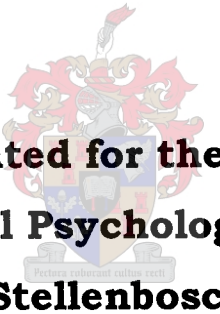
STRESS AND COPING IN RECENT CONJUGALLY BEREAVED RURAL BLACK SPOUSES

NCEBAZAKHE Z. SOMHLABA



Dissertation presented for the degree of Doctor of Philosophy in Clinical Psychology at the University of Stellenbosch

Promoter: Dr. J.W. Wait

December 2006

DECLARATION

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and has not previously, in its entirety or in part, been submitted at any university for a degree.

Ncebazakhe Z. Somhlaba **Date**

ABSTRACT

This study explored the relationship between stress and coping strategies in bereavement among 198 recently widowed rural black spouses (mean age 48.19 years). Correlations and multiple regression analyses were sought between coping strategies (as measured by the Coping Strategy Indicator) and anxiety (as measured by the Beck Anxiety Inventory), depression (as measured by the Beck Depression Inventory-Second Edition), social support (as measured by the Social Support Appraisals Scale), pre-loss marital relationship (as measured by the ENRICH Marital Satisfaction Scale) and demographic variables.

Of the participants who took part in the study, 87.88% were at least mildly depressed, while 69.19% experienced anxiety of above average intensity. While no significant correlations were found between anxiety and the three kinds of coping strategies, significant positive correlations emerged between depression and both the problem-solving- and social support-seeking coping strategies. Moreover, a problem-solving coping strategy emerged as a significant positive predictor of depression, while an avoidant coping strategy was found to be a significant negative predictor of depression.

Anxiety was negatively correlated with social support appraisal, and anxiety emerged as a significant negative predictor of perceived social support, with depression being a significant positive predictor of social support appraisal. Significant positive correlations emerged between the problem-solving coping strategy and perceived social support, while a problem-solving coping strategy emerged as a significant positive predictor of social support appraisal, and social support-seeking coping strategy being a significant negative predictor of social support appraisal.

Significant positive correlations were revealed between subjective retrospective assessment of pre-loss marital relationship and anxiety scores, while significant negative correlations were found between a problem-solving coping strategy and pre-loss marital relationship appraisal. While no coping strategies played a predictive role in the subjective perceptions of the nature of the pre-loss marital relationship, higher levels of subjective retrospective assessment of pre-loss marital relationship were strongly associated with such demographic characteristics as middle-income home earnings, the semi-literacy, the sexually inactivity, as well as closeness and cohesiveness of a marriage.

Qualitative data obtained from participant interviews revealed the compounding factors in the experience and manifestation of stress associated with the death of a spouse, such as marked social isolation, loss of 'protective' status of being married as well as single-handed parental and household responsibilities. Moreover, cultural aspects such as

continued bonds with the deceased – in the form of hallucinatory experiences towards the deceased spouse – as well as the highly anticipated unveiling ritual that would mark the culmination of the societal prescription of a mourning period, served as ameliorative factors in the experience of grief and coping with the additional stressors secondary to loss.

These findings point to the necessity for bereavement intervention programmes aimed at equipping the conjugally bereaved with practical problem-solving skills necessary for managing daily problems emanating from the loss of a spouse. Moreover, basic support groups need to prioritize psycho-educating the conjugally bereaved individuals to continuously evaluate their support structures and strengthen ties with social networks that readily render instrumental assistance and advice in times of need. Notwithstanding the short-term benefits of avoidant coping, the continued sustenance of social and emotional support requires fostering interpersonal transactions that are channelled towards exchanging problem-focused aid in order for the widowed to effectively deal with the strain of conjugal loss in a longer term. Furthermore, the traditional-religious aspects of the participants' bereavement necessitate channelling of bereavement intervention programmes to be congruent with the frame of reference and belief systems of these communities, in order to make a meaningful and culturally sensitive intervention aimed at facilitating individuals' coping with spousal death.

OPSOMMING

Die verband is ondersoek tussen stres en hanteringstategieë by 198 landelike wewenaars en weduwees wie se huweliksmaats onlangs gesterf het. Die deelnemers se gemiddelde ouderdom was 48.19 jaar. Korrelasie en regressie-analise is bereken tussen hanteringstrategieë (gemeet deur die *Coping Strategy Indicator*) en angs (gemeet deur die *Beck Anxiety Inventory*), depressie (gemeet deur die *Beck Depression Inventory-Second Edition*), sosiale ondersteuning (gemeet deur die *Social Support Appraisals Scale*), premorbiede huweliksverhoudings (gemeet deur die *ENRICH Marital Satisfaction Scale*) en demografiese veranderlikes.

'n Ligte graad depressie is by 87.88% van die deelnemers gevind, terwyl 69.19% 'n bo-gemiddelde angsvlak gehad het. Ofskoon geen beduidende verband gevind is tussen angs en drie tipes hanteringsvaardighede nie, is beduidende korrelasies tussen depressie en die probleemoplossings- en sosiale steun-soekende benaderings gevind. Wat meer sê, is dat die probleemoplossingsstrategie geblyk het 'n beduidend-positiewe voorspeller van depressie te wees. Daarteenoor was die vermydende strategie 'n beduidend-negatiewe voorspeller van depressie.

'n Negatiewe verband is gevind tussen angs en waargenome sosiale ondersteuning. Angs was 'n beduidende negatiewe voorspeller van waargenome sosiale ondersteuning. Depressie was egter 'n beduidend- positiewe voorspeller van waargenome sosiale ondersteuning. 'n Beduidend-positiewe verband is gevind tussen die probleem-oplossende strategie en waargenome sosiale ondersteuning. Die probleem-oplossende strategie was 'n beduidend-positiewe voorspeller van waargenome sosiale ondersteuning. Die sosiale steun-soekende benadering was 'n beduidend-negatiewe voorspeller van waargenome sosiale ondersteuning.

'n Positiewe verband is gevind tussen die subjektiewe retrospektiewe beoordeling van die huweliksverhouding (soos voor die dood van die huweliksmaat) en angs. 'n Beduidend-negatiewe korrelasie is egter gevind tussen die huweliksbeoordeling (soos voor die dood van die huweliksmaat) en die probleem-oplossende hanteringstrategie.

Geen hanteringstrategie het die subjektiewe retrospektiewe beoordeling van die huweliksverhouding voorspel nie. 'n Verband is wel gevind tussen hoër beoordelings en demografiese veranderlikes, soos middelvlak-inkomste, semi-geletterdheid asook nabyheid en samehorigheid asook seksuele onaktiwiteit.

'n Kwalitatiewe analise van data dui op die komulatiewe stres-effek wat die dood van 'n huweliksmaat het, soos sosiale isolasie, verlies van die "beskermde" status van getroud wees

en die verantwoordelikhede van die enkel-ouer-rol. Ook die kulturele aspekte soos voortgesette bande met die oorledene – in die vorm van hallusinasies – en die verwagte ritueel wat die die hoogtepunt van die gemeenskap se voorskrif ten opsigte van die rou-tydperk is, het gedien as beskermende faktore wat die ervaring van stres en die hantering van die verlies betref.

Hierdie bevindings dui op die noodsaaklikheid dat intervensieprogramme aangebied word vir wewenaars en weduwees, sodat probleem-oplossingsvaardighede aangeleer word waarmee hulle die sielkundige probleme wat ondervind word na die dood van 'n man of vrou effektief kan hanteer. Verder moet die primêre ondersteuningsgroepe psigo-opleiding as prioriteit beskou en toesien dat hulle leer om hul ondersteuningstrukture voortdurend te evalueer. Hulle moet hul bande versterk met sosiale netwerke waardeur instrumentele hulp en advies geredelik beskikbaar gestel kan word wanneer dit benodig word. Nieteenstaande die feit dat vermydingsstrategieë oor die kort-termyn voordele inhou, moet interpersoonlike transaksies verseker dat sosiale en emosionele ondersteuning oor 'n langer periode beskikbaar sal wees. Alhoewel vermyding op die korte duur voordelig kan wees, is volgehoue probleem-gefokusde sosiale en emosionele ondersteuning van geliefdes nodig indien die wewenaar of weduwee die stres van sy/haar verlies te bowe wil kom. Tradisionele godsdienstige aspekte van die deelnemer se rouproses vereis dat intervensies die geloof, waardes en verwysingsraamwerk van die gemeenskappe in ag neem. Intervensies moet betekenisvol en kultuur-sensitief wees en weduwees en wewenare so bemagtig dat hulle die eggenote se dood kan verwerk.

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to the following organisations and people:

- The financial assistance of the NATIONAL RESEARCH FOUNDATION (NRF, South Africa) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author and are not necessarily attributable to the National Research Foundation.

- The financial assistance of the DISTINGUISHED VICE-CHANCELLOR'S AWARD (MELLON FOUNDATION, South Africa) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author and are not necessarily attributable to the Mellon Foundation.

- DR. JOHN W. WAIT, my promoter, for his continued guidance and professional support. Without his selfless commitment to, and keen interest in, this research, this would not have been achieved.

- Prof. DAAN G. NEL, a statistician based at the Centre for Statistical Consultation, Stellenbosch University, for his instrumental assistance with statistical analyses.

- The local chiefs, research assistants and participants alike, who made data gathering possible.

- Sobahle, Zama, Hero, Soqhinga, Mfo kaBhuru, Mfo kaRere, and Mfo kaMandi - all my brothers, for their continued emotional support. A series of telephonic conversations and electronic mails from them throughout my doctoral research tenure enabled me to "keep going".

- Finally, all my friends and acquaintances whose support I continue to relish.

DEDICATION

This dissertation is dedicated to my mother, **MaHlangabezo**, and my paternal aunt, **MaSinama**, both who were, respectively, within *the first three years*, and *the first month*, of their widowhood period when the study was initiated in March 2002, and all those men and women out there who continue to bear the strain of conjugal loss.

TABLE OF CONTENTS

LIST OF TABLES

List of tables (continued)

List of tables (continued)

List of tables (continued)

List of tables (continued)

List of tables (continued)

List of tables (continued)

LIST OF FIGURES

List of figures (continued)

STRESS AND COPING IN RECENTLY CONJUGALLY BEREAVED RURAL BLACK SPOUSES

CHAPTER 1: INTRODUCTION, PROBLEM STATEMENT, AND OPERATIONAL DEFINITIONS OF MAIN CONCEPTS

1. Introduction and problem statement

Bereavement through the loss of a spouse remains one of the few areas in contemporary psychology to have received far more attention from bereavement researchers than any other in the areas of death and dying (Lund, 1989; Stroebe, Stroebe, & Hansson, 1993). To this effect, the areas of focus have been the impact that both the loss of a spouse and the entire bereavement process have on the psychological well-being of the bereaved spouse (Gallagher-Thompson, Futterman, Farberow, Thompson, & Peterson, 1993; Lund, Caserta, & Dimond, 1989; Thompson, Gallagher-Thompson, Futterman, Gilewski, & Peterson, 1991). It would thus seem that the attention proffered to a specific phenomenon such as conjugal bereavement stems from different conceptualisations offered by different researchers, authors and theorists as to what actually constitutes conjugal bereavement as a specific type of stressor, how it is reacted upon by the surviving spouses, and how these survivors successfully 'negotiate' a transitional widowhood phase.

In South Africa, the area of coping with the death of the loved ones seems to be one of the research areas that have received minimal attention from social science researchers. The paucity of research on how the bereaved individuals react to, make sense of, and deal with, such a traumatic event that

directly impacts on their psychological well-being, is surprising. With merely one study that investigated the widows' coping with stress associated with the death of their spouses (Spangenberg & Somhlaba, 2003), clearly research into the experience of stress and various ways of coping with conjugal loss among rural black South African widows and widowers is warranted. Since the area of bereavement in South Africa apparently continues to be largely ignored by social science researchers, and particularly since the psychological needs of black South Africans have received so little research attention up to now, these are factors important enough to argue for continued research in this specific area. Against this background, the present study sought to investigate the manner in which conjugally bereaved men and women coped with the stresses associated with the death of their spouses, and specifically the extent of their ability, or lack thereof, to adapt to their new and changed lives without the deceased spouse.

Many South Africans lose their close relatives because of violent killings, fatal accidents or diseases such as Tuberculosis or the A*cquired Immune Deficiency Syndrome* (AIDS, hereafter to be referred to as the HIV/AIDS). In a country where the recorded deaths of people nationally are seen to be increasing every year, it is surprising that there is still so little attention given by researchers to the impact these deaths have on the psychological well-being of the survivors. For example, the number of recorded deaths for the period spanning from 1997 to 2001, according to Statistics South Africa, rose from 46,941 deaths in 1997 to 64,817 deaths in 2001 (Statistics South Africa, 2002). Cited as the leading underlying causes of these deaths were the "unspecified

unnatural causes", "ill-defined causes of mortality", tuberculosis, *Human Immunodeficiency Virus* (HIV) disease as well as influenza and pneumonia.

With specific reference to the current prevalence of the HIV/AIDS, the United Nations Programme on HIV and AIDS (UNAIDS) indicates that up until 1998 South Africa was described as having one of the fastest growing HIV/AIDS epidemics in the world – with the infection prevalence having risen from 0.7% in 1990 to 24.8% in 2001 (UNAIDS, 2003). Using the extrapolated data from the National HIV and Syphilis Antenatal Sero-Prevalence Survey released in 2005, the Department of Health estimates that approximately 5.45 million South Africans were living with HIV infection (Department of Health, 2006). Given the numbers of people infected and dying, South Africa is regarded as having the most severe HIV epidemic in the world (AIDS Foundation of South Africa, 2005), it would be reasonable to infer that every day there are individuals who get bereft of their close relatives. According to the estimates of the UNAIDS Global Report, the number of AIDS related deaths in South Africa in 2003 ranged anywhere between 270,000 and 520,000 (UNAIDS, 2003). Therefore, given the scourge of HIV/AIDS many people in South Africa inevitably lose their loved ones at some point in their lives, and the manner in which South African individuals cope with grief arising from AIDS related deaths ought to occupy a central sphere in bereavement research.

In similar vein, accidents on South African roads seem to be claiming lives at much higher proportions. According to the Department of Transport, South Africa has one of the highest road accident tolls in the world, with just over 10,000 road-accident fatalities per year (Department of Transport, 2002). From this finding, it would thus also seem evident that each year many South

Africans do endure the traumatic experience of losing their loved ones through death.

Yet, the psychological experience and needs of the individuals who grieve at having lost their close relatives, have ostensibly not generated much attention from the social sciences researchers of South Africa, despite that death and dying appear to be the daily phenomena that people encounter in their daily lives. In fact, evidence from international research has highlighted that the areas of grief and bereavement continue to attract very minimal research audience. For example, Switzer (1970) has long noted that psychology as the science of human behaviour largely ignores grief, albeit that it is a powerful emotion. Switzer cites several factors as contributing to this minimal attention, including the psychologists' fondness of experimental procedures (of which grief is itself not manipulable); tendency of humans generally to withdraw from serious discussions pertaining to death as well as painful memories and emotions that surround it; and ethical/moral positions regarding the use, as research participants, of those individuals who have been recently bereaved (Switzer, 1970).

Lopata (1996) has also made an elaborate point when asserting that "*death has become so distanced through medical technology, pushed off into layers and sterilized environments, [so much so] that attention to it is avoided*" (p. 97). By the same token, Parkes (1998) has recently pointed out that a topic as central as the consequences of loss seems to have received little attention from social science researchers to date, due to the general assumption that loss of a loved one is irreversible and untreatable, that there is nothing that can be done about it, and hence the best way of dealing with it is to ignore it. It would thus

seem that even researchers have not been immune to these societal 'entrapments', since their apparent lack of interest in the fields of grief and bereavement could be largely influenced by the society's view of how insignificant death, dying, grief and bereavement have all been rendered.

As far as could be established, only one study (Spangenberg & Somhlaba, 2003) has been conducted in South Africa to determine the nature of the relationship between stress and coping in the process of bereavement. Moreover, three other South African studies that have been conducted in the area of death, grief and bereavement, include investigation of the effects of conjugal bereavement between widows and widowers (Freeman, 1984), the experiences of widowhood and beliefs inherent in mourning (Manyedi, 2001), as well as the African perception of death (Jali, 2000). However, none of these three latter studies investigated the relationship between stress and coping with spousal death. This remains one main reason that warrants a continued research on the specific area of stress-coping relationship in the context of loss in the South African communities.

1.1. Conjugal bereavement

Bereavement through the death of a spouse – hereafter to be referred to as the *conjugal bereavement* or simply the 'spousal bereavement' – may be understood as a life event that may be too stress-inducing to the surviving spouse and may prevent him or her from effectively coping and dealing with the loss and from adapting to the changed situation. In fact, the death of a spouse has long been identified as one of the profoundly life altering and yet most stressful events an individual is likely to encounter in his or her entire lifetime (Daggett, 2000;

Gass, 1989a; Holmes & Rahe, 1967; Marris, 1974). Similarly, Lindstrøm (1997) holds that "*the loss of a significant other is a stressor [that] is probably the most severe trauma a human being can go through*" (p. 253). It is during this period that the bereaved individual finds him- or herself grappling with the experience of loss and tries to adapt to the new widowhood status. It is also during this period that the shift occurs when the usual presence of a loved person is replaced by his or her stressful absence (Lindstrøm, 1997). More recently, Casement (2000) has also espoused that the loss of a spouse "*is the single most difficult adjustment [for the surviving spouse] to negotiate*" (p. 21). It has also been found that during bereavement, bereaved people not only have to cope with the loss of the loved person himself or herself, but also have to make major adjustments in their lives that come about as secondary consequences of the loss (Stroebe & Schut, 2001a).

A tacit assumption from these authors' conceptualisation of bereavement is that although grief may be expressed, understood and interpreted in many different ways, a general pattern exists that characterises a reaction to the death of a loved one, which involves a stressful reaction to loss as well as the need for survivors to successfully manage their lives during the bereavement process. In fact, the presumed 'universality' of the experience of bereavement is what some authors in this specific field (Carr, 1975; Corr, Nabe, & Corr, 2000; Wright, 1993) espouse. For example, Carr (1975) holds that grief, as a response to the loss of a loved one, is a universal reaction experienced and expressed by all individuals at some time in their lives. Similarly, Wright (1993) has recently maintained that the expression of what has been termed 'grief "is a universal response by which people adapt to a significant loss, the loss of something

which was theirs, a valued possession which had special meaning" (p. 1). A somewhat similar view is also espoused by Botha and Pieters (1987), who maintain that, "*...all people exposed to significant loss experience varying degrees of grief*" (p.3).

The implications this "stressful response to loss" has on the survivor's physical and psychological well-being have been investigated by a number of researchers (for example, Biondi & Picardi, 1996; Gallagher-Thompson et al., 1993; Hodgkinson, 1984; Lund et al., 1989; Peretz, 1970a, 1970b; Thompson et al., 1991; van Zandt, Mou, & Abbott, 1989) to date, who all conclude that the loss of a loved may detrimentally affect the survivor's psychological wellness. Also concerning the above viewpoint, Peretz (1970a, 1970b) has made a somewhat provocative reference to bereavement wherein he views it as an "illness" since it represents a significant deviation from the bereaved individual's usual feeling, thought and behaviour states. Peretz further contends that these altered states are closely associated with the precipitation of physical and emotional symptoms in the bereaved.

Specific reference to bereavement as a stress-inducing phenomenon has also been made by Marris (1974) who maintains that it "*is the most unarguable and, at its most severe, the most ill-prepared of all adjustments to loss with which we are commonly faced*" (p. 39). Related to this, Hodgkinson (1984) is of the opinion that the process of bereavement constitutes "*a major hazard to the health of the surviving spouse or relative*" (p.22). Some researchers (for example, Biondi & Picardi, 1996) have also found that bereavement impacts on the subjective well-being of the bereaved so intensely that it could be viewed as a risk factor for the development of major psychiatric illnesses, particularly if the

loss is abrupt and unforeseen. The idea that bereavement can have negative impact on the survivor's well-being has also been echoed by van Zandt et al. (1989), who view bereavement as phenomenon that not only can exacerbate existing mental and physical health problems, but that which also has a pathogenic role in onset of new illnesses.

As illustrated in the above-cited viewpoints, there is cumulative evidence to suggest that bereavement, as an experience known to human beings, may have serious negative repercussions on the well-being of survivors. Specifically, spousal loss through death is understood not merely as an emotionally draining experience for the bereaved, but may also impact so negatively on the life generally of the surviving spouse, and may prevent him or her from effectively coping with the loss and adapting to the new widowhood status.

In South Africa, direct involvement in violence, fatal accidents and infection from potentially deadly diseases are factors that render many South African men and women vulnerable to premature death. While the death of a loved one is generally considered stressful for the survivors, it has been indicated that if the deceased was a spouse, this may be even more stressful to the surviving spouse. Being left behind to "reconstruct" a partner-less life, it is of paramount importance to note how bereaved men and women cope with the stresses associated with the death of their spouses as well as how they adapt to their new life situation.

Generally, the research literature indicates that problem-focused, active coping styles are superior to emotion-focused, passive coping styles, including avoidance (Coetzee & Spangenberg, 2002). What researchers seem to agree on is that coping strategies play an important role in an individual's physical and

psychological well-being (Endler & Parker, 1990; Miller, Brody, & Summerton, 1988).

1.2. Operational definitions of main concepts

Defining the three main concepts, namely *stress*, *coping* and *bereavement* would be a prerequisite for the understanding of how women and men in the present study dealt with the death of their spouses.

1.2.1. Stress

The concept of stress – the use of which has become ubiquitous in people's daily communication – has long historical origins. It was pioneered by Hans Selye (1946, 1974, 1976), a distinguished physiologist, who has been credited as the first to note the existence of human stress, describe its qualities, define the concept and give the phenomenon an appropriate name (Allen, 1983). An important point Selye makes in this regard is that he draws an interesting distinction between what he terms *eustress* and distress. Accordingly, eustress (or, simply, "good stress") is necessary for a person to meet daily challenges and demands without interfering with his or her well-being, while distress ("bad stress") could be associated with emotional and physical burdens imposed on the individual by an array of stressors and these are of significant detriment to his or her well-being (Selye, 1976).

In spite of the latter distinction, Selye does *not* give clarity about where the exact line of separation between "eustress" and "distress" stands proves to be it a drawback to his conceptualisation of stress. One important contribution the distinction makes, however, is that *stress* ought not to be viewed as

necessarily inimical to the individual's well-being, but rather that a certain amount of stress (the *eustress*) may be needed to motivate the individual to execute some tasks that are essential for daily living.

In accordance with Selye's definition, **stress** is conceptualised as "*the non-specific response of the body to any demand made upon it*" (Selye, 1974, p. 27) to adapt whether that demand produces pleasure or pain. Centred on his theory of the General Adaptation Syndrome (GAS), this definition was based on the idea that the body requires adaptation to the constantly changing internal or external conditions, and this usually "tears and wears" the body as some of these changes may take too much effort to adapt to. From Selye's definition, it interesting to note that stress is defined in the strictest medical sense to refer to repercussions these "demands made upon the body" have mainly on the individual's *physiological* level. The latter idea has theoretical underpinnings to the "fight-or-flight" response, which was first coined by Walter B. Cannon (1963) – also a physiologist – who opined that, when faced with a physical threat to survival, an organism must either confront its attacker ("fight off") or escape ("flight") from the hazardous situation if it is to survive. It would thus seem that Selye's (1946) general adaptation syndrome and Cannon's (1963) "fight-or-flight" response could be categorised as the *response models* to stress as they both view stress as a physiological response to the demands posed upon the organism.

In the second model of stress – the *stimulus model* (for example, Holmes & Rahe, 1967) – stress is conceptualised mainly as a psychosocial demand (stimulus or precipitant) that leads to personal strain. According to this model,

stress is assumed to be representing a ramification of life events that would, in a predictable fashion, lead to the manifestation of stress symptoms.

It is noteworthy that in contrast to the stimulus models of stress as well as Selye's (1946) theory of general adaptation syndrome and Cannon's (1963) "fight-or-flight" response theory, the conceptualisation of stress has evolved to include what happens at the individual's psychological and cognitive levels – in essence what has become to be known as the *transaction model* of stress (for example, Lazarus & Folkman, 1984; McGrath, 1970). This model not only acknowledges the precipitating role of environmental factors as well as the physiological arousal, but also emphasises the role of appraisal in the manifestation of stress. Stress is thus viewed as involving a vast array of processes that also include cognition, which is considered to be playing a central role in determining whether an event is relevant, benign or stressful. In accordance with Lazarus and Folkman's (1984) transactional model, stress refers to any circumstances that threaten or are perceived to threaten one's well-being and thereby tax one's coping abilities. From the above definition, two significant factors emerge: first, the basic tenet of stress is the presence of a threat, which the individual perceives as potentially thwarting his or her state of being well, healthy and contented; and second, that the individual's capabilities of handling the potentially hazardous situation are far outstretched or exceeded by the testing situation itself.

In fact, since the inception of the stress concept, various taxonomies of stress have since been conceptualised. For example, Lazarus (1966) has distinguished between three different types of what he terms "psychological stress" as a way of defining stress. These include:

a) **Harm/loss** – dealing with damage or loss that has already taken place,

b) **Threat** – to do with harm or loss that has not yet occurred, but is possible or likely in the near future, and

c) **Challenge** – consists of the sensibility that, although difficulties stand in the way of gain, they can be overcome with verve, persistence, and self-confidence.

It would thus seem that both harm/loss and threat are consistent with Selye's (1976) "distress", while challenge would parallel "eustress".

In another attempt to define stress, Monat and Lazarus (1991) outline a taxonomy that includes three "types" of stress with which individuals grapple in their day-to-day life encounters, namely *systemic* or *physiological* stress, *psychological* stress, and *social* stress. Systemic stress would be primarily concerned with the disturbances of the tissue systems, while the psychological stress is concerned with the cognitive factors that lead to the evaluation of the threat, and social stress is about the disruption of a social unit or system.

As plausible as this distinction may sound, it seems that the attempt made at delineating these three 'types' of stress amounts to making an explanation that appears to be too *teleological* in nature – the one that seeks to explain the phenomenon (of stress) by the purpose it serves rather than by the postulated causes. For instance, it has long been established that stress may have negative impact on the individual's state of health, and that people generally develop physiological reactions to stress (Allen, 1983; Leventhal & Tomarken, 1987; Selye, cited in Taylor, 1991). Similarly, in his explanation of the physiology of stress, Rice (1992) makes a point by highlighting that the

brain, through the mental processes, translates emotional or stressful stimuli into specific physical processes.

Therefore, categorising such physiological *reactions* to stress as the specific type of stress (namely, the "physiological stress") becomes inevitably unconvincing, given that the very physiological reaction would arguably be a *result of* that which is perceived to be stressful to the individual, rather than a specific type of stress. Similarly, the "psychological stress" type appears to be a redundant and circular explanation of the concept of stress itself; for stress to be in existence in an individual, the cognitive, emotional and behavioural stress responses – hence the *'psychological'* processes – that lead to the evaluation of the threat (as to whether or not it is manageable) would be assumed to have already taken place. In other words, all stress involves psychological appraisal of the threat in the first place, and to imply that there is stress that is not *psychological* is tantamount to downplaying the role played by the very cognitive, emotional and behavioural factors that are pivotal in the initial evaluation of events and circumstances.

In similar vein, the 'social stress' type of stress sounds implausible as all stress is assumed to be happening in a social context in which the individual functions on a day-to-day basis, whereby other people in the individual's life may have directly or indirectly 'contributed' to the manifestation of stress, as these people may be imposing demands and high expectations on the individual. Since some of these demands and expectations may not be met if they far exceed the capabilities of the individual, this is likely to leave the individual with a sense of failure and incompetence, especially when measured against the socially agreed standards, and hence increased stress. In

explicating the extent of the stressful relationship the individual may have with his or her social milieu as well as how such individual handles those stressors, Pearlin (1991) offers the following insight:

> *...coping is often a response to stressors that arise in social situations, where other people are also involved with the stressor - either because they have helped to create it or because they, too, are attempting to cope with it... Coping actions of one person will be constrained, encouraged, or channelled by the expectations and actions of others.* (p. 270)

It becomes evident from the above point of view that the phenomenon of stress occurs in a specified social context, and implying that there is stress that does not have social ramifications would be discounting the role played by the social environment in which the individual functions. Therefore, any attempt towards categorising some stress as "social" would itself be an inherent tautology.

What is apparent from the above distinction (of the three 'types' of stress), however, is that stress is not necessarily internally induced, but rather a phenomenon that is conceptualised as a process of interaction between the individual and his or her environment – an idea also espoused by Lazarus and Folkman (1984) in their conceptualisation of stress. Accordingly, an individual tends to be in an anticipatory situation if he or she feels physically or psychologically threatened. If the initial evaluation of the event shows that it is stressful (the primary cognitive appraisal), then the individual evaluates the available coping resources and options at his or her disposal in order to deal with such a stressful situation (secondary cognitive appraisal). Of special interest to note, is that there seems to be a general agreement from many researchers and theorists that the role of appraisal becomes central in the

evaluation of events as to whether or not they are stressful. Even Selye (1991), despite having earlier confined his focus of stress on physiological level (Selye, 1946, 1974, 1976), has recently conceded that stress can have effects on mental level as well. As succinctly put in Selye's later definition, stress refers to "*a non-specific result of any demand upon the body, be the effect* ***mental*** *or somatic*" (Selye, 1991, p. 22).

Still pertaining to stress, Lazarus (1999) warns that stress ought not to be viewed as a one-dimensional concept that occurs in and by itself, but rather as one that involves an intimate relationship with emotion, for the two cannot be disentangled. Thus, Lazarus warns, "where there is stress there are also emotions" (p. 35), and he further argues that "*...we cannot sensibly treat stress and emotion as if they were separate fields without doing a great disservice to both*" (Lazarus, 1999, p. 36). It would make sense to argue that there is direct causality between stress and emotion, for the presence of stress (which is, in essence, a result of the individual's judgement of the situation or event as negative and hence harmful, threatening and challenging) is directly related to the manifestation of some negatively toned emotions such as fear, guilt, anger, despair, depression and hopelessness. Put differently, when confronted with an insurmountable stressful encounter, an individual is likely to evince negative emotions; in order to ward off these emotions, an effort must be put in place that seeks to deal with the situation at hand (coping) – with resultant substitution of positive emotions ***for*** the negative ones when those coping efforts succeed.

Pertaining to the presumed relationship between cognition (appraisal of stress) and emotion, Frijda (1993) acknowledges the pivotal role appraisal

occupies in the present-day theory of emotion - in the sense that emotions are considered to be resultant from the appraisal of events with regard to the implications they hold for the individual's psychological "*well-being or for the satisfaction of goals, motives or concerns*" (pp. 357-358). However, Frijda is critical of the "linear model" of the appraisal process, which presupposes that emotional events elicit an array of steps of cognitive appraisal steps that follow a fixed, variable or parallel sequence, which give rise to emotions. Rather than viewing the cognitive process as having emotion as necessarily its end-point, the "*emotional experience, including its cognitive content, [as well as] the awareness of the emotional event as appraised, belongs to the emotional* ***response****, [which] is... the emotion itself*" (Frijda, 1993, p. 360). What becomes evident from the above argument is that while the relationship between stress and emotion is deemed to exist, the direction of causality between the two is not always clear-cut.

With regard to this presumably intertwined relationship between stress and emotions, Folkman and Moskowitz (2000) make a compelling point when they opine that:

> *Under stressful conditions, when negative emotions are predominant, positive emotions may provide a psychological break or respite, support continued coping efforts, and replenish sources that have been depleted by stress.* (p. 649)

From the latter viewpoint, it becomes evident that emotions are not only reflective of the individual's mood state, but also representative of the general rubric under which the complex phenomenon of stress is embedded. In fact, this is in support of the earlier view of stress as an interactive process in which

both the individual and environment are directly involved (Lazarus & Folkman, 1984; Monat & Lazarus, 1991). Also related to this, Duffy (cited in Lazarus, 1999) recalls that in the past, stress used to be viewed as a "unidimensional concept" – that is, "*a continuum ranging from low to high, a concept superficially analogous to arousal or activation*" (p. 32).

Since it becomes evident that the general view of many theorists is that stress involves a multi-faceted, multi-dimensional process that involves an interaction within the individual as well as between the individual and the environment, the position this dissertation will adopt is Lazarus and Folkman's (1984) transactional model of stress, which construes stress as any circumstances that threaten or are perceived to threaten one's well-being and thereby tax one's coping abilities.

1.2.2. Coping

There is evidence from the literature that suggests that the way people cope with difficult or stressful circumstances and conditions has been subject of a considerable amount of research for more than the past decade (Carver & Scheier, 1994). In similar vein, Somerfield and McCrae (2000) have pointed out that coping is "arguably the most studied topic in all of contemporary psychology" (p. 620).

Historically, the study of coping seems to have been linked to the study of stress, as individual's manner of handling stressors is directly, or indirectly, related to how that stressor is perceived to be personally significant to that individual's life. To this effect, Pearlin (1991) makes the point that the study of coping and that of the origins of stress have become so inseparable due to the

fact that coping itself is "*viewed within the larger context of stress process*" (p. 267). Simply put, the latter view highlights that the relationship between stress and the coping process appears to be based on the idea that one solely depends on the other. So intertwined are the two concepts that there could never have been anything like coping in the psychology nomenclature without the presence of the stress concept. By the same token, the presence of stress gives rise to the attempts by the individual that are aimed at managing that which has become the source of strain – irrespective of whether or not the individual succeeds in these attempts. Though this kind of association between stress and coping appears to be too simplistic at face value, what becomes apparent is that in order to meaningfully talk about the process of coping, a reference to the stressor (that is, the source of *stress*) has to be made about that which the individual seeks to cope with.

There has not been any consensus as to what exactly is it that has been termed *coping* with stress, which some have viewed as a response to emotion (Folkman & Lazarus, 1991). Like stress, **coping** has received considerable attention from different authors, with each author providing his or her own conceptualisation as to what constitutes coping with a stressful situation. In an attempt to define coping, McGrath (1970) has defined it as "*an array of covert and overt behaviour patterns by which the organism can actively prevent, alleviate, or respond to stress-inducing circumstances*" (p. 33). Implicit in this definition is the assumption that the "organism" is not a passive recipient that is acted upon in the coping process, but rather that the responsibility rests on the organism to initiate the "behaviour patterns" if its goal is to reduce stress.

Viewed from the latter assumption, coping represents an *action-oriented* process in which the organism is "actively" and directly involved.

Another assumption yielded by the above definition is that the "organism" has the ability or intuition to foresee the serious repercussions of stress; hence, it can *prevent* the circumstances that induce this kind of stress. Though McGrath (1970) does not explicate as to whether such prevention is aimed at countering the initial occurrence of the stress-inducing circumstances, or at the *recurrence* of the similar circumstances, the above assumption seems to border on the overestimation of the control the "organism" has in the manifestation of its stress. It could then be argued that if the organism had some power to "prevent" some stress-inducing circumstances from happening, there would not be such a concept as distress from the present day's psychological literature.

