ASSESSMENT OF SPOUSAL GRIEF IN THE PRIMARY CARE SETTING

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By

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ABSTRACT

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Grief care relating to loss, that of recognizing, consoling and supporting, is not readily available in the primary care setting. Losses may be of a person, material, psychosocial or developmental. This project addresses human loss and the needs of the newly widowed woman. The death of her spouse catapults the woman into a difficult transitional state. Schlossberg's Model for Analyzing Human Adaptation to Transition addresses this transitional state. The purpose of this project was the development of an assessment tool to identify the high risk factors related to becoming a widow. Much of the information, however, will be appropriate for all bereavement issues. Advanced Practice Nurses working in primary care have a great opportunity to identify, support and facilitate this transitional period of grief to a more healthy conclusion.

DEDICATION

To Michael P. Landschoot who loved, believed and supported my dream; sons Matthew and Nathaniel, friends and family for their continued love and support.

ACKNOWLEDGMENTS

Continued improvement for the quality of patient care is made through challenging clinical and academic endeavors. I would like to thank all of my professors and clinical instructors in holding me to that challenge at hand. Thanks to my committee of Linda Keilman, Jackie Wright and Linda Spence for their efforts and suggestions for this project.

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Introduction

Grief is a universal experience crossing all ages and cultures and is normally experienced more than once during a life time (Cowles, 1996). How grief is worked through can greatly impact the physical and emotional health of an individual. The first year of grief has the greatest potential for physical and mental health concerns (Dershimer, 1990; Osterweis, Soloman & Greene, 1984). Compassionate, knowledgeable primary health care for the grieving person is a universal need that can be utilized by each and every person experiencing the death of a significant person in their lives.

All people grieve at one time or another for various types of loss. Loss is defined as being without something one once had (Peretz, 1970) and results in grief. Four types of grief/loss are identified. There is loss of a loved one through death, divorce, rejection or abandonment. The second type of loss is of a physical or psychological nature such as ideas, feelings of self worth or lovability. A third type of loss includes external objects of money, home, or other material possessions. The last type of loss is developmental, or tasks of development, that must be met in order to proceed through the life cycle, such as parenthood (Pertez, 1970). Significant losses, such as the death of a spouse, have great potential for illness, depression (Harlow, Goldberg & Comstock, 1991; Steele, 1992) and social adjustment (Jacob, 1993).

For the purpose of this project, grieving and loss will relate to human life, specifically loss of a husband, and the bereaved will be the female surviving spouse. The purpose of this project was the development of an assessment tool to use in identifying the high risk factors related to

becoming a widow. Much of the protocol could be utilized for all bereavement losses.

The primary care setting provides great opportunity to identify and counsel a grieving individual. Starfield (1993), defines primary care as the basic level of service provided to everyone including preventive, curative, and rehabilitative. Basic assumptions of primary care include a patient population seen over a long period of time, management of acute/chronic illness, preventive care, and appropriate health screening that is offered in an out patient setting. This care should be patient oriented, meeting psychosocial and biological needs and is holistic in scope (Inglis & Kjervik, 1993). The Michigan Primary Care Association (1988) defines primary care as a basic level of health care rendered by a general or family practitioner, obstetrician and gynecologist, pediatrician and/or specially trained non-physician health practitioner.

In the United States, 47.6% of married women 65 years and older are widowed, in contrast to 14.3% of men 65 years and older (US Bureau of the Census, 1993). The surviving female, living alone and frequently on a reduced income, has an extended number of years in which to cope and tend to experience a disproportionately high level of poverty. Widows can expect to survive an average of 14 years in widowhood compared to 7 years for men (US Bureau of the Census, 1996).

With 48% of married women over 65 years expected to be widowed, and women being the most frequent users of health care, a primary care setting affords an excellent opportunity for the Advanced Practice Nurse (APN) to identify the grieving person, facilitate healthy grieving, monitor the individual's response to the grief process, provide information, and teach strategies to cope with common, but normal

transitional difficulties. In the primary care setting, the APN functions in the role of patient advocate, support person and facilitator (Joffrion & Douglas, 1994), in addition to educator for patient and other health care providers.

Circumstances surrounding the cause of death have implications for the surviving widow's grief. Some circumstances include: 1) unexpected or sudden death, 2) removing life support, or 3) if the widow was the primary caregiver of the deceased. Each type of death has distinct issues associated with it and APNs in primary care need to have the knowledge to care for of all of these types of death events. Stigmatized deaths, such as those of suicide and AIDS, have many additional issues associated with them and are beyond the scope of this project.

Age of the survivor is an important factor in the grieving process. Widows age 76 to 85 frequently use denial of personal feelings and of the death as coping mechanisms (Steele,1992). The very young, age 25-35 years old, and the very elderly, experience more despair and hopelessness than middle aged women. These two age groups must be carefully monitored for despair, hopelessness, loss of meaning in life and any suicidal tendencies. Severity of the grief reaction is more intense in younger women who experience greater anger and hostility over the death (Steele, 1992).

Sudden death without forewarning is defined as death with less than two weeks (Carey, 1977) or fourteen days warning (Leahy, 1993). Sudden death is known to be a major factor in the long term outcome of the surviving spouse (Tye, 1993). The first two years after a sudden death have the greatest potential for morbidity (Lundin, 1984). The bereaved may experience an increase in somatic and psychological illnesses,

experience greater shock, take a longer time to reorganize, demonstrate increased psychological distress, and experience a longer period of social withdrawal (Grabowski & Frantz, 1993).

Purpose Statement

The purpose of this scholarly project was to develop an assessment tool for APNs that effectively assesses risks of spousal grief. This assessment provides information necessary for the delivery of appropriate care in the primary care setting for the newly bereaved female spouse, who is living through the recent death of her husband. The goal of this grief care is to avoid severe pathological outcomes related to unrecognized or unsupported grief.

Conceptual Definition

Grief is difficult to define as it is dynamic, changing, pervasive, and highly individualized (Jacob, 1993). The terms bereavement and mourning are frequently used interchangeably with grief and further complicate defining the experience. For the purpose of this paper, **grief** will be defined as an individualized response to the loss of a significant relationship, that of husband. This response is dynamic and multidimensional, resulting in psychosocial transition and continued growth.

Literature Review

Grief

Contemporary literature defines grief as phases between which the individual moves back and forth (Cowles, 1996). Grief is conceptualized "rather like a fingerprint, composed of identifiable universal characteristics and yet uniquely individual" (Brost & Kenny, 1992, p. 459).

The concept of grief is vague and ambiguous (Rodgers & Cowles, 1991), and is difficult to define accurately. Grief has been defined both as an adaptation response (Bowlby, 1973) and as a syndrome (Lindermann, 1944). Debate is ongoing as to the existence of complicated grieving, and if grief is considered an illness (Attig, 1991).

Normal grief is defined as a self-limiting process, not requiring psychotherapeutic interventions and is relatively benign (Zisook, 1987). Grief has been defined by Quint-Benoliel (1992) as a total organismic response of a human being to the loss of a significant relationship. Jacob (1996) redefines grief as a normal, dynamic, unique multidimensional response to a perceived loss. Grief is a complex, intense internal response to all perceived and felt losses (Dershimer, 1990). Grief is the emotional (affective) response to loss, which includes a number of psychological and somatic reactions (Stroebe & Stroebe, 1987).

