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**A DESCRIPTIVE CASE STUDY OF THE
PATTERN RESPONSE IN WIDOWS**

**By
Mary Rowe Somers**

A THESIS

**Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of**

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ABSTRACT**A DESCRIPTIVE CASE STUDY OF THE
PATTERN RESPONSE IN WIDOWS****By****Mary Rowe Somers**

The purpose of this study was to discover the pattern response for one woman who had experienced the death of a spouse. A descriptive case research design method was utilized for this study to uncover the meaning of the event as it is being lived. Open-ended interrogatory questions were asked in an intensive, face-to-face, one time interview with the researcher. Themes that emerged were isolated and then analyzed to depict the pattern response of bereavement for this woman. Themes were then synthesized with the researcher's perspective, based on the analysis. A hypothetical statement was generated.

Conclusions from this study indicate that bereavement is a process in which human beings freely choose. Bereavement encompasses a constantly evolving

Mary Rowe Somers

pattern with environment, leading to self understanding,
changed perspectives and a glimpse of the future.

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TABLE OF CONTENTS

	<u>Page</u>
CHAPTER I - Introduction	1
Research Questions	6
Purpose.	6
Phenomenon	7
Assumptions.	9
Limitations.	10
Overview of Chapters.	11
 CHAPTER II - Conceptual Framework	 12
Introduction	12
Rogers' Theory.	12
Interrelationship of Concepts.	15
Human Beings	16
Pattern and Organization	18
Pattern Response	18
Health	24
Nursing	25
Implications for Nursing	25
Summary	27
 CHAPTER III - Review of the Literature	 29
Introduction	29
Bereavement.	29
The Environment of Bereavement	34
Role Change Expectations	34
Perceived Social Support/Social Isolation.	36
Economic Factors	39
Forewarning of Spouse's Death.	41
Reported Physical and Mental Symptoms	43
The Role of Nursing	45
Personal Experience	47
Selected Nursing Research	50
Summary	55

	<u>Page</u>
CHAPTER IV - Methodology	57
Research Design	57
The Descriptive Method	58
Identifying the Phenomenon.	58
Structuring the Study	59
Research Question.	59
Conceptual Framework.	60
Objectives of the Study.	60
Study Sample	61
Protection of Human Rights.	63
Data Gathering.	64
Validity and Reliability	65
Procedure for Data Analysis	70
Summary	71
CHAPTER V - Data Presentation and Analysis	73
Overview.	73
The Case.	74
Objective One	78
Themes in the Language of the Subject	78
Themes from Opening and Closing Questions.	79
Themes from Guided Questions	80
Objective Two	82
Themes from Opening and Closing Questions.	83
Themes from Guided Questions	84
Objective Three	86
Themes from Opening and Closing Questions.	86
Themes Derived From Guided Questions	88
Methodology: Quality of Design	94
Summary	99
CHAPTER VI - Interpretation, Conclusions and Implications of the Study	100
Overview.	100
Discussion and Interpretation of Findings.	101
Objective One	104
Objective Two	106
Objective Three	108
Nursing Implications.	116
Summary	125

	<u>Page</u>
Appendices	
Appendix A	128
Appendix B	130
Appendix C	133
Appendix D	139
Appendix E	156
 References.	 159

LIST OF FIGURES

<u>Figure</u>		<u>Page</u>
1	Objective One -Themes in Subject's Language With Concepts.	91
2	Objective Two - Themes in Subject's Language With Concepts.	92
3	Objective Three - Themes in the Subject's Language With Concepts.	93
4	Logical Mapping of Concepts of Bereavement.	110

CHAPTER I

Introduction

We are separate people constrained by the forbidden and the impossible, fashioning our highly imperfect condition. We live by losing and living and letting go. And sooner or later, with more or less pain, we all must come to know that loss is indeed a lifelong human condition" (Viorst, 1986, p. 265).

Life, then, which is growing and learning and reaching and yearning and gaining, is also losing. In examining loss one recognizes that the word itself arouses feelings that like pain or joy or hope are at best illusive and most certainly subjective. In an attempt to investigate the meaning of this most common of human experiences a particular loss will be examined in order to gain added insight. The loss to be examined will be the death of a male spouse and, in particular, the accompanying bereavement surrounding the widow's experience.

Widowhood will be an inescapable reality for three out of four married women (Olson & Hanover, 1985). In 1975, there were twelve million widowed persons in this country. Of this number, eleven million were women. In

other words, widowhood is the likely consequence of marriage. Holmes and Rahe (1967) have developed a life events scale based on forty-three events or crises that the average person may expect to encounter and have given them stress ratings termed "life change units". The death of a spouse, by far one of the most stressful, is rated at one hundred life change units, the highest number possible. Shanas et al. (1968) also found that the death of a spouse is considered the major life stressor among survivors of varying ages and diverse cultural backgrounds.

It is important to look at the commonly identified areas of potential concern that most newly widowed women must face. These areas include economic difficulties, the occurrence of untoward physical and mental symptoms and feelings of loneliness (Berardo, 1968; Philblad, Adams & Rosencrans, 1972; Lopata 1979; Moustakas, 1977; Engel, 1971; Carey, 1979; O'Bryant & Morgan 1989; Strobe & Strobe, 1987; and Gass, 1987). It is also helpful to look at the predictors of successful adaptation to widowhood. These predictors include age, gender, forewarning of spouse's death and, perhaps most important, perceived social support (Caine, 1974; Vinick, 1978; Walters, 1980; Lopata, 1978; Ball, 1977; Glick, Weiss & Parkes, 1974; Madison, 1968, Kirshling & Austin, 1988.

Bereavement refers to all of the physiological, psychological, behavioral and social response patterns displayed by an individual following the loss of a significant person (Augspurger, 1978; Averill, 1968; Silverman & Cooperband, 1975; Vachon, 1976). Bereavement then, is manifested by individual pattern responses to environmental change. This individual response also suggests an interrelationship with others in the environment. To a great extent, human beings come to define themselves and thus give meaning to their lives by interaction with others. It is through this interrelationship with others, in situation, that the individual not only lives the experience, but also comes to know the experience (Parce et al., 1981). Hopson and Adams (1977) agree that events which cause an individual to experience a personal discontinuity in his or her life must result in development of new assumptions or behavior responses because the situation is new and/or the required behavioral adjustments are novel.

This then is the paradox. Bereavement, the evolutionary process that each and every widow must travel alone, has lately been given much attention in the literature. Though the process must be traversed in a very individual way by every woman, the preponderance of bereavement literature has focused on the stages of grief and commonalities of the event rather than the

specific responses experienced by the survivors (Berardo, 1970). Schneider (1987) reports common situations that are faced by widows. He clearly feels that in confronting these commonalities in order to repattern the loss, "there is an integration of energies from within the individual and an openness to energies outside " (p. 235). It is the uniqueness of the voyage that is most helpful to observe.

Nurses' role in this discovery of the lived experience is most appropriate. The Social Policy Statement of the American Nurses' Association (1980) specifies that the phenomena of concern to nurses are those human responses to actual or potential problems. The question, "What's happening here?", is most appropriately answered within the nurse-client interactive process. The ongoing challenge to develop nurses' domain through development of theory must begin from "the thorough description and analysis of nursing phenomena derived from the original source, that is, nurses' and clients' lived experiences in client situations (Munhall & Oiler, 1986, pp. 16-17).

The death and loss of a loved one is a common event in many people's lives. It is, however, a mistake to confuse the universality of the experience with uniqueness of how the event is experienced and lived by the bereaved individual. The bereaved person brings with

her a history of patterning and repatterning both internal and external resources developed over a life time which has given her a sense of her own self definition. These resources include her personal, social and emotional ties with others forming her network of relationships that is her very unique environment. In her process of bereavement, the widow will bring all of these resources to bear in her ongoing patterning of the new life she must face. This patterning, referred to in this study as pattern response, will be a series of choices that lead to further choices in the continuing process in which the widow redefines a way of being in her new and changed environment.

Rogers (1970, 1983) states that in patterning, human beings are involved in an active creative-formative process directed toward self-regulation that includes increasing complexity of organization. Inherent in self-regulation is choice. This choosing is multifaceted in that, "the process (of choosing) may go on even though the individual may not be consciously deliberating. At the same time, human beings have the capacity to knowingly rearrange their environment to exercise choices in fulfilling their potentialities" (Rogers, 1970, p. 65). Choice is an active process, conscious or unconscious, whereby available alternatives are selected.

With this in mind, the focus of this case study will be the individual and unique pattern response of one women as she faces life as a new widow.

Research Question

This present study was undertaken to answer the following question: What is the individual pattern response associated with widowhood?

Purpose

The purpose of this case study is to examine the individual pattern response of one women as she faces life as a new widow. The pattern response will be used to synthesize the essence of the qualitative reality of bereavement for one particular woman. A case study, descriptive qualitative approach was selected for this study not only because there is a noticeable lack of such research in the literature but more importantly because, "Relation with the world is a living impulse, nonirreducible, and understandable only as a unified experience. Coherence in the world is lived. The world as perceived is the first reality" (Merleau-Ponty, 1962, p. 42). It is this perception of the lived reality of bereavement that will give meaning in the context of the experience. The subject will be asked to describe her patterns of experience of bereavement as she is living

it. These patterns will then be analyzed to illuminate the meaning of her bereavement experience.

Phenomenon

Bereavement has been described as being set adrift, deprived of hope in a suddenly alien world (Caine, 1974). A picture is formed of a person without identity, out of touch with the familiar, who has lost the way of life's possibles. "Widows discover all too quickly what being a survivor is all about. Without choosing to do so - and perhaps that is the worst part - widows learn the dreadful lessons of aloneness" (Schiff, 1986, p. 5). This feeling of a lack of control over events is the pivotal aspect of the experience. The fabric of life is torn, made useless and without meaning. Life can no longer be lived according to a long established pattern, one that has worked over time. All of this happens without permission or the possibility of regaining what used to be.

Bereavement has been universally described as a process. It is normal, sequential and incredibly painful but must be undertaken to gain entry back to life. Weizman and Kamm (1985) agree, stating that:

The death of a loved one is a profound experience, disorienting and disturbing to the physical and emotional balance. You may feel confused, dazed and suspended. The loss is felt as if it were an assault, a blow to the self. The onslaught is especially burdensome because

you are called upon to cope with the impact of the death, attend to overwhelming feelings, and somehow continue the tasks of everyday life (p. 37).

The process then, must be an active one; unwelcome, unwanted and without direction. It is a new and foreign land with new language and new rules unknown to the traveler. Most researchers agree that the process begins immediately upon the death of the spouse with an overwhelming sense of shock (Kubler-Ross, 1968; Engel, 1971; Moustakas, 1972; Ramsay, 1977; Bowlby, 1980). These findings, well documented and helpful for study tend to view the experience in a retrospective, quantitative manner. Lindemann (1944) however, seems to take a more experiential view by describing the beginning of the journey as a loss of a pattern of conduct. Though the aim of his research was concerned with the biological manifestations of grief, he seems to have inadvertently uncovered a more lived meaning. Marris (1974) in an attempt to more clearly understand loss as experienced by widows discovered that the predominant theme was a feeling of unreality. Finally, Schlossberg (1981) discovered an awareness of change as the most identifiable manifestation. Dempsy (1981) concurs by saying that the "surviving partner feels diminished as a person, emotionally uprooted and uncertain of the future" (p. 63).

In summary, bereavement is a process that is thrust upon the widow and must be lived in a unique way chosen and known only to the survivor. It is characterized by a disruption of long established patterns formed over time with a partner, leaving the person adrift in a world that is suddenly alien and full of change.

Assumptions

This study is based on the following assumptions:

1. A human being is a unified whole manifesting characteristics that are that are more than an different than the sum of his parts.
2. Human beings and environment are an open system continuously exchanging matter and energy with one another.
3. The innovative wholeness of a human being is reflected in pattern and organization.
4. The experience of bereavement is a common human experience.
5. Human beings give meaning to experience in interrelation with others.
6. Human beings are capable of change and choice.
7. There are like elements in common human experiences.

8. The experience of bereavement results in disruption of familiar patterns and establishment of new patterns.
9. Nursing's central concern is with human beings in their entirety.
10. In client-nurse interaction, the nurse is part of the human being's environment.

Limitations

The limitations of this study are as follows:

1. The sample consists of one woman, widowed for 6 months. The individual pattern response to bereavement will be analyzed from transcription. Thus the themes generated are only generalizable to the one woman.
2. The purpose of a qualitative case study is to generate data that supports theory. These findings will then have to be further examined using other subjects.
3. The quality of the data depends on the subjects verbal skills, degree of articulation and ability to recall and make choices.
4. Due to the emotional significance of the subject matter to be investigated, a trusting interactive relationship between researcher and client is necessary.

5. Participation in the study is voluntary and as such required a preliminary choice to be made by the subject.

Overview of Chapters

This study is presented in six chapters. In Chapter II, a conceptual framework consisting of the interrelationships of the previously identified patterns of organization related to bereavement and nursing theory will be described. In Chapter III, the pertinent literature relating to the phenomenon of bereavement will be reviewed. The methodology of qualitative case study and research design as well as the rationale for data analysis will be explained in Chapter IV. In Chapter V, the data and the results of the data analysis will be presented. Study findings, conclusions, recommendations, and nursing implications will be included in Chapter VI.

CHAPTER II

Conceptual Framework

Introduction

In this chapter the conceptual framework for this study will be described and discussed. Martha Roger's theoretical basis of nursing was utilized as the fundamental underpinning for this framework. The rationale for looking at the loss of a spouse and in particular, bereavement, in light of Roger's theoretical perspective will be explored. The nurse's unique place in being with women as they find their individual pattern response to widowhood will be examined.

Rogers' Theory

Roger's worldview of nursing includes a simultaneity, humanistic paradigm. This paradigm which explains from Roger's perspective, what is important, legitimate and reasonable to the discipline of nursing, holds at its core the basic assumption of unitary human beings. All other assumptions spring from this basic belief. "Man is a unified whole possessing his own integrity and manifesting characteristics that are more than and different from the sum of his parts" (Rogers, 1970, p. 47).

With this as the foundation, Roger's theory proceeds to explore more fully how human beings interact with their world, how they determine and invent their lives and the role of nursing in this evolutionary process. Other concepts fundamental to Roger's theory are: energy field, unidirectional life process, four-dimensionality, continuous man-environment interaction, complementarity, helicy and the particular focus of this study - pattern and organization.

Energy fields are the fundamental units of the universe and therefore of living systems. In a continual state of flux, the energy field varies in intensity, density, and extent. It is this state of continuous motion or change that is the dynamic nature of the energy field. The energy field is four-dimensional, identified by its pattern.

The continuous human being-environment interaction is a major concept of Roger's theory. Roger's (1970) sees each person's environmental field as unique. Environment is all that is external to human beings and includes the personal, social and emotional ties with others forming her unique network of relationships and patterning her individual sense of self-definition. The relationship between the human energy field (the internal environment) and the environmental field (the external environment) is one of mutual exchange and

interaction. The universe is an open system that is inherently negentropic and characterized by continual change. "Human beings and environment, then, are open systems, are infinite, and are integral with each other; that is, they are complimentary, and their boundaries are imaginary and arbitrary" (Sarter, 1988, p. 61).

Fundamental to Roger's theory is the unidirectionality of life. "The life process evolves irreversibly and unidirectionally along the space-time continuum" (Rogers, 1970, p. 59). The space-time concept is understood in relation to the process of change. Becoming takes place in space along the time axis. "The process of life evolves through time and is concomitantly bound in space-time. At any given point in time, a human being is the expression of the totality of events present at that point in time" (Rogers, 1970, p. 57). Human beings are new and different with the passage of time, never to be the same person again.

The principle of hemodynamics including resonance, helicy and complementarity describes a way of perceiving human beings. "Changes in the life process in human beings are predicted to be inseparable from environmental changes and to reflect the mutual and simultaneous interaction between the two at any given point in space-time" (Rogers, 1970, p. 102). Changes are assumed to be irreversible and nonrepeatable and proceed by the

continuous repatterning of both human beings and their environment.

Interrelationship of Concepts

These concepts are fundamental to the understanding of how unitary human beings (widow) face the loss of a spouse (environmental energy exchange) and actively repattern and reorganize (bereavement). Rogers (1970) feels that change is a unidirectional, continuous repatterning of both human and environmental fields that is innovative and, further, depends on the "infinite now" of the individual. Others are in agreement with this activist, life/reality forming concept of man. Havighurst (1969) shares this view by pointing out that "man is a self-propelling individual who manipulates the environment to attain his goals." Further, he invents his future self, just as he recreates or 'reinvents' his past self (p. 123). It is clear that inherent in these ideas is the belief that human beings have the potential for growth through choice and change. Rogers' conceptualization of man, health, and nursing as well as the postulate of pattern and organization in relation to the widow facing the event of the loss of a spouse and the pattern response will be explored in the following section.

Human Beings

As stated earlier, Rogers (1977), has defined human beings as a unified whole possessing their own integrity and manifesting characteristics that are more and different from the sum of the parts. Key assumptions related to this concept identified by Rogers (1977) are:

1. Human beings and the environment are constantly exchanging energy.
2. The life process evolves irreversibly and unidirectionally along the space-time continuum.
3. Pattern and organization identify a human being and reflect his innovative wholeness.
4. Human beings are characterized by the capacity for abstraction and imagery, language and thought, sensation and emotion and the ability to choose.
5. Change is irreversible and nonrepeatable and proceeds by the continuous repatterning of both human beings and their environment.

Women who face the loss of a spouse (the environmental energy exchange of bereavement) must be capable of change. Parkes (1971) speaks to this element of being human by saying, "the way in which the bereaved individual copes with the process of change and restores a state of balance and predictability will depend on the

environmental and personal resources that can be brought to bear on the problem" (p. 217). It is this ongoing, flowing, dynamic interchange of energy with the environment during bereavement that allows the widow to maintain her personal integrity. The implication of this statement is that due to this open interaction, human beings are active interactionists with the ability to learn and predict outcomes. Antonovsky (1979) states that the two characteristics that are the strongest indicators of effective bereavement are flexibility and farsightedness.

The component of human beings that points to the life process as being unidirectional and irreversible holds special meaning for the bereaved. Life, for the widow, because of its unidirectional flow will never be the same. Carey (1979) found that the two prominent problems anticipated by persons facing the death of a spouse were the difficulty in accepting the reality of the situation and fear of what life would be like after the death. Rogers, however, views human beings as optimistic and forward looking. "The life process is a becoming" (Rogers, 1970, p. 55). Widows, even though faced with one of life's most difficult challenges, for the most part, continue to search for the future path of life (Parkes, 1971; Hauser, 1983; Martuccio, 1985; Olson & Hanover, 1985).

