Needs of grieving spouses in sudden death situations in the hospital setting
by Gelene Marie Osborne Berkram

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
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Abstract:
The death of a spouse has been recognized as unequalled in its potential to give rise to personal pain and suffering. Most research pertaining to loss of a spouse focuses on the multiple factors influencing the long-term adjustment to widowhood. Relatively little research has been done on the needs of grieving spouses in the sudden death situation. The purpose of this study was to determine whether spouses whose mates died suddenly in the hospital could identify their own needs, what those needs were and whether health professionals met those needs associated with the sudden death of their mates.

The data gathering method for this exploratory-descriptive study was the semi-structured interview with open-ended questions. A convenience sample was used of fifteen spouses whose mates suddenly died of an illness lasting less than 24 hours. Each spouse was interviewed once and the data was transcribed for data analysis. A content analysis was done to summarize the data using descriptive statistics.

All of the spouses identified 5 of the 7 categories of need that the interview was designed to elicit. The categories of need and the percentage of spouses who had their needs met included 1) the need to see or be with the mate after the onset of the acute illness (13%) and after death (60%) , 2) the need to be assured of the prompt attention to the needs of the mate (60%), 3) the need to be kept informed (27%), 4) the need to be aware of the possibility of death (40%) , 5) the need to express anxiety (53%) , 6) the need to receive comfort and support by family and friends (93%) , and 7) the need to receive comfort and support by health professionals (13%).

Based on the findings of this study, the following conclusions were identified: 1) spouses can identify their own grieving needs in the sudden death situation, 2) relatively few of the needs of grieving spouses in the sudden death situation are met, 3) nurses are not often meeting the needs of grieving spouses in sudden death situations, 4) the needs of grieving spouses are met less frequently in the sudden death situation than spouses of terminally ill mates, and 5) spouses need and want to talk about the death of their mates.

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DEDICATION

I dedicate this thesis to the memory of my husband, Alan T. Berkram, whose death taught me about grief in a very personal way.

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ABSTRACT

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Based on the findings of this study, the following conclusions were identified: 1) spouses can identify their own grieving needs in the sudden death situation, 2) relatively few of the needs of grieving spouses in the sudden death situation are met, 3) nurses are not often meeting the needs of grieving spouses in sudden death situations, 4) the needs of grieving spouses are met less frequently in the sudden death situation than spouses of terminally ill mates, and 5) spouses need and want to talk about the death of their mates.

CHAPTER 1

INTRODUCTION

The death of a spouse has been recognized as unequalled in its potential to give rise to personal pain and suffering. Holmes and Rahe (1967) found that the death of a spouse was ranked as the most stressful life event from a list of 43. Epidemiological findings indicate that the loss of a spouse is a common phenomenon in today's society. In 1977, the U. S. Bureau of the Census reported that 12.2% of all females 18 years and over were widowed (Hauser, 1983). It is now estimated that there are 12 million widowed persons in the United States. Loss of a spouse is an event that is much more common for women than men as a consequence of the differences in the life expectancy of the two groups. Barret (1977) stated that 3 out of 4 married women will be widowed sometime in their life. As the percentage of older population increases, the proportion of widowed people will continue to rise.

Most people used to die at home. However, in today's society death is more likely to occur in the hospital setting where family members often have limited access to and limited information about the health status of their loved one. This is particularly true when sudden death

occurs in the emergency setting. Hospital personnel are frequently involved in sudden death situations and must deal with both the dying patient and the patient's family.

Most research pertaining to spousal bereavement tends to focus on the multiple factors influencing the long-term adjustment to widowhood. Relatively little research has been done on the needs of grieving spouses in a sudden-death situation. Hampe (1973) conducted a study of the needs of grieving spouses in the hospital setting. The spouses (N=27) in her study had mates with terminal illnesses. Bucko (1979) did a descriptive study with 22 spouses of terminally ill mates using Hampe's instrument to determine the spouses' perceptions of nursing interventions to meet the spouses' needs. Fanslow (1983) replicated Hampe's study but used spouses experiencing sudden-death situation. However, because her sample (N=7) was too small to make any generalizations, Fanslow recommended additional studies using larger samples.

In the sudden-death situation in the hospital, grief work may begin immediately or it may be delayed. Since personnel are oriented toward prolongation of life and reduction of pain, many find it difficult to accept the reality that some patients are going to die. However, helping grieving spouses and their families is as important as helping patients live. With a good understanding of the grieving processes and a perception of what the needs of

grieving spouses are, nurses can facilitate the beginning of the grief in the hospital. They can learn to avoid interrupting healthy grief, to gently encourage hesitant grief, to recognize pathological grief, and to control destructive grief (Willis, 1977).

Purpose and Research Questions

Little research has been done on what spouses perceive their needs to be in the sudden-death situations and whether these needs are being met by hospital personnel. Benoliel (1983) reviewed the literature on the death of a spouse and concluded that the evidence suggests "...healthy and unhealthy adaptations to widowhood come about through an interplay of personal and social variables, and sophisticated research to understand these complex relationships is essential for the discipline of nursing" (p. 118). The stressful nature of death and dying for patients and their families has been repeatedly identified, yet relatively little is known about what can be done to facilitate productive and positive adjustment to these stresses.

The purpose of this study was a) to determine whether spouses whose mates die suddenly in the hospital setting from unexpected illness or trauma can identify their own needs, b) to determine what those needs are, and c) to determine whether health professionals met these needs with the sudden death of their mates.

This study was a replication of Hampe's (1973) study of the needs of spouses with terminally ill mates and Fanslow's (1983) pilot study of spouses experiencing sudden-death situation. Therefore, the purpose and research questions of this study were similar to those in Hampe's and Fanslow's studies.

Specific questions addressed in the study included:

1) Can the spouse whose mate suddenly died of an unexpected trauma or illness identify his/her own needs?
2) If identified, what were those needs?
3) If his/her own needs were identifiable, did the grieving spouse perceive that his/her needs were met?
    a) By whom were the needs met?
    b) Which needs of the grieving spouse did nurses meet?
    c) What nursing measures helped to meet those needs?

