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THE EXPERIENCE OF GRIEF AMONG THE BEREAVED WIDOWED AT ROTARUS HOME FOR THE AGED MAFIKENG

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MOYRA GAIL TSAMBOS

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DECLARATION

I declare that the dissertation for the degree of Masters in Clinical Psychology at North-West University has not been submitted by me at this or any other university, this is my own work and all materials contained herein have been duly acknowledged.

MOYRA GAIL TSAMBOS

Date: November 2010

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ABSTRACT

The purpose of this study was to comprehend and illustrate what bereaved widows experienced during their grieving and bereavement process. It succinctly and poignantly intended to investigate the psyche of the bereaved person and understand what it really meant to lose a spouse.

The grieving process poses a range of unique daily challenges for anyone who has lost a spouse. The widowed in this research were all distinctly faced with different experiences, occurrences and responses to their everyday predicaments. This study therefore endeavoured to delve beyond the intricacies and complexities of death and had intensely explored the psyche of the bereaved person in order to understand what it actually meant to lose a spouse.

The sample consisted of 12 recently bereaved widows in an old age home and a comparative group of 12 widows living with their relatives. A qualitative study was employed to gain insight into the experiences of the recently bereaved. The results gave insight into the emotions experienced and coping mechanisms of the bereaved.

The results indicated the multirole phenomenon which bereavement placed on the widowed, which, depending on the ability and desire to compensate for their new conflicting demands, as well as their responsibilities that had prevailed and how they had to come to terms with their depressing and disheartening challenges. Those results profoundly influenced the veracity of their grief reaction.

It is therefore that based on this study, assistance and support can be mobilised by the South African Government who could provide the stanchion for more trained professionals and counselors to assist with the behavioural and cognitive challenges that consequences from the passing away of a spouse.

CHAPTER ONE
INTRODUCTION

1.1ORIENTATION TO THE STUDY

When we lose someone close to us it is devastating. The process of working through our loss is a difficult and a confusing one. Just when we think things are all better, the feelings come back and we feel worse than ever before.

Everyone experiences and expresses grief in their own way, often shaped by how their culture honours the process or not. It is not uncommon for a person to withdraw from their friends and family and feel helpless; some might be angry and want to take action. One can expect a wide range of emotions and behaviour. In all places and cultures, the grieving person benefits from the support of others (Fenchuk, 2008 : 346). Similarly, where the process of grieving is interrupted for example, by simultaneously having to deal with practical issues of survival or by being the strong one that holds a family together, the bereavement process can remain unresolved and later resurface as an issue for counselling.

Death is a universal and unavoidable prodigy. It arouses strong feelings of dread and fear in dying patients as well as in their families (Archer, 2007 : 146). Death is not the special province of any single discipline or the specialty of anyone branch of medicine; rather, it is the universal reminder of life and its meanings (Jeffreys, 2008 : 37). Death is viewed

with fear because it symbolizes emptiness and failure (Sadock & Sadock, 2007 : 61).

People cope with the loss of a loved one in many ways. For some, the experience may lead to personal growth, even though it is a difficult and trying time. Neimeyer (2006 : 28) explicates that there is no right way of coping with death. The way a person grieves depends on the personality of that person and the relationship with the person who has died (Morgan, 2007 : 29). As Morgan (2007 : 30) extols, "How a person copes with grief is affected by the person's cultural and religious background, coping skills, mental history, support systems, and the person's social and financial status."

While attention is drawn to people who have a loved one actively dying or who have recently lost someone, chronic life-limiting conditions become less attended to by friends and neighbours after a while (Byock, 2007 : 227). For the family members providing continuing care for the chronically ill, there is no such thing as forgetting about it, they cannot "turn their eyes away." They become part of a less visible world of grievers who must cope daily with both accumulating, multiple and anticipated losses (Jeffreys, 2008 : 19).

The terms "grief", "bereavement", and "mourning" are often used in place of each other, but they have different meanings.

John Bowlby, a noted psychiatrist, outlined the ebb and flow of processes such as shock and numbness, yearning and searching, disorganization and despair, and reorganization (Byock, 2007 : 101).

Bowlby and Parkes (2008 : 256), note psychophysiologic components of grief as well. Included in these processes are feelings of depersonalisation, unreality, withdrawal and an anaesthetising of affect. The person feels unable to come to terms with what just occurred.

> "Whenever one's identity and social order face the possibility of destruction, there is a natural tendency to feel angry, frustrated, helpless, and/or hurt. The volatile reactions of hatred, terror, resentment and jealousy are often experienced as emotional manifestations of these feelings"
>
> (Bowlby & Parkes, 2008 : 256).

Bereavement is the period after a loss during which grief is experienced and mourning occurs. The time spent in a period of bereavement depends on how attached the person was to the person who died, and how much time was spent anticipating the loss.

Disorganisation and despair are the processes commonly associated with bereavement: the mourning and severe agony of being away from the loved person or circumstances. Reorganisation is the absorption of the

loss of something or someone and the redefinition of life and meaning without the person that has been lost (Smith, 2007 : 315).

According to Fenchuk (2008 : 346), bereavement, while a normal part of life for us all, carries a degree of risk when limited support is available. Severe reactions to loss may carry over into familial relations and cause trauma for children, spouses and any other family members. Issues of

personal faith and beliefs may also face challenge, as bereaved persons reassess personal definitions in the face of great pain. While many who grieve are able to work through their loss independently, accessing additional support from bereavement professionals may promote the process of healing (Byock, 2007 : 124).

Mourning is the process by which people adapt to a loss. According to Cohen (2007 : 42), mourning is also influenced by "cultural customs, rituals, and society's rules for coping with loss."

Grief work includes the processes that a mourner needs to complete before resuming daily life. As Galinsky (2009 : 6) propounds, these processes include separating from the person who died, readjusting to a world without him or her and forming new relationships. Galinsky (2009 :. 7) goes on to posit that "To separate from the person who died, a person must find another way to redirect the emotional energy that was given to the loved one." This does not mean the person was not loved or should

be forgotten, but that the mourner needs to turn to others for emotional satisfaction. The mourner's roles, identity, and skills may need to change to readjust to living in a world without the person who died. The mourner must give other people or activities the emotional energy that was once given to the person who died in order to redirect emotional energy (Galinsky, 2009 : 7).

According to Godwin (2008 : 17), people who are grieving often feel extremely tired because the process of grieving usually requires physical and emotional energy. The grief they are feeling is not just for the person who died, but also for the unfulfilled wishes and plans for the relationship with the person. Death often reminds people of past losses or separations. Godwin (2008 : 18) infers that mourning may be described as having the following two phases:

- The urge to bring back the person who died.
- Disorganization and sadness.

According to Attig (2008 : 212), persons react to death partly according to its context. For instance, persons may experience death as timely or untimely:

- **timely** when a person's expected survival and actual life span are approximately equal. Those left to grieve a timely death are usually not surprised or shocked by it

- **untimely** death such as that of a young person, a person who dies suddenly, or a person whose catastrophic death is associated with violence, an accident, or utter meaninglessness.

Death can also be regarded as intentional (suicide), unintentional (trauma or disease), and sub-intentional (substance abuse, alcohol dependence, cigarette smoking) (Sadock & Sadock, 2007 : 62). Death may have multiple psychological meanings, both for the person who is dying and for society in general.

1.2 STATEMENT OF THE PROBLEM

In a 2007 survey, Leming and Dickinson (2009 : 23) found out that from a group of 300 widows and widowers, 30 percent of those questioned reported that they had become isolated from friends, withdrawn from social life, and thus experienced feelings of isolation, desolation, wretchedness, loneliness and despair soon after their spouses had passed away. Leming and Dickinson (2009 : 23) went on to say that self-help groups offered them companionship, social contacts, and emotional support; which eventually enabled them to re-enter society in a meaningful and significant way (Leming & Dickinson, 2009 : 24)

A similar research study was undertaken by Impens and Long, also in 2007, whereby 225 elderly individuals who became widowed quite recently before the study period, were examined for the extent to which community support was provided and received by the group, as well as the extent to which emotional support and assistance within their

immediate community was offered and its impact on the study group. The research revealed that 29.2% of those studied had undergone counselling for depression, 24.3% of the group had sought psychological therapy and were diagnosed with major depressive disorder, 14.5% were associated with self-help group therapy for the depressed and 32% participated in religious self-help groups for depression (Impens & Long, 2008 : 321)

Yet another 2005 study undertaken by Templer, Ruff, and Franks (2007 : 319) reported that death anxiety is a common component of depression amongst the aged society. Their study of one hundred elderly participants between the ages of 62 – 72 years was scrutinized for depression. Templer et al. (2007 : 320) realized that 43% feared and loathed death after becoming widowed, 49% of the research group was chronically and psychologically distressed, as well as despondent, which correlated with the early onset of depression. Whilst a mere 8% of the respondents had accepted their spouses' death as an inevitable reality of life. Templer et al. (2007 : 321) thus concluded that losing a spouse was described by the respondents as "an end of our earthly journey, we have to let go all the things that are dear to us; belief in a happy and fulfilling afterlife may indeed be a daunting experience and miserable task ahead for us."

So much has been said on the impact and implications of bereavement and its fore-bearer, death, but little is known or extolled on the actual experiences of widowhood. To this end, the researcher has attempted to delve beyond the intricacies and complexities of death and bereavement

and intensely investigate the psyche of the bereaved person and understand what it really means to lose a spouse.

According to Thachil, Mohan and Bhugra (2007 : 229), major depression in the elderly seems to reduce their survival rates, even independently of any accompanying illness. Decreased physical activity and social involvement also certainly play a role in the association between depression and illness severity.

According to Kiibler-Ross,(2008 : 136) a psychiatrist and thanatologist[1] who made a comprehensive and useful organisation of reactions to death, propounded that a widow/widower seldom follows a regular series of responses that can be clearly identified; no established sequence is applicable to all those who have lost their spouses.

Anyone who experiences negative life events such as physical illness, the death of a loved one, impaired functioning, or loss of independence can become deeply depressed. The elderly are at the highest risk for such events.

Because of the complex relationship between depression, drug interactions and serious physical illness amongst the elderly, an accurate diagnosis in this group is important but not always straightforward. The characteristic symptoms of depression are not always present or readily apparent in older people (Schulz, Beach & Lind, 2007 : 312).

---

[1] Thanatology is the study of death, dying and bereavement

Given the significance of the knowledge of grief as a subjective encounter amongst the elderly who have lost their spouses through death, this research wishes to clarify and understand the experiences and manifestations of death.

1.3 AIM OF THE STUDY

The aim of the study is to seek and understand grief and the experiences of death amongst the widowed. Specifically, the study investigates the manifestation that the death of a spouse has on the widowed at Rotarus, Home for the Aged, Mafikeng, and makes a comparative study of the experiences of those widowed and living with their next of kin.

The purpose of this study is to identify significant experiences that death, bereavement and grief have on the lives of widowed elderly people and to determine the manifestations of the widoweds' loss after the death of their beloved spouse.

1.4 SIGNIFICANCE OF THE STUDY

As one ages, one is unreservedly faced with the death of a spouse, this results in a huge loss which senior members of our society must ultimately cope and deal with (Russel, 2008 : 240). The findings of this research work may contribute to other individuals who are similarly faced with

widowhood and may lead to applications that achieve practical, real-world change.

The findings may also have direct practical implications which will usefully contribute to the clinical profession and counselling fraternity as far as therapy and counselling for the prevention of the early onset of depression.

Social support systems can also be put in place which can assist the socio-economic needs of the elderly. Mobility changes could assist in-as-far-as societal collaboration, grief therapy alliance and counseling assistance.

Profound socio-cultural influence may eventuate, changing the way society thinks about the position of widows in society.

The concluding results may also assist the South African Government in recognizing the role that the authorities have in its part to play vis-a-vis task-demands for national bereavement programmes, grief counselling instruction and grief work training. In essence this would mean: the consequential difference between 'living in a home for the aged' and 'living with the children' scenario. This can fairly be translated in a set of differences in material support, practical and informational sustainability, social collaboration and relevant assistance. Stripped of these crucial aspects, the difference in environment is largely reduced to the inevitable housing situation of the bereaved elderly.

RESEARCH METHODOLOGY

This section discusses the following: the research method, the participants, the sampling method, data collection methods, independent and dependent variables, analysis and ethical considerations.

1.7.1 Research Method

The research methodology is a qualitative research approach illustrating a strong commitment to seeing the world through the eyes of those being studied. As Maykut and Morehouse (2004 : 57) posit, qualitative observations use your senses to observe the results as well as being able to actually feel and experience what the participant is really feeling and experiencing.

According to Lincoln and Guba (2008 : 214), qualitative research employs inductive data analysis to provide better understanding of the interaction of 'mutually shaping influences' and to explicate the interacting realities and experiences of the researcher and the participant. This is a major aspect of the phenomenological viewpoint, in which qualitative research speaks of the 'personal lifeworld', and tries to describe an individual's *experience* within this particular meaningful realm.

According to Hedegaard and Hakkarainen (2008 : 321), the commitment in understanding the world from the perspective of the experiencing individual, calls for a substantial intensity of

involvement with the cases or people that the investigator is researching.

Pertaining to phenomenology as one of the qualitative research methods, Frank (2007 : 187), posits that this approach primarily aims to understand and interpret the meanings that research participants attach to their everyday living experiences. By entering into the life world of the participants, a phenomenological researcher is in a position to place him or herself "into the shoes of the examinee" (Frank, 2007 ; 187). This will allow the researcher to methodically gather information, whilst at the same time scrutinizing the connotations and ideas that emerge from the data itself. Given the focus of the present study, the phenomenological method was considered appropriate.

The phenomenological method is a philosophy initiated at the beginning of the twentieth century by Edmund Husserl, the founder of the 20th century philosophical school of phenomenology at the University of Vienna (1883), describes structures of experience. The basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of a universal essence (van Maanen, 2006 : 25) According to Hesserl (1983 :16), phenomenology attempts to study peoples' perceptions, understanding their perspectives of a particular situation. A phenomenological study describes the meaning of several individuals of their description and what all participants have in

common as they experience a phenomenon, in this instance: grief as a universal experience (Langdridge, 2007 : 44).

1.5.2 Participants

A sample, according to Frank (2007 : 187), is a sub-set of the population under scrutiny, which must have properties which make it "representative of its entirety." It would not be possible to use an entire population, therefore for this purpose, the sampling method under this research is purposive sampling.

To this end, the researcher identified two specific predefined comparative groups to work with. Purposive sampling can be very useful for situations where one needs to reach a targeted sample quickly and where sampling for proportionality is not the primary concern.

- Three white and three black widows were identified and purposefully chosen from Rotarus Home for the Aged for this specific investigation, which offered a cross-cultural variance.

- In comparison, another target group, consisting of three white and three black widows was identified independently and living outside of Rotarus. All respondents were matched across demographic variables.

1.5.3 Method of Sampling

The criteria for sampling included:

- all women had lost their spouses
- they were all of a particular age group, ranging between 59 and 62 years. Average age: 60 years
- an interval period of at least 6 months had elapsed after the loss of each contributor's spouse
- all had been married at the time of their spouses' death
- racially black and white.

1.5.4 Data Collection Method

The following guidelines posited by Parkes and Weiss (2008 : 157) are relevant to this study:

a) Those participating in the research study should have had particular experience relating to the phenomenon being probed.
b) The interviewees should at all times be open and genuine towards the researcher as well as being able to verbally open-up to their unique experiences.
c) The participants should be favourably inexperienced to any psychological theory, since any familiarity thereof may impede on their account of live experiences.

d) The researcher should be conversant in the language of the interviewees, as this will prevent possible failure of any restrained semantic degree owing to the necessity to translate from one language to another.

1.5.5 Variables

Qualitative phenomenological approach concerns itself with people's real life experiences and harnesses importance on elucidating a system of objective variables. This research aims to discover the variables entailed in the bereavement situation and does not dissent from the orthodox view of the person as being part of a natural system of causes and effects (Hollway & Jefferson, 2008 : 14).

The experiences of grief and bereavement may be conceptualized as a collection of quasi-linguistic suggestions by which the widow construes her life-world and which concentrates on the social nature of the constructions of the world that guide thought and action. Extenuating variables which need to be noted are:

- sufficiency of emotional support from kinship
- physiological health issues i.e. somatic complaints, medicine consumption, sleep patterns
- aspects of psychological functioning since death of spouse i.e. search for meaning (meaning of their very existence),

detachment, intrusive and evasive thoughts, worries, anxieties, ambivalent feelings

- Attitudes towards the loss i.e. anger, guilt feelings with regards to the circumstances of the death and degrees of sadness over the death of the deceased.
- Social functioning i.e. social integration, social activities and social acceptance

1.5.6 Sampling Procedure

The researcher's view corresponds with Parkes and Weiss (2008 : 157) who postulates that phenomenological research recommends that the number of participants should range from five to twenty five. In this particular study, six participants with analogous similarities and distinctive characteristics were selected out of the population of 47 occupants of the Home and requested to participate and six widows external and autonomous of the confinements of any enclave, which in this instance is Rotarus Home for the Aged. This study will use purposive sampling for briefness of time's sake.

