

Grief and Mourning Among African American Elders After Spousal Bereavement

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SHEILA PUTMAN CAPP-TABER

University of Missouri-Columbia

Dr. Lawrence H. Ganong, Dissertation Supervisor

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The undersigned, appointed by the Dean of the Graduate School, have examined the dissertation entitled:

GRIEF AND MOURNING AMONG AFRICAN AMERICAN ELDERS
AFTER SPOUSAL BEREAVEMENT

Presented by Sheila Putman Capp-Taber

A candidate for the degree of Doctor of Philosophy

And hereby certify that in their opinion it is worthy of acceptance.

Dr. Lawrence H. Ganong, chair

Dr. Puncky P. Heppner

Dr. Roxanne W. McDaniel

Dr. Davina Porock

Dr. Gaynell M. Simpson

Dedication

I am keenly aware there have been many individuals in my personal and professional life that have made this dissertation possible, but I dedicate this work to the kind and generous women who invited me into their lives and shared their experiences with me. This work reflects the wisdom and integrity in the way they have lived their lives. Their faith in God was an inspiration to me in my own spiritual walk. I thank God that this work brought our lives together.

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GRIEF AND MOURNING AMONG AFRICAN AMERICAN ELDERS

AFTER SPOUSAL LOSS

Sheila Jean Putman Capp-Taber

Dr. Lawrence Ganong, Dissertation Supervisor

ABSTRACT

This grounded theory study explored grief and mourning processes of African American elders during the transition into widowhood. The participants were 9 African American women who had been widowed from 2-10 years. The age range of the widows was 67-98 with a mean age of 79. The couples had been married a range of 38-62 years before the husbands died. All of the husbands had experienced an anticipated death from progressive physical illness. Each participant was interviewed twice, except for one widow who was lost to follow up. Data analysis was completed between each interview. The results were verified with participants to ensure the credibility of findings. A six phase process model of the transition into widowhood emerged from the data analysis. There were clear distinctions between the phases, but the phases were not linear, and the widows could return temporarily to an earlier phase in the process. The core category was “Persevering” with two closely related subcategories of “Weathering the Storm” and “Overcoming Whatever Comes.

CHAPTER 1

INTRODUCTION

This is a grounded theory study of grief and mourning among African American female elders after spousal bereavement. Spousal bereavement is a significant loss that affects many areas of an individual's life. In this chapter I review the: (a) significance of study, (b) purposes of the study, and (c) research questions. Further parameters of the study are defined and definitions of terms are explained.

Significance of the Study

Changing Demographics among African Americans

In 1998, 45% of American women over 65 years of age were widowed (Administration on Aging, 2003; Center for Disease Control and Prevention, 2004). Minority populations of older adults in the United States are projected to increase from 16.4% in 2000 to 25.4% by 2030 (Administration on Aging, 2003). Minority elders are projected to increase by 219% compared to an 81% increase in Caucasian elders. These changes include increases of 328% for Hispanics, 131% for African Americans, 147% for American Indians, and 285% for Asians and Pacific Islanders (Administration on Aging, 2003).

African Americans are one of the largest minorities in the United States (U.S. Census Bureau, 2000). African Americans represent 12.3% (34.6 million) of the population and another 12.9% are African American in combination with one or more other races (36.4 million). In July, 2007, there were 40.7 million Black people in the United States (U. S. Department of Health & Human Services: The Office of Minority Health, 2008a). Projections indicate that 55.5% of African American

females and 23.3% of African American males will be widowed by age 65, compared to 47.6% of all women over age 65 and 14.3% of all men over age 65 (U. S. Census Bureau, 2000). Given the predicted increase in the number of widowed African Americans, the fact that 7% of the participants in the studies reported in an integrative review of research on spousal bereavement, grief, and mourning were black (Capp, 2001) indicates that little is known about this group of older adults.

The lack of research on African American elders and their bereavement process is inconsistent with the goals of *Healthy People 2010*, which has proposed to eliminate health disparities such as disparities among minority populations in health and access to healthcare services. (Baldwin, 2003; U. S. Department of Health and Human Services, 2000). The issues of health disparity and healthcare access disparity among minorities are both relevant to this study because of the potential for bereavement, grief, and mourning to affect the mental health of the bereaved and the need for access to healthcare during these critical times.

The effects of grief and mourning on the mental health of bereaved individuals have been frequently researched (Carr, 2004; Parkes, 1997; Winter, Lawton, Casten, & Sando, 2000), although findings are mixed. For instance, although some researchers indicate that for a majority of people there is an initial level of depression before mental health returns to baseline within 1-2 years (Caserta & Lund, 1992a; Harlow, Goldberg, & Comstock, 1991; Parkes, 1997; Thompson, Gallagher-Thompson, Futterman, Gilewski, & Peterson, 1991), other studies have shown that approximately 10%-20% of the elderly bereaved spouses have unresolved mental health issues after 2 years (e.g., Ott & Lueger, 2002; Parkes, 1997). In addition, prior

mental health issues or physical co-morbidity predispose individuals to increased incidence of mental health problems after bereavement (Caserta & Lund, 1992a; Caserta & Lund, 1992b; Lund, Caserta, & Dimond, 1994; McCruse & Costa, 1988; Mendes-de-Leon, Kasl & Jacobs, 1993; Parkes, 1997). Since the studies have dealt primarily with Caucasians, little is known about the mental health effects among African American elders. This study addresses African Americans' experiences with spousal bereavement, grief, and mourning.

Culturally Competent Health Care

Healthy People 2010 addresses the issue of providing culturally competent care to address some of healthcare access disparities described above. Culturally competent care refers to “health care services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients (that) can help bring about positive health outcomes” (U. S. Department of Health & Human Services: The Office of Minority Health, 2008b). Cultural competency among health care providers is considered to be one of the primary strategies to help decrease the disparities in health care. This study will contribute to the understanding of factors contributing to culturally competent care for the African American elder. *Healthy*

People 2010 states:

To work effectively, health care providers need to understand the differences in how various populations in the United States perceive mental health and mental illness and treatment services. These factors affect whether people seek mental health care, how they describe their symptoms, the duration of

care, and the outcomes of the care received (U. S. Department of Health and Human Services, 2000, section 18, p. 21).

There have been many studies that reflect racial and ethnic differences in a broad spectrum of health care utilization issues among elder adults, such as: (a) cognitive functioning (Zsembik & Peek, 2001), (b) health care service utilization (Iwashyna, Curlin, & Christakis, 2002; Miner, 1995), (c) living arrangements (Hays & George, 2003), (d) caregiver burdens (Allen-Kelsey, 1998; Williams, Dilworth-Anderson, & Goodwin, 2003), and (e) continuing bonds with the deceased spouse after death (Field, Gao, & Paderna, 2005). Several of these areas are examined in this study, but there are many other areas yet to be identified. Grounded theory methods allow this study to contribute to understanding some of the issues affecting health care utilization among African American elders.

Summary

This study addresses a timely issue. In view of changing demographics, and professional values of individualized care and national priorities to increase health care professionals' competency in working with minority groups, the results of this study can make a contribution toward developing culturally sensitive assessment and intervention strategies to promote positive mental health outcomes of African American elders experiencing spousal bereavement, grief, and mourning.

The literature on grief and mourning from spousal bereavement among elders focuses primarily on white Americans. There is growing awareness of the need for and research with minority groups. This grounded theory study of African American elders dealing with spousal death generated the beginnings of a substantive theory

that may aid health care providers to assess and intervene with them in a holistic, culturally sensitive way. This substantive theory that emerges could be developed further and used as a base for future work to develop a formal theory.

Glaser and Strauss (1967) suggested that even though it is possible to have a “one area formal theory” (p. 80), a more powerful method is to advance a substantive theory to a formal theory by the comparative analysis of groups in different substantive areas. “While the process of comparative analysis is the same for generating either a substantive or formal theory, it becomes harder to generate the latter because of its more abstract level and the wider range of research required” (Glaser & Strauss, 1967, p. 82). The results of this study can be used as one part of a comparative analysis of groups to generate a formal theory.

Purpose

The purpose of this study is to develop a grounded theory of grief and mourning for African American elders. This grounded theory will include the experiences of grief and mourning within the social and cultural contexts of older African American widows.

Research Questions

Grounded theory methodology is used when there have been few studies or theories related to a phenomenon. The purpose of grounded theory methodology is inductive theory development (Glaser, 1978; Glaser & Strauss, 1967). There is little published research related to bereavement, grief, and mourning among African American elders (Capp, 2001; Demi & Miles, 1986; Porter, 2000; Rodgers, 2004). Because theory development is the purpose of this study, the research questions need

to be broad enough to allow a thorough and in-depth exploration of the phenomena (Glaser, 1978; Glaser & Strauss, 1967). In addition, the research questions must generate enough data to develop a theory that “fits, works, and is relevant” (Glaser, 1978, p. 13). The research questions to be investigated are:

1. What are the grief and mourning experiences of African American elders after spousal death?
2. What are the transition processes from spouse to widow for African American elders?
3. What are the sociocultural influences on the grief and mourning experiences of African American elders?

Definition of Terms

Elder. There are multiple terms used to address the cohort of individuals over age 60. A brief survey of governmental agencies done from the U. S. Administration on Aging, 2004, yielded the following terms: (a) “older adults” from the Department of Health and Human Services, Administration on Aging; (b) “elderly Americans” from the Center for Disease Control; (c) “elders” or “Older Americans; and (d) “elderly” from the U. S. Census Bureau. The American Association of Retired Persons (2004) reported the use of the term, “seniors.” In addition, there are the terms “oldest Americans” and “later life” in the professional literature (Lund, Caserta, & Dimond, 1994). For the purpose of this study, “elders” is the term used for adults who are 60 and older. Not only is “elders” a part of one of the terms above, but in our society it denotes respect for an individual with wisdom, experience, and authority.

Age was a self-reported characteristic and no attempt was made to verify the accuracy of the reported age.

African American. African American was a self-reported characteristic. Self-reported bi-racial individuals that included African American as one of the races also were included.

Spouse. Spousal death was self-reported. No attempt was made to determine if there was a legal marriage. Only heterosexual couples were included. No persons who had been remarried and widowed were included; all were currently unmarried.

Bereavement, grief, and mourning. Although there are various definitions of the terms related to spousal loss, the most common definition is by Stroebe, Stroebe, and Hansson (1999): "...bereavement is the objective situation of having lost someone significant; grief is the emotional response to one's loss; and mourning denotes the actions and manner of expressing grief, which often reflect the mourning practices of one's culture" (p. 5). Bereavement, grief, and mourning are multi-dimensional terms that affect one another (Costello & Kendrick, 2000; Parkes, 2002; Stroebe et al., 1999).

Transitions. Schumacher, Jones, and Meleis (1999) presented a framework of transition for use with elders. This study uses the definition these authors set forth:

A transition is a passage between two relatively stable periods of time. In this passage, the individual moves from one life phase, situation, or status to another. Transitions are processes that occur over time and have a sense of flow and movement (Schumacher et al., 1999, p. 2).

Transitions occur during times of upheaval and disequilibrium when there are

profound changes in the environment of the individual (Schumacher et al., 1999). These changes must be dealt with for the person to continue his or her life.

Participant Criteria

Individual grief and mourning responses after spousal bereavement are affected by many factors, for example: (a) care giving by the spouse (Beery et al., 1997; Jacob, 1996; Ott & Lueger, 2002), (b) time since bereavement, and (c) whether the death was anticipated or unanticipated (Duke, 1998). Considering these variations, participants will be limited to individuals who: (a) experienced anticipated spousal death, (b) were not full-time caregivers for the deceased spouse at the time of death, (c) are 2-10 years post-bereavement, (d) have not remarried since the loss, (e) were apart from the spouse no more than six months, if care was transferred out of home, and (f) experienced the loss of a first spouse or if married before, the prior marriage did not end in widowhood.

Theoretical Framework

In grounded theory research, the use of an *a priori* conceptual framework or a theory can have a detrimental effect on the generation of the inductively developed theory derived from the data. Glaser and Strauss (1967) suggested that coming to the field with preconceived ideas or theoretical constructs can influence the emergence of the theory from the data. The presence of preconceived ideas or theoretical constructs can force the data into what is already known rather than allowing the theory to emerge from the data. Glaser (1978) cautioned that it might be difficult to know what concepts in the literature to elaborate on before the theory starts to emerge.

Glaser (1978) and Glaser and Strauss (1967) acknowledged that the researcher comes to the field with a knowledge of and sensitivity to the area of research. The researcher may find his or her prior knowledge serves as a sensitizing influence in the data analysis, but may not be used in the emerging theory. Strauss and Corbin (1990) echoed the notion that the researcher must have read enough to identify concepts and relationships that may reoccur in the literature. The researcher may further develop an extant theory or discover concepts as theory emerges from the data (Glaser & Strauss, 1967; Strauss & Corbin, 1990). This comparison to another theory does not occur until after analyses of the data.

An initial review of the bereavement, grief, and mourning literature revealed the use by researchers of several theoretical frameworks. In an integrative review of 19 quantitative studies published from 1990-2001, Capp (2001) identified theoretical frameworks such as stress, coping, adaptation, resiliency, and psychobiology (see Appendix A). The purpose of this study was not to extend a theory but to develop an inductive theory.

Assumptions

An important consideration when conducting qualitative research is the influence of the researcher on the participant and the research process (Charmaz, 2006; Rubin & Rubin, 1995). In addition, to conduct culturally sensitive research it is necessary to understand that an individual's culture influences attitudes, behaviors, and communications (Charmaz, 2006; Denzin & Lincoln, 1998; Thomas, 2001; Watts, 2003). I am a 55-year-old Caucasian female of Euro-American descent, so I am from a different generation and a different culture from the participants. My

family of origin is rural, working class poor. I have been a nurse for 34 years in medical-surgical nursing, psychiatric/mental health nursing, and baccalaureate nursing education. I had few experiences with persons from cultures different from my own until my doctoral education. I am a novice researcher. My assumptions were: (a) participants would be able to describe their bereavement, grief, and mourning after spousal loss; (b) the participants' voices will be heard in the interviews and analyses, (c) grief and mourning after spousal bereavement are processes that can be effectively studied with grounded theory methods, and (d) grounded theory methods are appropriate since there is minimal research with African American elders.

The dissertation continues with a review of literature in Chapter 2 that supports the need for the study. Chapter 3 details the methods, Chapter 4 presents the results. The paper closes with Chapter 5 that includes a presentation of the findings in the context of extant literature and a discussion of the results with recommendations for further research.

CHAPTER 2

LITERATURE REVIEW

Overview of the Literature Review

The literature review in a grounded theory study has several purposes. The literature review is used to: (a) stimulate theoretical sensitivity, (b) derive questions for participants, (c) guide initial observations of participants, (d) direct theoretical sampling, and (e) provide supplemental validation when writing up findings (Strauss & Corbin, 1990, pp. 51-52). Since there are several purposes of the literature review, different databases were used at different points of the research process. Over the course of the study, Ageline, ClinPSYCH, First Search (Article First, Psych First, Periodical Abstracts and World Cat), Ovid (CINAHL), PubMed (Medline) and Ebsco were used. Each database has different index terms, so even though the topics were all germane to the dissertation, the terms may not have been the same. In addition to the database searching, the technique of “snowballing” or “reference harvesting” was used to broaden the literature search. This technique uses the bibliography of an outstanding article as a source for further relevant literature (“Snowballing,” 2009, Introduction section, p. 1).

There is a broad range of literature related to bereavement, grief, and mourning (Neimeyer, 2004). I reviewed the literature pertinent to adults experiencing spousal bereavement in an earlier concept analysis of grief (Capp, 1984). This review focuses on what is known in areas relevant to grief and mourning among African American elders after spousal bereavement.

Developmental and sociocultural influences on bereavement, grief, and mourning are relevant to this study. The literature review begins with a discussion of the older population experiencing spousal bereavement. African American cultural influences are explored in two parts, one pertaining to the historical overview of influences on the African American world view that shaped contemporary bereavement reactions (Rosenblatt & Wallace, 2005). The second is contemporary literature specific to the elder African American population experiencing spousal bereavement, grief, and mourning, with some cross-cultural comparisons. The chapter concludes with a critique of the literature and rationale for this study.

Spousal Bereavement, Grief, and Mourning of Elders

Even though spousal loss is a generally stressful event, the majority of elders effectively copes with the negative effects (sadness, depression, anxiety, and loneliness) and make the life transition to life as a single person (Arbuckle & DeVries, 1995; Bennett & Bennett, 2000; Caserta & Lund, 1992a; Demi, 2000; Ott & Luger, 2002; Parkes, 1997). About 10% to 20% of elders have continuing problems with bereavement, grief, and mourning, such as depression, anxiety, or problems coping with daily life (Caserta & Lund, 1992a; Caserta & Lund, 1992b; Lund, Caserta, & Dimond, 1999; McCrass & Costa, 1988; Mendes-de-Leon, Kasl, & Jacobs, 1993; Ott & Luger, 2002; Parkes, 1997). While this is not a large percentage, given the numbers of elders now and projected for the future, the number of individuals affected could be large (U. S. Census Bureau, 2000).

One difficulty in reviewing these studies was the many definitions of elders. The studies cited reveal a lack of consistent definition of age markers for elders as

“older,” “elders,” and “elderly,” with some of those participants identified as “elderly” in their 30s or 40s. See Appendix C for complete summaries of the elder widowhood literature.

Physiological Responses to Bereavement, Grief, and Mourning

Bereavement, grief, and mourning can be viewed as stressors and as such the human body may respond physiologically (Porth, 2007). A wide range of physiological effects have been linked to bereavement, ranging from sleep disturbances (Brown, et al., 1996; Reynolds, et al., 1993) and nutritional disturbances (Rosenbloom & Whittington, 1993) to mortality (Mendes de Leon, Kasl, & Jacobs, 1993; Mineau, Smith, & Bean, 2002). The presence of traumatic grief (symptoms of separation distress, such as preoccupation with the deceased) has been a predictor of cancer, heart trouble, high blood pressure, suicidal ideation, and changes in eating habits (Kramer, 1997; Prigerson & Jacobs, 2001). Hall and Irwin (2001) have suggested an integrative model of bereavement that includes the social context of the loss, individual differences, and the perceived level of stress as mediators of the physiological responses of the autonomic, neuroendocrine, and immunologic systems resulting in adverse health outcomes. Spousal loss was considered the most stressful event experienced by 68% of the participants in one study (Caserta & Lund, 1992b). If physiological arousal is prolonged, it can exhaust the body's ability to ward off illnesses and diseases.

The assessment of the impact of bereavement, grief, and mourning on physical health of elders is complicated. Normal aging processes bring about individualized changes in physiological function and adaptive reserves for older

adults (Atchley, 2000). In addition, there may be pre-existing chronic conditions such as hypertension, diabetes, heart disease, or joint problems (Moss, Moss, & Hansson, 2001). With this context in mind, several studies have examined various effects of bereavement, grief, and mourning in elders.

A pair of studies examined parameters of overall physical health and supported the notion that age-related changes in health must be accounted for when examining health declines after bereavement. Neither of these studies indicated any cultural diversity in the samples. Bennett (1997) examined medium-term (1 to 4 years) and long-term (over 4 years) effects of widowhood on mental and physical health among elderly women in an eight-year longitudinal study. Results suggested that the effects of bereavement on health are short-term, but other factors such as prior health and concurrent illnesses can contribute to health changes for the bereaved. Although social participation, engagement, and physical health remained stable in the medium-term, in the long-term all of these indicators declined, but as a function of aging rather than widowhood. Bennett (1997) observed that effects of bereavement, grief, and mourning were longer lasting than previously identified in research.

Hegge and Fischer (2000) distinguished between seniors (60-74) and elderly (75-90) in their qualitative study of bereavement, grief, and mourning among community-dwelling elders. The most troubling problems were financial issues (23%), being lonely (83%), sleeping or eating problems (24%), and 23% physical declines (Hegge & Fischer, 2000). Positive coping strategies included: (a) keeping busy, (b) reflecting on memories, (c) visiting with others, (d) praying or meditating,

(e) developing new skills, and (f) relying on familiar routines. Negative coping strategies included: (a) sleeping excessively, (b) focusing on bitterness, (c) avoiding others, (d) blaming self, (e) making unrealistic promises, and (f) relying on medications or alcohol. The strength of this study was in the rich data obtained from the participants in their own words. However, diversity among the participants would have enriched the data for cross-cultural comparisons.

There is a paucity of research examining cultural variations in processes and outcomes of bereavement, grief, and mourning in the elder population group. In research of physiological changes in response to bereavement, grief, and mourning there is little or no cultural diversity among the study participants, with primarily Euro-American samples. African Americans are genetically vulnerable to certain types of physiological changes, such as those with sickle cell anemia (Spector, 2002), and some studies indicate physiological differences in outcomes of bereavement, grief, and mourning among African Americans (Fitzpatrick & Van Tran, 2002). These areas merit continued study, but as indicated in the discussion above, a sizable majority of the bereaved adapt to bereavement with a restorative resiliency after the loss (Bonanno, 2004; Dutton & Zisook, 2005). Refer to Appendix A for a table that provides detailed descriptions of these studies.

Mortality and Bereavement, Grief, and Mourning

The issue of mortality after bereavement, the so called “dying of a broken heart” phenomenon, has been examined by several researchers. Widowhood, particularly in the first six months, is associated with a higher risk of mortality and males are more likely than females to die after bereavement (Mendes de Leon, Kasl,

& Jacobs, 1993; Mineau, Smith, & Bean, 2002). Mineau and colleagues found a significantly higher risk of mortality for widowed men than for widowed women across most marriage cohorts. This finding of higher mortality for widowers was supported in a study by Mendes de Leon and colleagues (1993) where young-old men experienced a 22% mortality rate and old-old men experienced a 50% mortality rate after being widowed. Conversely, oldest widows had a lower mortality rate than expected and the younger of the old widows had an increased risk of mortality.

Beem et al. (1999) found that bereaved individuals subjects overall had greater lymphocyte proliferation response than did non-bereaved persons, indicating an immunological response. However, this change in cellular immunity has not been found to be directly related to long-term morbidity or mortality in humans and has not been consistently demonstrated in studies (Irwin & Pike, 1999; Kim & Jacobs, 1999). As more is learned about the psychobiologic correlates of stressors, the immunological impact of bereavement will be more clearly understood. Accounting for pre-existing conditions and age-related effects will need to be a component of any definitive statements about the relationship between mortality and bereavement.

Psychological Aspects of Bereavement, Grief, and Mourning

The psychological dimension of bereavement, grief, and mourning is expressed by Shuchter and Zisook (1999): “Faced with intense emotional anguish, a primary task (of the bereaved) is to shut off such pain. On the other hand, the disruptive changes that are the psychological and material reality of the survivor demand attention” (p. 30). This conflict is reflected both in the inner experiences and the behaviors of the bereaved elder adult. Research on the psychological aspects of

bereavement, grief, and mourning in the elder adult examines both the inner experiences and the outward expression of those experiences and often overlaps with the social aspects of these phenomena.

One of the limitations of research in this area is whether or not the myriad of quantitative measurement tools used to determine the psychological aspects of bereavement, grief, and mourning are appropriate for older adults and for African Americans. In the studies reported, there were approximately 35 different tools reflecting various aspects of bereavement, grief, and mourning, in addition to sociodemographic questionnaires (see Appendix B). Some of the tools have had extensive psychometric testing (e. g., Beck Depression Inventory, Revised Texas Instrument of Grief, and Zung Self-Rating Depression Scale) and others were specifically developed by the authors for the study (e. g. Health Costs Index, Financial Strain Variables, and Sickness Impact Profile). Few of these instruments have normative data for either the elderly (e. g. Beck Depression Inventory) or African Americans, calling into question whether the tools are age-sensitive and culturally-sensitive.

The focus of this section of the literature review is on the constructs measured in each study of bereavement, grief, and mourning. The measurement tools from studies below will not be described and critiqued individually, except for reliability and validity data given in Appendix B.

Psychological aspects of bereavement, grief, and mourning have been researched through both cross-sectional measurement and longitudinal measurement with repeated measures across time. The longitudinal studies illuminate the process

characteristics of bereavement, grief, and mourning through examining changes in the individual psychological status across time. However, longitudinal studies do not always account for the other variables in the individual elder's life that may be impacting the processes of bereavement, grief, and mourning, such as normal aging processes. The descriptions from the participants in the qualitative studies embody the essence of the experiences of bereavement, grief, and mourning, but lack the ability to examine long term outcomes. A weakness of most of the following studies is the lack of cultural diversity among the participants, with the majority of the participants being Caucasian.

Researchers examined not only the course of the grief and mourning symptoms, but also variations in coping responses, predictors of adjustment after loss, and personal and social characteristics that facilitated the positive resolution of the grief and mourning process (Anderson & Dimond, 1995; Beery et al., 1997; Carr, House, Wortman, Nesse, & Kessler, 2001; Caserta & Lund, 1992b; Fitzpatrick & VanTran, 2002; Futterman, Gallagher, Thompson, Lovett & Gilewski, 1990; Lund, Caserta, & Dimond, 1999; Ott & Lueger, 2002; Prigerson, Maciejewski, & Rosenheck, 2000; Steeves, 2002; Thompson et al., 1991; Zisook, Paulus, Shuchter, & Judd, 1997). A discussion of selected findings from these studies follows.

