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LOSS OF THE LIFELONG PARTNER: IMPLICATIONS FOR SOCIAL ADAPTATION

by

Anora Ackerson Grinwis

A Dissertation
Submitted to the
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requirements for the
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Department of Sociology

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LOSS OF THE LIFELONG PARTNER: IMPLICATIONS FOR SOCIAL ADAPTATION

Anora Ackerson Grinwis, Ph.D.

Western Michigan University, 1998

The death of a partner has long been recognized for its ability to alter the lifestyle of the survivor. This life event can be even more significant for older adults who may be facing loss in several areas of their lives simultaneously. The focus of this qualitative study is on how older adults socially reconstruct their lives following a partner's death. The social construction of reality (Berger and Luckmann, 1966) guides design and analysis. Semi-structured interviews were conducted with 29 individuals following the death of a lifelong partner, described as a relationship of 45 or more years. Participants had been widowed for a period of between six and forty-eight months prior to the interviews. It was found that social support was an essential component in the adjustment to bereavement and most respondents felt adequately supported. Adult children were most often named as providers of social support for the survivors, but the support provided by them was more instrumental than affective. Participants identified the church as the social institution that provided the most support, and spiritual beliefs were a source of comfort to a majority of the survivors.

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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

The death of a partner has long been recognized for its ability to alter the lifestyle of the survivor. Indeed, Holmes and Rahe (1967) ascribed death of spouse as the number one indicator on their stress scale.

Initially, researchers of widowhood focused their efforts on studies that were more epidemiologically based, primarily looking for a cause and effect relationship between death of spouse and ill-health or accelerated death of the survivor. During the past 15 years the research focus in thanatology has concentrated more on the adaptation to bereavement and the factors that are more likely to produce a successful readjustment of the survivor's life.

The death of older adults, however, falls into the description of one-time events, a phrase offered by Neugarten and Hagestad in 1976. This phrase suggests that with the continuing ability to extend life and treat chronic illnesses, these deaths fall into our normal expectations of when death should occur. However, that expectation can be counter-productive for the social community surrounding an older adult who survives the death of a lifelong partner.

The aging process includes many dimensions of loss that are often minimized by younger cohorts. The death of a lifelong partner

can involve the loss of: social role, residence, financial status, intimacy, opportunities for socialization, a sense of security, and a future orientation. An individual's health may also be compromised due to months of caregiving prior to the partner's death coupled with the caregiver's own health concerns.

The grief experienced by survivors of lifelong partnerships may fall under the definition of what Doka (1989) defines as disenfranchised grief. He describes it as "circumstances in which a person experiences a sense of loss but does not have a social right, role, or capacity to grieve" (p. 3). This situation usually does not allow much opportunity for public mourning. Indeed, the survivors may find that they are discouraged in the grief process by being reminded of the many years that they shared together, in effect discounting the length of social continuity in their lives that is being disrupted.

When death of a lifelong partner is coupled with other developmental losses, it is possible that older adults can reach a state defined as bereavement overload (Kastenbaum, 1969). Because the probability of bereavement overload is greater for older adults who are losing members of their peer cohort as well as a significant other, the process of grieving for a lost partner is likely to be significantly different from that displayed by younger persons.

Some older adults handle this overload by active or passive suicide, and there has been a concern about elder suicide in recent years, particularly among older white men aged 85+ (Bould, Sanborn &

Reif, 1989). Dychtwald (1990) claims that the suicide rate for retired men is four times higher than in any other stage of life. Other bereaved survivors may search for new relationships, although this can become more difficult as potential partners may be more limited than at any other life phase.

Rando (1993) also suggests that "complications in mourning can occur when the mourner's resources are compromised and the mourner has the perception of lack of social support" (p. 11). As persons continue to live longer, there is an increased possibility that they will live for an extended length of time without their partner. What are the social adaptations that they make during this time that assist them in reconciling their lives and moving forward? What are the social institutions and social arrangements that are most helpful to them in this process? What time frames are they allowed for the grieving process and who are the people that assist in that effort?

This study is being implemented to answer some of the preceding questions. While issues of loss are being studied more frequently during this decade, there is still a gap in the literature on how this loss specifically affects older adults.

Matthews (1991) reports that

widowhood research has persisted in its focus on younger age groups, despite the aging of the population and the increasing proportions of those aged 80 and over. This focus on the younger widowed also belies the fact that age is a critical feature of the widowhood experience. (p. 13)

Moss and Moss (1989) also state that "there is, to our know-

ledge, no systematic research that examines the range and characteristics of grief in response to the death of a very old person" (p. 221). They further discuss that the possibility of forming new relationships may be avoided due to the fear of potential new losses.

Indeed, the fast growing segment of the elderly population is that designated as the "oldest-old" (Bould et. al., 1989), defined specifically as "those aged 85 and older" (p. 27). As a result, some partnerships last 60 or 70 years. What are the specific bereavement issues of these persons and are the necessary sources of support offered and available? These are some of the issues that the proposed study will attempt to clarify.

To add further emphasis, Lopata (1996) asserts that we live in a society in which friendship tends to be couple companionate. Wolinsky (1990) also suggests that we now live in a culture where we have the potential to be partnered for a longer period of time in a society where the focus is on the dyad. She further elaborates that "while it lasts, the marital tie is the basic family relationship which offers emotional and physical companionship in later life and is one of the few sources of physical closeness available to the elderly" (p. 11). It thus becomes necessary to study how survivors of the death of a lifelong partner readjust their lives to continue into the future with a new life situation.

CHAPTER II

LITERATURE REVIEW

Current literature views grief and loss as a naturally occurring phenomenon with the affected undergoing a "normal" period of distress. (Klerman & Clayton, 1984, p. 19). This outlook is confirmed by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM IV, 1994) which included a category labeled "uncomplicated bereavement" (p. 684). A description of this diagnosis refers to a depression-like syndrome as being normal for up to three months following bereavement. While that time period is inconsistent with current projections of readjustment following spousal bereavement (Schucter, 1986), it nonetheless indicates an awareness of grief as a necessary process. Durkheim (1897/1951) was the first sociologist to stress a connection between loss of spouse and risk of suicide. He cites social factors as the basis of that risk by stating:

The suicides occurring at the crisis of widowhood. . . are really due to domestic anomy resulting from the death of husband or wife. A family catastrophe occurs which affects the survivor. He is not adapted to the new situation in which he finds himself and accordingly offers less resistance to suicide. (p. 259)

Comparison of Outcomes for Older and Younger Widowed Persons

As indicated previously, earlier bereavement literature focused on the epidemiological link between death of partner and ill-

ness or premature death. More recently, gerontologists have started to focus more attention on comparing outcomes of older and younger spouses who survive the loss of a partner, with mixed results.

Parkes and Brown (1972) reported younger widows, defined as under the age of 45, to be more at-risk for complicated grief reactions using their own at-risk assessment tool. Part of the explanation for this finding involved the necessity for the younger widow to support the family financially and to be responsible for young children which can serve to delay the spouse's reaction to the loss.

Barnes, Harvey, Clarson and Haig (1996) found that older bereaved persons gave more positive responses in their descriptions of their lives following loss than younger survivors. However, this study did not involve the direct loss of a spouse or partner and the authors credit this more positive response as a result of having had to deal with more losses in the natural course of events.

In a 1990 study, Beckwith, Beckwith, Gray, Micski, Holm, Plummer, and Flaa interviewed 73 survivors of spousal bereavement in a hospice program using the Parkes and Weiss Risk Index. Subjects were interviewed following the death at one, three, six and twelve months. In addition, a bereavement inventory was also taken which included 13 items such as financial needs, change in health, increased use of drugs, and need for intervention.

The findings from this study indicated that the high risk bereaved located from the use of indices tended to be younger than low risk bereaved. Correlatively, the high-risk bereaved tended to have

been married a shorter time. Other important predictors of outcome were the number of young children at home, existence of close relationships, and financial status.

Catherine Sanders (1980) studied two bereaved experimental groups, one comprised of those aged 65 or older, the other of persons aged 63 and younger. The subjects were interviewed shortly after the death of their spouses and then 18 months later and compared to a matched control group. At each interview, both the Grief Experience Inventory and the MMPI were administered.

The results indicated that, although not statistically significant, there was a trend toward higher intensities of grief for younger spouses initially. However, at 18 months, the reverse was noted with the exception of the scales for "Guilt" and "Anger" which remained higher for younger bereaved spouses. The older group exhibited elevations on twelve scales with significant differences noted on the scales of "Denial" and "Physical Symptoms."

As an explanation for these outcomes, Sanders (1980) comments that the younger spousal group appeared to have adequate social support and expressed more feelings of hope. In addition, she notes that

the results of this study suggest that being older does not appear to contribute directly to grief symptoms per se but rather to the constellation of debilitating variables which universally plague the elderly in our society. (p. 231)

A contrasting result was reported by Heyman and Gianturco (1973) whose pilot project to test stress reactions in elderly men and women indicates that the years following bereavement of those

over 65 are not necessarily characterized by social disintegration or health deterioration. As contrasted with younger widowers, "the elderly person who loses a spouse usually enters widowhood with grown independent children, often has relative financial stability, and undoubtedly has had opportunities for rehearsal of the widowed role" (p. 359).

In summary, most of the studies cited above tend to support the idea of more complicated bereavement outcomes for younger bereaved spouses. Behind these conclusions is the assumption that a compilation of losses over a lifetime better prepares an individual for the loss of a lifelong partner. This is an assumption that this proposed research will investigate more thoroughly.

Anticipatory Grief and Survivor Adjustment

Anticipatory grief is a term used to describe the adjustment to loss that occurs following the news that a loved one is expected to die. Anticipatory grief has also been used as a variable which has been associated with grief outcomes. During the past 20 years, persons studying the effects of grief have strongly debated the issue of whether a longterm chronic illness is less debilitating for the survivor in terms of grief outcome than sudden death. The results have been inconclusive.

Glick, Weiss, and Parkes (1974), in their studies of widows and widowers, report that "virtually all the widows and widowers who had known of the impending death of their spouses believed that al-

though they had begun to grieve prior to the actual death, this did not reduce subsequent grieving" (p. 31).

Catherine M. Sanders (1982) interviewed 86 persons shortly after the death of a close family member and again 18 months later. She compared survivors of three modes of death: sudden death, short-term chronic illness death, and long-term chronic illness. Her findings indicate that the short-term chronic illness group made the most favorable adjustment to bereavement. In addition, "the long-term chronic illness group displayed the greatest degrees of denial, social isolation, loss of emotional control, rumination, and loss of vigor which points to the psychophysical depletion suffered during the long death watch" (p. 231).

Part of the explanation that Sanders (1980) gave for the difficulties experienced by the family members of persons dying from long-term chronic illness is that because of the long death watch when the illness becomes the focal point, there was little time or inclination to keep up social ties. After the death occurred, there was even less energy for reaching out to others, and Sanders (1980) described the "empty hand" phenomenon that occurs when one's purpose for living is removed (p. 239).

Although Sanders (1980) results are intriguing, there appears to be one major methodological flaw that could make the results questionable. In comparing the three modes of death, she interviewed interchangeably and unequally, those who had lost a spouse, child, and parents. The three groups had comparable numbers of

subjects, but did not compare according to type of loss experienced. It could be argued that results would be different if only the loss of a spouse/partner had been measured.

Another explanation can be hypothesized as well. During a chronic long-term illness, the caregiving role is assumed and support systems tend to revolve around medical care personnel and others who are supporting the patient as well as the caregiver. When death occurs, the caregiver not only loses his/her primary role, but the medical support system, and often social support as well.

In a longitudinal study, Gerber, Rusalem, Hannon, Battin, and Arkin (1975) examined the differences between reactions to death from acute illness where there is little or no opportunity for anticipatory grief, and death from chronic illness where some anticipatory grief might be expected. Their results indicated that there were no significant differences in bereavement adjustment at the initial phase of bereavement. However, at six months after the death, they found that those survivors who had experienced anticipatory grief revealed poorer mental health and that, in cases where there was an extended death watch, widowers did more poorly than widows.

Gerber et al. (1975) further noted that the bereaved may have been seriously ill themselves and may have neglected their own health while caring for their spouses. In addition, the strain of watching a loved one slowly die, referred to as the death watch

above could serve to aggravate a previously existing physical condition.

An interaction effect between age and the consequence of being forewarned of the death has caused contradictions in the epidemiological findings. Ball (1977) argued that young widows, under age 46, whose husbands died suddenly (an illness of less than five days) and middle-aged widows, 47-59 years old, whose husbands' final illnesses lasted more than six days showed the greatest degree of self-reported increased irritability six to nine months after bereavement.

However, Gerber et al. (1975) claimed that elderly persons whose spouses died of long-term chronic illnesses, defined as durations of six months or more, fared worse in terms of medical adjustment than those whose spouses' deaths resulted from illnesses of a shorter duration.

Even a short period of anticipation has indicated a better adjustment to bereavement. Carey (1977) noted that a period of two weeks of forewarning prior to the death led to a better adjustment to bereavement. Lundin (1984) found that sudden and unexpected loss resulted in a significantly higher morbidity rate during the first two years after bereavement.

The literature on anticipatory grief would seem to indicate that forewarning of an impending death by even a few days can be helpful in bereavement outcomes. However, if the illness is chronic and debilitating (a more likely occurrence in the older population),

the adjustment to bereavement for the survivor is not that clear. And can the widowed role be anticipated and rehearsed? It will be the task of this proposed research to investigate these assumptions.

Social Support and Bereavement Outcomes

Recently gerontologists have focused more attention on the role of social support in bereavement outcomes. Some studies particularly noted the stress of bereavement on elderly persons who may be particularly vulnerable because of limited social resources. For example, the elderly are more likely to have experienced the loss of a greater number of peers through death, may have diminished health status, and a more fixed financial status.

Part of the literature on social support reveals an inherent hypothesis that interpersonal support or social relationships buffer individuals against stressful life events. Stroebe and Stroebe (1987) more specifically state that "the buffering hypothesis assumes that during stressful life events, individuals involved in close relationships provide each other with social support that serves to lessen the deleterious effects such stress would normally have" (p. 297).

These authors further distinguish between three types of social support that marital partners typically provide for each other which are: material and task support, validation support (of social roles) and emotional support. Therefore the studies of Stroebe and Stroebe (1981) suggest that the death of a spouse not only re-

moves that protective screen, but may leave the survivor worse off than if they had never been married. For example, if the couple practiced traditional role divisions, there is suddenly a whole new repertoire of tasks that need to be assumed by the other.

Women traditionally may have more support offered to them or seek alternative sources of support (Lopata, 1987). But why are widowers less likely to find alternative social supports? Lynch (1977) points out that present cultural norms make it much less acceptable for men than for women to admit loneliness and the need for companionship. Many times, the prevalent social contacts for men outside the home are at the workplace and the implications for retired men would appear to be even more severe. Also, since widows so greatly outnumber widowers, there is less likelihood that the widower can find a reference group with which to identify. Carter and Glick (1976) found that although widowers are less likely than widows to find same-sex reference persons, they are more likely to develop new romantic relationships and find another partner.

Widowhood has frequently been referred to as a roleless role (Lopata, 1987). When a person dies, the survivor also undergoes a transition and Lopata suggests that "once the role of widow is over and the circle drawn to it recedes, she is left in a limbo situation as far as marital status is concerned." She further states that "older women often do not have alternative identities to bring forth into central position in the role cluster" (p. 121).

The survivor of partner loss initially exists in a time period

where roles are less defined. DiGuilio (1989) also cites lack of reciprocal relationships as a potential reason for loss of social support during bereavement by suggesting that widowed people are highly self-focused during this time period and their capacity for giving back socially is diminished. This dynamic is not always understood by the existing social network and may result in loss or lack of support.

Duran, Turner, and Lund (1989) studied social support, perceived stress, and depression following the death of a spouse in later life. In a longitudinal panel design, these researchers examined the potential of social support to buffer the effects of stress and depression for 94 widows and widowers, aged 50 and older. Social support was identified as a key variable in the loss of a spouse and the data suggested evidence that a stable support system buffered the effects of stress two years after the loss of a spouse.

Berkman and Syme (1979), in the Alameda County Studies, suggested that persons with specific social ties had lower mortality rates than persons without such ties. These ties included (a) marriage, (b) contacts with close friends and relatives, (c) church membership and (d) informal and formal group associations.

Berkman (1984) also made a clear distinction between the concept of social support and social networks. She explains that "social networks are the web of ties that surround an individual. Social support may be seen as the emotional, instrumental, and financial aid that's obtained from one's social network" (p. 415).

Additionally Dimond (1981) argued that the effects of social support also depend on several phenomena: the nature of the situation, the timing, and the availability of resources.

Schuster and Butler (1989) conducted a study which explored the longterm impact of social networks and social support on mental health measures within the context of conjugal bereavement. This evaluation included self-report data of widowed persons aged 57 and older, comparing recall of support at the time of initial bereavement, as well as current levels of support. A series of background variables were controlled in the analysis including age, sex, income, length of widowhood and ability to perform Activities of Daily Living (ADLs). Overall, the analysis revealed the importance of various social and demographic variables in relation to mental health, most notably ADLs, gender, and income.

Schuster and Butler (1989), also made several interesting observations about widowhood. The first is that the emphasis in American society is on the nuclear family suffering the loss, rather than the larger community. The authors question whether this unit is equipped to handle the task of adjustment to grief on their own as it contrasts with societies in which the family system is more extensive and individual members are less vulnerable when a death occurs. They also delineated two functional types of support: affective (emotional) and instrumental (task-oriented). Participants in the study suggested that the support received initially tended to be instrumental, but as bereavement progressed, it became

more affective in nature.

Stephen Schucter (1986) administered the San Diego Widowhood Project run by the University of California at San Diego Medical School Department of Psychiatry. Twenty-one men and 49 women who had suffered spousal loss were followed prospectively between 1977-83 with follow-up every three months for two years, then yearly follow-up at 37 and 49 months. Rationale for the project was an effort to develop a standardized tool to assess the multiple dimensions of spousal bereavement.

Schucter (1986) emphasized the potential change in social relationships after loss of a spouse and relates that many participants reported that not all friendships established prior to the death continued to be helpful and supportive. He explains this finding by saying that

rather than confront their own discomforts or limitations, old friends may deal with the bereaved by avoiding them. Unlike old friends, new friends will relate to the bereaved individual as a single individual rather than as someone who was once part of a couple. (p. 227)

Glick et al. (1974) also state that "by the end of the first year, most widows had established a very different friendship network" (p. 201).

Just as levels and types of social support have been studied, so is the timing of that support an important issue for examination. In a study of 51 older Toronto residents, with a mean age of 66, Haas-Hawkings, Sangster, Ziegler and Reid (1985) hypothesized that a stable intimate and active social network was related to the re-

cently bereaved (4 to 12 weeks) person's psychosocial adjustment. This hypothesis was not supported, suggesting that the importance of a structured social network may have more relevance at a later point in the bereavement process.

Bankhoff (1983) also emphasized the importance of the timing of social support in widowhood. She states that

the role of social support for women suffering conjugal bereavement is complex. Whether support helps, hurts, or is inconsequential for the psychological well-being of widows during their lengthy period of adjustment seems to depend upon at least three factors: where the widow is in the adjustment process, the specific type of support provided, and the source of that support (p. 837).

Researchers have looked not only at the quantity of support but the quality as well. Several authors have actually suggested that a too closely knit social network could hinder rather than assist in readjustment. Walker, MacBride, and Vachon (1977) suggest that "a closely knit network made up predominantly of relatives could become a disadvantage to the widow if she seeks to make new friends, find a job, or develop a new life style" (p. 39). This network may encourage the widowed to remain in roles that no longer have meaning or reciprocity. Vachon and Stylianos (1988) observe that low-density networks which are comprised of persons not necessarily known to each other and without reciprocal relationships may enable the widowed "to develop new social roles consistent with their changed status" (p. 177).

Melanie Barnes (1996) also discusses the timing of social support in the lives of the bereaved and suggests that the survivors'

needs change over time. She notes that the support network operating for the bereaved "may find that supportive behaviors that were appropriate at one time may not be appreciated or helpful at another time" (p. 276). Coyne, Ellard and Smith, (1990) as well as Cutrona, Cohen, and Igram (1990), suggest that support described by the bereaved as most helpful is provided without being sought. But Conn and Peterson (1989) state that "the bereaved find themselves in the dilemma of trying to get their social needs met without appearing needy or dependent" (in Barnes, 1996, p. 277).

The major difficulty inherent in the support literature is that support providers and recipients have not been able to agree on what constitutes support (Reed & Greenwald, 1991; Antonucci & Israel, 1986).

In 1989, Dale A. Lund published a group of studies under the title, Older Bereaved Spouses: Research With Practical Applications. These studies were designed to measure such variables as the importance of support groups, competencies in activities of daily living, levels of depression, perception of social support, etc. This volume was a landmark in pointing out some of the difficulties of being bereaved in later life and offered suggestions for future research some of which have been incorporated in this proposal.

Lund (1989) suggested that "more research is needed to test the effectiveness of various types of interventions" (p. 228). He also proposed that

bereavement research on older spouses should include measures of self-esteem, competencies in tasks of daily living, social

supports and other coping resources, loneliness, positive and negative feelings and experiences, and transitory aspects of the adjustment process. (p. 230)

Summary

In conclusion, the aforementioned studies have shown how complex the study of bereavement variables are, often depending on demands that change over time and with influences that will affect some survivors' lives and not others. There as yet has been no single definitive study that has outlined a normal readjustment process to grief. It would seem that what each individual describes as his/her own experience is legitimate and to be regarded in the context of how, when, and why the death occurs in addition to who is available to support the bereaved in moving forward with life and how they provide that support.

CHAPTER III

THEORETICAL CONSTRUCTS

Introduction

This chapter examines theories that have potential applicability to the individual adaptation process following the loss of a lifelong partner. In determining a theoretical orientation that constitutes the most adequate framework for this study it is necessary to consider whether the individual involved in that adjustment process will be viewed as an active or passive agent.

In other words, being widowed can be viewed as a singular response to a social event that occurs at one point in time with subsequent determination of new roles and statuses. Bereavement can also be examined as a process of reintegrating one's life to its changed circumstances. How is the social construction of reality accomplished during bereavement where the survivor no longer has a face-to-face social relationship but is still engaged psychologically with the deceased?

In the following discussion, several theoretical frameworks including psychological, gerontological and sociological paradigms will be outlined and critiqued as to their value as a framework for understanding the process of bereavement in general, and to loss of the lifelong partner in particular. A closer examination of the social construction of reality theory included under the social def-

initiationist paradigm will be offered as it appears to provide the best theoretical explanation of the process of adaptation to bereavement.

Psychological Theories

The current study is sociological in its conceptualization and framework. However, studies of bereavement cannot be entirely separated from psychological theory as they involve intrapsychic adaptation to a major life event.

