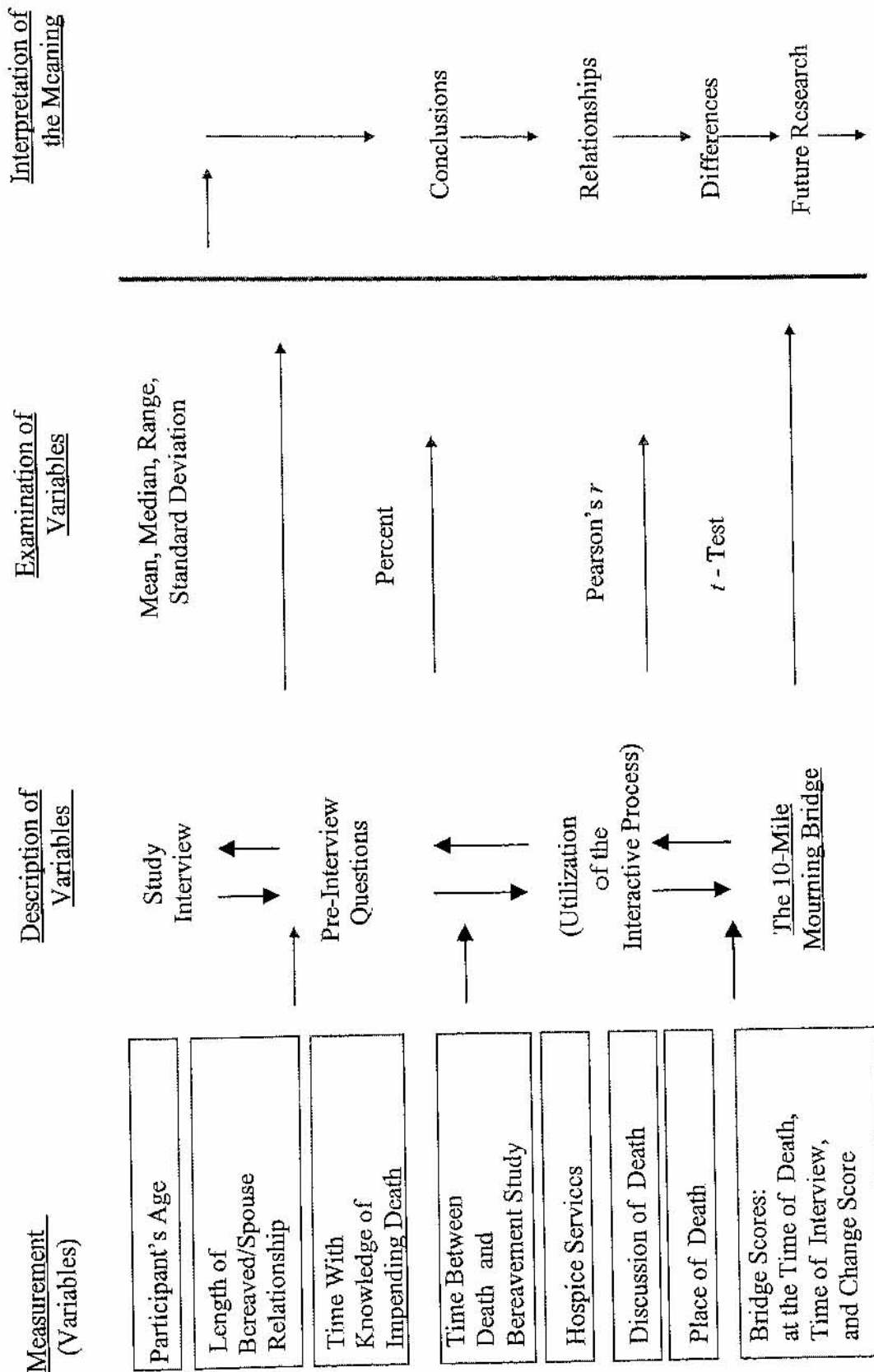


Figure 3. Design of the Study: Survivor's Progress in Bereavement Through Pre-Death Work.

Protection of Human Participants

A proposal for this research study, written permission granted by Ruth Huber to use the idea of "The 10-Mile Mourning Bridge", copies of the Mourning Bridge, the Informed Consent (Appendix D, p. 141), and Pre-Interview Questions, were submitted to each member of the Thesis Committee. This investigator answered the 17 questions on the "Human Subjects Concerns" checklist. The Thesis Advisor reviewed the responses. There was no need to make application for proposal review by the Protection of Human Research Subjects Committee. The research proposal was presented orally to the Thesis Advisor and two Thesis Committee Members as well as several faculty members from the Department of Nursing, College of Arts and Sciences, Pittsburg State University. The proposed research study, "Survivor's Progress in Bereavement Through Pre-Death Work" was endorsed by the Thesis Committee Members.

Each referring individual was sent a Referral Letter (Appendix E, p. 145) explaining the study prior to selecting potential participants. They were also sent copies of the Informed Consent, the Pre-Interview Questions, and the 10-Mile Mourning Bridge. A follow-up telephone call was placed to clarify information and answer questions. It was explained that the study was being conducted to gather information about an individual's personal bereavement journey. It was not intended to assist those having difficulty with grief. Physician offices, hospice organizations, home care agencies, and funeral homes located in Northeastern Oklahoma, referred the participants and obtained permission for this investigator to contact each potential participant.

This investigator provided each participant an Informed Consent, which contained the research purpose, study description, benefits, risks, confidentiality statement, and

subject's assurance (including their right to withdraw from the study at any time). This form was signed and dated by the participant and this investigator before the study interview. Each participant received a copy of the Informed Consent. As participants were interviewed they were assigned numbers from 1 to 16 for identification purposes.

This investigator was a Hospice Registered Nurse and a Palliative Care Consultant for over eight years and was certified in Hospice and Palliative Care. Any participant who became emotional during the interview was allowed extra time to express their emotions and concerns. Those participants were offered emotional support, which included explanation and normalization of grief reactions. This investigator also provided information about a local Bereavement Support Group, which was available for those who wanted further support. The bereavement group facilitator, a Licensed Social Worker with a Masters Degree, had additional training in Grief Counseling and was available to the participants for counseling and additional emotional support. Participants were offered a copy of the study results. Shredding once the data collection was complete destroyed the master file containing the participants' personal information. Removing the tape from the reels and cutting it into small pieces destroyed recorded tapes.

Population and Sample

Sixteen volunteer participants who each lost their spouse to a predictable life-limiting illness composed the study population. The sample of survivors included 5 males and 11 females. Physician offices, hospice organizations, home care agencies, and funeral homes located in Northeastern Oklahoma, referred the participants.

There was a controlled even distribution of those who did and did not have hospice services, as it was believed hospice care would assist some individuals with progress in

bereavement. Although each of the deceased had an illness that would qualify them for hospice care, only eight had that service.

An attempt was made to choose participants who lost their spouses approximately 12 weeks before the study interview. Time was measured in weeks to facilitate accuracy. Participant age and length of relationship were not considerations for study inclusion.

Setting

The sixteen participants who were interviewed for this research study completed the process. Twelve of the participants were interviewed in their own homes while four participants were interviewed over the telephone per their request. The study territory encompassed a large area of Northeastern Oklahoma. Participants came from both rural and urban communities with populations ranging from 3,326 to 367,302.

Instrumentation

This investigator requested and received written permission from Ruth Huber, Ph.D., University of Louisville, to use the idea of "The 10-Mile Mourning Bridge". Ruth Huber (1990) developed "The 10-Mile Mourning Bridge" a zero to ten, hypothetical visual analogue scale, to represent a bereavement journey. Huber and Bryant (1996) demonstrated the validity and reliability of "The 10-Mile Mourning Bridge". Study participants used the Mourning Bridge as a self-reporting tool as they visually traveled their own bereavement journey. Zero on the Mourning Bridge represented just learning their spouse would die and began their journey. Bereaved individuals successfully crossed the Mourning Bridge (traveled 10 miles) when they were able to reinvest their emotional energy into new interests and relationships. Participants who successfully crossed the Mourning Bridge experience resolution of their grief, an ability to get on

with the rest of their life without their spouse (Huber & Gibson, 1990). The 10-Mile Mourning Bridge was redesigned somewhat for this study. This author designed the Informed Consent and Pre-Interview Questions forms to gather and organized data received during this research study.

Instrument Validity and Reliability

According to Huber and Gibson (1990) "The 10-Mile Mourning Bridge" was a zero to ten, self-reporting, visual analogue scale used to measure progress through bereavement. This created a self-reflection, which is believed to be the best indicator of progress. Zero represented the moment the client first learned of the impending death; the emptiness felt before grieving began. The tenth-mile represented the point when the bereaved recovered emotional energy previously consumed by grieving, and was able to reinvest it in their life. Bereavement was conceptualized as a journey across "The 10-Mile Mourning Bridge" (Huber & Bryant, 1996). Two examples of other visual analogue scales were a vertical scale to mark degree of arousal from fear (Walk, 1956) and another scale that measures family tension (Abrego, 1981; Lovell, 1986; Lovell & Hawkins, 1988; Lovell, Reid, & Richey, in press) (Huber & Gibson, 1990).

Huber and Bryant (1996) examined the construct validity as they compared the performance of "The 10-Mile Mourning Bridge" against that of the well-established Brief Symptom Inventory (BSI) in measuring progress through bereavement. The self-reporting Mourning Bridge was significantly correlated to 8 of the 9 clinical scales of the BSI. Mourning Bridge performance was examined because the authors felt it could be dually useful as a clinical and a research instrument to measure how people progress through the painful process following the death of a loved one (Huber & Bryant, 1996).

The authors compared “The 10-Mile Mourning Bridge” with the Brief Symptom Inventory (BSI) because it is “a much more sophisticated instrument with substantial history” (Huber & Bryant, 1996, p.32). Huber and Bryant also reported that “Other researchers who have contributed to the history of the BSI, Kiger and Murphy (1987) reported that the instrument has both internal consistency and stability, and is appropriate for bereavement studies” (p. 33).

Huber and Bryant (1996) indicated that “The reliability coefficients of the Brief Symptom Inventory [BSI] scales and 10-Mile Mourning Bridge at both pre and posttest are generally strong. The coefficient alpha of the BSI scales ranged from .67 (Phobic Anxiety) to .91 (Obsessive- Compulsive) both at pretest [.65 to .90 posttest]” (p. 39). The General Severity Index is BSI’s strongest global index. Huber and Bryant (1996) share:

With the General Severity Inventory at posttest as the dependant variable, the strongest predictor (not surprisingly) is the General Severity Index at pretest, followed closely by the posttest 10-Mile Mourning Bridge ($R^2 = .71$, $p < .001$). In other words, 71% of the variance in the General Severity Index *posttests* can be predicted by knowing individuals’ *pretest* General Severity Index and Bridge scores” (p.43).