Depression is one of the common indicators of decline in mental health status associated with bereavement, grief, and mourning. Several studies about depression support that there is an initial increase in the level of depression among the bereaved, but that in a substantial majority levels of depression return to individual baseline in 1-2 years (Harlow, Goldberg, & Comstock, 1991; Thompson et al., 1991; Caserta &

Lund, 1992b). Ott and Lueger (2002) found that there was a consistent pattern of improvement in overall mental health status that is most rapid in the first three months, remains stable for about nine months, and then peaks at 15 months. Other studies, however, have found slightly different patterns; for instance, Thompson and colleagues (1991) found that there was a highly significant decline in the depression scores from 2-12 months, but grief was still high for up to 30 months. These findings indicate that grief symptoms may persist in some individuals, but that this persistence of grief need not be related to psychopathology or depression.

In another longitudinal study, symptoms of depression were experienced by 50% of the bereaved at some point after the loss. At two months post-bereavement, the participants exhibited the following syndromes: (a) 49% had no depression, (b) 11% were sub-clinically depressed, (c) 20% experienced minor depression, and (d) 20% experienced major depression. The rate of subsyndromal depression remained fairly stable across the other time checks, but the rates of minor and major depression decreased over time and the rate of depressive symptoms consistently decreased. The researchers concluded: (a) major depression prior to death predicts an increased risk for major depression following bereavement, (b) membership in any of the unipolar subgroups predicts future depression throughout the unipolar spectrum, and (c) subsyndromal and minor depression stand between major depression and no depression on their effects on widowhood (Zisook et al., 1997).

Both cross-sectional (Futterman et al., 1990; Thompson et al., 1991) and longitudinal studies (Prigerson et al., 2000) suggest that widowed individuals who had satisfying marriages were more depressed after bereavement than were

individuals who had less satisfying unions; being happily married was also related to more chronic conditions and higher functional disability (Prigerson et al., 2000.). These results lend support to the idea that people in a perceived happy marriage experience a greater sense of loss and more difficulty adjusting to life alone than do those in less happy marriages.

Lund, Caserta, and Dimond (1999) stated that the best predictors of bereavement outcomes were personal resources. “We have repeated evidence that supports the need for bereaved adults to take charge of their lifestyles and situation if they are to preserve and sometimes enhance their well-being” (p. 252). Positive initial or early bereavement adjustments were good predictors of long term well-being and the two positive predictors were positive self-esteem and personal competencies in managing the tasks of daily life.

In a study that compared African American participants with Caucasian participants, Fitzpatrick and Van Tran (2002) tested the hypothesis that bereavement related to death of spouse has a differential effect on self-reported health and depression among African American and Caucasians. African American self-reported ratings of health and depression showed no relation to bereavement, but for Caucasian Americans bereavement was a significant predictor of health in both the youngest (24-39) and the oldest (60 and over) groups.

Anderson and Dimond (1995) analyzed the experiences of elder adults over the two-year period after spousal loss and the categories that emerged from the data were: (a) feelings, (b) physical symptoms, (c) special hardships, and (d) coping. The immediate feelings after the death were shock and disbelief, with a deep feeling of

sadness and loneliness. There were emotional ups and downs reported in the first six months, with recurrent feelings of depression and loneliness. Even in the midst of the negative emotions, the bereaved individuals were able to describe themselves as happy in certain situations, such as the time spent with their children.

After one year, there were still feelings of loneliness and some continued to describe depression, but most of the bereaved were experiencing resolution of the most painful feelings. After two years, the bereaved talked little about their feelings. In the first six months, 9 of the 12 subjects experienced some physical symptoms of anxiety or depression, such as loss of appetite, sleep disturbance, lack of energy, heart palpitations and dizziness. The interviews at 1 year and 2 years revealed most physical symptoms experienced by the participants were related to chronic pre-existing conditions only.

There were several special hardships identified by the participants. The six most common hardships were loneliness, loss of companionship, daily reminders of the deceased, anniversaries of special dates, learning new skills formerly done by the deceased, and learning to socialize as a single person. Each of these challenges required adjustments by the bereaved in either ways of thinking or ways of doing tasks. The participants described their coping strategies as (a) keeping busy, (b) reflecting on the loss, (c) managing reminders of the loss, (d) talking with others, (e) relying on religion and prayer, (f) developing new skills, (g) continuing relationship with the deceased, and (h) relying on familiar sentiments (Anderson & Dimond, 1995).

Another study found that sleeping was difficult, and early morning and late at night were times when the waves of grief and sadness were strongest. Mealtimes, particularly the evening meal, were difficult because of the family and social nature of that meal. Several months after the bereavement the participants were still experiencing grief attacks, waves of sadness, and loneliness and felt like they were just coping with day to day life. Since most of their friends were in the same age cohort, the bereaved elder participants often faced multiple losses among their community of acquaintances (Steeves, 2002).

Whether spousal loss is anticipated or expected is a variable that affects the psychological impact of bereavement, grief, and mourning outcomes in the elder adult. Several studies addressed this issue. Carr, House, Kessler, Nesse, Sonnega, & Wortman (2001) examined psychological adjustment to widowhood and whether it was affected by the death being expected or not. Carr et al., (2001) chose to examine the effect of death forewarning on seven dimensions of psychological adjustment: (a) shock, (b) anger, (c) yearning for lost individual, (d) intrusive thoughts about the individual, (e) overall grief, (f) depression, and (g) anxiety. The researchers controlled for at baseline for mental health, physical health, age, gender, education, income, and home ownership based on a review of the literature. The results indicated that though there has been a belief that more forewarning positively affects bereavement outcomes, but that was not supported in this research. Sudden death did increase intrusive thoughts at the 6 month time interval, but this was no longer a significant effect at the 18 month time interval. However, greater than 6 months of forewarning significantly increased anxiety at both time intervals. The researchers

suggested that this might be due to increased issues of care giving and responsibilities. The results from this study suggest that among elders in this study, there seems to be no long-term poor outcomes on psychological health between anticipated and unanticipated death (Carr et al., 2001).

Beery et al. (1997) studied the effects of being a caregiver for a terminally ill spouse and the changing marital roles on bereavement, grief, and mourning outcomes. The results indicated that depression after bereavement was significantly associated with the increased perception of caregiver burden, caregiver change in role function, and the completion of activities of daily living (ADL) for the spouse. Changes in role function and less ADL assistance were predictors for depression. There were no significant associations between the time spent care giving or the duration of care giving with depression. A change in sports and recreational time available was a predictor of depression. The researchers suggested a need to assess caregiver needs for respite care pre-bereavement.

One study compared both the clinical presentation and the treatment outcomes of African Americans and Caucasians with complicated grief. Even though the researchers hypothesized that the African Americans would have less of a therapeutic alliance leading to higher dropout rates in the study, this event did not occur. This was predicted because of the African American general negative view of mental health care and health care in general. The severity of symptoms was not greater among African Americans, as expected either (Cruz et al., 2007).

Caserta and Lund (1992b) investigated whether anticipated problems with spousal bereavement, grief, and mourning were greater than what was actually

experienced in the presence of spousal bereavement, grief, and mourning. The bereaved individuals reported moderately high levels of stress, but this decreased over time. In the area of coping with the loss, the bereaved group reported moderately high levels of coping ability as early as the first time measure and 63%-68% of the bereaved group reported high coping levels at each time measure. These findings indicated that though anticipated stress related to spousal bereavement was high, the bereaved individuals found resources to cope with the loss when it occurred.

Costello (1999) analyzed the concept of anticipatory grief, both the nature of anticipatory grief and the effects on bereavement outcomes. Anticipatory grief is a term that refers to any grief that occurs before the actual loss, differentiated from the grief that occurs after the loss. The time span from being told that his or her partner was dying and the actual death ranged from 10 days to 2 months (mean time 3 weeks). All of the participants stated that they had experienced many emotional reactions after the time of diagnosis and before death, such as: (a) denial, (b) depression, (c) shock, and (d) sadness. One participant reported a sense of relief that his or her spouse's suffering would be ending soon. The researcher suggested that the participants' responses indicated that anticipatory grief was "cumulative" in the sense that the anticipatory grieving ended when the partner died and emotional intensity increased as death approached, but the researchers were unable to make any statements about anticipatory grief mitigating the long-term bereavement outcome.

Other themes that emerged from the data were that the spouse tried to normalize the imminent death by not sharing it with the dying spouse. Glaser and Strauss (1965) in their early work, *Awareness of Dying*, found that dying patients

were often aware that they were dying, even though no one told them directly. No attempt was made in this study to ascertain if the dying individuals knew they were dying. The importance of knowing the dying individual was also another theme that emerged. The nurses allowing the spouse to tell stories about what the dying individual was like before illness or injury facilitated this knowledge of the individual. This type of activity helped the bereaved spouse relive memories and develop a sense that the lost spouse would always be present with them. These findings indicate that health care providers need to assess for signs of anticipatory grieving.

Sociocultural Aspects of Bereavement, Grief, and Mourning

Several sociocultural aspects of bereavement have been investigated among elder adults. Much of the research focuses on the effects of social support on bereavement grief, and mourning, but researchers have investigated areas such as the quality and quantity of social support networks, social variables affecting loneliness, the effects of paid work on bereavement outcomes, and the effects of economic changes after bereavement (Aber, 1992; Fitzpatrick & Bosse, 2000; Hungerford, 2001; Kanacki, Jones, & Galbraith, 1996; Lund, Caserta, Van Pelt, & Gass, 1990; Van Baarsen, 2002). The strength of these studies is the longitudinal approach to depict the effects of the sociocultural aspects on bereavement, grief, and mourning over time. However, the myriad of sociocultural influences at any one time makes it difficult to know all factors influencing the bereavement responses. In addition, there is minimal cultural diversity among the participants.

One group of studies highlighted the effects of various types of social contacts on the affective responses after bereavement. Widows experienced an increased number of contacts with widowed friends over married friends, but the married friends were perceived as providing more support. Widowed friends initially provided more negative contact, but negative experiences with widowed friends and family members had a greater impact on depression. The effects of negatives from family members tended to decline from the earlier to the later phases of widowhood, while the effects of negatives from nonfamily members tended to increase. Sometimes it was the small negative life events that impacted the widows more profoundly (Lee, Willetts, & Seccombe, 1998; Morgan, Carder, & Neal, 1997a; Murdock, Guarnaccia, Hayslip, & McKibbin, 1998; Van Baarson, 2002).

Lund and colleagues (1990) delineated both the degree of the stability of social networks and the changes in the structural and qualitative components of social networks after bereavement among elder adults. The primary social network was defined as the close friends and relatives up to 10 individuals. The results indicated that the mean size of the primary network ranged from 7.8 to 9.1 individuals over the two years. Bereaved women started with larger secondary network member groups, but these groups remained stable over the two year period. Widows consistently reported more same-sex network individuals than widowers did, across the two-year period (Lund et al., 1990). These results indicated that social networks are a beneficial component of the recovery process from bereavement, grief, and mourning for both widows and widowers, even though the structures of those networks may be different.

Kanacki, Jones, and Galbraith (1996) analyzed the amount of social support used by both widows and widowers. The results indicated that higher depression levels correlated negatively with the amount of perceived social support for both widows and widowers. Depression was not related to the number of people the bereaved individual could count on in a crisis, their satisfaction with social support or the amount of contact bereaved individuals had with their children. The results of this research also indicated the value of social support networks to both widows and widowers.

Van Baarsen (2002) examined social support and self-esteem as variables affecting loneliness after elder bereavement. Even though the primary focus of this study was loneliness, the data on social support after bereavement helps to understand the complex interaction of factors affecting bereavement, grief, and mourning. Measurements of the changes in perceived loneliness, perceived social support, and self-esteem were conducted at 6 months, 1.5 years, and 2.5 years post-bereavement. The results indicated that emotional loneliness increased significantly after bereavement and though it gradually lessened, it never returned to the pre-bereavement level. High self-esteem was a positive correlate to bereavement outcomes. Perceived social support increased after the bereavement and remained stable over time. Higher contact with family was associated with reduced emotional loneliness and social loneliness/perceived support at the final measurement of the study (Van Baarsen, 2002). The findings offered support for the value of social support for positive bereavement outcomes.

Another social factor examined in the literature is the value of paid work as a buffer against the effects of bereavement. Aber (1992) examined the work history of bereaved widows during the marital years before bereavement, including the total time invested in paid work. Other factors examined in bereaved widows were the attitude toward employment, satisfaction with the jobs she has held, motivation for seeking employment, and overall commitment to paid work. The results indicated that work history was a significant predictor of health during bereavement. Widows who had accumulated a more extensive work history tended to have better health. Work attitude, prior health, education/social class and social support were significant predictors of health during bereavement (Aber, 1992). Fitzpatrick and Bosse (2000) examined bereaved widowers to differentiate the effects of employment on physical and mental health between elder widowers with 1 year of bereavement and elder widowers with 2 to 3 years of bereavement. The results demonstrated significant negative correlations between age, physical health, employment and education in both bereavement groups, but not mental health. Employment was positively correlated with physical health, but again, not mental health.

The final sociocultural factor highlighted is the economic impact of widowhood. Hungerford (2001) collected longitudinal data from both Germany and the United States to examine the economic well-being of women a year before widowhood and a year after widowhood. Even though different countries have different goals for social welfare policies and outcomes, comparisons can be made of the economic status related to widowhood. The results indicated that there were significant increases in the poverty level of widows in both countries one year after

widowhood. Many American women are poor before widowhood and become even poorer after widowhood. In the United States, women are 1 to 2 times more likely to fall into poverty when they become widows. Considerations of economic changes in widowhood with the current changing economy bring questions to bear about how this is affecting levels of poverty after widowhood.

Spiritual or Existential Aspects of Bereavement, Grief, and Mourning

The spiritual or existential aspects of bereavement, grief, and mourning are considered from several different aspects and the studies that follow illustrate the important role of spiritual or existential aspects of bereavement, grief, and mourning among elders. Some of the spiritual or existential factors delineated include areas such as continuing bonds with the deceased, meaning making after loss, religion, spiritual factors, hope, and residential spatial experiences (Bennett & Bennett, 2000; Costello & Kendrick, 2000; Cutliffe, 1998; Fry, 2001; Golsworthy & Coyle, 1999; Herth, 1990; Hockey, Penhale, & Sibley, 2001; Moss & Moss, 1984; Schucter & Zisook, 1988; Yalom & Liberman, 1991). A few of these studies are cross-cultural, but not African American, and are included to provide comparisons in the current study. The strength of these studies is the consideration of personal factors that are more subjective and interact with all the other areas considered in this literature review to affect bereavement outcomes. However, the measurement of existential or spiritual manifestations in a tangible means to measure the impact on bereavement is difficult.

Yalom and Liberman (1991) performed an analysis of data with a group of bereaved individuals who had agreed to participate in an 8-week support group. The

purpose of this study was to analyze the level of existential awareness before the group sessions started and 1 year later. The data were analyzed in light of three questions: (a) Were they more aware of the presence and inevitability of personal death?; (b) Were they struggling with the question of the meaning of life?; and (c) Did they have regrets about choices made in life?

The results indicated that 37% of the participants were engaged in the existential process. The researchers compared existential awareness and levels of personal growth. There were significant increases in personal growth among the existentially aware bereaved. The researchers suggested that the existentially-aware participants were able to bear and to experience their aloneness. Through this reflection on the meaning of their lives, they experienced personal growth. These participants were able to use their spousal loss in a meaningful way for personal growth.

The next group of studies reflects on the continuing bonds with the deceased. The effect of continuing bonds with the deceased has been a debated issue over the course of bereavement research. Continuing bonds with the deceased can take many forms and is generally a positive and meaningful experience for the bereaved (Bennett & Bennett, 2000; Costello & Kendrick, 2000; Moss & Moss, 1984; Shuchter & Zisook, 1988). However, Field, Gal-Oz, and Bonnano (2003) found that greater continuing bonds with the deceased were related to more severe bereavement-related distress. The forms that the continuing bonds with the deceased take affect the usefulness to the grief and mourning process. These differences suggest that even though the continuing bonds with the deceased are a generally positive experience, an

assessment in each individual circumstance is a necessity and further research is called for in this area.

Bennett and Bennett (2000) examined the presence of the dead spouse in the life of the elder women as more than just an illusion brought on by grief. Five themes of this phenomenon were embodied in their experiences: (a) being observed, (b) hearing a voice, (c) smelling a particular odor, (d) seeing the dead, and (e) sensing the dead man in bed (Bennett & Bennett, 2000).

Bonnano and Kaltman (1999) supported the findings of Moss and Moss (1984) and Shuchter and Zisook (1988) that the continuing with the dead beyond the grave can be reassuring evidence of a continuing link with the loved one. Moss and Moss (1984) suggested that the sense of continuing tie with the deceased can be a positive and helpful part of bereavement, grief, and mourning, rather than an interference with the healing process. Moss and Moss (1984) identified five themes that emerged from research about the continuing marital bond with the deceased that explain some of the ways that the elder bereaved individual experiences, recalls, or is affected by continuing bonds: (a) cultural and social supports of the tie; (b) caring and concern about deceased spouse; (c) intimacy and shared experiences; (d) reciprocal identity support and internalized relationship; and (e) home and shared spaces (pp. 200-204).

Moss and Moss (1984) stressed the normalcy of the continuing tie with the deceased and suggested that it can become a part of the new assumptive world of the bereaved elder. Even though these factors cannot be measured in an objective way,

they can be influential on the course of bereavement. These themes may continue to provide continuing comfort and support to the remaining spouse.

Shuchter and Zisook (1988) suggested that one of the most powerful mitigators of the grief experience for widowed persons can be a continued relationship with the dead spouse. Through their study with widowed persons, they found that several forms of this relationship can be through (a) hallucinatory experiences, verbal communication and prayer; (b) symbolic representation, through imbuing material possessions with the spirit of the deceased; (c) living legacies, which perpetuate the ideals and values of the deceased; and (d) social and cultural rituals, memories, and dreams.

Costello and Kendrick (2000) explored the cultural and social context of the death and the influence of the relationship with the deceased spouse relative to continuing bonds with the deceased. The researchers' central hypothesis was that successful grief resolution does not depend on disengaging from the deceased. The themes the researchers identified from the data were: (a) feelings of isolation; (b) a sense of loneliness and depression; (c) perceived inner representation of the deceased; (d) the presence of the deceased; and (e) dialog with the deceased. They suggested the data indicate a maintenance and modification of the relationship with the deceased, but not a relinquishing of that relationship.

Hockey, Penhale, and Sibley (2001) examined widowhood experiences among adult elders as related to the social and cultural space that surrounds them. Moss and Moss (1984) identified that this phenomenon was a way to maintain continuing bonds with the deceased. The fundamental hypothesis they began with is that spousal

relationships are connected with the spaces in their lives, both social spaces and material places. Hockey, Penhale and Sibley (2001) stated: “The shared relationship of long-married couples and their wider social relationships are intimately connected with the spaces that they have worked on, organized, and transformed but which have also constrained their lives-social relationships are mediated by space and place” (p. 739). The researchers identified the major theme as “changes in the embodied experience of space” (Hockey et al., 2001, p. 755). The participants generally avoided public spaces during holidays or found new companions to travel with to relatives’ houses. In their own homes, even though the furnishings and spaces were the same, nothing seemed the same without the presence of the deceased.

Existential factors were identified that contribute to the psychological well-being of elder adults after bereavement. Fry (2001) examined whether existential factors, such as meaningfulness, optimism, and spirituality help maintain psychological well-being after bereavement. The psychosocial predictors included: (a) personal meaning, (b) participation in organized religion, (c) comfort from religion, (d) sense of inner peace with self, (e) accessibility to religious support, (f) optimism, (g) social resources and social contracts, (h) physical health problems, and (i) negative life events. After controlling for the traditional measures of social support, social resources, and negative life events, several existential factors accounted for the variance in psychological support. These existential factors were significant in both the widows and widowers and were (a) personal meaning, (b) optimism, (c) importance of religion, and (d) accessibility to religious support (Fry, 2001, p. 78).

Golsworthy and Coyle (1999) explored how spiritual beliefs can affect the search for meaning after the loss. The experience of spousal loss demands that individuals evaluate their assumptions about the world and how they interact with the world. This study explored the interaction of religion and spiritual beliefs with the process of making meaning out of the spousal loss. The importance of faith was reported as highly associated with coping with the loss. Participants also placed a high value on spiritual support. The sense of ongoing relationship with the deceased was perceived as helpful as a coping mechanism, but also a source of spiritual support. The ongoing relationship with the dead was also a source of help for the bereaved. Spiritual support through connection with God or the deceased did not keep the bereaved from feeling loss and grief, but helped the bereaved to live with the loss and grief. In the area of making meaning around the death, some participants already had a prior belief structure that provided the meaning. For example, some participants believed that life was already planned out and though they did not understand it at the present, there was a purpose to the death. A majority of the participants had continuing doubts and questions about the loss that involved their faith. This created some uncertainty between the faith structures that had always helped them and the current bereavement experience. None abandoned their faith, but the uncertainty was used to develop a reintegrated religious meaning structure.

The significance of certain events or experiences often provided meaning through the spiritual associations. Events like the wake or funeral could help provide meaning for the loss and the acknowledgment that God was still influencing everyday life. Optimism and hope still pervaded the lives of the bereaved. Golsworthy and

Coyle (1999) concluded: “The meaning-making process among participants was evident in diverse ways with considerable variation in the nature of the meaning structure that was challenged by bereavement” (p. 36). The presence of a religious meaning structure did not lessen feelings of grief and loss, but supported the participants through those feelings. Both religious diversity and cultural diversity among the participants would broaden the scope of these findings among the elderly bereaved.

Herth (1990) explored the relationship of supportive networks, concurrent losses, and coping skills to bereavement adaptation. The results indicated that hope accounted for 79% of the variance in grief resolution. A longer duration of spouse’s illness, adequate present income, good health, fewer than two concurrent losses and visits by family and friends related to the presence of greater hope. Increased use of coping mechanisms that were more emotion based and evasive of the bereavement issue were related to less hope and less grief resolution.

Summary of Bereavement, Grief, and Mourning among Elders

Although the section above separated the areas of response to spousal bereavement into discrete domains, the evidence supports the idea that grief and mourning are interwoven and complex. The analysis of the research on bereavement, grief, and mourning among elders supports the following conclusions:

1. Bereavement, grief, and mourning are highly stressful processes, but only about 10% to 20% of elder adults have ongoing problems related to spousal bereavement in the long term.

2. The individual perception of the marital dyad and the relationship with the deceased affects the grief and mourning responses to spousal bereavement.
3. The course of spousal bereavement in elder adults is as a process that is most difficult in the first several months but improves gradually over time. The process may last for several years or never totally be over, but the acute phase is usually over by two years.
4. Most of the bereaved experience some level of depression early in the process of grief and mourning, but prolonged clinical depression is associated with prior depressive episodes.
5. Adjustments to spousal bereavement are multidimensional, in that nearly every aspect of a person's life can be affected by the loss.
6. The overall impact of spousal bereavement on the physical and mental health of many elders is related to many variables, such as pre-existing health conditions, the effects of aging, and the effects of spousal care giving, and these relationships are still being investigated.
7. Loneliness, financial strain, problems meeting the tasks of daily living, loss of companionship, managing feelings of grief, and changes in self-identity are common and difficult adjustments for elder bereaved spouses.
8. The continuing relationship with the deceased is an important part of the ongoing life of the elder adult and is generally a helpful part of the process of grief and mourning.
9. There is a great deal of diversity in how elder adults adjust to the death of a spouse, but most find positive ways to cope with the loss.

10. Faith and spirituality are generally important factors in the meaning making process after the death of spouse.

11. The use of social networks and kin relationships generally facilitate the process of adjustment to widowhood.

Historical Perspectives on African American Bereavement, Grief, and Mourning

The experiences of African Americans in the past have influenced their present bereavement, grief, and mourning practices through the decades (Harrison, Kahn, & Hsu, 2004-2005). Thousands of Africans were forcibly brought to America as slaves and they were considered to be chattel rather than human beings (Spector, 2002). During the trip many of them died in their chains: “Those who failed to survive were victims of starvation, suffocation, drowning, suicide, disease, and the whippings, beatings, mutilation, and direct killing by those who held them in bondage” (Jackson, 1972, p. 203).

Once Africans arrived in America their circumstances did not improve. Early death and violence were commonplace experiences. Married couples were separated and children were taken from their parents. Even though family members were often separated and community members changed frequently, a sense of family was fostered through the inclusion of non-relatives and church members as part of their kin networks (Locke, 1992). Although U.S. society has changed since the Civil War, slavery and its accompanying hardships still affects African American cultural beliefs and practices.

Religion has been historically one of the primary sources of coping resources for African Americans (Masamba & Kalish, 1976). For instance, African American

churches helped individuals cope with death and bereavement. Funeral services for African Americans honored the deceased and celebrated the living. Funeral services provided an avenue for emotional catharsis and psychological support for the bereaved and provided a rare opportunity for African Americans to congregate without fear. Masamba and Kalish (1976) identified major themes of African Americans' beliefs about life and death that often were reflected in their religious music:

- *Death as a Symbol of Liberation.* The spirituals were an underground symbol for liberation in the here and now. Death was a positive symbol for freedom and integrity, even though there was not social justice in the present.
- *Death as an Integral Part of Life.* Death was an ever-present threat in the slave society and African Americans lived with death, no matter what age.
- *Death as a Basis of Fear.* In the slave society, the mental health of the individual was partially protected from the presence of death by the strength of community relationships. Even in modern times, the presence of violence in some neighborhood communities threatens the mental health of African Americans by taking away significant relationships.
- *Death as a Cessation of This Life, Not Extinction of All Life.* Death was viewed as a bridge to the next life, between hopelessness and hopefulness. Dignified death was considered a strong statement against injustice.
- *Death as a Fear of Social Extinction.* Social extinction would happen when there were no relatives left behind or the individual is not buried with proper

ceremonies. The traditions and rituals of funerals prevent the social extinction since people put the deceased into their memories.

