Bereavement among elderly people: grief reactions, post-bereavement hallucinations and quality of life

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Ratings of grief reactions, post-bereavement hallucinations and illusions and quality of life were made during the first year after the death of a spouse among 14 men and 36 women in their early seventies. In both sexes, the reactions were generally moderate or mild and characterized by loneliness, low mood, fatigue, anxiety and cognitive dysfunctioning. Feeling lonely was the most persistent problem during the year. Post-bereavement hallucinations or illusions were very frequent and considered helpful. Half of the subjects felt the presence of the deceased (illusions); about one third reported seeing, hearing and talking to the deceased (hallucinations). Former marital harmony was found to make a person more prone to loneliness, crying and hallucinations or illusions. The quality of life was significantly lower among the bereaved than among married people and those who never married, but equalled that found among divorcees.

Key words: bereavement; elderly; hallucination; illusion; quality of life

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Even though there has been an increase in bereavement research, it mostly concerns physical and mental illness as a consequence of bereavement (1–6). A smaller part of the literature is focusing on bereavement among elderly people, mostly on the widows (7–9) and the way grief normally proceeds. However, many of the studies agree on the fact that elderly bereaved people usually exhibit about the same psychological symptoms as younger bereaved people, but that they experience less severe stress than young and middle-aged ones (10–16). Stern (17) found that the elderly bereaved also differ from the younger in that there is a preponderance of somatic illness.

Most studies also lean towards the opinion that elderly men and women respond to loss in a similar way and with similar intensity, and that bereavement progresses in a similar way for both sexes (18, 19). According to Lund et al. (18), bereavement adjustments are characterized more by similarities than by differences for men and women.

Besides the age and sex of the bereaved, a great number of predictors and correlates to adaptation to conjugal bereavement are suggested in the literature, such as the duration and quality of the marriage, the mode of death of the mate, the anticipation of grief or sudden death, the social network and the interpersonal support system (11, 14, 20–22). According to Breckenridge et al. (16), the contribution of such background variables to symptom variations among bereaved people has not been systematically explored. A more complete understanding of the impact of background factors on bereavement would enable persons responsible for caring for the bereaved to focus on the help resources that are most needed.

Special attention was paid to post-bereavement hallucinations and illusions, which are hardly recognized in Sweden. They are spoken about neither publicly nor among relatives or close friends in situations of mourning. One possible reason is the fear of being looked upon as mentally abnormal or insane. Another reason could be the negative connotations of the word hallucination, reminiscent of insanity.

The purpose of the present study was to look at mourning among elderly men and women as it normally proceeds, and without psychiatric consultation, but by merely using own coping mechanisms in the normal range of reactions. An opportunity to observe bereavement reactions was given in the longitudinal, multidisciplinary Intervention Study of Elderly in Göteborg (IVEG) (23).

Material and methods

The subjects were systematically selected (every second bereaved person born in 1912) periodically during 1985 and 1986 using the County Administration Register of recently (< 2 weeks) bereaved people in Göteborg. Within the third week following bereavement, 79 widowed people (22 men, 57 women), living independently, were sent a letter inviting them to have a physical examination performed by a physician and a visit to a psychologist. A few days later they were contacted by the psychologist by telephone, to confirm that they had consented to take part in the study.

The observations of grief reactions were made with the help of a semistructured interview of 1.5 to 2 h. Each person was encouraged to talk freely about the deceased spouse, but enough direction was given to ensure that all items listed on a standardized questionnaire were covered. For this purpose 13 grief reactions (Fig. 1) found in research on bereavement in elderly people (4, 16, 21, 24–26) were selected for use, after having been tested in a pilot study of 15 bereaved people. The reactions were rated by the psychologist with respect to frequency (presence or absence) and to intensity using a 5-point scale from 1 = mild to 5 = very severe. In the statistical analysis the grief reactions were also grouped into 3 dimensions: 1) low mood (dysphoria, loneliness, crying and pessimism), 2) cognitive dysfunctioning (fatigue, concentration problems, lack of interest, indecisiveness and memory problems) and 3) self-reliance (anxiety, self-reproach, anger and lowered self-esteem).

