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Development and Initial Test of the Self-report Grief and Bereavement Assessment

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Abstract

Implementing evidence-based and cost-effective bereavement care is a challenge. A self-report measure could assist to identify caregivers at-risk of prolonged grief. We developed a new measure via five steps: identification of risk and protective factors for prolonged grief, item generation, consultation with an expert panel (*n* = 8), review by the academic team and expert panel, and a pilot test with family caregivers (*n* = 19) from three palliative care services. The Grief and Bereavement Assessment is a brief self-report measure that is theoretically and empirically grounded, acceptable to caregivers, feasible for use in palliative care, and requires psychometric validation.

Key words: grief, bereavement, palliative care, assessment, caregivers

Introduction

Caring for a dying family member or friend is demanding and stressful (Breen et al., 2018). Approximately 40% of caregivers experience increased rates of distress, including anxiety, depression, and feelings of helplessness and hopelessness (Ullrich et al., 2017). Unremitting and intense distress characterized by yearning for and preoccupation with the deceased, functional impairment, and a range of symptoms, is accepted diagnostically as prolonged grief disorder (Prigerson et al., 2021). Given approximately 6-8% of caregivers meet criteria for prolonged grief disorder following the death (Aoun et al., 2015; Nielsen et al., 2017), such caregivers also have a heightened risk of a range of morbidities including cancer, heart disease, and suicide (Shear et al., 2016). People who meet criteria for prolonged grief disorder do not readily seek services (Lichtenthal et al., 2011) so it is essential to identify this vulnerable group.

Support for grief and bereavement is central to palliative care policy (National Hospice and Palliative Care Organization, 2008; National Institute for Health and Clinical Excellence, 2004; World Health Organisation, 2007). In Australia, standards for grief support in palliative care emphasize ongoing assessment, from intake into palliative care to after the patient’s death (Palliative Care Australia, 2018). However, implementing grief and bereavement care remains a challenge, resulting in a misalignment between policy and practice (Breen et al., 2014). Palliative care clinicians raise questions as to how to achieve the standards. They describe funding and resourcing constraints that limit their ability to provide grief support; practical and ethical difficulties of assessing caregivers because they are not patients/clients of service; and concerns that caregivers will feel burdened by assessment (Sealey, O’Connor et al., 2015).

Standards for palliative care articulate that “there should be multiple opportunities for bereaved persons to self-identify their requirement for bereavement support” (Palliative Care Australia, 2018, p. 18). Providing an opportunity for self-report assessment is congruent with a person-centered, consumer approach to care, which is regarded as a marker of quality health care (Australian Commission on Safety and Quality in Health Care, 2017). Further, self-report data may be more reliable than that gathered via staff observation alone (Osberg, 1989).

An important consideration in developing a self-report measure is that the measure needs to be brief to be acceptable to caregivers as they care for the patient in the approach to end-of-life and to be feasible in a busy clinical setting. There are several measures of grief, many of which are not feasible for use in palliative care due to their length and complexity (Sealey, Breen et al., 2015), and only one designed with the aim of establishing risk of prolonged grief. The Bereavement Risk Inventory and Screening Questionnaire (BRISQ) is a recently developed self-reported measure for use before and after bereavement. The BRISQ appraises three areas of risk for the caregiver: health background, such as previous mental health; issues relating to the death, such as medical procedures; and bereavement related characteristics, such as the relationship with the dying patient/deceased (Roberts et al., 2020). Its length is a possible barrier in busy clinical practice as the pre-death BRISQ-P has 34 items and post-death BRISQ-B has 38 items (Roberts et al., 2017). Recent feedback from family caregivers ($N = 36$) indicated receptiveness to completing the measures (Roberts et al., 2020). We aimed to develop a brief, self-report measure that could be used to screen caregivers prior to the patient's death when they are in contact with the palliative care service, rather than after the death when there is limited contact with the service.

Methods and Results

The development of the new measure was undertaken over a three-year period in Western Australia via five steps, based on an analysis of risk and protective factors for prolonged grief (step 1), item generation (step 2), expert panel consultation (step 3); review by the academic team and expert panel (step 4), and a pilot test with family caregivers and service providers (step 5). Ethical approvals were granted from Royal Perth Hospital, South Metropolitan Health Service, and Curtin University. All participants provided written informed consent.