According to Huber and Bryant (1996) While the Mourning Bridge did not claim the sophistication of the Brief Symptom Inventory, “it is intuitively easy to understand, use, and evaluate, and can be used in myriad ways” (p. 44). It facilitated the marriage of practice and research by serving as a catalyst for discussions about feelings and progress (Huber & Bryant). Participants assessed their own progress in bereavement by using the Mourning Bridge. The “individuals own perceptions and appraisals are the best way to assess where they are in the transition process” (Huber & Gibson, 1990, p. 56). Handling

information like social behavior, usually dealt with in qualitative ways, from a mathematical view, demonstrated limits - no more than true words (Aiken, 1969). It was particularly suitable for measurement of change and observation of its significance.

Data Collection

The primary data-gathering instrument was this author, a Hospice and Palliative Care Registered Nurse who worked with the dying and their families for over eight years at the time of the interview. During research, work related duties included Quality Assurance Coordinator, Hospice Primary Nurse, and Hospice and Palliative Care Consultant at Jane Phillips Hospice in Bartlesville, Oklahoma. She was a registered member of the Hospice and Palliative Care Nurses Association, was Certified as a Hospice and Palliative Care Registered Nurse, and was listed in Sigma Theta Tau's 1999 Media Guide to Health Care Experts under "Palliative Care, Hospice". She was a registered member of the American Nurses Association, the Kansas and Oklahoma Nurses Associations, the American Academy of Nurse Practitioners, the American College of Nurse Practitioners, Sigma Theta Tau International Nurses Honor Society, the Phi Kappa Phi Honor Society, and the American Association of University Women. She presented several hospice and palliative care related sessions at local and state hospice conferences. An article "The Role of the Advanced Practice Nurse in Hospice Care" was published in the Kansas Nurse in 1998. She contributed two chapters, "Palliative Care" and "Sedation" to Palliative Care Practices from A to Z for the Bedside Clinician, (in press). This Baccalaureate prepared nurse received preparation in the research process and sustained ongoing direction from individuals experienced in research, who were affiliated with Pittsburg State University, during development of this thesis.

Interviews were conducted between March 6, 1999 and June 14, 1999. Sixteen individuals who were approached were interested and completed the interview process.

The screening criteria were:

1. The participant must have been the spouse of the deceased.
2. The death must have been caused by a predictable, non-traumatic illness.
3. The participant must have known the death would occur.
4. There must have been an even distribution of those that did and did not have hospice.
5. This investigator must have interviewed the participant.

The exclusion criteria were:

1. The participant was not able to speak or read English.
2. The participant was suffering from any type of dementia.
3. The survivor was currently under psychiatric care for dysfunctional grief.

This research study utilized triangulation of both qualitative and quantitative procedures. An interactive interview process was utilized to conduct the research. Data were gathered on the Pre-Interview Questions form. These data were compared with participants' scores from the 10-Mile Mourning Bridge, which were also gathered during the interview. Each participant was offered an opportunity to discuss feelings and emotions related to their spouse's illness and death, after completing data collection.

Data were collected using the following procedure:

1. This investigator contacted physician offices, hospice organizations, home care agencies, and funeral homes located in Northeastern Oklahoma, to explain the research study. Prior to selecting potential participants, each referring individual was sent the

Referral Letter explaining the study. They were also sent copies of the Informed Consent, Pre-Interview Questions, and the 10-Mile Mourning Bridge forms, all by regular mail.

2. This investigator placed a follow-up telephone call to the referral sources to clarify information and answer questions. The exclusion criteria were reviewed. It was explained that the study was being conducted to gain information about each participant's personal bereavement journey. It was not intended to assist those having difficulty with grief. An attempt was made to choose participants who had lost their spouse about 12 weeks before the interview session.

3. The referring source received permission to contact from each potential participant. This investigator received contact information and permission to contact each potential participant from his or her referring source.

4. This investigator contacted each potential participant and briefly explained the research study. Permission was obtained from the potential participant to send the Informed Consent, Pre-Interview Questions, and 10-Mile Mourning Bridge forms. These were sent through the regular mail.

5. After allowing ample time to receive the Informed Consent, Pre-Interview Questions, and 10-Mile Mourning Bridge forms, the potential participants were telephoned. The items covered in the Informed Consent including; the research purpose, study description, benefits, risks, confidentiality statement, and subject's assurance (including their right to withdraw from the study at any time) were reviewed. Questions were answered and an interview time was scheduled. This conversation was kept short and business like so as not to influence the actual interview. Four of the potential 16

participants requested the interview be conducted over the telephone. These telephone interviews were also scheduled.

6. This investigator requested that the four potential telephone participants mail back their signed and dated Informed Consent form and their completed Pre-Interview Questions form. The potential participants were instructed to keep the 10-Mile Mourning Bridge form to use during the interview. The other 12 potential participants kept all their forms until their scheduled interview.

7. As potential participants began their interview they were assigned a number from 1 to 16 for identification purposes. These numbers were not revealed to the potential participants.

8. When a face to face interview began, this interviewer asked the potential participant to read the Informed Consent form. It was stressed that they could withdraw from the study at any time. They were encouraged to present any questions. If they agreed to participate they were asked to sign and date the form. This investigator also signed and dated the form. During telephone interviews this investigator verbally reviewed the signed and dated Informed Consent form that had been mailed back by the potential participant. It was also stressed that they could withdraw from the study at any time. This investigator signed and dated each of these forms. The telephone participants received the same explanations provided to those receiving the face to face interview.

9. This investigator explained that the interview would be recorded on tape by a voice recorder. The participant was informed they could request that either the interview not be taped, or that the tape be turned off, at any time during the interview.

10. Information that each participant shared was either written down or taped depending on the participant's preference.

11. This investigator invited the participant to answer the Pre-Interview Questions either in writing, or verbally if they were being interviewed over the telephone and had not filled out the questions beforehand. This investigator remained quiet but was available to answer any participant's questions or clarify information, except to ask the questions directly for those on the telephone. The answers provided by all participants were verbally reviewed with them. The Pre-Interview Questions included:

- A. The survivor's age, birthdate, and gender.
- B. The participant's relationship to the deceased.
- C. The length of that relationship.
- D. The deceased's age, birthdate, and gender.
- E. The cause of the patient's death.
- F. The place of the patient's death.
- G. The date they learned the illness was terminal.
- H. The date of the patient's death.
- I. Whether the participant or their loved one did or did not discuss the death.
- J. The types of support the participant had available including; children, family, personal friends, neighbors, reverend or pastor, church members, physicians, nurses, hired caregivers, hospice services, and a line for other (a place to designate an unlisted type of support).
- K. Of the support the participant used, which were most helpful.

12. This investigator used an instrument, a hypothetical zero to ten, visual analogue scale, to measure the participant's journey. The self-reporting 10-Mile Mourning Bridge was used to provide a sense of traveling on a bereavement journey.

13. This investigator explained that the Mourning Bridge represented the participant's personal journey through bereavement. There were no right or wrong answers.

14. This investigator explained that zero on the Mourning Bridge, represented the emptiness they might have felt when they first learned their loved one was going to die (like the empty barren tree). Zero symbolized being drained and having little or no emotional energy.

15. This investigator explained that 10 on the Mourning Bridge represented a feeling of being whole again, of having hope (like the tree full of leaves). Bereaved individuals had successfully crossed the Mourning Bridge (traveled 10 miles) when they were able to reinvest their emotional energy into new interests or relationships. Crossing the 10-Mile Mourning Bridge represented completion of their bereavement journey and an ability to get on with the rest of their life with out their spouse (Huber and Gibson, 1990).

16. This investigator asked each participant to answer the two questions related to the 10-Mile Mourning Bridge.

A. Where were you, on the 10-Mile Mourning Bridge, at the time of your loved one's death as a result of the support you received?

B. Where are you, on the 10-Mile Mourning Bridge, now, at the time of this interview?

17. After completion of the Mourning Bridge questions, this investigator invited each participant to share any feelings or concerns they might have, as a result of the illness and

death. The participant was encouraged to describe their journey in bereavement thus far. The participant determined the amount of time spent on this portion of the interview.

18. This investigator allowed any participant who became emotional during the interview, extra time to express their emotions and concerns. This investigator provided emotional support that included explanation and normalization of grief reactions.

19. This investigator provided information about a local Bereavement Support Group available for those who wanted additional support. The group facilitator, a Master prepared Licensed Social Worker, had additional training in Grief Counseling.

20. The participants were encouraged to ask questions at the end of the interview.

21. This investigator kept track of any common themes or occurrences.

22. Participants were offered a copy of the study results.

23. This investigator contacted each participant by telephone approximately one week after the interview to review information, answer questions, and thank them. This investigator sent each participant a Participant Thank You Letter (Appendix G, p. 149).

24. This investigator sent each referring individual or agency a Follow-Up Thank You Letter (Appendix H, p. 151).

25. This investigator organized the data by participant identification number.

26. This investigator recognized data as nominal, ordinal, or interval.

27. This investigator analyzed data using percentile, measures of central tendency, and dispersion.

28. This investigator analyzed data to discover correlation and significance.

29. Shredding once the data collection was complete destroyed the master file containing the participants' personal information. Removing the tape from the reels and cutting it into small pieces destroyed recorded tapes.

The interviews were conducted from March 6, 1999 to June 14, 1999. Study participants chose interview times that were convenient for them. The time involved in data collection was difficult to estimate. Telephone calls to referral sources and potential participants had to be repeated until individuals were contacted. Additional time was spent writing letters and sending materials. Travel time varied from 15 minutes to about an hour, each way, to interview participants. The length of each interview varied from as short as 30 minutes to about an hour and a half. Follow-up telephone calls lasted between 5 minutes and 20 minutes. Time was also spent thanking individuals by mail. This investigator estimated the time spent preparing, interviewing, and providing follow-up to be over 80 hours. These hours do not include organization, processing, or mathematical analysis performed on data, nor does it include time spent writing this thesis.

Data Analysis

This investigator examined the mean, median, range, and standard deviation for each of the following participants' ages, length of relationships in years, amount of time with knowledge of the impending death, as well as the time between the death and completion of the interview. Mean, median, range, and standard deviation were calculated for each of the Mourning Bridge scores. The percent of couples who discussed death was calculated, for both those who had hospice services and those who did not.

