Bereavement Risk Assessment Tool (R)

Reference Manual

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Disclaimer

Victoria Hospice Society has taken effort to provide accurate information in this manual in conjunction with hospice palliative care best practice in Canada as of 2016. Use of the BRAT is not intended to replace sound clinical judgement. It is the responsibility of each user or program of care to determine its applicability, reliability and validity for his/her own use. The application of this information in a particular clinical situation remains the professional responsibility of the user.

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1. Introduction

What is the Bereavement Risk Assessment Tool?

As part of its continuing commitment to the ongoing development and implementation of best practices, Victoria Hospice Society (Victoria B.C., Canada) has developed the Bereavement Risk Assessment Tool or BRAT (©2007). This tool was created to enhance Victoria Hospice's bereavement program through evidence-based bereavement assessment, to predict complications for bereaved persons, improve communication among team members and provided consistent service allocation. Not only does it attempt to describe bereavement risk through identification of both risk and protective factors, the BRAT also points to the likelihood of difficulties in bereavement prior to and following the patient's death. Finally, the BRAT can assist in service allocation by suggesting 'default' services to each estimated level of risk as well as identify the best-suited member of the bereavement team to provide that service. Of course, service allocation is dependent on each particular bereavement program's resources and practices.

Why Assess Bereavement Risk?

In recent years there has been, and continues to be, a push for both public and private service organizations to demonstrate greater fiscal accountability. Many organizations continue to struggle in responding to growing needs of the community they serve with no increase in resources or with even fewer resources.

There are several challenges in determining how to prioritize a bereaved person's needs. Need is a subjective and somewhat nebulous concept and by its very nature is often realized only retrospectively (e.g. "I never realized this would be so

helpful."). Moreover, in investigating a bereaved person's needs, caregivers may assume that bereaved people know what they want or what will help them mourn a death. Bereavement care providers may also assume that those who identify a problem will ask for help and those who don't ask for help don't need it. Parkes & Weiss (76) assert that some bereaved persons may not have the capacity to determine what might be helpful while in the depths of their grief. These authors further suggest that individuals who aren't coping well may delay or avoid asking for help and further complicate their grief process.

For some bereaved people, a pamphlet describing normal grief reactions and available bereavement services may be sufficient to help them identify their needs and request help accordingly. For others, a conversation with a trained volunteer or skilled professional can help the person clarify need and identify helpful interventions. Unfortunately, many programs do not have the resources to offer bereaved persons a broad range of services or helpful interventions. For example, hospice palliative care programs that deal with large numbers of patients would likely find it a formidable task to perform a detailed assessment on each bereaved family member or caregiver.

In light of these challenges, it would seem that a standardized assessment form could help providers gather information and serve their bereaved population in a more consistent and efficient manner. This tool could provide continuity among assessors and provide common understanding and language to identify known risks. The collection of relevant information can begin prior to the death of the patient through collection of personal, interpersonal and circumstantial information of family and caregivers. Health care professionals and volunteers who work with families to care for the patient are in a good position to gather and record this information. This can, in turn, be helpful in guiding psychosocial care and interventions during the illness and in estimating the likelihood of difficulties or complications in bereavement.

Estimating client need prior to contact by the bereavement service allows resources to be focused where the greatest need is initially estimated to be. The BRAT has been designed to identify those bereaved persons at greater risk of complicated bereavement outcomes. It provides a 'best guess' of future difficulties and suggests the

most appropriate level of service to offer a bereaved person, particularly when first referred to a bereavement service. The BRAT also ensures a consistent approach to service delivery by multiple users within a program of care. As with any instrument, the BRAT is used to support clinical judgement not replace it.

This manual provides specific information about the BRAT so that it may be used in an informed, consistent and clinically appropriate manner. The manual outlines the initial development and revision of the BRAT, supporting literature, a description of the BRAT's risk indicators and guidelines for use of the tool within a hospice palliative care setting.

2. Normal Grief, Complicated Grief and Bereavement Risk

Normal vs. Complicated Grief

There is currently no single, overarching theory of grief or bereavement care (1) and some critical thinkers reject the notion of any 'grand theory' of grief and bereavement (2). At the same time, there is evidence that some current thinking may be moving towards recognizing grief as a multifaceted experience, encompassing complex interrelationships with other phenomena and influences (2, 1, 116, 3). This point is illustrated by Stroebe et al. (13), who state "the usual reaction to bereavement… incorporates diverse psychological (cognitive, socio-behavioural) and physical (physiological-somatic) manifestations" (p 6).

It is generally agreed that grief is a normal reaction to loss and most people manage fairly well with no intervention at all (7, 14). However, it is also recognized that general support and relatively simple interventions such as information about grief's common experiences, are helpful to bereaved individuals who are not experiencing complicated grief (140).

The ability to make a distinction between *normal* and *complicated* grief (historically referred to as traumatic or pathological grief) is considered to be fundamental to bereavement risk assessment. Although this distinction appears frequently in the literature, it is difficult to find a specific and agreed upon definition of normal grief (141). According to the Report on Bereavement and Grief Research (1), uncomplicated or normal bereavement is not associated with enduring negative consequences for most people. This definition is somewhat problematic in that it attempts to describe a phenomenon by stating what it is not. Hogan, Greenfield and Schmidt (142) reiterate earlier cautions about developing criteria for complicated grief

without a solid understanding of the normal trajectory of bereavement. Nevertheless, the distinction between normal and complicated grief remains widely accepted yet largely unexamined (1).

More recently, complicated grief has received more attention. Stroebe et al. (13) define complicated grief as the presence of a single grief symptom or group of symptoms that deviate from the cultural norm in persistence and intensity. While denial of the death, intrusive or compelling thoughts of the deceased or pining for the deceased may not mean the person is experiencing complicated grief, manifestations are seen to be problematic when they persist over time or are so severe that they significantly intrude on the daily life of the bereaved. As such, a recent movement seeks to identify complicated grief as a disorder. Prigerson et al. have proposed that complicated grief be included in the fifth revision of the DSM (143). Despite this push to pathologize severe grief reactions, these authors have outlined useful criteria in the identification of complicated grief. They define it as the presence of yearning, pining or longing for the person who has died that is persistent, distressing and disruptive in daily life and present for a period of no less than six months. In addition, four of the following eight symptoms must be noted as causing marked dysfunction in the bereaved person's life:

1. Trouble accepting the death
2. Inability trusting others since the death
3. Excessive bitterness or anger about the death
4. Feeling uneasy about moving on with one's life (e.g. forming new relationships)
5. Feeling emotionally numb or detached from others since the death
6. Feeling life is empty or meaningless without the deceased
7. Feeling the future holds no meaning or prospect for fulfillment without the deceased
8. Feeling agitated, jumpy or on edge since the death

Though this framework had not been published prior to the initial development of the BRAT, there is a considerable amount of content overlap.

Bereavement Risk

The term *risk* was originally neutral in it's meaning, but has since become "closely linked to concepts of vulnerability, uncertainty, and susceptibility" (7). Aranda & Milne go on to stipulate "… the identification of risk suggests the probability of adverse outcomes rather than an indication of cause and effect". A useful definition of bereavement risk is "the extent to which a person is susceptible to adverse outcomes associated with the loss of someone significant through death" (7).

Beyond the theoretical versus clinical praxis of bereavement risk (144), there are questions about the role of the bereaved themselves in determining what constitutes risk. Who are the 'experts' or knowledge holders? (2, 142). Can the bereaved person best identify their vulnerabilities or is the professional necessary to assist in the self-realization process?

Recently, Stroebe and colleagues (3, 148) designed an integrative risk factor framework intended to improve the understanding of individual differences in adjustment to loss or death and the interaction between risk factors. They define a risk factor as "a variable that when present, increases the likelihood of poor outcome" (p 2441), and argue against examining any specific factor in isolation. These authors also suggest that the determination of risk should include assessment of factors that mitigate risk by enhancing the bereaved person's potential in adjustment to the loss. These *protective factors* acknowledge a person's resiliencies and strengths and may suggest why people cope differently with similar circumstances. Unfortunately, few studies use an assessment model that includes both strengths and deficits (7, 141) so there is little empirical evidence as to the benefits of such an approach.

Given the uncertain state of bereavement and risk in the literature, and evidence that a clinical bias exists towards using instruments developed in-house (87% of hospice organizations surveyed) (145), the question of how to assess risk in a consistent, ethical manner that is methodologically sound remains outstanding (1, 146). This suggests the need for the development of a reliable and valid tool that measures bereavement risk, informs the health care team of the potential needs of bereaved

persons and suggests an appropriate clinical response. The BRAT was designed with these goals in mind.

3. Bereavement Risk and the Literature

The need for reliable and valid bereavement assessment tools is frequently cited in the literature as integral to a larger commitment to standards of bereavement care (4) and hospice palliative care (5). As Brazil, Bédard & Willison (6) observe:

> Research on bereavement has moved from a concern to establish the range and severity of bereavement consequences, to the examination of factors that make particular persons more vulnerable (p 194).

Furthermore, Aranda & Milne (7) state,

> …bereavement risk assessment is seen as an important first step in determining the need for bereavement services and in assisting with targeting services to those in most need (p 6).

However, knowledge and understanding of the grief process, including bereavement risk, remains incomplete. This lack of empirical studies has been cited in the literature (8-10). In their review, Stroebe et al. (11) write, "…there is still a great deal to criticize, and little to praise, in research on risk factors in bereavement outcome" (p 366). They cite the absence of appropriate control groups as a major contributor.

A review of existing bereavement assessment tools suggests a high degree of consensus regarding critical bereavement risk indicators. The following regularly appear in the literature: kinship; social isolation/support; mental health issues; addiction/substance abuse; the caregiving experience; circumstances of death; spiritual practices/beliefs; previous losses; relationship to the deceased and the nature of that relationship; availability of material/practical resources; coping styles; concurrent adverse life events; and suicidal ideation/suicide attempts (16-21).

While deficiencies and controversies do exist within the research findings, it seems important to remember that these often point to gaps and uncertainties in knowledge rather than an outright refutation of current practices in bereavement support. Research about bereavement risk is a rich and evolving field, and needs to be integrated into everyday practice so that knowledge and practice can grow together.

Risk Indicators

Various clinicians and researchers have identified certain indicators as *high risk* and have shown them to be associated with significant complications in bereavement. While there is ongoing debate about some of the factors, these high risk indicators are itemized here (in no particular order) as they reflect current knowledge and practice:

1. Perception of limited or non-existent social support (21-24)
2. Previous experiences of ineffective coping with loss (21,24)
3. Concurrent stressors (21,23)
4. Complex or conflicted relationship with the person who has died, e.g. ambiguous or dependent relationship (21,23)
5. Psychiatric history/mental health problems (21, 24)
6. Sudden/unexpected death (25, 26)
7. Traumatic or violent death (27, 28)
8. Death of a child (26, 30)
9. Death perceived as preventable (28,30)

The remainder of the chapter has been organized to follow the risk indicators in order, as laid out within the BRAT. Literature highlighting the current thinking and understanding of bereavement risk indicators in relation to the BRAT follows. The inclusion of material within this review should not be taken as endorsement of the validity or reliability of any research findings. Furthermore, Larson & Hoyt (31) recommend in their evaluative review of the literature that all clinicians should become an active participant in the ongoing development and evaluation of bereavement risk research.

1. Kinship

There appears to be support for a correlation between two types of kinships and bereavement risk. These are *spouse* and *parent of the deceased*.

Being a spouse

Death of a spouse is considered to be an extremely stressful event and is often related to decline in physical and mental health (32, 33). In a study involving the validation of the Bereavement Risk Index (BRI), Kristjanson et al. (34) found partners/spouses revealed higher scores overall on the BRI than other family members, suggesting that when examining a variety of familial relationships, partners and spouses appear to be the hardest hit (e.g. have more anger, guilt, pining for the deceased, and less ability to cope as determined by their clinician).

Loss of an older spouse results in the dissolution of long-term emotional bonds and shifts in functional and social roles. There appears to be evidence that older bereaved spouses experience higher levels of anxiety (35), lower well-being and morale (36), depression (32), higher rates of substance abuse, and higher use of health care services (37). Younger bereaved spouses may face different challenges, such as becoming a single parent, experiencing financial strain and facing the loss of a shared future.

There can also be long-term effects from the death of a spouse. For example, the impact of widowhood has been shown to extend beyond short-term bereavement. Spousal loss has been found to predict long-term dysfunction including impairment in global functioning, sleep, mood and self-esteem at 18 months after the death (38).

Being a parent

The death of a child, regardless of age, often creates difficulties in the grief process. Loss of an adult child has been shown to result in more intense or persistent grief and depression compared to the loss of a parent, sibling, or even a spouse (39, 40). Stroebe et al. (10) offer an explanation for this: the attachment young children develop to their parents naturally recedes as they enter adulthood and form new intimate attachments with partners and friends. Parents, however, may not experience

this passage of dependence to independence as lessening the strength of that bond so that serious illness and death of a child may instinctively mobilize a well-engrained protection or caregiving response leading to feelings of responsibility and helplessness. The death of a child also goes against the assumption of the normal order of life; children are not supposed to die before their parents (41).

Early work by several authors (26, 29, 42, 43) found an association between the death of a minor or dependent child and complicated bereavement. Christ et al. (44) found that death of a minor child led to more intense grief than the loss of a spouse or a parent in their sample. They also reported the relationship between bereaved parents was characterized by increased conflict and anger and led to a breakdown in communication and lower levels of intimacy.

2. Caregiver

Some research on the impact of having responsibility as a *primary caregiver* for someone who is ill and dying has been noted in the literature. Cairns (45) investigated the current research on how caregiving affects bereavement outcome. She writes:

> Experiencing negative consequences of caregiving, such as increased depression while caregiving and poorer health as a result of caregiving, is related to poorer recovery in bereavement (Brazil, Bédard & Willison, 2003; Chentsova-Dutton, 2002). The level of caregiver involvement in patient care, whether perceived as either positive or negative, is related to depression levels in bereavement. Mullan (1992) and Boerner and colleagues (2004) both reported that the more assistance family caregivers gave to the patient in activities of daily living, the more depressed they felt after the death. The loss of the meaningful role of caregiver may be a further strain for bereaved family caregivers (Bonanno, Moskowitz et al, 2005) perhaps because the loss of an important and positive relationship leads to more intense grief (Bonanno, Wortman, Lehman, Tweed, Haring, Sonnega, et al., 2002).

There is also evidence that caregivers of people with Alzheimer's disease are at higher risk of mental and physical problems as a result of the strain that accompanies this specific caregiver role (46). Adkins (47) found that this group often had higher

depression levels than those in the control group and that as the patient's condition worsened, so did the level of depressive symptoms. In their qualitative study, Sanders & Saltz Corely (48) report that caregiver grief was characterized by multiple losses that accumulated during the disease process.

Bass & Bowman (50), Bass, Bowman & Noelker (50), and Schultz et al. (24) all concluded that the quality of the caregiving experience determines adaptation to death. However, the relationship between bereavement outcome and caregiver characteristics as well as experiences of caregiving is complex and would benefit from further study.

3. Mental Health

Compromised mental health issues are seen both as a risk factor and an outcome measure of bereavement in the literature. For the purposes of this review, attention is focused on how pre-existing mental health issues contribute to the person's well-being at various points during bereavement.

Overall, there is growing evidence that the mental health *status* of a family member or caregiver before the death is strongly associated with their health status following the death. Kristjanson et al. (51), Kurtz et al. (52), and Kelly et al. (23) all found that the greatest predictor of well-being during bereavement is well-being prior to the death. These studies used measures of stress, distress and depression as variables. Additionally, Kelly et al. (23) and Houts et al. (53) found the level of distress of the caregiver at time of referral to a palliative care program predicted the level of distress at six months after the death. Investigators suggested that the source of this distress lay with personality or coping styles and that people's responses to highly stressful events were consistent before and after the death. Stroebe, Folkman, Hansson & Schut (20) note that "bereaved persons are at elevated risk of developing a variety of mental and physical health problems that may persist long after the loss has occurred" (p 2440).

Mental illness

There is a large body of evidence that bereaved persons with pre-existing psychiatric disorders such as schizophrenia, phobias and personality disorders have a greater dispensation towards more intense and prolonged grief than those who do not have a mental illness or disorder (28, 54-56). Earlier work identified major depression as a risk factor for complicated grief (57-59), however, no further studies have been found that consider depression specifically as a risk factor. Cerel et al. (60) show that children with pre-existing psychiatric diagnoses are at greater risk for further psychiatric distress following the death of a parent.