Another attempt to define coping has been provided by Pearlin and Schooler (1978), in which they view the role of specific coping responses as subsumed under three general categories. These are: *(a) altering the problem, (b) changing one's way of viewing the problem, and (c) managing emotional distress aroused by the problem.* The main assumption the latter view yields is that while the individual seeks to change the circumstances surrounding the problem at hand, the role played by cognition is significant to the whole process of managing distress.

In their transactional model, Lazarus and Folkman (1984) maintain that coping refers to the continuous cognitive and behavioural attempts of the individual to manage the demands of a situation he or she perceives as taxing. Coping is thus conceptualised as consisting of constantly changing "*cognitive*

and behavioural efforts [made] to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Folkman & Lazarus, 1991, p. 210). Also apparent from the above definition is that coping is not a process that acts upon the individual, but that the individual actively engages in mental and behavioural attempts to handle the situation which is evaluated as potentially hazardous to his or her well-being.

Another attempt to define coping comes with Matheny, Aycock, Pugh, Curlette and Silva-Cannella (1986), who view it as "*any effort, healthy or unhealthy, conscious or unconscious, to prevent, eliminate, or weaken stressors, or to tolerate the effects in the least hurtful manner*" (p. 509). It is of interest to note in the above definition that the emphasis is not on the *outcome* of the effort, but rather the "effort" itself that is judged as constitutive of the coping process – whether or not this leads to desirable outcomes.

In fact, this is in sharp contrast to many schools of thought that put forth the outcome as the determining factor of the success of the coping effort. To this effect, Lazarus and Folkman (1991) acknowledge that the *best* coping effort an individual can make is the one that changes the relationship between the person and the environment for the better, though this does not necessarily mean all coping must lead to a positive outcome. Lazarus and Folkman elaborate:

> *In keeping with deeply ingrained Western values regarding individualism and mastery, and the Darwinian impact on the psychological thought, these definitions [of coping] tend to venerate mastery over environment as the coping ideal. Coping is [thus] viewed as tantamount to solving problems by acting effectively to obviate them. The problem here is not that*

> *solving problems is undesirable, but that not all sources of stress in living are amenable to mastery, or even fit within a problem-solving framework.* (Lazarus & Folkman, 1991, p. 205)

Viewed from the latter point of view, it would thus seem that even the coping efforts that, while serving the individual's sense of control and tolerance over stressful encounters may lead to negative outcome, do fall under the general rubric of coping. A somewhat analogous viewpoint has emerged with Rice (1992), who also concedes that coping, as a skill, is "*a means people use to combat or prevent stress*" (p. 267). Rice further argues that in whatever nature or form coping efforts may take, their functions have one commonality – that is, they serve to prevent, eliminate, or reduce stress. From this, it also becomes evident that coping styles that have often been associated with negative outcome and hence less desirable, such as denial, may be more useful in dealing with stress than generally thought. To this effect, Sue (1986) is of the opinion that the use of denial (which some have labelled it the "healthy denial"), while often regarded as a less desirable strategy, may be a much more widely efficacious means of coping with stress than many mental health professionals are willing to admit.

Also of interest to note is that Folkman and Lazarus (1991) view coping, from the psychoanalytic ego psychology model, as "*cognitive processes, such as denial, repression, suppression, and intellectualization, as well as problem-solving behaviours that are invoked to reduce anxiety and other distressing emotion states*" (p. 207).

Thus, there appears to be solid and cumulative evidence from literature to suggest that the concept of coping may be more complex than merely an

attempt of the individual to handle stress that leads to desirable outcome. Although coping conceptually refers to efforts in the positive direction, where an individual is presumed to be striving for amelioration in the state of well-being, the effects of such efforts can also be negative and hence detrimental to the well-being. Thus, a tentative conclusion this yields is that coping can be categorised into *positive coping* (which leads to positive and desirable outcome) and *negative coping* (the outcome of which tends to be negative and hence undesirable). It stands to reason, therefore, that coping should never be evaluated solely in terms of outcome, but rather be understood as "a response to [an array of] stressors that arise in social situations..." (Pearlin, 1991, p. 270).

To date, numerous taxonomies of coping have been proposed as a way of facilitating an understanding of the intricacies involved in the process of coping. An early coping taxonomy (categorisation) was proposed by Billigs and Moos (1981), who maintained that coping can be categorised, firstly, in terms of the method of coping, which subsumes the *active* and *avoidant* coping. Active coping refers to coping efforts in which the individual 'actively' engages in tasks and attempts to ameliorate the stress-inducing conditions and situations, while the avoidant coping entails simply ignoring the problem or engaging in other tasks that help to distract attention from the problem.

In the second categorisation, Billings and Moos (1981) conceptualise coping in terms of *focus* of coping, which holds that coping can be grouped into *problem-focused* coping and *emotion-focused* coping. Accordingly, problem-focused coping involves concerted efforts to solve the problem as a way of dealing with the situation at hand, while the focal point of emotion-focused

coping comprises the channelling or regulation of appropriate emotions associated with the stressful situation in response to stress.

The latter distinction between problem-focused and emotion-focused coping modalities has been echoed by various other authors (for example, Lazarus & Folkman, 1984; Holahan & Moos, 1987). For example, in a further attempt to distinguish between the above-cited two coping styles, Holahan and Moos described problem-focused and emotion-focused coping, respectively, as "*strategies that are active in nature and oriented toward confronting the problem; and strategies that entail an effort to reduce tension by avoiding dealing with the problem*" (Holahan & Moos, 1987, p. 946).

Furthermore, coping strategies have been grouped according to various categories in research. Two of the most common categorisations in this regard are (1) *problem-focused versus emotion-focused* coping strategies, and (2) *active versus passive* coping strategies. A specific coping style, namely avoidance, has been categorised as an emotion-focused coping style in the first categorisation and as a passive coping style in the second categorisation (Coetzee & Spangenberg, 2002). Moreover, the passive coping style of avoidance has been associated with symptoms of psychological distress (such as depression and self-blame), an external locus of control and overall reduced quality of life (Coetzee & Spangenberg, 2002; Holahan, Moss, & Schaefer, 1996).

Pertaining to the preferability and desirability of the two coping styles, it has recently been suggested that problem-focused coping styles are superior to emotion-focused coping styles (Coetzee & Spangenberg, 2002) since they are thought to lead to reduction of psychological distress. The presumed superiority of the problem-solving coping style stems from findings in literature, which

presupposes that problem-focused coping is *negatively* related, while emotion-focused coping style is *positively* related to distress (Coyne & Racioppo, 2000; Gass & Chang, 1989; Ptacek, Smith & Zanas, 1992). Folkman (2001) confirms the consistent relationship between problem-focused coping and positive affect, by contending that the reason for such relationship is that problem-focused coping gives the individual a sense of control in a context (illness or bereavement) that usually makes people feel completely helpless.

However, there appear to be conflicting findings from the literature, with some studies consistent with the above view (Felton & Revenson, 1984; Mitchell, Cronkite, & Moos, 1983; Mitchell & Hodson, 1983), while numerous others point to problem-focused coping as positively related to emotional distress (Baum, Fleming, & Singer, 1983; Bolger, 1990; Carver & Scheier, 1994; Coyne & Gottlieb, 1996; Marrero, cited in Aldwin & Revenson, 1987; Watson & Hubbard, 1996).

Due to these conflicting findings, it can therefore be inferred that the usefulness of each of the two coping styles largely depends on many situational, environmental, or personal factors of the particular individual engaging in coping efforts. Related to this, Lazarus (1999) attests that the choice of a coping strategy an individual uses "*will vary with the adaptational significance and requirements of each threat and its status as a disease, which will change over time*" (p. 113). With regard to both the emotion-focused coping and problem-focused coping, Folkman (cited in Thoits, 1991) holds that objectively controllable stressors, when they are appraised as controllable, should more often lead to the use of problem-focused coping, while objectively uncontrollable

stressors, when appraised as uncontrollable, should more often result in emotion-focused coping efforts.

The latter idea has been corroborated in some other studies to date (for example, Eckenrode, 1991; Folkman & Lazarus, 1991; Lazarus, 1999). For example, Lazarus maintains that it is when the conditions and circumstances surrounding stress are appraised as changeable (that is, falling within the individual's control) that the problem-focused coping style predominates; and when the conditions are appraised as unchangeable, emotion-focused coping predominates (Lazarus, 1999).

With regard to the distinction often made between problem-focused coping and emotion-focused coping, there seems to be some scepticism from other authors as to whether the two are truly distinct categories. For example, Folkman and Lazarus (1991), highlighting that there may be an overlap between these two coping styles, offer the following insight:

> *The actual function of any given type of coping can be determined only in the context in which it is used... a strategy that is at first glance problem-focused, can have emotion-focused function.* (Folkman & Lazarus, 1991, p. 212)

Evident from the above viewpoint, is that the two coping styles are inseparable to the extent that reference to one cannot be done without reference to the other. The idea that the two coping styles are not necessarily mutually exclusive is also offered by Carver and Scheier (1994) who proffer the following perspective:

> *Although these two coping strategies are easily distinguished in principle, they typically co-occur. Indeed, their effects can be difficult to disentangle.*

> *That is, emotion-focused coping can facilitate problem-focused coping by removing some of the distress that can hamper problem-focused efforts; similarly, problem-focused coping can render the threat less forbidding, thereby diminishing distress emotions.* (Carver & Scheier, 1994, p. 184)

A similar view on the presumed complimentary relationship between problem-focused coping and emotion-focused coping has recently been reiterated by Lazarus (2000) who holds that although problem-focused and emotion-focused coping are "*conceptually distinguishable..., [they are] both... interdependent and work together, [with] one supplementing the other in their overall coping process*" (p. 669). Moreover, there exists evidence in the literature that suggests that individuals make use of both the problem-focused coping and emotion-focused coping in almost every stressful encounter (Folkman & Lazarus, 1980, 1985; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986).

Given that there appears to be a general agreement that the two coping styles have an interdependent, complementary relationship, the question that arises would be whether there exist anything called an exclusively problem-focused coping or an exclusively emotion-focused coping. Related to the above view, Coyne and Racioppo (2000) have cast doubt on the presumed distinction between problem-focused and emotion-focused coping styles. Their criticism stems from the fact that the distinction puts too much emphasis on the controllability/uncontrollability dichotomy of events as pre-determining factors in the individual's choice of either of the two coping styles while, even in many of the uncontrollable events, the use of instrumental actions can be readily utilised to ameliorate harm, and that emotion-focused coping style can be useful in some controllable situations (Coyne & Racioppo, 2000).

It would thus seem that the choice of either problem-focused or emotion-focused does not always depend on whether the situation is perceived as, respectively, controllable and uncontrollable, but that an individual may simultaneously utilise both coping styles irrespective of the controllability of the situation, or the lack thereof. The latter point is significant given that an individual, in the face of a stressful situation, may be inclined to engage in efforts aimed at solving the problem while simultaneously regulating, processing and expressing the emotions associated with the situation at hand.

The second criticism Coyne and Racioppo (2000) make of the distinction between problem-focused and emotion-focused coping styles is that aspects that are crucial such as timing, sequencing and appropriateness do get lost once coping becomes reduced to a summary score. While they acknowledge the consistency in the literature findings that emotion-focused coping is positively related to distress, Coyne and Racioppo argue that it would be inconceivable that an individual could engage in emotion-focused coping without there being a negative emotion to process, express and obviate. Therefore, emotion-focused coping ought to be conceptualised as "*follow[ing] upon*, rather than [contributing] to, psychological distress" (Coyne & Racioppo, 2000, p. 657).

The latter attempt to address the apparent reverse causation is probably a necessary call for researchers to constantly interrogate some long-held, orthodox views pervading coping literature – one being that some coping styles have inherently deleterious effects on the psychological well-being, and hence are "inferior" to others. More research on individual coping would probably address this issue, especially surrounding the question of whether there really

exists anything as the universally healthy or adaptive coping versus the universally unhealthy or maladaptive coping.

Another coping taxonomy has been proposed by Matheny et al. (1986) who distinguish between what they term *preventive* coping and *combative* coping. Preventive coping seeks to "*prevent stressors from appearing either through cognitive structuring that buffers the perception of demand or through resistance to the effects of stress,*" while combative coping is "*an attempt to subdue or defeat a stressor that is present and needs to be eliminated*" (cited in Rice, 1992, p. 270). It would seem that the preventive coping is analogous to a passive, avoidant and emotion-focused coping style, while the combative coping would equate with active, problem-focused coping – herein referred to, respectively, as "avoidance learning" and "escape learning" (Rice, 1992, p.270).

Furthermore, it would be of interest to note whether these two coping categories are conceptualised as completely distinct and mutually exclusive categories, or that they act in a supplementary and interdependent manner. Matheny et al. (1986) do not address this critical issue in their paper. However, since the coping process is conceptualised as involving an array of cognitive and behavioural attempts to ameliorate the hazardous situation encountered, it can only be inferred that that the functioning of both the combative coping and preventive coping would be complementary of each other. Especially significant is that, when faced with a stressor, an individual is likely to engage in concerted efforts to 'defeat' it (combative coping) while simultaneously seeking to making the situation seem less threatening (preventive coping). Should the latter be a possible scenario, it stands to reason, therefore, that speaking of preventive coping cannot be sensible without referring to the combative coping.

On the basis of Lazarus and Folkman's (1984) conceptualisation of stress and coping, Amirkhan (1990, 1994) offers yet another coping taxonomy in which coping responses can be subsumed under three broad categories, namely *problem-focused*, *seeking social support*, and *avoidance*. There seems to be a close correlation between these response categories and the fight-or-flight response to threat that was earlier conceptualised by Cannon (1963). The problem-solving strategy would equate with actively and directly confronting (or "fighting") the stressor, avoidance would correspond with the "flight" response, while seeking social support would represent a primitive need for human contact when overwhelmed by stressful situations and encounters (Amirkhan, 1990).

Social support seeking, as a specific coping style, has been critiqued on its utility in ameliorating psychological distress. For example, Coyne and Racioppo (2000, p. 657) have interrogated the general reference to the social support seeking as a coping strategy, which does not take cognisance of the following three factors: (a) the actions to which support seeking refers; (b) how, what, and from whom support is sought; and (c) the timing and circumstances of this action. Much of Coyne and Racioppo's critique of the social support-seeking coping is that most studies of coping do not adequately address critical issues that include the distinction between support that is actively sought and support that is automatically forthcoming, and, therefore, evaluating the effectiveness of the strategy without considering these aspects becomes difficult (Coyne & Racioppo, 2000).

The above critique notwithstanding, there seems to be concordance between Amirkhan's (1990, 1994) conceptualisation of coping and the view that

some authors (for example, Folkman & Lazarus, 1991; Hobfoll, 1988) generally adopt, namely that coping serves as a mediator of emotional states or responses.

One other coping taxonomy, and which partially resembles that of Amirkhan, 1990, 1994), has emerged with Marshall and Dunkel-Schetter (cited in Bolger, 1990), who delineate coping as manifesting along six types. These include: (a) problem-focused coping, (b) seeking social support, (c) focusing on the positive (*that is, reappraising the situation in a positive way*), (d) distancing (*that is, minimizing threat by becoming psychologically detached from the stressful situation*), (e) wishful thinking (*that is, engaging in fantasies about escape or avoiding the situation*), and (f) self-blame.

A different line of thought pertaining to coping has emerged, which stems from the idea that it is the way the individual subjectively evaluates the personal significance of what is happening that is the main source of variation in the arousal of stress and how this affects human functioning. Thus conceptually referred to as the appraisal construct or appraisal theory (Allen, 1983; Folkman & Lazarus, 1991; Frijda, 1993; Kaplan, 1996; Lazarus, 1966, 1991, 1999; Lazarus & Folkman, 1984; Matheny et al., 1986; Pearlin, 1991; Zohar & Dayan, 1999), how a person copes with any given stressful encounter is largely determined by how that person interprets, categorises, and labels the encounter as whether or not it is relevant to his or her values, goal commitments, beliefs about self and the world, as well as whether he or she has sufficient resources to ameliorate the stressful situation.

It would thus seem that the concept of appraisal is so central in the study of stress and coping to the extent that one cannot refer to the stress-

coping process without considering the role of appraisal. For example, Lazarus and Folkman (1984) make this compelling point in their conceptualisation of stress when they opine that psychological distress, in all its forms, occurs when an individual appraises (evaluates) a situation as threatening (primary appraisal) and perceives his or her resources for coping as limited or inadequate (secondary appraisal). Pertaining to coping, Lazarus (1999) regards secondary appraising as a "*cognitive-evaluative process that is focused on what can be done about a stressful person-environment relationship, especially when there has been a primary appraisal of harm, threat, or challenge*" (p. 76).

While it indeed appears that appraisal has an inextricably intertwined relationship with the stress-coping process, the question that arises is whether appraisal and coping are truly distinct concepts that refer to dissimilar phenomena or processes, or that the two are conceptually overlapping. The latter question is especially significant given that, since appraisal is considered central in the stress-coping process, uncertainty over where appraisal ends and coping begins can be misleading in that the one can be easily mistaken for the other. Moreover, should the two concepts each turn out to be representations of the other in form and content, it stands to reason that further attempts to present them as conceptually distinct constructs amounts to a '*merely convenient*' dichotomy.

Pertaining to the above-stated, intertwined relationship between coping and appraisal, Troop (1998) acknowledges that determining whether a given behaviour is motivated by the desire to manage a problem (coping) or that it is simply an appraisal of the situation "is an old-age problem in psychology" (p. 84). Troop proceeds to argue that since appraisals can be made without the

individual's conscious awareness, relying on the subjects' accounts of what motivated them to engage in a particular behaviour is not sufficient for understanding the appraisal and coping process of that individual, given that these subjective accounts cannot accurately reflect the individual's underlying motivation for the behaviour elicited. Moreover, Troop maintains that despite that coping entails behaviours that are aimed at reducing, tolerating or managing the problems, having an effect on a given situation does not necessarily translate the elicited behaviour into a coping strategy (Troop, 1998). To resolve the apparent 'problematic' operational definition of appraisal and coping, Troop (1998) suggests that, as a compromise that will enhance and contribute to a better understanding of the coping-appraisal process, the two "constructs" ought to be combined and then be referred to as "*thoughts and behaviours in which an individual engages in negotiating a problematic situation*" (p. 85).

The idea of an intertwined relationship between coping and appraisal has recently been corroborated by Lazarus (1999) who has acknowledged that "*conceptually, appraisal and coping go hand in hand and overlap, which results in uncertainty about whether, in any given instance, a stress-related thought or action is an appraisal, a coping process, or both*" (p. 78). As it stands, the idea of coping and appraisal as conceptually related and overlapping comes as a compromise that results from the difficulty in solving the fundamental question of whether it can be ascertained when coping is *not* appraisal or when appraisal is not mediated by the processes involved in coping – a research terrain that, as it turns out, shall remain the subject of debate among stress-coping scholars.

Although much has been said about what constitutes coping as a reaction to stress, it does not seem that a consensus will be reached among proponents and theorists as to what coping in essence entails, or how it manifests itself. Some authors have opined that there is no universal way of coping with stress; rather, individual differences as well as the environmental variables that include the nature of the danger, its imminence, ambiguity and duration, as well as the quality of social support resources received, play a pivotal role in how each individual reacts to and copes with a stressful encounter (Billings & Moos, 1984; Cohen & Wills, 1985; Folkman & Lazarus, 1991; Holahan & Moos, 1987; Kessler, Kendler, Heath, Neale, & Eaves, 1992; Mikulincer & Florian, 1997; Pierce, Saranson, & Saranson, 1996; Thoits, 1986).

Furthermore, some authors have distinguished between coping and 'defense' – the latter derived from classical psychoanalytic theory (for example, Haan, cited in Parker & Endler, 1996), and assert that coping should be treated as distinct from a defensive reaction to the unpleasant or disturbing thoughts and emotions. Accordingly, while coping behaviour would be more flexible, purposive, reality oriented, and differentiated, defensive behaviour tends to be rigid, compelled, reality distorting, and undifferentiated (Haan, cited in Parker & Endler, 1996).

At heart of the above distinction lies the implicit idea that the reaction to unpleasant and disturbing thoughts and emotions *ought to* be 'beneficial' to that particular individual for effective coping to have taken place. It stands to reason, therefore, that while 'coping' efforts are understood as being aimed at ameliorating the resultant distress, some of these efforts, by their very nature, would have deleterious effects on the individual's psychological well-being.

Pertaining to this, Zeidner and Saklofske (1996) make this point when they examine the distinction between what has been termed 'adaptive' and 'maladaptive' coping efforts. These authors opine that although adaptive coping often leads to a good adjustment to the distressing situation, and that maladaptive coping leads to poor adjustment, deciding whether specific coping mechanisms are adaptive or maladaptive requires an examination of the contextual factors around which the coping takes place, as well as such personal factors as personality, beliefs about resources for coping and their effectiveness. These all determine how that particular individual uniquely responds from one stressful encounter to another – an idea that has found resonance in numerous other studies to date (for example, Bolger, 1990; Costa, Somerfield, & McCrae, 1996; Folkman & Lazarus, 1991; Hewitt & Flett, 1996; Holahan & Moos, 1986, 1987, 1990; Krohne, 1996; Sue, 1986).

Other authors have maintained that gender differences exist in the way individuals cope with stress (Dressler, 1985; West & Simons, 1983), with males more apt to make use of active, problem-focused coping than females, and the latter more inclined to utilise passive, emotion-focused coping than their male counterparts (for example, Billings & Moos, 1981; Gore & Colten, 1991; Hobfoll, Dunahoo, Ben-Porath, Monnier, 1994; Ptacek et al., 1992; Thoits, 1991). Moreover, findings from Felsten's (1998) study have revealed that women are more inclined to make use of social support-seeking coping strategy than males, thus supporting the notion of gender differences in coping with stress. However, the perceived efficacy of the social support-seeking coping strategy in Felsten's study was not significantly different for the two gender groups.

Other research findings have revealed gender to be not a determining factor in the choice of coping strategies, as the choice of coping styles was found to be minimally different between the two gender groups (for example, Porter & Stone, 1995) – also analogous with Felsten's (1998) study that revealed no gender differences in associations between stress, coping and depression for problem-solving and social support-seeking strategies.

At another front, age has come to be understood as a determining factor in the stress-coping process, with younger people more inclined to use more active, interpersonal, problem-focused forms of coping than the older ones; while the older people make more use of passive, intrapersonal emotion-focused forms of coping (Folkman, Lazarus, Pimley, & Novacek, 1987).

Since the outcome of the efforts aimed at handling and dealing with stressful encounters is not necessarily a determining factor in qualifying those efforts as coping (with resultant inclusion of reputedly counter-productive strategies such as denial, self-blame, distancing and wishful thinking; Bolger, 1990; Holahan & Moos, 1987; Sue, 1986), there has even been some scepticism over whether coping truly helps in the wake of stress (Aldwin & Revenson, 1987), particularly given that some life exigencies seem to be particularly resistant to individual coping efforts (Pearlin, 1991).

For the purposes of this dissertation, the working definition of coping to be adopted will be Lazarus and Folkman's (1984) transactional model, which views coping as the continuous cognitive and behavioural attempts of the individual to manage the demands of a situation he or she perceives as taxing. This is particularly significant considering the emphasis of the latter model on the person-environment relationship as central to the experience and ultimate

resolution of grief, as well as the idea that those with more coping resources, such as social support, are likely to recover more quickly and completely than those with fewer resources (Richardson & Balaswamy, 2001; Wortman, Silver, & Kessler, 1993). Specifically, the circumstances surrounding the loss, such as whether it was sudden or anticipated, as well as the extent of the grieving individual's support structure and resources in wake of the loss influence the response to the trauma of loss that forms the basic tenet of the model. The coping taxonomy to be used will be that of Amirkhan (1990, 1994), which conceptualises coping as subsumed under three coping strategies that include problem-solving, seeking social support and avoidant coping strategies.

1.2.3. Bereavement

Having described the concepts of stress and coping and the complex interplay between these two concepts in individuals under duress, this study is interested in examining how men and women bereft of spouses cope with such death in the entire process and duration of bereavement. What bereavement implies and how it relates to, and differs from other death-related concepts such as grief and mourning, has received attention from some authors, and it would seem that a clear distinction between these three related concepts has become necessary to avoid confusing one concept for the other(s).

For example, Kalish (1985) has referred to *bereavement* as any state involving loss; *grief* as the feelings of sorrow, anger, guilt and confusion that can arise when an individual has suffered a loss; and *mourning* as an overt expression of grief and bereavement. Similar distinctions have been made by Cook and Oltjenbruns (1998) who have opined that while bereavement is a state

of being that results from a significant loss (which may be due to death), grief is the outcome of being bereaved and involves a variety of reactions constituting grief response; mourning denotes social prescriptions for the way in which people are expected to display their grief and often reflects the practices of their culture (for example, wearing black clothing). Put simply, bereavement implies a state of loss of something or someone who was significant in one's life (the "significant other"), while grief is the manifestation of the loss in an individual, which includes feelings, physical sensations, cognitions, and behaviours. A rather meticulous description is the one provided by Engel (1994) who regards grief as "*the characteristic reaction to the loss of a valued object, be it a loved person, a cherished possession, a job, status, home, country, an ideal, a part of the body...*" (p. 10). Mourning, on the other hand, signifies cultural manifestation of the expressions of grief and bereavement.

For the purpose of discussion in this dissertation, bereavement will be used to include grief and mourning as well, unless 'grief' and 'mourning' (as separate phenomena involving, respectively, the emotional reactions and the socio-cultural prescriptions and prohibitions) are specifically referred to reflect the distinctions outlined in the above operational definitions.

As difficult as it may be to provide a precise definition of what constitutes **bereavement** as a specific type of stressor, Hodgkinson (1984), in an attempt to provide an integrated picture of the features involved therein, has elaboratively described bereavement as:

> *...a complex set of psychological and somatic reactions which must be worked through by the surviving spouse. This grief process may become abnormal if the process is delayed in starting, unduly prolonged, if it*

comes to a halt, or if certain feelings are either distorted or do not appear. (p. 22)

Implicit in the latter description, is the notion that there are certain reactions to the loss of a loved one that the individual must evince for bereavement to be presumed to have taken place. The idea of bereavement reactions as "normal" processes following a significant loss has long been held by Schulz (1978) who argues that bereavement and grief have long been recognised as characteristic human responses to loss, whether it is loss of a person or loss of some other important organism or object. This has recently been echoed by Corr, Nabe and Corr (2000) who maintain that loss, death and grief "*are natural parts of human life... reacting and responding to loss is a healthful process, not a morbid one*" (p. 217).

As assuring as these authors apparently are in their argument, they do not specify the parameters within which normal bereavement ought to be, nor when should bereavement reactions be considered to have reached extreme proportions. In fact, such uncertainty leaves the reader with the impression that all bereavement reactions are normal and that no grief reactions could be considered detrimental to the individual's psychological and other well-being.

Another definition of bereavement is the one outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (the DSM-IV) (American Psychiatric Association; APA, 1994). Bereavement is described as constituting a reaction to the death of a loved one, and the bereaved individual presents with symptoms characteristic of a Major Depressive Episode. These symptoms include feelings of sadness and associated symptoms such as insomnia, poor appetite and weight loss – all which can be considered "normal"

reactions of grief, as long as they do not last for more than two months after the loss (APA, 1994). There are certain symptoms, however, which the DSM-IV does not consider "normal" grief reactions and which may help differentiate bereavement from the Major Depressive Episode. These include guilt feelings over one's influence, or the lack thereof, over the loved one's death, thoughts of death – wishing that he or she should have died with the deceased, morbid preoccupation with worthlessness, marked psychomotor retardation, prolonged and marked functional impairment, and hallucinatory experiences – all these directly related to the deceased, in which the bereaved wishes that the deceased had not died (APA, 1994).

Given that no single definition has been offered to date as to what differentiates normal grief from pathological grief (Middleton, Raphael, Martinek, & Misso, 1993), it is not surprising that there continues to be wide debate with regard to what constitutes the "normal" duration of the bereavement process. Apparent in these diverse points of view is an observation that Shuchter and Zisook (1993) have recently made, namely that there has been a general increase through the years, in the expected duration of time of what would be accepted as a "normal" duration of grief.

For example, Kalu (1990) and, recently, Sossou (2002) have viewed bereavement as extending to a period of one year during which the widow keeps a period of confinement after the burial of her husband. In similar vein, Lindstrøm (1995) is of the opinion that one year of bereavement is sufficient for a considerable degree of grief resolution. Also related to the above viewpoints, Raphael and Dobson (2000) have maintained that throughout the first year

after the major loss, periods of intense grief may reappear, especially with triggers or reminders of the loss, and at anniversaries.

While the authors above share the idea of one-year duration of bereavement, the DSM-IV alludes to the first two months after the person's death as constituting the duration of bereavement (APA, 1994). Viewed differently, Carnelley, Wortman and Kessler (1999) maintain that the effects of conjugal bereavement on the bereaved individual's subjective well-being are very substantial during the first two years following the loss and tend to decrease in the third year of widowhood. Similarly, Wortman and Silver (2001) have recently opined that it is the general assumption that within a year or two, people will recover from psychologically taxing effects of loss, and return to the earlier (pre-loss) levels of personal, occupational and other areas of functioning.

From yet another divergent viewpoint, Thompson et al. (1991) suggest that the effects of grief through spousal death may persist for at least 30 months in both widows and widowers. In fact, the latter view is analogous to Sable's (1988) earlier word of caution that bereavement may last "*longer than we used to believe, and [that] it encompasses a range of feelings – from sadness and anger to fear and anxiety*" (p. 553). The latter view of duration of bereavement is especially significant given that some authors have gone as far as arguing that there is no time schedule for recovery from grief, nor an single way to express grief (for example, Hyrkäs, Kaunonen, & Paunonen, 1997; Kalish, 1985; Lindemann, cited in Pine, 1989). Moreover, it would thus seem that the views articulated by different authors pertaining to the duration of grief are partially consistent with Glick, Weiss and Parkes's (1974) long-held

sentiment, which is that it can take between four and five years for the surviving spouse to move on with a new life after the death of a spouse.

Amidst the divergent views pertaining to what constitutes a "normal" duration of bereavement, Bonanno and Kaltman (cited in Bonanno, 2001) have made a rather reassuring assertion that there are considerable individual differences in the duration and severity of grief. From the latter assertion, it stands to reason that emphasis on individual differences needs to be carefully made before adhering to generally established conventional wisdom on how long grief should last.

From these different views cited above, what is apparent is that bereavement comprises a very complex process that occurs within the bereaved individual himself or herself (that is, intra-personally), and these are largely influenced by norms and expectations that in some cultures include a humble attitude and awe towards death and dying.

To date, numerous schools of thought have emerged, each offering its own version of the explanation on the nature of the manifestation of the phenomenon of bereavement. From the school of psychoanalysis, and on his paper on *Mourning and Melancholia*, Sigmund Freud has long opined that grief occurs when the individual's libido that was attached ("cathected") to the loved object and everything that was associated with it, is in the process of getting withdrawn or detached ("decathected") from that love object (Freud, 1925). Put simply, this point of view supposes that when a person realises that a love object is irrevocably and irretrievably lost, he or she has to bring forth to the consciousness all the thoughts concerning the (lost) object in order to detach all the energies (the libido) previously invested in the relationship with the lost love

object. This process of "decathexis" is explicated by Sanders (1989) who describes it as when the bond that was formed between the mourner and the loved object gets released so that the person can emotionally invest into other relationships. In other words, "*a fixed amount of energy that was once invested ('cathected') in the loved person must be retrieved ('decathected') before the individual can become free again to reinvest in another [interpersonal relationships]*" (Sanders, 1989, p. 26).

It would thus seem that the grieving person is confronted with the loss of a lost love object while simultaneously never readily and willingly abandoning the 'libido-position' with which he or she was attached to the object. In fact, the reluctance to 'let go' of the deceased person could be suggestive of the initial denial component of the reality that the significant other has been lost, something that would be expected to wane as the reality of death starts to become accepted and acknowledged to the mourner. The idea of "denial of death" as a compounding factor in the manifestation of grief has been openly acknowledged by Freud himself (cited in Schulz, 1978) in which he argues that grief is representative of a breakdown of the denial of death in which the mourner can no longer deny the reality of loss.

From this, it becomes apparent that grief would continue for as long as the grieving person is "locked" into the close relationship with the deceased person. Relating to this, Cleiren (1993) makes a point that for any recovery from bereavement to take place 'emancipation' from the relationship with the deceased must take place, and this would result in the re-adjustment to the environment and the formation of new relationships.

Another school of thought that has emerged in explicating the phenomenon of bereavement is John Bowlby's attachment theory (Bowlby, 1973, 1980), which pre-supposes that grief is essentially a 'separation anxiety' – that is, an unwanted separation from an attachment figure which gives rise to 'attachment behaviours' akin to those often observed in animals and children when faced with the absence of the major attachment figure. The phenomenon of grief, in Bowlby's terms, should be viewed as a reaction to the separation, in which the bereaved wishes to remain physically and psychologically close to the lost attachment figure. Separation from such attachment figure may, therefore, evoke behaviour patterns (such as searching for the deceased as well as intensely yearning to meet him or her), all which are aimed at preserving the lost closeness.

The idea of grief as an expression of separation anxiety has also been shared by many authors to date (for example, Jackson 1957, 1977; Switzer, 1970). Recently, Raphael and Dobson (2000) have opined that the pathologies that stem from grief (which include chronic grief, complicated grief, and traumatic grief) all have at their core continuity and excessive separation anxiety, and that they all represent an intense avoidance of giving up the deceased person. Similarly, Neimeyer (2001) maintains that bereavement can be understood *"as a process of 'letting go' of one's attachment to the deceased person, 'moving on' with one's life, and gradually 'recovering' from the depression occasioned by the loss so as to permit a return to 'normal' behaviour"* (p. 2). Grief is thus viewed as essentially a separation experience and mourning as a means of achieving some form of emotional and spiritual restoration of the lost relationship with the deceased.

At first glance, it would seem that both Freud's (1925) *mourning and melancholia* and Bowlby's (1973, 1980) *attachment theory* share the similar fundamental principle in that they both postulate that attachment bonds with significant others, which have been developed early in life, become the key determining factors in both how grief manifests when that attachment figure is lost, and in the manner grief gets expressed and subsequently resolved. Both schools of thought maintain that for grief to be successfully resolved, the energies, thoughts and emotions that were invested in the lost figure need to be withdrawn and reinvested into new relationships.