Grief Process

The grief process involves an interpersonal aspect that may last years (Brost & Kenney, 1992) and may be experienced in three major ways: 1) psychologically, 2) socially, and 3) physically. Grief is a highly individualized, dynamic, pervasive process with strong normative component (Rando, 1988; Rodgers & Cowles, 1991). Processing grief becomes a complex coping process of psychosocial transition towards a life without the deceased (Attig, 1991; Caplan, 1974; Hoff, 1984).

Variables that affect the grieving process include length of illness, elapsed time since the loss, relationship of the deceased, perceived appropriateness of the timing of death and quality of the relationship (Lev, Munro, & McCorkle, 1993). In addition, type of death, age of the widow or other survivors, past coping ability, social support system, and physical

and mental health of the individual influence this process (Jacob, 1993). Providing timely support and care can assist an individual through the process in a more healthful way.

Bailey (1988) outlines six stages of the journey of recovery through grief. These six stages are not rigid or stagnant; individuals move back and forth frequently on their unique journey. The individual must recognize that the death has occurred and it is a loss. This first step must be experienced in order to proceed with the journey and consists of shock, denial and confusion that initially serves as a coping and protective mechanism.

The second stage is that of protest. In this stage the reality of the death penetrates and becomes more real for the widow. This protesting may present in the form of anger, feelings of abandonment, or rage and be directed at anyone and everyone. Searching for a new sense of normalcy in her life becomes the third stage. During this stage, answers are sought out from others, and assistance found through friends, clergy, support groups, coworkers and other types of support systems. Searching turns to despair in the fourth stage and becomes the most painful period of grief. Signs and symptoms of depression may appear in this stage. Action and concentration is slowed, spontaneous crying occurs and the potential threat of suicide is present. This despair stage is particularly taxing, and the individual may experience extreme fatigue.

Reorganization is the fifth step in this journey of transition. During this time the depression starts to resolve, and the widow can start to enjoy life again in intervals. Seeking of some meaning for this painful event and developmental growth is sought during this stage of reorganization.

In the last stage, that of reinvestment, energy has been detached from the lost individual. The widow may reinvest in other relationships and or activities.

Schneider (1994) describes grief as a transformation to a loss. Two types of loss are presented, natural and developmentally disruptive. Natural loss includes those in our maturation, such as loss of family, friends, health, work and our own death. Developmentally disruptive losses are not natural or universal. Examples of this type of loss may be missed milestones of independence, traumatic loss of life, rape or murder. Grief involves all dimensions of our being--physical, emotional, behavioral, spiritual, and cognitive.

Transformation is recognizing the opportunities that may result from the loss. Grieving is a process of discovery including, 1) what was lost, 2) what is left, and 3) what is possible. Discovering what was lost and how it will affect us begins with shock, followed by holding on, letting go and finally awareness. In phase two, healing starts through gaining perspective and integrating the loss into new life. Phase three is discovering what is possible through reformulating, self-empowering and transforming.

Successful transformation requires recognition and validation of the loss for the individual. Type of loss, and life stage, will impact on the particular loss, but all losses need recognition and validation. Recognition of a loss is necessary to grieve and move on. Death is easy to identify as a loss, however other losses are not. Validation of grief includes the acceptance of the current experience and that it is real. Reactions and coping methods utilized are appropriate to this experience, and the individual is doing the best they can under the circumstances.

Grief Work

The tasks of grief, or "grief work", have common themes and subtle differences. These tasks include: 1) accepting the reality of the loss, 2) experiencing the pain related to the loss, 3) readjusting to an environment without the lost person, and 4) withdrawing energy from the deceased and reinvesting in other relationships (Worden, 1982). In addition, Horacek (1995) includes a life and relationship review.

Grief Care

For the purpose of this project, grief care consists of support, counseling and monitoring of physical and emotional aspects of the grief process of an individual or family. There are few guidelines available and generally this type of care is not recognized as a need by the health care provider (Osterweis, Soloman, & Greene,1984). Possible reasons for this lack of care include: 1) health care professionals are not adequately prepared, 2) work load is too heavy to incorporate time for this type of care, and 3) financial restraints of third party reimbursement which do not reimburse for this task in primary care.

Health care providers are frequently uncomfortable, or at a loss, to identify grief and support the grieving individual. Misconceptions regarding grieving are sometimes perpetuated by health care providers through their lack of knowledge about the grief process. Some misconceptions include: grief and mourning are the same event, grieving occurs in a straight forward fashion without any regression, avoiding grief is desirable, the goal is to "get over" it, and tears are considered a weakness. None of these misconceptions are true (Brost & Kenney, 1992).

The impact of death results in initial shock which can last from hours to months. Eventually the numbness wears off and intense grief evolves. Widows have to become active in their own grief process. Guidance through this process will result in better resolution, compared with those who do not acknowledge their grief (Attig,1991; Caine, 1988).

Health Problems

Health problems related to grief include depression, suicidal ideology, numbness, restlessness, lack of concentration, crying, sleeping problems and nightmares, overeating/anorexia, work related difficulties, low self-esteem, feelings of insanity, lack of energy, and higher incidence of chronic problems (Steele, 1992; Zisook & Shuchter, 1991). Physiological changes associated with grieving include changes in immune functioning, endocrine changes, autonomic nervous system stimulation, cardiovascular changes, increased vulnerability to external agents, neuroendocrine findings such as depression and anxiety, and increased adrenocortical activity (Kim & Jacobs, 1993). Assessment for increased use of drugs and alcohol is essential as increased use indicates real potential with the grieving process (Ewton, 1993).

Relationship quality and type of death are important predictors of potential problems and needs of the surviving spouse. Death of the spouse is frequently listed as the most traumatic loss for a woman (Curry & Stone, 1992; Leahy, 1993). Immersed in the relationship, women frequently bind their identity on spousal social relationships. With the loss of the relationship, identity and social support is frequently revised or lost, and loneliness becomes an additional stressor, as the woman must "uncouple" and become "I" (Saunders, 1981).

Culture

Culture of the survivor has substantial influence on the grieving process, especially the individual's interpersonal aspects of grief (Cowles, 1996). Each culture has specific meanings attached to death, unique customs of mourning and funerals (DuBray, 1993; Grabowski & Frantz, 1993). As APN's, working knowledge and resources are needed to provide culturally effective care to the population being served. APNs working with cultures outside their own must learn about that cultures health care beliefs, traditions, excepted expression of emotions and ceremonial practices. This knowledge may be acquired through research of the culture, practical experience, and having a cultural mentor to confer with. With knowledge of a widow's cultural grieving behaviors, erroneous diagnosis of psychopathology may be avoided and healthy effective grieving facilitated. Universally experienced emotions and reactions to grief must be assessed and care provided, regardless of culture (Cowles, 1996).