Jackson (1972) analyzed African American writings to examine norms surrounding death. Sacred norms centered on the supernatural and metaphysical at the time of death, while not emphasizing the material world. Secular norms considered death as a normal part of life that was to be expected, although not necessarily welcomed. Jackson argued that the literature of African American death was more secular than sacred, due to their familiarity with death.

These two studies (Jackson, 1972; Masamba & Kalish, 1976) illustrate some of the historical social and cultural influences on current African American bereavement, grief, and mourning. They suggested death was accepted as a part of life, viewed as a thief and a savior, with both practical and eternal consequences.

Current African American Bereavement, Grief, and Mourning Experiences

Funerals

Grief and mourning are embedded in the funeral rituals and proceedings. The rituals and concomitant beliefs help those who directly experienced the loss as well as extended family, friends, and those taking family roles for the mourners. Graham (2002) concluded that funerals functioned: (a) to warn and encourage people to live the Christian life, (b) to give history lessons through remarks and stories from the past, (c) to help the bereaved to emotionally accept their loss, and (d) to serve as social gatherings. Graham (2002) felt that telling their bereavement stories was healing for the elderly African American widows he interviewed, and “these

particular narratives also have the unique ability to disseminate cultural knowledge and information from the voices of African American women” (p. 142).

Although no research was found on age differences in perceptions of and participation in African American funerals, the culture of African American elders who experienced the United States prior to the civil rights era may affect their bereavement, grief, and mourning because of their experiences in a segregated society (Collins & Doolittle, 2006). Family histories also may be relevant; Barrett and Heller (2002) reported diversity in funeral rites among African Americans, depending on whether their immediate families were from West Africa, Jamaica, or had lived in the United States for generations. For instance, West Africans were more likely to bathe the body, Jamaicans closed the grave more often, and African Americans delegated these tasks to funeral directors. Barrett and Heller (2002) suggested the importance of three variables on bereavement, grief, and mourning: (a) cultural identification with Africa or a specific country of origin, (b) spirituality, and (c) social class. More affluent African Americans tended to leave their traditional communities and become less traditional, while the poor tended to follow more traditional practices. In contrast to this finding, cultural anthropologists Metcalf and Huntington (as cited in Holloway, 2002) found marked uniformity in the structure of funerals in general, regardless of where families were from.

Religion and Spirituality

Although most researchers who have investigated bereavement, grief, and mourning among African Americans have not specifically addressed older adults (e.g., Abrams, 2000; Smith, 1999), they support the notion that religion and

spirituality are important tools in coping with widowhood (Michael, Crowther, Schmid, & Allen, 2003). Older African American widows incorporate religious and spiritual beliefs and rituals during their experiences with widowhood.

Abrams (2000) conducted an ethnographic study to explore the meanings of death and experiences of grieving among the deeply religious members of a storefront church. The church members expressed a strong belief in the afterlife and there was a perception of “heaven as home.” Even when it was obvious that a person was going to die, they maintained hope for the individual couched in their beliefs about God’s power over death. A common concept to the group was the need to “let go of the deceased.” There was a double meaning to this: release of the person to death and a release of the bereaved from them. The participants identified four components of the dying process: (a) preparing physically, (b) finishing up emotionally, (c) looking both forward and back, and (d) getting set in one direction. Frequently, there were experiences of visitations or visions from the dead. Occasionally, these were frightening, but more often they were comforting and served as a means to maintain relationships with the dead and as part of a life review.

In a qualitative study of African American middle-aged daughters’ responses to the deaths of their elderly mothers, three themes emerged (Smith, 1999). First, the daughters discussed the value of their mothers’ lives and the loss not only to the family, but to the broader community. The daughters found comfort in the belief that their mothers were in God’s hands. Reciprocity in the mother-daughter relationship over the course of life was the second theme. Daughters recounted how the mothers had cared for them physically, emotionally, and spiritually throughout their lives. As

the mothers declined in health, the daughters were able to repay their mothers. This reciprocity reduced guilt and left them more at peace with the death. Continuity of the family was the third theme. Areas of concern were to prepare the next generation for experiences of loss and to fill the void left by the death of the mother.

Widowhood

In a qualitative study of black and white widows ranging in age from 19-53 years Salah-Din (1996) reported more commonalities than differences in coping strategies that were used to deal with loneliness, children, health issues, loss of task support and the use of social support networks. The widows of both races reported positive growth experiences from bereavement, grief, and mourning (Salahu-Din, 1996). There were some culturally specific differences, such the use of “fictive kin” (Jordan-Marsh & Harden, 2005) among African American widows and having more familial social support at times than they needed. Caucasian widows spoke about having positive relationships with family and friends, but needed more concrete and emotional support than their families were willing or able to provide (Salahu-Din, 1996).

In another study, African American widows reported gaining independence and personal growth despite their loss and the initial shock (Harrison et al., 2004-2005). They relied on their faith to provide a social support throughout the grieving process. Cultural influences were evident in how they managed grief and mourning, such as accepting the situation and determining to persist and overcome it (Shellman, 2004).

Summary of African American Bereavement, Grief, and Mourning Experiences

The studies above underscore the need to account for cultural influences when reflecting on the bereavement, grief, and mourning experiences of African Americans. These studies illustrate the importance of the funeral and wake practices as an honor to the deceased. These practices benefit the living as a time of expression of feelings, solidifying social bonds, and establishing social networks to manage with the grief and mourning after the funeral as life is being reorganized. The attitudes of the mourners reflect a determination to persist and overcome this life tragedy, as they had many other hardships and discriminations.

Rationale for the Study

Although the research base about African American response to bereavement has been growing in the last few years, there is still much to be known about the unique influences and responses to the experience of spousal loss by people of African American heritage.

This study used qualitative grounded theory methods to study the bereavement, grief, and mourning experiences of older African American widows. A qualitative perspective assists in theoretical development. Grounded theory was selected as the method for this investigation because grief and mourning are processes and grounded theory methods are designed to uncover processes.

Most studies indicated bereavement, grief, and mourning are multi-dimensional phenomena, affecting the whole person. While quantitative measurement tools can reflect parts of the response of the whole person, the researcher must hear

the voice of the one who has experienced spousal bereavement to fully understand their experience. Quantitative studies give an incomplete picture of the bereavement, grief, and mourning experience of African American elder adults. Few of the quantitative measurements have normative data for either elders or African Americans, which raises the concern they may not accurately reflect the experiences of those individuals.

Since little qualitative research specific to African American elders exists, this study helps illuminate the bereavement, grief, and mourning experience for African American elders who bring a unique cultural heritage to the literature on spousal bereavement, grief, and mourning. For these reasons a qualitative approach was used for this study, to allow individual voices to emerge from the data.

CHAPTER 3

METHODS

Overview of Grounded Theory

Grounded theory is a qualitative research method that has the goal of generating an inductive theory systematically derived from data. Glaser and Strauss (1967) described the process as, “the discovery of theory from data obtained from social research” (p. 2). Grounded theory is a rigorous method of providing exploratory or preliminary research in an area where little is known (Glaser & Strauss, 1967). These theorists introduced the method for sociological research, but grounded theory has been applied as a research method by other disciplines, including nursing. Grounded theory evolved from the perspective of symbolic interactionism and developed rich interpretive methods from assumptions about the relationships between individuals and society (Milliken & Schreiber, 2001).

Symbolic interactionism focuses on the understanding of human behavior as a dynamic process that is enlightened by the understanding of the meaning ascribed to the situations and processes occurring in everyday life. Understanding the symbolic meaning of objects and interactions within the environment assists in the interpretation of behavior and human interactions within a culture. These interactions are dynamic and synergistic processes and the symbolic meaning may change over time as the individual attributes new meaning to objects or interactions (MacDonald & Schreiber, 2001; Milliken & Schreiber, 2001).

Grounded theory is recognizable by several characteristics. Glaser (1978) suggested the use of gerunds to indicate the processes involving the individual in

action or change. In addition, process has a trajectory and stages or phases throughout that trajectory. Through the constant comparative analysis, line by line within the interview and among the interviews, eventually a core variable or category is identified that is unified in a basic social or social psychological process.

Morse (2001) asserted that the level of theory produced by grounded theory research is mid-range substantive theory. Middle-range theories are literally in the middle of the continuum as described by McEwen (2002b, p. 206). Middle-range theories are less abstract and narrower in scope than a grand theory and there may be some generalizing across settings of practice. In a middle-range theory there is a limited number of concepts that may be concrete. Propositions are clearly stated and a middle-range theory may generate testable hypotheses. Middle range theories can address social processes. Meleis (1997) suggested that middle-range theories reflect administration, clinical, or teaching in nursing and address specific phenomena that are in the mid-point between the metaparadigm concepts and specific concrete actions or events (e.g. medication administration) at the other end. Grounded theorists address behavioral concepts or phenomena of interest. Grounded theory is particularly useful when the desired outcome is a theory that is closely wedded to the context of the phenomenon being studied (Creswell, 1998).

Grounded theory has roots in the discipline of sociology, and as such, the areas of concern are human beings and the processes they experience in their everyday reality. The theory that emerges from a grounded theory study is inductively derived from data the participants in the study provide for the researcher (Glaser, 1978). The theory is grounded in the data from the interaction between the

researcher and the participants. The researcher is the data collection instrument and the life cycle issues of the researcher are considered as a possible influence on the study (Glaser & Strauss, 1967). One assumption that underlies grounded theory is that there are many different types of material that can be data sources. Even though interviews and observations are traditionally considered to be the main sources of data, other material such as movies, plays, stories, music, history, and other documents can reveal various aspects of the social process examined in the study. In addition, social processes or phenomena are viewed as complex and need a conceptually dense theory to adequately address them (Glaser, 1978; Glaser & Strauss, 1967; Morse, 2001; Strauss & Corbin, 1990).

Considering the researcher as the instrument to collect data, one of the concepts basic to grounded theory is theoretical sensitivity. Theoretical sensitivity refers to a characteristic of the researcher that is based on the personal experience of the researcher and what the researcher knows from literature and professional experiences about the process under study. In addition, theoretical sensitivity requires that the researcher analyze and bring new insights and awareness to the data. Through theoretical sensitivity, the researcher recognizes the subtleties in the data and brings the process to life.

Extensive literature review is not recommended before doing the data collection. The researcher does enough reading to have a sensitizing concept in mind from literature, research literature, or personal and professional experience (Glaser, 1978). The researcher is asked to go to the research setting with few predetermined ideas (Glaser, 1978; Glaser & Strauss, 1967; Morse, 2001; Schreiber, 2001; Strauss &

Corbin, 1990). Although I had done extensive reviewing of the literature I stopped reading during data collection.

Rationale for Grounded Theory Methods

Preliminary Work

During the course of my doctoral studies, I completed two preliminary projects, one to learn grounded theory methods and the other to synthesize the quantitative literature in the area of elder grief and loss. These projects helped set the stage for the current research.

Pilot study using grounded theory methods. The first project was a pilot study in grounded theory with five elderly widows, one of whom was African American. The purpose of this study was to gain experience in conducting grounded theory research. The widows' ages ranged from 66 to 81 and the women had been married 20-50 years prior to their husbands' deaths. Through analysis, concepts that emerged were: (a) participating in the living wake, (b) maintaining the vigil, (c) embracing death as the thief and death as the savior, and (d) remembering mother's advice. The African American woman in this study was the youngest widow, and she had experienced the only traumatic death (drowning) of the five. Her perspectives and responses led me to examine the cultural issues in other research studies. The descriptions of participants' experiences reflected a trajectory in the processes; a sense that the grief and mourning lightens, but never totally leaves. These observations contributed to my selection of grounded theory methods for this study (Capp, 2004).

Integrative review of the literature. Following the pilot study, I conducted an integrative review of the quantitative literature about spousal loss in the elderly. Nineteen studies in the integrative review had a total of 6163 participants (see Appendix A). These studies indicated about 10-30% of the elderly have ongoing significant problems after loss of spouse. These chronic problems were physiological, psychological, spiritual, and sociocultural (Capp, 2001).

Ethnic minorities, less educated individuals, and the poor were underrepresented in these studies. There is growing interest and research about the impact of cultural diversity on many aspects of healthcare. The paucity of culture-specific studies of bereavement, grief, and mourning supports the need for further study. Grounded theory is an appropriate methodology when little is known about the phenomenon of study (Glaser & Strauss, 1967). Few of those studies have centered on the bereavement, grief, and mourning of African American elders.

Usefulness of Theory to Nursing

The selection of grounded theory was based on the usefulness of theories to the discipline of nursing. One purpose of this study is the development of a beginning inductive theory. Through the development of mid-range theories, specific assessments and interventions can be developed for clinical practice (Creswell, 1998; Chenitz & Swanson, 1986; Glaser, 1978; McEwen, 2002a). Streubert and Carpenter (1999) stated: "...the need for more middle-range theories in nursing that can be empirically tested is one reason for using grounded theory to conduct scientific investigations of phenomena important to nursing" (p. 104). Bereavement, grief, and mourning are common life experiences; phenomena that will likely be experienced in

clinical practice. In addition, these phenomena overlap all areas of clinical nursing practice and should be part of the nursing education curriculum (Carpenter, 2007).

Theoretical Perspective of This Study

For the purposes of this study, the early Glaser and Strauss (1967) and Glaser (1978) approach to grounded theory was used. Also used were some methods from Strauss and Corbin (1990) and other grounded theory literature. The early work was adhered to as it was used successfully in the pilot study about widows (Capp, 2004). Recognizing grounded theory methods continue to evolve, being a purist and only using one method was not the intent in this study. The grounded theory approach offers many challenges and its strengths offer many opportunities to describe the phenomena of bereavement, grief, and mourning in African American elders experiencing spousal loss.

Data Collection

The Naturalistic Setting

To successfully analyze the process being studied, the researcher must observe the study participant in his/ her natural environment where the phenomenon is being experienced in a dynamic way. One technique used to gain this type of knowledge is participant observation by the researcher which involves entering the social world of the participant and conducting the interviews in that setting. As the researcher is immersed in the milieu and dynamics of the environment, enough detachment is maintained to “think theoretically about what he has seen and lived through” (Glaser & Strauss, 1967, p. 226).

The homes. To facilitate understanding the influence of the social milieu in this study, all but one of the interviews took place in the participant's home. Being present in the home for the interview helped gain a better understanding of the social environment and its influence on each woman's experience with grief and mourning. The homes were quite varied and included rent-controlled assisted living apartments, private homes, and upscale assisted living apartments. Regardless of the type of living space, each woman had personalized it to reflect her values and interests. There was always memorabilia that reflected important events and family life, an obvious source of great pride among the women.

The homes offered interesting settings and situations for the interviews. Occasionally, other people dropped by and entered the conversation briefly, such as a daughter, a personal care assistant, or a maintenance man. In one apartment I had to step over a mattress that was to be hauled away to get into the living room. On one occasion I dropped by to say hello to a woman I had interviewed previously as I was in her building. She was with her personal care assistant and I was going to leave, but she insisted I come in the bedroom and talk with her. When I walked in the bedroom she was naked in her wheelchair, but she had thought of some other things to talk about with me. I was not uncomfortable with her being naked, but I was thinking about the consent form and the IRB. We had had a great discussion of the poets that she liked and she could quote large sections of her favorite poet, some in the "dialect" as she called it, and she discussed her difficulties with getting adequate personal assist care.

Several of the apartments were arranged so that I had to do some moving of the items that the women wanted to save to have a place to sit. Frequently there were interruptions by telephone calls; one woman was the chair of the “Mother’s Board” at church and somewhat of a confidante to many people. There were health care providers calling or family members checking on the women during the interviews. Being in the participants homes required great flexibility in conducting the interviews.

The communities. All of the study participants lived in a major metropolitan area and even though they resided within the city, there was a wide variety in the type of residential neighborhoods in which they lived. As part of enhancing my sensitivity to their social milieu, I observed and wrote field notes about the communities in which they resided. I was attentive to the community access to major thoroughfares, and while I am not confident I always took the most direct route to the residence, I got a sense of how close they were to grocery stores, retail outlets, and churches. I observed the street where they lived, placement of houses, the condition of buildings, and general activity of the neighborhood. I often sat in my car, listened and observed, and asked myself the questions about what would it be like to live in the participants’ neighborhood as an elder widow.

Some neighborhoods were gated communities, while others were working middle class neighborhoods, some stable and some deteriorating. The area around the church that was the original recruiting site for the research study was located in an inner city neighborhood. In this neighborhood there were pockets of “regentrification” occurring with new townhouses and apartment complexes in

proximity to businesses with barred windows. The prior summer a murder had occurred in a park located nearby and the participants were sensitive to the need for caution and some commented on the changes in the neighborhood, both as a community and the availability of close resources. Surrounding the church were empty homes and businesses known to have gang and drug activity. There was a community working group established to obtain these properties from the city and convert them into neighborhood gardens or provide other green space activities. The church was an active part of this neighborhood change, working to reclaim the area as a safe place and “holy ground.”

Structural changes had been made in the traffic flow, with large concrete barriers disguised as flower pots, preventing drive-through traffic on many streets. The homes were quite close together, with most having minimal yard space, front or back. The apartment complexes were usually bustling with activity.

Other neighborhoods were close to thriving retail centers with the accompanying noise of traffic and people passing by the area. In this particular assisted living facility there was considerable construction in progress during the times of the interviews which was a source of consternation. We tried to find a day when the noise was at a minimum.

In some of the neighborhoods the participants expressed concern about the changing demographics and the upkeep of the properties on various parts of the street. Where access to community resources was limited with no close to any retail centers shopping for necessities required planning.

Summary

Conducting research in the naturalistic setting provided a wealth of rich data about the participants within their homes and communities. The data was invaluable to understand the participants' experiences, but required flexibility and problem solving at times to make it an optimal situation for the interview.

Researcher as Instrument

The data collection instrument in qualitative research is the investigator. From an epistemological point of view, qualitative research is focused on investigating phenomena from a naturalistic approach. Qualitative research requires seeking out the data where it naturally occurs rather than causing it to occur through experimental means. The questions center on "where can I find the phenomena?" rather than "how can I produce the phenomena?" Rather than manipulating and controlling, the qualitative researcher functions as an agency, a channel, a force, for the expression of qualitative data (Kipker, 1999). The term "bricolage" can also be useful to describe the process of qualitative research - piecing together the reality being offered to the researcher from participants. The researcher as bricoleur requires the investigator to be intimate with the methods used to collect the data (Denzin & Lincoln, 1998).

From this perspective, the investigator has a specific influence on the research and must have a keen level of self-awareness to understand the contribution of self to the actual data obtained in the study. This self-awareness and the relationship to the study began with reflecting on the motivation and interest in the study. At each phase of the research endeavor, I reflected on how who I was as a person might be

influencing the study, whether by my physical presence, the questions asked, the words I used in the descriptions, or how I interpreted data.

As Glaser and Strauss (1967) suggested, the developmental issues of the researcher can influence the research. To facilitate awareness of these issues, I maintained a reflexive research journal of my reactions and what was influencing those reactions to the research process and the participant/researcher relationship. Glaser and Strauss (1967) noted that the awareness of personal issues and their potential impact on the research is a necessity. Due to the intense relational nature of qualitative research and the grief and mourning issues explored during this specific research, I maintained a research journal, a reflexive journal, and monitored with a professional counselor any personal issues that might be impacting the research process. I also discussed these issues informally with a member of my committee either by telephone or by e-mail. An example of the type of personal issue that arose was when one of my participants was lost to follow-up because of progressive cognitive decline and admission to a nursing home. I experienced surprising grief at this loss, but was able to understand the grief was related to my own mother who was developing Alzheimer's disease and ultimately had to be admitted to a nursing home during this research.

I used the tools described above, such as the reflexive journal and the research journal to monitor the ongoing relationship with participants, to ascertain that I was not prompting them with what I wanted to them to say and that my questions were not leading them to specific answers. In addition, I reviewed my questions with a

qualitative researcher on site to evaluate whether they were leading in any way, might be reflective of stereotypes, or suggest to the respondent I expected a specific answer.

Fine (1998) discussed “working the hyphens” in the self-other dyad and how this dynamic impacts the research process. How I viewed both myself as investigator and the “other” in the dyad changed me as the data collector and how I perceived the data. Both commonalties and differences of those on the opposite sides of the hyphen influence the research process, but the researcher is still the one collecting data.

This personal context of both the researcher and the participant requires a negotiated space and relationship for data collection to occur. This relationship is formed and directed by the skills of the researcher as data collection instrument and the ability to negotiate that space and make that connection with the other person. In addition, this process is enhanced by ongoing reflexivity in the research relationship. Reflexivity refers “not only to conscious consideration of how the research process is proceeding but also to the reshaping of the research process in response to the reflective learnings” (Wuest & Merritt-Gray, 2001, p. 161). This process is also facilitated by the feedback from participants about the data collected and analyzed in the interview process in an on-going dialog as the analysis continues. Receiving feedback from the participants and reflecting immediately through the use of field notes, the research journal, and dialog and feedback from the participants provided the framework for this process.

Researcher-Participant Cultural Diversity

Cultural diversity between the researcher and the participant can affect the dyad development, as well as the data understanding generated from that dyad. This

is not so much an obstacle as another variable that enriches the research relationship. It does call out some considerations for both the recruitment of participants and the research itself. Ladson-Billings (2000) suggested that there are ethnic epistemologies that are different from the Euro-American epistemological tradition and these can influence both the ways of knowing and the systems of knowing. My goal was to let the participants' voices be heard and to be the channel for their words to be heard. To meet this goal, I requested each participant review my analysis after the interview to validate the integrity of my interpretation of meaning. Each participant also reviewed the composite analysis between the first and second interviews to help refine, confirm, or offer suggestions about analyses.

Understanding that I have not experienced being an African American, I read a sampling of African American literature related to mourning and culture to broaden my understanding of African American epistemology (e.g. Du Bois, 1989; Hooks, 1993a; Hooks, 1993b; Hooks, 2005). I also read research where there was cultural diversity between the researcher and participant (e.g. Fletcher, 2002; Franklin & Meier, 1982; Hudley, Haight, & Miller, 2003; Stack, 1974). I engaged in other activities to gain some understanding of the culture and historical events that helped shape modern-day African American thought and individuals. I attended and reflected on a gallery presentation of photography in Chicago entitled "Without Sanctuary: Lynching Photography in America." The book that explained the history of the display (Allen, Als, Lewis, & Litwack, 2004) provided additional insights about that period of time and the social injustices that were occurring to African Americans. At the end of the presentation, there was a book for attendees to write reflections and

reactions to gain a sense of how this topic affected younger generations of Black Americans. I read the many comments that were made in the book by the different individuals and groups who had attended the presentation. I reflected and wrote in my research journal about my reactions to the display as well. I also toured and reflected on the African American museum in Chicago to gain some understanding of the art and history of the African American culture.

Finlay (2002) discussed another method to increase the trustworthiness and integrity of qualitative research. She proposes “outing” the researcher through the process of reflexivity. Reflexivity is a process of “. . . explicit, self-aware meta-analysis of the research process . . . continual evaluation of subjective responses, intersubjective dynamics, and the research process itself” (pp. 531-532). One particular issue for the reflexive researcher to consider is the power balance between the researcher and participant. Methods such as using humor to defuse the distance between the researcher and participant or to openly discuss the differences between the researcher and participant can facilitate the “outing” of the researcher. Finlay suggested using field notes before and after interviews to do reflexive analysis.

I approached each interview with the attitude of being the learner and the participant the teacher (Adamson & Donovan, 2002). In each interview, the participant and I laughed together, often as I set up the recording devices or they shared an amusing anecdote with me. I also approached each interview with social courtesy, such as standing until offered a seat or the participant had sat down and using “ma’am.” In addition, nonverbal language such as smiling and eye contact was used throughout the interview as appropriate. I used each participant’s last name and

title of “Mrs.” throughout the interviews, until asked to do otherwise, and then I usually maintained the more formal title anyway to maintain the relationship on a researcher/participant level. Other strategies were used and modified as the relationship developed and were unique to each participant.

Kauffman (1994) discussed what she called the “insider/outsider” dilemma of a white researcher accessing a black community. She stated:

Differences in the set of characteristics comprising social status, such as ethnicity, age, and class, between the researcher, the *Outsider*, and the group being studied, the *Insiders*, are believed to provoke prejudicial and discriminatory responses and impede *getting in*, the process of initially gaining, and over time, building and maintaining mutual trust and acceptance. (p. 179)

Kauffman (1994) identified 5 stages of the “getting in” process and strategies to help researchers who are studying groups different from themselves. I used some of the strategies that she suggested, such as: (a) maintaining political and personal neutrality, (b) following rules and customs of the insiders, (c) appearing more as an insider, (d) identifying several key informants who are liked and respected by the insiders, who can teach the outsider, (e) being genuine in unconditional acceptance, (f) learning the language, and (g) engaging in “swapping” behavior, not necessarily materially, but emotionally and socially. I identified early who were key informants and gatekeepers in the community, but as I got involved with the participants in the setting, it was obvious that occasionally there was a different person than I initially thought. An example of this is that I thought the parish nurse was the gatekeeper

because she was well known and trusted by that group of participants during the recruitment process, but when the time came to get informed consent to participate in the study, some of the participants in the initial assisted living facility checked with me to be sure that the administrator had given me permission to be in the setting. In addition, when I recruited from the American Association of Retired Persons (AARP) group, I had a key contact related to the group and then someone who was an officer in the group who legitimized me being there.

