

## Dignity Therapy: Family Member Perspectives

SUSAN McCLEMENT, Ph.D.,<sup>1,2</sup> HARVEY MAX CHOCHINOV, M.D., Ph.D.,<sup>3</sup>  
THOMAS HACK, Ph.D., Psych.,<sup>4</sup> THOMAS HASSARD, Ph.D.,<sup>5</sup>  
LINDA JOAN KRISTJANSON, Ph.D.,<sup>6,7</sup> and MIKE HARLOS, M.D.<sup>8</sup>

### ABSTRACT

**Purpose:** Dignity Therapy is a novel therapeutic intervention designed to address psychosocial and existential distress among the terminally ill. This brief, individualized approach to end-of-life care invites patients to discuss issues that are most important to them and to articulate things they would most want remembered as death draws near. These discussions and recollections are recorded, transcribed, and edited into a generativity document, which are usually given to family or loved ones. While the marked benefits of Dignity Therapy on patients' psychosocial and existential distress have been reported elsewhere, this paper presents data on bereft family members' perspectives regarding the impact of dignity therapy on patients and themselves.

**Subjects and methods:** Sixty family members of deceased terminally ill patients who previously took part in Dignity Therapy completed a questionnaire to elicit feedback about the impact of Dignity Therapy on both the dying patient and themselves.

**Results:** Ninety-five percent of participants reported that Dignity Therapy helped the patient; 78% reported that it heightened the patient's sense of dignity; 72% reported that it heightened the patient's sense of purpose; 65% reported that it helped the patient prepare for death; 65% reported that it was as important as any other aspect of the patient's care; and 43% reported that Dignity Therapy reduced the patient's suffering. Regarding family members, 78% reported that the generativity document helped them during their time of grief; 77% reported that the document would continue to be a source of comfort for their families and themselves; and 95% reported they would recommend Dignity Therapy to other patients of family members confronting a terminal illness.

**Conclusion:** Family members endorse Dignity Therapy as a therapeutic intervention that moderates their bereavement experiences and lessens suffering and distress in terminally ill relatives.

### INTRODUCTION

**A** TERMINAL ILLNESS affects the dying individual and their family members.<sup>1-4</sup> Research suggests that the patients' illness experience deeply affects family members' psychological and physical health,<sup>5,6</sup> with

recollections of those final months, weeks, or days sometimes complicating the grief of the bereft or leaving them with feelings of regret.<sup>6,7</sup> One of the primary goals of palliative and end-of-life care is to improve the quality of life of dying people and their families. The challenge for health care providers is to know

<sup>1</sup>Faculty of Nursing, <sup>4</sup>Patient and Family Support Services, Department of Nursing, <sup>5</sup>Community Health Sciences, University of Manitoba, Winnipeg, Manitoba, Canada.

<sup>2</sup>Manitoba Palliative Care Research Unit, <sup>3</sup>Department of Psychiatry CancerCare, Manitoba, Winnipeg, Manitoba, Canada.

<sup>6</sup>Department of Research and Higher Degrees, Edith Cowan University, Perth, Australia.

<sup>7</sup>Office of Research and Development, Curtin University of Technology, Perth, Australia.

<sup>8</sup>Department of Palliative Care, St. Boniface Hospital, Winnipeg, Manitoba, Canada.

what interventions might lessen family psychosocial distress, increase family satisfaction with the provision of palliative care, and enhance the bereavement experience.

A central tenet in palliative care is that both the patient and family constitute the unit of care.<sup>8</sup> Family members receive care from health professionals in the form of information and support.<sup>6</sup> Relatives vicariously experience patient distress, which can be mitigated by the care the patient receives.<sup>5-11</sup> The quality of life of family members of someone who is dying is thus intimately connected to the care and well-being of their loved one. Several studies have demonstrated the importance of perceived personal dignity among the terminally ill.<sup>12,13</sup> One can thus assume that concerns about the issue of dignity and how best to support it in the provision of end-of-life care would have implications for both patients and family members throughout the palliative phase and into bereavement.