Depression

Wordon and Silverman (1993) estimate that depression occurs in 15 to 50% of bereaved spouses in the first year. Considered a normal expected grief response, depression results from the re-examining and reorganization of one's interpersonal world (Martinson, Davis, & McClowery, 1991). The absence of grief may be an abnormal response to bereavement (Rando, 1984). Other concurrent stressors and losses may contribute to long term depression such as children leaving home, menopause, or retirement.

Confusion exists regarding bereavement and depression and how to distinguish the two (Worden & Silverman, 1993). It is important to not label a person clinically depressed when they are experiencing grief. The presence of feelings of worthlessness, functional impairment and psychomotor retardation are not part of bereavement reactions (Diagnostic and Statistical Manual of Mental Disorders -IV, 1994). The absence or presence of low self-esteem is the major difference between depression and grief reactions (Osterweis, Solomon, & Greene, 1984).

Depression was found to be greater in widows with children under six years old (Worden & Silverman, 1993). Distinguishing between grief and depression for these women could prevent additional problems for the surviving children. With early assessment for depression of the parent, development of appropriate interventions can be made to assist the whole family (Osterweis, Solomon & Greene, 1984).

Summary and Critique

A review of the literature reveals much research related to grieving; most being written within the last twenty-five years. Concentration has been primarily on the surviving female spouse, prenatal and neonatal loss, and loss of a child. Minimal research has been identified regarding loss of the adult sibling, loss of parent as a young adult child, grief for the partner related to HIV death, grief response of men, family-centered care, and cultural differences. Spousal grieving has been studied mostly with the fifty year and older population. Research of young widows under fifty has been sparse. The only guidance for care during grieving has been found in the lay literature. Studies of long term sequelae, greater than two or three years are limited (Martinson, Davis, & McClawry, 1991). Research on the

grief of individuals, who have had to make decisions to remove life support and allow the inevitable death to occur, are lacking.

Studies regarding interventions that are useful in reducing the intense pain of grief, shorten the duration of grief, or intervene/reduce the effect of long term negative effects of bereavement need to be done (Houldin, McCorkle & Lowery, 1993). Additional studies are needed in the area of grief outcomes related to ambivalence and quality of the relationship, as other work has found this to be an important variable (Parkes, 1985; Steele, 1992). Research to identify potential high risk individuals is necessary as well as developing an updated comprehensive theory of grief (Jacob, 1996; Steele, 1992). Recent literature has moved towards theories that emphasize the greater context in which death occurs, well in advance of the actual death, and extending for an indefinite time after the death (Mullin, 1992).

The loss of a significant other is a stressor affecting emotional and physical health, and social adjustment (Jacob, 1993). While most widows will not need extensive additional health care during this time, having a caring health care provider to consult with, and monitor progression, can assist the individual through the transition of loss. Periodic follow-up assessments can detect early any maladaptive behaviors, reassure the individual that what they are experiencing is probably normal and help lessen their anxiety about whether their reactions, behaviors and feelings are normal. Knowledge of the grieving process and its many variations can greatly reassure the widow and reduce her feelings of going insane. The APN, or primary care provider, can give permission for grieving (Dr. Mark O'Brian, personal communication, Oct. 1996) and also permission to reinvest in life (Stroebe & Stroebe, 1987).

Conceptual Framework

Thomas Attig (1991), believes that while the death of a loved one is a choiceless event, the grieving process as an active process is not. Grieving becomes a complex coping process, requiring energy for the challenges and opportunities ahead. There is resistance to move from grief to the active process of grieving, and this affords an opportunity for health care providers to encourage and support the undertaking of tasks of coping with the challenges presented by the loss. As a survivor, the person can choose to remain in paralyzing grief, or choose to work through the grief to a new life. Existing values, belief systems, convictions and hope that affirm life decide the direction of grieving. Grief work includes a through, comprehensive restructuring of personal integrity and transforming the love/ relationship for the deceased person into a cherished memory.

The death of her spouse catapults the woman into an unwanted and frequently unexpected transitional state. Schlossberg (1981, 1984) addresses this time of transition in order to understand the continued growth and development that adults experience in "A Model For Analyzing Human Adaptation To Transition" (figure 1). Individuals have different abilities to adapt to change and this ability may change during the life span.

Transition can be defined as an event or nonevent that results in a change in assumptions about oneself and the world requiring a corresponding change in one's behavior and relationships. Inclusive in the definition of transition are "nonevents," the other more subtle disappointments in life. Transition may result in both negative and positive aspects of growth or deterioration of the individual and includes a person's perception of the event. With identification of these "events",