To maintain the relationship, I wrote thank you notes after each interview, but also sent a variety of cards over the course of the research such as Easter cards, Thanksgiving cards or Christmas cards and called to check in with them periodically. I also provided any small service to help them get ready for the interview and establish the relationship. Examples of these services include such things as I helped one woman get her cornbread out of the oven and set her lunch up so she could eat before we talked, since she was running behind schedule. Other services included retrieving mail, examining something physically when requested, and on the participant's request using the honorarium to go get some hearing aid batteries so she could hear me better during the interview. I also dressed casually since they were usually dressed casually for the interviews.

A final consideration about engaging in research with African American participants is the general distrust felt by many for the biomedical community. This distrust dates back historically to medical experimentation done on slaves in the 1800s (Gamble, 1997). However, even today it is easy to document health care disparities between whites and blacks in areas such as cardiovascular care (U. S.

Department of Health and Human Services, 2000). Fears about genocide, oppression, and health care disparities are not unfounded when examining the history of the United States (Washington, 2006). I made it clear to the participants through the informed consent process that they controlled whether to answer any questions or to stop participating in the research. I made it clear that any data gathered would be kept secure and confidential, with no names used. I also explained the limits of the data use as quotes in the dissertation or presenting aggregate data.

Recruiting Elderly Subjects of Differing Developmental Levels

The elderly are sometimes reluctant participants in research; Souder (1992) reported their overall willingness to participate at 60% or less. To increase recruitment success, Souder suggested a consumer-oriented approach to recruitment that ties in to eight motivators, classified from analyses of a 4 year study. She suggested individualizing the recruitment approach based on which motivator might be working in the situation. These motivators are: (a) altruism, (b) interpersonal contact, (c) documentation, (d) novel experiences, (e) hope, (f) scientific involvement, (g) second opinion, and (h) reassurance (pp. 314-315). Based on assessment of an individual's motivation, the specific individual needs can be addressed through participation in the study. I listened to each participant carefully and they did enjoy the interpersonal contact, but universally they expressed participating in the research because they wanted to help me and other people grieving in the future.

Researcher as Nurse

Often individuals feel very comfortable talking with nurses about health-related issues and concerns. In addition, individuals are accustomed in our society to “talking to the nurse” about almost anything that concerns them (Sword, 1999). Since I am also a nurse, it may occur that the interview begins to digress into health-related issues not connected with the bereavement, grief, and mourning experience. In that situation, if there was a medical concern that needed to be addressed I made sure that referral for an appropriate follow-up was done, rather than intervening.

Protection of Human Subjects

Prior to data collection, the study was approved by the Institutional Review Board (IRB) of the University of Missouri-Columbia Health Sciences Center. I completed the compliance training required of all researchers and the written materials and procedures in this study comply with the regulations and guidelines established by the federal government and contained in the University of Missouri system regulations for research involving human subjects. All participants were recruited by written information, personal contact, or group presentations and were strictly voluntary. No coercive tactics were used in recruitment. All amendments to the study were approved by the IRB, such as adding recruitment sites and increasing the years since bereavement to be eligible to participate. Any time I had a question about whether some issue needed to come before the IRB, I contacted a member of the IRB staff.

Informed Consent

The study was explained thoroughly, both verbally and in writing, and any sensory deficits were compensated for individually. For example, one woman asked me to read it to her out loud because her vision was decreasing. I generally sent the informed consent with the packet I sent to each participant, because some of them wanted to make sure it was acceptable to be in the study and they consulted with their children. I reviewed the informed consent again with them when I met with them the first time and often read it with them and let them ask questions. The rights of research participants were explained in a manner understandable to them. The consent form was at approximately the 8th grade reading level, as recommended by the Institutional Review Board standards for the University of Missouri (University of Missouri, 2003c). The informed consent form is at the 8.3 grade level according to the Flesch-Kincaid formula and the reading ease is at the 65.2 level (60-70 target range) according to the Flesch Readability formula. Print was at least 14 font and large enough to consider the visual needs of elders and verbal interaction considered the hearing and processing needs of the elders (Atchley, 2000). All questions were answered honestly and as fully as able at the time. Any questions that needed further information were promptly followed up and the information provided to the participant. Participant understanding was assessed by asking them to explain in his or her own words what the study was about and what participation in the study involved (University of Missouri, 2003a).

Written permission to participate was obtained from each woman and the consent form included a statement about withdrawing from the study at any time. The

criteria for informed consent for the University of Missouri were used to develop the consent form (see Appendix D). These criteria include: (a) research purpose, (b) research procedures, (c) risks, (d) benefits, (e) alternatives, (f) confidentiality, (g) disclosure of potential conflict of interest, (h) research-related injury, (i) contact information, and (j) withdrawal (University of Missouri, 2003b).

Potential Risks

Since data were collected via an interview where the individual shares whatever information she chose, there was minimal risk. However, there is always a risk of negative emotions when discussing loss of a spouse. I made sure that each participant told me the name of someone they could call if they became upset by the interview and experiencing continued negative effects. If I was concerned about the woman after the interview, I followed up with a telephone call. After the interview I asked them how they were feeling and if negative emotions had been triggered. Most of the time, they expressed relief or gratitude for being able to talk about the situation, even though it may have made them a little sad, too. There were no participants who were extremely upset by the interviews.

Potential Benefits

There were several potential benefits for participating in the study. Each individual was provided with an honorarium of \$10 after each interview. The participants also assisted to expand the knowledge base for other African Americans who have lost their spouse. In addition, participation in the study gave the participants the opportunity to discuss their experiences and feelings in an atmosphere of acceptance and concern.

Sampling Procedures

Inclusion Criteria

The criteria for inclusion were that the individuals:

1. were not full-time caregivers for the deceased spouse at the time of death.
2. were 2-10 years post-bereavement.
3. had not remarried since the loss.
4. were apart from the spouse no more than six months, if care transferred out of home.
5. experienced loss from first marriage or prior marriages did not end in widowhood.
6. experienced an anticipated spousal death.

From reviewing the literature, I knew that time since loss of spouse affected the experiences of grief so limits were set on time since loss. With the broad range I had set, it was clear in the interviews that there were different reactions no matter how long since the time of death. I also knew that there are many sociodemographic variables related to grief and mourning (i.e., place of residence, gender, income level, educational level, and social support system), so I recruited participants with as much variation in these variables as possible.

Sample Size

In grounded theory studies sample size is not determined *a priori* because as the data are analyzed from the initial sample the codes determine the direction and amount of further sampling needed in the study (Glaser & Strauss, 1967; Glaser, 1978). In general, the sample size needed for qualitative studies using purposive samples is less than quantitative studies needing sample sizes for probability statistics

to generalize to a population. However, Sandelowski (1995) cautioned that the researcher must be clear about the purposes of the sampling and what the end product will be for the study. In grounded theory, analysis continues until theoretical saturation of codes, no new information, is revealed from the analysis that can add to the emerging theory.

Creswell (1998) recommended 10-20 interviews with the understanding that in each interview there are many units of analysis. However, Morse (2001) recommended about 30-50 interviews and/or observations. In prior studies of grief and loss the range was 6-19 participants (See Appendix E). In this study, 17 interviews were needed before codes were saturated and the theory “emerged.”

Sampling Methods

Initial sampling. A purposive sample of individuals who have experienced the phenomenon is selected to begin the data collection and analysis. This is known as selective or criterion based sampling that is aimed at phenomenal variation (Sandelowski, 1995). Initially, the sampling is done based on a general perspective about a substantive area, not on a preconceived idea or problem. Further sampling was determined as I coded the data and the variables and concepts of the theory started to emerge from the analysis (Glaser, 1978; Glaser & Strauss, 1967; Morse, 2001; Strauss & Corbin, 1990).

Theoretical sampling. Theoretical sampling is used in grounded theory after the initial sample has been analyzed and coded. Glaser (1978) described theoretical sampling as a procedure to “...elicit codes from raw data from the start of data collection through constant comparative analysis as the data pour in. Then to use the

codes to direct further data collection” (p.36). Theoretical sampling is based on the analysis from the data from the first participant. As Glaser and Strauss (1967) stated: “The basic question in theoretical sampling... is: *what* groups or subgroups does one turn to next? And for *what* theoretical purpose?” (p. 47). The next group to be sampled is dependent on the emerging theory from the initial sample and the data analyses that led to the theory’s beginnings.

Initially, the sampling is based on a general perspective about a substantive area, not on a preconceived idea or problem. Further sampling was determined as the data and concepts of the theory start to emerge from the analyses (Glaser, 1978; Glaser & Strauss, 1967; Morse, 2001; Strauss & Corbin, 1990). My initial sample was four participants and I continued to recruit by looking at the variations in the categories that were being revealed in the data and their attributes. I maintained the initial inclusion criteria and looked for variations as the other data were analyzed to see what level of fit was present with the analyses, or what variations I was seeing in the new data.

Recruitment

Two different settings were used for recruitment of subjects. One setting was an assisted living apartment complex within the inner city urban area. This three-story apartment complex has 72 one-bedroom units that are 540 square feet each. There are central laundry facilities, activity and meeting rooms, library, offices, elevators, and secure parking areas. The assisted living apartment complex is one block from a major bus line. The apartment complex is managed by the National Benevolent

Association of the Christian Church (Disciples of Christ) and funded by the U. S. Department of Housing and Urban Development (HUD).

Through an urban initiative at the college where I teach and a clinical experience with my student nurses I gained access to this group of residents. An initial contact with the administrator and the parish nurse who serves the community revealed that all of the residents are widowed, over 65, and African American. He was open to the possibility of the research and indicated that the residents had participated in other research endeavors with local colleges. He also thought that since the college where I work is affiliated with was a Disciples of Christ school that would be a plus in recruiting.

The administrator, the parish nurse, and I discussed recruitment strategies and developed a plan. The apartment complex has a monthly publication and I wrote an article about my study and invited residents to the recruitment event. The parish nurse and I sponsored a tea for residents so I could talk with them in person about the study and invite participation. The parish nurse provided a tray of pastries and fruit and I furnished tea and coffee as an incentive. The Administrator suggested that we have the tea on a Tuesday or Thursday at 10:30 AM, which is right after a scheduled hour of “intercessory prayer” when some residents are already congregated.

In addition to the residential participants, the parish nurse gave me the name of a prospective participant in the community dwelling in her own home. After follow up and explanation of the study, this woman was eager to participant in the study.

The second recruitment site was a local chapter of the American Association of Retired Persons (AARP) in the same general area as the first recruitment site.

Through a local contact, I met the President, explained the study, and asked for permission to present it to the group. After consultation with the other officers, they welcomed my presentation and were responsive to presenting it to the members at large. I was invited to monthly meetings over a succession of two months to present the research project and received responses from potential participants during the meeting. If anyone completed a form expressing interest in participating, I followed up by telephone with them to explain more about the study and affirm their desire to participate. Some of these participants lived in congregant living settings, while others lived in their own homes.

The Participants

The final sample size was nine widows. Each woman was interviewed twice, except one who was lost to follow up. This was a total of 17 interviews. Five of the participants lived in assisted living settings that were income-based housing, one lived in an upscale, gated assisted living facility, and three women lived in houses they had shared with their husbands and had lived in for years.

Between the first and second interviews, each participant had experienced either the onset of a chronic illness or an exacerbation of pre-existing illness. One of the nine participants was lost to follow up between the first and second interview due to cognitive decline and subsequent admission to a nursing home. The staff of the facility where the participant resided reported that she would not be able to participate further because of her changes in mental status and I received a note from one of her family members further explaining the situation. My final sample was all women because few men expressed interest or they were remarried.

The participants ranged in age from 67 to 98 and had been widowed from 1 to 11 years at the time of initial contact. Four of the deceased spouses had experienced progressive cognitive impairment during their final illness and five had maintained their cognitive functioning. All of the deceased spouses had experienced progressive physical decline. See Appendix H for more complete demographic information.

Eight of the widows had been involved in spousal care giving, but had varying degrees of physical care responsibilities and had received varying amounts of support. The women who had more physical care responsibilities verbalized the immense emotional and physical toll it had taken on them, especially when their spouses had experienced more profound cognitive impairment. Not all spouses experienced what they called “peaceful” deaths in which the husband did not suffer physically or emotionally.

Watching the suffering of the spouse, whether physically or emotionally, often brought tears of emotion when the participants discussed the dying process. Those who had not witnessed a lot of suffering during the dying process expressed gratitude for this and often reported it as a “blessing” (“I am so grateful that I didn’t have to watch him suffer long”) and (“It is such a blessing that he did not suffer as much as some”). Not all women were present at the time of their husbands’ death and if they were not present that was generally talked about with regret.

All of the participants had worked outside of the home at some point during their marriages and their occupations included factory worker, prep chef, school teacher, journalist, hair stylist, licensed practical nurse, and registered nurse. The husbands’ occupations included city worker, judge, attorney, waiter, and barber. All

of the participants identified with and expressed the importance of a religious faith and were associated with a faith community. Each of them expressed repeatedly the importance of her faith to help her both during the dying and after the death.

A few of the participants had grown up in urban areas, but more of them grew up in the rural South and had migrated north for various reasons. Since all of them grew up in pre-Civil Rights Movement America, they all had stories of segregation and instances of dangerous racist acts they had witnessed or experienced themselves.

The Interviews

Process of the Interview

Several considerations went into the design of the interview to create a relationship in which the participants felt comfortable sharing their life experiences. Each interview day, time, and setting was chosen by the participant. Two recording devices were always used, one digital and one standard audiotape. Although I was initially concerned about the effects of the recording devices on the interview, they were a source of lighthearted banter at the beginning and end of the interview and not disruptive. The use of two recording devices allowed me to maintain eye contact and sensitivity to the nuances of the interview without being concerned about technical difficulties. Each participant's response to the process and content of the interview was monitored closely to guide the interview. The interview was allowed to progress as long as the participant wished to talk.

Follow-up interviews were negotiated prior to the first interview during the informed consent procedures so the participants would have an opportunity to contribute to the verification and credibility of the data collected and clarify or

expand on what they said. Even though we had contracted for two interviews, I gave them the opportunity to “opt out” of the second interview at any time. We generally spent some time just socializing both before and after the interview, testing the recording equipment, catching up on what had been happening in the participant’s life, or taking a walking tour of the home to see new pictures.

All but one of the women chose to be interviewed in her home. The home setting allowed me to observe not only the structural and functional components of the living space, but also those artifacts and memorabilia that made the setting unique to the individual participant. Discussion of memorabilia often elicited more interview data that were of significance to the participant

One of the participants could not tolerate being in her home much because of the reminders of her husband (“Everywhere I look, he is there”) and doing the interview in her home was not something she chose to do. A private conference room in the building where the recruitment event had occurred provided a comfortable place for the interviews.

Before and during each interview, I reminded each participant that we could stop at any time and she was not obligated to answer any question. Due to the nature of the interview material, I remained actively attentive to verbal and nonverbal cues from the participants and reminded them we could stop any time they needed to or wanted to without problem. As Charmaz (2006) suggested, I directed the interview to end on a positive and social level. When they cried, I sat quietly and provided support, and even though they always apologized, I quickly normalized the crying for them. Rubin and Rubin (1995) suggested that qualitative interviews are more focused,

deeper, and more detailed than an ordinary conversation, but that many of the same rules apply. Some of the rules include: (a) cover a few topics in depth, (b) make smooth transitions between topics, (c) take turns talking and listen when the other person is talking, (d) indicate nonverbally that you are hearing the speaker, and (e) clarify if not certain about what was said. These conversational rules were incorporated into the interviews. In addition, I listened actively and either provided nonverbal cues such as head nodding or verbal cues that I was hearing the participant. Follow up questions or probes consisted of reflections on what was said or questions asking for clarification.

The widows physically or verbally digressed from the topic at times and I allowed that to happen. For example, I knew it was time to pause for awhile when one participant, who always fed me, no matter what time of day I came, offered me a coffee refill. The women always reengaged when they were ready with or without prompting from me. There were other times during the interviews that my observations of them led me to digress from topic briefly or even to start closing the interview. I always checked to be sure that they had a person they could call or talk to if they needed to after our interview had concluded.

Tools of the Interview

Demographic questionnaire. I started with general demographic questions to help the participant become used to talking (P. LeMone, personal communication, January 2000). These questions were less open-ended than the main interview questions and focused on information about the age of the participant, former or current occupation, length of time from illness or injury and death, lengths of time

since the death, and circumstances surrounding the death (see Appendix F). I knew from the literature that when these events occurred can affect grief, bereavement, and mourning. In addition, these generally less threatening factual questions may be used as to gauge the individual affective responses to the thoughts and feelings elicited during the interview. I used these initial responses as springboards for discussion or to modify the planned questions for the interview.

Study introduction. I used an introduction to the study that read like this, modified for the participant's understanding level and questions:

Thank you for agreeing to share your experiences with me. As you know, I will be conducting one or more interviews with you that will be audio taped. I will ask you a few questions, but mostly I just want to hear about how it was for you after your husband died. Grief and mourning are very individual experiences and I want to understand what it has been like for you since your spouse died. There are no "right" or "wrong" answers during the interview, but I may ask you to explain something a little more so I can understand it better. Please feel free not to answer any question that you are not comfortable with during the interview. Let me know if you need to stop the interview at any time. What can I answer for you before we get started?

Interview guide. Typically in grounded theory studies the questions are more open-ended and allowed the participant to respond in a free form way. Usually, even through the grounded theory researcher may start out with a broad question, other

questions or probes are based on what the participant shares, with no set list of questions that must be covered (Fontana & Frey, 1998).

The semi-structured interview guide used in this study provided for breadth and depth of the information shared by the participant. These questions were included in the interviews:

1. Tell me about your experience of losing your husband.
2. What has life been like for you since you lost your husband?
3. How did your day to day life change after your husband died?
4. What was the experience of grief like for you?
5. What advice would you have for someone experiencing the loss of a husband?
6. Is there anything else I should know about the experience of losing your husband that you want to tell me or I didn't ask?

Some examples of follow up probes that were used during the first and second interview were:

1. When did it happen in your mind that you started thinking of yourself as a widow?
2. What made that transition seem real to you?
3. How do you make sense of the experience of your husband getting sick and dying?
4. How do the grief and mourning experiences of this situation differ from the ones you experienced or witnessed growing up?

Data Management

The methods used to protect the anonymity of the participants and ascertain that the transcribed tapes were accurate reflections of their words were of primary concern to me when managing the data. Several steps were taken to preserve both of these goals.

Anonymity of Research Participants

Each research participant was given a code number that represented who they were, the recruitment site and the date of the interview. The tapes and the transcribed interviews were kept in folders in a secure environment known only to me. The initial demographic sheet and the file I kept with names, addresses, and telephone numbers were the only items that had the full identifying information. These were kept in a secure environment under my control. When the electronic copies of the transcripts were stored in the computer, they were password protected. The transcriptionists e-mailed the transcribed tapes to me and they were in a password protected storage area. They had been instructed to block out any names that were mentioned.

Transcription Methods

I had two transcriptionists during the study. Both worked in settings where they managed confidential data and they used the same precautions when typing the transcripts. They shared the information and the tapes with no one and kept the tapes in a secure place. Upon recommendation from my committee, for the early interviews I had an African American transcriptionist, in case there were nuances of language that I was unfamiliar with during the interview.

I listened to the tapes before I gave them to the transcriptionists, but occasionally I listened again and read the transcript with the tape. Sometimes I could clarify or give more detail when the tape was not clear for some reason.

Computer Aided Qualitative Data Analysis

I selected ATLAS-ti for data storage and analysis. I opted for ATLAS-ti because of screen presentation and the flow of the theory building tools from the toolbar (Lewis, 2004). Also, one of my committee members had used ATLAS-ti and helped me examine the functionality of the program.

Data Analysis Processes

The data analysis included several phases. A discussion of the procedural steps in the data analysis in grounded theory methods with specific application to this study begins this section. This section ends with a discussion of the procedures to ensure rigor in the data collection and analysis and the data analysis tools.

Field Notes

In grounded theory the essential relationship between the data and the theory is a conceptual code (Glaser, 1978). The researcher examines the pattern in a set of empirical indicators and conceptualizes the pattern in the form of a code. Memoing and coding start immediately after the first data collection and can begin with the field notes.

Data collection included the transcription of field notes before and after the interviews and observations. Field notes are descriptions by the researcher regarding content and context when participating intently in the researcher-participant relationship. The field notes included descriptions of my thoughts, feelings, and

reactions, as well as descriptions of the nonverbal behavior of the participant and the environment (Glaser & Strauss, 1967; Glaser, 1978).

Memoing

Memoing allows researchers to put down ideas, perceptions, and descriptions as they occur. Early field notes written as I arrived and as I left the setting of data collection began the process. After the interview, I immediately went to a nearby location where I could listen to the interview with headphones and not be disturbed to jot down memos and codes. When I had a driver, I listened to the interview with headphones on the way home. These early memos were about significant thoughts, feelings, or observations that were a part of the data collection session. As the process of analysis continues, memoing continued to give further insight about the emerging theory. Memos were sorted and reviewed in relationship to the developing theory (Glaser, 1978; Glaser & Strauss, 1967; Morse, 2001; Strauss & Corbin, 1990). Glaser states: “The four basic goals in memoing are to theoretically develop ideas (codes) with complete freedom into a memo fund that is highly sortable” (p. 83). I have some memos on computer program, but also a notebook of memos that I wrote on many different things, such as napkins, pages of a magazine, or on a program of an event, because thoughts often came to me by something I witnessed, read, or processed from an event. One of my instructors had described this process somewhat jokingly as: “Some times you are opening a dryer to take clothes out and a thought about the research comes to you.” I labeled both the memos and codes for which participant and which interview it was referring to so I could locate it again. In reality, memoing occurred any day, time, or place when I was thinking about the participants and the

interviews and the memos were recorded immediately on paper or in the electronic database.

Open Coding

Open coding began immediately as I listened to the audiotapes and then read the transcribed interview line by line and coded each line. During coding, the data are broken down, “fractured” and analyzed bit by bit. Glaser (1978) suggested a group of questions to ask about the data: (a) “What is this a study of?”; (b) What category does this incident indicate?”; (c) “What is actually happening in the data?”; and (d) “What is the basic social psychological problem faced by the participants in the action scene?” (p. 57). The analytic tasks involved in open coding center around identifying concepts and naming them and defining categories. Codes may be developed from single words or phrases of the participants. I found doing this immediately after the interview and then reviewing them again was a helpful process.

Constant Comparison

Constant comparison takes place from line to line, incident to incident, concept to concept and both horizontally and vertically to examine for commonalties or differences. I maintained a list of codes as I analyzed the data. There are many other types of coding used in theory development and Glaser (1978) described 18 coding families. I will just describe one coding family used in this study, and speak to several aspects of a social process.

Glaser (1978) described the “process” coding family with a series of words that can describe the phenomenon, such as stages, staging, phases, phasings, progressions, passages, gradations, transitions, steps, ranks, careers, orderings,

trajectories, chains, sequencings, temporalizing, shaping, and cycles (p.74). The criteria for this coding family are of two or more identified stages and the phenomenon occurring over time. I chose this coding family because it matched well with the data presentation and the codes that were being elicited from the interviews with participants.

Theoretical Coding

After the open coding of the raw data, codes can be developed into more abstract entities such as concepts, categories or variables and the properties of these entities. From this level of coding, theoretical coding can help uncover the core concept/core category, relationships, and finally theoretical constructs can be developed for the theory. The theoretical codes put the data back together and this allows the development of a theory grounded in the data. As described above, coding is a vital activity, since the theoretical codes conceptualize how substantive codes may relate to each other as hypotheses to be integrated into a theory (Glaser, 1978; Glaser & Strauss, 1967; Morse, 2001; Strauss & Corbin, 1990).

Integrative Diagrams

Integrative Diagrams are used as the theory emerges to help put the core categories and their properties together. Diagrams are also used to illustrate the indicators or referents used to develop concepts. Diagrams are visual representations of what has emerged during the data analysis and are useful to put order to the memos and codes and propose relationships that have become evident during the analysis.

I drew integrative diagrams early and continued the process throughout the research. I often sought an expert qualitative researcher on site to verbally express

and think through what was emerging from the data. I kept the different versions of the visual depictions, along with the progress of my thinking, in a notebook. I sometimes relied on a tape recorder as we worked to make sure that I captured what was being discussed and did not use the computer program. I started with blank pieces of paper, but I soon went to a white board and then large sections of newspaper stock as I was incorporating the codes that were elicited from the interviews and where they fit within the theory that was emerging. I saved everything in all media so I could go back and review the progress of the theory development to make sure I had remained true to the interview, codes, and memos throughout the process.

Theoretical Saturation

When can the researcher stop collecting and analyzing data? Glaser (1978) stated that theoretical saturation is evident "...when coding and analyzing both no new properties emerge and the same properties continually emerge as one goes through the full extent of the data" (p. 53). Saturation helps the theory be conceptually complete. Strauss and Corbin (1990) identified when saturation occurs:

1. No new or relevant data seem to emerge regarding a category.
2. The category development is dense, insofar as all of the paradigm elements are accounted for, along with variation and process.
3. The relationships between categories are well-established and valid.

One final attribute about grounded theory methodology is that it is not linear. Even though I have presented the process in a linear manner, the constant process of coding, comparing, and memoing is a cyclical interaction. I reached tentative

saturation at interview 13, but did the second interview on the last 4 participants to be sure. I also relied on the confirmation from the participants.

