The development and initial validation of the Terminally Ill Grief or Depression Scale (TIGDS)

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ABSTRACT

Patients often experience 'preparatory-grief' as they cope with the dying process. Some may be depressed. The Terminally Ill Grief or Depression Scale (TIGDS), comprising grief and depression sub-scales, is a new self-report measure designed to differentiate between preparatory-grief and depression in adult inpatients.

The initial 100-item inventory was assembled based on literature review, interviews with clinicians and dying patients and then shortened to 42 items based on consensus expert opinion. Validity and reliability were tested in a sample of 55 terminally ill adults. The consensus clinical opinion was used as the gold standard to differentiate between preparatory grief and depression. The intra-class correlation coefficient was high (it was calculated to estimate the test-retest reliability for the 47 patients who had completed the TIGDS twice – retest was administered 2 to 7 days after the initial test), ranging from 0.86 (grief) to 0.97 (depression). The validity of TIGDS was assessed using a receiver operating characteristic curve analysis, comparing the first test with the clinical criterion. The first and only variable and cut-point was the depression score ($\chi^2 = 18.4$, $p < 0.001$, cut point = 3). The sensitivity of the TIGDS was 0.727 and specificity was 0.886 for the depression = 3 cutoff score. The construct validity of the TIGDS was tested by comparing with the Hospital Anxiety and Depression Scale (HADS). The TIGDS depression subscale showed strong convergent validity and the TIGDS grief subscale showed strong discriminant validity with the HADS total score. Copyright © 2005 John Wiley & Sons, Ltd.

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Virtually all patients experience 'preparatory grief' (Kubler-Ross, 1997) when faced with the prospect of impending death. These feelings are usually present for a variable period of time and then often diminish in intensity over time. In some patients the dysphoria persists in great intensity and may be associated with a sense of hopelessness, helplessness, worthlessness, negative self-image and an *active* desire for an early death. Such patients are thought to be clinically depressed. Depression is one of the most common psychiatric illnesses affecting terminally ill patients with an estimated prevalence varying between 3% and 45 % (McDaniel et al., 1995 ; Minagawa et al., 1997; Plumb and Holland,

1997; Hotopf 2002). Depression significantly decreases terminally patients' quality of life (Hotopf 2002) and also complicates the optimal palliation of other physical symptoms present secondary to the terminal illness. If diagnosed and treated appropriately, depression can be significantly alleviated even in terminally ill patients.

Challenges exist in the diagnosis of depression at the end of life for the following reasons:

- the vegetative signs of depression including weight changes, sleep problems, loss of libido etc. are often present secondary to the patients' advanced illness; and

- the affective signs of depression including sadness, crying spells and frequent thoughts of death are also seen as a part of preparatory grief.

Existing survey instruments designed to detect depression are unsuitable for terminally ill patients as they often use somatic criteria and do not differentiate between preparatory grief and depression. Differentiation between preparatory grief and depression, although often difficult, is essential as it has important therapeutic implications. In this study, we will describe the development and initial validation of a screening measure specifically tailored to differentiate between preparatory grief and depression in a terminally ill population.

Preparatory grief in a terminally ill population

The Merriam-Webster dictionary defines grief as 'a deep and poignant distress caused by or as if by bereavement'. Grief refers to a specific pattern of mood and behaviour associated with loss (Goodkin et al., 2002) and includes a wide array of psychological processes including numbness, shock, yearning, disorganization, despair and reorganization (Bowlby and Parkes, 1970). Preparatory grief is the grief 'that the terminally ill patient has to undergo in order to prepare himself for his final separation from this world' (Kubler-Ross, 1997). It is often associated with profound physical, psychological and spiritual suffering but it is nevertheless a normal reaction to the losses that occur during the terminally ill process, as perceived by the patient. Terminally ill patients (consciously or unconsciously) *prepare* for their anticipated death by mourning the various losses implicit in the death. Preparatory grief is also a *process* by which terminally ill patients adjust to the losses due to a radical change in their self-image and lifecourse. Grief can be understood as the physical, psychosocial and cognitive reactions and readjustments that occur in response to the abrupt changes the terminal illness enforces on the patient.

