Deaths caused by cancer have been increasing worldwide each year; 7.6 million people died of cancer in 2008, and 13.1 million are estimated to die by 2030 (World Health Organization, 2012). In Taiwan, 41,046 people died from cancer in 2010, accounting for 28% of all deaths (Department of Health, Executive Yuan, 2012). As more patients die of cancer, more family caregivers face bereavement. Adaptation to bereavement has been suggested to follow a dual-process model (Stroebe & Schut, 1999), which involves two kinds of coping: loss- and restoration-oriented coping. The process of recovering from a loved one’s death is modeled as fluctuating between ruminating about the loss and attempting to redefine life without the deceased (Stroebe & Schut, 1999). After bereavement, caregivers experience grief, a normal, uncomplicated emotional, cognitive, functional, and behavioral reaction to the death of a loved one that typically subsides over time (Kacel, Gao, & Prigerson, 2011). Failure to assimilate and integrate the losses from the patient’s death into a new life without the deceased may result in complicated grief (i.e., prolonged and unresolved grief) (Zisook & Shear, 2009). Caregivers who experience complicated grief commonly present with long-lasting depression (Kacel et al., 2011).

Bereaved caregivers’ prevalence rate of depressive symptoms was shown in cross-sectional studies to be 50%–58% in the first month (Ando et al., 2010; Harlow, Goldberg, & Comstock, 1991), 24%–25% in 2–4 months (Ando et al., 2010; Zisook, Paulus, Shuchter, & Judd, 1997), 23% in 6 months (Harlow et al., 1991), and 16% in 12 months (Ando et al., 2010; Zisook et al., 1997) after the patient’s death. Bereavement-related depression leads to adverse outcomes such as somatic distress; sleep disorders; social dysfunction; feelings of hopelessness, guilt, and worthlessness; suicidal ideation; and even suicide, thereby impairing bereaved caregivers’ quality of life (Stroebe, Schut, & Stroebe, 2007; Zisook...