Methods to Insure Credibility of Findings

Leininger (1994) recommended criteria to be used in substantiating qualitative studies. The criteria and ways I insured them are:

Credibility. This criterion refers to the “believability” of the findings. I facilitated credibility by making sure that I had adequate exposure to the participants, not only in time, but in depth of interview to understand their experiences of bereavement, grief, and mourning. I conducted two interviews with each participant. The second interview was done after analyzing the first and the findings from the first were checked with the participant to ascertain that I had accurately captured the essence of her words. I did this by restating ideas or my interpretation or analysis of the ideas to the participants.

I maintained contact with the participants informally to strengthen the relationships I had established with them and took an interest in their lives. I sent cards at various holidays and checked with them on issues we had discussed at the prior interview. If they had immediate needs at the time of the interview, I helped them with those needs. Examples of these activities include reading a letter and suggesting resources to help them deal with an issue in their lives.

Confirmability. This refers to checking with the participants about the data obtained during the interview. I did this by restating ideas or my analysis of the ideas to the participants throughout the study. I took my analysis of the first interview with me to the second interview and completed a “member check” with the individual

participant about what I heard them say and as the categories developed over time. I asked them to reflect on what I had heard in general across the participants. Beyond the participants' input, having experts from the appropriate fields formed part of the confirmation. In addition, I took the final written analysis back to selected participants for their opinions as to whether their experiences were captured adequately. I have consulted regularly with a qualitative researcher on site and members of my committee periodically. In addition, I presented the conceptual categories of the developing theory to two different peer groups of African American widows for their input about the analysis.

Meaning-in-context. This refers to examining the participant holistically within the setting or the environmental context. I paid careful attention to and documented details about the participant's living environment and the meaning she attached to the environment related to the loss of spouse. Comments were frequently made about alternative arrangements that needed to be developed to accomplish some household tasks that their husbands had taken care of or difficulties in obtaining the help that they needed. All of them wanted to be informed of my progress and so I included that when I wrote cards at various holidays or talked with them on the telephone. When I was in the building where three participants lived, I checked on their status.

Recurrent patterning. Some events or circumstances recur in an individual's life and noting the patterns can help understand the context and meaning of life experiences. Conducting the two interviews provided an opportunity to note recurring patterns of coping pertaining to the present loss of spouse and her on-going life

experiences. The identification of recurrent patterning was assisted by using a variety of memoing methods.

Saturation. This refers to an exhaustive exploration of the topic of the study. I did this by listening for redundancies or duplications in the words of the participants or the analysis of the data and observing for emerging patterns. The analysis was complete when the conceptual categories were identified along with the properties/attributes and the process was understood from the perspective of the participants.

A second set of criteria specific to grounded theory proposed by Strauss and Corbin (1990) are guidelines, but the authors suggested that they be utilized to aid in evaluation. These criteria are in the form of questions: (1) Are concepts generated?; (2) Are the concepts systematically related?; (3) Are there many conceptual linkages and are the categories well developed? Do they have conceptual density?; (4) Is much variation built into the theory?; (5) Are the broader conditions that affect the phenomenon under study built into its explanation?; (6) Has process been taken into account?; and (7) Do the theoretical findings seem significant and to what extent? (p. 255-256). I have used these criteria to ensure credibility by asking each of these questions of myself frequently during and after the data analysis, as well as asking committee members or the local qualitative researcher to provide input on the process. In addition, where appropriate, I have asked questions of the participants that reflect the essence of the concerns.

I have also had mentoring in grounded theory methods throughout the research process. A methods expert and other committee members with expertise in

various aspects of this work have supervised my work and provided advice and guidance through the research process.

Audit Trail

When I began my research, I developed a process to have regular checks by the participants, research and grounded theory experts, and individuals who had experienced widowhood. This audit trail was designed to maintain the rigor of the process and ascertain that the research process was staying true to accepted and valid research methods in the field while remaining grounded in the data from the participants (see Appendix G). The goal was to be transparent in the data collection and analysis procedures so other researchers could evaluate the methods as I performed the analysis (Charmaz, 2006).

Chapter 4

RESULTS

This chapter presents the grounded theory model of the grief and mourning process experienced by the African American elder women. First, I briefly examine the most relevant cultural influences on the process. These sociocultural factors are the context within which these women coped with their husbands' illnesses and death. Next, I present an overview of the grief and mourning process, followed by an explanation of the phases through the transition to widowhood. The grounded theory is presented as a visual model as well and the core category that emerged from the data concludes the chapter.

Sociocultural Influences on the Grief and Mourning Experiences

Four African American sociocultural influences emerged from the narratives. These cultural influences were echoed in the research of Rosenblatt and Wallace (2005) about other African American family losses, such as parent, sibling, and child.

Racism

All of the women felt that they still experienced veiled prejudice and racism. One woman recounted an experience:

I went in to try on a hat and the lady said I couldn't try it on before I purchased, I had to buy it without trying it on . . . I said I did not know if it would look good on me without trying it on . . . I just turned around and walked out.

The participants accepted racism as part of their reality ("That's just the way it was") despite having to contend with their grief and mourning. They often had faced

great adversity in their lives (“If all you’ve ever known is hard times, it’s just more of the same”) and they acknowledged prejudicial behavior against themselves, but had found ways to make it work to their advantage. For instance, one woman stated that even though they were not allowed to sit in the front of public buses, “We filled the bus from the back forward, so that we ended up sitting there anyway.” Another woman recalled:

They wouldn’t serve us our drinks in the glasses, but made us use paper cups, but the glasses weren’t clean, a lot of times they still had lipstick on them, so it really was better to use the paper cups, anyway.

Such common current incidents of racial prejudices contributed to the women mistrusting helping agencies and this was coupled with historical events such as the Tuskegee syphilis study where treatment was withheld from African American males without their knowledge or consent (Centers for Disease Control and Prevention, 2008). One participant described an incident when she was a child and a white doctor treated her for an emergency, but only after a movie he was watching had ended (“. . . You could be dead by then!”). Because of these past experiences several widows delayed seeking health care for their husbands or they delayed accessing agencies that would have provided support for them in caring for their husbands. When they were compelled to rely upon these distrusted agencies, they engaged in acts they felt would ensure better care. For example, a participant explained, “[I]slipped the worker a little something on the side,” to make sure that her husband was well taken care of in the nursing home. Instead of trusting the health care system to care for their husbands, reliance upon family members was preferred by these African American women.

These examples illustrate the lived value of persistence in the face of adversity. The general attitude of participants was to persist in meeting goals and creating the life that they wanted for themselves and their families. This value was evidenced as they described raising children and now in facing the loss of spousal, physical changes, and chronic illnesses.

Family Support

Another factor that contributed to delay in accessing health care was the strong sense of familial loyalty and the desire to maintain the family unit. Historically, when African American family members were exposed to physical, mental, and emotional hardships by a racist society, a sense of family helped individuals cope (Churn, 2003; Parkes, 1993; Rosenblatt & Wallace, 2005). When genetic kin were unavailable, African American individuals created new families through “fictive kin” or a “play family” where possessions were freely shared and exchanged. Often, individuals joined another family for a period of time or took on a familial role, such as mother, grandmother, or aunt, with non-related individuals (Jordan-Marsh & Harden, 2005; Stewart, 2007). Non-family members thus provided a source of badly needed social capital and support. The family, formed from individuals who chose to bond together, was a safe haven from a hostile, racist world, a value still held by the study participants. This strong family value influenced the meaning of losing their husbands and intensified their grief, and it also influenced who they relied upon for social support as they rebuilt their lives after the spouses’ deaths.

As one participant stated:

...If I have a problem I can call him and will say well ____, if it costs more than I want to spend I'll get my family together and I'll take care of it. There are three women at church speak of me as their adoptive mother and they will do little things...there is one of the girls, that is my play daughter.

Funeral as Rite of Passage

The importance of the funeral also reflected the participants' African American heritage. Historically, the oral tradition of sharing life experiences and family history occurred during the funeral and the congregating of friends and family members after the funeral. The sharing of food and celebrating the life of the deceased was an important aspect of the transition to widowhood (Barrett & Heller, 2002). Sharing the life story of the deceased, socializing with friends and family members, and reminiscing about the deceased facilitated family bonding. For African Americans, death was a passage and an expected part of life, representing a freedom from oppressive conditions experienced in American society (Hooks, 1993b).

The participants in this study made only a few comments about the funeral. They did talk about how they had tried to honor the husband and allow family members and friends the opportunity to say good bye. Participants occasionally commented on specific aspects of their husbands' funeral services - the number of people who attended, where they fit in their husband's life, or the details of the funeral service. One family, upon the wishes of the husband, had a small memorial service with only family members present after her husband had been cremated. This

family also planned and conducted the whole memorial service themselves including the songs, readings, and eulogy. Another participant gave me a copy of the program from the funeral that was printed on glossy paper with her husband's picture on the front detailing his life and the funeral service, the so-called "alpha and omega" (Churn, 2003) of his life. A picture of her husband's favorite recreational vehicle with the saying "on the road again" on the funeral program was one woman's way of memorializing her husband and their good times traveling together. One woman recalled that he had a beautiful white coffin, but she could not yet bring herself to visit the gravesite. Some participant's memories of the funeral day were only recalled with help from family members later because the actual day was a "blur" or "foggy."

Historically for African Americans, the wake and funeral were times to re-establish relationships and gather resources necessary for bereaved family members to rebuild their lives (Barrett & Heller, 2002). Individuals or families offered to help the bereaved with tasks that were a challenge for them, such as tending crops, preparing food, caring for children, or other activities needed to maintain the household. The tasks facing widows have changed over time, yet the function of providing support for the bereaved still presents itself today.

Faith

Historically, religion, faith, and spirituality were highly important during grief and mourning among African Americans (Anderson, 2000). The most common religion was Christianity, sometimes intermixed with spiritual traditions from Africa (Hooks, 1993a; Hooks, 1993b). Christian beliefs offered hope that a better future awaited and that there would be relief from suffering after death. Religion legitimized

congregating; religious services were social as well as spiritual gatherings. Food and fellowship at religious gatherings were opportunities for sharing information and strengthening ties with family and friends. The value of faith in God was a frequent remark by all participants. Many were active in their churches; several maintained contact with a church even when they could not attend due to physical limitations, transportation problems, or no longer lived near the church. They frequently expressed the comfort and hope faith provided them during their grieving and mourning experiences when their husband died. Faith helped them keep going after the loss, “If you are a religious person that helps a lot.” God and His ability to sustain them through the loss and life was a common theme. For instance, one widow stated, “If it wasn’t for the Lord being on my side, I wonder where I’d be”

Religious beliefs and faith in God also helped with making sense of the death and assisted them in accepting it:

Well, you know the only thing that I can dare say to anybody that it is God’s will and just go to God about it and He will comfort you, that is about the only solution that is the only thing that ever helps me, is that when I get depressed is just get on my knees and talk to the Lord about it.

I asked one widow, “What has helped you with your grief?” and she replied:

. . . I would go back to the 23rd Psalm...the Lord is my Shepherd, I shall not want. He maketh me lay down in green pastures, He restoreth my soul, yea, though I walk through the valley in the shadow of death I will not fear.

Summary

The African American roots of oppression and racism in this country have influenced all aspects of current life. These experiences of oppression and racism have fostered values and rituals that are reflected in grief and mourning after spousal bereavement through such areas as literature, music, funeral rites, and faith practices (Rosenblatt & Wallace, 2005; Wardi, 2003). The developmental level of the study participants influenced their memories of overt acts of racism and prejudice and the values inculcated by their families about race relations.

The Grief and Mourning Process

In this grounded theory study, the grief and mourning process emerged as a transition characterized by a series of phases beginning as a husband's health moved from stable to progressive debilitation, followed by his death and the rebuilding of his widow's life. There are no clear boundaries of the phases during the grief and mourning process. This process was experienced by the participants as a period of instability and change.

In brief, the grief and mourning process can be characterized as: When an ill husband's body (and sometimes mind) began to deteriorate, a transformation of the spousal relationship began. Social, emotional, and marital roles changed with his condition. After his death, some widows immediately got involved in "public" life again while keeping their grief hidden deep inside themselves, dealing with it a little at a time. Others chose to withdraw socially from many aspects of the "outside

world” to nurture and protect the self as they grieved. Every woman had to redefine herself and learn to live in the world in a new way, without a husband.

Grief became less overwhelming over time; most participants felt that they never completely got over the loss of the spouse and the relationship. The husband and the marriage would always be a part of them. The women identified “time,” “staying busy,” and “God’s help” as aids in the grief and mourning process. “It takes time” or “it gets better with time” were heard among all participants and all talked about the need to share their feelings with someone, “get it off my chest,” “talk it over,” “...not hold it in, to get it out, you’ve lost a loved one!” There were frequent references to God’s help, prayer, Bible reading, helping others, and church involvement as being effective ways to cope with loss.

Some of the participants moved to philosophical views of the situation as time passed. “I have to accept the truth of what is... I can’t do anything about it although I don’t like it.” “For everything that happens there is a reason” and “There is no bad thing if you learn from it,” were views expressed. Others continued to question their situation: “What was the lesson?”; “I don’t understand why it happened to a good person, rather than one of the hateful, mean people” or were resigned to the situation: “If all you’ve known your whole life is hard times then it is just more of the same.”

The Grief and Mourning Model

The grief and mourning model is six nested spheres seen in cross-section representing the phases of the grief and mourning process. The encompassing sphere reflects the concept that each woman was an integrated being and the grief and mourning experiences affected all dimensions of her life. The African American

sociocultural influences encapsulate the individual in the environment and the dominant culture is outside of the African American sociocultural influences. The arrows in the model represent the recursive nature of this process; participants can move back to earlier phases at any point. The process begins at the core of the model and move outwards; the participants' viewed themselves as stripped of their identity, redefined by the loss of their husbands, and regenerated as they moved through the process (see Appendix I).

The description of the phases of the grief and mourning process follows in the next paragraphs. The descriptions begin with the innermost sphere and move outward to the wholeness of the individual.

Uncoupling the Links of Our Life Together

The first phase of grief and mourning began before the husband died. Physical and/or cognitive changes occurred as the husband's health deteriorated; this series of events signaled it was time to begin "letting go" of the marital relationship as they had known it. Changes in the spouse and marriage were mourned and new ways of relating developed. Uncoupling from the relationship as the husband's health declined was accompanied by intense grief beginning long before the husband died. Three attributes emerged as characteristic of this phase in the grieving process – *dying with my husband, the living wake, and letting go.*

Dying with my husband. Not only was "he" dying, but each woman felt part of herself dying as well. She felt the loss of social and emotional aspects of the relationship such as entertainment activities, companionship, and mutual emotional

support. These losses generated a sorrow that transformed their marriage in tangible ways, such as what they talked about and what they did together.

Their interdependent roles shifted as she assumed more responsibilities and the reality of losses, real and impending, began pervade her life and awareness. “I was losing my man” was part of the angst of this time. Each woman identified that the transformation of her spouse transferred responsibilities for some household tasks (paying the bills, cooking) and his personal care to her or to someone else.

During this time, marital roles shifted. For instance, throughout most of one 56-year marriage the husband worked long hours as the breadwinner while the wife stayed home. During his illness she worked long hours physically caring for him and constantly monitoring to make sure his needs were met:

I had to get up around ‘bout 6’o clock in the morning. I had to give him a bath and wash him off and I had to hold his hand and everything and then I had to come in the room and fix the bathroom and then about that time I would take him outside and check the mail....

The living wake. The second aspect of *Uncoupling* was marked by constant preoccupation with their ill husbands. In the past, these women had enjoyed a mutual give and take in their marriages, but now the husband and his illness was the center of all that occurred within the household. As long as the husband was still in the home, she kept vigil, constantly aware of what needs he might have at any point during the day or night.

There were new questions and fears during this time, such as how will he be in the next hour or day, what can I do to make it better for him, and when will he die?

Participating in the living wake was yet another way that that their lives were becoming uncoupled. One woman, who cared for her husband for 3-4 years during his progressive debilitation with Alzheimer's disease, succinctly reflected this in her description of life before her husband went to a care facility:

I kept him here for quite awhile, and then it seemed like he started getting evil a lot, he wanted to go outside all the time and you had to lock the door to keep him in, sometimes I would come in here and he would be on top of the bed with his feet toward the window like he was going slip out the window, it's just hard to keep up with him all the time and then he seemed like he would sleep during the day and then when time to go to bed he was awake walking around, and banging chairs and things and I couldn't sleep at night cause I had to watch him...I was so tired but I just kept going.

Letting go. Concerns about safety, both his and hers, as well as gradually becoming unable to manage increasing demands for care giving, led the wives to begin *letting go*. This was not easy, and at times she was filled with sorrow, resignation, and guilt that they might need outside help or would have to place her husband in care outside of the home.

Depending on the husband's physical and mental state, some wives became very concerned about their own physical safety because the husband was "getting evil a lot" or "getting mean." "He would say things like, 'I ought to buy me a baseball bat and beat you upside the head.'" One woman described an incident:

I began to get kinda scared of him. 'Cause one time I was scared he was still up and I was trying to take a nap..... and I heard somebody

calling on me and I woke up and he just crawled on me on the bed and he had a big blanket and he was holding it like this (demonstrates), like he was going to smother me, and I just happened to come to and I told him to get off me!

The wives often were concerned about his safety as well, especially when cognitive decline was occurring:

...he had a way of getting out, I don't know if he had a key or how in the devil he got out of this house, I've never found that out...so the police told me, 'would you rather your husband get hit by a car out there and be killed' [instead of putting him in a nursing home], because we had followed him a lot of times up the street.

Other participants began to let go when they felt unable to handle the increasing physical care tasks for their husbands, such as assisting with dressing, bathing, and providing transportation. As his physical debilitation progressed, the amount of care increased and most wives had help from outside the home. Those without sufficient financial resources or adequate social support were overwhelmed with the intensity of the care and the constant attention needed. Constant demands on them stretched their personal resources:

Now for the last 10 years that he was so sick, I had to jump here, here, here (snaps fingers), call the doctor, going to the doctor appointments, sometimes I would have to drive him, most times he wanted to drive, but he had gotten so sick he couldn't drive or anything else...because he couldn't breathe to do

anything strenuous, so I had to do everything. But I did take care of him, and I'm so happy I did...I took care of him to the end.

On a psychological level, one participant felt like her husband gave in to the illness: "I just didn't face it (at first), but I think he would have done a lot better, if he had just kinda worked with it, but he didn't, and just got kinda depressed, that was the biggest thing." Other couples continued to fight death to the end. Often, the participant or her husband came to a point where they realized nothing else could be done and it was time to stop fighting. One participant described that moment in time:

I was there so much (hospital) he couldn't hardly speak...he kept doing this (gesturing for her to come close) and I had to lean over, I say 'what' (and he said) 'let me go', I say 'what are you talking about', he said 'let me go...if you were in this position I would let you go, I wouldn't hold on to you'...I am constantly praying 'God help him, don't take him...I say, 'well, Okay, _____, I will let you go', ...they called me that day and told me everything had stopped, he died he's gone. I said 'that is all it took [permission from her to die], but I did want to see his face for the last time.

Near the end of life, there was an awareness of the need to "let" her husband die either in the home or in assisted care outside of the home. Physical separation was difficult and the decision for a professional care setting was a difficult decision in the face of the African American cultural value for maintaining the family and a deep distrust of the medical world. Women tried to delay the decision as long as possible and sometimes conflict arose within the family about impending changes.

Preserving the Core of my Personhood

The participants felt they had been stripped of a central part of their lives when their husbands died. They began rebuilding life with the core that was left after their husbands' died. None of them reflected a sense of total hopelessness; all wondered about how life would be without him and who they were without the marriage. Most of them had been married for the majority of their lives.

This transformation began when he died. Most of the participants had vivid memories of their husbands' death and remembered the last hours or days before death. One described the grief as "knives that was cutting us." Others described rituals they went through such as stroking his face, taking a lock of his hair, holding his hand, or sitting with the body until the funeral home personnel came. Other participants described how they learned of the death if they were not present. All expressed regret if they were not present or awake when the death occurred.

Most remembered little about the funeral and relied on what other people told them or the artifacts they had as reminders. One widow shared a copy of the detailed program for the funeral service and reviewed the events of the service. Others described the situation as remembering "bits and pieces" while in a "haze" or a "fog." One participant expressed a common sentiment:

...numbness, I was tired from having so much contact with the care and I just felt kinda empty, but not really painful, it was just I thought about it later, but I wasn't real miserable, just kinda vacant, kinda out of space, I don't remember who was there . . .

The participants noted a sensation of being “numb” or in a “fog” right after the death and often during the funeral. The psychological pain was described in physical terms often with a “hollowness” or “pain in the stomach” or “heart.” They talked about how difficult his absence was during the early days, just in the normal routines of life.

Sleep disruption was common, especially in the early stages of grief and mourning. All of the participants experienced some disruption in sleep; difficulty falling asleep and getting adequate sleep were most common issues. Others described a fitful sleep when they did fall asleep or falling into the sleep of exhaustion after their husband had died and the care responsibilities were no longer there.

Changes in appetite and food intake and sleep have been reported in various studies (Reynolds et al., 1993; Rosenbloom & Whittington, 1993). The participants in this study reported a lack of appetite or others providing them food so they had something to eat. Overall decline in health status was experienced among the participants, either developing chronic illnesses or exacerbation of a present illness.

The women talked about “living in limbo,” and they experienced a new “pattern” to their lives. All talked about missing the intangible parts of the relationship like support, love, affection, and having someone to talk to and depend on. They had to adapt from their married lives when “we did everything together” and each had their jobs in the household: “He liked to cook and I did the cleaning up.”

One woman talked about the change in her identity from wife to widow:

I had to sit and tell myself that (I was a widow). That I had to do everything for myself, that I was going to have to do everything for

myself...I'm going to have to look after myself from now on and maybe I will never go married again. So therefore I need to know how to do things...that I had to learn how to fend for myself...that meant going to a restaurant alone, eating alone, can't do that one yet, just doing my stuff myself.

Cocooning the Grief

This phase of the grief and mourning process began after the funeral, visitation, or memorial service, when family and friends left and the participant had to face the reality of the death. Two patterns were characteristic of this transition. Some widows cocooned themselves with the grief and experienced it immediately, *being by myself with myself*. That is, they stayed to themselves as they mourned. Other women “cocooned” the grief inside themselves and immediately became involved in social and occupational activities either out of necessity or out of choice. They allowed themselves to grieve a little at a time – the balance of time was spent *distracting myself*.

Being by myself with myself. Immediately after the funeral or at the time of death, some of the participants drew inward, wrapping the grief inside. As one woman described it, when her children tried to get her to live with them after their Dad died:

No! I'll just go home by myself I will be alright and I just sit here and cried, but I had to let it all out. I just wanted to do it all myself, I didn't have nobody to talk to, I didn't want to talk to nobody, so I sit here by myself and think about him, and at night I think about him... I sat here

and cried and I couldn't go to sleep until early in the morning about 4 o'clock in the morning, (but now) sometimes I'll shed a few tears, and it seems like the bad feelings is kinda going away now, you get used to it...

The night was described as being the worst time because the woman was alone with her thoughts, memories, and reminders. Night was also the time when some felt most free to express grief. The key element here was of being alone with grief and allowing the grief to be expressed freely.

Distracting myself. Other women described becoming immediately involved in life again, with the grief cocooned inside.

I've been lonesome, you know, and I tried to explain to the kids that I like to go as much as I do so I won't have to think about him. Because he's there and you know everything you do, whatever you see, he's there....

Involvement in activities that the participant had given up during the decline of her husband provided a distraction from the death and grieving; for example, she would say, "I didn't want to think about it" or "There were too many painful reminders in the house of (my husband)." Others distracted themselves with the telephone: "I will call just as early the next morning as possible, ya know, so I can get it off my mind, that is the way I do. I manage to deal with it."

Some women took leadership positions in community organizations such as AARP or National Association for the Advancement of Colored People (NAACP). Others became involved in organizations that were important to their husbands. Those

who were not mobile busied themselves where they were; for example, one woman led an “Intercessory Prayer” group at the senior housing where she lived. Another women became very active in her church as part of the “Women’s Board” and also served as the confidante and “taxi driver” for other elder women in her church and neighborhood. She also served on a neighborhood coalition and a community group to bring about some changes in the neighborhood. One frequented the gambling boats, because as she said, “You can forget everything while you are there.”

Living in Limbo

This phase reflects an intermission between the way life used to be and the way life would be in the future. After the loss of the physical presence of her husband each woman had to integrate her persona as a married woman with who she was now as a widow. She experienced a sense of loss of self along with the unease and unfamiliarity of her new widowhood.

Accomplishing daily household tasks, managing finances, finding companionship for social events, and maintaining relationships with adult children were common concerns during the course of grief and mourning. Some participants felt other women treated them differently as they were after their men. The widows believed others forgot how they still needed to be part of a couples group, even though they were single now. Some married women treated them with suspicion and some excluded them from activities that they had been part of before the husband died. As one participant said, “...I think that your friends don’t realize that it’s not two of you anymore and then they don’t know how bad you need to be invited.” Others reported no change in the way people treated them, however.

Living without the tangible parts of “us.” In the early days after the funeral, the tangible reminders of the husband brought pain and often interfered with her daily activities. As one widow stated, “Everywhere I look, he is there,” referring to the presence of his belongings and his hobbies. Others dreamed about their husbands.

Some participants missed the husband’s voice and talking to him:

It made me very sad, because we always talked and I called him and he called me and we talked about ya know, old times about the children and I miss talking to him and just to think of the idea that he is gone and I’ll never see him again it’s kinda sad.

One participant could not sleep until early morning:

I just sit here thinking and now I said ‘Now you gone, I can go to bed at night and I get to go to sleep’ ...I just couldn’t go to sleep, and I would wake up the next morning I would be so tired and everything.