This investigator compared the mean Mourning Bridge scores for those who did and did not have hospice services. Mean Mourning Bridge scores for those who had a longer

time with knowledge and those who had a shorter time with knowledge were examined for differences. Finally, mean Mourning Bridge scores for participants whose spouses died at home and those who died in the hospital were examined for differences. All were subjected to the Two-Tailed t-Test for Significance.

This investigator recorded participants' scores for their personal journeys in bereavement, as measured on the 10-Mile Mourning Bridge for (a) time of death, and (b) time of the interview. The difference or (c) change score was then calculated. Each of these scores, and the length of time with the knowledge of the impending death, were examined for relationships using Pearson's Product-Moment Correlation Coefficient. Relationships discovered between variables were then subjected to correlational analysis to determine their direction and magnitude.

Summary

This chapter contained a description of the research design. It provided a description of the protection of human participants, identification of the population and sample, and the setting. The instrumentation, instrument validity and reliability, data collection, and data analysis were also presented. The results of the study are reported in Chapter IV.

Chapter IV

Results of the Study

Chapter IV of this descriptive correlational study contains the research results. This investigator utilized triangulation of qualitative and quantitative procedures to explore personal progress in bereavement and associated phenomena of participants who lost their spouses to a predictable death. Relationships between bereavement progress, the support participants received prior to the death and other variables were examined.

The interview process incorporated an interactive approach to gather data. Much of the data were collected on the Pre-Interview Questions form (Appendix C, p. 139). Data were compared with participants' scores from the 10-Mile Mourning Bridge (Appendix A, p. 135), also gathered during the interview. This investigator received permission to use and adapt "The 10-Mile Mourning Bridge" (Huber & Gibson, 1990) from Ruth Huber, Ph.D., University of Louisville (Appendix B, p. 137).

Data were gathered from the Pre-Interview Questions and the 10-Mile Mourning Bridge. Information can be found in Appendix F, p. 147, Summary of Study Data. Nominal, ordinal, and interval data were measured. Data were statistically analyzed using percentile, measures of central tendency, and dispersion. Differences between variables were explored and examined for significance. Once relationships among variables were discovered they were investigated to determine direction and strength.

In this chapter the results of the research study are presented through examination of the demographic and research variables. Research questions are answered and analyzed by finding the significance of any differences and the strength of any relationships. Study findings are then reported and summarized.

Demographic Variables

Of the original data gathered, age and gender of deceased were considered unimportant. The survivor was the study participant. All the participants had been married to the deceased. The study sample of participants ($N = 16$) included more females ($n = 11$, 69%) than males ($n = 5$, 31%). The majority of the participants' spouses died from some form of cancer ($n = 13$, 81%). The remainder died from chronic illness, either heart disease ($n = 2$, 13%) or renal disease ($n = 1$, 6%). More patients died at home ($n = 9$, 56%) than in the hospital ($n = 7$, 44%). The number of participants that did not discuss death with their spouse was greater ($n = 9$, 56%) than those that did ($n = 7$, 44%).

A comparison of the following demographic statistics can be found in Table 2. There was a broad variation in the age of the participants with a mean (M) age of 65.5, a median (Mdn) of 68, a range of 48, and a standard deviation (SD) of 12.76. The oldest and youngest were female, they were 84 and 36 years old.

Bereaved and spouse relationships were measured in years ($M = 40.9$), ($Mdn = 44.5$), (range = 62), and ($SD = 19.01$). The shortest relationship was 6 years. In the longest relationship the participant and spouse had been together 68 years.

There was an attempt to recruit subjects who lost their spouse about 12 weeks before their interview date. Two variables involved time measurements. The first measurement was the number of weeks a participant was aware their spouse would die. This interval began the date a participant first learned their spouse would die and ended with the date of death. Time varied from 1 week to 156 weeks ($M = 18.6$), ($Mdn = 7.5$), (range = 155), and ($SD = 37.71$). The second measurement was the number of weeks since the death.

The interval began on the date of death and ended with the date of the interview. Time varied from 8 weeks to 22 weeks ($M = 12.7$), ($Mdn = 11.5$), (range = 14) and ($SD = 4.33$).

Table 2

Comparison of Demographic Statistics

	Mean	Median	Range	Standard Deviation
Age of participant, in years	65.5	68	48	12.76
Length of relationship, in years	40.94	44.5	62	19.01
Amount of time bereaved had knowledge of impending death, in weeks	18.56	7.5	155	37.71
Time between death and completion of interview, in weeks	12.7	11.5	14	4.33

Research Variables

Participants' rating of progress in their personal bereavement journey was conducted using a zero to ten visual analogue scale, the 10-Mile Mourning Bridge. Zero symbolized first learning their spouse would die, feeling empty or drained. Traveling 10 miles on the Mourning Bridge represented resolution of grief, feeling whole again. Completion of the journey suggested an ability to reinvest emotional energy, previously used for grief, into new interests or relationships.

The three Mourning Bridge scores were calculated for (a) time of the death, (b) now (at time of the interview), and (c) the change score (the difference between score [a] and [b]). For a comparison of the three Mourning Bridge scores refer to Table 3.

Table 3

Comparison of Participant Mourning Bridge Score

	Mean	Median	Range	Standard Deviation
Bridge Score at time of death	0.44	0	2	0.66
Bridge Score at time of interview (now)	4.94	4.5	8	2.15
Bridge Change Score	4.5	4.25	8	2.07

In order to identify the support participants received prior to the death of their spouse, answers from the Pre-Interview Questions forms were reviewed. The research study contained an even distribution of those who did ($n = 8$) and those who did not have ($n = 8$) hospice services. Each of the ten possible choices on the form had been selected at least once, while the space for other support was less utilized ($n = 2$, 13%). The majority ($n = 13$, 81%) of the participants named more than one type of support. For study purposes, the main interest was support the participant found most helpful prior to the death of their spouse. The types of support the participants named as most helpful to them can be found in Table 4. Hospice was named as most helpful by only four although eight participants had this assistance. One participant named her husband, who was the dying spouse, as her most helpful support. She explained that although her husband was the patient, "he was so cooperative that I couldn't have done it without him. He supported me!" Another participant named, being home, as his most helpful support. He explained that "had I not been in my own home, I couldn't have done it." The freedom and routine of his own home, combined with family and friends coming and going, was the most helpful support he received.

Table 4

Support Participants Found Most Helpful Prior to the Death

Had Hospice Services	Did Not Have Hospice Services
1. Daughters	1. Friend
2. Husband (patient)	2. Sister-in-law
3. Being Home	3. Son
4. Surgeon	4. Kidney Doctor
5. Hospice	5. Church
6. Hospice	6. Sisters
7. Hospice	7. Nurses
8. Hospice	8. Nurses

Research Questions

Significance and correlation. The Two-Tailed *t*-Test for Significance was used to determine whether differences existed between variables. The mean Mourning Bridge scores for those who did and those who did not have hospice services were examined for differences. The mean Mourning Bridge scores for those who had a longer and those who had a shorter time, with the knowledge of the death, were also examined for differences. Mean Mourning Bridge scores for those whose spouses died at home and those who died in the hospital were examined for differences. The Two-Tailed *t*-Test of Significance was a useful method for this small sample size. In all cases where a *t*-test was performed, a paired two-tailed distribution with a critical value of 2.14 was used. An alpha level of .05 was chosen. According to Burns and Grove (1993) choosing an absolute cut-off point will assure the results of statistical analysis indicate a statistically significant difference between groups. Pearson's Product-Moment Correlation Coefficient was used to determine if any relationships existed between the Mourning Bridge scores, and the participants' length of time with the knowledge of the impending death. Relationships

discovered between variables were then subjected to correlational analysis to determine their direction and magnitude.

Analysis of the four research questions. Does hospice care make a difference in a survivor's progress in bereavement as measured on the 10-Mile Mourning Bridge? Research question number one was answered with the following data. There was a controlled even distribution of participants who did and did not have hospice services. The mean bridge scores for these two groups were analyzed using a t-test. The analysis showed no significant difference for the mean bridge score at the time of death for the two groups; $t(14) = +2.12, p > .05$, two-tailed. There was no significant difference for the mean bridge score now, at the time of interview, for the two groups; $t(14) = +1.31, p > .05$, two-tailed. There was also no significant difference found for the bridge change score; $t(14) = +0.71, p > .05$, two-tailed.

Do differences exist between participants' scores on the 10-Mile Mourning Bridge, who had a longer time with knowledge of their spouses' impending death, and those who had a shorter time with that same knowledge? Research question number two was answered with the following data. The variable, length of time with knowledge of the impending death, was divided evenly into those who had a longer and those who had a shorter time with that knowledge. These were subjected to the t-test for each bridge score. Analysis showed a significance difference between the mean bridge score at the time of death for the two groups; $t(14) = +2.74, p < .05$, two-tailed. There was also a significant difference between the mean bridge score now, at the time of the interview, for the two groups; $t(14) = +3.04, p < .05$, two-tailed. Finally, there was not a significant difference between bridge change scores for the two groups; $t(14) = +1.99, p > .05$, two-tailed.

Do differences exist between those participants' scores on the 10-Mile Mourning Bridge whose spouses died at home and those who died in the hospital? Research question number three was answered with the following data. Participants were divided into two groups based on place of death, home or hospital. The mean bridge scores for these two groups were analyzed using a *t*-test. Analysis showed a significant difference between the mean bridge score at the time of death for the two groups; $t(14) = +2.87, p < .05$, two-tailed. There was not a significant difference between the mean bridge score now, at the time of the interview, for the two groups; $t(14) = +1.62, p > .05$, two-tailed. There was not a significant difference between bridge change scores for the two groups; $t(14) = +0.85, p > .05$, two-tailed.

Do relationships exist between participants' progress in bereavement as measured by the 10-Mile Mourning Bridge scores; at the time of death, at the time of the interview, and the measured difference between these two scores; when they are compared with length of time with knowledge of the impending death? The correlations found for the parts of question number four are contained in the following data. See Table 5. There was an almost nonexistent relationship between the bridge score at the time of death and length of time with knowledge of the impending death ($r = 0.01, r^2 = 0.0001$). This was also true of the relationship found between the bridge score at the time of death and the bridge change score ($r = 0.02, r^2 = 0.0004$). The relationship found between the bridge score at the time of death and bridge score at the time of the interview was weak ($r = 0.28, r^2 = 0.0784$). This indicates that the bridge score at the time of death can explain just over 7% of the variance of the bridge score at the time of the interview.