Hallucinations and illusions were rated with respect to presence or non-presence, to occurrence (seldom, rather often or very often) and to quality (frightening, unpleasant or pleasant). Hallucinations refer to speaking to the dead spouse, to visual, auditory and tactile experiences; illusions refer to feeling the presence of the deceased. In the correlation analysis with respect to grief reactions, background factors and quality-of-life assessment, the hallucinations and illusions were combined to achieve a sufficient number of observations. The assessments very strictly excluded doubtful answers, dreaming, falling asleep or awakening reactions. The same assessments were made at all 3 visits and were conducted by the same observer throughout the study.

Quality of life (QL) was assessed by an instrument measuring the dimensions of self-esteem, anxiety, psychosomatic health and satisfaction with life, derived and revised from Rubenowitz (27) and Berg (28), introduced at the end of the first examination. The participants were asked to complete the questionnaire at home and mail it. The QL assessment was performed only once in order to limit the number of instruments and to maintain the compliance in the study. The questionnaire contained 23 questions with answers scored from bad to very good, using 4 or 5 steps. The sum score for each dimension was obtained by dividing (100 times the sum of the score of each item) by the sum of the maximum of all items.

For comparison of QL, data were used from 190 men and 213 women, 73 years old, in the IVEG study (23). This reference population was divided into married ($n = 237$), single (never married) ($n = 35$), divorced ($n = 30$) and previously bereaved ($n = 101$).

Background factors were also registered. The length of marriage was recorded, as well as the subjective marital harmony (in a four-grade scale from absence of harmony to great harmony). Having children (never had, deceased children or children now living) and children living close to Göteborg were recorded, as well as the frequency of contacts with children (daily, a few times per week, once a week or a month, more seldom or never). Having friends (none, 1, > 1, > 3 or > 5) and interest in seeing friends (much, some, very little or not at all) were recorded. Questions were asked about education (elementary and secondary school, upper secondary school or university or vocational school), interest in attending church (much, some, very little or not at all), clubs (yes or no) and having pets (none, dog or cat). The experience of the spouse's illness preceding death was recorded as traumatic, severe, rather severe or not at all severe. Place of care (hospital, long-term geriatric hospital or at home) and expectancy of the death (expected or not expected) were recorded. The person's financial situation was recorded in subjective terms of no, mild, moderate and great worry about finances.

For statistical trend tests and for gender comparison, the Fisher's exact test and permutation trend tests were used (29). All results given refer to $P < 0.05$ unless otherwise stated.

The study was approved by the Ethics Committee of the Faculty of Medicine, University of Göteborg, Sweden.

Results

Of the 79 selected subjects, we got in contact with 62. Twelve did not participate in our study, 3 due to illness and 8 due to deinclination. One died before the start of the study. Of the 50 persons (14 men and 36 women) who participated, two thirds had a positive attitude to coming and one third were undecided but rather easy to persuade to attend. The age range was 71–74 years (mean age = 72.7 years). At the second visit, 5 people did not attend but participated at the third visit. At the third visit 47 people participated, as 3 others did not attend. Thus, data

from 42 people were available from all 3 visits and used for the trend analysis.

Grief reactions

One month after bereavement, most subjects expressed dysphoria and loneliness. Fatigue, anxiety, lack of interest and reduced cognitive functioning were also quite common. Less common was lowered self-esteem (Fig. 1). Almost all reactions tended to be more frequent among the women, but the gender differences were significant only for anxiety and concentration, meaning that more women than men were anxious (75% and 29% respectively) and had problems with concentration (75% and 43% respectively). Twenty-two percent of the women, but none of the men, expressed reduced self-esteem.