Depression in a terminally ill population

Clinically significant depression appears to be somewhat more common in terminally ill patients than in the general population, where the lifetime prevalence rate of depression is about 13% (Kessler et al., 1994), but such depression is not an inevitable part of the normal dying process. One of the reasons for the

higher prevalence of depression at the end of life could be due to the misdiagnosis of preparatory grief as depression as the two have common symptoms and may coexist. Intense grief and sadness are normal responses when faced with the prospect of impending death. As part of the grief process the patient can experience a profound sadness, which can then manifest *temporarily* as social withdrawal, hyperarousal, apathy, somatic symptoms (anorexia, sleep, sexual disturbances, and so forth) and fleeting suicidality. A temporal variation of mood is characteristic of grief. In contrast, patients with depression often have a persistent flat affect. Profound and persistent hopelessness, helplessness, worthlessness, excessive guilt, persistent anhedonia and dysphoria, and ruminating thoughts about death and suicide are hallmarks of depression in hospice patients (Block, 2000; Periyakoil and Hallenbeck, 2002). When present, depression significantly diminishes quality of life and if identified and appropriately treated can significantly improve the patient's quality of living even in the last 4 to 6 weeks of life (Maguire, 2000).

Existing depression and grief scales are not adjusted for terminally ill patients

Distinguishing between depression and preparatory grief in terminally ill patients is difficult as the factors we traditionally look for as clues for depression (sadness, low energy, sleep and sexual disturbances) are also found in grief. Many of the existing survey instruments designed to detect depression are unsuitable for terminally ill patients as questions addressing somatic, affective and functional criteria often generate false positives. For example, the Hamilton Scale for Depression identifies decreased social activities and feeling of sadness (Hamilton, 1960) and the Center for Epidemiologic Studies Depression Scale (CES-D) screens for poor appetite and sleep disturbances (Radloff, 1977). These symptoms are often present as a part of the normal terminally ill process. 'Are you basically satisfied with your life?' (Yesavage et al., 1983), a very effective question in identifying depression in a geriatric patient (Geriatric Depression Scale), often triggers the 'process of life review' in terminally ill patients.

Two screening instruments that have been studied in a terminally ill population include the Hospital Anxiety and Depression Scale (HADS) (Lloyd-Williams, 2001) and the Edinburgh Postnatal

Depression Scale (EPDS) (Lloyd-Williams, 2000). The HADS, which has anhedonia as its major construct, consists of anxiety and depression subscales. The HADS when used to identify depression in a terminally ill population had a sensitivity of 68% and specificity of 67% compared to a Present State Examination interview (Lloyd-Williams, 2001) at a combined (anxiety and depression subscales) cutoff of 19 (the depression subscale was not effective by itself). The EPDS was thought to be an useful screening instrument for palliative care patients (Lloyd-Williams, 2000, 2001) but neither the HADS nor the EPDS seek to differentiate between depression and preparatory grief.

Existing grief scales measure grief in bereaved individuals and are not focused towards preparatory grief – the patients' own grief about their impending death. From a more practical point of view, most terminally ill patients have limited access to physicians and mental health experts. Therefore, there is a need for a simple screening instrument distinguishing depression and grief that can be utilized by those clinicians who do care for terminally ill patients in hospice and elsewhere. At present there is no instrument that specifically addresses this need.

This study aimed to develop a reliable, valid, brief and easily administered instrument suitable for use as a screening instrument for depression and preparatory grief in a terminally ill population. Such an instrument could be used to investigate more fully the association between depression and preparatory grief and could prove useful in clinical practice. We wish to remind readers that the grief described in this paper is the terminally ill patient's preparatory grief and that this type of grief may be somewhat different from the grief of bereavement (as experienced by the survivors due to the death or anticipated death of a loved one), which has been extensively studied and described in literature.

