From a good death to a better bereavement? The impact of the end of life experience on bereavement adjustment, a thematic analysis

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Abstract: To date, the majority of research into a good death has focused on the experience of the person who is dying. Taking the perspective of bereaved individuals, this qualitative study explores which elements of the end of life experience constitute a good death and how these elements influence the process of bereavement adjustment. Following interviews with ten bereaved adults four themes were identified which together define a good death: a lack of physical distress, emotional resolution, 'naming death as death' and death at 'the right time'. The value of open communication prior to death is highlighted. For those working with bereaved individuals these results support an understanding of the impact of the manner of death on bereavement adjustment. For those in palliative care settings, potentially modifiable elements of the end of life experience which may support better bereavement are suggested.

Keywords: good death, bereavement, end of life, palliative care

Introduction

Bereavement, the experience of loss due to death, is a very common life event but one which can be devastating for individuals. Whilst the effects of grief can differ greatly between individuals in terms of duration, intensity and impact (Strada, 2013), research has demonstrated that bereavement adjustment can be predicted by the circumstances of the loss (Costello, 2012). Recent research has demonstrated that the end of life experience of an individual has a potential long term impact on bereavement outcomes for their family members (Wilson, MacLeod, & Houttekier, 2016) and that the quality of death is related to the quality of bereavement (Garrido & Prigerson, 2014).

A good death

The concept of a good death is multifaceted and not clearly defined. In general, however, it is understood to include a death which reduces both physical and emotional suffering (Miyashita et al., 2008), is congruent with the personal values and stated wishes of the dying person (Balducci, 2012), takes place at a time where death is accepted and planned for (Semino, Demjén, & Koller, 2014), meets the spiritual needs of the individual (LeBaron et al., 2015) and maintains close relationships and open communication with family members throughout the final illness and death (Carr, 2003).

To date, research examining what constitutes a good death has focussed on the perspective of the patient experience (Kastbom, Milberg, & Karlsson, 2016). Bereaved family members are frequently involved as participants in research post-death but their role in these studies has primarily been providing information about patient care. However, the factors which comprise a good death are dependent on the role and perspective of the individual, for example, as the person who is dying, the family member or the professional involved in providing care (Semino, Demjén, & Koller, 2014). In a qualitative study of culturally diverse bereaved individuals, Lee, Woo

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and Goh (2013) identified differences between patients and family members in terms of the perception of a good death and further study is required in order to understand what a good death looks like from the point of view of bereaved individuals.

Context and intended contribution

Recent literature suggests that bereaved individuals define and experience a good death differently from those who are dying (Lee, Woo & Goh, 2013) and that factors of the death experience can improve bereavement outcomes (Kim, Carver, Speigel, Mitchell, & Cannady, 2017; Wilson, MacLeod, & Houttekier, 2016). Taking the perspective of bereaved individuals, the objective of the current study was to investigate which elements of the end of life constituted a good death and to consider the effect these elements had on subsequent bereavement adjustment. Limited research directly connects these two areas from the perspective of the bereaved individual. This study used qualitative data from bereaved individuals who experienced non complicated grief reactions. Many previous studies have recruited participants via clinical services for bereavement suggesting a bias towards people who were struggling to find balance in bereavement. With a focus on participants who were dealing with their grief within their own personal and social support networks it was anticipated that findings would be able to highlight some of the potentially modifiable factors of the end of life which positively influence non complicated bereavement.

This study aimed to answer the research question: from the perspective of bereaved individuals, which elements of the end of life experience comprised a good death and how did these elements relate to the process of bereavement adjustment?

Method

Design

This research was conducted using a qualitative design to allow the richness and depth of the individuals' lived experience to be portrayed (Butcher et al., 2001). The approach was to use semi-structured interviews followed by thematic analysis (Braun & Clarke, 2006) of the transcripts.

The use of a qualitative methodology ideally enables the participants' own social reality to be safeguarded rather than producing results that are the construct of the researcher (Fereday & Muir-Cochrane, 2006). However, the authors of this study recognise the impact of their previous values and life experience, as a bereaved person and bereavement counsellor, on the research process.

Prior to commencing this study, the research and its protocol received full ethical approval from Northumbria University's Faculty of Health and Life Sciences Ethics committee.