Our quantitative and qualitative studies have examined the concept of dignity from the perspective of the terminally ill patient, and identified various factors that bolster or erode it.<sup>12-18</sup> The importance of generativity (a term coined by Erik Erikson concerning the satisfaction that adults experience as a result of having generated meaningful or productive ideas and activities including concern about guiding the next generation) as a significant theme in our empirically derived model of dignity in the terminally ill offered direction about how to construct dignity-enhancing interven-

TABLE 1. DIGNITY PSYCHOTHERAPY QUESTION PROTOCOL

---

Tell me a little about your life history; particularly the parts that you either remember most, or think are the most important? When did you feel most alive?

Are there specific things that you would want your family to know about you, and are there particular things you would want them to remember?

What are the most important roles you have played in life (family roles, vocational roles, community service roles, etc)? Why were they so important to you and what do you think you accomplished in those roles?

What are your most important accomplishments, and what do you feel most proud of?

Are there particular things that you feel still need to be said to your loved ones, or things that you would want to take the time to say once again?

What are your hopes and dreams for your loved ones?

What have you learned about life that you would want to pass along to others? What advice or words of guidance would you wish to pass along to your [son, daughter, husband, wife, parents, other(s)]?

Are there words or perhaps even instructions you would like to offer your family, to help prepare them for the future?

In creating this permanent record, are there other things that you would like included?

---

TABLE 2. DIGNITY THERAPY PROTOCOL

- 
1. Identify mentally competent, terminally ill patients who wish to take part in Dignity Therapy.
  2. Assisted by a therapist, patients are guided through a Dignity Therapy interview that uses the question protocol to direct its content.
  3. Depending on the patient's ability and wishes, offer one or two sessions—as described above—in as close proximity as possible (1–3 day interval).
  4. Transcribe conversations within 2–3 days of final interview.
  5. Over next 24–48 hours, edit transcripts so as to convert dialogue format into polished narrative (involves removing colloquialisms, correcting time sequences, eliminating material not intended for generativity purposes).
  6. When editing is complete, revisit the patient to read the entire manuscript, ensuring that all changes are correct and meet the patient's specifications.
  7. Any necessary corrections to the document are made within 24–48 hours.
  8. When corrections are completed, the patient is provided a hard copy of the generativity document.
  9. When they wish to do so, patients may share or bequeath the document to friends, family, or loved ones of their choosing.
- 

tions for patients nearing death, including Dignity Therapy. The goal of Dignity Therapy is to provide patients a generativity or legacy-making opportunity, in order to decrease their sense of suffering, while bolstering their sense of meaning, purpose, dignity, and quality of life.

The framework for Dignity Therapy is informed by our empirically derived theoretical framework of dignity in the terminally ill. Information concerning the analytic procedures involved in this qualitative work has been reported elsewhere.<sup>12</sup> The themes and sub-themes that arise from the dignity model form the basis of an interview guide that invites patients to discuss issues that matter most to them, or say things they wanted to say and be known to the people closest to them (Table 1). Patients consenting to take part in the study were guided through the Dignity Therapy protocol (Table 2), the details and results of which have been reported elsewhere.

In a cohort of terminally ill patients from Winnipeg, Canada, and Perth, Australia, Dignity Therapy was shown to increase patient preparedness for death, heighten their sense of dignity, increase will to live, and, according to participants, help prepare their family members for the future.<sup>1</sup> Patients who participate in this therapy create a generativity document intended for family members and loved ones. As such, patients and families may directly or indirectly experience the

effects of the Dignity Therapy. Our study protocol assessed family members 9 to 12 months after the death of the patient, focusing on the effect Dignity Therapy had on their deceased loved one and themselves.