A MODEL FOR ANALYZING HUMAN ADAPTATION TO TRANSITION

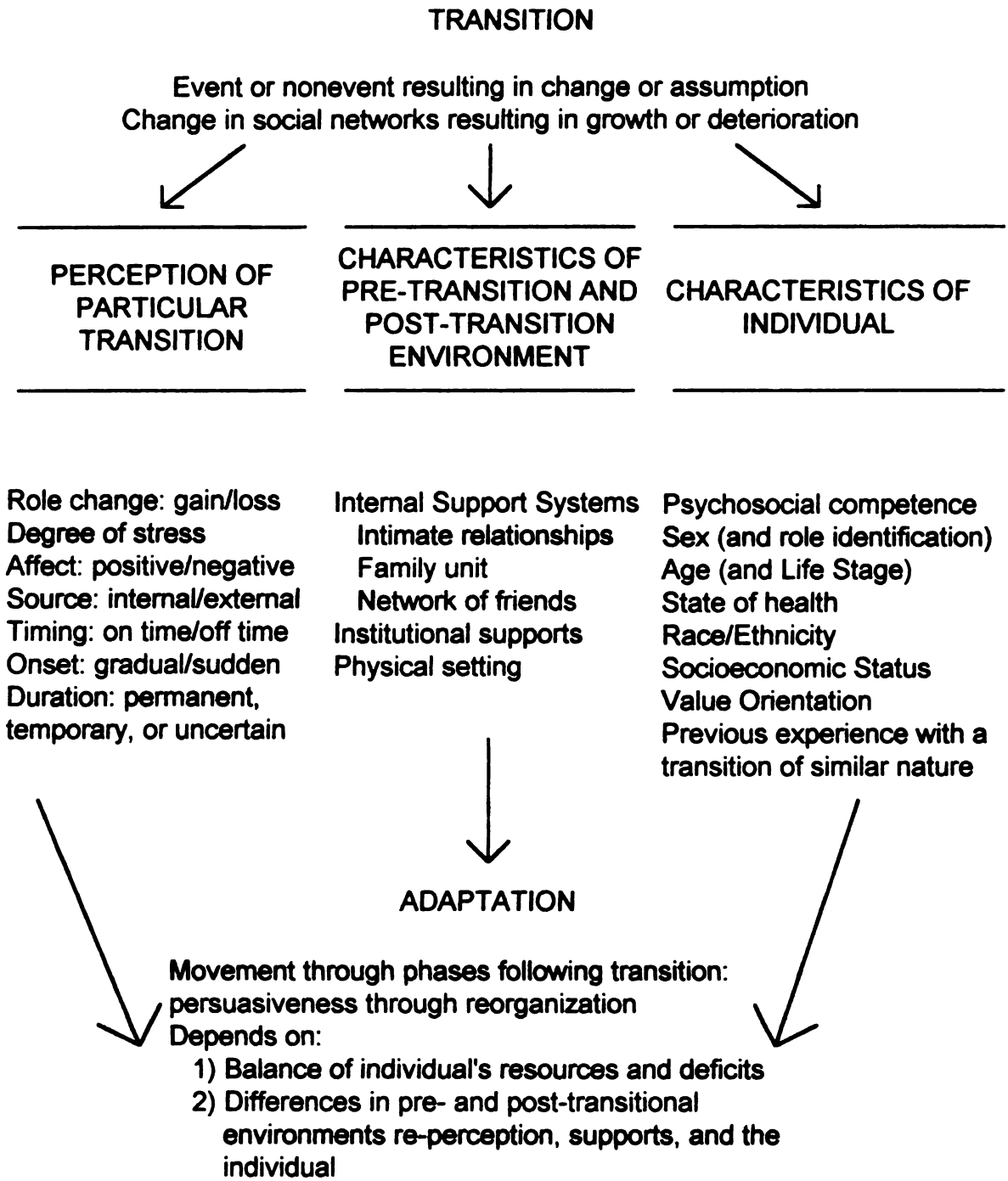

Figure 1: Schlossberg's (1984) Model for Analyzing Adaptation to Transition.

assistance for an individual may be provided through anticipatory guidance. Transition has ended when a new stable life organization has occurred and a new identify of self is evident.

In adaptation to transition, the individual proceeds from being totally preoccupied with the transition to integrating the transition into his or her life. Viewed as dynamic, adaptation occurs over time and requires elements of adequate accurate information, maintaining good internal condition, and keeping autonomy of the person intact. When viewed as dynamic, measuring adaptation has a more productive approach.

Another aspect of adaptation to the transition is that of ease/effort, which depends on the perception of the person experiencing the event, the environment before and after the event, and the person's own inner well-being and strength. Availability of resources such as social support, health, and finances greatly influence adaptation. This resource-deficient balance can help avoid labeling a person as ill, when adaptation is slowed by an imbalance of resources. The process of transition also necessitates the exploring of individual characteristics and other external events. Factors that influence adaptation include role change, affect, timing, onset, duration, and degree of stress.

Timing of the event is a great factor in transition. If the event occurs in an expected social context, the transition may be less stressful than that of untimely death. Source of transition, whether internal or external, denotes the element of control over the event; less control results in more stress.

Gradual transition allows for some time to adjust to the event. Unexpected events provide no time to prepare or rehearse the future.

Expected duration of the stressful event helps to ease the transition. Duration, whether temporary, permanent or an uncertain future, effects one's coping with the event. An uncertain future produces the greatest stress. Perception of stress with change, and accumulative stress, impacts the ability to adjust and increases vulnerability to illness.

Factors that affect adaptation include pre-transitional and post-transitional environments. The first of these environments are essential interpersonal support systems. Three types of systems comprise the interpersonal support system: 1) intimate relationships; involving support, trust and sharing of confidences, 2) the family unit; having common interests, affection, sense of economic interdependence and common history, and 3) network of friends to help soften the shock of the event, and help support the individual.

Institutional supports are the formal support of churches, professional organizations, political and social-welfare groups. Community support groups, and the ritual occasions of weddings, funerals and retirement dinners, are also institutional support. Physical settings that influence well-being and outlook include workplace, neighborhoods, climate, seasons, and living arrangements. Important to physical setting, and easily overlooked, are comfort, privacy and aesthetics. In addition, the changing seasons influence the setting.

Individual characteristics influence adaptation. Competencies in psychosocial assets including positive self-esteem and personal worth, sense of internal locus of control and a sense of responsibility are needed to survive. Having a world attitude of optimism and hope, a degree of trust and the behavior attitudes of seeking and using information are required to

make future plans. Life stage also influences coping and adaptation to crisis.

Adaptation and gender are very complexly related to transition. Women have a much greater capacity for intimacy and mutuality with others and have a much better capacity to adapt to change. Gender socialization of men and women is an important factor to consider in loss.

Potential co-stressors that influence transition during times of crisis include age, health status and culture. Age and life stage affect transition as many transitions may already be occurring prior to the traumatic event. Health status at the time of crisis affects the widow's ability to adapt and cope with the transition and loss. Health may be an additional stressor, and must be evaluated objectively and subjectively. The cultural aspects of race and ethnicity affect values and cultural norms and may also be a stressor. Risk of isolation may result in poor transition.

The socioeconomic status of a widow becomes critical during this time of transition. Poor adaptations are linked to less educated, poor women because of lack of material and psychological resources. An individual's own value system is important, and may vary with life-stage. These values include religious values and cultural norms, ideology, and belief in life purpose. Previous experience with a similar transition, either positive or negative, will impact on the current event and adaptation to it.

Figure 2 represents the potential risk factors and adaptation support of being widowed. Spousal death results in an immediate change in individual and social status. If the risk factors related to widowhood are minimal, and the adaptation support is adequate, there is expectation of successful transition in time.