Methods

Content definition

An ideal scale tailored to differentiate between grief and depression in dying patients, should:

- allow *self-rating*, without requiring extensive observation of the patient;

- be *easy to use*, and, ideally, should be composed of a small number of true/false items;
- be *geared towards terminally ill patients* – it should be considered relevant by clinicians experienced in hospice and palliative care and then standardized on the basis of empirical research with terminally ill patients.

Underlying theoretical model

Depression

The cognitive domains of the DSM-IV criteria thought to be helpful in identifying depression in a terminally ill population include depressed mood/dysphoria, hopelessness, worthlessness/excessive guilt, helplessness, anhedonia and ruminating thoughts of death/suicide.

Preparatory grief

Review of the grief and bereavement literature reveals that coping has become a dominant theme of bereavement research in the past decade (Strobe and Schut, 2001).

Coping refers to the processes of managing and adapting to the stressors precipitated by the loss(es) experienced by the individual. Several models of bereavement specific coping models have been described in the recent years including intra-personal models, interpersonal models as well as integrative models (Worden 1982/1991; Cook and Oltjenbrun, 1998; Bonanno and Kaltman, 1999). The dual process model (Strobe, 2001) postulates that the grieving subject experiences a number of stressors that can be broadly classified into loss-oriented or restoration-oriented stressors. Strobe explains that loss orientation refers to the grieving person's focus on the loss experience and restoration orientation refers to the focus on secondary stressors that are consequences of the loss. Both orientations are associated with anxiety and distress. The dual process model conceptualizes grief as a dynamic process with the grieving person alternating between loss- and restoration-oriented stressors.

Adapting the framework of Margaret Strobe's dual process model of coping with grief, (Strobe and Schut, 2001) we propose a theoretical framework for preparatory grief.

Terminally ill patients who are preparing for their impending death experience varied stressors which can be broadly classified as follows:

- *The loss-oriented component* refers to the terminally ill person's concentration and process of the various aspects of the loss (due to the advanced illness and impending death) experience itself. When patients recognize that they have a life-limiting illness and are going to die as a result of the illness they experience a wide array of psychological processes including numbness, shock, anger, separation anxiety, sadness and despair as a direct response to the loss. These can be thought of as primary stressors and are directly due to the patient's focus on and processing of some aspects of the perceived losses due to the terminal illness.
- *The restoration-oriented component* refers to the focus on the secondary stressors that are also consequences of the loss. As terminally ill patients process the implications of their existing and the anticipated future losses and as they struggle to reconcile with their present situations, the focus of their hopes may shift. They often try to find meaning in and amidst their illness process. They may re-examine and strengthen existing relationships and/or form new relationships, thereby restructuring their lives to establish a new equilibrium that integrates the terminal illness into it. These processes may help them cope functionally with their illness, but they are nevertheless intrinsically stressful.

Stroebe and Schut state that the grieving person will alternate between loss- versus restoration-oriented

coping with occasional 'time outs' when grieving is left alone. The dual process model (DPM) postulates that the oscillation between loss-oriented and restoration-oriented coping is necessary for adaptive coping.

Our extensive experience with terminally ill patients led us to believe that this bereavement model may be appropriate for patients with preparatory grief. Adapting Stroebe and Schut's DPM model for preparatory grief can be depicted in Figure 1.

Item generation

We generated depression and preparatory grief items by two methods. First, we did a review of recent literature on grief and depression and instruments assessing depression in palliative care. Second, the primary author (VSP) conducted informal interviews with terminally ill patients, their caregivers and hospice providers. Based on this information and based on our proposed theoretical model, the primary author compiled a total of 100 true/false items thought to distinguish between preparatory grief and depression in terminally ill patients. This inventory was then reviewed by a group of hospice clinicians and further reviewed by an expert psychometrician and shortened to a 69-item inventory by removing redundant or ambiguous questions.