Significance of the Study

Nurses need to recognize the fact that when a patient has died the family members also become patients. The emergency room staff must facilitate the acute grief reaction to lay a healthy foundation for coping with the long-term effects of bereavement. Nurses must assess and

work with the family to help each begin the grieving process. Nursing educators must teach nurses about normal grief processes and also the needs of grieving families. However, first those needs must be identified. Identification of the needs of a grieving spouse is only one step toward identification of the needs of grieving families.

Definition of Terms

Grief - The emotional, physical, cognitive, behavioral, and attitudinal changes occurring in an individual in response to loss (Frears and Schneider, 1981).

Grieving Process - The adaptive process whereby an individual comes to terms with loss and the changes generated by the loss (Bowlby, 1980).

Loss - State of being deprived of or being without something one has had. (Irwin and Meier, 1973).

Mate - The person who has suddenly died.

Need - A requirement of the person, which would relieve or diminish his immediate distress or improve his immediate sense of adequacy or well being (Orlando, 1961).

Spouse - The husband or wife of a mate.

Sudden Death - A patient who unexpectedly dies of an acute illness lasting no longer than 24 hours from the onset until the death occurs.

Assumptions

This research is based on the following assumptions:

1) Significant feelings of loss occur when a valued person dies.

2) The grieving process will be precipitated when a loss occurs.

3) Individuals will honestly express their feelings about a situation.

4) The death of a mate will be perceived as a loss by the surviving spouse.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

For the purposes of this study, review of selected literature was divided into three areas. These areas included summaries of literature on a) grief and loss, b) loss of spouse, and c) needs of spouses in death and dying.

Grief and Loss

Numerous sources of literature were identified by the researcher on grief and the grieving process. Lindemann (1944) observed and documented the acute grief syndrome experienced by survivors of a disaster. The symptomatology of acute grief as described by Lindemann was remarkably uniform among the survivors. Symptoms included sensations of somatic distress occurring in waves lasting from twenty minutes to an hour, a feeling of tightness in the throat, shortness of breath and choking, a need for sighing with an empty feeling in the abdomen, lack of muscle power, and intense subjective discomfort described as tension or mental pain. The sensorium was usually altered often with a sense of unreality. A feeling of emotional distance from other people and an intense preoccupation with the image of

the deceased was common. Feelings of guilt were another strong preoccupation. Grieving people often developed a loss of warmth in their relationships with other people. Instead, they responded to friends and family with irritability and anger indicating a wish not to be bothered by others. Often, there was intense restlessness, an inability to sit still, and a continual search for something to do. At the same time, there was a lack of capacity to initiate or maintain organized patterns of activity.

Several authors have identified the stages of grief (Bowlby, 1973; Engel, 1964; Kubler-Ross, 1969; Parkes, 1970). Two of the most well-known authorities include Engel and Kubler-Ross. Engel described three stages of grief while Kubler-Ross identified five stages. Engel described the initial response as one of shock and disbelief; the one who grieves cannot comprehend the reality of what has happened. This stage is similar to the initial reaction of shock and denial described by Kubler-Ross. The grieving person may intensely and desperately deny the reality of the situation. Engel's second stage was developing awareness which is analogous to Kubler-Ross's stages of anger, bargaining, and depression. In these stages, reality begins to set in. The final stage of grief identified by Engel was one of restitution and recovery, where peace and well-being are re-attained.

Kubler-Ross identified a similar stage as acceptance. There are no definite lines of demarcation between stages. The time frame to work through these stages also varied, often lasting a year or longer.

The literature documents that the grieving process follows any loss that is perceived as such by the individual experiencing the loss. The grieving process may vary in duration and magnitude; both variables are related to the degree of perceived significance of the loss. However, there is marked similarity of experience in symptomatology observed and reported by grieving individuals. The symptomatology is a reflection of the distress an individual experiences in the event of a personal loss. The grieving process itself has to do with resisting the loss, acknowledging the loss, and re-integrating the loss into one's behavior in order to go on without that which was lost (Kelly, 1985).

Lindemann (1944), Engel (1964), and Parkes (1965) all support the concept of healthy and adaptive grieving; deviations may lead to less healthy functioning or actual physical, emotional, behavioral, or social pathology. Engel uses an analogy between grief and wounds by stating that, "...the subsequent psychological responses to the loss may be compared to the tissue reaction and the processes of healing..." (p.94). Healing of a physical wound may take a healthy course or it may develop complications as a result

of improper or inadequate healing. The individual may become septic and experience impairment of functioning capabilities. Peretz (1970) described a variety of reactions to loss: a) "normal" or healthy grieving, b) inhibited, delayed or absent grief, c) chronic grief, d) hypochondriasis and exacerbation of pre-existent somatic conditions, e) development of medical symptoms and illness, f) acting out, which may include psychopathic behavior, substance abuse, or promiscuity, and g) specific neurotic and psychotic states.

The eventual outcome of healthy grieving results in a withdrawal of the emotional ties from that which was lost and a renewed interest and ability in forming new relationships. Many factors influence what the eventual outcome will be. Major factors include the importance of the lost object as a source of support, the social support following the loss, the age of the lost object as well as the age of the mourner, and the physiological and psychological health of the mourner (Engel, 1964).

Loss of Spouse

Ample reviews of the literature exist which have studied demographic, sociological, and psychological variables and their relationship to the outcome of the grieving process of the grieving spouse (Benoliel, 1983; Demi, 1986; Hauser, 1983; Vachon, 1976; Windholz, Murmar,

and Horowitz, 1985). Vachon (1976) reviewed the literature related to the criteria for predicting high risk individuals following the death of a spouse. Criteria included gender, age, length of final illness, psychological symptom patterns, marital relationships, social class, and social support. Vachon's literature review identified poor social support as the greatest risk factor, followed by those under 45 whose spouse died suddenly or over 65 whose spouse had illness over 6 months, ambivalent marital relationship, minimal funeral ceremony associated with denial of impact of death, and previous psychiatric history.