Participants

Ten adults (eight female, two male) participated in this study (ranging from 40-75 years in age, mean age 54). Participants lived in the northeast of England and were recruited through word of mouth, including advertising on social media, or through email contact with interest groups. All the participants had experienced the death of someone they were close to within the last eleven months to four years and had been either present at, or felt they were able to comment on, the experience of the death (see Table 1 for further demographic information). In order to enable maximum diversity of experience no exclusion criteria were set as to the cause of death, place of death or relationship between the participant and the person who died. All participants are identified by pseudonym.

Data collection

Data was collected using semi-structured individual interviews. Author CW carried out all the interviews and they were audio recorded and transcribed verbatim within 48 hours. The interview schedule was piloted and the final version was designed to ensure that data was collected about the participants' experience at two key time points: the time of the death and their bereavement experience after the immediate time of the death. The interview began with very open questions to allow each participant to describe their personal experience of bereavement and to feel emotionally comfortable. The researcher then asked specific questions to elicit data that linked the end of life and bereavement, for example 'Are there any factors about the death of the person that you think had an impact on your own experience of bereavement?' Throughout the interview, participants were encouraged to consider the death from their perspective rather than that of the person who died. If participants displayed any distress during the interview, the researcher suggested taking a break or ending the session. In all cases participants were happy to continue and despite many finding the interviews emotionally challenging all participants expressed gratitude for the opportunity to tell their story. Finally, participants were thanked and given contact information for local bereavement support services.

Data analysis

Data was analysed following the procedure of thematic analysis described by Braun and Clarke (2006). The transcripts were read and re-read by the researcher and initial codes were generated from the whole data set. To identify common features and patterns, each code was reviewed and initial themes, or central organising concepts, were developed. These candidate themes were discussed by both authors and assessed against the full data set to

Table 1. Summary information for each participant.

Pseudonym	**Age**	**Gender**	**Relationship to participant of person who died**	**Time since death**	**Cause of death**	**Place of death**	**Length of illness preceding death**	**Age at death**
Peter	75	Male	Wife *	3 years 2 months	Cancer	Home	2 months	63
Sue	70	Female	Friend	3 years 7 months	Cancer	Hospital	Undefined	46
Karen	58	Female	Father *	1 year 3 months	Age/Kidney failure	Hospital	One week	89
Heather	45	Female	Father-in-law	2 years 7 months	Age/Stroke	Nursing home	Nine months	93
Anne	47	Female	Mother *	3 years	Age/Heart failure	Hospital	Gradual decline, two days in hospital	78
Rachel	48	Female	Father *	3 years 10 months	Cancer	Nursing home	Six months	76
Holly	49	Female	Mother *	4 years	Alzheimer's/ pneumonia	Nursing home	Five years	74
Rebecca	42	Female	Grandmother	2 years 6 months	Pneumonia	Home	Sudden death	87
Carol	40	Female	Father *	11 months	Alzheimer's/chest infection	Nursing home	Sudden illness	78
Tom	61	Male	Father *	1 year 6 months	Dementia/Old age	Nursing home	Undefined	94

*Next of kin

ensure that, when taken together, they told a 'faithful' story of the data. Finally, all formulated themes were given names to provide a succinct and evocative sense of what the theme was about (Braun & Clarke, 2006).

Findings and discussion

Four themes were identified that comprise, from the perspective of a bereaved individual, the elements of the end of life that constitute a good death. These themes are: 'lack of physical distress', 'emotional resolution', 'the right time' and 'naming death as death'. The results of this study suggest that if any one, or more, of these elements is missing, then the experience of bereavement adjustment can be more difficult for the bereaved individual. A thematic map (see Figure 1) visually demonstrates the integrated nature of these themes.

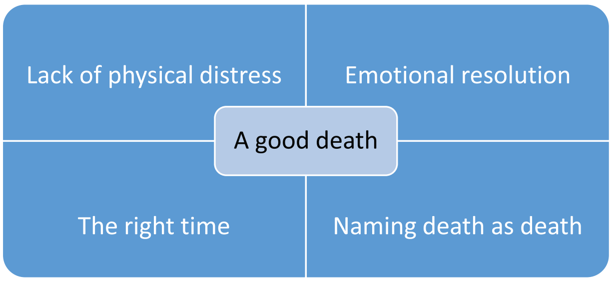

Figure 1: Thematic map showing integrative nature of themes.

Theme 1: Lack of physical distress

The results of this study, in line with previous research, provided evidence that a 'bad death' is one where bereaved individuals witnessed physical suffering (Balducci, 2012). For those who witnessed physical pain or distress there was additionally a negative and potentially long term effect on bereavement. Bereaved individuals described being unable to let go of the mental image of the death or having their memory of the person who died tainted by the nature of their death.