Human beings are sentient: They think, feel and imagine. These are the special qualities that speak to the humanity of our being. As discussed earlier, a large part of the process of bereavement includes wondering about the future of unknowns. Because widows are sentient, they are capable of experiencing great pain, both physical and emotional. Breckenridge et al. (1986) found that bereaved individuals were significantly more likely to report heightened dysphoria, dissatisfaction, and somatic disturbances typical of depression. Loneliness, the need to be needed by someone, was identified as the main problem experienced by over half of the widows surveyed by Carey (1979).

Pattern and Organization

Pattern Response

Human beings seek to organize the world of their experience and to make sense of it (Rogers, 1970). This organizing then, is the culmination of the essence of being. The assumptions about human beings that have been previously discussed; unidirectional/irreversible life process, human being/environment energy exchange, and sentience must be present all at once, all the time, for human beings to reach this pinnacle of experience; the ability to make change through active choice. "The patterning of the human field is more than as assembling

and reassembling of parts directed toward automatic self-regulatory acts. Man knowingly makes choices" (Rogers, 1970, p. 71). Barrett and Schneweis (1980) support this with findings of their study showing that rather than adjustment to widowhood (bereavement) transpiring through successive and predictable stages, each widow chose her own pattern of coping with the demands that bereavement has placed upon her.

In this study the individual pattern response of one woman who is experiencing bereavement will be examined. Rogers (1970, 1980) feels that the potential for conscious involvement in the self-regulatory process (of choice) is little understood. And further, "even less understood is the evolutionary creativity that is going on continuously and that is postulated to express itself in identifiable, growing complexity of organization and patterning in man and environment" (p. 71).

In examining this process, it is important to look at the commonly identified changes in the environment that most newly widowed women must face. The first of these are the economic difficulties associated with being suddenly alone. Berardo (1968), Philblad, Adams & Rosencrans (1972), Lopata (1979), Morgan (1986), and O'Bryant and Morgan (1989) among others have examined this aspect of widowhood. Earlier studies found that the median income for older widows was less than half of

that for older marrieds. In addition, fully one-half of all widows lived at or below the income adequacy level determined by the Social Security Administration.

O'Bryant and Morgan (1989) conducted a study concerned with the lack of financial experience on the part of the new widow and the effect of this on well being. These researchers sought information from 300 recently widowed women concerning their perception of their financial situation rather than actual income. The respondents were asked to choose among describing their financial situation as being, the same, a little worse, and much worse. The response of 44% was "the same", 31% reported "a little worse", and 14% saw their situation as "much worse". These results are certainly valuable in helping to understand the perception of the financial situation on the part of the widowed.

Another glaring change accompanying widowhood, again well documented in the literature, is the physical symptoms which surround the period following the death of a spouse. Berardo (1968), Parkes, Benjamin and Fitzgerald (1970), Gove (1973), Strobe and Strobe (1987), Gass (1987), and Goldberg, Comstock and Harlow (1988) as well as others, have found that death rates, chronic, physical and mental illnesses are higher among the widowed than their married counterparts.

Arling (1976), Kivett (1978), Lopata (1979), Weizman and Kamm (1985), and Whelan (1985) as well as others mention loneliness as a universal response to widowhood. Copel (1988) describes loneliness as, "an emotional state in which an individual is aware of the feeling of being apart from another or others, along with a vague need for individuals" (p. 15). Moustakas (1977) sees this loneliness aspect of bereavement as existential encounters with the self.

The predictors of successful adaptation to widowhood, identified through quantitative studies, should now be examined in light of Roger's assumptions. These include gender (role change expectations), age, forewarning of spouse's death and perceived social support. Caine (1974) feels that the impact of widowhood increases when there is a rigidity in proscribed societal spousal roles that involve gender. Lopata (1969), Olson and Hanover (1985), Rigdon, Clayton and Dimond (1987), and Morgan (1989) view role change expectations from the perspective of both the widow and the surrounding environment. Widows continue to see themselves as married people while society sees them as single. This plays a large part in the individual pattern responses of the widow including, among others, work roles, family roles and roles involving personal identity.

With regard to age, Lopata (1978) and Ball (1977), found that young widows had a much more difficult time with adjustment to their new circumstances. Another predictor of successful assimilation of the event, forewarning of the spouse's death, produced different findings also based on age. Glick, Weiss, and Parkes (1974) found that for women under the age of 45 years, the sudden death of a spouse (defined as an illness of less than two weeks duration with a terminal decline of less than three days) was associated with a longer time to complete grief work. Schlossberg (1984) agrees by noting that most adults have built-in social clocks by which they judge whether they are "on time" or "off time" with respect to life events. It can be postulated that the living of life which brings more complexity and diversity enables the older widow to have had the experience of previous repatterning therefore enabling her to be more able to act on her environment with increasing ease. Gass (1988) found that women whose husband's had died from a chronic illness rather than suddenly, felt that they had more opportunity for anticipatory grieving which they found helpful and reduced stress.

Finally, social support, perceived by the widow as having someone with whom to share feelings as a means of overcoming loneliness, is the most important predictor

of successful bereavement (Lopata, 1979; Madison, 1968, Capal, 1988).

These findings should be viewed in light of the continuous and active patterning and repatterning on the part of all human beings. This patterning is based most assuredly on the experience of living life itself. "All characteristics and behaviors of any field are manifestations of pattern, and it is these manifestations that are changing in the process of evolution" (Sarter, 1988, p. 61). It is the ongoing choosing and changing that occurs over the span of life (age) together with the constant exchange of energy with the environment (role expectations and social support) in light of the search for meaning of life (forewarning of death) that better explains successful bereavement.

Roger's theory is one of great optimism. In the face of sorrow, human beings can imagine a time of future joy. Widows can find hope in hopelessness as well as peace in time of turmoil. "Man's consciousness and creativity are integral dimensions of man's wholeness" (Sarter, 1988, p. 60). The ability of human beings to have a future view is found in the continuing emergence of new patterns and ways of being. These unique pattern responses in one widow will be examined.

Health

Health is not specifically defined by Rogers. This is consistent with her theory in that she feels that human beings are the authors of their lives and, as such, are the only ones qualified to define their personal sense of health. Further, health patternings are influenced by human values and choices. Health and illness are not at opposite ends of a continuum but exist on the same unidirectional, irreversible space-time axis. Fitzpatrick (1988) proposes that the "meaningfulness that one attaches to life is directly related to health" (p. 14). Health, then, is an active, ongoing process, a process toward wellness. People are responsible for choosing health over illness by creating a state of wellness; synchrony with the environment. "Maintenance and promotion of health are a nation's first line of defense in building a healthy society" (Rogers, 1970, p. 122). Clearly, Rogers believes that health is an important human need. In this study, health will be seen as the widow's active interaction with her environment to repattern and reorganize her life during bereavement to create a new reality and sense of being.

Nursing

"The focus of nursing is human beings" (Rogers, 1970, p. 82). This statement, deceptively simple, sums up the nurses' reason for being. The eloquence of the statement implies much more. Nursing can not exist in a vacuum. Nursing only happens when there is active interaction with others, in situation, seeking to pattern their lives. Rogers (1970) further elaborates that the goal of the professional nurse is to promote symphonic interaction between man and environment, to strengthen the coherence and integrity of the human field and to direct and redirect patterning of the human and environmental fields for maximum health potential. This is the art of the humanistic science of nursing.

Implications for Nursing

The study of the loss of a spouse and the resulting bereavement has several implications for nursing practice. Losses, a consequence of living, become more numerous as we age. Loss cannot be "fixed"; it must be lived. The nurse, whose mission is to attend to the wholeness of man and his integrity seems most suited to intervene at this time (Rogers, 1970). The humanistic science of nursing seeks to describe, explain and predict phenomena central to its concern. This is the key.

The central phenomenon of nursing is not medicine, or psychology, or sociology; it is nursing. It may be helpful to look at the literature to begin to have a better grasp of this unique phenomenon. Carey (1979) found that when widowed persons were asked to respond to the question, "Who helped you most?" at the time of the illness and ensuing death of a spouse, the overwhelming majority named - nurses. The reasons are enlightening.

The nurses were praised for showing concern for the patient and/or relatives, including physical touch and listening to their concerns. In addition, they were grateful for information regarding tests and equipment. On quick examination, these responses seem mutually exclusive. A closer look, however, may get to the heart of the matter. The prospective widows were constantly exchanging energy with the environment and in turn repatterning and reorganizing their worldview. These seemingly diverse interventions on the part of the nurses served to clarify, organize and illuminate the quickly changing environment of the soon to be widow.

Rogers (1970) has said that prediction is the key to knowledgeable intervention. This is not to be confused with prediction of outcomes but prediction of process: a process that is individual, unique and the special concern and domain of nursing. It is the patterns and rhythms of the interactive nurse-client relation, in

situation, that will encourage us to think anew our particular place in health care. In short, nurses do not promise to cure pain; nurses promise to be with human beings as they experience and try to find meaning in their pain.

This study proposes to describe one woman's journey through the process of bereavement by examining her particular pattern response to examine her individual sense of health. The value of this and similar studies will be to reinforce the understanding that human beings remain their own individual and unique selves with the ability to choose and change. The accompanying validation of theory will be of universal benefit to the domain of nursing.

Summary

The nurse in synchrony with the widow, seeks to participate in a caring, therapeutic way to traverse the process of bereavement in order that the widow may reach her highest individual health potential. The nurse will accomplish this by recognizing that the widow is the author of her own destiny, capable of change and choice. Roger's theory provides the nurse with the theoretical basis for understanding human beings and their ability to determine their own future. "We don't run other people. We have the capacity to participate knowingly in

the process of change, but we are just that - participants" (p. 36). Rather than directing care, the nurse will recognize that the real focus of nursing is empowerment. The nurse, appropriately brings to this interactive relationship the ability to validate the widow's perception of her environment of which the nurse is a part. With this added information, the widow will repattern her new way of being toward the goal of wellness. Therefore, the widow (human being) in synchrony with the nurse, actively acts on her environment (loss of a spouse) by repatterning and reorganizing (bereavement) to attain and maintain maximal health.

In the next chapter, the review of the literature relevant to this study will be presented. Included will be a discussion of the experience of bereavement from both a qualitative and quantitative perspective. Personal experience from autobiography will be addressed. Additionally, literature which contributes to an understanding of the nurses' role in interaction with the bereaved person will be reviewed.

CHAPTER III

Review of the Literature

Introduction

The focus of this chapter is the significant literature and research surrounding the phenomenon of bereavement. Historically important literature concerned with the changing attitudes toward the process as well as conceptualization of the phenomenon from the perspective of several authors will be presented. The environment of bereavement, including factors affecting bereavement, identified in the literature will be addressed. Autobiographical writings of a widow found in the popular culture will be included. Finally, nurses' contribution, including interventions, will be included.

Bereavement

For those who have studied bereavement, the concept has been a controversial one. The controversy has been linked to various researcher's ongoing disagreements as to whether or not grief, the work process included in bereavement, is a healthy one or intrinsically pathological. Historically, bereavement was seen as a

maladaptive condition in which the bereaved had few choices and was therefore at the mercy of events. Freud (1915) was the first significant figure to attempt to discuss the phenomenon. Bereavement, from his perspective, was a gradual withdrawal of energy that tied the bereaved individual to the lost object (the deceased). Clearly, he viewed bereavement from a pathological perspective.

In the early nineteen thirties, Eliot (1930, 1932), proposed the next significant look at the concept. His findings appear to be focused on the isolated event alone, and the crisis nature of the experience of bereavement was emphasized. The great value of his work was that he saw the crisis experience not only involving the bereaved individual but also the families of the deceased. He suggested that survivors experienced a sense of abandonment, shock and denial, sometimes anger, and always intense and persistent longing for the one who has died. However, his work, because of the preoccupation with the event alone, continued to view bereavement as an innately debilitating experience.

In the classic study of the Coconut Grove fire in Boston, Lindemann (1944) attempted to describe normal grief. In doing so, his major contribution to the field of study was to begin to view grief as a process. Though not specifically addressing bereavement, he pos-

tulated that survivors eventually "recover" from the event, implying that the passage of time was a variable. The other glaring implication is, of course, that the term "recovery" continues to suggest a disease state that only requires "getting over" in order to be well, and live normally once again. Current researchers also disagree with Lindemann's findings that the grief process can be resolved in as little as several weeks.

Fulconer (1942) also viewed bereavement as a process. His major contribution to the field was to suggest that recovery occurs in stages. The individual establishes a new and stable way of life by going through stages beginning with shock and ending with the stage of repatterning. His findings are most significant in that the term "recovery" continues to suggest a pathological state while "repatterning" introduces the new perspective that the bereaved have control over outcomes in the process.

Subsequent researchers agree that bereavement is a process that includes stages in which the bereaved has choices and control. The most significant development has been that the process is now viewed as "normal" rather than pathological, and that pathology appears only when the bereaved's attempts at progression through the stages is thwarted. Parkes (1965) described normal grief as a stereotyped set of psychological reactions in

which the three stages of shock, despair, and recovery can be delineated. Glick et al. (1974) described the normal grief process in three phases including; the initial response phase beginning at the time of death, the intermediate phase beginning several weeks after the funeral and ending at approximately one year, and the recovery phase occurring at the beginning of the second year. Averill (1968) defined bereavement behavior as the total response pattern, psychological and physiological, displayed by an individual following the loss of a significant object, usually a loved one. He, like his fellow researchers of this era, continued to see the process as a series of well defined, discrete, and predictable stages that had to be accomplished by all bereaved regardless of individual differences.

Current researchers have studied bereavement from a different and more individualistic perspective. Kavanaugh (1972) and Kubler-Ross (1968), early proponents of the grief-stage theory, have subsequently changed their view. They have come to recognize that the stages are not separate entities, but subsume one another or blend dynamically. These researchers also conclude that the stages are not necessarily successive, that it is not necessary to experience every stage, the intensity and duration of any one stage may vary idiosyncratically among those who grieve, and, finally,

there is little empirical evidence to substantiate the theory of stages. Bugen (1977) also postulates that the "stage" concepts of grieving contain a number of theoretical weaknesses and inconsistencies. His thesis holds that, "in the strictest sense, (stages) do not exist in the grieving process. Instead it is proposed that the existence of a 'variety of emotional states' is the essential point, and 'not' the need to order them" (p. 197). Finally, Norris and Murrell (1988) concur by stating that, "we prefer to think of grief as 'psychological work' that is the normal process of coming to terms with the meaning of the event" (p. 606). Rigdon, Clayton and Dimond (1987) found that grief is a very individual experience and specific to each person who is experiencing the process. Finally, Murphy (1988) concurs by stating that, "it (bereavement) cannot be explained by the commonly accepted paradigm of bereavement recovery-denial, anger, bargaining, depression, and acceptance, suggesting that loss responses are distinct and time limited". "Rather, the bereavement transition is a lengthy process that is influenced by numerous events and personal and social factors."

It is clear from the latest work, that the focus of inquiry has evolved from studying the event to studying the person experiencing the event. It is the uniqueness

of the repatterning choices made by the bereaved individual that are most significant and consequently deserve more study.

The Environment of Bereavement

Several specific factors have been isolated in the literature that contribute to the repatterning process during bereavement. These include; role change expectations, financial status, social support (including loneliness), and forewarning of the spouse's death. In addition, there appears to be an increase in untoward physical and mental symptomology experiences by the widow following the death of a spouse. In the following section, each of these factors including pertinent related research will be addressed.

Role Change Expectations

Brock and O'Sullivan (1985) have looked at the older woman in relation to the traditional and often sexist as well as ageist view of their proscribed roles in the larger society. Their findings point out that the strong focus on primarily "helper" roles assumed by women including marriage, homemaker, and parent have left them uniquely unprepared to cope with the requirements of the role change brought about by widowhood. Women have been forced by social sanction and tradition to forestall any primary thought of their own needs.

Instead, over a lifetime, they shape their attitudes, behavior, values, status, and societal integration dependent on those of others; mainly husband and, as necessary, children. With the event of widowhood, women are left, as a result, singularly without direction. They are asked, often for the first time in their lives, to think of themselves first. "These women have little to look forward to, for our society's customs, values, and mores do not sanction the role of widow" (p. 6). Weizman and Kamm (1985) concur that women may be dependent on their role as mate for their complete identity and will experience the loss of self in addition to the loss of their husband.

In 1985, Brock and O'Sullivan studied a population of widows (N=92) to determine if there is a significant relationship of between psychological well-being and quality of lifestyle changes since widowhood, happiness during marriage, social participation, and identity independent of wifehood. Subjects were limited to women one year after the death of their spouse. The researchers found that lifestyle pre-widowhood (self governance that was not contingent or reliant on spouse), functional health status (subject's preparation of her health limits or constraints on her social functioning), and social readjustment (few life stressors/changes) together significantly predict psychological

well-being (R=352). Brock (1984) conducted a similar study examining 273 widows. Subjects were examined on their degree of psychological well being after the spouses death. A significant variable related to positive well being was found to be identity independent of wifehood.

Perceived Social Support/Social Isolation

Kahn (1979) postulated that social support as perceived by the widow was comprised of three key elements. These include; expression of positive feeling, acceptance of another's behaviors, perceptions or expressed views, and giving of symbolic or material aid. If widows are unable to obtain the support they feel they need, they will come to experience the subjective phenomenon of loneliness. Gubrium (1974) supports this premise by arguing that it may be the discontinuity in social interaction that widows experience because of role and interpersonal losses that contribute to their sense of relative isolation and accounts for their loneliness. Simply being a widow has been found to be a significant factor in explaining loneliness (Lopata, 1969; Shanan & Sussman, 1981; Weiss, 1973). Arling (1976) found that when widows engaged in relationships that required reciprocal exchange (social interaction) loneliness was mitigated. Further, the perception of

personal control over one's social interactions and environment may be an important variable in staving off loneliness (Peplau et al., 1982).

The problem of how to provide this needed support is a complex one. It seems that bereaved widows, though desperately needing support at this time, have difficulty asking for it, and those would-be supporters are unaware of what is needed and how to give it.

Several factors play a part in this confusion. The emotional display as well as the response to grief is a learned one. Averill (1968) found that grief may be displayed in various ways that could include weeping, stoicism, or laughter or any combination of the same. Warner (1987) supports this finding by stating that emotional display is a learned response that may not be representative of the inherent feelings of grief. If the widow's social network (environment) has taught her, over a lifetime, a pattern of response that precludes an external show of emotion, she may not display grief in ways expected by the larger population and in turn she may not receive the support she so desperately needs at this time.

Glick, et al. (1974) noted that the supporters of the bereaved may also be, in a sense, responding to a learned way of behaving in attempting to meet the widow's needs. A well defined hierarchy predominates.

Devoted friends assist the widow but prefer to be "asked". Family is more helpful than friends and female kin more helpful than their male counterparts.