While Piper et al. (56) report that the rate of intense or complicated grief may be as high as 15% in the general population, almost a third of persons with psychiatric diagnoses, in her study, experienced intense grief and had been doing so for an average of 10 years. Interestingly, one study (65) found that situational factors such as strong dependency on the deceased, suddenness of the death, lack of social support and concurrent stressors, were greater determinants of bereavement difficulties than was the presence of a mental illness. Again, this speaks to the complexity of the interaction of variables in determining risk.

Mental disabilities

Persons with mental disabilities are a very diverse population, which makes standard forms of bereavement assessment and treatment challenging. Niemeier & Burnett (62) assert that normal grief reactions can potentially worsen the condition of people who are cognitively compromised through strokes, traumatic brain injuries, or congenital, progressive, or dementia-type illness. The authors suggest that new theories incorporating stress-coping and trauma perspectives are needed to explain the reactions of these populations to death and loss.

There is considerable debate as to whether people with intellectual disabilities grieve and what effect bereavement has on their behaviour and mental health (63). Bowlby (64) suggests that persons with mental disabilities inherently have difficulty comprehending abstract concepts of death, and communicating their experiences. He found their experiences of grief and loss were similar to those of young children who

experienced problems in adjustment after a death. In fact, the American Psychiatric Association (65) reported that following a death, further mental complications are three to four times more likely to occur for those who are mentally challenged than for the general population.

Dodd, Dowling & Hollins (63) report that, "there is growing evidence that bereavement and loss have a distinct effect on the mental health of people with ID's (intellectual disabilities). Many studies have shown that symptoms of depression and anxiety increase and that the person's behaviour changes following bereavement." Additional challenges of groups with special needs, as Dodd, Dowling & Hollins (63) point out

> … people with [intellectual disabilities] are living longer than previously and are experiencing more and varied relationships both within their families and within the community at large. In many cases they are looked after at home by relatives well into adulthood. When these bonds are broken by the death of the family [caregiver], it may prove catastrophic for the individual. The death of a parent, particularly a sole surviving parent, can lead to additional associated losses for someone who has an [intellectual disability]. They may have to leave their home at short notices and go to emergency accommodation (p 538).

It is unclear to what extent Alzheimer's disease influences bereavement outcome. Harkulich & Calamita (66) found that caregivers of Alzheimer's patients may erroneously believe that as cognitive abilities decline, emotional abilities also decline, and that a bereaved person with Alzheimer's does not fully experience grief. The study goes on to support the idea that these patients do actively grieve and there is an emotional impact on even the most regressed patients.

4. Coping

Stroebe et al. (20) found that, as with mental health, coping is both a predictor of risk and an outcome measure of risk. The following addresses the literature that examines coping as a predictor of risk.

Substance abuse and addiction

Not much recent research substantiates *substance abuse and addiction* as an indicator of risk in bereavement. Early studies found that even with normal grief, the use of cigarettes, alcohol, and prescription medicine likely increases after a death (59, 67, 68). Byrne, Raphael & Arnold (69) report that elderly men were found to increase their use and abuse of substances following the death of a significant other. One early study also suggested that alcoholics are at high risk for suicide after the loss of a close relationship (70).

Suicide ideation and completion

It is difficult to clearly identify particular individuals or circumstances that pose the greatest risk for suicidal behaviours or completed suicide (71). For this reason, most research examining risk factors associated with suicide are based on correlation studies. The National Institute for Mental Health (NIMH) reinforces that assessment of risk for suicidal behaviour is an ongoing process and should be considered any time influential circumstances of the individual change.

Stroebe, Stroebe & Abakoumkin (72) looked at 60 recently bereaved widows and widowers and the prevalence of *suicide ideation*. Compared to a control group of non-bereaved spouses, these authors found that bereaved individuals, particularly women, are at greater risk of suicidal ideation. This was mediated by extreme emotional loneliness and severe depressive symptoms.

Byrne & Raphael (69) studied matched pairs of widowers and non-widowed men in a longitudinal study in Australia. They measured 'thoughts of death', 'wanting to die' and 'suicidal thoughts' at 6 weeks and 13 months after the death. At 6 weeks, 44% of the widowed men had thoughts of death (4% in the control group), 12% indicated they had thoughts of wanting to die (0% in control group), and 2% indicated suicidal

thoughts (0% in control group). At 13 months, these levels decreased, although, 2% of the bereaved men had attempted suicide since the 6-week interval.

One recent study (73) used data from the Swiss Federal Statistical Office for the years between 1987 and 2004, and found approximately 1 out of 600 men and 1 out of 2500 women committed suicide within the first year after the death of a spouse; rates for young and middle-aged women were at least as high as for the men. Risk was highest within the first week then declined throughout the first year, at which time suicide rates became equal to those of non-bereaved individuals. These findings were supported by a similar study using Belgian census data (74). Duberstein, Conwell & Cox (75) found that suicide risk increases for recently widowed men and women, particularly when they have pre-existing mental illness, substance abuse and/or early loss/separation experiences.

The NIMH as well as a recent study by Ramadan (76) report that risk for attempt of suicide is characterized by the presence of the following – with risk increasing substantially with co-morbidity:

1. Mental illness, particularly depression or bipolar disorder
2. Borderline, antisocial or histrionic personality disorders
3. Previous suicide attempt
4. Impulsive behaviour
5. Recent financial, employment or relationship losses
6. Family history of suicide; public attention to suicide
7. Social isolation; being single or widowed
8. Feelings of hopelessness
9. Having a terminal illness
10. Being male
11. Access to a means of carrying out

Although no direct evidence was found to support the making of *a suicide plan* itself a predictor of suicide attempt or completion, the literature tends to indirectly suggest identifying a means of killing oneself to include making a plan to do so.

Concerns regarding own coping

Bereaved individuals who tended to be highly anxious and saw themselves as having an inability to cope had severe symptoms over a five-year period and displayed excessive grief in line with a chronic grief pattern. As well, clinical experience suggests that bereaved persons who had an intense connection with, or an emotional or practical dependency on, the deceased often have concerns about coping after the death (see Supports & Relationships: relationships with the patient/deceased).

Heightened emotional states

Robinson et al. (77) found that spouses who demonstrated *heightened emotional states* such as constant anger or guilt scored high on dimensions of somatic symptoms, depression and anxiety. Nolen-Hoeksema & Larson (40) and Parkes & Weiss (78) found that individuals who have personality styles that are more emotionally unstable and insecure, cope less adaptively in their bereavement. Field & Sundin (79) examined the inter-relationships among attachment, bereavement symptoms, and ways of appraising and coping with loss.

Yearning/pining and rumination

Ongoing *yearning* for the deceased that leads to difficulties in moving through grief has been identified as a primary symptom of complicated grief (80, 81). These investigators, along with Nolan-Hoeksema (82), conclude that *intense, intrusive thoughts* are also indicators of stress and loss. Michael & Snyder (83) examined a large cohort of college students who had experienced a death in the latter part of their lives and found that those who ruminated more tended to demonstrate poorer psychological well-being.

Declines available support

Stroebe, Schut & Stroebe (84) described persons who are uncomfortable with closeness and find it difficult to trust or depend on others and may also tend to avoid seeking support from others (85), which could place them at risk in their bereavement. They term this as a *dismissing* style of attachment. Stroebe et al. (84) go on to suggest that people with this type of insecure attachment style often limit expressions of distress in grief but, while they may not demonstrate greater levels of grief or depression

compared to other (attachment style) groups, they do report more physical complaints and a greater difficulty in expressing their grief (84, 86).

Denial, avoidance and inability to experience feelings of grief

Denial and avoidance may be functional coping mechanisms employed when a person is overwhelmed by grief, at least as a temporary buffer from reality (87). These processes are also part of the dual-process model of grief (88) in which there is an oscillation between confronting and avoiding feelings and other challenges of grief. In his paper regarding attachment and unresolved grief, Field (89) writes that if the bereaved person has experiences such as seeing the face of the deceased in a crowd, hallucinatory images of the deceased or mistaking sounds for the deceased's presence, this would be considered normal within the first year after death. However, the presence of these experiences beyond one year suggests an avoidance of grief resulting in an unresolved loss. In their study, Boelen, Van den Bout & Van den Hout (90) found that people who used avoidance strategies also tended to be more depressed 16 to 19 months after the death.

Boelen, van den Bout & van den Hout (90) discuss what they call *maladaptive avoidance*. They stipulate that this is characterized by anxious and depressive behaviour in which situations, people or activities that remind the bereaved person of the death are avoided. It may also be characterized by suppressing memories because the bereaved individual fears some disastrous consequence, such as loss of control, if the loss is confronted. They suggest these forms of maladaptive avoidance maintain negative associations with confronting and resolving the loss.

Kelly et al. (23) also found that avoidance of emotion was predictive of negative outcomes on two bereavement measures: the General Health Questionnaire and the Impact of Events Scale (see Appendix A). From another perspective, Fraley & Shaver (91) discuss problems in interpreting how the absence of the expression of grief emotions (e.g. sadness) is related to bereavement adjustment. They state this absence may be harmful for some, although such harmfulness may be overestimated. Boelen, Van den Bout & Van den Hout (90), Field (89) and Stroebe & Schut (84) all conclude

that it is still unclear when or to what degree denial and avoidance are advantageous or harmful.

Martin & Doka (92) recommend further assessment to determine whether absence of expression actually represents avoidance of emotion or is instead a natural grieving style. While it was once commonly accepted that expression of emotion was an essential part of the grieving process, it is now clear that some people successfully rely on other ways of dealing with their grief. These *instrumental* grievers may gravitate, for example, towards activities that focus on more cognitive or intellectual approaches and will not usually respond well to strategies aimed at emotional release or sharing.

Martin & Doka (92) also suggest complications can occur when a person's expression of grief is incongruent with their way of experiencing grief. This is demonstrated when a person believes they need to talk about and share his or her grief but is not able to do so. Consequently, additional difficulties can be created if bereavement support is not tailored to meet the differing needs of bereaved people's individual grieving styles.

5. Spirituality and Religion

Currier, Holland & Neimeyer (93) found that people's ability to make sense of a death mitigated complications in their bereavement. Davis & Nolen-Hoeksema (94) suggest that most people make sense of death in the context of their existing worldviews, some of which are expressed through religious and/or spiritual beliefs. If an experience of loss is inconsistent with this view, then people face the task of either revising their interpretation of the loss or revising their worldview to accommodate the loss.

A significant inconsistency between the meaning attributed to a death and a person's worldview may constitute *spiritual distress*. Spiritual distress can be defined as "…an impaired ability to experience and integrate meaning and purpose in life through a person's connectedness with self, other persons, art, music, literature, nature, and/or

a power greater than oneself"(95). This suggests that spiritual distress preceding or following a death may predict future problems in bereavement.

Fenix & Cherlin (96) address how religion helps caregivers cope and they cite the availability of spiritual support after the death as crucial. Matthews & Marwitt (97) also stress the importance of addressing the role of religion in bereavement. They found that after a death people may

> …turn toward [religion] or consider alternative practices. The interest may be a functioning of a religious 'reawakening' or a search for a greater sense of spirituality, connectedness, or self-actualization, often associated with the Baby Boomer generation. Religion provides cultural identity even as mass communication and immigration weaken geographical boundaries (p 93).

As different religions treat dying, death and bereavement differently, more research is needed to examine these different coping styles.

6. Concurrent Stressors

Concurrent stressors use important coping resources and create extra strain for bereaved individuals (25). These stressors may include competing demands, insufficient resources and other losses or threats to the psychological well-being of the individual.

Competing demands

Ott (98) found that the 29 subjects in her study who met the criteria for complicated grief also reported significantly more concurrent life stressors than those who did not meet the criteria. Payne, Horn & Relf (99) found that bereaved people left to care for a child or another dependent relative after a death were also at higher risk. Similarly, when Stajduhar et al. (100) asked bereaved caregivers to identify factors during their caregiving experience that seemed to make their grief more difficult, a number of respondents named concurrent caregiving for people other than the patient, such as a parent or handicapped child, as a significant factor.

Insufficient resources

In considering insufficient resources as a predictor of negative bereavement outcome and complicated grief, Ott (98) investigated lack of financial resources. She identified financial burden resulting from an extended terminal illness as a significant factor. Van der Houwen et al. (148) found that people experienced more grief, including loneliness and depression, when the survivor's income declined after the death or was lacking financial means prior to the death. Cerel, Fristad et al. (101) note that,

> …a parent's death, especially in the context of a family who is struggling financially, typically represents a loss of additional income, which may be a significant stressor. Financial hardship also affects the concrete ways in which a family can cope with a death, such as obtaining high-quality child care (p 688).

Little research has been found that examines a lack of physical (health) resources or the impact of the physical impairment or disease state of caregivers and family members. Kelly et al. (23) found that, in the short-term, illness-related factors did have a bearing on caregiver bereavement outcome. Fitzpatrick & Van Tran (102) found an association between health of the bereaved after the death and further complications in bereavement. Some early work by Krause (103) suggested chronic health strains such as diabetes and hypertension, act as concurrent stressors. There are, however, other studies that found no association between pre-existing physical health concerns and bereavement outcome (27, 98). This line of investigation appears to continue to be understudied.

Non-death losses

Some stressors result from *non-death losses* or losses secondary to the decline or death of a partner or family member. For example, single parenting, change in residence, new diagnoses, and changes in personal and work relationships.

Others with life-threatening illnesses

There appears to be an absence of research regarding how bereavement is affected by the presence of other life-threatening illnesses within a family.

7. Previous Bereavements

Despite the assumption by many clinicians to the contrary, previous bereavements, as a risk indicator, have received little attention in recent literature. Clinical experience suggests that the number, frequency, importance of relationship and difficulties associated with previous deaths does contribute to complications in grieving the current death. More research in this area appears to be much needed.

Despite Rando's (104) theories regarding loss and grief, in which she identifies *unresolved previous losses* that have not been *accommodated* as a risk factor for complicated grief, there appears to be little evidence-based research. Also, no research was found that specifically addresses the impact of the death of another significant person within one year. Clinical practice, however, suggests that dealing with another significant death adds to the burden experienced by bereaved individuals. Insufficient time to grieve one death can result in an accumulation of grief. In these situations, a person's support system may be challenged and it may pose a particular problem in making meaning of these losses. With regard to the impact of *cumulative grief* as a risk factor, a study by Gamino, Sewell & Easterling (28) did find that the number of other losses was statistically significant as a predictor of negative bereavement outcomes.

With regard to the *loss or death of a parent or parental figure*, Kelly et al. (23) and Vanderwerker et al. (105) found evidence that separation from a key attachment figure in childhood with resulting separation anxiety, contributed to poor bereavement outcome after a loss as an adult. Rando (104) explains that if an early loss is not appropriately integrated, this may interfere with the child's personality development and can compromise mental health, leaving the child less able to cope with losses later in life.

8. Supports and Relationships

Social support

In their review of the literature, Shultz et al. (24) and Rando (25) found social support to be the single most important variable in determining bereavement outcome. Other studies provide conflicting evidence of the significance of social support mitigating poor outcomes.

Dyregrov, Nordanger, & Dyregrov (22) found self-isolation to be the best predictor of psychosocial distress resulting from loss due to suicide, SIDS and childhood accidents. There is evidence that caregivers' perceptions of having insufficient support can increase morbidity and mortality during bereavement (23, 106). Other studies have also found social isolation as a co-factor in predicting complicated grief reactions (98, 107). Van der Houwen et al. (148) found that higher levels of avoidance attachment was related to worse mental health outcomes in bereavement. Kelly et al. (23) found that the perception of lower levels of practical assistance during the illness predicted higher guilt scores for the caregiver.

Writing about disenfranchised grief, Doka (108) points out that lack of support due to the unacceptability or stigmatization of the death (e.g. suicide, AIDS, auto-erotic asphyxiation) or the relationship (e.g. death of a secret lover, of a homosexual partner or of an abusive husband) results in imposed isolation, which exacerbates problems in bereavement. The bereaved person may isolate given feelings of despair, abandonment, shame and victimization.