The relationship between the length of time with the knowledge of the impending death and the bridge score at the time of the interview was strong ($r = 0.7$, $r^2 = 0.49$). The relationship was also strong between the length of time with the knowledge of the impending death and the bridge change score ($r = 0.73$, $r^2 = 0.53$). This indicates that close to 50% of the variance of both the scores at the time of the interview, and the change scores, can be explained by the length of time the participant had with the knowledge of their loved one's impending death.

There was a very strong relationship found between the bridge score at the time of the interview and the bridge change score ($r = 0.95$, $r^2 = 0.9025$) meaning that the bridge change scores explain 90% of the variance of the scores at the time of the interview. Although, the strength of these relationships does not indicate causation, the findings are relevant and may warrant further investigation for possible causes.

Table 5

Correlation MatrixLength of Time With Knowledge of Impending Death and Bridge Scores

	Length of Time With Knowledge of the Impending Death	Bridge Score at Death	Bridge Score at the Time of the Interview	Bridge Change Score
Length of Time With Knowledge of the Impending Death	$r = 1$ $r^2 = 1$	$r = 0.01$ $r^2 = 0.0001$	$r = 0.7$ $r^2 = 0.49$	$r = 0.73$ $r^2 = 0.53$
Bridge Score at Death		$r = 1$ $r^2 = 1$	$r = 0.28$ $r^2 = 0.0784$	$r = 0.02$ $r^2 = 0.0004$
Bridge Score at the Time of the Interview			$r = 1$ $r^2 = 1$	$r = 0.95$ $r^2 = 0.9025$
Bridge Change Score				$r = 1$ $r^2 = 1$

Findings

There were three significant differences found in this study:

1. The variable, length of time with knowledge of the impending death, divided evenly into longer and shorter time with that knowledge, showed a significant difference between the mean bridge score at the time of the death, for the two groups.
2. The same variable, length of time with knowledge of the impending death, divided evenly into longer and shorter time with that knowledge, showed a significant difference between the mean bridge score now, at the time of the interview, for the two groups.
3. The participants were divided into two groups based on the place of death, home

or hospital. Analysis showed a significant difference between the mean bridge score at the time of the death, for the two groups.

There were three strong relationships discovered in this research study:

1. There was a strong relationship found between the length of time with knowledge of the impending death and the bridge score at the time of the interview.
2. There was a strong relationship found between the length of time with knowledge of the impending death and the bridge change score.
3. There was a very strong relationship found between the bridge score at the time of the interview and the bridge change score.

Summary

The study data can be summarized through the answers discovered to each of the four research questions:

1. Does hospice care make a difference in a survivor's progress in bereavement as measured on the 10-Mile Mourning Bridge? No, there were no significant differences found between having or not having hospice care, and a survivor's progress in bereavement, as measured on the 10-Mile Mourning Bridge.
2. Do differences exist between participants' scores on the 10-Mile Mourning Bridge, who had a longer time with knowledge of their spouses' impending death, and those who had a shorter time with that same knowledge? Yes, analysis showed a significance difference between the mean bridge score, at the time of death, for the two groups. There was also a significant difference between the mean bridge score now, at the time of the interview, for the two groups.
3. Do differences exist between those participants' scores on the 10-Mile Mourning

Bridge whose spouses died at home and those who died in the hospital? Yes, analysis showed a significance difference between the mean bridge score, at the time of death, for the two groups.

4. Do relationships exist between participants' progress in bereavement as measured by the 10-Mile Mourning Bridge scores; at the time of death, at the time of the interview, and the measured difference between these two scores; when they are compared with length of time with knowledge of the impending death? Yes, the relationship between the length of time with the knowledge of the impending death, and the bridge score at the time of the interview, was strong. The relationship was also strong between the length of time with the knowledge of the impending death, and the bridge change score. In addition, there was a very strong relationship found between the bridge score at the time of the interview, and the bridge change score.

In this chapter the results of the research study were presented through examination of the demographic and research variables. Research questions were answered and analyzed by finding the significance of any differences and the strength of any relationships. Study findings were then reported and summarized. In Chapter V these results and their significance, as well as future recommendations are discussed.

Chapter V

Discussion

Chapter V of this descriptive correlational study contains a discussion of the research results. This investigator utilized triangulation of qualitative and quantitative procedures to explore the phenomena of progress in bereavement for survivors who lost their spouses to a predictable death. Relationships between bereavement progress, the support participants received prior to the death, and other variables, were examined. An interactive approach was used to collect data during the interview process. Information was gathered from the completed Pre-Interview Questions form (Appendix C, p. 139). Data were compared with participants' scores on the 10-Mile Mourning Bridge (Appendix A, p. 135), which were measured during the interview. This investigator received permission to use and adapt "The 10-Mile Mourning Bridge" (Huber & Gibson, 1990) from Ruth Huber, Ph.D., University of Louisville (Appendix B, p. 137).

An interpretation of the research results is presented in this chapter. This interpreted evidence is examined and summarized. Conclusions are formed. The significance of findings as they relate to research questions, nursing, and family are explored. Future study is suggested and implications are considered and summarized.

Research Findings

Four research questions were answered using data gathered during the interactive interview process. The research and demographic variables were gathered from two sources of information provided by the participant. Demographic data and support available to the participant were reported on the Pre-Interview Questions form. The survivor's self-report of personal progress in bereavement was received as 10-Mile

Mourning Bridge scores. The 10-Mile Mourning Bridge was a self-reporting, zero to ten, visual analogue scale, used to measure the participant's perception of progress on a personal bereavement journey. There were significant differences and strong relationships discovered among study variables. These findings are discussed as each research question is interpreted separately.

Research Question One

Research question. Does hospice care make a difference in a survivor's progress in bereavement as measured on the 10-Mile Mourning Bridge? The findings do not support this research question. There were no significant differences found between having or not having hospice care and survivor's progress in bereavement, as measured on the 10-Mile Mourning Bridge. The three Mourning Bridge scores were examined for differences.

Summary of findings. This research question involved differences in bereavement progress, for participants who had and did not have hospice care for their spouse. The findings do not support the literature for hospice care. The literature suggested that having hospice care eased the bereavement journey for the survivor. Studies concluded that hospice bereaved adjusted better. Spouses of patients who died with hospice suffered less anxiety and associated symptoms than a control group (Cameron & Parkes, 1983). Huber & Gibson (1990) reported that the routine, pre-death work of the hospice team had a "strong and positive impact on survivors' subsequent bereavement"(p. 63). "The hospice bereaved are significantly better adjusted than the hospital bereaved *at 12 months*. The hospice group reports a profound decrease in their psychological symptomatology and an increase in social participation" (Ransford & Smith, 1991, pp. 301 & 302). There is empirical support that survivors who participated in hospice

care experienced less guilt, despair, numbness, shock, and disbelief, than those who did not (Robinson & Pickett, 1996). Study findings from Steele (1990) “support the idea that hospice care prior to death . . . subsequently contributes to a less traumatic bereavement for the survivor” (p.239). The caregivers of hospice patients had successful bereavement outcomes. This component of the hospice mission is a preventative service (Speer, Robinson, & Reed, 1995).

The findings for question one did not reveal a significant difference. There are, however, findings that are less than statistically significant. A difference was found. The survivors who had hospice services traveled slightly farther on the 10-Mile Mourning Bridge than those who did not have hospice services. This was measured as a .75 positive difference in the mean Mourning Bridge change score for the two groups. Although not significant, these findings did support the reviewed literature, which described a positive outcome for bereaved that had hospice services.

Theoretical framework. The findings of this study do not statistically support the effectiveness of an interactive framework used in hospice care for bereaved individuals. The principle of meeting patient and family where they are, in their need for support, has guided care since the foundation of hospice. Hospice professionals know that to provide this care, they must use an interactive approach. Well adjusted, competent individuals can interact with clients without interfering with their freedom to develop and meet their own needs (Rogers, 1961). The focus of an interactive process is the relationship between the helping practitioner and the bereaved (Rogers, 1980; Torres, 1986; Travelbee, 1971). The quality of this relationship is fundamental to the success of the interaction. Emphasis is on interaction and results. Vulnerable individuals, suffering from end-of-life experiences,

benefit from caring provided by an interactive approach (Byock, 1997; Travelbee, 1972). Being there, really being with the patient and family, gives them courage to face the loss and find meaning (Kübler-Ross, 1969). Joyce Travelbee (1971) expected that an interactive process would develop coping skills, prevent suffering, and assist patients as they searched for meaning in their experience of illness. Findings for hospice bereaved were not statistically significant, but were different, and do support the literature related to the use of an interactive framework for hospice care.

Empathy is an essential component of this interactive process (Rogers, 1961; Travelbee, 1966). Through empathy and support the nurse helps the patient and family find meaning in their suffering and consequently hope (Urquhart, 1999). To receive the benefit patients, families, and bereaved should face an end-of life situation in their own unique way. Hospice professionals help prepare them with an interactive approach. The therapist maintains a high level of awareness to keep the interaction focused on the client's perception of his world and his personal experience (Thorne, 1992). This support can be provided by a hospice team and is more complete than hospital support. Literature describes hospice bereaved as better adjusted, but findings do not support this with a statistically significant difference. There was a difference in the mean Mourning Bridge change score of .75 between the two groups. Findings are supportive, but not significantly so, of literature supporting an interactive framework for hospice care. Hospice bereaved did travel slightly farther, on the 10-Mile Mourning Bridge.

Conclusion. The amount of time a patient and family have hospice support may impact benefits received by bereaved. It takes time to develop an interactive relationship between hospice professionals and family members. Rogers (1961) and Travelbee (1966)

developed steps or phases that were traveled before an individual felt safe and could engage in therapeutic communication. Communication began the interactive process and the potential positive results. Developing this level of trust takes time. It is not known how long the bereaved from this study or the literature had hospice. Bereaved, who have less time with hospice support might receive fewer positive benefits.

The length of time from the patient's death to the research interview is unknown in the majority of the literature reviewed. This amount of time could influence study results. In the Huber and Gibson (1990) study the average length of time since death was 20 months. The Huber and Gibson sample contained only hospice bereaved and can not be compared to this sample that contained bereaved who received hospice care and bereaved who did not receive hospice care. In the Ransford and Smith (1991) study the average time since death was 12 months; in contrast the average time since death in this study was 12 weeks. Time helps bereaved adjust to their loss. Adjustments may be different for bereaved three months after a death, than for bereaved one year after a death. This may explain the difference between the Ransford and Smith study, where hospice care reportedly made a difference, and this study where hospice care reportedly did not make a statistically significant difference in bereavement.