> …*but there are certain things that I can't forget, I mean it was thick, black, horrible*…*certain things that to the day I die I just won't forget.*

Worden's task theory (1991) connects the 'mode of death' with the ability of the bereaved individual to made sense of the loss. Where an individual is observed to die in pain and without physical dignity, the bereaved person may find cause for anger either towards themselves or care professionals for not enabling a good death to take place. A negative memory of the death can make it more difficult for individuals to make sense of their loss in bereavement (Neimeyer, 2000). The findings of this study reinforced this impact on bereaved individuals.

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Potential physical distress for the dying person included medical treatments and loss of dignity due to symptoms of the illness. For example, one participant identified an occasion where, during the period of palliative care, an invasive treatment was given to her close friend.

> *They had given her one dose of chemo the December before she died it was horrendous she should never have had that because that made her little bit quality of life she had took all of that away.*

For this participant the use of a perceived Non Beneficial Treatment (NBT) was associated with a bad death and that as a result grieving for her friend was '*harder*' than for other deaths she had experienced.

Interestingly, this study found limited evidence of physical distress during the end of life suggesting that, in most cases, pain management and other physical symptoms were well controlled.

> *…our local doctor was also very good and so pain wise um it was well controlled…it's funny I had this form from the doctor afterwards what could have been done better and I said the care was fantastic, it was.*

In line with these findings, a recent review of good death literature identified distress from pain as a less significant factor than in earlier research (Cottrell & Duggleby, 2016). This may be a result of changes over time in the most common causes of death from acute conditions to slower chronic illness where symptoms can usually be more easily managed (Cottrell & Duggleby, 2016). The current study, which included a variety of causes of death, adds support to these findings and suggests other factors, such as advance planning, which may have also improved physical care for patients.

For participants in this study a lack of physical distress was typically attributed to well communicated care plans, including the withdrawal of perceived NBTs prior to death. The results of this study may suggest that care plans were successfully implemented and that, at the time of death, pain and the treatment of other physically distressing symptoms were well managed.

> *We started to talk to the consultant about where we would go from there because, well he did have a feeding tube in at one point, and he didn't tolerate it well, he made it quite clear that he did not want that again. Em, so basically…we'd keep him comfortable, but they'd not be using a feeding tube, you know we'd allow him salt, water, dextrose and things and obviously the chances were that nature would take its course.*

The results of this study may suggest that care plans are successfully implemented and that, at the time of death, pain and the treatment of other physically distressing symptoms are well managed. If bereaved individuals are able to take a role in planning and are clear that they are acting on the wishes of the person who is dying, they are better able to make sense of the death (Neimeyer, 2000). This finding resonates with previous studies which have shown that open, advanced planning with the use, for example, of Do Not Resuscitate (DNR) orders has enabled relatives to know prior to the death what was likely to happen and could be predictive of better mental health during bereavement (Garrido & Prigerson, 2014).

It is important to note that despite relatively little data evident in this study concerning physical distress during the end of life, this does not diminish its fundamental importance as an element of a good death from the perspective of a bereaved individual. There is a sense from the relatively few comments reflecting physical distress from the study's participants in comparison to earlier papers about the importance of pain/pain relief in good death (Cottrell & Duggleby, 2016) that physical discomfort is only noticed when it is not achieved. In fact, improvements in aspects of physical comfort in palliative care in recent decades may have allowed the opportunity for consideration of a good death to include more psychological, emotional and spiritual elements.

Theme 2: Emotional resolution

The realisation of emotional resolution, where any outstanding conflicts were resolved before death and there was an opportunity to 'say goodbye' was important for both the person who was dying and the soon to be bereaved person. The emotional resolution of the dying person as well as the emotional support given to the soon to be bereaved person affected the subsequent bereavement. A good death, in terms of emotional resolution, was one where death was as free of emotional distress as was possible, and where both those who were dying and soon to be bereaved felt able and ready to 'let go'.

Our findings indicated that the importance of emotional resolution was seen as an integral part of a good death and of equal importance as physical comfort.

> *It's spiritual isn't it yeah…it's the resolution of death…so a good death being without pain and without discomfort and without any sort of panic but actually whether someone has resolved themselves…And that for me that makes a good death as well.*

Individuals took great comfort following death from the opportunity they had to spend time with their loved one prior to death. For some bereaved people having the time to say goodbye or spend some final hours with the dying person provided a sense of completeness in

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their relationship that supported moving forward in bereavement.