Item reduction

The next issue was to assess the extent to which clinicians could reliably distinguish between the preparatory grief and depression items. Twelve expert

Figure 1. Preparatory Grief Dual Process Model.

clinicians, who were experts in depression, grief, and bereavement and palliative care, were asked to classify each of the 69 items as indicative of either preparatory grief or depression. Any item left blank was randomly assigned to grief or depression. The kappa coefficient and the confidence intervals, calculated using a jack-knife method (Efron, 1982) were computed to assess the degree of concordance among the 12 raters (95% CI for the 12 rater kappa (0.42) is 0.33 to 0.51). The kappa for all 12 raters was found to be 0.42 (Noda et al., 2001), and for the 4 raters who responded to all items was 0.58, 95% CI between 0.46 to 0.70 (Kraemer et al., 2002). The inventory was then shortened to retain only those 44 items on which all 4 raters who classified every item agreed. Review of these items by hospice patients and a Veterans Affairs (VA) Hospice Care Center committee for 'environmental impact of research'¹ resulted in some wording changes and the deletion of two additional items. The remaining 42 items were then arranged in a random order. The resulting 42-item TIGDS questionnaire (30 preparatory grief items and 12 depression items), shown in Table 1, was reviewed and approved by the Institutional Review Board of Stanford University School of Medicine.

Validation of TIGDS

There is no gold standard by which to differentiate preparatory grief from depression. In lieu of such a standard we decided to use the consensus clinical opinion of the VA Hospice and Palliative Care Unit inter-disciplinary team (nurses, palliative care physicians, psychologists, social workers, chaplains, massage therapists, occupational therapists, and hospice volunteers). After a review of existing literature on depression in terminally ill patients and after pilot studies, a four-item questionnaire was developed (see Table 2).

Each member of the hospice team who felt that he or she knew the patient sufficiently well rated the patient on each of the four items in the clinician-rating Leikert scale ranging from strongly disagree (value = 1) to strongly agree (value = 5) and the aver-

ages were computed. In order to avoid missing a diagnosis of depression an average score of at least 2.5 was taken to be indicative of positive diagnosis (depression). The questionnaire was given to the inter-disciplinary team at the same time period the TIGDS was administered to the patient for the first time.

Adult terminally ill inpatients were recruited from the VA Hospice Care Center, VAPAHCS, Palo Alto. The VA Hospice and Palliative Care Center is a 25-bed adult inpatient palliative care unit that serves both terminally ill veterans and non-veteran community patients. All patients admitted to the centre who were willing to participate were included in the study, except those patients deemed by their attending physician/charge nurse as unable to participate as they were actively dying or having an altered level of consciousness.

After obtaining permission from the attending physician/charge nurse and the patient's family as appropriate, the lead author (VSP) approached the patients and obtained informed consent, and then administered the 42-item terminally ill grief or depression scale (TIGDS). A retest was administered within 2 to 7 days of the initial test to establish the reliability of the scale. A total of 55 patients were recruited over a 17-month period. 44 out of the 55 patients (80%) were able to participate in both the test and the retest. 11 out of the 55 patients were unable to participate in the retest as they were actively dying or dead at the time of the second assessment. These 11 patients who were not able to participate in the reassessment were comparable to the 44 patients who completed reassessment. All patients were between 46 and 88 years of age, with a mean age of 75.6 (SD = 10.6). There were 40 veterans (72.7%) and 15 non-veterans (27.3%). Twelve out of the 55 patients (21.8%) were female. Thirty-six patients (65.5%) had terminal cancers and 19 (34.6%) had terminal non-cancer diagnosis. All patients were terminally ill and admitted to our inpatient palliative care unit for terminal care.