As Strydom and Delport (2007 : 374) proposed that purposive sampling is a particular and specific case that is chosen for inclusion because it has some unique features that are of particular relevance and importance to a study being undertaken by a researcher. Therefore, the inclusion of participants should be channeled by a procedure that enables the researcher to obtain

abundant facts correlating specifically with the phenomenon under scrutiny.

1.5.7 Tools for Data Collection

Each participant was individually interviewed in this study and data and information were collected by verbatim digital-recording. As Hedegaard and Hakkarainen (2008 : 322) posit, qualitative questioning, requires the researcher to assume and implement an amenable, legitimate and compassionate approach which will be concerned with the interview as a special encounter with the participant. Therefore, in this respect, it would be very important for the researcher to pay attention to what is being said, without concluding on any fastidious investigative hypotheses. A semi-structured interview allowed the researcher and interviewee to engage in a dialogue whereby initial questions were adjusted in the light of the participant's response and the researcher was able to probe interesting and crucial areas which arose. Therefore the interviewer aimed to:

- Use short precise questions
- Read each question exactly as in the schedule
- Ideally have pre-coded response categories, enabling the interviewer to match what the respondent has said against one of those categories
- Ask each question in the identical order specified in the schedule.

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It must be also borne in mind as Creswell (2007 : 171) argues, that the process of data collection in a qualitative study is embryonic, rather than structured. Parkes and Weiss (2008 : 158), posits that qualitative interviews are continuous in character and, consequently, questioning may be redesigned throughout the interview process. Qualitative interviews require a flexible data collection instrument.

1.5.7 Interview Schedule

An interview schedule was designed by the researcher to answer the interview questions. In order to guarantee its accuracy as far as possible, the substance of the schedule was finalized after the initial list of questions were tested on two people who had not been part of the final sample. During the pilot test, the respondents' comments on how they experienced the questions, in terms of whether or not questions were threatening, difficult to understand were used to finalise the list of questions.

1.6 ETHICAL ASPECTS

There is however an ethically-troubling issue associated with this kind of trial. The most important ethical concern is the exception from informed consent. How can one morally justify using another human being in an experimental trial without their prior consent? It is clearly a repulsive notion to be insensitive of adherence to autonomy. However, the

justification is that societal interests, under certain narrow conditions, can take priority over autonomy; this is one of those specific situations. Another important issue remains to be evaluated, however, namely, the risk and benefit calculation, and whether the study is fair. Therefore, the researcher informed the interviewees about the aim of the study and solicited their consent to participate in the study, by requesting each person to sign a consent forms, ensuring that each participant comprehended the veracity of the study. It was also made clear that each participant would not be compelled or obliged to participate; and if at any time anyone wished to terminate his/her participation at any stage during the research process he or she would be free to do so.

- Permission and clearance from the University of North-West's Research/Postgraduate Ethics Committee were attained.
- Cooperation and permission were obtained from the Management and administration of Rotarus, Home for the Aged, North Street, Mafikeng.
- The participants' personal files were perused by the researcher, with the assurance that during the course of the research, confidentiality and anonymity of the subjects will be strictly preserved and stringently maintained at all times.
- Acquiescence was also acquired from the six widows outside of Rotarus Home for the Aged, with the assurance that during the course of the research, confidentiality and anonymity of the subjects would be preserved and maintained at all times during the research procedure.

- Assurances were clearly pointed out that those who felt "vulnerable" or distressed during the course of the study would be referred to the local hospital for psychological/psychiatric or other social services. It was also emphasized that it is the moral obligation of the researcher that when participants who might be identified as being 'vulnerable' and have already established a relationship with the researcher, should not perceive themselves as being abandoned by the researcher after the study.

1.7 MOTIVATION FOR THE STUDY

The researcher was motivated to conduct this study because of her personal experiences amongst her widowed friends who are currently struggling with symptoms of depression as they come to terms with the death of their beloved spouses.

As Parkes and Weiss (2008 : 119) posit, death and grieving is a personal and highly individual experience. How one grieves depends on many factors, including the personality of the bereaved and his/her coping style, their life experiences, their faith, and the nature of the loss. "The grieving process takes time" (Parkes & Weiss, 2008 : 120). Healing happens gradually; it cannot be forced or hurried in any way, and as Cohen (2007 : 43) proposes, there is no "normal" timetable for grieving. Some people start to feel better in weeks or months (Parkes & Weiss, 2008 : 120). For others, the grieving process is unfortunately measured in years.

As Cohen (2007 : 43) infers, there is no right or wrong way to grieve, "but there are healthy ways to cope with the pain." Cohen (2007 : 43) assures

us that the bereaved can ultimately get through the emotional pain. Parkes and Weiss (2008 : 121) also advise that grief that is expressed and experienced has a potential for healing that eventually can strengthen and enrich life.

1.8 DEFINITION OF CONCEPTS

The following words are defined below as used in the content of this work:

Death

According to The American Medical Dictionary (2008 : 328), "death is the end of life, the permanent cessation of all vital bodily functions." The common law standard for determining death is traditionally demonstrated by "an absence of spontaneous respiratory and cardiac functions" (The American Medical Dictionary, 2008 : 328).

Bereavement

According to the Chambers English Dictionary (2008 : 133), bereavement is the act of a person who mourns; it is the act of sorrowing or lamentation. Bereavement is the conventional manifestation of sorrow for a person's death, especially by the wearing of black clothes or a black armband. Bereavement is the period or interval during which a person grieves or formally expresses grief (Chambers English Dictionary, 2008 : 133).

Grief

Grief may be described as the presence of physical problems, constant thoughts of the person who died, as well as guilt, hostility, and a change in the way one normally acts. Grief is the normal process of reacting to the loss (Godwin, 2008 : 16). It is the post-bereavement stage. It is the coping mechanism of loss.

CHAPTER TWO
THEORETICAL AND CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

Yalom (2009 : 17) very aptly and precisely declares "There are four fundamental and harsh facts of life's existence, these basic facts emerge from a person's endeavours, conscious and unconscious and are continuously whirring just beneath the membrane of life: the inevitability of death for each of us and for those we love; the freedom to make our lives as we will; our ultimate aloneness; and, finally, the absence of any obvious meaning or sense to life. However grim these facts may seem, they constantly remind us of our fragility as mortals.

Of these ominous facts, death is the most obvious, most intuitively apparent (Bryman, 2008 : 147). Bryman (2008 : 148) also believes that at an early age, we learn that death will come, and that from it there is no obvious escape. "Nonetheless, at one's core, there is an ever-present conflict between the wish to continue to exist and the awareness of inevitable death" (Bryman, 2008 : 148).

To adapt to the reality of death, we are incessantly resourceful in conceiving ways to repudiate or flee from it (Parkes & Weiss, 2008 : 137). When we are young, we deny death with the help of parental comfort, secular and religious myths; later, we personify it by transforming it into an entity, a sandman, a monster, a demon. As Parkes and Weiss (2008 : 138) posit, "Assuming that death is some pursuing entity, then one would presume that there would be a way to elude it." Parkes and Weiss (2008 : 139) continue to speculate that when we become young adults, we experiment with other ways to taunt and challenge

death through daredevilry, or desensitize it by rendering ourselves in the reassuring company of peers to horror films, ghost stories and cryptic crime thrillers. As we become older, we become skilled at putting death out of our minds; we distract and divert ourselves; we transform death into something positive (passing on, rejoining God, and going home.) The elderly strive for immortality through embracing a religious system that offers spiritual perpetuation, through imperishable works, by projecting their seed in the future through their children (Bryman, 2008 : 150).

The goal of the present chapter is to show that although a number of theories have been developed to describe and explain the processes associated with bereavement, none of them can be fully adopted without limiting the aspects one has to take into consideration. Thus, a brief outline of some of the influential theories on the bereavement process is discussed, together with their merits and limits in understanding the bereavement process.

2.2 PSYCHOANALYTICAL THEORY ON BEREAVEMENT

In 1917, Sigmund Freud wrote in *Mourning and Melancholy* that "normal grief (mourning) results from the withdrawal of libido from its attachment to the lost object" (Ricoeur, 2006 : 192) In normal mourning, the loss is clearly perceived, and the person who died is eventually, through the grief work, internalised as a loving and loved object. In abnormal grief (melancholia), the object is not given up but is incorporated in the survivor's psyche as 'an object infused with negative feelings' (Ricoeur, 2006 : 192). These negative feelings toward the deceased person are experienced as part of self, and the survivor becomes depressed, has low self-esteem, feels worthless, and becomes self-accusatory, with possible

delusional expectations of punishment. Freud's distinction between mourning and melancholia is still considered valid; that is, exaggerated loss of self-esteem is not part of normal grieving (Ricoeur, 2006 : 198).

According to Cleiren (2007 : 121), Freud's theory concentrates on the intra-psychic aspects of bereavement. Cleiren (2007 : 123) goes on to suggest that Freud himself was less concerned with death-specific characteristics or environmental factors. "He was the first to propose a framework for the intrapersonal dynamics of the bereavement process" (Cleiren, 2007 : 124).

According to Sadock and Sadock (2007 : 374), another psychoanalytic theorist in Germany during the early 1900's, Karl Abraham, was an important collaborator of Sigmund Freud who stressed the role of unconscious dynamics in grief reactions. According to Abraham, the greater the role unconscious and ambivalent factors precipitate (e.g., anger toward a spouse who has died), the greater the likelihood of an abnormal reaction later on. Karl Abraham described the "introjections of an ambivalently loved lost object and the subsequent direction of anger toward the introjected object" (Shengold, 2008 : 67).

2.3 COGNITIVE THEORY ON BEREAVEMENT

John Bowlby, in 1969, formulated the first influential theory on loss and attachment, which in a number of ways explicitly rejects Freudian theory (Parkes and Weiss, 2008 : 156). Like Freud, Bowlby presupposes unconscious processes and considers childhood experiences in bonding of importance in later development. Parkes and Weiss (2008 : 157) goes on to argue that Bowlby was dissatisfied with some of the abstract concepts such as 'psychic energy' and

'pychic drives' in psychoanalysis. Bowlby, especially in his later work, seeks to draw links with cognitive psychology. In his attachment theory (Van der Horst, van der Veer & Van IJzendoorn, 2007 : 439), Bowlby postulates that attachment behaviour in human beings has a function of committing themselves to each other. Van der Horst et al. (2007 : 442) see it this way, "The young child is extremely dependent on his environment. In order to survive, it has to make certain that it is cared for. This, it does by showing attachment behaviour: behaviour that serves to maintain certain degrees of proximity to, or of communication with, the discriminated attachment figure(s)". Examples of such behaviour are smiling when the attachment figure is present, crying or calling, to make the attachment figure appear, and searching behaviour. In attachment relationships (of which the first most often is the mother-child relationship) the individual is and feels protected (Parkes & Weiss, 2008 : 159). Attachment is thus goal-directed and has a function in survival. Attachment behaviour, also when expressed in adult life, is considered by him to be normal (Parkes & Weiss, 2008 : 160).

According to Bowlby, grief is essentially 'separation anxiety' (Attig, 2008 : 224). He draws an analogy between young animals and children's reactions to separation from their mothers and reactions to loss in bereaved adults. Bowlby views bereavement as an unwanted separation from an attachment figure which gives rise to 'attachment behaviours' similar to those observed in animals and children. A brief period of protest is followed by a longer period of searching behaviour. After some time these behaviours cease, as they prove to be ineffective in bringing back the attachment figure and the bereaved enter a phase of despair and depression sets in (Attig, 2008 : 225). After that, a fourth and final stage is the 'reorganisation' phase, in which the cognitive restructuring

of one's situation takes an important place. Proceeding through these phases constitutes the 'grief work'. According to Attig (2008 : 225), in contrast to Freud, Bowlby asserts that in a healthy bereavement process, the relationship with the deceased is often not broken. The bereaved may have a feeling of 'inner presence' of the deceased that is comforting and supportive in restructuring their lives.

Bowlby's model is more or less an organic or medical one: it stresses the instinctual and congenital determination of the grief process (Parkes and Weiss, 2008 : 162). Like Freud's theory, it is a cathexis theory, where the childhood bond plays an important role as the model for later relationships. Recovery from loss is seen as analogous to recovery from a disease. There is some empirical basis for this theory. Behaviour sequences, following the phases described above, have been found among animals in behavioural experiments (Rosenblum, 2007 : 62) as well as in psychobiological research (Laudenslager, 2008 : 392).

2.4 BEHAVIOURAL THEORY ON BEREAVEMENT

Ramsay's (2009 : 228,) 'bereavement behaviour' indicates the integral psychological and physiological response-pattern of a person after a significant loss. Grief is seen as the general complex of psycho-physiological reactions with a biological origin, while 'mourning' is seen as the behaviour that is defined by social conventions and customs. Ramsay (2009 : 228) sees grief as a universal phenomenon among higher animals and humans. It is a complex but "stereotyped response-pattern with physiological and psychological symptoms." Stimulus for grief is the real or imagined loss of a significant object. It ceases

when new object relations are formed. The emotion is accompanied by severe psychological and physiological stress. Still, much of the behaviour of the grieving subject during a period of grief is dysfunctional in establishing new relationships and alleviating the problems (Ramsay, 2009 : 229).

The depressive mood he explains from a combination of theories. One is Seitz's (2008 : 182) low reinforcement theory: the depression is caused by a massive loss of formerly provided reinforcement (e.g. by the partner's death). The other is Seligman's theory of learned helplessness (Seligman, 2007 : 24). Seligman (2007 : 24) posits that the bereaved is powerless to change the situation, in other words, he cannot get the object back. This leads to a depressed mood in which potentially adaptive behaviour does not occur.

The importance of Ramsay's approach lies in incorporating the role of reinforcement, environmental and situational factors such as social support into a theory of grief (Ramsay, 2009 : 231). Empirical evidence for the theory is scarce however and largely provided by Ramsay himself in "an impressionistic basis." One problem is that the theory is of little value for describing and investigating the 'normal' grief process, since it is only concerned with the disturbances of that process (Ramsay, 2009 : 234).

Fenchuk (2008 : 349), in his theory, ascribes a prominent role to the social environment in the "genesis of pathological grief." The severeness of bereavement reactions is determined by disposition, abruptness of the loss, its significance, the availability of a replacement and social reinforcement for grieving or avoidance. In the course of a normal grief process the social environment initially reinforces grief. Later the reinforcement shifts to recovery

and the development of new activities (Fenchuk, 2008 : 349).

The main cause of prolonged grief, according to Fenchuk (2008 : 350), lies in inadequate or misplaced social reinforcement, grief symptoms being reinforced rather than adaptive behaviour. They state that grief is reduced by appropriate manipulation of social reinforcement and prolonged stimulus exposure.

2.5 EXISTENTIAL THEORY ON BEREAVEMENT

A recent model by Marrone (2007 : 220) highlights and incorporates existential change and psycho-spiritual transformation as a significant part of the grieving process. Marrone's (2007 : 220) four-phase model includes:

2.5.1 **Phase 1** *Cognitive Restructuring*

This phase involves reorganizing and restricting of the bereaved thoughts and concepts, allowing for the death of the loved one to be assimilated.

2.5.2 **Phase 2** *Emotional Expression*

This requires the bereaved to begin to identify and accept, and in some way, express the emotional turmoil and cognitive confusion related to the loss experienced.

2.5.3 **Phase 3** *Psychological Reintegration*

This involves developing new coping behaviour and cognitive strategies

that allow the individual to adjust to a world in which the deceased is absent.

2.5.4 **Phase 4** *Psychospiritual Transformation*

This is a penetrating growth-orientated spiritual/existential transformation that may fundamentally change the individual's central beliefs, attitudes and assumptions about life, death, love and God.

2.6 PERSON-CENTRED THEORY ON BEREAVEMENT

The psychiatrist Carl Rogers has propounded a theory embracing what he calls the 'phenomenological perspective' (Gotesky, 2007 : 132). Rogers assumes that society pressurizes the individual to act in certain socially approved ways, and this may lead to a discrepancy between one's true 'inner self' and the self manifested to others. Simply performing a social role does not maintain and develop this 'inner self'. Rogers writes:

> Loneliness ... is sharpest and most
> poignant in the individual who has,
> for one reason or another, found himself
> standing, without some of his
> customary defenses, a vulnerable,
> frightened, lonely but real self, sure
> of rejection in a judgmental world.
>
> (Gotesky, 2007 : 247)

According to Rogers those who do not trust their real selves to command the respect and approval of others use their social role as a shield to

protect them in a world they perceive as hostile. Thus a man who has managed to lead a fairly successful life in the role of a sergeant-major, once he has retired to civilian life may find that other people do not give him the respect to which he is accustomed, and if his wife dies and his children are grown up and far from home he may be a particularly lonely and vulnerable widower.

Carl Rogers' theories were, of course, developed in the course of his work with emotionally disturbed patients and are, therefore, not entirely applicable to ordinary, emotionally stable people. However, we may all learn something from this point of view. In preparing for retirement, and the various changes that come with age, we should be aware of all possibilities and what strategies we should adopt to avoid the rocks ahead. For those who lose their prized status in later life are especially likely to develop this.