## PARTICIPANTS AND METHODS

Patients completing the Dignity Therapy feasibility study at the Canadian ( $n = 50$ ) and Australian sites ( $n = 50$ ) were asked to provide the name and contact information of a family member whom they wished to receive a copy of the generativity document. These family members also agreed to be approached by a trained research nurse, who sought their participation in the family follow-up portion of the study. Nine to 12 months following the death of the patient, these individuals were contacted by a research nurse and invited to provide feedback about their feelings and reactions to Dignity Therapy. Based on our experience, this timeframe allows resolution of the acute phases of family grief, while still providing enough proximity to the loss to enable accurate recall, thus making it ethically and strategically appropriate.

After obtaining written consent, family participants were asked to complete an evaluation, consisting of Likert scales, and open-and closed-ended questions that assessed the perceived impact of Dignity Therapy on patients and families. This inquiry focused primarily on psychosocial and bereavement related issues. Depending on participant preference, questionnaires were completed face-to-face, over the telephone with the research nurse, or returned by mail.

## RESULTS

Over a 2-year period (2002–2003), 113 patients produced a generativity document. Of those, 18% had breast cancer, 17% had lung cancer, 15% had gastrointestinal cancer, 13% had genitourinary cancer, 5% had primary brain tumors, 5% had hematologic malignancies, 19% had various solid tumors, 5% had tumors of unknown primary, and 3% had nonmalignant conditions. Of these 113 patients, 16 of their family members declined to take part in the study (11%), 8 patients had not specified a particular individual family member for receipt of the document (5.8%), and 7 family members did not return the research nurse's phone call (5%). Within the remaining group of 82 family members, 14 had not yet experienced the death of their relative (10.1%), 3 had been bereft for less than 6 months (2.2%), 4 were waiting (2.9%) to make a decision to

take part, and 1 family follow-up questionnaire was incomplete. Of the 113 patients who created a generativity document, 100 completed the full Dignity Therapy protocol; 60 family members provided feedback about their experience of this intervention. In 17 of the 60 patient interviews (28%), 1 or more family members were present for the Dignity Therapy session(s); (12 wives; 1 husband; 1 daughter; 1 wife and daughter; 1 sister; 1 wife, daughter, and son-in-law).

The mean age of family participants was 54.5 years (range, 21–81 years; standard deviation [SD] = 14.3). Seventy percent of the sample was female, most often the spouse (53.3%) or adult child of the patient (31.7%). Seventeen percent had less than a high school education, 18% had graduated from high school, 12% had some community college or technical school training, 17% had graduated from a community college or technical school, 7% had some university education, 20% had a baccalaureate degree, and 3% had a master's degree. Educational data for 6% of the family sample was missing. Participants' religious affiliations were 33% Protestant, 32% Roman Catholic, 17% other, and 12% no religious affiliation. Religious affiliation data for 6% of the family sample was missing. The mean time of questionnaire completion following the patient's death was 11.33 months (range, 8–19; SD = 3.10). Ninety-three percent of the family sample lived in an urban setting.

## QUALITATIVE FINDINGS

Family follow-up data is summarized in Table 3. Of the 60 family members completing the questionnaire, 95% reported that Dignity Therapy helped the patient. In particular, the intervention was seen as a mechanism that empowered patients to share their feelings in a therapeutic and safe environment. Regarding her mother's participation in dignity therapy, one daughter observed, "Mom was extremely closed emotionally and had huge difficulties expressing her feelings. This gave her an opportunity to do so without feeling vulnerable."

Seventy-eight percent of family members reported that Dignity Therapy heightened the patient's sense of dignity, and 72% reported that that it heightened the patients' sense of purpose. Said a family member of her father's participation in dignity therapy, "He had something to say, wanted to be heard, wanted to pass on a message of hope. It helped him find some value in what he had done and remember who he was."