Psychological examination of bereavement began historically with case studies and accounts of individual experiences when confronted with the death of a loved person. They are described in autobiographical or biographical accounts as well as documented in clinical observations. Indeed, many of the current assumptions about grief and loss are based on the work of psychological theorists and clinicians including Freud (1917), Lindemann (1944), Kubler-Ross (1969), Bowlby (1969), and Parkes (1970). Each of the psychological theories that will be considered have clear implications for the grieving process.

Sigmund Freud

Bereavement theory has its roots in psychoanalytic theory and Sigmund Freud's Mourning and Melancholia (1917) is often touted as one of the first works to deal with the effects of grief in an individual's life. Freud contends that the libido (psychic energy) is

attached or cathected to a loved object as well as to all of the associations attached to that object. When the individual realizes that the loved object (or person) no longer exists, the individual is called upon to bring to consciousness all of the thoughts and feelings regarding that object in order to detach the libido from them. The individual does not accomplish this task without difficulty and resistance, which Freud labeled as grief work. When this work is accomplished, the ego is free to again invest in another attachment. If these feelings are repressed (turned inward), the outcome would be melancholia, which is an earlier name for categorizing depression.

Freud concentrated primarily on the intrapsychic aspects of bereavement and not on the environmental or social aspects that may also influence an individual grief reaction.

Erich Lindemann

Erich Lindemann (1944) also used a psychoanalytic framework when he systematically observed the clinical symptoms of the survivors of the Coconut Grove fire. He concentrated primarily on acute grief reactions of survivors of traumatic death and outlined five components that are consistent with this type of grief: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and loss of patterns of conduct.

Lindemann (1944) also outlined some pathological responses to acute grief which include social withdrawal, development of the sym-

ptoms of the deceased's illness, hyperactivity, and psychosomatic illness. He proposed that in order to recover from grief an individual must do grief work which is an analytic process involving letting go of his/her relationship with the deceased, adjusting to a new environment without that person, and the formation of new relationships (Rando, 1993).

Lindemann (1944) associated the recovery of an individual following acute loss to the successful completion of the grief work. He was the first to outline the grief experience with specific tasks or goals. Again, as a psychological theorist, Lindemann neglected the interaction of society as well as mitigating external factors with the survivors of traumatic loss.

Elisabeth Kubler-Ross

One of the best known models of separation was proposed by Dr. Elisabeth Kubler-Ross in her 1969 classic On Death and Dying. She outlined five stages through which a dying person typically proceeds: denial, anger, bargaining, depression, and acceptance. While originally formulated as a theoretical model for the dying, these five stages have been incorporated into the literature as bereavement stages as well.

The difficulties in this transfer of application from the dying to the bereaved are numerous but include assumptions that there is a normal and predictable way to grieve. This outline of stages, although not so originally envisioned by the author, has been used

to label individuals as abnormal if their responses do not follow prescribed patterns.

John Bowlby

John Bowlby's theory of attachment and loss (1969), while specifically non-psychoanalytic in orientation, has some commonality with those theories because of its emphasis on unconscious and instinctual processes. Bowlby, through observation of children, hoped to predict their later behavior and adjustment while Freud, in effect, did the opposite: through observation of adult behavior he sought to reconstruct childhood experiences and especially traumas.

Bowlby was the first to make an explicit connection between attachment behavior and subsequent mourning. Bowlby's work deals with the formation of attachment and the aftermath of severed attachment. A basic tenet in his theoretical orientation is that the way in which an individual's attachment behavior becomes organized within his/her personality is dependent on the depth of attachment and patterns of affectional bonds formed in early life.

Bowlby (1980) outlines four phases that individuals pass through in response to loss of loved one which consist of: (1) numbing, (2) yearning and searching, (3) disorganization and despair, and (4) reorganization. He depicts grief as separation anxiety from an attachment figure which demands a reorganization period involving cognitive restructuring.

Bowlby's theory has been criticized for making the assumption

that adults experience the same feelings of loss and the same behavior patterns as children do in the grief experience. In addition, much of his work focuses on the pathological model of adjustment following bereavement rather than providing a general model of coping behavior.

Colin Murray Parkes

The theoretical work of Colin Murray Parkes (1970, 1983) was directly influenced by Bowlby in terms of viewing grief as a form of separation anxiety as well as in the emphasis on cognitive restructuring as a requirement for recovery following loss (Cleiren, 1993). In his classic work Bereavement: Studies of Grief in Adult Life (1972), Parkes concluded that there is a predictable course to mourning, beginning with a period of distress and impaired functioning, followed by cognitive restructuring and moving on to a different life with the possibility for forming new relationships.

The need for cognitive restructuring comes about because after the loss of a loved one, an individual's assumptive world is significantly changed so that predictability of the greater social world becomes impaired. H.Z. Lopata (1996) argues that after the death of a spouse, "failure to reconstruct identity and the worldview can lead to the kind of disengagement [to be discussed below] proposed by Cumming and Henry in 1961" (p. 121).

While Parkes' theory does factor in environmental and situational influences on the individual, he still views grief as primar-

ily an intrapsychic phenomenon.

Summary

Gee and Kimball (1987) describe most of the current widowhood research as atheoretical "issue-related descriptive work" (p. 10). Many of the psychologically oriented studies done in the past 30 years borrow heavily on the assumption that there are particular tasks or stages that a bereaved individual must move or work through to reconcile grief. These assumptions can lead to an attempt to create feeling rules for older adults that may not fit. Matthews (1991) points out that "the widowed are frequently treated in the literature as a homogeneous group, which may not be accurate" (p. 14).

Although useful as a basis for understanding how an individual internalizes a grief experience and develops a pattern of coping that is either adaptive or maladaptive, psychological theory disregards the interaction between the survivor and the society in which readjustment following bereavement must take place. Psychological theory necessitates a micro-subjective view of coping behaviors with the result of placing an individual within a normal or pathological range of functioning and does not adequately explain the multi-dimensional aspects of the bereavement experience.

Social Gerontology Theories

There is very little empirical evidence to explain how older

adults manage the latter part of their lives. The relatively new field of social gerontology, gaining prominence in the 1950's and 1960's, has not yet generated enough substantive theory of its own to lead to generalization.

Authors such as Rose (1965) and Rosow (1974) have claimed that an essential point in understanding about aging in twentieth century western society is that there are very few, if any, societal or cultural expectations about how older adults should organize their lives.

There are, of course, constraints on an individual's choice of action based on social, psychological, and biological factors, and Coleman (1990) argues that "people require some framework in which to understand their experience of life, including growing older and interpreting other people's behavior" (p. 93).

With that in mind, several major social gerontological theories are presented: disengagement theory, activity theory, and continuity theory in an attempt to explain what happens when the aging processes are coupled with societal expectations (or lack thereof).

The relationship of these theories to bereavement study is generalistic, but the assumptions they carry for the behavior of the survivor of lifelong partner loss may be more explicit.

Disengagement Theory

Some of the major theories in social gerontology have had an influence on current bereavement studies. Indeed, some of the earl-

iest theories such as the disengagement theory proposed by Cumming and Henry (1961) still contribute to basic assumptions prevalent in the grief literature today. Disengagement theory, a functionalist perspective, presumes that loss of individual functioning coupled with societal losses will encourage older adults gradually to withdraw from society, and society from the individual. Birrens and Bengston (1985) state that "the term disengagement refers to the universal, mutual, and inevitable withdrawal of older people from the configuration of the roles characteristic of middle age" (p. 336).

Disengagement theory makes the assumption that this process is mutually adaptive for both the individual and society. Society benefits by making room for younger persons to assume positions of responsibility in the system, and allows individuals to prepare for the ultimate withdrawal from social life, their own deaths. Blauner, in his article "Death and the Social Structure," (in Neugarten, 1968) stated that:

the disengagement of the aged in modern societies enhances the continuous functioning of social institutions and is a corollary of social structure and mortality patterns. Disengagement, the transition period between the end of institutional functioning and death, permits the changeover of personnel in a planned and careful manner, without the inevitably disruptive crises of disorganization and succession that would occur if people worked to the end and died on the job. (p. 533)

Thus, some of the assumptions outlined in the disengagement theory framework are a result of viewing aging individuals as increasingly more passive participants in the social system.

The disengagement theory proposes that individuals, as they

age, will have fewer and less intense social contacts. This may not, however, be the individual's choice, but rather the only option available as a person experiences diminished health capacity and other losses of choice and control in his/her life. Attig (1996) states that in bereavement, "we feel disconnected not only from those who have died but from our customary patterns of social interaction with our fellow survivors" (p. 144). This disconnection may be a social fact, but can produce a much greater risk for older adults who are having their societal contacts removed generally, through disengagement, and more specifically, through bereavement.

The societal disengagement process can also be seen in the manner in which an older adult's death is handled by the greater society. Blauner (In Neugarten, 1968) notes that "one of the consequences of the devaluation of the old in modern society is the minimization of the disruption and moral shock death ordinarily brings about" (p. 532).

Major criticisms of disengagement theory relate to the assumptions that the process of disengagement is functional and inevitable for the older adult. It is very culture-specific as contrasted with societies in which an individual only increases his/her level of prestige in later life. Also, since disengagement theory relates to a person's role in the workplace, it does not take into account individual variations in disengaging. For example, certain careers or avocations such as teaching, painting, and acting may not require

the same level of disengagement as in a work environment where retirement is encouraged and expected.

In addition, the level of disengagement may vary within the individual. One might remain engaged cognitively by reading and listening to informational programs, but may choose to withdraw socially. Is this individual then considered to be disengaged from society?

Disengagement has also overlooked the importance of personality in adjustment to aging. Is it likely that persons who have been highly involved in their social worlds all their lives will withdraw or will they be more inclined to continue to find ways to adapt to their changing environments?

Finally as Hooyman and Kiyak (1991) point out, "when older people have disengaged, this may not represent a personal preference, but rather the failure of our society to provide opportunities for continued engagement" (p. 84). Thus, expected roles in society may become problematic with increased life expectancy in general, and the death of a lifelong partner in particular.

As related to bereavement research, disengagement theory assumes that the death of older adults is not as disruptive to society because with social disengagement, the loss does not specifically affect the social order. Grief studies have provided mixed results regarding the social well-being of the survivor of a lifelong partnership indicating that the death may indeed be disruptive to survivors with whom the person is likely to have remained engaged. To

that extent will be the focus of this research.

Activity Theory

Activity theory (Havighurst, Neugarten, & Tobin, 1963) is another classic theory in social gerontology that continues to have a potential influence on survivors of the loss of a lifelong partner. It assumes that older adults who maintain the activities of middle-age will adjust better to aging than those who are less active.

Activity theory also encourages the substitution of new roles for those that are lost through widowhood or retirement (Lemon, Bengtson, & Peterson, 1972), while also making the assumption that older adults have the same social and psychological needs as middle-aged adults. This view supports the idea that societal disengagement and a decrease in social interaction is not a desirable state for the older individual.

As Havighurst et al. (1963) point out that

the older person who ages optimally is the person who stays active and who manages to resist the shrinkage of his social world. He maintains the activities of middle age as long as possible and then finds substitutes for those activities he is forced to relinquish: substitutes for work when he is forced to retire; substitutes for friends and loved ones whom he loses by death. (p. 161)

Activity theory makes the assumption that older adults are a homogeneous population, both in response to stressors and in their chosen ways of coping. Activity theory can also encourage activity as a replacement for thinking about it a cognitive component that is

considered essential in the process of reconciliation to a major loss (Worden, 1982).

In terms of societal interaction, the bereaved are often encouraged to refrain from dwelling on the traumatic event that has occurred in their lives and instead to make choices for activities such as travelling, volunteerism, and increased socializing. This response from the larger community succeeds in denying the bereaved older adult the opportunity to "work through to the pain of grief," which Worden (1982, p. 13) considered necessary in the healing process following bereavement.

Some of the major criticisms of activity theory are in response to its focus on middle-aged values and activities, leaving the inevitable conclusion that behavior inappropriate to middle-age culture and expectations is considered maladaptive.

Havighurst et al. (1963) encouraged the substitution of new relationships for those lost through death. While there is an understanding of a need to have social relationships, can there possibly be an adequate substitute for the loss of a lifelong partner or indeed of any strong cohort friendship that has lasted many years through many shared experiences?

More recently it has been recognized that the value placed by older adults on being active probably varies with their own experiences and needs. Havighurst, Neugarten, & Tobin (1968) modified their original theory to acknowledge the importance of personality in predicting the association between activity and life-satis-

faction.

Activity theory has had mixed empirical support and has not provided a description of what happens to older persons who cannot or choose not to maintain the activities of middle age. As Atchley (1980) stated, "No single standard can be used to determine the adequacy of behavior patterns among mature adults" (p. 183).

Activity theory contributes to current understanding of the bereavement process because it explains the assumption that if former activities are maintained or new activities are sought out, adjustment will be enhanced. This is not an adequate explanation for several reasons. First, many older adults find their social choices narrowing as they age and are often reluctant to specifically ask for what they need. Secondly, activity theory proposes a reintegration into social life for the survivor at precisely the time s/he is the most physically and psychologically depleted.

Continuity Theory

Another major social gerontological theory of adaptation in old age is continuity theory (Neugarten, Havighurst, & Tobin, 1968). Continuity theory proposes that one theory is inadequate to explain the aging process and makes the assumption that people maintain a consistent pattern as they age. This theory also suggests that older adults will replace lost roles with similar ones in order to maintain psychological as well as social continuity.

Continuity theory seems to have emerged as a hybrid of activ-

ity theory and role theory. In contrast to them, it acknowledges individual personality as a predominant factor in aging. The major assumption in continuity theory is that the patterns observed in old age are consistent with those established earlier on in life, rather than as a response to changing circumstances. The priority is for the individual to maintain equilibrium (Atchley, 1989).

This adaptation to earlier losses might predict, to some extent, how partner loss is dealt with. However, the relevance of this orientation for the social adaptation to the death of a life-long partner is still questionable because there really cannot be any previous rehearsal for what this specific loss will mean to the individual's life. In addition, the concept of role replacement is dubious, as the survivors will unlikely have a partnership again which has as many role expectations and consequences.

Because it focuses primarily on the individual personality as the unit of analysis, continuity theory has been difficult to test empirically. Another one of its criticisms is that it overlooks the effect external social factors have on the individual who is attempting to maintain continuity.

Summary

As the preceding discussion of social gerontological theories indicate, aging in Western societies brings with it many changes and a disproportionate number of those changes involve loss. Kuypers and Bengtson (1973) in their description of reconstruction theory

outline three losses typically associated with old age: (1) loss of roles, (2) loss of normative guidance, and (3) loss of reference groups. As a result of these losses, older adults risk being labeled as incompetent and may elect not to use the functional skills that have served them in the past.

The process of losing one's lifelong partner would, by definition, challenge one's current social identity. A vital component of re-establishing an adequate sense of self may involve determining how individuals assess their worth, both in relation to themselves and others.

One of the difficulties prevalent in social gerontological theory is the recurrent failure to develop explicit theory. Fennell, Phillipson, and Evers (1988) point out that

another difficulty has been the dominance of a particular kind of theorizing about the relationship between older people and the social structure which has contributed to the mood of cultural pessimism about the role and status of older people. (p. 42)

Grief studies done in the last decade have only begun to incorporate the significance of partner loss in older adults (i.e., Lund, 1989, Matthews, 1991) and much work still needs to be done in order to understand the unique aspects of such a significant loss in later life.

Sociological Theory

Ritzer (1975) speaks of sociology as being comprised of three major paradigms: (1) social-behavior, (2) social facts, and (3) so-

cial definition. Ritzer describes the social-facts paradigm as focusing on the large scale social structures and institutions and their influence and effect on individual actors.

The social-behavior paradigm consists of individual behavior and how it is affected by reinforcement and punishment. The social-definition paradigm is primarily concerned with the way in which actors construct social reality and the actions that result from that construction. Actors in this paradigm are described as having more freedom and creativity than those in the other two.

According to Ritzer (1980) these three paradigms are in conflict with each other because assumptions of one paradigm are constantly being questioned by adherents of another paradigm, making normal science nearly impossible. Using Ritzer's model of sociology, we will examine these three paradigms for possible relevance to the current study.

Social-Behavior Paradigm

The social-behavior paradigm is a model for sociologists who base their theoretical assumptions on the unthinking behavior of animals as in the work of B.F. Skinner (Ritzer, 1988). Of particular importance in this perspective is studying the rewards that elicit desirable behaviors and the punishments that inhibit undesirable behaviors through the use of the experimental method. Ritzer includes two theoretical approaches in sociology that are included under this framework: (1) behavioral sociology, and (2) exchange

theory.

Behavioral Sociology

Social behaviorists are interested in the relationship between individuals and their environments which are comprised of both social and non-social objects (Molm, 1981). In the Skinnerian or behaviorist view, the individual is not granted much creativity and freedom in that s/he is influenced primarily by external stimuli.

This framework differs from that of the social-definition paradigm wherein the actor works at consciously constructing social reality. Social behaviorists view the actor as much more mechanical, unconsciously responding to external stimuli. Baldwin and Baldwin (1986) claim that behavioral sociology (or as they refer to it, behavior science) is an effort to combine psychological behaviorism with sociological questions. They state that

the behavioral sociologist is concerned with the relationship between the effects of an actor's behavior on the environment and their impact on the actor's later behavior. This is basic to operant conditioning or the learning process by which behavior is modified by its consequences. (p. 6)

Even as behavioral sociologists are concerned with the unconscious relationship between the actor and his/her environment, some of the resultant behavior occurs in patterns that can be naturally determined as well as socially determined. In other words, a person's behavior can be shaped by biological imperatives such as a need for food, or social imperatives such as the need to be accepted.

Because of the association with behavioral modification, behavioral sociology has been referred to as having more of an applied practical character than any other sociological theory (Baldwin & Baldwin, 1986). While it may be accurate to claim that an individual reacts to being bereaved in ways that are likely to be rewarded by the greater society, behavioral sociology does not appear to be an adequate framework for the present study. The more mechanistic cause and effect dynamic disregards the complexity of the bereavement experience for human beings in general, and the additional challenges that may face older adults who have lost life-long partners in particular.

Exchange Theory

Exchange theory is considered a rational and economic model of social behavior (Birren & Bengtson, 1988). In this framework, individuals are presumed to have ongoing social exchanges and their continuation of these interactions is dependent on the perceived costs and benefits associated with them.

Exchange theory was originally formulated as a sociological theory by Homans (1961) and Blau (1964). They claim that a major premise for their theory (cited in Hooyman & Kiyak, 1991) is that

individuals and groups act rationally to maximize rewards and minimize costs to themselves, including those of time, energy, and wealth. These transactions are not only economic, but also encompass intrinsic psychological satisfaction. (p. 78)

More succinctly stated, individuals are considered likely to choose interactions in which they profit in some way, whether motivated by

economics, psychological satisfaction, or power.

Homans (1961) and Blau (1964) also view exchange theory in an historical context by making the assumption that individuals will use past experience to predict future exchange outcomes. They will also continue to socially interact as long as they are receiving more than they are giving in that exchange. If the balance changes, power will result to the person less dependent on the interaction, as power is derived from imbalances in the social exchange.

Dowd (1975) made the most extensive application of exchange theory to gerontology theory. He claimed that "both activity and disengagement theory failed to question why interaction and activity tend to decrease with age. Exchange theory does predict that with increasing age, social interaction is likely to decrease" (cited in Hooyman & Kiyak, 1993, p. 79).

Much of this decreased social interaction can be attributed to the social system as well as major social institutions as older people are systematically deprived of access to needed resources that contribute to rewarding social exchange. Loss of power in the exchange or in the ability to control one's environment is considered an explanation for why older adults may choose to disengage, not because it is mutually satisfying.

Our economic system also gives older adults the message that they are compromised due to outmoded skills in the workplace, leaving them little to exchange. Despite limited resources, most older adults choose to maintain some level of exchange and Dowd (1975) in

applying exchange theory to gerontology "suggests that a principle for the development of policies and services for older people should be a quest for strategies to maximize their resources that are valued in our society" (cited in Hooyman & Kiyak, 1991, p. 79).

Criticisms of exchange theory have included the lack of empirical research of exchange as an economic and behavioral model for the aging process. Homans (1974) later admitted that exchange theory involves the behavior of individuals as opposed to groups or societies and has admitted to being a psychological reductionist. Homans defined reductionism as "the process of showing how the propositions of one named science (in this case, sociology) follow in logic from the more general propositions of another named science" (in this case, psychology) (p. 338).

Exchange theory seems to fail at explaining both societal and cultural processes as well as internal mental processes. It provides a mechanistic view that reduces individuals to reactors as opposed to creative actors. It overlooks the quality of the exchange process in deference to the number of exchanges.

Finally, the focus on the dyadic interchange has significance as applied to the bereaved older adult in that the primary exchange partner has been lost. However, as exchange theory would indicate, there will be decreased opportunity for establishing new interaction.

The grief process by necessity calls the survivor to a social exchange precisely at a time when the individual has the least power in the exchange process. A survivor of lifelong partner loss would

appear to be compromised in the exchange process due to the effects of the loss itself as well as other mitigating factors such as health, available social relationships, ability to drive, etc., that may contribute significantly to the adaptation process.

Summary

The theorists utilizing the social-behavior paradigm are primarily concerned with an individual's behavior and the rewards and punishments that influence it. This theoretical paradigm largely ignores the influence of larger social structures and has been criticized for the lack of attention to internal mental processes. As applied to the process of aging in general, and bereavement, specifically, this paradigm would appear to be severely challenged in explaining individual and cultural differences in coping and reconstructing life after the loss of a lifelong partner. The attempt to define this adaptation through economic systems of reward and punishment would fail to explain the complex restructuring process believed to occur after such a traumatic event.

Social-Facts Paradigm

Durkheim (1897/1917) argued that "unlike psychology, social facts are external to and coercive of the actor" (cited in Ritzer, 1988, p. 71). In this framework, behavior and social conditions are heavily influenced by the larger social structures and institutions. Sociologists working in this paradigmatic tradition generally treat

behaviors and social problems as objective conditions with the norms and values of society simultaneously held constant so that any divergence in these standards of behavior can be viewed as non-normative (Rubington & Weinberg, 1978).

Theorists who adhere to the social-facts paradigm examine not only large scale social structures and institutions, but also their effects on individual thought and action. Ritzer (1988) claims that there are two major theories that are included in this paradigm: structural functionalism and conflict theory. The interview-questionnaire and historical-comparative methods are the most common forms of research employed.

For purposes of this study, role theory will be examined in more depth as the structural functionalist perspective in particular emphasizes the impact of social roles and the expectations of how they are to be performed as a major determinant of individual behavior.

Role Theory

Role theory (Cottrell, 1942) is included in the social facts paradigm and is a predominant theoretical orientation in both sociology and gerontology. The major assumption in this theoretical framework is that older adults are vulnerable to multiple loss of significant roles in their lives, i.e., employment, parenting, loss of partner and peers through death, etc., that may compromise their desire or ability to remain actively involved with their society. It

is also assumed that there will be, as one ages, increased difficulty in replacing former roles with new ones.

Rosow (1976) contends that old age is the one stage of life for which we are not properly socialized. Therefore, old age represents a major loss of roles that most aging persons, as well as society, view as negative and would prefer to avoid.