Cultural barriers

Various cultures have differing practices and beliefs around dying, death and bereavement. These depend on the culture's traditions, death rituals, belief systems, gender and role differences, and socio-political constructs. Stroebe et al. (13) state cross-cultural differences can be significant and require attention, "… if we are to learn how to mitigate some of the suffering caused by (non-westernized) grief" (p 35). Without knowing or understanding the customs and rituals of a person from another country, religious affiliation or culture, counsellors face challenges in trying to offer appropriate services.

Ata & Morrison (109) write:

> Where rituals involving a dynamic relationship between the grieving and support-providers are used as healing powers in traditional spiritually-oriented societies, western psychiatry dismisses them as something irrelevant to its biomedical treatment methods (p 1).

At the same time, there is general agreement that certain types of reactions to death are universal and that grief has a meaning that transcends cultural differences (13).

Access to formal or informal support systems within a non-dominant culture may be limited and create isolation during bereavement. Although there does not seem to be any empirical evidence to support this, practice suggests that bereaved individuals from ethnic or culturally diverse groups embedded within a mainstream culture are at greater bereavement risk if there is little support for their customs and beliefs or if language creates a barrier. The types of support that would normally have been available to the bereaved may not be available in a dominant westernized culture, which includes the health care system and other social service agencies.

Family relationships

Kristjanson, Cousins, Smith & Lewin (34) note that the health of family members, the way they respond to the death and subsequent family functioning may be predicted by previous family functioning. With regard to the role of family relationships within bereavement, Schoka Traylor et al. (110) and Walsh & McGoldrick (111) found evidence that increased expression of family affection, open communication and

cohesion were predictors of fewer grief symptoms over time. The impact of communication within a family network parallels earlier findings of the benefits of social support. This does not mean that the absence of expression of affection, open communication, or lack of family cohesion is necessarily an indicator of complicated grief.

In terms of spousal relationships in particular, Dutton & Zisook (112) write:

> The death of a husband or wife deprives the surviving spouse of friendship and companionship… often at the center of each other's social worlds. Thus, the ability to strengthen existing social ties with friends and family, reengage socially, and explore the possibility of new friendships and intimate relationships is crucial to adapting to bereavement (p 893-894).

Relationship with the patient/deceased

As previously stated, the circumstances or state of the caregiver's relationship with the patient does appear to influence bereavement (23, 54). Carr et al. (32) found that widows who were involved in conflicted relationships experienced less yearning and better adjustment up to 48 months after the death. Wortman & Silver (113) concluded from their research that it was possible for the bereaved person to find relief rather than despair when the person who dies has been difficult to love. Parkes & Weiss (78), however, found that bereaved individuals from conflicted relationships were more likely to display delayed grief. Further research is needed to address these discrepancies.

Carr et al. (32), in their study of marital quality on post-bereavement adjustment, write "psychological adjustment to widowhood varies considerably on the basis of the nature of one's marriage" (p S205). They conclude that the level of intimacy shared, reliance on each other for ongoing emotional or tangible support, and relational strains such as communication breakdown, all affect characteristics of the person's bereavement.

More recently, marital closeness has appeared in the literature as a "risk factor for the onset of severe post-bereavement distress" (114). These authors refer to extreme marital closeness as a form of dependency. Bonanno, Wortman & Nesse (115)

compared groups of individuals of different bereavement trajectories and found "one factor that clearly distinguished the chronic grief group from other bereaved individuals who were not depressed prior to the loss was excessive dependency, both in general and in relationship with the spouse." Furthermore, Johnson, Zhang, Greer & Prigerson (114) write:

> …that a history of strict parental control during childhood may be associated with risk for the development of spousal dependency and post-bereavement [complicated grief] symptoms among adults in the community. … married adults who are highly dependent on their spouses may be particularly likely to experience severe [complicated grief] symptoms following spousal bereavement (p 28).

Wayment & Vierthaler (86) found that individuals who reported having a close attachment to the deceased and who had a sudden loss reported greater levels of grief. A study by Parkes & Weiss (78) suggested that bereaved persons who reported previous dependency on their spouses exhibit more persistent, intense and chronic symptoms of grief. These results have since been replicated (32, 116). Carr et al. (32) specifically found widowhood was most difficult for those who experienced the highest levels of emotional closeness and practical dependence in their marriages. An earlier study by Parkes & Weiss (59) asserted that previous extreme dependency on the deceased is a disorder of attachment and leads to chronic mourning.

9. Children and Youth

Until the 1970's, for many adults it was generally believed that it was important to protect children from the tragedy and pain of death, and that they should be sheltered from full knowledge about the circumstances of the death and other people's reactions to it. Research has shown that, while well intended, this approach often results in the child's increased sense of isolation, a belief that others have minimized the significance of the loss, a diminished trust in those around them, and misconceptions about what really happened (117, 118).

In contrast to earlier work that suggests all young children are at risk after a death (119), Oltjenbruns (120) state that as difficult and challenging as grief may be, most children seem to have the capacity to deal effectively with their losses. They believe that being a child does not, in and of itself, place the child at greater risk.

Death of a parent

The Centre for the Advancement of Health (1) states that when a parent has died, the child's gender and age at the time of death, in combination with factors such as the gender of the parent who died and the suddenness of the death, does effect the child's ability to cope with the loss, especially at two years post-death and beyond. Stroebe et al. (10) assert that if the death of a sibling in childhood was not 'fully grieved', then it too, will likely affect the child's development and mental health.

Extreme behaviours and symptoms

Stroebe et al. (144) suggest that, as is true for adults, it is not useful to look for single indicators that a child is struggling. Instead, it is important to watch for a heightened intensity and frequency of otherwise normal manifestations of a child's grief, that is, a demonstration of extreme, ongoing behaviours/symptoms. Examples of common somatic, intra-psychic and behavioural factors that may be indicators of complicated grief are:

1. *Somatic*: sleep difficulties, refusing to eat, bed wetting, headaches, stomach aches (extreme: serious illness)
2. *Intra-psychic*: emotional distress, separation anxiety, fear that others will also die, death fantasies, learning difficulties, guilt (extreme: school phobia, severe depression)
3. *Behavioural:* regression, explosive emotions, acting out, extreme shyness, disinterest in play, overdependence, demand for attention (extreme: delinquent activity)

Parental concern

There appears to be no support in the research literature for increased risk to a child's bereavement due to parental concerns about their ability to provide the child

with adequate support. This indicator does suggest a parents' openness to support and creates an opportunity to intervene with families. Whether this concern constitutes a risk factor is still to be investigated.

Parental grief

Two studies were found to support the proposition that children are at greater risk if the surviving parent is at considerable risk. A large sample study of parent-bereaved children, which interviewed both surviving parents and their children at four intervals over two years (50), found that a bereaved parent struggling with depressive symptoms posed a greater risk for increased depression scores in their children. The clinical implication then, is that "risk factors most notable for bereaved children include a parent struggling with depressive symptoms following spousal death, the presence of other stressful life events in the family, and lower [socioeconomic status]" (60). Moreover, a study by Harris, Brown & Bifulco (121) reports that a lack of adequate parental care following a death, along with the inability of the child to accommodate the loss are more powerful predictors of later adult impairment rather than the simple fact that a parent has died.

10. Circumstances Involving the Patient, the Care or the Death

This group of indicators considers the age of the patient, the circumstances of the death that were particularly difficult in some way and anger at health care professionals. Most importantly, it is the perspective or perception of the family member or bereaved person that should be considered and not the health care professional making the assessment.

Age of deceased

In a review of several studies, Doka (122) suggests that the death of a younger person results in a higher likelihood of complications in bereavement. Gamino, Sewelland & Easterling (28) found a heterogeneous sample of 85 bereaved people scored higher on the Hogan Grief Reaction Checklist (see Appendix A) as the age of the person they were grieving decreased. Unfortunately, neither of these studies were clear regarding the precise age range of these 'younger' people. However, it is

generally accepted in most cultures that children and young adults are not supposed to die and it can be argued that this marks the death as exceptional, tragic and unfair.

Preparedness

A considerable amount of research suggests that a lack of preparedness for death, as interpreted by the bereaved person, may result in later difficulty acknowledging and accepting the death, and may be related to extended difficulties in bereavement (27, 122, 148). When death occurs in an unexpected way, it can result in feelings of shock and disbelief, even when the death is the result of a long-term illness. Rando (123) proposes this can produce feelings of helplessness, blame, anger and guilt. Rando (26) also writes that sudden or unexpected death is not determined by the objective length of time that the bereaved knew the person was dying, but rather by their subjective expectations and state of mind. Individuals who reported having a closer attachment to the deceased, along with poor self-esteem after a sudden loss, reported greater levels of grief (10, 86). Barry, Kasl & Prigerson (27) also found that a lack of preparedness for the death was associated with complications in grieving, particularly significant long-term depression.

In contrast, Blazer II & Hybels (124) suggest in their review of the literature, that most stressful events that tend to lead to depression in later life, such as the death of a spouse who is older, are somewhat expected. The authors contend that by observing their peers, older married people begin contemplating the event of their spouse's death and they may even rehearse how to cope for when their spouse dies. Clinical practice suggests that there certainly are exceptions to this viewpoint.

Distress witnessing the death/perception of preventable

Prigerson et al. (126) used a measure called the Stressful Caregiving Adult Reactions to Experiences of Dying (SCARED) to assess levels of fear and helplessness in distressing caregiving circumstances. They found that the most common distressing event was watching the patient experience recurring severe pain. Other distressing events were such things as witnessing a collapse, observing the patient's inability to eat or swallow, seeing them choking and having to deal with the patient's delirium. Individuals who believed that the patient had 'had enough' were also distressed.

Higher SCARED scores were associated with a higher incidence of major depressive disorder as well as greater impairment in mental functioning, social functioning, energy and general health perceptions.

There is also evidence that the perception of a death being preventable may also influence the severity and duration of grief and mourning (28). The bereaved person is often left with a sense of the unfairness and injustice of the death, which in turn may challenge their ability to make sense of it.

Violent, traumatic or unexplained

Barry, Kasl, & Prigerson (27) found that people's perception of a death as *violent* were associated with major depressive disorder. *Traumatic* deaths can engender long-lasting distress, including imagined memories of the event as in PTSD, no matter how intact the person's coping abilities may be (127). Violent deaths in which the bereaved person feels responsible, for example, when the bereaved person's actions caused a fatal auto accident, were also associated with a higher risk for complicated bereavement (122).

The impact of death by suicide on bereaved people has been well studied, although the findings are controversial. Cerel et al. (128) found that spouses who survived a partner's suicide did not express later problems, although, they found family stability was impaired. Similarly, Harwood et al. (129) found levels of depression in those bereaved by suicide were not significantly different than for non-suicide bereaved people. Stigmatization, shame and rejection were, however, significantly higher for those bereaved by suicide within that study. A further study by Dyregrov, Nordanger & Dyregrov (22) also demonstrated that those bereaved through suicide and accidental death reported high levels of bereavement distress.

Rando (25) cites several studies that identify suicide as one of the most difficult deaths to grieve. She writes:

> For the most part, the literature has revealed little if any dispute that suicide is – along with sudden accidental death and homicide – one of the most difficult deaths with which a mourner must contend. The majority

> of authors assert that suicide is the precipitant for the worst kind of bereavement experience and the most disturbed mourning (e.g. Cain, 1972; Stroebe & Stroebe, 1987) placing survivors at a risk for physical and mental health problems greater than that for individuals bereaved due to other causes of death (e.g. Gonda, 1989; Osterweis et al., 1984). (p 523)

In direct contrast to these findings, in a review of the literature by Stroebe et al. (13), these authors conclude that there is little empirical evidence to support the idea that death by suicide results in greater problems of bereavement adjustment than deaths from other causes. They go on to say:

> In fact, the few studies that compared the psychological consequences of bereavements because of suicide with that of other forms of losses have typically failed to find any marked differences in bereavement outcome (Barret & Scott, 1987 as reported in Cleiren, 1991; Farberow et al., 1992; Shepherd & Barraclough, 1974; Sherkat & Reed, 1992) (p 355).

It is interesting to note that the preceding statement by Rando (21) cites Stroebe et al. to support her contention that grieving a suicide death does in fact result in higher incidences of complicated mourning.

De Groot, De Keijser & Neeleman (130, 131) found that people grieving a suicide death are likely to experience complicated grief and exhibit suicide ideation themselves. Rando (25) suggests 4 factors that increase the risk of suicide among those bereaved by suicide:

1. Often the same social, environmental, and psychological conditions exist for the bereaved as for the deceased (e.g. abuse, alcoholism, depression, poverty)
2. Suicide usually occurs in a family experiencing stress or multiple crises
3. The bereaved identify with the deceased via suicidal behaviours
4. In some situations, the suicide of one person removes its taboo for others

Rando (25) then goes on to recommend that professionals need take note if any of these circumstances exist and if so, provide the person who is grieving a suicide death with strategies to assist them in their grief that are preventative for subsequent suicidal behaviour.

Reed (107) found through open-ended questioning, that some people who are bereaved by suicide describe their personal and family relationships with the deceased as fraught with abuse, discord and relational strain. Although tragic, the death of such a family member may turn out to be an emotional relief, allowing the bereaved to live without the concern and stress of the relationship.

While there are both conflicting evidence and mitigating factors to consider in evaluating the impact of suicide, it remains a sudden, often unexpected and violent death. For these reasons, it is considered a risk factor in the assessment of complicated bereavement.

There is also some evidence that *unexplained death* is a marker for risk in bereavement. As noted earlier with regard to religious coping (93-95), it is important for people to make sense of a death, to understand the reason for it (attribution) and attempt to make it fit with their existing worldview. Sometimes this involves looking for something or someone to blame, which can include the person him or herself (36). Field & Bonnano (79), in their review of the literature, found that when the focus of a bereaved person's grief is on blame, outcome is generally poor. Bennett (36), however, found no evidence for this phenomenon in their qualitative study of 65 widows in the UK, most of whom whose husbands had died of cancer or heart disease, and were asked to talk about why their spouses died of these causes. Clearly, this is yet another area requiring further investigation.

Anger with health care providers

Significant anger towards care providers does not appear to have received attention in the literature. Anger itself can be a normal response to loss (68), and persistent anger is more likely to occur following violent, sudden and unexpected deaths for which someone is blamed, or following the loss of a highly dependent relationship (26). Anger can be counterproductive if it becomes the primary expression of grief, thereby obscuring other feelings of loss. It can also be harmful to the bereaved if its intensity and persistence result in the loss of that person's support network, including health care and bereavement support. Rando (25) makes the point, however, that a

one-to-one correspondence between antecedents and consequences of anger does not exist since the experience of anger is dependent on numerous intra-psychic variables.

11. Protective Factors that Support Positive Bereavement Outcomes

A growing body of literature has begun to examine health-promoting factors and strategies that mitigate the risks associated with complicated bereavement. Stroebe at al. (20) use the term *protective factor* and define it as "a variable that when present, increases the likelihood of good outcome" (p 2441). Although there are a number of protective factors that appear in the literature, secure attachment styles, strong social support, optimism and religious coping are the four factors that appear best supported by available evidence.

Belief in own ability to cope

Stroebe, Shut & Strobe's (84) work on attachment style and its effects on coping and bereavement suggests that among the four styles they describe, only *secure attachment* style coincides with effective coping after a death. People who are characterized as having a secure attachment style have an internalized belief of their own ability to cope effectively. They are comfortable becoming close with others and have no concerns about depending on others or having others depend on them. They take responsibility for their feelings and behaviours, openly express their distress and generally welcome support. People with secure attachment styles are unlikely to suffer complications in bereavement unless the death has been particularly traumatic (84). Individuals with this attachment style report lower levels of depression and are more likely to display outcomes of normal grief (23, 86, 132, 133).

Stroebe & Stroebe (119) and Rando (25) suggest that if the person has coped with prior losses successfully in the past as an adult, this may help them in future circumstances and in developing new skills. Prior losses, therefore, should not be assumed to have only a negative impact on bereavement. In order to understand

people's ability to cope with a current death, it is important to know about past loss experiences such as when the deaths occurred, who was involved, what it meant to them, how they coped with it and what they learned from the experience.