¹ Institutional Review Boards have traditionally evaluated projects to ensure that research is conducted ethically. However, such boards do not examine the potential 'environmental' effect of one or more studies on a fragile 'ecosystem' such as a hospice ward. This committee was established to ensure that any research projects conducted on the VA Hospice Care Center, VAPAHCS, do not negatively affect the ward. Beyond any potential impact on research subjects, the committee considers effects on other patients, family members, staff and trainees. All research on the ward must be so approved before it is allowed to proceed. The committee also monitors all research projects on an ongoing basis and retains the right to request that the project protocol be revised or the project discontinued in event of adverse impact on hospice patients and their families.

Table 1. The TIGDS showing the preparatory grief and depression subscale items.

Category	Inventory	% multi-rater agreement for 12 experts
Restoration oriented grief	I hope to die peacefully.	75.00%
	I am thankful for all the care and concern I am getting.	87.50%
	I pray for a miracle that will cure me.	100.00%
	I will not let this situation get me down.	88.89%
	There is a reason and purpose to my life.	70.00%
	I now see a new meaning in my life.	77.78%
	I feel that I am better off than many others in a similar situation.	100.00%
	I hope to feel better.	88.89%
	I am at peace with the world.	88.89%
	I am coping better now than I did earlier.	88.89%
	My situation has helped me grow and enhance myself.	100.00%
	I plan to make the most of the time I have left.	81.82%
	My suffering has made me a better person.	90.00%
	Though my body is weak, my spirit is strong.	90.00%
	My faith is helping me cope with my illness.	100.00%
	I do not want to die; I have a lot to live for.	72.73%
Loss oriented grief	Nothing can disturb my inner peace	88.89%
	I am more concerned for my loved ones than for myself.	77.78%
	I regret not being able to live as long as I'd like to.	88.89%
	I do not want to leave my loved ones.	100.00%
	I was totally devastated when I first found out about my illness.	100.00%
	I feel very sad whenever I think about my diagnosis.	88.89%
	I would not feel so down if I felt better physically.	88.89%
	I have felt numb ever since I was told about my diagnosis.	88.89%
	I wish I had the strength to do my favorite activities.	88.89%
	I cannot stand the thought of being separated from my loved ones.	90.91%
	The thought of death fills me with immense sorrow.	100.00%
	I have difficulty accepting that I have this illness.	88.89%
	I am very angry over what is happening to me.	100.00%
	I am often very sad but I am not depressed.	81.82%
Depression	I am a total failure.	100.00%
	The world would be a better place without me.	100.00%
	Nothing gives me pleasure.	100.00%
	I am a loser.	100.00%
	I do not know why anyone bothers with me.	100.00%
	Everything seems gray and colorless.	100.00%
	I am empty of all feelings.	100.00%
	I do not look forward to anything.	100.00%
	Nothing can make me happy even for a few minutes.	100.00%
	I do not seem to care what happens to me.	100.00%
	I cannot seem to shake off the blues.	100.00%
	I am an unnecessary burden to others.	100.00%

Results

The intra-class correlation coefficient (ICC) was calculated to estimate the test-retest reliability for the 44 patients who had completed the questionnaire twice.

Three different scores were calculated: the preparatory grief score (sum of the 30 preparatory grief items), the depression score (sum of the 12 depression items) and the grief versus depression score (difference of the per-

Table 2. Clinician assessment of patients on a scale ranging from strongly disagree (1) to strongly agree (5). Average score of 2.5 and above were interpreted to be depressed.

	Item
i	Patient actively desires to hasten his/her death.
ii	Nothing seems to make the patient happy even for a few minutes.
iii	Patient seems depressed most of the time.
iv	Patient seems to be very pessimistic (negative) most of the time.

centage of the grief and percentage of depression items). The ICCs were quite high at 0.86 (95% CI 0.76 to 0.91) for the preparatory grief scores, 0.97 (95% CI 0.95 to 0.98) for the depression scores and 0.92 (95% CI 0.84 to 0.95) for the grief versus depression scores, indicating that the TIGDS is quite reliable, despite the anticipated rapid changes in the condition of the patients.