As part of larger action research study, whereby an earlier cycle indicated healthcare providers were hesitant to use a self-report measure of grief (Sealey, O'Connor et al., 2015), we aimed to assess the acceptability and feasibility of a self-report grief measure that may be used as a screening tool in palliative care. Furthermore, the many barriers to providing bereavement support in palliative care (Sealey, O'Connor et al., 2015), obscured a clear way forward to address bereavement care in this setting. With these constraints in mind, we developed the measure as part of an action cycle and in collaboration with stakeholders. We thus used a stepwise, iterative process similar to that used in the development of other measures identified in an earlier scoping review of grief measures (Sealey, Breen et al., 2015).

Step 1: Identification of Risk and Protective Factors

We developed a list of risk and protective factors associated with prolonged grief based on a systematic review of empirical studies (Lobb et al., 2010). This is the most comprehensive review of risk and protective factors that also included an analysis of evidence quality, and its findings are consistent with very recent reviews (Mason et al., 2020). A risk factor relating to grief and bereavement is a behavioral, lifestyle, or environmental attribute to which one may be exposed, that is associated with a certain condition or outcome that may be preventable (Stroebe & Schut, 2001). Considering other risk factor literature (Burke & Neimeyer, 2013; Stroebe et al., 2006), six broad domains were salient: 1) relational/interpersonal; 2) cognitive processing; 3) dispositional/personality/coping and resilience; 4) spiritual/religious and meaning making; 5) previous or comorbid mental health issues; and 6) situational factors (encompassing environmental, instrumental, and social domains; see Table 1).

Step 2: Construction of a Pool of Items

Existing grief measures, relevant to palliative care (Sealey, Breen et al., 2015), were scrutinized by the academic team, comprising experienced bereavement and palliative care researchers from psychology and public health disciplines, for questions/items aligned with the risk/protective domains outlined in Step 1. Item wording was modified for applicability prior to the patient's death and terminology amended to suit Australian vernacular. There was a total of 55 items for the six domains (see Table 1).

Step 3: Consultation with an Expert Panel

For the measure to have clinical utility and acceptability to caregivers, an expert panel (clinicians and bereaved former caregivers) was formed to guide item selection. The bereavement clinicians were recruited via letters to palliative care services and their bereavement referral organizations, seeking expressions of interest to participate as members of the expert panel. As hospice volunteers largely comprise people who have been bereaved through life-limiting illness, the bereaved former caregivers were recruited via notices placed in the volunteer common rooms in an in-patient palliative care facility. The eight panelists were women (age range: 49-64 years). Three clinicians were counseling psychologists, two were counselors, one was a licensed clinical social worker, and all had substantial palliative care experience. Years of experience in grief counseling ranged between four and 15 years (*Mdn* = 6 years). The two bereaved former caregivers had cared for their husbands who had died three and four years previously; one from motor neuron disease and one from melanoma. One had also cared for her sister-in-law and brother prior to their deaths; this was before the death of her husband and so could draw from multiple experiences of caregiving at end-of-life. Both women had extensive contact with the healthcare system and palliative care services as caregivers.

Each panelist was interviewed individually (*M* = 48.02 minutes, *SD* = 11.26) using a low-structure interview technique so that the content of each interview was directed by the panelist (Hesse-Biber & Leavy, 2011). Each panelist was asked to read and comment upon each item. These interviews were conducted over a three-month period so that feedback and suggested changes from each round of interviews could be incorporated into the next round of discussion until all panelists were satisfied with the measure. Each interview was digitally recorded and transcribed verbatim prior to the next interview so that any comments regarding an item could be specifically probed during the subsequent round. In each iteration, if a panelist believed an item was unsuitable, it was substituted with another item from the pool of items until the final draft was deemed satisfactory for piloting. Thus, all panelists had the opportunity to comment on each potential change and no changes were made until the proposed changes were presented to each panelist for feedback.

For example, there was considerable discussion concerning items that aimed to assess the degree to which a caregiver might be practically and/or emotionally dependent on the patient. Both caregivers described that their ill husbands had been more dependent on them than they had been on their husbands. They talked through several possible scenarios to describe how situations may differ. One caregiver said that she was not at all dependent, either emotionally or physically, on her daughter, but would “be absolutely devastated if anything happened to her” and, as such, commented that the draft items about dependence did not capture information about the depth of a relationship. The psychologists shared similar concerns about these items. The interviews resulted in removal of items pertaining to feeling at peace, a negative outlook on life, an inability to adjust or cope with the situation, and acceptance of the patient’s impending death. The clinicians reported that these items would not deliver clinically useful information for risk screening.