Significance. Although not a statistically significant difference, a difference was found in survivor's progress in bereavement as measured on the 10-Mile Mourning Bridge. Examination of the mean Mourning Bridge change score for those who had and did not have hospice support revealed a .75 difference. Those with hospice support reported being farther on the 10-Mile Mourning Bridge than those without hospice support. This supports the literature for an interactive framework used by hospice. It is

important to note the results may reflect the small sample size.

This investigator also believes the disparity in results between bereaved in question one and bereaved in the literature might be related to measures of time. It is important to know how long bereaved individuals receive hospice support. This information was not available for bereaved in the Ransford and Smith study or bereaved in this study. The second time concern is length of time from the patient's death to the research interview. Interviews conducted, 12 weeks and 12 months after death, could produce different results. Ransford and Smith's bereaved had more time to feel comfortable with the death of their spouses. The blow was softened. They might have felt more stable, making it easier to review the circumstances surrounding death. Considering findings and current literature, study replication with a larger sample size might produce different results.

Research Question Two

Research question. Do differences exist between participants' scores on the 10-Mile Mourning Bridge, who had a longer time with knowledge of their spouses' impending death, and those who had a shorter time with that same knowledge? Data analysis supported research question two. Analysis showed a significant difference between the mean bridge score, at time of death, and at the time of the interview for the two groups. Those who had a longer time with knowledge of the impending death reported they were farther along in their bereavement journey, when their spouses died, and about twelve weeks later, at the interview. There was not a significant difference for the bridge change score for the two groups. Each group traveled roughly the same distance across the Mourning Bridge. Length of time since death was nearly the same for each participant; the mean was 12.7 weeks, with a median of 11.5, and a standard deviation of 4.33.

Summary of findings. Although, in this study, hospice support did not make a statistically significant difference in how far the bereaved traveled across the 10-Mile Mourning Bridge, findings for question two indicate the knowledge of impending death may have allowed the journey to begin sooner. These results highlight the importance anticipatory grief plays in an individual's bereavement journey and support the literature. The importance of anticipatory grief was substantiated by the literature, which described anticipatory grief as an experience or expression of grief before the actual loss. Erich Lindemann (1944/1994) coined the term. He described anticipatory grief as:

A common picture hitherto not appreciated is a syndrome, which we have designated *anticipatory grief*. [The person] is so concerned with her adjustment after the potential death, that she goes through all the phases of grief – depression, heightened preoccupation with the deceased, a review of all the forms of death which might befall him, and anticipation of the modes of readjustment which might be necessitated by it. In such situations apparently the grief work had been done so effectively that the [person] has emancipated herself. (p.160)

Norris and Murrell's (1987) subjects began to adjust to their loss long before the actual death, "Our findings strongly suggest that the adaptational requirements of bereavement begin well before the death event" (p. 611). Cameron and Parkes (1983) found that bereaved who were aware of the outcome, adjusted better after the death, than those who were unaware. According to Costello (1996) anticipatory grieving provides bereaved with an opportunity to perform grief work before the death. As death becomes more imminent emotion is more intense, but recovery time and adjustment to life without a spouse may be considerably reduced. "Glick *et al* and Parks found that anticipation of

loss increases the chances for successful adjustment following death” (Costello, p. 172). “This leads to the recognition of one’s vulnerability” (Speck, 1978, p. 147). “The more prolonged the illness, the more one can accomplish the most painful part of mourning in anticipation of the loss” (Blank, 1969, p. 206).

Bereaved individuals have time to consider new or changed roles and be comfortable with them. “Those who allow feelings of loss prior to an expected death can gradually absorb the reality of the loss over time, finish unfinished business, and begin to change their assumptions about life and identity” (Huber & Gibson, 1990, p. 51). “Much of the grief work will have occurred by the time of death and the reaction may be one of relief” (Goldberg, 1973, p.404). “Findings that spouses who expected death fared better than those who did not, highlights the value of preparation for loss” (Potocky, 1993, p. 298).

To experience anticipatory grief, and do the work, one must know about the coming loss. “Awareness of imminent death permits anticipatory grief. Evidence indicates that it usually leads to greater calm and accepting of the ensuing death and that it permits the bereaved person to regain full capacity for effective functioning and subsequent happiness more rapidly” (Randford & Smith, 1991, p. 296). Individuals generally want to know the prognosis of their illness (Byock, 1997; Kübler-Ross, 1969). Burns and Groves (1993) reported on Glaser and Strauss’s 4 year study of death, as reported in 3 books;

Awareness of Dying, Time for Dying, and Status Passage, which described the social environment of dying patient’s in hospitals. The gestalt commonly held was that people could not cope with knowing that they were dying, and must be protected from that knowledge. The study changed our gestalt. Instead of protecting, we saw the traditional care of the dying as creating loneliness and isolation. (p. 64)

By examining what the social environment meant to the patient, the study performed by Glaser and Strauss, changed the way we saw the dying patient. Their findings support the current belief that the practice of withholding knowledge of impending death creates loneliness and isolation. Perhaps Elizabeth Kübler-Ross (1969) was influenced by this historic work as she began to work with dying patients and families in hospitals. She described several patients “who were depressed and morbidly uncommunicative until we spoke with them about the terminal stage of their illness. Their spirits were lightened, they began to eat again, and a few of them were discharged once more, much to the surprise of their families and the medical staff” (p. 142).

Theoretical framework. This research question examined bereavement differences for those who had longer and shorter time with knowledge of a spouse’s impending death. Those who knew longer traveled farther on the 10-Mile Mourning Bridge. This supports literature, which encourages the use of an interactive approach to conversation surrounding death. Individuals, who receive the benefits of an interactive approach, feel safe and communication is more effective. The bereavement journey can then involve growth and maturational development.

Carl Rogers believed this type of growth was demonstrated by the accomplishments of the individual (Torres, 1986). The imminent death of a spouse is a new, often frightening experience for most individuals. They may feel alone and in need. They must heal from the pain of grief to begin a new life without a spouse. The findings from question two suggest knowledge about the impending death of a spouse is important to subsequent bereavement progress. Findings support literature related to use of an interactive process.

Care based on an interactive framework facilitates sharing of this sensitive

information and is supported by the findings. Those who knew longer reported they traveled farther. Once an individual knows about the death intellectually, he or she will need to know about the death emotionally. Knowing emotionally takes more time and energy, and may require assistance. Rogers believed an interactive approach, a Person-to-Person Relationship, freed the client to find new meaning and form new goals while they explored their life and experiences in depth (Rogers, 1961; Torres, 1986). Joyce Travelbee (1966) also believed an interactive approach, based on a Human-to-Human Relationship, allowed patients to recognize and reach goals. Nurse practitioners providing care to patients and families facing end-of-life issues will provide effective palliative care, by using an interactive approach that addresses issues openly and honestly.

Conclusion. Research has shown that patients and families receive benefits from their anticipatory grief work. Quite possibly, the most important benefit is realized by the bereaved. This work can prepare an individual for the anticipated loss, decrease the pain experienced when the actual loss occurs, and enable the individual to face grief in a more positive way (Byock, 1997; Costello, 1996; Huber and Gibson, 1990; Kübler-Ross, 1969; Norris & Murrell, 1987; Wheeler, 1996). Anticipatory grief work requires an interactive approach to communication. This allows individuals to feel trusted. They are able to share and listen. The findings support literature related to the benefits of knowing longer about an impending death.

The bereaved must live on. They have adjustments to make as they adapt to a life without a spouse. The adjustments might consist of: social, because they now assume a different role with family and friends; emotional, because of a change in their support

system; or financial, because of a change in income or a need to join or rejoin the workforce. Results for question two are: Those who knew about the impending death for a longer time, started their journey farther out on the 10-Mile Mourning Bridge, and were therefore farther along the Mourning Bridge at the time of the interview. Findings support literature relating the benefits for anticipatory grief and use of an interactive process.

Significance. Anything that can ease the grief process for the bereaved is invaluable. Findings for question two revealed there was a significant difference for two mean Mourning Bridge scores for those that had a longer and shorter time with the knowledge of their spouses' impending death. Scores were for the time of death, and time of the interview. Results suggest anticipatory grief provided by an interactive approach, which contributes to knowing longer about a coming death, might shorten bereavement.

Research Question Three

Research question. Do differences exist between those participants' scores on the 10-Mile Mourning Bridge whose spouses died at home and those who died in the hospital? Data analysis supported research question three. Analysis showed a significant difference between the mean bridge score, at the time of death, for the two groups. Participants whose spouses died at home reported being farther in their bereavement at the time of death, as measured by the 10-Mile Mourning Bridge.

Summary of findings. Participants were divided by their spouses' place of death, home or hospice. Their bereavement progress was examined for differences. The participants, whose spouse died at home, reported being farther on the 10-Mile Mourning Bridge, at the time of death. The findings support the literature related to death in the home. Patients who remain home usually remain in control of their lives until death. This

generates a sense of peace. Watching a loved one remain in control, even of simple things, helps reduce stress caused by witnessing the deterioration from disease. "Viewing one's spouse in control should reduce some of the bereaved's stress and anxiety in the last months of the patient's life (Ransford & Smith, 1991, p. 296). Research related to death at home described it as usually peaceful for the patient, spouse, and family. They had time to be together and interact while providing care to the patient.

Hospice patients often share that; one reason they have the service "is so I don't ever have to go back to the hospital again!" They describe their home as more peaceful. Interruptions in the patient's day, which result from the task oriented hospital schedule, prevent interaction between patient and family. "Death is a threat to hospital routine; it upsets other patients and staff. As a result, hospital organization discourages intensive interaction with dying patients" (Ransford & Smith, 1991, p. 296). Hospital settings are not conducive to the lengthy listening and emotional support needed for effective anticipatory grief work. "Cameron and Parkes maintain, 'It takes time to break bad news and to give the support necessary if it is to be digested and to give rise to appropriate "work worry" ' [10, p.23] . . . Hospital organization and routines can introduce problems of grief resolution for the bereaved" (Ransford & Smith, 1991, p. 296). Working through unresolved issues and future plans with a loved one prevents future doubt and guilt. Support group bereaved who had a spouse die in a hospital expressed feeling guilty (Fenner & Manchershaw, 1993). They wished they had said or done certain things.