In a 1987 study conducted by Warner, the relationship between perceived social support and the grief profiles of widows and widowers during the first year of bereavement was examined. The Grief Experience Inventory (representing despair, anger, guilt, social isolation, locus of control, rumination, depersonalization, somatization, and death anxiety) demonstrated a linear relationship with the social support variables (Total Functional, Total Network and Total Loss) as measured by Norbeck's Social Support Questionnaire. Significant relationships were found between the Total Functional variable (the total score of Aid, Affect and Affirmation scales of Norbeck's Social Support Questionnaire) and the somatization scale ($r = .21, p < .05$) and with the loss of control ($r = .24, p < .05$) scale from the Grief Experience Inventory. The relationship was also found between the Total Functional variable (a cumulative score for the number in the support system, the length of time known, and the frequency of contact) with the Somatization scale ($r = .21, p < .05$) and the loss of Control ($r = .24, p < .05$) scale of the Grief Inventory.

The importance of these findings is clear. If the support system is numerous enough to provide variety,

has a sense of history with the bereaved and is in contact often enough, the widow feels more comfortable going through the work of bereavement including crying (loss of control) and reminiscence without "wearing out" her support system. The normal somatization response, postulated by Parkes (1972), involving sympathetic stimulation and parasympathetic inhibition, can be experienced and voiced without fear of dismissal or rejection.

Economic Factors

Berardo (1968) and Philblad, Adams and Rosencranz (1972) among others, have found that the median income for widows was less than half of that of their married counterparts. Balkwell (1981) points out that the sudden decrease in economic level brought about by widowhood may have as great an impact on the bereaved as longstanding poverty does on others. Lewis and Berns (1975) report an average reduction of 44% from previous income levels was found to occur in the first two years of widowhood. This drop in income necessitated 6 out of 10 widows to alter their former standard of living. Poncar (1989) concurs by stating that the new widow is often faced with the financial reality of needing to uproot herself from her home due to financial pressures. O'Bryant (1985) adds another interesting finding. If the mortgage is paid on the residence that the widow

maintained with her spouse she may, conversely, be trapped in her home for economic reasons since that may be the least expensive housing available to her. In either case, circumstances seemingly beyond the control of the widow may be dominant at this time.

Barry and Fleming (1988) state that the financial burden is often magnified due to a lack of marketable skills if the need arises to enter or reenter the job market. Though 25% of new widows experience no financial concerns, the remaining 75% are required to make functional changes in the ways they carry out life activities due to reduced financial and socioeconomic status.

O'Bryant and Morgan (1989) report that the adjustment to widowhood may be affected by a lack of financial experience or knowledge. Three hundred widowed women aged 60 years and older were studied to determine the effects of financial experience prior to widowhood and financial planning prior to the death of the spouse on well being in early widowhood (12 to 22 months of the death). It was found that preparation was positively correlated with self perceived well being while prior financial experience had no significant effect. In addition, these researchers looked at the widow's self-perception of the "ability to get along" on their income after a spouse's death. They found that 12% reported,

"fairly well off"; 68% reported, "comfortable"; and 20% reported, "rather short" or "really restricted". Empirically, those widows reporting they were "comfortable" had yearly incomes ranging from under \$3,600 to over \$24,000. Clearly, the widow's perception of her financial situation and not necessarily the actual monies available to contribute to her personal sense of well being and control.

In summary, there are various outcomes in widowhood directly related to economic factors. There may be an actual decrease in available monies as a result of the spouse's death. This fact of limited funds may dictate how and where the widow must live her new life. The role of financial manager, if formerly held by the husband, may seem overwhelming or simply not acceptable to the widow's sense of herself. Any one of these factors or a combination thereof may increase the potential for decreased sense of well being by seeming to limit her choices.

Forewarning of Spouses Death

Most of the work surrounding the effects of the unexpectedness of the death as a factor in bereavement have centered on the results of natural disasters. Several interesting findings have been noted. Murphy (1988) found that bereavement resulting from natural

disasters could be expected to be intense and prolonged. Other findings include feelings of helplessness and hostility on the part of the bereaved (Bugen, 1977). Weisman (1973) discovered that the sudden death may be viewed by the widow as having been preventable. Murphy (1984) and Parkes and Weiss (1983) report conflicting findings suggesting that various factors including role change, financial loss, and concurrent stressors are positively correlated with lack of forewarning of death as a predictor of a prolonging of the bereavement process. Murphy (1988) in a subsequent study of mental distress and recovery in a bereavement sample 3 years after an untimely death found that self perceived mental distress associated with an untimely death bereavement persisted 3 years following a natural disaster. This mental distress accounted for 42% of the unique variance; other variables (age, gender, education, social support and self-efficacy accounted for only 4% of additional variance.

Gass (1988) studied the relationship between type of death and appraisal, coping and resources on the part of the widow. She found that widows reported no significant differences in appraisal, ways of coping, coping strength or resource strength. However, she found that women whose husbands died from a chronic illness rather than from sudden death reported receiving more support

from religious beliefs, more helpful information on grieving and widowhood from friends or others, and more opportunity for anticipatory grieving.

Carey (1979-1980) conducted a qualitative study that included 78 widows and 41 widowers looking at the adjustment of the widowed during the first year. Participants were asked to describe the main problems faced before and after the death of their spouses. Significant findings included the fact that widows who had forewarning about the death of their spouse (the critical time being two weeks) reported a significantly higher level of positive adjustment.

Reported Physical and Mental Symptoms

Several authors including Berardo (1968), Glick, Weiss and Parkes (1974), Gass (1987), and Poncar (1989) reported a physiological response symptoms associated with bereavement. These response symptoms include self-reported gastrointestinal disturbances, sleep pattern changes, respiratory changes and loss of appetite. Psychologically significant symptoms were also reported more frequently. These include restlessness, anxiety, forgetfulness or confusion and inability to concentrate (Ferraro, 1985).

Clayton, Desmarais and Winokur (1968) in looking at the symptomology surrounding the death of a spouse

reported three symptoms occurring in more than one-half of the 48 subjects examined. These findings, termed "normal bereavement symptoms", were depressed mood, sleep disturbance, and crying. Two to four months later, 81% reported a decrease in their symptoms.

In another study conducted by Valanis and Yeaworth (1982), the physical and mental symptomology of 60 widowed persons was examined from both a subjective and objective perspective. Sections of the Duke University Older Americans' Resources and Services Multidimensional Functional Assessment Questionnaire (OARS) served as the basic data collection instrument. Participants in the study were asked to respond to questions concerning feelings of overall health status. At the same time, clinicians were asked to rate subjects on the same criteria. Subjective ratings of physical health were significantly higher than the objective ratings (-0.69 , $p < .001$). Generally, subjective and objective ratings of mental health did not differ appreciably (-0.45 , $p < .001$). It can be postulated that in commenting on their general feelings of health they were unconsciously reporting their feelings about the more wholistic concept of wellness.

Parkes (1975) studied the predictors of deterioration of physical and mental health (sic) in the conjugally bereaved. In this longitudinal study, 68 bereaved

persons were interviewed shortly after bereavement and, subsequently, a year later. The findings that were significant demonstrated that low socio-economic status ($r=.44$, $p. < 0.01$) as well as lack of preparation for loss ($r=.29$, $p. < 0.05$) correlated with reported increase in untoward physical and mental symptoms.

In summary, the specific factors that have been isolated in the literature that contribute to the repatterning process surrounding bereavement were discussed in the preceding section. These factors make up the environment of bereavement and must be faced by the widow in her own unique way as she lives the process.

The Role of Nursing

Death as a natural life experience, formerly witnessed and attended primarily by family, has been gradually but almost entirely moved both by medical advancement and passive societal sanction out of the home and into the acute care setting. Though there is an organized effort on the part of some, through the hospice movement, to reclaim ownership of the experience, medical management remains the dominant and directing force. With this in mind, the role of the nurse in assisting both patients with dying and survivors with bereavement becomes obvious. The nurse is the one professional with the knowledge, expertise and wholistic view that enables

her to better assist those involved in the experience of death and bereavement. Being in constant attendance and seen by the family as helper, the nurse is the most logical person to assist in this complex process.

Freihofer and Felton (1976) examined nursing behaviors in bereavement. Twenty-five pairs of terminally ill patients and their significant others were looked at to discover the nursing actions and behaviors that offered the greatest support, comfort, and ease of suffering to the loved ones. A Q-sort methodology was used asking loved ones to rank 88 most-desired behaviors, pertaining to the patient and the most-desired behaviors pertaining to the loved ones. Nursing behaviors were ordered under a three-tier classification system. These included; behaviors that promote the dying patient's comfort and hygiene, behaviors that indicate understanding of the emotional needs of the dying patient, and, finally, behaviors that indicate understanding of the impact on the bereaved of grief, grieving, and loss.

The findings are very meaningful in guiding the interventions of the nurse. Rather than selecting behaviors that would be principally directed towards themselves, the loved ones chose interventions directed toward comfort, support, and easing the suffering of the patient. The one striking exception is the desire to have "all of their questions answered honestly." In the

most clear terms, loved ones indicated that the current work of bereavement and what would bring them the most personal satisfaction, while the patient remained alive, was the secure knowledge that all aspects of care, physical and emotional, were being attended to for their loved ones.

Personal Experience

In her book Widow, Lynn Caine (1974) speaks eloquently about her experience of bereavement. She confirms that bereavement is a process that must be faced on a daily basis. "There was a transition period when every morning I had to grapple with the fact of Martin's death all over again. Every morning it was new. A raw wound that took a long time to heal over (p. 79)." In addition, the process is unique to each bereaved person. "I know what it is (bereavement), but do not know for you, because each of us has our own way to go (p. 84)."

Throughout the telling of her story, Caine reiterates her need for support from the people around her. This began immediately after her husband's death at a gathering following his memorial service. "I think it was the best thing that could have happened. I needed people around. I needed to talk. I wasn't ready to mourn. This was a terrible moment and I needed a bridge of people to help me cross it (p. 77)".

Caine experienced a sense of changing role even before the death of her husband. "And as Martin came closer to death, I hated the thought that men would no longer see me in sexual terms, but only as a widow (p. 47)". Later, after her husband's death she imagines herself like a goose who has lost its mate and becomes shy, reluctant to approach others and develops a tendency to panic.

I was unpleasantly startled. I didn't want to have that much in common with a goose. One sentence struck me on a particularly raw nerve: 'The lonely goose rapidly sinks to the lowest step in the ranking order.' That was exactly where I was. I had become a second-class citizen, a member of the invisible minority of widows. And like all members of minority groups, I was deprived-sexually, emotionally, socially and financially. My very identity was shaky. At times I felt practically non-existent (p. 147-148).

Caine reports experiencing both physical and psychological symptoms during her bereavement. She describes this happening when, what she terms the protective fog of numbness, dissipated. It was then that she was, "almost immobilized by the stomach-wrenching, head-splitting pain of realizing that I was alone (p. 97)". Further, she experienced, "a sense of Martin, of some quality of Martin that had filtered into me. A very real feeling that part of me was Martin (p. 102)".

Finances were Caine's biggest worry. Before her husband's death she became fearful. "I had no idea what

our situation was . . . That was the beginning of the financial anxieties that still haunt me (p. 28)". After her husband's death, she feels she went back to work before she should have out of fear of losing her job. "Nothing had been said, done or intimated that I could have interpreted as a threat to my job security. No, this was just part and parcel of the financial insecurities - some real, some imagined - that bedeviled me (p. 78)".

It is clear that changing perspectives was part of the process of bereavement for Caine. Among other things, she came to see her major concern, finances, in more realistic terms.

Most of my craziness involved money and security. I was terrified because Martin had left no insurance and the money had stopped. This was realistic enough. A widow with two children has to be concerned with money. What was unrealistic was that I never stopped to consider the fact that I was still earning a decent salary and that I was now getting Social Security payments for the children. We were certainly not going to starve. But somehow, after Martin died I was possessed with the idea that I was penniless (p. 100).

Finally, Caine comes through the process with a new understanding of herself and her place in the world.

Acceptance finally comes. And with it comes peace. Today I carry the scars of my bitter grief. In a way I look upon them as battle stripes, marks of a fight to attain an identity of my own. I owe the person I am today to Martin's death. If he had not died, I am sure I would have lived happily ever after as a twentieth-century child wife never knowing

what I was missing. But today I am someone else. I am stronger, more independent. A different perspective. And I am a different woman. And the next time I love, if I ever do, it will be a different man, a different love. Frightening. But so is life. And wonderful (p. 222).

Selected Nursing Research

While most of the literature surrounding bereavement has focused on the general factors associated with the process, nurse researchers are beginning to look at the individual differences that women encounter coping with the loss of a spouse and the necessity of repatterning a new life. Nurse researchers have based their studies on the assumption that it is usually the professional nurse who will most likely encounter the bereaved person especially if she seeks treatment from a physician for untoward physical or psychological symptoms (Brock, 1984). The major focus of this body of research has been to identify facilitative interventions that assist the widow in reorganizing and reintegrating her sense of self.

Remondet and Hansson (1987) developed a short-form instrument that was administered to persons experiencing extended psychological distress associated with widowhood, extrapolated from other tools, entitled the Grief Resolution Index. The items focused on behaviors indicative of short and long term grief resolution and

successful social transition. The four measures from which items were secured, focusing on short-term adjustment, included: the Survival Expectation Index, indicating emotional and financial factors; the Fear Index, examining fear for personal safety, health, loss of independence and being alone; the Preparation Index, measuring feelings of preparedness for life after the event of death; and the Desperation Index, indicating the widow's feelings of anger, resentment and hostility. Long-term adjustment was measured using items secured from four scales. These included the Depression Inventory, a short form of the Beck Depression Scale; the Anxiety Index, examining the global anxiety level; the Adjustment to Widowhood Index, looking at continued feelings of control of life; and the Health Index, indicating frequency of illness and self-estimate of overall health.

The study consisted of seventy-five widowed, non - remarried women, ranging in age from 60 to 90 years with a median length of widowhood of 10.3 years. Results indicated that persons who felt that they had successfully resolved their grief reported that they had attempted to prepare for the upcoming death of their spouse. Those widows also experienced less fear and desperation and experienced fewer physical and psychological symptoms. In addition, controlling for the

varying lengths of widowhood did not substantially alter the correlations. Most certainly the findings indicate appropriate intervention opportunities for the nurse that begin by viewing each widow and her experience as unique.

Copel (1988) has examined the general phenomenon of loneliness, described as "an emotional state in which an individual is aware of the feeling of being apart from another or others, along with the experience of a vague need for individuals" (p. 14). Using a framework based on the interaction/interpersonal relationship theories developed by Harry Stack Sullivan and Hildegard Peplau, Copel developed a theoretical framework from which to study the phenomenon of loneliness. Copel viewed the nurse, because of her strategic position, in situation, with the client, as the most appropriate health care provider to assist the client in repatterning and reorganization. Logically, she felt that in order to assist those experiencing loneliness, the nurse must be able to recognize the manifestations and effects of bereavement. To this end, Copel developed The Arc of Loneliness, a framework to conceptualize the relational properties of loneliness identified in Sullivan's and Peplau's interpersonal frameworks.

Based on the premise that every person has an innate longing for interpersonal intimacy, the framework

suggests that when individuals are prevented from making human connection, tension will develop. If not overcome, this tension will lead to loneliness. Copel further maintains that grief, the process of responding to a loss, can generate tension that is overwhelming to the individual. Because of its debilitating nature, grief must be shared and supported by others in order to overcome the tension.

Clearly, this framework is a tool that can assist the nurse in assessing the person's risk for loneliness, one of the identified factors in bereavement. In addition, interventions can be directed toward facilitating effective coping with the unique stressors identified by the particular client.

Gass (1987) examined the coping strategies of widows. Included in the study were 100 non-remarried, English speaking, non-institutionalized widows aged 65-85 years whose spouse had died between 1 and 12 months prior to the interview. Folkman and Lazarus' Ways of Coping Checklist was used to identify the methods used by widows in coping with bereavement. The purpose of the study was to identify helpful coping strategies with the goal of future intervention by health care workers (primarily nurses) in assisting and enhancing effective coping efforts.

Participants identified several helpful coping strategies. These included: keeping busy (79%), participation in social groups (10%), learning new skills (no data reported), review of the death (64%), religion and prayers (89%), talking with the diseased spouse (17%) and recalling happy memories (no data reported). Less helpful strategies included: taking medications or alcohol (16%), blaming oneself (17%), bargaining or compromising (22%), sleeping more (11%), avoiding (12%), getting mad at people (16%), making promises to oneself (10%), and using fantasy (20%). The strategies were deemed helpful versus less helpful based on correlation of coping strategies used with physical and psychosocial dysfunction. The use of fewer and more effective coping strategies was positively correlated with low physical and psychological dysfunction. Implications are clear that increased knowledge of coping strategies which are identified as helpful, can provide a beginning base from which to provide appropriate nursing intervention to bereaved widows.

Toth and Toth (1980), Silverman (1972), and Utley and Rasie (1984) among others have clearly identified the beneficial effects of support groups in facilitating the coping work of the bereaved. The most significant outcome appears to be the realization on the part of the bereaved that she is "not alone" and that while her

situation is unique, she can, in a sense, gain strength in interaction with a group of people who have the best possible chance of understanding "what she is going through". In addition, as the process of bereavement progresses, the widow is given the opportunity to become a caregiver to the more recently bereaved.

Nurses, given this knowledge, can direct the bereaved toward appropriate support groups to facilitate this therapeutic interaction. With special expertise, nurses in advanced practice can organize and implement such groups as part of their practice.

Summary

The review of the literature was divided into four sections. Bereavement from an historical perspective was traced. Theorists and researchers have changed their view of the phenomenon over time. Bereavement was first seen as a single-event pathological crisis. Later, bereavement was viewed as a process shared by both the survivor and her family that had discrete, predictable phases. Bereavement is presently seen as a process in which the widow is capable of change and choice and is the author of her own individual coping pace and patterns.

In the second section, the environment of bereavement including the factors affecting bereavement were

addressed. In both quantitative and qualitative studies, five main factors emerge. These include; role change expectations, perceived social support/social isolation, forewarning of death, financial factors, and physical and mental symptoms. The bereaved person will, based on her own individual response pattern, encounter and cope with these areas.

In the third section, an autobiographical account of the experience of bereavement was addressed. These accounts replicated the findings noted in the research literature but were distinctly unique to the person telling them.

Finally, nursing's contribution to the study of bereavement was included. Nurses have been identified by widows as the health care giver who was most helpful at the time of a spouses death and beyond. Anticipating this, a majority of the research was directed towards intervention strategies.

In Chapter IV, the methodology for this study will be discussed. This will include a discussion of the research design including the objectives for this study. The criteria for selection of the sample subject, the procedure for gathering data and the subsequent method for data analysis will be addressed. Finally, procedures for the protection of human subjects will be included.

CHAPTER IV

Methodology

The research design which is intended to discover the meaning of an event as it is being lived, 6 months later, through the process of isolating themes, is the focus of this chapter. Included in this section are:

- 1) a discussion of the research design and method including the objectives for this study;
- 2) the criteria for selection of the same subject;
- 3) the procedure for data gathering;
- 4) the procedure for the protection of human subjects; and
- 5) the procedures for analyzing data.