Throughout the interviews, a variety of item responses was discussed. Emotionally loaded items were described as best positioned in the middle rather than at the beginning or end of the measure. There was agreement that five responses were ideal in allowing breadth and interestingly the BRISQ also has a 5-item scale (Roberts et al., 2020). Initially, a neutral option was suggested but in subsequent iterations the responses related to frequency—never, rarely, sometimes, often, and always. An open-ended question was also added to capture relevant details in the caregivers’ personal context: “Can you think of anything that may affect your ability to care for yourself, and/or any other people you have responsibility for over the coming weeks?” The iterations ensured that items were brief, relevant, unambiguous, specific, and objective (Peterson, 2000) and acceptable to caregivers. Step 3 resulted in four drafts of the measure being scrutinized by the panelists until consensus was reached.

Step 4: Review of Measure by Academic Team and Expert Panel

The measure was reviewed by the academic team of bereavement and palliative care researchers to ensure theoretical relevance, clarity, and parsimony of wording of the items. Item wording was further simplified to focus on the underlying construct. An additional open-ended question was added to the second page asking if there had been “anything identified in the questionnaire that needs to be addressed now?” As the Step 3 panelists had indicated rumination to be common, two items referring to rumination were added: “I can’t stop thinking about ….’s impending death” and “I can’t help thinking about how unfair ….’s terminal illness is.”

The academic team also reviewed the layout of the measure. The items were designed to fit on one A4 page, with a second page for the open-ended responses. The panelists’ earlier recommendation that the frequency of thoughts or feelings provided useful clinical information was supported by the academic team, who decided on a 1 to 5 score for each item. Finally, instructions on how to complete the measure were written. This version of the measure has 20 items and was named the Grief and Bereavement Assessment (GABA; see Appendix). This version was viewed once again by the panelists and all described it as understandable and easy to complete.

Step 5: Pilot of Measure with Family Caregivers and Service Providers

A previous study showed that, although health professionals believed that caregivers would be unlikely to complete a self-report measure in the pre-death period, bereaved former caregivers believed caregivers want to have their needs addressed (Sealey, O’Connor et al., 2015). Thus, we pilot-tested the GABA in three service models of palliative care—a community based in-home service, an in-patient unit, and a consultative service in an acute teaching hospital, reflecting the three models of palliative care services in Western Australia—and sought feedback on the acceptability of the GABA from family caregivers and service providers.

Family caregivers. After providing informed consent, caregivers were invited to complete the GABA and a feedback questionnaire. The questionnaire was used to gather information about how long it took to complete the GABA, ease of completion (very easy, easy, neither easy nor difficult, difficult, and very difficult) and whether the meaning of items was clear (yes/no) appropriate to ask (yes/no). Space was provided for caregivers to indicate reasons for their responses and any other questions they thought should have been included. Caregiver demographics were also collected (gender, age, relationship to the patient, patient's diagnosis, length of diagnosis, palliative care service contact and length of stay this admission, whether the caregiver had responsibility for the care of others, main language spoken at home, cultural background; and educational level). A total of 19 caregivers participated in the pilot across three palliative care services (14 women, 5 men, age range: 30-86 years). Table 2 shows demographic information.

The length of time taken to complete the GABA ranged between 5 and 30 minutes ($M = 10.00$, $SD = 6.24$) and the majority found it easy to complete (see Table 3). Two caregivers reported that the GABA was difficult to complete. Both were men caring for an adult child; one aged in his late 80s indicated English was the main language spoken at home but that he had no formal education; the other stipulated that English was not the main language spoken at home.

All caregivers agreed the GABA items were clear and all but one caregiver indicated that the items were appropriate. One caregiver stated, "you know they [clinicians] are telling you what's happening, but it's not until you fill that in [the GABA] that the penny really drops down." Another caregiver offered that she did not like the use of "terminal illness" (item 13) believing that “general aged decline” was a more accurate representation. As the care recipient had been in hospital only two days, this caregiver may not have had time to comprehend the transition from restorative care to palliative care. When asked if the items on the GABA met their needs, all agreed it did. Responses to the items from four caregivers had indicated some distress, which enabled timely conversations with staff and support offered where needed.

Service providers. The in-home palliative service ceased operating shortly after the pilot commenced so only staff from the two remaining services provided feedback. Palliative care clinicians from the in-patient unit were invited to participate in a single focus group. Four participated (three women, one man). They represented professions and role designations typical of a palliative care multidisciplinary team: one was a clinical nurse manager; one was a clinical nurse; one was a palliative care physician; and one was a chaplain. Their years of palliative care experience ranged from 11 years to 25 years (*Mdn* = 16) and ranged in age from 38 and 54 years (*Mdn* = 43).