Windholz, Murmar, and Horowitz (1985) also reviewed the literature on spousal bereavement focusing on prevalence, morbidity, and predictors of adjustment including intervention. Findings from this review include increased mortality and morbidity risks for surviving spouses with increased risks factors related to lack of perceived social supports, presence of other stressful life events, and unanticipated death of mates which interfered with the ability to gradually accept the loss. Age, gender, and social class as well as the strength of the marital relationships are controversial risk factors for adaptation which need more research. The effect of this event on physical health has been supported by many studies, although most of the typical symptoms are more often linked with psychological distress. Reviewing the literature for

predictors of adaptation to conjugal bereavement led Windholz et al. to conclude that the studies "...reflect a very unclear picture of what specifically predicts poor adjustment following the loss of a spouse" (p. 441). Intervention studies with the grieving spouses have also shown mixed results.

Epstein, Weitz, Roback, and McKee (1975) and Jacobs and Ostfeld (1977) did extensive reviews of the literature; and both groups of reviewers concluded that grieving spouses have an increased mortality risk in the first 2 years after their loss. An overview of the studies on morbidity leads to the conclusion that loss of a spouse can be a profoundly traumatic event.

Demi (1986) reviewed nursing research on bereavement from 1970 to 1984. Generally, the researchers reviewed concluded that "...the death of a significant other was a stressor that affected emotional health, physical health, and social adjustment" (p. 118). Overall, the research reviewed focused on a) the feelings experienced during grief, b) the needs of the bereaved, c) the availability and adequacy of social support, and d) the coping responses used by the bereaved. Findings by Demi indicated that current theories on grief in nursing research have been built on earlier conceptualizations about grief from Bowlby (1973), Kubler-Ross (1969), Lindemann (1944), and Parkes (1970). Demi discussed the exploratory study by

Fanslow (1983) related to the needs of the bereaved and concluded further research was warranted. Weaknesses of Fanslow's study identified by Demi included "...insufficient description of the methods, lack of attention to reliability and validity of data collection methods, too much heterogeneity of subjects, and lack of a conceptual framework" (p. 114). Walker, MacBride, and Vachon's study (1977) was discussed by Demi in regard to the role of social support in bereavement as a basis for further research. Two intervention studies with the bereaved indicated that bereavement crisis intervention was effective in improvement of adaptation outcome (Constantino, 1981; Vachon, Freedman-Letofsky, Freeman, Lyall, and Rogers, 1980). Constantino compared social adjustment and levels of depression in three groups of widows. One group received bereavement crisis intervention, a second group participated in a socialization program, and the third group received no intervention at all. Constantino found the depression increased and socialization decreased in the no-treatment group, while the two treatment groups showed improvement on both depression and socialization. The second intervention study by Vachon et al. was part of a larger study by Vachon and her associates. Widows were randomly assigned to treatment or control groups. Findings in the study were that both groups followed similar courses

of adaptation, but the speed of achieving landmark stages was increased in the treatment group.

Demi (1986) also assessed the strengths and limitations of all the studies in her review and concluded that many problems with grief research done by nurses are similar to grief research in general. The problems identified included four major areas: research design, data collection, sampling, and the use of conceptual model. Recommendations included a) better controlled, more in-depth multivariate designs based on well developed conceptual models, b) greater effort toward instrument development that measures both grief as a process and outcome, c) use of more representative sampling procedures, increased sample sizes, and a concentrated effort to include all socio-economic classes, minorities, and males, and d) use of a conceptual model to strengthen studies and to evaluate the outcomes of the research conducted. Nursing research is increasingly drawing upon conceptual frameworks and models to advance nursing science as well as in an attempt to integrate an accumulated body of knowledge (Polit and Hungler, 1987).

Needs of Spouses in Death and Dying

People used to die at home. Today they are more apt to die in the hospital. The pain and suffering of a grieving spouse has been identified as potentially

unequalled to any other life event. Holmes and Rahe (1967) found that death of a spouse was ranked as the most stressful life event. However, few researchers have asked surviving spouses what they perceived their needs to be.

Hampe (1973) interviewed 27 spouses during the terminal illnesses of their mates. The study was conducted at a midwestern university medical center. The purpose of the study was to determine if the spouse could identify his/her own needs and whether the perceived needs had been met. Two interviews were done during the study. Initially, all of the spouses were interviewed in the hospital during the mate's terminal illness. Eighteen of the 27 mates subsequently died; 14 of their spouses were again interviewed after the death had taken place. A semi-structured interview with open-ended questions was used; interviews were recorded on a tape recorder. The following 8 needs of grieving spouses were identified: 1) need to be with the dying patient; 2) need to be helpful to the dying person; 3) need for assurance of the comfort of the dying person; 4) need to be informed of the mate's condition; 5) need to be informed of the impending death; 6) need to ventilate emotions; 7) need for comfort and support of family members; and 8) need for acceptance, support, and comfort from health professionals. According to Hampe's study, the spouses reported that not all of these needs were met. Attention to the needs of the family

of the dying patient has not been sufficiently emphasized as indicated by the identified unmet needs. This study demonstrated the need to teach nurses which needs exist and to deal effectively with them. When a patient is dying health professionals must realize that the family members also become patients in need of help. Hampe suggested that further research include provisions for follow-up interviews at longer intervals than the 3-to-12 week period she used between the first and second interviews. She also suggested conducting a similar study with spouses of acutely ill patients.