2.7 BIOLOGICAL THEORY ON BEREAVEMENT

At the biological level it might seem that grief is universal. In every culture people cry or seem to want to cry after a death that is significant to them. Grief, then, could be conceived as an instinctual response, shaped by evolutionary development (Rosenblatt, Walsh & Jackson, 2007 : 242). According to Jeffreys, (2008 : 40), grief is both a physiological and an emotional response. During acute grief, as with other stressful events, persons may suffer disruption of biological rhythms. Grief is also accompanied by impaired immune functioning, in other words, decreased lymphocyte proliferation and impaired functioning of natural killer cells (Jeffreys, 2008 : 41).

Schulz, Beach and Lind (2007 : 414) found that it is beneficial to encourage the expression of distressful emotions and to facilitate an appropriate relationship with the deceased.

Regardless of which stage or phase theory one accepts or adopts as a guide; malleability, flexibility, and "the realization that individual's behaviour exists on a vast continuum which must temper the outcome" (Schulz et al. 2007 : 417). Schulz et al. (2007 : 419) go on to say "The model or theory embraced must respect individuality as well as universality." There is no "correct way to die or to grieve a loss, there is only the human way" (Jeffreys, 2008 : 42).

2.8 STAGES FOR GRIEF

2.8.1 Stage I : Shock and Denial

According to Zisook, Zisook and Bent (2002 : 21), the shock of death is to be expected, even after a long terminal illness and months of anticipatory grief, the ultimate loss of a loved one normally feels that the experience does not seem real. Nuss and Zubenko (2003 : 29), recognise that the first few weeks of grief as having been on "auto-pilot". That the grieving person can go through the motions at the time of loss and sometimes through the time of the funeral as though they are spectators watching from a distance. There is little actual memory of specific details, merely the knowledge that one has to do what has to be done. According to Freeman (2005 :131), shock usually wears off after five or six weeks, but may last much longer, depending on the person's skill at self-protection from painful feelings and the significance of the relationship that has been lost.

This can be a stage of bargaining as well, telling God they will do or change anything if the person can be brought back to life (Sadock & Sadock, 2007 : 66). Over a period of time, however, reality is faced. It is important to talk about it, not to keep it at a distance with frantic activity, pills or alcohol (Schulz, 2007 : 323).

Losing a loved one normally feels that the experience does not seem real (Sadock & Sadock, 2007 : 64). The grieving can go through the motions at the time of loss and sometimes through the time of the funeral as though they are spectators watching from a distance.

Self-reproach is common, although it is less intense in normal, than in pathological grief. According to Jeffreys (2008 : 54), self-reproachful thoughts usually centre on some relatively minor act of omission or commission toward the deceased. A phenomenon known as survivor guilt occurs in those who are relieved that someone other than them has died. Survivors sometimes believe that they should have been the person who died and may (if the guilt persists) have difficulty establishing new intimate relationships from fear of betraying the deceased person. Forms of denial often occur throughout the period of bereavement often, the bereaved person inadvertently denies the dean or acts as if the loss had not occurred (Conwell & Caine, 2001 : 118).

2.8.2 **Stage 2 : Anger**

Roberts and Owen (2005 : 156) propound that when the shock finally dissipates, the bereaved will often find strong, possibly unsettling emotions such as fear, frustration, irritability, remorse and anger at their loved one's death. They

commonly ask, "Why me?" They may become angry at God, their fate, a friend, the clergy person or a family member, anyone who could have saved the person (Seitz, 2008 : 183). They may even blame themselves. They may displace their anger onto the hospital staff members and the doctor, whom they blame for the loved one's illness (Freeman, 2005 : 127).

Physicians treating dying patients must realize that the anger being expressed from the patient's healthy spouse cannot be taken personally. (Roberts & Owen, 2005 :. 215). An empathic, non-defensive response can help defuse patients' anger and can help them refocus on their own deep feelings (e.g., grief, fear, loneliness) that underlie the anger. Physicians, according to Schulz, Beach & Lind (2001 : 359), should also recognize that anger may represent the person's desire for control in a situation in which they feel completely out of control.

Anger abounds once the spouse has died, it may be directed at the doctor, nurses, ambulance people, innocent bystanders, God, the person who died, the clergy person, anyone who could have saved the person, or even someone else who has not lost that particular relative or loved one (Shulz, Beach & Lind, 2001 : 359)

2.8.3 **Stage 3 : Bargaining**

According to Roberts and Owen (2005 : 157), guilt is anger turned outwardly. The bereaved might contemplate and may feel bad about things they may have said or done to hurt the person who has died. Since there is no time for apologies, the bereaved can be left with unfinished business. Guilt can extend to their failure to see the future or to prevent the death. They may say over and

over, "If only . . ." They may even feel guilty when they find themselves having a good time or forgetting about their grief for a period of time (Roberts & Owen, 2005 :157).
According to Roberts and Owen (2005 : 217), the soon to be widow may attempt to negotiate with physicians, friends, or even God; in return for a cure, they promise to fulfill many pledges, such as giving to charity and attending church regularly. Some may believe that if they are good (compliant, non-questioning, and cheerful), the doctor will make them better. Patients must also be encouraged to participate as partners in their treatment and understand that being a good patient means being as honest straightforward as possible. (Sadock & Sadock, 2007 : 66)

Once the spouse has passed on, guilt is anger turned toward ourselves. None of us are always kind, sensitive or thoughtful as we would like to be. We may feel bad about things we have said or done to hurt the person who has died. Since there is no time for apologies, we can be left with unfinished business. Guilt can extend to our failure to see the future or to prevent the death. We can say a million times, "If only . . ." We can even feel guilty when we find ourselves having a good time or forgetting about our grief for a period of time (Roberts & Owen, 2005 : 216).

2.8.4 Stage 4 : Depression

In the minds of those who are grieving, nothing will ever be all right again (Nuss & Zubenko, 2003 : 30). Depression paralyzes those who are grieving (Sadock & Sadock, 2007 : 66). The simplest and most ordinary jobs become almost impossible for them to do. Looking forward to tomorrow or anything is impossible.

According to Nuss and Zubenko (2003 : 30), this is the most difficult and frightening stage.

In the fourth stage, the bereaved may show clinical signs of depression withdrawal, psychomotor retardation[2], sleep disturbances, hopelessness, and, possibly, suicidal ideation. The depression may be a reaction to the effects of the death on their lives (e.g., loss of a job, economic hardship, helplessness, hopelessness, isolation from friends and family). According to Frank (2007 : 320) a major depressive disorder with vegetative signs and suicidal ideation may require treatment with antidepressant medication or electroconvulsive therapy (ECT)[3]. All widowed feel some sadness at the prospect of their spouse's death. Frank (2007 : 320) however argues that "major depressive disorder and active suicidal ideation can be alleviated and should not be accepted as normal reactions to death of a loved one." A person who suffers from major depressive disorder may be unable to sustain hope, which can enhance the dignity and quality of life and even prolong longevity.

2.8.5 Stage 5 : Acceptance and Healing Through Memories

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[2] **Psychomotor retardation** comprises a slowing down of thought and a reduction of physical movements in a person. This is most commonly seen in people with major depression where it indicates a degree of severity. Psychomotor retardation comprises real physical difficulty performing activities that normally would require little thought or effort, such as walking up a flight of stairs, simply getting out of bed, clearing dishes from the table, straightening a room, vacuuming, or doing laundry

[3] **Electroconvulsive therapy** (**ECT**), also known as **electroshock**, is a well established, albeit controversial psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect. Today, ECT is most often used as a treatment for severe major depression which has not responded to other treatment

The time emerges when the grieving begins to believe they will make it through. That does not mean things will be the same as they were or that they will not miss the person any more, but it means things will be all right. They begin to talk about the loved one and remember them often, but they go on with their life. They can find that their experience of loss can be very helpful to others facing similar losses (Nuss & Zubenko, 2003 : 31).

In the stage of acceptance, the bereaved realize that death was inevitable and they accept the universality of the experience. According to Parkes and Weiss (2008 : 128), their feelings may range from a neutral to a euphoric mood. Under ideal circumstances, patients resolve their feelings about the inevitability of death and can talk about facing the unknown. Those with strong religious beliefs and a conviction of life after death sometimes find comfort in the ecclesiastical maxim[4], "Fear not death; remember those who have gone before you and those who will come after" (Parkes & Weiss, 2008 : 130).

Fenchuk (2008 : 351) propogates that the bereaved move back and forth between good memories and bad. At times it seems to the bereaved that there is a need "for self-punishment and so all the negative aspects of the relationship are resurrected and relived" (Freeman, 2005 : 129). The happier moments often seem too painful, and it may take many months before these can be faced, but there is healing in remembering.

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[4] **Ecclesiastical Latin** (sometimes called **Church Latin**) is the Latin used by the Roman Catholic Church in all periods for ecclesiastical purposes

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Glick, Weiss, and Parkes (2004 : 12) posit that with time will come a lessening of the anguish, until finally the pain can be touched, remembered, accepted as a new part of life.

According to Parkes and Weiss (2008 : 130), feelings may range from a neutral to a euphoric mood. Under ideal circumstances, the near to be widowed resolves their feelings about the inevitability of their spouse's death and talk about facing the unknown alone. Those with strong religious beliefs and a conviction of life after death sometimes find comfort in the ecclesiastical maxim[5], "Fear not death; remember those who have gone before you and those who will come after" (Parkes & Weiss, 2008 : 130)

According to Erik Erikson, the eighth and final stage in the life cycle brings either a sense of integrity or despair (Rosumblum, 2004 : 23) As elderly adults enter the last phase of their lives, they reflect on their time and how it has been lived (Neimeyer, 2006 : 18). When one has taken care of things and is relatively successful and adapted to the triumphs and disappointments of life, one can look back with satisfaction and only a few regrets; one experiences a sense of integrity about oneself, feeling that one has lived totally and well and that one's life has been meaningful, that is, integrity of the self. This allows an individual to accept inevitable disease and death without fear of succumbing helplessly Glick, Weiss & Parkes (2004 : 21). However Glick et al. (2004 : 21) posit that a person who looks back on life as a series of missed opportunities or as filled with personal misfortunes has "a sense of bitter despair, a preoccupation with what might have been if only this or that had happened". Then unfortunately, death is

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viewed with fear, because it symbolizes emptiness and failure (Hendin & Klerman, 2003 : 143).

It is recognized that of all the experiences that are seriously traumatic even for the most well-balanced people, bereavement is probably the worst (Hendin & Klerman, 2003 : 144).

There is no merit in trying to 'keep a stiff upper lip'; grief must be acknowledged and a period of mourning gone through to enable the bereaved man or woman eventually to readjust their lives (Jeffreys, 2008 : 44).

According to Maronne (2007 : 34), on logical grounds, it might be supposed that the death of an elderly person might be less of a tragedy than the death of a young or middle-aged relative or friend because the latter might have a considerable length of life to fulfill. However, illogical as it may seem, the death of an elderly spouse or friend may be even more traumatic (Maronne, 2007 : 35). Maronne (2007 : 35) goes on to say that in later life, most couples (although they may not regard themselves as being particularly dependent on one another, or even think of themselves as a 'couple'), have come to be like two beams in a building propped against each other, and, "if one is removed, the whole structure collapses."

According to Neimeyer (2006 : 21), "the surviving partner may have to cope with things that he or she never thought about before, and although it sounds shamefully mundane, it is often trivial things that assume an

overwhelming and disproportionate importance."

Widowers tend to be harder-hit than widows, and there is a raised incidence of death among men in the year following bereavement (Neimeyer 2006 : 22). "The bereaved person may feel ashamed of some aspects of his or her deprivation." Glick et al. (2004 : 17) write of "one aspect of bereavement that many people do not like to admit to, especially when they are of quite an advanced age."

The pain of this overwhelming loss is often made worse because the surviving partner quite unexpectedly finds that he or she has sexual feelings that demand satisfaction (Parkes and Weiss, 2008 : 130). Some of the need may be for touching, comfort or caring, but some people still have strong physical sexual desires. Parkes and Weiss (2008 : 130) go on, these feelings create confusion for those for whom it is still a struggle to find emotional stability, and the lack of open discussion arouses fear that no-one else has such feelings or desires. Parkes and Weiss (2008 : 130) argue that the conspiracy of silence that society imposes on this topic often prevents widows and widowers to seek appropriate advice and reassurance.

Sometimes, to the horror of the bereaved person, he or she experiences an increase in sexual desire and yearning, as reported by Parkes and Weiss (2008 : 130). As Parkes and Weiss go on, "but this is simply a perfectly understandable and primitive desire for physical contact to alleviate loneliness, just as a lonely child wants to be cuddled."

According to Attig (2008 : 220), there is a sense of loss that is difficult to

describe; some writers have referred to it as lack of a confiding relationship and it is important in the generation of a depressed state. As Attig (2008 : 225) posits, women are rather better than men at forming 'confiding relationships' in our society, and, as mentioned above, in a large section of Christian society in the Western World.

Bereavement, grief, and mourning are terms that apply to the psychological reactions of those who survive a significant loss. Grief is the subjective feeling precipitated by the death of a loved one. The term is used synonymously with mourning, although, in the strictest sense, mourning is the process by which grief is resolved; it is the expression of post-bereavement behaviour. Bereavement literally means the state of being deprived of someone by death and refers to being in the state of mourning. As Conwell and Caine (2001 : 112) propound that regardless of the fine points that differentiate these terms, the experiences of grief and bereavement have enough similarities to warrant syndromes that have signs, symptoms, a demonstrable course, and an expected resolution.

These syndromes are noted below from the DSM-IV-TR, (2000 : 740) which differentiates the depressive symptoms associated with bereavement from Major Depressive Disorder:

2.8.5.1 Bereavement

Symptoms may meet syndromal criteria for major depressive episode, but the survivor rarely has morbid feelings of guilt and worthlessness, suicidal ideation, or psychomotor retardation

2.8.5.2 Dysphoria

Often triggered by thoughts or reminders of the deceased
Onset within the first 2 months of bereavement
Duration of depressive symptoms is less than 2 months
Functional impairment is transient and mild
No family or past personal history of major depressive disorder

2.8.5.3 Major Depressive Disorder

Depression often becomes chronic, intermittent, or episodic
Clinically significant distress or impairment
Family or past personal history of major depressive disorder

Physicians must determine when grief has become pathological and has evolved into major depressive disorder (Archer, 2007 : 152). Grief is a normal, albeit intensely painful state.

Persons suffering from major depression lack hope; they cannot imagine ever feeling better. Persons who have experienced previous depression are at risk for becoming depressed at times of major loss and a bereaved person's clinical history may be helpful in judging a current reaction. Depressed persons threaten suicide more often than grieving persons, who, except in unusual instances for example, physically dependent and older persons do not seriously wish to die, even if they claim that life is unbearable (Jeffreys : 2008 : 145). Major depressive disorder is potentially a medical emergency that requires immediate

intervention to forestall a complication such as suicide (Sadock & Sadock, 2007 : 569).

2.9 UNCOMPLICATED GRIEF

Uncomplicated grief is a normal response, in view of the predictability of its symptoms and its course (Zisook, Zisook and Bent, 2002 : 43). Initial grief is often manifested as a state of shock that may be expressed as a feeling of numbness and a sense of bewilderment. This apparent inability to comprehend what has happened may be short-lived and is followed by such expressions of suffering and distress as sighing and crying. Feelings of weakness, decreased appetite, weight loss, and difficulty in concentrating, breathing, and talking also appear. Sleep disturbances may include difficulty in falling asleep, waking up during the night, and awakening early. Often, dreams of the deceased person occur, after which the dreamer awakens with a sense of disappointment in finding that the experience was only a dream (Sadock & Sadock, 2007 : 65).

2.10 SELF-REPROACH

Self-reproach is common, although it is less intense in normal, than in pathological, grief. According to Jeffreys (2008 : 149), self-reproachful thoughts usually centre on some relatively minor act of omission or commission toward the deceased. A phenomenon known as survivor guilt occurs in those who are relieved that someone other than them has died. Survivors sometimes believe that they should have been the person who died and may (if the guilt persists) have difficulty establishing new intimate relationships from fear of betraying the deceased person. Forms of denial often occur throughout the period of

bereavement often, the bereaved person inadvertently denies the death or acts as if the loss had not occurred (Conwell & Caine, 2001 : 115).

A sense of the deceased person's presence may be so intense that it constitutes an illusion or a hallucination (e.g., hearing the deceased person's voice or feeling the person's presence). According to Sadock and Sadock (2007 : 65), in normal grief, however, the survivor realises that the perception is not real. As part of what has been labelled 'identification phenomena', a survivor may take on the qualities, mannerisms, or characteristics of the deceased person to perpetuate the person in some concrete way. This maneuver can reach potentially pathological expression with the development of physical symptoms similar to those experienced by the person who died or suggesting the illness from which the deceased person died (Jeffreys, 2008 : 150).

2.9.1 Grief Period

Because persons vary greatly in their expressions of grief, the signs, symptoms, and phases of mourning and bereavement are not as discrete as their characterizations might imply (Zisook, Zisook and Bent, 2002 : 44). Nevertheless, the manifestations of grief usually tend to subside over time. The length and intensity of grief, especially the acute phases, can be shaped by the suddenness of the death. If death occurs without warning, shock and disbelief may last for a long time; when death has been long anticipated, much of the mourning process may have already occurred by the time death intervenes (Fenchuk, 200 : 351).