Zhang, El-Jawahri & Prigerson (81) conclude in their review of the literature that:

> …resilient bereaved individuals are not likely to benefit substantially from the receipt of (bereavement) services and, therefore, resources should not be wasted by making such persons the targets of bereavement interventions. (p 1196)

Strong social support

Earlier in this chapter, evidence was presented that having a strong social support network, both during the illness and after the death, helps to 'inoculate' the person from the risks of bereavement (28). Various types of social support include emotional (listening, acknowledging feelings), instrumental (helping with physical tasks such as child care or household repairs), informational (filling out tax returns or learning about normal grief reactions), validational (acknowledging the bereaved person's loss and experience of grief) and relational (providing companionship and intimacy).

It is important to differentiate between the availability of support and a person's ability or willingness to access or take advantage of that support. It is not uncommon for caregivers and newly bereaved people to isolate themselves from family and friends, despite a large available social support system, as a way to cope with the stress of caregiving or bereavement. Although a degree of social isolation is to be expected in bereavement, a more severe lack of trust in others and difficulty forming new relationships after the death pose a threat to an uncomplicated passage through grief (81).

Optimism

Moskowitz, Folkman & Acree (134) found that high levels of optimism and positive states of mind, in combination with low levels of cognitive escape and avoidance strategies, were associated with more rapid declines in depression and a greater increase in positive states of mind later on in bereavement.

Spiritual/religious coping

Research suggests that people who profess strong spiritual and religious beliefs seem to resolve their grief more rapidly and completely after a death than do people who have no spiritual beliefs (23, 40, 94, 135). Walsh et al. (136) found that bereaved individuals who reported even 'low intensity' spiritual beliefs had fewer and less severe bereavement symptoms at 14 months post-death. Other studies have also reported the effects of spiritual beliefs to be significantly correlated with positive effect for bereaved respondents (137, 148).

Davis & Nolen-Hoeksema (94) also found their sample of 455 bereaved people were 2.65 times more likely to make sense of the loss if they reported having religious or spiritual beliefs and Pearce et al. (138) found empirical evidence that people who relied more heavily on religion to cope with their loss showed fewer health disabilities and fewer use of health services in bereavement follow-up.

Pargament (139) has proposed that it is not simply having religious or spiritual beliefs that aids in coping, but whether these beliefs are used to facilitate problem-solving or prevent or alleviate negative emotional outcomes of stressful life circumstances. He coined the term *religious coping* and found it to be a stronger predictor of psychological well being following a major life stressor than general measures of religiousness. Michael et al. (135) examined this idea further and proposed that religious/spiritual coping assists bereavement outcomes by:

1. Aiding in construction of meaning
2. Assisting in acquiring social support
3. Providing a means of maintaining connection to the deceased

Summary

Despite some instances of conflicting results, there appears to be empirical and clinically supported evidence in the literature that substantiates most of the BRAT's 40

items. Evidence could not, however, be provided for all of the BRAT's items. Some risk indicators are included despite conflicting, inconclusive or absent research, based primarily on the clinical experience of the Victoria Hospice counselling team. Examples of these are 'patient or deceased less than age 35', 'cultural or language barriers to support', 'significant other with life-threatening illness/injury (other than patient/ deceased)', and 'parent expresses concern regarding his/her ability to support child's grief'. Further development of the tool will need to address concerns regarding the validity of these indicators.

4. Tool Development

The BRAT was developed to achieve four primary goals:

1. Identify, prior to and following the death, multiple factors that may place bereaved persons at risk for bereavement complications
2. Communicate and share consistent information among health care professionals
3. Assess bereavement status
4. Ensure equitable distribution of program resources

The tool has been developed based both on clinical experience and an extensive review of literature including various studies in grief and bereavement risk factors (see Chapter 3) as well as relevant bereavement assessment tools (see below).

Existing Predictive Bereavement Assessment Tools

A number of measurement tools identify current phenomena associated with a person's bereavement. Appendix A lists the tools most commonly cited in the literature. Seven of these tools have been designed to predict negative bereavement outcomes and a brief review of these tools has been included here as a context for understanding the contribution BRAT may make to the field of bereavement risk assessment.

Anticipatory Grief Scale (Theut et al., 1991)

This instrument measures grief experiences prior to death but has not been developed to have predictive utility for bereavement outcomes. Although content validity and reliability are good, it does not allow identification of specific factors (e.g. subscale items such as anger or guilt), which makes it too general a measure to have clinical utility.

Anticipatory Grief Inventory (Levy, 1991)

This tool is composed of 22 self- assessed items thought to be associated with the concept of anticipatory grief. Its strengths include identification of mental and emotional readiness for the death of a spouse and preparatory ways of coping with the anticipated death. Challenges include its sole focus on spousal grief and exclusion of circumstances of the death, relational dynamics outside of the marriage (e.g. social supports) and individual characteristics such as mental health, spirituality, or previous losses.

Colorado Hospices Bereavement Assessment (Colorado Hospice Organization)

This recently developed tool identifies 23 risks as well as 9 resources or strengths of the bereaved person. Low, moderate or high risk is subjectively determined by the assessor, based on interpretation of the number and nature of items identified on the tool. The exception to this is suicide ideation or intent, which is pre-determined to be high risk. The level of subjectivity in using the tool poses challenges for consistency and reliability in interpretation. The tool is still in development and further revisions are likely.

Inventory of Complicated Grief (ICG) (Prigerson et al., 1995) &
Inventory of Traumatic Grief (ITG) (Prigerson & Jacobs, 2001)

The ICG is a self-report symptom inventory consisting of 19 items that measure a single underlying construct of complicated grief. It has been shown to predict higher levels of social, mental and physical impairments and the ITG, like its predecessor, does not include physical, social, religious and psychological factors. This tool has not been validated regarding its long-term negative effects on health.

Grief Evaluation Measure (GEM) (Jordan et al., 2005)

An extensive self-report instrument with 7 sections measuring demographic data, pre-death information such as loss history and available resources, circumstances of the death and a section for respondents to provide written comments that augment the quantitative information. Two sections identify experiences of the bereaved since the death and problems they have encountered over the past month. It is these two sections in which the GEM demonstrates predictive validity. This tool does not predict bereavement risk from a point in time prior to the death.

Bereavement Risk Inventory (BRI) (Parkes & Weiss, 1983)

This 8-item instrument is intended to predict negative outcomes of somatization, interpersonal sensitivity, depression and anxiety over a bereavement period of 13 months. A later study identifies four modified items (clinging/pining, anger, self-reproach and family cohesion) from the original eight items that could, on their own, provide similar differentiation of high and low risk outcome. The instrument only considers factors such as social support, concurrent stressors and religion from an indirect and subjective perspective and does not address physical health, addictions, previous losses or circumstances of the death. The tool's brevity allows for easy administration, but its narrow scope means it would have limited use as a communication or bereavement assessment tool.

Bereavement Risk Factor Questionnaire (Ellifrit, Nelson, & Walsh, 2003)

A 19-item questionnaire that was designed to be used with bereaved individuals prior to a death. It was initially conceived following a review of the literature and a national survey of bereavement coordinators in the United States. This tool is currently in development.

Review of the literature found one study that addresses the four goals that guided development of the BRAT. Kelly et al. (23) identified caregiver characteristics and context prior to the death of a spouse (at admission to a palliative care program) and related these variables to bereavement outcomes four months post-death. The study assessed pre-death information regarding the caregiver and their situation through twelve extensive questionnaires as well as a structured interview process. The researchers assessed physical and psychological symptoms, social functioning, adjustment and coping, past health and psychosocial history, spiritual/religious beliefs, and quality of the relationship with the patient. All were found to impact bereavement outcome. Despite finding many of these multiple variables predictive of poor bereavement outcome, given its length and complexity, the impracticality of their study methodology for clinical use must be acknowledged.

Development of the BRAT

A team of twelve palliative care psychosocial professionals consisting of counsellors, social workers and child and youth care specialists at Victoria Hospice Society were asked to consider their clinical experiences with bereaved clients and identify factors that placed these clients at risk for problems in bereavement. The professionals identified factors regarding the bereaved person, his or her relationships with others, circumstances of the patient, caregiving and the death. A compilation of factors was sorted and common themes identified. A few items did not fit within the criteria of clearly identifiable and measurable phenomena and thus were discarded. Thirty-eight factors resulted and were captured within 10 themes. The themes were:

1. Spouse/primary caregiver
2. Physical/mental challenges
3. Addictions
4. Coping
5. Spirituality
6. Previous losses
7. Concurrent stressors
8. Family relationships
9. Children
10. Circumstances regarding the caregiving experience and the nature of the death

Subsequently, the themes and factors were presented to other groups of bereavement and psychosocial professionals at provincial and national levels. This early version of BRAT received face validity confirmation of its items from these colleagues along with suggestions of re-wording some items to improve clarity.

Based on the clinical experience of the Victoria Hospice team, each indicator was assigned one of 4 levels of risk:

1. Minimal (weighting score '1')
2. Low (weighting score '4')
3. Moderate (weighting score '16')
4. High (weighting score '64')

Absence of any indicators resulted in a fifth level, No Known Risk (weighting score '0').

Each risk level was assigned a numeric value and the presence of more than one risk indicator results in a cumulative score. The combined effect of indicators necessary to constitute a higher level of risk was also determined. For example, four indicators designated at low level of risk would increase the level of risk to moderate risk. An Excel worksheet was then created to facilitate the calculation of the cumulative score for each client (see Appendix B). In our clinical bereavement program, this resulting cumulative level of risk was then linked to a level of service in which a set of predetermined bereavement services (e.g. phone calls, mail-outs) and a service provider (e.g. professional or volunteer) was assigned.

The team at Victoria Hospice began to formally use the BRAT in September 2004. In subsequent months, small adjustments were made to the numeric values (or weightings) of some indicators in order to better align the tool with achievable service delivery. Late in 2006, the BRAT underwent a significant revision commensurate with an extensive review of literature and two years of clinical experience. Some category headings were added or changed, indicators were added or altered and numeric values were further adjusted to reflect support from the literature and further practice.

In 2011, an inter-rater reliability study (147) was performed by the Victoria Hospice team. This study suggested collapsing "minimal" and "low" levels into a "Lower Risk" delineation and "moderate" and "high" levels into "Higher Risk". This would provide more consistent identification of risk and the BRAT(R) has since been revised to reflect these changes. Fewer levels of risk will likely be more relevant for smaller or resource limited programs who do not have multiple levels of service to offer. There are plans to do further revisions with the BRAT in the future by evaluating its concurrent validity.

5. *Assumptions, Strengths and Limitations*

Assumptions

There are a number of assumptions upon which the BRAT has been developed and these should be considered when using the tool. They are:

1. Grief is a physical, emotional, intellectual, social and spiritual experience; it is not an illness or something to "get over"
2. Not everyone experiences distress when grieving
3. Grief can be a life-long process
4. Good things can come from grief (28)
5. Not all bereaved people require or benefit from professional intervention
6. Complicated grief represents a deviation from the (cultural) norm and can contribute to poor quality of life, considerable suffering, health deficits and even death
7. It is to be expected that some identified indicators may be present for many bereaved persons; however, these indicators need to be severe and prolonged in order to be considered a bereavement risk
8. Prediction is a statement of probability, not certainty
9. Since the BRAT is based on available information, not all personal, interpersonal or situational factors will be known in order to determine the person's bereavement risk
10. Bereavement risk is dynamic and subject to change
11. The BRAT is part of a broader psychosocial assessment. Practice wisdom and intuition are augmented, not eliminated, by use of the BRAT

Strengths

Perhaps the BRAT's greatest strength is that it gives palliative and bereavement care providers a clear and consistent language to communicate concerns about

caregivers and family members, both prior to and following a death. When making referrals to a bereavement service, the BRAT helps the team clearly articulate their knowledge and concerns about the individual. It also promotes consistency in assessment and ongoing evaluation of risk indicators.

The BRAT is unique as a risk assessment tool in that it differentiates degrees of risk among its 40 factors. This mirrors clinical knowledge and experience in that not all risk indicators will carry the same level of risk. For example, the BRAT assigns less risk to the presence of relational difficulties within the bereaved person's family than it does to evidence of suicidal thoughts or plans. The BRAT now identifies three distinct risk levels based on reliability testing performed in 2011 (147).

An important strength of the BRAT is that it can be used to identify bereavement risk prior to death. When palliative care providers initially make contact with a family during the patient's illness and dying, the BRAT offers a means to communicate information to other team members during the illness and to the bereavement program immediately after the death. Early identification of issues or concerns allows for an immediate response and may result in prevention or de-escalation of problems prior to death, thereby potentially decreasing bereavement risk. It may also facilitate outreach from bereavement care providers in order to further assess risk and offer beneficial interventions.

Assessment of risk prior to death aids in the assignment of a preliminary level of service at the time of referral to the bereavement service. This, in turn, guides how bereavement services may be introduced to the bereaved and can help tailor care to meet specific needs. The BRAT may be used to determine if there is a need for direct contact between a bereavement professional and the bereaved. This is particularly beneficial to hospice palliative care programs or other organizations with large numbers of referrals and limited professional resources.

The BRAT also identifies factors that have been shown to have a mitigating effect on a bereaved person's ability to cope with or grieve a death. These are also referred

to as *protective factors* (3). Few other bereavement assessment tools formally incorporate these factors, making it somewhat unique.

Limitations

No psychometric tool is without its limitations. Of the 27 grief measures identified (see Appendix A), each has its own shortcomings and the BRAT is no exception.

The most notable limitation with the BRAT lies in the complexity of some of the indicators, which can lead to variation in interpretation even among experienced bereavement professionals. Ongoing use and communication among those using the BRAT will likely build consistency in its utilization, making it important to regularly discuss interpretation of descriptors such as sign*ificant*, *limited*, *heightened* and *long-standing*.

It is important, too, that identification of risk indicators be based on information provided by the team's direct interactions with the family member or by the user's own contact with the bereaved person, avoiding speculation whenever possible. For example, the assessor may believe that a sudden death would leave the family unprepared and shocked (see BRAT indicator *X.b*). However, without evidence the bereaved person actually interpreted the circumstances in this way, it would be premature to make this assumption. Similarly, hearsay information obtained from other family members or friends should be treated with caution and, if included, should be clearly documented as having been alleged or reported via a third party. For example, where one family member alleges that another is an alcoholic, the assessor should look for collateral information or, ideally, ask the individual directly. Making notes on the BRAT form adjacent to an indicator also aids in communicating details specific about the bereaved person and their situation.

Another limitation of the BRAT (and most other tools) is that minimal consideration is given to cultural variance. Although one indicator attempts to acknowledge cultural differences (Cultural/language barriers to support), this does not make the BRAT reflective of various cultural differences. For example, heightened emotional states of anger, guilt or anxiety as a typical response to stressors may be a more normal reaction within some cultures than others. This limitation requires those

using the BRAT to develop cultural sensitivity appropriate to the clients they serve and adjust assessment practices accordingly.

There may be additional circumstances that affect bereavement risk that are not captured by the BRAT's 40 items. An example might be an excessive sleep disturbance. The BRAT does not address somatic symptoms such as sleeping patterns or appetite changes. Best judgment is required to incorporate this additional information when determining a level of risk.

The benefit of the BRAT to other hospice palliative bereavement programs is still uncertain in that they may have varying mandates, resources and practices. Each indicator's assigned risk level and the determination of a cumulative risk score have been predominantly based on clinical experience at Victoria Hospice. Caution is advised when considering the accuracy (validity) of the assigned levels of risk. Without empirical evidence of further reliability and validity, it falls upon individual programs and professionals to assess the BRAT's utility and applicability within their own practice. Should there be concerns regarding its current empirical shortcomings, sufficient face and content validity exists to support its use as a communication and assessment tool just the same.

6. BRAT's Risk Indicators

The BRAT is comprised of 40 items (see Appendix B). Of these, 30 items identify personal, interpersonal and situational characteristics that can be identified prior to death. A further 6 items identify the nature of the death or the person's response to it and can only be identified after the patient has died. These are marked with an asterisk. A final 4 items identify personal attributes that act as protective factors that mitigate bereavement risk. It is important to reiterate that many of these risk indicators are present within the scope of a normal grief experience. It is the number, persistence and severity of indicators that constitute the risk and hence require a level of professional interpretation.

One of the major shortcomings of risk assessment tools in general is the sole focus on negative characteristics of the situation, the person or both with no attention to the person's strengths and resiliencies. While the BRAT identifies 4 particular items that support a positive bereavement outcome, assessment should always include any additional strengths or resiliencies. Not only does this information provide a fuller picture of the bereaved person and their life experience, it can help other providers to better support the bereaved by affirming those strengths.