Bucko (1979) did a descriptive study with 22 spouses of terminally ill mates to determine the grieving spouse's perceptions of nursing interventions necessary to meet the spouse's needs. A questionnaire by Hampe (1973) was adapted and utilized to collect the data. Each interview item of the questionnaire was categorized according to the eight needs of the grieving spouse identified by Hampe and the spouse's perception of the nurses' role in meeting their needs. The conclusions drawn by Bucko based on her study were as follows: a) grieving spouses did not perceive nurses as being responsible for their grieving needs, b) nurses were not meeting all of the needs of the grieving spouse, c) nurses may be uncomfortable in meeting the needs of grieving spouses of terminally ill patients, and d) the

spouse's need to ventilate emotions was not met through professional nurses.

Dracup and Breu (1978) conducted a quasi-experimental intervention study by developing a standardized nursing care plan based on Hampe's (1973) eight identified needs of grieving spouses. The convenience sample consisted of 26 men and women whose spouses were admitted to the University of California at Los Angeles Coronary Care Unit. During the first 72 hours after admission of the patient, 13 spouses received specified nursing interventions based on Hampe's identified needs, while the other 13 spouses received no specific interventions. Implementation of a standardized nursing care plan did affect the number of spouse needs met. The needs of the spouses who received specific nursing care interventions based on the research-identified needs were met more consistently and more completely. One limitation identified by the authors was the small sample size; therefore, replication of this study using a larger sample is warranted.

Fanslow (1983) replicated Hampe's (1973) research by conducting a pilot study on the needs of grieving spouses in sudden death situations. Needs were divided into two broad categories: 1) the needs that center on the spouse's relationship with the dying patient, and 2) the personal needs of the grieving person. The purpose of the study was to see if spouses whose mates die suddenly from an

unanticipated illness could identify their own needs and whether these spouses perceived their needs as having been met. This research was done in the emergency department of a 600-bed hospital in Texas. A convenience sample of 7 spouses was selected from the population of patients whose deaths had occurred as an emergency situation within a 5-month period. A semi-structured interview with open-ended questions was used. Variables used in Fanslow's study were based on six of the needs identified by Hampe. They included: 1) an opportunity to see the patient after admission and before death, 2) assurance that prompt attention is given to the physical needs of the mate by health professionals, 3) assurance that personnel would make the spouse aware of the possibility of death may occur, 4) spouse's opportunity to express anxieties about the mate's condition and possible death, 5) demonstration of comfort and support given by family members, and 6) demonstration of comfort and support by hospital professionals. Results of this study indicated that the needs of the spouses were only partially being met. None of the spouses were able to see their mates after admission to the emergency room. None of the spouses were told of the severity of the situations on arrival in the emergency room and only one of the spouses was given the opportunity to express anxieties of the mate's condition. Five of the 7 spouses identified the need for support and concern of

health professionals, but 4 of the spouses felt the doctors and nurses were too busy to help them. The need for comfort and support of family members was partially met. The data indicated that spouses can identify their grief needs but many of these needs were not met. No conclusions were drawn as the sample size was too small (Fanslow, 1983).

Conceptual Framework

The grief process described by George Engel (1964), Elisabeth Kubler-Ross (1969), and Erich Lindemann (1944) is the framework for this study. Loss has been described as "a state of being deprived of or being without something one has had" (Irwin and Meier, 1973, p. 120). Grief and the grieving process occur as a response to loss.

Engel (1964) described three stages of grief. The first stage is "shock and disbelief"; the grieving person cannot comprehend the reality of the loss. He/she may accept the loss intellectually but is unable to accept the loss emotionally as these feelings are too overwhelming. Engel's second stage is "developing awareness" in which the greatest degree of anguish and despair is experienced and expressed. The need to cry is typical of this phase in addition to feelings of guilt, anger, and anxiety. "Restitution and recovery" is the third and final stage identified by Engel. Peace and well-being are re-attained

when the mourner is able to take new interest in life and reinvest feelings in new relationships.

Elisabeth Kubler-Ross (1969) identified five stages in the grief process. The first stage is denial and isolation. The grieving person desperately denies the reality of the situation. The grieving person is typically angry during the second stage expressing rage and resentment toward anyone and everyone. In the third stage, the grieving person tries to bargain in an attempt to postpone the inevitable. Most bargains are made with God and are usually kept secret. Depression and a great sense of loss replaces bargaining as the mourner moves into the fourth stage. Reality has set in. The final stage is acceptance in which the grieving person comes to terms with his/her loss.

Lindemann (1944) identified the symptomatology of normal grief based on the observations and documentation of the survivors of a disaster. The process of grieving consists of five major features: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and interruptions of usual behavioral patterns. Somatic distress lasting twenty minutes to an hour includes a feeling of tightness in the throat, shortness of breath and choking, marked tendency to sigh, lack of muscular power, and an intense subjective distress described as tension or mental pain. There is a tendency

to avoid these waves of somatic discomfort at any cost which leads to feelings of emotional distance and loss of warmth in relationships to other people. At a time when friends and relatives make a special effort to keep up friendly relationships, the grieving person responds with irritability and anger. Intense restlessness, an inability to sit still, and a continual search for something to do is common. The duration of the grief reaction depends upon the success with which the grieving person does "grief work" which Lindemann (1944) described as the "emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and formation of new relationships" (p. 143).

CHAPTER 3

METHODS

Design

The purpose of this study was twofold: to identify the needs of grieving spouses and explore related factors including how, if, and by whom these needs were met. The exploratory-descriptive research design was appropriately used in this study. Descriptive studies are important for laying the foundation for future research where little or no literature exists on the topic of interest. As indicated earlier, little research has been done on the needs of grieving spouses in sudden-death situations. The exploratory component is also appropriate in the early investigation of a problem in order to expand the descriptive component to include factors which influence, affect, or relate to the needs of grieving spouses (Polit and Hungler, 1987).

Exploratory-descriptive studies are also classified as qualitative. Qualitative studies are recommended by Benoliel (1975) when the topic is difficult to study "...because of their personal nature and emotionally laden meanings associated with them" (p. 189). A qualitative

research design was recommended for studies dealing with suffering, loss, and death by Davitz and Davitz (1980), Gow (1982), Oiler (1982), Parkes (1972), and Rosenblatt, Walsh, and Jackson (1976). The need for qualitative research was supported by not only the sensitive subject investigated but also due to a general lack of research done on the needs of grieving spouses in sudden death situations.