Other participants experienced a sense of the husband’s physical presence.

One widow was convinced that she literally had seen her husband:

But I really saw him, I was wide awake and I saw him standing there in the door and he just looking down at me and I didn’t say nothing to him because I said to myself, ‘he can’t talk he just looking and it didn’t make me scared...I guess it was a comfort to me...so it seems like after that I don’t think about it like I use to, I don’t go to the doors thinking about him and all of that.’”

A neighbor she shared the experience with suggested that he had just come to see if she was doing alright.

Strangeness in my being and in my house. This period was a time in which the women redefined their identities, both socially and in self concept. Homes were not the same without their husbands, yet reminders of the life they had together were everywhere.

One participant described a sudden realization of the death two months after he died:

I couldn't believe that God had sustained me so much, I couldn't believe that I had no anxieties, or no real worries, or no real pressure, and then about two months later, I started feeling kinda eerie, ya know, and I missed him and like with my mother, when I started fooling with his clothes, I thought, 'oh no!' and they are still hanging up there now.

Participants needed to learn how to get household tasks done that husbands had performed. There was much trial and error involved in learning who could be trusted to be honest and do jobs they agreed to do. One participant described an incident that typified this situation:

...like there's a young fella that took care of the lawn a whole year, he doesn't know that I know he took the spark plugs out of my mower, (he also) came by to rake snow off the sidewalk and he took my salt to a house two or three doors down and used up all my salt...I've got nephews I was counting on and they failed me, like one nephew in particular, he took my other hedge trimmers...he sold my hedge trimmers.

"Home" was affected by socioeconomic well-being and whether they lived in their own homes or in assisted living: some widows were in a survival mode, trying to

meet basic needs. For others, their needs were more emotional or relational; someone to go out to eat with, attend social events, or listen when they needed to talk. One participant had considerable assistance from a Roman Catholic priest. The only woman who had no children developed relationships with “play daughters” and “play grandchildren” to provide her emotional and relational needs.

Rebuilding the Lost Half of My Life

This phase was gradual, but one participant expressed the core motivating factor when she quoted an African slave: “‘Because I was once loved, I can hold my head up and go on.’” Even though the loss was a devastating experience in their lives and they felt stripped of something of great value, they were determined to overcome this adversity. One participant expressed it, “I grew up in poverty...cotton fields...white doctors who only treated you if they felt like it when they got out of the movies, but my mama taught me to overcome.” Another participant succinctly said: “I want to live again!”

Laying down the burden of grief. This attribute was characterized by a time when they perceived a reduction of their grief; for example, one said: “I don’t cry the ‘Big Tears’ no more,” or “I’ve wept out all of my tears.” This change seemed to come with time and success in everyday life experiences, exemplified by this statement:

...I used to sit in here and cry all the time, and I got used to it (her husband’s death) and I don’t cry that much no more. Because I got my grandchildren and my children coming over here all the time, at first I just felt so lonesome, but now I don’t feel lonesome, ‘cause they come around a lot... (now) I feel like

at night it get so quiet up here, and think everybody gone to bed but me and I just go right on to sleep.

Other participants realized the change in themselves, “I couldn’t mention his name for five years,” or “It gets easier as the years go by...”, but most expressed the sentiment of one woman in one way or another: “I still get emotional.” Other participants expressed the change in the quality of grief, “The pain will grow old, it is not quite as sharp.” Most participants expressed the view expressed by one participant, “...never get over it, you just go on.”

Mending my heart with memories. All participants spoke of the memories they had of their marriage and their husband as an aid in the rebuilding process. One recalled the words of her mother, “Build for yourself beautiful memories, it’s the only thing you can take to your grave.” Another participant expressed the sentiment of many, “It’s a treasure to remember,” and all had fond memories of their husbands and the relationship that they shared for many years, “We got a lot of memories.” Every home had mementos displayed of pictures, awards he had won, or memories from special occasions in their marriage. All of them shared stories of how family life had been in the early days of marriage:

We would go to church and then we would get in the car and go driving because we would always do something on a Sunday and the kids when they were little, well we would take them to the park or show or anyplace...we always had a good time. We were close.

These memories seemed to be the foundation for rebuilding their life and a means to keep him as a part of who they were. They often reflected the mutual values that they shared together as a couple.

Emerging Whole Again

All of the lessons learned and wisdom gained culminated in this phase. The essence of this phase was expressed by one participant when she said, “Yes, I been through a lot, but I am still weathering the storm.” All of the participants developed new or continued existing interests that were community-centered. Some women also engaged in solitary activities including watching television, cooking, reciting poetry, and reading. The recurrent theme expressed by all participants was to “keep busy.” One participant had moved back to the neighborhood of her youth and was working to improve life in the neighborhood. The attributes of this phase reflect the woman solidifying a new sense of self and place in the world while continuing to hold and value the marital relationship. The husband was honored as a part of the woman’s new life and self.

Making peace with my new identity. Participants continued to experience pain at the loss of the husband at times, but they found ways to manage it: “When I get depressed, I just get on my knees and talk to the Lord about it.” All of the participants were living independent lives and one woman had recently moved from her daughter’s house to assisted living and said, “Usually people are trying to get closer to their children at this age, but I just moved out on my own!” Each woman had found ways to manage everyday tasks and had set a routine for themselves; there was a sense of accomplishment: “But now I’m adjusting...I go when I want to, I do what I

want to do, I have to do all my shopping, and buy gasoline, go to the car wash, and all of that. But I have adjusted to the point that I know when I'm going to do it, I don't have to think about it. I know if I don't do it, it won't get done."

Some of them had considered the possibility of relationships with another man, but all were very clear that remarriage was not an option. Several women engaged in companionship dating and the sentiment expressed by one participant reflected all those who considered it:

I've been with no one, I don't want to be with anyone, I don't want to date, I don't want another man, but sometimes I would like a friend, a companion, we'd go to a movie or have dinner, go Dutch, I pay mine, you pay yours. But I think that way, and then I had an opportunity, but I still want the companionship but I don't want to go through moods again or go through pain again.

Honoring the past while living the present. All of the participants acknowledged that their husbands and marriage would be a part of them forever, but just in a different way ("He's in my heart"). Many had pictures, honors, and events framed and placed in prominent places in their living spaces and as one participant stated, "I feel like he is looking down at me," indicating a framed picture on the wall. Others continued their husband's work in civic or religious organizations. One participant eloquently expressed the sentiment of the whole group:

I don't think it will ever go away totally, I don't really miss him because every place I look he is there...I think about him all the time... (you should) put him

in your heart, he's there, (in same way) you know you look at your hands, they are a part of you, look at your kids, he's there, he's a part of them.

Overall, this was an ongoing transition in each participant's life; honoring the relationship with the husband was always present. The women reflected on the positive parts of the marital relationship, which were incorporated into who she has become in the present.

It only took a small reminder to bring to the widows a momentary experience of the intense grief of the early days after a husband died. For example, at certain times of day such as the early morning or late at night when they were not busy, their sense of loss and sadness was often acute. For one participant, it was the smell of fried potatoes and onions that brought back the grief. As one woman commented, "Sometimes it comes back as fresh as if it was yesterday." I witnessed this phenomenon during each interview as our discussion brought back memories or as they shared pictures and other mementos with me. All enjoyed reminiscing about their husbands and became wistful when talking about him. All became involved in activities, organizations, or church groups where they could make active contributions.

The structure of the model and the movement through the phases testifies to the strength and resourcefulness of the women. The norm of the model reflects consistent movement toward renewing self and rebuilding life through the devastation of the spousal loss.

Core Category

The transition from being a married woman to a widow is an uneven, complex process that occurs over the course of months to years and sometimes just changes in character but never is completed. The process of grief and mourning encompasses every part of the woman, even down to the very cellular level and the intimate spirit within her. As the women vividly described their struggles, hardships, and triumphs during the grief and mourning process, it became apparent that there was an internal force of character that ultimately determined their responses and resiliency to the destructive force of spousal loss. The central concept that underlines the process of grief and mourning that emerged as the core category “Persevering” with two closely related subcategories of “Weathering the Storm” and “Overcoming Whatever Comes.” Two women expressed the sentiments of the group with quotes: “I’ve been through a lot, but *I’m still weathering the storm*” and “My Mama taught me, that no matter what comes, *to overcome*.” When speaking about why she consciously chose to lay down her burden of grief, one woman stated: “*I want to live again.*”

Chapter 5

DISCUSSION AND RECOMMENDATIONS

The last chapter begins with a discussion of deconstruction as a fundamental process of grounded theory research. Findings from this study are placed within the context of extant research in relevant areas of bereavement, grief, and mourning to determine contributions to the body of knowledge. The chapter concludes with implications for current practice and recommendations for further research.

Deconstruction

Deconstruction is a process in the naturalistic paradigm that challenges the assumptions and meaning of traditional ways of viewing phenomena and as such, reforms ideas and structures in new ways (Polit & Hungler, 1999). Social phenomena and processes are viewed within the context in which they occur to influence the meaning attributed to them (Pfohl, 1985). As MacDonald and Schreiber (2001) reflect about ground theory methods: “Although meaning is central in grounded theory, we do not view it as stable... in both grounded theory and symbolic interactionism meanings are constantly created and re-created and are the basis for action by situated individuals and collectives” (p. 45).

Deconstruction is also viewed as a critical analysis of prior research related to particular phenomena and the commonalities and contrasts to the current research. The issue of interest is how previous research and current research integrate with one another in view of the differences in sociocultural context (Denzin & Lincoln, 1998; Glass & Davis, 2004). In this study, African American women shared their experiences with grief and mourning after spousal bereavement. The majority of the

extant literature of bereavement, grief, and mourning is from the Euro-American perspective. Although women as a whole are considered part of an oppressed group, women are diverse and there are many social dimensions that can affect the meaning ascribed to a particular situation (New, 1998). Euro-American experiences with bereavement, grief, and mourning are influenced by the sociocultural context, just as the African American women in this study are influenced by the sociocultural context of their formative years and present day influences. The next section addresses grief and mourning experiences, prior theories of bereavement, grief, and mourning, and current African American bereavement, grief, and mourning research.

Integration with Previous Research

The findings from this study reflected many commonalities with previous research and extended the findings from previous studies to African American elders (Hardy- Bougere, 2007; Laurie & Neimeyer, 2008). In this study, the grief and mourning model reflected multi-dimensional phenomena that permeated all aspects of the bereaved individuals' lives, with identifiable phases that the women experienced as they moved through the transition to widowhood. The model addresses the concept that movement among the phases could occur in a non-linear or recursive fashion with experiences from earlier phases being common place.

Grief and Mourning Experiences

Comparable grief and mourning responses to the spousal death have been found in prior research, not necessarily specific to loss of spouse, African Americans, or elders. There are somatic, emotional, cognitive, and social responses to bereavement. These characteristics of the grief and mourning period have frequently

been described in the literature, with some of the common emotions described as “shock,” “numbness,” “lonesomeness” or “loneliness,” with crying being common in the early days and elements of “pining” or yearning for the husband accompanied by “waves of grief.” Grief is also experienced as lack of appetite, inability to sleep, emptiness, difficulty thinking clearly, and expectations to see or hear the deceased (Bennett & Bennett, 2000; Bowlby, 1961; Hegge & Fischer, 2000; Hickman, 2006; Kubler-Ross & Kessler, 2005; Lindemann, 1944; Mineau, Smith & Bean, 2002; Parkes, 1972; Parkes & Brown, 1972; Parkes, Benjamin, & Fitzgerald, 1969; Reynolds et al., 1993; Rosenbloom & Whittington, 1993; Stroebe, Hansson, Stroebe, and Schut, 2001). The participants in this study shared the experiences described above and in addition, experienced grief so sharp, that in this study one woman described it as “being stabbed by a knife.” In addition, the participants in this study described the spiritual components of the grief process that included loss of meaning and purpose in life and even losing a part of their personhood, as described in the phase “preserving the core of my personhood.”

Theories of Bereavement, Grief, and Mourning

Several theoretical perspectives are used in the bereavement, grief, and mourning literature including cognitive, psychoanalytic, stress/adaptation/coping, social support/social network, and resiliency (Capp, 2001). There are other classic theories specific to bereavement, grief, and mourning that use a stage or phase approach to examining the process (Bowlby, 1961; Kubler-Ross, 1969; Lindemann, 1944; Parkes, 1970; Parkes, 1997). Rather than focusing on one particular aspect of bereavement, the model proposed in this study entails a multi-dimensional approach

incorporating the whole person within the sociocultural environment and her movement through the phases of the transition. This model is a process model and dynamic movement through the phases is individually determined and may encompass earlier phases as forward movement occurs.

Current African American Bereavement, Grief, and Mourning Research

The participants in this study drew on their life experiences to cope with the experiences each had during the process of her husband dying and the subsequent grief and mourning. In addition, they had a great acceptance of the reality of “the way things were” from dealing with the racism and discrimination in their lives and used that to guide the coping with the grief and mourning process. Rosenblatt and Wallace (2005) also identified in their research among African Americans with varying types of losses, that there were many commonalities of the grief experiences. They identified sociocultural influences on the mourning experiences and rituals and the ways of managing the grief and mourning process after the loss.

In addition, there have been three recent qualitative studies, two phenomenological studies (Rodgers, 2004; Shellman, 2004) and the other a hermeneutic phenomenological study (Harrison, Kahn, & Hsu, 2004-2005) of African American elders. They identified many themes that resonate with the phases identified in this study. Rodgers (2004) used storytelling as the method for widows to illuminate and communicate their experiences. “Six themes were identified: Awareness of Death, Care giving, Getting Through, Moving On, Changing Feelings, and Financial Security” (p. 10). Shellman (2004) used reminiscence interviews with “Nobody Ever Asked Me Before”, Stories of Discrimination, Coping with

Discrimination, The Hurt of Discrimination, and Self Discoveries emerging as themes. Harrison, Kahn, and Hsu (2004-2005) specifically examined the loss and subsequent changes within the context of the marital relationships, churches and friends. The themes they found were: “ Defining Needs and Relaxing Boundaries, Releasing the Sadness and Keeping Busy, Being Together and Going on Alone” (p. 131). Even though the words identifying the themes are different, the essences of all are present in this study: the oral tradition, discrimination, new identity, changing feelings over time, and getting through the experience. However, this study identified several other elements, such as the importance of memories for building a new life, the necessity of creating a legacy for the deceased husband, the sense of survivorship no matter what came in life and building on past adversity to emerge stronger through this experience.

Contributions to the Research on Grief and Mourning

This study suggests a process model with phases in the grief and mourning experiences of African American elder women during the transition into widowhood that would be useful for clinical practice. Although the model is in the beginning formation, it identifies several areas for consideration of sociocultural and developmental influences when working with this age group. There have been other theories of grief and mourning presented in stages/phases, but the phases in this grounded theory during the transition into widowhood are unique.

As a framework for discussing these new insights influencing the process of grief and mourning, consider the social events and social changes that were present not only during their “coming up years” as they described it, but throughout their

adulthood as well. As they vividly described their lives through their narratives, they reflected at times on the Great Depression, World War II, the Korean War, the Civil Rights movement, and the impact of these events on the social world of their lives. These social and world events influenced the worldview of the African American elder and contributed to their approaches for managing the care of the dying spouse, as well as the depth and breadth of the grief and mourning process they experienced during the process and afterward.

Several new insights about the grief and mourning process came from the analysis of the women's narratives in this study:

The strength of the marital dyad. Even though the value of the nuclear family came through strongly in descriptions of their families over the course of the marriage and with children growing up, the bond of the marital dyad was stronger. There were times when protectiveness of the husband and the respect for his wishes put the women at odds with what the children wanted or thought would be best for their father. Two incidences in particular stood out from the narratives that illustrate this characteristic. One incident, described by the woman, occurred when her husband was becoming more and more demented; he was urinating wherever he was at the particular time. The daughter commented that the house was starting to smell like a "pissery" and suggested that her father needed to be moved to a nursing home. The woman got upset with her daughter and basically told her it was his house and he could go to the bathroom anywhere he wanted to. The other incident occurred when a woman and her husband were deciding where to stay when he became ill. He wanted to stay at their retirement home on the Gulf coast, even though it was hundreds of

miles from their children. The children were not happy with that decision, but the woman defended her husband and chose to stay right where they were during the dying process.

Life values influenced by “Mother’s Advice” or another matriarch in the family. The women often alluded to or quoted advice or guidance their mothers had given them, the wisdom of their own life experiences. Two examples of this are: one woman talked about her mother teaching her early on to “build for yourself beautiful memories, because it is all you can keep with you.” Another woman spoke about how her mother had taught her she could overcome any obstacle in life and not to let anything stop her from reaching her goals.

Tangible legacy. Each woman was concerned about a tangible legacy for her husband. Some of them spoke of the good done in a particular neighborhood or organization. Another woman was very regretful and disappointed during our last interview because the whole town where she and her husband had retired was wiped out by one of the hurricanes that hit the Gulf Coast. She shared with me the many good works he personally did for the community, particularly for the good of the African American teenagers. Other of the women gathered awards, accomplishments, or special recognitions on a wall to honor their husbands. Some women used the funeral to detail the life’s work and special accomplishments of their husbands.

Survivorship. Although not unique to this study, hardship was a prominent characteristic brought on by racism or poverty. These hardships had helped them view the loss of their husbands as “more of the same.” Adversity and hardship were the norms of their lives; this death was the most devastating event yet. Many of

the women had a calm belief that it would be used by God and themselves eventually for something good. They expressed they were often able to take racist acts and view them as something positive for themselves. For example, at a soda fountain one woman said they would not serve them drinks in the glasses that the white people used. They were served in paper cups. She said the glasses were not very clean and it was really better to have the paper cups. In another instance, they were forced to go to the back of the bus; there were so many of them that they ended up sitting up front anyway.

There was a conscious awareness that death is a part of life. In the African American tradition, it is recognized and acknowledged that grief and mourning are present in everyday life, not something to be hidden and put away as soon as possible. In the days of slavery death was a common everyday experience and a legacy in the lives of many African American elders. Hooks (1993a) stated something that is often taught and remembered today, “a body that know how to die well, will know how to live well” (p. 58).

Implications for Nursing and Healthcare Practice

The findings from this study can be applied to several areas of healthcare. The multi-dimensional nature of grief and mourning make it an area of concern for multiple disciplines. Many of these suggestions reflect current approaches. Application to this particular type of loss and developmental level among African American elders, is discussed below from the results of this study.

Grief Counseling

Individuals may seek counseling primarily for a felt emotional or psychological need related to bereavement and mourning. The nature of the responses to grief is such that the grief counselor should consider and assess the whole life of the individual. The bereaved individual may be having difficulties with sleep and eating, in addition to coping with the changes in the dynamics and structure of the family. Churn (2003) chronicles a poignant account of her many years of being a grief counselor and the experience with the various types of loss. In her insightful book, she suggests that it would be helpful to remind the griever and those who are close to them to be attentive to indicators of changes in health and measures the individual is taking to maintain his/her health.

The participants in this study provided valuable insights as to what was helpful to them in the dark days of bereavement and the days that followed as they rebuilt their lives. Although this is a limited sample with a specific focus on the African American elders, the lessons learned are valuable for individuals experiencing spousal bereavement.

Hospice and End of Life Care

None of the participants were involved in a hospice program. One participant was offered the program, but received some misinformation that caused her to reject using their resources. Many experienced great stresses associated with the care giving of cognitively impaired loved ones. They only accepted help when the danger became too great to themselves or their husbands. Some had visiting nurses and others found their own resources.

When offering hospice services, the physician, nurse, or other hospice representative should consider the cultural and developmental influences on the acceptance of hospice services. Services need to be framed in such a way that they would be acceptable options. The values of independence in wanting to provide the care themselves, family coherence when dealing with health care outsiders, and the acceptance of life as it comes, need to be addressed when offering hospice care. Relationship building and service offerings within the boundaries of the value systems expressed by the individual and the family would assist in the acceptance of these services.

A chaplain can be a key support in helping the bereaved individual or even the couple before the death. The foundational value of spirituality and religion suggests that a chaplain or personal minister be involved in providing end of life care. The use of music, scripture, and prayer were very important to the participants in the study. It would be worthwhile to explore spiritual needs with the individual and the family and arrange for an acceptable person to assist with this type of comfort.

Physicians and Nurses

Primary care practitioners need to be alert for grief issues when approached with a physical problem after bereavement. Questions need to be asked to sensitively elicit information and answers require attentive listening. If the healthcare provider is of a different culture, consideration needs to be given to the differences in world view, such as the value of the extended family and the oral tradition. Avoidance of psychological care in general and the activated stress response, may cause grief issues

to present themselves as a physical problem. An exacerbation of a pre-existing health care condition such as diabetes or hypertension may occur.

The grieving woman may find it more acceptable to speak with a physician or nurse. The grieving individual may not want her pastor to be involved because of the need to do it on her own with God's help; or that may be the only acceptable person the widow would consider speaking with about these issues. The grieving widow needs to be approached in a sensitive way that normalizes the effects of the grief on a person's whole life, while offering acceptable sources of assistance if needed.

These suggestions can be applied in any area of healthcare practice. Healthcare providers come in contact with grieving individuals in many practice settings and social and community organizations.

Ways of Knowing

The African American history of oral tradition and narratives can be of value when intervening or assessing individuals experiencing grief and mourning. All participants freely shared their stories of grieving before their husbands died, the death experiences, and the grief and mourning that ensued after the loss. They discussed "talking it out" or "letting it out" as things that helped them as they went through the grief process or even now, "I talk about him all the time." Allowing the grieving individual to reminisce and talk about the loved one can be a key way to build a relationship with the individual and a verbal means of support. The oral tradition is a key element of the African American culture and was found to be so in other studies (Harrison, Kahn, & Hsu, 2004-2005; Hooks, 1993a; Rodgers, 2004; Rosenblatt & Wallace, 2005). Interventions such as tapes or compact discs about the

grieving process or small groups to discuss their grief are strategies to help the grieving individual. An audio journal might be a useful alternative, if the individual did not want to talk to someone in person. Some were accustomed to the use of computer technology, but most were not familiar with it, so using this to augment the verbal interventions was generally not an alternative. This technology issue was most likely related to developmental level and not particularly African American elders.

Building on the strong spiritual traditions can also be a way to help them find meaning in songs, poems, and sermons for example and can be a method for them to write about their own grief experiences. Historically, African Americans used those modalities to express grief when a loved one died and find hope for in the future, even in the face of current suffering. Most participants quoted Bible verses that were meaningful to them during their grieving process.

Summary

Applying the unique cultural and developmental influences suggested from this study and other literature can be helpful to offer individualized options when assisting grieving African American widows. These recommendations can be useful tools in assessment of and intervening with the grieving individual and can contribute to providing culturally competent care.

Recommendations for Further Research

This study poses new questions about sociocultural influences and the developmental level of the mourner. Interviews with the participants and the analysis of the results raised issues for further research in the area of grief and mourning

among African American elders. This list is not exhaustive, but contains the key issues that arose during the analysis.

Faith Tradition and Strength of Faith

All of the participants in this study were of the Christian faith, even though they were of varying denominations. Examining the grief and mourning experience from other faith traditions would enrich the understanding of how different beliefs and values affect not only the experience of grief, but the mourning practices that are acceptable and helpful. Among this age cohort, the Christian faith is quite common, but there is increasing diversity in faith traditions in America that may be influencing this group. The expression of grief and mourning within the Christian faith by modern day Africans of this age cohort residing in Africa would be a helpful comparison to explore the commonalities of experiences and universal components of grief and mourning experiences.

The second half of that issue is about the strength of the faith. All of the participants in this study identified themselves as having a strong faith and it was one of the key values that helped them get through their grief and mourning. The question remains what elements of faith helped them and how that faith expresses itself in the life of the individual. Since this is a self-report characteristic, the individual would have to identify the elements of her faith that were helpful and how they assisted in the grief and mourning process.

Socioeconomic Level

The participants in this study varied considerably in their economic levels. This factor seemed to affect the level of stress that they felt, as well as their ability to

manage the day to day demands of life after the spouse died. When adequate financial resources were available, it was not such a struggle to get what she needed for her husband before he died and to get her basic needs met after he died. These were all observations limited to this study; socioeconomic level affects other health issues such as access to resources (Center for Disease Control and Prevention, 2007) and would be a worthwhile factor to investigate regarding its impact on the course of grief and mourning.

Rural and Urban Influences

There are many aspects of life that are affected by whether an individual lives in a rural area or an urban area, such as access to healthcare, comfort with seeking healthcare, and the availability of other resources. These participants were all residing in an urban area. The methods and networks of support and effects on the grief and mourning process in this age group in a rural community would be an area leading to new insights about the range of coping strategies and resources available and utilized.

Legacies

All of the participants found meaning by determining a tangible or intangible legacy for her husband. This ranged from hanging awards, pictures, and mementoes of special occasions to reflecting on his work or their children as part of his legacy. The value of legacies to the process of grief and mourning would be an area for continued study with this group, both due to the African American history and the progress being made in social issues today.

Part of this legacy for the widows seemed to be a continuing relationship with the dead spouse. This has been studied in the literature in various forms, such as

visual experiences, talking to the deceased, or considering what the spouse would do in certain situations. (Field & Friedrichs, 2004; Field, Gal-Oz & Bonanno, 2003; Harrison, Kahn, & Hsu, 2004-2005; Hooks, 1993a; Rodgers, 2004; Rosenblatt & Wallace, 2005). Further examination of this issue within this African American age group would be useful to determine the further expressions and value of this continuing relationship with the dead.