This chapter contains a detailed description of each indicator with some examples. The word "person" refers to the family member, caregiver or friend of the patient prior to death, or to the bereaved individual after death.

I. Kinship

a. Spouse/partner of patient or deceased: this relationship is defined by the person him- or herself and may include those who are legally married or living common-law, same-sex partnerships, dating couples or an ex-spouse/partner still emotionally connected to the patient before the death.

b. Parent/parental figure of patient or deceased: refers to mothers, fathers, or guardians/relatives who have historically acted in a parental role to the person, regardless of the age of the child who has died (e.g. adult children as well as children less than age 19 or age of majority).

II. Caregiver

Family member or friend who has taken primary responsibility for care: includes organizing care or providing direct physical or emotional care for the patient. There may be more than one caregiver, such as when family members take turns or when the patient's primary care is shared concurrently between two or more persons.

III. Mental Health

a. Significant mental illness: for example, when the bereaved person has been clinically diagnosed with a major depression, schizophrenia, personality or anxiety disorders. If the illness is not currently manifesting (is managed well by medications), then a history of the illness is relevant only if the person has demonstrated previous susceptibility to relapse when under stressful conditions.

b. Significant mental disability: for example, when a person has a developmental disability, significant dementia, stroke, head injury or autism that impairs cognitive functioning and challenges the person's ability to cope.

IV. Coping

a. Substance abuse/addiction: includes the use of alcohol, street or prescription drugs or any other substance as a method of coping with stress. Addictions to food, sex or gambling may also be considered. Risk is indicated when the use of a substance or a patterned behaviour negatively impacts the ability of the person to cope or function.

b. Considered suicide: the person has thought about intentionally ending his or her life as a means to cope with an anticipated loss or the actual death. This does not include bereaved persons who question their ability to go on without the deceased or state life isn't worth living (although such statements warrant further exploration and assessment).

c. Has suicide plan and a means to carry it out OR has made previous attempt: the person has thought about suicide as a way to cope with the anticipated loss or actual death, has considered a plan, and has the means to carry it out. An example would be a plan to overdose with a narcotic that is sufficiently at hand. This also pertains to thinking about killing oneself AND having made previous suicide attempts.

d. Self-expressed concerns regarding own coping, now or in future: the person is unsure of his or her own ability to cope prior to or after the death. An example would be a person who feels unprepared emotionally, mentally or practically to cope with daily aspects of living.

e. Heightened/sustained emotional states (anger, guilt, anxiety, sadness): a person is prone to emotional volatility, as opposed to one or two episodic demonstrations under stress. For example, the person remains angry, bitter or feels excessively guilty with regard to diagnosis, treatment or negative outcomes such as the death itself; the person is typically in a state of agitation or anxiety (but not with a diagnosed anxiety disorder – see 'Mental Health'); or appears

unusually sensitive to stressful circumstances and typically responds in a highly emotional manner.

f. Yearning/pining for the deceased OR persistent disturbing thoughts/images (in excess of 3 months): the person describes frequent yearning, pining or longing for the deceased to a degree that disrupts daily functioning. This may or may not be accompanied by persistent, disturbing thoughts (e.g. "I should have done more" or "he suffered horribly at the end") or rumination of visual images of the circumstances of the death or of the deceased. Since these experiences may occur initially for some after the death, it is the persistence and uncontrollable nature of these thoughts over several months that constitute risk.

g. Declines available resources or support: a person who, when dealing with difficult situations, either avoids asking for help or consistently declines assistance that is offered.

h. Inability to experience grief feelings or acknowledge reality of the death (beyond 3 months): the person describes feeling numb and unable to access their feelings around grief and loss, although they expect to be able to do so. This also includes people who have trouble intellectually accepting the death and who continue to live as if the deceased has not died. The lack of emotional expression or lack of intellectual acknowledgement of the death must be recognized by the person him or herself and continue for more than 3 months. Note: it is possible that a concurrent stressor, such as needing to complete an important project or caring for a newborn baby, may draw on the person's coping resources such that the person's grief is delayed beyond 3 months. The assessor might determine that such a delay is a reasonable coping strategy, either deliberately chosen or adopted due to exceptional circumstances and, therefore, not necessarily a risk factor as long as the mourning process is eventually actualized.

V. Spirituality/Religion

Significant challenge to fundamental beliefs/loss of meaning or faith/spiritual distress: the person's core belief system or worldview is significantly challenged by the illness or death. For example, the person may believe life is empty or meaningless and the future holds no prospect for fulfillment without the person who died. This often occurs after sudden or traumatic deaths, or multiple losses and may result in a loss of normal functioning and in difficulty making decisions. As this commonly occurs in early bereavement, it is the persistence and impact on daily life that reflects true risk.

VI. Concurrent Stressors

a. Two or more competing demands: multiple competing demands that are persistent and significant (e.g. single parenting, working or other caregiving).

b. Insufficient financial, practical or physical resources: includes having restricted access to financial resources due to low or interrupted income; unavailability of practical support, such as childcare or transportation; or a physical health challenge which further strains a person's ability to cope (e.g. pain, blindness, cancer treatments or post-operative rehabilitation).

c. Recent non-death losses: includes retirement, the loss of one's job, a recent move to a new home or the end of a significant relationship.

d. Significant other with life-threatening illness/injury: a family member or friend (not the current patient/deceased) has an illness or injury that could be life-threatening (e.g. recent cancer diagnosis, stroke or motor vehicle accident).

VII. Previous Bereavements

a. Unresolved previous bereavement(s): one or more previous deaths to which the person continues to have a strong emotional response or when the current situation reawakens or compounds former feelings of grief. There is no time limitation regarding this unresolved loss.

b. Death of other significant person within 1 year (from time of patient's death): a previous death of a significant person (not the current deceased) that has taken place within one year of the current death.

c. Cumulative grief from more than 2 OTHER deaths over past 3 years: the person has experienced multiple deaths of family, friends, work colleagues or acquaintances within the past 3 years (approximately).

d. Death or loss of parent/parental figure during own childhood: losses that occurred before the person reached the age of 19 (or majority). It includes the death of a parent and an unexpected or unexplained absence when the person was a child, such as a parent's disappearance or abandonment.

VIII. Supports & Relationships

a. Lack of social support/social isolation: a perceived or actual lack of emotional, informational or tangible connection or assistance. In some instances, isolation could be the person's choice or usual style of coping, or may be due to an inability to mobilize out of the home. This could also refer to someone experiencing disenfranchised grief from a stigmatized loss (e.g., the death of secret lover, a gay or transgender partner or a stigmatized death from AIDS, alcoholism or suicide). As a result there is not only a lack of validation of the loss, but also knowledge that support is being withheld because of the stigma.

b. Cultural or language barriers to support: the person may not have access to others from their own culture (defined as a religious, ethnic or distinct social group) whose beliefs and practices around death and grief may not align with the mainstream culture. Also, there may be barriers to bereavement or social support from the dominant culture because the person does not speak or easily understand the primary local language.

c. Longstanding or current discordant relationship(s) within the family: a pattern of conflict or communication breakdown between one or more family members that may then limit primary social supports. This can result in differing opinions regarding caregiving practices, decision-making on behalf of the patient or an issue after the death such as a dispute over the estate.

d. Relationship with the patient/deceased: includes someone who experiences ambivalence within the relationship or has been the recipient or provider of verbal, emotional or physical abusive with the patient/deceased. He or she may also have been emotionally or physically dependent on the patient/deceased.

IX. Children & Youth

a. Death of a parent, parental figure or sibling: pertains to a bereaved child less than age 19 (or age of majority) who has lost a parent, parental figure (e.g., a grandmother who was involved in the upbringing of the child); or the loss of a brother or sister.

b. Demonstration of extreme, ongoing behaviours/symptoms: one or more indications of an exaggerated expression of grief are exhibited by the child, reflected by a heightened intensity and frequency of otherwise normal manifestations of grief. For example, extreme or persistent sleep difficulties, refusing to eat, bed wetting, headaches, stomach aches, emotional distress, separation anxiety, fear that others will also die, death fantasies, learning difficulties (including difficulty concentrating), feelings of responsibility for the

death, developmental regression, explosive emotions, acting out, extreme shyness, disinterest in play, overdependence, or demand for attention.

c. Parent expresses concern regarding his/her ability to support child's grief: a parent/parental figure who is concerned about his/her child's exposure to dying/death or is unsure how to differentiate between normal and potentially problematic expressions of grief in children. The parent is likely unsure how to support the child and is looking for guidance.

d. Parent/parental figure significantly compromised by his/her own grief: a situation where a parent or other person in the home who has responsibility for the child exhibits behaviours that place both adult and child at risk. For example, a parent has a serious addiction to drugs or alcohol, severe depression, suicidal ideation or excessive anger.

X. Circumstances Involving the Patient, the Care or the Death

a. Patient/deceased less than age 35: reflects the cultural belief that children and young adults are not supposed to die marks the death as exceptional, tragic and unfair.

b. Lack of preparedness for the death: the bereaved person perceives the death as sudden and unexpected which has left him or her mentally and/or emotionally unprepared, resulting in shock or disbelief. Because a lack of preparedness for the death may be difficult to assess, it may be easier to look for evidence of preparedness such as when the person has considered life without the patient or has shown a readiness to "let them go", even if only to end the patient's suffering

c. Distress witnessing the death OR death perceived as preventable: the person has observed disturbing elements of the death, which has caused strong reactions of fear, helplessness or anger. Distressing events may include witnessing

severe pain, a collapse, drowning, choking, delirium or bleeding. This also refers to a death that is perceived as preventable (e.g. someone killed by a drunk driver, belief or knowledge that incompetent medical care caused the death).

d. Violent, traumatic OR unexplained death: the nature of the death was violent, overwhelming or otherwise atypical. (e.g. motor vehicle accident, fall, industrial accident, homicide or suicide, or a natural disaster such as floods or hurricanes). Unexplained death refers to situations where the cause of death was not identified. This indicator also includes situations where someone disappears and death is assumed without evidence of a body.

e. Significant anger with OTHER health care providers: the person attributes blame to the health care system or a specific health care provider regarding diagnosis, care of or death of the patient. Anger is the primary expression of grief and may serve as a barrier or obstacle to the person accepting or receiving support.

f. Significant anger with OUR hospice palliative care program: the person attributes significant blame to the program of care that provides bereavement services or to a specific staff member of that program who provided what is believed to be poor or incompetent care. This is particularly significant if the action in question was seen as a contributor to the patient's death. His or her anger and blame may result in refusal of follow-up support from the program. Assigning the highest risk level to this circumstance alerts both the bereavement team and the larger program to the need for timely contact with the bereaved person in order to clarify any misinformation or misperceptions and demonstrate responsiveness to the concern.

XI. Protective Factors Supporting Positive Bereavement Outcome

a. Internalized belief in own ability to cope effectively: the person believes he or she can cope effectively with most negative external events and takes responsibility for his or her response to them. He or she may also have had

previous experiences with loss and death and affirmed their ability to successfully deal with the current loss.

b. Perceives AND is willing to access strong social support network: the person believes that helpful support is readily available from family, friends or community before and after the death and demonstrates a willingness to use it.

c. Predisposed to high level of optimism/positive state of mind: throughout much of his or her life, the person has demonstrated genuine hopefulness for the future and tends to look at the positive aspects of a situation.

d. Spiritual/religious beliefs that assist in coping with the death: there is evidence the person has spiritual or religious beliefs that assist to make meaning of the loss, facilitate problem-solving, lessen negative emotional experiences related to the death or provide a means of maintaining connection to the deceased.

7. *Using the BRAT*

The BRAT was designed to become a part of a patient's chart when he or she is registered with a hospice palliative care program. This allows for the notation of information regarding family and caregivers prior to the patient's death. It is important to remember that the BRAT does not record information about the patient, but about caregivers and family members.

Identification of Risk by the Team

Early on in the patient's disease trajectory, various members of the hospice palliative care team may identify risk indicators for family members. Hospital- and community-based physicians, nurses, social workers, clergy and volunteers often witness family dynamics and coping behaviours and can contribute valuable information regarding bereavement risk. Use by interdisciplinary team members provides a comprehensive collection of information since each discipline brings its own perspective of patients and families, their relationships and circumstances. In turn, each discipline may also benefit from having this information, which contributes to better understanding of the patient's and family's needs. This being said, it is most likely that social workers, counsellors, nurses and spiritual care providers will be primary users of the BRAT.

A single BRAT Form (see Appendix C) can be placed on the patient's chart and used to track the status of the family as a whole, or multiple copies can be used to track individual family members. As noted earlier, the BRAT is intended to be used as part of a wider psychosocial assessment and should accompany this information in the patient's chart.

There are limitations and cautions in the use of any tool, and the BRAT is no exception. Interpretation of terms, assumptions and additional risk factors must all be

considered when assessing bereavement risk. Refer to Chapter 5 for discussion of limitations.

Referral to the Bereavement Service

Approximately ten percent of bereaved persons followed by a hospice palliative care program experience complicated grief (105). Given that many bereavement programs cannot realistically attempt to perform an individual assessment on each bereaved person, and given that most people will not have complicated grief or extra-ordinary needs, it is reasonable to use a system that, at least initially, can estimate need. While risk could be underrated due to a lack of available information, the BRAT provides a 'best guess' of bereavement risk prior to death and provides a starting point for the bereavement team.

As appropriate, the deceased patient's file with the BRAT form is passed on to the hospice palliative care program's bereavement service after the patient has died. Information gathered before the death can be reviewed by a bereavement professional in order to assure the most thorough assessment and appropriate allocation of resources. This person may review other team notes in the chart that may provide further clarification of risk. Ultimately, the bereavement professional must use his or her best judgment to interpret the information provided by the BRAT and any additional charting from team members.

Community Referrals from Outside the Hospice Palliative Care Program

Some hospice palliative care programs also offer bereavement support to bereaved persons from outside their program of care. When a client is referred from the community at large, a professional's initial interview with the bereaved person is the first opportunity to gather information and complete the BRAT.

Whereas referrals from hospice palliative care programs might include patients who have died from cancer, heart failure, or AIDS, referrals from the community at large may include people grieving sudden deaths, such as those resulting from motor vehicle accidents, suicide or heart attack. The BRAT has been designed to capture all of these circumstances.

The diversity in cause and circumstances of death from both within and outside the program of care requires the user to have a broad knowledge base and clinical experience that encompass these various types of loss.

Completing the BRAT on a Child

A child's BRAT assessment is initially recorded on his or her parent's BRAT (child risk is assessed in Section IX). The parent's or others' concerns can be reviewed and if the child is identified as being at risk, the parent is contacted directly to provide further information to the assessor. The most helpful intervention to the parent at this time may be education about normal grief behaviours. However, if the parent requests or consents to additional support services, a separate BRAT can be completed for the child. This allows for the child to be tracked independently of the parent.

Using the BRAT(R) Excel Worksheet

Collecting and Entering Data

An Excel worksheet has been designed to store the BRAT in electronic format, facilitate the calculation of the cumulative risk score, and designate a level of risk for complications in bereavement (see Appendix C). The electronic BRAT also provides an explanation of each indicator. This information is accessed by placing the cursor over the small red triangle located at the end of each indicator line. The information provided on the Excel worksheet is representative of the text in this manual. (see Chapter 6).

Having reviewed the information in a deceased patient's chart, or once the assessor has conducted an intake interview with a community-referred bereaved person, data entry can begin. The assessor checks each relevant risk indicator by clicking on the corresponding box. The assessor may also record additional comments or details in the text box adjacent to each category of risk. Each assessor can determine how much detail will be useful to colleagues who might later access the BRAT. Once completed, the BRAT can be printed and placed in the bereaved person's chart or file, or saved electronically by linking it to an electronic file. If an Excel program is not available or compatible with the assessor's computer hardware, the BRAT can be completed manually. The cumulative score and corresponding risk level can be determined using the information listed in Appendix E. This is a time-consuming option however.

