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<thead>
<tr>
<th>Title</th>
<th>Hope in bereavement - the silver lining</th>
</tr>
</thead>
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<tr>
<td>Author(s)</td>
<td>Chow, AYM</td>
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<tr>
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<td>The 5th Singapore Palliative Care Conference (SPCC 2012), Singapore, 14-15 July 2012.</td>
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<tr>
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</tr>
</tbody>
</table>
Hope in Bereavement – the Silver Lining

Amy Y. M. Chow  Ph.D., RSW, FT.
Associate Professor, Dept. of Social Work & Social Adm., The University of Hong Kong
What is Hope?

希望
What is HOPE?

Do you have hope? Is it a simple question. If your answer is “yes,” then how much hope do you have and do you have enough? If the answer to the initial question is “yes,” then would you describe yourself as “hopeless” or have you been grouped with over the centuries by philosophers and many others psychologists and who see us as we conduct our philosophers’ spiritual leaders.

In the late 20th century, social scientists and their individual theoretical lenses have converged on the topic of hope. In this regard, we have located at least 55 theories or definitions, and a handful of validated measures. In this chapter, we have decided to focus on conceptualizations of hope. Therefore, we will present details about social psychologists and practitioners of hope. In the process, we will address a widely debated question of hope, and in the process, we will address a widely debated question: How will we address the question of hope, and in the process, we will address the question of hope.

Conceptualizations of Hope

Theories and ideas regarding the concept of hope can be grouped into two categories: hope-oriented or cognition-based categories. These two perspectives are not mutually exclusive. The reader may notice overlap.
HOPE (Snyder, Rand, & Sigmon, 2002)

- The perception that one can reach desired goals
- Serves to drive the emotion and well-being of people
- Involved 2 components of goal directed thought
  - Pathways: one’s perceived capability at generating workable routes to desired goals;
  - Agency: one’s perceived capacity to use one’s pathways so as to reach desired goals. (the motivational component)
A paradoxical relationship??

Bereavement

- Goal vanished
- Future Shattered
- Hopeless about future

Hope

- Clear Goal
- Visualization of Future
- Way and Will
What is the relationship of Hope with Bereavement?
### Correlations between Hope and Emotional Reactions in Bereavement

*Chow, 2010*

<table>
<thead>
<tr>
<th></th>
<th>Hope (Pathway)</th>
<th>Hope (Agency)</th>
<th>Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HADS</strong> (Anxiety)</td>
<td>-.427**</td>
<td>-.560**</td>
<td>-.509**</td>
</tr>
<tr>
<td></td>
<td>(270)</td>
<td>(270)</td>
<td>(267)</td>
</tr>
<tr>
<td><strong>HADS</strong> (Depression)</td>
<td>-.535**</td>
<td>-.591**</td>
<td>-.584**</td>
</tr>
<tr>
<td></td>
<td>(271)</td>
<td>(271)</td>
<td>(268)</td>
</tr>
<tr>
<td><strong>CGI</strong> (Symptoms)</td>
<td>-.346**</td>
<td>-.465**</td>
<td>-.420**</td>
</tr>
<tr>
<td></td>
<td>(276)</td>
<td>(276)</td>
<td>(273)</td>
</tr>
<tr>
<td><strong>CGI</strong> (Coping)</td>
<td>.575**</td>
<td>.545**</td>
<td>.588**</td>
</tr>
<tr>
<td></td>
<td>(277)</td>
<td>(277)</td>
<td>(274)</td>
</tr>
</tbody>
</table>

* <.005, ** P <.001
Discussions

• Hope is moderately correlated with emotions and symptoms, and slightly correlated with health indicators

• Would there be a chance that alternating level of hope → alternating level of depression and anxiety?
Moderating Effect of Hope on the relationship between Hope and Bereavement Outcome (Chow, 2010)

BEREAVEMENT

Hope (Agency)

Depression (HADS)

Anxiety (HADS)

Symptoms (CGI)

F(1,403)=6.70, p=.01

F(1,412)=4.25, p=.04
Hope (Agency) on relations between bereavement and Anxiety

Figure 10.4: Moderating Effect of Hope (Agency) on Relations Between Bereavement and HADS (Anxiety)
Hope (Agency) on relations between bereavement and Symptoms

Figure 10.5: Moderating effect of Hope (Agency) on Relations Between Bereavement and CGI (Symptoms)
Discussion

- **Hope (Agency)** but not **Hope (Total)** or **Hope (Pathway)** has moderating effect on the relationship of bereavement on outcome.