From Rosow's (1976) perspective, roles are related to statuses that are socially prescribed and they tend to become more ambiguous as people age. The norms that do exist for older adults in our society tend to reflect middle-aged standards and values which can actually hinder socialization to aging. In this framework roles are viewed as static and functional, a status individuals are expected to occupy in accordance with their positions in society.

Role theory relates to widowhood with the presumption that being a marital partner is one of the most defined and pervasive roles that an individual can have. Therefore, when one loses this role, and the prospect for replacement is limited, the individual may be at a loss as to how to function and/or face the future.

Blau (1973) refers to widowhood as a "roleless role, at least in Western culture, without culturally prescribed rights and duties towards others in one's social world" (p. 13).

Indeed, Lopata (1996) confirms that Western culture is one where widowhood is experienced personally rather than culturally. She also states that "the age at which the wife experiences the death of her husband is a very important feature of widowhood be-

cause of the way her life is immersed in other social roles" (p. 33).

Role theory is currently viewed as having many limitations due to inherent assumptions that role loss is necessarily negative rather providing the potential for a new identity to form. In recent years, the term "role transition" has been used more frequently in the literature implying a more adaptive outlook of role change for individual members of society.

Troll, Miller, and Atchley (1979) urge that widowhood be viewed as a process rather than just a status. DiGuilio (1989) also contends that "although marriage physically ends at the moment of death, one can remain psychologically married (or partnered) for a period of time" (p. 90).

Atchley (1987) suggests that another way to view the adjustment of role transition is to look at the adaptation process as one of consolidation of commitments and redistribution of available energy. In this perspective, people who are involved with several roles and activities may choose not to substitute for a lost role, but rather to redistribute time and energy among their remaining ones. This would seem to have potential significance with the older bereaved population who may not have the opportunity or desire to attempt to establish another primary relationship in their lives.

In addition, other theoretical frameworks have incorporated explanations of role change as part of their analysis. The social interactionist approach, for example, recognizes that some social

roles are not even defined before they are performed. Brown (1990) says that "instead, they are negotiated in our interactions with those in our environments. In order for us to make sense of them, every interaction requires the definition and performance of some kinds of roles" (p. 50).

Berger and Luckmann (1973) incorporate roles into their social construction of reality theory proposing that "by playing roles, the individual participates in a social world. By internalizing these roles, the same world becomes subjectively real to him" (p. 69).

In addition to viewing roles as static rather than dynamic, another criticism of role theory has been its application to occupational status, particularly when applied to older adults. The assumption that persons deprived of their major status as worker either substitute alternative roles or choose to disengage may have outlived its application as post-retirement opportunities would appear to be more prevalent at the end of the century than they were at mid-century.

Role theory also does not generalize cross-culturally. In non-Western societies, the presumed role conflict and isolation assumed to be part of the aging process may not present a clear pattern of role loss, particularly in societies where elders are presumed to be the leaders of the culture and hold positions of high esteem in the social worlds they occupy.

Role theory is not adequate to explain the multi-dimensional aspects of the grief process. Surviving the loss of a lifelong

partner cannot be described as merely substituting one role for another in the adjustment to bereavement. It more specifically involves a restructuring in all areas of an individual's life.

Summary

Ritzer (1988) states that "the social-facts paradigm primarily has a macro-objective or macro-subjective focus" (p. 517). Because of the difficulty in viewing death or bereavement in an institutional context, it is problematic to apply the social facts paradigm to the current study. Even though it is acknowledged that institutions and social structures may have an influence on individual response to loss, the current focus is on the readjustment process rather than on the definition of a social problem or the societal resolution of conflict.

Social-Definition Paradigm

The social-definition paradigm uses Max Weber's analysis of social action as the unifying model. Weber's work led to further interest in the ways that actors define their social situations, and the effect of these definitions on future action, interaction, or inaction.

Weber (cited in Ritzer, 1980) concluded that social action consists of all human behavior when subjective meanings are attached to it. He further explained that

action in this sense may be overt, purely inward or subjective; it may consist of positive intervention in a situation, of deliberately refraining from such intervention, or passively acquiescing in the situation. Action is social insofar as by virtue of the subjective meaning attached to it by the acting individual (or individuals) it takes account of the behavior of others and is thereby oriented in its course. (p. 85)

Thus, the social-definition paradigm looks at the subjective interpretation that individuals give to behavior and events in their social worlds. This paradigm includes symbolic interaction theory, ethnomethodology, and social construction of reality.

Symbolic Interaction Theory

Symbolic interaction theory presents a dynamic view of life with a person and the environment in a constant transitional process. In the process of symbolic interaction, humans interpret their interactions with other individuals, groups, and social structures and their response is based on the meanings they attach to that interaction. Symbolic interactionist theory is best exemplified by the work of George Herbert Mead (1932) and Herbert Blumer (1955) who emphasize that by taking the role of other, individuals attempt to see themselves as viewed by others.

Ritzer (1988) lists three points that are critical for symbolic interactionism:

(1) a focus on the interaction between the actor and the world; (2) a view of both the actor and the world as dynamic processes and not static structures; and (3) the great importance attributed to the actor's ability to interpret the social world. (p. 291)

In symbolic interaction, the focus is on the self rather than

individual personality and this semantic difference indicates a process of unique definition as opposed to a classification of individual psychological traits. The self becomes defined cognitively through language and other symbols of the social world.

Other key concepts of symbolic interaction are self-awareness and self-concept. Self awareness is the ability to be aware of self as an object separate from but related to others. Self-concept as defined by Rosenberg (1979) is "the totality of the individual's thoughts and feelings having reference to himself as an object" (p. 7).

Mead described this as the "I" and "me" which are constantly interacting with each other. The "me" is the part of the self that represents established norms and values whereas the "I" is the impulsive aspect of self which also provides innovation and creativity.

As part of this dynamic process, both the self and society are viewed as able to create new alternatives to established patterns. While acknowledging that some roles are established to the degree that they appear as functional, others are not even defined before they are performed.

Using the symbolic interaction perspective, the ways in which an older adult attaches meanings to the events occurring in his/her life and the feedback that is incorporated from others in the social world contribute to the continual redefinition of self. This process becomes especially significant when examining the symbolic

interaction that takes place with the loss of a lifelong partner, particularly the aspect of self-concept and self-awareness of what is happening in the adjustment process.

Through the process of interpreting their interactions with other individuals, groups, and social structures in response to partner loss, older survivors may feel constrained in their choice of action. This inhibition may also be the result of symbolic interactions that have occurred throughout their lives with regard to loss issues.

The criticisms of the symbolic interaction perspective were best summed up by Meltzer, Petras, and Reynolds (1975), who stated:

Of all the presumed difficulties of the symbolic interactionist paradigm, then, two stand forth as the most crucial: (1) limited consideration of human emotions, and (2) unconcern with social structure. In effect, the first of these shortcomings implies that symbolic interaction is not psychological enough, while the second implies that symbolic interaction is not sociological enough. (p. 120)

Ethnomethodology

Ethnomethodologists study the way people construct or reconstruct reality (Ritzer, 1980). John Heritage (1984) defines ethnomethodology as the

study of the body of commonsense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves. (p. 4).

Ethnomethodology has sometimes been referred to as a study of commonplace practical reasoning which has evolved from the Thomas

(1928) theorem which states, "if men define their situations as real, they are real in their consequences" (p. 572).

The work of Harold Garfinkel (1967) has been the dominant influence in ethnomethodological theory. Garfinkel offers two reasons for why it is important to study how people in ordinary life explain their world. They are that:

1. The social world does not exist, objectively, except as people construct it; and
2. The way in which people account for their world is the same thing as the way they act it out.

Garfinkel (1967) also claims that the two basic constructs of ethnomethodology are the concepts of indexicality and reflexivity. Indexicality refers to the fact that everything has a context, which must be taken into account in order to make sense of that particular thing. In addition, it has to be taken for granted that people know what that context is. Reflexivity refers to the act of people interpreting what is given in each situation as instances of something more general, but what this something is never appears, except in particular situations. Garfinkel argues for a very cognitive view of reality by claiming that the procedures by which people account for what is going on are also the way social reality is created in the first place.

Ethnomethodologists, while utilizing experimental instruments like the questionnaire, are more likely to use the observation method than those working within other paradigms. In particular, conversa-

tional analysis has been a major branch within the theoretical framework. Conversational analysts look for "the procedures by which conversationalists produce their own behavior and understand and deal with the behavior of others." (Heritage & Atkinson, 1984, p. 1). Conversations are thus presumed to be the dominant form of an individual's social interaction. These conversations are often audio or videotaped as are the interviews in the current study which allows for examination and re-examination of the data.

Ethnomethodology has been criticized for its lack of scientific positivism. It examines the individual social experience subjectively without looking at the influence of prevailing social structures. Ritzer (1988) explains that ethnomethodologists criticize traditional sociology for its tendency to impose its sense of reality on the social world rather than allowing the meaning to be taken from the social world itself.

Zimmerman and Wieder (1970) argue that social order is not a reality in and of itself, but rather the continuing process of social actors:

The ethnomethodologist is not concerned with providing causal explanations of observably regular, patterned, repetitive actions by some kind of analysis of the actor's point of view. He is concerned with how members of society go about the task of seeing, describing, and explaining order in the world in which they live. (p. 289)

The primary focus of ethnomethodology is micro-subjective which allows for individual interpretation of events. By minimizing the prevailing social structures, however, this theoretical framework may be incomplete in describing how older adults have incorpor-

ated their belief systems around loss, thereby negating the historical context of behavior.

In the grief process, there are constraints on what is considered normative adaptation in any given society and those constraints coupled with the norms more specifically imposed on the behavior of older adults reveal ethnomethodology to be too unstructured a framework for interpreting such a major loss.

Social Construction Theory

Ritzer (1988) describes the social construction of reality as Berger and Luckmann's (1967) attempt to integrate Weber's work on social action with Durkheim's thoughts on social facts as external realities. Thus, Berger and Luckmann have outlined a theory to deal in an integrated fashion with "the dual character of society in terms of objective facticity and subjective meaning" (p. 18).

Berger and Luckmann (1967) studied individual interaction in everyday life. They proposed that the social construction of reality is a process by which people develop an understanding of the nature of their environment. Ritzer (1988) further asserts that the social construction of everyday reality is "particularly interested in people's phenomenological tendency to view subjective processes as objective realities" (p. 346).

As Schutz and Luckmann (1973) have outlined,

the everyday reality of the life-world includes, therefore, not only the 'nature' experienced by me but also the social (and therefore the cultural) world in which I find myself; the life-world is not created out of merely material objects and

events which I encounter in my environment. (p. 5)

They further add that "accordingly, we act and operate not only within the life-world but also upon it" (p. 6).

Language, as the most important symbol in society, is very integral to the social construction process. It can lead to shared meanings as well as being used to define situations that have never been experienced before. Berger and Luckmann (1973) also refer to language as the most important social structure because "I encounter language as a facticity external to myself and it is coercive on me" (p. 38).

In the process of the social construction of reality, actions that are habitual may lead to their institutionalization or incorporation as part of society. This occurs through repetition, as persons develop typifications of what others are likely to do in a given situation. Berger and Luckmann (1967) define an institution as a reciprocal process of typification which is not a large-scale phenomena, but nonetheless external and coercive. They argue that these institutions "control human conduct by setting up predefined patterns of conduct" (p. 55).

Using this analysis, roles are not objective positions, but rather typifications of what to expect from individual actors in particular social circumstances. As Berger and Luckmann (1967) suggest,

the analysis of roles is of particular importance to the sociology of knowledge because it reveals the mediations between the macroscopic universes of meaning objectivated in a society and the ways by which these universes are subjectively real to

individuals. (p. 73)

Franks (1985) in his discussion of "The Sociology of Emotions" contends that human beings live in symbolic worlds which indicate to themselves how they feel and the reasons behind those feelings. But the social world into which the individual is socialized contains "structured accounts of emotions which provide a script that defines the situations in which persons can feel these emotions, defines the emotions, and indicates how they can be expressed" (p. 162).

Schutz and Luckmann (1973) further elaborated on social construction by describing the everyday life world as "the province of reality in which man continuously participates in ways which are at once inevitable and patterned" (p. 3). But they also allow for introduction of novel experiences that have not yet been part of an individual's repertoire of experiences. They claim that the life world that currently exists for an individual is sometimes only valid until further notice.

Schutz and Luckmann (1973) further state that

In the natural attitude, I only become aware of the deficit tone of my stock of knowledge if a novel experience does not fit into what has up until now been taken as the taken-for-granted valid reference scheme. (p. 8)

One's previous stock of knowledge would most likely be based on personal experiences, the shared experiences of others, books, films, and other elements of the surrounding culture.

Within a social construction framework, the individual is presented with an objective fact--their lifelong partner is dead. It then becomes the researcher's challenge, at least in this study,

to try to determine what the subjective reality of the individual's situation is. Berger and Luckmann (1967) state that

all legitimations of death must carry out the same essential task--they must enable the individual to go on living in society after the death of significant others and to anticipate his own death with, at the least, terror sufficiently mitigated so as not to paralyze the continued performance of the routines of everyday life. It may readily be seen that such legitimation is difficult to achieve short of integrating the phenomenon of death within a symbolic universe. Such legitimation, then provides the individual with a recipe for a correct death. Optimally this recipe retains its plausibility when his own death is imminent and will allow him, indeed, to die correctly. (p. 94)

Assuming the bereaved individual lives in a society that offers choices in response patterns, there still exists the greater societal framework that provides feedback as to whether or not these individual choices are acceptable. This idea is further supported by Berger and Luckmann (1967) who propose that

while the individual may improvise reality maintaining procedures in the face of crisis, the society itself sets up specific procedures for situations recognized as involving the risk of a breakdown in reality. Included in these predefined situations are certain marginal situations, of which death is by far the most important. (p. 143)

Summary

The social-definition paradigm allows the greatest flexibility in interpretation of individual life (and death) experiences. The individual actor is able to attach his/her own meanings to certain events, but that process does not occur in a vacuum. There also exists a social/societal component that provides interaction and feedback which may influence the individual to re-evaluate a current

reality and work on establishing a new one.

In the current study, the impact of age, social support, and multiple loss will be examined to assist in determining how surviving the loss of a lifelong partner is experienced by the individual as well as how construction of one's individual world is accomplished in order to continue surviving, and perhaps thriving.

Conclusion

What all of the preceding theoretical orientations have in common is that they require that, whether through accomplishment of specific tasks, or adaptation to changed roles and environments, an individual will redefine his/her changed circumstances both in collaboration with, and as a reaction to a changed social environment.

Schutz and Luckmann (1973) state that death is an element of the life-world that is inalterable. Attig (1996) states that "loss sunders the coherence of our present living patterns" (p. 79). He views grief as an active response to what has happened and defines the process as "relearning the world" (p. 49). He further asserts that after the death of a loved one, the survivor can never experience, or be at home in that world in the same way they were prior to the death (p. 105).

Indeed, Attig describes "relearning the world" as a multifaceted transitional process that involves the following: "adjusting emotional and other psychological responses and postures; transforming habits, motivations and behaviors; finding new ways to meet

biological needs; and altering spiritual perspectives" (p. 107).

It is also important to mention that this process of construction/reconstruction has the possibility of positive changes, of new and more expansive redefinitions of self. Silverman (1987) distinguishes between problematic accommodation to widowhood (remaining psychologically committed to the past) vs. satisfactory adjustment (feeling satisfied with one's life). Under the social construction framework, it will be important to record how each individual has continued to live in a way that makes internal sense and how chosen ways of coping have both influenced and been influenced by the greater society.

Schutz and Luckmann (1973) perhaps outlined this process of social construction after loss in the most eloquent manner by stating:

We realize. . . why the fellow man with whom we spoke, whom we loved or hated, who was thus and not otherwise, should have suddenly become different only because he is not there at the moment. We still love him or hate him, and nothing in the everyday course of events forces us to notice that our experience of him has been essentially changed in its structure. (p. 70)

Therefore, the current research will follow most directly the theoretical framework of social construction of reality following the loss of a lifelong partner. The research questions that follow have been designed to indicate how the survivor is reconstructing his/her personal world following the loss and the societal influences on that process.

However, this research does not purport to test a particular

theory implicitly but will serve as an exploratory study which may lead to an understanding of more appropriate theory, either through expansion of existing theory, modification of existing theory, or development of new elements of theory.

Research Questions

This research proposes to investigate and clarify the following questions:

1. What, if any, is the significance of anticipatory grief in the adjustment process for older adults experiencing the loss of a lifelong partner?
2. What is the significance of the social support network in adjustment to bereavement among the survivors?
3. What individuals or groups in the network are the most significant in the readjustment process?
4. What institutions are the most significant in the readjustment process?
5. Is social support more frequently offered in the affective (emotional) area or in the instrumental (task-oriented) area?
6. Is there an optimal time for these social interventions to occur? Does the optimal time vary dependent on type of support given?
7. What are the ways the social responses towards the bereaved individuals change over time?
8. Are there any positive aspects of working through the

bereavement process for survivors of lifelong partnerships?

CHAPTER IV

RESEARCH METHODS

The purpose of this study is to discover and interpret how survivors of the loss of lifelong partners reconstruct their social lives. It is qualitative in design and uses social construction of reality (Berger & Luckmann, 1966) as a framework for describing the experiences of persons at a particular point in time during the bereavement process. Before proceeding with the research design, it is important to clarify the terminology used in this study. Then issues involved in the handling of a sensitive topic will be discussed. Next, selection of the participants will be addressed as well as interviewing techniques and other issues pertaining to the gathering and analysis of data. Finally, demographic information from the respondents themselves will be presented.

Terminology

For purposes of this study, lifelong partnership will be defined as a marriage or nonlegal partnership which has endured consistently for 45+ years. This figure was selected because that length of partnership most likely places the survivor in the post-retirement years and living independently and to include more male participants.

Social support is defined as either instrumental (task-

oriented) or affective (emotional). This will more clearly delineate the different types of support offered to the older bereaved individual. Social adaptation will refer to adaptation after bereavement as opposed to adaptation to bereavement. This semantic difference is important because it implies a more dynamic state of readjustment and gives the survivor the permission to have a positive outcome even though his/her life will never again be quite the same (although it could hypothetically be even better).

Sensitive Topics

Seiber and Stanley (1988) state that the sensitivity of the subject matter is a potential factor in every step of research design. Faberow (1963) considers sensitive topics to be those areas of social life surrounded by taboo. It is the assumption of this research that death and bereavement are included under the designation of sensitive topics.

Claiming bereavement to be a sensitive topic is further supported by Raymond Lee (1993) who stated that

. . . research into such areas may be threatening to those studied because of the levels of stress which it may induce. An additional problem here, which also affects research into the private sphere, has to do with maintaining an appropriate demeanor in face-to-face conduct with the researcher. (p. 6)

Sensitive areas of social research provide more necessity for ethical responsibility toward participants than in other avenues of inquiry. Part of this responsibility is handled by the Human Subjects Review Board prior to the start of research by approving the

research plan and instrument. However, the greatest responsibility lies with the researcher, and precautions taken during the interview to make sure the respondents felt comfortable will now be presented.

The efforts made to counteract the potential stress for the participant included making certain that the topic to be discussed was known and agreed upon prior to the interview. This was done either on the phone or in person. The consent form was reviewed with each participant and read to three respondents who were legally blind. The interviewer also informed the participants that they were free to stop at any time and it is recorded on tape that respondents were asked how they were doing and if they were able to continue during the course of the interview.

There were no participants who chose to terminate the interview while it was being conducted. In one situation, it was necessary to complete the interview several weeks later due to the participant's desire to answer all the questions at length and it was his schedule that prevented it being done at one time, not the interviewer's.

In researching sensitive topics, it is necessary to guard against the possibility of an intrusive threat in the participant's life. Due to health and/or safety issues, three of the interviews were conducted with another person present in the room or immediate area. One of these observers was a professional caregiver, one was a friend, and one was an adult daughter.

It is not felt that the presence of third parties inhibited

the responses to questions. However in one situation the caregiver started correcting times and dates for the interviewer and the researcher intervened by saying "I appreciate your help but my purpose is to find out what Mr. X remembers and feels about these events." She apologized and then kept a low profile during the rest of the interview. There were very few verbal interruptions from other observers in this study.

Although working with a sensitive topic requires an additional system of safeguards, it can also have some potential benefit for the participants. Out of a final sample of 29 participants, 13 gave unsolicited appreciation for being given the opportunity to talk about their loved one and what had occurred in their lives.

Investigating sensitive topics also has the potential of contributing new information to an existing knowledge base. Lee (1993) states that studies involving sensitive topics may aid in theory building "because they challenge taken-for-granted ways of seeing the world." (p. 2).

Sample Selection

Because of the nature of this research topic, participation was voluntary and involved purposive sampling to include those who met the descriptive requirements of the study. Participants were obtained through area retirement communities, senior centers, medical and hospice personnel, as well as through word of mouth. In this particular study, potential participants were asked to call the

researcher as a further safeguard to obtaining a voluntary sample.

By definition, the sample was self-selecting and snowball sampling occurred as a result of contacts with initial participants. Snowball sampling has the disadvantage of limiting the diversity of a particular study (i.e., referring persons of the same socio-cultural background) but also has some positive aspects. Lee (1993) argues that snowball sampling has advantages in studying persons in a vulnerable group as "security features are built into the method because the intermediaries who form the links of the security chain are known to potential respondents and trusted by them" (p. 67).

Thirty-one interviews were conducted which produced 29 that were usable. Two persons who were interviewed had been partnered for 43 years prior to the death of their spouses, and had originally stated that they had been married 45 years. This made them ineligible under the requirements of the study. One of these two women, Mrs. #14 had an interesting story in that her 43 year partnership was the second marriage for each and they had remarried at approximately 40 years of age.

In these two instances, interviews were conducted using an abbreviated form of the interview without indicating to participants that their interviews would not be used.

Interview Method

The interview method was selected for several reasons. First, it provided the opportunity to add more depth to the topic and added

more context of meaning than responses on a written or telephone survey. Of the 29 useable interviews, 28 were conducted in the individual's home which allowed the interviewer to get a larger sense of the individual's life and the things that were important to him/her. In at least two-thirds of the interviews, there was a spontaneous sharing of photos, mementos, letters, etc. It also allowed the interviewer to observe non-verbal behavior which added to the depth of the interview.

A second reason for selecting the interview method was that filling out a lengthy questionnaire could be too demanding for a person who has suffered a significant loss and who might also be experiencing difficulties with sight and the ability to write for long periods of time.

Interviews were semi-structured with a total of 29 questions; 26 of them open-ended, and three ranking questions. The semi-structured approach allows the collection of comparable data, and permits the individual to interpret the questions in varying ways and according to his/her own understanding. It also allows for inserting probing questions in an attempt to clarify the information being given.

The questions are open-ended in design which gives respondents the ability to assign their own meanings to them. This format makes it possible for interview questions to be asked out of sequence due to the direction the respondent is taking in his/her answers. Open-ended questions also allow for answers to be placed in the partici-

pant's own language and phrasing and avoids the possibility of the interviewer suggesting answers.