Once all risk indicators have been identified, the Excel worksheet will calculate an overall level of risk. **The risk level indicated boldly at the top of the right hand column** (above "comments") **will display the mitigated risk.** In order to assist the assessor in considering how the protective factors might actually impact bereavement risk, the Excel worksheet additionally displays unmitigated risk at the top left side of the worksheet. The unmitigated risk level calculates risk without considering any of the protective factors that have been identified whereas the mitigated risk level incorporates the identified protective factors and their assigned (negative) weightings. The reason for displaying these two risk levels is to draw the assessor's attention to any discrepancy between them and provide an opportunity for re-assessment. Since each risk level is intended to correspond to a particular set of bereavement services (as suggested in Appendix D), it is important to recognize the implications of differing risk levels. For example, a Higher Risk level might correspond to a counsellor or social worker follow-up, while a Lower Risk level might suggest contact by mail only or perhaps a volunteer follow-up. Being able to view both the unmitigated and mitigated risk levels allows the assessor to review the implications for service response and, based on clinical judgment, the user has the option to override the mitigated risk designation. Although the additive nature of positive and negative factors has some face validity, it remains poorly studied. It seems prudent to watch for further research and clinical investigation in this area.

Given the dynamic nature of bereavement, if, with further contact with the bereaved person, previously identified risk indicators resolve (e.g. the person is no longer socially isolated, concurrent stressors are reduced, or he or she is no longer pining for the deceased) or a new indicator is discovered, the BRAT Excel worksheet can be reopened, updated and re-printed.

Completing the BRAT(R) – Some Examples

The following five examples demonstrate use of the BRAT when persons are first referred to a hospice palliative care bereavement program. For those families registered with the palliative care program before death, it is the care team that has provided the information (examples 1 to 4). For bereaved people referred or self-referred from the community at large, the assessor gathers information directly from the bereaved individual at the initial meeting (example 5).

The BRAT examples offer an interpretation of the information provided, showing how that interpretation translates into decisions about risk and, ultimately, service provision. While different interpretations may be possible, it is critical to apply clinical knowledge and experience in a way that ensures consistency within each bereavement program.

Example 1 – "Susan"

Susan is a woman in her 50's whose husband, Stan, recently died from COPD and pulmonary fibrosis. As much as Susan was Stan's caregiver, Stan had been Susan's caregiver since she has experienced anxiety disorders for more than 20 years. She reveals she has panic disorder and agoraphobia. Susan refers to Stan's death as not only the loss of her life partner, but of her "anchor" when it came to helping her control her anxiety. Susan was observed to be highly anxious throughout team visits and became almost distraught when Stan became the slightest bit short of breath. Two hours before Stan's death, he suddenly went unconscious while talking with Susan while sitting in bed, likely due to a pulmonary embolism. When the care team visited to support Stan's final minutes and his death, they noted Susan said she didn't know how she was going to manage without him.

A bereavement risk assessment for Susan is on the following page.

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name
24-May-2015	sp	676768	Stan	**Susan**

Unmitigated Risk Level: Higher Risk

Mitigated Risk Level: Higher Risk

Risk Level Override

Higher Risk

I. Kinship

- [x] a) spouse/partner of patient or deceased
- [ ] b) parent/parental figure of patient or deceased

II Caregiver

- [x] a) family member or friend who has taken primary responsibility for care

III. Mental Health

- [x] a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)
- [ ] b) significant mental disability (eg developmental, dementia, stroke, head injury)

IV. Coping

- [ ] a) substance abuse / addiction (specify)
- [ ] b) considered suicide (no plan, no previous attempt)
- [ ] c) has suicide plan and a means to carry it out or has made previous attempt
- [x] d) self-expressed concerns regarding own coping, now or in future
- [x] e) heightened/sustained emotional states (anger, guilt, anxiety, sadness)
- [ ] f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*
- [ ] g) declines available resources or support
- [ ] h) inability to experience grief feelings or acknowledge reality of the death > 3 months*

V. Spirituality / Religion

- [ ] significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress

VI. Concurrent Stressors

- [ ] a) two or more competing demands (eg single parenting, work, other caregiving)
- [ ] b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness)
- [ ] c) recent non-death losses (eg divorce, unemployment, moving, retirement)
- [ ] d) significant other with life-threatening illness / injury (other than patient/deceased)

VII. Previous Bereavements

- [ ] a) unresolved previous bereavement(s)
- [ ] b) death of other significant person within 1 year (from time of patient's death)
- [ ] c) cumulative grief from > 2 OTHER deaths over past 3 years
- [ ] d) death or loss of parent/parental figure during own childhood (less than age 19)

VIII. Supports & Relationships

- [ ] a) lack of social support/social isolation (perceived or real - eg housebound)
- [ ] b) cultural or language barriers to support
- [ ] c) longstanding or current discordant relationship(s) within the family
- [x] d) relationship with patient/deceased (eg abuse, dependency)

IX. Children & Youth

- [ ] a) death of parent, parental figure or sibling*
- [ ] b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)
- [ ] c) parent expresses concern regarding his/her ability to support child's grief
- [ ] d) parent/parental figure significantly compromised by his/her own grief

X. Circumstances Involving the Patient, the Care or the Death

- [ ] a) patient/deceased less than age 35
- [x] b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*
- [ ] c) distress witnessing the death OR death perceived as preventable*
- [ ] d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*
- [ ] e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")
- [ ] f) significant anger with OUR hospice palliative care program (eg "you killed my wife")

XI. Protective Factors Supporting Positive Bereavement Outcome

- [ ] a) internalized belief in own ability to cope effectively
- [ ] b) perceives AND is willing to access strong social support network
- [ ] c) predisposed to high level of optimism/positive state of mind
- [ ] d) spiritual/religious beliefs that assist in coping with the death

COMMENTS

Stan and Susan were each other's caregiver.

Susan has a panic disorder and agoraphobia x 20 years.

Susan expressed concern about her own ability to cope. Stan was her "anchor". She has demonstrated highly anxious behavior. *(Although her panic disorders are indicated as a Mental Health risk, Susan also seems to have an anxious personality style, and so indicator IV. e) is also appropriate to check.)*

Susan appeared to have an emotional dependency on Stan.

An unknown medical event resulted in Stan suddenly becoming unconscious 2 hours prior to his death. *(We might assume in this instance that there was a lack of preparedness for the death.)*

Example 2 - "Marvin"

Marvin is a 34 year old man whose wife, Melanie, recently died of breast cancer. They have two daughters, one age 5 (who has autism) and the other age 2. Marvin is a substitute teacher but has taken the past two months off to care for his wife and family. A few weeks before Melanie's death, he learned that the school board would not be renewing any substitute teacher contracts as a cost saving measure. Marvin feels he has successfully coped with some pretty difficult circumstances in the past and has the attitude that whatever life throws at him, he can manage. Even though he is devastated by Melanie's death, he states he'll manage somehow. He says he has good support from his parents, siblings and close circle of friends, all of whom have offered to help him with the children.

The completed BRAT for Marvin can be found on the following page.

Note that in this example the mitigated and unmitigated risk levels are different (see upper left side of the worksheet, below Assessment Date*). This information is provided for the benefit of the user should he/she choose to over-ride the mitigated risk level based on professional judgement as to how Marvin is coping overall. Should the user have little insight beyond the information already provided on the sheet, then the risk level can be left as is at Lower Risk.*

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name
5-Jul-2015	LM	15-0000	Melanie	Marvin

Unmitigated Risk Level: Higher Risk

Mitigated Risk Level: Lower Risk

Risk Level Override

Lower Risk

	COMMENTS
I. Kinship	
☑ a) spouse/partner of patient or deceased	Spouse and caregiver.
☐ b) parent/parental figure of patient or deceased	
II Caregiver	
☑ a) family member or friend who has taken primary responsibility for care	
III. Mental Health	
☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)	
☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)	
IV. Coping	
☐ a) substance abuse / addiction (specify)	
☐ b) considered suicide (no plan, no previous attempt)	
☐ c) has suicide plan and a means to carry it out or has made previous attempt	
☐ d) self-expressed concerns regarding own coping, now or in future	
☐ e) heightened/sustained emotional states (anger, guilt, anxiety, sadness)	
☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*	
☐ g) declines available resources or support	
☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*	
V. Spirituality / Religion	
☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress	
VI. Concurrent Stressors	Recently lost his job as a substitute teacher. *(Marvin at some point will likely need to look for a new job, and along with parenting, will constitute two or more significant competing demands [item VI.a)]. We would not check this item until his search for employment is*
☐ a) two or more competing demands (eg single parenting, work, other caregiving)	
☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness)	
☑ c) recent non-death losses (eg divorce, unemployment, moving, retirement)	
☐ d) significant other with life-threatening illness / injury (other than patient/deceased)	
VII. Previous Bereavements	*confirmed. We did not assume financial hardship as it was not mentioned.)*
☐ a) unresolved previous bereavement(s)	
☐ b) death of other significant person within 1 year (from time of patient's death)	
☐ c) cumulative grief from > 2 OTHER deaths over past 3 years	
☐ d) death or loss of parent/parental figure during own childhood (less than age 19)	
VIII. Supports & Relationships	
☐ a) lack of social support/social isolation (perceived or real - eg housebound)	
☐ b) cultural or language barriers to support	
☐ c) longstanding or current discordant relationship(s) within the family	
☐ d) relationship with patient/deceased (eg abuse, dependency)	
IX. Children & Youth	Left with 2 daughters, ages 5 and 2. The 5 year old has autism. *(Should the 5 year old exibit behaviours as listed in IX.b) in the future, this item can then be checked.)*
☑ a) death of parent, parental figure or sibling*	
☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)	
☐ c) parent expresses concern regarding his/her ability to support child's grief	
☐ d) parent/parental figure significantly compromised by his/her own grief	
X. Circumstances Involving the Patient, the Care or the Death	Melanie was age 34.
☑ a) patient/deceased less than age 35	
☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*	
☐ c) distress witnessing the death OR death perceived as preventable*	
☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*	
☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")	
☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")	
XI. Protective Factors Supporting Positive Bereavement Outcome	Has successfully coped with previous adversity. Believes he will cope given a strong support system of family and friends who will assist with childcare.
☑ a) internalized belief in own ability to cope effectively	
☑ b) perceives AND is willing to access strong social support network	
☐ c) predisposed to high level of optimism/positive state of mind	
☐ d) spiritual/religious beliefs that assist in coping with the death	

Example 3 - "The Smith's"

Mrs. Smith's 78 year old husband died last week on the palliative care unit. Harry had lived with lung cancer for 3 years and Mrs. Smith was his primary caregiver until a week before he died, when he was moved to the palliative care unit. She had to give up caring for her husband when his needs became too much for her, partly because of her arthritis which is quite painful at times. Mrs. Smith's sister in Ontario has recently been diagnosed with bowel cancer. Mrs. Smith has strong faith, which has always "seen her through the bad times". The Smiths, who called themselves a close couple, were married 45 years and had 3 children, who are now grown and married, with children of their own. The Smiths' eldest child, Jane, lives in town and has been supportive of her parents throughout her father's illness. At the same time she has been caring for two young children and working part-time. Jane's 7 year old son, who was quite close to his grandfather, was having difficulty focusing on his school work in the weeks after his grandfather died. Jane was concerned about this behaviour at the time and not sure how to deal with it.

On the next two pages are BRAT's for Mrs. Smith and for her daughter, Jane, based on the information above.

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name
12-Nov-2015	CR	15-0000	Mr. Smith	**Mrs. Smith**

Unmitigated Risk Level: Lower Risk

Mitigated Risk Level: Lower Risk

Risk Level Override

Lower Risk

	COMMENTS
I. Kinship ☑ a) spouse/partner of patient or deceased ☐ b) parent/parental figure of patient or deceased ***II Caregiver*** ☑ a) family member or friend who has taken primary responsibility for care	Spouse and caregiver.
III. Mental Health ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder) ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)	
IV. Coping ☐ a) substance abuse / addiction (specify) ☐ b) considered suicide (no plan, no previous attempt) ☐ c) has suicide plan and a means to carry it out or has made previous attempt ☐ d) self-expressed concerns regarding own coping, now or in future ☐ e) heightened/sustained emotional states (anger, guilt, anxiety, sadness) ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months* ☐ g) declines available resources or support ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*	
V. Spirituality / Religion ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress	
VI. Concurrent Stressors ☐ a) two or more competing demands (eg single parenting, work, other caregiving) ☑ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness) ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement) ☑ d) significant other with life-threatening illness / injury (other than patient/deceased)	Has arthritis which can be debilitating. Sister in Ontario recently diagnosed with bowel cancer.
VII. Previous Bereavements ☐ a) unresolved previous bereavement(s) ☐ b) death of other significant person within 1 year (from time of patient's death) ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years ☐ d) death or loss of parent/parental figure during own childhood (less than age 19)	
VIII. Supports & Relationships ☐ a) lack of social support/social isolation (perceived or real - eg housebound) ☐ b) cultural or language barriers to support ☐ c) longstanding or current discordant relationship(s) within the family ☐ d) relationship with patient/deceased (eg abuse, dependency)	
IX. Children & Youth ☐ a) death of parent, parental figure or sibling* ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares) ☐ c) parent expresses concern regarding his/her ability to support child's grief ☐ d) parent/parental figure significantly compromised by his/her own grief	
X. Circumstances Involving the Patient, the Care or the Death ☐ a) patient/deceased less than age 35 ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)* ☐ c) distress witnessing the death OR death perceived as preventable* ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)* ☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis") ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")	
XI. Protective Factors Supporting Positive Bereavement Outcome ☐ a) internalized belief in own ability to cope effectively ☐ b) perceives AND is willing to access strong social support network ☐ c) predisposed to high level of optimism/positive state of mind ☑ d) spiritual/religious beliefs that assist in coping with the death	Has strong religious faith which has always seen her through the bad times.

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name
12-Nov-2015	CR	15-0000	Mr. Smith	Jane Smith-Jones

Unmitigated Risk Level: Higher Risk

Mitigated Risk Level: Higher Risk

Risk Level Override

Higher Risk

	COMMENTS
I. Kinship ☐ a) spouse/partner of patient or deceased ☐ b) parent/parental figure of patient or deceased	*(No mention of taking primary responsibility for care.)*
II Caregiver ☐ a) family member or friend who has taken primary responsibility for care	
III. Mental Health ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder) ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)	
IV. Coping ☐ a) substance abuse / addiction (specify) ☐ b) considered suicide (no plan, no previous attempt) ☐ c) has suicide plan and a means to carry it out or has made previous attempt ☐ d) self-expressed concerns regarding own coping, now or in future ☐ e) heightened/sustained emotional states (anger, guilt, anxiety, sadness) ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months* ☐ g) declines available resources or support ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*	
V. Spirituality / Religion ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress	
VI. Concurrent Stressors ☑ a) two or more competing demands (eg single parenting, work, other caregiving) ☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness) ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement) ☐ d) significant other with life-threatening illness / injury (other than patient/deceased)	Has 2 young children and works part-time. *(There is no evidence that Jane's aunt who has cancer is a significant other to Jane.)*
VII. Previous Bereavements ☐ a) unresolved previous bereavement(s) ☐ b) death of other significant person within 1 year (from time of patient's death) ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years ☐ d) death or loss of parent/parental figure during own childhood (less than age 19)	
VIII. Supports & Relationships ☐ a) lack of social support/social isolation (perceived or real - eg housebound) ☐ b) cultural or language barriers to support ☐ c) longstanding or current discordant relationship(s) within the family ☐ d) relationship with patient/deceased (eg abuse, dependency)	
IX. Children & Youth ☐ a) death of parent, parental figure or sibling* ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares) ☑ c) parent expresses concern regarding his/her ability to support child's grief ☐ d) parent/parental figure significantly compromised by his/her own grief	Concerned about son's (age 7) behavior. The boy was close to his grandfather. He was having difficult time focusing at school the week Harry died. Need to reassess this behavior at next contact. *(At this point, would not consider this behavior as extreme.)*
X. Circumstances Involving the Patient, the Care or the Death ☐ a) patient/deceased less than age 35 ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)* ☐ c) distress witnessing the death OR death perceived as preventable* ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)* ☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis") ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")	
XI. Protective Factors Supporting Positive Bereavement Outcome ☐ a) internalized belief in own ability to cope effectively ☐ b) perceives AND is willing to access strong social support network ☐ c) predisposed to high level of optimism/positive state of mind ☐ d) spiritual/religious beliefs that assist in coping with the death	

Example 4 - "The Gallagher's"

Tony Gallagher was in his 50's and died at home of end-stage liver disease secondary to alcoholism. He was registered with the hospice palliative program and a hospice nurse visited regularly to support care at home until his death. During her visits, the nurse had several concerns about Tony's home life and recorded her observations in Tony's chart. Tony lived in an older and run-down mobile home with his two sons, both in their 20's. Tony's wife had unexpectedly left when the boys were in their early teens and they have had no contact with her since. Bob, his older son, is unemployed and was often seen inebriated during the day. He was often passed out on the couch when the nurse visited. Bob was described by his father and brother as a "loner". Steve, Tony's younger son, is a student at a technical school and his best friend recently died in a motorcycle accident. The two sons rarely communicated with their father except by using expletives and talking sarcastically behind his back. On several occasions the nurse suggested that Tony have support in the home to help him with his father's personal care and meal preparation, but neither Tony nor the boys would agree to it. They felt that they would be fine on their own, but the nurse indicated that Tony was not getting the degree of help he needed from his sons and was often too weak to help himself. Bob frequently talked about how angry he was with Tony's family doctor for not doing more to help their father, and blamed the doctor for the fact that Tony was not getting better. Both sons had been told on more than one occasion that Tony's condition was palliative, yet did not appear to acknowledge their father was dying until a few days before his death.