Research Design

A case study was undertaken to discover the lived meaning of bereavement for a woman who has experienced the death of a spouse. The case study examines a social unit, to gain a complete, organized picture (Issac and Michael, 1981). Methodologically, description was employed in this study. The descriptive method, while examining a moment in time, includes an elaboration of the context of the situation. This elaboration, because

of the wholistic nature of persons includes the remembrance of past experiences and the anticipation of future plans that have meaning in relation to the life event (Parse et al., 1985). The individual provides data through oral or written responses to open ended questions derived from research objectives. The objectives of the study flow from the conceptual framework. For this study, oral descriptions of the bereaved woman were obtained through the use of tape recording. After transcription, these descriptions became the raw data for analysis. Through the analysis/synthesis of that data, major themes were uncovered which served to illuminate the nature and meaning of the lived experience of bereavement for the subject.

The Descriptive Method

Like other qualitative and quantitative methods, the descriptive method encompasses five basic elements. They are 1) identifying the phenomenon; 2) structuring the study; 3) gathering the data; 4) analyzing the data; and 5) describing and interpreting the findings. A discussion of these elements follows.

Identifying the Phenomenon

The phenomenon is a proposition based on a set of cues that exist because of their experiential meaning in the world of the observer. Evolving from a particular

frame of reference, the phenomenon guides the organization of the study. Set forth in Chapters I and II of this thesis, the frame of reference that is the basis for the phenomenon of bereavement relates to the theory of Unitary Human Beings (Rogers, 1983). Based on this theoretical framework, bereavement is described as a process that is thrust upon the widow and must be lived in a unique way, chosen and known only to the survivor. It is characterized by a disruption of long established patterns, formed over time with a partner, leaving the person adrift in a world that is suddenly alien and full of change.

Structuring the Study

Structuring the study includes specifying a research question, developing a conceptual framework, identifying the objectives of the study, identifying a study sample, and protecting the rights of the subjects (Parse et al., 1985).

Research Question

This present study was undertaken to answer the following question: What is the individual pattern response associated with widowhood?

Conceptual Framework

The conceptual framework, as discussed in Chapter II of this thesis, that served as the rationale for this study and explained the phenomenon was the Theory of Unitary Human Beings (Rogers, 1970, 1983). Human beings are wholistic, manifesting characteristics that are more and different than the sum of their parts. Human beings are constantly exchanging energy with the environment in a unidirectional life process. Human beings are sentient and seek to organize the world of their experience and to make sense of it. In patterning (and repatterning) the human field, human beings make choices, that are innovative, and based on the "infinite now". Health is active interaction with the environment to pattern a reality that creates a sense of well being with a future view (Rogers, 1983).

Objectives of the Study

From this conceptual base, the objectives for this study were developed. These objectives contain both a content and a process component, identifying a single activity related to one element of the phenomenon (Parse, 1985). They are as follows:

1. To describe the pattern response related to the significance, interpretation, and meaning of the lived experience of bereavement.

This objective was developed from the concept that human beings are sentient and seek to organize their world and make sense of it.

2. To describe the pattern response related to validation, overcoming obstacles, and interaction with others in the lived experience of bereavement.

This objective was developed from the concept that human beings are constantly exchanging energy with the environment and that in patterning and repatterning the human field they make choices that are innovative.

3. To describe the pattern response related to changed perspectives and a future view in the lived experience of bereavement.

This objective was developed from the concept that human beings come to experience the process of health by patterning a reality that provides a sense of well being and holds a future view.

Study Sample

In the descriptive method, the sample is found in the population experiencing the phenomenon being studied. In this case study, the sample consisted of one woman whose husband had died more than three months but not more than twelve months from the time of interview. Gass (1987) has pointed out that in the first three

months, widows were more inclined to use denial as their major coping mechanism. It is therefore supposed that participation in a descriptive study which requires the subject to articulate the meaning of a lived experience would be inappropriate at this time in the process of bereavement. The one year parameter is generally considered by researchers to be the most intense period of bereavement and therefore more rapidly lends itself to this type of study. In addition, the subject was to be 60 years of age or older. This criterion was based solely on the fact that gerontology is the area of interest and expertise for the researcher. In addition, the phenomenon is not considered age specific but rather person specific.

Criteria for selecting the participant for this study were based on the premise that the subject had the capability, both intellectually and psychologically, to participate and the ability to make choices. The area to be addressed, bereavement, is one that has the potential for evoking feelings and responses that might be painful to the subject. With this in mind, the criteria are as follows:

1. The ability to understand and express one's self in the English language.

2. The ability to relive the past and present (global) experience of bereavement without undue difficulty.
3. The ability to conceptualize, after reflection, and describe the experience, including the feelings surrounding it.
4. Having been a widow for more than 3 but no longer than 12 months.
5. An interest in participating in the study and the ability to make choices.

Protection of Human Rights

Specific procedures were followed to assure that the rights of the participant were not violated. In accordance with Michigan State University College of Nursing requirements, application was made to the University Committee on Research Involving Human Subjects for permission to conduct this research. Permission was granted and all possible efforts were made to ensure the protection of the participants' human rights. A consent form was signed identifying the researcher and briefly explaining the nature of the study. Along with assuring confidentiality and anonymity in written reports of the study, and the right to withdraw from the study at any time, permission was obtained to allow the researcher to

tape record responses to interrogatory statements (Appendix A).

Areas covered in the consent form were initially explained during a telephone call. At that time, an opportunity to ask questions was also provided. The respondent was made aware of the only possible risk inherent in participation in the study, that is, the possibility of becoming more aware of, and possibly disturbed by, any new or old issues raised by experiencing the thoughts surrounding the discussion of bereavement. The participant was urged to discuss her concerns and feelings, if engendered, with supportive persons, her health care provider, or if desired, the researcher.

In order to carry out the promise of confidentiality, the participant was given a fictitious name which was used in reporting the data. Transcriptions of the data obtained from interviews were placed in the researcher's private file. Tape recordings were erased after transcription and validation of the accuracy of the transcript.

Data Gathering

Potential participants were garnered from the general population by referral from nurse colleagues. All met the inclusion criteria. Four prospective participants were then contacted by telephone. One subject was

chosen based on willingness to participate and the ability to coordinate schedules for meeting.

An interview time convenient to the subject was arranged by telephone. The interview took place in the participants home where, after explanation, the consent form was signed (Appendix B). Approximately 10 minutes were used at the beginning of the interview to establish rapport and collect basic demographic data. The subject was asked, in section one, to respond into a tape recorder to open-ended questions aimed at obtaining a more indepth picture of the subject. In addition, in section two, guide questions derived from the research objectives were asked (Appendix C).

Validity and Reliability

The issues of validity and reliability will be addressed in the following section. In quantitative research, validity and reliability are the accepted concepts of measurement established through the use of certain procedures for data collection and analysis. Because the nature and manner of the research process is different in a qualitative methodology, the concepts of validity and reliability are not addressed in the same way.

Guba and Lincoln (1981) suggest that it is perhaps inappropriate to define the scientific rigor inherent in

the qualitative process in terms of validity and reliability. Rather, qualitative findings should be viewed in terms of credibility, confirmability, auditability and fittingness. Credibility is comparable to construct validity and refers to the maintenance of the operational measures of the study. Confirmability is comparable to reliability in that the procedures for data gathering are specifically stated and followed. Auditability refers to the maintenance of the research process in that the segments of the study proceeded in a logical sequence. Fittingness refers to the ability to follow the logical flow of the process, forward and back, from conceptual framework to hypothetical statement. Further these authors maintain that the researcher's sensitivity, conceptual ability, creativity, and insight are vital to the analytical process in qualitative research.

Validity refers to the degree to which an instrument measures what is supposed to be measuring (Polit & Hungler, 1983). Validity can be further divided into construct validity, internal validity and external validity. Each of these concepts will now be addressed with regard to this study.

Construct validity refers to establishing correct operational measures for the concepts being studied

(Yin, 1989). In qualitative research this is accomplished by having the researcher develop a sufficiently operational set of measures in collecting data. Specifically, the researcher should include two steps:

1. Select the specific types of changes that are to be studied in relation to the original objectives of the study.
2. Demonstrate that the selected measures of these changes do indeed reflect the specific types of change that have been selected (Yin, 1989).

In this study, the first step was satisfied by very specifically identifying the changes (pattern responses) to be observed in bereavement based on objectives derived from Roger's Theory of Unitary Human Beings (1983). The second step was satisfied by employing a tactic known as maintaining a chain of evidence (Yin, 1989). Maintaining a chain of evidence means that an external observer can follow the derivation of findings from the initial research question to the ultimate conclusions of the study. Further, the observer should be able to follow the logic of the process in either direction. In this study this tactic was insured by the following means: 1) A case representation was presented as part of the results of the study based on actual data (Appendix D). 2) Nonverbal behaviors of the subject were observed and recorded by the researcher during the

interview to note congruity of behavior and affect (Appendix E). 3) Questions derived from objectives were approved by a four person thesis committee and were adhered to during the interview. 4) The subject fit the inclusion criteria stipulated in the study.

Internal validity is concerned with establishing causal relationships, whereby certain conditions lead to other conditions, as distinguished from spurious relationships (Yin, 1989). It is appropriate to apply this concept to the case study method which is not concerned with establishing causal relationships and, for this reason, was not done in this case study.

External validity establishes the domain to which a study's findings can be generalized (Yin, 1989). It must be remembered that unlike quantitative research, which relies on statistical generalization, qualitative research relies on analytical generalization. This means that the aim of the researcher is to generalize a particular set of results to some broader theory. In this study, the results are generalizable to the Theory of Unitary Human Beings (1983) from which the objectives were derived and upon which the interview questions were based.

Reliability is the degree of consistency with which an instrument measures the attribute it is supposed to be measuring (Polit & Hungler, 1983). In qualitative

research this concept is particularly concerned with accuracy and credibility (Chenitz & Swanson, 1983). Yin (1989) suggests that the most appropriate way to approach reliability in the case study method is to make as many steps in the process of the research, as operational as possible.

In this study, the researcher included the following steps related to reliability: 1) Procedures for data gathering and analysis were specifically stated in detail before data collection and were subsequently adhered to. 2) Two persons, in addition to the researcher, compared the audiotaped responses of the subject with the transcript to insure accuracy.

With regard to credibility, as discussed earlier, findings are based on the sensitivity, conceptual ability, creativity and insight of the researcher (Guba & Lincoln, 1981). Qualitative findings are based on the way the researcher connects data bits to each other and to a body of literature (Ammon-Gaberson & Paintanida, 1988). Therefore, unlike quantitative studies, analytical findings from qualitative data may not be the same.

It should be noted that in this study, two sets of questions were asked of the subject. One, an unguided set, was aimed at gaining a better picture of the subject and the other set were guided questions based on

objectives and literature. It was found that the subject's responses to both the guided and unguided questions yielded data that contained the same critical elements.

Procedure for Data Analysis

In analyzing the data from this study, utilizing the descriptive method, the subject-researcher interaction was carefully examined. The interaction was then synthesized into a reconstructed case giving a picture of the subject in the lived experience. Major themes articulated by the subject about the phenomenon were isolated through analysis-synthesis. Analysis is the separation of the whole into constituent parts for the purpose of study. This then was followed by synthesis which is the recombination of the elements to form a more coherent whole. In this case, themes (critical elements) were separated according to the major concepts in the objectives. These major concepts were: 1) significance, meaning and interpretation, 2) validation, overcoming obstacles and interaction with others, 3) changing perspectives and future view. The themes, in the subject's language, were examined in light of the major concepts and formed the basis for constructing a unified description of the phenomenon as lived by the subject (Parse et al., 1985). A higher level of

discourse was reached as the themes were moved from the subject's language to the researcher's language. In order to verify the fittingness of the themes, the raw data was examined by a researcher who is familiar with, and has experience in implementing the qualitative research methodology in research activity. In addition, the chair of this thesis committee and one additional member examined the data for the logic of flow.

The themes, in the language of the subject, moved to the language of the researcher, were interrelated to form a coherent, integrated reconstruction of the unit of study (the bereaved widow). These findings were then synthesized and transformed into a hypothetical statement regarding the pattern response of bereavement for this particular subject, at this point in time (Parse, 1985).

Summary

In Chapter IV, the research design as well as the data gathering and data analysis procedures were described. The study's sample selection, protection of subject rights and the interview setting were also discussed. Objectives of the study derived from the conceptual framework were presented. In addition, guide questions designed to uncover the lived experience of

the elements of the phenomenon of bereavement were listed.

In Chapter V, the data will be presented in the form of the reconstructed case. Data analysis will be carried out by identifying themes in the words of the subject. Themes, at a higher level of discourse, in the words of the researcher will then be presented.

CHAPTER V

Data Presentation and Analysis

Overview

A case study was undertaken to discover the lived meaning of bereavement for a woman who had experienced the death of a spouse. The aim of this research was to examine the responses of the bereaved woman, in depth, to gain a complete, organized picture of her bereavement. The person studied was a 60 year old woman, married 38 years who had been widowed 6 months previously. The subject was asked to respond to guided questions based on a specific theoretical framework, the Theory of Unitary Human Beings, in order to uncover themes which served to illuminate the nature and meaning of the lived experience of bereavement for her.

The data will now be presented in a reconstructed case scenario. Following this, themes in the subject's words with supporting raw data and rationale will be presented. A grouping of these themes by objective with emerging concepts will follow. Themes, at a higher level of discourse related to each objective, in the words of the researcher will then be presented. Finally, the tests of the quality of design including

credibility, auditability, fittingness, confirmability and external validity will be discussed.

The Case

Mr. and Mrs. P. had been married 38 years when he died 6 months ago. They met in college, were always good friends, and lived their lives by planning ahead. Their three children were a major part of both of their lives and, as a result, Mrs. P. feels that the way the children are now is no accident. She and Mr. P. worked with them to help them develop into the adults they have become.

Mrs. P. describes herself as extraverted, intelligent, caring and a good friend. Though she has worked outside the home for the last 17 years, she does not see herself as a career person. Rather, she maintains that she loves her home and remains, primarily, a wife and mother.

When Mrs. P. faces new situations she thinks that there are choices that have to be made. One of the choices that she is facing is whether or not she will continue to work. At this time, she has decided that she will work until she doesn't want to anymore. She describes this decision as being primarily because she has a lot of energy and needs to be doing something productive.

In the near future, she has planned a trip to England to visit her son. Traveling was something she and her husband enjoyed together, and she feels that this is the kind of thing that she wants to continue doing now.

According to Mrs. P., making decisions isn't really difficult for her. When her husband was alive they made decisions together, and she feels they have always been the kind of people who faced the world they lived in. She has a habit of talking about problems with different people and then making up her own mind. She does not go to her children for advice because she is used to them as well as other people coming to her for decision making. When a decision is made, right or wrong, she lives with it.

Mr. P. was diagnosed with cancer 6 years before he died. Through his long course of treatment, Mrs. P. feels that the couple was in control of the situation especially due to Mr. P's. very strong will. They had planned to build their retirement home in the future but decided to build earlier due to Mr. P's. illness. At different times in the course of the illness, the couple felt that the cancer was under control. As new symptoms appeared, they were shocked but remained hopeful.

When cancer was found in Mr. P.'s lung, they were again shocked and dumbfounded but saw chemotherapy as the only choice. Mrs. P. still feels that where there

is life, there is hope. She saw her most important job during her husband's illness to be providing proper nourishment for him. She wouldn't hear of Mr. P. not eating. Mr. P. continued to eat until 2 weeks before his death. Mrs. P. is convinced that her husband lived 2 months longer than the doctor predicted because she provided the proper diet. Mrs. P. has since decided that "when people don't eat is when they die".

Mrs. P. now feels that time has given her a clearer perspective about things that happened during the course of the illness. It is only now, when she reflects back, that she realizes what was happening. She not only feels Mr. P. had been ill for a long time but also that he alone realized the seriousness of his condition. Through sheer will, Mr. P. never gave up and in doing so, spared her. She remembers him saying as he lay dying, "I will maintain my dignity as long as I am able." This so impressed her that she wrote it down.

Two weeks before he died, when she realized that the end was near, she arranged for her children to come home and spend time with their father for their sakes. The couple never talked about his dying: "we haven't to this day".

In explaining how very strong willed and very much in control her husband was, Mrs. P. says that the puppy her husband loved died two weeks after he did. "I swear

to goodness that that dog and he are somewhere up there together, roaming in the daisies, watching the blue heron".

Currently, Mrs. P. has no financial worries because she makes enough money to support herself and has planned carefully. She has no problems talking to others as needed but sees no problems in the future.

She sees herself in a very positive way and can talk to people but will, in the end, do what she wants. She hasn't thought a great deal about how she sees herself relative to the future. At this time she is terribly lonely but positive about her life and her abilities.

Family and friends are very important to Mrs. P. She doesn't know what she'd do without them. She feels she has a really good support system and does not see this changing in the future.

In terms of her husband's death she thinks it's a pretty good idea they didn't know what was ahead of them because she doesn't know if they would have done anything differently anyway. They took things one day at a time and did what needed to be done. Mrs. P. feels free to talk about her husband's death when she wants.

Mrs. P. is very aware of her health. She thinks she is in relatively good physical condition and is able

to work and enjoy life. She will take the future day by day.

Mrs. P. has identified the most difficult thing in this situation as loneliness. She feels they were a very close couple who shared everything. She misses this very much.

She feels that this time has resulted in growth and she sees herself in a new role, that of matriarch. In that role she guides and directs her children and helps to bind the family together. She feels very much needed. (See Appendix F, Field Notes related to this interview.)

In the next section, themes in the subject's words with supporting raw data and rationale will be presented. Following this, themes in the language of the researcher, at a higher level of discourse will be listed. The numbering sequence merely represents the order in which themes were found in the raw data based on the identified objective and set of questions and in no way signifies priority.

Objective One

Themes in the Language of the Subject

To describe the pattern response related to the significance, interpretation, and meaning of the lived experience of bereavement.

Themes from Opening and Closing Questions:

Theme 1. She and her husband always faced the world they live in: she continues to do so.

Supporting Data.

And we always have been the kinds of people that faced the world we lived in.

She acknowledges the need to find meaning and significance in the world by taking it as it is.

Theme 2. Believing that nothing happens by accident, she continues to plan and take responsibility for herself.

Supporting Data.

Well we have always planned, I mean, accidents just don't happen . . . You are responsible . . . As I say, it was no accident.

In this passage, the subject's belief that all action is significant and meaningful with choices being made is acknowledged.

Theme 3. She feels that while there is life there is hope.

Supporting Data.

I mean you know, hey - where there is life, there is hope.

The subject believes that while life continues, it is meaningful and significant.