They described that they and other staff would be unwilling to use the GABA because doing so would “open a can of worms… and [staff] are not equipped to deal with what comes out” (clinical nurse) and that the questions should be asked “unless you’ve actually got a procedure in place” (nurse manager) to manage responses. They were also concerned that the GABA would add to workloads: “you are going to need an hour and a half or two hours to sort that out” (nurse manager). They described being reticent to move away from their present assessment practice that did not involve a caregiver self-report: “What we use as gold standard at the moment is really knowing the patients’ families and knowing and talking to them, and us being involved with them as a team…and us collaborating together” (physician).

The clinical nurse manager of the consultative service engaged in a one-on-one interview. She had worked in that role for five years and had 12 years of palliative care experience. She described that, in the consultative setting, many patients and caregivers were suddenly transitioned from acute curative care to supportive care at end-of-life and that most were not thinking ahead to the patient's death and bereavement; rather, they were struggling with the acuity of the patient's care in an acute setting. She reported that she and her staff used the GABA to facilitate dialogue with caregivers: "It also gives us a conversation point; that ability for us to get to know the family that bit more." In cases where introducing palliative care is problematic, she shared that the GABA may help caregivers more readily understand the benefits of palliative care involvement. She described that staff found the GABA to be useful in identifying caregivers at risk, particularly in the instances where staff found it difficult to decide how to follow-up caregivers*:*

> "It may dictate to us people that require a 'phone call rather than just a card. It may highlight those borderline people…and maybe that's more the group we are looking at. Do we actually miss those that are a bit tenuous when it comes to bereavement, you know?"

She described the GABA as enhancing the service's ability to provide a timely, holistic service because it assisted with identifying and addressing psychosocial and spiritual issues and aligned with advance care planning and care pathways.

Discussion

Implementing evidence-based and cost-effective bereavement care can be challenging. Self-report screening measures are needed to facilitate the offer of grief support to those who are most likely to benefit. Strengths of the GABA are threefold. First, it was developed via a systematic process drawing upon literature on risk and protective factors, expert panel review, and a pilot test across three palliative care settings. Second, with 20 items, the GABA is substantially shorter that the other self-report measure, the BRISQ (Roberts et al., 2017, 2020). Third, feedback from bereaved former caregivers was central to the development of the measure and aligns with calls to ensure consumer involvement in the design and development of health care (Australian Commission on Safety and Quality in Health Care, 2017) and palliative care (Rumbold & Aoun, 2021).

Given the high burden of care for family caregivers, having an opportunity to express caregiver concerns and needs is thought to facilitate timely support and improved health outcomes (Stroebe & Boerner, 2015). Research has indicated that family caregivers, who are provided with the opportunity to have their needs assessed and addressed, experience benefits pre- and post-bereavement (Aoun et al., 2018). Studies in Western Australia reiterated that family caregivers may not be adequately supported by health services during caregiving and bereavement (Aoun et al, 2021; Breen et al., 2020). Therefore, the use of a measure like the GABA would be beneficial to meet their support needs. The GABA may facilitate the identification of more than just the presence/absence of risk factors; instead, it may promote a more thorough and holistic approach to care, which is regarded as being a key indicator of quality end-of-life care (Brown & Vaughan, 2013). Written documentation has the potential to clarify issues, leads to greater understanding, and lessen anxiety for staff, patients, and family members. Documentation empowers people by fostering patient/family autonomy and ensuring person-centered healthcare (Australian Commission on Safety and Quality in Health Care, 2017). Additionally, the use of documentation in communicating goals of care and determining care pathways improve care and coordination of services and result in improved outcomes for clients by allowing clinicians to direct their attention to other essential clinical activities (Secunda et al., 2020).