ROC analysis

To assess the validity of TIGDS we compared the initial test with the clinical criterion using a receiver operating characteristic curve analysis (ROC). The ROC procedure examines each of the three predictor variables (preparatory grief scores, depression scores and grief versus depression scores) and all possible cut points and combinations, and identifies the variable and its cutpoint with the optimal balance between sensitivity and specificity for identifying those particular patients with the specific outcome of interest (namely, clinician depression average score ≥ 2.5). The total group is then divided into two subgroups – those above and below the selected cutpoint on the selected variable – and the process is reiterated until no further

discrimination can be achieved. The result is a decision tree (see Figure 2) (Kraemer, 1992). Here, the possible predictor variables in this analysis are: the preparatory grief scores (mean = 19.5, SD = 4.3, range = 8 to 30), the depression scores (mean = 1.7, SD = 2.5, range = 0 to 12) and the grief versus depression scores (mean = 0.51, SD = 0.27, range = 0.73 to 0.97). The first and only variable and cut-point isolated by the ROC analysis (see Figure 3 for ROC plane) was the depression score (chi-square = 18.4, $p < 0.001$, cut point = 3). Of 13 patients with a depression score ≥ 3 , eight patients (62%) were defined by clinicians to be depressed (≥ 2.5 average score). Of the 42 patients with a depression score < 3 , only 1 patient (7%) was defined by the clinicians as depressed.

Construct validity

Comparison with the Hospital Anxiety and Depression Scale (HADS)

The construct validity of the TIGDS was further tested by administering both the TIGDS and the HADS in random order to a different group of consenting adult terminally ill in-patients ($n = 20$, mean

Figure 2. ROC analysis.

Figure 3 displays the Receiver Operating Characteristic (ROC) plane. The optimal cutpoint for the preparatory grief scores (black diamond), depression scores (black circles) and grief versus depression scores (black squares) are located on the ROC plane, where equal clinical weights are placed on false positives and false negatives. The Random ROC Line, the Ideal Test Point and the Diagnosis Line are shown. All non-random tests will lie above the Random ROC Line. The Diagnosis Line is the line connecting the Ideal Test Point to the Random ROC line at a point determined by the prevalence: here (0.2, 0.2). The optimal test (here depression score ≥ 3) is the one nearest the Ideal Test Point.

Figure 3. ROC plane with individual points for the preparatory grief, depression and grief versus depression scores.

age in years = 69.4, standard deviation in years = 14.7). The depression subscale of the TIGDS showed strong correlation (Spearman correlation, $r = 0.50$) with the HADS total score. More importantly, the preparatory grief subscale of the TIGDS was not correlated (Spearman correlation, $r = 0.01$) with the HADS total score, thus indicating that the two TIGDS subscales were measuring two different constructs.

Discussion

We have developed and refined a new questionnaire, the TIGDS, to assess and differentiate between preparatory grief and depression in a terminally ill patient population. The scale was easy to administer and was acceptable to patients. Our data indicate that

the TIGDS may be a valid and a reliable screening tool. Validity was tested by ROC analysis. Concurrent validity of the TIGDS was also further tested against the HADS and found to be acceptable with excellent convergent validity between the HADS total scores and the depression subscale of the TIGDS and a striking and highly significant discriminant validity between the HADS total scores and the preparatory grief subscale of the TIGDS.

This study is also noteworthy for the following reasons. First, to the best of our knowledge, the TIGDS is the first scale to attempt to distinguish between preparatory grief and depression in terminally ill adult in-patients. Second, our study was conducted in an ecologically valid VA inpatient hospice and palliative care unit that also serves community non-veterans.

The VA Hospice and Palliative Care Center, VAPAHCS, Palo Alto, is the first VA facility in the country to establish community partnerships with Medicare – certified home hospices enabling us to serve non-veteran terminally ill patients. Thus we have a mixed study population of veterans and non-veterans, which we hope will help make the TIGDS applicable to patients with terminal illnesses in all settings, although this needs to be tested further in larger cohorts across different venues.