Using this research instrument, all questions were asked no more than twice. If, after the initial question, the respondent did not give a direct answer or took the topic in another direction, the question was eventually asked again. However, if it was not then directly answered, the researcher made the assumption that for some reason the question was either not understood or was being avoided and did not repeat it.

The interview schedule (Appendix B) included several measures of subjective well-being. Lund et al., (1989) state that "subjective well-being is generally regarded as a multi-dimensional construct that encompasses both stable and transitory dimensions as well as global and specific indicators" (p. 4).

This research also utilizes the point in time framework for analysis which allows for understanding that the responses obtained were those of that individual on that particular day and one might obtain different results at another point in time.

It was anticipated that completing the interview schedule would take approximately two hours, with adjustments made for the health and emotional well-being of the participants. This time estimate was reasonable. There were only two interviews which lasted less than two hours, and eleven that were longer than two hours.

Interviews were taped and numbered and in the findings, participants will be referred to by number, i.e., Mrs. #24. The as-

signing of numbers is not meant to dehumanize the participant, but rather to serve as an additional protection of confidentiality. Several times, during the course of an interview, a respondent asked to give a response with the tape recorder turned off. These requests were granted, and the resulting information will not be included in the findings.

In the further interests of confidentiality, data have been excluded that might be recognizable in the greater community for the protection of the participants. There was however, one person, Mrs. #29, who had lost a son to AIDS two years previous to her husband's death and she explicitly stated that it was all right to include that information as she had been very public about it herself.

At the conclusion of the interview, participants were given a reference card with the researcher's business as well as home telephone number. This was done to safeguard their well-being and they were encouraged to call if they had any additional questions or comments. Within a week of their interviews, two respondents called to supply additional information that they had thought of since the original interview took place. Notes of appreciation were sent to each participant within the week following their interview, once again stating that they were free to contact the researcher.

Interviews began on February 13, 1998 and concluded on June 24, 1998. Since that time the researcher has been contacted by 8 additional participants who said that they called just to see how things are going. This researcher believes that the population in-

terviewed felt they were not just helping an individual complete a study, but that their responses could be helpful to others who might have a similar experience at a future point in time.

Frances Carp (Lawton & Herzog, 1989), in her discussion on data quality in studies involving older people states that "in my experience the most effective motivator for most older persons to take part in research is the opportunity it affords to provide information that may prove useful to other aging persons" (p. 11).

Tape Coding

Interview data were taped and coded. The coding process was selected because of the length and number of the interviews as well as the amount of information that was gathered due to the open-ended format. Coding involved recording quotes relevant to the study in general, and to the research question categories in particular. When a participant said something that needed to be recorded, it was written down verbatim and the place on the tape counter recorded next to it, i.e., (142), so that it could be retrieved later. If the interview used more than one side of the tape, the subsequent tapes were coded with an additional prefix number, i.e., 2(142).

After the initial tape coding was completed, the tapes were again listened to and the information further coded into categories pertaining directly to the research questions. Sometimes there were several items on the interview schedule that attempted to answer the same research question and this structure provided some inter-re-

liability of data.

Aggregate Demographics

This study was designed with a sample size of 25 to 30 participants. Twenty-nine interviews were completed that met the demographic criteria. Of the 29 respondents, 19 were women and 10 were men. The youngest person interviewed was 67 years of age and the oldest was 95. The mean age in this sample was 78 years. Participants had to be partnered a minimum of 45 years, but the average length of marriage or partnership was 52 years with the longest partnership in the sample lasting 68 years.

The sample population was further divided into post-death times of up to 2 years, and 2-4 years, which subsequently will be referred to as the acute period and the sub-acute period. These divisions are consistent with current bereavement literature that advises a two to four year period for adjustment following a major loss. Ferraro and Barresi (1982) suggested a four year time span following death to be a significant period in the readjustment process. Vachon et al., (1980) found that "not until two years after bereavement did a difference in overall disturbance between intervention and control groups become apparent" (p. 1384).

In this sample, 13 participants had experienced the loss of their partners during the past two years, and 16 respondents were between two and four years post-death. As part of the research design, a six month minimum period had to elapse following a partner's

death before an individual could be included in the sample because less time than that was regarded as too intrusive of the grief process.

All participants were white, although this was not the intention of the study. Unsuccessful efforts were made to contact minority widowed persons. There was, however, some cultural diversity, particularly expressed around issues of faith.

Socio-economic status was not specifically measured, but implied by issues brought up in response to the questions as well as having the interview take place in the individual's home. Informal observation would indicate that the majority of respondents could be designated as middle-class, with 5 persons giving the appearance of substantial income, and 7 persons living within more moderate means.

R.M. Lee (1993) states that "whether they have anticipated it or not, the depth interview can often be a cathartic experience for interviewees" (p. 107). It is hoped that the choice of an in-depth interview was comfortable to all participants and that having the opportunity to share their experiences was in some way beneficial for them.

CHAPTER V

FINDINGS: RECONSTRUCTION AND SOCIAL ADAPTATION

Introduction

In this chapter, data are reported from interviews with 29 survivors of the loss of a lifelong partner, whose losses occurred between six months and four years prior to the interviews. Demographic data obtained at the time of the interview are presented including type of death and memories surrounding that time. Also included are feelings about having to provide care for one's partner, if that was a relevant issue.

Next, the participants' responses to the research questions will be presented. In particular, the focus will be on identifying where individuals have obtained support and what type of support they have received during the process of reconstructing their lives following the loss of their lifelong partner.

Description of the Sample

This study is based on interviews conducted with 29 individuals, 19 women and 10 men, whose partners died during the four years preceding the interviews. They ranged in age from 67 to 95, and had been married between 45 and 68 years. Thirteen participants were living in family homes, four in condominiums, five in apartments, five in retirement communities, and two were living in the

home of an adult child. The two living with adult children were doing so because of compromised physical conditions, one being legally blind, and the other having limited mobility as the result of an auto accident that killed her husband. Additional information on the participants is listed below in Table 1.

Table 1
Survivors of the Loss of a Lifelong Partner

Person	Survivor's Age at Death of Spouse	Survivor's Age Now	Years Married	Months Since Death
Mr. #1	87	88	62	12
Mrs. #2	70	73	48	42
Mrs. #3	76	78	48	26
Mrs. #4	72	76	51	48
Mrs. #5	84	85	58	13
Mr. #6	77	78	52	10
Mrs. #7	79	81	53	30
Mrs. #8	84	85	58	6
Mrs. #9	79	81	53	24
Mrs. #10	82	84	59	24
Mrs. #11	83	85	53	29
Mr. #12	74	75	49	6
Mrs. #13	76	78	50	32
Mrs. #14*				
Mrs. #15	73	75	52	29

Table 1--Continued

Person	Survivor's Age at Death of Spouse	Survivor's Age Now	Years Married	Months Since Death
Mr. #16	71	74	48	34
Mrs. #17	74	75	52	9
Mr. #18	69	73	48	45
Mr. #19	94	95	68	13
Mrs. #20	73	75	49	31
Mr. #21	65	67	45	15
Mrs. #22	75	78	56	41
Mrs. #23	86	89	65	40
Mrs. #24	64	67	45	28
Mr. #25	69	70	46	12
Mr. #26	74	76	50	16
Mrs. #27	78	81	55	48
Mrs. #28*				
Mrs. #29	71	73	45	32
Mr. #30	70	70	46	7
Mrs. #31	75	77	57	21

*Data not included for analysis because length of partnership was < 45 years.

In the opening stages of the interview, this researcher spent some time talking with participants about the death itself: what had caused it, what they remembered about events surrounding the

death and immediately afterwards, and whether they perceived the death as sudden or expected.

The cause of death reported by the surviving partners (Table 2) was not consistent with national data on leading causes of death for the adult population with cancer occurring more frequently than heart disease or stroke (World Almanac, 1997).

Table 2
Partner's Cause of Death

Cause of Death	Number
Cancer (Various)	11
Heart Disease	8
Brain Tumor	3
Stroke	2
Diabetes (complications)	1
Huntington's disease	1
Emphysema	1
Edema	1
Accident	1
Total	29

The Partner's Death

This section deals more specifically with the death itself and how it was perceived by the participants in this study. As a

general background to the actual focus of research, some examples of responses will be provided regarding the place of death, timing of the death, and the actual death event. In addition, the effects of being a caregiver to one's partner will be explored as well as the care provided by outside organizations. It is hoped that these descriptions will provide a context for understanding the answers to the research questions that follow.

Place of Death

The 29 respondents reported that 16 of the deaths occurred at home, seven in the hospital, and six at a nursing home. Of those who died at home, no one said that they would have preferred their loved one to be elsewhere. Mr. #16 described why he preferred to have his wife at home:

I knew I didn't want her to die in a nursing home and we knew she was going to die. When you die from cancer it takes a long, long time. I think the last day or so she knew what was going on around her. It was better here at home--with the family all around.

Of the 13 survivors whose partners' deaths occurred in hospitals or nursing homes, 7 were not present with their partner at the time of death. Only one respondent said that having her spouse die in the nursing home was difficult for her.

Mrs. #8 described it this way:

So I had to put him in the nursing home right before his birthday and I hated to do that. The doctor said I should do something with him because he was worried about me. I felt I should have kept him here--that's one regret. They (nursing home personnel) seemed to think he was dying but I didn't realize it, I guess. He was in a private room when he died.

I wasn't there. They called me, told me his heart had stopped. It was kind of a shock. I decided not to go over. They knew what they were going to do.

Four other participants who had partners die in nursing homes said that they were able to be present at the death in the way they would have wished to be.

Mrs. #13 described her experience this way:

I was right there with him and I knew that something was happening. I called the staff, stayed right with him, and he passed away that way. It seemed like somebody came and took him by the hand and away he went. The nursing home staff was very helpful because my son wasn't with me, my daughter wasn't with me. I was there alone. At the time it wasn't hard, but when you look back now, it's hard.

Mrs. #3 also had hospice involved in the nursing home care:

Hospice came to the nursing home. I didn't want him to die alone. The morning he died, I had been there. I was always there in the morning. I had gone back home and they called me and I went back. The amazing thing is we got to tell him that he could go. I told him that I loved him. It was just like he kind of melted away.

Mrs. #11, whose husband died in the hospital after a brief episode of a chronic illness, described the death this way.

We were in the hospital (adult children and herself) night and day. We never left him. Just before he went into the operating room--he really shouldn't have had that operation--he said I love every one of you. And that was it.

Timing of Death

In the majority of cases, there was a period of at least several months between diagnosis and death. However, ten participants perceived the deaths as sudden. The following recollection of Mrs. #27 is representative of some of the answers given in response to

being asked whether the death was seen as sudden or expected:

He had congestive heart failure. It was a slow process--on the doctor's report they said he had it for about five years. The Dr. had told me he wasn't going to make it but he couldn't give me a deadline of how long. (My husband) himself told me one day sitting here that he was going to die. I told him that the doctor said if he took care of himself he would be around forever.

Mrs. #27 said that she did not view the event as sudden, but it still surprised her. Mr. #25 described an illness of six months duration and said that even though the death was expected, "we were just hoping and praying that a miracle might happen and we had a lot of support from the church for that."

Mrs. #15, whose husband died after a six month illness stated her perception of the death in the following way:

It seemed sudden to me. I was up with him all night. And he was always wetting everything and it was such a chore. I didn't get any sleep and my weight went down to 110. I'm still 110. I called someone from Hospice. I think they knew when they expected him to go, but they didn't tell me. It wasn't long afterwards that he passed away. I just didn't know, I just didn't know.

Even after that description, Mrs. #15 said that she would not have wanted her husband to be anywhere else at the time of death.

Mrs. #24 described her husband's death as "very much expected."

She further elaborated:

We knew he couldn't live. It had been pretty much downhill all week. I remember that the whole family was here. He was pretty much in a deep coma. I did have some records and CD's on very soft. He liked classical music. And in dealing with other deaths in the family they say you never know how conscious a person really is. So I spent that final time reading favorite psalms to him. It was so peaceful. It was just wonderful. We knew he was with God.

Mrs. #24 also felt that the death experience drew her family closer

together and it gave her joy to watch her adult children help with his care.

The Death Event

The death itself, wherever it took place, was remembered in great detail by 26 of the participants. Three reported that they view that particular time as rather unclear in their minds. One respondent was, at the time of her partner's death, still in a coma with her own injuries and missed his funeral. Mrs. #10 describes the time of death in the following way: "He died the next morning. I was kind of a zombie. I was moving around like I didn't know what I was doing. I don't know what I would have done without my son and daughter-in-law.

Mrs. #22, whose husband died after a lengthy battle with cancer, and had been in a hospital bed in their home for nearly a year described the death this way:

It's firmly in my mind which I sometimes wish it wasn't. Neighbors had to come over in the middle of the night to help him to the commode. He said thanks a lot guys and happy (holiday). About 7:00 a.m. his breathing started to change. About 10:30 or 11:00 I heard the death rattle. I yelled at him, that he couldn't do that to me, he'd never gone anywhere by himself and he wasn't about to go by himself this time. I was going to go with him. They say you're supposed to talk quietly and gently with them. I didn't. I carried on something fierce.

Mr. #6 remembers the time of the death this way:

I got up and went to the bathroom, then she did. I said 'copycat' and patted her when she got back. I got up, made coffee, went in there and she was gone. The death was silent. I didn't hear any thrashing or anything.

Except for the participant whose spouse was killed in an auto accident, no one else reported continuing distress over the way in which their partner died.

Caregiving Issues

Since most of the participants had several months to several years to experience the illness that led to the death of their partners, caregiving issues, both personal and institutionally influenced the way in which the illness and death were perceived.

Outside Sources

Participants were asked to comment on the care their partners received from outside agencies and individuals (interview question #8, Appendix B). Many of them had very positive things to say, particularly about hospice programs, home health care agencies, and a local rehabilitation hospital. Mr. #19 described the home care agency that took care of his wife as "wonderful, it was very good. Everything was perfect." Mrs. #20 described her husband's care as "just marvelous, both here and in Florida."

Mrs. #29 had her husband at home for most of the illness up until the last six days when he went to a local rehabilitation hospital. She described it as "a wonderful place. There are beautiful, kind people out there."

Mrs. #24 described the experience of working with a local hospice program this way:

Oh, it was a beautiful experience. They couldn't have been more thoughtful and they were there every step of the way. There wasn't a need that they couldn't provide. It was particularly helpful to feel that we always had a number to call, anytime of the day or night.

Several male participants spoke of their initial reluctance to have an outside agency in their home. As Mr. #29 recalled:

The only reason we went on hospice...the girls said, "Dad, you shouldn't be doing that..." (giving her baths and personal care). So they set it up. That worked out pretty good. It worked out real well. They were great. I have nothing but high praise for hospice and high praise for the personnel.

Mr. #25 remembers it this way:

We had doctors and a hospice program involved in her care. One doctor was a very close friend and would come more often because of the friendship we had. In getting hospice involved...I finally broke down and said "I've got to have some help." It was really good. I can't speak highly enough of their program. The nurse explained very well what was going on and what we could expect. Excellent, excellent program.

But not all memories of involvement with outside agencies and personnel were positive for the survivors. As Mrs. #27 explained:

He was in and out of the hospital for a period of about thirty days in the critical care unit and intensive care unit. He set up in his chair all day the day before he died. He wouldn't go to bed. But that night he was very restless and I slept in the bed with him and I was covering his shoulders and talking to him. I had no idea that it was the last. And the Hospice nurse said, "Well _____ you lived a good life, you'll probably just fall asleep." And that really upset me. And I asked her later on to please not talk like that to him because he would get depressed. And she said, "that's my job, I'm supposed to prepare you."

Mrs. #9 lost her partner to prostate cancer: "And I was so mad at the medical profession because he took such good care of himself. It should have been detected before that. He had regular testing."

Mr. #16 had some concerns about the medical personnel they saw in Florida during the six year duration of his wife's treatment for cancer:

You're never able to see the head guy. He's either on vacation or he's unavailable. Whenever you get so far along, everybody turns away, they turn in different directions. If they think you're not going to make it, there's not much they can do. They don't want to go near you.

Mrs. #10 shared some concerns about how the hospital handled some express wishes of her partner and herself:

I was very distressed at the way the hospital handled some things. When he entered the emergency room, my son and I signed a paper that we wanted no heroics. The doctor and the chaplain signed it and it was in his chart. During the next five weeks he was moved all over the hospital due to other problems he developed. The last few weeks he was in ICU and the chart followed him up there. All of a sudden something happened and the nurse grabbed me and pushed me out the door. Things came alive with people coming from everywhere. They performed a red-alert. They called my son. We supposed, of course, that he was gone. Then they came back and said, "we've revived him." We were so distressed. Of course we'd love to have him, but we just didn't want him to suffer anymore. We confronted them about his D.P.A. (Durable Power of Attorney). They said they didn't look at his chart. I don't know how hospitals can function that way. He lived another two days.

One participant expressed a great deal of frustration over the scheduling of home care help while his wife was dying. As Mr. #12 explained:

Home care agency X failed me. I was always concerned about whether somebody was going to show up or not. I found it to be a very unsatisfactory time and I was very resentful. I wasn't very nice. They didn't return calls--said they'd take care of it and I wouldn't hear back for three days. They should have told me to begin with that they didn't have the personnel. I was pretty dissatisfied with them too. I guess I'm an old crab.

In addition to the preceding stories of specific incidents

with outside agencies and individuals, there were some general comments made by several survivors that they hadn't felt like certain hospital personnel cared about them, and some complaints about hospital billing systems.

Personal Caregiving

Participants were asked whether they had provided care for their partner during the illness, and asked to describe that experience. Seven survivors said that they were not really involved in taking care of their partner primarily due to their own fragile health or limited mobility.

The majority of respondents, 22, were involved in providing care for their partners prior to the death. Of that number, 2 survivors took care of their partners prior to a nursing home placement but continued to visit daily and provide care such as feeding and some personal hygiene. Mrs. #13 described the experience in this way:

I went to the nursing home every day. He couldn't see, but I took him down the hall or outside in the wheelchair. It made me feel better because I was doing something for him. He never asked to come home. I took the dog over to see him. I was there when he was eating because he didn't like to eat. I don't regret it.

Of the remaining 20 survivors who talked about the caregiving experience, 6 were able to discuss positive aspects of the experience. Mrs. #4 talked about some changes that occurred in their partnership as a result of her husband's illness:

He never counted on me to do much because he was always in

charge. When he became really ill, he was glad I was there. I had to learn to do a colostomy before I could bring him home. I never thought I could do something like that. There were some very intimate things that I had to do to him that I never thought I could do but you'd be surprised what you can do.

Mr. #6 said, "I took care of her since her heart attack in 1991. I did most of the housework. It made me feel better that I was helping."

Mrs. #22 was pleased with the expertise she developed in providing care for her partner:

I wrote a journal of medicines he had and you know output and input and all that. Dr. _____ said, "I wish you were my nurse, but they're going to be jealous of all those letters after their names." They don't have any common sense like you do." I can't say it was my pleasure (caregiving). It was something that I wanted to do. He had taken care of me so many times. He died in my arms and that's the way I wanted it. I used to crawl into the hospital bed with him.

Mrs. #24 described her feelings about caregiving this way:

I can't say I enjoyed it but I wouldn't have done anything else. It was a pleasure, you know when you love someone so much you want them to be comfortable. Anything I could do to make him comfortable was just fine. He was an easy person in that he never complained.

Mr. #25 said that he tried to be a caregiver for his wife and "I wanted to be. I wanted to do as much for her as I could. I can't say helping her was anything but the fact that I loved her and I was doing it for her." Mrs. #29 said "it was wonderful (the caregiving experience). I mean I'd never shaved anyone before." She then described an elaborate morning shaving ritual that she and her husband both enjoyed and said, "I wanted to do everything I could."

Nine of the 22 persons who provided care for their partners

seemed to view the experience as having elements of both good and bad, but saw the help as something that they owed their partners or was expected as part of the partnership. Mrs. #17 explained:

It was something I would expect to do as his partner. I was up a lot during the night to give him his medicines. I would be lying there thinking, "What am I doing wrong, if I'm doing anything wrong or what can I do to help the situation." Thinking about stuff like that, I didn't sleep too well.

Mr. #21 also talked about his partnership obligation when he discussed his caregiving role:

It wasn't too bad. People kept saying "how can you take care of her?" Well, heck, it was no big deal, I mean I ... we had been together all our lives. I would have expected the same thing out of her. She would have taken care of me the same way I took care of her. A lot of times I got tired but I wasn't that bad off. I didn't think I was doing too bad. The kids bitched at me a lot of times but I didn't think I was doing too bad.

Mr. #16, who took care of his wife during an illness lasting six years, described the caregiving experience this way:

I didn't mind that. When people die, your world comes in around you and just keeps getting smaller and smaller and smaller. It's just a big problem to move from here to there. The least little effort is more and more hard to do. They (other people) don't appreciate that they can do that (move around) until they can't do it anymore. You know when you're taking care of sick people. You don't have the strength to even take the newspaper out of the wrapper.

Mr. #12 spoke of some of the difficulties in being a male caregiver:

It was very hard but I did the best I could. I'm not a very domestic person. I always sort of left that up to her but when I could take care of her I did. I cooked meals, she didn't eat well. I felt fairly proud of myself that I was able to do some good.

Mr. #26 also talked about new skills he acquired as part of

the caregiving experience:

I was the chief cook and bottle washer. Well, I learned to cook rather decently and my wife was quite critical of it because I improvised once in a while on a recipe. Almost always it fell flat. It was difficult for her because she knew she was never going to get better. It was a one-way street. We talked around it more than we talked about it. Sometimes I went out in the yard to cry.

Six respondents stated that the caregiving experience was very difficult for them. Several said that it was hard because they didn't think they were as helpful as they would have liked to be. Mrs. #7 described that time as "very difficult. He was much the better caregiver than I was. He just had a way about him of taking care of people. I think he had a lot more empathy."

Mr. #30 was preparing for at least six months of caregiving, but his partner died several days after returning home from the hospital. He stated:

Very honestly, when she died I had a feeling of relief as well as remorse. I was pretty exhausted myself at the time and I just kind of pictured what am I going to be like and what is she going to be like six months from now 'cause that was the unspoken anticipated time of survival. I'd have been up on the hill on (local mental institution) if they still have it. Since then I've felt guilty that I shouldn't have had a sense of relief. I'd take her under any circumstances.

Mrs. #27, whose husband's illness lasted for a period of several years found the experience difficult due to the level of fatigue that she reached:

I was the sole caretaker. He died here at home. I helped him when they (the professionals) weren't here. In the end, farther down you know, I had it all (cries), you know like I even had to brush his teeth, shave him, spoon feed him, give him B-12 shots, change diapers, the whole bit. It was rough. I didn't mind taking care of him but I'd get so tired because see he'd want to go to the bathroom all through the night. I

think the caregiver needs respite at night the most. But I didn't want to put him in a nursing home and I didn't.