- Are discussions on **goal and alternatives** adequately helping the reduction of bereavement reactions?

- **What is the role of motivation in the helping process?**
How to instill Hope in Hopeless Bereaved Persons?

• **Assessment:**
  - Using hope measures as an assessment tool
  - Pre-death screening for low-hope group: Early intervention

• **Intervention:**
  - Goal Formulation
  - Alternative Discussion
  - Motivation Enhancement ***
Motivation (Deci & Ryan, 1985)

- **Intrinsic motivation** results from the needs for competence, autonomy, and relatedness, and also fosters engagement and enjoyment.

- **Extrinsic motivation** promotes behavior through contingent outcomes that lie outside the activity itself, such as awards or evaluations; the purpose of a behavior is to gain benefits or avoid negative consequences that are expected to occur afterwards.
What is Grief?
Trajectories of Grief:

Chronic Depression Group (about 8%)
- about 8% of widows reported ongoing psychological difficulties.
- They did not score higher in conflicted marriage or ambivalent towards spouse.
- Higher level of personal dependency and dependency on the relationship prior to the death of their spouse.
- More likely to have a healthy spouse, and less likely to have provided health care for the spouse.

Depressed improved Group (about 11%)
- Had poorest quality marriages.
- Higher on ambivalence towards the spouse in the pre-loss stage.
- Mainly on those with a seriously ill spouse.
- Had frequent talking and thinking about the spouse.

Resilient Group (about 46%)
- About 75% of this group reported experiencing intense yearning (painful waves of missing the spouse) as well as pangs of intense grief in the earliest months of bereavement.
- They also ruminating, or going over and over what had happened.
- Better able to gain comfort from talking about and thinking about the spouse.
- Had relatively lower scores on avoidance and distraction, as well as having fewer regrets.
- But less likely to make sense of or find meaning in the spouse’s death.

Common Grief (about 11%)
- Had relatively lower scores on avoidance and distraction, as well as having fewer regrets.
- But less likely to make sense of or find meaning in the spouse’s death.

Take home message #1

• Not all bereaved persons are having problems
Who are the one that might have problems?

- The importance of Assessment
  - Risk Factor Assessment
  - Outcome Assessment

- How: Clinical Interview, Paper and pencil test or observation?
- By whom: self, proxy or professional?
- What: Depression, Anxiety, Grief Reaction, Distress, Morbidity, Functionality or ….
- When: immediately ? 2-month period? 6-month period?
Map for Assessment

Risk Factor Assessment

General Group

Identification of High Risk Group

Outcome Assessment

Care as Usual

Grief Intervention
Fig. 1. The integrative risk factor framework for the prediction of bereavement outcome.
Possible Risk factors identified in Hong Kong (Chow, in preparation)

- Dependency on the deceased
- Loneliness (emotional and social loneliness)
- Perceived Traumatic effect of the death
Findings: Relationships between death nature and grief reactions
(widowed older adult group, n=142)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Perceived Traumatic Effect</th>
<th>Perceived Readiness of the death</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICG (Complicated Grief)</td>
<td>.643**</td>
<td></td>
</tr>
<tr>
<td>HADS (Anxiety)</td>
<td>.174*</td>
<td></td>
</tr>
<tr>
<td>GDS (Depression)</td>
<td>.307**</td>
<td></td>
</tr>
<tr>
<td>Social Loneliness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Loneliness</td>
<td>.292**</td>
<td></td>
</tr>
<tr>
<td>General Loneliness</td>
<td>.423**</td>
<td></td>
</tr>
</tbody>
</table>
### Findings: Relationships between martial relationship and grief reactions (widowed older adult group, n=142)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Dependency on</th>
<th>Dependency from</th>
<th>Marital Satisfaction</th>
<th>Sharing with spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICG (Complicated Grief)</td>
<td>.198*</td>
<td>.192*</td>
<td></td>
<td>.307**</td>
</tr>
<tr>
<td>HADS (Anxiety)</td>
<td></td>
<td>.181*</td>
<td>-.253**</td>
<td></td>
</tr>
<tr>
<td>GDS (Depression)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Loneliness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Loneliness</td>
<td>.274**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Loneliness</td>
<td>.226**</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Findings: Relationships between different grief reactions (widowed older adult group, n=142)