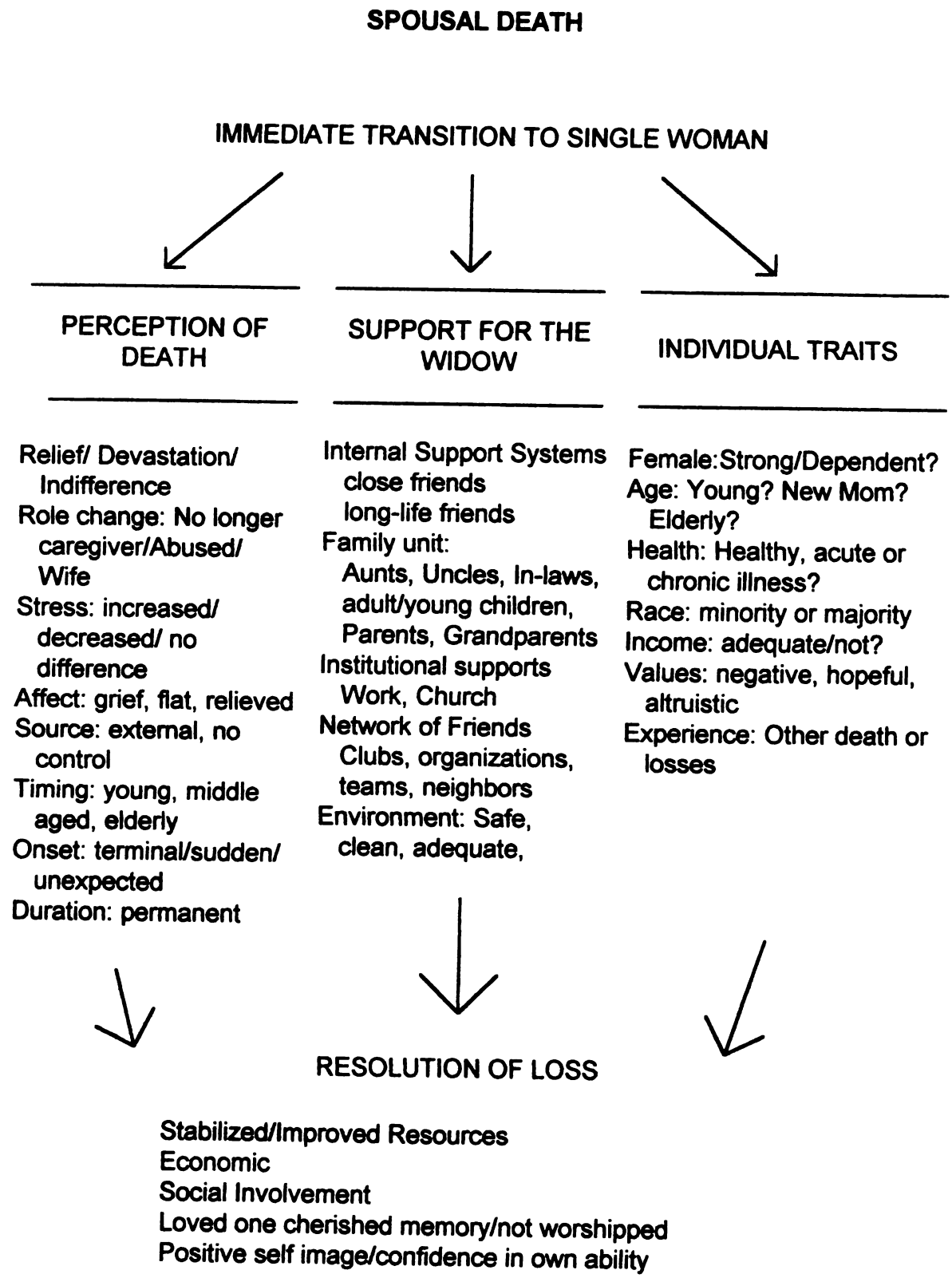

Figure 2: Model for Analyzing Adaptation to Spousal Death (Adapted from Schlossberg, 1984).

Assessment Tool Development

The Spousal Grief Assessment Inventory was developed for use in a primary care setting by professional clinicians, such as physicians, registered nurses, mid-level practitioners and social workers. This assessment tool requires knowledge and expertise in therapeutic communication. Utilization of empathy, excellent listening skills, use of exploratory and open-ended questions will help assure that meaningful answers are obtained, and appropriate grief care may be provided. The tool is intended to identify trends and patterns of deficits and strengths of the widow/family.

Critique of the tool, by potential users of the tool, was accomplished in a primary care setting. An APN, three registered nursed and two social workers reviewed the tool's content and analyzed potential use in the primary care setting. Positive comments included the thoroughness of the questions and perceived need for such an assessment. Concerns were expressed regarding the length, and "a lot of questions". While the tool appears lengthy, utilization of one word (yes/no) answers, short phrases and dates facilitates usage. Identified needs requiring additional evaluation and intervention will be included in the SOAP note for that visit.

Implementation of the Spousal Grief Assessment Inventory requires education of all primary care providers, nurses and clerical personnel in a specific setting. This education would consist of defining the target population, exploring why this type of information is important and useful, and providing competent holistic care. Additional education is needed on the potential long and short term benefits and outcomes for the widow, the practice and the health care provider, how to document advantages for collaborative care, and how this grief care may be interwoven in other

primary care health services to meet reimbursement requirements. Education sessions can occur at regular intervals during staff meetings, or one on one, especially when obtaining initial support for tool implementation in the practice.

A timeline of when this grief care should be provided, and the areas that need to be assessed and addressed, and time estimated time requirements, during the grieving process is provided in Appendix B. This guide was adapted form Curry and Stone (1992) and integrates Schlossberg's Transition Model (1984), and a review of the literature. As always, individual needs and priorities will guide the care and assessment. It is expected that, over time, with utilization and evaluation of these guidelines and assessment tool, changes will evolve.

Identification

Identification of the grieving person is necessary to assist widows through the process of the grief transition. All individuals require education regarding when it is appropriate to seek assistance in non-illness situations, for example, bereavement. Re-evaluating each visit for major changes/ stress may identify many of these losses.

Communication

The Spousal Grief Assessment Inventory was developed based on an assessment tool for perinatal loss by Ewton (1993), an extensive literature review of the concepts related to a widow's needs, concerns, anticipated problems, risk factors and potential need for resources. The characteristics of transition, environments and individual developed and presented in Schlossberg's theory are incorporated into the tool. Utilization of the Spousal Grief Assessment Inventory can help guide the assessment and help assure addressing the needs of the widow in primary care.

Communicating efficiently and effectively in the clinical record will allow another health care provider to follow the bereaved person appropriately and address their unique needs. Possible ways to identify the chart to grieving and loss issues may include a "sticker" or by using different colored clinical notes for the chart. If the Spousal Grief Assessment Inventory (Appendix A) is a different color, duration of the transition may be better evaluated for appropriate interventions, and the grief information or knowledge will not be not lost in the numerous pages of the clinical record. When using the assessment inventory, any identified areas requiring additional assessment, or re-assessment, can be documented in the plan (P) section of SOAP charting format.

Demographics

As health care providers for grievers 65 years and older, there are implications for the older widow. Horecek (1991) has found that the grieving process may take longer for older widows. Signs of grief may be mistaken for dementia, depression and other signs of deterioration. Initially, older widows may cope effectively, only to find grieving and coping more difficult after a year or so.

Quality of Relationship

When obtaining the history of a widow, Lamberti and Detner (1993) suggest a genogram to help identify family patterns of grief response, "traditions" of individual families, lack of rituals, and any unresolved grief issues that may impede the current grieving process. Assessment of the relationships within the family of origin are essential to identify support and facilitate stronger bonds.

Identification of support systems is crucial for the widow to recognize. It is the support system that provides emotional support,

provides material and service help, information and assistance in developing a new social life. Support is needed in all areas of her life-family, spiritual, work and/or school.

Social readjustment occurs with much effort for the woman. Widows, still having young children at home, are even more stressed when the single parenting aspect sets in. Caring for the children's needs may overwhelm these women. Assisting moms to understand the probable need for extra emotional support for an extended time is vital. Assistance of grandparents, an aunt or uncle, or another trusted adult to help the children through this time is appropriate. Educating the new widow to not place inappropriate expectations on the children (adult or child) to be her main support, is healthy for all those involved (Rando, 1988).

Economic Status

Complicating the grief experienced by widows are economic aspects. Severe economic changes may occur with a death; particularly vulnerable are widows (Zick & Smith, 1991). These economic changes may become a major health risk factor for women due to the impact on a widow's ability to receive health care, purchase medications and maintain lifestyle. When widowed, women frequently lose the spouse's adequate income and medical/health insurance, adding to the stressful event (Zick & Smith, 1991). Depression has a greater incidence and greater severity in widows experiencing financial distress (Leahy, 1993; Steele, 1992).