However, one key difference between the two theories, as also noted by Cleiren (1993), is that while Freud (1925) is of the view that the relationship with the lost object gets broken when the griever recovers from grief, Bowlby (1973, 1980) asserts that in an adaptive grieving process such a relationship is often not broken as the bereaved may continue to have a feeling of 'inner presence' of the deceased. Figure 1.1 illustrates the points of differences and overlapping principles between Freud's (1925) and Bowlby's (1973, 1980) view of grief and mourning. Bowlby further contends that such feeling becomes the very source of solace when the bereaved engages in the process of restructuring their lives after the loss. The latter point would be especially significant given that the actions and decisions the bereaved person makes at post-loss are largely determined by the belief that he or she thinks the deceased would have done or preferred things to have been done in a certain way. While an acknowledgement exists that the deceased is irretrievably lost, an inner feeling remains that the deceased will continue to be part of the bereaved individual's life.

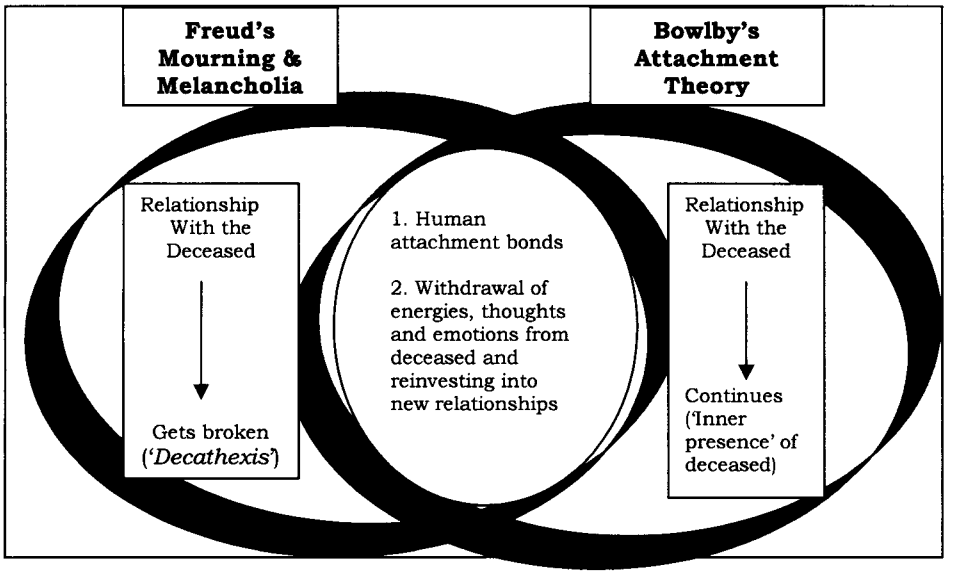


Figure 1.1. The hypothetical graph depicting differences between principles postulated by Freud (1925) and Bowlby (1973, 1980) in the conceptualisation of grief. The oval-shaped area in the middle represents an overlap between the two schools of thought. *(Note: the graph is the impression of this dissertation's author).*

Yet another school of thought on the manifestation of grief has emerged with Colin Murray Parkes (Parkes, 1975, 1996, 2000), who views grief as essentially an emotion that draws grievers towards that which or whom is missing, and that it arises out of an awareness of the discrepancy between the world that *is* and the world that *should be*. In Parkes's terms, this implies that for adaptive grief to take place an internal awareness of loss should be in line with the external events (absence of the significant other). In other words, one's reaction to the loss (the "internal awareness") as well as the implications this has for one's well-being, being congruent with the 'objective reality' of the loss of the significant other. Parkes further contends that when there is discrepancy between the outside world and the internal awareness, this often leads to frustration which comes in the form of maladaptive *grief* (Parkes, 1975, 1996).

Two problems with the above conceptualisation of grief emerge; first, the idea that grief is "*essentially an emotion that draws us toward something or someone missing*" (Parkes, 2000, p. 326) is a truism. It is obviously true that grief arises out of the lost 'loved object' or the significant other, and, therefore, nothing new is being offered in this part of the definition. Second, the author provides no explanation as to how the *discrepancy* between internal awareness and outside world comes into being, which leaves the conceptualisation prone to vagueness. Nor does he explain how individuals successfully deal with such discrepancy upon resolution of their grief experience.

Other schools of thought that have been offered as per the manifestation of grief include the stage theories, most notably Elisabeth Kübler-Ross (1981; 1989), all who view grief as progressing along different phases or stages that span from initial shock through to the resolution of the entire grief process. In accordance with Kübler-Ross's (1989) theory, grief can be subsumed under distinct phases, which all individuals go through upon the death of their loved one. These phases are conceptualised as ranging from initial numbness, shock and denial, proceeding to anger, bargaining and depression, through to ultimate acceptance. Kübler-Ross has further maintained that a temporary disavowal of reality (avoidance) is a means of getting through the initial devastating early period of loss and threat, before reaching the later stage of acknowledgement and adjustment.

While stage theories have made a significant contribution in understanding the manifestation of grief following the loss, they have been criticised primarily for assuming that a phenomenon as complex as grief can be delineated as occurring in a straightforward, predictable, and hence *universal*,

pattern. Moreover, a school of thought that assumes grief to be following a certain fashion underplays the role of individual differences in the manifestation and expression of grief.

Closely related to the above, Bugen (cited in Cook & Oltjenbruns, 1998) has critiqued the stage models in threefold observation: first, in that stages are not necessarily sequential and individuals may experience emotions in an order different from the suggested one; second, there are no clear-cut beginning or ending points for particular stages – instead, these stages blend dynamically; and third, stages do not adequately reflect the uniqueness of individual's grief.

From a somewhat similarly critical viewpoint, Osterweis, Solomon and Green (cited in Wortman et al., 1993) as well as Stroebe, Hansson and Stroebe (1993) have also cautioned against the use of the term 'stages' of response to grief primarily for two reasons. First, they argue that this term might lead to expectations that the bereaved would proceed from one clearly identifiable reaction (to loss) to another in a more orderly fashion than the usual occurrence. Second, the use of 'stages' might also result in hasty assessments about where individuals *are* (or *ought to be*) in the grieving process. Lopata (1996) has also found the stage theory of grief problematic as it is more inclined to putting immense pressure on the griever as he or she is expected to move from one stage to another 'quickly'.

As it turns out, the stage theory defeats the very purpose for which it is intended: to establish an understanding of the patterns and processes of grief in order that such understanding can be of relevance to helping individuals undergoing bereavement.

A rather elaborate insight into the critique of the stage models of grief is also offered by Wortman and associates, who assert that:

> *An implicit assumption underlying the stage approach is that virtually everyone will recover from a stressful life experience. However, according to the stress and coping model, those with more coping resources, such as social support, are likely to recover more quickly and completely than those with fewer resources.* (Wortman et al., 1993, p. 351)

Notably, other authors have also cautioned against the understanding of grief as progressing along the universal pattern. For example, Margaret Stroebe and her colleagues have warned against regarding phases of grief as following a pre-determine fashion (Stroebe, Hansson, Stroebe, & Schut, 2001). Thus, these authors warn that:

> *Phases should be regarded as descriptive guidelines, [and] not as set rules or prescriptions regarding where people ought to be at any particular duration of bereavement... there is much overlap, and passing back and forth through these phases [very often occurs].* (Stroebe et al., 2001, p. 9)

It is also the contention of the authors that contrary to the traditional view of grief as progressing 'smoothly' and predictably along a set of presumably discrete phases (which, by implication, suggests that people undergoing bereavement and grief will at some stage recover from its emotional strain), the general view nowadays is that the bereaved individuals do not "get over" their loss and revert to pre-loss normality, but rather adapt and adjust to the irrevocably changed situation (Stroebe et al., 2001).

Parkes (2001) also corroborates the above view when asserting that "*the sequence [of the stages of grief] was never intended to be more than a rough*

guide, and it was recognised from the start that people would move back and forth through the sequence rather than following a fixed passage" (p. 30).

A more skeptical viewpoint on the notion of phases of grief has been expressed by Neimeyer (2001, p.3) who asserts that:

> *At the most obvious level, scientific studies have failed to support any discernible sequence of emotional phases of adaptation to loss, or to identify any clear endpoint to grieving that would designate a state of "recovery"... Neither is it clear that a universal and normative pattern of grieving exists that would justify the confident diagnosis of symptomatic deviations from this template as "disordered" or "pathological".*

Neimeyer's (2001) overt skepticism stems from his observation that critics of the stage theories have begun to draw attention to the manner in which conventional models of grief indirectly disempower both the bereaved person and the caregiver by implying that there is a sequence of transitions that the grieving persons must passively negotiate, which are forced upon them by external events. Moreover, doubt has been cast on the "*highly individualistic nature of traditional theories, which [seek to] construe grief as an entirely private process [that is] experienced outside the context of human relatedness* (Neimeyer, 2001, p. 3). It thus appears that although stage theories seek to explain and understand the course of grief following the death of a loved one, they do not adequately account for the variations in the manifestation of bereavement.

As put forth by different authors, the context in which grief takes place is of cardinal importance in the understanding how individuals would react to their loss. Also pertaining to this, Sanders (1989) has observed that the "integrative theory" of grief would be applicable in answering the questions and

critique constantly posed on the stage theories. The integrative theories presuppose that while the phases of grief are set forth in a particular sequence, this should not be interpreted as representative of an inflexible grief pattern; rather, the griever moves forward and backwards, sometimes getting stuck in one phase of grief or another for extended time (Sanders, 1989).

A somewhat divergent viewpoint, albeit also partly acquiescent to the stage theories, is the one offered by Davenport (1981), which maintains that grief reactions result when the individual is compelled to acknowledge that his or her control over life was a mere illusion. Accordingly, grief suffering becomes an attempt to protect those illusions from having been "assaulted". Notwithstanding Davenport's support for stage theories, she further proposes that stages of grief can be understood as the "*result of trying to maintain our illusions of invulnerability and omnipotence in the face of lack of control*" (Davenport, 1981, p. 333).

It would thus appear that grief can be understood as an attempt by the individual's psyche to oscillate between narcissism (believing that the world evolves around him or her) and an acute denial (reluctance to relinquish fantasies of unlimited power and control over that world). This pattern is exemplified by Davenport (1981) in which she argues that each stage of grief can be better explained and understood in terms of the underlying narcissistic underpinnings, which stem from the individual's belief that loss can only happen with his or her permission, for example:-

- **Denial** – This couldn't *possibly* happen to me without my permission!
- **Anger** – How *dare* this happen? It's not fair, and I won't allow it!

- **Bargaining** – The only circumstances under which I'll go along with these are...
- **Depression** – I'm not worth much if this could happen. I must have some irremedial inadequacy that caused this.
- **Panic** – My psychological survival depends on keeping this loss from occurring.
- **Guilt** – If only I had done _____ differently, I could have prevented this from happening.
- **Worry** – If I plan things carefully enough, I can at least make sure nothing makes me feel this vulnerable again.

As evident from the above viewpoint, the grief can be explained as attempts individual makes in striving to maintain a sense of control over feelings of loss. However, Davenport (1981) does not shed light on how resolution of this ostensible narcissistic denial gets overcome, and hence how grief gets resolved. Second, Davenport does not tell whether this pattern is healthy and necessary for resolution of grief or that it has a poor grief outcome.

Although stage theories seem to have pervaded grief literature, it is worth noting a completely different model of grief that has long been propagated by Bugen (1979), and the area of its focus was linking two pivotal determinants of grief with its associated reactions. Thus, two dimensions on which Bugen believes grief hinges are *centrality-peripherality* and *preventability-unpreventability* of the loss. Accordingly, centrality-peripherality dimension includes the level of closeness of the relationship the griever had with the deceased at pre-loss, and preventability-unpreventability dimension involves the extent to which the griever subjectively believes the loss might have been

averted or prevented. Pertaining to the centrality-peripherality dimension, when a central relationship is lost, the mourner characteristically feels that his or her life has become meaningless, whereas the loss of a relationship that was only peripheral in nature is recognised by the mourner as not affecting significant aspects of his or her life (Bugen, 1979).

With regard to preventability, a mourner is usually preoccupied with the thought that factors directly contributing to the death could have been otherwise controlled and hence death prevented – this irrespective of the objective judgment that may point to the contrary. Unpreventability, on the other hand, pertains to the belief that everything was done to divert the forces contributing to the death, thus absolving the mourner from both responsibility and inherent guilt (Bugen, 1979). The interaction of the two dimensions with the potential to created four reactive states is diagrammatically presented by means of a grid presented in Figure 1.2.

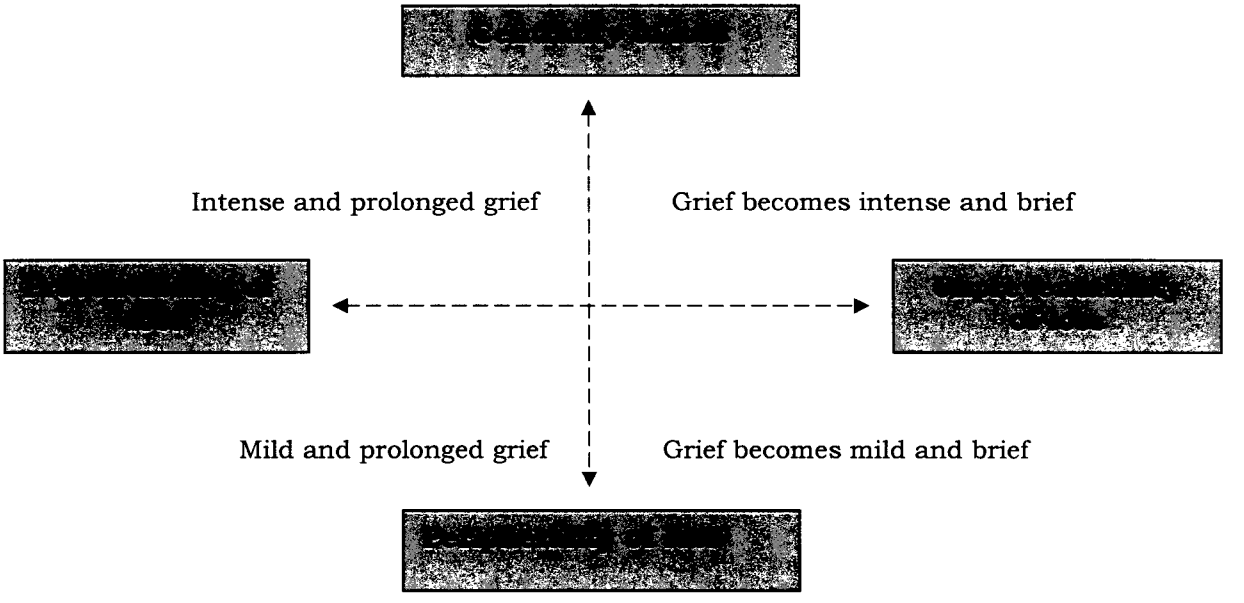


Figure 1.2. Diagrammatic representation of Bugen's (1979) theory of the interaction grid outlining the two dimensions that determine the grief outcomes as well as the potential to create four reactive states. *(Note: the graph is the impression of this dissertation's author).*

Also established from the above viewpoints, is the idea that grief, albeit a necessary condition following loss, may have far-reaching consequences on the individual's psychological well-being, especially when it has not been attended to in time.

In summary, grief is conceptualised as a state involving the loss of a central relationship, and that it can manifest in the form of grief reactions that range from sorrow, anger, guilt, and confusion, or can be expressed in the form of social prescriptions that 'govern' the expression of the sense of loss.

Many contradictory camps of conventional wisdom exist in the continuing debates centred on what constitutes 'normal' from 'abnormal' grief reactions, with some authors proposing two weeks, others arguing that one year, while others point to two to five years, as necessary period for expression of 'normal' grief. Also noteworthy, some authors espouse the idea that for grief and bereavement to be resolved, the relationship and attachment to the deceased should be broken, while some see some semblance of continuation of the relationship with the deceased as central to the psychological adjustment to the loss. Finally, while some authors emphasise the progression of grief along a set of predetermined stages, others propose that the extent of the grief and bereavement reactions is contingent upon both the level of closeness to the deceased and the extent to which the griever believes death should have been prevented.

From all the above-cited schools of thought, there appear to be many ways in which the process of bereavement can be understood. All the points of view have one common agreement: that grief manifests itself in an array of emotions that are representative of the reaction to the loss of the loved one, and

that its resolution comes about when the griever successfully withdraws energy that was previously invested to the deceased and re-invests in new relationships.

For the purpose of the dissertation, bereavement will be used to refer to the emotional, behavioural and cognitive state an individual evinces, which represents a reaction to the death of the 'significant other'. This is in line with Hodgkinson's (1984) conceptualisation of bereavement as involving "*...a complex set of psychological and somatic reactions which must be worked through by the surviving spouse...*" (p. 22).

To provide an overview of the general structure of this dissertation, Chapter 1 entails the introduction, problem statement, and operational definitions of the main concepts that include stress, coping and bereavement. Chapter 2 encompasses a literature review on coping with conjugal bereavement, while Chapter 3 focuses on research methodology, including the aims, objectives, research questions and hypotheses, participants, measuring instruments, procedure and data analyses. Results of the quantitative data analyses are dealt with in Chapter 4, while the in-depth analyses of participants' subjective account of their conjugal loss (qualitative data) are addressed in Chapter 5. The final chapter (Chapter 6) deals with discussion of the main findings, including contribution and limitations of the study as well as implications and suggestions for the future research.

CHAPTER 2: LITERATURE REVIEW

As mentioned earlier, much international research has focused on bereavement through spousal death (Lund, 1989; Stroebe et al., 1993) as well as the stress such a painful process induces (Gallagher-Thompson et al., 1993; Lund et al., 1989; Thompson et al., 1991).

In South Africa, the area of stress and coping appears to have received considerable attention from some prominent social science researchers to date. The populations that have been studied with regard to how they cope with inherent stresses include, among others, families with allergic children (Wiehahn, 1991), families with learning disabled children (Turk, 1991), families with physically handicapped children (Jansen, 1991), families with diabetic children (Corna, 1992), families with visually handicapped children (Zimmerman, 1993), families of adult cancer patients (Tharratt, 1993), dentists in private practice (Möller & Spangenberg, 1996), males and females in professional occupations (Mallach, 1997), recently detoxified alcoholics (Spangenberg & Campbell, 1999), spouses of depressed patients (Spangenberg & Theron, 1999), patients with systemic lupus erythematosus and rheumatoid arthritis (Venter, Spangenberg, Hugo, & Roberts, 1999), managers involved in post-graduate managerial studies (Spangenberg & Orpen-Lyall, 2000), parents of children with Down Syndrome (Spangenberg & Theron, 2001), black adolescents (Spangenberg & Henderson, 2001), and mothers of children with an intellectual disability (Hill, 2002). However, research on coping with bereavement seems to have been almost limited to studies conducted outside of South Africa. While two previous South African studies have focused on the experiences of widowhood and mourning and the associated beliefs as well as

the African perception of death (Jali, 2000; Manyedi, 2001), the relationship between stress and coping with bereavement was not the area of investigation for the two latter studies. Therefore, only one South African study of note to date has investigated the nature of the relationship between stress and coping among the bereaved population (Spangenberg & Somhlaba, 2003).

The death of a spouse has long been identified as one of the most stressful events an individual is likely to encounter in his or her entire lifetime (Casement, 2000; Daggett, 2000; Gass, 1989a; Holmes & Rahe, 1967; Marris, 1974; Norris & Murrell, 1990). Moreover, Wright (1993) maintains that the expression of what has been termed 'grief "*is a universal response by which people adapt to a significant loss, the loss of something which was theirs, a valued possession which had special meaning*" (p. 1). These views have been recently echoed by Lindstrøm (1997) who holds that "*the loss of a significant other is a stressor [that] is probably the most severe trauma a human being can go through*" (p. 253). It is during this period that the bereaved individual finds himself or herself grappling with the issue of loss and tries to adapt to the new widowhood status. It is also during this period that the shift occurs when the usual presence of a loved person is replaced by his or her stressful absence (Lindstrøm, 1997).

In fact, since the loss of a spouse usually involves the loss of a primary relationship, the surviving spouse is often left to grapple with, adapt to, and single-handedly negotiate, the challenges that 'accompany' the widowhood period. Moreover, cumulative evidence from literature suggests that the period of widowhood inevitably comes with adjustment to a new "partner-less" identity as well as new roles, some of which were shared with the deceased spouse

(Bowling & Cartwright, 1982; Cook and Oltjenbruns, 1998; Littlewood, 1992; Lord, 1987; Parkes, 1993; Richardson, & Balaswamy, 2001; van Baarsen, van Duijn, Smit, Snijders, & Knipscheer, 2002).

In the last two decades, much has been written on how bereaved people cope with the loss of their loved ones. During the phase of bereavement, which some authors have viewed as a period of psychosocial transition (Balkwell, 1981; Brock, 1984; DiGiulio, 1992; Krause, 1986; Levy, Martinkowski, & Derby, 1994; McCrae & Costa, 1993; Parkes, 1993), bereaved individuals have been seen as in dire need of support from their significant others. In fact, the emphasis of social support as an ameliorating factor during the process of bereavement has been corroborated in bereavement literature to date (Gallagher-Thompson et al., 1993; Hall & Irwin, 2001; Krause, 1986; Norris & Murrell, 1990; Stroebe & Stroebe, 1993; Stylianos & Vachon, 1993; Vachon & Stylianos, 1988).

At the heart of the view of social support as having incremental adaptive value during bereavement, lies the assumption that bereavement as a psychosocial stressor, particularly widowhood, is compounded by social isolation – an idea long espoused by many researchers to date (for example, Babchuk & Anderson, 1989; Berardo, 1970; Maddison & Raphael, 1975; Morgan, 1984; Wilson, 1971). The idea that social support is critical for the bereaved to have and cope with the phase of bereavement, could be traced back to the early 1980s with Bankoff's (1983) assertion that social support is critical for the bereaved to successfully adapt to the widowhood phase. However, Bankoff has cautioned that the extent to which support helps, hurts, or is inconsequential for the psychological well-being of widows during their lengthy

process of adjustment hinges on three factors; firstly, where the widows are in the adjustment phase; secondly, the specific type of support received; and thirdly, the source of the support provided (Bankoff, 1983).

From the above conceptualisation, what becomes apparent is that the social support received by the bereaved should not be understood as following a universal, orderly and predictable fashion; rather, it is the conditions in which such support is rendered that determine the extent of its usability and adequacy to the person receiving it – an idea that has also found resonance in other research findings (for example, Morgan, 1989).

Pertaining to the role of social support in mitigating the effects of stress, Duran, Turner and Lund (1989) have viewed social support as a buffering mechanism against stressful events. According to these authors, this buffering effect occurs at two levels; firstly, between a stressful event and stress reaction, thereby lessening a stress appraisal response by allowing the person at risk to perceive that significant others will provide resources necessary for coping with the stressful event. These authors' view is that it is through contact and emotional support that the bereaved would be better able to deal with the bereavement-induced stress. At the second level, social support may intervene between the experience of stress and the possible pathological outcome, hence "*an otherwise stressful situation may be relabelled to be minimally stressful due to anticipated support from others*" (Duran et al., 1989, p. 70).

The view of social support as having a decrementing effect on distress levels following spousal bereavement has also been echoed by other researchers (for example, Faletti, Gibbs, Clark, Pruchno, & Berman, 1989; Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Greene & Feld, 1989). A

common feature in these authors' idea of decremental effects of social support on distress is that the conjugally bereaved people with distress tend to garner support from their significant others, who in turn recognise and respond according to the need profiles of widows.

Despite the wealth of evidence advocating that social support is crucial for the bereaved to cope with bereavement, some authors (for example, Wellman & Hall, 1986) have gone as far as distinguishing between what they term *social networks* and *social support*. These authors hold that while members of a social network are not necessarily supportive, the network may mediate the availability and provision of social support. Similarly, Schuster and Butler (1989) differentiate between *affective (emotional)* support and *instrumental (task-oriented)* support. Emotional support is concerned primarily with availability of the support figures to be confided in, talked to when upset, nervous, or depressed, while instrumental support is concerned with more mundane activities, such as helping with finances, chores, shopping, errands and caring for the bereaved when ill.

The sentiment these authors ostensibly share from these distinctions is that it is the provision of emotional support, rather than instrumental support, which is critical for the bereaved to go through grief and reach a positive outcome. Analogous to the latter view is Rook's (1987) distinction between social support and companionship. Companionship refers not merely to global social connections but rather to shared leisure and other activities that are undertaken primarily for the intrinsic goal of enjoyment, while social support entails not (just) the feeling of being adequately supported or cared for by significant others, but rather to interpersonal transactions that are channelled

towards exchanging problem-focused aid. Therefore, according to Rook, companionship has the main effect on psychological well-being and a buffering effect *on minor life stresses*, while social support has a buffering effect *on major life stresses* (Rook, 1987).

Lund (1989) is of the opinion that social support is only *moderately* helpful to adjustment of many bereaved people. As succinctly put,

> *Merely having a social convoy is not enough [for the bereaved to deal with their grief], since the convoy might not be a supportive convoy... It is probably more important to know what support networks do rather than to simply know about their existence and their structural characteristics.* (Lund, 1989, p. 223)

Related to the above, Stroebe, Stroebe, Abakoumkin and Schut (1996) are of the opinion that social support is able to aid only with the social, and not the emotional, loneliness of the bereaved person. As these authors put it, "*losing a partner means losing a major attachment figure, and social support from family and friends cannot compensate for this effect*" (Stroebe et al., 1996, p. 1248).

Partly related to Stroebe et al.'s (1996) view above, is Jacobson's (1986) categorisation of social support, which stems from the idea that social support can be defined in terms of resources that meet (other person's) needs, and social relationships as entities through which an individual's needs are met. Jacobson maintains that social support can be subsumed under three broad categories:

- **Emotional support** – behaviour that fosters feelings of comfort and leads an individual to believe that he or she is admired, respected and loved, and that others are available to provide caring and security.

- **Cognitive support** – information, knowledge, and/or advice that helps the individual to understand his or her world and to adjust to changes within it.
- **Materials support** – goods and services that help to solve practical problems.

Consistent with the above categorisation of social support, House (cited in Rook, 1987; also cited in Vachon & Stylianos, 1988) delineates social support under four basic types; namely, *emotional support* (which involves actions that enhance self-esteem), *appraisal support* (which provides feedback about one's views or behaviour), *information support* (which includes advice or information that promotes problem solving), and *instrumental support* (which is the provision of tangible assistance).

At the core of the above categorisation, lies the idea that contingent upon the support being appraised as being valuable, is whether the type of support offered is the *required* support, and whether it is offered at a right time. As succinctly put:

> *The same [behaviour], offered by others and intended to be supportive, may be seen as helpful by the recipient if provided at the right time and as unhelpful if provided at the wrong time.* (Jacobson, 1986, p. 255)

In fact, the latter view has been corroborated by Dakof and Taylor (1990) who regard the perception of whether social support is helpful of unhelpful as contingent upon such factors as the relationship between support provider and recipient as well as the source and quality of such support – a view that has found resonance in many other research findings (for example, Bankoff, 1983; Fiore, Coppel, Becker, & Cox, 1986; Morgan, 1989).

Viewed from a different, but related, angle, social support has been categorised as either *positive* or *negative* (Morgan, 1989). Accordingly, positive social support aspects represent those aspects of widow's reactions to relationships that are perceived as flexibly facilitating and promoting adaptation to widowhood, while negative social support aspects refer to those relationships that fail to meet the basic standard of acceptance for the widow's grief-related feelings, but instead involve imposition of problematic obligations onto the widow (Morgan, 1989).

In attempting to ascertain the sources from which widowed individuals have the propensity to seek social support, Morgan, Carder and Neal (1997) maintain that following the death of a spouse widows tend to shift their contacts from married friends to widowed friends, with whom they regard as sharing similar (widowhood) roles and statuses – a phenomenon accordingly referred to as *homophily*, which has been operationally defined as "*a preference for similar others within one's personal networks*" (Lazarsfeld & Merton, cited in Morgan et al., 1997, p. 746). It would thus seem that widows' preference for interactions with people they perceive as 'similar' to them stems from the idea that only people who have experienced, or are undergoing, conjugal loss are believed to be in a position to empathise with, and render necessary social support to, them. The latter idea resonates with findings from previous other studies (Babchuk & Anderson, 1989; Bankoff, cited in Greene & Feld, 1989; Silverman, cited in Bankoff, 1983; Thoits, 1986).

A divergent view, pertaining to the impact of social networks in the wake of spousal death, is the one espoused by Kalu (1990) who highlights the stresses embedded in widowhood, which include extended visits by relatives

after the death of the husband. These relatives, while they may be assisting with the household chores and funeral preparations, may be excessively demanding and interfering – an exacerbating factor in the widow's stress levels. It appears that, due to their burdensome nature, social contacts may adversely affect the widowed spouses' psychological well-being, despite that such transactions may have been well intended. The idea of interpersonal transactions as potentially taxing to the widow's bereaved state has found resonance in numerous other studies (for example, Greene & Feld, 1989; Rook, 1984; Talbott, 1990). Moreover, other studies have also cited the negative effects of social interaction in the face of stress (Fiore, Becker, & Coppel, 1983; Revenson, Schiaffino, Majerovitz, & Gibofsky, 1991).

Of specific note pertaining to the above view, is Revenson et al.'s (1991) contention that given that the behaviours by significant others that are aimed at rendering social support can be subjectively perceived by the recipients of such support as either helpful or non-supportive, the provision of social support in times of stress "*can be likened to a double-edged sword*" (p. 811), wherein close interpersonal relationships can serve as potential source of distress and a source of support for individuals undergoing stressful encounters.

Thus, it seems that not all social support efforts that are directed at ameliorating stress levels necessarily lead to (better) psychological adjustment for the person undergoing a stressful encounter; rather it is the subjective perception of whether such behaviours by others is supportive and helpful that determines adjustment outcome.

As it stands, the benefits of social support in the wake of stress can be compromised if the recipient of such support perceives the behaviours of supporters as directly interfering with manner in which such stress is subjectively experienced and expressed. In such circumstances, the support rendered, albeit well intended, may adversely affect the recipient's psychological well-being and hence detrimental to the adjustment to the stressful encounter. To this effect, Morgan (1989) has highlighted the loss of independence involved in receiving support from significant others is a potential threat to the older widows' self-esteem.

Despite the debates and reservations expressed surrounding the role that support from significant others plays in the process of bereavement, it becomes evident that the idea of social support as having an incremental value in ameliorating stress, does pervade bereavement literature. For example, Siegel and Kuykendall (1990) have emphasised the role of social support during bereavement. In their study, they compared the psychological resilience of widows and widowers who belonged to community organisations, like the church, to those who did not belong to the church. The results revealed that membership of a church had a far more mediating effect on loss-related stress than non-membership, since the depression, arising out of such loss, was moderated by the social ties formed by membership of the church. As revealed by their study, belonging to a church served as a coping mechanism in the event of loss through death, as the church offered an opportunity for a shared experience (Siegel & Kuykendall, 1990), an idea also earlier alluded to by van Zandt et al. (1989). Pertaining to the social benefits of religious affiliation, Stroebe and Stroebe (1993) have also asserted that religion "*...not only offers a*

system of beliefs that may be comforting to the bereaved (for example, belief in the life after death), but also usually offers a religious community and thus a social support network" (p. 218).

The idea of religion as having a 'decrementing' value in stress manifestation stems from the understanding that religion provides an intellectual and spiritual perspective on what has happened, thereby channelling healthful patterns of emotional expression surrounding the stressful event (Jackson, 1977). Notably, Gass (1989a) concurs that during times of grief and bereavement, people have often been found to turn to God and religion, as the latter are seen as providing the bereaved with a source of meaning and a sense of belonging, which in turn positively influences well-being. In a similar vein, Wethington and Kessler (1991) have indicated that when confronted with illness and death, pervasive "*feelings of helplessness and depression may be moderated by the belief that one's fate is in the hands of God*" (p. 20). Thus, while death is experienced as a painful experience for the survivor, the role played by religion in the grief context is that it serves to facilitate positive reappraisal of the otherwise stressful situation (Wethington & Kessler, 1991).

Similarly, an American study (Frantz, Trolley, & Johll, 1996) has revealed that religious affiliation has a mediating effect during the process of bereavement. These authors maintain that religion can be a source of solace for the bereaved; that is,

> *...A means of finding answers to seemingly [inexplicable] natural events, a source of comfort, and a guideline for human behaviour... a sense of strength for the bereaved, [in which they] ascribe meaning to the loss, and*

> *a means to resolve the ambivalence over death as a welcome visitor or a relentless intruder.* (Frantz et al., 1996, pp. 151-152)

Religion thus serves to boost the morale of the bereaved person, as religious participation tends to increase his or her self-esteem, an idea earlier espoused by Sherkat and Reed (1992).

The manner in which religious orientation mediates between coping and stress induced by bereavement has been the subject of investigation by researchers within the stress-coping discipline. As evident from the literature, it would seem that, irrespective of the outcomes, religious participation is likely to increase following the death of a spouse (Bahr & Harvey, cited in Spilka et al., 2003; Loveland, 1968). Lessons derived from the broad domain of the psychology of religion and coping point to the idea that people usually appeal to their faith, which provides them with a spiritual authoritative body through which they find guidance about how to 'negotiate' and manage their stressful encounters. As succinctly put:

> *...People bring a reservoir of religious resources with them when they face stressful times... [and that] the religious reservoir is tapped and revealed for whatever it does (or does not) hold [for the person concerned].* (Pargament, 1997, p.5)

The above view also illustrates the idea that, for religiously inclined people, religion serves as a source of comfort in times of stress, wherein the individual under stress would interpret the stressful event in terms of the spiritual significance it presumably had for his or her life – an idea also analogous with views of numerous other authors (for example, Calhoun & Tedeschi, cited in Frantz, Farrell, & Trolley, 2001; Davis, 2001; Frantz et al., 1996; Lemming &

Dickinson, 1998; Lord, 1987; Morris, 1977; Wethington & Kessler, 1991) specifically on the amelioratory role of religion in wake of bereavement.

In accordance with Pargament's (1997) conceptualisation of coping as per religion, religious orienting system (that is, a global, stable, and personal disposition to religion as marked by faith in God, long-standing religious beliefs, regular church attendance, and the commitment to live by a religious set of ideals) forms the basic tenet of religious coping. As such, people with a religious outlook in life are more inclined to make interpretation of stressful events that is consistent with their belief systems, and coping with such encounters will thus assume a more religiously determined path. Therefore, religious coping would take the form of perceptions of support and guidance by God in times of trouble (spiritual support), looking to the church or synagogue for support in times of crisis (congregational support), and making negative events easier to bear by understanding them from a benevolent religious framework (Pargament, 1997).