<table>
<thead>
<tr>
<th>Variables</th>
<th>ICG (Complicated Grief)</th>
<th>HADS (Anxiety)</th>
<th>GDS (Depression)</th>
<th>Social Loneliness</th>
<th>Emotional Loneliness</th>
</tr>
</thead>
<tbody>
<tr>
<td>HADS (Anxiety)</td>
<td>.410**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDS (Depression)</td>
<td>.509**</td>
<td>.600**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Loneliness</td>
<td></td>
<td>340**</td>
<td>.369**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Loneliness</td>
<td>.472**</td>
<td>305**</td>
<td>.391**</td>
<td>.237**</td>
<td></td>
</tr>
<tr>
<td>General Loneliness</td>
<td>.480**</td>
<td>.223**</td>
<td>.462**</td>
<td>.252**</td>
<td>.460**</td>
</tr>
</tbody>
</table>
Take Home Message # 2

- **Multiple risk factors:**
  - Individual
  - Relational
  - Contextual
Proposed Diagnostic Criteria for Prolonged Grief Disorder for DSM-V

(Prigerson, Vanderwerker, & Maciejewski, 2008)

A. Persons has experienced the death of a significant other and experience at least one of the following three symptoms daily or to an intense or disruptive degree:

- Intrusive thoughts related to the deceased
- Intense pangs of separation distress
- Distressing strong yearnings for that which was lost.
Proposed Diagnostic Criteria for Prolonged Grief Disorder for DSM-V (Prigerson, Vanderwerker, & Maciejewski, 2008)

B. The bereaved person must have five of the following nine symptoms daily or to an intense or disruptive degree:

- Confusion about one’s role in life or a diminished sense of self (e.g. feeling that a part of oneself has died)
- Difficulty accepting the loss
- Avoidance of reminders of the reality of the loss
- An inability to trust others since the loss
- Bitterness or anger related to the loss
- Difficulty moving on with life (e.g. making new friends, pursuing interests)
- Numbness (absence of emotion) since the loss
- Feeling that life is unfulfilling, empty, and meaningless since the loss
- Feeling stunned, dazed, or shocked by the loss
Proposed Diagnostic Criteria for Prolonged Grief Disorder for DSM-V (Prigerson, Vanderwerker, & Maciejewski, 2008)

C. Duration of disturbance (symptoms listed) is at least six months

D. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning
Common Measurement Tools in Grief and Bereavement

Inventory of Complicated Grief (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, Frank et al., 1995)

• 19 items

• Scores greater than 25 were significantly more impaired in social, general, mental and physical health functioning and in bodily pain
### 複雜哀悼反應量表 (Inventory of Complicated Grief)

請圈出最能形容您此刻的感受。句中的「他」是指你離世的親人。

<table>
<thead>
<tr>
<th>畫圈</th>
<th>無</th>
<th>偶</th>
<th>有時</th>
<th>經常</th>
<th>完全</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 因太想念他，我很難去完成平常我能做到的事。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. 有關他的回憶令我難過。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. 我感到很難接受他的死亡。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. 我很懷念他。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. 我渴望前往與他有關的地方，見與他有關的東西。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. 對於他的死亡，我不能自控地感到焦慮。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. 對於所發生的事，我感到難以置信。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. 對於所發生的事，我感到愕然。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. 自他死後，我難對他人有信任。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. 自他死後，我失去關懷他人的能力或我與關懷我的人有很大隔膜。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. 我身體的痛楚及徵狀與他所感受的相同。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. 我避免觸景傷懷。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. 自他死後，我感到人生空虛。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. 我聽到他對我說話。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. 我見到他站在我面前。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. 我認為他死去而我活著是不公平的。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. 他的死令我感到孤獨。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. 我妒忌那些沒有失去親人的人。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. 他死後我很多時間感到很孤獨。</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Chinese version of ICG
(Chow & Fu, in preparation)

• The best fit model excludes 4 items.
• Instead of a single factor, 3 factors are identified
  – Separation Distress (8 Items)
  – Traumatic Distress (4 items)
  – Contact with the deceased (3 items)
Take Home Message # 3

- **Multiple Assessment tools**
Cohen’s definition of strength of Effect size

- **Strong**: 0.8 (explained about 14% of variance)
- **Medium**: 0.5 (explained about 6% of variance)
- **Low**: 0.2 (explained about 1% of variance)
Efficacy Studies