BRATs for Bob and Steve follow on the next two pages, based on our team's evaluation of the nurse's notes.

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name
19-Dec-2015	PH	15-0000	Tony Galagher	**Bob Gallagher**

Unmitigated Risk Level: Higher Risk

Mitigated Risk Level: Higher Risk

Risk Level Override

Higher Risk

COMMENTS

I. Kinship

- ☐ a) spouse/partner of patient or deceased
- ☐ b) parent/parental figure of patient or deceased

Eldest son of deceased. Lived with Tony but caregiver role appeared to be minimal.

II Caregiver

- ☐ a) family member or friend who has taken primary responsibility for care

III. Mental Health

- ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)
- ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)

IV. Coping

- ☑ a) substance abuse / addiction (specify)
- ☐ b) considered suicide (no plan, no previous attempt)
- ☐ c) has suicide plan and a means to carry it out or has made previous attempt
- ☐ d) self-expressed concerns regarding own coping, now or in future
- ☐ e) heightened/sustained emotional states (anger, guilt, anxiety, sadness)
- ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*
- ☑ g) declines available resources or support
- ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*

Abuse of alcohol observed by care team. Declined help with care for his father.

V. Spirituality / Religion

- ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress

VI. Concurrent Stressors

- ☐ a) two or more competing demands (eg single parenting, work, other caregiving)
- ☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness)
- ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement)
- ☐ d) significant other with life-threatening illness / injury (other than patient/deceased)

(Financial resources appear on the surface to be limited; however, there is no direct evidence of this. Although he is unemployed, Bob could have an undisclosed source of income.)

VII. Previous Bereavements

- ☐ a) unresolved previous bereavement(s)
- ☐ b) death of other significant person within 1 year (from time of patient's death)
- ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years
- ☑ d) death or loss of parent/parental figure during own childhood (less than age 19)

Mother left home when he was a young adolescent.

VIII. Supports & Relationships

- ☑ a) lack of social support/social isolation (perceived or real - eg housebound)
- ☐ b) cultural or language barriers to support
- ☐ c) longstanding or current discordant relationship(s) within the family
- ☑ d) relationship with patient/deceased (eg abuse, dependency)

Described by his father and brother as a"loner". Relationship with his father characterized by verbal conflict. Father was an alcoholic.

IX. Children & Youth

- ☐ a) death of parent, parental figure or sibling*
- ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)
- ☐ c) parent expresses concern regarding his/her ability to support child's grief
- ☐ d) parent/parental figure significantly compromised by his/her own grief

X. Circumstances Involving the Patient, the Care or the Death

- ☐ a) patient/deceased less than age 35
- ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*
- ☐ c) distress witnessing the death OR death perceived as preventable*
- ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*
- ☑ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")
- ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")

May have been unprepared for his father's death as he did not acknowledge openly the possibility that his father might die until a few days prior to death. Anger/blame expressed at father's GP. *(We place the comment about preparedness here to communicate the circumstances, but there is no direct evidence that Bob was unprepared for the death and so item X.b) was not checked. Later contact may allow for assessment of this possibility.)*

XI. Protective Factors Supporting Positive Bereavement Outcome

- ☐ a) internalized belief in own ability to cope effectively
- ☐ b) perceives AND is willing to access strong social support network
- ☐ c) predisposed to high level of optimism/positive state of mind
- ☐ d) spiritual/religious beliefs that assist in coping with the death

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name
19-Dec-2015	PH	15-0000	Tony Galagher	**Steve Gallagher**

Unmitigated Risk Level: Lower Risk

Mitigated Risk Level: Lower Risk

Risk Level Override

Lower Risk

	COMMENTS
I. Kinship ☐ a) spouse/partner of patient or deceased ☐ b) parent/parental figure of patient or deceased	Son of deceased. Lived with Tony but caregiver role appeared to be minimal.
II Caregiver ☐ a) family member or friend who has taken primary responsibility for care	
III. Mental Health ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder) ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)	
IV. Coping ☐ a) substance abuse / addiction (specify) ☐ b) considered suicide (no plan, no previous attempt) ☐ c) has suicide plan and a means to carry it out or has made previous attempt ☐ d) self-expressed concerns regarding own coping, now or in future ☐ e) heightened/sustained emotional states (anger, guilt, anxiety, sadness) ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months* ☑ g) declines available resources or support ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*	Declined help with care for his father.
V. Spirituality / Religion ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress	
VI. Concurrent Stressors ☐ a) two or more competing demands (eg single parenting, work, other caregiving) ☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness) ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement) ☐ d) significant other with life-threatening illness / injury (other than patient/deceased)	*(Financial resources appear on the surface to be limited; however, there is no direct evidence of this. Although he is a student, Steve could have an undisclosed source of income.)*
VII. Previous Bereavements ☐ a) unresolved previous bereavement(s) ☑ b) death of other significant person within 1 year (from time of patient's death) ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years ☑ d) death or loss of parent/parental figure during own childhood (less than age 19)	Best friend recently died in motorcycle accident. Mother left home when he was a young adolescent.
VIII. Supports & Relationships ☐ a) lack of social support/social isolation (perceived or real - eg housebound) ☐ b) cultural or language barriers to support ☐ c) longstanding or current discordant relationship(s) within the family ☑ d) relationship with patient/deceased (eg abuse, dependency)	Relationship with his father characterized by verbal conflict. Father was an alcoholic.
IX. Children & Youth ☐ a) death of parent, parental figure or sibling* ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares) ☐ c) parent expresses concern regarding his/her ability to support child's grief ☐ d) parent/parental figure significantly compromised by his/her own grief	
X. Circumstances Involving the Patient, the Care or the Death ☐ a) patient/deceased less than age 35 ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)* ☐ c) distress witnessing the death OR death perceived as preventable* ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)* ☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis") ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")	May have been unprepared for his father's death as he did not acknowledge openly the possibility that his father might die until a few days prior to death. *(We place this comment here to communicate the circumstances, but there is no direct evidence that Bob was unprepared for the death and so item X.b) was not checked. Later contact may allow for assessment of this possibility.)*
XI. Protective Factors Supporting Positive Bereavement Outcome ☐ a) internalized belief in own ability to cope effectively ☐ b) perceives AND is willing to access strong social support network ☐ c) predisposed to high level of optimism/positive state of mind ☐ d) spiritual/religious beliefs that assist in coping with the death	

Example 5 - "Sharon"

A therapist in the community referred Sharon because she has lost several important people in her life over the past few years and is "depressed" because of this. Sharon and you meet for an assessment session at which time the following information becomes known to you.

Sharon is a single woman in her 30's and when you meet, you notice she has been crying and looks visibly upset. She states that she isn't sure how she will manage now that "all the important people in my life are gone". Sharon's father and mother both died over the past two years; her father died suddenly from a heart attack and her mother died 8 months ago from breast cancer. Sharon is an only child. She especially misses her mother as they were close and spoke daily on the phone. Just as she was starting to feel like she was going to survive her grief from these deaths, her boyfriend of 3 years, Tommy, was killed in a work related accident two weeks ago. Sharon reports he fell from a building and says she has repeatedly re-created the gruesome fall in her mind, picturing his body hitting the ground. She has been crying almost continuously for two weeks and has little energy for anything else. Sharon is struggling to make sense of all these deaths, questioning why her family was taken away from her. She states that God must be punishing her. She has thought twice about ending her own life, but doesn't have a plan and can't imagine having the courage to do so.

The BRAT on the following page shows how the above information would be recorded. The BRAT has a primary focus on a single death (with other deaths considered to be secondary) so the most recent death of the boyfriend, Tommy, is considered to be the primary death.

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name
2-Jan-2016	CT	16-0000	Tommy/multiple	Sharon

Unmitigated Risk Level: Higher Risk

Mitigated Risk Level: Higher Risk

Risk Level Override

Higher Risk

	COMMENTS
I. Kinship	Boyfriend of 3 years.
☑ a) spouse/partner of patient or deceased	
☐ b) parent/parental figure of patient or deceased	
II Caregiver	
☐ a) family member or friend who has taken primary responsibility for care	
III. Mental Health	
☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)	
☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)	
IV. Coping	Considered suicide twice. No plan. Stated she is questioning how she will manage with so many deaths. *(Would not consider Sharon's disturbing visions of Tommy's fall a risk indicator [IV.f)] unless these visions persisted beyond 3 months.)*
☐ a) substance abuse / addiction (specify)	
☑ b) considered suicide (no plan, no previous attempt)	
☐ c) has suicide plan and a means to carry it out or has made previous attempt	
☑ d) self-expressed concerns regarding own coping, now or in future	
☐ e) heightened/sustained emotional states (anger, guilt, anxiety, sadness)	
☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*	
☐ g) declines available resources or support	
☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*	Struggling to make sense of multiple losses. States God must be punishing her.
V. Spirituality / Religion	
☑ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress	
VI. Concurrent Stressors	
☐ a) two or more competing demands (eg single parenting, work, other caregiving)	
☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness)	
☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement)	
☐ d) significant other with life-threatening illness / injury (other than patient/deceased)	
VII. Previous Bereavements	Father died suddenly 1-2 yrs ago and mother died of breast cancer 8 months ago. *(Would not call these deaths "unresolved" as time since deaths is not reasonably sufficient to determine "resolution".)*
☐ a) unresolved previous bereavement(s)	
☑ b) death of other significant person within 1 year (from time of patient's death)	
☑ c) cumulative grief from > 2 OTHER deaths over past 3 years	
☐ d) death or loss of parent/parental figure during own childhood (less than age 19)	
VIII. Supports & Relationships	
☐ a) lack of social support/social isolation (perceived or real - eg housebound)	
☐ b) cultural or language barriers to support	
☐ c) longstanding or current discordant relationship(s) within the family	
☐ d) relationship with patient/deceased (eg abuse, dependency)	
IX. Children & Youth	
☐ a) death of parent, parental figure or sibling*	
☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)	
☐ c) parent expresses concern regarding his/her ability to support child's grief	
☐ d) parent/parental figure significantly compromised by his/her own grief	
X. Circumstances Involving the Patient, the Care or the Death	Tommy's death was sudden/unexpected, conceivably preventable and traumatic. *(Although it is possible that Tommy may be less than age 35 at time of his death, we are not provided with his age and therefore can't infer this.)*
☐ a) patient/deceased less than age 35	
☑ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*	
☑ c) distress witnessing the death OR death perceived as preventable*	
☑ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*	
☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")	
☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")	
XI. Protective Factors Supporting Positive Bereavement Outcome	
☐ a) internalized belief in own ability to cope effectively	
☐ b) perceives AND is willing to access strong social support network	
☐ c) predisposed to high level of optimism/positive state of mind	
☐ d) spiritual/religious beliefs that assist in coping with the death	

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Appendix A - Other Grief and Bereavement Assessment Tools

1. 10-Mile Mourning Bridge (Huber & Bryant, 1996) - This visual analogue scale ranging from 0 – 10 is intended as a self-assessed measure of progress through bereavement. *Mile 0* marks the point prior to grieving and *mile 10* signifies the point at which grieving is no longer the primary focus of life. The intervening miles are not labelled to allow for individualized grieving processes.

2. Adult Attitude to Grief Scale (Sim, Machin & Bartlam, 2013) – composed of nine statements to which the person choses responses on a five-point Likert scale with corresponding numbers. Three factors are measured: overwhelmed, controlled and resilient. An overall vulnerability score is determined.

3. Anticipatory Grief Inventory AGI (Levi, 1991) - This tool is composed of 22 items (self-assessed) thought to be associated with the (theoretically ambiguous) concept of anticipatory grief. Contains 3 theoretical components (factors) which identify mental and emotional preparedness for the death of a spouse, conjugal coping and cognitive coping with the anticipated death.

4. Anticipatory Grief Scale AGS (Theut et al., 1991) - A 27-item self-report tool designed to assess the bereavement experience of women whose spouses have been diagnosed with dementia. Items are scored on a 5-point Likert scale, ranging from "strongly disagree" to "strongly agree" (see "Review of Potential Instruments" below for a more detailed summary).

5. Bereavement Experience Questionnaire BEQ (Demi & Schroder, 1987) - A 67-item self-report measure with 8 theoretically derived sub-scales (guilt, anger, meaninglessness, yearning, depersonalization, stigma, morbid fears, isolation). Items are scored on a 4-point Likert scale corresponding to the frequency of occurrence, ranging from “never” to “almost always”.

6. Bereavement Experience Questionnaire Short-form, BEQ-24 (Guarnaccia & Hayslip, 1998) - A 24-item measure intended to assess a variety of aspects of grief and

bereavement in both clinical and research settings. Factor analysis reveals 3 sub-scales: existential loss/emotional needs, guilt/blame/anger, and preoccupation with thoughts of deceased. Items are coded on a 4-point response scale with anchors.

7. Bereavement Phenomenology Questionnaire BQ (Byrne & Raphael, 1994) - A 22-item self-report measure intended to rate the frequency of bereavement phenomena in the prior two weeks. The measure is self-reported but has been administered by interviewers. Items are scored on a 4-point Likert scale (never, rarely, sometimes, and often).

8. Bereavement Response Scale II BR-II (Weiss & Richards, 1997) - A 6-item measure developed to predict recovery from the loss of a long-term partner (hetero- or homosexual). The instrument is intended as a guide for coding narrative data about the bereavement process in order to predict an outcome of the recovery process.

9. Bereavement Risk Factor Questionnaire (Ellifrit, Nelson & Walsh, 2003) – A 19-item questionnaire designed to be used with survivors, prior to death. It was developed based on a review of the literature and a national survey of bereavement coordinators in the United States. This tool is currently in development.

10. Bereavement Risk Indicator (Parkes & Weiss, 1983) - This tool can be administered prior to death. It is composed of 8 items that measure psychological distress and then rate the person as high or low risk. Only one further literature citation found.

11. Complicated Grief Symptoms Questions (Horowitz et al., 1997) – This tool identifies 30 possible symptoms of complicated grief divided into 3 clinically derived categories (avoidance, intrusion, and failure to adapt). These questions were added to an interviewer-rated assessment using the SCID-NP.

12. Composite International Diagnostic Interview CIDI (Robins et al., 1988) - A fully structured psychiatric interview. A modified version including the somatization, anxiety, and depression modules have been used to assess depressive symptoms and episodes in recently widowed older men (69).

13. Core Bereavement Items CBI (Burnett et al., 1997) - A 17-item questionnaire that measures the intensity and evolution of bereavement experiences among a variety of bereaved persons (e.g. spouses, adult children losing parents, parents losing children). Items are rated on 4-point scales and fit within 3 sub-scales: images and thoughts, acute separation and grief.

14. Grant Foundation Bereavement Inventory (Balk & Vesta, 1998) – A tool that assesses aspects of the grief process with an emphasis on attachment, reunion fantasies, disbelief, identification phenomenon and feelings of disloyalty.

15. Grief Experience Questionnaire GEQ (Barrett & Scott, 1989) - A 55-item self-administered questionnaire representing 11 dimensions of grief (somatic reactions, general grief reactions, search for explanation, loss of support, stigmatization, guilt, responsibility, shame, rejection, self-destructive behaviour, unique reactions). Items are scored on a 5-point Likert scale measuring frequency of experience (from "never" to "almost always"). The instrument originally was developed to compare bereavement experiences of suicide vs. non-suicide survivors.