Care giving

There are many aspects of care giving that have been investigated in the literature. The effects of care giving during the dying process in this age group of African Americans is an area for continued study, both as it affects the physiological and the psychological well-being of the widow. Their lack of trust and reliance on outside sources often made the care giving more stressful. The participants reflected on the amount of suffering their husbands had experienced and whether they died quietly without much struggle. The verbalized perception of stress and psychological pain related to these two characteristics of the care giving during the dying process were notable.

There are many aspects of care giving that still need to be investigated when a dying spouse is part of the dyad and how health care providers can intervene to prevent physiological and psychological sequelae in the surviving spouse. There are many variables in this age group of African Americans that make this a significant stressor, but it was also a source of deepening and fulfilling the marital relationship.

Physical and Psychological Impact

Psychoneuroimmunological researchers are exploring the mind body connections and the effects of the sustained activation of the hypothalamus-pituitary-adrenal axis during ongoing stressful events, such as bereavement. Continued investigation of how that affects the health of the surviving individual and how those effects can be mitigated could be supportive of controlling the individual's health care costs over time. The stressful nature of the spousal bereavement and the whole life adjustments that need to be accommodated increases the risk to the life of the widow.

Widowers

African American men were not part of this study, but some literature has investigated gender differences (Benedict & Zhang, 1999; Bierhals et al., 1996; Quigley & Schatz, 1999) and it would be helpful to compare the grief and mourning experiences of African American males with the results of this study to determine what helped them manage during the process of grief and mourning. The participants in this study discussed the ways their husbands had managed their own dying process and how it impacted their own grief. When I commented to the participants that I was not finding many men who had not remarried, they were not surprised and suggested that the men find someone to take care of them very quickly after the death of their spouse.

State of Marital Dyad

Each woman described her marriage in positive terms, even though there were issues that occurred during the marriage and at the end of the husband's life. The

perception of the spousal loss and subsequent grief and mourning when there is a negative perception of the marital dyad is another area of study.

Limitations and Generalizations of This Study

There are some inherent limitations in this study. Personal interviews and narrative descriptions of the participants' experiences were used to generate the data for this study. This data collection method produced rich descriptions of their experiences, but these descriptions are subjective in nature and based on recall of information occurring over time. It must be considered that memories can be affected by many things, such as stress levels at the time, loss of recall of details over time, and selective memories. In this method, when interviews are used, the data presented by the participants is accepted as factual from their perspectives and representing truth as they perceive it.

The sample size was relatively small and was all female. All were of the Judeo-Christian faith tradition and urban dwelling African Americans over the age of 60 who had been widowed up to 10 years. Some of these characteristics were established by the design of the study and other characteristics were the result of the participants' the self-selection of participation into the study. Participant variation in some characteristics adds to the depth and richness of the analysis and produces insights about other aspects of the grieving process that may need to be investigated.

The final limitation is that this study takes a cross-sectional view in time of a longitudinal process that occurs over the course of years. Through the use of the interview process, care was taken to facilitate the sequencing of grief and mourning experiences, even though participants did not report fixed boundaries as they moved

through the process. Recall of information over the course of time can be affected by many factors occurring during the grief and mourning experience both psychologically and socially.

In light of these limitations, the recommendation is to use caution when generalizing these results to broader populations. There are still many issues to be considered as the theory continues to be developed. My analysis of the data and the participants own suggestions offer many avenues for further exploration of the dimensions and properties of the grief and mourning process.

Summary

The grief and mourning experiences of the nine African American widows who participated in this study were testimonies of their abilities to prevail over life circumstances that at times seemed insurmountable. Each persisted and endured through the loss of a fundamental part of her life and how she defined herself as a person. Their grief descriptions resonated with the grief description of the participants in the Rosenblatt and Wallace's (2005) study of African American grief as "personal, painful, long-term, and largely private responses to missing the person who died" (p. 51). This description of the grief experience was not uncommon to the descriptions of grief among studies involving Caucasian participants as well (Costello & Kendrick, 2000; Parkes, 2002). This description of the grief experience seemed to be a point of commonality among both African Americans and Caucasians.

Sociocultural influences emerged from the data as the participants described significant life events that influenced their lives. Since all of the participants grew up in pre-civil rights America, these early experiences inculcated them with a unique

paradigm that influences yet today how they view life and their place in the world. Even though the dying and death of her husband, and rebuilding of life without her husband was devastating, each participant reflected on other life experiences where oppression, poverty, racism, or prejudice were overcome. "That's just the way it was," spoke to their ability to face reality, work for a better outcome. One participant's description of how she had managed adversity in her life and came out stronger typified the sentiment of the group: "...I'm weathering the storm." The metaphorical images of a vessel being battered, but not sinking, and maintaining seaworthiness aptly fit the participants' descriptions of the transition in their lives after their husbands died.

African American history of slavery and oppression and the use of kin networks to meet needs were reflected in the re-development and enhancement of social support networks when the primary marital dyad was disrupted. The one participant who had no children expressed the difficulty this situation created in her life after her husband had died. She had no adult children or grandchildren to act as a support for her. Even though the participants initially wanted to be alone with their grief, they eventually accepted the support in both tangible and intangible ways from their children. Another sociocultural influence is the importance of the wake and funeral, not only as a time to mourn, but as a celebration of the life of the individual and to comfort and assure the survivors of an afterlife where there is no pain and suffering. It was important to make it individualized and meaningful to the dead, an alpha and omega review of his life, and a time of socialization with family and friends. These traditions reflective of the period of slavery when a funeral or wake

was one of the few times that African Americans were allowed to congregate without fear. Music is also a reflection of the freedom and movement into a better place, even though the person will be missed by the people who are left behind.

The results of this study supported commonalities in the grief and mourning experiences across all humans. There are many unique influences linked to the history and traditions of different cultures, ethnic groups, and races about grief and mourning. As Rosenblatt and Wallace (2005) caution, there are individual and familial influences. All members of a particular group should not be stereotyped by generalities, but considered as individuals. There is still much to be learned about African American grief and mourning, not only in this developmental level, but also across the life span. The social influences of high rates of poverty, illness, and early death contribute to the continued presence of extreme adversity. In the times of slavery, death was a daily presence, but with the drive by shootings, drug related deaths, and other forms of violence today this is still an issue that needs to be studied as it impacts the younger generations of African Americans and their experiences with grief and mourning.

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Appendix A

Cultural Representation in Integrative Review Elderly Grief and Loss Literature

Author and Date	Purpose	Sample	Ethnicity
Herth, K., 1990	Examine the relationship of supportive networks, concurrent losses, and coping skills to adaptation among elderly widow(ers)	N=75 Widowed 12-18 Months Married an average of 49 years	72% Caucasian
Harlow, S.D., Goldberg, E.L., & Comstock, G.W., 1991	Identify and evaluate depressive symptomatology among women before widowhood, to follow up these women for 2 years after bereavement, and to include a control group of married women.	N=136 Husbands died within the study years	100% Caucasian
Thompson, L.W., Gallagher-Thompson, Futterman, A., Gilewski, M.J., & Peterson, J., 1991	Report the effects of spousal bereavement on psychological distress over a 2 ½ year (30 months) period in a community sample of older men and women over 55.	N=212 Spouse died within the Previous 2-4 weeks over age 55	100% Caucasian
Aber, C.S., 1992	Examine the paid work role as a predictor of widows' health during conjugal bereavement	N=157 Spouse died within 18-24 months of the start of the study	No ethnicity reported
Caserta, M.S., & Lund, D.A., 1992a	Determine the characteristics of older bereaved spouses who sought early professional help related to their grief	N=339 Widowed within 2-3 months	98.8 % Caucasian
Caserta, M.S., & Lund, D.A., 1992b	Compare stress and coping levels of 108 older adults who recently lost their spouse with expectations of stress and coping reported by 85 matched nonbereaved controls	N=108 Widowed within 2-3 months married an average of 39 years	96.3% Caucasian

Mendes de Leon, C.R., Kasl, S.V., & Jacobs, S., 1993	Examine the mortality risk of widowhood in a representative community sample of persons aged 65 years and over, and to determine whether this risk is modified by health status and other predictors of mortality which may differ between the widowed and non-widowed, and which were assessed before onset of widowhood over a 6.5 year period.	N=1046 at baseline N=236 who became widowed during the 6.5 year study	Not reported
Reynolds, C.F., Hoch, C.C., Buysse, D.J., Houck, P.R., Schletnitzauer, M., Pasternak, R.E., Frank, C., Mazumdar, J., & Kupfer, D.J., 1993	Describe REM sleep changes during the first 2 years following spousal bereavement in elders who have negotiated this transition in life without becoming depressed. Determine if REM sleep measures (REM latency or REM density) in non-depressed bereaved subjects differ over time in any consistent way from those of non-depressed, nonbereaved healthy controls	N=27 bereaved and N=27 non-bereaved controls. Subjects experienced death of spouse within 12 months	93% Caucasian in bereaved and 100% Caucasian in Controls
Rosenbloom C.A., & Whittington, F.J., 1993	Identify the effects of recent widowhood on nutritional behaviors.	N=50 for widows and N=50 for married Controls Bereavement within 2 years. mean years married=44 for widowed and 43 for controls	94% Caucasian 6% Black
Meuser, TM., Davies, R.M., & Marwit, S.J., 1995	Examine the degree to which an individual's tendency to experience emotional distress and restraint are predictive of grief intensity.	N=51 bereaved elders Most married over 30 years 88.3% lost spouse in past 5 year	No ethnicity reported

Morgan, D., Carder, P., & Neal, M., 1997b	Determine if widowed persons demonstrate an increasing “homophily” in their friendship networks	N=277 1-3 years of widowhood	Ethnic minorities were “under represented”
Kanacki, L.S., Jones, P.J., & Galbraith, M.E., 1996	Examine the relationships between social support and depression and the amount of social support used by widows and widowers.	N=31 widows N=35 widowers Widowed for up to 6 months Average length of marriage=44 years	92% Caucasian
McKibbin, C.L., Guarnaccia, C.A., Hayslip, B., & Murdock, M.E., 1997	Examine the ability of peer-led bereavement interventions to alter locus of control to internality	N=17 for the bereaved treatment group N=6 for waiting list Control Average time since death of spouse was 34 days to 474 days, with the mean of 231 days	96% Caucasian
Morgan, D.L., & Carder, P.C., Neal, M.B., 1997a	Examine the differences in the roles that networks of personal relationships play in earlier and later stages of widowhood	N=376 Divided into 3 cohorts of being widowed 1 2, or 3 years. Actual time was 3-6 months 15-18 months, or 27-30 months	No ethnicity reported
Lee, G.R., Willetts, M.C., & Seccombe, K., 1998	Examine the gender differences related to depression after widowhood.	N=396 for the Florida sample N=350 in the Kansas sample Time since widowhood was a mean of 11.7 years	No ethnicity reported

Murdock, M.E., Guarnaccia, C.A., Hayslip, B., & McKibbin, C.L., 1998	Compare the contribution of small life event stressors to psychological distress in the elderly married and elderly widows groups.	N=21 recently widowed persons N=50 married persons who had healthy spouses living with them at home Mean of 40 years married before loss over all participants	97% Caucasian
Carr, D., House, J.S., Kessler, R.C., Nesse, R.M., Sonnega, J., & Wortman, C., 2001	Examine whether psychological adjustment to widowhood is affected by three aspects of marital quality-warmth, conflict, and instrumental dependence-assessed prior to loss	There were two analytic samples: 1 st : N=290, 203 widows and 87 matched controls 2 nd N=203, widowed persons, controls were not available due to funding constraints	84% Caucasian 16% other groups
Winter, L., Lawton, M.P., Casten, R.J., & Sando, R.L., 2000	Investigate the long-term and moderately short-term effects of bereavement and marriage on the psychological well-being (PWB) among older people.	1 st group: N=811 of community elders 2 nd group: N=108 widowed 3 rd group: N=38 recently married participants	No ethnicity reported
Lee, G.R., DeMaris, A., Bavin, S., & Sullivan, R., 2001	Compare the adverse effect of widowhood on the psychological well-being of men than women	N=1686	Non-white subjects were “poorly represented in the sample”

Appendix B

Quantitative Measurement Tools of Bereavement, Grief, and Mourning

Author and Date	Quantitative Tools	Reliability and Validity (NR= not reported)
Ott & Lueger, 2002	<ul style="list-style-type: none"> • Subjective Well-Being • Current Symptoms • Current Life Functioning • Mental Health Index • Abbreviated Mental Health Inventory • Integra Outpatient Tracking Assessment 	<ul style="list-style-type: none"> • .79-.82 • .85-.92 • .76-.93 • .82-.87 • NR • NR
Prigerson, Maciejewski, & Rosenheck, 2000	<ul style="list-style-type: none"> • Marital Satisfaction and Harmony Scale • Health Service Utilization • Health Costs Index 	<ul style="list-style-type: none"> • .67 for refined and shortened tool • NR • NR
Futterman, Gallagher, Thompson, Lovett, & Gilewski, 1990	<ul style="list-style-type: none"> • Beck Depression Inventory • Marital Adjustment Scale 	<ul style="list-style-type: none"> • Reliability and concurrent validity has been demonstrated in elders as “adequate” • NR
Zisook, Paulus, Shuchter, & Judd, 1997	<ul style="list-style-type: none"> • Hopkins Symptoms Checklist • Zung Self-Rating Depression Scale • Widowhood Questionnaire 	<ul style="list-style-type: none"> • NR • NR • NR
Lund, Caserta, & Dimond, 1999	<ul style="list-style-type: none"> • Scale of Life Satisfaction • Zung Self-Rating Depression Scale • Revised Texas Instrument of Grief • Inventory of Bereavement 	<ul style="list-style-type: none"> • NR • NR • .74-.89 • NR
Thompson et al., 1991	<ul style="list-style-type: none"> • Beck Depression Inventory • Texas Instrument of Grief 	<ul style="list-style-type: none"> • Norms for elders adequate • NR
Gass, 1988	<ul style="list-style-type: none"> • Appraisal of Bereavement • Ways of Coping Checklist • Assessment of Resources • Sickness Impact Profile 	<ul style="list-style-type: none"> • NR • .34-.75 • Content validity • .94-.97
Umberson, Wortman, & Kessler, 1992	<ul style="list-style-type: none"> • Center for Epidemiological Studies-Depression 	<ul style="list-style-type: none"> • “Consistently demonstrated reliability and validity in large scale epidemiological studies” (table continues)

Bierhals et al., 1996	<ul style="list-style-type: none"> • Inventory of Complicated Grief • Beck Depression Inventory 	<ul style="list-style-type: none"> • .93
Benedict & Zhang, 1999	<ul style="list-style-type: none"> • 51 Item of Nature of Loss and Emotional Reactions 	<ul style="list-style-type: none"> • NR
Lund & Caserta, 2001	<ul style="list-style-type: none"> • Zung Depression Scale • Texas Revised Instrument of Grief 	<ul style="list-style-type: none"> • “Adequate reliability and validity demonstrated elsewhere”
Quigley & Schatz, 1999	<ul style="list-style-type: none"> • Grief Experience Inventory 	<ul style="list-style-type: none"> • “Adequate reliability and validity demonstrated elsewhere”
Beery et al., 1997	<ul style="list-style-type: none"> • Hamilton Rating Scale of Depression • Inventory of Traumatic Grief • Care giving Difficulties Questionnaire 	<ul style="list-style-type: none"> • “Proven internal consistency and reliability” • .92 • .94
Caserta & Lund, 1992b	<ul style="list-style-type: none"> • Zung Depression Scale • 7 Single Item Indicators of Stress and Coping 	<ul style="list-style-type: none"> • NR • NR
Carr et al., 2001	<ul style="list-style-type: none"> • Center for Epidemiological Studies Depression • Symptoms Checklist 90 	<ul style="list-style-type: none"> • “Adequate” 1. NR

Appendix C

Elder Widowhood Research

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Aber, 1992 Cross-sectional	N=157 women	55-75 M=66	None reported	Paid work; work history of bereaved widows during marital years, including total time invested in paid work; attitude toward employment, satisfaction, motivation, commitment	Work history and work attitude: A significant predictor of better health; also prior health, education/social class, and social support.
Anderson and Dimond, 1995 Ethnographic	N=12	53-89	96% C; 7 females and 5 males; Mormons	Interviewed at 3wks, 6 months, 12 months, and 24 months; categories from data were feelings, physical symptoms, special hardships and coping	Shock and disbelief, sadness and loneliness; 1 year, loneliness, but most painful feelings were resolved, 2 year talked little about their feelings; physical symptoms were common, but many were due to pre-existing chronic illnesses; 1 and 2 years most were due to chronic illness; special hardships were loneliness, loss of companionship, daily reminders of the deceased, anniversaries of special dates, learning new skills formerly done by deceased, and learning to socialize as a single person. Coping strategies keeping busy, reflecting on the loss, managing reminders of the loss, talking with others, relying on religion and prayer, developing new skills, continuing relationship with deceased, relying on familiar sentiments.

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Beery et al., 1997 Longitudinal	N=65 48 women 22 men	M=70	86% Caucasians	Forewarned or anticipated, study started pre-loss; before loss, 3 months, 6 months, 13 months post loss	Depression after bereavement significantly associated with the increased perception of caregiver burden, caregiver change in role function, and completion of ADL's for spouse. Traumatic grief and depression not associated; Increased depression with changes in role function, less ADL assistance, change in sports and recreational time. No depression or traumatic grief with time spent care giving, duration of care giving
Bennett, 1997 (longitudinal, repeated measures)		No age data	No culture	Medium (1-4 years) and long-term (over 4) various indicators of physical and psychological health.	Medium term, poor mental health; mixed support for continued low morale; social participation, support and engagement, physical health remain stable in medium term and decrease depression and increased morale, but neither return to baseline; social participation and engagement and physical health decline, but only as a function of aging. Effects of bereavement in late life are more marked and long-lasting than was previously recognized

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Bennett and Bennett, 2000 Qualitative	2 studies	60-76; widowed 2- 26 60-96, other losses too and other age groups, but majority of sample elderly	No cultural diversity, but did take place in England; left in since about a concept related to grief	Continuing bond with deceased experiences, not negative, but a comfort	Supernatural or mystic experience to belief that it was a normal part of it. 5 themes being observed, hearing a voice, smelling a particular odor, seeing the dead and sensing the dead in bed
Brown, et al., 1996 (2 group comparison of diary like instrument and sleep studies)	94 who didn't become depressed; 45 healthy non- depressed comparison group	55-85	No culture	Social rhythm stability, sleep impairments, activity level	Bereavement not associated with changes in social rhythm stability, sleep impairments or activity level, unless major depression; negative correlation between social rhythm stability and depression; positive correlation between depression and sleep impairment
Carr, House, Wortman, Nesse, and Kessler, 2001 Longitudinal	N=1532	Over 65	None	Forewarned or anticipated death; 6 months and 18 months	Sudden death increased intrusive thoughts at 6 months but was no longer significant at 18 months; Greater than 6 months warning increased anxiety at both time intervals; higher yearning among women; no long-term on psychological if forewarned

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Caserta and Lund, 1992b longitudinal	N=108 bereaved N=85	“elderly” 6 times data after spousal death during first 2 years	97% Caucasian	Expectations of grief verses actual 3-4 weeks, 2 months, 6 months, 1 year, 18 months, 2 year. Analysis of variance	Question if anticipated symptoms were worse than actual; Anticipated stress related to spousal bereavement was high, found ways to cope with it; 63-68% of bereaved reported high coping levels at each time, while non-bereaved reported 19-25% with high coping.
Costello, 1999 Qualitative ethnographic	N=12	M=74 8 female 4 male	None reported	Anticipatory grief; one time interview	Reactions seemed as acute grief responses: denial, depression, shock and sadness. Emotional intensity increased as death approached; tried to normalize imminent death by not sharing with dying spouse; telling stories about dying individual to share knowledge of him/her better.
Costello & Kendrick, 2000 Ethnographic			No cultural diversity	Grief experiences of elder spouse who had died in hospital; hypothesized that successful grief resolution does not depend on disengaging from the deceased	Feelings of isolation, sense of loneliness and depression; perceived inner representation of the deceased; presence of the deceased, and dialog with the deceased. Suggested that the data indicate a maintenance and modification of the relationship with the deceased, but not a relinquishing of that relationship.

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Cruz, Scott, Houch, Reynolds, Frank, and Shear, 2007 16 sessions of 2 different types of psychotherapy	N=36	Controls matched on age, sex, and intensity of grief at baseline	50% each African American and Caucasian	Cultural comparisons; psychotherapy and psychotherapy with grief components	African Americans not lower rate of treatment drop out or severity of symptoms or outcomes.
Field, Gal-Oz and Bonanno, 2003	N=39	21-55	Caucasian	Continuing bonds with the deceased after 5 years	Higher continuing bond scores were associated with a more elevated grief-specific symptom pattern over the 5-year post loss period.
Fitzpatrick and Bosse, 2000 Cross-sectional; 2 group comparison	N=248 at 1yr and N=262 at 2-3year	M=58; 39-86	None reported	Repeated measures; 1 and 3	Significant negative correlations between age, physical health, employment and education in both but not mental health.
Fitzpatrick and Van Tran, 2002 Multiple regression	N=3460	Not all specific to spousal or elders, but included 24-over 60	Comparing African Americans and Caucasian	Multiple regression health and depression,	African Americans showed no relation to bereavement, but Caucasian were significant predictor of health in youngest and eldest groups (not all elderly)
Fry, 2001 Analysis of variance	N=101 widows N=87 widowers	65-87	Canada	Examined whether existential factors, such as meaningfulness, optimism, and spirituality helped maintain psychological well-being after bereavement.	Existential factors significant in both widows and widowers were personal meaning, optimism, importance of religion, and accessibility to religious support. Widows participated more in organized religious activities, spirituality, religious beliefs, and practices. Income for widows was significantly related to psychological well-being.

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Futterman, Gllagher, Thompson, Lovett & Gilewski, 1990 and Thompson, et al., 1991 Longitudinal	212 bereaved and control 162	55-83; M=68 for bereaved and 70 for non-bereaved (bereaved, but not spouse)	None reported	Depression and marital adjustment over 30 months; repeated measures	Bereaved more depressed at 2 months but became statistically non-significant at 12 months and remained non-significant; higher depression was related to positive marital adjustment in bereaved and related to negative marital adjustment in non-bereaved Psychological distress highly significant at all time measurements, but grief and not depression or psychopathology; steady decline in current grief symptoms, but bereaved higher current grief and past grief at 30 months
Glosworthy & Coyle, 1999 Qualitative; phenomenological methods	N=6 widows N=3 widowers	M=67 53-78	England, Christian faith	How spiritual beliefs can affect the search for meaning after the loss; interaction of religion and spiritual beliefs with the process of making meaning out of the spousal loss	Importance of faith highly associated with coping with the loss; continuing bond with deceased helpful coping mechanism and source of spiritual support; connection with God/ deceased helped bereaved live with loss and grief; Events like wake and funeral helped provide meaning for the loss and the acknowledgement that God was still influencing everyday life. Overall presence of religious meaning structure did not lessen feelings of grief and loss, but support participants through those feelings.

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Hegge and Fischer, 2000 qualitative	39	Seniors=60-74 Elderly=75-90	No culture	Thematic analysis of troubling problems	Loneliness, financial issues, sleeping, eating problems Positive and negative coping strategies: keeping busy, reflecting on memories, visiting with others, praying or meditation, developing new skills, familiar routine
Herth, 1990 Descriptive study	N= 75	Over 65 Widowed 12-18 months	72% Caucasian 62% widows	Examine the relationship of supportive networks, concurrent losses, and coping skills to bereavement adaptation	Hope accounted for 79% of the variance in grief resolution; Greater hope was related to a longer duration of spouse's illness, adequate present income, good health, fewer than two concurrent losses and visits by family and friends.
Hockey, Penhale & Sibley, 2001 Exploratory study	N=20	60-70's Length of marriage 35-66 years; Length of bereavement from 8 months to 25 years	England, no other diversity	Shared relationship with public and private space between a couple and how that spatial relationship is both transformed and maintained after spousal bereavement	Nothing seemed same in home without presence of spouse; Loneliness, but also new-found freedom in certain areas of space. Factors that influenced the spatial experience in widowhood were type, position and shape of the home, social relationships, health of the widowed elder adult, dying trajectory, and the relationship with the dead.