Effect Size: 0.34

• Reviewed 35 studies, with Effect Size: 0.34


Efficacy Studies

• Reviewed 23 studies
• Effect size = 0.13
• Treatment induced deterioration (TIDE)

Differentiated care for different targets

Primary Preventive Interventions
- Design to prevent the development in the general population of bereaved persons
- Receive hardly any empirical support for their effectiveness

Secondary Preventive Interventions
- Focused on high risk bereaved persons
- More evidence of efficacy, but modest when compared with traditional psychotherapy outcome studies

Tertiary Preventive Interventions
- For bereaved persons with complicated mourning responses
- Generally successful when compared with control groups

(Schut, Stroebe, van der Bout, & Terheggen, 2001)

Dale G. Larson
Saints Cler University
William T. Hoyt
University of Wisconsin--Madison

A pessimistic view of grief counseling has emerged over the last 7 years, epitomized by R. A. Neimeyer’s (2000) claim that “therapeutic interventions are typically ineffective, and perhaps even deleterious, at least for persons experiencing a normal bereavement” (p. 541). A negative characteristic of grief counseling, however, is the lack of empirical evidence. The lack of an unassailable analysis of the literature is a problem that the authors have highlighted in Neimeyer’s (2000) claim. Furthermore, the analysis conducted by Neimeyer (2000) failure to find support for the author’s conclusion of the existing literature on grief counseling has been criticized as being overly comprehensive. The authors believe that the lack of empirical evidence for grief counseling is due to the lack of research methodology and the meta-analysis.

Keywords: grief therapy, grief counseling, treatment effectiveness, scientific-practitioner model, bereavement.


- **Limited Effect**
- **Research methodological problem**
Efficacy Studies

- Effect Size for bereavement Intervention is still small
- $= 0.14$

### Efficacy Studies

**Differentiate Intervention**

<table>
<thead>
<tr>
<th>Primary</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 studies before 2001</td>
<td>Not effective in most</td>
<td>Absence of effects possibly because nearly all studies used outreaching recruitment procedures (help offered rather than asked for)</td>
</tr>
<tr>
<td>4 studies after 2001</td>
<td>More positive results than previous studies [78,79,173,174] Suggestions of better results seen in females (adults and young girls) than in young males; [78,79,134] Better results in people with mental-health problems at baseline, for both adults [79,134] and children [79,134]</td>
<td>Positive results possibly because three of four studies were inreaching studies (bereaved requested help). Efficacy for those with higher levels of mental-health problems before intervention suggests rationale for secondary intervention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 studies before 2001</td>
<td>Generally, though not unequivocally, more effective than primary intervention, though effects were modest and improvements were temporary</td>
<td>Effectiveness associated with strict use of risk criteria, showing need to differentiate more within groups and tailor intervention to the subgroup (eg, by gender)</td>
</tr>
<tr>
<td>3 studies after 2001</td>
<td>Improvements in children bereaved by suicide in group intervention (compared with community care) [177] Families at high-risk showed slightly more improvement after family-focused grief therapy [79,179] in terms of general distress (not family functioning). Those with worst symptoms had most improvement. No effects of a highly-specific (body touching) therapy [79] on bereaved mothers. Emotion-focused interventions most effective for distressed widowers; problem-focused for distressed widows [181] Fathers in general, and mothers with low baseline values of distress and grief did not benefit from group intervention focused on problems and emotions; highly distressed or grieving mothers improved most through intervention [181]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tertiary</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 studies before 2001</td>
<td>Modest but lasting positive effects on symptoms of pathology and grief (individual and group interventions; from analytically oriented dynamic psychotherapy to cognitive and behaviour therapy)</td>
<td>Therapy for complicated grief or bereavement-related depression and stress disorders has led to substantial and lasting results. 3 additional studies were difficult to interpret (no non-intervention control group) but were interesting for future research [5,11,150,185]. For example, gender differences in effects of time-limited supportive and interpretative group therapy in bereaved people with major depression: women improved more than men in depression, anxiety, avoidance and general distress; men reported less grief than women after interpretive group therapy [185]. A specific individual treatment module for complicated grief was more effective than standard interpersonal psychotherapy [185]</td>
</tr>
<tr>
<td>2 studies after 2001</td>
<td>Substantiate earlier findings: strong effects in terms of intrusion, avoidance, grief, depression &amp; anxiety [181,184]. Assessed nortriptyline and interpersonal psychotherapy (alone and in combination) for people with bereavement-related major depressive episodes examined [184]. Nortriptyline led to less remission than placebo and psychotherapy. Indication that combination of medication and psychotherapy gave best results</td>
<td></td>
</tr>
</tbody>
</table>