16. Grief Measurement Scale GMS (Jacobs et al., 1986) - A 38-item structured interview developed to assess grief numbness/disbelief and separation anxiety (as conceptualized by attachment theory) as well as sadness and despair (as constructed by the CES-D). Interviewers recorded the frequency of each item within the past week (never/rarely, 1-2 days/week, 3-4 days/week, 5-7 days/week).

17. (Chinese) Grief Reaction Assessment Form GRAF (Ho, Chow, Chan & Ysui, 2002) - A self-report measure of 16 items designed to assess psychological symptoms associated with bereavement among Hong Kong Chinese. Items are based on evidence from Western culture.

18. Grief Resolution Index GRI (Remondet & Hansson, 1987) - A 7-item measure focusing on behaviours associated with grief resolution and the transition into widowhood.

Items are rated on a 5-point scale, ranging from “very poorly” to “very well” (see "Review of Potential Instruments" below for a more detailed summary).

19. Hogan Grief Reactions Checklist (Hyrkas et al., 1997) - A 61-item measure assessing a range of topics related to the bereavement process. Topics include fears of loss of control, difficulty with concentration, culpability and survival guilt, panic attacks and desire to die to be with the deceased person. Items are scored on a 5-point scale, ranging from "does not describe me at all" to "describes me very well”.

20. Impact of Event Scale IES (Horowitz et al., 1979) - A 15-item scale intended to assess response to stressful life events, including the death of a loved one. Two sub-scales (intrusion and avoidance) are theoretically suggested and empirically supported through factor analysis. Responses are coded on a 4-point scale, ranging from "not at all" to "often," and the reference period is the past seven days.

21. Inventory of Complicated Grief ICG (Prigerson et al., 1995) - A 19-item assessment of symptoms of complicated grief. Items describe an emotional, cognitive, or behavioural state associated with complicated grief. Respondents rate the frequency with which they experience each item on a 5-point scale, ranging from "never" to "always".

22. Monologue Questionnaire (Field & Horowitz, 1998) - A 13-item questionnaire measuring unresolved grief and relating to an empty-chair monologue task undertaken before the completion of the questionnaire. Items are 5-point unipolar rating scales and address 5 domains (self-blame, helplessness, blame toward the deceased, non-acceptance, and being at peace).

23. Revised Grief Experience Inventory REGI (Lev et al., 1993) - A 22-item scale measuring 4 domains (existential concerns, depression, tension and guile, and physical distress) of the grief experience of bereaved persons with a variety of relationships to the deceased. Responses are scored on a 6-point scale, ranging from “slight disagreement” to “strong agreement”.

24. Satisfaction with Bereavement Experiences Questionnaire SBEQ (Warren, 1998) - A 24-item self-report measure developed to assess family members' satisfaction with bereavement experiences both before and after the death of a loved one in a critical care unit. Items are rated on a Likert scale, and factor analysis reveals 4 components – hospital experiences, personal experiences, ritual experiences, and post-hospital experiences.

25. Semantic Representation of Others Scale SROS (Bonanno et al., 1998) - A 16-item measure of interpersonal ambivalence. Respondents rate another person on 8 positive traits and 8 corresponding negative traits. Instrument has been used to examine the relationship between ambivalence during conjugal bereavement and prolonged grief.

26. Texas Inventory of Grief TIG (Faschingbauer et al., 1977) - A 7-item scale to measure the extent of unresolved grief in response to the loss of a family member. Items are rated on a 5-point scale, ranging from "completely true" to "completely false". The measure is intended to serve as a brief screening tool and is based on the theory that grief resolution is a function of time (also see Expanded Texas Inventory of Grief and Texas Revised Inventory of Grief).

27. Expanded Texas Inventory of Grief ETIG (Zisook, 1982) - A 58-item instrument to assess a variety of behaviours, feelings, and symptoms associated with bereavement. Items are rated on a 5-point scale (from "completely false" to "completely true") and concern both present feelings and feelings when the loved one died (also see Texas Inventory of Grief and Texas Revised Inventory of Grief).

28. Texas Revised Inventory of Grief TRIG (Fashingbauer et al., 1987) - A self-report measure that includes demographic questions about the deceased and bereaved persons, 26 items regarding the bereaved person's feelings and actions at the time of the death and presently and an open-ended question to communicate additional issues. Scale items are rated on a 5-point scale (from "completely true" to "completely false") or as dichotomous true/false statements. The instrument is

intended to measure past adjustment, present feelings, and progress through stages of grief (also see Texas Inventory of Grief and Expanded Texas Inventory of Grief).

Appendix B - The BRAT(R) Form

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Patient / Deceased Name	Bereaved Name

Risk Indicators and Protective Factors

Comments

I. Kinship

- ☐ a) spouse/partner of patient or deceased
- ☐ b) parent/parental figure of patient or deceased

II Caregiver

- ☐ a) family member or friend who has taken primary responsibility for care

III. Mental Health

- ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)
- ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)

IV. Coping

- ☐ a) substance abuse / addiction (specify)
- ☐ b) considered suicide (no plan, no previous attempt)
- ☐ c) has suicide plan and a means to carry it out OR has made previous attempt
- ☐ d) self-expressed concerns regarding own coping, now or in future
- ☐ e) heightened emotional states (anger, guilt, anxiety) as typical response to stressors
- ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*
- ☐ g) declines available resources or support
- ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*

V. Spirituality / Religion

- ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress

VI. Concurrent Stressors

- ☐ a) two or more competing demands (eg single parenting, work, other caregiving)
- ☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness)
- ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement)
- ☐ d) significant other with life-threatening illness / injury (other than patient/deceased)

VII. Previous Bereavements

- ☐ a) unresolved previous bereavement(s)
- ☐ b) death of other significant person within 1 year (from time of patient's death)
- ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years
- ☐ d) death or loss of parent/parental figure during own childhood (less than age 19)

VIII. Supports & Relationships

- ☐ a) lack of social support/social isolation (perceived or real - eg housebound)
- ☐ b) cultural or language barriers to support
- ☐ c) longstanding or current discordant relationship(s) within the family
- ☐ d) relationship with patient/deceased (eg abuse, dependency)

IX. Children & Youth

- ☐ a) death of parent, parental figure or sibling*
- ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)
- ☐ c) parent expresses concern regarding his/her ability to support child's grief
- ☐ d) parent/parental figure significantly compromised by his/her own grief

X. Circumstances Involving the Patient, the Care or the Death

- ☐ a) patient/deceased less than age 35
- ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*
- ☐ c) distress witnessing the death OR death perceived as preventable*
- ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*
- ☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")
- ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")

XI. Protective Factors Supporting Positive Bereavement Outcome

- ☐ a) internalized belief in own ability to cope effectively
- ☐ b) perceives AND is willing to access strong social support network
- ☐ c) predisposed to high level of optimism/positive state of mind
- ☐ d) spiritual/religious beliefs that assist in coping with the death

Appendix C - The BRAT(R) Excel Worksheet

Bereavement Risk Assessment Tool (R)

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Assessment Date	Assessed by	ID#	Deceased Name	Bereaved Name

Unmitigated Risk Level: No Known Risk

Mitigated Risk Level: No Known Risk

Risk Level Override

No Known Risk

COMMENTS

I. Kinship

- ☐ a) spouse/partner of patient or deceased
- ☐ b) parent/parental figure of patient or deceased

II Caregiver

- ☐ a) family member or friend who has taken primary responsibility for care

III. Mental Health

- ☐ a) significant mental illness (eg major depression, schizophrenia, anxiety disorder)
- ☐ b) significant mental disability (eg developmental, dementia, stroke, head injury)

IV. Coping

- ☐ a) substance abuse / addiction (specify)
- ☐ b) considered suicide (no plan, no previous attempt)
- ☐ c) has suicide plan and a means to carry it out or has made previous attempt
- ☐ d) self-expressed concerns regarding own coping, now or in future
- ☐ e) heightened/sustained emotional states (anger, guilt, anxiety, sadness)
- ☐ f) yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*
- ☐ g) declines available resources or support
- ☐ h) inability to experience grief feelings or acknowledge reality of the death > 3 months*

V. Spirituality / Religion

- ☐ significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress

VI. Concurrent Stressors

- ☐ a) two or more competing demands (eg single parenting, work, other caregiving)
- ☐ b) insufficient financial, practical or physical resources (eg ↓ income, no childcare, illness)
- ☐ c) recent non-death losses (eg divorce, unemployment, moving, retirement)
- ☐ d) significant other with life-threatening illness / injury (other than patient/deceased)

VII. Previous Bereavements

- ☐ a) unresolved previous bereavement(s)
- ☐ b) death of other significant person within 1 year (from time of patient's death)
- ☐ c) cumulative grief from > 2 OTHER deaths over past 3 years
- ☐ d) death or loss of parent/parental figure during own childhood (less than age 19)

VIII. Supports & Relationships

- ☐ a) lack of social support/social isolation (perceived or real - eg housebound)
- ☐ b) cultural or language barriers to support
- ☐ c) longstanding or current discordant relationship(s) within the family
- ☐ d) relationship with patient/deceased (eg abuse, dependency)

IX. Children & Youth

- ☐ a) death of parent, parental figure or sibling*
- ☐ b) demonstration of extreme, ongoing behaviours/symptoms (eg sep anxiety+, nightmares)
- ☐ c) parent expresses concern regarding his/her ability to support child's grief
- ☐ d) parent/parental figure significantly compromised by his/her own grief

X. Circumstances Involving the Patient, the Care or the Death

- ☐ a) patient/deceased less than age 35
- ☐ b) lack of preparedness for the death (as perceived or demonstrated by bereaved)*
- ☐ c) distress witnessing the death OR death perceived as preventable*
- ☐ d) violent, traumatic OR unexplained death (eg accident, suicide, unknown cause)*
- ☐ e) significant anger with OTHER health care providers (eg "my GP missed the diagnosis")
- ☐ f) significant anger with OUR hospice palliative care program (eg "you killed my wife")

XI. Protective Factors Supporting Positive Bereavement Outcome

- ☐ a) internalized belief in own ability to cope effectively
- ☐ b) perceives AND is willing to access strong social support network
- ☐ c) predisposed to high level of optimism/positive state of mind
- ☐ d) spiritual/religious beliefs that assist in coping with the death

Appendix D - Matching "Default" Services to Risk Levels

Bereavement services vary widely across programs of care. The number of bereaved served by a bereavement program as well as its human, technological and financial resources, and the demographics of the bereaved within the community it serves, all will affect what type of service is offered and by whom. Where it is not possible to directly provide bereavement services, a bereavement program may elect to refer people to resources outside their organization.

In order to assign services in an equitable and suitable way, the Victoria Hospice counselling team explored which available services seemed most appropriate for each level of risk. If, for example, a bereaved person had a pre-existing anxiety disorder along with depression (i.e. higher level of risk), then an experienced psychosocial professional would best make the first bereavement contact and assess further needs of the person. If, however, a bereaved spouse stated she had concerns about how she might cope without her husband and showed no other signs of risk (i.e. lower level of risk), then information about normal grief mailed to the home or perhaps phone contact by a volunteer might be appropriate. In addition, if risk indicators were not apparent or known for a family member, service could be limited to sending information with an invitation to access follow-up support if needed.

For the purposes of the BRAT, "default" services are defined as predetermined services that form the bereavement program's regular practice (e.g. letters or telephone calls). Non-default services are resources offered to clients upon request or when recommended by a bereavement professional or volunteer (e.g. individual counselling or support groups). The BRAT was developed to assist with the designation of default services only; allocation of non-default services should be determined at the discretion of the bereavement professional or program manager.

Some bereaved individuals may have risk indicators not known to the bereavement service. For example, information may not be available because the palliative care team was not involved with the patient and family prior to the death. It is also possible that the bereavement team is not able to make contact with someone

identified at risk, or perhaps the person has declined services offered. A letter introducing the program's services in these instances serves as a reminder to the person that help is available if and when they want it.

Risk assignment is fluid and changes as circumstances of the bereaved change. For example, resolution of concurrent demands, or conversely, experiencing an onset of panic attacks several months after the death, will cause a decrease or increase in the BRAT risk level, respectively. It is important to remember that the BRAT is part of a larger psychosocial assessment process and if the BRAT's risk level assignment for an individual does not seem appropriate given this wider assessment, the bereavement professional should over-ride the designated service assignment based on his or her clinical judgement.

Appendix E - Risk Indicator Scoring

Table I below shows the 40 risk indicators of the BRAT and each indicator's risk weighting. Once risk indicators have been identified for a bereaved person, the risk weightings for all indicators are added to obtain a risk score. Should one or more protective factors also be present, their values are then subtracted from the risk score. The final cumulative score corresponds to a risk level as shown in Table II. It should be noted that two of the indicators cannot be modified by protective factors (scored 640).

The scores can be determined manually or by using the Excel worksheet that has been designed to calculate the cumulative risk score and its corresponding risk level. The Excel worksheet is available with the purchase of this manual.

Table I: BRAT Indicator Risk Weightings

I. Kinship		**Score Weighting**
a)	spouse/partner of patient or deceased	1
b)	parent/parental figure of patient or deceased	16
II Caregiver		
	family member or friend who has taken primary responsibility for care	1
III. Mental Health		
a)	significant mental illness (eg major depression, schizophrenia, anxiety disorder)	16
b)	significant mental disability (eg developmental, dementia, stroke, head injury)	16
IV. Coping		
a)	substance abuse / addiction (specify)	16
b)	considered suicide (no plan, no previous attempt)	4
c)	has suicide plan and a means to carry it out OR has made previous attempt	640**
d)	self-expressed concerns regarding own coping, now or in future	1
e)	heightened emotional states (anger, guilt, anxiety) as typical response to stressors	16
f)	yearning/pining for the deceased OR persistent disturbing thoughts/images > 3 months*	4
g)	declines available resources or support	1
h)	inability to experience grief feelings or acknowledge reality of the death > 3 months*	4

		Score Weighting
V. Spirituality / Religion		
	significant challenge to fundamental beliefs / loss of meaning or faith / spiritual distress	4
VI. Concurrent Stressors		
a)	two or more competing demands (eg single parenting, work, other caregiving)	4
b)	insufficient financial, practical, or physical resources (eg ↓ income, no childcare, illness)	4
c)	recent non-death losses (eg divorce, unemployment, moving, retirement)	4
d)	significant other with life-threatening illness / injury (other than patient/deceased)	4
VII. Previous Bereavements		
a)	unresolved previous bereavement(s)	16
b)	death of other significant person within 1 year (from time of patient's death)	4
c)	cumulative grief from > 2 OTHER deaths over past 3 years	4
d)	death or loss of parent/parental figure during own childhood (less than age 19)	4
VIII. Supports & Relationships		
a)	lack of social support/social isolation (perceived or real - eg housebound)	4
b)	cultural or language barriers to support	4
c)	longstanding or current discordant relationship(s) within the family	4
d)	relationship with patient/deceased (eg abuse, dependency)	16
IX. Children and Youth (less than age 19)		
a)	death of parent, parental figure, or sibling*	16
b)	demonstration of extreme & persistent behaviours or symptoms (eg anxiety+, nightmares)	16
c)	parent expresses concern regarding his/her ability to support child's grief	16
d)	parent/parental figure significantly compromised by his/her own grief	16
X. Circumstances Involving the Patient, the Care, or the Death		
a)	patient/deceased less than age 35	4
b)	lack of preparedness for the death (as perceived or demonstrated by bereaved)*	4
c)	distress witnessing the death OR death perceived as preventable*	16
d)	violent, traumatic, OR unexplained death (eg accident, suicide, unknown cause)*	16
e)	significant anger with OTHER health care providers (eg "my GP missed the diagnosis")	16
f)	significant anger with OUR hospice palliative care program (eg "you killed my wife")	640* *
XI. Factors Supporting Positive Bereavement Outcome		
a)	internalized belief in own ability to cope effectively	- 16
b)	perceives AND is willing to access strong social support network	- 16
c)	predisposed to high level of optimism/positive state of mind	- 4
d)	spiritual / religious beliefs that assist in coping with the death	- 8

* This indicator can be identified only after the death

** Protective factor weightings CANNOT modify Higher Risk level

Table II: BRAT Risk Cumulative Score – Risk Level Equivalency

Risk Level	Score Range (points)
No Known Risk	0
Lower Risk	1 - 15
Higher Risk	16 – 64+