Economic needs of the new widow include emotional, physiological, social, and spiritual. Disorientation and denial results in the widow feeling like she is going crazy, and act without thinking. In this mental state, decisions about money, selling the house, and employment are sometimes made with results that are not in the best interest of the

widow. Guidance education about waiting to make these decisions may prevent problems and regrets.

Confusion is frequently present in the grieving individual for several weeks to months after a significant loss. Fear and uncertainty may cause the widow to make major decisions regarding finances, housing or moving in with others without careful thought of long term effects. Postponement of these major decisions for at least a year, if possible, is suggested. Seeking the help of a competent, trustworthy person to assist widows in making these decisions is prudent. This helps widows avoid making decisions they may regret later (Rando, 1988).

Health Insurance

Employers and retirement benefits vary greatly regarding surviving spousal health insurance coverage. The widow may be covered under the husbands policy for a specific length of time before losing the health insurance coverage, or having to purchase the coverage (Personal communication, UAW Local 375, March, 1997). Frequently, health care benefits are terminated with the death of the husband. The widow needs to have knowledge of the companies survivor benefit policies.

Education/Work

Education and work status of the widow impacts greatly her ability to adjust and cope with death of her husband (Carey, 1977). Education impacts the ability of the widow to earn a wage that is adequate to meet her needs and provide benefits of her own (Leahy, 1993). Work also helps the widow maintain some normalcy, greater feelings of control, and an additional support system (Steele,1992).

Functional Status

Early interventions for the widow need to be identification of her support systems, her own and family's coping abilities, and if there are enough resources available to meet her and the family's needs. Additionally, assessment of what has been done, what needs to be done, and if she needs assistance with these tasks also needs identification. During the acute early phase of grief, instrumental support is likely needed. The widow may need assistance for many things depending on her support systems, financial resources, if young children are in the home, age, and functional, mental or physical status. Appropriate referrals need to be made at this time.

Motivation and energy for the widow to care for herself are frequently lacking. Many widow's have not learned to drive, pay the bills, write checks, or deal with home and car maintenance. Physical and emotional disabilities may prevent her from being able to care for herself. Practical support and referrals for transportation, financial management, legal assistance, personal care and household tasks are frequently needed by widows (Jacob, 1996).

Concurrent stressors

Widows of any age frequently have concurrent stressors relative to their age group. When already coping with other stresses or losses, adaptive resources are at a minimum. This leaves the widow more vulnerable and helpless (Sanders,1993). Heath (1990) found better coping and adjustment with two or fewer losses.

Nutrition

In order to have the energy to proceed with grief work, eating regularly and in a healthful manner are required. However, a widow

frequently does not have the desire, energy, or resources, to obtain food, or to provide transportation to food stores in order to buy food necessary for preparing nourishing meals. Altered nutrition in the newly widowed is a potential problem if left undetected. Strategies to improve nutrition include: frequent small meals, sharing a meal with others, family/friends cooking and freezing some meals so they are readily available, and daily multivitamin for nutrition maintenance. Good hydration is necessary. Plenty of non-alcoholic and non-caffeined beverages are needed to replace fluids lost during grieving.

Sleep

Sleep disturbance frequently becomes a major problem when experiencing grief (Caine, 1988). Normal patterns of sleep are greatly disrupted. Disruption ranges from either sleeping all the time or unable to obtain restful sleep at all. Adequate rest is vital to do the "grief work" necessary to move through the process. Extreme fatigue, or intermittent bouts of extreme fatigue, are common complaints of a grieving person. Restorative rest is difficult to obtain due to the stress and many changes the person is experiencing. Sleeping whenever possible, and giving in to the fatigue, is helpful in the initial stages. This state is usually temporary and will improve. Sleeping pills and other medications are normally not desired, as they may cause other problems.

Other Complaints

Grief may result in vague somatic complaints and can be very frightening to the widow who experiences them without any type of reassurance. All complaints need to evaluated for underling pathology, however, most are benign. Some common complaints may include

dizziness, chest pain, palpitations, sweating, difficulty breathing. and those that are unique individual responses to the stress.

Return to Normal Activities

Return to normal activities of school, social obligations and work is encouraged as soon as possible for the widow. Uphold and Graham (1994) suggest return to previous activities within two weeks of the death, if possible. This return to activity helps to regain some normalcy, receive support, and assist in the difficult transition period.

Activity

Physical exercise provides a way to reduce some of the anxiety, stress and depression that may be experienced by the widow and reduces the impact these feelings have on mental and physical health. Alternative therapies of breathing exercises, visualization and meditation will also assist in regaining some sense of stress relief and regaining control over feelings.

Grieving people are preoccupied, potentially resulting in accidents and injury. Safety is a concern, especially to identify early and quickly any idea of suicide tendencies/behavior. Other safety concerns include home, car, and personal safety with instruction to use extreme care while operating a car or other machinery. Personal safety regarding dangerous risks or activity, that could result in harm or death, need to be emphasized to the individual, during times of despair. While not suicidal, the grieving individual does not really care about living either. Home safety for a widow includes increased awareness of operational secure door locks and windows and awareness of safety from home invasions and personal attacks.

Drug/Alcohol Use

Assessment for increased use of drugs and alcohol is essential as increased use indicates real potential problems with the grieving process (Ewton, 1993). Medications need to be used with great caution and judiciously to prevent even more problems for the woman. Tranquilizers are addictive, do not allow for problem solving at the psychosocial level and serve as a "crutch" that does not alleviate the stressor. Individual needs for these drugs must be assessed thoroughly before prescribing. Rationale for use of these medications may include: (1) increased anxiety causing the widow to feel out of control and preventing her participation in the problem solving process, (2) inability to sleep over an extended period of time, (3) if the widow is at risk for suicide, and (4) if they are unable to communicate (Hoff, 1984; Parkes, 1985). In most cases, the use of psychotherapeutic drugs are not helpful to the client as it does not allow for the full impact of the death to be realized, and may prevent the expression of grief through crying, verbalization of feelings and despair that are a necessary part of the grief process.

Physical Exam

A health assessment of the widow should ideally be done within the first three to four weeks after the death. If the widow was a caregiver for the deceased, her own health care may have been neglected while caring for that person (Jacob, 1996). Evaluating, identifying and stabilizing any chronic or acute health conditions is important as grief aggravates or accentuates preexisting health problems (Stroebe & Stroebe, 1987). Good internal environment is critical to the grieving/ transition process.

Emotional Status

Denial becomes a temporary defense mechanism to protect the widow from the intense magnitude of her loss, allowing her time to realize the loss and to penetrate her reality at a controlled and manageable rate. Allowed to go on too long, denial begins to interfere with the healing and grieving process.

Anger is a very common emotion of protest for the widow to experience and presents in many ways including irritation, depression, injury to self, increased sensitivity and other unexplained behaviors (Caine, 1988; Stroebe & Stroebe, 1987)). Permission and strategies to release anger safely need to be provided the widow, as unexpressed anger may result in both potential physical and somatic health problems (Steele, 1992).