The above view is analogous with Rosik's (1989) earlier conceptualisation of religious coping with conjugal bereavement, wherein the widowed individuals are understood as reflecting a propensity to endorse religion for social support as well as emotional validation that comes in the form of psychological security and comfort. Pertaining to religiousness, distinction has been made between ***intrinsic*** and ***extrinsic*** religion: intrinsic religion as religion as an ultimate goal for its own sake, and extrinsic religion as the religion used by the person as a means to some other self-determined end (Allport & Ross, 1967; Donahue, 1985; Rosik, 1989). Using the above categorisation of religion in respect of coping with stresses embedded in conjugal bereavement, Rosik reasons that:

> *...individuals experiencing more difficulty adjusting to widowhood accentuate the extrinsic dimension of their faith in order to cope. Thus, in the midst of great distress, these bereaved turn with renewed intensity to the support and comfort aspects of their faith.* (Rosik, 1989, p. 257)

Recently, Spilka and associates have also corroborated the idea of religious coping with grief-induced stress, and they espouse that when a loved one dies, family and friends are highly likely to turn to religion for solace and understanding of the stressful events (Spilka, Hood, Hunsberger, & Gorsuch, 2003). As succinctly put, "*faith is often a basic part of the coping process, and death is frequently confronted and conceptualised in religious terms*" (Spilka et al., 2003, p. 233).

Central to the above conceptualisation of religious coping, is *making sense* out of the loss, wherein the role played by religion in coping with the loss of the loved one is that it (religion) becomes the main source of meaning available to the survivors, thereby reducing distress symptomatology while engendering a sense of hope (Spilka et al., 2003).

As evident from the review of the literature above, religion can play a significant role in coping with the stress induced by grief, and that religious coping offers not only a source of solace and social support over the loss, but also that it serves to restore psychological stability to those individuals affected by grief so that they view death and loss in religious ways that attenuate distress.

Notwithstanding the cumulative evidence pointing to the beneficial effects of religious coping, some studies have questioned the role of religion in coping with bereavement. For example, Lund (1989), Stroebe and Stroebe (1993), and

Lindstrøm (1999) have cast doubt on the idea that religion has any measurable effects on bereavement, and have expressed reservations about the role of religious faith to this end. Stroebe and Stroebe's (1993) have revealed that although nearly half of their sample were religious enough to believe in life after death, these religious beliefs did not seem to help with their loss experience. Lindstrøm (1999) cautions that while religious faith may be a coping mechanism during bereavement – that is, promising a reunion with the dead in an after-life – such a belief of a reunion, she warns, can be a "double-edged sword" in the sense that while it comforts some, it can also lead others into death wishes and total rejection of all that could be enjoyed in this life (Lindstrøm, 1999).

At the centre of the above argument of religion as having a hindering effect on coping, lies the idea that an appeal to religion represents an approach to the loss that is characterised by an 'escapist' form of denial of death, wherein the bereaved individual makes concerted efforts to psychologically distance or remove him- or herself from the realities of the loss. The view of religion as tantamount to denial has been documented in numerous studies to date (for example, Jackson, 1957, 1977; Pargament, 1997; Spilka et al., 2003). Of religion in the context of bereavement, Jackson (1977, p. 96) makes an elaborative account when asserting that:

> *The kind of religion that tends to reduce resources for coping with death realistically is usually centred about the denial of responsibility, the distortion of reality and the creation of illusory concepts of the person and the universe.*

In fact, associations between religiousness and denial have also been found in the study of patients with terminal cancer (Gibbs & Achterberg, 1978), wherein patients with high levels of support from the church were more likely to be in denial of their illness and the imminence of their death.

From the above-cited observations, it becomes evident that while religion – in its form, purpose, and content – is geared towards assisting the bereaved individual to cope better with the death of a loved one, it may significantly inhibit the very coping process it purports to promote when it is not adequately integrated to meet the individual's immediate needs that stem out of bereavement. Pertaining to how religion is supposed to meet the individual's psychological and spiritual needs in the wake of grief, Jackson (1977) maintains that:

> *Healthy religion helps put death into perspective... it helps to create a discriminatory attitude toward death so that [people] recognise the meaning of the pain that comes with some death...; it helps to undergird life and death with an adequate philosophy, a philosophy that is willing to run the risks of love relationships and accept the penalties of fractured love relationships, but unwilling to allow life to be destroyed in the process.* (Jackson, 1977, p. 102)

Specifically noteworthy from the above-cited anecdote of religious coping is the idea that when inadequately integrated into the individual's spiritual and belief system, and when emotions surrounding loss do not find proper and meaningful expression, religion may prove deleterious to the individual's coping efforts with the loss. Also significant to note is the idea that the grieving individual *ideally* ought not to lose his or her sense of personal identity in the

process of engagement with his or her spiritual beliefs, for religion to be said to have played an integral part in coping with grief.

A different line of thought pertaining to coping with bereavement has recently emerged with Aber (1992), who maintains that having a paid work has a mediating effect in dealing with the death of a spouse. This idea stems from the general understanding that the death of a spouse translates into a substantial economic loss for the surviving spouse as well as from the idea that following spousal death, a surviving woman's life could be disrupted if she does not have economic means of support (Gass, 1987; Lopata, 1996; Parkes, 1975; Zick & Smith, 1988), especially if she lacks skills with which to obtain a well-paying job.

Concerning having a paid work as well as its presumed benefits pertaining to coping with spousal death, Aber (1992) maintains that "*having a paid work role identity, in addition to a spousal identity, may help mitigate the impact of the stressful life event of a husband's death*" (p. 95). To this end, Aber believes that having a paid work is generally attributable to an increase in self-respect regarding the bereaved individual's personal potential following spousal death, which allows her to interpret the hardships and stresses embedded therein as manageable. Concerning this idea, two studies could be traced in the research literature (Lindstrøm, 1999; McCallum, Piper, & Morin, 1993) that supported the idea of a paid work having ameliorating effects on bereavement. For example, Lindstrøm (1999) holds that widows benefit from having a paid job as it provides a daily and weekly rhythm of activities, social resources, and a "*divertimento*" from sad thoughts and emotions.

Implied from the above viewpoints is the idea that the paid work they refer to needs to be rewarding both financially and emotionally for it to have a positive effect on loss-related stress. It would appear that the stresses embedded in widowhood, which tend to be compounded by severe economic deprivation arising out of the loss of a spouse who played the role of the provider, could be mitigated by the paid work identity of the surviving spouse. Especially significant is the idea that coping with the death of a spouse gets facilitated in a situation where the loss of material resources previously provided by the deceased at pre-loss is compensated by a sustainable paid work

Still from a different perspective, Nolen-Hoeksema and associates have pioneered the concept of 'ruminative coping' with bereavement (Nolen-Hoeksema, 2001; Nolen-Hoeksema, Parker, & Larson, 1994). These authors regard rumination as an attempt in which the bereaved tries to cope by passively focusing on his or her negative emotions following loss through death. People engaging in ruminative coping are inclined to persistently and repetitively focus on the negative emotions without taking action to relieve these emotions. The reluctance to relinquish ruminative coping (which is characterised by attention to negative emotions, thoughts and memories of the deceased, sadness, guilt over the loss, grief) is that it represents for the 'ruminators' their last and final tie to the deceased (Nolen-Hoeksema, 2001). The authors warn, however, that this form of coping is maladaptive since it prolongs distress, as the person who ruminates tends to engage in pessimistic thinking that perpetuates the very distress the loss generates (Nolen-Hoeksema, 2001; Nolen-Hoeksema, Parker, & Larson, 1994). These authors also reveal that although 'ruminators' often report to ruminate with the purpose of trying to

grasp an understanding of their emotions and solving their problems, ruminative coping has been found to be negatively correlated with and problem-solving coping efforts.

The manner in which ruminative coping impedes good problem-solving coping stems from the finding that 'ruminators' are often thinking negatively about themselves and their lives, notwithstanding their belief that through rumination they are gaining meaningful insight into their problems and themselves. Strong associations between rumination and social isolation stem from the idea that persistent rumination tends to violate conventional social norms for coping and, due to critical and/or hostile responses from others, ruminators end up receiving minimal social support (Nolen-Hoeksema, 2001).

It would thus seem that the benefits of ruminative coping, which include emotionally processing of the loss as well as gaining insight into the problems emanating from grief, tend to be far outweighed by the costs of rumination in the long term as the grief-invoked distress becomes prolonged to the extent that the 'ruminator' cannot successfully adjust to the context of post-loss.

It has been acknowledged that the majority of the bereaved manage to adjust to their traumatic experience of loss without seeking professional help (Stroebe & Stroebe, 1983; Stroebe & Stroebe, 1993). However, what is of particular interest is that while coping with bereavement is viewed as occurring intra-individually, with the bereaved person making a concerted effort to deal with the distress inherent therein, two studies of note have alluded to therapy-aided coping with the loss (Beem et al., 1999; Schut, Stroebe, van den Bout, & de Keijser, 1997). For example, Schut et al. (1997) compared gender differences in the efficacy of two counselling programmes: the problem-focused counselling

and emotion-focused counselling. According to Lazarus and Folkman's (1984) distinction between problem-focused coping and emotion-focused coping, problem-focused coping involves the efforts to solve the problem as a way of dealing with the stressful situation, while in emotion-focused coping the individual copes through emotionally processing the traumatic experience.

In their study, Schut et al. (1997) found that men fared well with emotion-focused counselling while women responded well with problem-focused counselling. These findings were contrary to the widely held view that men generally utilise more problem-focused coping while women make more use of emotion-focused coping. Schut et al. maintain that this finding can be explained by considering that when the usual coping style (problem solving for men, and emotion-focused for women) has not worked effectively, switching from one coping strategy to the other can be expected.

The manner in which therapeutic intervention facilitates coping with loss has not escaped the lens of the research microscope. Stroebe and Schut (2001) have recently cited the benefits of 'disclosure intervention,' which is closely related to social sharing, as a means of alleviating bereavement-induced stress. Thus, these authors have affirmed that:

> *Social sharing does not further emotional recovery but that disclosure intervention is indeed effective in improving the health status of bereaved people who have suffered a traumatic bereavement or who are unable to talk naturally about their loss or come to terms with it.* (Stroebe & Schut, 2001, p. 382)

With regard to social sharing as a coping tool, Pennebaker and O'Heeron (cited in Pennebaker, Zech, & Rimé, 2001) have emphasised the benefits of social

sharing by asserting that bereaved individuals who are able to talk about their spouses' death become relatively healthier in the year following the loss.

Also pertaining to therapeutic intervention, Margaret Stroebe (cited in Wortman & Silver, 2001) has suggested the "working through grief" as a form of coping with loss. Working through grief entails a cognitive process of confronting the loss, of going over the events before and at the time, of focusing on memories (both good and bad), and working towards detachment from the deceased. The latter idea of the goal of grief being the detachment from the deceased person stems from Sigmund Freud's (1925) psychoanalytic perspective in which the psychological function of grief is conceptualised as aimed at freeing the individual of his or her bond to the deceased, thus "*achieving a gradual detachment ["decathexis"] by means of reviewing the past and dwelling on the memories of the deceased*" (Stroebe & Schut, 2001b, p. 384).

Some authors (notably, Stroebe el al., 2001; Wortman & Silver, 2001) have noted that there is generally a new trend followed by researchers and clinicians working on grief and bereavement, which is to think about the recovery process in new ways; that bereaved individuals may not return to their pre-loss state, and hence the coping task may not be to return to previous levels of functioning but to negotiate a meaningful life without the deceased's existence.

It would thus seem that any form of therapeutic intervention that is aimed at assisting the bereaved to cope with the loss, should take cognisance of the fact that grief, as an expression of thoughts and emotions surrounding the loss, represents attempts by the bereaved to adapt to the post-loss situation –

an idea that is analogous to Freud's (1925) earlier theory of "decathexis" or libidinal detachment from the lost love object, and which has also found resonance in Klass's (2001b) recent conceptualisation of grief.

Gender differences in coping with bereavement have also been investigated in quite a number of studies. Berardo (1970) has long espoused the view that the male survivors of spousal bereavement encounter rather severe difficulties in their efforts to adapt to the widowhood status than their female counterparts, and this in turn differentially affects their experience, expression and coping with conjugal loss. Gallagher, Lovett, Hanley-Dunn and Thompson (1989) as well as Thoits (1991) have found that men tend to suppress their emotional responses in favour of action-oriented behaviours, while women tend to use more cognitively oriented and expressive coping strategies. In support of this finding, Frantz et al. (1996) also allude to these gender differences when they maintain that men generally have difficulty asking for support with the result that people may not realise that support is needed, or that the perception may arise that men do not want help. Some men therefore seem to be very much alone in coping with the loss of bereavement – an idea that has also found resonance in numerous other studies to date (for example, Doka & Martin, 1998; Lund, Caserta, & Dimond, 1986; Nieboer, Lindenberg, & Ormel, 1998; Stroebe & Stroebe, 1983).

Several other studies have been conducted to determine gender differences in terms of the course of, and adjustment to, conjugal bereavement, although with conflicting findings. For example, while Carey (1980) as well as Gilbar and Dagan (1995) have found widows to be evincing distress symptoms significantly more than their male counterparts do, Bierhals and associates

found the similar pattern to prevail throughout the first three years after bereavement (Bierhals et al., 1996; Chen, Bierhals, et al., 1999). However, this pattern tended to be reversed during the period between the third and the fifth year following loss, wherein widowers' grief symptoms were found to be increasing, while decreasing for widows (Bierhals et al., 1996). Similarly, Zonnebelt-Smeenge and DeVries (2003) have recently found women to be better adjusted than men in respect of accepting the reality of the spouse's death as well as in investing in life as individuals without their deceased spouses.

From these findings, it would appear that gender differences do exist in the adjustment to conjugal bereavement. However, due to the inconsistent findings yielded by different studies, it would prove impossible to formulate a descriptive framework on the manifestation of grief and coping for either gender. This is especially significant when considering that other findings have revealed that no significant differences exist between men and women in terms of bereavement outcomes (Lund et al., 1986), and especially in the first year after the spouse's death (Bierhals et al., 1996).

Within-gender variations concerning the expression of bereavement have also been studied. However, in this regard only one study of note (Lindstrøm, 1999) could be traced in the research literature. In her study, Lindstrøm investigated the differences in coping with bereavement in relation to different feminine gender roles. To this effect, comparisons were made between *traditional* gender role widows – that is, those who had no paid work at the time of the study, and had not had paid work during most of their married years; and *modern* gender role widows – that is, those who had paid work at the time of the study, had had paid work during a considerable portion of their married

years, or were retired from such work. As also revealed in other studies (for example, Aber, 1992; McCallum, Piper, & Morin, 1993), those who were directly involved in generating an income were found to be better copers when compared to those who subscribed to the traditional feminine gender roles of not working outside the home. In fact, the traditional gender role widows are believed to bear an extra risk of developing a strong sense of helplessness, and of generally giving up control over their lives (Lindstrøm, 1999).

The nature of the spouse's death has also been found to be a strong determinant of the nature of the expression of grief and bereavement (Gass, 1988, 1989b). For example, in Gass's (1989b) study comparisons were made between a group of widowers whose spouses had died suddenly, and those whose spouses had died from a chronic illness. The results revealed that widowers whose spouses had died suddenly tended to use more problem-focused coping and more wishful thinking, self-blame, and overall emotion-focused coping strategies than those whose spouses had died from a chronic illness. Two explanations have been provided for this different bereavement pattern: Firstly, the forewarning of spousal death, which allows for potential anticipatory grieving, has been found to have a salutary effect on the adjustment of the widowed, while the sudden death of a loved one may contribute to more physical and mental distress in the bereaved and perhaps more grief reactions. A second, and related, factor is that anticipatory grief possesses adaptational value for the bereaved in the sense that the individual gets the opportunity to start working through grief reactions, to prepare for necessary adjustments, and to conciliate for the wrongs that may have been done to the ill spouse through providing the spouse with special care and

attention she might need (Gass, 1988, 1989b; O'Bryant, 1991). Recently, Donnelly, Field and Horowitz (2001) also found greater expectancy of spousal death as being associated with lower depressive and grief symptoms for conjugally bereaved adults at 6, 13, and 25 months post-bereavement – a finding that corroborates the idea of anticipatory grief as facilitating better psychological adjustment after the loss.

The latter findings are consistent with studies conducted previously. For example, in an earlier study Ball (1977) investigated the impact of age and mode of spouse's death on the manifestation of widow's grief. From this study, younger widows (aged between 18 and 46 years) whose spouses had died suddenly had a significantly higher grief response scores than those whose spouse's death was anticipated. Interestingly, though, the latter study also found while this pattern was reversed for the older widows (aged between 60 years and 73 years) – showing less vulnerability in response to sudden death – the grief reactions for the middle-aged group (between 47 years and 59 years) were less severe regardless of the mode of death. In this regard, age appeared to be a strong determinant for the manifestation of grief than the mode of spouse's death (Ball, 1977).

The greater vulnerability of the "sudden death" individuals at post-loss has also received the attention of Sanders (1983), who found that sudden death invokes an internalised emotional response described as "*anger in*", which is an intropunitive response causing the bereaved individuals to sustain prolonged physical distress, as opposed to those whose loved ones died after a prolonged illness. For the latter group, grief reaction is said to take the form of "*anger-out*" response, which, while creating a picture of dejection, frustration, and

loneliness, does not cause harm to sustain the prolonged physical stress (Sanders, 1983). Lundin (1984) as well as Norris and Murrell (1987) also make a compelling point that persons exposed to sudden and unexpected death of a close relative are susceptible to increased psychiatric morbidity and hence should be regarded as the high-risk group – all this being due to the idea that they could not have prepared themselves psychologically for the loss. Similarly, Blauner (cited in Lopata, 1996) has regarded the sudden death as a more traumatic experience because, by its very suddenness, it has the potential to leave a lot of 'unfinished business' to contend with.

From the above findings, it stands to reason that the suddenness of death leaves the surviving spouse with fewer resources to cope which in turn increases his or her appraisal of threat (an attributing factor in heightened distress levels); the concerted efforts to practical problem solving, therefore, would be made more than when death was anticipated. In the case of anticipated grief, as Gass and Chang (1989) have also confirmed, widowed persons whose spouses died after a chronic illness may have had time to develop coping resources before and after the loss.

While the above-cited findings point to sudden death as adversely affecting the bereavement outcome for the bereaved spouses more than anticipated death, it is of interest to note that other studies have cited the greater vulnerability in the individuals bereaved after the spouse's chronic illness. For example, Clayton and associates have found that those individuals with 'anticipatory grief' evinced more grief symptoms in the first month after spousal loss than those without an anticipatory grief reaction (Clayton, Halikas, Maurice, & Robins, 1973).

Similarly, Gerber, Rusalem, Hannon, Battin, and Arkin (1975) found that the bereaved of a lengthy chronic fatal illness were poorer adjusters than those bereaved of a shorter illness death. Two explanations for such a trend are offered by these authors: Firstly, the neglect of their own health in order to care for the terminally ill spouse may take its toll on the surviving spouses' well-being such that they may develop morbid symptoms closely associated with the loss; secondly, the emotional pressure of watching a spouse slowly 'consumed' by a slow and fatal illness may detrimentally affect psychological adjustment to loss, which could in all likelihood exacerbate an otherwise existing morbidity after the spousal death (Gerber et al., 1975; Norris & Murrell, 1987).

Also noteworthy, studies investigating the relationship between caregiving to the terminally ill and subsequent bereavement cite the implications for post-bereavement adjustment (Bass & Brown, 1990; Kramer, 1997). Specifically in the context of serious (and potentially fatal) illness, Hays, Kasl and Jacobs (1994) have suggested that some dimension of threat or uncertainty surrounding the potential loss is as adverse an experience as the actual loss itself, which triggers and elevates depressive symptoms and pervasive feelings of hopelessness and helplessness.

Yet another interesting finding pertaining to the role of anticipatory bereavement in adjustment to widowhood has emerged with Hill, Thompson and Gallagher's (1988) study of older widows, in which the expectancy of death has emerged as not related to the subsequent adjustment to bereavement in older women. Partially consistent with these findings has been Ball's (1977) earlier study in which the mode of spouse's death appeared not to be a

determining factor for the middle-aged group's (between 47 years and 59 years) grief reactions at post-loss.

At the centre of the divide that separates sudden death and expected death, lies the concept of 'anticipatory grief', which seems to have generated much interest and controversy among bereavement researchers to date. Originally coined by Eric Lindemann in the 1940s, the term was initially used to refer to the separation of two people, with one anticipating the death of the other and preparing for it to such an extent that upon the return of the other person, there is rejection rather than happy acceptance of that person (Lindemann, 1944). Although Lindemann's concept of anticipatory grief was concerned with the 'potential death', it has since been used by some authors to refer to the 'inevitable death', wherein grief takes places in the context of an imminent death – as in the case of someone grieving for the person who is about, or most likely, to die (Clayton et al., 1973).

Concerted calls by some authors for a reconsideration of the concept of anticipatory grief from viewing it as a potential coping mechanism for a prospective loss (for example, Fulton & Gottesman, 1980; Fulton, Madden, & Minichiello, 1996; Rando, 1988; Siegel & Weinstein, 1984; Sweeting & Gilhooly, 1990) reveal the phenomenon of anticipatory grief as conceptually fuzzy, since guidelines are not clearly specified regarding its operational description. Moreover, as Binik (cited in Fulton & Gottesman, 1980) has argued, distinctions between sudden- and non-sudden death tend to be arbitrary and may be meaningless. To clear the apparent mystery surrounding the very nature, process, and content of anticipatory grief (and its relevance in coping with grief), it has been argued that due consideration needs to be given to the

socio-psychological aspects or the socio-cultural contexts in which such grief is understood to be operating (Fulton & Gottesman, 1980). These authors contend that:

> *...It is not simply the presence of anticipatory grief that determines its benign or harmful nature; rather it is the manner in which it is experienced and responded to by those concerned [that is relevant]. To recognise this fact emphasises the difficulty of using the concept as a predictor of adjustment to loss.* (Fulton & Gottesman, 1980, p. 52)

From the different findings cited above pertaining to the role of anticipatory grief vis-à-vis sudden death in coping with conjugal bereavement, it becomes evident that the conflicting views point to the need for more research on the issue, especially if coping with spousal death is to occupy a central stage in bereavement-intervention programmes.

A completely different finding in terms of coping with bereavement has emerged with Field, Nichols, Holen and Horowitz's (1999) notion of "continuing attachment". According to Field and associates, the bereaved tries to cope with the death of a loved one by making use of the deceased's possessions, which he or she believes would provide comfort and maintain a sense of connection with the deceased. As these authors put it, "*the possessions therefore take on a symbolism in providing the bereaved with a sense of continued contact with the deceased*" (Field et al., 1999, p. 212). The authors further maintain that although continuing attachment provides "*continuity in the context of the loss*" (p. 213), it is doubtful if it provides any long-term adaptation to such loss as the excessive reliance on the possessions of the deceased at six months post-loss tends to have maladaptive consequences. Related to the above, is the idea

recently espoused by Field, Gal-Oz, and Bonanno (2003), who view greater continuing attachment as maladaptive in the long term. Instead, these authors maintain that continuing bond involvement may be indicative of an outcome of greater difficulty in coping with the death.

As an alternative, a monologue role-play has been suggested, which is a therapy-aided form of grieving that involves gaining comfort through fond memories, images or dreams of the deceased be used, as it is a powerful intervention in highlighting the reality of death (Field at al., 1999). Related to the above, is the idea also espoused by Lindstrøm (1999) who cautions that retaining all the deceased husband's belongings may be viewed as expressions of a denial of the husband's death, and should be classified as an avoidance-focused coping strategy. In similar vein, Wortman and Silver (2001) have also noted that continued attachment has generally been viewed as pathological form of grief, while the necessity of breaking down the attachment to the deceased is often considered a key component of the entire grief and mourning processes.

It is interesting to note that the classification of continuing attachment as a pathologic form of grief, is in stark contrast to Goin, Burgoyne and Goin's (1979) earlier assertion that rather than being seen as pathology, continuing attachment should be viewed as "*an inevitable means of ego adaptation [to the loss]*" (p. 989). These authors' argument stems from the idea that the comfort derived in attachment to the immortal psychic representation of the deceased, illustrates involvement of increased emotional significance for the bereaved, which points to the intensity of the relationship with the deceased person.

The occurrence of the pattern of continuing attachment to the deceased persons has received attention from other bereavement researchers to date, particularly the personal and situational conditions that render such attachment a characteristic feature of grief (for example, Carr, 1975; Glick, Weiss, & Parkes, 1974; Klass, 2001a; Klass & Walter, 2001; Moss & Moss, 1985; Richards, 2001). Also noteworthy is that the view earlier propagated by Goin et al. (1979) that continuing attachment is adaptive form of coping with loss, has found corroboration. For example, Moss and Moss (1985) have emphasised the positive and supportive nature of the widow's (or widower's) tie with the deceased, wherein the tie is deemed as having never broken but continues as welcome memories and associations of daily life, notwithstanding the deep loss and the recurrent accompanying grief-related feelings.

Similarly, Klass, Silverman, and Nickman (cited in Wortman & Silver, 2001) have observed that it is common for the bereaved individuals to remain connected to the deceased, and that these connections provide solace, comfort, and support, and ease the transition from the past life (with the loved one) to the future (without the deceased). The benefits of continued attachment have also featured in Richards's (2001) study investigating the nature of grief following death from AIDS, wherein the bereaved found a great deal of comfort in the belief that the relationship with the deceased partner continued in some way.

As revealed in the studies of continuing attachment as a coping mechanism in wake of spousal death, such attachment may be of adaptive value in the post-loss context, especially as it enables the bereaved to accept the reality of loss while finding solace in the existence of the relationship with

the mental representations of the deceased. As also revealed, over-emphasis of such relationship, as marked by retaining of material possessions of the deceased could be indicative of both denial of death and maladaptive grieving that significantly interferes with the resolution of, and adjustment to, loss.

Furthermore, a specific form of 'attachment' to the deceased spouse, which comes in the form of grief hallucinations about the deceased, has also received attention from researchers to date. There is a generally held view at some points following loss, grief will take the form in which individuals often identify with or incorporate aspects of the lost person into the process of mourning, to the extent that they may even undergo hallucinatory experiences as a means of clinging to the lost person (Baethge, 2002; Hoyt, 1981; Rees, 1971). Thus referred to as the *hypnagogic hallucinations* (Parkes, 1998b; Sanders, 1989), these hallucinatory experiences are conceptualised as symbolically representing the surviving spouse's continuing bonds and persistent tie to the deceased spouse, and are often regarded as common experiences during the widowhood period – an idea that has found resonance in numerous other studies to date (for example, Bennett & Bennett, 2000; Grimby, 1998; Hoyt, 1981; Rees, 1971, 1975; Simon-Buller, Christopherson, & Jones, 1989).

It is noteworthy that there are markedly contradicted views pertaining to the role of the hallucinatory experiences in psychological adjustment to spousal loss, with some studies pointing to the maladaptive function of such experiences (Simon-Buller et al., 1989) while some emphasise the adaptive value of grief hallucinations in the process of mourning (Baethge, 2002; Goin et al., 1979; Klass, 2001a, 2001b; Moss & Moss, 1985; Rees, 1971, 1975).

Lessons from the early psychoanalytic thinking (notably, Freud, 1925) suggest that grief reactions represent the grieving individual's attempts to detach from the lost love object, while Bowlby's attachment theory (Bowlby, 1973, 1980) pre-supposes that grief is essentially a 'separation anxiety' – that is, an unwanted separation from an attachment figure. Taking these two schools of thought together, it could thus be inferred that the hallucinatory experiences following the death of spouse represent reluctance of letting go of the deceased, on the one hand, and an intense want for the restoration of the relationship with, and continued attachment to the deceased spouse, on the other. It remains unclear whether adaptive coping borders on the reluctance to give up on the lost relationship or on the yearning for the restoration of the lost relationship. It is reasonable to suggest that the exploration of the aspects of the lost relationship, the subjective appraisals of that relationship as well as the contextual understandin of what such grief hallucinations mean to the grieving individuals should be a means of arriving at a determination of their adaptive value within the psychological adjustment to the loss.

From the review of the different studies discussed above, it is apparent that although authors do not reach consensus as to how people cope with the loss of their loved ones, there seems to be a variety of coping mechanisms people utilise in the event of loss – depending on the personal and situational variables as well as the coping resources the bereaved have at their disposal. Of significance is that some studies seem to highlight the importance of social support in coping with spousal death, while others see religious coping as central to adjustment to conjugal loss.

Also evident were the therapy-aided coping with bereavement, sex differences, within-gender variations, and of the spouse's death as determining the expression of bereavement, while some authors have pointed out to the post-loss "relationships" the bereaved form with their deceased as central to the process of coping with the death of a spouse. It is interesting to note that within each form of coping with spousal loss, there exist divergent and contradictory camps of conventional wisdom, which highlight that coping with grief ought not to be viewed as a monolithic process but as a complex interplay of emotions and behaviours or efforts aimed at mitigating the strain borne out by grief. The choice of a given coping style, therefore, would be contingent upon the personal and situational variables as well as on the resources available at the given time.

With only a single study done in South Africa to investigate the nature of the relationship between stress and coping with bereavement (Spangenberg & Somhlaba), research into the experience of stress and various ways of coping with conjugal loss among rural black South African men and women is warranted. Such a study is even more important because the psychological needs of the black South African population have received little research attention up to now. From the study of Spangenberg and Pieterse (1995), there seems to be an increasing interest in research on black South African people as well as what inherent stress levels they are confronted with on a daily basis. It is hoped that the present study will stimulate continuing attention to a broader area of how black people in South Africa cope with their stressful life events.

The results of the study would help in understanding what black South African widows and widowers perceive as stressful during their new widowhood period, and which coping mechanisms they tend to use in the wake of such a

stressful time of their lives. Furthermore, an in-depth understanding of how these widowed men and women cope with bereavement-related stressors would help to develop appropriate psychosocial interventions. Such understanding could also serve as a means of identifying and supporting individuals whose coping strategies lead to increased psychological, social and physical vulnerability. It is such an understanding that would assist community psychologists in the development of effective therapeutic interventions, where indicated.

CHAPTER 3: RESEARCH METHODOLOGY: AIMS, OBJECTIVES, RESEARCH QUESTIONS, RESEARCH HYPOTHESES, PARTICIPANTS, MEASURING INSTRUMENTS, PROCEDURE, AND DATA ANALYSES

3.1. Aims and objectives, and research questions/hypotheses

3.1.1. Aims and objectives

Firstly, the study aimed to determine how conjugal bereavement as a specific type of stressor was experienced by the group of spouses recently[1] bereaved of their spouses. This was done by examining their depression and anxiety levels.

Secondly, the study aimed to determine which coping strategies these women and men tended to use in the wake of their spouse's death.

Thirdly, the study explored whether there were any correlations between specific coping strategies and the widows and widowers' stress levels, as manifested in anxiety and depression.

Fourthly, the study sought to explore the interrelationships between participants' perceived social support, their subjective experience of pre-loss marital relationship, and each of the main variables (depression, anxiety and coping strategies).

Fifthly, the study aimed to ascertain the extent to which certain demographic variables or participant characteristics shaped the experience, expression, and manifestation of stress and coping following spousal death, as

---

[1] Recognising that *'recently'* is more a relative than an absolute concept, and that the duration and expression of 'normal' bereavement depends entirely on the norms and values of the particular cultural group that defines it (APA, 1994), individuals to be considered as 'recently widowed' will be those who are in their first year of conjugal bereavement. This is quite analogous to the view some authors share (for example, Kalu, 1990; Lindstrøm, 1995; Sossou, 2002), which is that the first year after the death of spouse is a critical phase of bereavement.

well as the manner in which these variables influenced the subjective appraisals of social support received and pre-loss marital relationships.

Sixth and finally, the study sought to explore the widowed spouses' subjective accounts of widowhood, how they made sense of the loss and what they did to manage in such stressful situations.

3.1.2. Research questions

3.1.2.1. What were the average levels of anxiety and depression amongst recently bereaved blacks, and were there any significant differences between the average stress levels of widows and widowers?

3.1.2.2. Which coping strategies were mostly used by this sample of South African widowed spouses, and did significant differences exist in the use of coping strategies between this sample of widows and widowers?

3.1.2.3. Did significant correlations exist between specific coping strategies and the widows and widowers' stress levels, the participants' perceived social support, their subjective experience of pre-loss marital relationship, as well as certain demographic characteristics?

3.1.2.4. Did statistically significant correlations exist between the nature of pre-loss marital relationship and the anxiety levels and depression levels, respectively, in this sample of bereaved South Africans?

3.1.2.5. How did the selected black South Africans subjectively experience conjugal loss, and what effects did factors such as the cause of death (for example, HIV/AIDS), religious orientation (for example, Christian or traditional), violent or destructive pre-loss marital relationship, or contact or communication with the dead spouse have on the bereavement process?

3.1.2.6. How did specific demographic variables or participants' personal characteristics shape the stress-coping relationship as well as the overall subjective appraisals of social support received and pre-loss marital relationship? These variables include age, sex, religion, level of education, job status of widowed spouse and that of the deceased, total monthly family income, number of people in the household, duration of bereavement, status of pre-loss marriage, spouse's cause of death, involvement in intimate relationships since the death of spouse, and subjective perceptions of overall physical health.

3.1.3. Research hypotheses

The study was based on the following research hypotheses, but also considering the Type I and Type II errors as possible limitations to the determination of hypothesis testing.

3.1.3.1. The average anxiety and depression levels of this sample of bereaved South Africans will be high.

3.1.3.2. This sample of bereaved South Africans will make predominant use of an avoidant coping strategy.

3.1.3.3. The correlations between specific coping strategies and the widows and widowers' stress levels will be significant.

3.1.3.4. The differences in the use of coping strategies between this sample of widows and widowers will be significant.

3.1.3.5. The correlations between the nature of pre-loss marital relationship and the anxiety levels and depression levels, respectively, in this sample of bereaved South Africans will be significant.

3.1.3.6. The differences between the nature of pre-loss marital relationship and stress levels of widows and widowers will be significant.

3.1.3.7. The correlations between participants' perceived social support and stress levels will be significant.

3.2. Procedure

The study was done using a combination of the quantitative and qualitative research methodologies. The quantitative research methodology, which is based on a positivist epistemology that assumes that there are social facts with an objective reality apart from the beliefs of individuals (Firestone, 1987), may arguably not have been best suitable when used alone in investigating the arguably 'relative' phenomena like grief and bereavement. This is because the expression of these phenomena depends entirely on how a particular individual responds to the experience of loss, and on how each cultural group defines them. Similarly, a qualitative research methodology also may not have been

best suited when used alone in focusing on these phenomena, the expression of which is assumed existential, internal conflicts that supersede the individual's conscious awareness and control.

Therefore, combining these two different research methodologies, a strategy that has been coined the 'between-methods triangulation', was deemed beneficial in that the potential "*flaws of one method are often strengths of another, [and] combining methods can help achieve the best of each while overcoming their unique deficiencies*" (Denzin, cited in Mathison, 1988, p. 14). On the one hand, to meaningfully assess the magnitude of relationships between different variables, the quantified, multivariate analyses, and the use of established procedures, were indicated in order to reduce error and bias. Qualitative methodologies, on the other hand, were believed to be helpful in exploring those aspects that may not be "captured" with the use of quantitative method, which included participants' subjective experience of the loss, how they made sense of such loss, and how they managed in the wake of spousal death.