Grief lasts about six months to one year, as the grieving person experiences the calendar year at least once without the lost person. Some signs and symptoms of grief may persist much longer than one or two years, and a survivor may have various grief related feelings, symptoms, and behaviour throughout life (Jeffreys, 2008 : 150). Eventually, however, normal grief resolves, and persons return to a state of productivity and relative well-being. In general, the acute grief symptoms gradually lessen, and within one or two months the grieving person is able to eat, sleep, and return to functioning (Sadock & Sadock, 2007 : 65).

2.9.2 Anniversary Reactions

When the trigger for an acute grief reaction is a special occasion such as a holiday or birthday, the rekindled grief is called an anniversary reaction (Sadock & Sadock, 2007 : 66). It is not unusual for anniversary reactions to occur each year on the day the person died, or in some cases, when the bereaved individual becomes the same age the deceased was at the time of death. Although these anniversary reactions tend to become relatively mild and brief over time, they can be experienced as the reliving of one's original grief and may prevail for hours or days.

2.9.3 Complicated, Pathological, or Abnormal Grief

Some persons experience an abnormal course of grief and mourning (Archer, 2007 : 150). Pathological grief can take several forms, ranging from absent or delayed grief to excessively intense and prolonged grief to grief associated with suicidal ideation or frank psychotic symptoms. According to Hendin and Klerman (2003 : 144), persons at greatest risk for an abnormal grief reaction are those

who suffer a loss suddenly or through horrific circumstances, those who believe they are responsible (whether the responsibility is real or imagined) for the death, and those with an intensely ambivalent or dependent relationship to the person who died.

Archer (2007 : 150) identifies that other forms of abnormal grief which occur when some aspects of normal grieving are distorted or intensified to psychotic proportions. Identifying with the deceased person, such as taking on certain admired traits or treasuring certain possessions, is normal, however, believing that one is the deceased person or is dying of exactly what the deceased person died of, if, in fact, this is untrue, is not normal. According to Jeffreys, (2008 : 150), hearing the fleeting, transient voice of a deceased person may be normal, but persistent, intrusive, complex auditory hallucinations are certainly not normal. Denial of certain aspects of the death is normal, however, denial that includes the belief that the dead person is still alive is not normal.

2.9.4 Grief vs Depression

According to the Sadock & Sadock (2007 : 569), grief and depression share many features: sadness, tearfulness, loss of appetite, poor sleep, and diminished interest in the world.

The mood disturbance in depression is typically pervasive and unremitting; any mood fluctuations are relatively minor. Fluctuations in grief are common (Sadock & Sadock, 2007 : 66). Many persons often describe grief coming in waves, washing over them, and then subsiding. Even in intense grief, moments of lightheartedness and happy reminiscence are possible. Shame and guilt are

common in depression. When they occur in grief, they usually involve not having done enough for the deceased before his or her death; in depression they commonly arise from a fundamental belief that one is wicked or worthless. Many persons suffering from major depression lack hope; they cannot imagine ever feeling better. Persons who have experienced previous depression are at risk for becoming depressed at times of major loss and a bereaved person's clinical history may be helpful in judging a current reaction. Depressed persons threaten suicide more often than grieving persons, who, except in unusual instances-for example, physically dependent and older persons-do not seriously wish to die, even if they claim that life is unbearable. (Jeffreys, 2005)

2.9.5 **Grief Therapy**

According to Archer (2007 : 158), an attending physician should not routinely recommend that a bereaved person see a psychiatrist or psychologist unless a markedly divergent reaction to the loss is noted.

When professional assistance is sought, it usually involves a request for sleeping medication from a family physician. A mild sedative to induce sleep may be useful in some situations, but antidepressant medication or anti-anxiety agents are rarely indicated in normal grief. Bereaved persons may have to go through the mourning process, however painful it is, for successful resolution to occur. Narcotisising patients with drugs, interferes with the normal process that ultimately can lead to a favourable outcome (Fenchuk, 2008 : 219).

Because grief reactions may develop into a depressive disorder or pathological mourning, specific counselling sessions for those bereaved are often valuable.

Grief therapy is an increasingly important skill. In regularly scheduled sessions, grieving persons are encouraged to talk about feelings of loss and about the person who has died. Many bereaved persons have difficulty recognising and expressing angry or ambivalent feelings toward a deceased person, and they must be reassured that these feelings are normal (Jeffreys, 2005 : 56).

Grief therapy need not be conducted only on a one-to-one basis; group counselling can also be effective. Self-help groups also have great value in certain cases. In a 2007 survey, Leming and Dickinson (2009 : 25) found that from a group of 300 widows and widowers, 30 percent of those questioned, the group reported that they had become isolated from friends, withdrawn from social life, and thus experienced feelings of isolation and loneliness soon after their spouses had passed away. Leming and Dickinson (2009 : 25) went on to say that self-help groups offered them companionship, social contacts, and emotional support; which eventually enabled them to re-enter society in a meaningful and significant way (Leming and Dickinson, 2009 : 26).

A similar research study was undertaken by Impens and Long also in 2007, whereby 225 individuals who became widowed quite recently before the study period, were examined for the extent to which community support was provided and received by the group, as well the extent to which emotional support and assistance within their immediate community was offered and its impact on the study group. The research revealed that 29.2% of those studied had re-married within one year, 24.3% of the group had regularly engaged in assisting actively in part-time social support networks, 14.5% were associated with full-time self-help initiatives and 32% participated in religious self-help groups (Impens & Long, 2008 : 321).

Viktor Frankl, a Jewish psychiatrist who survived Auschwitz, and later became a convert to Catholicism, said in his classic book *Man's Search for Meaning* (2006 : 57) that we could survive any "how" as long as we knew the "why". That is, if we could somehow find meaning in our suffering we could draw strength from it to continue on and survive. The "whys" of the horrors of the Nazis, come under the great mystery of evil. But as his book shows, after the initial shocks, Frankl, coped, and ultimately survived the death camp by observing the day to day life there as the clinician that he was, gathering research in his mind on how people cope with and endure such extreme evils, planning a book based on the experience that would help people. He certainly knew people would need help when it was all over. He had every intention of surviving and helping the other survivors when the time came. Living through it with purpose got him through (Boeree, 2006 : 140).

Grief is a journey with a beginning, middle and an end. It is not for the faint-hearted. It takes tremendous courage and is extremely draining. It takes great strength and when it is over, it leaves us with tremendous strength and even joy. But until then, it is a full time job.

CHAPTER THREE
LITERATURE REVIEW

3.1 INTRODUCTION

Our attitudes towards death vary greatly and are sometimes, oftentimes, less than positive. Kavanaugh (2007 : 68) makes a unique contribution to those who study and work in the field of death and bereavement. Kavanaugh (2007 : 72) notes that our attitudes and feelings do not preclude us from working effectively with the dying and the bereaved if we are aware of them. He says,

> Most people have no more that a
> shadowy Indication of their feelings
> toward death. Ask anyone how they
> feel about dying or death and you will
> hear how they would like to feel or
> how they think they ought to feel...
> It became incredibly clear to me that an
> Honest and humane approach to death
> can begin only when we allow ourselves
> to get in touch with our visceral feelings.
> It is not the dying or dead that we fear
> as much as the unknown and the untested
> feelings they evoke within ourselves.
> Feelings have no morality. They are neither
> good nor bad, always ethically neutral.
>
> Kavanaugh (2007 : 72).

3.2 PSYCHOLOGICAL MANIFESTATIONS OF NORMAL GRIEF

Uncomplicated grief is a normal response, in view of the predictability of its symptoms and its course (Jordan & Niemeyer, 2002 : 214). Initial grief is often manifested as a state of shock that may be expressed as a feeling of numbness and a sense of bewilderment. This apparent inability to comprehend what has happened may be short-lived and is followed by such expressions of suffering and distress as sighing and crying. Feelings of weakness, decreased appetite, weight loss, and difficulty concentrating, breathing, and talking also appear. Sleep disturbances may include difficulty in falling asleep, waking up during the night, and awakening early. Often, dreams of the deceased person occur, after which the dreamer awakens with a sense of disappointment in finding that the experience was only a dream. (Sadock & Sadock, 2007 : 66)

The immediate impact of bereavement is much the same whether it has been a sudden death or one which has been anticipated for some time when it is known that someone is dying (Gibson, 2000 : 115). Gibson (2000 : 115) posits that there may often be a strange disjunction between what is known to be true and a half-belief that reality is otherwise. The widow may know quite well that her husband is dead but finds herself searching for him in a crowd because momentarily she has seemed to see him.

An important indicator of psychological well-being is the extent to which depression manifests in the bereaved. Depressed mood is regarded as one of the most common phenomena after loss, with sadness, tearfulness, problems with sleeping and listlessness as the earliest observed component

(Brom & Kleber, 2007 : 143). However, depression, in contrast to depressed mood, consists of more elements. Full blown depression, among other things, comprises a specific perception of the environment, negative beliefs about oneself and one' own abilities to cope with life, and pessimism with regard to the future.

According to Jordan and Niemeyer (2002 : 213), on being told that their loved one is dying, there is initially a reaction of shock. They may appear dazed at first and then may refuse to believe the diagnosis; they may deny that anything is wrong. Some persons never pass beyond this stage and may go from doctor to doctor until they find one who supports their position. Nuss and Zubenko (2003 : 74), cite that the degree to which denial is adaptive or maladaptive appears to depend on whether a person continues to obtain treatment even while denying the prognosis. In such cases, physicians must communicate to patients and their families, respectfully and directly, basic information about the illness, its prognosis, and the options for treatment. For effective communication, physicians must allow for the patients' emotional responses and reassure them that they will not be abandoned.

Because persons vary greatly in their expressions of grief, the signs, symptoms, and phases of mourning and bereavement are not as discrete as their characterizations might imply (Jordan & Niemeyer, 2002 : 215). Nevertheless, the manifestations of grief usually tend to subside over time. The length and intensity of grief, especially the acute phases, can be shaped by the suddenness of the death. If death occurs without warning, shock and disbelief may last for a long time; when death has been long anticipated, much of the mourning process may have already occurred by the time death intervenes (Fenchuk, 2008 : 217).

Grief lasts about six months to one year, as the grieving person experiences the calendar year at least once without the lost person. According to Bryman (2008 : 72) some signs and symptoms of grief may persist much longer than 1 year, and a survivor may have various grief related feelings, symptoms, and behaviour throughout life (Jeffreys, 2008 : 52). Eventually, however, normal grief resolves, and persons return to a state of productivity and relative well-being. In general, the acute grief symptoms gradually lessen, and within 1 or 2 months the grieving person is able to eat, sleep, and return to functioning (Sadock & Sadock, 2007 : 67).

After the funeral, the time emerges when the grieving begin to believe they will make it through. That does not mean things will be the same as they were or that they will not miss the person any more, but it means things will be all right. They begin to talk about the loved ones and remember them often, but they go on with their life. They can find that their experience of loss can be very helpful to others facing similar losses (Nuss & Zubenko, 2003 : 79)

Bowlby concludes that the widowed begins to realize and understand the irrevocability of death and the inevitable separation process. (van der Horst, van der Veer & van IJzendoorn, 2007 : 401).

3.3 ANTICIPATORY GRIEF

According to Jeffreys (2008 : 55), anticipatory grief is expressed in advance of a loss perceived as inevitable, as distinguished from grief that occurs at or after the loss. By definition, anticipatory grief ends with the occurrence of the anticipated loss, regardless of what reactions follow. Unlike conventional grief, which diminishes in intensity with the passage of time, anticipatory grief may either increase or decrease in intensity as the expected loss becomes imminent. In some instances, particularly when the occurrence of the loss is delayed, anticipatory grief may be expended and the bereaved person shows few manifestations of acute grief when the loss occurs. Once anticipatory grief has been expended, the bereaved person may find it difficult to reestablish a previous relationship; this phenomenon is experienced with the return of persons long gone (e.g., to war or confined to concentration camps) and of those thought to have been dead (Jeffreys, 2008 : 56).

3.4 MANIFESTATIONS OF PHYSICAL GRIEF SENSATIONS

Besides the psychological grief reactions of people, the physical sensations associated with grief should be noted. Physical sensations are frequently overlooked but may be key indicators of a bereaved individual's grief reaction. Many times it is the physical sensations that prompt the bereaved to seek assistance initially with their physician. The following is a list of commonly reported sensations associated with grief reactions:

- Hollowness in the pit of the stomach
- Tightness in the chest or throat

- Muscular weakness
- Lack of energy
- Dry mouth
- Insomnia
- Loss of apetite
- Depression
- Generalised anxiety
- Anhedonia (absence of pleasurable experiences)
- Sense of depersonalization (nothing seems to be real, including me)

Frequently with the passage of time, somatic symptoms are the only indicators that grief is still unresolved.

3.5 COGNITIONS OF NORMAL GRIEF

A natural cognitive response to a death loss is preoccupation with the deceased. This occurs as a wish to undo the loss and may take the form of obsessional thinking (Conway, 2001 : 65). This may be viewed as mentally hugging and holding the deceased tightly before acknowledging that one must let go, say good-bye, and part (Freeman, 2005 : 127). Hallucinations (both visual and auditory), though normally associated with severely disturbed functioning, are included because they are frequent experiences of the bereaved.

A sense of the deceased person's presence may be so intense that it constitutes an illusion (e.g., hearing the deceased person's voice or feeling

the person's presence). According to Becker (2008 : 248), in normal grief, however, the survivor realises that the perception is not real. As part of what has been labelled 'identification phenomena', a survivor may take on the qualities, mannerisms, or characteristics of the deceased person to perpetuate the person in some concrete way. "This maneuver can reach potentially pathological expression with the development of physical symptoms similar to those experienced by the person who died or suggesting the illness from which the deceased person died." (Jeffreys, 2008 : 42). According to Freeman (2005 : 128), they are usually transient and occur within a few weeks or a month of the loss.

Other cognitions may include disbelief, confusion and passive suicidal thoughts. As Conway (2001 : 66) propounds, it is important to remember that what is dysfunctional in one individual is not the same for everyone. Zisook, Zisook and Bent (2002 : 29) explicate that the potential for withdrawal and isolation is great, because the widowed may deny their fear of abandonment by actually repulsing friendly gestures.

Bereavement is one of the most serious problems of later life causing people to be lonely: this stems from a number of attendant factors (Maronne, 2007 : 318). Not only does the bereaved person miss the presence of the loved one, but such a loss leads to a falling-off of the social contacts that were dependent on the presence of the partner. For example, a wife may have had many contacts through her husband's friends, and when he is dead, these contacts may no longer be available to her. Indeed, her husband's friends may actively shun

her, "feeling guilty all the time, but not knowing how to cope with her on her own, there is an aura of death about her, as it were" (Maronne, 2007 : 316).

Most people are living in couples when they reach the age of retirement and although they may not be very dependent on each other in the relationship, when it is dissolved through the death of one of them, the survivor may feel far more bereft than was expected (Leming & Dickinson, 2009 : 24).

The dreadful modern taboo on the mention and acknowledgement of death in many western countries leads to an unexpected withdrawal of social support making the widow or widower feel additionally alone (Yalom, 2009 : 17). According to Yalom (2009 : 18), "This is a sociogenic component that makes the loss especially painful."

The process of mourning must be got through and this may involve facing some unpalatable facts that arouse guilt and hence a self-punishing depression (Parkes & Weiss, 2008 : 121). As Yalom (2009 :18) posits, it is perfectly natural in some circumstances to feel anger against the deceased spouse for their 'desertion' – "If only the fool hadn't drunk so much he wouldn't have died!" "If she'd had the sense to take my advice about her health she'd still be here today!"

Many writers on the subject of mourning have divided its progress and recovery from it into a number of stages. Archer (2007 : 148) has outlined five stages: alarm, searching, mitigation, anger coupled with

guilt and lastly, gaining a new identity. Others, Bryman (2008 : 75) and Engel (2001 : 45) have both described three stages: shock and disbelief, developing awareness and resolution. Becker (2008 : 249) describes the process of mourning with its attendant loneliness in terms of the three stages outlined below.

3.5.1 Extreme Pessimism

The immediate impact of bereavement is much the same whether it has been a sudden death or one which has been anticipated for some time when it is known that someone is dying. There may often be a strange disjunction between what is known to be true and a half-belief that reality is otherwise (Becker, 2008 : 249). The bereaved spouse may know quite well that her husband is dead but finds herself searching for him in a crowd because momentarily she has seemed to see him. She may also wake in the morning and be surprised not to find him next to her (Becker, 2008 : 249).

In the shock occasioned by a recent death the bereaved person may experience a certain numbness so that, even when in the presence of friends and engaging in conversation, there is nevertheless a sense of appalling loneliness and an inability properly to comprehend what is being said (Becker, 2008 : 248). As Becker (2008 : 249) argues, the loneliness is not dispelled by their company and the sufferer may even wish that they would go away and leave him/her in peace.