Population and Sample

The sample of convenience was drawn using the snowball sampling approach. Convenience sampling is the weakest form of sampling, but it is also the most commonly used. Convenience sampling uses the most readily available people as subjects in the study. Grieving spouses whose mates died suddenly, in a hospital setting, at least 6 months but no longer than 5 years ago, of an acute illness lasting less than 24 hours, were asked to participate in the study. Spouses who were or had been in counseling were not eligible for the study. The snowball sampling approach began with a few people who met the criteria for the study. These people were asked to refer the researcher to any of their friends or acquaintances who also met the study criteria. The snowballing process continued until an adequate sample size was obtained. Parkes (1972) maintained that "...relevant data can be obtained from detailed studies from a few" (p. 119). Evaluating the significance

of statistical studies using larger samples must be preceded by small intensive studies. Enough informants were interviewed to identify and saturate data categories. Fifteen subjects were interviewed, at which time the researcher concluded that the saturation had occurred. Only 3 spouses who fit the criteria for the study declined to participate in the study. The 3 spouses who declined to participate in the study stated that they did not want to talk about the death of their mates.

Procedure for Data Collection

Grieving spouses known by the researcher were initially contacted by telephone by a mutual acquaintance of both the spouse and the researcher. The mutual acquaintance stated four things: 1) the researcher was conducting a research project on grieving spouses for a Master's Degree in Nursing; 2) the purpose of the research project was to determine what did, did not, or could have helped the spouse in the hospital when his/her mate died; 3) the researcher was interested in talking to the spouse about the project and the possibility of being interviewed for 30-60 minutes; 4) the researcher was a widow herself. Widowhood status of the researcher was revealed because some of the participants already had this knowledge and the goal was consistency for all participants. A second reason for the revelation was the researcher's belief that the

participants would be willing to consent to the interview if they knew the researcher was a widow herself.

The spouses who indicated a willingness to talk with the researcher were contacted by the researcher by telephone. (See Appendix A for telephone guidelines.) The snowball sampling approach started with a few people who met the criteria for the study and were presently known by the researcher. These people, as well as other acquaintances of the researcher, were then asked to refer the researcher to any of their friends or acquaintances who also met the criteria.

If the spouse agreed to participate, an interview was arranged at a time and place mutually acceptable by both the researcher and the spouse. The interviews lasted approximately 60 minutes.

Before beginning the interview, the researcher again discussed the purpose of the research. The guidelines standardized the beginning of the interview while explaining the purpose of the study and the interview schedule (see Appendix A). Informed signed consent and demographic data was also obtained prior to the initiation of the interview (see Appendix B and C). Demographic data was collected to compare the differences and similarities of the participants. Gathering demographic data prior to the interview can serve as a means for developing rapport with the informants (Hampe, 1973). Demographic data

included age of spouse and mate, gender, number and ages of children, number of years married, whether living alone or remarried, years in and size of the community, and size of hospitals where mates died. After these preliminary steps, the researcher proceeded with the interview.

The semi-structured interview with open-ended questions as used by Hampe (1973) and Fanslow (1983) was determined to be the most appropriate method for data collection. Goode and Hatt (1952) describe the interview as fundamentally a process of social interaction with the primary purpose of obtaining information. The semi-structured interview allowed the researcher to elicit what the respondent considered to be important questions concerning a given topic. Semi-structured interviews focus on topic areas but allow some flexibility for the input of the participants being interviewed. Open-ended questions allow the respondent to answer the questions in his own terms (Polit and Hungler, 1987). Sellitz, Jahoda, Deutsch, and Cook (1963) suggest that the interview encourages the creation of an atmosphere that encourages the respondent to express feelings or report behaviors about emotionally laden topics. An interview was the most appropriate method for identifying the needs of the grieving spouse in a sudden death situation.

The interview method did have disadvantages in its use. As indicated earlier, the interview is a process of

social interaction. "Respondent and interviewers interact as human beings, and this interaction can affect the subject's responses" (Polit and Hungler, 1987, p. 243). Interviewer bias may develop when the respondents answer questions based on their perception of what the interviewer thinks is an appropriate answer. The interviewer may respond verbally or non-verbally to influence the respondent's answers. Interviews are more expensive and time-consuming than other methods of data collection but are also less likely to lead to misinterpretation of questions. Despite these disadvantages, this researcher chose the interview as the most appropriate tool for identifying the needs of grieving spouses.

Seven of the participants agreed to be tape recorded and field notes summarizing the interview process were made after each interview. Eight spouses who agreed to participate in the study refused to be tape recorded. When 15 interviews were completed, they were transcribed for use in data analysis.

Instrument

The instrument used in the study was the semi-structured interview with open-ended questions originally developed by Hampe (1975) and adapted by this researcher to fit the sudden-death situation. (See Appendix D for instrument.) Permission to adapt Hampe's instrument to the

sudden death situation was obtained after a lengthy process to locate Hampe. (See Appendix C for consent from Hampe.)

One category of need identified by Hampe (1973) in spouses of terminally ill mates was the need to feel helpful and of assistance to the dying person. This category was not applicable in the sudden death situation, and questions pertaining to this need were eliminated for the purposes of this study. Another category of need identified by Hampe was the need to receive comfort and support from family. In the sudden death situation, family may not be immediately available. Therefore, the researcher included family and friends in this category.

The interview was designed to elicit grieving spouses' descriptions of their experiences of loss and grief. An example of a question designed to elicit the needs of the grieving spouse included, "What was the most difficult for you during your mate's hospitalization?" An example of a question designed to ascertain whether the spouse's needs were met is, "Can you remember anything that was particularly helpful to you during your mate's hospitalization?" Whether the need identified in the first question was met was determined by questions such as, "What was being done about this?" or "What has been most helpful to you?" Through the use of open-ended questions, specific areas of content were included. The interview was designed to validate the needs of the grieving spouse.