The measure is not diagnostic; the intention was to develop a self-report measure that could be administered and scored by any palliative care team member. The aim would be that palliative care staff have sufficient information to *refer* the caregiver to a health professional who could assess and make intervention plans if needed. The identification of caregivers in need requires skilled monitoring or treatment, if necessary, by an appropriately trained health professional in a timely manner (Shear et al., 2016). In the pilot, most caregivers reported that the measure was reasonably easy to understand, most completed it within 10 minutes, and most believed it encompassed the issues they faced with a family member at end-of-life. However, feedback from the clinicians was more variable, highlighting the importance of having someone on site to champion the testing of the measure, as well as a reticence to ask caregivers about their needs because doing so requires having to address them. The negative feedback concerned structural, systemic issues, and highlights the importance of organizational change to support the implementation of screening as well as the resources to support referral. Such challenges must be acknowledged and addressed to improve care (Dixon-Woods et al., 2012). The importance of effective communication skills and eliciting and responding to emotional cues has been emphasized in research in cancer where the discussion of options, values, and needs are crucial to the provision of client- and caregiver-centered care (Clayton et al., 2012). Feedback from one of the services indicated the GABA was useful to prompt and guide end-of-life conversations, suggesting the GABA could be implemented in future. This would require validation of the measure and require that staff were trained in using the measure alongside appropriate referral pathways to support services.

Despite attempts to recruit widely, the small size and relative homogeneity of the caregiver sample are limitations, as they were in the development of the BRISQ (Roberts et al., 2020). All expert panelists were women, but this reflects the wider context where most grief experts in Australia are women (Hay et al., 2021). Obstacles to recruitment of participants at the in-home and inpatient services meant that a comparison between the service types could not be made. The measure is not likely to be suitable for those who do not have a good command of English or with no formal education, a common limitation shared with all such measures and one that needs work to find a solution. Finally, the pilot proceeded very differently at each of the services; the services each reflected a different model of palliative care delivery. This highlights the different issues between service types that need to be considered in future testing and implementation of the GABA. Further research is needed to determine the optimal time for the palliative care services to use the GABA, considering the practical and ethical complexities associated with this potentially traumatic period (Breen et al., 2018). Delayed referral to palliative care is common (Aoun et al., 2017) and likely impedes the introduction of such screening when insufficient rapport and trust has been established between the family and the palliative care team; communication skills might mitigate this issue (Clayton et al., 2012). Finally, although the GABA appears acceptable to caregivers and feasible for use in busy clinical settings, its psychometric properties are not yet determined. Examination of the GABA's psychometric properties through item response theory principles will identify item redundancy, whether to use a 5-, 4- or 3-point response set, and whether items with a reversed valency are understood satisfactorily. It is possible that the expert review process prematurely excluded items that are important to include in screening. The measure is not recommended for use until its formal validation is completed, and this process might benefit from including some of the excluded items.

The practice of bereavement support in palliative care practice has a tenuous relationship with guidelines and screening/assessment measures and is therefore seldom as intentional or targeted as it should be (Aoun et al., 2017). The pre-death period is the ideal window of opportunity to screen family caregivers and develop referral pathways to enable caregivers to receive support that meets their self-reported needs (Stroebe & Boerner, 2015). Our study shows that self-reported assessment using the GABA is acceptable to caregivers in palliative care and that concerns that caregivers would be burdened by it appear to be unfounded. Without embedded systematic screening of family caregivers’ bereavement care needs, such as that offered by the brief GABA measure, palliative care services will continue to struggle to make evidence-informed decisions about the provision of grief and bereavement care.

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Table 1. Risk and Protective Domains for Prolonged Grief and the Number and Content of Items for Each

Domains and Factors	**Items**	**Content of Items**
Relational/interpersonal – attachment style, separation distress/anxiety; previous adversities, prior losses/deaths; dependency on the patient; perceived emotional and instrumental support from family and friends	13	Dependency on the patient; extent of support/dependency; family communication styles; perceived support; connection with others.
Cognitive processing – depressive/negative rumination/repetitive thinking; anxious worry/negative thinking, view of self, of life, of future; avoidance and/or intrusive thoughts	14	Patterns of worry/rumination; feelings of confusion and uncertainty; effect thinking has on activities; negative outlook; self-blame; thoughts of avoidance and intrusion.
Dispositional/personality/coping and resilience – trait dependency; neuroticism; trait anxiety; pessimistic worldview versus optimism	7	Beliefs about coping; discovering personal resources; history of overcoming problems; belief about the future.
Spiritual/religious and meaning making – faith community as a supportive network; challenge to self-narrative; loss of meaning	5	Degree to which beliefs and values are supportive; faith in a higher power; feelings of meaninglessness and emptiness; feeling at peace.

Previous or comorbid mental health issues – pre-existing or co-morbid mental health issues; substance use; sleep disturbance/insomnia	7	Suicidal ideation; physiological symptoms of anxiety and panic; feelings of anxiety and fear; use of alcohol/substance use to cope; sleep patterns.
Situational factors – caregiver burden; patient care and circumstance during the episode of care and end-of-life; concurrent stressful events; financial resources; preparedness for the death; practical support.	9	Consequences of caregiving/caregiver burden; physical health status; physical wellbeing; financial problems; preparedness for the death/acceptance of the situation; perceived support from friends/family.