The bereaved spouse may need a measure of solitude to work through. According to Jeffreys (2008 : 27), extreme pessimism characterizes this first stage of mourning. Jeffreys (2008 : 27) posits that intelligent people will realize that in the course of time they will recover from the misery of bereavement and be on an even keel again because they have seen this happen to other people, but it may seem at the time that this is quite impossible and that there is no light at the end of the tunnel (Becker 2008 : 250).

3.5.2 The Process of Change and Developing Awareness

Becker (2008 : 250) goes on to posit that if a widow, has responsibilities she cannot avoid and she has to go on being busy, she may indeed repress her feelings of loss and despair and outwardly appear not to suffer too much (Jeffreys, 2008 : 28). Friends may comment on how well she is coping, and she herself may think that being constantly busy may overcome her sense of devastation. As Jeffreys (2008 : 29) proposes that to some extent this is an illusion; her non-expression of emotion may prolong the process of coming to terms with her new and altered state; life will never be quite the same again and she might as well admit it. Being denied solitude in which to readjust her life may do her no good at all (Jeffreys, 2008 : 29).

Leming and Dickinson (2009 : 25) acknowledge that people may use various techniques temporarily to overcome their sense of loss, and one of them is to idealize the deceased, and this may be especially true when there was indeed a good deal of discord in the relationship. Leming and Dickinson (2009 : 26) go on to posit that only the good aspects of the deceased are admitted and any criticism of him provokes anger in a widow who sets out to idealize her dead husband.

As Thachil, Mohan and Bhugra (2007 : 133) posit, the time it takes to recover from the experience of bereavement varies greatly according to the personality of the bereaved person, the circumstances in which they are placed, and what the deceased has meant to them. Obviously the loved one can-not be replaced entirely, as every individual and every relationship is unique, but there is no reason why those who found fulfillment in an earlier marriage, or such a relationship, should not find happiness in the future with somebody else if they should be so fortunate as to meet someone suitable (Thachil et al., 2007 : 223). It may be that a future partner and a future relationship may be very different from what was fulfilling in the past, for one changes as one ages and what was necessary in the past, may no longer apply now.

As Templer, Ruff and Franks (2007 : 335) propose, as bereavement subsides and a subsequent marriage follows, one must remember that one cannot afford to deny love in

later life, whatever its imperfections. It may be of a kind one would never have considered in earlier, more idealistic days, but now one must enjoy what one may while one is able to (Templer et al., 2007 : 335).

Schulz et al. (2007 : 314) argue that, of course not everyone who is lonely through bereavement may want to find a new relationship to replace the lost one, and some people have quite other plans for their future and aim to find satisfactions in life that do not depend on close personal relationships Schulz et al. (2007 : 314) propogate that this is just as well for women because of the gross numerical disparity between the sexes in later life, there being about twice as many women as men by the age of 75. (Schulz et al. 2007 : 314).

Tunstall (2005 : 75) argues that after the death of a partner, it is often for the spouse who has been widowed to look ahead to a new partner without feelings of guilt or disloyalty to the memory of the dead one. In enshrinement, the widowed keeps things just as they were when the loved one was alive and spends his or her energy revering the memory of the dead person, surrounded by photographs and rooms maintained intact. The widowed believes that to live fully is a betrayal of love or loyalty for the dead (Tunstall, 2005 : 76). This guilt and fear of infidelity leads to emotional stagnation and stands in the way of forming new relationships. Once the period of mourning is over and the initial shock and grief have abated.

Tunstall (2005 : 76) argues that the widowed should become realistic about their need to have a new life of their own. This means, according to Tunstall (2005 : 76), the appropriate preservation of one's memories without excessive dwelling on the past.

The usual cure for enshrinement is to take an active role in getting life moving again. This, Tunstall (2005 : 77) postulates, is an act of will and determination. It can happen only if the individual decides to make it happen. Removing from sight the personal possessions of the deceased will help. It may also be necessary to put away obvious marriage symbols, such as a wedding ring. It is not a betrayal of a past marriage to accept the present and build a future (Tunstall, 2005 : 78)

Russell (2008 : 244) views remarriage after bereavement from another angle, the children of someone who has been rendered single in later life by bereavement may have a vested economic interest in discouraging their parent from remarriage, or their objection may simply be based on neurotic jealousy. As Russell (2008 : 244) posits, one of the possible ploys is to accuse their parent of disloyalty to the dead spouse. Russell (2008 : 245) argues that such children are reprehensibly selfish; they would rather see their parent single and lonely than settling into a new life with a loving and caring partner.

3.5.3 Behaviours of Normal Grief

A number of specific behaviours are frequently associated with normal grief reactions, some of which have already been mentioned.

Dreams of the deceased are quite common and can be a source of comfort (Cook & Oltjenbruns, 2000 : 46). Some bereaved individuals find it necessary to avoid places and things that trigger painful feelings of grief. They avoid the place where the person died and objects that remind them of the deceased. According to Cook and Oltjenbruns (2000 : 49), this behaviour is counterbalanced by those who need to visit the cemetery daily and carry the deceased's picture with them constantly, fearing that they will forget his or her face. Still others will treasure objects of the deceased and find it difficult to part with them.

Conway (2001 : 66) expounds that other behaviours include absent-mindedness, sighing, social withdrawal, restlessness and crying.

Bowlby proposed that the mourning process resembles the separation process in having three phases: protest, despair, and detachment. (van der Horst et al., 2007 : 406). In the protest phase, a widow has a strong desire for the spouse who has died and cries for his/her return; in the despair phase, the widow begins to lose hope about the spouse's return, crying is intermittent, and withdrawal and apathy sets in. In the detachment phase, the wieow begins to relinquish some

emotional attachment to the dead spouse and exhibits a reawakened interest in the surroundings.

3.6 ANNIVERSARY REACTIONS

When the trigger for an acute grief reaction is a special occasion such as a holiday or birthday, the rekindled grief is called an anniversary reaction. (Bryman, 2008 : 72). It is not unusual for anniversary reactions to occur each year on the day the person died, or in some cases, when the bereaved individual becomes the same age the deceased was at the time of death. Although these anniversary reactions tend to become relatively mild and brief over time, they can be experienced as the reliving of one's original grief and may prevail for hours or days.

3.7 COMPLICATED, PATHOLOGICAL, OR ABNORMAL GRIEF

Some persons experience an abnormal course of grief and mourning. (Archer, 2007 : 311). Pathological grief can take several forms, ranging from absent or delayed grief to excessively intense and prolonged grief to grief associated with suicidal ideation or frank psychotic symptoms. According to Hendin and Klerman (2003 : 143), persons at greatest risk for an abnormal grief reaction are those who suffer a loss suddenly or through horrific circumstances, those who believe they are responsible (whether the responsibility is real or imagined) for the death, and those with an intensely ambivalent or dependent relationship to the person who died.

Archer, (2007 : 315) expounds that other forms of abnormal grief occur when some aspects of normal grieving are distorted or intensified to psychotic proportions. Identifying with the deceased person, such as taking on certain admired traits or treasuring certain possessions, is normal, however, believing that one is the deceased person or is dying of exactly what the deceased person died of, if, in fact, this is untrue, is not normal. According to Jeffreys (2008 : 58), hearing the fleeting, transient voice of a deceased person may be normal, but persistent, intrusive, complex auditory hallucinations are certainly not normal. Denial of certain aspects of the death is normal, however, denial that includes the belief that the dead person is still alive is not normal.

3.8 GRIEF THERAPY

Jeffreys (2008 : 39) propounds that the importance of managing grief reactions is highlighted by the increased evidence that depressive disorders and suicide attempts occur more frequently in those who experienced the death of a spouse.

Lindemann (2004 : 129), Neimeyer (2006 : 29), Rubin and Schechter (2001 : 284) and Parkes and Weiss (2008 : 187) propose three tasks for the therapist that they see as constituting grief work:

3.8.1 Emancipation from the bondage of the deceased

When two people form a relationship there is an investment of self that is made with the other person. They are intertwined emotionally, investing

psychic and emotional energy in the loved one (Neimeyer, 2006 : 27). When one of the individuals dies, the remaining individual has to withdraw the psychic and emotional energy that was invested in the person who is no longer alive. Attachments to the deceased person must be relinquished and a new altered status developed (Neimeyer, 2006 : 27).

Parkes and Weiss (2008 : 187) see anxiety and vigilance against threats of new loss as problematic for the bereaved individual's recovery. Only by developing an adequate explanation of how the loss happened that answers all their questions and identifies an inevitable cause of death can the anxiety and related vigilance be overcome.

3.8.2 Readjustment to the environment in which the deceased is missing

According to Rubin and Schechter, (2001 : 281) to accommodate the world without the deceased attachment figure is the task at hand. Roles as well as identity may have to be redefined. For example, the surviving spouse must shift from thinking about "we" to thinking about "I" and face the fears associated with one's new autonomy. Adjustments will be required in all areas: emotionally, socially, physically and financially (Rubin & Schechter, : 282).

Parkes and Weiss (2007 : 189) expound that obsessive preoccupations with the deceased serves to bring about emotional acceptance. Parkes and Weiss (2007 : 190) continue, it is only through repeated confrontations with every detail of the loss and obsessive review of memories, thoughts, and feelings that the pain abates and gradual acceptance is achieved.

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3.8.3 Formation of new Relationships

In dealing with a bereaved person, the clinician should recognise the bereaved's need to find a person to substitute for the lost spouse. If there is no consistently available person, severe psychological damage may result, so that the widowed no longer looks for, or expects, intimacy in any relationship (Kleespiese, 2004 : 35).

This is not a quest to replace the person who has died; however, it will establish a new and different attachment with another person who can return the energy investment (Lindemann, 2004 : 128). The time required for this reinvestment in someone or something else will depends on a host of factors, at some time the bereaved will be able to reinvest in life again.

Parkes and Weiss (2008 : 189) posit that the bereaved develops new identities over time that reflect their new circumstances. This is a process brought about by an awareness and discomfort with the way the world is now and the way it used to be. Just as the handicapped learn to adapt to the loss of a limb or sight, so does the bereaved learn to stop including the deceased in their everyday plans and thoughts as if they were not dead. Each time the bereaved mistakenly includes the deceased, as if they were living, in thought or plan, and the inevitable confrontation with reality occurs and the pain of frustration, grief and absence of security is felt (Parkes & Weiss, 2008 : 190). It is only when the bereaved has established and no longer forgets the new identity that the painful

reminders end. The speed of acquisition is not as important as progress itself (Parkes & Weiss, 2008 : 190).

Because grief reactions may develop into a depressive disorder or pathological mourning, specific counselling sessions for those bereaved are often valuable. Grief therapy is an increasingly important skill. In regularly scheduled sessions, grieving persons are encouraged to talk about feelings of loss and about the person who has died. Many bereaved persons have difficulty recognising and expressing angry or ambivalent feelings toward a deceased person, and they must be reassured that these feelings are normal (Jeffreys, 2008 : 59).

Elderly patients may talk or joke openly about dying and sometimes welcome it (Rynearson & Balk, 2004 : 34). In their 60s or beyond, they no longer harbour illusions of indestructibility; most have already had several close calls, and they have gone to funerals for their friends and relatives. Although they may not be happy to die, they can be reconciled to it (Jeffreys, 2008 : 42)

According to Erik Erikson, a Danish-German-American developmental psychologist and psychoanalyst, known for his theory on social development of human beings postulates that in the eighth and final stage in the life cycle brings either a sense of integrity or despair (Fitzpatrick, 2006 : 299). As elderly adults enter the last phase of their lives, they reflect on their time and how it has been lived. When one has taken care of things and is relatively successful and adapted to the triumphs and disappointments of life, one can look back with satisfaction and only a few

regrets; one experiences a sense of integrity about oneself, feeling that one has lived totally and well and that one's life has been meaningful. Integrity of the self allows an individual to accept inevitable disease and death without fear of succumbing helplessly. However, a person who looks back on life as a series of missed opportunities or as filled with personal misfortunes has a sense of bitter despair, a preoccupation with what might have been if only this or that had happened; then death is viewed with fear, because it symbolizes emptiness and failure (Hendin & Klerman, 2003 : 143).

Bereavement, grief, and mourning are terms that apply to the psychological reactions of those who survive a significant loss. Grief is the subjective feeling precipitated by the death of a loved one. The term is used synonymously with mourning, although, in the strictest sense, mourning is the process by which grief is resolved; it is the expression of post-bereavement behaviour. Bereavement literally means the state of being deprived of someone by death and refers to being in the state of mourning (Cohen, 2007 : 47). As Conwell and Caine, (2001 : 120) state that regardless of the fine points that differentiate these terms, the experiences of grief and bereavement have enough similarities to warrant syndromes that has signs, symptoms, a demonstrable course, and an expected resolution.

These syndromes are noted below from the DSM-IV-TR, (2000 : 640) which differentiates the depressive symptoms associated with bereavement from Major Depressive Disorder:

3.8.3.1 Bereavement

Symptoms may meet syndromal criteria for major depressive episode, but the survivor rarely has morbid feelings of guilt and worthlessness, suicidal ideation, or psychomotor retardation

3.8.3.2 Dysphoria

Often triggered by thoughts or reminders of the deceased
Onset within the first 2 months of bereavement
Duration of depressive symptoms is less than 2 months
Functional impairment is transient and mild
No family or past personal history of major depressive disorder

3.8.3.3 Major Depressive Disorder

Depression often becomes chronic, intermittent, or episodic
Clinically significant distress or impairment
Family or past personal history of major depressive disorder

Physicians must determine when grief has become pathological and has evolved into major depressive disorder (Archer, 2007 : 313). Grief is a normal, albeit intensely painful state.

Persons suffering from major depression lack hope; they cannot imagine ever feeling better. Persons who have experienced previous depression are at risk for becoming depressed at times of major loss and a bereaved

person's clinical history may be helpful in judging a current reaction. Depressed persons threaten suicide more often than grieving persons, who, except in unusual instances for example, physically dependent and older persons do not seriously wish to die, even if they claim that life is unbearable (Jeffreys, 2008 : 49) Any Major Depressive Disorder is potentially a medical emergency that requires immediate intervention to forestall a complication such as suicide. (Sadock & Sadock, 2007 : 65).

3.9 CULTURAL VIEWS ON BEREAVEMENT

The expression of grief encompasses a wide range of emotions, depending on cultural norms and expectations i.e., some cultures encourage or demand an intense display of emotions, whereas others expect just the opposite. According to Rosenblatt, Walsh and Jackson (2007 : 430), Uni Wikan, an anthropologist at the University of Manchester, England, did a cross-cultural project to compare the rules on the emotional expression of grief (Schulz, Beach & Lind, 2007 : 324). Wikan compared the rules in Egypt and Bali, both Islamic cultures. She found that in Bali, women were strongly discouraged from crying, while in Egypt, women were considered abnormal if they did not incapacitate themselves in demonstrative weeping (Schulz et al., 2007 : 327).

According to Kleespies (2004 : 47), various cultures over the world have different social customs designed to overcome the shock of bereavement and to help the bereaved overcome their loss. As Kleespies propounds (2004 : 47), anthropologists have recorded very many of these customs and they generally involve a rather public mourning and an emphasis on, and even exaggeration of, the grief that the death has caused.

Kleespies (2004 : 47) goes on to expound that mourning rites in some parts of India involve the hiring of professional mourners who express grief in a very histrionic manner, even though they have not known the deceased. The object of these various mourning ceremonies is to get the surviving spouse and immediate family to accept that the death is not just a private loss, but a loss to the whole community, and they are not alone in their private sorrow (Kleespies, 2004 : 47).

Japanese folk-tales present a theme of the ghosts of the deceased spouse being spiteful against the widowed and having the power to injure them if they do not constantly make a show of placating them, thus the Japanese are moved by a superstitious fear of death and being continuously haunted by the deceased spouse (Cumming & Henry, 2000 : 57). It is best to try to work towards a realistic appreciation of the fact that in all relationships there may be an element of conflict, and that there were faults on both sides. Cumming and Henry (2000 : 60) go on, when a more realistic image of the deceased takes over, the bereaved begin to come to terms with their lonely state, and evaluate it for what it is, and look forward constructively to the future.

In Britain, according to Zisook, Zisook and Bent (2002 : 20), men may make their depressed state worse by endeavouring to 'keep a stiff upper lip' after bereavement. There is no way of dealing with bereavement so as to make it painless (Russell, 2008 : 242). According to Russell (2008 : 242) that neither the British technique of pretending that death didn't happen, nor the American mortician-promoted technique of cosmetics,

exploitation and open coffins succeed. Both tend only to limit the normal expression of normal emotions of grief, rage and despair which surface a bit later as depression or illness. Bereaved Britons tend to be quite unexpectedly boycotted by friends who don't know how to handle death at all (Maronne, 2007 : 316).