Reliability is "...the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit and Hungler, 1987, p. 535). Hampe (1973) determined the reliability of her informants' responses by comparing their responses to demographic questions with information from the mate's chart. The reliability of the interview schedule was tested by using more than one question for each content area. The responses to the similar questions were compared for reliability. All of the comparable questions were answered in consistent forms. Similar methods for testing for reliability were used in this study. Since the researcher was a widow herself, this may have introduced cohort centric biases. To control for "cohort centricism", a clinical psychologist and a pastor, both with active counseling practices, were asked to randomly select one of the interviews and independently compare their analyses of the data with the researcher's data analysis to determine if similar categories were identified. There was 100% agreement between both the psychologist's and the pastor's analyses with the researcher's analysis.

Validity is "...the degree to which an instrument measures what it is intended to measure" (Polit and Hungler, 1987, p. 538). Hampe (1975) validated her interview schedule by having an oncologic clinical specialist for patients with cancer evaluate the instrument prior to

the interviews by analyzing questions for relevance to content area. After the interviews, both the investigator and the clinical specialist independently analyzed randomly chosen interview questions to identify which expressed need of the spouse the questions related to. There was 90% agreement between the clinical specialist and the investigator. Similar tests of validity were appropriate for this study. Specialists on the concept of grief were asked to validate the interview tool by analyzing the questions to be asked. These specialists included a clinical psychologist and a pastor with active counseling practices that deal exclusively with people in the grieving process. These two counselors were asked to evaluate the questions in the instrument to insure the validity and the relevance of the content of the questions. There was 86% agreement between the interview item and the corresponding need with both the psychologist's and the pastor's analyses when compared to the researcher's rationale for each interview question.

Procedures for Protection of Human Rights

The requirements for the protection of human subjects in research were met before this study began. The human rights proposal was reviewed by the Montana State University College of Nursing, Great Falls Extended Campus Committee for Human Rights.

Before the interview began, the spouse was given the consent form (see Appendix C). The consent form explained the purpose of the study as well as what the researcher's expectations were of the spouse who chose to be interviewed. Benefits, as well as possible risks to the subject, were identified in the consent form. The researcher believed the benefits of participation in the study outweighed the risks for the spouses who chose to do so. The opportunity to express feelings about the loss of their mates could be therapeutic for those who have not been allowed to ventilate their emotions. Bachmann (1964) indicated that "...when a grieving person is allowed to ventilate his emotions, there is a release of feeling and the beginning of the acceptance of the loss" (p. 99). Based on her professional training and clinical experience, the researcher was comfortable with the interviews and the expression of feelings about the loss of their mates. However, back-up emergency counseling was available for any of those being interviewed as deemed necessary by the researcher. A list of available counseling resources were left with the participants at the conclusion of the interview (see Appendix E). In addition, the participants were not interviewed around the anniversary of their mate's death or any other special holidays. Provisions were made for the participant to withdraw from the study at any time without consequences or to stop the interview at any time.

Confidentiality was also stressed in the consent form. The signed consent forms, the tape recorded interviews, and field notes from the interviews will be saved and stored in a locked file per guidelines set forth by the Montana State University College of Nursing.

Data Analysis

Using the transcribed interviews, a content analysis was done to classify and summarize the data from the interviews. Content analysis is "...a procedure for analyzing written, verbal, or visual materials in a systematic and objective fashion" (Polit and Hungler, 1987, p. 527). The data were analyzed using descriptive statistics to determine which categories of need were met for each spouse. Tables were developed to summarize the data. The categories of need are the same as used by Hampe (1973) and Bucko (1979) in their research studies: 1) the need to be with or see mate, 2) the need to be assured of prompt attention to needs of mate, 3) the need to be kept informed of mate's condition, 4) the need to be aware of the possibility of mate's death, 5) the opportunity to express anxiety, 6) the need to receive comfort and support from family and friends, and 7) the need to receive comfort and support from health professionals.

CHAPTER 4

ANALYSIS OF DATA

Introduction

This chapter presents the results of the analysis of data from a convenience sample of 15 spouses whose mates died at least 6 months but no longer than 5 years ago. Data were collected through the use of a 17 item semi-structured interview adapted from Hampe's (1973) study of spouses with terminally ill mates. All of the 60-minute interviews were conducted personally by the researcher over a 6-week period in 1988. The interviews were conducted in quiet environments chosen by the participants. The research took place in northcentral and northwestern Montana in areas where emergency back-up counseling was arranged prior to initiating the interviews. Of the 15 spouses, 9 (60%) of their mates died of myocardial infarctions or heart related illnesses, 2 mates died of cerebral hemorrhages, 2 mates died from acute complications of gastrointestinal illnesses, 1 mate died from asthma, and 1 mate died from an undiagnosed illness. Six (40%) of the mates died within 1 hour after admission to the emergency room of the hospital. Four (26%) of the mates were in the

hospital when stricken by the sudden terminal illness. Two mates (13%) died in the operating room after unsuccessful heart surgeries. Three mates (20%) were admitted to the hospital in critical conditions and died in less than 24 hours. Sixty percent (n=9) of the spouses were with their mates when the mates became ill with the acute illness. Forty percent (n=6) were not with their mates when the mates became ill. Seven of the interview participants agreed to be tape-recorded. Eight of the spouses declined to be tape-recorded. The researcher took extensive field notes during all of the interviews which were used for the data analysis. Table 1 summarizes the relationship between each question on the interview schedule with the needs of the grieving spouse.

Although there are no specific rules for analyzing qualitative data, Polit and Hungler (1987) identified general guidelines which were followed in this research. The first step began with the search for themes or categories which were previously identified in the literature (Hampe, 1973; Fanslow, 1973; Bucko, 1979). The next step involved validation of the categories using the data for a more formal tabulation of the frequency of data within the categories. Next, the researcher summarized the data by categories, using illustrative quotes from field notes as evidence to support the researcher's results.