Sixty-five percent of family members indicated that Dignity Therapy helped the patient prepare for death; 65% indicated that the intervention was as important

TABLE 3. FAMILY DIGNITY FOLLOW-UP DATA ( $N = 60$ )

<i>Question</i>	<i>Percentage</i>
Helped patient	95%
Recommend it to other patients and families	95%
Heightened patient's sense of dignity	78.3%
Helped surviving family during time of grief	78%
Will continue to comfort family	76.7%
Gave patient heightened sense of purpose	71.7%
Helped patient prepare for death	65%
Was as important as any other aspect of patient's care	64.6%
Reduced patient's suffering	43.3%

as any other aspect of the patients care; and 43% reported that it reduced the patient's suffering. Families perceived that Dignity Therapy allowed their relative to reflect and thus more fully appreciate their accomplishments and the meaningful things in their lives. A daughter observed, "Reading the document gave my mom a sense of accomplishment I believe. It gave her a tangible way of looking back at a life well lived." Said another family member about the impact of Dignity Therapy for her relative, "To share feelings and the past is a valuable and important means of showing that life has meaning."

Notions of the patient being able to leave behind a tangible legacy for immediate and subsequent generations was also identified by families as being a positive outcome of Dignity Therapy. The wife of a patient remarked, "He felt that our grandsons, including our latest whom unfortunately he never lived to see, would get some idea of his life and what he had achieved." Another family member stated, "It [Dignity Therapy] legitimises your life and provides an opportunity to put down on paper what you hope is your legacy."

With regard to family members' reports of their bereavement course, 78% reported that the generativity document helped them during their time of grief; 76% indicated that the document would continue to be a source of comfort for their families and themselves; and 95% reported they would recommend Dignity Therapy to other patients of family members dealing with a terminal illness. One family member explained, "I think the Dignity Therapy truly helped him feel as though he were doing something useful and to be able to leave behind a part of himself. That in turn has helped myself and the children as it is almost like receiving a special gift of his words that we can have for our life time." Another family member remarked, "I would say it [the document] was more helpful than any mourning aspect. It helped me move past it. Family and friends are certainly a support but through the

document, my Mom was also able to provide support." Generativity documents typically contained messages of love, affirmation and support that gave family members solace in their bereavement. Such messages were characterized as tangible "gifts" to the living. Said a daughter, "The comfort comes from feeling I'm sharing in my Mom's life even after her death." Said another daughter, it was something to hold onto at the time of Dad's passing and it made Dad's life and ways alive and tender."

Information was also collected from family members concerning the ways in which the generativity document was stored, shared, and reviewed. The document tended to be stored in a "safe place", often with important personal/legal papers, family heirlooms and collections of patient-related memorabilia. Copies made of the original document ranged from 1 to 30 with a mean of 5.6 copies. Families indicated that they had shared the manuscript extensively with friends and other family members (e.g., posting it on-line as a virtual memorial); using it as the basis for eulogies and obituaries.

With the exception of one family member who stated, "I still feel too sad to read it, but in time, I will," all family members reported reading the generativity document at least once upon receiving it, with a range of between 1 and 12 readings. While some family members found it helpful to read the document soon after the patient's death; others chose to read it later into their bereavement period.

While the vast majority of family feedback was positive, there were some instances of dissatisfaction. One wife was concerned that the document contained some material that might be hurtful to her husband's siblings. (The protocol is extremely vigilant in addressing these issues with patients and their families, but in this instance, unbeknownst to the patient and his spouse, the document was taken by others who did not have permission to access its content). In two instances, spouses felt that the document was not an entirely accurate depiction of their deceased husband; in one instance this was because of perceived errors of omission, while in another instance, was attributed to a tone of depression that the wife felt created a rather distorted picture of her late husband.

## ETHICAL CONSIDERATIONS

In a small number of instances, the audio-recording of the patient's dignity therapy session spawned an unforeseen ethical issue; how to respond to family member requests for a copy of the actual taped interview. Two family members contacted the research nurse to

inquire about receiving a copy of the unedited audio-taped interview. Reasons for requesting the tape included seeking out clarification for something that appeared in the generativity document, and in one instance, the opportunity to be able to listen to their deceased loved ones actual voice. Such a request posed a moral dilemma for the research team.