The grief reactions were generally moderate or mild, the most intensely expressed reactions being loneliness, crying and dysphoria (Table 1). There were no major gender differences in the intensity of reactions, except for anxiety, which was more intensely expressed by the women than by the men.

Three months after bereavement, all the reactions were expressed by almost the same number of subjects as at 1 month after bereavement (Fig. 1). Gender differences were found for pessimism and problems with concentration, these aspects being more common among the women (84% and 69%) than among the men (42% and 33%).

The intensity of grief reactions diminished from the first to the second observation, except for difficulties in concentrating, indecisiveness, self-reproach and lowered self-esteem (Table 1). The mostly strongly expressed reaction was still the feeling of loneliness followed by crying and dysphoria. There were no gender differences in intensity of reactions except for pessimism, which was expressed more intensely by the women than by the men.

At 12 months after bereavement, about the same number of subjects expressed loneliness, crying, anxiety, anger, self-reproach and lowered self-esteem as at the previous observation (Fig. 1). Recovery in the period between 3 and 12 months took the same course for both sexes but was more complete among the women with respect to dysphoria, pessimism, concentration, fatigue, memory, lack of interest and indecisiveness. Significant gender differences existed only for pessimism (58% of the women, 23% of the men). Reduced self-esteem was still reported only by the women.

Loneliness was still the most intensely expressed reaction, followed by dysphoria, crying, fatigue and pessimism (Table 1). There were no gender differences in the intensity of the reactions.

During the first 12 months of bereavement, the number of subjects reporting the reactions of loneliness, anxiety, self-reproach and lowered self-esteem did not decrease significantly (Fig. 1); feeling lonely was the most common and persistent reaction.