Theme 4. She believes that her husband willed himself to stay alive and, in doing so, avoided talking about his death.

Supporting Data.

Well, up until three weeks before he died I was taking him to San Francisco. But he went down hill fast. But I really and truly do believe that he had forced himself; that he had willed that he was going . . . We never talked about his dying; we haven't to this day.

In this passage, the interpretation of the force of sheer will be explained.

Themes from Guided Questions

Theme 1. Careful planning in life has given her a sense that she can support herself and has no financial problems.

Supporting Data.

I don't have any financial problems. I make enough money to support myself. I mean, you know, that's why I say, careful planning in life has been very good for me.

This passage supports the belief that planning means fewer money worries.

Theme 2. She doesn't know what she would do without her friends.

Supporting Data.

My thoughts and feelings? I don't know what I would do without them. So, and as I told you before, they've been very good to me.

In this passage, the subject acknowledges that friends are significant and of great need at this time.

Theme 3. She feels terribly lonely but at the same time sees herself and her abilities in a very positive way.

Supporting Data.

I see myself in a very positive way. And I feel basically, terribly lonely but very positive about myself and my abilities.

This passage reinforces the fact that the subject's view of herself is meaningful and positive.

Theme 4. She sees herself in good physical condition with the ability to work and enjoy life while making choices.

Supporting Data.

And I have to think that I am in relatively good physical condition and able to work and enjoy life . . . Hey, I mean you know you have choices. I'm not afraid of hard work.

For the subject, good physical condition means the ability to choose and enjoy life.

Theme 5. Though she thinks her husband recognized the seriousness of the illness surrounding his death,

she now thinks he spared her from awareness by never giving up.

Supporting Data.

I think it is very important because he spared me. And as I said, I think he realized how ill he was but he never gave up.

The subject believes that her husband's never giving up means she was spared.

Theme 6. She feels her husband was a person who had a will strong enough to control his dying and remains in control even now.

Supporting Data.

We had Sam and Sam was the dog. And actually Sam was a year and a half old and he was just really a puppy and he died two weeks after J____. J____ loved that dog, I swear to goodness that that dog and he are somewhere up together roaming in the daisies, watching the Blue Heron. That's the kind of person that . . . He would have willed for that to have happened. But very strong willed, very much in control.

This supports the subject's feelings that control means having a will strong enough to preserve.

Objective Two

To describe the pattern response related to validation, overcoming obstacles, and interaction with others in the lived experience of bereavement.

Themes from Opening and Closing Questions

Theme 1. She sees herself as a person who is still a wife and mother as well as a friend.

Supporting Data.

First of all, how would you describe yourself? Oh, probably extraverted, and I would have to say relatively intelligent, caring . . . I don't know. Actually, I still love my home and I am a wife and a mother . . . I'm a friend, J___ and I were good friends.

This passage validates the person she sees herself to be.

Theme 2. She feels she has more energy than most people she knows and because of this, she needs to do something fulfilling and meaningful.

Supporting Data.

Because I probably have more energy than most of the people you know. But uhm, I need to do something. And I can't do yard work all the time.

This theme further validates her view of herself in her world.

Theme 3. Her habit is talking about problems with different people and then making up her mind.

Supporting Data.

What I have a habit of doing is talking about the problem with different people and then making up my own mind . . . So on those kinds of decision, I have had people that I could

talk about the problem with and then I have made up my mind.

This passage supports the importance to the subject of interacting with others.

Theme 4. Although he had an original prognosis of 6 months, she now feels he lived 8 months because of her efforts.

Supporting Data.

He (doctor) said that he really didn't think that it was necessary to put him through chemo because he wasn't going to live beyond 6 months anyway. And actually the man was right because from February when we found it - about - that would be March, April, May, June, July, August, September. Hey, we did good work; he lived 8 months. . . (doctor) said, that the only reason that he lived as long as he did, was because we had taken such good care of him.

This passage acknowledges that obstacles can be overcome through effort.

Themes from Guided Questions

Theme 1. She does what she wants to do and says what she wants to say.

Supporting Data.

I mean, if I want to say something to somebody, I say it. But I do what I want to do.

This acknowledges that obstacles can be met head-on and with choice.

Theme 2. She feels that she has a very good support system and that people bear with her. She has the choice to talk to people about her loneliness and is very open.

Supporting Data.

Well here again, I have a real good support system. It was hard to go to Florida, because we had all been there together. So, but people will, they bear with me. . . I feel sorry for the people who couldn't talk. . . I think that's one of the things that you have choices about. But people are used to me now because I just am very open with anybody that I come in contact with. . . And so no, I have no problems talking about him (husband), none whatsoever.

For the subject, interaction is a choice she can make to alleviate loneliness.

Theme 3. She sees her changing role as that of matriarch who will guide and direct her family and help bind the family together.

Supporting Data.

And as (son) is calling me now, I'm the matriarch as far as he's concerned. . . And those are the kind of things that bind the family together and get us through. (Daughter) needs strength now and I am her strength and sort of guide and direct her.

The subject validates her role through interaction in a new way.

Theme 4. She continues to see herself as a needed and valued person.

Supporting Data.

I feel a need. And I think that's the important thing. Are you needed?

The subject is further validated as special and needed.

Objective Three

To describe the pattern response related to changed perspectives and future view in the lived experience of bereavement.

Themes from Opening and Closing Questions

Theme 1. She thinks that one has choices that need to be made. One of those choices is to work until she doesn't want to work anymore.

Supporting Data.

I think. . . you have choices that you have to make. And uh so, I realized that I have choices that I have had to make. One of them was, am I going to work?. . . So I have decided that I am going to work. Now, am I going to work until I'm 62? Am I going to work until I'm 65? I'm not making any decisions about that at this point in time. I will work until I don't want to work.

This passage speaks to the subject's belief that the future involves choices for which she is responsible.

Theme 2. She takes responsibility for her future by being willing to live with her decisions.

Supporting Data.

I'm used to people coming to me for decision making. I'm not used to. . . And if it's right or if it's wrong, I live with it. I don't know whether its good or not but that's the way it is.

Free choice as a way to face the future is acknowledged in this passage.

Theme 3. As she went along, she gained more perspective and was able to see things more clearly than when she was going through them but was glad she didn't know what was ahead of her.

Supporting Data.

Well I think, that as you go along, things that happened. . . you begin to put into perspective and I think you might have been able to pick up on things that maybe you don't pick up on, uh. . . at the time you're going through them. . . So, but I mean you know, you're going through this, you don't realize what's happening until you reflect back. . . So I mean you know, what are you going to do? Are you going to x-ray everybody that has a bladder tumor? I mean, you know, that isn't par for the course. But if we had caught it back then, we probably could have removed the lung, done radiation - because we did, we did with the chemo and with the radiation - we were able to reduce the tumor in the spinal cord to nothing but scar tissue. . . there for a while. . . I think now that I can reflect back; I think he was more ill. But I think probably it's a good thing we don't know what's ahead of us. . . Because if we had known, I don't know if we would have done anything any differently anyway.

That perspectives change with time is acknowledged by the subject.

Theme 4. Through living this experience, she has come to understand that when people don't eat, they die.

Supporting Data.

I have decided that when they don't eat is when they die.

The process of changing perspectives is further acknowledged by the subject.

Themes Derived from Guided Questions

Theme 1. She has come to realize she is taking on, for a time, the role that once belonged to her husband.

Supporting Data.

I told father (husband) this afternoon that it used to be; he always teased me about the rhetorical 'we'. 'We were always going to do something. But it always ended up being 'he' who did it. And I told him today - I laughed. . .Anybody driving by would probably think I was nuts. I said, 'well, it looks like the role has reversed for a while. You're going to watch 'me' doing instead of 'we' doing, which was basically 'you' doing.

The perspective of a new role is recognized in this passage.

Theme 2. Having what she wants at this time, she does not see money as being a problem now or in the future.

Supporting Data.

I don't see money being a problem. . . I figure that I am going to have what I want at this point in time. . . I don't envision money as being a problem.

In this passage, future view about finances is examined.

Theme 3. She is lonely now and hasn't thought a great deal about the future relative to herself.

Supporting Data.

I hadn't thought a great deal about the future. Right now I'm as I say, lonely.

For the subject, the future view of herself is not clear at this time.

Theme 4. Those people who supported her when her husband was alive are doing the same thing now and she doesn't see that changing.

Supporting Data.

They supported us when he was alive and they are doing the same thing now. . . I don't see real change.

The subject sees no real change in the future relative to social support.

Themes for each objective, in the language of the subject with supporting data and rationale, were analyzed and then synthesized into themes in the language of the researcher. All themes relating to each

objective have been grouped with the emerging concepts (see Figures 1, 2, and 3) in accordance with the objective. Following this are themes in the language of the researcher, on a higher level of abstraction and containing the central element or essence of the theme relative to the objectives. They are as follows:

Objective One. To describe the pattern response related to the significance, interpretation, and meaning of the lived experience of bereavement.

Resulting Theme. With careful planning and assuming responsibility, the experiences of life are not accidental. Optimism continues with choice and a sense of control.

Objective Two. To describe the pattern response related to validation, overcoming obstacles, and interaction with others in the lived experience of bereavement.

Resulting Theme. In choosing interaction, sense of self is validated in understanding that patterns can be redirected through effort.

Objective Three. To describe the pattern response related to changed perspectives and future view in the lived experience of bereavement.

THEMES IN SUBJECT'S LANGUAGE WITH CONCEPTS

OBJECTIVE ONE -- significance, interpretation, meaning

Human Beings seek to organize world and make sense of it

She and her husband always faced the world they lived in; she continues to do so. [choice]

Believing that nothing happens by accident, she continues to plan and take responsibility for herself. [planning; responsibility]

She feels that while there is life, there is hope. [optimism]

She believes that her husband willed himself to stay alive and, because of this, the couple avoided talking about his death to this day. [control]

GUIDED QUESTIONS

Careful planning in life has given her a sense that she can support herself and has no financial problems. [planning]

**She doesn't know what she would do without her friends.
[planned support]**

She feels terribly lonely but at the same time, sees herself and her abilities in a very positive way. [optimism]

She sees herself in good physical condition with the ability to work and enjoy life while making choices. [choices]

She feels her husband was a person strong enough to control his dying and remains in control even now. [control]

THEME IN RESEARCHER'S LANGUAGE

With careful planning and assuming responsibility, the experiences of life are not accidental. Optimism continues with choice and a sense of control.

Figure 1. Objective One - Themes in Subject's Language With Concepts.

THEMES IN SUBJECT'S LANGUAGE WITH CONCEPTS

OBJECTIVE TWO -- validation, overcoming obstacles, interaction with others
Human Beings constantly exchange energy with environment making choices that are innovative.

She sees herself as a person who is still a wife and mother as well as a friend. [sense of self]

She feels she has more energy than most people she knows and in addition, needs to do something fulfilling and meaningful.
[sense of self]

Her habit is talking about problems with other people and then making up her own mind. [interaction; choice]

Although her husband had an original prognosis of 6 months, she now feels he lived 8 months because of her efforts. [active effort]

GUIDED QUESTIONS

She does what she wants to do and says what she wants to say.
[active effort; choice]

She feels that she has a very good support system and that people bear with her. She has the choice to talk to people about her loneliness and is very open. [interaction; choice]

She sees her changing role as that of matriarch who will guide and direct her family and help bind the family together.
[interaction; choice]

She continues to see herself as an active and valued person.
[sense of self]

THEME IN RESEARCHER'S LANGUAGE

In choosing interaction, sense of self is validated in understanding that patterns can be redirected through effort.

Figure 2. Objective Two - Themes in Subject's Language With Concepts.

THEMES IN THE SUBJECT'S LANGUAGE

OBJECTIVE THREE -- changed perspectives, future view

Human Beings come to experience the process of health by patterning a reality that provides a sense of wellbeing with a future view.

She thinks that one has choices that need to be made. One of those choices is to work until she doesn't want to work anymore.

[choice; responsibility]

She takes responsibility for her future by being willing to live with her decisions. [responsibility; future view]

As she went along, she gained more perspective and was able to see things more clearly than when she was going through them but was glad that she didn't know what was ahead of her.

[clearing perspective]

Through living this experience, she has come to understand that when people don't eat, they die. [changing perspective]

GUIDED QUESTIONS

She has come to realize that she is taking on, for a time, the role that once belonged to her husband. [choice; changing perspective]

Having what she wants at this time, she does not see money as being a problem now or in the future. [choice; future view]

She is lonely now and hasn't thought a great deal about the future relative to herself. [future view]

Those people who supported her when her husband was alive are doing so now and she doesn't see that changing. [future view]

THEME IN RESEARCHER'S LANGUAGE

In assuming responsibility for choosing, a clearer perspective emerges with the existence of possibilities.

Figure 3. Objective Three - Themes in Subject's Language.

Resulting Theme. In assuming responsibility for choosing, a clearer perspective emerges with the existence of possibilities.

Methodology: Quality of Design

Unlike quantitative research, which relies on statistical generalization, qualitative research relies on analytical generalization. To ensure the quality of design with regard to this study, five areas will be addressed. The first of these areas is confirmability.

Confirmability is comparable to construct validity and refers to the maintenance of operational measures used in examining the phenomenon. This is done to ensure that the study measures what it is supposed to be measuring. In this study, confirmability was accomplished by several means:

1. The subject fit the inclusion criteria in that she was 60 years old and had been widowed 6 months previously.
2. Affect and behaviors were noted throughout the interview and subsequently recorded. They were found to be congruent by this researcher, who has an expertise in communication skills.
3. The objectives were based on a conceptual framework and subsequently examined by the thesis committee.

4. Open-ended questions were formulated that incorporated the conceptual base and significant factors surrounding the environment of bereavement, derived from relevant literature. Again, these questions were examined and approved by the thesis committee.

Based on adherence to these steps, with consultation and agreement of the thesis committee during the process, this researcher believes that confirmability exists. In order to ensure construct validity, further studies with larger populations need to be surveyed longitudinally.

The next area to be discussed is auditability. Auditability refers to the maintenance of the process. This aspect is especially important in qualitative research in that the work of the study must be done in a sequential manner in order that the researcher's thinking proceeds in a logical way. In this study, this was accomplished by:

1. This researcher began with an area of interest.
2. The theoretical framework, Martha Roger's Theory of Unitary Human Beings was studied by the researcher, in depth, to gain operational and conceptual understanding.

3. Relevant literature surrounding bereavement was examined and significant environmental factors were isolated.
4. The research question was developed.
5. Objectives of the study were developed based on the conceptual framework.
6. Interview questions were developed.
7. Data were collected.
8. Data were analyzed for themes.
9. The themes were synthesized to the researcher's language.
10. A hypothetical statement was formulated.

Because the research process proceeded in the sequential manner described above, this researcher believes that auditability exists.

Fittingness, the quality of the research that addresses the stability of response, will now be examined. This area refers to the fact that an observer can attest to the logic of the flow of the data being presented. This logical flow should be able to be traced forward and backward from conceptual framework to hypothetical statement. In this study, this was accomplished by:

1. Conceptual framework and relevant bereavement literature were examined in depth.

2. Objectives were developed from the conceptual framework and examined by the thesis committee.
3. Interview questions were formulated that incorporated the conceptual framework and significant factors surrounding bereavement. These questions were examined by the thesis committee.
4. Data were collected and analyzed for themes related to objectives. In addition to this researcher, the logic of the selection of themes was examined by the chairperson as well as one other member of this thesis committee, along with a nurse researcher who is familiar with and has experience in implementing the qualitative research methodology and a graduate student in the College of Nursing at Michigan State University.
5. Critical elements, concepts inherent in the themes, were isolated. The logic of the selection of these critical elements was examined by the above mentioned persons.
6. Themes in the language of the researcher were developed containing the critical elements.
7. A hypothetical statement was developed containing the themes.

Because these steps in the process were adhered to, it is the feeling of this researcher that fittingness exists in this study.

Confirmability is comparable to reliability and refers to the degree of consistency with which an attribute is being measured. In qualitative studies, this aspect is especially concerned with accuracy and the measures taken to insure credibility, discussed in detail above. In this study, accuracy was maintained by having two (2) persons in addition to the researcher, compare the audiotaped responses of the subject with the transcript to insure accuracy. Though procedures to insure confirmability were followed in this study, this researcher feels that other subjects need to be surveyed using these procedures in order that confirmability can be said to exist.

External validity in qualitative studies refers to the fact that findings and underlying theory are compatible. In this research, it was found that compatibility exists between the findings and Martha Roger's Theory of Unitary Human Beings. Therefore it is the feeling of this researcher that in this study, external validity exists.

Summary

Analysis of the data was undertaken by presenting a reconstructed case scenario. Themes in the subject's words with supporting raw data and rationale were presented. At a higher level of discourse, the themes were analyzed then synthesized to include critical elements and then placed in the words of the researcher. Finally, the quality of the data was discussed with regard to credibility, auditability, fittingness, confirmability and external validity.

In Chapter VI, the hypothetical statement developed from the researcher's themes will be presented. This hypothetical statement will be discussed in relation to the subject. In addition, application to conceptual framework and relevant literature will be discussed. Finally, implications relative to research, education and practice will be presented.

CHAPTER VI

Interpretation, Conclusions and Implications of the Study

Overview

A descriptive case study was conducted to examine the individual pattern response of one woman as she faces life as a new widow. The purpose of this research was to synthesize the essence of the qualitative reality of bereavement for one particular woman. The research question formulated for this study was: What is the individual pattern response associated with widowhood?

In accordance with the case study methodology, the concepts underpinning the study were derived from a theoretical framework. That framework is Rogers' (1970) Theory of Unitary Human Beings. These concepts were developed into objectives and examined with reference to the widow's environment including role change, social support, finances, physical/emotional symptoms and circumstances surrounding the death of the spouse.

In Chapter V, themes in the subject's language were separated according to the major elements in the objectives. Using these themes as a basis, in the language of the researcher, at a higher level of discourse,

elements were interrelated to form a coherent, integrated reconstruction of bereavement for this subject. As stated earlier, bereavement refers to all of the psychological, behavioral and social response patterns displayed by an individual following the death of a significant person and is manifested by individual pattern response to environmental change. However, for this subject, loss as such was not mentioned as a significant factor. The hypothetical statement synthesized from these themes, for this woman is: Bereavement is a process in which human beings freely choose, in a constantly evolving pattern with environment, leading to self understanding, changed perspectives, and a glimpse of the possible.

Discussion and Interpretation of Findings

In the next section, the findings that emerged from this case study will be presented in relation to the data of the subject, the conceptual framework and the relevant literature.

Discussion/Interpretation of Findings as Related to Data. For the subject, bereavement is indeed a process. In her telling of her experience of bereavement, she repeatedly states that she has come to understand the meaning of what has happened, and is happening, only because of the passage of time. She expresses this

succinctly saying that "as you go along, you're able to pick up on things that you don't pick up on at the time you're going through them". The subject is thinking and rethinking events in order to interpret, for herself, her own bereavement.