Zisook, Zisook and Bent (2002 : 25) go on to posit that "We may contrast this with the institution of '*shivah*' in the Jewish religion, which prescribes that for seven days there is a very definite effort to support the chief victims of bereavement." During this period, prayers are said for the dead and the mourners are expected to spend much of their time talking to visitors about the dead person. Parkes and Weiss (2008 : 181) have strongly criticized the conduct of this Jewish rite. They have pointed out that while it is true that the '*shivah*' still serves its traditional function of drawing the family together at a time of bereavement, Parkes and Weiss (2008 : 182) argue that there is a tendency for it to be used as a distraction from grief rather than an occasion for its expression. Conversation with the bereaved person often takes the form of dispassionate chatter and the expression of overt emotion is avoided, as it is in other 'public' situations. Sadly so, Parkes and Weiss (2008 : 184) go on to contend that, "The 'successful' mourner is unfortunately thought to be one who shows a proper control of his feelings on all occasions."

According to Ramsay (2009 : 38), it is unfortunate that one of the great taboos in the Western world, and perhaps especially in the 1st World countries, is acknowledging the reality of death in a matter-of-fact way. According to Ramsay (2009 : 39), it sometimes leads to a most unhappy

position of the bereaved person being almost ostracized by the friends whom he or she expected to be supportive. "Such friends do not mean to be unkind, it is just that they are so overwhelmingly embarrassed by the subject of death that they do not know how to relate to the bereaved person" (Ramsay, 2009 : 42).

3.9 GRIEF vs DEPRESSION

According to the Sadock & Sadock (2007 : 65) grief and depression share many features: sadness, tearfulness, loss of appetite, poor sleep, and diminished interest in the world.

The mood disturbance in depression is typically pervasive and unremitting; any mood fluctuations are relatively minor. Fluctuations in grief are common (Sadock & Sadock, 2007 : 68). Persons often describe grief coming in waves, washing over them, and then subsiding. Even in intense grief, moments of lightheartedness and happy reminiscence are possible. Shame and guilt are common in depression. When they occur in grief, they usually involve not having done enough for the deceased before his or her death; in depression they commonly arise from a fundamental belief that one is wicked or worthless. Many persons suffering from major depression lack hope; they cannot imagine ever feeling better. Persons who have experienced previous depression are at risk for becoming depressed at times of major loss and a bereaved person's clinical history may be helpful in judging a current reaction. Depressed persons threaten suicide more often than grieving persons, who, except in unusual instances-for example, physically dependent and older persons-do not seriously wish to die, even if they claim that life is unbearable (Jeffreys, 2008 : 57).

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Lindemann (2004 : 126) thinks it is easy to confuse loneliness with depression. The latter term is used to indicate a persistent lowering of mood that is more serious than just being down in the dumps, thoroughly fed up or temporarily being afflicted by 'the black dog'. As Maronne (2007 : 319) posits, depression implies suffering from a definite illness. Bereavement can cause an actual alteration in the chemistry of the brain, and while this physiological condition persists, one's normal adjustment to life is impossible. Psychiatrists used to refer to 'reactive' as contrasted with 'endogenous' depression, the latter term referring to a more serious condition that has arisen from some basic physiological disorder, in contrast to just a strong reaction to ongoing circumstances (Maronne, 2007 : 320)

Nowadays it is more usual to refer to the milder reactive form as 'dysthymia' and the more serious form as 'major depression'. It is not unusual for the experience of bereavement to bring on a period of dysthymia, where the sufferer may feel very 'lonely' even though surrounded by friends and family in a close supportive network (Parkes & Wiess, (2008 : 127). People in this condition frequently go to their doctor who will prescribe some form of anti-depressant drug, but unfortunately with some people these drugs have no effect on the depression. Ramsay (2009 : 46) propogates, this is not the fault of the doctor, for it is an area of psychological and medical debate and a great deal more needs to be found out about the physiology of this state. Apart from drug treatment there are some forms of psychological therapy which are used in the treatment of depression. States of minor depression tend to be

self-limiting, and time alone works a cure (Ramsay, 2009 : 46).

Kleespies (2004 : 35), asserts that it is also natural to feel a sense of relief that the loved one has died, especially when there has been a long illness that has been stressful for the carer. These feelings about one's own selfishness and human weakness should be frankly acknowledged during the mourning process, as well as the remorse that can be summed up as, "If only I'd been a more caring wife/husband maybe he/she would be alive today" (Kleespies, (2004 : 35). Depression generally has a component of self-punishing guilt that can only be got rid of by consciously admitting reality, rather than shrouding the whole matter of bereavement in conventional platitudes (Yalom, 2009 : 18).

Grief is an expedition with a beginning, middle and an end. It is not for the faint-hearted. It takes tremendous audacity and is extremely strenuous. It takes great forte and when it is concluded, it leaves us with incredible strength and even joyfulness. But until then, it is a full time job.

Viktor Frankl, a Jewish psychiatrist who survived Auschwitz, and later became a convert to Catholicism, said in his classic book, *Man's Search for Meaning* that we could survive any "how" as long as we knew the "why" (as cited in Boeree & George, 2006 : 317). That is, if we could somehow find meaning in our suffering we could draw strength from it to continue on and survive. The "whys" of the horrors of the Nazis, come under the great mystery of evil. But as his book shows, after the initial shocks, Frankl, coped, and ultimately survived the death camp by observing the day-to- day life there as the clinician that he was, gathering research in his mind on how people cope with and endure such extreme evils, planning a book based on the experience that

would help people. According to Boeree and George (2006 : 318), he certainly knew people would need help when it was all over. He had every intention of surviving and helping the other survivors when the time came. Living through it with purpose allowed Victor Frankl through his horror he faced (Boeree & George, 2006 : 319).

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter focuses on the methodology that was applied in this particular study. Consideration was given to the research design that was conducted in the analysis and which guided the study. A deliberation was offered in this regard of the qualitative research approach, and in this instance, the phenomenological technique of investigation.

Consideration was also given to the contributors who made this research possible. The main focus was on the procedure that was used to collect the important data. The collection process and examination of the data that was gathered were given serious consideration and the ethical aspects that were contemplated in this investigation were considered.

4.2 RESEARCH METHOD

A qualitative research approach shows a strong commitment to seeing the world through the eyes of those being studied. According to Hedegaard and Hakkarainen (2008 : 326), the commitment to understand the world from the perspective of the experiencing individual calls for a substantial intensity of involvement with the cases or people that the investigator is researching.

Pertaining to phenomenology as one of the qualitative research methods, Frank (2007 : 187) recognises that this approach primarily aims to understand and interpret the meanings that the research participants attach to their everyday living experiences. By entering into the life world of the participants, a phenomenological researcher is in a position to place him or herself "into the shoes of the examinee" (Frank 2007 : 187). This allows the researcher to methodically gather information, whilst at the same time scrutinizing the connotations and ideas that emerge from the data itself. Given the focus of the present study, the phenomenological method was considered the most appropriate.

According to Hedegaard and Hakkarainen (2008 : 327), the commitment to appreciate the world from the perspective of the experiencing person calls for a considerable level of involvement with the population or set of circumstances that the researcher is investigating. In qualitative research, as Strydom and Delport (2007 : 422) proclives, the process of research usually produces more elaborate descriptions of the phenomenon under investigation. According to Strydom and Delport (2007 : 422), such complex descriptions assist the researcher to have a deeper understanding of the explicit and accurate social context when compared to quantitative research approaches which mainly seek to test hypotheses. Qualitative research has been found to be intense in generating assumptions and conjecture when compared to quantitative methodologies which are predisposed to be far more concerned with the formulation of hypotheses before any research can be undertaken (Hedegaard and Hakkarainen, 2008 : 327). Such clearly formulated hypotheses are necessitated by the orientation of quantitative methods

which are concerned with prediction, specificity and definition.

Given the motivation of the present study, the phenomenological method was considered most suitable and apt.

4.2.1 Participants

The researcher's view corresponds with Frank (2007 : 167) who postulates that phenomenological research recommends the number of participants should range from five to twenty five. In this particular study three white and three black widows were identified and purposefully chosen from Rotarus Home for the Aged for this specific investigation, which offered a cross-cultural variance.

In comparison, another target group, consisting of three white and three black widows were identified independently and they were living outside of Rotarus. All respondents were matched across demographic variables.

This study used purposive sampling for briefness of time's sake.

As Strydom and Delport (2007 : 377) propose, purposive sampling is a particular and specific rationale that is chosen for inclusion because it has some unique features that are of particular relevance and value to the study being undertaken by the researcher. Therefore, the inclusion of participants should be channeled by a procedure that will enable the researcher to obtain

abundant facts correlating specifically with the phenomenon under scrutiny.

4.2.2 Sampling Method

A sample, according to Frank (2007 : 187), is a sub-set of the population under scrutiny, which must have properties which make it "representative of its entirety."

It was not possible to use the entire population, therefore for this purpose, the sampling method was considered. The sample method under this research was purposive sampling. In purposive sampling, one samples with a *purpose* in mind. The researcher usually would have one or more specific predefined groups which are worked with. Purposive sampling can be very useful for situations where one needs to reach a targeted sample quickly and where sampling for proportionality is not the primary concern. With purposive sampling, studies are likely to get the opinions of one's target population. Thus, this method had an intrinsic and fundamental purpose in mind.

This method was ideal for this study because Rotarus Home for the Aged was established from this specific population, which the research work was utilized for. All respondents depicted the same characteristics and were relevant for this particular study, i.e. they had all lost their spouses, all concurred within a particular age group; which ranged between 59 and 62 years and that more significantly; an interval period of at least 6 months had elapsed after the loss of each contributor's spouse.

Strydom and Delport (2007 : 378) consider purposive sampling as a particular and specific case that is chosen for inclusion because it has some unique features that are of particular relevance and importance to a study being undertaken by a researcher. Therefore, the inclusion of participants was channeled by a procedure that enabled the researcher to obtain abundant facts correlating specifically with the phenomenon under scrutiny.

4.3 Data Collection Method

The following guidelines posited by Kruger (2008 : 170) were relevant to this study:

a. Those participating in a research study should have had particular experience relating to the phenomenon being probed.

b. The interviewees should at all times be open and genuine towards the researcher as well as being able to verbally open-up to their unique experiences.

c. The participants should be favourably inexperienced to any psychological theory, since any familiarity thereof may impede their explanation of live experiences.

d. The researcher should be conversant with the language of the interviewees, as this will prevent possible failure of any restrained

semantic degree owing to the necessity to translate from one language to another.

Each respondent was firstly given paper on which each was asked to answer three questions **(Annexure B)** that required understanding of their own encounter and knowledge of grief. Each widow/widower was asked to record as much information as they could about their personal feelings and experiences of the passing away of their spouse.

In addition to their subjective experiences, each participant was then individually interviewed in this study. Data and information was collected by verbatim digital-recording. As Hedegaard and Hakkarainen (2008 : 330) posit, qualitative questioning requires the researcher to assume and implement an amenable, legitimate and compassionate approach which is concerned with the interview as an exceptional and unique encounter with the interviewee. Therefore, in this respect, it was very important for the researcher to pay meticulous and careful attention to what was being said, without concluding on any fastidious investigative hypotheses.

A semi-structured interview schedule allowed the researcher and interviewee to engage in a discourse whereby initial questions were adjusted in the light of the participant's response and the researcher was able to probe interesting and crucial areas which arose. Therefore the interviewer aimed to:

- Use short precise questions
- Read each question exactly as in the schedule

- Ideally had pre-coded response categories, enabling the interviewer to match what the respondent had said against one of those categories
- Ask each question in an identical order, specific to the schedule.

It must be also borne in mind that, as Creswell (2007 : 171) puts it, the process of data collection in a qualitative study is embryonic, rather than structured. Kruger (2008 : 162), posits that qualitative interviews are continuous in character and, consequently, questioning may be redesigned and reconstructed throughout the interview process. Qualitative interviews require a flexible and adaptable data collection instrument.

Each interview lasted for approximately an hour and a half and was conducted at a time that was opportune for each interviewee. Each participant was interviewed individually to ensure confidentiality. The questions were open ended and the responses were captured verbatim on a digital recorder.

4.3.1 Interview Schedule design

An interview schedule was devised by the researcher to respond to the interview questions **(Annexure A).** In order to guarantee its accuracy as far as possible, the substance of the schedule was finalized after the initial list of questions was tested on three people who were not part of the final sample.

4.4 Analysis of data

The transcriptions obtained from the digital recordings were read by the researcher and re-read to obtain any restrained semantic level of understanding; this included noteworthy pauses, significant awkward moments, hesitant laughter and ill at ease silences. As Creswell (2007 : 214) posits, transcriptions, together with the interviewees' written notes should be read over and over by the researcher in order to understand the experiences of the participants.

The aim of the researcher is to explore in detail how the participants are making sense of their personal and social world (Hedegaard & Hakkarainen, 2008 : 330). The interviewees' complex and multifaceted world was reconstructed and their reality was then transformed by the researcher into themes that were communicated in the form of psychological descriptions. In analysing the data, the researcher engaged in a two-way hermeneutic process which required the researcher to unilaterally set aside her own individual scrutiny, insights and encounters which could unduly manipulate the research process (Kruger, 2008 : 169). What is implied here is that the researcher's bias, preconceptions and conjectures are put aside so as to enable the psychological meaning entrenched in the participants' experiences to emerge without presuming or intruding on the researcher's own personal connotations.

4.4.1 Pilot study

Before the twelve participants could take part in the study, a pilot study was conducted with three participants who did not form part

of the sample that was selected. The pilot study was conducted to concentrate on possible vagueness and to improve the research instruments' dependability, legitimacy and subsequent usefulness.

During the pilot test, the respondents' comments on how they experienced the questions, in terms of whether or not the questions were threatening and difficult to understand were used to finalize and conclude the list of interview questions.

4.5 Ethical Aspects

The researcher firstly sought and obtained permission and clearance from the University of North-West's Research/Postgraduate Ethics Committee.

The researcher then informed the interviewees about the aim of the study and solicited their consent to participate in the study, by requesting each participant to sign a consent form **(Appendix C).** It was also made clear that each participant would not be coerced to participate; and if at any time anyone was inclined to terminate her participation during the research process, she would be liberated to do so.

The issue about confidentiality and the distribution of findings was discussed with the participants. The participants were also advised about the impending threat of the emotional sorrow that

may result from reflecting on the loss of their spouse. In this regard, the participants were advised about gratis grief counselling that would be made available by the researcher, if the need arose.

Cooperation and permission was obtained from the Management and administration of Rotarus, Home-for-the-Aged, North Street, Mafikeng (**Appendix D).** The participants' personal files were also perused and scrutinised by the researcher, with the assurance that during the course of the research, confidentiality and anonymity of the subjects would be strictly preserved and stringently maintained.

CHAPTER FIVE
DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

The first section of the chapter expounds the biographic information about the participants. In the second section, the themes that transpire from the data are presented. In the third section of the chapter, the psychological premises that are obtained from the emerging themes are distinguished and presented.

5.2 BIOGRAPHIC INFORMATION

The participants' ages ranged between 57 and 62 years, the average age therefore being 60 years old. All were women who had lost their spouses in the last 24 months. Six hailed from Rotarus Home for the Aged and six were widows from the Mafikeng/Mmabatho community, all were living with their families. Their grieving period ranged from six to twelve months. A further look at the profile of the sample indicated that on average, the participants were married at the age of 23 years. The respondents' distinctive attributes are presented in the following table:

Table 1 <u>Biographic Data of Participants</u>

**Name	Age in Years	Level of Education	Cause of Deceased Spouses' Death	How did The Widow Experience her Marriage	When Deceased Spouse Demised	Next of Kin
Joan	61	Grade 10	Lung Cancer	Happy	14 months prior to interview	Living with her married daughter
Jenny	59	Grade 12	Pancreatic Cancer	Happy	17 months prior to interview	Living with her divorced son
Barbara	60	Grade 12	Heart Attack	Happy	13 months prior to interview	Living with her niece
Lerato	62	Grade 7	Emphysema	Happy	22 months prior to interview	Living with her spinster sister
Mildred	59	Grade 11	Heart Attack	Happy	24 months prior to interview	Living with her married son
Pretty	61	Grade 8	Sugar Diabetes Related	Happy	16 months prior to interview	Living with her two grandsons
Martie	60	Grade 9	Heart Attack	Happy	19 months prior to interview	A daughter who visits her once a month
Peggy	62	Grade 11	Throat Cancer	Happy	15 months prior to interview	A son who visits her once every 4 months
Ilse	60	Grade 12	Car Accident	Happy	21 months prior to interview	A granddaughter who visits her once in a while
Florence	59	Grade 12	Asthma Related	Happy	20 months prior to interview	A daughter who visits once every six months, as presently her daughter lives in the Northern Cape
Francina	60	Grade 10	Stroke Related	Happy	18 months prior to interview	Her grandchildren visit her monthly
Gloria	61	Grade 10	Stomach Cancer	Happy	17 months prior to interview	Her sister visits once in a while

*** Name of Participant has been changed for confidentiality and anonymity's sake*

5.3 PHENOMENOLOGICAL ANALYSIS AND INTERPRETATION

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The following are the emerging themes that were gleaned from the information written by the respondents. The data was studied and re-read once more by the researcher to analytically and fastidiously identify the themes.