Summary

In the previous section, respondents shared information about the experience of losing their lifelong partners by describing the physical death itself as well as the additional losses that preceded and accompanied it. Survivors were also asked to share their personal experiences of providing care to their partners and to comment on how they felt their partners were cared for by outside agencies.

This information was used to introduce the participants as well as to supply background information about what had transpired in their lives prior to beginning the adjustment process to bereavement.

Adjustment After Bereavement

In this section, the responses to the individual research questions are reported. Sometimes several questions in the interview schedule were used to elicit the same information to see if there was some consistency of responses for the individual participants.

Anticipatory Grief

This study attempted to discover what, if any, is the significance of anticipatory grief in the adjustment process for older adults experiencing the loss of a lifelong partner? (Research Ques-

tion #1). Respondents were asked whether they felt they had done any grieving prior to their partner's death. This question was used to determine if anticipatory grief, which is considered a preparation or rehearsal before the death served to ease the adjustment process following bereavement.

The results obtained included 9 participants who said they felt they had done some grieving ahead of time, 12 who said they had not, and 8 whose answers were inconclusive, i.e., their responses were not able to be placed in either the affirmative or the negative category.

Several of the respondents who said they had done some grieving ahead of time had placed a partner in a nursing home prior to the death. Mrs. #3 stated "I'm very grateful for this year of preparing myself, of being able to say good-bye. Even though his body was still there, his mind--he wasn't the same guy." Mrs. #8 said, "Yes, I think I did some but it wasn't the same I guess. But you just feel sorry for them. You can't do the things you would like to. I did grieve for him, I'm sure."

Mrs. #29 felt that she began grieving prior to the death and recollected that the grieving began at the time of her husband's diagnosis:

I remember the day when I went up to the hospital and the doctor had just told him he didn't have too long. And I didn't see (him) right away. He was going around the corner and the doctor told me, "your husband wanted me to tell you that." And (husband) was in a little waiting room down there. We cried together. But never did he want to talk about it after that.

Mrs. #22, when asked if she felt she'd done any grieving prior to her partner's death said:

Oh yeah. I was lying down with him when his nephew and niece and sister came over to see him and when they came in I made a beeline for the bedroom and I sat there crying. And his sister came in and I said "I'm losing him, I know I am." And then I got myself together and went back out. I did that a couple of times where I would kind of accept it, and then I wouldn't-- I wasn't going to let him go, I wasn't going to let him go.

Mrs. #24 was able to clearly express the process she went through during her partner's illness:

I did a lot (of grieving prior to his death). What helped me most was reading. (Names several books). . . You realize you're not alone. Others have walked the same path you have and that helped me a lot. I said to him, "I just can't imagine living without you." After he got more ill I never did that again because I thought he has enough on his plate. I can't add to his grief or worry about me. And I think that's really why God let him rally for six months because none of us could have said goodbye to him so soon...I don't know. And I did read a book that said you have to be able to say it's all right to die. And I never thought I would ever ever be able to say that, but I realized I really could say that to him. And I could.

The respondents who said that they had not done any grieving prior to their partners' deaths most frequently mentioned that they were still hoping for a recovery or change in the situation. Mr. #1 said, "No, I didn't grieve. We still kept praying for a miracle." Mr. #21 described his experience this way, "It hits you like a ton of rocks, there's no doubt about that. I don't know. I don't think so. I mean, hey she was still with me. We just did everything we could do.

Several participants who said they had not done any grieving prior to their partner's death attributed it to being too busy as a

caregiver. When asked if he had done any grieving prior to his wife's death, Mr. #25 responded "not really. I think I was too busy taking care of her and bringing her to the hospital. Probably at times I knew it was going to come but you just say no in the back of your mind."

Mrs. #4 said that she also did not grieve prior to the death because "I was too concentrated on what I was doing. I'd had cancer two years before he did and that prepares you a little bit for anything else that can come along." Mrs. #7 stated, "I didn't have time (to grieve). I didn't have time to think about what it was going to be like when he was gone."

A response was considered inconclusive if the respondent gave elements of both affirmative and negative aspects of the process or used the phrase "I don't know." The response given by Mr. #6 is typical of these responses. He said, "It's a funny thing. I did some pre-funeral planning and I thought I had a good handle on it and then I didn't do a damn thing that I'd been talking about." Mrs. #23 answered the question by saying, "Yeah, I don't know. I don't think so."

Mr. #26 observed that "You know it's going to happen, it's inevitable. It shouldn't be a surprise, but it is. You never know. You're not quite prepared for that day." Mr. #30 responded to being asked about grieving before the death saying "Yes and no. It's hard to determine. You're concerned with the immediate problem. I was hoping that she might have a slight remission. I really didn't have

time to grieve prior."

Several participants mentioned that they knew their partner could not continue to live with their conditions declining so rapidly. Mrs. #27 felt that she had made some preparations for her partner's death but:

You think you've prepared for it--you never are. I'll tell you how prepared I was. I sold two lots in (another city) and bought two here. I also made pre-paid funeral arrangements about a month ahead of time. I would do things when I could feel that I was up to it, emotionally speaking. Because I would look at him. He was just melting away in front of my eyes. A couple of days before he died, I said a prayer to God that if you can't make him get well, don't let him go on.

Mrs. #31 also reported that:

You think you're ready and you think you're going to face it and you're prepared for it, but you're not. I kept praying "Lord if you can't heal him or make him whole, take him home." I grieved every time he moaned or hollered. Maybe that's why I didn't cry at the wedding. I did so much grieving then. (Laughs) At the wedding...

Mrs. #20 perhaps best summarized the conflictual aspect of losing one's partner over a long period of time:

I guess I would have to say that I was always planning for what we were going to do--and he was a great planner. I knew it was coming and it could come any time. I am very grateful that he didn't have to suffer anymore. Someone called me several weeks after he died and asked me how I was doing. I said, "so-so" and the friend replied "Well (Mrs. #20) you knew he was going to die. He's been so bad for so long." I thought I was doing real well too but you're never ready for the final thing. You never can be prepared for death. You can think you are but when the time comes, it's a big shock.

Three male participants mentioned they had not expected their partners to die before them which has made the loss more difficult to accept. Mr. #18 stated that the death was further complicated for him because "I always thought I'd go first." Mr. #25 mentioned

the longevity of his wife's family as an explanation for why "I figured I was going to be gone long before she died. I didn't expect that she was going to die, let's put it that way." Mr. #12 summed up his experience by saying, "I didn't think it was fair. I was supposed to go first. I'm a diabetic, I have cardiovascular disease, very high cholesterol, angina, and I didn't picture her leaving first in my wildest imagination.

Summary

In this study, the significance of anticipatory grief to the survivor's adjustment process was not shown. Of the nine participants who felt they had done some grieving prior to the death, there was still a tendency to say the death was expected and yet express surprise that it had happened. Mrs. #22 who said that she had grieved prior to the death, expressed the ambivalence of the situation when she said, "I would kind of accept it, and then I wouldn't. I wasn't going to let him go."

The twelve respondents who said they had not grieved prior to the death felt they had been too busy in the caregiving process and taking care of other details for their partners as well as hoping the situation itself would change. Twenty out of 29 survivors either did not feel they had done any grieving prior to the death of their partners or were not able to answer the question in a conclusive way.

Social Support

This study attempted to determine the significance of the social support network in adjustment to bereavement among the survivors (Research question #2). This section reports the responses of participants when asked about who and what they found to be supportive in their lives in the adaptation process following bereavement. Research question #3 asked "What individuals or groups in the network are the most significant in the readjustment process?"

Initially, the specific support persons mentioned by respondents are listed. Then, in order to provide inter-reliability, responses regarding whether the participant had someone with whom s/he felt comfortable to share feelings of grief with will be examined, as well as if they felt encouraged to grieve openly.

The institutional structures that the survivors found supportive will be discussed. Finally, the participants were asked questions regarding whether they felt they had received enough social support since their partner's death and whether or not they felt that the level of support had changed over time in their bereavement process.

Support by Persons

When the survivors of the loss of a lifelong partner were asked about support they had received from persons in their lives, the results represented each person's individual definition of the word support. In response to interview question #20 which asks,

"Who have you relied on most to keep you going through this time of transition?" (Appendix B), the first person or persons mentioned fell into the following categories (see Table 3).

Table 3
Social Support Network--Primary Support

Support Provider	Number of Responses
Adult Children	17
Myself	1
Grandchildren	1
Significant Other	1
God	4
Friend/s	3
Professional Caregiver	2
Total	29

Taking into consideration all responses as to who had been relied on most during the transition following bereavement, friends, with 7 additional responses, adult children with 6 responses and extended family with 5 responses were next in order of significance. Four persons reported the people from their churches as significant support persons and 3 additional participants listed themselves as a major support. Other support mentioned included; neighbors (3), hospice staff (3), hospice chaplain (3), pastor of specific church (3), C.P.A. (2), Broker (2), Psychiatrist/Mental Health Worker (2),

retirement community residents (2), and trailer park residents in Florida (1).

When participants discussed persons they had relied on most during the transition, Mrs. #15 said "I would say anybody who would listen." Mrs. #9, in explaining the support of her family stated, "Some people have family and don't have their support and that's pathetic." Mrs. #11 listed her two adult children and then declared "I don't really need anybody else. I can take care of myself." The two people who listed their professional caregivers as their primary supports were estranged from adult children. One person listed a significant other who had been a part of this individual's life many years ago and was now also widowed as being the most significant social support person.

Another question addressed to the participants was "Do you have someone in your life with whom you can comfortably express your grief?" (question #16, See Appendix B). When the question was asked this way five respondents said that they didn't choose to grieve with others around. Mrs. #31 said, "At first, I didn't. At first I tried to hold it in." Mr. #1 also stated that he tried not to do it (grieve), but if he had to it would be with his son and daughter-in-law.

Mrs. #2 expressed that she felt comfortable expressing her grief with "no one. You (the researcher) are the only one. I wouldn't dare in front of my son. He will say, 'Mom, get over it.'" Mrs. #5 felt that "I don't want to talk about my problems with some-

one else. I think it would depend on the person. I really don't think it's necessary."

Two respondents replied with a generic answer. Mr. #18 said "I would talk to myself or to someone encouraging." Mr. #16 stated his only requirement for a person to express his grief with:

All you have to have is somebody to listen. There are very few people in this world who will listen. It's harder to stop and listen to someone than to give your side of things and I think people just bypass each other. Today's world is superficial. You don't get too deep.

Ten survivors still listed adult children as persons with whom they could grieve most comfortably, and two daughters-in-law were specifically mentioned. But in several instances, an adult child was mentioned as a primary support with the older adult trying to protect the younger.

Mr. #30 lost a grandchild several months before his wife died. He named one of his daughters as a person he could express his grief with, but with reservations:

I can talk to any of my children but I'm a little reluctant with my oldest daughter because she's the one that lost the son. We talk openly together. But I wouldn't want her husband there when I do it, I wouldn't want any of my other kids there. We do a little grieving together sometimes.

Mrs. #8 said that she could grieve with her daughter but felt she was relying on her "too much probably. She has her own life. I think she's devoting too much time to me on weekends."

Six respondents named friends as people they would feel comfortable expressing grief with. Mrs. #20 described a couple that she is friends with and how she called upon their friendship.

A year ago I called them up and said, "Are you going to be home tonight." And the husband said "yeah" and I said, "Well, I need to get in a conversation that's got a man in it. I'm getting sick and tired of these luncheons where there's no man's voice and there's no man's input."

Mrs. #22 mentioned her best friends (a couple) as her major source of support:

They are like my brother and sister. They've been real good to me. They took care of me when I passed out...fainted at church. They came and got me, took care of me for ten days to make sure I was all right. They wouldn't let me go home and I think I must have cried for a half an hour. They said, "Let it go (Mrs. #22) because you've kept it in for almost a year," which I did.

Mrs. #24 named God as the only person with whom she could comfortably express her grief.

I think he knows what I need. He's become my best friend. He's my answer. I wouldn't want to burden my children with it because it's not their burden. They've lost their father, they haven't lost their mate and there's a big difference. I know because I lost my father. I lost my mother. I lost my brother. And those are all big losses and hurts. But nothing compares to losing the other part of you.

Summary

In this section, the significance of social support on the adjustment process was examined. The majority of the survivors were able to name individuals from whom they felt they had received support, although one participant gave the response "myself" and four participants named "God." However, many responses were given without hesitation followed by the phrase, "I don't know what I'd do without them," indicating a perception of social support.

In response to what individuals or groups in the social net-

work were the most significant, adult children were by far the most frequent persons mentioned (17 responses). However, they were not as frequently named as the person/s with whom the survivors could comfortably express their grief (ten responses).

Institutional Support

This study was concerned with "What institutions are the most significant in the readjustment process?" (Research Question #4). The survivors of the loss of a lifelong partner mentioned several larger societal structures as being helpful in their adjustment process following bereavement. They were not limited to one response due to the open-ended format of the questions. (See Table 4).

Church was by far the institution most often mentioned as a support mechanism. One respondent watched televised church services as her limited mobility made it very difficult to attend church outside of her home. But even though church was mentioned as a supportive place, several survivors mentioned some struggles they had while at church.

Mrs. #9 said, "We never went back to our previous church because the minister didn't support us at the time we needed help." Mrs. #22 also changed churches during that time because she did not like the minister's style. She did find support from the pastor of her new church as well as the hospice chaplain.

Mrs. #20 talked about what happened when she returned to church following her husband's death:

Table 4
Social Support Network--Institutions

Support Provider	Number of Responses*
Church	15
Grief Support Groups	6
Senior Center	5
Hospice Program Aftercare	3
Retirement Community	2
Bible Study Group	2
Home Support Services	2
Television (Church Services)	1
Masonic Lodge	1
Small Town	1
Community Groups (Unspecified)	1
Home Health Agencies	1
Total	40

*Multiple responses were allowed

I went back to church the Sunday after he died by myself. People asked me what I was doing there. I said "I feel better here than at home." And I went to see old friends. We've gone to church there since 1949. My husband was on the building committee.

Mr. #25 was able to recall an incident that he had experienced at church a week earlier. "Last Sunday I was in church and this one family sat next to me. And the lady is an R.N. who came here and I can still remember her talking to (my wife) and I had trouble."

He was also able to recollect how he felt when he returned to church following the death:

It was at first, very, very hard. The first time I went, I lasted about three minutes, then I had to leave. The next time I got through about half of it. Finally, the third time there I got through 90% of it and I thought "well, I'm improving." I've noticed now that if I go to church and sit with somebody I'm better than if I sit alone. I sit in a different place than I did when my wife was alive.

Mrs. #29 talked about the importance of her church in her feelings of being supported. She said the church has "helped a whole lot. I don't know what I would do if I didn't have it. It's very hard to sit in church and the hymns are so beautiful. And when I go up to take communion, I cry all the way there."

Six respondents mentioned area grief support groups as places where they felt supported. Mr #6 said he appreciated attending such a group because "they've all been down the road." Mr. #16 attended a grief group provided by a funeral home and said that "it answered some questions. You can get too busy and not allow yourself to grieve." Mrs. #31 felt that "it really helped me when I started going to those meetings. I thought I was alright and then I realized I wasn't."

Five participants mentioned a senior center as a place of support for them, but only one person was using the grief support group there. Mrs. #9 said that "I'm there every day" and struggles with what to do on weekends when the center is closed. Mr. #6 likes attending the senior center because "you can be as busy as you want."

Mrs. #5 found living in her retirement community helpful.

She had to move in due to compromised health and said, "I made up my mind when I moved in here that I was going to like it." Mrs. #3 appreciated the buddy system they have in her senior complex. Mrs. #10 said that "living in a small town helps. You can't live somewhere for 60 years without running into someone you know."

Two individuals felt supported by homecare agencies coming to their homes and services such as Meals on Wheels. Mrs. #23 expressed it this way:

I'm lucky beyond belief. I mean, why would they even care. But they're caring, wonderful people. You know that guy who brought my meal today--I think they must give a report when they get back because I saw him kind of looking inside. I was going to invite him in but I don't know if he'd get the point or not.

Other institutional supports mentioned did not generate much additional comment except that they provided a structure for being with other people.

Summary

In response to the question of which institutions were the most significant in the readjustment process, church was found to be named most frequently by the respondents (15 times), with one additional participant naming televised church services. Other institutions that provided frequent support for the survivors were grief support groups (six responses) and senior centers (five responses).

Kinds of Support

Research question #5 asked, "Is social support more frequently

offered in the affective (emotional) area or in the instrumental (task-oriented) area?" Survivors of the loss of the lifelong partner were asked to explain the kinds of support that the persons in their lives were providing. This support was differentiated into two categories: affective support and instrumental support.

Affective Support

Participants were considered to have received affective support from their social network if their responses indicated an emotional level of support, i.e., they were somehow allowed to express how they were feeling about the loss and provided a safe atmosphere in which to do that.

Seven of the respondents did not mention any specific emotional support they were receiving. Mr. #1 said, "people don't show it, but I know how they're feeling." The most prevalent area of perceived social support for six participants was, as Mr. #6 described it, "their presence." Allowing the survivor to talk about what had happened was described by four respondents. Mrs. #7 said, "they give me a chance to talk about it, and include my husband in their conversations." In describing his best male friend, and couple friends, Mr. #25 shared that "I could pour out my heart to them." Mrs. #17 said that "some of my friends and also my son--they'll grab me in their arms and tell me, Go ahead'."

Having someone who builds up the survivor's spirit was mentioned by four participants. Mrs. #27 said, "if I'm down, my daught-

er is great to build me up emotionally." Mrs. #29 talked about the group that she is still in contact with who supported her and her husband after the death of their adult son from HIV:

They supported me after my son's death too. They never left us. We lost some good friends during our son's illness and death. A man in this group said "Talk openly about (your son) to whoever will listen. Keep him alive in your heart." And I thought that was beautiful. Otherwise, people want you to get on with it.

Sometimes the description of emotional support took on a spiritual dimension. Mrs. #31 felt it when "I was sick. I got calls and phone calls from the church. I knew they were there, I could just feel it." Mrs. #24 described her support as coming from God:

You're given a peace. I also firmly believe that there's a life after this life and that my life has a purpose and for whatever reason (my husband) was taken and I was left--well, God has work for me to do. I feel very strongly that I must be a strength to my children and grandchildren. If I go around with a gloomy face, what are they going to say about it? I feel like I have to be a positive example.

Three respondents said they felt emotionally supported by having friends and family keep in touch through phone calls and notes. Three respondents also felt supported when they felt others were really listening to them. Mrs. #2 described the support she felt because "they listen to your world."

Mrs. #3 felt emotionally supported by what she terms "unexpected kindness," exhibited by friends who put a book in the library in memory of her partner, and went with her to the cemetery to put flowers on his grave.

Grieving Openly

Survivors of the loss of a lifelong partner were asked to rate the extent to which they had been encouraged to grieve openly by their support network. A four point Likert scale was used ranging from "not at all" to "frequently" as well as a designation for persons who did not answer the question directly. (See Table 5).

Table 5
Encouraged to Grieve Openly

Rating	N	Males	Females	%
1. Not at all	5	2	3	17
2. Rarely	11	4	7	38
3. Sometimes	4	2	2	14
4. Frequently	4	0	4	14
5. Didn't answer	5	2	3	17
Totals	29	10	19	100

The findings indicate that the majority of respondents (55%) felt they had not or rarely been encouraged to grieve openly. Mrs. #8 who responded "not at all" said "that's just not in my nature. In my whole family, you don't show your feelings too much, you know?"

Mr. #21 also felt that he had not grieved openly:

I don't know. I guess I just haven't done that. If I wanted to cry with them, I'd cry with them, but I've never really felt...And you know sometimes I wonder and I know it's not

true but you know you wonder, at least I do...it didn't seem like, I've heard people say, oh man they grieve for months on end, crying and everything and that never bothered me. I didn't have that and it makes you wonder, well did you love her as much as you think you did but there's no doubt in my mind I loved her. But I've not had any real bad down time as far as I'm concerned. I don't think I have.

Mr. #30's response to whether or not he had grieved openly was:

I just don't. I don't think anyone would have any objections to me doing it, but it's never been mentioned. I know intuitively that I give the impression that I'm not grieving or that I'm handling it very well. I think this is as much as I've done openly. I've said from time to time, I'm not handling this nearly as well as you think I am. But that's about it. I don't go into details. Maybe I should but I don't.

Mr. #12 discussed the ways in which he expressed himself but felt he was not grieving openly: "We mostly talk about things that she did and remember her. I talk to her picture at night all the time. I don't worry about it. I just think that sometimes I'm going nuts."

The largest number of respondents, eleven, felt that they were rarely encouraged to grieve openly. Mrs. #5 answered by saying "I don't get sad. I don't get blue. I wake up every morning and thank God for giving me another day." Mr. #6 explained his grief pattern by stating "I'm like my mother. It's hard to cry outside. I cry inside." Mrs. #13 explained:

I've never had the feeling yet. I've never had a depression. Whatever I say, I try to keep it in a very cheerful mood. I could sit here and think of all the things and really get teary-eyed and jerked up about things and I don't like to do that.

Mrs. #20 described herself as being rarely encouraged to

grieve but explained how she handled the situation with her friends:

When we would get together or they would meet me, they had a hard time saying (partner's) name because they were afraid I was going to burst into tears. And I thought it was because they didn't know how they were going to handle me. But I have heard many people, quite a few people say that they've had this same feeling. People don't want you to break down. So I had got to the point where I would say his name and the next thing I knew these friends were speaking of him automatically because they weren't getting a sad reaction from me.

Four respondents said that they were sometimes able to grieve openly but only two elaborated on the rating. Mr. #25 said he felt he could grieve openly sometimes because "I've gone to a grief group. Talking with my good (male) friend--I don't feel bad about crying in front of him." Mrs. #31 said that she grieves sometimes "but I do try to keep it controlled."

Four female survivors said they were frequently given the opportunity to grieve openly. Mrs. #3 explained that "the hospice bereavement person got me to cry. It's hard for me to cry in front of people, but I know it's good for me."

Of the five participants who did not give a ranking response, two did give explanations of their grief process. Mrs. #10 had abruptly lost an adult child three months before her husband died. She answered the question by saying, "I don't know. Different ones have said, 'oh, let it go, you know' and I couldn't answer. I can't go to church or I have to get up and leave. It feels like a bomb." Mrs. #27 explained, "I try not to cry in front of my daughter because poor (daughter)--that was her father."

Summary

Respondents clearly expressed their feelings of having received affective support primarily by the presence of others, and the feeling that they were being listened to and being built up emotionally. The survivors did not feel that they had been encouraged to grieve openly, but several of them stated that they would not be comfortable doing so even if they were encouraged. Only four respondents felt they could frequently express grief.

Instrumental Support

During the interview, respondents were asked what kinds of support they were receiving from persons in their social world. Many participants gave examples of instrumental support involving shared tasks, practical services, or material assistance. One survivor had an adult child living in the home, and one had a grandchild and spouse sharing living space. Another respondent was living with her son and his family but made it clear that it was not her choice, but rather a necessity based on health issues. One person had caregivers living with him around the clock but that situation was about to end as his family had made arrangements to place him in an assisted living facility.