3.3. Participants

The sample consisted of 198 participants who were black, first language speakers of the Xhosa language from the Eastern Pondoland region[2] in the Eastern Cape province, Republic of South Africa. The data were gathered over a three-month period, spanning from June 2003 through to mid-August 2003.

---

[2] The districts in this region comprise the areas of Bizana, Flagstaff, Lusikisiki and Tabankulu. Although the Mpondo language, which is a Xhosa dialect, is predominantly spoken in this region, participants in the present study were regarded as Xhosa-speaking. This was primarily because only Xhosa language, amongst many other Xhosa dialects, is currently recognised as one of the eleven official languages in South Africa.

Only those men and women whose spouses had died within the past 12 months were included in the study; considering that they were in the mourning phase for a period of less than one year after the burial of their spouses – a requirement that formed part of the cultural norms and values of their society.

The original sample comprised 213 widowed men and women from the municipal districts of Bizana, Flagstaff, Lusikisiki, and Tabankulu. However, because the participants' right to refuse participation in the study was emphasised, 12 participants declined participation – thus yielding a refusal rate of 5.63%. Various reasons were provided for such declination: a) "*it would be too painful to talk about it*" (n = 2); b) "*not interested*" (n = 4); c) "*I just would not like to participate*" (n = 3); d) "*it all seems a pointless and fruitless exercise*" (n = 2); e) "*I really don't understand its very nature, and would rather decline participation*" (n = 1). In three of the participants' questionnaires there was a lot of missing information, and the decision was made therefore to exclude these for statistical analyses. The sample size was thus reduced to a total of 198 participants.

Twenty-eight males (14.14%) and 170 females (85.86%) participated in the study. The participants' age ranged from 21 to 99 years (M = 48.19 years, SD = 14.59). A mere 5% of participants described themselves as practising the worship of ancestry as their religious orientation, while 93.43% of them described themselves mainly as 'Christian'.

The number of people in the participants' households were 1 (for 2.02%), 2 (for 2.02%), 3 (7.58%), 4 (11.11%), 5 (11.62%), 6 (15.15%), 7 (12.63%), 8 (12.12%), 9 (9.09%), 10 (4.04%), 11 (3.03%), 12 (2.02%), 13 (1.56%), 14 (2.53%), 15 (1.52%), 17 (1.52%), and 21 (.51% of participants). The total number of participants' own children were 1 (8.56%), 2 (10.10%), 3 (17.68%), 4 (15.66%), 5

(19.19%), 6 (11.62%), 7 (7.58%), 8 (5.05%), 9 (3.54%), while one participant (1.01%) had no children.

The number of those children whom participants described as still 'dependent' were 1 (10.61%), 2 (15.15%), 3 (19.19%), 4 (12.63%), 5 (14.65%), 6 (9.09%), 7 (5.56%), 8 (3.54%), 9 (3.03%), 10 (1.01%), 11 (1.01%), 16 (.51%), while 7 participants (3.54%) had no dependent children. As illustrated in Figure 3.1, the participants' monthly family income ranged from 'below R1000' to that 'between R10 001 and R20 000'.

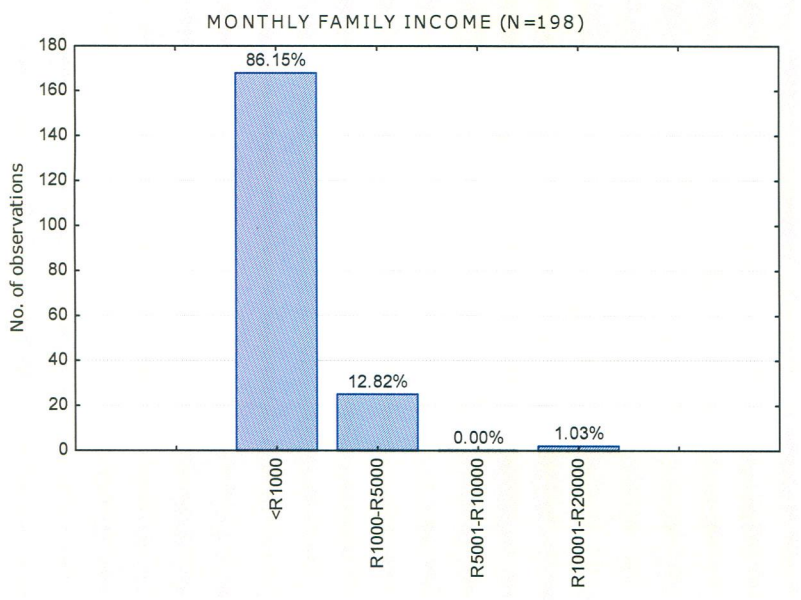


Figure 3.1. Histogram outlining the breakdown of the monthly family income.

The participants' job status ranged from unemployed (133 = 67.17%), self-employed (10 = 5.05%), catering job (1 = .51%), domestic worker (1 = .51%), teacher or educator (4 = 2.02%), mineworker (1 = .51%), construction worker (1 = .51%), builder of livestock kraals (1 = .51%), cobbler or "shoemaker" (1 = .51%), hotel waitress (2 = 1.01%), nurse (2 = 1.01%), wholesalers cashier (1 =

.51%), security guard (1 = .51%), taxi driver (2 = 1.01%), truck driver (1 = .51%), bus driver (1 = .51%), tea plantation worker (1 = .51%), to unspecified job (5 = 17.17%).

Of the men and women who took part in the study, 6 participants (3.21%) had a diploma from a teacher's college of education or related post-matric diploma, 17 (9.09%) had a high school education, 123 (65.78%) had Standard 6 (Grade 8) or below, while 41 (21.93%) had never received formal education (schooling). The information for the remaining 11 participants (5.56%) was missing on the questionnaires regarding their educational level. The breakdown of the participants' educational levels is presented by means of Figure 3.2 below.

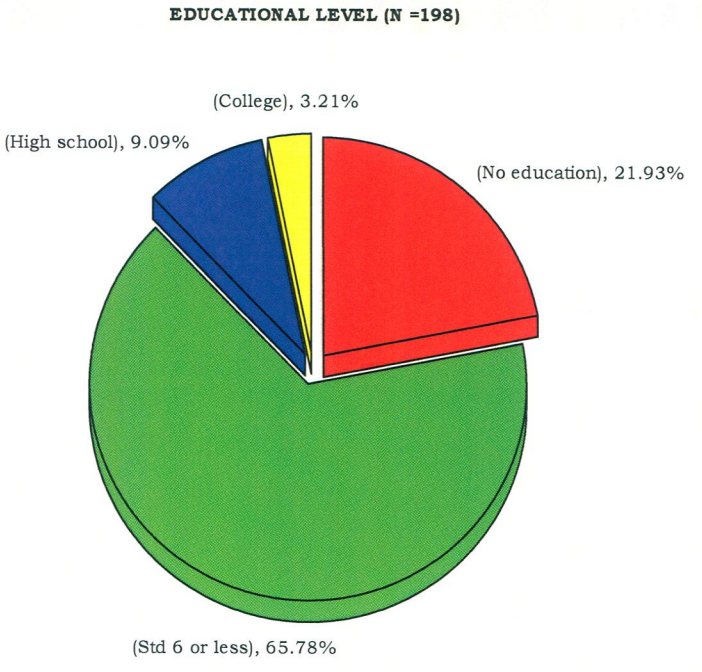


Figure 3.2. Pie chart outlining the breakdown of the categories of educational level.

The duration of participants' bereavement at the time of data gathering ranged from 1 month to 12 months (M = 6.06 months, SD = 3.33). The number of participants' marriage years at the time of spousal death ranged from 7 months to 62 years (M = 24.63 years, SD = 12.98).

The cause of death for the deceased spouse ranged from the 'natural causes' (86.36%), 'unnatural causes' (13.13%) to 'unspecified' other causes (.51%). Table 3.1 illustrates the breakdown of the specific causes of spousal death.

Of the participants who took part in the study, 37 of them (18.69%) said when the spouse's death occurred they had expected its finality, in contrast to 157 participants (79.29%) who said they had not expected it. At death, the age of the deceased spouse ranged from 23 to 98 years (M = 53.04 years, SD = 14.94). For 107 participants (54.04%), their spouses died at home, as opposed to 65 participants (32.83%) whose spouses died in hospital and 6 participants (3.03%) whose spouses died at the work place; and 20 participants (10.10%) whose spouses died in an unspecified environment.

The job status of deceased spouses at the time of death ranged from unemployed (68.18%), sugar plantation worker (.51%), mineworker (8.59%), prison warden (.51%), factory worker (2.53%), Public Works employee (1.01%), municipal worker (1.01%), truck driver (.51%), worker at Home Affairs department (.51%), construction worker (.51%), security guard (.51%), and unspecified job (15.15%).

Table 3.1.

Breakdown of the causes of spousal death (N = 198)

Cause of death		**n**	**%**
Illness factors (natural causes)			
Bodily complaints or ailments		87	43.93
Asthma		33	16.67
Tuberculosis		22	11.11
Stroke		9	4.55
Cancer		7	3.54
Aids-related illness		4	2.02
Heart-related illness or problems		3	1.52
Bone disease		2	1.01
High blood pressure		2	1.01
Pneumonia		2	1.01
	Subtotal =	*171*	*86.36*
Unnatural causes			
Murder		7	3.54
Motor vehicle accident		7	3.54
Struck by thunder lightening		2	1.01
Sustained severe burns		2	1.01
Suicide		2	1.01
Surgical operation complications		2	1.01
Injuries from collapsed mineshaft		1	.51
Labour (birth) complications		1	.51
Drowned at sea		1	.51
Unspecified accident		1	.51
	Subtotal =	*26*	*13.13*
Unspecified cause		1	.51
	TOTAL =	**198**	**100**

Ninety-six participants (48.48%) were present when the spouse died, in contrast to 101 participants (51.01%) who did not witness their spouses' death. Pertaining to the status of the marriage at the time of the spousal death, 139 participants (70.20%) were still living in the same house with the deceased and

sharing everything; while 48 participants (24.24%) were still married to the deceased spouse, although work and other commitments kept them apart; 6 participants (3.03%) were still legally married to the deceased and living in the same house, although they were sleeping in separate rooms from their spouses; 4 participants (2.02%) were not living with the deceased spouse, although they were still legally married; and 1 participant (.51%) was in the process of filing for divorce. Figure 3.3 below illustrates the breakdown of the status of marriage for participants.

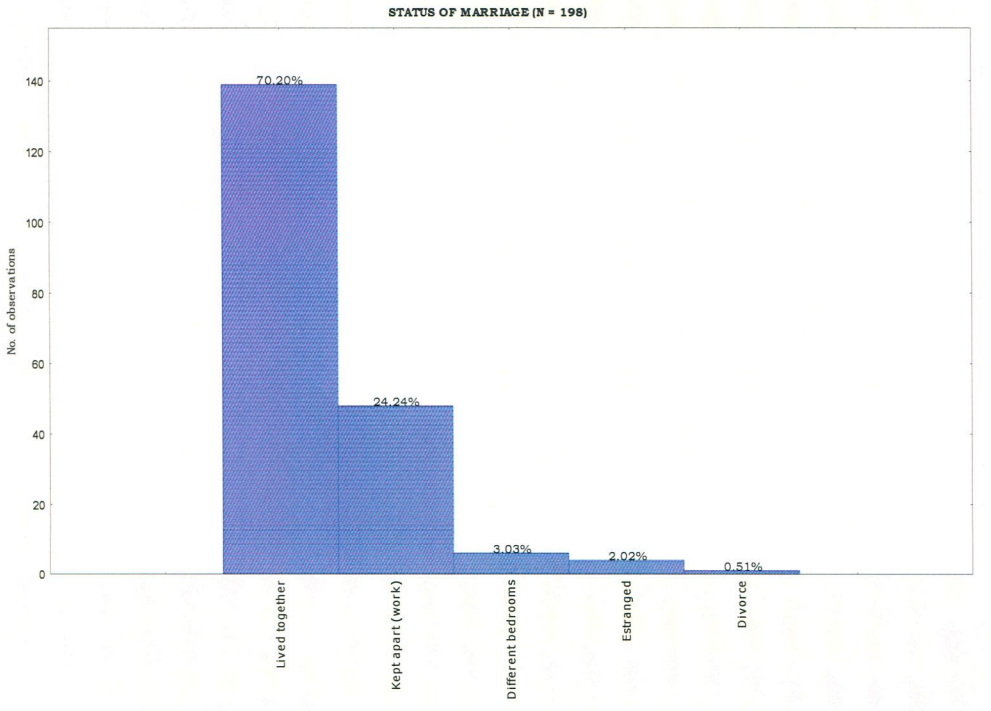


Figure 3.3. Histogram outlining the breakdown of the categories of the status of marriage at the time of spousal death.

A total of 67 participants (33.84%) had had at least one other relative, in addition to the deceased spouse, who had also died within the past 12 months, while 131 participants (66.16%) had not lost another relative.

Pertaining to the medical condition, 109 participants (55.05%) reported to be presently having a specific medical condition or illness, while 89 of them (44.95%) did not have a medical condition. Of those who admitted to having medical condition, 43 participants (39.45%) reported that the onset of their medical condition could be traced from the period immediately following the death of the spouse, while 66 of them (60.55%) reported their illness predated the spousal death.

Twenty-four participants (12.18%) subjectively rated their overall physical health as '*good*', while 95 participants (48.22%) rated their physical health as '*average*', and 78 participants (39.59%) rated theirs as '*poor*'. The latter breakdown is diagrammatically illustrated by means of a pie chart in Figure 3.4 below.

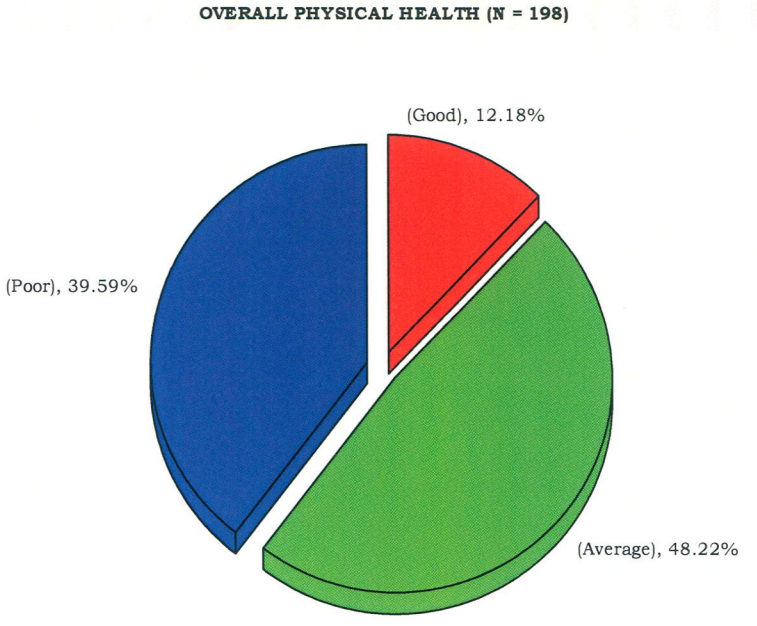


Figure 3.4. Pie chart illustrating the breakdown of participants' subjective accounts of their overall physical health.

With regard to the hallucinatory experiences in reaction to the death of the spouse, 85 participants (42.93%) reported to be more frequently experiencing hallucinations of an emotionally disturbing nature *'some of the time'*, *'a good part of the time'*, or *'most or all of the time'*, as contrasted to 113 participants (57.07%) who had hallucinatory experiences *'a little of the time'* or *'none of the time'*.

With regard to the post-loss intimate relationship status, only 4 participants (2.03%) were currently intimately involved with a new partner, in contrast to 193 participants (97.97%) who reported that they were not presently involved in any post-loss intimate relationship.

Having drawn the above sample from the four municipal districts of the Eastern Cape enabled meaningful extrapolations about the general widowhood trends in the rural areas of South Africa. Thus, the sample was considered as representative of the population of the widowed men and women in the rural South African black communities.

3.4. Measuring instruments

3.4.1. Demographic questionnaire

This questionnaire was used to obtain data regarding the following variables: age, sex, religion, district of residence, level of education, present and past job status of widowed spouse, total monthly family income, number of people in the household, total number of children, duration of marriage, duration of bereavement, whether deceased spouse lived with the bereaved spouse, and spouse's cause of death.

Other variables included the job status the deceased spouse had before his or her death, the status of the pre-loss marriage with the deceased, the experience of hallucinatory experiences following loss, and involvement in intimate relationships since the death of spouse.

3.4.2. Beck Anxiety Inventory (BAI) (Beck & Steer, 1990).

To measure the participants' degree of anxiety, the Xhosa-language version of BAI (Steele & Edwards, 2002) was used. The BAI comprises 21 items, and each item is descriptive of a symptom of anxiety and is rated on a scale of 0 (minimal anxiety) to 3 (severe anxiety) (Beck & Steer, 1990).

The cut-off points for the BAI are as follows: between 0 and 7: *minimal anxiety*; between 8 and 15: *mild anxiety*; between 16 and 25: *moderate anxiety*; between 26 and 63: *severe anxiety* (Beck & Steer, 1990). The loss of a spouse is believed to be both a fear-inducing and anxiety-provoking experience for many bereaved spouses throughout the first three years of their bereavement (Lindstrøm, 1995; Sable, 1988, 1991). The BAI has been designed for use in clinical and research settings, and has an average reliability coefficient of .92, test-retest reliability of .75 and correlation with the Beck Depression Inventory of .48 (Beck & Steer, 1990). The BAI was indicated as a suitable measure of the degree of the anxiety symptoms among the respondents in the present study.

3.4.3. Beck Depression Inventory – Second Edition (BDI-II) (Beck, Steer, & Brown, 1996).

To measure participants' depressive symptoms, the Xhosa-language version of the BDI-II (Steele & Edwards, 2002) was used. The BDI-II is a 21-item

questionnaire that was developed to assess the intensity of depression over the preceding two weeks in clinical and normal patients, and what it measures is considered to be in line with the depression criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (DSM-IV) (Beck et al., 1996).

Respondents indicate the severity of their depressive symptoms on a 4-point scale, with 0 indicating the absence of the symptoms and 3 indicating a severe depressive symptom. The cut-off scores for the BDI-II are as follows: less than 14: *minimal depression*; between 14 and 19: *mild depression*; between 20 and 28: *moderate depression*; 29 and above: *severe depression* (Beck, et al., 1996). The BDI-II has been found to show improved clinical sensitivity, with the reliability coefficient of .92 (Beck et al., 1996).

Since individuals bereaved of their spouses are assumed to be presenting with a variety of depressive symptoms (Clayton, 1990; Wortman & Silver, 1991; Zisook, 1993; Zisook & Shuchter, 1991; Zisook, Shuchter, Sledge, Paulus, & Judd, 1994), the BDI-II was considered a suitable measuring instrument for the participants' depressive phenomena following spousal death.

3.4.4. Coping Strategy Indicator (CSI) (Amirkhan, 1990, 1994).

To ascertain participants' coping styles, the CSI was used. The CSI is a 33-item self-report scale that measures the extent to which respondents make use of the three basic coping styles, namely problem solving, avoidance and seeking social support (Amirkhan, 1990). The CSI clearly distinguishes itself from previous coping inventories, which identify problem-focused coping and emotion-focused coping as the *only* coping modes human beings have at their

disposal (Lazarus & Folkman, 1984). In contrast, the CSI includes avoidance as a negative form of an emotion-focused coping style, on the one hand, while it specifically identifies the use of social support, which can be classified as both an emotion-focused and problem-focused coping strategy, on the other.

The CSI has demonstrated high internal consistency coefficients of .92, .89 and .83 for problem-solving, seeking social support and avoidant coping strategies respectively, as well as test-retest reliability coefficients of .82 and .81 (Amirkhan, 1990, 1994). The CSI has been used in many South African research settings (notably, Spangenberg & Campbell, 1999; Spangenberg & Orpen-Lyall, 2000; Spangenberg & Theron, 1999, 2001; Wissing & Du Toit, 1994).

3.4.5. ENRICH Marital Satisfaction Scale (EMS) (Olson, Fournier, & Druckman, 1983).

The marital satisfaction sub-scale of the Enriching & Nurturing Relationship Issues, Communication & Happiness Scale (ENRICH) was used to assess the nature of a pre-loss marital relationship the bereaved spouses had with the deceased spouses[3]. This 10-item questionnaire provides a global measure of satisfaction by surveying ten areas of the couple's marriage, which include

[3] For the purpose of investigating the nature of marital relationship retrospectively, permission to reformulate the items, from *present* tense to *past* tense, was granted by the author and developer of the EMS questionnaire, namely David H. Olson, Ph.D. (President: Life Innovations, Inc., Professor Emeritus, University of Minnesota, United States of America).

communication, conflict resolution, roles, financial concerns, leisure time, sexual relationship, parenting, family and friends, and religion.

Participants are required to assess each item on a 5-point Likert scale. A high score is indicative of adaptability and satisfaction with most of the aspects of the marital relationship, with a low score being reflective of a lack of satisfaction and concern over various aspects of the marriage. The internal reliability coefficient (Alpha) of this sub-scale is 0.81 and the test-retest reliability (after four weeks) is 0.86 (Olson et al., 1982).

The EMS was recently used in a South African study investigating couples' intimacy and marital satisfaction levels (Greeff & Malherbe, 2001). The nature of marital relationship participants had with the deceased spouse is probably one of the most important factors in determining the nature and process of the expression of spousal bereavement. Hence, it was deemed necessary that a measure of this variable be included in order to determine whether or not the nature of marital relationship participants had with their deceased spouses influenced the manifestation of stress following spousal death.

3.4.6. Social Support Appraisals Scale (SSA) (Vaux et al., 1986).

To measure the participants' perceived social support, the SSA was used. This 23-item instrument is based on the idea that social support is in fact support only if the individual construes it to be readily available (Vaux et al., 1986). Since the individual's subjective appraisals of social support are viewed as related to overall psychological well-being, the SSA aims to tap the extent to which such individual believes he or she is loved by, esteemed by, and involved

with family, friends and others (Vaux et al., 1986). In responding to the SSA, respondents rate the extent to which they received support on a 4-point scale - with 1 indicating "strongly agree" and 4 indicating "strongly disagree". The SSA has a very good internal consistency, with alpha coefficients that range from .81 to .90 (Vaux et al., 1986).

Since plenty of studies from the bereavement literature (Duran et al., 1989; Gallagher-Thompson et al., 1993; Schuster & Butler, 1989; Siegel & Kuykendall, 1990; Stroebe & Stroebe, 1993; Stroebe et al., 1996; Stylianos & Vachon, 1993) emphasised the ameliorative role of social support in dealing with grief, the present study sought to measure the support received from the respondents' significant others in the wake of their spouses' death as well as whether or not such perceived support impacted in the way participants coped with the their conjugal loss.

3.5. Procedure

With the exception of the Beck Depression Inventory – Second Edition (BDI-II) and the Beck Anxiety Inventory (BAI), all the other measuring instruments were translated[4] from English to Xhosa with the help of translators from the Department of African Languages, Stellenbosch University. The Brislin method of translation (Brislin, 1976) was used, which required that, subsequent to the initial translation of measuring instruments from the English language to the

[4] The Xhosa-language versions of both the BDI-II and the BAI (XBDI-II and XBAI, respectively) were obtained, and used with permission, from Mr. Gary Steele and Professor David J.A. Edwards (Steele & Edwards, 2002) – authors and developers of the XBDI-II and XBAI, Department of Psychology, Rhodes University, Republic of South Africa.

Xhosa language, the back-translation be done in order to determine the accuracy of the initial translation.

The gathering of data was done by the researcher with the help of three research assistants, at least one from each of the three municipal districts of Flagstaff, Lusikisiki and Tabankulu. The data gathering from the fourth municipal district of Bizana was covered by the principal researcher (present author). All research participants were speakers of the Xhosa language dialect as collectively spoken in these four focal areas of the study. The researcher trained the research assistants over a period of five to six weeks about how to gather the data. The research assistants were remunerated for their work.

The participants were identified through the help of the local chiefs of the respective rural communities, who presumably knew which women and men amongst their people had been widowed during the past year. Letters were sent out to the prospective participants, requesting them to participate. The right to refuse participation was emphasised. For those participants who gave informed consent research assistants went to see them on a door-to-door basis, in order to complete interviewer-administered questionnaires. The data were gathered in the form of tape-recorded semi-structured interviews, with research assistants recording the participants' responses on the questionnaires.

Upon completion of this process of data gathering, the author liaised with the three research assistants in order to identify those participants who could be interviewed in order to grasp their subjective experience of conjugal loss. Participants were selected for the open-ended interviews in terms of gender, stress scores on questionnaires, mode of spousal death, and duration of bereavement. These interviews were conducted exclusively by the author by

having selected participants respond elaborately to questions posed. These interviews were also conducted at the participants' respective homes at the times scheduled for the second visit by both the author and the research assistant in whose area of study that particular interview was taking place. For subsequent transcriptions and qualitative data analyses, the interviews were also tape-recorded after having obtained the participants' informed consent.

To guarantee confidentiality of the information given, all respondents responded to questions outlined in the interviewer-administered questionnaires as well as to open-ended interviews on an anonymous basis. Both the questionnaire interviews and the open-ended interviews were conducted on a one-to-one basis. Completing the interviewer-administered questionnaires each ranged from 45 minutes to an hour, while the open-ended interviews took about 40 minutes to complete.

The researcher adhered to ethical obligation for "emotional containment" through one-to-one debriefing sessions with those participants who appeared to be psychologically affected by having taken the trouble to "re-visit" or "re-live" (in other words, to talk about) their conjugal loss, by having individual de-briefing sessions with them at their respective homes.

3.6. Data analyses

Quantitative data analyses were done in consultation with Professor Daan G. Nel, a qualified statistician who was appointed by the Department of Psychology at Stellenbosch University. Such analyses were done with the use of the STATISTICA and SPSS computer packages; the aim was to determine the descriptive statistics of the database and variables, as well as the correlations

between variables under investigation. Step-wise discriminant analyses and MANOVA were used to clarify the nature of the difference between the clusters in terms of demographic variables. Simple correlation and multiple regression analyses were used to determine the relationship between the global stress level scores and coping strategy used, as well as between scores of each of the variables of received social support, pre-loss marital relationship, bereavement phenomena, and coping strategy used.

Qualitative data analyses were done through the *Atlas.ti* (Marshall, 2002; Muhr & Friese, 2004), a specific computer-assisted software programme that facilitates the analyses of the qualitative data. Thus, the data was analyzed through the 'thematic analysis', a strategy of identification of common analytic themes and fragmentation of the data according to emergent conceptual schemes (Coffey & Atkinson, 1996), in order to interpret the data obtained from interviews.

CHAPTER 4: QUANTITATIVE DATA ANALYSES

RESULTS

4.1. Prevalence of depression and anxiety

In accordance with the cut-off points of the Beck Depression Inventory-Second Edition (BDI-II) shown in Figure 4.1 below, the prevalence of the various categories of participants' depressive symptomatology was as follows: within minimal range = 24 (12.12%); mildly depressed = 20 (9.60%); moderately depressed = 48 (24.24%); and severely depressed = 106 (54.04%).

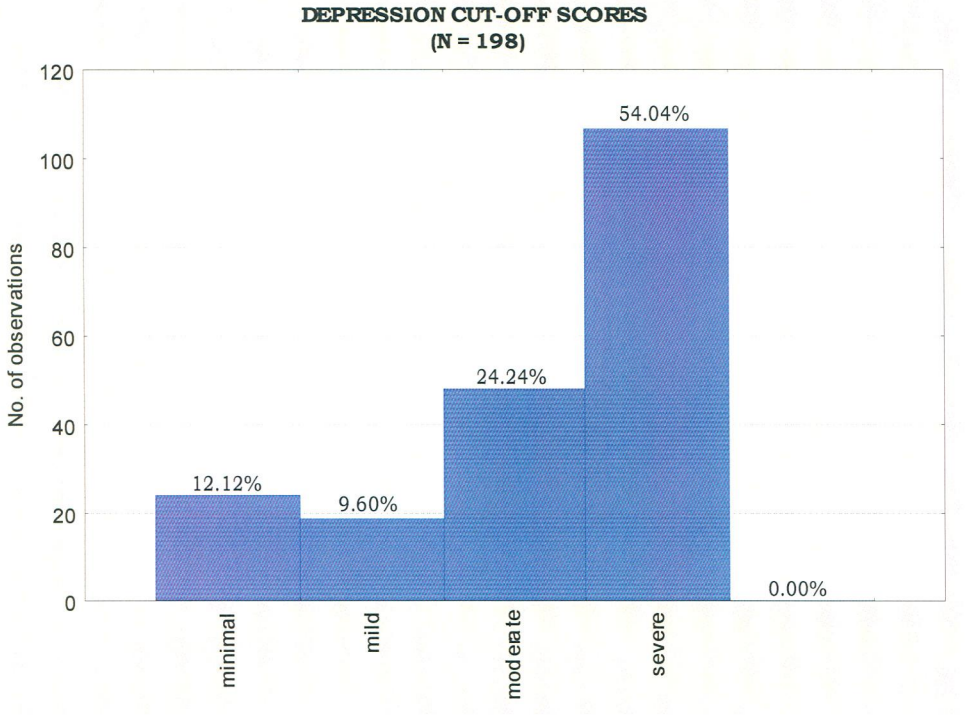


Figure 4.1. Prevalence of depression: BDI-II scores of participants.

The diagram presented in Figure 4.1, therefore, illustrates that 87.88% of the participants were at least mildly depressed and at least 78.28% were moderately or severely depressed.

With regard to participants' anxiety symptomatology, the cut-off scores on the Beck Anxiety Inventory (BAI) – shown in Figure 4.2 below – revealed that the prevalence of the various categories of anxiety was as follows: *minimal range*: 61 (30.81%); *mild*: 83 (41.92%); *moderate*: 42 (21.21%); *severe*: 12 (6.06%).

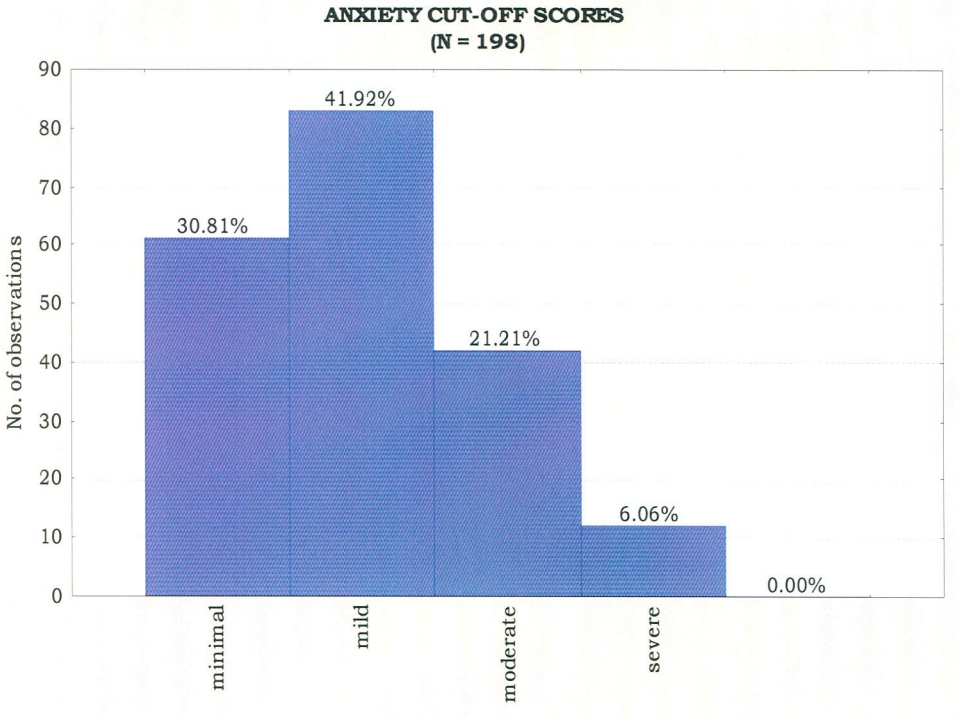


Figure 4.2. Prevalence of anxiety: BAI scores of participants.

As indicated in Figure 4.2, 69.19% of participants presented with at least mild anxiety symptomatology and 27.27% evinced anxiety of moderate or severe intensity.

As the participants' scores of depression and anxiety on the BDI-II and the BAI stand above, the following research hypothesis is thus confirmed:

The average anxiety and depression levels of this sample of recently conjugally bereaved South Africans will be high.

4.2. Prevalence of the three kinds of coping strategies

In accordance with the scores on the Coping Strategy Indicator (CSI) (Figure 4.3), it appeared that 58% of participants made a high use of the problem-solving coping strategy, compared to 24% who made high use of social support-seeking coping strategy and a mere 5% who made high use of avoidant coping strategy. The remaining 13% of participants' mode of coping was characterised by an oscillation between both the problem-solving and social support-seeking coping strategies.

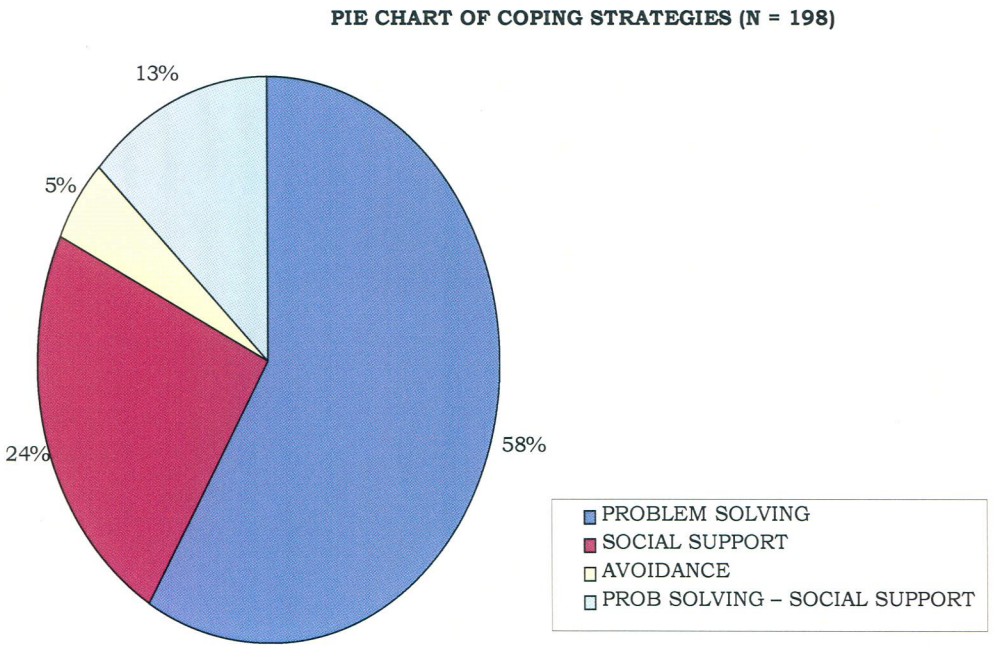


Figure 4.3. The breakdown of the participants' overall use of coping strategies.