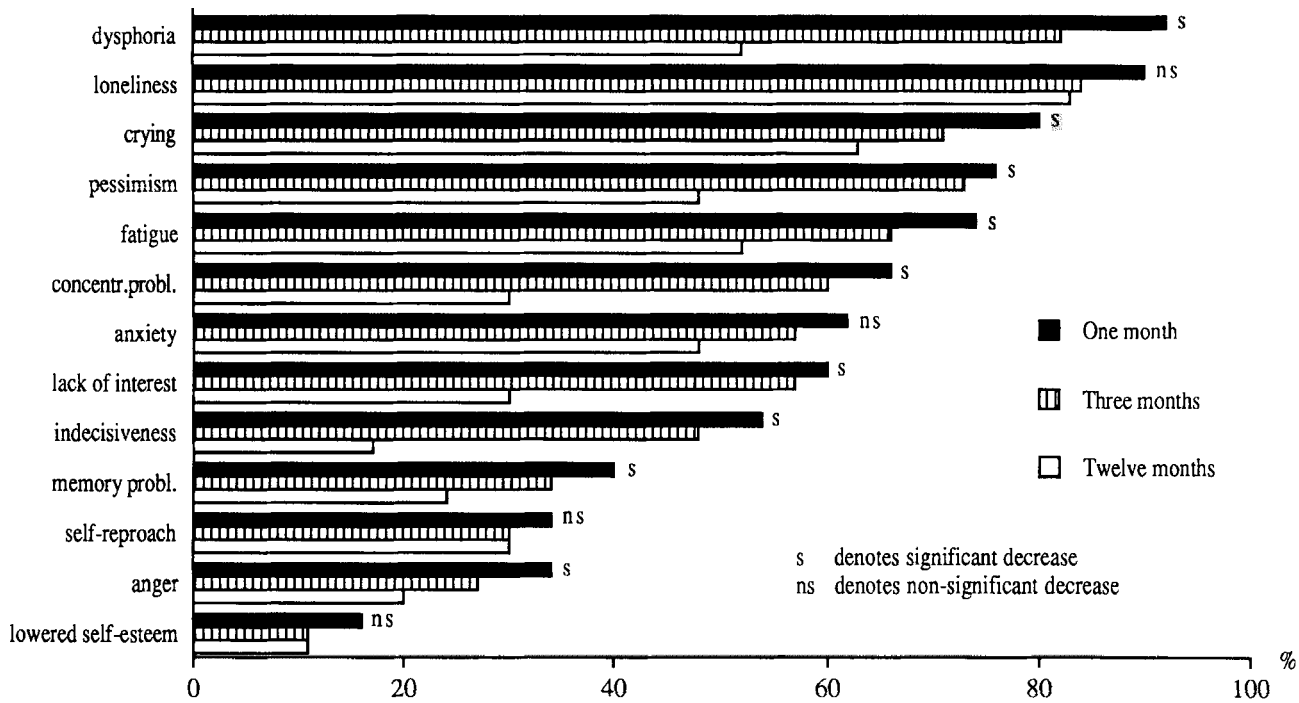

Fig. 1. Changes in percentage of the participants expressing grief reactions during the first 12 months of bereavement ($n = 42$)

Table 1. The intensity of grief reactions, as means of rating score 1 = mild to 5 = severe, during the first year of bereavement (n=42)

	1 month		3 months		12 months		Decrease over the 1-year period
	Mean	SD	Mean	SD	Mean	SD	
Loneliness	2.5	1.3	2.2	1.3	2.0	1.3	S
Crying	1.7	1.3	1.3	1.1	1.0	1.0	S
Dysphoria	1.7	1.0	1.3	1.0	0.6	0.7	S
Fatigue	1.6	1.3	1.1	1.0	0.8	1.1	S
Pessimism	1.3	1.2	1.1	1.0	0.8	1.1	S
Concentration difficulty	1.0	1.0	0.9	0.9	0.3	0.6	S
Anxiety	1.0	1.0	0.8	0.8	0.7	0.9	S
Lack of interest	1.0	1.2	0.8	0.9	0.3	0.6	S
Self-reproach	0.8	1.2	0.6	1.1	0.6	1.0	NS
Memory problems	0.7	1.1	0.5	0.7	0.4	0.9	S
Indecisiveness	0.6	0.8	0.5	0.7	0.2	0.5	S
Anger	0.6	0.9	0.4	0.7	0.3	0.7	S
Lowered self-esteem	0.2	0.6	0.2	0.5	0.1	0.3	NS

S: a significant decrease in intensity; NS: denotes a non-significant decrease in intensity.

The intensity of all reactions, except for self-reproach and lowered self-esteem, diminished over the 1-year period (Table 1). Initially high intensity (at 1 month) of the grief reactions tended to be related to high intensity at 12 months. The grouping of the 13 observed grief variables into the dimensions of low mood, cognitive functioning and self-reliance, as well as into a total sum of the grief variables, did not give more information than in using the single variables.

Comments to the grief reactions

A rather common statement in the beginning of widowhood was that life was not worth living, expressed as "I'll never get over it!" or "What's the good of being left behind?". However, the feeling of pessimism was rather mildly experienced and without suicidal thoughts. Only 2 of the childless widows and 1 widower found very little sense in life as a widowed person and said that a natural death would be welcome.

Anxiety was expressed as a feeling of restlessness and nervousness rather than as anxiety attacks or identification problems. The restlessness and the inability to sit still among some widowed people seemed to be caused by irrational and continual searching for the lost object. It resulted in problems getting started, initiating and performing everyday activities. Difficulties often arose even in choosing between simple alternatives, such as to accept an invitation from a friend or not. The lack of interest concerned self-care, news, activities or people, which used to give pleasure. Although the women usually expressed more distress, they seemed to handle the daily routines better than the men.

Cognitive dysfunctioning in terms of failing memory was only reported in a few cases as a total black-out in the days immediately after the death of spouse. During the first 3 months of bereavement, the memory resources seemed to be used for remembering the deceased; a remembrance that for some occupied the whole mind in seeking for situations of togetherness, during the day and at night in their dreams. Though painful at times, the memories were said to comfort and relieve the pain of loneliness.