Table 2. Family Caregiver Demographic Information (*N* = 19)

Characteristics	**n (%)**
Gender of caregivers	
Women	14 (73.68)
Men	5 (26.32)
Caregiver relationship to patient	
Adult child	10 (52.63)
Spouse	4 (21.05)
Parent	3 (15.79)
Sibling	1 (5.26)
Grandchild	1 (5.26)
Patient's diagnoses	
Cancers	7 (36.84)
Intracranial bleeds	3 (15.79)
Lung diseases (not cancer)	2 (10.52)
Organ failure	2 (10.52)
Neurodegenerative conditions	2 (10.52)
Aged decline	1 (5.26)
Unsure of diagnosis	2 (10.52)
Length of patients' diagnoses	
>10 years	1 (5.26)
Between 3 and 10 years	3 (15.79)
Between 1 and 2 years	4 (21.05)
Between 2 and 6 months	4 (21.05)
Between 4 and 6 weeks	1 (5.26)

< 1 week	4 (21.05)
Unsure of length of patients' diagnoses	2 (10.52)
Patient length of time under care of palliative care service	
Between 1 and 3 years	3 (15.79)
Between 2 and 10 months	4 (21.05)
Between 6 and 8 weeks	1 (5.26)
< 1 week	9 (47.37)
Unsure of length of time under care of palliative care service	2 (10.52)
Patient length of stay this admission	
Between 2 and 6 weeks	3 (15.79)
< 1 week	12 (63.16)
Unsure of length of stay this admission	4 (21.05)

Table 3. Time Taken and Reported Ease of Completion of Measure *(N = 19)*

Variable	**n (%)**
Time taken to complete measure	
5 minutes	7 (36.84)
7 minutes	1 (5.26)
8 minutes	1 (5.26)
10 minutes	5 (26.32)
15 minutes	4 (21.05)
30 minutes	1 (5.26)
Ease of completing measure	
Very easy	5 (26.32)
Easy	7 (36.84)
Neither easy nor difficult	5 (26.32)
Difficult	2 (10.52)
Very difficult	0

Appendix

Grief and Bereavement Assessment

For each item, please circle the number that best describes you, or how you are thinking or feeling at present. Wherever a line like this …………… appears, please answer the statement as if the name of the person you are caring for is written on the line.

Item		Never	Rarely	Sometimes	Often	Always
1	I think that arriving at this stage of the illness has happened so suddenly, that I'm not ready.	1	2	3	4	5
2	I'm confused and unsure about what's happening.	1	2	3	4	5
3	I avoid thinking about what is happening.	1	2	3	4	5
4	My spiritual beliefs are a source of support for me.	1	2	3	4	5
5	I am reliant on ………………. for assistance and support every day.	1	2	3	4	5
6	I turn to ………………. in times of need.	1	2	3	4	5
7	I am fearful of how life without ………… will be.	1	2	3	4	5
8	I believe what's happening now is the worst experience I've ever had.	1	2	3	4	5
9	I can't stop thinking about ……………'s impending death.	1	2	3	4	5
10	Since…………..'s diagnosis, I appreciate what's important.	1	2	3	4	5
11	I worry about what's happening.	1	2	3	4	5
12	I feel guilty about past choices we made in relation to this illness.	1	2	3	4	5
13	I can't help thinking about how unfair……………'s terminal illness is.	1	2	3	4	5
14	I feel anxious and panicky.	1	2	3	4	5
15	Life seems meaningless and hopeless.	1	2	3	4	5
16	I have thoughts of ending my own life.	1	2	3	4	5
17	I believe I am managing better than I thought I could on the whole.	1	2	3	4	5
18	My health is suffering as a result of being a carer.	1	2	3	4	5
19	I manage to overcome difficult events in my life.	1	2	3	4	5
20	I have good support from family & friends.	1	2	3	4	5

Can you think of anything that may affect your ability to care for yourself, and/or any other people you have responsibility for over the coming weeks? If so, please describe:
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Was there anything identified in the questionnaire that needs to be addressed now? If yes, please say what that is:
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Note: The GABA **has not been psychometrically evaluated** to detect risk of poor bereavement outcome in family caregivers caring for a patient in palliative care.