As the breakdown of the participants' overall use of coping strategies in Diagram 4.3 indicates, the following research hypothesis is thus rejected:

This sample of bereaved South Africans will make predominant use of an avoidant coping strategy.

4.3. Correlation Analyses

4.3.1. Correlations between anxiety and depression

The Pearson correlation coefficient was used to investigate the relationship between anxiety and depression. Analyses of results revealed significant positive correlations between scores on anxiety and depression scores ($r = .174$, $p < .05$). This implies that the more participants evinced anxiety symptoms following spousal death, the higher was their depressive symptomatology and *vice versa.*

4.3.2. Correlations between anxiety and coping strategies

The Pearson correlation coefficient was used to investigate the relationship between anxiety and the three types of coping strategies. The results yielded by the analyses are recorded in Table 4.1.

Table 4.1.

Correlations between Participants' scores on the BAI and the scores on the Three Coping Strategy Scales of the CSI (N = 198)

Coping strategies	**r**	**p**
Problem-solving strategy	-.131	.066
Social support-seeking strategy	-.045	.527
Avoidant strategy	-.117	.102

As illustrated in Table 4.1, all negative correlations between scores on the BAI and scores on the three different kinds of coping strategies were not significant. This implies that the choice of coping strategies participants used had no mediating effect in the manifestation of their anxiety symptomatology. Put differently, the degree of the participants' anxiety levels could not be explained by the use of coping strategies they used. Therefore, in relation to the above results the following research hypothesis is rejected:

The correlations between specific coping strategies and the widows and widowers' stress levels [in this case, anxiety levels] will be significant.

4.3.3. Correlations between depression and coping strategies

The relationship between depression and the three types of coping strategies was also investigated by means of Pearson correlation coefficient. The results yielded by the analyses are given in Table 4.2.

As illustrated in Table 4.2, a significant positive correlation was found between depression scores and scores on the problem-solving coping strategy scale ($r = .219$, $p < .01$). This implies that the more participants made use of problem-solving coping strategies, the higher were their depression scores and *vice versa*. A significant positive correlation was also found between depression scores and scores on the social support-seeking coping strategy scale ($r = .174$, $p < .05$). This implies that the more participants made use of social support-seeking coping strategies, the higher were their depression scores and *vice versa*. The negative correlation between depression scores and scores on the avoidant coping strategy scale was not significant.

Table 4.2.

Correlations between Participants' scores on the BDI-II and the scores on the Three Coping Strategy Scales of the CSI (N = 198)

Coping strategies	**r**	**p**
Problem-solving strategy	.219	.002*
Social support-seeking strategy	.174	.014**
Avoidant strategy	-.034	.636

*p < .01

**p < .05

As the results of the analyses in Table 4.2 stand, the following research hypothesis is thus partially confirmed:

The correlations between specific coping strategies and the widows and widowers' stress levels [in this case, depression levels] will be significant.

4.3.4. Correlations between perceived social support and stress levels

The relationship between perceived social support and stress levels was also investigated by means of Pearson correlation coefficients. The results yielded by the analyses are given in Table 4.3.

As illustrated in Table 4.3., significant negative correlations were found between scores on perceived social support and anxiety scores (r = -.291, p < .001), which implies that the more participants perceived to have received social

support from the significant others in wake of spousal death, the lower were their anxiety scores (anxiety symptoms) and vice versa.

Table 4.3.

Correlations between Participants' scores on the SSA and the scores on the Depression Scales of the BDI-II and Anxiety Scales of the BAI (N = 198)

Stress markers	**r**	**p**
Depression	-.036	.613
Anxiety	-.291	.000*

*p < .001

As the above results of the analyses stand, the following research hypothesis is thus confirmed:

The correlations between participants' perceived social support and stress levels will be significant.

However, the negative correlations between scores on perceived social support and depression scores were not significant; therefore the same hypothesis as cited above, with particular reference to depression, is rejected.

4.3.5. Correlations between pre-loss marital relationship and stress levels

Table 4.4 illustrates the results of the Pearson correlation coefficient analyses that were used to investigate the correlations between participants' subjective

account of the nature of a pre-loss marital relationship and their depression and anxiety.

Table 4.4.

Correlations between Participants' scores on the EMS and the scores on the Depression Scales of the BDI-II and Anxiety Scales of the BAI (N = 198)

Stress markers	**r**	**p**
Depression	-.036	.613
Anxiety	.215	.002*

*p < .01

As illustrated in Table 4.4, significant positive correlations were found between scores on pre-loss marital relationship and anxiety scores (r = .215, p < .01). This implies that the more participants reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship, the more they evinced anxiety symptoms and *vice versa.*

As the analyses of results stand in Table 4.4, the following research hypothesis is confirmed:

The correlations between the nature of pre-loss marital relationship and anxiety levels... in this sample of bereaved South Africans will be significant.

However, the negative correlations between participants' scores on pre-loss marital relationship and depression scores were not significant, which leads to the rejection of the following hypothesis:

The correlations between the nature of pre-loss marital relationship and... depression levels in this sample of bereaved South Africans will be significant.

4.3.6. Correlations between perceived social support and coping strategies

Table 4.5 shows the Pearson correlation coefficient analyses that were used to investigate the correlations between participants' perceived social support and coping strategies they utilised.

Table 4.5.

Correlations between Participants' scores on the SSA and the scores on the Three Coping Strategy Scales of the CSI (N = 198)

Coping strategies	**r**	**p**
Problem-solving strategy	.203	.004*
Social support-seeking strategy	-.048	.501
Avoidant strategy	-.028	.693

*p < .01

As results in Table 4.5 indicate, a significant positive correlation was found between perceived social support scores and scores on the problem-solving coping strategy scale (r = .203, p < .01).

The above findings imply that the more participants perceived themselves to have received, or to be receiving, social support from their significant others, the more they made use of problem-solving coping strategy, and *vice versa.*

The negative correlations between social support-seeking coping strategy scores and scores on perceived social support as well as the negative correlations between the avoidant coping strategy scores and perceived social support scores were both not significant.

4.3.7. Correlations between pre-loss marital relationship and coping strategies

Table 4.6 illustrates the results of the correlations between pre-loss marital relationship and the three types of coping strategies that were investigated by means of Pearson correlation coefficients.

Table 4.6.

Correlations between Participants' scores on the EMS and the scores on the Three Coping Strategy Scales of the CSI (N = 198)

Coping strategies	**r**	**p**
Problem-solving strategy	-.216	.002*
Social support-seeking strategy	-.138	.052
Avoidant strategy	.069	.335

*p < .01

As illustrated in Table 4.6, significant negative correlations were found between scores on the pre-loss marital relationship and scores on the problem-solving coping strategy scale (r = -.216, p < .01). This implies that the lower was the adaptability and satisfaction with most of the aspects of their pre-loss marital relationship, the more likely did participants use problem-solving coping strategies; and the higher their pre-loss marital satisfaction and adaptability, the less likely they were to use problem-solving coping strategy.

Both the negative correlations between pre-loss marital relationship scores and scores on the social support-seeking coping strategies, and the positive correlations between pre-loss marital relationship scores and scores on the avoidant coping strategies were not significant.

4.4. Multiple Regression

4.4.1. Coping strategies that functioned as key variables in predicting anxiety

Table 4.7 illustrates the results of the stepwise multiple regression analyses that were conducted in order to determine which of the three types of coping strategies predicted anxiety.

As Table 4.7 indicates, the directions of causality in the negative correlation between the problem-solving coping strategy scores and anxiety scores, and that between avoidant coping strategy scores and anxiety scores, as well as the direction of causality in the positive direction between the social support-seeking coping strategy scores and anxiety scores, were all insignificant. This suggested that none of the three coping strategy types played a predictive role in the manifestation of anxiety symptomatology.

Table 4.7.

Multiple Regression of Anxiety (BAI) on the three Subscales of the CSI (N = 198)

Predictor	**B**	**Std. Error of B**	**β (Beta)**	**t-ratio**	**p**
Constant	21.719	4.609		4.723	.000*
Problem-solving strategy	-.232	.166	-.121	-1.397	.164
Social support-seeking strategy	.064	.116	.047	.553	.581
Avoidant strategy	-.205	.195	-.083	-1.051	.295

F(3.194) = 1.5508 R = .1530 R^2 = 2.34%

R^2 (adjusted) = .83% SE = 7.8696

*p < .001

4.4.2. Coping strategies that functioned as key variables in predicting depression

Table 4.8 indicates the results of the stepwise multiple regression analyses that were conducted in order to determine which of the three types of coping strategies predicted depression.

As illustrated in Table 4.8, a problem-solving coping strategy emerged as a significant positive predictor of depression (p < .01). This trend points to the direction of causality in the positive correlation between scores on the problem-solving coping strategy scale and depression, which implies that the use of

problem-solving coping strategy played a predictive role in the heightened depression levels.

Table 4.8.

Multiple Regression of Depression (BDI-II) on the three Subscales of the CSI (N = 198)

Predictor	**B**	**Std. error of B**	**β (Beta)**	**t-ratio**	**p**
Constant	17.196	7.070		2.432	.016*
Problem-solving strategy	.690	.255	.228	2.700	.007**
Social support-seeking strategy	.246	.178	.113	1.382	.169
Avoidant strategy	-.651	.300	-.166	-2.167	.031*

$F(3.194) = 5.2584$ $R = .2742$ $R^2 = 7.52\%$

R^2 (adjusted) = 6.08% SE = 12.0984

*$p < .05$

**$p < .01$

An avoidant coping strategy was found to be a significant negative predictor of depression ($p < .05$). This indicates the direction of causality in the negative correlation between scores on the avoidant coping strategy scale and depression, and implies that the use of an avoidant coping strategy played a

predictive role in the lessening of depressive symptomatology levels. The direction of causality in the positive correlation between scores on the social support-seeking coping strategy scale and depression was not significant.

4.4.3. Coping strategies that served as key variables in predicting perceived social support

Table 4.9 illustrates the results of the stepwise multiple regression analyses that were conducted in order to determine which of the three types of coping strategies predicted perceived social support.

As illustrated in Table 4.9, a problem-solving coping strategy emerged as a significant positive predictor of perceived social support ($p < .001$). This indicates the direction of causality in the positive correlation between scores on the problem-solving coping strategy scale and perceived social support, and implies that the use of the problem-solving coping strategy played a predictive role in the experience of heightened levels of perceived social support.

The social support-seeking coping strategy was found to be a negative predictor of perceived social support ($p < .05$). This indicates the direction of causality in the negative correlation between scores on the social support-seeking coping strategy scale and perceived social support, which implies that the use of the social support-seeking coping strategy played a predictive role in the lessening of perceived social support levels.

As also illustrated in Table 4.9, the direction of causality in the negative correlation between the avoidant coping strategy scores and perceived social support scores was not significant, thus indicating that the use of the avoidant

coping strategy played no predictive role in the experience of perceived social support.

Table 4.9.

Multiple Regression of Perceived Social Support (SSA) on the three Subscales of the CSI (N = 198)

Predictor	**B**	**Std. error of B**	**β (Beta)**	**t-ratio**	**p**
Constant	33.297	4.909		6.782	.000**
Problem-solving strategy	.618	.177	.296	3.485	.000**
Social support-seeking strategy	-.282	.124	-.188	-2.275	.024*
Avoidant strategy	-.056	.209	-.021	-.268	.789

F(3.194) = 4.3589 R = .2513 R^2 = 6.31%

R^2 (adjusted) = 4.87% SE = 8.4014

*p < .05

**p < .001

4.4.4. Coping strategies that served as key variables in predicting pre-loss marital relationship

Table 4.10 indicates the results of the stepwise multiple regression analyses that were conducted in order to determine which of the three types of coping

strategies predicted the participants' subjective experience of the nature of pre-loss marital relationship.

Table 4.10.

Multiple Regression of Pre-loss Marital Relationship (EMS) on the three Subscales of the CSI (N = 198)

Predictor	**B**	**Std. error of B**	**β (Beta)**	**t-ratio**	**p**
Constant	42.110	4.652		9.053	.000*
Problem-solving strategy	.009	.168	.005	.054	.957
Social support-seeking strategy	-.053	.117	-.038	-.450	.653
Avoidant strategy	.022	.198	.009	.110	.912

F(3.194) = .0766 R = .0344 R^2 = .11%

R^2 (adjusted) = -----% SE = 7.9603

*p < .001

As Table 4.10 indicates, the directions of causality in the positive correlation between scores on the EMS and both the problem-solving coping strategy scores and avoidant coping strategy scores, as well the direction of causality in the negative correlation between scores on the EMS and social support-seeking coping strategy scores, were all not significant. This implies that all the three

types of coping strategies played no predictive role in the subjective perceptions of the nature of the pre-loss marital relationship.

4.4.5. Stress indicators that served as key variables in predicting perceived social support

Table 4.11 indicates the results of the stepwise multiple regression analyses that were conducted in order to determine the degree to which the two stress indicators (depression and anxiety) predicted the participants' subjective experience of the received social support.

Table 4.11.

Multiple Regression of Perceived Social Support (SSA) on the Depression scales of the BDI-II and Anxiety scales of the BAI (N = 198)

Predictor	**B**	**Std. error of B**	**β (Beta)**	**t-ratio**	**p**
Constant	41.906	1.625		25.791	.000*
Depression	.155	.047	.224	3.259	.001**
Anxiety	-.306	.075	-.281	-4.089	.000*

$F(2.195) = 11.70103$ $R = .3273$ $R^2 = 10.7\%$

R^2 (adjusted) = 9.80% SE = 8.1806

*$p < .001$

**$p < .01$

As Table 4.11 indicates, depression emerged as a significant positive predictor of perceived social support ($p < .01$). This indicates the direction of causality in the positive correlation between scores on the depression scale and perceived social support, and implies that depressive symptoms played a predictive role in the experience of heightened levels of perceived social support.

Anxiety was found to be a significant negative predictor of perceived social support ($p < .001$). This indicates the direction of causality in the negative correlation between scores on the anxiety scale and perceived social support, and implies that anxiety symptoms played a predictive role in the lessening of perceived social support levels.

Both predictors (depression and anxiety) accounted for 9.8% of the variance on perceived social support.

As results of the analysis in Table 4.11 illustrate, the following research hypothesis is thus confirmed:

The correlations between participants' perceived social support and stress levels will be significant.

4.4.6. Stress indicators that served as key variables in predicting pre-loss marital relationship

Table 4.12 illustrates the stepwise multiple regression analyses were conducted in order to determine which of the two stress indicators (depression and anxiety) predicted the participants' subjective experience of the pre-loss marital relationship.

Table 4.12.

Multiple Regression of Pre-loss Marital Relationship (EMS) on Depression scales of the BDI-II and Anxiety scales of the BAI (N = 198)

Predictor	**B**	**Std. error of B**	**β (Beta)**	**t-ratio**	**p**
Constant	40.169	1.566		25.651	.000*
Depression	.071	.046	.116	1.612	.109
Anxiety	-.065	.072	-.065	-.900	.369

$F(2.195) = 1.4976$ $R = .1230$ $R^2 = 1.51\%$

R^2 (adjusted) = .50% SE = 7.8842

*$p < .001$

As Table 4.12 illustrates, the directions of causality in the positive correlation between scores on the EMS and depression scores, as well the direction of causality in the negative correlation between scores on the EMS and anxiety scores, were all not significant. This implies that none of these two stress indicators played a predictive role in the experience of the nature of the pre-loss marital relationship.

As results of the analyses stand in Table 4.12, the following research hypothesis is thus rejected:

The correlations between the nature of pre-loss marital relationship and the anxiety levels and depression levels, respectively, in this sample of bereaved South Africans will be significant.

4.5. DEMOGRAPHIC VARIABLES:

Differences between demographic variables regarding anxiety, depression, perceived social support, pre-loss marital relationship, and coping strategies

Step-wise discriminant analyses, t-tests for significance, and MANOVA were used to clarify the nature of the differences between the clusters in terms of demographic variables regarding the manifestation of anxiety and depression, perceived social support, the subjective experience of pre-loss marital relationship, and the prevalence of the coping strategies used.

4.5.1. Age

In an attempt to investigate the differences between younger (aged 21 to 49) and older participants (50 – 99 years) in terms of perceived social support, the results showed a significant difference in the means of the two groups, $F(1, 196) = 7.50$, $p < .01$ (Table 4.13).

This thus reflected the fact that the differences between the two age groups generally were greater for the younger participants ($M = 44.06$) with regard to perceived social support as compared to older participants ($M = 40.73$), $t(196) = 2.74$, $p < .01$.

Moreover, significant negative correlations were found between age and perceived social support scores ($r = -.192$, $p < .01$), which implies that the older the participants, the less did they perceive to have received social support from their significant others in the wake of spousal death.

Table 4.13.

The Univariate Tests of Significance for Age on Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	348767.0	348767.0	4855.911	.0000*
Age	1	538.7	538.7	7.501	.0067**
Error	196	14077.3	71.8		
Total	198				

*p < .001

**p < .01

4.5.2. Sex

In investigating the sex differences, the results showed a significant difference in the means of the two groups in terms of depression, $F(1, 196) = 5.86$, $p < .05$ (Table 4.14).

These results revealed that widows ($M = 29.91$) evinced depressive symptoms significantly more than widowers ($M = 23.82$), $t(196) = 2.42$, $p < .05$.

Table 4.14.

Analysis of Variance for Sex on Depression (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	69410.80	69410.80	456.3164	.0000*
Sex	1	891.71	891.71	5.8622	.0164**
Error	196	29813.78	152.11		
Total	198				

*$p < .001$

**$p < .05$

Significant differences were also found in the means of the sex groups in respect of anxiety, $F(1, 196) = 10.94$, $p < .01$ (Table 4.15) – thus indicating a pattern of anxiety symptomatology being significantly greater for widows ($M = 13.02$) when compared to their male counterparts ($M = 7.82$), $t(196) = -3.31$, $p < .01$.

Significant differences also emerged between males and females with regard to their subjective perceptions of the marital relationship they had with their deceased spouses, $F(1, 196) = 12.61$, $p < .001$ (Table 4.16). This pointed to the pattern in which widowers ($M = 46.29$) reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship significantly more than widows did ($M = 40.72$), $t(196) = 3.55$, $p < .001$.

Table 4.15.

Analysis of Variance for Sex on Anxiety (BAI) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	10445.85	10445.85	175.7110	.0000*
Sex	1	650.58	650.58	10.9435	.0011**
Error	196	11652.01	59.45		
Total	198				

*p < .001

**p < .01

Table 4.16.

Analysis of Variance for Sex on Pre-loss Marital Relationship (EMS) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	182000.5	182000.5	3084.829	.0000*
Sex	1	743.8	743.8	12.606	.0004*
Error	196	11563.7	59.0		
Total	198				

*p < .001

Table 4.17.

Analysis of Variance for Sex on the three types of Coping Strategies of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Problem-solving coping strategy					
Intercept	1	79418.55	79418.55	4646.015	.0000*
Sex	1	6.59	6.59	0.385	.5354
Error	196	3350.41	17.09		
Total	198				
Social support-seeking coping strategy					
Intercept	1	61739.30	61739.30	1860.654	.0000*
Sex	1	3.74	3.74	0.113	.7373
Error	196	6503.58	33.18		
Total	198				
Avoidant coping strategy					
Intercept	1	44671.63	44671.63	4362.235	.0000*
Sex	1	0.03	0.03	0.003	.9559
Error	196	2007.15	10.24		
Total	198				

*p < .001

As Table 4.17 indicates, there were no significant differences between males and females in respect of the use of three types of coping strategies. Therefore, the following research hypothesis was rejected:

The differences in the use of coping strategies between this sample of widows and widowers will be significant.

4.5.3. Number of people in the household

Significant differences in respect of the number of people living in the participants' households and the use of the avoidant coping strategy, $F(1, 196) = 9.02$, $p < .01$ (Table 4.18) were found.

Table 4.18.

Analysis of Variance for Number of People in the Household on the Avoidant Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	83462.12	83462.12	8525.104	.0000*
No. of people in the household	1	88.31	88.31	9.020	.0030**
Error	196	1918.87	9.79		
Total	198				

*p < .001

**p < .01

The results outlined in Table 4.18 pointed to a pattern in which participants from households that had fewer people (with 5 people or less; M = 22.48) made use of avoidant coping strategy significantly more than those who live in households with a sizeable number of people (more than five people; M = 21.07), t(196) = 3.00, p < .01.

Moreover, significant negative correlations were also found between the number of people living in the household and avoidant coping strategy scores (r = -.222, p < .01), which implies that the more the people living in the participants' households, the less likely participants were to use the avoidant coping strategy in the wake of spousal death and *vice versa*.

4.5.4. Family monthly income

Significant differences emerged in the means of family monthly income in respect of the participants' subjective perception of the pre-loss marital relationship, $F(2, 192) = 3.69$, $p < .05$ (Table 4.19).

The above results pointed to a pattern in which participants living in households with a monthly income in the range of R1000.00–R5000.00 (hereafter to be referred to as *middle-income home earners*; M = 45.40) reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship significantly more than the participants from households with a monthly income of R1000.00 or less (hereafter to be referred to as *low-income home earners*; M = 40.90), t(191) = -2.68, p < .01.

Table 4.19.

Analysis of Variance for Family Monthly Income on Pre-loss Marital Relationship (EMS) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	28759.44	28759.44	469.9224	.0000*
Family monthly income	2	451.99	225.99	3.6927	.0267**
Error	192	11750.48	61.20		
Total	195				

*p < .001

**p < .05

No significant correlations were found between the family monthly income and pre-loss marital relationship scores.

4.5.5. Level of education

Results of the analysis of variance are illustrated in Table 4.20. Significant differences were found in the means of educational levels groups in respect of the overall use of the problem-solving coping strategy, $F(3, 183) = 3.69$, $p < .05$. These results pointed to a pattern in which those with Standard 6 education or below ($M = 29.11$) used the problem-solving coping strategy significantly more than those with no formal education ($M = 27.41$), $t(162) = -2.30$, $p < .05$. Those with education of Standard 6 or below ($M = 29.11$) still made significantly more

use of problem-solving coping strategy when compared to those with high school education (M = 26.24), t(138) = 2.78, p < .01. No significant correlations were found between education and the problem-solving coping strategy scores.

Table 4.20.

Analysis of Variance for Educational Level on Problem-solving Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	47115.53	47115.53	2813.890	.0000*
Educational level	3	185.49	61.83	3.693	.0129**
Error	183	3064.14	16.74		
Total	187				

*p < .001

**p < .05

Another investigation of the differences in the means of the educational level groups with regard to the use of the problem-solving coping strategy was made by combining the categories of those with no formal education together with those with Standard 6 or below (hereafter to be referred to as the *semi-literate group*), and comparing this group with the one that comprised high school education when combined with teacher's- or nursing college of education

(hereafter to be referred to as the *literate group*). The results of the analysis of variance appear in Table 4.21.

Table 4.21.

Analysis of Variance for Education Level on Problem-solving Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	61569.48	61569.48	3605.496	.0000*
Education groups	1	90.46	90.46	5.297	.0225**
Error	185	3159.16			
Total	187				

*$p < .001$

**$p < .05$

Results outlined in Table 4.21 revealed significant differences in the means of the two groups, $F(1,185) = 5.30$, $p < .05$, with the semi-literate group ($M = 28.68$) making use of the problem-solving coping strategy significantly more than the literate group ($M = 26.57$), $t(185) = 2.30$, $p < .05$.

Significant negative correlations existed between the educational groups and the problem-solving coping strategy scores ($r = -.167$, $p < .05$), which implies that the less literate the participants, the more they made use of the problem-solving coping strategy in the wake of conjugal loss and *vice versa*.

Significant differences also emerged in the means of educational levels groups in respect of the overall use of the social support-seeking coping strategy, $F(3,183) = 2.92$, $p < .05$ (Table 4.22), with participants with no formal education ($M = 25.95$) making use of social support-seeking coping strategy significantly more than those with a high school education ($M = 21.65$), $t(56) = 2.71$, $p < .01$.

Table 4.22.

Analysis of Variance for Educational Level on Social Support-seeking Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	35611.19	35611.19	1128.530	.0000*
Educational level	3	276.01	92.00	2.916	.0356**
Error	183	5774.63	31.56		
Total	187				

*$p < .001$

**$p < .05$

Moreover, participants with a Standard 6 education or below ($M = 25.42$) made use of the social support-seeking coping strategy significantly more than those with a high school education ($M = 21.65$), $t(138) = 2.50$, $p < .05$ (Table 4.22). Significant negative correlations were also found between the level of education and social support-seeking coping strategy scores ($r = -.172$, $p < .05$). This

implies that the higher the level of education, the less were participants inclined to use the social support-seeking coping strategy in the wake of spousal death.

Further investigation of the differences in the means of the educational level levels with regard to the use of the social support-seeking coping strategy was made by comparing the semi-literate group with the literate group. The results of the analysis of variance appear in Table 4.23.

Table 4.23.

Analysis of Variance for Educational Level on Social Support-seeking Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	45532.94	45532.94	1454.987	.0000*
Education groups	1	261.18	261.18	8.346	.0043**
Error	185	5789.46	31.29		
Total	187				

*p < .001

**p < .01

The results outlined in Table 4.23 revealed significant differences in the means of the two groups, $F(1,185) = 8.35$, $p < .01$, with the semi-literate group ($M = 25.55$) making use of the social support-seeking coping strategy significantly more than the literate group ($M = 21.96$), $t(185) = 2.89$, $p < .01$. Significant

negative correlations were also found between literacy and social support-seeking coping strategy scores (r = -.209, p < .01), which implies that the more the level of literacy, the less did participants make use of the social support-seeking coping strategy in the wake of spousal loss and *vice versa*.

Furthermore, significant differences were found in the means of the two education groups with regard to their subjective perception of their pre-loss marital relationship, $F(1, 185) = 7.47$, p < .01. Results of the analysis of variance are recorded in Table 4.24.

Table 4.24.

Analysis of Variance for Educational Level on Pre-Loss Marital Relationship (EMS) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	151462.4	151462.4	2409.906	.0000*
Education groups	1	469.5	469.5	7.470	.0069**
Error	185	11627.2	62.8		
Total	187				

*p < .001

**p < .01

A pattern consistent with results in Table 4.24 was that the literate group (M = 45.74) reporting adaptability and satisfaction with most of the aspects of their

pre-loss marital relationship significantly more than the semi-literate group (M = 40.91), t(185) = -2.73, p < .01.

Moreover, significant positive correlations also emerged between literacy and pre-loss marital relationship scores (r = .197, p < .01), which implies that the more literate the participants, the more they reported adaptability and satisfaction with most of the aspects of the pre-loss marital relationship they had with their deceased spouses.

4.5.6. Participants' job status

Job status was grouped according to employed versus unemployed participants. Significant differences were found in the means of groups of participants' job status in respect of the manifestation of anxiety symptomatology, $F(1, 196) = 5.10$, $p < .05$. The results of the analysis of variance are recorded in Table 4.25.

Table 4.25.

Analysis of Variance for Job Status on Anxiety (BAI) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	24436.87	24436.87	399.4483	.0000*
Job status	1	311.98	311.98	5.0997	.0250**
Error	196	11990.61	61.18		
Total	198				

*p < .001

**p < .05

A general pattern that was yielded by results in Table 4.25 was that the unemployed participants (M = 13.17) evinced anxiety symptoms significantly more than their employed counterparts (M = 10.49), t(196) = 2.26, p < .05.

Moreover, there were significant negative correlations between job status and anxiety scores (r = -.159, p < .05), which implies that the steadier and more secure the participants' employment, the less did they evince symptoms of anxiety and *vice versa.*

Furthermore, significant differences were also found in the means of groups of job status in respect of the participants' subjective appraisal of social support received from their significant others, $F(1, 196) = 5.59$, p < .05. The results of the analysis of variance are illustrated in Table 4. 26.

Table 4.26.

Analysis of Variance for Job Status on Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	325242.3	325242.3	4485.733	.0000*
Job status	1	404.9	404.9	5.585	.0191**
Error	196	14211.2	72.5		
Total	198				

*p < .001

**p < .05

Consistent with the results in Table 4.26 was a pattern in which the employed participants (M = 44.68) perceived to have received social support significantly more than the unemployed participants (M = 41.63), t(196) = -2.36, p < .05.

Significant positive correlations were also found between job status and social support appraisal scores (r = .166, p < .05), which implies that the steadier and more secure the participants' employment, the more they perceived to have received social support from their significant others and *vice versa*.

4.5.7. Period of bereavement

Significant differences were found in the means of the groups of period of spousal bereavement in respect of the manifestation of anxiety symptoms, $F(2, 194) = 5.82$, p < .01. Results of the analysis of variance are recorded in Table 4.27.

The results in Table 4.27 revealed that participants who had been within the first month of conjugal bereavement (hereafter to be referred to as the *most recently bereaved*; M = 19.17) evinced anxiety symptoms significantly more than participants whose period of bereavement ranged between 1 month and 6 months (hereafter to be referred to as the *intermediately bereaved*; M = 12.58), t(96) = 2.78, p < .01.

Moreover, the most recently bereaved participants (M = 19.17) had anxiety symptoms significantly more than participants whose period of bereavement ranged between 7 months and twelve months (hereafter to be referred to as the *distantly bereaved*; M = 11.18), t(109) = 3.28, p < .01.

Table 4.27.

Analysis of Variance for Period of Bereavement on Anxiety (BAI) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	17541.74	17541.74	293.2864	.0000*
Period of bereavement	2	696.32	348.16	5.8210	.0035**
Error	194	11603.32	59.81		
Total	197				

*p < .001

**p < .01

Significant negative correlations were found between period of conjugal bereavement (months post-loss) and anxiety scores (r = -.203, p < .01). The above correlation implies that the shorter the period of spousal bereavement, the more did participants display anxiety symptoms and *vice versa*.

4.5.8. Deceased spouse's job status

As illustrated in Table 4.28, significant differences were found in the means of groups of deceased spouse's job status (at the time of death) with regard to participants' appraisal of social support received, $F(1, 195) = 5.41$, $p < .05$. Consistent with these results were the findings that participants whose spouses were employed at the time of death (M = 44.68) perceived to have received social support from their significant others significantly more than participants whose

spouses were unemployed at the time of death (M = 41.64), t(195) = -2.32, p < .05.

Table 4.28.

Analysis of Variance for Deceased Spouse's Job Status on Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	316538.3	316538.3	4356.412	.0000*
Deceased spouse's job status	1	392.7	392.7	5.405	.0211**
Error	195	14168.8	72.7		
Total	197				

*p < .001

**p < .05

Significant positive correlations were also found between deceased spouse's job status and perceived social support scores (r = .164, p < .05), which implies that the steadier and more secure the employment of participants' spouses at the time of death, the more participants perceived to have received social support from their significant others following spousal death and *vice versa*.

4.5.9. Age of deceased spouse

Significant differences were found between means of the deceased spouse's age groups, $F(1, 196) = 8.04$, $p < .01$. Results of the analysis of variance are illustrated in Table 4.29.

Table 4.29.

Analysis of Variance for Age of Deceased Spouse on Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	360387.0	360387.0	5031.055	.0000*
Age of deceased spouse	1	576.1	576.1	8.043	.0050**
Error	196	14040.0	71.6		
Total	198				

*p < .001

**p < .01

The results consistent with the above finding revealed that participants whose deceased spouses were younger at death (aged between 23 and 49 years; M = 44.43) perceived to have received social support from their significant others significantly more than participants whose deceased spouses were older (aged between 50 and 98 years; M = 41.01), t(196) = 2.84, p < .01.

Significant negative correlations were also found between age of the deceased spouse and social support appraisal scores (r = -.199, p < .01), which implies that the younger were the deceased spouses, the more participants perceived to have received social support from their significant others following the loss and *vice versa.*

4.5.10. Status of pre-loss marriage

Significant differences were found in the means of status of the marriage participants had with their deceased spouses in respect of the manifestation of depressive symptomatology, $F(4, 193) = 3.89$, $p < .01$. Results of the analysis of variance are recorded in Table 4.30.

Table 4.30.

Analysis of Variance for Status of Marriage on Depression (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	8186.77	8186.769	55.60993	.0000*
Status of marriage	4	2292.47	573.117	3.89299	.0046**
Error	193	28413.03	147.218		
Total	198				

*p < .001

**p < .01

Consistent with this result was a pattern in which participants who were living together, and sharing everything, with their deceased spouses at the time of death (M = 30.11) evinced depressive symptoms significantly more than participants who, although still legally married at the time of spousal death, were estranged from their deceased spouses (M = 15.50), t(141) = 2.32, p < .05. Moreover, participants who were living in the same house, but used separate bedrooms with their deceased spouses (M = 36.33) evinced depressive symptoms significantly more than participants who were estranged from their spouses at the time of spousal death (M = 15.50), t(8) = 5.68, p < .001.

Furthermore, depressive symptoms were significantly less for the sole participant who was filing for divorce at the time of spousal death (M = 0.00)[5] when compared to participants in the following three categories: first, those who were living with their deceased spouses (M = 30.11), t(138) = 2.40, p < .05; second, those participants who were still married to their deceased spouses at the time of death, but were kept apart because of work and other commitments (M = 26.81), t(47) = 2.25, p < .05; and third, those who were living in the same house with their deceased spouses, but used separate bedrooms (M = 36.33), t(5) = 6.33, p < .01.

Significant negative correlations were also found between status of marriage and depression scores (r = -.184, p < .01), which implies that the less

[5] It is worth stating that, since there was only one participant who was in the process of filing for divorce at the time of spousal death, the statistical mean *in respect of depression*, as herein indicated, is 0.00, hence (M = 0.00).

physically distancing[6] the marriage to their spouse at pre-loss, the more depressed participants were in the wake of spousal death and *vice versa.*

Significant differences were also found in the means of status of the marriage participants had with their deceased spouses in respect of the subjective perception of the marital relationship participants had with their deceased spouses, $F(4, 193) = 10.28$, $p < .001$. Results of the analysis of variance are illustrated in Table 4.31.

Table 4.31.

Analysis of Variance for Status of Marriage on Pre-loss Marital Relationship (EMS) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	17535.55	17535.55	333.5565	.0000*
Status of marriage	4	2161.19	540.30	10.2774	.0000*
Error	193	10146.29	52.57		
Total	198				

*$p < .001$

[6] In this context, *physical distance in marriage* is measured by the proximity to, and time spent with, the spouse at preloss; the greater physically distancing marriage refers to the degree in which the partners spent time and their married lives apart from each other (ranging from estrangement and separation to divorce), while the lesser physically distancing marriage pertains to the maximal marital cohesion and co-existence (living together and sharing everything for the greater part of their married lives) between partners.