> *…and the most precious thing I've ever done was holding Jill's hand all night all her last night…because obviously it made it all so much better for me that we had spent so much of our lives together and we were together on our last night.*

In contrast, not being there at the time of death could leave unanswered questions about the emotional state of the dying person.

> *As I say I wasn't there and I would have liked to be there and I think that in turn it would have been better for me in the long run because it would save me worrying because you know I sometimes think back and worry what about his last moments like was he frightened?*

The dual process model of bereavement (Stroebe & Schut, 1999) suggests that the process of finding balance in bereavement involves an oscillation between loss and restoration orientation, over time looking forward more than looking back. For this participant, with a focus on loss orientation due to a lack of clarity about the emotional state of her father at the time of his death, there was a potential negative impact from this lack of emotional resolution during the end of life.

However, being physically present at the time of death was not seen a determining factor for bereavement adjustment if the bereaved individual was confident that their relative or friend had the death they wanted. When describing the death of her mother, who died alone, a participant suggested a more individualised concept of a good death as 'the right death' for that individual.

> *Maybe she waited until everything had calmed down and everyone had left the room and went to sleep she didn't look fearful at all…and that's how…exactly how she wanted to go so maybe it was the right death do you know what I mean?*

The theme of emotional resolution includes the role of the soon to be bereaved person in the death as well the emotional state of the dying person. Bereaved individuals felt a potentially conflicting pressure to provide support for the emotional needs of the person who was dying, as well as being able to accept emotional help for themselves as they transitioned into grief. When this was achieved, there was evidence that the resulting lack of regret was supportive during bereavement.

> *I would always try to be there…that one did the best one could do obviously that's always helpful 'cos guilt or regret is a really sad thing and if it's there it's there and you have to cope with it but I don't feel I would have done anything differently and that's a really nice thing.*

However, when bereaved people felt unable to protect the dying person from emotional distress, even when this would have been impossible, this carried forward into bereavement in a very personal way.

> *I know that he didn't have that closure and it took a long time for me to get over the fact that he was probably very sad when he died.*

The tasks of mourning are more difficult and longer lasting where guilt about not providing good enough care during the end of life is experienced (Worden, 1991). For participants in this study, the definition of good enough care was explicitly linked to the provision of emotional support alongside physical care.

In addition, the bereaved individuals in this study considered resolution of their own relationship with the dying person as a benefit to their bereavement and that professional support to enable this, sometimes in the form of talking therapy, could be useful for them prior to death. However, participants identified a disparity between the support given to the dying person and the support they were offered.

> *When the person's dying and they're offered counselling and they're offered so much you know even 'til their death so they can have a good death I think more should be done for the family around someone who's dying…I think that would make it a lot easier for everyone…then the family might come to terms with things easier for afterwards.*

This finding is supportive of previous studies which suggest that pre-bereavement care may be important for the bereavement outcomes of individuals (Wright et al., 2008). However, there was evidence that individuals close to the dying person, particularly those with a caring responsibility, were at times unwilling or unable to consider their own needs as a priority. For one participant, this affected his ability to obtain emotional support.

> *I would have valued more talking therapy and by the time I got to make a phone call that was properly asking for it it was err too late…I never followed it up because it wasn't that important but it would have helped me it would have made it easier and I know there are people who do that so I em anyway it doesn't really matter.*

This participant, fully aware of his own needs, was able to request appropriate emotional support but when it was

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not forthcoming he quickly downgraded his own need for help. It is suggested that this highlights the importance of focussing on the emotional needs of soon to be bereaved individuals as well as on those of the person who is dying.

Our findings showed that for bereaved individuals a good death leading to a better bereavement was one where emotional resolution was witnessed in the person who was dying, but was also one where they themselves were supported to make their own peace with their loss and with the person who was dying. The importance of professional support for the soon to bereaved person has been clearly highlighted in this theme.

Theme 3: 'Naming death as death'

This theme is defined as an open understanding of the knowledge, nature and expectations of the process of the end of life between all the individuals and groups involved–the dying person, their next of kin who often acts as a decision maker, the wider family, and friends and any professionals involved in the death. In circumstances where death is anticipated in advance, 'naming death as death' includes an honesty about both the inevitability of death and, as far as possible, what the physicality of what death might look like. Where there is poor communication, or even conflict, between those involved in the death the subsequent bereavement can be more challenging.