Choice is not only an option for the subject, it is a responsibility. She expresses this belief with the statement, "I think you have choices that you have to make." In line with this choice, for the subject, is also a process, not an event. It is important, then, to look at the previous patterns of choosing for the subject. She is convinced that the process of choice begins with planning. Events do not happen by accident. She gives an example of this in describing her children's life success. She and her husband carefully planned their approach to childrearing and this is the reason, for her, that they are now successful. "The kids have all done well and that's because they were taught. . . As I say it was no accident".

Further, this choosing is made in concert with her environment and is an active process rather than a passive one. She feels free to seek advise, counsel and comfort from others but the final responsibility for decisions rests with her. "I have people that I could talk about the problem with and then I've made up my own mind. . . and if it's right or wrong, I live with it."

The subject is also rethinking her sense of herself. She remains very clear in her belief that she has her own individual identity. "I still love my home and I am a wife and mother". The subject is able to keep her sense of self intact because of changing perspectives. She recognizes that she is assuming roles that her husband once had. "Well it looks like the role has reversed for a while. . .". Further, she is willing to forego discussing problems with her children because she highly values the long established pattern of them coming to her for advice. This pattern has been further solidified in that she has now assumed the role of "matriarch." In discussing her daughter she says, "I am her strength and sort of guide and direct her".

The future is not entirely clear to the subject. What is clear is that she is not troubled because, again she feels she has planned well. She sees herself remaining in control of her life. She will continue to assess and reassess as time goes on, ultimately making decisions that she feels are right for her.

Discussion/Interpretation of Findings as Related to the Conceptual Framework. The findings of this study will now be examined in light of the conceptual framework on which it was based, Rogers' Theory of Unitary Human Beings (1980). In Chapter II, Rogers' view of

nursing was described and discussed. In this section, the study's findings will be examined and compared with the objectives derived from the theoretical concepts.

From Rogers' (1983) perspective, human beings are wholistic, manifesting characteristics that are more and different than the sum of their parts. Human beings are constantly exchanging energy with the environment in a unidirectional life process. Changes in the life process of human beings are predicted to be inseparable from environmental changes. Human beings are sentient and seek to organize the world of their experience and make sense of it. In patterning (and repatterning) the human field, human beings make choices that are innovative and based on the "infinite now". Health is active interaction with the environment to pattern a reality that creates a sense of well being with a future view.

Objective One

To describe the pattern response related to significance, interpretation and meaning of the lived experience of bereavement. This objective was developed from the concept that human beings are sentient and seek to organize their world and make sense of it.

Clearly, the subject is thinking and rethinking her unique experience of bereavement in order to interpret its special meaning and significance for her. In doing

so she brings to the process, patterns that are deeply embedded in her sense of self and way of being. She sees herself as a planner and an active shaper of her world. She firmly believes if one plans carefully and takes responsibility, accidents don't happen. This pattern has worked, over a lifetime, and the subject must now reconcile that belief to include the death of her husband, an event that came unplanned and seemingly by accident.

It is interesting to follow, through her own words, how she is doing this. She remarks often that it is in looking back that the meaning of the event becomes clearer to her. "I think you might have been able to pick up on things that maybe you don't pick up on. . . at the time you're going through them". It is postulated that her lifetime pattern response of planning to maintain choice was seriously threatened. This is further borne out when she reflects back to the time of her husband's illness. "But I think probably its a good thing we don't know what's ahead of us. Don't you? Because if we had known, I don't know if we would of (sic) done anything any differently anyway. Because we just sort of took one day at a time and did what was needed to be done." There was no possible way to plan for this event and at each progressive stage of the illness she was "shocked" and "dumbfounded". This

seemingly contradictory pattern of taking one day at a time, may have been the only way for this woman to organize and make sense of her world.

The resulting and ongoing pattern response related to objective one includes a subtle but telling change from her previous patterning. While seeking to organize her world and make sense of it to interpret the special meaning and significance for herself, the subject has held on to her belief that planning in order to have choices remains valid, the difference being that planning will now be on a more short term basis.

Objective Two

To describe the pattern response related to validation, overcoming obstacles, and interaction with others in the lived experience of bereavement. This objective was developed from the concept that human beings are constantly exchanging energy with the environment and that in patterning and repatterning the human field they make choices that are innovative.

Choice is the very foundation of the subject's lifetime of patterning. "I think that you have choices that you have to make. . . I mean you know you have choices you can make". The subject also has a lifetime pattern of interacting with her environment in order to gather the information to make these choices. "I have

had people that I could talk about the problem with and then I've made up my own mind".

In order to validate herself the subject has repatterned some self-imposed restrictions in interaction with others. In handling her feelings of loneliness and need to talk about these feelings with others she continues to believe she has, "a real good support system." The difference is that, "I try not to put them through a great deal. Because nobody likes to see you sit and feel sorry for yourself." Obviously this is a conflicting issue with the subject because later she says, "And people listen out of politeness or whatever." "I really don't care what it is, they don't like it they can move on." With regard to other interactions, the subject remains very comfortable with continuing her previous pattern of gathering information and solving problems by actively accepting responsibility for her decisions.

While the subject actively interacts with persons in her environment to validate herself and overcome obstacles, the resulting and ongoing pattern response related to objective two has been a repatterning to include a degree of self-censorship with regard to validation of the subject's very personal feelings of loneliness. She seems willing, at this time, to limit her interactions with others on the subject of loneliness in

order to hold on to her support group and face new obstacles.

Objective Three

To describe the pattern response related to changed perspectives and future view in the lived experience of bereavement. This objective was developed from the concept that human beings come to experience the process of health by patterning a reality that provides a sense of well being and holds a future view.

The subject, in facing her own life, has changed her perspectives to include enlarged roles. She verifies this in her statement, "Well it looks like the role has reversed for a while." She continues to see herself as a wife, rather than a single woman, but is taking on some of the roles formerly held by her husband. The role she seems most comfortable adopting is that of matriarch in which she guides and directs her family and provides the touchstone that helps to bind them together. "I feel a need." "I think that's the important thing." "Are you needed?" The future is not clear. "I hadn't thought a great deal about the future." "I will work until I don't want to work."

The subject's pattern response related to objective three includes a somewhat changed perspective and a limited future view. This repatterning provides her with a

future view that, while not completely clear to her, remains optimistic, in her control, and provides a sense of well being, while she clearly maintains a sense of control.

In summary, the subject's pattern response is generally consistent with Rogers' Theory of Unitary Human Beings. It is the subtle repatterning, unique to this woman, that is interesting to note and truly describes her individual, ongoing pattern response.

Logical Mapping with Further Discussion Specific to the Findings in this Study. In this study, the overriding pattern response found for this particular woman involved the element of choice. It should be noted as discussed earlier in the limitations of the study that because participation in the study was voluntary, inclusion required a preliminary choice on the part of the subject.

The findings of this study were incorporated into a logical mapping (see Figure 4) that includes the constructs derived from Martha Rogers' Theory of Unitary Human Beings. This mapping also includes the concepts derived from these constructs and that were specifically examined in the study. The common element, choice, found in examining each objective is represented.

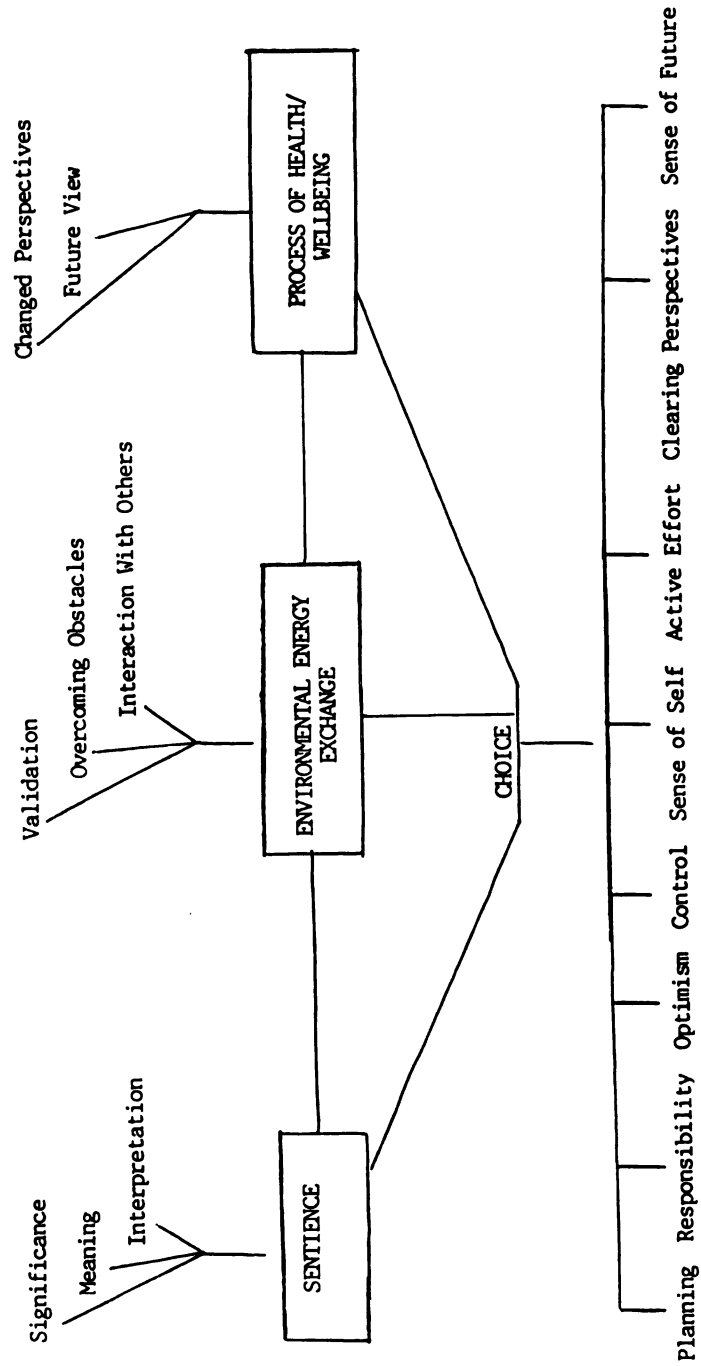


Figure 4. Logical Mapping of Concepts of Bereavement.

Finally, the focal elements that were found to enable or illuminate the ongoing choosing are also indicated.

Specifically, the logical mapping indicates that in the process of bereavement, the subject relied on the ongoing ability to make choices in order to pattern her new way of being. Further, the focal elements identified were found to be inextricably involved in this choosing. However, what is not clear from these findings is whether these elements enable the making of choice or result from the making of choice. These elements should guide further research.

Discussion/Interpretation of Findings Related to the Relevant Literature of Bereavement. In the literature concerning bereavement, there are several perspectives from which this phenomenon has been viewed. The findings of this research support the view that bereavement is indeed a process lived in an individual way by the widow and not characterized by discrete stages or proscribed behaviors. Kavanaugh (1972), Kubler-Ross (1968), Bugen (1977), Norris and Murrell (1988), Rigdon, Clayton and Dimond (1987), and Murphy (1988) concur in this finding. All have agreed that bereavement is a normal process of indeterminate length without discrete stages that is influenced by many events and personal, social factors unique to the person experiencing the

transition. Further, the psychological work of bereavement is a self-definition of and a coming to terms with the meaning of the event.

The environment of bereavement which contributes to the repatterning process has been addressed in the literature. This environment includes: role change expectations, financial status, social support (including loneliness), and forewarning of (circumstances surrounding) the spouse's death. In addition, there is a reported increase in physical and mental symptomology experienced by some widows following the death of a spouse.

With regard to role change expectations, this study supported the fact that there is a feeling of a shifting of roles that includes keeping past roles and enlarging others to repattern a new life. Brock and O'Sullivan (1985) and Weizman and Kamm (1985) found in their research that some women may have relied entirely on their role of wife to give their life direction and meaning, and when this role was removed they experienced a profound loss of self. This finding was not true for this subject. While continuing to identify herself as primarily a wife and mother, she remains able to see herself as a separate person with a separate identity from that of her husband. This appears to be the case

for this subject. She is a life long planner who states that she has the support she needs at this time.

In looking at perceived social support/social isolation, this study uncovered some contradictory findings. Kahn (1979) and Peplau et al. (1982) have reported that when widows are unable to receive the support they feel they need they will come to experience loneliness. While the subject was very positive in her assertions that she felt she was receiving adequate support in this process, at the same time, she described the most difficult area of her life as loneliness.

A more complete understanding of these seemingly contradictory statements may be found in light of the results of a study conducted by Warner in 1987. Warner (1987) found that the size of the available support system, a sense of history with the bereaved and frequent contact were the triad of variables that predicted the widow's comfort with interaction with others. The subject reports a somewhat self-limited support group. She chooses to limit discussion of her husband based on her sense of what and to how much people are willing to listen. In addition, she does not go to her children for some advice in order to hold on to the role of advisor for herself. In making these choices about interaction, she has put some individuals in her self described personal support system, perhaps those who have the

greatest sense of history with the deceased, out of her reach.

Financially, the subject reports no difficulty now or in the foreseeable future. O'Bryant and Morgan (1989) found that adjustment to widowhood may be adversely affected by lack of financial experience or knowledge. These findings concur with the subject's perception of her financial status. She handled the family monies before her husband's death, has planned well with regard to daily living and the future, and feels financially secure.

In looking at forewarning of the spouse's death, the subject reports feeling generally contented with the circumstances surrounding the death of her husband. Carey (1979-1980) found that widows who had at least two weeks forewarning of their spouse's death reported a significantly higher level of positive adjustment.

Gass (1988) found that forewarning of death afforded the widows more opportunity for anticipatory grieving. The subject's forewarning included a diagnosis of six month's duration. The couple were life long planners who faced the world they lived in. They remained in control of the day to day living of their lives during the unwanted and unexpected illness of the subject's husband. The subject feels her husband willed the way he lived and died and maintained his dignity.

Though she does not speak directly to anticipatory grieving, the subject reports that she was able to recognize that the end was near and was able to gather her children together to spend time with their father before he died.

Berardo (1968), Gass (1987) and Poncar (1989) report physical symptoms surrounding bereavement including; gastrointestinal disturbances, sleep pattern changes and loss of appetite. Ferraro (1985), Clayton, Demaris and Winokur (1968) studied psychological symptoms associated with the phenomenon, including depressed mood and crying.

The subject feels that she is in basically good health and anticipates this continuing in the future. She experienced some early morning sleeplessness and appetite loss for about a month following her husband's death but denies that this remains a problem. She has been able to cry throughout her bereavement and feels that this gives her relief. She is occasionally bothered that she becomes tearful without warning, but this happens less frequently than earlier in the process.

The subject's profession is as an ancillary health care clinician and as such, good health has always been a value. She feels she has a more than ordinary knowledge of how to remain healthy and access the health care system.

Nurses played an important part in the days surrounding the death of the subject's spouse. Friehofer and Felton (1976) report that the most desired nursing behaviors on the part of significant others were behaviors that supported the comfort of the dying person and having all questions answered honestly. This was true for the subject. She reported that during the short time her husband was hospitalized before his death, he received excellent care both physically and emotionally from nurses.

In summary, the findings of this study support findings in the literature that bereavement is an individual and unique process determined solely by the individual. The unique contribution provided by this research is that the process was found to be inextricably tied to the concept of choice. The major questions raised by the study are which elements are involved on this choosing. These questions should be examined in future research.

Nursing Implications

In this last section of Chapter VI, the nursing implications and recommendations for research, practice and education will be discussed as they relate to this study, advanced nursing practice, and primary care.

Research. This study was conducted using the descriptive, case study method. The individual pattern response of bereavement was elicited from one woman as she faced life as a widow, and the results are only generalizable to that woman. It is recommended that further descriptive qualitative surveys be undertaken to examine the patterns of bereavement in other women. In addition, it is suggested that qualitative data be collected from multiple sources including those people identified as part of the environment of the subject to provide a larger data base and a clearer picture of the process. Longitudinal studies should be carried out to further examine the qualitative process of bereavement, over time. In addition, phenomenological studies which look to retrospective descriptions in order to arrive at a clearer and more indepth description of the phenomenon should be undertaken.

One of the desired outcomes of qualitative research includes further enhancement of underlying theory. The findings of this examination were used to enhance and support the Theory of Unitary Human Beings (Rogers, 1980) that formed the conceptual framework of the study. Parse et al. (1985) notes the unique value of qualitative research lies in enhancing those nursing theories, including the Theory of Unitary Human Beings, emerging from the simultaneity paradigm. The results were

consistent with that framework and bereavement was better understood from the principle of patterning. Additional research should be undertaken utilizing other principles from Roger's theory to further illuminate the lived experience of bereavement as well as enhance theory.

The widow brings to the bereavement process unique resources including personal, social and emotional ties that form her very unique environment. With this in mind, the process should be studied from a qualitative ethnographic approach to allow researchers to understand the bereavement process within various cultural contexts.

Quantitative research studies were examined in this study to identify the specific environmental factors that were found to be included in the process of bereavement. These studies are important to the understanding of the universality of the experience related to these identified factors and to any new factors yet undiscovered. This research should be continued with various populations.

Specific to this study, the pattern response for this woman was found to include several elements, the predominant one being choice. When studying the process of bereavement, prospective researchers are encouraged to examine carefully literature surrounding the concept

of choice. Choice should be examined quantitatively in a similar population using a reliable and valid instrument. Following this, choice should then be compared to another element identified in the study, such as optimism, to note the presence or absence of relationship. Intervention studies should be developed utilizing these findings.

The results of this study support Rogers' (1980) Theory of Unitary Human beings. Thus this theory guides the implications for further research, practice and education. In the next section, Nursing practice recommendations will be discussed.

Practice. The findings of this study support the proposition that bereavement is a process that is thrust upon the widow and must be lived in a unique way chosen and known only to the survivor. In the experience of the subject of this study, bereavement was characterized by a disruption of long established patterns which left the subject with a sense of uncertainty but at the same time with the knowledge that choices were possible and deliberate and the responsibility, alone, of the subject. As discussed earlier, the focus of the case study method is, in addition to uncovering the experience of a lived phenomenon for the individual being studied, also enhancement of underlying theory that directed the

objectives of the study. Implications for the Clinical Nurse Specialist (CNS) in Primary Care indicate that intervention should be process oriented.

Bereavement was found to be a process in which action (choices) are patterned and repatterned in the "infinite now" of the person living the experience. As such, the CNS should see support of that process as the primary intervention. Ideally, the CNS would recognize that support of the process should begin with a clear understanding of the essence and uniqueness of the person living the bereavement process. This would include how the person sees herself, interacts with her world, depends on others and sees her future.