The largest number of respondents, seven, perceived support as going to places and doing activities with other people such as attending the theater, playing golf, activities with grand-children, playing cards, and shopping. Six responses dealt specifically with

having meals with others, or going out for a meal.

Six respondents said that they felt supported when other people did things to help them out such as lawn mowing, housecleaning, assistance with legal and financial matters, help with picking out a grave stone, moving, picking up groceries, and aid in selling the house.

Mr. #16 explained why he felt supported by the people he played golf with "a guy on the golf course says 'Well, I don't know what your problems are, and you don't know what my problems are. We're here to play golf and that's what we like to do.'"

Two respondents simply said they felt supported when others did nice things for them. Two other survivors said that they were supported knowing that their neighbors keep track of them. Mrs. #22 described her friend's support as needed "when I have to put up with you (researcher), she'll come and help me (laughed)."

Perceived Level of Support

The survivors of the loss of a lifelong partner were asked, "Do you feel you have received enough support during the bereavement process?" Table 6 illustrates their responses:

Seventy-six percent of the respondents reported that they felt they had received enough support since their partner died. Some of the responses were unqualified such as the one given by Mrs. #4: "Oh, you bet. I haven't wanted for a thing. I don't ask for help unless I really, really need it and the kids know this. I

also know that if I need anything, they're around."

Table 6
Perceived Level of Support

Response	Number
Received Enough Support	22
Needed More Support	1
Don't Know	6
Total	29

Mrs. #17 said she had received enough support and "the one good thing is that if I need help, I know where I can go to get it." When asked if he felt he had received enough support since his partner died, Mr. #21 replied, "Oh yes, I do. I remember telling the doctor that I had taken care of (partner) for so many intense months that I was to the point where I wanted somebody to take care of me."

Although some of the survivors felt they had enough support, Mrs. #31 also felt that "some of it's been the wrong way. I would have done better without having it. I know they're (adult children) worried but I shouldn't have to report every time I leave." Mr. #16 felt he had received enough support but "there's only so much you can expect from people. I think that what affects a person more is if one of your children goes. I think that would be harder than if your wife died before you."

Mrs. #24 also stated that she has had good support: "But I

guess I'm a private person too. I have a lot of wonderful support. I mean, I know people love me, care for me, and would do anything for me, but they can't fill my heart."

Mr. #25 agreed that he had enough support but; "there's still lonely times. Last night I got into bed and I thought, 'Gee, this bed's lonely again.'" It's been a whole year. You'd think you'd be over it by now but you don't..."

Mrs. #27 answered the question about support in a way that represented ideas expressed by many respondents:

Oh yes (I've received enough support). I feel that I have. I try not to depend on people. I don't want to be a drag on my children. I want to be independent as long as I can. I don't want to be down and crying around them. I want to enjoy them. And I want them to enjoy me.

The one respondent who felt as though enough support had not been provided went for counseling to help with additional coping mechanisms and said, "I think that was a turning point for me." Of the six persons who did not give a definitive answer, several made generalized statements about how they were doing such as Mr.#18 who said, "She gave me so much love that I'm happy right now. I'm not feeling sorry for myself." Mrs. #2 spoke for several others when she answered, "I don't know, I never thought about it."

Summary

Survivors of the loss of the lifelong partner were able to identify ways they were receiving instrumental support from their social networks. Much of this support had to do with sharing meals

and activities. The majority of respondents (76%) felt that they had received enough support since their partners died.

Timing of Support

Research question #6 asked "Is there an optimal time for these social interventions to occur and does the optimal time vary dependent on the type of support given?" Research question #7 considered "What are the ways the social responses towards the bereaved change over time?" The survivors of the loss of a lifelong partner were asked if they had felt a change in the level of support over time. Their responses are shown in Table 7.

Table 7

Support Change Over Time

Response	N	Percent
Yes	12	41
No	8	28
Indirect Answer	9	31
Totals	29	100

The results obtained were mixed. Twelve respondents felt that the level of support had changed over time. Of those 12, 9 persons had been widowed from 6-24 months, placing them in the acute period of bereavement. Survivors recalled that they had started to notice a change in support levels at various times in

the first year following the death.

Mrs. #6 said:

Of course people don't talk about it much anymore. So many of the people living in these apartments have lost someone. So I thought it was kind of queer 'cause I didn't get over it (at six months). I kind of thought I would.

Mr. #12, who was six months post-death at the time of the interview said the level of support had changed: "Oh yeah--even in six months. It changed after the funeral. People who used to call don't call anymore. All these people who were trying to be supportive when she was ill, I haven't heard from them since."

Mrs. #26 was 16 months post-death when she said, "Oh yeah (level of support has changed). The kids, not that they get tired of it, but they have their own families. I would guess it changed probably a month after."

Several respondents explained the change in support as one of the conditions of our society. Mrs. #10 felt the level of support had changed "but then people get involved with their own life and you just figure you can adjust." She said she noticed the amount of support changing after three months or so. Mr. #16 also said support changed because "people are so busy. Everybody's scheduled so much. Nothing is ever done spontaneously."

Mr. #25 noticed that after the first year the church was not as supportive as it had been at first. Mr. #1 also stated that after the first year, "I think from now on it's going to be more difficult." Mrs. #3 who spoke 26 months after her partner died said she "felt the level of support change after the first year."

During the first year you seem so determined to get on with your life, then all of a sudden, whammo! You feel all alone. The second year is even worse."

Mrs. #22 responded to the question about support changing over time 41 months after her partner died. She had the following comments:

Well, for most people, it's been a long time so they go on with their lives and that's fine but I'd say it changed at about a year and a half, two years maybe at the most. And then the only ones that really supported me were my brother and my sister, and they have now both died.

One participant, Mrs. #9, at 24 months post death claimed that the support had changed over time but in a positive direction. She said, "You know I get more support now because at first I wasn't associated with this church. With friends maybe it's not so concentrated now, but I don't need it all."

Of the eight respondents that didn't feel their support levels had changed over time, three were between 6 and 15 months following the death of their partners. Mr. #10 responded that "No, it's relatively the same. I don't ask for it and it's offered sometimes and I turn it down." Mrs. #11 said that "it doesn't change much" and Mrs. #13 agreed that "nothing has changed. People keep calling and bringing up his name. We keep him in our conversations."

The indirect responses were those that gave an explanation without a direct response. For example, when asked if he felt the level of support change over time, Mr. #18 replied, "All they gave me was sympathy and sympathy is no good unless they mean it or you

can find sympathy in the dictionary." Another answer that fell in this category was Mrs. #27 who said, "I just don't know."

Summary

The results regarding the timing of social support were inconclusive although several respondents were able to clearly delineate a time when they felt the support start to diminish, and that encompassed a time period between the conclusion of the funeral to the end of the first year of bereavement.

Perceived Positive Changes

Research question #8 asked, "Are there any positive aspects of working through the bereavement process for survivors of lifelong partnerships?" During the interview, respondents were asked about positive things that had occurred in their lives following the loss of their lifelong partner. In particular, they were asked "What strengths have you found in yourself since your partner died?" and "What has helped you most during this transition?" (See Appendix B).

Perceived Strengths

When asked about strengths they had found in themselves since their partners died, the responses provided were varied. Twenty-one survivors felt they had found some new strengths in many different areas of functioning.

The two largest categories where new strengths were reported

were in the areas of doing things by oneself (five responses) and doing more for oneself (four responses). Mrs. #7 said that a new strength was: "Just the ability to make friends and go ahead and do things on my own. I did the planning of activities more in the marriage. I was the party girl."

Mrs. #11 found that a strength was that

I discovered I can get along without him and I'm surprised about that. Never in the world did I think I could live without him, you know? Because he did everything. When he was traveling I did a lot, but when he retired, he took over.

Mrs. #23 said that her new strength was that "I think that I can face things. I think I can just pick up and go on." Mrs. #31 claimed that she had changed her way of handling life:

I was a big coward. I'm not now. I can stay alone overnight. I'm doing things now that I haven't felt like doing. My husband always leaned on me and I guess I let him. The kids used to say, and I did too, that if one had to go before the other, they hoped it was Dad because they didn't think Dad could take it and they still say that.

Fifteen respondents said that they now do more for themselves in many diverse areas. Several people such as Mr. #6 said "I have to do a little more for myself rather than getting my orders from the back room there." Mr. #12 said "I've had to learn to get my own meals and just take care of things. I never did laundry before so I had to learn to do it."

Five respondents mentioned that they had to take over financial responsibilities they had not handled before. Mrs. #2 said that "money went through (my partner's) hands like water. I've taken responsibility for myself financially." Mr. #16 reported that "my

partner always took care of the checkbook. Years went by and I never wrote a check. It became my responsibility when she went into the nursing home."

Mrs. #24 had to make some decisions regarding her husband's business and said, "I'm self-sufficient in that I took over many business duties during my husband's illness. He's gone and people need to know it's me they're dealing with, not my husband."

Keeping their home maintained was a source of strength for three respondents. Mrs. #4 said, "I feel tremendous strengths. A lot of it has come from God. I was able to handle the finances, the outside maintenance of the home, the car, which I was not able to do before my husband's death."

Mrs. #22 said that she also found a little strength that she didn't have previously:

But I'm learning to cope. There's so much more physical things I can't do. And things that he did, well I had no idea and all of a sudden they were dumped on you and I don't know. The yard, maintaining the buildings... I think the biggest thing is the loss of the well. That was a decision I had to make. I had to have a well. I talked it over with him (deceased partner). I had to make my own decision because we never did anything without talking it over. So I had that decision to make because I wasn't going to ask anybody what to do.

Three female participants talked about the hassle of taking care of the car and felt a sense of strength that they'd learned to pump gas, etc. by themselves. Mrs. #20 said that her strength was in "finding that I can make decisions by myself. I thank the Lord that we were as frugal as we were that I have money I can do things with."

Several survivors talked about feeling new strengths in relating to other people. Mrs. #17 felt strength in "the fact that I can get out and volunteer and I know my neighbors, can help them and others." And Mr. #18 said, "The ability to encourage others, that's my strength." Mrs. #27 stated that "I think the main thing I discovered is I feel like I can handle almost anything. And also seeing him die, I'm not afraid to die."

Eight respondents felt that they had not discovered any new strengths in themselves since their partners had died or did not directly answer the question. Mrs. #8 said she had discovered, "nothing new. I've always been self-reliant." Mrs. #9 said she has not discovered much except, "I didn't realize how much I depended on (partner) although my children tell me I'm strong. I'm not strong when it has something to do with the car. I didn't know how to put the gas in."

Mrs. #10 said, "It's the strengths you don't have that you discover, instead of the strengths you do have." Mr. #30 said of himself: "Oh, I'm as weak as a kitten. I've just felt a little guilty about not being as considerate as I could have been. I'm just trying to be more considerate to everybody. I've probably become more outspoken and frank."

Most Helpful Interventions

Respondents were asked, "What has helped you most during this transition?" (Question #25, Appendix B). The majority of responses

fell into three categories: family (11), friendships (9), and faith (9). Mrs. #10 said that the most helpful thing was "people...people. Get involved, be involved. I just think that friends and family keep me going." Mrs. #4 said that she has been helped by "my friendships and knowing that my family is always there no matter what and that they love me. I am so contented."

Mrs. #20 responded that "I just think family and friends. And my faith. What else do you have? Everything else is materialistic." Mr. #18 also talked about being helped by "music and helping other people. Everything I have is the Lord's. If I had a million dollars, I'd help people out."

Faith also seemed to be helpful to a number of participants. Mrs. #24 said "my faith. I don't know what I would do without it." Mrs. #27 said the most helpful thing was "I think my faith in God. I feel that if I get to feeling down, I can pray. I feel like I'm not alone. I feel like I have been guided."

Mrs. #31 said she felt helped by:

The Lord and the church, I guess. And having such wonderful kids. And the comfort I'm getting now from staying in this house. At first I didn't want to. I will stay here as long as I can take care of myself.

Mr. #30 said that he feels helped by attention. "I think you need attention. I personally don't like to be alone. I don't even like to cut the grass because every time I cut the grass I usually got called in to lunch."

Mrs. #3 said that "I have learned not to rely on money or wealth. I now know I have the ability to let go of possessions as

the situation has demanded." Mrs. #23 said the most helpful thing for her has been her caregiver because:

Anything that came up, you know if I didn't right at the time, I waited and discussed it with (care-giver) and we talked about it. That really was helpful because then sometimes I would see things I hadn't even thought of.

Summary

The majority of survivors were able to talk about new strengths they had discovered in themselves since their partners died. Eight individuals could not think of a strength. Respondents found the most helpful interventions occurred as the result of family (11 responses), friendships (9 responses), and faith (9 responses).

Most Difficult Aspects of Adjustment

When respondents were asked what had been the most difficult part of their transition process, 14 people mentioned the aspect of their partner not being there and the feeling of loneliness. Mr. #1 said that the most difficult thing for him is "her not being here, not being able to share things with her." He then admitted that he talks to her picture. Mrs. #13 said it is difficult "maybe sometimes being alone. You want to go to certain things and you don't want to go alone." Mrs. #15 stated that "Sundays are just lonesome."

Mrs. #20 said the most difficult thing in her life has been "being by myself. I used to play a lot of tapes or discs, whatever, because I never knew how quiet a house can be. We spent a lot of time together and it's just that closeness that you have."

Mr. #26 said that the most difficult thing is that "you feel like you're the last of the Mohicans. I'm the only one left in my family. At my age, I've lost most of my friends. I don't like the evenings, eating alone."

Mr. #30 explained his feelings this way:

I don't like being alone. I never spent much time alone. I went on business trips occasionally. You leave your family and start your own. I was never a bachelor living alone. I was with my wife a long time.

Mrs. #31 claimed that her difficulties were "in learning to adjust to being by myself because it's just learning to live all over." Mr. #25 said that he had difficulty with:

Just the fact that she was gone. Even now I'll sometimes hear a noise and I think "Oh, is somebody here, is (partner) here?" Then I'll think, no-no-no she's not. But at first that would happen quite a bit. There would be times I would be sitting here reading the paper and I would look up at the clock and think, "Oh, (partner) will be home soon...then I'd say, "Oh, no." There'd be times I'd expect her to come up from the basement or something like that. One of the tough times was after deer season. The other guys were all anxious to get home. I'd just tell them that I didn't feel like I wanted to go home.

Six respondents expressed difficulty with various aspects of daily living that have been complicated by the loss of their partners. Mrs. #4 said that "the most difficult was the crash course where I had to learn just the basics." She then elaborated on many home repair difficulties she faced right after her partner died. Mrs. #5 said that her finances and selling her house had been most problematic.

Mrs. #8 said it was difficult "just the things you have to do, getting checks changed, all that sort of stuff." Mrs. #11 also ex-

pressed a very practical difficulty by saying, "When I get dressed, I can't zip up the back of my dress and I can't fasten anything. I think it's terrible not even to be able to get dressed." Mrs. #27 said that her difficulties were with the car and insurance. She didn't realize that "little accidents and fender benders would make the insurance go up."

Three respondents did not answer the question directly. Two respondents specifically mentioned problems with adult children as providing difficulty in the transition. Mr. #19 expressed frustration because his son and daughter-in-law would not let him write checks anymore, forcing him to take haircut money, etc. out of the grocery money. He was also, he felt, being forced to move to an assisted living situation:

I don't want to go. My wife, at her last breath said, "Honey, don't ever leave your home. You promise me now." I promised her. I'm going to have to take it back. It's pretty expensive having these girls here all the time. I just hate to think of it, there's a lot of memories here.

Mr. #6 particular had difficulty with Christmas.

I was particularly worried about Christmas because she was Christmas. She started planning for next Christmas on January 1st. This year I bought myself a couple of presents (from her). I got the presents for the family done, but not fancy wrappings, they were in plastic bags.

Mrs. #9 found it difficult when her doctor told her she was depressed and needed a therapist:

But I didn't think I was depressed. It was just grief. Like I said we were together some 50 years. After our first date I never looked at anyone else. He never talked about his illness after he was diagnosed. I wish we could have.

Mr. #18 replied, "You want me to be honest? The loving part,

that's what I miss. Not lustful, just the loving." Mrs. #23 said that it was very difficult for her because;

I get awfully discouraged if you really want to know, but I don't like to talk about it. I think it aggravates the condition. I think I'm better off to ride with it. That's the way it is and I have to tough it out.

State of Health

The attempt to determine the physical well-being of the survivors required asking them to rank their health status, both prior to the death and afterwards (See Table #8).

Table 8
Changes in Health Status After Partner's Death

Reported Change in Health Status	N	Percent
No Change:	15	54
Excellent (8)		
Good (4)		
Fair (3)		
Poor (0)		
Health improved To this level after partner's death	6	21
Excellent (2)		
Good (3)		
Poor (0)		
Health declined To this level after partner's death	7	25
Excellent (0)		
Good (3)		
Fair (2)		
Poor (2)		
Total	28	100

Fifteen respondents reported no change in health status after their partners' death, seven persons felt they'd declined physically, and six participants felt they had improved. One person did not directly answer the question.

Two participants listed their health status as currently poor, with an additional person categorizing health as "fair to poor."

Six respondents reported that their health status improved after their partner died. Mr. #16 felt he had improved from good to excellent health and attributed it to the fact that:

I've learned so much from being in hospitals and listening to people's stories. I'm now excited about alternative medicine. I just had some blood work done. Couldn't believe it. I've improved everything. When there are two of you, you don't pay attention to it as much.

Of the 15 survivors who reported no changes, Mrs. #11 said her health had remained excellent and "I'm well, I'm so well...isn't that wonderful? I had an eye operation last week, a miracle. I've always had good health." Mrs. #9 said her health had remained fair both before and after her partner's death and "I have developed diabetes. The doctor said it's because of the stress of (partner's) illness and death." Mrs. #24 said that she had always been in excellent health but:

I felt guilty because (partner) always had health issues and I didn't. I thought, "Why can't I have one or two things instead of him having all of them." But that's not for me to say. But now I'm so grateful because it allows me to be independent. It's helpful if you can maintain your health when you're living alone so that you can live alone.

Mr. #21 said that his health remained good both before and after the death but:

I've already had cancer. I had cancer even before my wife had cancer. So we'd already gone through that. I'm still getting checked out. Now...Don't I look good? I've gained weight since my wife passed away. About 20 lbs. because I go out to eat a lot. I'm not a cook. Burger King and I have become pretty good friends. Every once in a while I'll binge on food.

Seven respondents felt that their health declined following the loss of their partner. Mrs. #3 said she had declined from excellent to good due to the insertion of a pacemaker. Mr. #25 felt he had also gone from excellent to good:

But when (partner) was ill I really had problems with high blood pressure. All the attention went to her. I wasn't paying attention to my own health. The visiting nurse noticed and took my blood pressure. It was 240/130--it was really terrible. She sent me to a cardiologist.

Summary

There was no direct relationship between loss of the lifelong partner and health decline. The majority of respondents reported no change in health status, while health improved for six survivors, and declined for seven.

Issues of Faith

As another measure of subjective well-being respondents were asked "How have issues of faith helped you during this time of loss?" (Question #22, Appendix B). Twenty-three respondents (79%) made solid statements about a spiritual belief system, two survivors (7%) labeled themselves as agnostics, and four other persons (14%) said they were at some level of questioning their belief systems.

Of the participants who said that issues of faith had been helpful in the transition, five specifically mentioned that the belief in an afterlife assured them that they would see their partners again. Mr. #1 said, "It's (faith) meant a great deal. It's been good for me. I will see her in heaven." Mr. #18 also said that "when the Lord takes me home, I'm going to see her again." Mrs. #20 felt "that would be a terrible feeling if you didn't know what had happened to their spirit."

Mrs. #2 claimed that without faith, "I wouldn't have made it. I don't think I would have lived without it. (Talked about almost taking her life). What's the point of going on? "

Mr. #21 described the importance of faith this way:

Well my faith has helped me all the way through. And even now it helps to study the Bible and keep going to church. I have fellowship with the people that are there. I don't really see how people can get by if they don't have faith in the Lord or faith in something. I believe in the Lord Jesus Christ as my Savior. This is where we got all our friends. I don't have friends outside the church. I really don't.

Mrs. #8 questioned the influence of faith in her life because "I don't know that faith helped me a lot. Some. I still don't know what I believe." Mr. #12 said that faith had not played an important role in his life because "I think there's a void. I guess maybe I don't think there's a void."

Mrs. #10 also felt that she was questioning her faith after the loss of her daughter and husband within six months of each other:

I've always been a religious person, always felt like I had a close relationship with God but everything was gone and I

couldn't even pray. Even now, I question, and I question, and I question. Because I couldn't find something to get ahold of.

Mr. #30 said:

I'm going to church but I'm very agnostic still. I hope that what the church says is true but George Carlin said that we picture God as a person just like us who said that if you live by ten rules everything will be fine and if you don't live by those ten rules, you're going to burn in hell forever. And he's a loving God? Of course George meant it to be funny, but it makes sense in a way. No, faith has not been a real source of strength for me. I hope so. I'd like to see my wife and my grandson again and my parents and so on, who wouldn't?

Summary

Issue of faith were designated as important to a majority of the participants. Of the six respondents who did not feel faith had positively contributed to their adjustment process, four were actively questioning their belief systems.

Future Orientation

In an attempt to document how individuals reconstruct their lives following the loss of their lifelong partner, it was necessary to see what changes the participants had made in their daily routines, how they viewed their current role status, and how they perceived the future at this particular point in time.

Changes in Daily Routines

Participants were asked if they had made any changes in their daily routines since the death of their partners. Many of the reported changes involved doing things alone for the first time. Mr.

#1 said that he and his partner went to Florida every year and "I went for a month this winter and I don't know if I'll do it again." Mrs. #9 reported that "I don't stay at home. I'm more active than when my partner was alive." Mrs. #11 said, "It is dull. You know we did everything together. I don't like being alone."

Several survivors found it very difficult to leave their homes after their partners died. Mrs. #22 felt she had made changes because:

I didn't go anywhere for a long time. I didn't want to--I didn't want to see people. I talked to them on the phone but I was completely at a loss and yet I just couldn't leave home. It was two years before I could get back to normal.

Mrs. #29 said that she didn't like being told how she was doing:

My friend said, "She's doing real well, she puts her best foot forward." But I'm lonely. I'm very lonely. I have isolated myself socially. And Sundays seem so very lonely to me. I don't know why, but you see I had a bout with this about 30 years ago when I had a nervous breakdown. And I have panic attacks under the umbrella of agoraphobia. So sometimes I feel very alone.

When asked how his daily routine has changed, Mr. #12 reported "My life's miserable. I do nothing. I sit around doing nothing. I don't drive much or get out socially."

Mr. #30 explained that "I used to be organized. I wandered around a little bit. I wasn't organized at all. If I got it done fine. If I didn't, do it tomorrow or next week." Mrs. #23 changed her daily routine because "I ran away from the nursing home." She is currently living back in her own home with support.