Remaining at home creates positive memories. It creates memories of family and friends as well as "favorable memories of the patient, factors which should translate into more rapid grief resolution" (Ransford & Smith, 1991, p.296). As bereaved recall the last

days, they remember how their loved one enjoyed being home. According to Steele (1990) the memory helped them realize that they participated in the patient's care and did all they could for their loved one. There is a sense of peace about those last days. "A sense of meaning and hope is maintained by meeting biophysical and spiritual needs and by validating the dying person as a living individual" (Steele, p. 236). These patients and families exhibited higher levels of adjustment and were less anxious and depressed. Participants in this study, whose spouses died at home, reported being farther on their journey, at the patient's death. This finding is also supported in the literature.

Theoretical framework. Participants whose spouse died at home reported being farther in bereavement at the time of death, than those participants whose spouse died in the hospital. The findings support the use of an interactive approach to assist patients and families discuss an impending death and make choices. Choices made by patients and families, at the end-of-life, can be as individual as the patients and families who made them. Healthcare practitioners, who use an interactive approach, practice a style of caring that is uncontaminated by judgements or evaluations of the thoughts, feelings, or actions of the client (Rogers, 1961; Thorne, 1992). Caring for a loved one who is dying at home can be a very difficult task. "People must be allowed the opportunity to heal themselves through their own coping mechanisms and natural support systems" (Potocky, 1993, p.298). Once safety has been considered, the option for death at home, should be offered to terminally ill patients and their families. Families, who receive support through an interactive approach to caring, benefit and can then care for a loved one dying at home.

Empathy is a core condition necessary for Carl Rogers' theory of caring (Rogers, 1961; Thorne, 1992). Carl Rogers (1961) and Joyce Travelbee (1966) considered

empathy an essential factor in their interactive process. Empathy, or being sensitive to changing feelings, to fear, to confusion, or whatever they feel, is invaluable when working with a terminal patient and family in their own home (Rogers, 1961; Torres, 1986; Travelbee, 1966). The findings support the use of empathy in an interactive framework to assist individuals and families caring for a dying loved one at home.

Conclusion. The findings support the literature related to the benefits of death at home for the bereaved. Participants reported being farther in bereavement at the time of death if their spouse died at home. For patients and families facing a life-limiting illness, death at home can be less stressful, which may contribute to a more peaceful bereavement. The hospice palliative care movement is a leader in end-of-life care and assists thousands to experience a peaceful death at home each year. “Over the past 20 years hospice has grown from a grassroots movement into a mainstream healthcare option. In that time hospice has helped millions of terminally ill people and families approach death in a safe and comfortable way” (National, 1999b). Bereaved felt peaceful with home death, regret was rarely reported.

Significance. When a spouse died at home rather than a hospital, participants reported being farther in bereavement at the time of death. When professionals discuss end-of-life care they should provide information about options. “Studies examining this issue have reported that, given the choice, most people prefer to die at home” (Steele, 1990, p. 236). A Consumer Reports study determined hospital care for the dying is in dire need of improvement. Forty families were interviewed. Families were seriously dissatisfied with a loved one’s care, just before dying in a hospital. “Ferrell found that spouses of those dying in the home felt less guilt, numbness, shock, and confusion and tended to dwell on

the events surrounding the death less than spouses of those who died in the hospital” (Steele, 1990, p. 236). Programs that facilitate home death should be considered.

Research Question Four

Research question. Do relationships exist between participants’ progress in bereavement as measured by the 10-Mile Mourning Bridge scores; at the time of death, at the time of the interview, and the measured difference between these two scores; when they are compared with length of time with knowledge of the impending death? Yes, research findings showed that the relationship between the length of time with the knowledge of the impending death, and the mean bridge score at the time of the interview was strong. The relationship was also strong between the length of time with the knowledge of the impending death, and the mean bridge change score. This indicates that close to 50% of the variance of both, the scores at the time of the interview, and the change scores, can be explained by the length of time the participant had with the knowledge of the impending death. There was a very strong relationship found between the bridge score at the time of the interview, and the bridge change score. This indicates that the bridge change scores explain 90% of the variance of scores at the time of the interview. The strength of these relationships does not indicate causation, but findings are relevant and warrant further investigation for possible causes.

Summary of findings. The final research question involved relationships between variables. There were strong to very strong relationships found between the length of knowledge of impending death and the 10-Mile Mourning Bridge scores. Although terminal illness and end-of-life care are difficult to discuss, families benefit from these discussions in unsuspected ways. “Empirical work on healthy adults indicates that

individuals who know when and under what circumstances an event will occur, will experience less stress, anxiety, and tension than those experiencing similar circumstances with insufficient information (Miller, 1981)” (Burns & Grove, 1993, p. 189). Uninformed patients, who believe an illness can be cured, will choose aggressive treatment.

Physicians do not always use frank language to inform patients that a condition is terminal. They discuss the illness using terms like serious and critical. Patients who want a positive message cling to any offer of hope. “You look better today” may lead a patient to believe he is getting better, when the physician really meant, he looked more rested. In some instances lack of awareness appeared to intensify the shock of death for a spouse.

Survivors are affected in a number of negative ways. They might become angry with the physician for not informing them. They may find bereavement difficult. They are unprepared for adjustments to life without a spouse. Anticipatory grief work facilitates completion of end-of-life tasks. Assistance with an interactive approach frees the bereaved to accept their grief and experience an uncomplicated bereavement journey.

Conclusion. Research findings showed that there were strong to very strong relationships found between the length of knowledge of impending death and the 10-Mile Mourning Bridge Scores. The findings from question four supports the literature reviewed in this chapter and indicates that knowing about an impending death can begin the grief process. In this study knowing longer correlated with being farther on the 10-Mile Mourning Bridge at the time of the interview. Knowing longer also correlated with the bereaved traveling farther between the time of death and the time of the interview. There was a very strong correlation between how far the bereaved traveled

between the time of death and the time of the interview. Patients must know the prognosis of an illness, that it is terminal, before they can begin anticipatory grief work

Significance. Based on study findings, which support the literature reviewed, the bereaved will travel farther in their bereavement if they are helped by an interactive process that facilitates anticipatory grief work. Healthcare professionals should use an interactive approach to communicate relevant information about the prognosis of an illness in a timely manner. This approach not only helps the patient and family, but also has the potential to safeguard healthcare dollars by preventing illness in the bereaved.

Serendipitous Findings

During the interview 12 (75%) of the participants cried. For some crying was a welling up of tears and an inability to talk for a few moments. Others wept openly. No participants were offered tissue. The offer could signal they should stop crying. They were not interrupted. All participants stopped crying in a short time. There was no intention that participants cry during the interview.

Many participants shared that it was difficult to talk about events surrounding the death of a spouse. Although none of the participants were asked, 15 (94%) said the interview was helpful to them. Some comments from those that both cried and said the interview was helpful were: "It still helps to talk about Bill." "This was good for me." "Not sure I could do it, but I feel better" "Thank you, there aren't a lot of people I can bring this up to." The one participant who did not comment on whether the interview was helpful or not, also did not cry. He kept the conversation pleasant, but short and focused.

These serendipitous findings indicate that even months after the death of a loved one there remains a need to share and cry. Findings also indicate that sharing was helpful. It

appears that increased opportunities to talk about the events surrounding the death of a loved one are beneficial for the survivor. Support groups that focus on the grieving process should be available for individuals in every community.

Significance to Nursing

Nurses who recognize the benefits of an interactive approach develop more effective means for rendering care. Rogers (1961) and Travelbee's (1966) models of an interactive process are useful with individuals who are in physical, emotional, or spiritual pain, and are psychologically vulnerable. Nurses who "confront personal values and beliefs about death, dying and bereavement and have an understanding of the process of normal grief" (McKissock & McKissock, 1996, p. 30), will intervene effectively.

According to Travelbee (1966) "the more knowledge and skillful a nurse is in the area of interpersonal relationships, the more likely it is that she will be able to meet the nursing needs" (preface). Nurses caring for dying patients and families can influence the grieving process "at three points: before a loss occurs (primary prevention); following a loss, before the grief process becomes dysfunctional (secondary prevention); and after symptoms of morbid grief appear, (tertiary prevention)" (Potocky, 1993, p. 289).

Nurses must be comfortable talking about death and dying. " 'Much of the work . . . is about human relationships and helping the patient and family adjust to changes in life style that illness may cause' " (Karrer, 1996, p. 378). Hospital nurses were asked if they discuss bereavement with relatives before a patient dies, 56% said that they did not. Seventy-two percent of those same nurses said they received no training in bereavement (Lloyd-Richards & Rees, 1996). Betty Ferrell (1999a) proposed "Students need to understand that excellent care at the end of life is also an integral part of nursing" (p. 33).

“There is a need for accurate information about the situation together with emotional support that allows time for the impending loss to be taken in and the changes anticipated and prepared for” (Couldrick, 1992, p. 1521). We are obligated to train nurses about this specialized care for dying patients and families.

Nurses skilled in end-of-life care are comfortable “facilitating expression of anticipatory grief, providing optimal care and symptom control for the dying, fostering open communication between the patient and loved ones, and encouraging the survivor to be present at the time of death” (Cameron and Parkes, 1983, p. 74). These tasks can be accomplished by an approach that promotes empathetic interaction and a peaceful death. Graduate nurses “. . . assume a leadership role in the managing of human, fiscal, and physical health care resources” (Cronin and Ladd, 1997, p. 47). End-of-life care requires skill that challenges nurses to develop roles, which provide optimal care to the dying.

Significance to Family

Nursing recognizes the significance of family, to the health of its individual members. Healthcare that relies on families involves assessment of interaction and relationships between patient, family, and the nurse. This may change some of usual patterns of care (Wright & Leahey, 1994). Involving family members in end-of-life care in a hospital setting is difficult. Current quality and future implications of interactions between family members must be considered when planning care for a terminal patient. “It is this ability to ‘think interactionally’ that raises the delivery of health care from an individual to a family (interaction) level” (Wright and Leahey, p. 3).

To consider the entire family the nurse must consider the interrelationships of each individual. “There needs to be a sensitive awareness of the value of the loss to the person,

and the implications for the person's life subsequently. This implies a relationship between the patient and staff which allows for listening; controlled involvement; and the sharing of realistic information, emotional responses and encouragement" (Speck, 1978, p. 146). This requires use of Rogers (1961) and Travelbee's (1966) interactive approach.

Patients and families should understand that although difficult, talking about death beforehand could facilitate completion of end-of-life tasks, which will ease the survivor's bereavement journey. Open discussion may mobilize "the person's strengths and defenses beforehand so that one is able to meet a loss more constructively" (Speck, 1978, p.147). Greifzu (1996) urges nurses to encourage families to talk about death and grief. Communication skills facilitate healing and expression of emotions. These skills must be taught and nurtured. While there is still time, families should be told about end-of-life options, including death at home, which can be a peaceful and memorable event.