In addition, a sense of the person's past interaction with her environment to pattern and repattern her ongoing well being would have to be understood from the widow's perspective. This would include, how past decisions have been made, how new situations have been faced, what roles she has seen herself filling and how she has coped with change in the past. This completed picture would guide intervention of the CNS toward an individual, client-centered facilitation of the process rather than a generalized intervention strategy aimed at all people experiencing the phenomenon.

As the person moves through the process, continuously patterning and repatterning according to her sense

of her changing world and her needs, the CNS would, reflect, support and facilitate this patterning. Clearly, client advocacy lies in the validation of the widow's unique and chosen way of being at any given point in the process.

In line with this, the CNS may help the widow with skills that better enable her to meet her needs. Though remembering that the bereaved person is always the first, best authority of how to live the process, the CNS can provide helpful ways for the widow to better express her needs and, therefore, make her choices. These could include values clarification, assertiveness techniques and problem solving strategies.

The widow, alone, can experience the bereavement surrounding the death of a spouse. The CNS, recognizing this, should also bear in mind that the widow's family will be processing their own loss in their own way and, in most cases, attempting to "help" the grieving widow. The CNS should assist the family in realizing that the bereaved person is living the process in her chosen way and that the best help at this time will be to support the individuality of the process rather than trying to "fix" it by either ignoring it, trying to minimize the pain, or hurrying the process.

In the role of Clinician, the CNS should be mindful of the well identified environmental factors that may

exist during the bereavement process. Among others are included untoward physical and mental symptoms. When a client presents with this symptomology, assessment should always include the discussion of recent losses and the client's perception of how that the process of repatterning is being lived.

Education. Nursing implications for education can be derived from this study for nurses in both learning and teaching roles. The practice of nursing at all levels can be taught based on research. Research based interventions once learned, can, in turn, be taught and modeled to others.

In this study, as in all case studies, the results are only generalizable to the subject. The results are reflected back to the theory underpinning the concepts that guided the study. In this research, the underlying theory is one of nursing, in this case, Rogers' Theory of Unitary Human Beings. This theory speaks to the process of living as it is uniquely experienced by the individual. In order to encourage nurses to value process as well as outcome, process based frameworks such as the one utilized in this study should be included in nursing curricula, most especially in advanced practice.

It is suggested that nursing education at all levels be theoretically based. Theory based education is

not only necessary to maintain a universal frame of reference for defining the uniqueness of the discipline of nursing but absolutely vital in order to guide practice. With this in mind, nurses in advanced practice, should be required to have theory content as a basic, underlying component of their curriculum. Baccalaureate nurses should be educated with the inclusion of a basic understanding of the theories that will guide their future practice. Associate degree nurses should be introduced to the idea of theory and its relationship to practice. Nurse educators at all levels should be well grounded in theory and its relationship to all practice levels.

Traditionally, bereavement has been taught as a process. The problem lies in the fact that the focus of the study of bereavement has been more exclusively placed on the process rather than the person experiencing the process. Bereavement has been viewed as a series of discrete and separate phases that all bereaved persons would go through in much the same manner. Each phase was seen as having a beginning and an end with proscribed behaviors and universally ascribed time lengths. It was thought that to deviate from the behaviors or exceed the time frame was pathological. This study's findings indicate that bereavement is indeed a process. The difference was found to be that the process was solely determined by the person living it.

This widow's perception of her ability and willingness to make the choices involved in repatterning her life was found to be the significant factors to assess.

Advanced practice nurses should see the role of Educator as extending to the general public. Because bereavement is a very universal experience, the need for informed understanding of the process is certainly obvious. Nurse developed self-help groups for the bereaved would be appropriate to assist this population to better understand the process they are living. Educational programs directed toward those persons who make up the widow's support system could be developed to provide the opportunity to learn about more positive ways of interacting with the widow as she experiences her bereavement.

Physicians in collaborative practice with Advanced Practice Nurses should be made aware of the implications of the process of bereavement. The nurse member of the practice should make a home visit 3 to 6 weeks after the death of a spouse to assess the widow's perception of her ongoing process and intervene as directed by the widow.

Finally, the goal of nursing research, education, and practice is to better understand the mission of nursing. That mission is the ongoing facilitation of

the person's living (patterning and repatterning) that includes a self identified sense of well being.

Summary

In Chapter VI an overview of the study was presented. In addition, the findings were discussed and analyzed with regard to the subject's transcriptions, Roger's Theory of Unitary Human Beings and the significant literature related to bereavement. Finally, the significance of this study with regard to nursing research, practice and education was discussed.

Appendices

Appendix A

MICHIGAN STATE UNIVERSITY

UNIVERSITY COMMITTEE ON RESEARCH INVOLVING
HUMAN SUBJECTS (UCRIHS)
206 BERKEEY HALL
(517) 353-9738

EAST LANSING • MICHIGAN • 48824-1111

May 5, 1989

IRB# 89-209

Mary Somers
1135 Marigold Ave.
East Lansing, MI 48823

Dear Ms. Somers:

Re: "BEREAVEMENT: THE INDIVIDUAL PATTERN RESPONSE IN A
RECENTLY WIDOWED WOMAN IRB# 89-209"

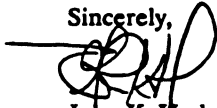
The above project is exempt from full UCRIHS review. I have reviewed the proposed research protocol and find that the rights and welfare of human subjects appear to be protected. You have approval to conduct the research.

You are reminded that UCRIHS approval is valid for one calendar year. If you plan to continue this project beyond one year, please make provisions for obtaining appropriate UCRIHS approval one month prior to May 5, 1990.

Any changes in procedures involving human subjects must be reviewed by the UCRIHS prior to initiation of the change. UCRIHS must also be notified promptly of any problems (unexpected side effects, complaints, etc.) involving human subjects during the course of the work.

Thank you for bringing this project to our attention. If we can be of any future help, please do not hesitate to let us know.

Sincerely,



John K. Hudzik, Ph.D.
Chair, UCRIHS

JKH/sar

cc: S. King

Appendix B

Consent Form

The study in which I am asking you to participate is designed to learn more about the experience of bereavement. You will be interviewed in your home one time. During the interview, you will be asked to respond to a series of questions and verbalize your responses into a tape recorder. The session will take approximately two hours. If you agree to participate, please sign the following statement.

1. I have freely consented to take part in a study of the experience of bereavement conducted by a graduate student of the College of Nursing at Michigan State University.
2. The study has been described and explained to me and I understand what my participation will involve.
3. I understand that participating in this study is voluntary and I can withdraw from participating at any time or not answer certain questions without recrimination.
4. I understand that no immediate benefits will result from taking part in this study, but am aware that my responses may add to the understanding of health care professionals of the experience of bereavement.
5. I understand that all descriptions will be treated with strict confidence and that I will remain anonymous.
6. I will be able to review my remarks before they are used in this study.

I, _____, state that I
(print name)

understand what is required of me as a participant and
agree to take part in this study.

Signed_____

Date_____

Appendix C

Format and Interview Questions

I would like to begin this interview by getting a clearer picture of you with some more open kinds of questions. You know yourself better than anyone and can help me to understand who you are. I'm going to ask you a series of questions, some of which may be difficult, and I would like you to tell me all your thoughts and feelings until you have no more to say.

Section One:

- How would you describe yourself?
- We all have various roles. For example I am a woman and a student. What do you feel your roles have been?
- What have your interests been?
- When you faced a new situation, what have been the ways you've coped in the past?
- What is it like for you when you have had to make decisions?
- Could you please describe your relationship with your husband?
- Please describe the circumstances surrounding your husband's death.

- What were your thoughts? What did you do?
- Who did you call on for support?

Section Two

Objective One. Significance, Interpretation, Meaning

Now I'm going to ask you some questions about your life now. Again, tell me all your thoughts and feelings until you have no more to say.

- How would you describe your current thoughts and feelings about the meaning of finances? How does this affect your life?
- How would you describe your current thoughts and feelings about the meaning of family and friends? How does this affect your life?
- How would you describe your current thoughts and feelings about the meaning of the way you see yourself? How does this affect your Life?
- How would you describe your current thoughts and feelings about the importance of your health? How does this affect your life?
- How would you describe your current thoughts and feelings about the importance of the circumstances surrounding your husband's death? How does this affect your life?

Objective Two. Validation, Overcoming Obstacles,
Interaction With Others.

- In your life now, how would you describe people's response to you when you want or need to talk about finances? If you have financial worries, how do you handle them?
- In your life now, how would you describe people's response to you when you want or need to talk about the way you see yourself? If you are troubled about the way you see yourself, how do you handle it?
- In your life now, how would you describe people's response to you when you want or need to talk about health? If you have concerns about your health, how do you handle them?
- In your life now, how would you describe people's response to you when you want or need to talk about the circumstances surrounding your husband's death? If you are troubled about your husband's death, how do you handle it?
- In your life now, how would you describe people's response to you when you want or need to talk about any feelings of loneliness? If you are lonely, how do you handle it?

Objective Three. Changed Perspective, Future View

The next set of questions will focus on how you see your life in the future.

- Since your husband's death, how have your thoughts or feeling about finances changed, if any? What do you see in your future related to finances?
- Since your husband's death, how have your thoughts or feeling about the way you see yourself changed, if any? How do you see yourself in the future?
- Since your husband's death, how have your thoughts or feeling about the circumstances surrounding your husband's death changed, if any?
- Since your husband's death, how have your thoughts or feeling about your own health changed, if any? How do you see your health in the future?
- Since your husband's death, how have your thoughts or feeling about the need to have the support of friends or family changed, if any? Do you feel you will continue to have these same feelings in the future?

To bring the interview to termination, the following questions will be asked.

- What has been most difficult for you in this situation?
- Sometimes crises and very difficult times provide an opportunity for people to grow. Do you think this is true for you? And if so, in what ways do you feel you've grown?

Appendix D

Transcript

SUB: I get tired.

INT: Sure. You were just saying that you're 60 years old and you were married how many years?

SUB: 38.

INT: And (husband) has been dead how many months?

SUB: Actually 6. He died on the 13th of October. So that would have been November, December, January, February, March, April, May.

INT: I would like to start by getting a little clearer picture of you with some more open kinds of questions, ok? You know yourself better than anyone and you can help me understand who you are. So I'm going to ask you some questions, some of which may be difficult, because it brings up memories. But I'd like for you to tell me all your thoughts and feelings about what I ask until you feel you don't want to say anything else about it. First of all, how would you describe yourself?

SUB: Oh, probably extroverted. And I would have to say relatively intelligent, caring...I don't know.

INT: That sums it up, huh?

SUB: That's right, probably.

INT: Good, ok. We all have various roles. For example, I'm a woman and a student. What do you feel your roles have been?

SUB: Over a lifetime?

INT: Uhuh.

SUB: Well, before I'm anything else I have always been, well, in my married life, a wife and a mother. And I am a career person although my responsibilities would lead you to believe - that I was a career person but I'm not. Actually, I still love my home and I am a wife and a mother. And uh...probably that's one of

the reasons that I have a very good rapport with the women that work with me because I can understand where they're coming from in a work setting and, they haven't caught up with me yet, but I give a lot of liberties that other people don't. I mean, you know...nursing, I think really doesn't bend at all and my people, sometimes they take advantage I think...Overall that, not being career oriented makes me a little bit more personal...to people. I'm a friend, (husband) and I were good friends. That was, uh...neat.

INT: What have your interests been?

SUB: Mostly traveling and we liked to travel and yard work, gardening, whatever. And it's still that way.

INT: When you faced a new situation, what have been the ways that you've coped with it?

SUB: By a new situation, what do you mean, by his death, particularly? Uhh - I think, Maribeth, that you have choices that you have to make. What am I going to do? And we have always been the kinds of people that faced the world we lived in. Ok? And uh so, I realized that I have choices that I have had to make. One of them was, am I going to work? Well I mean, I'm in a nice situation, I guess, in that actually I could quit work and I would not starve to death and I could stay here. But the choice there, is what in the name of goodness am I going to do with myself? Because I probably have more energy then most of the people you know. At least most of the people I know. And I doubt that the people that we know are too far different. But uhm, I need to do something. And I can't do yard work all the time. I mean, pretty soon it's going to look pretty good and it didn't take me too awfully long to do it. But then I have a boy that helps me too. So I have decided that I am going to work. Now, am I going to work until I'm 62? Am I going to work until I'm 65? I'm not making any decisions about that at this point in time. I will work until I don't want to work. And uh, it was - like I'm going to England in September and (friend) didn't want me to go for 3 weeks. Well (friend) really didn't have any choice in the matter because I intended to go for 3 weeks. And he went to the president of the hospital and he said, "Let her go for 3 weeks". It's a good thing they decided that, because I mean you know, those are the kinds of opportunities you take advantage of and (son) lives in England and we're going to

Germany during Oktoberfest and Austria and then we'll tour Germany for 2 weeks and then we'll go back and I'll see the places. In fact, they're in Amsterdam this weekend. They're at the tulip festival. So those are the kinds of things that (husband) and I would have done together, and I feel that those are the kinds of things that I want to do. So, we'll see.

INT: Ok. What's it been like for you when you've had to make decisions?

SUB: It isn't really difficult. What I have a habit of doing is talking about the problem with different people and then making up my own mind. (Husband) and I always made decisions together and it was no problem for me to make decisions. I might have, I mean you know, a few investments or something like that I might of felt that I needed advice. But if I did, then I would call the tax man. Or I have, (husband) and I have another good friend who is in insurance and tax shelters at the hospital. So on those kinds of decisions, I have had people that I could talk about the problem with and then I've made up my own mind. I don't discuss most those things for advice with my children because...Oh yesterday, I got a phone call from my son in Indiana. He was having a question. He is a very bright young man and has developed a technique of pickle fermentation without salt and he said "Ok mom, what do I do?" I'm used to people coming to me for decision making. I'm not used to...And if its right or if its wrong, I live with it. I don't know whether its good or not but that's the way it is.

INT: Can you tell me just a little bit about your relationship with your husband? You talked about the fact that you were good friends.

SUB: We were. We always have been and we met in college and our lives we planned; our children, we worked with. The way our children are was no accident, we worked together. And uh, we enjoyed each others company and uh, like I was complaining about those kids in Dewitt, I mean you know, there's no way that those kinds of things...And our children's education, our children - that is why (daughter) is still in school because her father was very determined that she was going to be prepared. And she went as far as of course her LPN. But uh, oh I think that probably within (daughter) was the desire to compete with her

brothers...So we were good friends and we enjoyed visiting. We've had, had several people who have commented, we were very close. Uhhuh.

INT: Tell me a little bit about the circumstances surrounding your husbands death.

SUB: Well I think, Maribeth, that as you go along, things that happened...you begin to put into perspective and I think you might have been able to pick up on things that maybe you don't pick up on uh...at the time you're going through them. Let's see, it must have been about 6 years ago. We have had this land for oh, probably, we've owned it for 10 - 12 years. I don't know. But he had, common to men, a prostate infection. And uh...well we didn't, I mean you know, I've been around hospitals for years but I don't pay attention to men's prostate problems. And he got quite ill. It was a flu type thing and uh, he couldn't urinate and he was sick to his stomach well, you know what happened. The BUN level was so high that it was causing him to vomit. So we ended up in the hospital and uh, because he just wasn't getting any better. I brought him into ER and they admitted him. And the following morning he got up - well we have always planned, I mean, the accidents just didn't happen. We were poor as church mice when we were first married because I didn't work. And then when the kids were born I didn't work until (daughter) was, what was she? She was a senior in high school when I went back to work. So we decided to be poor but at least have the kids taken care of and I have never regretted that. In fact, I encourage people to do with a little less because (daughter) didn't have a store bought coat until she was a senior in high school. And she bought it herself on babysitting money because that was the way we were raised. You are responsible. And the kids have reflected that. (Son) probably is sitting on a salary of \$45,000 a year and he is only 29 years old. And, I mean you know, the kids have all done well and that's because they were taught. As I say, it was no accident. So anyway, I remember going upstairs because I worked at the hospital here for 20, oh, 17 years and when he was unaware I think of how ill he was. We've never been aware of how ill he was because he was a very strong willed man; the one that can get blue heron and such to come and visit him. But anyway, he said, his comment was, "I only hope I live long enough", because we hadn't built out here yet, "to be able to do some of the things that I want to do". So I made up my mind

well all we were waiting for was a little more money. And what's a little more money among friends? So we began to find a builder. And so then he had a TUR, there was no malignancy there but I think a lot of times that the cells that are in those areas are just probably not what they ought to be anyway. So he did have a little bit of blood show up a couple of years later in the urine, and our Director of Nursing at the time was a good friend of mine and when she retired, her husband had prostate problems and one of the doctors had said that, "There is always a reason why blood appears somewhere". And in a man you hit the road. So we took him into Dr. _____ and he had the IVP and they gave you know a thorough check and he was going in for a scope and I'll be doggone, it was St. Patrick's Day what, 3 or 4 years ago that they did the scope that he found cancer, a tumor, but it was superficial he thought he got it all but he did the chemo. And of course, that process is every 3 months you go in for a scope until the, I mean you know, the sucker is no longer. Well he had, actually, another tumor in that next 3 months and then they became cells in transition but he had chemo. And we, I mean you know, he, we, were shocked but felt we had it on the run. And then a year ago February he had gone back to work. He'd had a lot of stress and just really wasn't responding quite the way that he should have. In fact we had, he had a stomach scope because he had ulcers so badly that we were thinking, doctor was talking about a stomach resection. Well, I just started giving him oatmeal and Tagamet and he got along real well. And we got through that one. But later he had some sick leave and uh really wanted to retire very very badly; was not happy at work, wanted to be here and was very glad that he was coming to that age. So we did decide that it was better that he go back to work because he was going to retire in March of this past year of 88. And uh, so he went back to work. It must of been the 1st of December and he hadn't worked a tremendous amount of that year because he just was having a lot of - wasn't really sick but he wasn't really good and psychologically it wasn't good for him to go back to work. And with the connections I had at the hospital, the doctors kept putting him off on sick leave and until he could retire. So anyway, he went back to work in December and in February he was - what he was doing was he was going through chemicals that were old and throwing them out. They had given him help to do this and there was a lot of dust and he had had allergies and actually he'd had a couple of colds that just didn't seem, I mean you know. He'd been in

for sinus and so anyway. It was about the 9th or 10th of February and he was fighting this cold. He'd been to the doctor a couple of times and it just wouldn't cure. And so we decided that it was almost, I mean you know, figured that it was pneumonia so (doctor) put him in the hospital and we drew fluids and found that it was just full of cancer cells. So, needless to say, we were all shocked. The doctors were shocked, everybody, the whole, everyone that knew him. We were just dumfounded. So anyway, uhm, let's see...the MSU group, (doctor) and actually, what's the one? Oh shoot, I can't think of his name...

INT: Dr...

SUB: No. Well anyway, (doctor) ended up, (doctor) and (doctor). But the one that took care of him, he is the one that is called back to (hospital).

INT: Shoot, I know who you mean...