Several survivors talked about things they had to learn about

themselves in adjusting after partner loss. Mrs. #4 said, "I'm still adjusting. I'm learning to take care of myself and invest my money. My partner was controlling is what he was." Mrs. #10 stated that "adjustment, that's the most important word in my life. Every day it's adjusting, adjusting, adjusting."

Mr. #16 reported that:

Right now, I get in the car and go to places, go down and see the grandkids. She used to plan all of our social life; "you're going here, we're going there." I never realized everything a woman does in the house. I don't like to hire help, I'd rather do it myself.

~ Mrs. #20 found that "since I crashed last summer, I have to monitor myself and not let myself get too tired." Mrs. #27 said that "I try to keep very, very busy (lists activities). I think I'm very active. But in a different way than I was when he was sick." Mrs. #24 explained how she views the changes in her life:

What does God say, "Occupy?" So you have to occupy yourself. And there's so much that's wonderful in life. Count your blessings, that was my husband's theme song. And if I get down, I just start counting my blessings.

Mr. #30 felt that after six months, he was still discovering the changes in his life:

I go to bed later. I probably sleep a little later. Uncomfortably. Each day is a challenge. I guess you go through a lot of firsts. The first Thanksgiving was so close, it didn't bother me very much. The first Christmas I was still pretty numb. I started setting goals--the things I was going to do. It's still very much on my mind.

Mrs. #31 said that attempting to make changes since her partner died she struggles with several questions, "What should I do? What's the best? What do the kids want me to do? What do I really

want to do?"

Role Change

To clarify how participants viewed their current role status, they were asked "Have you begun to see yourself as a single person?" (Question #23, Appendix B). Out of 29 respondents, twelve considered themselves to be single and twelve did not. Five individuals gave indirect answers as in the case of Mrs. #7 who said "I don't know. I don't think about that."

The responses were further broken into categories; the acute period of bereavement (0-24 months) and the sub-acute period (25-48 months) following the death of the partner. Table 9 illustrates that comparison.

Table 9

Differences in Perceived Role Change--Length of Bereavement

See Self as Single	<2 yrs	>2 yrs	N
Yes	5	7	12
No	6	6	12
Don't Know	2	3	5
Total	13	16	29

At times the responses to this question were quite adamant. Mrs. #11 (at 29 months) responded, "Oh heavens, no." Mrs. #2 (at 42 months) stated, "No I think (partner) will always be there." Mrs.

#3 (at 26 months) said "No, I think I'm his wife." Mr. #18 (at 45 months) responded, "No, I have never been a single person." Mrs. #22 (at 41 months) stated, "No, I don't, I'm not." Two female respondents indicated that they still preferred to receive their mail as Mrs. followed by husband's name.

Mr. #30 (at 6 months) felt he was still struggling with the issue of whether or not he considered himself single:

I have gone to functions with other women since my wife died, but I don't feel like I'm cheating or anything like that and also I don't feel involved with these other people. They don't live up to what I'm looking for.

Mr. #16 (at 34 months) also felt "that's a big puzzle to me. The women in Florida got mad at me because they'd like to get married. I'm not so sure at this point in life I should be thinking about that." Mrs. #9 (at 24 months) said, "No, I don't exactly (consider myself single). I consider myself as someone who was married, not is married." Mr. #6 said, "I see myself as a married man whose wife is not available. I can't say that I'll always consider that."

Mrs. #31 (at 21 months) when she discussed whether she considered herself single spoke to the issue of being a caregiver when she said "I've thought about that a lot. I would never find another one like him. Well, I'd never find another one. I'm not even looking. I might get one that I'd have to take care of."

Of the participants who responded that they now considered themselves as single, several were quick to point out that they had no intentions of remarrying. Mr. #1 (at 12 months) said, "Yeah, I

do, but I'm not interested in any other women." Mrs. #4 (at 48 months) said, "Yes I have for quite a while. I have no intentions of dating or getting married." Mr. #12 (at 6 months) said that he considered himself "very single at this point (laughed) and I have no aspirations to become unsingle."

Mrs. #20 (at 31 months) said that she considers herself single but has still chosen to wear her wedding ring:

I was shocked, oh a couple of months after he passed away and I don't know where this happened, if it was church or someplace else, anyhow, someone saw my ring on and they said, "Well, you're still wearing your wedding ring" and I said, "Why not?"

Mr. #25 (at 12 months) discussed the process of feeling like a single person again:

Maybe about two months after she died, I realized it was just me now. Yeah, as I look back at that I think that was kind of interesting because I thought, well now I am going to be alone here, now I'm going to have to do things by myself. And then one day I'd been working out in the yard and I came in and said, "Boy I'm really tired. I think I'll just lay down. No, I can't do that, I've got to get this work done." Then I said, "Well, why can't I lay down. I'm here by myself." I finally realized that. That was very interesting when that concept finally hit me."

Mr. #21 (at 15 months) said that he considered himself single and was actively seeking a companion:

I've come to the point where I'd like to find someone--at least to do things with. The other day was the first time I've ever called a woman in 49 years. I don't handle rejection well so if I get turned down, that will probably be it for awhile. This is all new territory.

Future Orientation

At the conclusion of the interview, survivors of the loss

of a lifelong partner were asked how they viewed the future at this particular point in time (Question #28, Appendix B). Their answers, in order, will be directly quoted to provide a greater sense of where they were in their adaptation process.

Mr. #1: I don't suppose that you ever get over it. I pray every morning to be kind and helpful to people around me who need help and I do all that I can.

Mrs. #2: They (son's family) tell me I'm moving with them to another state.

Mrs. #3: I look forward to another 10 years with the help of my pacemaker. I'm enjoying that I'm not tied down like I was the past 5 years. I can visit children and grandchildren.

Mrs. #4: If my life could go on the way it is now, I'd be very happy. I think it's going to be nice.

Mrs. #5: I really plan to live out my days here. My biggest concern is what will happen to my child.

Mr. #6: Well, I'm taking it one day at a time. I'm not making any big, big plans because at my age...

Mrs. #7: I'm not afraid of the future. If I can keep my wits about me and be comfortable in life until the very end. My mother was 92 when she died, a very active woman, and that's the way to be.

Mrs. #8: Oh, just to get along I guess. I don't have any plans in particular. That's kind of a horrible prospect isn't it-- not to have any plans for the future? Do other people my age have

plans for the future? Well, I know I'm not going to do some earthshaking thing.

Mrs. #9: I don't know that my plans for the future have changed. I just keep myself busy and away from home.

Mrs. #10: I wake up every day and say, "What am I going to do today. Nobody needs me." Well, I don't know if I have any future plans. I'm glad that we did the traveling that we did. I can't imagine doing it alone. You know, we do survive and we do go on.

Mrs. #11: I don't know, I really don't know. I'm content here at home. I wouldn't move unless I had to.

Mr. #12: I guess it's just been too soon and it's very lonesome. I dislike living alone like this so I feel aimless.

Mrs. #13: I just live each day as it comes. You never know. I'm just happy that I'm alive, can get out of bed every morning and put one foot in front of the other. I don't really have anything planned for the future. I'd like to live a long time but who knows? But I'll do what I can and try to be a friend to everybody, help out as long as I can and not be a burden to anybody.

Mrs. #15: I'm going to write my obituary ahead of time. That will save my daughter a lot of grief.

Mr. #16: I'm not discouraged about the future because I have a lot of grandchildren that have a lot of potential. My children all have good jobs. I'm happy. I enjoy life. All the enjoyment in life is what we do. For some reason, I'm contented here in this

house.

Mrs. #17: I know how to get around. I'll be o.k. without my husband. The worst thing is that I have to drive. I'm not at ease, I'm tense when I'm driving. I think there are a lot of ways for healing after something like this and I think my best deal is to volunteer and be with people, and help them in any way that I can.

Mr. #18: I just work for the Lord. If the Lord decides to take me home, fine. If I get killed at the prison (where I preach), they'd be doing me a favor.

Mr. #19: My future is pretty bleak. I'm going to leave this house with all the memories and I don't know how I'm going to like it but I've got to do it.

Mrs. #20: I will sell my time share--and figure out how to continue traveling.

Mr. #21: It's funny because just this week I've decided that now I'm going to get out and maybe meet some women or something, get out and do some things. It looks good to me so far. Probably if I get a gal it will look even better. Who knows?

Mrs. #22: I don't know. I just take it day by day.

Mrs. #23: I don't (think about the future). I asked the caregiver the other day if she thought I should consider moving.

Mrs. #24: I think you face it one day at a time. Don't look ahead and say, "Oh, am I going to live like this for 5 years, 10 years, 20 years? Enjoy the day and look for the positive.

Mr. #25: I don't really do a lot of planning ahead of time

although...traveling. I get schedules of what the grandkids are doing...I just got the whole schedule of their softball and baseball games.

Mr. #26: Death was so slow in coming that my plans had already started to change. I think about my wandering around and everything and I think I was feeling sorry for myself. I'm sure I was. The bereavement over my partner was more of a "poor old me, why did this have to happen to me?"

Mrs. #27: Well, I'm not bored and I'm really not lonely anymore. Sometimes in the evening it's lonely but most of the time, I'm quite contented, quite happy with my life as it is. I sometimes wonder what lies ahead, what will I do, how long will I be able to live alone and take care of myself. If you dwell on those things you get depressed and down so I just take each day at a time.

Mrs. #29: I haven't made any plans for the future. I believe, I absolutely cannot believe that all of a sudden I yearn for just a man to welcome me home, to take me out to dinner, or just go out for coffee or something. I never, never, and I can almost swear on the Bible, never want to get married again. But I never thought I would ever say that, you know?

Mr. #30: The best advice I've had is to take one day at a time and set yourself a few goals, longterm goals even if they're kind of insignificant. Try to live up to them. It gives you something to look forward to. And let it take care of itself. It will. I'm sure. I hope.

Mrs. #31: I seem to feel so good and at peace with myself. I've felt like I've got enough ambition to try and do things that I was leery of doing. Right now, I feel pretty optimistic--just in the last few weeks. It will get better, but as for me now, it will never go away. But I will learn to live with it because you have to. Life has to go on.

Final Summary

This chapter began with some demographic data on the survivors of the loss of a lifelong partner. First, descriptive information was provided on the participants. This section also presented recorded memories of the death event and the place, timing, and cause of the death. The next inquiry involved issues in the caregiving experience, both from outside sources and from personal impressions.

In the second section, the responses to the eight research questions related to social support were recorded. The results are revisited in Table 10.

Table 10

Summary of Research Questions Results

Research Question	Summary of Results
Significance of Anticipatory Grief	Not Supported
Significance of Social Support Network for Adjustment to Bereavement	Significant by Self-Report

Table 10--Continued

Research Question	Summary of Results
Individuals or Groups in the Network Most Significant in the Readjustment Process	Adult Children
Institutions Most Significant in the Readjustment Process	Church(15) Grief Support Group (6) Senior Center (5)
Support More Frequently Offered in Affective or Instrumental Areas?	Offered in Both Areas
Optimal Time for Social Interventions to Occur? Does Optimal Time Vary Dependent on Type of Support Given?	Mixed Varies with Individual
The Ways that Social Responses Change Over Time	Mixed Varies with Individual
Positive Aspects of Working Through Process	Yes for 21 of 28 Bereavement Survivors

Finally, the continuing issues of transition were examined including changed patterns of daily living, role change, and outlook for the future. By letting the survivors speak for themselves, it was possible to see how they were feeling about their lives at that particular point in time.

CHAPTER VI

DISCUSSION AND CONCLUSIONS

The final chapter begins with an overview of the important findings in this study related to social adaptation to the loss of a lifelong partner. The findings will be considered as they relate to the research questions and current theory, as well as their relevance to previous studies in the field.

Limitations of the research will be examined that may affect the generalizability of results, followed by recommendations for future research as well as implications of the study for professional practice.

Important Findings Related to the Research Questions

Research Question #1: What, if any, is the significance of anticipatory grief in the adjustment process for older adults experiencing the loss of a lifelong partner?

It was found that anticipatory grief was not an important process for the survivors of the loss of a lifelong partner. Only nine respondents said they had done any grieving prior to their partners' deaths, but then indicated that having done so was not necessarily helpful in adjustment to bereavement. A common response when participants were asked if they had done any grieving ahead of time was, "You think you're ready for it but you're not." These types of

statements also indicate that there is not a rehearsal process for loss.

A topic that has been debated in the literature for some time is the relationship between having forewarning of the death to the eventual adjustment of the survivor. According to Sanders (1982) those persons with some forewarning had the least problematic adjustment to bereavement, implying that anticipatory grief may have played a part in that process. In this study, with the exception of one respondent, there was a period of at least several weeks from the onset of the final illness to the time of death.

Although this study did not explicitly test the relationship between forewarning of the death and eventual adjustment, the results indicated that even though at least a third of the respondents reported the realization that their partners were declining, the death still came as a surprise. Several participants stated that looking back now they could better interpret the signals that indicated death was approaching.

One explanation for this reported element of surprise is that persons may believe that the medical care system has the capability to continue aggressive treatment indefinitely. Another explanation is that the ill person may have undergone so many hardships during the illness trajectory that the survivors are surprised when a small health crisis becomes the final one. In addition, perceptions of the death as sudden reveal more about the psychological process of the survivor than the physical status of the dying partner.

Research Question #2: What is the significance of the social support network in adjustment to bereavement among the survivors?

The survivors of the loss of a lifelong partner had many things to say about life after their partner died. A major question to be answered was whether the social support network was significant in the adjustment process to bereavement. The respondents were clear about their reliance on other people in their social worlds. When asked whom they had relied on most during the transition, only one person answered "myself" and four others named "God." However, for those who believe in a personal relationship with God it can be argued that this designation qualifies as a social relationship.

Social support was felt by eight respondents because of the number of persons who were present at their partner's funeral. As they recalled aspects of the funeral, these respondents identified a sense of support because the "the place was packed" or that "there were so many people there we didn't expect."

Research Question #3: What individuals or groups in the network are the most significant in the readjustment process?

Adult children were named by seventeen respondents as primary social support persons, but when asked about people with whom survivors could most comfortably express their grief, those responses dropped to ten. Even then, participants made comments such as "I need to be strong around my family," thereby either diminishing the value of that social support or indicating its reciprocity.

Participants in this study were reluctant to express their

grief around others. More than half of the participants, 55%, indicated that they rarely or never were encouraged to grieve openly. Several people who gave either of those two responses pointed out that they did grieve but chose to handle it privately. It was interesting that several of the male survivors described talking to their partner's picture when no one else was around.

Research Question #4: What institutions are the most significant in the readjustment process?

The institution most often named by the participants in this study was the church which received fifteen responses with one additional person watching televised services at home. Other supportive institutions named were area grief support groups with six responses, and senior centers with five responses.

In keeping with the emphasis on the church, faith was considered by twenty-three respondents to be important to the coping process. This was a surprising result in that the process of obtaining participants did not involve institutions of faith. In addition, four other survivors were actively questioning their spiritual belief systems and did not indicate that they had abandoned it altogether.

Part of the explanation for this high level of expressed spirituality may have to do with the hope of seeing the partner in an afterlife as was expressed by five participants. In a larger sense, it indicated the need for the survivors of the loss of a lifelong partner to search for a sense of coherence in the social construc-

tion of their worlds. So many of them replied, "I don't know what I would do without my faith" as a response to what had been helpful to them in the transition process. In addition, after the loss of a lifelong partner, survivors may have been dealing with their own issues of mortality and finding comfort in a spiritual framework.

Research Question #5: Is social support more frequently offered in the affective (emotional) area or in the instrumental (task-oriented) area?

Schuster and Butler (1989) indicated from their studies that instrumental support was more often offered initially by the social network followed by affective support. These results were not duplicated in the present study. Most respondents felt more emotionally supported in the initial weeks and months following the death, and later received more support in such areas as being asked to social events, shared meals, and assistance with maintenance tasks.

Twenty-two out of twenty-nine participants felt they were receiving enough support from their social network. Only one person indicated that he could have used more attention and he sought that out through a therapeutic intervention. It was interesting that most persons felt adequately supported in their adaptation to bereavement because Rando (1993) pointed out that complications in mourning can occur when there is a perceived lack of social support.

Research Question #6: Is there an optimal time for these social interventions to occur? Does the optimal time vary dependent on the type of support given?

Research Question #7: What are the ways the social responses towards the bereaved individuals change over time?

Questions regarding an optimal time for social support interventions to occur were not specifically answered in this study although some respondents were able to notice that the social responses changed over time. The reported level of support dropped off after the funeral for one respondent and up to one year after the death for several others.

Research Question #8: Are there any positive aspects of working through the bereavement process for survivors of lifelong partnerships?

Most of the participants were able to name some positive experiences that had occurred in their lives since the death of their partners including new strengths (or learned tasks), strong relationships, and renewed plans and hope for the future. There seemed to be a consistent understanding that although life would never again be the same, that it could still be appreciated.

The survivors of the loss of a lifelong partner in this study had not significantly changed their social networks after death as indicated a study done by Stephen Schucter (1986). He suggested that this is sometimes a healthy adaptation because the new social network can better relate to the new identity that emerges from the loss of a partner.

Several respondents such as Mrs. #29 talked about loss of friends prior to her son's death but no one indicated that they had

sought out new people in their lives after the death. The exception to this may have been those who chose to attend area support groups or senior centers but even then, no new significant friendships were reported.

Walker, MacBride and Vachon (1977) indicated that having too tight a social network could actually be a hindrance to adjustment after bereavement. Only one respondent, Mrs. #31 reported that her adult children had been too controlling during the first year following the loss but that the situation had improved.

The findings in this study were consistent with those of Cohn and Peterson (1989) who found that bereaved individuals face the dilemma of trying to get their social needs met without appearing needy. Evidence of the survivors' fear of reaching out and expressing their needs to others in their social networks came up repeatedly as revealed by statements like, "I wouldn't want to bring them down," or "they have their own problems."

To summarize, participants felt they had been helped most by family, friendships, and faith. A conclusion could be drawn that the persons most at risk for complicated bereavement would be individuals who had limited social networks and did not have a spiritual structure. Conversely, participants described the most difficult aspect of their lives as being the absence of the other person or loneliness.

Findings Related to Existing Theory

The findings of the current study will now be viewed in relation to the theoretical frameworks presented in Chapter III to see if major theories that have been used to explain bereavement issues in the past were strengthened or found not to apply. Psychological theories will be addressed first, followed by social gerontology and sociology theories.

Psychological Theories

This study did confirm that the grief experience is an individual psychological one but that it is also multi-dimensional. Several respondents spoke of past grieving patterns related to earlier losses but stated that these patterns were not necessarily applicable to the loss of their lifelong partners.

Four respondents gave evidence that they had suffered from debilitating depression such as the melancholia described by Freud. Mrs. #20 spoke of the "crash" she experienced one year after her partner died. She stayed extremely busy as a way to avoid being home and ended up in the emergency room and was hospitalized for inpatient psychological services.

Three other respondents had received outpatient psychiatric or psychological services. In one case, this was related to a lifelong pattern of depression. In two other situations, the depression was a response to a series of losses or traumatic events that were occurring simultaneously with the death of the partner.

Attachment disorder, as described by Bowlby, was not evidenced in this particular study. All respondents were able to speak openly of their attachment to their partners, although Mr. #21 expressed concern about the relatively smooth transition he had experienced during the first sixteen months following his wife's death. He was still very much connected to his social world involving church friends, children, and grandchildren.

The findings from this study do not support the idea that grief can be compartmentalized into time frames or various stages of adjustment as outlined by authors such as Elisabeth Kubler-Ross. An assumption of the social construction of reality theory is that actions that are habitual may lead to their institutionalization (Berger & Luckmann, 1967). Therefore, through the influence of popular culture, arbitrary stages have been developed as a guide for locating oneself in an adjustment framework that did not appear relevant to the study population.

It could be argued, however, that survivors were undergoing what Colin Murray-Parkes labeled the process of cognitive restructuring in order to form a new identity. Because participants were interviewed anywhere from six months to four years after the loss of their partners, it was possible to observe some new identities forming through the assumption of new tasks and responsibilities, as well as the consideration of the formation of new partnerships.

However, in this study, there were no particular time frames or tasks that emerged as the most helpful to the majority of survi-

vors. When questions were asked regarding such issues as viewing oneself as a single person, there were no clear differences between those survivors in the acute (up to 2 years) and the sub-acute (2-4 years) periods following bereavement. Mr. #16 summed up the individuality of the experience when he stated that he did not feel he would "be much for giving advice to other people. I think that probably what works for me doesn't work for somebody else."

The limitations of psychological theory were apparent in this study as each person experienced the adjustment process in ways that resisted categorization.

Social Gerontology Theories

The social gerontological theory of disengagement was evident with at least three survivors in the current study but the disengagement was not necessarily of their own choosing. One respondent, Mrs. #22 did report that during the first year following her partner's death, she chose to stay home where she felt closest to her husband. However, the other persons who mentioned feeling isolated saw disengagement more as imposed from without rather than deliberately chosen. Mrs. #13 shared how she dealt with feelings of isolation:

I guess you just have to be strong and depend on on yourself. You just got to make it yourself. You can't always have other people help you too much. You can't always have your way. I can't sit in the chair and rock. I don't have a rocking chair anyway.

In addition, many respondents gave evidence that they were

still psychologically engaged with the deceased partner including speaking to the photograph, having imaginary conversations, and even seeking guidance for decision-making. Mrs. #2 stated that, "I lived with my mom. I lived with my aunt and uncle and I lived with my partner. I talk to him just like he was here." Mrs. #29 said, "My husband and son are with my daughter and I in spirit. I know it. I can feel it. I have just felt it."

Participants were asked what advice they would give to a person going through a similar experience of the loss of a lifelong partner (See Appendix B, Question #26). Five respondents gave advice that fully supported the activity theory such as that shared by Mrs. #13 when she said, "Find something to do. Always have a hobby. Get interested in something. You have to keep busy."

The activity theory continues to be influential in the area of societal advice giving with the additional implication that one should be a help to others. Mrs. #17 advised:

I would say just try to go along as you possibly can as you had lived before. I mean do the things, go out with your friends, get yourself involved with life. Feel like you're making a contribution to something.

Mrs. #27 also felt that "I would tell them to keep busy at whatever whether it's volunteer work (which I do). I would tell them that just keeping busy is good."

This study did support the premise of continuity theory in that participants were, for the most part, still approaching life with many of the same patterns they had maintained in the past. This was evidenced by talking about changes participants had made in

their daily routines. The majority of responses involved changes in daily life due to the absence of the partner rather than radical changes in the patterns of living that the survivor had employed prior to the death. Several survivors were able to relate that they had experienced emotional patterns that were new to them during this time and that were confusing.

There was no theory in social gerontology that emerged as an adequate framework for explaining the reconstruction process for the survivor after the loss of a lifelong partner.

Sociology Theories

Findings of the current study were applied to sociological theories in three distinct paradigms: social-behavior, social-facts, and social-definition. In the social-behavior paradigm, the individual interacts with his/her social world based on a system of rewards and punishments, as in the behavioral framework of B.F. Skinner, or in costs and rewards as outlined by Homans and Blau.