While providing a copy of the tape to family members might meet their perceived need and afford them some benefit in the bereavement period, the patient had not given *a priori* consent for the tape to be released. Moreover, unlike the pristine generativity narrative, edited and approved by the patient for dissemination to family members, the raw data from the taped interview often contained errors of omission, material not targeted in any way to generativity-related issues, and occasionally details that might cause pain or offense to the document recipients. In one instance, the husband of a deceased participant wanted to hear the tape, so as to clarify something he had read in the document. However, the tape made reference to a longstanding conflict the patient had had with another family member. The research team was concerned that the patient would not have wanted this information released, as she had in fact indicated this particular reference be omitted from the final written generativity document. In consultation with the University Ethics Committee, a decision was reached to provide him with the tape, providing the contentious portion of the tape be erased. This compromise was well received by the family member, who found listening to the tape provided the peace of mind and clarification sought. In another instance, a woman asked that she receive a copy of her husband's unedited Dignity Therapy tape. In this case, the ethical issues were less problematic, in that this was a close and nonconflicted couple. The wife had in fact sat in on the entire Dignity Therapy process, and was well aware of the content of the tape sessions. When asked, about 1 year after the death of her husband, to compare the experience of the tape with the document, she stated that the tape was raw, painful, and so difficult to listen to that only she and her son would ever even know of its existence. On the other hand, she stated that everyone in her family and extended family had a copy of the generativity document, and that it provided comfort to, and was read frequently by, each of them.

## DISCUSSION

Although the literature frequently refers to the importance of dignity in end-of-life/palliative care, little

empirical work related to this construct has been reported. Moreover, the focus has tended to be on questions about how to enhance the dignity of the patient. This study examined a novel intervention—Dignity Therapy—directed toward the patient and the family. The intervention provides a potential enduring bridge between the patient and surviving family, offering solace and support at the end stages of the patient's life and during the bereavement period. The vast majority of family participants who participated in this study evaluated the intervention favorably, both for themselves as well as their terminally ill relative. Families clearly endorsed the notion that Dignity Therapy helped the patient, conferred a heightened sense of purpose and dignity, helped the patient prepare for death, and reduced the patient's suffering. From a family member's perspective then, Dignity Therapy is seen as a potent intervention that helps affirm the value of the patient's life in the face of death.

Dignity Therapy also appeared to have a positive impact on family bereavement. Bereaved family members are challenged to adjust to a world devoid of the physical, social and psychological presence of the deceased.<sup>19</sup> In addition to experiencing the death of the family unit as it has been known, families lose their interactional selves in relation to the deceased.<sup>20</sup> Bereavement care must therefore help family members find ways of transforming their attachment to the deceased and establishing new forms of ongoing relationship to the memories of that person.<sup>21,22</sup>

Zisook states, "perhaps the most powerful means of mitigating the anguish of losing a loved one is to maintain a continuing relationship with the deceased person" (p. 324).<sup>23</sup> Our findings suggest that the generativity document helps forge such a relationship for surviving family members. In so doing, Dignity Therapy has the potential to help family members who must cope with both the death of the patient and the death of the family unit as it had previously been experienced.

While satisfaction for Dignity Therapy was largely positive, there were some instances where the family expressed some misgivings. This occurred either as a result of feeling the document created an incomplete or inaccurate picture of their loved one; that the document might hurt others reading it; or fear that the content might stir painful emotions during the bereavement process. These rare but notable instances of dissatisfaction raise some important issues regarding Dignity Therapy as a bereavement intervention. First, it is critical that patients be selected carefully, so as not to be at risk of delivering a document that provides a distortion of their former self. Next, it is important

that patients are able to indicate who they wish to bequeath the document to, and that every effort is made to adhere to their expressed wishes. Finally, it must be understood that family members will read the generativity document at a time of their choosing. Like photographs, video recordings, or personal effects, the generativity document can evoke memories and emotions that should be confronted when the bereft feels able to do so. One final observation is that while 19 family members were present during Dignity Therapy sessions with the patient and interviewer in every instance of later dissatisfaction, the family member had not been an active participant in the Dignity Therapy process. Perhaps participation by family members ensures that there are no later surprise revelations. Additionally, family members are often able to help facilitate the interview process by offering suggestions or cues that might lead to more meaningful and fulsome disclosures.