Self-reproach, often regarded as a cardinal symptom of pathological grief, was expressed as a sense of guilt for hard words or omitted actions: not taking the spouse to the doctor "in time", not letting him or her have the best possible care or missing the deathbed. Such feelings of guilt seemed to be difficult to get rid of. Anger and hostile feelings could be directed to God, to friends who still were a couple, to the deceased himself or to the caregivers at the hospital, "not doing their very best to cure". However, the cognitions were rather mild and seemed not to differ much from normality.

Hallucinations and illusions

One month after bereavement, altogether 82% of the subjects (89% of the women and 57% of the men) reported hallucinations and/or illusions; 36% of those affected experienced only one type of hallucination or illusion, 30% had 2 types, 12% had 3 and 2% had 4 or 5 types. Most common was the feeling that the deceased was present (illusion) (Fig. 2). Claiming to speak to, to hear and to see the dead

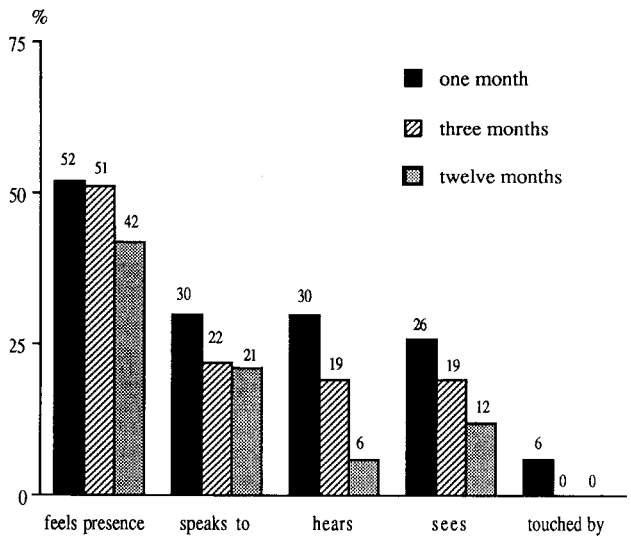

Fig. 2. Incidence of post-bereavement hallucinations (speaks to, hears, sees or is touched by the dead) and illusions (feels the presence of the dead) 1, 3 and 12 months after loss of spouse (n = 42)

spouse (hallucinations) was rather common. Very few, mostly men, had tactile hallucinations and only at the first observation. Three months after bereavement, 71% of the subjects (78% of the women and 50% of the men) had hallucinations or illusions, while at 12 months, 52% of the subjects did (54% of the women and 46% of the men). At each of the 3 observations, significantly more women than men reported hallucinations or illusions. For each experience separately, however, no gender difference could be demonstrated. During the observation period, the frequency of subjects reporting visual and auditory hallucinations diminished significantly (Fig. 2). The number of women with hallucinations diminished significantly but not the number of men. Feeling the presence of the deceased did not diminish significantly.

When analysing the relationship to grief reactions, hallucinations or illusions were more frequently found in subjects suffering from severe loneliness, crying and memory problems 1 month after bereavement.

Experiencing hallucinations and illusions was mostly reported to happen seldom or rather often. Very often was reported by 5 widows and 1 widower one month after bereavement; 4 of the reports concerned the presence of the dead, 1 concerned seeing the dead person, and 1 speaking to the dead person. Three months after bereavement, 3 of the subjects felt the presence of the deceased very often and 1 conversed with her dead husband very often. Two of the widows felt the presence of their dead husbands very often throughout the first year of bereavement.

The disclosure of hallucinations or illusions to other persons than to the interviewer was not systematically recorded, but seemed, when notes from the interview were analysed, to be rare, and when it did occur, it was only to close friends or relatives. Despite great care being taken to create confidence in the interview situation, only one subject, a female spiritist, spontaneously reported hallucinations, referring to the frequent "contacts she had with her dead husband". Only after being informed about the commonness and normality of post-bereavement hallucinations and illusions did most of the other widows and widowers speak freely, expressing relief from thoughts that they "might become or be considered insane". Two widowers dispatched the questions about hallucinations, labelling them ghostly disturbances.