5.3.1 Stages of Bereavement

Upon studying the responses obtained, it appeared that the various stages of bereavement were applicable in the case of the participants in the present study. The following extracts bear evidence to this:

Gloria (61 years): *I could not believe it when I realized Tsepo was dead....(pauses, sighing deeply)....I somehow still cannot believe it, I don't want to believe it happened...I feel so numb at times and I experience a tightening in my throat, that sometimes I cannot even speak."(sighing again).*

Martie (60 years): *I still cry a lot, especially when I lie in bed at night, all the good times come back to me and I whimper in the darkness of my bedroom. I seem to have this feeling of emptiness in my stomach, I cannot explain it, but it is like a hollow feeling.*

Pretty (61 years): *I often sit and think about Abie and become anxious....(pausing) I always think he is coming back and I sit at the window, hoping to hear the gate open and see his laughing face again.*

Mildred (59 years): *I dream about Joss, he holds me in his arms and soothes my tears…(tearful)…I wish I could have him back with me today. I sometimes deny that he has gone; it's as if he has just gone on a journey and he will surely return to me soon. Yes, I cannot believe he is no more; it is really unbelievable to me.*

Peggy (62 years): *Why did this happen to me, if only I could have alerted the doctor earlier about my husband's illness.....you know he died of cancer.....cancer of the throat….he was a smoker (pausing) so was I up until his death…then I stopped…I was too afraid what I saw my husband go through…(heavy sighs)…(tearful and pausing)…during his hospitalization. I wish I could have done more for him before he passed away (sobbing). Sometimes the anger that wells up inside of me is so profound, the fact that surely the doctors could have saved him, or done something to save him. My anger is so tremendous, it overwhelms me, it is quite frightening.*

Joan (61 years): *I wish the Lord could have taken me rather, I sometimes don't want to go on….I am so sad and lonely….(pause)…I'm also feeling so guilty, I should have treated him better when he fell ill and I really didn't….(tearful)….if only….if only (sighing), if only it could have been me rather.*

Florence (59 years): *I don't sleep very well at night, I will pace up and down in my bedroom, with extreme heaviness in my heart. A sense of foreboding overcomes me. It is all very disturbing, no one really knows this awful feeling until*

they are faced with this unthinkable dilemma…believe me no one knows..until they have lost their loved one…..(tearful), it is so terrible.

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Francina (60 years): *I don't like facing anybody (tearful), I wish I could just stay in my room all day and not see anyone. I've developed this awful shyness of facing anyone. I really was not like that before now, it shows what losing a loved one can do to the other person…believe me, I know…(sighing).*

5.3.2 Memories

The following respondents have lucid memories of their spouse and their spouses' funerals.

Mildred (59 years): *It was an awful day, it had rained the night before, in fact it had rained all night and the morning of the funeral was cold and grey, it seemed that the entire universe had been crying tears, everywhere was wet…the graveside (pausing)…the mud, I remember all the mud, it was so awful at the graveside when we had to bury my husband.*

Joan (61 years): *I did not want to have to face the throngs of people who came to the funeral; I wanted to just be alone with my Peter. I remember crying all the way home from the funeral and then I had to face the people at the wake…that was not easy to talk to anyone, I didn't want to talk at all, I just wanted to be alone, to face my misery by myself…(tearful).*

Gloria (61 years): *I often dream of the time we lived in Taung, my husband and I, before he fell ill and then we had to move to Mafikeng to be nearer the specialists and the doctors. He always put on such a brave face when we had to go for his chemo…I remember how much pain he endured…(sighing), I'll never forget the discomfort and the pain he had to bear…(sighing and tearful), it was so terrible for us both. You know…sometimes I can hear him talking to me about the pain he had to endure whilst he was dying.*

5.3.3 Psychological Impressions

The following are the respondents' recollections and visualizations:

Martie (60 years): *I keep experiencing distressing recollections of my husband's death. It happened at home…….in fact…(pause)….in our garden. He was fine that morning, he (husband) was busy pruning some bushes, the next thing I heard him scream out, and then I rushed outside to find him lying on the ground, he was fighting to breathe. I rushed to telephone my next door neighbor. When the ambulance eventually did arrive……my husband was already long dead. It was awful looking at his distorted face; it was blue and sort of swollen up. He looked so helpless just lying on the ground like a limp rag. How I miss him…(pause)….it was so tragic.*

Francina (60 years): *I keep getting recurring dreams of seeing my husband lying in the IC unit at the hospital, with all those tubes and pipes coming out of his nose and mouth, not to mention the oxygen mask and the intravenous drip in both his arms....(head bowed and tearful), I wish I could have the good old days back, those good old days, when things were normal.*

Florence (59 years): *I don't know what it is, whenever I see an ambulance, it reminds me of our frantic trip to the hospital on that fateful day when my husband was fighting for his life... I hate to ever see an ambulance on the road, it makes me get heart palpitations, (pausing) I start sweating and I tremble a lot...(sighing).*

Peggy (62 years): *It was an absolute shock when I learnt the terrible news. I was at the hospital and I had fallen asleep just for a moment when the nurse came to tell me what had happened...it was awfully shocking for me and I didn't want to believe what I was hearing. Now I try all in my power not to think about that traumatic day.*

Joan (61 years): *Oh my dear, the hospital that Peter was in was so terrifying...patients all full of terrible ailments...the nurses rushing here and there in the wards. All the misery I experienced, it was so distressing for me to experience. I don't ever want to be hospitalized like Peter was, I would rather die at home than have to go to die in such a cold, heartless place like the hospital.*

Jenny (59 years): *I cannot concentrate anymore, all I seem to ever think about is my late husband's death and how he died. He was diagnosed with pancreatic cancer. People talk to me and it as if I don't hear what they are saying; it is like I am in a trance. I saw his (husband's) rapid deterioration, because I was the one nursing him all through his illness. I saw how he suffered the terrible pain from the cancer and how he lost weight so very quickly.....(sighing and tearful).*

The foregoing statements portrays that the respondents experienced invasive psychological flashbacks of their spouses' death. Post traumatic stress disorder is tantamount to flashbacks, illusions and intrusive distressing recollections. Symptoms such as lack of concentration and intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event present themselves. The death of their spouses could have been psychologically traumatic for them, hence the symptoms of PTSD.

5.3.4 Clinical Impressions

The following extracts indicate that some of the interviewees may perhaps be suffering from significant clinical pathological features.

Pretty (61 years): *I still try to think of him (husband) as he was, not the wretched soul that he ended up in that hospital ward. I cry a lot lately, when the memories well up inside (tearful and head bowed low). This is not fair, it really is not fair that I'm left alone like this...why me...it should have rather been me who had died? I can also hear him calling me from a distance.*

Florence (61 years): *Yes, it is very, very difficult for me most of the time, just sitting here thinking and thinking. I end up wanting to go mad, you know, scream and shout out the emotional pain that I'm feeling daily…(crying loudly and sobbing, with her hands covering her face). I hardly see my daughter and that also kills me, the touch of a familiar hand is all I really long for….. (sighing).*

Gloria (61 years): *It is so difficult for me most days, the thoughts that come to my mind. I feel like dying myself to get out of this pain that I keep experiencing after my husband's death. I never realized that it can be so hard to overcome this loss, this terrible loss that I constantly feel. Don't even mention the challenges that I now have to face alone, the financial implications that have burdened me down….the abandonment from my family that I'm feeling, it is overwhelming at the best of times. I never hear a word from my family, can you believe it?….*(sighing deeply)*…they are too busy with their lives to think of me.*

Jenny (59 years): *I cry myself to sleep most nights you know. I also don't want to eat anymore. What is the point of all this, you tell me how do I find a solution to this hell I am going through?"*

Peggy (62 years): *I just sleep all the time lately, I don't want to get up from my bed, what is really the point of getting up and washing….it is just another useless day to endure without him (husband)….(sighing). I'm left with only memories, yes memories my dear…no children's*

	support or any sort of compassion from them, they are too busy with their lives....no money...no hope...nothing to look forward to anymore.....nothing! (tearful and sobbing).
Joan (61 years):	*I startle easily...(pause)...you know....when I hear a loud noise or a bang. I really don't want to go out anymore, I am safer at home, I'm too afraid to go out, even into my garden."*

5.3.5 Integrity vs Despair

The following extracts show that the participants now face their final frontier, integrity or despair, the eighth epigenetic stage of man's life according to Eric Erikson:

Francina (60 years):	*I feel so anxious most of the time, I feel that my life has been too short, especially the precious time I had with my husband...far, far too short (sighing). We wanted to do so much more together, now it is too late. Where has the time gone, it has evaporated like sand in a sand storm and settled down to be buried in the earth forever...I feel abandoned from everything (sighing loudly again).*
Martie (60 years):	*Where has the time gone? I still had so much to do with my late husband before he passed away. We wanted to visit the Angel Falls in Venezuela together and experience the canals of Venice in the Spring, oh wow, we even wanted to take a hot air balloon over the*

Serengeti and see the wildebeest running under us, now it is too late…too late….(tearful).

Lerato (62 years): *I don't know what has happened, my late husband thought he would live forever, now look at me….I'm alone with my own despair, and you know what I am scared, I'm afraid to be alone like this until I die. Bah…(pause)..my family don't really care, they have their own busy lives to live….it is so very sad…(sigh).*

Ilse (60 years): I don't really get any real support from my family, my daughter is overseas and my two sons are also dead, it is just my granddaughter who cares for me now…she lives in Zeerust and visits me once in a while…it is lonely and discouraging....no family to lean on….if you know what I mean? It feels sometimes that no one really cares for me anymore, I feel so terribly alone….who do I turn to, if family has turned their backs on me…who will really knows and cares in my sorrow?

Florence (59): My husband and I used to do everything together…(sigh)…we were such a lovely couple….(pause)…now the 'we' has become just 'I'. This does not feel good for me, I still cannot grasp the idea of it only being me….'I'…(sighing with tears in her eyes).

5.3.6 Defense Mechanisms

Some participants used defense mechanisms to cope with their veracity, herewith a few extracts of interviews taken:

5.3.6.1 Denial

Martie (60 years): *Life goes on, we must all go with the flow of things to survive, despite this terrible confusion inside of me…it is all about survival….but you know what, things will just be fine, it will all get better, I know it will.*

Lerato (62 years): *It is not that hopeless, my dear sister Agnes always cheers me up with a nice cup of tea…it helps a lot, especially when I'm really low and nothing seems as it should be anymore…you know that terrible lowliness (laughing).*

Avoidance of the awareness of some painful aspect of reality by negating sensory data (Sadock & Sadock, 2007) .

5.3.6.2 Regression

Peggy (62 years): *I have a soft teddy bear which I hold onto all the time, it really offers me a lot of comfort, especially when I feel so terribly low. I hug it and sometimes talk to it. My teddy even embraces my tears when I cry into it….(tearful)*

Ilse (60 years): *Oh my dear, I have this lovely soft blanket, it is pink and has white polka dots on it. I cannot sleep without that blanket…(smiling)…it is my comfort and joy…does that sound very silly…yes my dear, it does sound silly, …(smiling again coyly)….but you know what I mean?*

Barbara (60 years): *Lettie, my niece, always makes me a nice cup of cocoa when I long for my Bill (late husband) and she sees me down and tearful. I remember my mother making me a cup of cocoa when I was feeling sad as a child. It really helped…(pause)…it used to pick me up and still helps for sadness, you should try it sometime when you are down my dear…(smiling)!*

Attempting to return to an earlier phase of functioning to avoid tension and conflict evoked at the present level or development (Sadock & Sadock, 2007).

5.3.6.3 Hypochondriasis

Jenny (50 years): *I have this awful pain in my back everyday…Dylan (divorced son) has taken me to several specialists, but nothing…..they can't pick up a clue to what is going on with m…(sigh). Sometimes I cannot get out of bed in the mornings, it is that bad….I mean the unbearable pain that I have….(sighing).*

Florence (59 years): I get these awful migraine headaches. It is so debilitating for me, I cannot think and the room feels like it is spinning around and around. I've had this problem since my late husband passed away…(pausing)….it is so strange though, when I go to the doctor…(pause)…and for tests, they never can detect anything really serious with me, it is so very strange."

Exaggeration or overemphasizing an illness for the purpose of evasion and regression. Reproach arising from bereavement, loneliness, or

unacceptable aggressive impulses towards others is transformed into self-reproach and complaints of pain, somatic illness (Sadock & Sadock, 2009).

5.3.6.4 Suppression

Martie (60 years): *I'll still go to Venice you know...once I get over my late husband's death and I receive his Sanlam policy payout.....I'll go and enjoy myself....(sigh), I've heard so much about Palazzo Saint Marco and the Via del Rossi....it will make me a new person....can you just imagine?*

Mildred (59 years): *I don't feel a thing, I mean this foreboding feeling, it will come right one day, I know it will...it has to...(laughing). Maybe I'll even meet someone who will carry me into the sunset...(giggling).*

Consciously or semiconsciously postponing attention to the conscious Impulse or conflict. Issues may be deliberately cut off, but they are not avoided. Discomfort is acknowledgd but minimized (Sadock & Sadock, 2007) .

5.3.7 Psychological Themes

The subsequent are the psychological themes that emanated from the data obtained:

5.3.7.1 Emotions

The respondents experienced fluctuating emotions. Most of the participants experienced sadness and cried often, especially when their circumstances were difficult to endure. For some, it was anger and intolerance that they felt for their deceased spouses, for having been left behind. Confused feelings were also apparent from the gleaned data. Feelings of abandonment, hopelessness and not knowing what to do in order to cope, was another strong emotion which emerged from the data.

Some expressed how they were coping, whilst others experienced no coping mechanisms. Some participants talked about mixed feeling i.e. happiness and unhappiness which might suggest that the possibility of mood disorders abounds. Insecurity, frustration and fears are portrayed in most of the participants, as they have been plunged into their circumstances.

5.3.7.2 Disturbing Thought Patterns

Some of the participants were subjected to relentless and disturbing thoughts about their deceased spouses. Rumination and reflection abound in most of the participant's responses regarding how their spouses had died and how it would have been if their spouses had lived. As well as how difficult their circumstances are without their spouses. Other intrusive thoughts correlate with what some of the participants perceived as the cruelty of death which ultimately leads to endurance and suffering.

5.3.7.3 Complicated Grief

Upon perusal of the responses, some of the participants are going through complicated grief which is associated with the death of their spouses. This can be evidenced from the information that most of the participants had not yet resolved their grieving process and accepting the loss of their spouses after a 11 month grieving period. They still wish and *'always think he is coming back and I sit at the window, hoping to hear the gate open and see his laughing face again.'*

The pain of dealing with the reality of a dead spouse appeared to be too much to bear. They were often too sad and forlorn when they recalled their stories and most were always near tears. Some said they heard their deceased voice, which may also indicate complicated grief.

5.3.7.4 Clinical Conditions

Most of the participants were found to be acutely depressed. There were signs of despondency, despair and in some suicidal ideation. Some felt that their children had abandoned them and this situation made them to isolate themselves from the social environment. There were signs of anhedonia, lack of interest in doing daily tasks. Flashbacks were abundant, which seemed to contribute to their depressed state of minds.

5.3.7.5 Coping Mechanisms

The study found that the participants rely on a variety of coping strategies to deal with their loss. Some relied on instinctive reserves such as self motivation, positive self-talk and a resolve to focus into the

future with more resolve. Some used defense mechanisms such as denial, suppression and regression to cope on a day-to-day basis with the loss of their spouse.

5.3.7.6 Socio-economic Standing

Almost all of the participants interviewed were familiar with a low socio-economic status which worsened after the death of their spouse. Most of the participants had relied on their spouse's income for sustainability before their spouses had passed away. A few of the respondents are being taken care of by their relatives, whilst others were taken care of by the state.

5.4 Summary

This chapter focused on analyzing the data and its interpretation. Biographical information was presented in Table 1. The phenomenological analysis and interpretation focused on the themes that become apparent and clear. The emerging themes included the emotional pain experienced by the participants; the painful memories the respondents experienced, the stages of bereavement that they were enduring, the financial implications that they are facing; the clinical conditions that they are suffering from, which included flashbacks and nightmares; the social support that they considerably lack; the self motivation that encouraged them to cope; the defense mechanisms that they engaged to also cope.

The last part of the chapter focused on the psychological themes that emerged and were also discussed. The respondents were found to be undergoing complicated grief as portrayed from the emotional pain that they endured. There were clinical conditions that were verified by the symptoms present in the participants. The death of their spouses impacted on the socio-

economic situation of the respondents. The participants developed strategies for coping from day-to-day. The results can be found in the following chapter.

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CHAPTER SIX
DISCUSSION

6.1 INTRODUCTION

This chapter discusses the results of the study. The discussion is based on the findings in responding to the aims of the study. The discussion focuses on what the participants' loss meant to them; the emotions they endured owing to their loss; how these emotions had impacted on their day-to-day living experiences by their demise and also what strategies were used to deal with them.

6.2 MEANING OF THE LOSS OF A SPOUSE

For most of the participants in the present study, the death of their spouse resulted in a considerable socio-economic deficit, as well as financial difficulties, as most of the deceased spouses were the greater breadwinner in their families. Such a financial loss of economic support, resulted in the participants agonising about their impending future.