This study is limited by the small sample size and also by the fact that it was conducted in a single inpatient palliative care unit in a VA hospital, although 27.3% of our study patients were non-veterans from the community. Furthermore, this is a cross-sectional study and we acknowledge the need to study both depression and preparatory grief longitudinally for changes over time. Longitudinal observations may be especially relevant for the further study of preparatory grief owing to its intrinsic variation over time. It is also to be noted that no attempt was made in this study to identify the severity of patients' depression or preparatory grief (the instrument as currently developed is only designed to distinguish between states of depression and preparatory grief).

In summary, our study offers valuable preliminary data that should be influential in guiding future advances in differentiating between preparatory grief and depression in terminally ill adult patients. The TIGDS may be a valid and reliable screening tool that can be used to make this important clinical distinction. The scale is not time-intensive and can be used either as a self-report measure or can be administered by clinicians.

Before recommending the TIGDS for more general use, it should be tried by others in various clinical settings and on larger samples to test the generalizability of our results. It would also be desirable to track the changes in the patient responses to the preparatory grief and depression subscales over time as well as concurrently tracking variables like quality of life and spiritual distress. Furthermore, it is crucial to ascertain whether discrimination of preparatory grief from depression is of any clinical utility. One approach to further study the TIGDS might be a randomized clinical trial in which the information from the TIGDS is provided to hospital staff for a random half of the patients, and used to facilitate clinical decision making, the results to be compared to the other

random half who undergo usual care. Differential treatment responses could be measured by determining the impact of focused interventions on depression as measured by the Hospital Anxiety and Depression Scale.

In conclusion, the TIGDS is a promising tool that may help clinicians differentiate between preparatory grief and depression in terminally ill adult patients. We hope that such differentiation will lead to appropriate management strategies for grief and depression, thereby augmenting the quality of life of patients at the end-of-life.

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Appendix: Terminally Ill Grief or Depression Scale (TIGDS)

- 1 I hope to die peacefully.
- 2 I am a total failure.
- 3 I am thankful for all the care and concern I am getting.
- 4 I am more concerned for my loved ones than for myself.
- 5 The world would be a better place without me.
- 6 Nothing gives me pleasure.
- 7 I pray for a miracle that will cure me.
- 8 I am a loser.
- 9 I do not know why anyone bothers with me.
- 10 I regret not being able to live as long as I'd like to.
- 11 Everything seems gray and colorless.
- 12 I do not want to leave my loved ones.
- 13 I will not let this situation get me down.
- 14 I was totally devastated when I first found out about my illness.
- 15 There is a reason and purpose to my life.
- 16 I am empty of all feelings.
- 17 I feel very sad whenever I think about my diagnosis.
- 18 I now see a new meaning in my life.
- 19 I feel that I am better off than many others in a similar situation.
- 20 I hope to feel better.
- 21 I would not feel so down if I felt better physically.
- 22 I have felt numb ever since I was told about my diagnosis.
- 23 I wish I had the strength to do my favorite activities.
- 24 I cannot stand the thought of being separated from my loved ones.
- 25 I am at peace with the world.
- 26 The thought of death fills me with immense sorrow.
- 27 I am coping better now than I did earlier.
- 28 My situation has helped me grow and enhance myself.
- 29 I have difficulty accepting that I have this illness.
- 30 I am very angry over what is happening to me.
- 31 I do not look forward to anything.
- 32 I plan to make the most of the time I have left.
- 33 My suffering has made me a better person.
- 34 Nothing can make me happy even for a few minutes.
- 35 I do not seem to care what happens to me.
- 36 Though my body is weak, my spirit is strong.
- 37 My faith is helping me cope with my illness.
- 38 I cannot seem to shake off the blues.
- 39 I am often very sad but I am not depressed.
- 40 I am an unnecessary burden to others.
- 41 I do not want to die; I have a lot to live for.
- 42 Nothing can disturb my inner peace.