Guilt is often an emotion experienced by grieving widows. Feelings of "could have, should have" are intensified with the death of the spouse. Identification of guilt feelings, and adequate explanation for the source of the guilt, are vital to relieve the widow. Not all widows experience guilt. If the marriage was not ideal, and the couple had many problems, there may only be relief after the death of the spouse. This woman needs as much support as any other widow. Early assessment of the meaning of her loss must be made so that appropriate interventions and support can be provided.

Crying and sadness are part of the grieving process and often a widow perceives that she has to avoid crying because it makes others uncomfortable. Stress and anxiety are part of a widow's grief, and contributes a great deal to all of the potential problems related to being widowed. A sense of control over these problems is necessary to continue

the grieving process and educating women on how to gain control is vital.

Previous Grief Work (if applicable)

Older widows are more likely to experience "bereavement overload" of multiple losses. Care needs to be taken not to encourage an older widow to become involved too soon in normal activities that can increase their chance of depression, and decrease socialization. This may be a time of suicidal ideology and they must be assessed for increased despair, hopelessness and loss of meaning of life. Increased age results in more tendency for widows to deny their feelings and use denial as a coping mechanism (Steele, 1992).

Discussion of Future plans/Anticipatory Guidance

Education is important for the widow regarding the grief process, its progression and regression, and potentially periods of renewed grief intensity. This is equally important for the family and support systems to understand to reduce any anxiety about behaviors. Intense renewed grief may occur between four to nine months after the death. Grief may be renewed when the head stone is placed, at anniversaries, birthdays, holidays, certain music, pictures or scents causing the grief to reemerge. This is not an uncommon event and there is nothing wrong with the individual. Reassurance of being "normal" cannot be over emphasized.

Meeting with the widow and appropriate family/support person(s) to educate about the grief process, how both young and adult children may grieve and behave differently from the mom/widow, and gender differences in grieving to help each family member understand their behavior and prevent misunderstandings may be warranted. Providing ideas of how they can be supportive to each other will help all involved to proceed through the process with potentially fewer complications.

Strategies to keep the memory of their spouse alive, but in an appropriate manner, are important. Activities such as planting a tree in their memory, starting a memorial, talking about and recalling events about the deceased, are a few ways to accomplish this. The goal for the widow is not to forget the deceased and their life together, but have a loving memory, and move towards the future and a new "normal" life.

Sexuality and the desire to reinvest energy to another relationship eventually start to emerge out of the despair. Creating a new and safe social life can be both frightening and challenging after many years in one relationship. Starting over can be difficult for the widow as social and moral attitudes have changed, new deadly diseases have emerged, and being safe is more important than ever before. Education on birth control, safe sex and safety in general becomes necessary when resuming dating.

Being touched is important for the good health of human beings, and sexual expression is one aspect of this. Because of less opportunity for the women to remarry, the widow may have to develop a new value system, to meet her needs for sexual expression (Rando, 1988). Possible solutions for sexual expression may include sex without marriage, masturbation or exploring a lesbian lifestyle.

Rebuilding self confidence is a challenge to most widows. Identifying their own strengths in the midst of this transition is most difficult, but necessary to continue to grow. Identification of current and future areas that need education and training requires tremendous support and encouragement. Behavior patterns that need to be identified and assessed are those of nonassertive, passive or aggressive tendencies. These behaviors are not helpful to the woman in regaining control in her life.

Grief resolution has occurred when the widow becomes reconciled with the physical, psychological and social aspects of her life and reinvolvement is possible and starting to occur (Herth, 1990). While there may always be some reoccurrence of grief, these are short periods of time that occur infrequently. Other researchers believe that complete release of emotional attachment to the deceased is neither possible or desirable, and is not an indication of dysfunctional grieving (Zisook & Shuchter, 1991).

Implications for Nursing

Interventions for the grieving individual need to start prior to a death event with education and evaluation of survivor skills and deficits (Collins, Liken, King & Kokinakis, 1993). This evaluation becomes part of the ongoing relationship between the APN and client. Among the possibilities are vocational training, education, learning about financial and pension matters, house and car maintenance (Mullan, 1992). All women need to be encouraged to learn of these matters in the event they are widowed unexpectedly.

Clients need instruction on when it is appropriate to seek help and information in traumatic events such as the death of a spouse. In private practice, the APN ideally would have knowledge of the individual's significant others major health problems such as any chronic conditions, cancer occurrences/remissions and hazardous work and inquire regarding status on routine and acute visits.

With ongoing evaluation of the client's independence, support systems, work and education abilities under "normal" conditions, the health care provider can help the client to learn or identify skills and support systems in the event of the spouse's death. Encouraging the woman to be knowledgeable about the surveyor benefits from her

husband's employer may be a motivation for enhancing her job/educational opportunities, in addition to advocating for greater surviving spouse benefits.

Contact with the provider at regular intervals, that correspond with the grieving process timeline, will allow anticipatory guidance for the bereaved, be of support for the person, and assist them through that phase of grief. Grieving is now believed to last much longer than a few months; from one to four years and more (Stroebe & Stroebe, 1987). A grief renewal, with increased grief behaviors, can occur between 4 and 9 months, at 18 months and 2 years and may occur especially in case of sudden death (Caine, 1988; Mullin, 1992; Rando, 1988). Follow-up of the individual, at anticipated times of crisis, would allow for appropriate education and reassurance from the APN. Regular contact will allow the provider to identify any emerging issues sooner and prevent additional stress and problems. Maintaining contact with the widow, even when things appear to be going well, is essential (Lev, 1993).

Intervention strategies suggested by Hoff (1984) include active concerned listening and encouraging expression of feelings. Assisting the person to gain understanding of the crisis, helping them accept their new reality, developing new ways of coping, and linking to social networks if more counseling is needed, are some interventions to consider. In addition, reinforcing information and follow-up of post crisis are paramount. With the death of the spouse, evaluation of immediate needs and concerns must be addressed within three to four weeks. The primary need at this time is to reassure the widow that her grief behaviors, feelings and expressions are normal. It is also within the first 3 months post death, that the immune function is at it's lowest (Houldin, McCorkle & Lowery,

1993). The first four months are when the level of grief is greatest (Jacobs, Kasl, Ostfeld, Berkman, Kosten, & Carpentier 1986).

As APNs working with newly bereaved individuals, our role in their care is to assist them and support their own active participation in their grief. To do this, frequent and timely visits are necessary. Utilizing assessment intervals developed by Caseatra and Lund (1992) for the widow would be: within 3-4 weeks of the death, at 2 months, 6 months, 12 months, 18 months and 2 years to evaluate coping and stress. These intervals roughly coincide with expected grief events and potential difficulties. If there is a need, continue visits every 6 months until there is some resolution and stabilization for the widow. However, individualization of any schedule is needed.

Frequent visits with the APN assist the widow in transition by providing ideas about their experience, and identifying and charting strategies to cope with tasks and challenges. This helps to reduce the "helplessness" widows experience. Support and identification of meaningful activities to form a new and meaningful life helps to overcome the passivity in grief. Support of active coping as their reality is beneficial. As difficult tasks arise, assisting the widow in choosing her own preferred way to act on, or deal with the problem is a role of the APN.