A general trend consistent with results in Table 4.31 was that participants who were living together, and sharing everything, with their deceased spouses at the time of death (M = 42.35) reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship significantly more than both the participants who were living estranged lives with their deceased spouses (M = 25.25), $t(141) = 4.71$, $p < .001$, and participants who were filing for divorce (M = 10.00), $t(138) = 4.52$, $p < .001$.

Moreover, participants who were still married to their deceased spouses at the time of death, but were kept apart because of work and other commitments (M = 41.23) also reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship significantly more than both the participants who were living estranged lives with their deceased spouses (M = 25.25), $t(50) = 4.45$, $p < .001$, and those who were filing for divorce (M = 10.00), $t(47) = 4.57$, $p < .001$.

Significant negative correlations were also found between status of marriage and pre-loss marital relationship scores ($r = -.338$, $p < .001$), which implies that the less physically distancing the marriage was to the spouse pre-loss, the more did participants report as adaptable and satisfactory the aspects of their pre-loss marital relationship in the wake of spousal death and *vice versa*.

Significant differences were also found between the means of status of the marriage participants had with their deceased spouses in respect of the subjective appraisal of the social support received from the significant others in

wake of spousal bereavement, $F(4, 193) = 3.10$, $p < .05$). Results of the analysis of variance are recorded in Table 4.32.

Table 4.32.

Analysis of Variance for Status of Marriage on Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	36741.22	36741.22	516.3423	.0000*
Status of marriage	4	882.84	220.71	3.1018	.0167**
Error	193	13733.24	71.16		
Total	198				

*$p < .001$

*$p < .05$

These results pointed to a trend in which participants who were still married to their deceased spouses at the time of death, but were kept apart because of work and other commitments ($M = 45.04$) perceived to have received social support from their significant others significantly more than participants who were living together, and sharing everything, with their deceased spouses at the time of death ($M = 41.84$), $t(185) = -2.28$, $p < .05$.

Moreover, it appeared that participants who were filing for divorce at the time of spousal death ($M = 63.00$) perceived to have received social support

significantly more than participants who were still married to their deceased spouses, but were kept apart because of work and other commitments at the time of spousal death (M = 45.04), t(47) = -2.34, p < .05.

Similarly, participants who were filing for divorce at the time of spousal death (M = 63.00) perceived to have received social support significantly more than participants who were living together, and sharing everything, with their deceased spouses at the time of death (M = 41.85), t(138) = -2.45, p < .05. No significant correlations were found between status of marriage and social support appraisal scores.

4.5.11. Hypnagogic hallucinations

Significant differences were found in the means of the groups of participants' hypnagogic hallucinations (seeing or hearing the deceased person during relaxation or sleep-like states) with regard to the manifestation of depressive symptomatology, $F(1, 196) = 11.20$, $p < .001$. Results of the analysis of variance are recorded in Table 4.33.

Consistent with the above findings was a pattern in which participants with hypnagogic hallucinatory experiences ranging from "good part of the time" to "most or all of the time" (hereafter to be referred to as *severe hallucinatory experiences*; M = 32.39) evinced depressive symptoms significantly more than participants whose hallucinatory experiences ranged from "none of the time", "a little of the time", to "some of the time" (hereafter to be referred to as *mild hallucinatory experiences*; M = 26.54), t(196) = -3.35, p < .001.

Table 4.33.

Analysis of Variance for Hypnagogic Hallucinations on Depression (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	168452.1	168452.1	1136.691	.0000*
Hypnagogic hallucinations	1	1659.2	1659.2	11.196	.0009*
Error	196	29046.3	148.2		
Total	198				

*$p < .001$

Significant positive correlations were found between hypnagogic experience and depression scores ($r = .233$, $p < .01$), which implies that the more prevalent and intense the hypnagogic hallucinatory experiences, the more the participants evinced depressive symptoms in the wake of conjugal loss and *vice versa*.

Significant differences were also found in the means of the groups of participants' hypnagogic hallucinations with regard to the use of the problem-solving coping strategy, $F(1, 196) = 22.39$, $p < .001$. Results of the analysis of variance are presented by means of Table 4.34.

Table 4.34.

Analysis of Variance for Hypnagogic Hallucinations on the Problem-solving Coping Strategy of the CSI (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	160262.0	160262.0	10425.79	.0000*
Hypnagogic hallucinations	1	344.1	344.1	22.39	.0000*
Error	196	3012.9	15.4		
Total	198				

*p < .001

A pattern consistent with the above findings was that participants with severe hallucinatory experiences (M = 30.07) made use of the problem-solving coping strategy significantly more than participants with mild hallucinatory experiences (M = 27.41), t(196) = -4.73, p < .001.

Significant positive correlations were also found between hypnagogic hallucination and problem-solving coping strategy scores (r = .320, p < .001), which implies that the more prevalent and intense the hypnagogic hallucinatory experiences, the more participants made use of the problem-solving coping strategy in the wake of spousal death and *vice versa*.

Furthermore, significant differences were found in the means of the groups of participants' hypnagogic hallucinations with regard to the use of the

avoidant coping strategy, $F(1, 196) = 4.76$, $p < .05$. Results of the analysis of variance are presented by means of Table 4. 35.

Table 4.35.

Analysis of Variance for Hypnagogic Hallucinations on the Avoidant Coping Strategy of the CSI (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	90619.22	90619.22	9063.996	.0000*
Hypnagogic hallucinations	1	47.63	47.63	4.764	.0303**
Error	196	1959.55	10.00		
Total	198				

*$p < .001$

**$p < .05$

A pattern that was consistent with the above results was that participants with severe hallucinatory experiences ($M = 22.11$) made use of the avoidant coping strategy significantly more than participants with mild hallucinatory experiences ($M = 21.12$), $t(196) = -2.18$, $p < .05$.

Significant positive correlations were also found between hypnagogic hallucination and avoidant coping strategy scores ($r = .154$, $p < .05$), which implies that the more prevalent and intense the hypnagogic hallucinatory

experiences, the more participants made use of the avoidant coping strategy in the wake of conjugal loss and *vice versa*.

Furthermore, significant differences were found in the means of the groups of participants' hypnagogic hallucinations in respect of the appraisal of the social support received, $F(1, 196) = 4.09$, $p < .05$ (Table 4.36).

Table 4.36.

Analysis of Variance for Hypnagogic Hallucinations on the Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	355562.5	355562.5	4867.466	.0000*
Hypnagogic hallucinations	1	298.5	298.5	4.087	.0446**
Error	196	14317.6	73.0		
Total	198				

*$p < .001$

**$p < .05$

A general trend compatible with the result presented in Table 4.36 was that participants with severe hallucinatory experiences ($M = 44.05$) perceived to have received social support from their significant others significantly more than participants with mild hallucinatory experiences ($M = 41.57$), $t(196) = -2.02$, $p < .05$.

Significant positive correlations were also found between hypnagogic hallucination and social support appraisal scores (r = .143, p < .05), which implies that the more prevalent and intense the hypnagogic hallucinatory experiences, the more participants perceived to have received social support from their significant others in the wake of spousal death and *vice versa*.

4.5.12. Concurrent bereavement

Significant differences were found in the means of groups of concurrent bereavement (having lost – also through death – another relative within the past twelve months, in addition to the deceased spouse) in respect of the manifestation of depressive symptoms, $F(1, 196) = 6.59$, $p < .05$. The results of the analysis of variance are illustrated in Table 4.37.

Table 4.37.

Analysis of Variance for Concurrent Bereavement on Depression (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	141842.4	141842.4	935.8439	.0000*
Concurrent bereavement	1	998.5	998.5	6.5878	.0110**
Error	196	29707.0	151.6		
Total	198				

*p < .001

**p < .05

Consistent with these results was a pattern in which participants who had not lost any other family member or close relative besides the deceased spouse (hereafter to be referred to as *non-concurrently bereaved participants*; $\underline{M}$ = 30.66) evinced depressive symptoms significantly more than those who had lost other family members or close relatives in addition to the lost spouse (hereafter to be referred to as *concurrently bereaved participants*; $\underline{M}$ = 25.91), t(196) = 2.57, $\underline{p}$ < .05.

Significant negative correlations were also found between concurrent bereavement and depression scores ($\underline{r}$ = -.180, $\underline{p}$ < .05), which implies that the more concurrently bereaved the participants, the less did they evince depressive symptomatology in the wake of spousal death and *vice versa*.

Significant differences were also found in the means of groups of concurrent bereavement with regard to the manifestation of anxiety symptoms, F(1, 196) = 13.08, $\underline{p}$ < .001. The results of the analysis of variance are presented by means of Table 4.38.

What the results in Table 4.38 pointed to was a trend in which concurrently bereaved participants ($\underline{M}$ = 15.04) evinced anxiety symptoms significantly more than their non-concurrently bereaved counterparts ($\underline{M}$ = 10.89), t(196) = -3.62, $\underline{p}$ < .001.

Significant positive correlations were also found between concurrent bereavement and anxiety scores ($\underline{r}$ = .250, $\underline{p}$ < .001), which implies that the more concurrently bereaved the participants, the more did they evince anxiety symptoms in the wake of conjugal loss and *vice versa*.

Table 4.38.

Analysis of Variance for Concurrent Bereavement on Anxiety (BAI) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	29787.86	29787.86	506.2400	.0000*
Concurrent bereavement	1	769.68	769.68	13.0806	.0004*
Error	196	11532.91	58.84		
Total	198				

*p < .001

Significant differences were also found in the means of groups of concurrent bereavement in respect of the use of the problem-solving coping strategy, $F(1, 196) = 43.17$, p < .001. The results of the analysis of variance are presented by means of Table 4.39.

A general trend revealed by results illustrated in Table 4.39 was that the non-concurrently bereaved participants (M = 29.80) made use of the problem-solving coping strategy significantly more than the concurrently bereaved participants (M = 26.10), $t(196) = 6.57$, p < .001.

Significant negative correlations were also found between concurrent bereavement and the problem-solving coping strategy scores (r = -.425, p < .001), which implies that the more concurrently bereaved the participants, the less did they make use of the problem-solving coping strategy in the wake of spousal death and *vice versa*.

Table 4.39.

Analysis of Variance for Concurrent Bereavement on the Problem-solving Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	138547.2	138547.2	9870.660	.0000*
Concurrent bereavement	1	605.9	605.9	43.166	.0000*
Error	196	2751.1	14.0		
Total	198				

*p < .001

Significant differences were also found in the means of groups of concurrent bereavement in respect of the use of the social support-seeking coping strategy, $F(1, 196) = 7.82$, $p < .01$. The results of the analysis of variance are recorded in Table 4.40.

Consistent with results presented in Table 4.40 was a pattern in which the non-concurrently bereaved participants ($M = 26.00$) made use of the social support-seeking coping strategy significantly more than their concurrently bereaved counterparts ($M = 23.63$), $t(196) = 2.80$, $p < .01$.

Significant negative correlations were found between concurrent bereavement and the social support-seeking coping strategy scores ($r = -.196$, $p < .01$), which implies that the greater the magnitude of concurrent

bereavement, the less did participants make use of the social support-seeking coping strategy in the wake of spousal death and *vice versa*.

Table 4.40.

Analysis of Variance for Concurrent Bereavement on the Social Support-seeking Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	109172.8	109172.8	3419.463	.0000*
Concurrent bereavement	1	249.6	249.6	7.819	.0057**
Error	196	6257.7	31.9		
Total	198				

*$p < .001$

**$p < .01$

Furthermore, significant differences were also found in the means of groups of concurrent bereavement in respect of appraisal of the social support received, $F(1, 196) = 16.03$, $p < .001$. The results of the analysis of variance are illustrated in Table 4.41.

A pattern that was consistent with this result is that the non-concurrently bereaved participants ($M = 44.32$) perceived to have received social support from their significant others significantly more than their concurrently bereaved counterparts ($M = 39.33$), $t(196) = 4.00$, $p < .001$.

Table 4.41.

Analysis of Variance for Concurrent Bereavement on the Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	310171.6	310171.6	4499.463	.0000*
Concurrent bereavement	1	1104.8	1104.8	16.026	.0001*
Error	196	13511.3	68.9		
Total	198				

*p < .001

Significant negative correlations were also found between concurrent bereavement and the social support appraisal scores (r = -.275, p < .001), which implies that the less the magnitude of concurrent bereavement, the greater were the participants' subjective perceptions of social support received from their significant others in the wake of spousal death and *vice versa.*

4.5.13. Post-loss intimate relationship status

Significant differences were found in the means of the post-loss intimate relationship status (whether or not participants were involved in an intimate relationship after the death of the spouse), with regard to the manifestation of depressive symptoms, $F(1, 195) = 4.32$, $p < .05$. Results of the analysis of variance are presented by means of Table 4.42.

Table 4.42.

Analysis of Variance for the Post-loss Intimate Relationship Status on Depression (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	8116.09	8116.092	52.89247	.0000*
Post-loss intimate relationship	1	663.20	663.198	4.32206	.0389**
Error	195	29921.80	153.445		
Total	197				

*p < .001

**p < .05

Consistent with this finding was a pattern in which participants who were not intimately involved (hereafter to be referred to as *sexually inactive participants*; M = 29.26) evinced depressive symptoms significantly more than participants who were involved in an intimate relationship post-loss (hereafter to be referred to as *sexually active participants*; M = 16.25), t(195) = -2.08, p < .05.

Significant positive correlations were also found between post-loss intimate relationship status and depression scores (r = .147, p < .05), which implies that the greater the magnitude of participants' disengagement in intimate relationships post-loss, the more they evinced depressive symptoms and *vice versa*.

Significant differences were also found in the means of the post-loss intimate relationship status with regard to the use of the problem-solving coping strategy, $F(1, 195) = 6.23$, $p < .05$. Results of the analysis of variance are presented by means of Table 4.43.

Table 4.43.

Analysis of Variance for the Post-loss Intimate Relationship on the Problem-solving Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	10656.65	10656.65	639.1944	.0000*
Post-loss intimate relationship	1	103.84	103.84	6.2285	.0134**
Error	195	3251.04	16.67		
Total	197				

*$p < .001$

**$p < .05$

Compatible with this finding was a trend in which sexually inactive participants ($M = 28.65$) made use of the problem-solving coping strategy significantly more than their sexually active counterparts ($M = 23.50$), $t(195) = -2.50$, $p < .05$.

Significant positive correlations were also found between intimate relationship status and problem-solving coping strategy scores ($r = .176$, $p < .05$), which implies that the greater the magnitude of participants'

disengagement in intimate relationships post-loss, the more they made use of the problem-solving coping strategy and *vice versa*.

Significant differences were found in the means of the post-loss intimate relationship status with regard to the use of the avoidant coping strategy, $F(1, 195) = 6.68$, $p < .05$. Results of the analysis of variance are illustrated in Table 4.44.

Table 4.44.

Analysis of Variance for the Post-loss Intimate Relationship on the Avoidant Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	5996.155	5996.155	603.1332	.0000*
Post-loss intimate relationship	1	66.409	66.409	6.6798	.0105**
Error	195	1938.627	9.942		
Total	197				

*$p < .001$

**$p < .05$

A pattern that was consistent with this finding is that the sexually inactive participants ($M = 21.62$) made use of the avoidant coping strategy significantly more than the sexually active participants ($M = 17.50$), $t(195) = -2.58$, $p < .05$.

Significant positive correlations were also found between post-loss intimate relationship status and avoidant coping strategy scores (r = .182, p < .05), which implies that the greater the magnitude of participants' disengagement in intimate relationships post-loss, the more they made use of the avoidant coping strategy and *vice versa.*

Significant differences were also found in the means of the post-loss intimate relationship status with regard to the participants' subjective perceptions of the nature of the pre-loss marital relationship they had with their spouses, $F(1, 195) = 4.70$, $p < .05$. Results of the analysis of variance are recorded in Table 4.45.

Table 4.45.

Analysis of Variance for the Post-loss Intimate Relationship on the Pre-loss Marital Relationship (EMS) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	22050.00	22050.00	364.9489	.0000*
Post-loss intimate relationship	1	283.91	283.91	4.6990	.0314**
Error	195	11781.79	60.42		
Total	197				

*p < .001

**p < .05

A pattern compatible with the findings in Table 4.45 was that the sexually inactive participants (M = 41.76) reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship significantly more than the sexually active participants (M = 33.25), t(195) = -2.17, p < .05.

Moreover, significant positive correlations were found between the post-loss intimate relationship status and pre-loss marital relationship scores (r = .153, p < .05), which implies that the greater the magnitude of participants' disengagement in intimate relationships post-loss, the more they reported adaptability and satisfaction with most of the aspects of the marital relationship they had with their deceased spouses and *vice versa*.

4.5.14. Onset of medical illness

For those participants who reported to be suffering from a medical illness (who constituted 55.05% of the sample), investigations were done to determine whether any significant differences existed in the means of the group whose onset of medical illness predated the conjugal loss and of the group whose onset of illness followed the loss in respect of each of the main variables (depression, anxiety, coping strategies, social support appraisal, and pre-loss intimate relationship).

Significant differences were found in the means of onset of medical illness with regard to the manifestation of depressive symptoms, $F(2, 195) = 10.63$, $p < .001$. Results of the analysis of variance are recorded in Table 4.46.

Consistent with the above findings was a pattern in which participants whose onset of medical illness could be traced only after the death of the spouse (such illness hereafter to be referred to as *illness succeeding death*; M =

36.16) evinced depressive symptoms significantly more than participants whose onset of medical illness preceded the conjugal loss (illness hereafter to be referred to as *illness predating death*; M = 25.64), t(107) = -4.95, p < .001. There were no significant correlations between scores on the onset of medical illness and depression scores.

Table 4.46.

Analysis of Variance for the Onset of Medical Illness on Depression (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	162965.5	162965.5	1147.718	.0000*
Onset of medical illness	2	3017.3	1508.6	10.625	.0000*
Error	195	27688.2	142.0		
Total	198				

*p < .001

Significant differences were also found in the means of onset of medical illness with regard to the use of the problem-solving coping strategy, $F(2, 195) = 8.85$, p < .001. Results of the analysis of variance are presented by means of Table 3.47.

Findings outlined in Table 4.47 pointed to a pattern in which participants with illness succeeding death (M = 30.09) made use of the

problem-solving coping strategy significantly more than participants with illness predating death (M = 26.98), t(107) = -4.15, p < .001.

Table 4.47.

Analysis of Variance for Onset of Medical Illness on the Problem-solving Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	149135.9	149135.9	9449.683	.0000*
Onset of medical illness	2	279.5	139.7	8.854	.0002*
Error	195	3077.5	15.8		
Total	198				

*p < .001

Moreover, significant positive correlations were found between scores on onset of medical illness and problem-solving coping strategy scores (r = .196, p < .01), which implies that the more prevalent the medical illness following spousal death, the more did participants make use of the problem-solving coping strategy and *vice versa*.

Significant differences were also found in the means of onset of medical illness with regard to the use of the social support-seeking coping strategy, *F*(2,

195) = 5.80, p < .01. Results of the analysis of variance are illustrated in Table 4.48.

Table 4.48.

Analysis of Variance for Onset of Medical Illness on the Social Support-seeking Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	117576.0	117576.0	3732.974	.0000*
Onset of medical illness	2	365.5	182.7	5.802	.0036**
Error	195	6141.8	31.5		
Total	198				

*p < .001

**p < .01

Findings in Table 4.48 pointed to a pattern in which participants with illness succeeding death (M = 27.49) made use of the social support-seeking coping strategy significantly more than participants with illness predating death (M = 23.74), t(107) = -3.66, p < .001.

Moreover, there were no significant correlations between onset of medical illness and social support-seeking coping strategy scores.

4.5.15. Overall physical health

Participants were asked to provide their subjective ratings of their overall physical health along the dimensions of 'good', 'average', and 'poor'. Investigations were done in order to determine if significant differences existed in the means of the three groups of ratings.

Significant differences were found in the means of participants' subjective ratings of their overall physical health in respect of the manifestation of depressive symptomatology, $F(2, 194) = 7.58$, $p < .001$. The results of the analysis of variance are presented in Table 4.49.

Table 4.49.

Analysis of Variance for Overall Physical Health on Depression (BDI-II) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	101806.4	101806.4	702.6112	.0000*
Overall physical health	2	2195.4	1097.7	7.5758	.0007*
Error	194	28110.1	144.9		
Total	197				

*$p < .001$

In accordance with the results presented in Table 4.49, depressive symptoms for participants who rated their overall physical health as *average* ($M = 28.63$)

were significantly higher than they were for participants who rated their overall physical health as *good* (M = 20.92), t(117) = -2.67, p < .01.

In similar vein, participants who rated their overall physical health as *poor* (M = 31.81) evinced depressive symptoms significantly more than participants who rated their overall physical health as *good* (M = 20.92), t(100) = -4.05, p < .001.

Significant positive correlations were also found between participants' subjective ratings of their overall physical health and depression scores (r = .256, p < .001), which implies that the poorer the overall physical health as subjectively rated by participants, the more they evinced depressive symptoms and *vice versa*.

Significant differences were also found in the means of participants' subjective ratings of their overall physical health in respect of the manifestation of anxiety symptomatology, $F(2, 194) = 9.76$, p < .001. Results of the analysis of variance are illustrated in Table 4.50.

Consistent with the findings outlined in Table 4.50 was a pattern in which participants who rated their overall physical health as *poor* (M = 15.21) evinced anxiety symptoms significantly more than both the participants who rated their overall physical health as *good* (M = 10.75), t(100) = -2.23, p < .05, and the participants who rated theirs as *average* (M = 10.23), t(171) = -4.61, p < .001.

Significant positive correlations were also found between participants' subjective ratings of their overall physical health and anxiety scores (r = .257, p < .001), which implies that the poorer the overall physical health as subjectively

rated by participants in the wake of spousal death, the more they evinced anxiety symptoms and *vice versa*.

Table 4.50.

Analysis of Variance for Overall Physical Health on Anxiety (BAI) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	20141.63	20141.63	350.1912	.0000*
Overall physical health	2	1122.15	561.08	9.7551	.0001*
Error	194	11158.12	57.52		
Total	197				

*$p < .001$

Furthermore, significant differences were found in the means of participants' subjective ratings of their overall physical health with regard to the use of the problem-solving coping strategy, $F(2, 194) = 10.49$, $p < .001$. Results of the analysis of variance are illustrated in Table 4.51.

The above findings pointed to the pattern in which participants who rated their overall physical health as *average* ($M = 29.60$) made use of the problem-solving coping strategy significantly more than both the participants who rated their overall physical health as *good* ($M = 25.58$), $t(117) = -4.74$, $p <$

.001, and the participants who rated theirs as *poor* (M = 28.17), t(171) = 2.45, p < .05.

Table 4.51.

Analysis of Variance for Overall Physical Health on the Problem-solving Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	106858.2	106858.2	6847.469	.0000*
Overall physical health	2	327.4	163.7	10.490	.0000*
Error	194	3027.5	15.6		
Total	197				

*p < .001

In turn, participants who rated their overall physical health as *poor* (M = 28.17) made use of the problem-solving coping strategy significantly more than participants who rated theirs as *good* (M = 25.58), t(100) = -2.52, p < .05. No significant correlations were found between overall physical health and problem-solving coping strategy scores.

Significant differences were also found in the means of participants' subjective ratings of their overall physical health with regard to the use of the social support-seeking coping strategy, *F*(2, 194) = 4.86, p < .01. Results of the analysis of variance are presented by means of Table 4.52.

Table 4.52.

Analysis of Variance for Overall Physical Health on the Social Support-seeking Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	82722.82	82722.82	2591.106	.0000*
Overall physical health	2	310.47	155.23	4.862	.0087*
Error	194	6193.58	31.93		
Total	197				

*p < .001

**p < .01

Consistent with the findings presented in Table 4.52 was a pattern in which participants who subjectively rated their overall physical health as *average* (M = 26.21) made use of the social support-seeking coping strategy significantly more than participants who rated their overall physical health as *good* (M = 22.29), t(117) = -3.04, p < .01. Similarly, participants who rated their overall physical health as *poor* (M = 24.83) made use of the social support-seeking coping strategy significantly more than participants who rated their overall physical health as *good* (M = 22.29), t(100) = -1.99, p < .05.

Moreover, there were no significant correlations between overall physical health and social support-seeking coping strategy scores.

Significant differences were also found in the means of participants' subjective ratings of their overall physical health with regard to the use of the avoidant coping strategy, $F(2, 194) = 4.67$, $p < .05$. Results of the analysis of variance are recorded in Table 4.53.

Table 4.53.

Analysis of Variance for Overall Physical Health on the Avoidant Coping Strategy of the CSI (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	61977.79	61977.79	6297.501	.0000*
Overall physical health	2	91.82	45.91	4.665	.0105**
Error	194	1909.28	9.84		
Total	197				

*$p < .001$

**$p < .05$

The results as outlined in Table 4.53 reflected a pattern in which participants who subjectively rated their overall physical health as *average* ($M = 22.15$) made use of the avoidant coping strategy significantly more than both the participants who rated their overall physical health as *good* ($M = 20.13$), $t(117) = -2.73$, $p < .01$, and the participants who rated their overall physical health as

poor (M = 21.21), t(171) = 2.02, p < .05. No significant correlations were found between the overall physical health and avoidant coping strategy scores.

Furthermore, significant differences were found the means of participants' subjective ratings of their overall physical health in respect of the appraisal of the social support received from the significant others following spousal death, $F(2, 194) = 7.99$, p < .001. The results of the analysis of variance are presented by means of Table 4.54.

Table 4.54.

Analysis of Variance for Overall Physical Health on Perceived Social Support (SSA) (N = 198)

Source	***df***	**SS**	**MS**	**F**	**p**
Intercept	1	235875.2	235875.2	3389.840	.0000*
Overall physical health	2	1111.3	555.7	7.986	.0005*
Error	194	13499.1	69.6		
Total	197				

*p < .001

Consistent with the results in Table 4.54 was a pattern in which participants who subjectively rated their overall physical health as *average* (M = 44.68) reported to have received social support from the significant others significantly more than both the participants who subjectively rated their overall physical

health as *good* (M = 37.46), t(117) = -3.93, p < .001, and the participants who rated their overall physical health as *poor* (M = 41.69), t(171) = 2.40, p < .05.

In turn, participants who subjectively rated their overall physical health as *poor* (M = 41.69) reported to have received social support from the significant others significantly more than participants who subjectively rated their overall physical health as *good* (M = 37.46), t(100) = -2.03, p < .05.

Moreover, no significant correlations were found between the participants' subjective account of their overall physical health and social support appraisal scores.

In summary, depressive symptoms following spousal death were more strongly associated with widows, sexually inactive participants whose medical illness could be traced after the death of a spouse, with participants who lost no other relative in the past twelve months, whose marriage was characterized by cohesion and those who were undergoing divorce during spousal death, and with severe hallucinations and subjective description of physical health as either 'average' or 'poor'. Anxiety was higher for widows, unemployed participants, those most recently bereaved, for concurrently bereaved, and whose physical health was subjectively appraised as 'poor'.

The use of problem-solving coping strategies were higher for semi-literate participants, with severe hallucinations, concurrently bereaved, sexually inactive, with illness succeeding death and whose health as described as 'average' or 'poor'. Social support-seeking coping strategies were highly associated with the semi-literate participants, while avoidant coping strategies were more strongly linked to severe hallucinations, sexual inactivity following

spousal death, 'average' physical health, and with participants from households with five people or less.

The social support appraisals were strongly associated with younger participants, employed, whose deceased spouse was employed at the time of death, with participants whose deceased spouses were younger, whose marriage was characterized by either divorce or physical distance, severe hallucinations, non-concurrent bereavement, medical condition succeeding spousal death, and physical health subjectively appraised as either 'average' or 'poor'. Meanwhile, adaptability and satisfaction with most aspects of the pre-loss marital relationship were reported more strongly by semi-literate, middle-income earning, sexually inactive participants as well as participants whose marriage was characterized by marital closeness and cohesion.

CHAPTER 5: QUALITATIVE DATA ANALYSES

RESULTS OF THE THEMATIC ANALYSES

The analyses of the qualitative data that were obtained from the interviews conducted with the participants, gave rise to the identification of the common analytical themes. The emergent themes yielded by the analyses constitute the thematic discussion presented below. After each quotation[7], the participant in question will be identified by the number, followed by the sex of the participant who expressed the cited words.

5.1. STRESS

5.1.1. Loss of partner

It appears that the loss of a spouse was experienced by the participants not merely as death of a loved one, but also as a loss of a partner with whom they had shared most of their married lives, as illustrated in:

> "*Eh, ndingathi nje, okokuqala ndiphulukene nokuba nomfazi... kuba ebenguyena mfazi weli khaya...* and *ke futhi, alikho ithemba lukuba ndingaphinde ndizeke...*" (Participant 16: male)

> 'What I can say is that, firstly, I have lost a state of being a married man as she was the only woman figure for this house... and I have no hope of remarrying'. (Author's translation)

Of interest to note was that central to the married life was the status that was afforded married couples – stemming from social recognition by others, which inevitably got eroded through the loss of spouse. Such conceptualisation of

---

[7] In the author's English version of the participants' quotations, the words that get presented in an underlined format, denote that particular participant's *actual* spoken words.

marriage as having an attached status could well explain participants' difficulty with coming to terms with the spousal loss, as the loss of spouse itself translated to the loss of the status that had afforded the individual full membership in a 'coupled' society. The death of a spouse as having meant the loss of the privileges associated with the married life was also revealed in the following expressions:

> "*...Ndalahlekana nesithunzi soku... sikatata...*" (Participant 101: female).
>
> 'I lost the dignity of having a male figure *in the house.*' (Author's translation, *emphasis added*)

For some participants, the death of a spouse also translated to the loss of a protective figure whose presence ensured a symbiotic relationship between the family and the outside community.

> "*Akukho mntu ubekwazi ukufane angene nje nakanjani... nasezintweni ezichaphazela umzi...*" (Participant 100: female)
>
> '*At the time my husband was alive*, no one would just interfere into the private affairs of this house.' (Author's translation, *emphasis added*)

Also, the death of a spouse was perceived by participants as a period in which they found themselves not only having to deal with the stressful loss, but also to adjust to a spouseless life.

> "*Ndingatsho ukuba indichaphazela kakhulu kuba ngoku kufuneka ndizame ukuziqhelanisa nento yokuba ndingasenaye utat'ekhaya. Ndingatsho nje ukuba... izinto zitshintshe mpela ebomini bam nje.*" (Participant 80: female)
>
> 'I can attest that I am greatly affected as I have to try to familiarise myself with having lost a male figure of this home. I can say that things have significantly changed for the worse in my life.' (Author's translation)

As illustrated in the above sentiments, conjugal loss was conceptualised as a constellation of many factors, which included the 'erosion' of all forms of protection having a spouse has, as well as having to endure the stresses embedded in a spouseless and widowed life, and the loss of social status.

Furthermore, it was intriguing to note the participants' apparent sense of vulnerability from others' intrusion into their private lives, coupled with heightened sensitivity to social evaluation in a society that views widowed households as 'incomplete' or 'incompetent' family systems. The latter point being illustrated in the following sentiment:

> *"Kufuneka bangabon'abantu uba ndihamba nzima... Ilal'ingaboni... ngoba kaloku ndawuhlekwa."* (Participant 159: female)
>
> 'I suppose people should not see that I am experiencing difficulties *in the wake of spousal death*... I'd rather that the community did not see, otherwise I would be a laughing stock.' (Author's translation, *emphasis added*)

5.1.2. Material deprivation

It seems that with the death of a spouse came significant loss of material possessions that were closely associated with the deceased spouse, in the sense that the latter played a major role in the sustenance of family life.

> *"[Izinto] ezalahlekayo za[ba] ziimpahla nje ezi zifuywayo...ebengumntu obethand'imfuyo...ngoku kwathi esomka andabi namfuyo ke ngoku... Andaphinde ke ngoku ndibe nayo imfuy'wenjengempahla...Ebengumntu obethanda ukuyelusa...Ngeli xesha ebesekhona imfuyo bendinayo...[yaye] bendingathand'ukuba ndibenayo imfuyo njengabany'abantu."* (Participant 119: male)
>
> 'What I lost was livestock... *My wife* used to like rearing livestock. After she *died* I was left without livestock, and I have since been without. She used to like looking after the livestock... so, by the time she was still alive I used to own

> livestock,' and I would like to have livestock again, just like other people.' (Author's translation, *emphases added*)

Also from the above illustration, it appears that the death of spouse not only equated to the material deprivation but also translated to the loss of socio-economic standing, especially in a society that viewed material possession as a symbol of social worthiness.

5.1.3. Loss of income

For the greater part of the time, participants experienced the death of their spouse as accompanied by a decline or a complete loss of income, wherein the deceased spouse often had served as a sole breadwinner.

> "*Kukungabi namali; umyeni wam ngoyena mntu ebedla ngokuzisa imali ekhaya, nanjengoko ebesebenza.*" (Participant 80: female)

> '*The root of the problem* is having no money; my husband was the person who used to provide money as he was working.' (Author's translation, *emphasis added*)

Also interesting to note was the conceptualisation of the deceased spouse as a medium through whom participants could meet daily challenges, and without whom life operated in a material vacuum and deprivation.

> *"Into endilahlekelwe yiyo yeyokuba andinamxhasi... ixesh'elininzi, nantso into endikhala ngayo, kuba kwiinto zonke... akukho nto ndinayo kuba akukho mntu ozis'imali..."* (Participant 158: female)

> 'One thing that I have lost is that I don't have a supportive figure for most of the times... that is my source of agony, because in everything... I just don't have anything as there is now no one who provides *the family with* money.' (Author's translation, *emphasis added*)

Inability to cater for the children's needs seemed to be central to the participants' apparent despondency over the loss of income as they felt they were helpless and powerless to play the role that used to be the deceased spouse's; that of financially supporting the family.

> "*Ndiye ndalahlekelwa kukufundis'abantwana; imali yokusa abantwana esikolweni. Ewe, ndiyazam'ukuziphilela, kodwa ke kunzima kuba andiphangeli. Ebengekh'omnye umntu ozisa imali...*" (Participant 118: female)

> 'I have lost an ability to send my children to school; *I mean,* the money to send them to school. I try to sustain my life, but it's challenging because I am unemployed. There was no one else to provide us with money.' (Author's translation, *emphasis added*)

Of particular interest to note from the above illustrations was the embeddedness of grief with sudden deterioration in families' financial position, to the extent that the death of spouse got conceptualised as tantamount to financial deprivation, especially in traditional families where one spouse served as a source of income.