A very minimal argument can be made that behavioral theories had an influence on the participants of this study. It should be acknowledged that individuals work to increase their rewards in any given social system, but the survivors of the loss of a lifelong partnership are not operating with adequate resources for participation. It can be argued that they are being asked to interact or exchange precisely at a time when their personal resources and power are at their lowest.

However, behavioral theories can be applicable in the context of how the survivors are rewarded for expressing grief or refraining from expressing grief, and what patterns the greater society allows the individual in the adjustment process. For example, several respondents indicated quite clearly that they were not comfortable expressing their grief around others, particularly their adult children. It was not within the scope of this study to be able to ascertain whether those feelings were the result of being externally rewarded for being stoic, or whether they emerged from internal sources.

The social-facts paradigm contains role theory which has some relevance to the current study. Several participants were experiencing role confusion because they still considered themselves to be a part of a couple even though their partners were deceased. The respondents were split in their answers as to whether or not they viewed themselves as single persons. This indicated that role theory is not adequate to explain the process of the reconstruction of self that occurs after the loss of a lifelong partner.

This research did show some support for the idea of role redistribution as proposed by Atchley (1987) who argued that certain roles may not be replaced, but that the energy involved in the lost role will be redistributed to the other remaining roles. Several of the participants in this study had not yet begun to redistribute that energy to other roles and it is unclear when and if they would choose to do so.

The social-definition paradigm was the most applicable to the current research. This paradigmatic framework coincided with the world view of the participants who acknowledged that this was both an internal reconstruction process as well as a social one. Respondents' comments clearly indicated that they understood this was an individual journey and that the loss of partner differed from loss of parent or other loss as experienced by the social system. There was some evidence of cognitive restructuring as survivors indicated that they were at different points in the process of constructing their identities as individuals.

Several participants had already started a new partnership or were hoping to begin one. There was some reluctance to share that information so it has been dealt with very generally in reporting the findings.

Social construction of reality also allows for the introduction of novel experiences which may not fit into the currently existing schema. There is probably no more novel experience than the loss of a lifelong partner and the participants gave evidence that they were, as Attig (1996) put it, in the process of "relearning the world." As Mrs. #23 said when asked what she would tell other survivors of the loss of a lifelong partner, "I don't think you could tell anybody...I don't think you could communicate that. I think it would have to be a reaction to your experience and we're all different."

Inconclusive Results

Several questions asked of the survivors produced results that could not be related to past studies or did not fit into any previous body of theory.

This study did not support the idea that losses of older adults are handled better due to previous loss rehearsal (Heyman & Gianturco, 1973). The majority of respondents were able to specify that elements of the grief experience were novel to them and indicated there was no way they could have been emotionally prepared for the loss. Several participants, like Mrs. #24, were able to explain a distinct difference between the loss of a lifelong partner and other losses by stating "that nothing compares to losing a part of you."

Survivors produced interesting but inconclusive results when asked to rank themselves subjectively on the health status scale both before and after their partner's death (Appendix B, questions #19 and #20). More than half of the respondents indicated no change in health status after the death, and the other half were divided between feeling their health had improved or declined.

Frequently, persons rated themselves in good or excellent health, but then listed a number of major health concerns. An example of this is the response by Mrs. #22 who, at the time of the interview had a broken arm and ranked her health as good: "I've had a mastectomy. I've had renal failure. I've had so many things go wrong. And then I've had (goes off the record). I don't sleep

well. I walk the floor."

An explanation for this phenomenon may be that the survivors were very invested in maintaining their own independence for as long as possible and did not want the perception to exist that they were somehow failing. Another explanation may be that people subjectively rank their health as better or worse than might be observed by an independent appraiser.

Another finding that has been mentioned earlier is the split in responses as to whether or not the participants considered themselves to be single. The results would have been more meaningful if the breakdown had been related to the timing of the death, but this finding did not emerge. Mrs. #9 spoke in the following way of the continuing attachment to her lifelong partner:

I'm sure that the day that I was born I was designed to be (partner's) wife. I think God planned it that way. I hear these women talk and they don't talk very nice to their husbands whether their husbands are living or whether they're gone and I just can't tolerate that.

The inability to make distinct conclusions in several areas of this self-report study further indicated that the survivors were putting their lives back together in their own unique ways.

Limitations of the Study

Although it is felt that the participants were comfortable expressing their difficulties with regards to the loss of a lifelong partner, it is also possible that the results could be skewed due to an attempt to maintain appropriate demeanor in front of the inter-

viewer. This is a potential difficulty in working with sensitive topics as outlined by Lee (1993).

Another limitation of the current study is that it is not culturally diverse. It would not be possible to generalize the results obtained with those of other cultural groups in which there may exist different social frameworks for allowing the expression of grief and social support.

The participants had difficulty answering several items on the research instrument. The most difficult question for participants was a ranking question that asked "To what extent have you been encouraged to grieve openly?" (Appendix B, Question #5). More than half of the respondents needed to hear the question again, or have it reframed. Five survivors did not give a response that directly answered the question, and, as it involved a ranking choice, it is felt that this question was not worded in a way that made sense to participants and should not be used in future research.

Participants in general had difficulty with questions involving the public expression of grief. They paused the longest and were more reluctant to answer these particular items indicating that they either were uncomfortable in expressing their grief or in talking about it during the interview. That distinction was not clear.

This study did not incorporate a question asking the participant, "What would you have done differently" as is sometimes done when asking for retrospection of a past event. It was felt that the survivors were doing enough speculation on their own without having

it imposed from the interviewer. This is evidenced by comments such as those made by Mr. #21 who spoke regarding his wife's treatment for cancer and felt that "maybe if we'd checked it out more, researched it more, we would have come up with something different. I don't know."

The final limitation of the study is that it examined people's beliefs and feelings at a particular point in time rather than in a longitudinal framework which is more ideal for getting a more definitive idea of how people's reactions change over time. It would have been interesting to interview these participants again after six months or a year had passed to see if their responses had changed to any great extent. However, with longitudinal studies the issue of attrition of older survivors, particularly through relocation or death, need to be given serious consideration.

Recommendations for Future Research

This study revealed several topics that call for future examination. The present study did not allow for an in depth examination of the psychological and social experience of seeing one's partner die. Through the framework of the social construction of reality with its emphasis on language, it is interesting that two respondents used the same terminology in describing their partners' final hours as a "melting away." It is also potentially significant that three participants claimed that as a result of being the survivor of the loss of a lifelong partner, they no longer feared death as they

had before.

In future research, it would be important to incorporate a question on the interview schedule such as "Do you have any new friends in you life since your partner died?" There was almost no mention of any new friendships which would seem to be a necessary part of the reconstruction process.

Several survivors were experiencing what Robert Kastenbaum (1969) referred to as "bereavement overload." Mrs. #2 lost her partner in an automobile accident that had compromised her own physical status and was currently living with an adult child who was being moved to a different state. She was grieving many things including her own physical losses, the loss of her friends at the senior center, and the loss of the greater community. She described the loss of independence as especially difficult.

Mrs. #10 had experienced the sudden death of an adult child several months before her partner died and described herself as continuing to feel numb two years after the deaths. Mr. #19 had lost his partner of 68 years and was being moved to an assisted living residence which was causing him great sorrow. Mr. #30 had lost a grandchild several months previous to his partner's death and also was experiencing a sense of confusion about the future. Mrs. #29 had lost an adult child several years prior to her partner's death and felt very alone.

In fact, at least half of the 29 participants mentioned issues of multiple loss. Their losses did not always involve people but

they included personal health, change of residence, inability to drive, concerns about finances, problems with other family members, and questioning their faith. It would seem to be important in future studies to examine the ways in which multiple loss affect the transition to bereavement.

As a result of the current study, it would also be interesting to examine the gap in communication between what medical personnel said to survivors at critical times during their partners' illnesses, and what the respondents may have selectively heard. This lack of communication with the medical profession was mentioned frequently when the survivors were asked, "If you could share anything with persons who attempt to support people going through the loss of their lifelong partner that would help them to be more sensitive, what would it be?" (Appendix B, Question #27).

The majority of responses given to this question involved interaction with the physician. Participants tended to have felt either very supported by their physician(s) or very non-supported. Mrs. #11 felt there was a lack of good communication about the dying process with her partner's physician. She advised: "I think that they should at least talk about it to their patients. If everybody ignores what has happened to you, then you feel like you're alone. Rather than ignoring the subject, they should talk about it."

Mrs. #8 felt that physicians should just "be sympathetic and act concerned." Mrs. #4's advice was to "let them talk. No preaching or pushing to get me over the hard time. Listening is very

important."

Mr. #19, the oldest participant in this study, at age 96, felt very dissatisfied with his current medical care and stated his feelings this way:

It seems that all these doctors think about is getting your money and to heck with you. These guys, I think they're a bunch of bums, most of them. I have a new doctor, but you never see him, you see his nurse. He doesn't even come in to say hello to you.

Mr. #26 advised that "you gotta come down off your horse a little and talk with these people. Realize what they're going through and then probably recommend therapy or a support group."

Mr. #16 felt that

doctors particularly need to learn to listen. I don't know when you talk to a doctor if he's really listening to you or whether he's already figured out what's wrong with you and what he's going to do. These doctors don't take the time to understand each patient. They look at the individual disease rather than the inter-relatedness. They're too high paid. So why should they spend their time listening to your problems. It would probably be different if you went to Mayo's. Just take this pill and that's it. Got seven minutes to size you up, put you on a pill and they never take you off the pill. If you're too far gone, they don't want to work with you. They don't even want to see you.

Several respondents mentioned that they didn't feel physicians had paid enough attention to them as caregivers during their partners' illness process. Mrs. #27 said that doctors should "see that they (caregivers) get enough rest. I was totally exhausted. I think within a month I would have had to have help because I was just exhausted." Mr. #25 also felt doctors need to give:

I think maybe just a little follow-up, maybe inviting you in to just talk for 15-20 minutes to find out how you're doing. Maybe check you physically more often for high blood pressure

and things like that. Maybe do a little bit more counseling.

Because so many responses to an open-ended question specifically mentioned physicians, it would be worthwhile to pursue future research about the relationship of older adults to their physicians.

Finally, due to comments provided by the male participants in this study, it seems there is potential for research regarding the male caregiving experience specifically. What are the differences in the expectations for male caregivers, both from themselves and from the larger society? Do they call in outside assistance sooner or later than female caregivers? Do they have particular coping mechanisms that are gender specific. This is an area that may be under-researched and have potentially interesting results.

Implications of Research for Professional Practice or Applied Settings

The current research has several applications to professional practice that need to be addressed here. First, it is necessary for professionals to be able to distinguish between a grief reaction and clinical depression. Although a grief reaction can mimic depression, it is altogether another type of response. In this study, there were four respondents who sought professional help when they felt their reactions no longer fell within a predictable pattern of grieving. They were very accurate in their perceptions and said that the help they received was very vital to their adjustment after bereavement.

This study also helped verify that persons make the adaptation

to bereavement in their own time frame and in their own way, not following any particular pattern of events. This is best exemplified by some of the responses given to Question #26 on the interview schedule (Appendix B) which asks "If you could tell those who have lost partners anything from your experience that would be helpful to them, what would it be?"

Two male respondents gave advice about selecting the right partner in the first place. Mr. #19 said the most important aspect of partnership was "the one thing. Fall in love with a wonderful girl and keep her. You've got to have a girl in your life. Stay with her until death do us part." Mr. #16 was also concerned about the partnership issue when he gave the following advice:

I would ask "How long were you married with your wife, tell me about her, what kind of girl was she?" Find out if they were married for love or lust. Try to find a girl who can give you just like what you got before. Because a lot of girls their age can't produce as much as their wives did. Face it. A lot of girls are a bit worn out too. All they want is companionship and that's it. Another thing, a lot of those guys were waited on hand and foot. And they always picked on their wives. Their wife was nothing but a servant. That was wrong. Now, you'd better change your attitude. If you want to have a friend, be a friend. A woman is not a piece of meat, she is your partner.

Mrs. #22 seemed to feel that a male friend would suffer the loss of his partner even more than she had:

I had a friend who recently lost his wife. I told him, "It's hard and it's going to be harder for you losing her than it was for me because men are helpless." I mean go out, don't stay at home like I did. Be with people because he's the type of person who has to be with people. I don't need people.

Some of the advice the respondents said they would give to others in a similar life situation had to do with keeping continued

faith in God and maintaining an active prayer life. Others concentrated on continuing relationships with family and friends. The predominant response to what advice one would choose to give other survivors was a variation on the idea of living one day at a time. Mrs. #5 expressed this when she said you should have "no negative thoughts by any means because that's what will get you into trouble. Live one day at a time."

Several respondents said that they now realized that they would never really "get over" the loss. Mrs. #2 said that "there are people who say 'you'll get over it' and you'll never get over it. I don't want anyone else. I had a good man." Mrs. #7 said that the death of her partner "leaves a void that nothing can fill. I realize that you don't get over it."

Several respondents gave advice related to nonverbal support. Mrs. #10 said she would not try to advise, "I'd just hold them." But other survivors felt that having someone listen was instrumental to the healing process. Mr. #26 concluded that:

You really don't know until you put the shoes on. So I think you need to find somebody you can do your talking to. Tell them all of your problems. It may seem like you're repeating yourself but don't let that bother you, just keep right on rambling on. Something good will come out of your conversation normally. Maybe you'll get some feedback.

Mrs. #29 reflected on something that she once said:

Well I know there's so many people worse off than I am and the doctor said, "Don't ever say that. You have to say how you feel and that you're hurting so badly." And I don't compare. Do not compare. Because what you're handling at the time is the main thing at the time. You are going through this yourself.

Several respondents were adamant about the necessity to go through the process in their own way. Mrs. #31 said that "you have to trust your own instincts and your own judgements and not look so much at what other people say." Mr. #30 also gave the following advice:

Don't listen to any advice anybody gives you. Do what you feel. Sometimes I've gotten advice and I listen to it politely and do what I feel because I think it's great that what works for one person works for them but it's not necessarily going to work for me. I've been told to get a job, get a hobby, travel, sell everything in the house and go to an apartment, staying busy is the best thing and time heals and so on and so forth but I look at them and I'm going to do what I damn well please. And I'll recover.

The preceding comments given by survivors of the loss of a lifelong partner have significance in an applied setting because they indicate that one intervention method or style is inadequate to address the needs of a person going through such a significant life altering experience.

Final Summary

In this study, the social construction of reality theory was used as the framework to examine how survivors of the loss of a lifelong partner readjust their lives and make social adaptations after their partner's death.

It has been shown that the definition of what constitutes support is still individual and can differ dramatically from one survivor to the next. It was also shown that there is no prescribed method for working through the transition process with the appro-

priate accompanying stages. Each individual reconstructs his/her life in the way that is considered most adaptive for one's own circumstances.

It was also found that the period of grieving for the lost partner is longer than was originally thought. Participants who had been alone for four years still felt that they might always be grieving the loss in some ways. Most respondents still wanted to participate actively in social life and wanted the feeling of being needed and sought after by friends and family.

Issues of faith were of great importance to participants in this study. They allowed the individual to continue a feeling of connectedness with the deceased partner as well as offering stability in the day to day adjustment process.

Finally, the loss of a lifelong partner was seen as a process rather than an event, that started with the illness or other significant event and continued through the death to encompass the process of reconstruction by the survivor. Mr. #25 may have summed up this experience best when he said:

The whole grieving process is the most interesting experience I've ever encountered. I used to think, "Come on, get over it, forget it, get your life going." But it doesn't work that way. You can get your life going but there are times that someone can say one thing and boy, you just get a welling up, you know?

In this study, it was clear that if survivors are given the opportunity to speak, their responses are well worth listening to.

Appendix A

Letter of Permission From the Human Subjects
Institutional Review Board to
Conduct Research

Human Subjects Institutional Review Board



Kalamazoo, Michigan 49006-3899

 WESTERN MICHIGAN UNIVERSITY

Date: 4 February 1998

 To: Ellen Page-Robin, Principal Investigator
 Anora Grinwis, Student Investigator

From: Richard Wright, Chair

A handwritten signature in black ink that reads "Richard A. Wright".

Re: HSIRB Project Number 98-01-08

This letter will serve as confirmation that your research project entitled "Loss of the Lifelong Partner: Implications for Social Adaptation" has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 4 February 1999

Appendix B
Interview Tool

INTERVIEW TOOLSOCIAL ADAPTATION STRATEGIES OF SURVIVORS OF LIFE PARTNER LOSS

Thank-you for agreeing to participate in this interview.

Participant's gender: Female _____ Male _____

Participant's birthdate: _____

Year of marriage or beginning of Partnership: _____
(demographic data)

1. When did the death occur?
2. How many months/years has it been since your partner died?
3. How old was your partner when s/he died?
4. How old were you?
5. What was the cause of death?
6. Tell me about the death itself. Was it sudden or expected?
Describe other circumstances around the time of the death that are significant to you.
7. Were you involved in providing care for your partner?
Describe that experience.
8. Were other agencies or individuals involved in the care of your your partner? Comment on the care your partner received from these sources.
9. Do you feel that you did some grieving prior to your partner's death?
10. Describe the funeral and/or burial process. Did you find that experience helpful?
11. What are some of the changes you have made in your life since your partner's death:
Daily routines:
Plans for the future:
12. What are some of the difficulties that you have experienced since your partner's death?
13. Who have you relied on most to keep you going through this time of transition?
Children
Grandchildren
Friends
Other Widowed Persons
Neighbors
Pastors/Church Personnel
Funeral Home Personnel
Senior Center Staff
Medical Care Community:
Doctors
Nurses
Support Staff
Hospice Care Personnel
Recreational Groups
Community Groups
Grief Support Groups

14. Of those sources identified above, what kinds of support are they providing?
15. To what extent have you been encouraged to grieve openly?
1) Not at all 2) Rarely 3) Sometimes 4) Frequently
16. Do you have someone in your life with whom you can comfortably express your grief? Your fears?
17. Do you feel you have received enough support during the bereavement process?
18. Have you felt the level of support change over time?
If so, when did it start to change?
19. What was your state of health before your partner's death?
1) Excellent 2) Good 3) Fair 4) Poor
20. How would you describe your current state of health?
1) Excellent 2) Good 3) Fair 4) Poor
21. What strengths have you found in yourself since your partner's death?
22. How have issues of faith helped you during this time of loss?
23. Have you begun to see yourself as a single person? How does your name appear for mailing and other forms of personal address? (if female).
24. What has helped you most during this transition?
25. What has made the transition more difficult?
26. If you could tell those who have lost partners anything from your experience that would be helpful to them, what would it be?
27. If you could share anything with persons who attempt to support people going through the loss of their life partner that would help them be more sensitive, what would it be?
28. How do you view the future, at this particular point in time?
29. Is there anything else you would like to share?

Thank-you for your help with this study.

Participants Needed for a study conducted by Western Michigan University Gerontology Program. The study will be looking at surviving the loss of a lifelong partner. Persons are being sought for interviews who were married or in a partnership 45+ years and lost their partners between June 15, 1994 and December 15, 1997.

Persons who agree to be a part of this confidential study will be asked to be interviewed at a location of their choice. The interview should last 1-2 hours. It is hoped that the information obtained will be helpful to people who will experience this situation in the future, as well as to assist those who work in the helping professions to have a better idea of how to be of assistance.

If you would be willing to participate, you can call Anora Grinwis at 383-9343.

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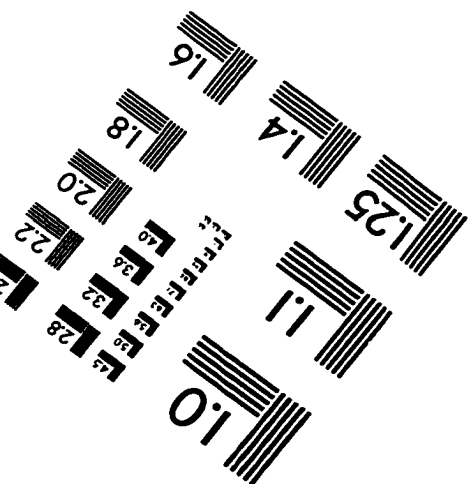
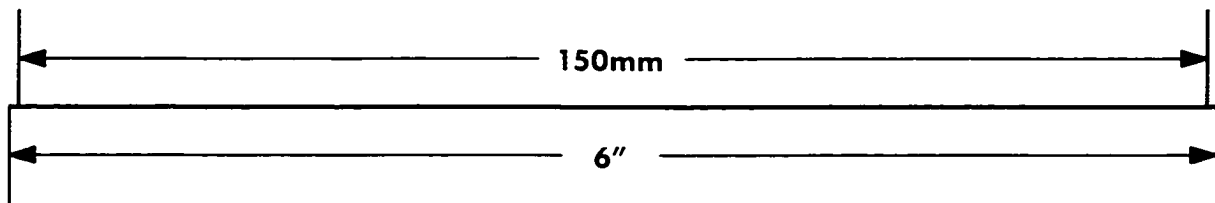
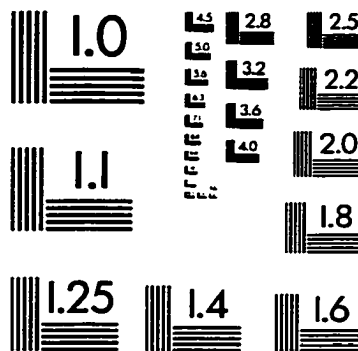
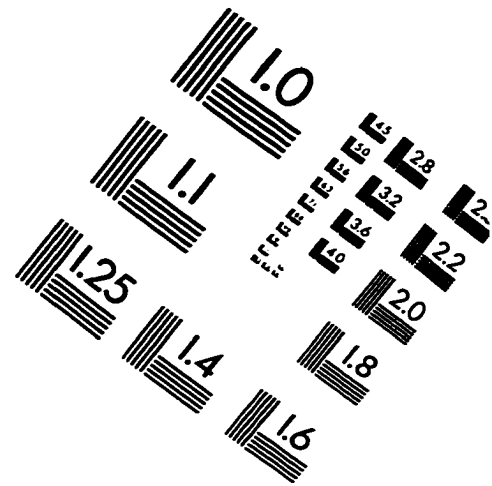
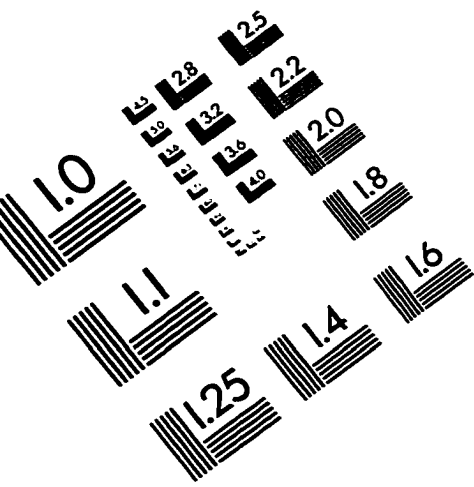
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IMAGE EVALUATION TEST TARGET (QA-3)



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