APNs can assist widows in recognizing the life enhancing aspects of their grief, some of the personal growth and development that may occur during the grief experience includes: recognition of the positive aspects of greater confidence in their own strengths; better self-understanding and self-esteem; greater understanding and sensitivity for others; increased perspective on personal relationships, both current and future; and a better perspective on their reality and man kind.

"It is in choosing to actively grieve, that the bereaved choose life" (Attig, 1991).

APPENDIX A

SPOUSAL GRIEF ASSESSMENT INVENTORY

Date: _____

Name: _____ DOB: _____ Gender: ____ Race: _____

Name of deceased: _____ DOB: ____ Years married: _____

Date of death: _____ Cause of death: _____ Where died: _____

Expected/Unexpected? _____ Caregiver? _____ Autopsy? _____

Who was present at time of death? _____

Memorial Service/Funeral? _____ Buried/Cremated? _____

Genogram:

Quality of relationship:

With Spouse:

Extremely close ___ Very close ___ Somewhat close ___ Not close _____

With children/age: _____

Extremely close ____ Very close ___ Somewhat close ____ Not close ___

Support Person(s) _____ Relationship _____

Extended Family support: _____

Type of support provided? _____

Social support: _____ Spirituality/church support: _____

Work: _____ School: _____ Other: _____

Economic status:

Increase: _____ Decrease: _____ Remain the same: _____

Is there enough for the Mortgage? _____ Utility bills? _____ Car? _____

Groceries? _____ Self maintenance? _____

Home? _____ Hospital bills? _____ Funeral bills? _____

Medical Insurance:

Lose? ____ Maintained? ____ For how long? _____ Payments? _____

Office care? _____ Hospital?_____ Prescription coverage? _____

Education/Work:

Work outside the home? _____ Occupation: _____

Years of education? _____ Type of environment? _____

Stressful? _____

Functional status:

Able to care for self? _____ Do own shopping/chores? _____

Banking/ pay bills? _____ Care for house? _____

Children? _____ Transportation? _____

Others in home? _____

Do you need any help at this time? _____

Concurrent stressors:

Retirement? _____ Recent move? _____ Menopause? _____

LMP (pregnant?) _____ Children leaving home? _____

Grief issues/ recent losses? _____

Known health problems: _____

Physical Status:

General survey:

_____

_____

_____

_____

_____

Appetite:

More? _____ Less? _____ Same? _____ Previous weight? _____

Current Weight? ____ Subjective reason for weight change: _____

What are you doing for meals? _____

Sleeping habits:

Can't sleep at all: _____ Sleep all the time: _____

Experience overwhelming fatigue? _____ When? _____

What are you trying for this? _____

Other complaints:

Numbness/tingling? _____ Dental pain? _____ Joint pain? _____

Chest pain? _____ Palpitations? _____ Dizziness? _____

Change in vision? _____ GI? _____ Other? _____

Return to normal activity:

Work? _____ School? _____

Senior citizen activities? _____ Church? _____

Volunteer activities? _____

Use of alcohol:

What? _____ How Much? _____

How often? _____ When? _____

Use of Drugs:

Rx? _____ Street? _____ OTC? _____ Herbal? _____

What drug are you using? _____ How much? _____

How Often? _____ When? _____

Reason? _____

Smoking habits/changes:

Increased? _____ Decreased? _____

Activity level:

Increased? _____ Decreased? _____

Recent injury? _____ Falls? _____ Tripping? _____

Other mishaps? _____ Near misses with car? _____

Regular exercise? _____ Other? _____

Pets:

Companion animal? _____ Type? _____ Name: _____

Emotional status:

General Affect: _____

Suicidal? _____ Denial? _____

Anger? _____ Guilt? _____

Sadness? _____ Loneliness/isolation? _____

Other/comments: _____

Previous Grief Work (if applicable):

Other recent losses within one to five years: _____

Perception of loss: _____

Memorial/funeral service? _____

Resource information provided: _____

Ability to communicate with significant others/family: _____

Response to previous crisis: _____

Support systems: _____

Other Stressors: _____

Physical exam identified needs of the client:

_____

_____

Discussion of future plans/anticipatory guidance:

Change in life style: _____ Work: _____

Grief renewal: 4-9 months_____ Deceased birthday:_____

Death date: _____Coping: _____

Anniversary/Holiday reactions: _____

Preventive health services: _____

Grief process: _____

Resources: _____

Other/concerns: _____

Medical/nursing diagnoses: _____

Follow-up referral made (if needed):

_____

Plan: _____

Signature:_____

APPENDIX B

FOLLOW UP GRIEF PROTOCOL

Name: _____ Client DOB: _____ Deceased DOB: _____

Date of death: ____ Marriage anniversary: _____ Years of marriage: ____

Religious holidays/Significant Days: _____

Visit/Date	**Assessment**
I. 2-3 wk	Initiate Spousal Grief Assessment Inventory
Date	**Financial**
1 Hr.	Estate:
	Insurance: Life/Health
	Funeral Expenses:
	Veterans:
	Other:
	Decision Making
	Postpone decision
	Trusted individual:
	Living arrangements/home:
	Selling home/possessions:
	Dispensation of personal objects:
	Other:

	Interaction with Others
	Empowerment/decision making:
	Pressure from children/others:
	Other:
	Immunizations
	Flu:
	Pneumonia:
	Other:
	Education
	Range of potential emotional response:
	Grief relapse with headstone/significant dates/holidays:
II. 2 mo.	Complete grief assessment inventory
Date:	Complete Immunizations
.45-1 Hr.	Physical/Safety
	Educate potential grief renewal approx. 4-9 months
	Review accomplishment/continued need
	Encourage life review:
	Evaluate how remembering deceased
	Coping/daily schedule or routine:

	Life style changes experienced/reaction to
	Support/family concerns
	Assessment for depression/withdrawal
III. 6 mo.	Comfort/confidence making decisions/delayed decisions
Date:	Able to visualize the future/make plans
.5 Hr.	Support/family concerns
	Assesses coping/significant dates or events
	Assess for depression/grief renewals/withdrawal
	Safety/Injury/Physical
	Readiness for future relationship/Safe sex, birth control
IV. 12 Mo.	Assess changes in support system/new network?
Date:	Anniversary reactions/grief renewal/coping
.5 Hr	Assess need for delayed decisions/Job/Home
	Explore and identify strengths/defects/strategies
	Assess current outlook for the future/positive/negative
	Assess depression/withdrawal
	Safety/Injury/Physical
V. 18 Mo.	Assess continues support/from whom?
Date:	Actions taken to follow-up on own aspirations/dreams
.5 Hr.	What does their reality consist of now/need change?

	Safety/Physical
	Grief renewal/Depression/Withdrawal?
	Social network/support
VI. 2yr.	Grief renewal/depression/withdrawal
Date:	Physical/Safety
.5 Hr.	Assess evolving lifestyle/positive/negative

Continue grief evaluation every six months or as necessary until the widow feels that she has successfully made the transition and feel that she has stabilized. Assessments may be completed and discontinued at any point that the widow no longer feels that she needs this support.

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