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Kanacki, Jones, and Galbraith, 1996 Descriptive study	N=35 men and 31 women	53-93; M=72	92% Caucasians	Social support and depression relationship; amount of social support used by widows and widowers	Higher depression negatively correlated with amount of perceived social support for both male and female; Depression not related to numbers of individuals could count on in a crisis, satisfaction with social support or contact with children.
Lund, Caserta, and Dimond, 1999 Longitudinal		M=67 50-93, 39 married years bereaved Non- bereaved M=66 38 married years	97% Caucasian; 98% Non- Caucasians	Bereavement adjustments, 2-2 ½ years, interviewed 4-6 times	Predictors of bereavement adjustments; predictors unimportant were age, gender, education, income, religious membership, perceive health status, marital happiness, and pet ownership. Best predictors were person resources unique to each individual. Need to take charge of their lifestyles and situation, two positive predictors are positive self-esteem and personal competencies in managing the tasks of daily life
Lund, Caseta, Van Pelt, and Gass, 1990 Longitudinal		50-90; M=67 79% women 21% men	97% Caucasians	Social network; Questionnaire 6 times over 2 years and interviews. Primary social network includes close friends and relatives up to 10 individuals.	Social networks are beneficial to recovery from bereavement, grief, and mourning even though structure may be different. Women more same sex networks than men; Older smaller networks; Men smaller secondary networks, but increased.
Mendes de Leon, Kasl & Jacobs, 1993			None reported (Utah)	mortality	Widowers higher mortality across age cohorts than widows

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Mineau, Smith & Bean, 2002			None reported (Utah)	mortality	Widowers higher mortality across age cohorts than widows
Moss & Moss, 1984	Review of studies	Not reported	Not reported	Continuing bonds with the deceased as helpful part of healing process rather than an interference in the healing process	5 themes: Cultural and Social Supports of the Tie (family & friends, common interests, financial support); Caring (causes important to deceased, watch out for or protect, gravesite); Intimacy; Reciprocal identity support (continued interaction); Home (space represents family and helps maintain the tie) Normalcy, part of new assumptive world and continuing comfort and support.
Ott & Lueger, 2002 Longitudinal	118	27-87; M=60	None reported	2 years changes in mental health status; repeated measures	Overall improvement in mental health in first 3 months, stable for 9 months and peaks at 15 months; MI symptoms improved to peak at 12 months and then moved lower at 24 months; life functioning increased to 12 months, plateaued and never reached mean of general population

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Reynolds, et al., 1993 2 group repeated / sleep quality	27 within last 12 month; 27 non-bereaved	M=68 for bereaved; M=73 for controls	No culture	Sleep impairment	Bereaved increased REMS over 2 year period; increased REM density may be a psychobiological correlate of bereavement when depression is not present
Rosenbloom and Whittington, 1993 2 group	50 bereaved over 60 and 50 married	Over 60	6/100 black	Eating behavior and nutrient intake	Bereaved greater weight loss, diet quality down and poor eating behaviors such as skipping meals, etc.
Shuchter & Zisook, 1988				Continuing bond with deceased mitigate of grief experience	Hallucinatory experiences, verbal communication and prayer, symbolic representation, imbuing possessions with the spirit of the deceased, living legacies, and social and cultural rituals, memories, and dreams.
Steeves, 2002 Face to face interviews for 16 times and hermeneutical analysis	N=29	M=70 yrs. ; 18 women; 10 men	10 African Americans and 19 Caucasians	Staging 13-29 months at various social events;	3 stages of grief not totally discrete, numbness for few weeks; 2 nd several months, grief attacks, waves of sadness, daily or several times a week. Not making adjustments to life just coping with day to day; 6 months not grief but loneliness; Sleeping problems, meal times, concurrent losses, early morning and late at night; mealtimes

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Van Baarsen, 2002 Longitudinal	N=111	M=73; 2.8 years of widowhood at time of study over	None reported	Social support and self-esteem as variables affecting loneliness; measures at 6 months, 1.5 years; 2.5 years	Increased emotional loneliness after bereavement got better, but never returned to pre-bereavement level; Perceived social support increased after bereavement and remained stable; Higher contact with family associated with reduced loneliness; higher contact with family associated with reduced emotional loneliness and social loneliness for widowers than widows.
Yalom & Liberman, 1991 Repeated measure before and after group sessions of 1 year	N=36	M=57 27 females 9 males	All Caucasians	Level of existential awareness before and after 8 week group sessions such as events surrounding spouse's death, adjustment to widowhood, history and texture of marriage, death awareness, regrets. 3 questions: presence and inevitability, meaning of life, regrets about choices made in life.	Significant increases in personal growth among the existentially aware bereaved; more women than men were engaged in the existential process and individuals who were engaged in the existential process were more likely to show higher symptoms of grieving at first time measure and perceive overall relationship with spouse as positive. 37% of participants engaged in the existential process. Personal death awareness present in 22%; 34% struggling with issues centered on meaning of life; 64% having regrets about some aspect of marriage. No significant difference between groups on the course of bereavement. Suggest personal growth need to be included in models rather than returning to baseline.

Citation/Design	Participants (Widowed)			Phenomena of Study and Findings	
	N	Age	Culture/ Ethnicity Reported	Area	Findings
Zisook, Paulus, Shuchter, and Judd, 1997 Longitudinal	259	25-85 M=61 Bereaved and non- bereaved controls	95% Caucasian	Subclinical depression, minor depressive disorders, and major depressive disorders; repeated measures 7-8 weeks, 7 months, 13 months, 19 months, 25 months	50% showed depression at some point; 2 months, 51% had some form of depression; past major depression predicts an increased risk for major depression, unipolar subgroups presices future depression throughout the unipolar spectrum

Appendix D

Informed Consent Form

CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

INVESTIGATOR'S NAME: SHEILA CAPP, PhD, RN

PROJECT # 1042078

DATE OF PROJECT APPROVAL:

FOR HS IRB USE ONLY	
APPROVED	
_____	_____
HS IRB Authorized Representative	Date
EXPIRATION DATE: _____	

STUDY TITLE: GRIEF AND MOURNING AMONG AFRICAN AMERICAN ELDERS AFTER SPOUSAL BEREAVEMENT**INTRODUCTION**

This consent may contain words that you do not understand. Please ask the investigator or the study staff to explain any words or information that you do not clearly understand.

This is a research study. Research studies include only people who choose to participate. As a study participant you have the right to know about the procedures that will be used in this research study so that you can make the decision whether or not to participate. The information presented here is simply an effort to make you better informed so that you may give or withhold your consent to participate in this research study.

Please take your time to make your decision and discuss it with your family and friends.

You are being asked to take part in this study because you have lost your spouse within the past ten years.

In order to participate in this study, it will be necessary to give your written consent.

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to find out what it has been like to lose your spouse. I am interested in your thoughts and feelings about your experiences. I would also like to hear about how the death of your spouse changed your everyday life and how things are going now. I believe that the best way to learn about what it is really like is to hear it from people who have gone through it. I hope to be able to help other people in the future from what you share with me.

HOW MANY PEOPLE WILL TAKE PART IN THE STUDY?

About 12 people will take part in this study.

WHAT IS INVOLVED IN THE STUDY?

We will have two interviews, at separate times and days. I will ask you some questions about your experiences when you lost your spouse and how your life has been since that time. We will talk as long as you are comfortable, generally about 1-2 hours, but it will be up to you when we stop. If a question makes you uncomfortable or you just don't want to talk about it, just say so. If you decide not to answer a question it won't affect any part of our relationship or your health care in any way. Mainly I want you to know that I am interested in hearing your story in the way you want to tell me.

The interviews will be face to face in a comfortable setting and will be audio taped. I want to listen to the tape again so I can really hear what you are telling me. I will talk to you again to make sure I completely understand what you were telling me, but again you are free to say no. If any time you have questions, please feel free to ask me in person or call me.

HOW LONG WILL I BE IN THE STUDY?

We think you will be in the study for about 1 to 2 hours, but it will be up to you when we stop. If a question makes you uncomfortable or you just don't want to talk about it, just say no.

You can stop participating at any time. Your decision to withdraw from the study will not affect in any way your medical care and/or benefits.

WHAT ARE THE RISKS OF THE STUDY?

There are no physical risks with this study. However, sometimes talking about things that have happened to you like losing your spouse can bring up feelings that you may have had when it happened or feeling you still have about the experience. Expressing feelings during the interview is fine with me. If feelings that may come up during the interview are creating a problem for you, let me know and I can help you get further help with your feelings.

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?

Some people find that talking about their experiences helps them feel better and honors the memory of their lost spouse. It may make you feel better to know that your experiences may assist doctors and nurses help people who are in situations like you.

WHAT OTHER OPTIONS ARE THERE?

An alternative is to not participate in this research study.

WHAT ABOUT CONFIDENTIALITY?

The records of this study will be kept private. I will use only numbers to identify the interview information. The list of names and identification numbers will be kept locked up. The audiotapes that are made will be kept locked up. No names or identifying personal information will be on the transcripts of the interviews. The transcripts cannot be traced to you and I will keep the transcripts locked up.

I will get written permission from you if I want to use any individual identifying information about you. Any reports that are made will not identify you individually, but may include a direct quote to illustrate a point you were trying to make. I will review my notes and analysis with my instructor.

The results of this study may be published in a medical book or journal or used for teaching purposes. However, your name or other identifying information will not be used in any publication or teaching materials without your specific permission.

WHAT ARE THE COSTS?

There are no costs for participating.

WILL I BE PAID FOR PARTICIPATING IN THE STUDY?

You will be compensated \$10 for your time.

WHAT IF I AM INJURED?

It is not the policy of the University of Missouri to compensate human subjects in the event the research results in injury. The University of Missouri, in fulfilling its public responsibility, has provided medical, professional and general liability insurance coverage for any injury in the event such injury is caused by the negligence of the University of Missouri, its faculty and staff. The University of Missouri also will provide, within the limitations of the laws of the State of Missouri, facilities and medical attention to subjects who suffer injuries while participating in the research projects of the University of Missouri. In the event you have suffered injury as the result of participation in this research program, you are to contact the Risk Management Officer, telephone number (573) 882-1181, at the Health Sciences Center, who can review the matter and provide further information. This statement is not to be construed as an admission of liability.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

Participation in this study is voluntary. You do not have to participate in this study. Your present or future care will not be affected should you choose not to participate. If you decide to participate, you can change your mind and drop out of the study at any time without affecting your present or future care. Leaving the study will not result in any penalty or loss of benefits to which you are entitled.

WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?

If you have any questions regarding your rights as a participant in this research and/or concerns about the study, or if you feel under any pressure to enroll or to continue to participate in this study, you may

contact the University of Missouri Health Sciences Institutional Review Board (which is a group of people who review the research studies to protect participants' rights) at (573) 882-3181.

You may ask more questions about the study at any time. For questions about the study or a research-related injury, contact

Sheila J. Capp
2020 Madison
Quincy, IL 62301
217 224-0954

My instructor:
Dr. Larry Ganong
573 882-0225

A copy of this consent form will be given to you to keep.

SIGNATURE

I confirm that the purpose of the research, the study procedures, the possible risks and discomforts as well as potential benefits that I may experience have been explained to me. Alternatives to my participation in the study also have been discussed. I have read this consent form and my questions have been answered. My signature below indicates my willingness to participate in this study.

 Subject/Patient*

 Date

 Legal Guardian/Advocate/Witness (if required)**

Date

 Additional Signature (if required) (identify relationship to subject)***

Date

* A minor's signature is not required if he/she is under 7 years old. Use the "Legal Guardian/Advocate/Witness" line for the parent's signature, and you may use the "Additional Signature" line for the second parent's signature, if required.

**The presence and signature of an impartial witness is required during the entire informed consent discussion if the patient or patient's legally authorized representative is unable to read.

***The "Additional Signature" line may be used for the second parent's signature, if required. This line may also be used for any other signature which is required as per federal, state, local, sponsor and/or any other entity requirements.

"If required" means that the signature line is signed only if it is required as per federal, state, local, sponsor and/or any other entity requirements.

SIGNATURE OF STUDY REPRESENTATIVE

I have explained the purpose of the research, the study procedures, identifying those that are investigational, the possible risks and discomforts as well as potential benefits and have answered questions regarding the study to the best of my ability.

*Study Representative*****

Date

****Study Representative is a person authorized to obtain consent. Per the policies of the University of Missouri Health Care, for any 'significant risk/treatment' study, the Study Representative must be a physician who is either the Principal or Co-Investigator. If the study is deemed either 'significant risk/non-treatment' or 'minimal risk,' the Study Representative may be a non-physician study investigator.

Appendix E

Grounded Theory Study Topics and Sample Size

Author(s)	Topic	Sample Size
Aroian, 1990	Adaptation to Migration and Resettlement	25
Beck, 1993	Post-Partum Depression Patients	12
Brown and Powell-Cope, 1993	Caring for A Family Member with AIDS	53
Carmack, 1992	Balancing Engagement/Detachment in AIDS-related Multiple Losses	19
Dildy, 1996	Suffering in People With Rheumatoid Arthritis	14
Morse and O'Brien, 1995	Disabled Person Identity	19
Fitzgerald, 1994	Adults' Anticipation of the Loss of Their Parents	6
Jacob, 1996	Grief Experience of Older Women Whose Husbands Had Hospice Care	6
Johnson, 1990	Restructuring After Weight Loss	13
Lewis, 2002	Substance Abuse Treatment Among Pregnant African Americans	17
Montgomery, 1990	Nurses' Perceptions of Caring Communication Encounters	33
Norris, Kunes-Connell and Spelic, 1998	Reimaging After Body Image Disturbance	28
Portillo, 1990	Bereavement for Mexican-American Widows	19
Van-Dongen, 1990	Survivors of Suicide	35
Wagnild and Young, 1990	Resilience Among Older Women	10

Appendix F

Demographic Questionnaire

Answer only the questions that you want to answer and feel comfortable answering

1. What is your age? _____
2. How many years have you been widowed? _____
3. How many years were you married before your spouse died? _____
4. How long was it between the time you first found out your spouse was seriously ill or injured until the time he died? _____
5. How many children do you have? _____
6. Do you identify with some religion or spirituality? _____
If so, which one? _____
7. What is your occupation? _____
8. What is your highest level of education

Appendix G

Audit Trail of Research Activities

Step Number	Brief Description	Rationale
1.	Present and defend proposal to dissertation committee.	To receive external confirmation from experts both in the field of research and the grounded theory methods about the design, validity and rationale for the research.
2.	Submit for approval to the Institutional Review Board (IRB).	To maintain acceptable legal, ethical, professional, and institutional standards for research.
3.	Presentation of research proposal to the Parish Nurse I had established a relationship with and the administrator of the assisted living community for my first round of participant recruitment.	To begin the recruitment process in an urban environment where I had made previous contact through a parish nurse and Culver-Stockton College.
4.	Advertise and presentation of a short program on bereavement, grief, and mourning and the research opportunity, inviting the residents of this assisted living facility to participate in the research. The Parish Nurse provided a light lunch while I talked with the participants individually after the program and helped them complete the participation interest forms and discuss anything that they had questions about the research.	To follow the research protocol and the suggested methods that would be effective in that institution I placed flyers and wrote a short article for the monthly newspaper that was circulated to all residents.
5	Follow up with thank you cards and telephone calls to set up individual appointments at an acceptable time and place for the research interview.	To give prospective participants an opportunity to think over their agreement to participant in the study, to allow them to think of additional questions, and to conduct the interview in an environment most comfortable for them.

6.	Confirm the appointment with the participant both in writing and verbally closer to the date.	To give the research participant an opportunity to ask further questions and to confirm the date, time, and place as still being acceptable.
7.	Confirm on the day of the appointment, either before starting to travel to the field or on the way to the interview site.	To confirm that the established interview time was still acceptable, since the research participants were elders, some with multiple health problems and family issues, and each of them had individual issues that might change his or her status even on the day of the interview.
8.	Write field notes when reaching the neighborhood or the residential facility prior to entering.	To reflect on my thoughts and feelings that might affect the research interview or the relationship with the participant. In addition, this pause in the environment allowed me to consider what it was like for the participant to live in this neighborhood or residential facility. I often conducted a windshield tour of the neighborhood to assess the impact of the environment on the residents prior to the interview.
9.	Prepare and check my technical gear and the research paperwork prior to entering the home.	To unobtrusively enter the research environment, but be prepared for technical or methodological issues as they might arise. I always carried two sets of all paperwork and used two tape recorders to tape the interview.
10.	Contact the participant while assessing the living local living environment and the house or apartment.	To gather more data about each participant and her life.
11.	Review the equipment set up and allows the participant to lead the direction of the social conversation.	To allow the participant to feel comfortable sharing what she would like to about her personal life on a social level.
12.	Review the written consent both verbally and with written copy and explain any areas that the participant has questions about. Ask each participant to sign two copies,	To ascertain informed consent and the parameters of the research for the participant.

	one for the participant's records and one for my records.	
13.	Start the interview with explaining the technical equipment and the purpose for the two tape recorders, as well as reinforcing again that the participant may stop the interview at any time she would like to if she becomes uncomfortable or just does not want to talk about the subject any more.	To enhance participant comfort with the presence of the technical equipment and her control of the interview length, questions, and direction.
14.	Begin the interview with another explanation of the research purpose, then move into the demographic questions and then the interview questions.	To allow the participant a final time to ask questions or express concerns.
15.	Complete the interview, being sensitive to verbal and nonverbal cues from the participant about comfort, fatigue, and ability to continue the interview.	To remain sensitive to the effects both physically and emotionally on each elder participant, considering their chronic health conditions and concerns of the day.
16.	At the conclusion of the interview, ask them again if they have questions, concerns, or additional information they would like to share.	To leave the interview with the each participant feeling comfortable and satisfied that she has been heard as she wanted to be heard.
17.	Before leaving the interview site, ascertain that the participant can verbalize access to an individual or group if she needs to talk about the issue further.	To facilitate each participant having access to a way to express further feelings about the issues discussed in the interview, if needed.
18.	After leaving the research site, immediately write field notes and start initial coding process.	To be as accurate as possible about impressions of the living environment, family and personal artifacts the participant had shared, and the participant's reaction to the interview.

19.	Find a safe and private place to immediately listen to the taped interview and do initial open coding of the audio tape.	To do the initial analysis close to the data and hear it again without being in the position of directing the interview.
20.	Continue processing of the data, while waiting for transcribed interview by an African American transcriptionist.	To continue the analysis and writing initial memos for further consideration. Relying on an African American transcriptionist will assist in hearing the nuances of the language of the participants.
21.	Load transcribed interview into Atlas-TI.	To continue electronic analysis and open coding.
22.	Share initial interview with dissertation supervisor for input about interview process and content.	To get feedback about process of interview and content of analysis.
23.	Repeat of Steps 6-21 for the next three participant interviews for a total of four participants. The final code list was 216-221 codes for this group.	To continue open coding to build the data base for grounding the analysis, until there were no new codes being identified in the first four interviews.
24.	Periodical verbal, written, or face to face discussions with the members of my dissertation committee.	To get feedback on the rigor of the research process and the data analysis itself.
25.	Continue ongoing analysis of data as collecting the next data set.	To maintain the grounded theory technique of staying close to the data during analysis.
26.	Through analysis, identify concepts grounded in the data from the initial codes.	To collapse the open coding into conceptual statements that encompasses several of the codes.
27.	Continue data analysis to hypothesize about relationships among the concepts. The 216 -221 open codes were classified into groups with commonalities into ATLAS.ti language of "code families," down to 21, which relate to the conceptual category stages.	To continue examining relationships and further analysis of the data.
28.	Return to the initial four participants to do member checking about the initial analysis.	To ascertain that the research so far is reflecting the experience that they communicated during the interviews.

29.	Consult with a peer review committee of an elder African American widow not in the study, a qualitative expert, and an elder African American widow who had experienced loss of a relationship. Do visual representations of relationships both in ATLAS-ti and manually on paper.	To obtain critique of the analysis and maintain the rigor of the research.
30.	Continue coding and analysis as described above with each new participant, using theoretical sampling as the concepts/categories of the theory continue to emerge and their properties/attributes.	To advance the development of the elements of the theory and hypothesize relationships.
31.	Continue periodic member checks, counsel with the dissertation committee, consultation with peer group, as further data collection and analysis continues. Recruit from local St. Louis American Association of Retired Persons (AARP) for further participants and repeat Steps.	To maintain the rigor of the research.
32.	Explore properties/attributes, relationships between codes and conceptual categories while maintaining contact with the data.	To continue analysis of the data to a more abstract level.
33.	Continue hypothesizing the relationships among elements of the theory using visual diagrams and physical mapping on white boards.	To develop a visual description of the emerging theory to clarify relationships.
34.	Compare existing literature in various relevant areas, such as grief and care giving, with the emerging theory to find similarities and compare patterns.	To find differences and similarities among current research and extant literature.
35.	Continue analysis and refinement of elements by returning to the original data	To maintain grounding in the participant data as the theory develops.

	and visually exploring integrative diagrams.	
36.	Determine the next steps in the continuing development of the theory.	To maintain the rigor of the research process.
37.	Add a second peer group of five African American widows for another peer review as the theory is developing.	To review and critique the emerging theory.
38.	Repeat Steps 5 and on in the description.	To provide continuity and rigor in the process.

Appendix H

Demographic Characteristics of Participants

Number	Age	Children	Married	Death (Yrs.)	Care giving (Yrs.)
#1	79	4	56	1	3-4
#2	71	3	40+ ^a	1	0 ^b
#3	83	3	62	3	5
#4	67	3	47 ^c	1	3
#5	77	6	53	2	2
#6	79	0	38	8	2 ½
#7	68	2	43	5	2
#8	98	6	41	11+ ^d	unknown
#9	93	3	45	8	2 months

^aParticipant estimation

^bParticipant not physically living with deceased to care for him.

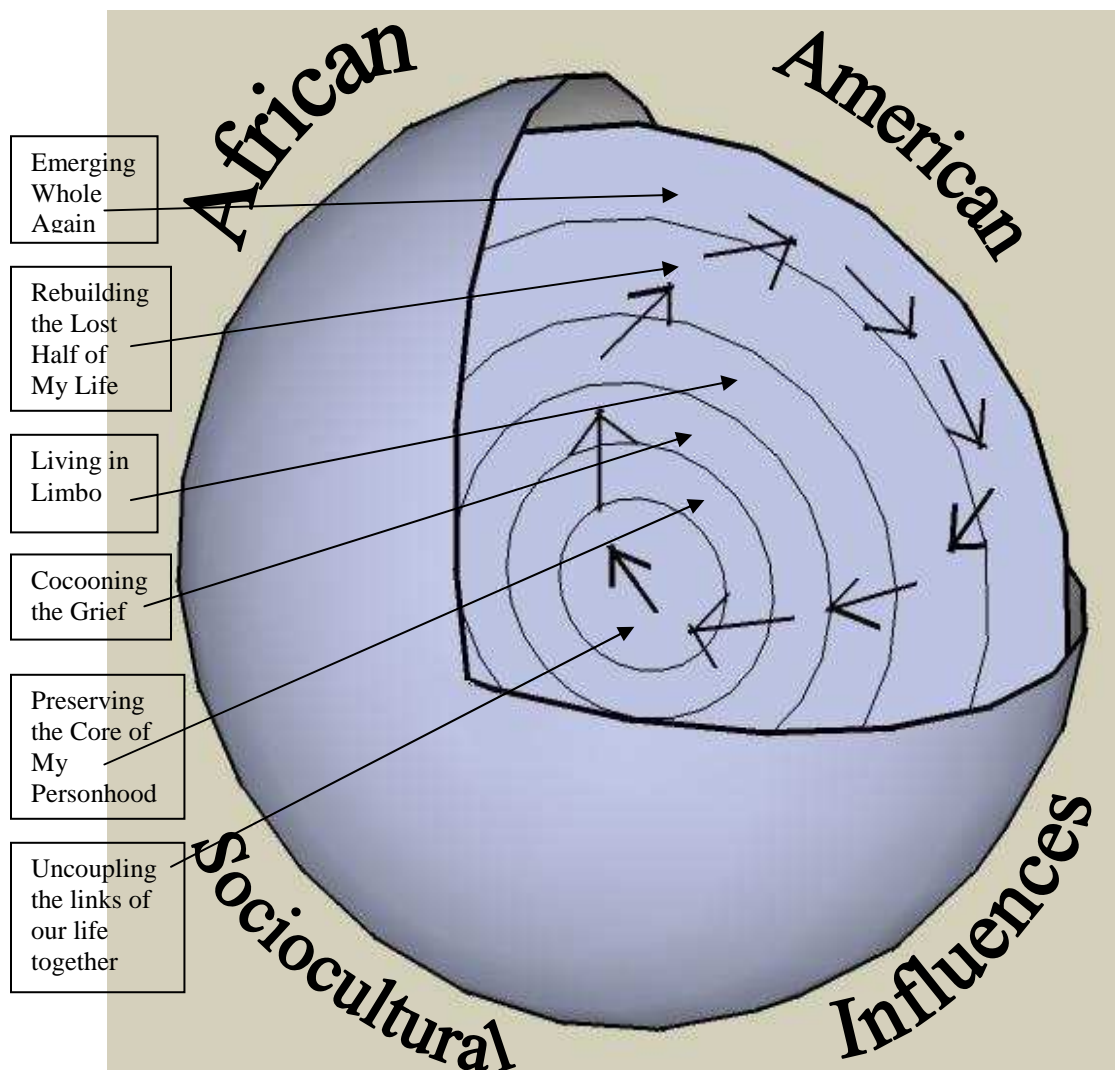
^cParticipant wanted to note that 10 years were “common law” of the number.

^dParticipant reported different lengths of time during the interviews.

Appendix I

African American Elder Grief and Mourning After Spousal Bereavement:
Nested Transitions in Concentric Spheres Culminating in Reintegrated Life

Dominant Culture



Dominant Culture

VITA

Sheila Putman Capp-Taber graduated from Olivet Nazarene University in 1975 with a Bachelor of Science in Nursing. She began her nursing career as a Medical/Surgical nurse and then a supervisor on that unit. Following this she began her career in education in Educational Services. She left this position to pursue her Master of Science in Nursing with an Educator Track at the University of Missouri-Columbia for the years of 1982-1984. During this time, she also began nursing in the area of Psychiatric/Mental Health Nursing and found the area that she loved. After graduating from the University of Missouri-Columbia, she took a position as a nurse educator in the then Blessing Hospital School of Nursing and has been there through the transition into a baccalaureate program in nursing. She has been teaching in this program now since 1984 and has developed many courses. Her passion has remained in Psychiatric/Mental Health Nursing, but she has taught many other courses, including Professional Concepts, Pharmacology, Whole Person Nursing, Medical Terminology, Parish Nursing, and Dimensions of Professional Nursing.