Except for one widow, all the subjects experiencing the presence of the dead spouse found it pleasant. All widowers and three fourths of the widows having hallucinations found them pleasant. Of the widows finding their hallucinations unpleasant or frightening, half referred to hallucinations that were heard and the other half to those that were seen. One year after bereavement there was a positive correlation between the intensity of grief reactions and the number of pleasant hallucinations. The subjects reporting hallucinations, however, had a dualistic attitude to their experience. On the one hand, the hallucinations were considered ridiculous sensations, never experienced before; on the other hand, they were a pleasant and comforting rendezvous with the lost, beloved spouse. Once a subject had had a hallucination of a pleasant character, he or she wanted it to happen again.

Background factors

The length of marriage varied between 20 and 56 years, the average length being 42.8 years (SD 7.8 years); 76% had been married more than 40 years. Length of marriage was not associated to the incidence of grief reactions or hallucinations or illusions. Marital harmony was rather good or great for all subjects, except for two widows with absence of harmony. When men and women were grouped together, marital harmony was correlated to loneliness and crying, but such a correlation was not possible to demonstrate in men and women separately. Happy marriages were also correlated with the frequency, as well as the good quality of hallucinations 1 and 3 months after bereavement.

Fifty-seven percent of the men and 71% of the women had children, most of them living in Göteborg and environs, and had quite frequent contact. All of the men and 80% of the women had more than one friend. Interest (much or some interest) in seeing friends was reported by only 17% of the women and 7% of the men. These background factors did not correlate to grief reactions or hallucinations or illusions, except for the interest in seeing friends, which was lessened the more dysphoric the subjects (women) were. Neither did education (79% elementary and secondary school, 17% upper secondary school and 4% university or vocational school), regularly attending church (22% of women and 7% of men), membership in clubs (32% of women, 27% of men) or having pets (11% of women, 14% of men).

Seventy-two percent of the women and 93% of the men reported a rather traumatic to traumatic experience of the illness period of the deceased. Neither this nor caring at home (31% of women, 23% of men) and expectancy of death (64% of women, 86% of men) showed any impact on grief reactions or hallucinations or illusions.

About half the widows reported financial worries but only one fifth of the widowers (NS). Worrying about finances did not decrease over the 1-year period. Loneliness, dysphoria, crying, pessimism and anxiety were reactions connected with worrying about finances.

Table 2. Quality of life (QL) and civil status. Values of the reference population (Grimby & Svanborg, unpublished observations) and the recently bereaved in the present study. The scores for each dimension in the QL questionnaire go from 0 to 100, high values representing high QL.

	Control population								Study population recently bereaved $n=47$	
	Married $n=237$		Single $n=35$		Divorced $n=30$		Bereaved $n=101$			
QL dimension	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Self-esteem	72	14***	69	15	72	21	71	14**	64	14
Freedom from anxiety	75	18***	73	19**	64	25	70	17*	63	19
Psychosomatic health	79	16***	79	16***	66	20	72	15***	63	19
Life satisfaction	80	18***	80	19**	70	25	76	18**	68	21

* $P<0.05$, higher QL compared with the recently bereaved; ** $P<0.01$; *** $P<0.001$.

Aspects of quality of life

The QL of the recently bereaved was lower than that of married, single (never married) and not recently bereaved persons of the same age. Compared with divorcees, there was no statistical difference (Table 2).

For the control subjects there were gender differences concerning the quality of life, women generally having more complaints than men (Grimby & Svanborg, unpublished observations). There were no gender differences among the recently bereaved subjects.