Results of this study indicate that work done in anticipation of death may impact the grieving process. Kristjanson, Sloan, Dudgeon, and Adaskin (1996) shared, "Most importantly, the results suggest that the family's care experience during the palliative phase has a bearing on family members' health and the family's ability to function during the early bereavement period" (p. 18). Families should be told there is no established time to finish grieving. "It may take months for some, years for others. Bereavement ends only when the survivors have accepted their loss, adjusted to living without the loved one, and reinvested their emotional energy into other relationships" (Greifzu, 1996, p. 26). An interactive approach, which promotes anticipation in terminal situations, may protect families from needless emotional suffering, increased health risks, and financial burdens.

Recommendations for the Future

Recommendations for future research are suggested based on current findings. Of relevance is the need to gather data from a larger sample size. A longitudinal design, which studies the grief experience during the illness and after the death, might contribute to theoretical and empirical data. To replicate or expand on this study, an investigator would repeat the use of the 10-Mile Mourning Bridge, in each face-to-face interview. This may add depth of understanding and validate participants' feelings and progress. New ideas may be discovered during research obtained through this interview process. Participants should know their feelings are valid and valued, and the investigator can be trusted with them. Glaser (1978) believed the investigator should become engaged "Make the enterprise worthwhile, it assumes a future contribution to a field" (p.7). Awareness of factors that influence the grief process will benefit the entire healthcare community.

Study findings and supporting literature suggest a relationship between bereavement progress and length of time with knowledge of an impending death. Literature, for at least the past 57 years, is available, which describes the benefits received from anticipatory grief work. Anticipatory grief work can only happen if one knows about the coming death, and has enough time to digest and work with the implications. Problems infect all aspects of the dying trajectory related to this knowing. Patients and families share they were not told. Physicians and nurses express apprehension when they do tell.

Further research could be done to examine basic precepts related to knowing. The questions would be who, what, when, where, why, and sometimes how. Individuals would be asked who they told, what they told, when they told, where they told, why they told, and sometimes how they told. Answers given by physicians, nurses, social workers,

clergy, patients, family members, and friends might provide insight into concerns related to knowing. Applying this technique to the words, heard, knew, and understood, might result in deeper insight. As the American population ages, demand for terminal care will increase. "Rosalynn Carter recently said that 'We must focus . . . on the changes that need to take place to ensure that systems exist to help us die with dignity' "(Bales, 1997, p. 2). Answers to the proposed questions may stimulate further research, which could redesign our current approach to, talking about and knowing about, dying and end-of-life care.

If a request were made to name an entity, that honestly confronts death and dying, and compassionately manages people's last days, loud voices would cry out, hospice! Although, the difference between hospice and non-hospice participants in this study was not statistically significant, there was a difference. Those who had hospice were slightly farther in bereavement. Regardless, the literature is full of significantly successful hospice study results. Other variables made more difference to participants. Death at home was helpful, especially at the time of death itself. The variable that seemed to make the most difference, both at the time of death and 12 weeks later was, knowing. Knowing longer, about the coming death made the most difference to study participants.

Summary

As an experienced hospice nurse, this investigator hoped results would show hospice made a difference in survivor's progress in bereavement. In research, a first step to gain "theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible" (Glaser, 1978, pp. 2-3). Results discovered in this study require a step back, and a new look at the current healthcare picture. It is interesting to note, although hospice has been providing cost effective care, to the dying and their families in the United States for

30 years, to date, only 15% to 20% of the population eligible for this service, use it. In addition, despite cries that the healthcare dollars used in the last 6 months of many lives exceeds the total of all their other care, hospice length of stay continues to decline.

The National Hospice and Palliative Care Organization tracks and records how long patients have hospice care. Numbers are reported, in days, as patients' average length of stay. In the early 1990's patients' average length of stay was in the 40's to low 50's, by mid 1990's it had decreased into the 40's. Despite improved awareness and a tremendous increase in the number of hospice programs, the number dropped into the 30's in the late 1990's. During first year of this century many hospice patients and families had hospice support for a month or less. It was not unusual for 35% to 40% of an agency's population to have the service for two weeks or less. At hospice admission, many families shared that they just learned the patient was dying. If hospice is the leader in the discussion of death and the provision of end-of-life care, it's no wonder we don't know long enough.

These facts seem to explain that although hospice does an excellent job, and appears to be an answer to personal, financial, and healthcare problems at the end-of-life; it is not the solution. To improve end-of-life care the structure and function of our current healthcare system, and the beliefs and hopes of individuals and professionals must be examined. "It is sad that the knowledge acquired from the work of pioneers in the field of bereavement (Kübler-Ross, 1972; Parks, 1972) is not being fully applied to practice over twenty years later" (Lloyd-Richards & Rees, 1996, p.109). Professionals who research a field, and discover areas of concern, are responsible for stimulating further examination. The purpose of qualitative research is to raise issues that may need to be addressed in further studies.

End-of-life care has potential for further research. Is care different today than when Travelbee (1972) proclaimed “We cling to the glorious delusion that our job is to cure people. We have failed to come to grips with the unpopular fact that most illness we see is incurable” (p. 6). The problems are not simple. They may be outside the realm of hospice. After all, hospice never touches the lives of 80% to 85% of patients with chronic diseases that die, within any 6-month period. When a box was created around end-of-life care and hospice, it relieved others of obligation and potential satisfaction. Hospital personnel have said, “Don’t worry about it, hospice will take care of it” or, after the death of a patient, “They sure needed hospice”. These statements symbolize a separation between hospital and hospice care. Although unintentional, this quite possibly happened when hospice was encouraged to become the expert, in care of the dying. The box was created. As hospice professionals became experts, the walls became thicker and taller. Since the dying are not coming to hospice, quality end-of-life care must go to the dying.

Current chronic care could be examined and redesigned into a palliative model. Patients would be evaluated where they are, in the disease process. They would receive the level of palliative care appropriate for them. This care would be provided along a continuum, which addressed patient and family, physical, emotional, spiritual, cultural, and social needs. Healthcare dollars would be preserved because ineffective treatments would not be offered. Patient and family understanding would be increased with fewer, more feasible, options available. Professionals, patients, and families would be satisfied as care would be provided on an honest, compassionate continuum. Humans have the capacity to hope in the most deplorable conditions. They have an ability to draw from within and meet any challenge put before them. But before strength and courage can be

brought from within, the person must know what the challenge is. They must know in order to think, analysis, and act. They must know before they can hope. They must know about their disease, they must know about their condition. This approach would create a hopeful environment leading to a peaceful death.

Although, feelings are subjective phenomena beyond absolute analysis, we rely on them to guide us in patient care. Results from this research study raised questions about the practice of waiting to tell bad news, so that hope isn't taken away. Discovering what impacts the survivor's ability to move more effectively through bereavement has far-reaching humanitarian and resource implications. Knowing about impending death and effective anticipatory grief work will avert complications. This will prevent emotional pain, physical and financial problems, and psychological suffering. Research is warranted and necessary to investigate the concepts of knowing and anticipating. Enlightened care should focus on the hope that is attainable in the final phase of the human experience.

An interpretation of the research results was presented in this chapter. This interpreted evidence was examined and summarized. Conclusions were formed. The significance of findings as they related to research questions, nursing, and family were explored. Future study was suggested and implications were considered and summarized.

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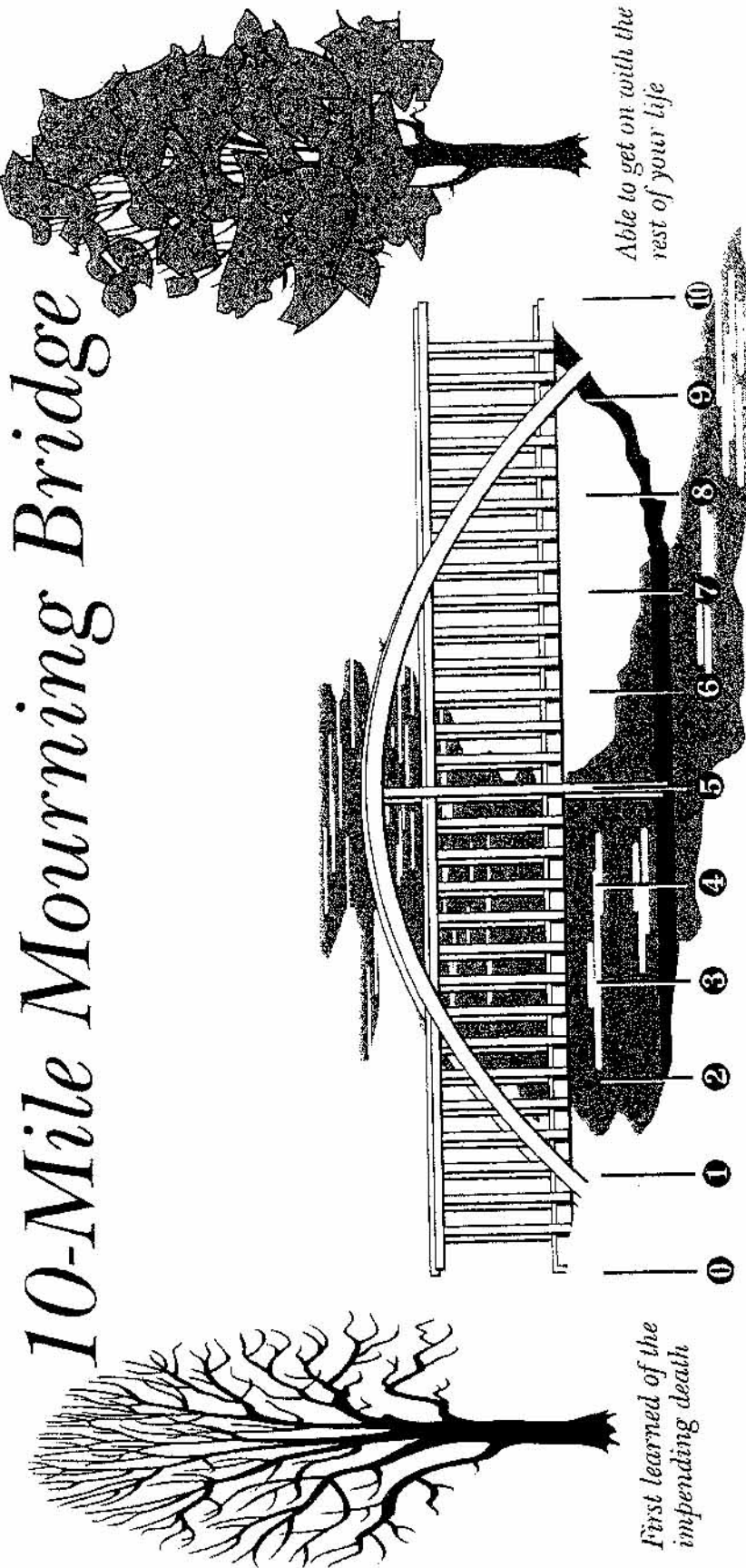
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Appendixes

Appendix A

10-Mile Mourning Bridge



Appendix B

10-Mile Mourning Bridge Permission

Raymond A. Kent School of Social Work

University of Louisville
Louisville, Kentucky 40292
(502) 852-6402
FAX: (502) 852-0422

UNIVERSITY of LOUISVILLE

June 18, 1997

Helen K. McHale, RA, CRNH
518 SE 16th Street
Bartlesville, OK 74003

Re: The 10-Mile Mourning Bridge (with apologies!)