Efficacy Studies

• Effect Size for bereavement Intervention is still small
  • = 0.14 - 0.38

Efficacy Studies

Grief Therapy
Evidence of Efficacy and Emerging Directions

Robert A. Neimeyer¹ and Joseph M. Currier²

¹Department of Psychology, University of Memphis, and ²Memphis VA Medical Center

Effect Size for bereavement Intervention is still small
= 0.14 - 0.38

**Fig. 1.** Overall effectiveness of grief therapies compared to general psychotherapy. Bars represent effect sizes for different classes of interventions relative to untreated controls, with taller bars indicating more effective treatments. Compared to general psychotherapy for other problems (see Wampold, 2001), the effects of grief therapy are unimpressive; the apparently more substantial effects for nonrandom studies of grief therapy likely reflect confounding factors, such as the assignment of more motivated clients to the active treatment condition.


Fig. 2. Effect sizes of grief therapies for targeted populations. At both posttreatment and follow-up, bereavement interventions for “indicated” groups of mourners suffering from clinically elevated symptoms outperform interventions for “selective” groups of “at risk” mourners (e.g., bereaved parents) and “universal” interventions for all bereaved people, regardless of risk or demonstrated distress. Effects for general psychotherapy for other problems (see Wampold, 2001) are included for comparison.
Take Home Message # 4

• Differentiate Intervention
What is the hope in Bereavement Counseling?

Grief Therapy for Bereaved Adults after Catastrophe (Ho, Chow, Leung, & Hui, 2010)
**Overall Framework: Integrated Model**

**Assessment:** Structured Interview and Measuring tool

- **Ritualistic-Behavioral Approach**
  - To smoothen ventilation of emotions and thoughts
  - To address issues arisen in the 6 domains
  - To reconstruct the problem-saturated story into healthier story

- **Cognitive Approach**
  - To address issues arisen in the 6 domains with the use of cognitive techniques
  - To reconstruct the problem-saturated story into healthier story

**Supportive Story Telling Approach**

- Bereavement Support

**Traumatic Grief**

- Finding Meaning
- Tempering Mastery
- Reconstructing Identity
- Normalizing Ambivalence
- Revising Attachment
- Discovering Hope

- CG
- Not CG
What is the hope of Bereavement Counseling?

- To adapt the DPM Model in working with widowed older adults in Hong Kong
- To evaluate the effectiveness of the Chinese DPM Model
## Intervention (DPM intervention)
*(Lund, Caerta, Utz, de Vries, 2008, 2010)*

<table>
<thead>
<tr>
<th>Loss Orientated Intervention</th>
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<td><strong>S3. L3: Emotional reactions</strong></td>
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<tr>
<td><strong>S4. L4: Emotional reactions (Secondary)</strong></td>
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<tr>
<td><strong>S6. L5: Loneliness</strong></td>
<td><strong>S5. R1: Goal Settings &amp; addressing one’s need</strong></td>
</tr>
</tbody>
</table>
Intervention (DPM intervention)  
(Lund, Caerta, Utz, de Vries, 2008)

Loss Orientated Intervention

S8: L6: Unfinished businesses

S10: L7: Challenges in grieving

S14: L8: conclusion

Restoration Orientated Intervention

S7: R2: Attending to life changes

S9: R3: Finances and Legal Issues

S11: R4: Household

S12: R5: Nutrition

S13: R6: Social Participation

S14: R7: Conclusion
**Intervention (Chinese DPM intervention)**  
*(Chow, 2010)*

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</tr>
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<td><em>S2. L2: Physical, behavioral and emotional reactions</em></td>
<td><strong>S4. ½ R2: New Relationship with others</strong></td>
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<td><strong>S8. 7/8 R6: A time to dance</strong></td>
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<tr>
<td><strong>S8. 1/8 L7: A time to mourn</strong></td>
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</table>
Facilitate the movement between...

The Past
Review, And working Through the Unfinished Businesses...

The Present
Adjust to Life without the deceased & Meaning Making...

The Future
Goal setting, Pathways to Goals, Motivation towards Goals...
The Manchester Wheel

Figure 2
The Manchester Color Wheel
Thank you.
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References