Family members commented upon the importance of the generativity document for adult family survivors, as well as children and grandchildren. It is apparent that the generativity document has potential intergenerational impact. As Kuhl<sup>24</sup> observes:

To know who we are as adults we must understand who we were as children in the context of our family of origin. This is strengthened by knowing the context of our family history through past generations. A feature of knowing one has a terminal illness is visiting or revisiting one's place in, one's relationship to, the family of origin. (p. 235).

This "knowing," consisting of understanding one's place in and relationship to the family of origin may be gleaned through reading a generativity document. Such understanding may in turn inform and shape the experiences of future family members when faced with their own mortality. To the extent that such knowledge is fundamental to one's understanding of self and can help engender peace and a sense of meaning in the context of a life-threatening illness,<sup>1</sup> the potential generational effects of the generativity document must not be underestimated.

We recognize several limitations to the family portion of this project. Family respondents in this study were primarily elderly female spouses of the patient and adult-children. We cannot presume that their perspectives reflect those of other family members. While we are currently conducting a small study of Dignity Therapy in patients with amyotrophic lateral sclerosis (ALS), perceptions of families whose relative died

from an illness other than cancer warrants investigation. Sixteen family members (11.5%) declined to take part in an evaluation of Dignity Therapy. Little is known about these individuals regarding their characteristics, end-of-life concerns, or conflicts that influenced their decision not to provide their perspectives. The family members participating in this study were largely white, Anglo-Saxon, and Protestant. This raises the question as to what extent notions of dignity are culturally bound. The ways in which dignity is understood and experienced in other cultures has not been explored, and merits further investigation.

Despite these limitations, it appears that Dignity Therapy is a feasible, effective, and novel intervention, which can enhance the bereavement course for palliative care families. The bereaved may be at risk for disturbances of physical and psychological health,<sup>25-27</sup> and often decline self-care activities.<sup>28</sup> Therefore a range of sensitive and appropriate interventions are needed to support family members adjusting to loss. An international randomized controlled trial (RCT) of Dignity Therapy, funded by the National Institutes of Health (NIH), is currently underway in Winnipeg, Canada, New York, and Perth, Australia. This RCT will allow us to extend this work and examine the impact of Dignity Therapy on family depression, complicated grief, and family satisfaction with advanced cancer care. This RCT could provide additional support for the application of Dignity Therapy as an intervention that improves quality of care for both palliative patients and their family members.

## REFERENCES

1. Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, Harlos M: Dignity therapy: A novel psychotherapeutic intervention for patients near the end of life. *J Clin Oncol* 2005;23:5520-5525.
2. Redinbaugh EM, Baum A, Tarbell S, Arnold R: End-of-life caregiving: what helps family caregivers cope? *J Palliat Med* 2003;6:901-909.
3. Sherman DW: Reciprocal suffering: the need to improve family caregivers' quality of life through palliative care. *J Palliat Med* 1998;1:357-366.
4. Perreault A, Fothergill-Bouronnais F, Fiset V: The experience of family members caring for a dying loved one. *Int J Palliat Nurs* 2004;10:133-143.
5. Kristjanson LJ, Aoun S: Palliative care for families: Remembering the hidden patients. *Can J Psychiatry* 2004;49:359-365.
6. Kristjanson, LJ, Sloan JA, Dudgeon D, Adaskin E: Family members' perceptions of palliative cancer care: Predictors of family functioning and family members' health. *J Palliat Care Winter* 1996;12:10-20.