Our findings showed that a good death for bereaved individuals was one where they, and the dying person, were able to speak openly about the inevitability of death. In circumstances where soon to be bereaved people knew that death was imminent but this knowledge was not shared with the dying person problems in bereavement adjustment were identified. One participant was told by doctors that her father was dying, however, despite him being fully conscious and cognitively able no one in the hospital had discussed his prognosis with him. Following his death, she identified the impact not sharing his prognosis had on her bereavement.

> *I think they're the … things that have kind of haunted me em for the two things I did worry about were the fact that in those three days he didn't he clearly didn't realise how poorly he was and whether I was right in not telling him … my great dilemma is whether I take comfort in the fact that he didn't know he was dying or whether a part of me thinks I should have told him, but I didn't.*

The knowledge that things may not have happened in a way which met the specific needs of each individual at the time can lead to a sense of guilt and isolation which is linked to a more challenging bereavement (Worden, 1991).

In addition to an openness about the inevitability of death, results of this theme suggested that individuals were supported in bereavement by a death that was well communicated so it did not present a fearful experience. For one participant, however, a lack of knowledge about the physicality of death meant that she experienced fear and uncertainly during her father's death.

> *I didn't know that* (demonstrated laboured breathing) *was going to be his last breath you know is someone going to come in to talk to me is this going to happen does he need to have more painkillers you know there was that kind of it's always like he should have been on a four hourly watch or something like that the way they would have done if he was poorly but they'd been saying someone saying yeah he's dying and then they kind of left us*.

For this participant being left alone with her father at this time was a frightening experience which negatively impacted on her later memory of his death.

The current study suggests that in terms of supporting a good death family members value honesty, even if this means clinical staff openly stating that they do not know when or how the death is likely to happen. However, this is difficult in a culture where death is increasingly medicalised and death is more usually considered as something to fight against rather than accept (Greenwood, 2015). Doctors, and other clinical professionals, value open communication in order to support a good death but face a range of barriers in discussing end of life issues with patients and family members, not least that they are not able to accurately predict how death will be for each individual (Periyakoil, Neri, & Kraemer, 2015).

In contrast with a medicalised view of preserving life at all costs, when all individuals involved in the end of life are able to 'name death as death' and to understand death as a natural and inevitable life event this contributes to a good death. This in turn reduces anxiety, guilt and fear and contributes to better bereavement outcomes.

Theme 4: 'The right time'

The timing of death is an area where the needs of the dying person and the bereaved can diverge. A sudden, pain free death can be seen as a good death for the dying person but, for the soon to be bereaved individual, there is no time to resolve psychological or practical matters (Carr, 2003). Evidence from this study suggests, in line with Worden's theory of the tasks of mourning (Worden, 1991), that when death was very sudden bereaved relatives described a feeling of shock and reported the process of bereavement adjustment taking longer and having a greater impact.

> *The grief does hit you … this was very much* [claps hands suddenly] *like a railroad, so yes* [pause] *I*

> *suppose it did come as a shock, quite hard to go from one extreme to another.*

In contrast, in situations when death was known about in advance, participants in this study suggested that they could have benefitted from a chance to prepare for their loss and could, in some situations, begin to grieve prior to the death occurring.

> *Really the grieving for him started the minute he had that stroke. You do still feel the loss but in a much more reflective way.*

Niemeyer's theory of benefit finding in bereavement (Neimeyer, 2000) suggests that a traumatic death negatively impacts on bereavement by initially making the death more difficult to process and make sense of. However, participants in this study suggest that a sudden death can affect bereavement in more nuanced, not necessarily negative ways. In the longer term, whilst initially more challenging, a sudden and traumatic death can lead to a deeper level of engagement with the death and, as a result, a more profound, and potentially more positive, identity change (Tedeschi, Park, & Calhoun, 1998).

> *In a funny kind of way it's helped me appreciate bereavement more … because I've thought about it more … and it's made me do more with my life I've made decisions and pushed myself out of me comfort zone which I didn't normally do because of that experience.*

In this study, when the end of life was extended this too had a negative impact on bereavement. Interestingly, a number of participants identified that the length and type of illness prior to death, particularly where the dying person had a minimal quality of life, overshadowed other elements of a good death such as the lack of physical distress.

> INTERVIEWER*: Would you say he had a good death?*
>
> *No. I think in the end he did go quite quietly but I mean for the life he had led to get to that point … would you let a cat or dog get to that point? You wouldn't.*

Participants suggested a number of negative impacts of an extended end of life. These included physical distress and reduced quality of life for the dying person, and increased trauma and stress for the soon to be bereaved person due to caring and other practical responsibilities. A combination of these negative conditions for the bereaved person during the end of life was identified as having a long-term effect on bereavement.