Table 1. Relationship between Interview Questions and Categories of Need (Hampe, 1973).

Rationale	Interview Question
Needs	
To be with or see mate	3,4,17
To be assured of prompt attention to needs of mate	12
To be kept informed	2,4,15
To be aware of possibility of mate's death	8
Opportunity to express anxiety	10,11
To receive comfort and support by family and friends	5,6,9,13,16
To receive comfort and support by health professionals	5,6,7,9,11,12, 13,14,16
Establish rapport	1

The data from this research were analyzed in three sections. A summary of the demographic data comprises the first section; the second section includes a category analysis; and the third section includes additional data from the study.

Description of the Sample

The study sample consisted of 15 spouses whose mates died within 24 hours after the onset of an acute illness or injury. The death of the mate was at least 6 months but no more than 5 years ago. The demographic information which was gathered for this study included age, gender, living alone, marital status, children at home, years married before mate died, months since mate died, population of communities where the spouse lived, and number of beds in hospital where mates died.

The mean age of the spouses at the time of the mate's death was 53.9 years with a range of 36-76 years. The mean age of the mates who died was 56.3 years with a range of 29-81 years. Thirteen of the spouses (87%) were females and 2 of the spouses were males (13%). The mean of the number of years married was 30.6 years with a range of 9-53 years. At the time of the interview, 6 of the 15 spouses (40%) were living alone, while the other 9 (60%) had remarried and/or had children living at home. The mean number of months since the mate died was 36 months with a

range of 14-59 months. Table 2 summarizes the sample distribution by age, gender, children at home, remarried and living alone. Table 3 summarizes years married before mate died and months since mate died.

The size of the communities where the spouses lived ranged from 600-65,000. One spouse (7%) lived in a community of less than 1,000; 11 spouses (73%) lived in communities between 2,500-5,000; 2 spouses in communities between 10,000-15,000; and 1 spouse (7%) lived in a community of 65,000. The size of the hospitals where the mates died ranged from 20-300 beds. Nine mates (60%) died in hospitals with 20 beds or less and 6 mates (40%) died in hospitals with more than 40 beds. Table 4 summarizes the size of the communities where spouses resided and the number of beds in the hospitals where the mates died.

Table 2. Frequencies and Percentages for Demographic Characteristics of Spouses (Living) and Mates (Deceased).

Characteristic Description	Response Frequency		Percent	
	Spouse	Mate	Spouse	Mate
Age				
20-30	0	1	0	7
31-40	4	2	27	13
41-50	2	2	13	13
51-60	5	2	33	13
61-70	1	5	7	33
71-80	3	2	20	13
81-90	0	1	0	7
Total	15	15	100	99
Gender of Spouses				
Male	2		13	
Female	13		87	
Total	15		100	
Living Alone				
Yes	6		40	
No	9		60	
Total	15		100	
Remarried				
Yes	5		33	
No	10		67	
Total	15		100	
Children at Home				
Yes	6		40	
No	9		60	
Total	15		100	

Table 3. Frequencies and Percentages for Years Married Before Mate Died and Months Since Mate Died.

Characteristic Description	Response Frequency	Percent
Years Married Before Mate Died		
Less than 10	1	7
11-20	4	27
21-30	1	7
31-40	5	33
41-50	2	13
51-60	2	13
Total	15	100
Months Since Mate Died		
6-12	0	-
13-24	5	33
25-36	2	13
37-48	4	27
49-60	4	27
Total	15	100

Table 4. Frequencies and Percentages of Population of the Communities Where Spouses Reside and Size of Hospitals Where Mates Died.

Characteristic Description	Response Frequency	Percent
Population of Communities Where Spouses Reside		
0-2,500	1	7
2,501-5,000	11	73
5,001-10,000	0	-
10,001-25,000	2	13
25,001-50,000	0	-
50,001-100,000	1	7
Total	15	100
Number of Beds in Hospitals Where Mates Died		
10-20	9	60
21-50	1	7
51-100	0	-
101-200	2	13
200+	3	20
Total	15	100

Category Analysis

The category analysis of data is divided into seven categories of needs identified by Hampe (1973). These categories of need include: 1) to be with or see the mate, 2) to be assured of prompt attention to the needs of the mate, 3) to be kept informed, 4) to be aware of the possibility of the mate's death, 5) the opportunity to express anxiety, 6) to receive comfort and support by family and friends, and 7) to receive comfort and support by health professionals.

Individual interview items are discussed in the category of need which they were designed to validate. All of the interview items were related to the categories of need except question one which said, "How long had your mate been at the hospital?" This question was designed to develop rapport with the spouse. All of the spouses responded to this question by telling the entire sequence of the events surrounding their mates' death.

To protect the confidentiality of the spouses, only one gender was used to analyze the data. Only 2 male spouses were interviewed in this research. In order to ensure that their anonymity was maintained, all references to the spouses are female and the mates are all males. The direct quotes of the male spouses were changed

to "she" and "her" where necessary. In addition, all nurses will only be referred to in the female gender.

Category 1: Need to Be With Mate

The need to see or be with the mate after the onset of the acute illness and after death was addressed in the 3rd, 4th, and 17th interview items. The third interview item read, "Were you able to stay with your mate as long as you wanted after you arrived at the hospital?" The fourth interview item read, "Was there any time you had to leave your mate?" Those items assessed the need to be with the mate before death. The 17th item read, "Can you tell me, as nearly as you can remember, what you did after you were told of your mate's death? Regarding viewing the body?" This item assessed the need to see the mate after the death occurred. Data from this category was analyzed in two sections: after the onset of acute illness and after death.