7. Shiozakie M, Morita T, Hirai K, Sakaguchi Y, Tsuneto S, Shima Y: Why are bereaved family members dissatisfied with specialised inpatient palliative care service? A nationwide qualitative study. *Palliat Med* 2005;19:319–327.
8. Kemp C: *Terminal Illness: A Guide to Nursing Care, 2nd ed.* Philadelphia: Lippincott, 1999.
9. Connor SR, Teno J, Spence C, Smith N: Family evaluation of hospice care: Results from voluntary submission of data via website. *J Pain Symptom Manage* 2005;30:9–17.
10. Exley C, Tyrer F: Bereaved carers' views of a hospice at home service. *Int J Palliat Nurs* 2005;11:242–246.
11. McPherson CJ, Addington-Hall JM: Evaluating palliative care: Bereaved family members' evaluations of patients' pain, anxiety and depression. *Pain Symptom Manage* 2004;28:104–114.
12. Becker R: "How will I cope: Psychological aspects of advanced illness. In: Kinghorn S, Gamlin R (eds): *Palliative Nursing: Bringing Comfort and Hope*. Edinburgh: Bailliere Tindall, 2001, pp. 183–196.
13. Chochinov HM, Hack T, McClement S, Harlos M: Dignity in the terminally ill: An empirical model. *Soc Sci Med* 2002;54:433–443.
14. Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, Harlos M: Dignity in the terminally ill: A cross-sectional cohort study. *Lancet* 2002;360:2026–2030.
15. Chochinov HM: Dignity-conserving care: A new model for palliative care. *JAMA* 2002;287:2253–2260.
16. Chochinov HM: Dignity and the eye of the beholder. *J Clin Oncol* 2004;22:1336–1340.
17. Hack T, Chochinov H M, Hassard T, Kristjanson L, McClement S, Harlos M: Defining dignity in terminally ill cancer patients: A factor-analytic approach. *Psychooncology* 2004;13:700–708.
18. McClement SE, Chochinov HM, Hack TF, Kristjanson LJ, Harlos MS: Dignity conserving care: Application of research findings to practice. *Int J Palliat Nurs* 2004;10:173–179.
19. Corless IB: Bereavement. In: Ferrell BR, Coyle N (eds): *Textbook of Palliative Nursing*. Oxford: Oxford University Press, 2001, pp. 352–362.
20. Rando TA: *Grief Dying and Death: Clinical Interventions for Caregivers*. Champaign, IL: Research Press, 1984.
21. Ruskay S: Saying hello again: A new approach to bereavement counseling. *Hosp J* 1996;11:5–14.
22. Boerner K, Heckhausen J: To have and have not: Adaptive bereavement by transforming mental ties to the deceased. *Death Stud* 2003;27:199–226.
23. Zoosik S: Understanding and managing bereavement in palliative care. In: Chochinov HM, Breitbart W (eds): *Handbook of Psychiatry in Palliative Medicine*. Oxford: Oxford University Press, 2000, pp. 321–334.
24. Kuhl D: *What Dying People Want: Practical Wisdom for the End of Life*. Canada: Anchor Canada/Random House, 2003.
25. Priggeron HG, Bierhals AJ, Kasal SV, Reynolds CF, Shear MK, Day N, Beery LC, Newsom JT, Jacobs S: Traumatic grief as a risk factor for mental and physical morbidity. *Am J Psychiatry* 1997;154:616–623.
26. Zisook S, Shyter S: Uncomplicated bereavement. *J Clin Psychiatry* 1993;54:363–372.
27. Li J, Precht DH, Mortensen PB, Olsen J: Mortality in parents after death of a child in Denmark: A nationwide follow-up study. *Lancet* 2003;361:363–367.
28. Jacob SR: The grief experience of older women whose husbands had hospice care. *J Adv Nursing* 1996;24:280–286.

Address reprint requests to:

*Susan McClement, Ph.D.*

*Faculty of Nursing*

*University of Manitoba*

*CancerCare Manitoba*

*Manitoba Palliative Care Research Unit*

*3017-675 McDermot Avenue*

*Winnipeg, Manitoba R3E 0V9*

*Canada*

*E-mail: susan.mcclement@cancercare.mb.ca*

Copyright of *Journal of Palliative Medicine* is the property of Mary Ann Liebert, Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.