Analysis of the relationship between the QL dimensions and the grief reactions showed that the members of the recently bereaved group reporting lowered self-esteem were more fatigued and anxious. Those who expressed more anxiety reported more crying, fatigue and pessimism. Those who had more psychosomatic symptoms also expressed more crying, anxiety, pessimism, anger and lack of interest. Subjects with less life satisfaction reported more loneliness, pessimism, concentration difficulties and lack of interest.

Hallucinations (hearing the deceased) were found to be more frequent among the recently bereaved men with low self-esteem. Visual hallucinations were more often found among the subjects reporting low life satisfaction.

Discussion

A century ago, grief was officially regarded as a cause of death (30). It is still seen to be connected to a variety of physical and mental illnesses, and most of the literature on grief focus on the pathological aspects. As the subjects of the present study were selected by means other than consulting psychiatric care, they probably represented the normal and universal experience of bereavement. There was a high degree of participation, as 84% of the initially attending subjects came to all examinations. Although a high number of the recently bereaved expressed emotional distress, the reactions were moderate or mild in intensity and usually gradually subsided during the first year of bereavement. However, loneliness was common and persisted during that period. As there were only slight features of pathological depression in a small number of the subjects, occasioning little antidepressant medication and no referral to psychiatric care (von Sydow, personal communication), the conclusion is that the bereavement reactions may generally be considered normal grief resolution behaviour.

Such reactions as dysphoria and crying, among the most prominent reactions in the present study, are common and normal in grief according to Clayton (25). She found that the 3 cardinal symptoms of normal bereavement were depressed mood, sleep disturbance and crying. The prevalence of sleep disturbances is not presented here, but was reported to be common by the participating physician; only 20% regarded their sleep as satisfactory (von Sydow, personal communication).

Loneliness among elderly people in Sweden is said to be found predominantly among the widowed and to cause an increased level of medical care and medication as well as increased mortality in both sexes (31). Loneliness was extra overt in the studied sample, probably because most of the subjects had had a lifelong relationship with the deceased. However, an increase in morbidity or mortality was not demonstrated (von Sydow, personal communication), but it cannot be excluded that the medical and psychological intervention might have had a positive effect. The feeling of loneliness was about equally represented among the sexes, in contrast to findings by Carey (32), according to whom twice as many widows as widowers found loneliness to be a great problem. This might be caused by differences in age: the median age of the widowed in Carey's study was 57 years. Loneliness, however, seemed to mean about the same to the subjects in both studies: the longing for the need to be needed by someone and

the wish to share activities and feelings. Longitudinal bereavement research (18, 32–34) generally indicates that grieving extends well beyond 1 year, and that loneliness is found to persist for a considerably longer period than the observation period of the present study.

In general, the grief reactions did not differentiate much between the sexes. A noteworthy finding, however, is that the self-esteem was affected only among the women. Ball (13) states that widows are unique in that they experience not only object loss but also role loss. Besides the psychological grief dimension, there are also cultural and social dimensions, as loss of financial security, status and social relationships. Especially the widows seem to be vulnerable to the loss of self-identity, also according to other bereavement studies (35, 36).

Among the variety of predictors in the literature describing the outcome of bereavement (11, 14, 21, 37), the present study was able to point out only a few. It was found that the happier the marriage, the more frequent the reports of loneliness and crying, and also that the stronger the initial reactions, the more long-lasting was grief.

Most of the subjects in the present study experienced the spouse's last illness period as long, fatiguing and stressful. Nevertheless, their grief reactions did not differ from the reactions of those whose spouse died after a short-term illness. This is in contrast to the findings by Gerber et al. (20) that the bereaved of a lengthy fatal illness did worse than the bereaved of a shorter chronic illness death. If the loss is anticipated, that is, expected and not sudden, this is also said to be accompanied by more severe initial depressive symptoms than if the loss is not expected (22, 23). This was not found in the present study, perhaps because most of the widowed subjects in the present study did anticipate the death of their spouse. However, the age of the bereaved is found to have a more significant impact on grief reactions than the mode of death, older persons reacting to bereavement less severely than younger ones (11, 13).