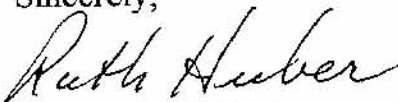
Dear Helen:

I am so embarrassed! I started through a stack on my desk and came across your 3/28/97(!) unanswered letter. Please forgive my tardiness and I'm sure my response is no good to you now, except to tell you that students are all-important and I am so sorry that I neglected your request.

The two articles that you have are the only two on the Bridge and, of course, you are welcome to use them (although citations will always be appreciated). Hospice of Louisville has used the Bridge and I am consulting with them currently for additional use of the tool. The Bridge itself is too simple to copyright, although, of course, the journal articles are copyrighted.

Of course I remember Margaret and would love to know where she is and what she's doing -- please give her my warm regards. Good luck in your studies and if I can help you down the line, please write or call--and I'll try to be much more responsive.

Sincerely,



Ruth Huber, Ph.D.
Assistant Professor

Appendix C

Pre-Interview Questions

Survivor's Progress in Bereavement Through Pre-Death Work

Pre-Interview Questions

Your Age _____ Birthdate _____ Gender _____

Relationship to the Deceased _____

Length of Relationship _____

Deceased's Age _____ Birthdate _____ Gender _____

Cause of Patient's Death _____

Place of Death _____

Date Learned This Illness Was Terminal _____

Date of the Patient's Death _____

Did you and your loved one discuss the death? _____

Types of Support Available:

Children _____

Family _____

Personal Friends _____

Neighbors _____

Reverend or Pastor _____

Church Members _____

Physicians _____

Nurses _____

Hired Caregivers _____

Hospice Services _____

Other _____

Of those used which were most helpful? _____

Appendix D

Informed Consent

PITTSBURG STATE UNIVERSITY DEPARTMENT OF NURSING

COLLEGE OF ARTS AND SCIENCES

Informed Consent

Title of Project: Survivor's Progress in Bereavement Through Pre-Death Work.

Investigator: Helen K. McHale, R.N., B.S.N., CRNH

_____, voluntarily agree to participate in the study entitled: Survivor's Progress in Bereavement Through Pre-Death Work, under the supervision of the Department of Nursing, College of Arts and Sciences, Pittsburg State University.

Purpose: The purpose of this study is to investigate support that individuals receive before the death of a loved one. The study will attempt to discover the types of support that were most helpful to the bereaved. The time frame considered will be the period between the realization of the terminality of the patient's illness and the death itself.

Description of Study: I may ask questions about this study prior to participation. As a participant, I understand that I will be asked to take part in an interview. I may terminate the interview at any time. I will be asked to complete a form containing pre-interview questions prior to the interview. If I need assistance filling out this form it will be provided to me. The named interviewer will present questions relevant to the support I received from the time I first realized my loved one had a terminal illness to the time of the death itself. To facilitate recording of data the interview may be taped. I may ask that the tape recorder be turned off anytime during the interview. The interview will take approximately one hour to complete.

Benefits: I understand there are no direct benefits to me as a result of participating in this study.

Risks: I understand that there are no known risks to me through participating in this study. I understand that my participation or lack of participation will not affect the way I am treated.

Confidentiality: I understand that the information obtained from or about my deceased spouse or me will be kept confidential using the following procedures:

1. All information will be identified and recorded using a code number assigned to me.
2. All completed records will be kept in a locked file.
3. The master file that will contain information connecting names and numbers will be kept under lock and key during the study and destroyed once the data collection is completed.
4. Reports of study findings will be reported as group data in a manner in which no individuals can be identified.

Subject's Assurance: I understand that no assurance regarding the results can be made.

By signing this consent form, I acknowledge that my participation in this study is voluntary. I understand that I can withdraw my permission and withdraw from the study at any time. My treatment, and the relations with the interviewer and Pittsburg State University College of Arts and Sciences, now and in the future, will not be affected in any way if I refuse to participate, or if I enter the program and withdraw later. Records of this study will be kept confidential with respect to any written or verbal reports making it impossible to identify me individually.

If I have any questions or need to report any adverse effect about the research procedures I can contact the investigator, Helen K. McHale, by writing to her at 518 S.E. 16th Street, Bartlesville, OK 74003.

If I have any questions about my rights, I may contact Pittsburg State University Committee for the Protection of Human Research Subjects, Telephone: (316) 231-7000.

Signatures: I have read this informed consent document. I understand the consent and I freely agree to participate in this study under the conditions described in this document. I understand that I will receive a copy of this signed consent form.

Date: _____ Participant: _____

Date: _____ Investigator: _____

Appendix E

Referral Letter

518 S. E. 16th Street
Bartlesville, OK 74003
(918) 336-3740

(Name of Individual and/or Agency):

As a graduate student in the Nursing Department of Pittsburg State University, I am conducting a research project titled "Survivor's Progress in Bereavement Through Pre-Death Work" for my Masters Thesis. My research consists of interviewing individuals who have lost their spouse in the last few months to a life limiting illness. This may include diseases such as Cancer, Heart Disease, Lung Disease (COPD, Emphysema, etc.), ALS (Lou Gehrig's Disease), Alzheimer's Disease, Multiple Sclerosis, or any other that has death as the predictable outcome.

I am attempting to identify the types of support that are helpful to individuals during the time of their loved one's illness. It is believed support of this type may help to prevent unnecessary suffering and more readily prepare individuals for life after the loss of their spouse.

I have enclosed a copy of the Informed Consent, the Pre-Interview Questions, and The 10-Mile Mourning Bridge which will be used in the interview. I am requesting your support in locating individuals willing to be included in this study. These individuals should be contacted for interview permission prior to my contacting them. I will allow the individual time during the interview process to 'tell their story', which can be helpful during the healing process. I will follow this letter with a telephone call and greatly appreciate any assistance you can provide as I complete my Graduate Education. Thank you for your support.

Sincerely,

Helen K. McHale RN, BSN, CRNH

Appendix F

Summary of Study Data

Summary of Study Data

BerID	Age	Gndr	Yrs	1st-Dth	Tm-DOD	Hosp	PlDth	BrgD	BrgN	BrgCg
1	72	1	52	2	10	0	0	0	4	4
2	48	1	15	8	11	1	1	1	6	5
3	58	0	23	18	11	1	1	2	7	5
4	67	0	42	18	10	0	1	1	6	5
5	70	1	53	30	9	1	1	1.5	4	2.5
6	66	1	32	4	8	0	0	0	3.5	3.5
7	78	0	55	2	12	1	1	0	5	5
8	75	1	57	24	8	1	1	1	6	5
9	74	0	54	7	8	1	1	0.5	5	4.5
10	52	1	6	156	22	1	1	0	10	10
11	54	1	28	1	16	0	0	0	4	4
12	68	1	43	13	16	0	0	0	8	8
13	78	1	68	2	17	0	0	0	3	3
14	84	0	66	8	12	0	0	0	3	3
15	68	1	46	2	20	1	1	0	2	2
16	36	1	15	2	13	0	0	0	2.5	2.5

Key:

1. BerID = Numbered order in which the participant was interviewed
2. Age = Age of the participant
3. Gndr = Gender of the participant
4. Yrs = Years of the relationship between the participant and spouse
5. 1st-Dth = Amount of time participant had knowledge of impending death, in weeks
6. Tm-DOD = Time between the death and completion of the interview, in weeks
7. Hosp = Utilization of Hospice Services, 0 = No, 1 = Yes
8. PlDth = Place of death, 0 = Hospital, 1 = Home
9. BrgD = Bridge Score at time of death
10. BrgN = Bridge Score at time of interview
11. BrgCg = Bridge Change Score (difference between BrgD and BrgN)

Appendix G

Participant Thank You

518 S.E. 16th Street
Bartlesville, OK 74003

(Date)

(Participant's Name)
(Participant's Address)

Dear (Participant)

Thank you for your recent interest and participation in my research thesis, "Survivor's Progress in Bereavement Through Pre-Death Work". This study was part of the requirements for completion of my Master's Degree in Nursing from the Nursing Department, School of Arts and Sciences, Pittsburg State University at Pittsburg Kansas. Findings from studies such as this one can be used to further nursing's understanding of patient and family needs during times of illness. The results may also help nurses plan care and programs that prevent illness and unnecessary suffering. Your participation enhanced my understanding of grief and the bereavement process, thank you. Please feel free to contact me with any future questions or concerns you may have.

Sincerely,

Helen K. McHale RN, BSN, CRNH

"Survivor's Progress in Bereavement Through Pre-Death Work"

Appendix H

Follow-Up Thank You

518 S.E. 16th Street
Bartlesville, OK 74003

(Date)

(Street)
(City)

Dear (Name of Referring Individual)

Thank you for your recent interest and participation in my research thesis, "Survivor's Progress in Bereavement Through Pre-Death Work". This study was part of the requirements for completion of my Master's Degree in Nursing from the Nursing Department, School of Arts and Sciences, Pittsburg State University at Pittsburg Kansas. Findings from studies such as this one can be used to further nursing's understanding of patient and family needs during times of illness. The results may also help nurses plan care and programs that prevent illness and unnecessary suffering. Your participation enhanced my understanding of grief and the bereavement process, thank you. Please feel free to contact me with any future questions or concerns you may have.

Sincerely,

Helen K. McHale RN, BSN, CRNH

"Survivor's Progress in Bereavement Through Pre-Death Work"