SUB: Tall, uglier then hell, but good. Uh huh.
Really, I mean you know, he was just, he was just really something else again, what's his name?

INT: I can't remember. I know the (hospital) group better.

SUB: Yeah well, I've been very...We also went the (hospital) route because they did radiation on the lungs. Now, (doctor) is the one that uh (husband) went to and he was another...I think he's very good. But, uh, well anyway, through tests that they found at the hospital, when he had had, an accident several years, well actually, it was about 30 years ago. And uh, he had had some problems - well they found, I mean you know that it was not a crack or anything but, probably, when, well, what they called a hot spot, probably arthritis over the period of years and we just thought it was arthritis. Well it wasn't. There was a lesion there and so it had already, in fact, that was where the most serious cancer was at that time...was in the neck because it had gone in, it had totally encompassed two vertebrae, So, but I mean you know, you're going through this, Maribeth, you don't uh realize what's happening to you until you reflect back -- (doctor), (doctor). Ok. He came into the room and he laid it on the line and (husband) didn't want to hear it because he said that he didn't really think that it was necessary to put him through chemo

because he wasn't going to live beyond 6 months anyway. And actually the man was right because from February when we found out - about - that would be March, April, May, June, July, August, September. Hey, we did good work; he lived 8 months. And he said that it would be a matter of months but he was in such good physical condition. And (husband) opted to go the chemo route, so and, and I would have, I mean you know, hey - where there is life, there is hope. But he said that there were 3 ways that we could go. I mean we could go with the chemo or we could go with just maintenance or what was the other one? I don't know. But anyway, we went for the chemo and, of course, we had to go for radiation before we could start on the chemo because, of, I mean you know, say on a scale of 1 to 10, already up to 8 coverage; he was probably going to be paralyzed within weeks, months, whatever. He couldn't even walk straight. (Doctor) said I mean it had already affected his gait and so on. And so, and we didn't realize that. I mean you know...But as I look back, now, I mean there were so many things that he procrastinated about. And he just really didn't feel good enough and (doctor) seemed to think that uhm, he had had the - well - okay we came to where we were deciding what was the prime source. Well, everybody I knew thought that the prime source was the bladder because that was where we found the tumors. But (doctor) insisted that is was not the bladder, that was the source, that the lung was the prime source. And he had two spots on the lung that had metastasized to the spinal cord and, beyond a doubt, had metastasized to the bladder. So, I mean you know, what are you going to do? Are you going to x-ray everybody that has a bladder tumor? I mean you know, that isn't par for the course. But if we had caught it back then, we probably could have removed the lung, done radiation - because we did, we did with the chemo and with the radiation - we were able to reduce the tumor in the spinal cord to nothing but scar tissue...there for a while. But my own theory in watching him, but he was a very strong, very very strong-willed man, and he wanted no one in here to take care of him but me. And he tolerated (daughter). She thinks that she was the pillar of strength and it doesn't do any harm to let her think she was but, he didn't even want her coming in here. I got up at 4 o'clock in the morning and got his breakfast. He went back to bed until he got up and he was able to take care of his lunch. But, I mean you know, it was a situation where, her being here forced him to go with her and I mean you know, but it wasn't what he would

have chosen. And then I would go to work and come home and we'd hit the road and we'd go to the movies when the weather was hot, because we didn't have, at that time, central air...we do now. But anyway, we'd go out for dinner and I took him all over hells-half-acre. We had an ice cream cone. I'd go to the grocery store 90 dollars worth of groceries and we'd throw out 95, I mean you know, but at least his appetite, and he lost very, very little weight. (Doctor) said, that the only reason that he lived as long as he did, was because we had taken such good care of him. And I think it has a lot to do with the diet. I have decided that when they don't eat is when they die. And he ate up until the last 2 weeks because I wouldn't hear of him not eating. He'd eat whether he wanted to or not. But we fed him high fat things, he didn't lose the weight so his body did not go down hill the way it does. He didn't consume himself. He had plenty of calories to live on. And uh, so that was the way we handled it. But I think that he had really been very ill for a long time.

INT: But you felt like you really had, and he had control...

SUB: He had control. If you, did I ever tell you how much control he had?

INT: No.

SUB: Ok. He was here and he was holding up the wall. Finally I got oxygen in here. I just, I mean you know, you didn't do anything. I mean, we did it very carefully but he had a hard time breathing and towards the end he, in fact, the week before I admitted him to the hospital, he never went to bed. He sat up and slept at the table and at the desk. We put all those jig saw puzzles together. We did that every night and he worked on jig saw puzzles all day. So, anyway, the morning that I took him into the hospital, I knew that he was bad but I didn't have any idea he was sick enough to die. I mean you know, I had made arrangements at the hospital because we have extended care beds and they were going to let me put him in there because he wouldn't have anything to do with hospice. He didn't want anybody in the home. I was doing just fine. It was great. I mean you know, I was up all night, up and down with him, and working all day and that was no problem. So anyway, uh, he, at 4 o'clock in the morning I got up in the morning and he said "I can't go on this way", so, I said, "Ok, I'll call

(doctor) when he gets up". And we admitted him and he died - 7 days he was there. But we were going to transfer him. I had already made the arrangements to the extended care. Because, as it was, we could no longer, we couldn't keep him in the room because of utilization review. And it was only because (name) was Chief of Staff that we were able. Because when I took him in there the week before he said, "I just can't". He said, "There was a man that was sicker than (husband) is that week". Well up until 3 weeks before he died, I was taking him to San Francisco. We were going out there. I mean you know, I knew that we were going to have problems but (doctor) and (doctor) both said that he was able to go. But he went down hill that fast. But I really and truly do believe that he had forced himself; that he had willed that he was going. In fact, it was really funny. I sat in the room. We never talked about his dying; we haven't to this day. And we made no funeral arrangements, we made no nothing. He, we, he was going to be alright. And uh, anyway, where was I?

INT: You said something about going to San Francisco.

SUB: Oh, well about 3 weeks before he passed away, there was no way I knew that I could handle him out there. Because here, I had my own support network. And being an employee of the hospital, and in the position that I have been, I had a lot of support. And I just couldn't...(TELEPHONE RANG)

INT: Ok. I'm going to ask you some questions about your life now. So again just tell me what your thoughts and feelings are about what I'm going to ask. How would you describe your current thoughts and feelings about the meaning of finances and how does this effect your life?

SUB: I don't have any financial problems. I make enough money to support myself. And investments, we were well taken care of because we were going to, he was retiring in March when he was ill. And uh, so we were able to take care of ourselves and we had planned for our retirement. So I don't have financial problems. That is good. (Son-in-law's) mother has a lot of problems. I mean you know, that's why I say, careful planning in life has been very good to me from the stand point that, what would you do if you had only social security? And she hasn't even worked!

INT: Ok. How would you describe your current thoughts and feelings about the meaning of family and friends and how does this effect your life?

SUB: My thoughts and feelings. I don't know what I would do without them. So and, as I told you before, they've been very good to me. Too good. (LAUGHS).

INT: How would you describe your current thoughts and feelings about the way you see yourself?

SUB: I see myself in a very positive way. Actually, I probably have been concerned subconsciously for quite a while, and I feel basically, terribly lonely but very positive about myself and my abilities.

INT: How would you describe you current thoughts and feelings about the importance of your health and how does this effect your life?

SUB: Well, I'm very well aware of my health. I mean you know, I think most health career oriented people are. And I have to think that I am in relatively good physical condition and able to work and enjoy life. Probably have more energy then most of the people I know.

INT: I saw you with the shovel...boy.

SUB: Hey. I mean you know, you have choices you can make. And this is going to be my way of life and of course I've always been pretty good with a shovel. But I haven't been quite as good as I'm having to be right now. Like in raking. In fact, it's strange that we should talk about that because I told father this afternoon that it use to be, he always teased me about the rhetorical 'we'. 'We' were always going to do something. But it always ended up being 'he' who did it. And I told him today - I laughed. Anybody driving by would probably think I was nuts. I said, "well, it looks like the role has reversed for a while, you're going to watch me doing instead of 'we' doing, which was basically you doing". So, no, I enjoy this. I've always, I'm not afraid of hard work. I don't do much of it. In fact, I don't clean my house. I don't do much of anything. But this, I enjoy and will do.

INT: Ok. How would you describe your current thoughts and feelings about the importance of the circumstances surrounding your husbands death?

SUB: How do I feel what?

INT: Ah, we just talked about what led up to his death and the fact that he sort of controlled that, how important is that, that happened?

SUB: That he controlled it?

INT: Uhuh.

SUB: I think it is very important because he spared me. And as I said, I think he realized how ill he was but he never gave up. And in the hospital, it was really kind of funny cause this was what I was going to tell you before we went on. I'm sure that the tumor had reappeared because his, in the spinal cord, I'm sure of that because he was in and out of it. And he was mentally a very strong man; very strong willed. And (son and daughter-in-law) had come. I wanted all the kids to have time with him and my daughter-in-law and she dearly loved him. (VERY TEARFUL). Go on.

INT: That's ok.

SUB: It may not end.

INT: Those memories that come back, it's hard.

SUB: Well, anyway, she and (grandson) had come and spent the week. Well, he had a fit. And that was the week before I put him in the hospital. And he really didn't need the commotion but I thought, I mean you know, I figured out, that he wasn't going to go too far. And that the kids really needed that time with him. And I was able to get (son) here from England. He had just gone to England. Anyway, uh, I got him home so that he could spend the last year, the last week that (husband) lived. He was with him all the time. So anyway, they had gone back. (Son and daughter-in-law) had gone back too. I'm looking for a picture of my grandson, because you would love it. But anyway, (son) had been here and they had gone back to Indiana. And actually, (husband) was, he was talking to himself, (husband) was. And he was funnier than all outdoors. And he said, "I will maintain my dignity as long as I am able". I wrote these things down. And (daughter-in-law) was able to put together the jig saw puzzle. And he said, "She is so damn, (daughter-in-law) is so damn fast at that, that I can't keep up with her". So that's why I think it was

one more time, had gone in to the spinal cord. It was just funny. He was having all of these conversations with himself and he didn't care for Heidi (THE DOG). We had Sam and Sam was the dog. And actually Sam was a year and a half old and he was just really a puppy and he died two weeks after (husband). (Husband) loved that dog, I swear to goodness that that dog and he are somewhere up together roaming in the daisies, watching the Blue Heron. That's the kind of a person that...He would have willed for that to have happened. But very strong willed, very much in control. As he said the last week he died, before he died, "I will maintain my dignity as long as I am able". And the only thing that we spoke about at all about his dying was that he was very glad that (VERY TEARFUL)...ok, let go on.

INT: Take your time. We've got time.

SUB: Are you sure?

INT: Yeah.

SUB: You may end up going to Flint. That was (daughters) husband.

INT: Ok. I'm going to ask a couple questions about, again, this is about your life now, and how would you describe people's response to you when you need, want or need, to talk about money, if that's anything you want to do?

SUB: I don't...I mean, if I want to say something to somebody I say it. But I do what I want to do.

INT: In your life now, how would you describe people's response when you want or need to talk about the way you see yourself?

SUB: I don't have any problems talking with people. How I see myself, I mean you know...

INT: We talked about things like, oh, should you work, should you retire, should you, in case you needed to talk about those things with someone would there be someone?

SUB: Oh yes. There certainly would be. Uh, actually (friend). I've got two friends at the hospital. One of them, that drives...well, both of them are men that I have worked with very closely. One of them is

(friend) and the other one's our Senior Vice President at the hospital. And I feel, and then this, and I mean you know, like I have some competent people. I mean you know, we visit all the time. And of course, (friend), as far as he's concerned, I'm not going to retire 'til he does. So I really don't have much choice in the matter, he thinks. But I will do what I want. And as I say, it may be funny, that's just the way that I feel about it. It's kind of scary for health care. Going back as to what my needs are at the hospital or what I can do. I do a doggone good job with food service. However, I had to realize that my place is not as great as the patient care, and that I can be replaced by a food service. And uh, that's one of the things that motivates me in my present position. Because I feel very responsible. We have a patient count of probably between 80 and 90 and maybe 100. And I have 60 employees in dietary. Well you don't have to be too swift to figure out that I've either got to keep them extremely busy and pay my way, or...And I really question...I have a lot of thoughts about clinical diet management and just really how effective are we. How much would we be really missed if we didn't exist? Ok. If you stop and think about it. How many people would you know adhere to their diets strictly? Be it, well now, the diabetics, they still have choices. But anyway...

INT: Ok. In your life now, how would you describe people's response to you when you want to or need to talk about feelings or loneliness and if you are lonely how do you handle it?

SUB: Well there again, I have a real good support system. It was hard to go to Florida, because we had all been there together. So, but people will, they bear with me. And I try not to put them through a great deal. Because nobody likes to see you sit and feel sorry for yourself. Really.

INT: Are you able to talk about (your husband) with people when you want to?

SUB: Oh yes, heavens yes, all the time. In fact, I have this son, in Indiana, who was extremely close to his father. And he has had a real hard time. But he wouldn't talk about it. And so, always, when he comes anymore, we talk very openly. And I think its probably - I hope it will help him in the long run. Because I think you need to. I would feel sorry for the people who couldn't talk.

INT: They say its painful. I've never lived through it so I don't know, but they say as painful as it is, in the end, it is therapeutic.

SUB: Oh, I believe that. Wouldn't you feel sorry for the people who couldn't talk? I think that's one of the things that you have choices about. But people are use to me now because I just am very open with anybody that I come in contact with. Well (husband) would have done this. I mean, in fact, we were over at Dewitt last night. We played a game of hearts with him the Monday before he went in the hospital on Friday. And he could hardly hold the cards in his hands. That's what makes me, he was just unable to really coordinate. But we were talking about that last night. And we thought we were going to play another game cause she beat us and usually you don't beat him. And so no, I have no problems talking about him, none whatsoever. And people listen whether its out of politeness or whatever. I don't really care what it is; they don't like it - they can move on. They waste too much of my time anyway.

INT: The next set of questions focuses on how you see your life in the future, ok. Since your husbands death, have your thoughts or feelings about money changed, if any, and how do you see your future related to money?

SUB: It all depends, of course, on how long I work. But, I don't see money being a problem. I spend a lot of money and some that I don't even earn right away. But I figure that I am going to have what I want at this point in time. And after you grow a little older those things really aren't important, the traveling and so on. I don't envision money as being a problem, If it is, I'll go on welfare. (LAUGHED).

INT: Ok. Since your husbands death, how have your thoughts and feelings about the way you see yourself changed, if any, and how do you see yourself in the future?

SUB: Oh, I don't know, I hadn't thought a great deal about the future. Right now I'm as I say, lonely. But, I mean you know, I don't have that many problems.

INT: Since your husbands death, how have the thoughts or feelings about the circumstances surrounding his death changed, if any?

SUB: Oh, as I said earlier, I think now that I can reflect back. I think he was more ill. But I think probably its a good thing we don't know what's ahead of us. Don't you? Because if we had known, I don't know if we would of done anything any differently anyway. Because we just sort of took one day at a time and did what needed to be done. Actually we thought he was going to get well up until the first part of September, because, or not really well, but that he was going to be able to go on with the chemo and all of a sudden the Cysplatnin quit working.

INT: Since your husbands death, how have your thoughts or feelings about your own health changed, if any, and how do you see your health in the future?

SUB: Take it day by day there too.

INT: Since your husbands death, how have your thoughts and feelings about the need to have the support of friends or family changed, if any, and do you feel that you will continue to have the same feelings in the future?

SUB: Well, (friends names) were here practically every 2 or 3 days. They supported us when he was alive and they are doing the same thing now....and I talk to (son) every week. I don't see where the people that...I think there were people who weren't able to come out here when (husband) was so ill. I think you'll find that. There are a lot of people that can handle illness, but they aren't a close support group anyway and I have a lot of support from the people at work, a lot of it. So I mean, my own employees, but I don't see any real change, the people who were with me then are still with me.

INT: That's not always true, that's nice.

SUB: It is.

INT: Ok. I only have a couple of more questions.

SUB: Aren't you glad?

INT: I'm worried that this is...

SUB: No, that doesn't bother me.

INT: Ok. What has been the most difficult think for you in this whole situation?

SUB: Loneliness. Cause we were very close, as I said, and there wasn't anything that we didn't talk about, visit about, whatever. And that I miss.

INT: Sometime, crises, very difficult times, in your life, they say, provide you will an opportunity for growth.

SUB: Oh, I'm a firm believer in that. I'm not so sure I wanted to grow in this way. No, there is no growth without stress. I firmly believe that. But I didn't have that much more growth that I needed. Actually at this point in time, probably I'm what's holding (daughter) together. Well, no, really!

INT: You mean in terms of her...

SUB: She's had a lot to contend with. And as (son) is calling me now, I'm the matriarch as far as he's concerned. We went to Chicago 2 or 3 weeks ago when (husband) birthday; it was over the 24th of March. And that's what I say, I have a good relationship with my children. Always have. And (son and daughter-in-law) were going to Florida and then they decided that they really couldn't afford it. So they were going to Chicago for their vacation and they wanted me to go along. Well, as it was, I was going to take (grandchildren) and (daughter) decided she wanted to go. So the 8 of us went to Chicago. We went to the Brookfield Zoo, and we went to the Aquarium, and to the Museum and to the Water Tower. And we just had a ball. And those are the kind of things that bind the family together and get us through. (Daughter) needs strength right now and I am her strength and sort of guide and direct her. And (son), I mean you know, they're strong people but they - I feel a need. And I think that's the important thing. Are you needed? Or are you whatever...

Appendix E

Field Notes

The subject was working in her yard when the interviewer arrived in the late afternoon. The home, which sits on a lake, is spacious and comfortable and decorated with mementos and memorabilia that hold special meaning for the subject. After a tour of the yard, the subject chose to proceed with the interview at her dining room table where the late afternoon sun came through the windows.

During a tour of the house which she proudly showed the interviewer, she make a special point of pointing out the book shelves and desk her husband had built saying "(husband) was a voracious reader". She referred to the bedroom as, "This is our bedroom". Further, she said, "We like to look out in the morning and watch the lake". "We planned this house for our retirement and we almost made it".

The subject was casually dressed, wearing no makeup. Before the interview began the subject got a box of tissues and placed them in front of her on the table. She seemed somewhat nervous at the beginning of

the interview, crossing and uncrossing her legs and twisting her wedding rings which she continues to wear.

Throughout the interview, the subject remained warm and open with appropriate eye contact. She was very attentive to questions, pausing to think before responding with good detail.

The subject was quietly tearful during the interview while answering questions. She became very tearful twice during the interaction and was unable to continue for a few minutes. At times, the subject displayed a sense of humor which was appropriate to the situation and discussion. At all times, the client's affect and behavior were congruent.

At the end of the interview, the subject seemed very reluctant to end the discussion. Taking her cues, the interviewer stayed and conversed with the subject for an additional 40 minutes before leaving.

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