Social interaction, as measured by the subject's interest in seeing friends, was considerably decreased. The withdrawal correlated to depressive reactions among the women, as also demonstrated by Vachon (14). Other background factors concerning interpersonal relationships and environmental support, such as contacts with children, attending church and memberships in clubs could not be demonstrated to be of significant importance to the outcome of bereavement reactions. This might be due to the limited number of subjects in the present study.

Adaptation to loss has also been studied socioeconomically, suggesting, for example, that people with a poorer education and financial situation would exhibit worse adaptation (21). It would not have been meaningful to test the effects of education in the present study, because four-fifths of the subjects had the same education level. Changes in income were not registered, but financial worries were found to be rather common among the widows, causing discussion of financial problems during the interview. Thus, there is a need for financial counselling in the bereavement situation, reducing the risk of moving or selling property too rashly.

Olson et al. (38) found that nearly two thirds of the elderly residents of 2 nursing homes in the United States had hallucinations and illusions. As many as 79% had visual and 50% auditory experiences of the deceased; one-fifth spoke with the dead, and the same number had tactile hallucinations; about one third felt the presence of the deceased. Similar to Olson's findings, almost half the subjects of the present study who experienced hallucinations and illusions had a combination of two or more types. In a bereavement study in England of 227 widows and 66 widowers (young, middle-aged and old subjects), Rees (39) found that 47% of his subjects had hallucinations and illusions. His study covered a 40-year post-bereavement period, showing that the closer the subjects were to bereavement, the more common were such experiences. He also found that the incidence was higher among old people than among young people. Therefore, the high frequency of hallucinations and illusions in the present study may be true, bearing in mind that the first observation was made as close to bereavement as 1 month. Furthermore, the distribution of types of hallucinations or illusions in the present study is similar that described by Rees: the feeling of the deceased's presence is the most common one, followed by conversing, hearing and seeing (in Rees' study by seeing, hearing and conversing), whereas tactile hallucinations are unusual. Like Rees' and Olson's findings, the majority of the subjects in the present study found it pleasant and helpful, especially conversing with, being touched by and feeling the presence of the deceased. When discussing hallucinations or illusions with the non-experiencing subjects, some wanted to become percipients.

The very lonely and the severely crying subjects of the present study were more prone to have hallucinations and illusions than those who reacted less severely, but it is hard to tell whether the former constituted a personality more prone to have these experiences than the later, because no personality inventory was used. Using a hysteroid-obsessoid questionnaire, Rees (39) demonstrated that the hysteroid personality type was the most likely to be hallucinated and have illusions. Rees also found the length and the happiness of the marriage to be predictors: the longer and the happier the marriage had

been, the more frequent the hallucinations and illusions were. The other studied background variables of the present study did not influence the prevalence of hallucinations or illusions, the analysis being limited by the small study population.

Since experiences of hallucinations and illusions may be expected in the newly bereaved, early information should be given, both to the bereaved and other persons concerned, about the incidence and character of these phenomena, to prevent fear of insanity and other negative reactions. With respect to hallucinations, there also seems to be a desire for a more proper and positive expression, diminishing the negative connotations of the word (38, 40, 41). In the Japanese culture, however, hallucinations are looked upon as normal concomitants of bereavement, so that not one of the hallucinating bereaved people studied was worried about his or her sanity (42). In Sweden and in other western countries, post-bereavement hallucinations need to be spoken about publicly, to increase knowledge and to change attitudes.

Not surprisingly, the quality of life of the newly bereaved is lower than that of married people. It is noteworthy, however, that there is a statistical difference in quality-of-life scores between the newly bereaved and the previously bereaved in the control group. This may be interpreted as showing that recovery from bereavement is not too prolonged. But once bereaved, either recently or earlier, the widowed subjects of the present age group never regain the quality of life of married people (Grimby & Svanborg, unpublished observations).

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