All participants had clear and lucid memories of their dead spouse and wanted to keep those recollections very much alive. They seemed not to want to forget them as they had indicated that they deemed their departed spouses were, in spite of everything, still very much with them. They shunned the realism of death by all measures and opted to embrace their conscious reminiscence.

The participants indicated that they missed the providence, as well as their spouses' devotion and affection that they enjoyed when their spouses were still living. According to Cumming and Henry

(2000 : 82), grieving adults need social and emotional support; nurturing, empathy, encouragement and continuity in order to cope with their bereavement. According to Conway (2001 : 120), social and emotional support can be assuaged by friends and support groups, as well as a sense of security found in dedicated inter-personal relationships. Conway (2001 : 122) posits that If elderly bereaved women experience emotional loneliness and isolation, depression inevitably follows loss. Bowlby (2008 : 302) wrote that sooner or later, some of those who avoid conscious grieving break down, most often than not usually with some form of ultimate depression.

Frank (2007 : 339), on the other hand found that elderly bereaved women who had found new partners had lower psychological distress and scores than those who remained alone. Frank (2007 : 339) goes on to postulate that emotional loneliness was even reduced in women who had dogs or cats for companionship.

Whilst some participants remained being given shared support from their next-of-kin, they nevertheless felt that such continuance could not replace the love and devotion that they received from their spouses. The participants who had no real family support had to be left alone for weeks on end without any family contact, they inevitably felt abandonment, deserted and isolated. This implies that such bereaved widows end up assuming greater responsibility, dependability and conscientiousness when compared to their non-bereaved counterparts of their age. These circumstances may cause considerable emotional distress, as was found in most of the participants during the study.

6.3 DEPENDENCY NEEDS

Dependency in the relationship with the deceased has been noted thus making adaption to the loss more difficult. Parkes and Weiss (2008 : 128) found in their Boston study that widowed individuals who were overly dependent, were prone to function poorly. The dependent spouses clung to their partner after their death in order to maintain their accustomed role of helplessness and inability to cope, as was seen in some of the participants. Widows who were intensely involved with their husband's lives, and who were psychologically and socially dependent on them, had more problems adapting, than autonomous widows had (Parkes and Weiss, 2008 : 128).

Parkes and Weiss (2008 : 129) draw attention to the interlocking of dependency and dominant needs of the spouse in marital relationships: dependence during a marriage, as it was found in the case of some of the participants, may have mainly been the result of the need for dominance from the side of the deceased spouse. Thus, according to Parkes and Weiss (2008 : 129), the widowed of a dominant partner may instead experience feelings of helplessness and, feel a certain degree of relief from the dependent role, as well as experience little problem in taking control of her life.

6.4 AMBIVALENT FEELINGS

The most frequent type of relationship that hinders people from adequate grieving is one which involves extreme ambivalence, coupled with unexpressed hostility, as was in the circumstances of some in the sample group.

A few of the participants met the diagnostic criteria for Dysthymic. Disorder, as reflected in the Diagnostic and Statistical Manual of Mental Disorders IV- TR. They showed depressed mood for most of the day as indicated by their subjective account. There were feelings of low energy, lowered self esteem and feelings of hopelessness which resulted in significant impairment in their social functioning. Other participants also showed signs and symptoms of depression (Sadock & Sadock, 2007 : 62). These included worthlessness, helplessness, vulnerability, despondency, and in some suicidal ideations.

Most participants were found to be suffering from complicated bereavement, which seemed to account for their emotional pain. According to Sadock and Sadock (2007 : 62), complicated bereavement can be experienced if grief has been prolonged over a period of more than twelve months. In this study, the time frame categorized was 12 months. Some of the clinical symptoms of complicated bereavement that were revealed by some of the respondents comprised weeping, resentment towards the deceased, frustration and disappointment in general about confronting life with difficulty in the absens of their spouses, fear of the unknown, hurt, emotional uncertainty and longing to see their spouses coming home.

Some participants also showed signs and symptoms that are consistent with Generalised Anxiety Disorder. According to Sadock and Sadock (2007 : 63), Generalised Anxiety Disorder is excessive anxiety and worry about several events or activities for most days during at least a six month period. The worry is difficult to control and is associated with somatic symptoms such as irritability, muscle tension, agitation, and difficulty sleeping.

Defining the phenomenological description, it is evident that some of the participants also displayed signs and symptoms of generalised anxiety. Some of the symptoms of generalised anxiety shown by the participants included excessive worry, fatigue, concentration difficulties, irritability and sleeping difficulties.

According to George Kelly, who was perhaps the first cognitive theorist in the 1950's (Rubin & Schechter, 2001 : 285), postulated that anxiety results from being confronted with information that is inconsistent with the way one thinks about one's self. As Kelly's personal constructs theory proposes, a person interprets occurrences in order to be able to anticipate similar occurrences in the future. The inconsistency of concepts and constructs of anticipation of similar events occurring in the future, resulted in the participants developing anxiety and having a negative outlook on life. Such harmful apprehension leads to the development of lack of assertiveness and possessing poor self-esteem on the functioning of the grieving widow.

6.6 COPING MECHANISMS

The respondents who had emotional support from their next of kin were found to be managing much better than those who did not receive any such support. It was also found that those who were more financially secure were found to be in a better position to cope with their life circumstances.

Whilst some of the participants managed to cope by utilizing the fond memories of their deceased spouses, others appeared to use defense mechanisms to cope. Sigmund Freud in Shengold (2008 : 71) advocated that defense mechanisms are instinctive patterns

into which energy is directed in order to defend the ego against anxiety and threat of trepidation. The ego therefore endeavours to mimimise anxiety by utilizing its dilemma elucidation. However in some instances, anxiety is occasionally so overwhelming that the ego's approach proves ineffective. According to Shengold (2008 : 72), defense mechanisms correlate with the ego trying to circumvent agony and remorse.

In this study, it appears that the utilization of defense mechanisms may have been a contributing factor to some of the respondents who are facing complicated grief, as this coping approach may have averted them from challenging and confronting the pain associated with the passing away of a their loved ones.

Some of the defense mechanisms used by the participants were: denial, suppression, hypochondriasis, idealisation and regression. According to Templer et al. (2007 : 341), utilization of defense mechanisms such as idealisation, may bring about apprehension through inducing unfounded dread.

6.7 SUMMARY

The results of the study were discussed in this chapter. The meanings of the loss for the participants were looked into. The results found that there were suggestions of an absence of love, providence, direction, appeasement and safety that were previously offered by their deceased spouses.

The participants experienced the emotions related to the loss as depicted from their impaired mood and emotional anguish. They suffered dysthymic disorder, anxiety, complicated bereavement

and portrayed symptoms of depression,

The disturbance in their normal pattern of thinking impacted on their day-to-day livelihood. Some were apprehensive with their loss, which resulted in the participants' fears that had eventually led to anxiety. Being unable to think realistically may have influenced harmfully on the participants. Lack of fundamental requirements was also a constant daily trial for the participants.

In the following chapter, the summary of the findings are outlined and the conclusion presented.

CHAPTER SEVEN
SUMMARY AND CONCLUSION

7.1 SUMMARY OF FINDINGS

The objective of this study was to comprehend and illustrate the experiences of grief amongst bereaved widows who had lost their spouses through death. John Bowlby's influential cognitive theory formulated his conjecture on loss and attachment (Parkes and Weiss, 2008 : 156) of which forms the theoretical framework of the present study. Like Freud, Bowlby presupposed unconscious processes and considered childhood experiences in bonding of immense importance in later development. As Parkes and Weiss (2008 : 157) preclude that Bowlby was dissatisfied with some of the abstract concepts such as 'psychic energy' and 'drive' in psychoanalysis and especially in his later work, Bowlby sought to draw links with cognitive psychology. In his attachment theory, Bowlby (as cited in van der Horst et al. 2007 : 439), postulated that attachment behaviour in human beings has a function of committing themselves to each other. Van der Horst et al. (2007 : 442) go on to say that the young child is extremely dependent on his environment. In order to survive, it has to make certain that it is cared for. This, it does by showing attachment behaviour: behaviour that serves to maintain certain degrees of proximity to, or of communication with, the discriminated attachment figure(s). Attachment is thus goal-directed, and has a function in survival. Attachment behaviour, also when expressed in adult life, is considered by Bowlby to be normal (Parkes and Weiss, 2008 : 160).

Grief, as Bowlby posits, is essentially 'separation anxiety' (Attig, 2008 : 224). He draws an analogy between young animal's and children's reactions to separation from their mothers and reactions to loss in

bereaved adults. Bowlby views bereavement as an unwanted separation from an attachment figure which gives rise to 'attachment behaviours' similar to those observed in animals and children. A brief period of protest is followed by a longer period of searching behaviour. After some time these behaviours cease, as they prove to be ineffective in bringing back the attachment figure and the bereaved enter a phase of despair and depression sets in (Attig, 2008 : 225). After that, a fourth and final stage is the 'reorganisation' phase, in which the cognitive restructuring of one's situation takes an important place. Proceeding through these phases constitutes the 'grief work'. According to Attig (2008 : 225), in contrast to Freud, Bowlby asserts that in a healthy bereavement process, the relationship with the deceased is often not broken. The bereaved may have a feeling of 'inner presence' of the deceased that is comforting and supportive in restructuring their lives.

Bowlby's model is more or less an organic or medical one: it stresses the instinctual and congenital determination of the grief process (Parkes and Weiss, 2008 : 162). Like Freud's theory, it is a cathexis theory, where the childhood bond plays an important role as the model for later relationships. Recovery from loss is seen as analogous to recovery from a disease. There is some empirical basis for this theory. Behaviour sequences, following the phases described above, have been found among animals in behavioural experiments (Rosenblum, 2007 : 62) as well as in psychobiological research (Laudenslager, 2008 : 392).

To this end, owing to the loss of a loved spouse and the incredible suffering and hurt, as well as fixation and anxious preoccupations with the bereavement process, abstract thinking proved to be a tremendous challenge to the grieving widows. They were unable to engage in any abstract judgment. They dwelt constantly on thinking about their thoughts. This may have replicated their unsubstantiated resonance in

their ultimate suffering.

The following are some of the poignant conclusions uncovered:

7.2 Daily Effects of the Loss

The bereaved widows were found to be lacking financial support. Some relied on their families for financial succourance.

7.3 Consequence of the Loss of a Spouse

Loss of a spouse meant long term enduring torment for the widows. There were clear and lucid signs which lacked nurturance, affection, love and support which they had enjoyed from their longtime partners.

7.4 Emotions correlated to the Loss

The grieving widows portrayed to be suffering emotional demise, owing to apparent psychological indicators. There were suggestions of complicated grief which denoted to the denial to accept their loss (Sadock & Sadock, 2007 : 65).

There were severe indications of feelings of frustration, guilt and anger which made it difficult for most of the widows to continue with their lives. They had also become preoccupied with the emotional sorrow that they felt. Their preoccupation had derived from their irrational thought processes about their deceased spouses. They had become preoccupied with the emotional distress that they felt. Their thought functioning had influenced them not to accept death as inevitable and irrevocable.

Some of the widows were found to be depressed, whilst others were extremely anxious. Those that were found to be depressed had felt feeble, vulnerable and discouraged about their lot. Those that were found to be anxious had suffered profound trepidation owing to their loss. They were engrossed with not wanting to lose the providence of their families. Some of the widows portrayed signs and symptoms of dysthymia (Sadock & Sadock 2007 : 564), which presented with their suffering for a long period of time.

7.5 Coping Stratagems

Some of the widows had utlised healthy approaches of dealing with their loss. Some had managed to use their intrinsic reserves such as hope, optimism, expectation and self motivation to assist them to focus. Some of the widows used ego defense mechanisms such as substitution, idealization and denial to elude their agony (Sadock & Sadock, 2007 : 202-204).

7.6 Recommendations and Conclusion

7.6.1 Based on the findings of this study, the following recommendations are thus made:

7.6.1.1 Provincial Departments of Health and Social Development, through the auspices of the South African Government can be requested to promote organizations that can be mobilized to oversee the psychological wellbeing and welfare of the bereaved. This may reduce the suffering and affliction of the widowed as they will be offered the support service and deemed necessary assistance that they will require.

7.6.1.2 Future reviews, research and investigations on bereavement and the consequential effects of grief amongst the aged will have to be undertaken by psychologists, grief counsellors and social workers.

7.6.1.3 The aide of psychiatrists should also be involved in the management of these bereaved ladies.

7.6.1.3 Given the disturbing emotional bearing and other psychological outcomes that are related with bereavement, it is therefore recommended that identifiable psychological, psychiatric and counselling services be afforded by the national government to assist the bereaved elderly in old age homes and the community at large to cope with the behavioural and cognitive challenges that consequence from the loss of a spouse.

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NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

PSYCHOLOGY DEPARTMENT
Private Bag X2046
Mmabatho
2735

Telephone: +27 18 389 2160
Telefax: +27 0865358863
E-mail: Moyra.Tsambos@nwu.ac.za
Web: www.nwu.ac.za

ANNEXURE A

Date: ……………………………………

TO WHOM IT MAY CONCERN

Dear Participant

Thank you for agreeing to participate in this reseach study.

Would you be so kind and give me in not more than six pages your written experiences of being a widow, in particular:

- Your emotional experiences, including the pain you felt, after your loss and how you feel now
- Your initial day-to-day thoughts after your loss and how you feel now.
- Do you have any coping mechanisms in place to help you?

There are no right or wrong answers and please **DO NOT WRITE YOUR NAME ON YOUR WORK.**

There is a strong likelihood that the information that you are requested to write about may arouse distressing feelings of sorrow, in this respect; the researcher will provide you with de-briefing therapy.

It may be noted that the information offered by you will also assist you to air any unpleasant sentiment that you may not have been able to deal with since your loss.

May I also assure you that you will not be compelled or obliged to participate; and if at any time you may wish to terminate your participation at any stage during the research process, you would be free to do so.

The researcher is an M Soc.Sc (Clinical Psychology) student. The information you are going to share will be used as part of the research study towards her degree fulfillment.

Thanking you for your valuable time.

Yours sincerely

MOYRA TSAMBOS

....

I,agree/disagree to participate in this research project.

______________________________ ________________________

SIGNATURE **DATE**

ANNEXURE B

INTERVIEW SCHEDULE

The researcher used the following questions as a guideline to interview the participants. Open-ended questions were used to persuade the participants to explain their subjective experiences of their loss:

1) How long has it been since you lost your spouse?

2) What were your initial thoughts when your spouse passed away?

3) Looking back on how you lived before the loss, how have you managed since then?

4) What challenges do you experience since your late spouse's absence?

5) How does the death of your spouse mean to you?

NORTH-WEST UNIVERSITY
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NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

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Web: www.nwu.ac.za

APPENDIX C

LETTER OF CONSENT

Date: ....

Dear Participant

You are requested to participant in a research study by writing your experiences concerning the death of your spouse to the best of your ability. You will also be interviewed by the researcher to get a clear understanding of your experiences. Anonymity and confidentiality will remain throughout this research process.

Please note that you will not be compelled or obliged to participate; and if at any time you may wish to terminate your participation during the research process, you would be free to do so.

The researcher is an M Soc.Sc (Clinical Psychology) student. The information shared will be used as part of the research study towards her degree fulfillment.

Thanking you ahead for your kind cooperation.

Yours sincerely

MOYRA TSAMBOS

....

I agree/disagree to participate in this research project.

______________________________	______________________________
SIGNATURE	**DATE**

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

PSYCHOLOGY DEPARTMENT

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Mmabatho
2735

Telephone: +27 18 389 2160
Telefax: +27 0865358863
E-mail: Moyra.Tsambos@nwu.ac.za
Web: www.nwu.ac.za

APPENDIX D

LETTER OF CONSENT

Date: ....

The Management
Rotarus Home for the Aged
North Street
Mafikeng
2745

Dear Madam

You are requested to allow the participant to participate in a research study by writing his/her experiences concerning the death of his/her spouse to the best of his/her ability. The participant will be interviewed by the researcher to get a clear understanding of his/her experiences. Anonymity and confidentiality will remain through this research process.

The participant will not be compelled or obliged to participate; and if at any stage he/she wishes to terminate his/her participation during the research process, he/she would be free to do so.

The researcher is an M Soc.Sc (Clinical Psychology) student. The information shared will be used as part of the research study towards the fulfillment of her degree.

Thanking you ahead for your kind consideration.

Yours sincerely

MOYRA TSAMBOS

....

I, ________________________________ agree/disagree for participants of Rotarus Home for the Aged to participate in this research project.

________________________________   ________________________________

SIGNATURE   **DATE**

18 Boipelo Street
Unit 3
MMABATHO
2735

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12 November 2010

CERTIFICATE OF LANGUAGE EDITING

TITLE OF DISSERTATION

The experience of grief among the bereaved widowed at Rotarus, Home for the Aged, Mafikeng

SUBMITTED BY

Moyra Gail Tsambos

FOR THE DEGREE OF

Master of Social Science
(Clinical Psychology)

IN THE

Psychology Department
Faculty of Human and Social Sciences
North-West University
Mafikeng Campus

Has been edited for language and other details by:

Prof. SA Awudetsey

Prof. SA Awudetsey
0722371390