For the participants in this study, maintaining a good quality of life during the dying process was of paramount importance both to the dying person and on the perception of a good death by bereaved relatives. In addition, the findings of the current study suggest a link between patient quality of life before death and bereavement adjustment.

> INTERVIEWER: *Are there any things you could have changed about the death that would have made your bereavement better?*
>
> *I think really had it happened earlier yeah the NHS were too good.*

For one participant, appropriate use of medical treatments during the last hours of her mother's life supported emotional resolution for her and other family with no adverse effects.

> *It was a positive intervention get fluids in get the rehydration back and purely by doing that she was able to see her sister and see her son.*

The experience of this participant suggests that the use of perceived NBTs in palliative care is further complicated by the potential positive effects of medical interventions during the period of palliative care at the very end of life. The ability to discriminate between supportive treatments and negative interventions is a very complex one but is considered to be a key factor in realising a good death from the point of view of bereaved individuals. Aggressive care has previously been associated with poorer bereavement outcomes (Wright et al., 2008) and this study strongly supports the view that the use of perceived NBTs in order to extend life has a negative impact on bereavement adjustment. For the bereaved individuals in this study, a good death was one where unnecessary distress was avoided and life was allowed to end naturally, even if that meant that death came sooner.

Conclusion

The results of this study suggest there are four elements which together constitute a good death for bereaved individuals: a minimum of physical distress for the person who is dying, death at the 'right time', the ability to openly 'name death as death' and an emotional resolution prior to death for both the person who is dying and the soon to be bereaved individual. If any of these elements are not present at death, the experience of the participants in this study suggests that bereavement adjustment can be more challenging.

The four themes in this study need not be viewed as isolated concepts but rather as an interconnected explanation of what a good death means to bereaved individuals. However, in each end of life experience these elements will vary according to circumstances and, for individual bereaved people, each will take different importance. For bereaved people, a key aspect of a good death is to openly accept death as a natural process. Where possible, bereaved relatives can be supported in bereavement by a death where all those who are involved in the end of life (the dying person, professionals involved in the care and the soon to be bereaved individuals) are able to openly acknowledge that death is inevitable. This minimises conflict between individuals and allows advance planning, thereby minimising physical distress. By making the inevitability of death explicit, both the dying person and those close to them would be better able to engage in a process of emotional resolution and have the opportunity to say goodbye. Fear about the physicality of death would be able to be minimised through open communication thus reducing the likelihood of distress and feelings of guilt following the loss. A good death, for bereaved individuals, is one where it is not considered necessary, or in fact desirable, to extend life with the use of NBTs. Openly naming death as death could enable the reduction of such treatments.

Strengths, limitations, implications for practice and future research

The current study, in contrast with the majority of previous research into a good death, has placed the focus on bereaved people. By making connections between the two study areas of end of life care and bereavement, new insights bridging the experience of bereaved individuals both before and after the death have been generated. In addition, a UK based study was valuable as previous similar research in other countries (Bussmann et al., 2013; Witkamp, van Zuylen, Borsboom, van der Rijt, & van der Heide, 2015; Lee, Woo & Goh, 2013; Dumont Dumont & Mongeau, 2008) is potentially limited in a UK context due to different palliative care policies and settings (Ahmedzai et al., 2004).

As participants in the current study were from a culturally homogenous group (all were white, British and the majority were female) future research including participants from more diverse ethnic, spiritual and cultural groups could add weight to the development of culturally sensitive support programmes for bereaved individuals. In addition, whilst the circumstances of death were varied for this participant group, a number of specific death loss situations were not included in this research, for example, families with young children who experienced loss or adults who experienced the loss of a child. Future research into the impact of the manner of the death on bereavement of those groups, and its relation to a 'good death' would be valuable. Finally, the use of an opportunity sample may suggest a bias towards those individuals who felt better able to talk openly about death and, as a result, may represent more positive bereavement experiences; the ability to talk and share experiences has been linked to better bereavement outcomes (Chapple, Ziebland, & Hawton, 2015). Whilst this does not limit the validity of the individual experiences of participants, a more balanced participant group may potentially yield further insights. The results of this study have potential implications for clinical practice. By providing evidence for the impact of the end of life on longer-term bereavement adjustment, the findings highlight the value of supporting the needs of soon to be bereaved individuals in palliative care settings. ■

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