After Onset of Acute Illness. All 15 (100%) identified the need to see or be with the mate after the onset of the acute illness. Two (13%) of the spouses met their need to see or be with their mates after the onset of the acute illness, while for 87% (n=13) of the spouses this need was unmet. Two of the dissatisfied spouses were able to see their mates after the onset of the acute illness but specifically expressed dissatisfaction over how much time

they were allowed. One spouse, whose husband died 6 hours after the onset of a cerebral hemorrhage, stated,

> A nurse came and tried to get us to leave, but I just decided I wasn't going to leave him alone. What possible difference could it have made? The doctor already told me there wasn't anything that could be done.

Another spouse stated,

> I went in once, but I just thought I was in the way, so I went and sat outside the door. That really bugged me. I would have like to have just stayed with him. No one ever did tell me I could come in. I felt excluded.

Six (40%) of the spouses were not with their mates when their mates became ill. When 4 of the spouses were notified of their mate's illness, they went to the hospital but were not allowed to see their mates as all of the mates were undergoing unsuccessful cardiopulmonary resuscitation. Five (33%) of the mates whose spouses were unable to see or be with their mates became ill at home and were unsuccessfully resuscitated at the hospital. Two (13%) of the mates died in the operating room after unsuccessful heart operations.

After Death. Thirteen (87%) of the spouses identified the need to see their mates after they had died. Two (13%) of the spouses stated they "did not want to," although they did have the opportunity to do so. Nine (60%) of the spouses did see their mates after they died, while 6 (40%) did not. Of the 6 that did not see their mates, 2 (13%)

did not want to and 4 (27%) did not ask nor were they asked by the staff if they wanted to see their mate. These 4 spouses now regret not seeing their mates after they had died. All felt the nurse should have given the family the opportunity to do so. As one spouse said, "No one asked. It's such a blow -- you don't have time to think of those things." Another spouse said, "They (the nursing staff) didn't ask and I was too upset." Tables 5 and 6 summarize the data for the spouse's need to see or be with the mate after the onset of the acute illness and after death.

Category 2: Need for Prompt Attention to the Needs and Comfort of the Mate

The 12th interview item was, "Do you think the nurses were interested and concerned about your mate?" This question assessed the need to be assured of the prompt attention to the needs and comfort of the mate and the spouse's perception of the nurses' role in meeting those needs. All 15 (100%) of the spouses identified the need for prompt attention to the needs and comfort of their mates. Nine (60%) of the spouses felt this need was satisfactorily met, while for 6 (40%) of the spouses this need was not met. There were several indications that this need was met. One said, "They (the nurses) were right there." Four spouses said that they could tell by the nurse's "body expression, by the look in her eyes." Three spouses were assured of the nurses' prompt attention and

Table 5. Frequencies and Percentages of Responses for Need to See or Be With Mate After the Onset of the Acute Illness Before and After Death.

Response	Frequency	Percent
After the Onset of the Acute Illness		
Need Identified		
Yes	15	100
No	0	-
Total	15	100
Need Met		
Yes	2	13
No	13	87
Total	15	100
After Death		
Need Identified		
Yes	13	87
No	2	13
Total	15	100
Need Met		
Yes	9	60
No	6	40
Total	15	100

Table 6. Frequencies of Reasons Spouses Not Able to See or Be With Mates After the Onset of the Acute Illness and After Death.

Response	Frequency
After the Onset of the Acute Illness	
Cardiopulmonary resuscitation	5
Spouses not present when mate became acutely ill - when spouse arrived mate undergoing CPR	4
Acute illness in operating room	2
Intensive care rules	1
Spouse didn't know why not allowed	1
After Death	
Didn't ask/not asked by staff	4
Didn't want to	2

concern by the hugs of the nursing staff to the spouses. Seven spouses said frequent information and assistance to the spouse satisfied this need. Of the 6 (40%) who did not feel that this need was met, 3 (20%) said the nurses were very "businesslike -- they just do their job." Another 2 (13%) said that no one said a word or even came in to tell them a thing. One spouse (7%) cited the general atmosphere of the hospital as dissatisfying -- "like nothing happened; like it wasn't important that a life was gone." This spouse saw the doctor and one of the nurses "laughing about something" moments after learning her husband had died. She said, "It made me feel like they didn't care." Tables 7 and 8 summarize the data for the need for prompt attention to the needs of the mate.

Table 7. Frequencies and Percentages of Responses for Need for Prompt Attention to Needs of the Mate.

Response	Frequency	Percent
Need Identified		
Yes	15	100
No	0	-
Total	15	100
Need Met		
Yes	9	60
No	6	40
Total	15	100

Table 8. Frequency of Responses Spouses Identified as Ways Nurses Did or Did Not Give Prompt Attention to Mate's Needs.

Response	Frequency
Need Met	
Frequent information/assistance	7
Body expression of nurses	4
Hugs from nurses	3
Talking	3
Continuous presence	1
Need Unmet	
Nurses businesslike	3
No communication with nurses	2
General atmosphere	1

Category 3: Need to be Kept Informed of Mate's Condition

Assessment of the satisfaction of the need to be informed about the mate's condition was the purpose of interview items 2, 14, and 15. Interview item two read "What were you told about your mate's illness?" Part of interview item four read, "Were the treatments and procedures explained to you?" Question 15 read, "How did you learn of your mate's death?"

All 15 (100%) of the spouses identified the need to be kept informed about the mate's condition. Only 4 (27%) were satisfied that this need was met, while 11 (83%) did not feel satisfied with the information they received about their mates. One spouse who was not satisfied with the information she received said, "No one explained what they did or tried; no one said a word." Another spouse said, "No one told me anything. I don't know how long I sat there. If I asked a question, they just said to wait until the doctor came out." Still another dissatisfied spouse said, "I felt like an outsider. It would have helped if someone would have come out and said, 'We don't know, but we're doing this.'"

Three (20%) of the spouses were informed by the doctor about the onset of the acute illness, 3 (20%) were informed by friends or relatives, 2 (13%) were informed by a nurse; 1 (7%) by an unidentified person, and 1 (7%) said, "I