5.1.4. Single-handed responsibilities

More frequently, the loss of spouse seemed to have evoked pervasive feelings of self-doubt as the envisaged inability to single-handedly carry out parental responsibilities found overt expression, as illustrated in:

> "*Iyoo, kunzima ekhayeni. Kunzima, umzi awuyonto yakudlala... Ubukhuni, ebantwaneni nasekufundiseni... Ukucinga nje ukuba 'aba bantwana ndizakubathini na'.*" (Participant 2: female)

> 'Oh, it is difficult here at home! It is *really* hard; running a household is not a child's play. It is difficult, especially with regard to children – having them get education. One often thinks, "I wonder what I will do with the children!" (Author's translation, *emphasis added*)

For these participants, the death of a spouse also brought about burdensome responsibilities, some of which used to be performed by the deceased spouse. Thus, widowhood came to be experienced not just as the absence of the other spouse, but also as an overwhelming experience of having to single-handedly play the role of both spouses.

> "*Iyandichaphazela kuba izinto ebezisenziwa nguye sele kunyanzelekile ukuba mazenziwe ndim ngoku... Ezinye andizubanawo amandla wokuzenza... Ndinoxanduva lokuba mandibheke ukuba iihagu ziphiwe, iinkukhu ziyazalela kahle, ngoku loo nto ifuna ukuba mandisoloko ndi... ndi-*supervise *ekhaya.*" (Participant 16: male)

> 'I am affected because I am now supposed to do things that used to be done by *my wife*. I will not have the strength to perform some of the tasks... I now have such responsibilities as to feed the pigs, ensure the rearing of fowls; things that require that I constantly supervise here at home.' (Author's translation, *emphasis added*)

The multiplicity of responsibilities participants now had to execute did evoke a nostalgic sense of having lost a person with whom they used to share some of the household chores, as evidenced in the following participant's account:

> "*Uyabona ngeliya xesha ebesekhona, njengokuba mhlawumbi... njengokulim'iigadi ezi kanje, eh, bekuba lula ke ngoko, ngoba bendisazi ukuba noko kukho umntu ondincedisayo xa ndisemsebezini...Ewe, ndazi ukuba izinto ezinjalo kuyaqhubeleka xa ndingekho...*" (Participant 100: female)

> 'At the time he was still alive it used to be relatively easy – just like tilling the garden – because I knew that at least there was someone who helped out while I was at work. So *during those times*, things like those would continue even in my absence.' (Author's translation, *emphasis added*)

It was interesting to note that with the responsibilities added in the wake of spousal death, participants had a sense that their leisure and recreational

activities had been curtailed, and hence they experienced their social life as having been immensely disrupted.

> "*Eyokuqala yeyoba ndi[ngasa]kwazi ukuthi ndivakashe nje. Qha ndifumana i-hardship ke ngoku, kuba bendiba nexesha loku-relaxa kwezinye izinto ebe.....ebezisenziwa nguye; ngeliya xesha zisenziwa nguye ndi-relaxe...*" (Participant 16: male)

> 'Firstly, *the problem* is that now I can't even visit friends. It's just that I experience hardship now, because I used to get time to relax as some of the tasks were performed by *my wife*, which gave me time to relax.' (Author's translation, *emphases added*)

Also noteworthy was that looking after children also featured among the responsibilities participants had to single-handedly endure after the death of the spouse, something they had also "shared" with the deceased. It was interesting to note the female participants' readiness to subscribe to the notion of irreconcilability of gender differences, thereby confirming the 'validity' of the traditional stereotyping of femininity as an incomplete entity in a patriarchally defined social order.

> "*Ndifuman'ubunzima gqitha ingakumbi ekuhlaleni nje nabantwan'aba, Njengomntu onabantwana abangamakhwenkwe, kuse kubekho... uyaqonda abantwana abangamakhwenkwe bangabantwana oye u-*notice *ukuba akululanga ukuba* handle*isha wena, kuba ungumama... Ingathi kungakho utata... Bendithi nje ubuncinane njeee ilizwi likatata livakala bhetele emntwaneni oyinkwenkwe. Andazi noba ke mhlawumbi kukwazi ukuba ithuba elide bendisoloko ndingenayo le-responsibility,* and *iye ngathi ifike yandongamela.*" (Participant 163: female)

> 'I experience a lot of difficulty, especially in living with children; as I have children who are boys, I have noticed that handling male children is particularly challenging to a mother. It's better if there is a father figure; the father's voice on its own has some authority to male children. I don't know if the problem is

knowing that this was not my responsibility, but I am feeling overwhelmed.' (Author's translation)

Moreover, having to play single-handed roles as parents tended to evoke a diminished sense of competence insofar as catering for their children's needs.

"*Indichaphazele kakhulu (utata) uz'uba ndihlelelwe sithetha ngaye nje... iyona nto bendincedisana naye, ise ngathi ngoku ndiye ndihlulakala ke ngoku...Uz'uba obefund'u-[Std.] 10 umntwana akafundi kulo unyaka...Ngenxa yaloo nto... Zinintsi, tana, izinto ezi... eziye... endikhalazela zona... Ebendincedisa ngamandla kuzo...esikolweni ebendinceda kakhulu...*" (Participant 159: female)

'I am left adversely affected so much that *my children and I* often talk about *my husband* as he was very supportive. As far as I can see, I am really failing to live up to being a provider, such that even the child who was doing Standard 10 is not at school this year because of the circumstances. Many things are a cause for concern. *My husband* used to be very supportive in terms of paying for children's school fees.' (Author's translation, *emphases added*)

Notably, the power of resilience regularly continued to manifest itself in which participants expressed their determination to provide for their children, notwithstanding the burden of single-handed parenting. This may be seen as an attempt to defy the entrapment into the cycle of learned helplessness, a pattern that often characterised most participants' conjugally bereaved state.

"*Izinto zitshintshe mpela kangangoku ngenxa yokungabikho kwemali ebidla ngokusetyenzwa ngumyeni wam, ngoku ndizibhaqe sele ndingumntu ogawula iinkuni ngelizama ukuzithengisa. Iyonke loo nto ndiyenzela ukuba abantwana bakwazi ukulala betyile apha ekhaya.*" (Participant 80: female)

'Things have changed dramatically because of the absence of the money that used to be provided by my husband. As a result, I have had to chop wood in order to sell it; I am doing all this so that my children do not go to sleep in empty stomachs.' (Author's translation)

> "*Ifuna yonke into ndizizamele; akekho umntu endincedisana naye, ndiyazizamela yonke into. Ndithengisa ke, ndizama nokuthenga 'impahl'ethile, ndithengise...*" (Participant 118: female)

> 'Everything requires that I stand up for myself. There is no one whom I am striving together with; I am all by myself. I buy certain clothing items which I then sell *in order to generate income.*' (Author's translation, *emphasis added*)

The above expressions exemplify the burden of responsibilities and hardship suddenly imposed upon the surviving spouse who is forced to make major adjustments in order to cope.

Moreover, at times there seemed to be a pattern of participants' covert inclination to challenge the traditional societal prescriptions that invariably consign widowhood as inherently an incompetence-laden phenomenon.

5.1.5. Sudden change of circumstances

Additionally, participants bemoaned the fact that they found themselves having to 'negotiate' a transitional phase from married life to a spouseless life – a phase to which they found difficult to adjust.

> "*Indichaphazela ngokuthi ke a... andiphathekanga kakuhle ngokupheleleyo...izinto zam azika... azikahambi kakuhle... Ukusukela nje ukuba engekho yena... Ewe, ndidandathekile... Nje qha, ukudandatheka kwam kukungabikho kwakhe.*" (Participant 144: female)

> 'I am affected... I do not feel particularly well. My life is generally not going well, ever since *my husband* passed away. I feel dejected, particularly over his absence *in the family.*' (Author's translation, *emphases added*)

The above sentiment served to highlight the pervasive perception of loss as unwelcome 'intruder' into the participants' lives, against which a desperate

remonstrance at the apparent irreversibility of the loss itself seemed to permeate.

Nevertheless, participants at times seemed to derive containment, coupled with a sense of validation, at being afforded an opportunity to share adjustment to loss with others who had been similarly bereft.

> "*Entliziyweni yam ndiye ndonwabe into yoba abantwana bam bebemazi into yoba utata wabo unendawo ngakubo,* unlike *uba babe bazi into yoba bahlala nomama kuphela.*" (Participant 163: female)
>
> 'In my heart I get pleasure at noting that my children also still have a place for their deceased father in their hearts, unlike a situation where they acknowledged only their mother as their close parent.' (Author's translation)

5.1.6. Uncertainty about the future

A heightened uncertainty about the future in the wake of spousal death dominated the discussion, wherein participants intimated that they had lost hope things would turn out for the better.

> "*Andiqinisekanga. Njengoko izinto zisandul'ukwenzeka ndingumntu ongenangqiniseko yokuba ndinekamva eliqaqambileyo; ise ibengathi alindiphathelanga nto.*" (Participant 80: female)
>
> 'I am uncertain *about the future.* As things have recently happened, I tend to have no certainty as to whether or not my future is bright; I get the feeling that the future holds nothing for me.' (Author's translation, *emphasis added*)

At times the process and experience of grief, and the resultant uncertainty about the future, tended to be compounded by the pervading stressors that ran concurrently with the loss of the spouse, such that participants had to deal with not only spousal death, but also the already enduring life crises.

> "[*Ikamva lam*] *limfiliba (kona-kona belingazikuba mfiliba ukuba bekungekho le ngxaki ndijongene nayo* [*yesifo se*-HIV/AIDS]), *kodwa ngenxa yayo, ndilibona*

> *limfiliba... Kukufa qha into endiyilindeleyo. Kuba andingekhe nditsho ukuba ezondincenda ngekhe indincede. Xa kufik'imini, andinakutsho - yaye andingekhe ndime ngaphambili.*" (Participant 6: female)
>
> 'My future is bleak (it would not be if it was not for the problem I am faced with HIV/AIDS illness), but because of the problem I see my future as bleak. Death is the only thing that I am waiting for. Yes, I cannot say nothing would help me. What I could not say is when would the day *for death* come, and I would not stop it *when it finally came.*' (Author's translation, *emphases added*)

The poignancy in which the above expression was expressed seemed to suggest that the grief experienced did not merely stem from the spousal loss, but also from the prospects of the participant's own demise. In fact, this brings into focus Kübler-Ross's (1981, 1989) and Davenport's (1981) conceptualisation of bereavement as comprising an overlapping relationship between grieving over the loss of the significant other, and grieving over the realisation that belief in the infinite life (that is, one's immortality) is an illusion.

Of interest to note, however, was that for some participants the loss of spouse – as stressful as it was perceived to be – did not necessarily 'erode' hope that things could change for the better.

> "*Andiboni bunzima endinokubufumana... Kusazakubangcono, ...[yaye] libakhona ithemba.*" (Participant 6: female)
>
> 'I do not foresee difficulties. Things are still going to turn out for better, and I still have hope.' (Author's translation)

The participant's glimmer of hope in the face of adversity (as exemplified in the above expression) served to pose a challenge to the notion of widowhood as a period that is fraught with hopelessness and helplessness. From this point of view, such a notion did not merely acknowledge the stresses embedded in

widowhood but also served to consign widows and widowers into a social pigeonhole from which psychological resilience was perceived to be inherently lacking.

5.1.7. Deteriorating physical health

The notion of spousal loss as having had a detrimental effect on physical health predominantly featured in the participants' account of physical well-being, with deteriorating physical health being the trend subjectively experienced by participants.

> "[*Into yokusweleka komyeni wam*] *ndiyiva indongamela, indichaphazela gqitha... Iyandichaphazela,* especially *kwimpilo...*" (Participant 163: female)

> '*The death of my husband* is overwhelming me a great deal. It affects me, especially my health condition.' (Author's translation, *emphasis added*)

In this respect, the reported feelings of grief as having a triggering effect on the onset of physiological pathology served to highlight the notion of the body as inextricably intertwined with emotions, in the sense that strenuous emotional processes (accompanying the grieving process) were thought to have a direct impact on the physiological systems and vice versa.

Moreover, it seemed the deteriorating physical health was perceived generally as a frustrating challenge for participants as it posed as hindrance to their attempts to execute their daily tasks.

> "*Eh, mandithi kulaph'empilweni ngoba ke ngoku, eh, isimo esi sam... Njengokuba asi... sithand'ukundikhathaza... Impilo – ewe, yona impilo yona ayindivumeli.*" (Participant 119: male)

> 'My *gravest concern* is with regard to my physical health, and this adversely affects me. My health condition no longer allows me *to carry on*.' (Author's translation, *emphases added*)

5.1.8. Diminishing physical strength

Resultant from spousal death was the experience of physical strength as having diminished, wherein participants felt they were no longer physically able to perform the tasks as they did at pre-loss.

> "*Kwamna sendeziwa ne-*operation *yesibeleko esibhedlela; andisenamandla a-*strong *kangako... Andisenawo nje tu amandla.*" (Participant 101: female)

> 'I have had also a surgical operation of the uterus, I no longer feel that strong... I do not have physical strength *to carry out household tasks* any more.' (Author's translation, *emphasis added*)

Also noteworthy, was the participants' frustration over the idea that their diminished physical strength had detrimentally affected the execution of their activities of daily living.

> "*Ndithi nokuba ndiyapeta aph'egadini... kufunek'uba ke mandiyeke, kuba uba ndikhe ndapeta kakhulu [isinqe] sikhe sakrunquka ndingaphinde ndisebenze. Ukuba ndikhe ndaphakamisa int'wenzima... akusalungi...*" (Participant 119: male)

> 'Even if I till the land in the garden, I need to take it easy because if I overdo it my waist starts aching, which makes me unable to work again later. Even lifting something weighty is always a challenge.' (Author's translation)

From the above illustrations, what became evident was the participants' sense of desperation over their perceived lack of usefulness to themselves and others. Interestingly, the pre-occupation with self-perceptions of usefulness seemed to define each individual's social worthiness in a society that emphasised

productivity as an ideal virtue. From this vantage point, therefore, the perceived loss of physical strength that apparently pervaded the period of widowhood served to militate against the participants' striving for such societal ideal.

Moreover, the intense wish for social recognition through being productive, as manifest in the participants' expressions, would thus be symbolic of their need for solidifying the social and emotional bonds with others, a factor that in turn would accredit them full membership status in the society.

5.1.9. Relational problems

Problems in interpersonal relationships with the significant others dominated the participants' discourse, and these problems were generally perceived as adversely affecting the process of conjugal bereavement. When describing the relationship with in-laws, one participant provided a rather equivocal sentiment:

> "*Ngumntu we*-family *phofu... okhe wazama [ukutyhuluba]... Nabantu be*-family *bebengenzi nakanjani [ngexesha esaphila umyeni wam]... izinto ezinje ngokuba afane athethe njee...*" (Participant 100: female)

> 'It is someone from the extended family who tried to interfere, and family members did not do as they pleased *when my husband was still alive...* like talking anyhow.' (Author's translation, *emphasis added*)

At times, the described relationship with in-laws appeared to be of an ambivalent nature. In such instances, participants expressed mixed feelings over having to assume deceased spouse's responsibilities, which included playing a custodianship role over the dependants.

> "[*Ubom*] *bu*-right, *qha into eyenza kube nzima kukuthi [umama wenkosikazi] ungumntu oselayo..., othi ke ma sel'eselile angabi ngumntu o*-right... *intombi yakhe ibikwazi ukumqoqa. Ngoku ke kunzima, ma ndizam'ukumqoqa mna kuzakuba ngathi ndidlala ngaye kuba ingasekho intombi yakhe.*" (Participant 16: male)
>
> 'Life is right, the only difficulty is that my late wife's mother is a heavy drinker, which makes her a difficult person when under the influence of alcohol; only her daughter (my wife) could contain her behaviour. Now *that she is no longer with us*, things are different; *I am a bit concerned that* should I try to contain her, it might appear as if I am abusing her now that her daughter is no longer with us.' (Author's translation, *emphases added*)

At times, participants' concerns pertained to the perceived psychological distance and 'unfair treatment' they experienced in their relationship with the extended family members. The subjective experience of themselves as 'outsiders' in a bigger family unit, highlighted the maladaptive nature of the relationship participants had with their significant others.

> "*Zizinto ezinxulumene nokuhlalisana – aph'ekhayeni. Andingetsho ukuba ngabantu... endisondelelene nabo kakuhle... Akukho nto endingayitsho... abandiphethe kakuhle ngayo... Ziintetho nje zabo endibona ukuba zezithikamez'umoya... malunga nokusweleka kwakhe...*" (Participant 121: female)
>
> '*The problem rests in* issues pertaining to interpersonal relationships with the extended family. I can hardly say that I am close to any of them, and there is no sign that I am fairly treated. Mostly, things they say about my husband's *suicide* do break my heart.' (Author's translation, *emphases added*)

For the above expressions, the poignant characterisation of in-laws as 'the un-containable problem', and of extended family as both distant and 'unfair' – coupled with heightened sensitivity to social evaluation – could be seen as a complicating factor in the process of conjugal bereavement, wherein

participants not only had to cope with the stress arising from spousal death, but also grappled with the vicissitudes embedded in negatively attuned interpersonal relationships.

5.1.10. Diminished social contact

Dominant in the participants' accounts of their experience of conjugal bereavement was the situation where they found themselves having minimal social engagement with their communities, as required of them for a certain period during the first year of mourning the spousal loss.

> "*Andikabi nabo abantu [endibonana nabo], kuba ndihlal'aph'ekhaya – andikayi mzini, andikabonani nabantu...*" (Participant 164: female)

> 'As yet, I do not have people I can socially relate to, because I always stay at home – I do not yet visit other households; I do not mingle with other people yet.' (Author's translation)

At times, participants' covert endorsement of the societal prescriptions forbidding social contact in the expression of mourning following spousal death became manifest.

> "*Ndisamile okwangoku, [yaye] andiyi emizini, ngaphandle kokuba ndiye nje apho kuyi... ndiyi-family khona..., hayi emizini engave iyi*-family *yalaph'ekhaya.*" (Participant 16: male)

> 'I am still in seclusion, and do not go to other households, except for cases in which those are part of my extended family. I may not visit households that are not part of our extended family network.' (Author's translation)

A tacit assumption apparently espoused by some participants was that minimal social contact served ironically to offer them an opportunity for execution of household tasks, which could have otherwise been missed.

"*Kaloku ndisoloko ndizihlalel'aph'ekhaya, ndisenza umsebenzi wam [wekhaya].*" (Participant 101: female)

'In fact, I am always at home, doing my household chores.' (Author's translation)

Viewing competency tasks as diametrically opposed to the benefits of social contact could be understood as symbolic of implicit protestation against societal subjection to cultural isolation – that is, a prostestation that took the form of passive compliance necessary for fitting into the socially defined order. Since the rationale for prescription of seclusion following spousal death was that the recently bereaved individuals were presumed to be unable to cope with, and meet the challenges embedded in, social interaction, the participants' apparent commitment to running their household tasks in the face of social isolation could thus be seen as satirical of the contradictions embedded in the social construction of conjugal bereavement – in which the latter is viewed as essentially an incompetence-laden phenomenon.

Participants' account of their experience of seclusion also often revealed some deep-seated agony over having been excluded from the social milieu, which ironically defined their basic survival and sense of belongingness in a society.

"*Into ekunayo, sisengabantu abangakwaziyo ukuya komnye umzi, siyohlala... ngenxa yezila. [Noba ndifuna into ekhaya] bathi mandithumele umntwana, njengoba ndingekayi kubo - ndoya kubo kusokombulwa...*" (Participant 159: female)

'The problem is that currently, we *as widowed women* are still not able to visit other households, because of the black veil. Even if I need something from my parents, a child has to run my errand as I am still barred from visiting them; I will only visit after the unveiling ritual.' (Author's translation, *emphasis added*)

More often than not, participants' expressed 'fears of being alone' served to openly challenge the societal prescription of cultural seclusion following spousal death, wherein the validity and contextual appropriateness of such seclusion was put into question, especially given the human need for social contact in the face of adversity.

> "*Ndiyakoyika ukuba ndibendodwa, kangangokuba ndiye ndifune ukuba abantwana babekhona ekhaya xa engekho umazala. Nditsho nokuba kusemini, andikhululeki xa ndihleli ndedwa, ngokungathi kuzakwenzeka into embi kube kungekho mntu ukhoyo.*" (Participant 80: female)
>
> 'I am scared of being alone, such that I usually need my children's company when my mother-in-law is not around. Even if it is during the day I do not feel free when I am alone, as if something awful may happen when no one else is around.' (Author's translation)

Moreover, the notion of cultural seclusion as definitively characteristic of mourning the loss of spouse seemed to be vigorously questioned by some participants.

> "*[Xa ndindedwa] ndizifumane ndifana nomntu olilolo.*" (Participant 158: female)
>
> 'When I am alone, I find myself very much like a lonely person.' (Author's translation)

The poignancy through which the above sentiment was expressed could be understood as a symbolic appeal for a renewed look at the process of grief and mourning, thereby rendering obsolete some of the societal prescriptions about mourning that serve to undermine psychological adjustment to conjugal loss.

5.1.11. Pre-loss marital relationship

Predominant in the participants' discussion about the nature of the marital relationship they had had with their deceased spouse at pre-loss, was the reminiscence over the satisfactory nature of the relationship, the absence of which was experienced as a source of agony now that the spouse was deceased.

> "*Ndiye ndikhumbule ulonwabo lodwa, nanjengoko sasithandana kakhulu nomyeni wam... Xa ndicinga ngexesha ebesaphila ndiye ndizive ndifikelwa yintlungu ingakumbi ndakufikelwa ziingcinga zamaxesha esasonwabe ngayo emtshatweni wethu.*" (Participant 80: female)

> '*When I think of my husband* I usually remember happiness only as he and I were much in love with each other. When I recall the times, I feel heartache, especially when thoughts cross my mind of what we had in our marriage.' (Author's translation, *emphasis added*)

The reported mutually satisfactory and supportive pre-loss marital relationship seemed to have significantly reinforced the reminiscential tendencies for some participants, as illustrated in:

> "*Iinkumbulo zezokuba ebethi ukuba ndinento endiyirhalelayo, angayithengi into abeyithanda okanye abe ezimisele uzakuzithengela yona ngayo, ayincamele mna; ebeluncedo kakhulu kum.*" (Participant 16: male)

> 'Memories stem from that even when I wanted something *my wife* would rather not buy what she had thought of buying for herself, and sacrificed that for me; she was very supportive of me.' (Author's translation, *emphasis added*)

It appeared at times that the form of reminiscing about the lost relationship with the deceased seemed to manifest in a more 'denialist' nature, wherein participants' resolve was to act as if the deceased were still alive.

> "*Ngenye imini ndade ndathi ndinexhala lokuba make ndimlungiselele ukutya, fan'ukuba ulambile. Ndazokothuka kamva, 'nkosi yam, kambe utata akasekho'.*" (Participant 101: female)

> 'One other day, I was worrying over preparing food for *my husband*, thinking that he may be hungry. I then realised, "my Lord, by the way he is no longer alive!".' (Author's translation, *emphasis added*)

Such apparent psychological dissociating from the trauma of having lost their spouse could be understood as a desperate attempt by participants to temporarily gain some measure of control over their emotionally distraught state.

At times participants' accounts of the pre-loss marital relationship seemed to harbour ambivalent feelings towards both the relationship and the deceased spouse. In this case, material value associated with the deceased spouse emerged as a definitive characteristic of the ideal marital relationship.

> "*Kona besiphathisene kakuhle kona ngeli xesha ebesaphila. Qha kona ngeli xesha ebesasebenza ebendisokolisa kakhulu... apha emalini. Ngamanye amaxesha beziye zidlule nokuba iinyanga ziyi-8 engandithumeleli mali.*" (Participant 2: female)

> 'We got along very well when he was alive. The only problem at the time he was working was that he would create financial problems for us, sometimes going for up to 8 months without providing us with money...' (Author's translation)

For some participants, marital infidelity on the part of the deceased spouse featured strongly as having had a significantly negative impact on the pre-loss marital relationship, although tacit acceptance of infidelity as both 'normal' and inextricably linked to the relationship was expressed, as illustrated in.

> "*Izinto... zamadoda wonke ke: nento yokuhamba nje umntu angabuyi... [azokulala ekhaya; ahambe elala namantombazana].*" (Participant 100: female)

> '...Typical tendencies for all men: he frequently did not sleep at home; and instead slept around with girls.' (Author's translation)

In this expression the objectification of the 'girls' – which literally translated to a 'not fully developed- or immature woman' – could be seen as a means of seeking to trivialize the impact the spousal infidelity had had on the ambivalently experienced pre-loss marital relationship. The covert attempt to absolve the deceased spouse from responsibility for involvement in extra-marital affairs, by viewing only 'girls' as blameworthy, could be interpreted as the manifestation of the *husband sanctification* (Lopata, 1979, 1996), which entailed developing an extremely idealised image of the deceased husband and the life the bereaved had with the spouse at pre-loss. Moreover, drawing from the dynamics of the ego psychology, the ostensible conceptualisation of marital infidelity as an excusable behaviour that found qualified 'acceptance' to some participants could be seen as serving the function of the underlying defence mechanism of *reaction formation* (Vaillant, 1971), in which participants could be seen as professing sentiments that were incompatible with their true intimate feelings.

Furthermore, the ostensible mitigation of the impact of marital infidelity on the pre-loss marital relationship – particularly stemming from regarding the 'practice' of simultaneously having multiple sexual partners as 'normal' for African males (Sossou, 2002; Speizer, 1995) – served to highlight the intact traditional socio-cultural dynamics, which comprised the consignment of individuals into gender-differentiated pigeonholes.

> "*Besiphathisene kakuhle, kodwa hayi kakhulu... [ingxaki] ndingase ndithi nje zizinto nje ezimalunga namantombazana kanje... Bekukh'wizixaka-xakana nje ezincinci...*" (Participant 121: female)

> 'We treated each other well, but not that much. The problem lay with his extramarital affairs, which brought *minor* differences *in our marriage.*' (Author's translation, *emphases added*)

For some male participants, marital infidelity at pre-loss had seemed to offer means through which they could display their masculinity, notwithstanding the repercussions on the marital relationship.

> "*Besinobudlelwane kakhulu naye, qha yena into ebengayifuni kukuba... ndibe nomntu [osecaleni]. Nale yokuba ndibe nomntu ngasese bendiyenza ekhona..., kodwa ke ndimfihlela...*" (Participant 16: male)

> '[*My late wife and I*] had a great marital relationship; it is just that she was vehemently opposed to me having extramarital affairs. But despite her objections, I would do it but behind her back.' (Author's translation, *emphasis added*)

Another important aspect of the pre-loss marital relationship that some participants harboured strong ambivalence about was being deserted by the estranged spouse.

> "*Yena ebeziphethe kakuhle kakhulu..., into kunayo wasuka wemka ke wazihambela... wayozihlalela kowabo...*" (Participant 119: male)

> 'She was a very faithful wife. The only problem was that, *some time prior to her demise*, she had left me on her own accord, to live with her family of origin.' (Author's translation, *emphasis added*)

With the spouse having died, the above expression could also shed some light into the participants' experience of being 'abandoned' following spousal death. Hence, this could be seen as a symbolic cry over 'desertion' by the deceased spouse.

To recapitulate, the stresses associated with the death of a spouse stemmed from difficulties managing multiplicity of singlehanded parental and other related responsibilities, all which tended to undermine the surviving spouse's coping efforts. Compunding factors in the experience of stress accompanying conjugal loss included the loss of income, material deprivation,

uncertainty about the future, deteriorating physical health and strength, relational problems, diminished social contact, the overall loss of social prestige and status closely tied to being married, and conflicting – and yet unresolved – thoughts and emotions surrounding an ambivalently held pre-loss marital relationship.

5.2. COPING

5.2.1. Instrumental support

The social support received from significant others seemed to have played an integral part in the participants' experience of grief, in which the benefits of such support dominated the discussion.

> "*Izinto ezindizisela ulonwabo [yinkxaso esuka ku]...bahlobo... Noomakhelwane bam ke abaya abathi xa ndibenengxaki ndidibane nabo, nabahlobo bam basecaweni..., nomndeni.*" (Participant 2: female)

> 'Things that bring me happiness comprise support from friends. Even my neighbours whom I turn to for help when I have a problem are very supportive. And it is likewise with church friends and my family.' (Author's translation)

At times participants rendered an elaborate account of the benefits of emotional support, which was perceived as having a buffering effect in the experience of grief.

> "*Ibaluncedo ngamany'amaxesha ngoba iye ithi nokuba mhlawumbi unomvandedwa othile, ubone kungathi... [kuthand'ukuthi 'hu' kancinci]... Indlela andixhasa ngayo [umamazala] iyandomeleza... Andicebise indlela yokuba mandidlulise kanjani... Okanye mhlawumbi ndimbone ngenye imini exhasa ebantwaneni...*" (Participant 158: female)

> '*Emotional support* becomes helpful; like when one has *disturbing* feelings inside; *talking about it* brings some relief. The way my mother-in-law supports me makes me stronger; she would advise on how to let go of *emotional pain*, or at

> times she would assist with supporting children as well.' (Author's translation, *emphases added*)

It was intriguing to note that the support served as an indispensable factor in the gratification of both the basic physiological needs, without which survival was perceived to have been improbable.

> "*[Ukuba besingafumananga nkxaso]... bekungayingxaki kakhulu [yaye] besingalala singadlanga...*" (Participant 2: female)
>
> 'If it was not for the social support, it would have been problematic, and we would have gone without food.' (Author's translation)

The participants' perception of support as being indispensable seemed to have shaped their exponential need for continued social contact, which highlighted the notion of the primitive need for human contact when overwhelmed by stressful situations (Amirkhan, 1990).

> "*[Ngendlela endixhaseka ngayo] mna bendithanda ukuba ndingehlukani nomama[-zala].*" (Participant 158: female)
>
> '*Judging by* the way in which I subjectively experienced support, I would rather that I did not get separated from my mother-in-law.' (Author's translation, *emphasis added*)

Having a shared widowhood identity with some members of the community seemed to have an ameliorating effect for participants' experience of grief, as this provided participants an arena from which to garner social support necessary for coping with the stresses embedded in the widowhood period from the 'similar others'.

> "*Nokuy'ehlathini ke, ndiye ndihambe nomny'umama... naye ke, wayeswelekelwe yindoda..., kodwa sele wembulwa. Nguye ke umntu endihambisana naye.*" (Participant 159: female)

> 'Even going to collect wood in the forest, I usually go with another woman who also lost her husband, but has already had the unveiling ritual; she is the one whose company I keep *and value*.' (Author's translation, *emphasis added*)

Of particular interest to note was that the shared widowhood identity served as a medium through which participants' hope for a successful resolution of grief was based.

> "*Ndiyazixelel'uba,* at least, *ndizakufana nabanye abantu nam... Abalahlekelweyo baphinda bayilibala laa nto, bazixelel'into yoba... mabahlale loo ntlalo bayihleliyo.*" (Participant 163: female)

> 'I often tell myself that <u>at least</u> I will be like other people who also lost their loved ones, and moved on with their lives by accepting unto themselves that their lives had irrevocably changed.' (Author's translation)

The manner in which the above sentiment was conveyed served to highlight the sense of urgency in which participants sought the acceptance of their loss. The ostensible appeal to rational thought in explaining the loss, herein juxtaposed with the poignant expression in which such loss was subjectively experienced, may be interpreted as indicative of higher level, adaptive form of coping in which the emotional repercussions of loss got openly acknowledged, while simultaneously seeking to construct meaning that was aimed at shaping and facilitating the coping process.

It appeared that institutionalized support occasioned by membership in a church also served as a buffering mechanism against the stress associated with loss, as participants perceived to have received invaluable social support from fellow congregants following spousal loss.

> *"[Eyona nto ibaluncedo kakhulu] kukuthandaza... [no]kucela umthandazo wabanye abantu [endi]hlangana [ndi]kwacawa nabo. [Oyena mntu uluncedo] ngutat'uMfundisi wam nebandla..."* (Participant 6: female)
>
> 'One thing that helped was prayer as well as asking that I be prayed for by other members of the church. My Pastor and the congregation entirely have been instrumental in offering me support.' (Author's translation)

Noteworthy, was that for some participants religious orientation did provide some solace through which they could cope with the emotional strain associated with the death of the spouse.

> "*...Elona xesha ndiye ndizive ndi*-relieved *nakwi*-problem *yokucing'into yoba... ndakwimeko ethile, lixesha lokuba senkonzweni... lelona xesha ndiye ndizive uba* at least *ikhona into... ethathekayo... Ndiyakwaz'uku... thandaza njeeee noba ndindedwa,* but *ke elona thuba ndiye ndive uba noko intlungu neengcingane zimkile njeee, nje kuxa ndidibene nabany'abantu... Ndifumanisa ukuba ingathi yeyona ndlela ebhetele..."* (Participant 163: female)
>
> 'The time that I feel emotionally relieved from thinking about my problem is when I am in the church; that is the time I feel that at least there is some relief. I can pray even when I am alone, but the time I feel my worries and disturbing thoughts have waned is when I am with other people. I find this to be a better way *of coping.*' (Author's translation, *emphasis added*)

Religion was also revealed to be specifically playing a curative role in dealing with the upsetting memories about the lost spouse, which participants would have otherwise rather kept out of active awareness.

> *"Zazikhona kuqala [iinkumbulo zomsindo], kodwa ngokuna sendaxolayo... ndazithandazelayo ke ezo... UThixo ke wandixolisa ke ngoku, zadlula nje tu..."* (Participant 101: female)
>
> 'I used to have a lot of upsetting memories, but I have now gotten over them; I prayed to God so that he facilitates emotional healing, and I let all those go.' (Author's translation)

In the above expression, religion was appraised as having served to 'shield' participants from emotional vulnerabilities associated with spousal death.

It was also interesting to note how deeply ingrained religious affiliation was into the participants' worldview, particularly when it pertained to the construction of meaning surrounding the death of spouse.

> *[Emva kokugula kwakhe okude]...ndada ndanikezela kuThixo ngaye, ndanikezela into yokuba kunokuba amqaqambisele ngolu hlobo, kubhetele athabathe izigqibo zakhe... Wazithatha ke uThixo izigqibo. Ndayamkela.* (Participant 16: male)
>
> 'During my wife's lengthy illness, I surrendered to God so He could make His own decisions about her (rather than to have her endure such physical pain). God indeed took a decision *when my wife died*, and I accepted it *as His will.*' (Author's translation, *emphases added*)

As illustrated above, death is construed as a welcome, natural and hence a deity-ordained phenomenon, this being a meaning making that seemed to be central to the participants' quest for a facilitated coping with the loss.

The centrality of religion in the participants' worldview also emerged in their general assessment of future prospects, wherein lay the predominant view of their fate as contingent upon the ordaining of the supernatural power.

> "*...Bendingathandazela ikusasa lam liqhakaze. Ndithemba kuThixo ukuba uzakuzenza zibebhetele [izinto]...*" (Participant 118: female)
>
> 'I would like to pray for a brighter future. I also hope that God will make things better for me.' (Author's translation)

Of interest to note, however, was that sometimes a more 'intellectualizing' approach to making meaning about the death would be adopted, wherein participants' explanation of death tended to be divorced from the religious domain.

> "*[Ukufa yinto] eyamkelekayo, ingakumbi [njengokuba] iyinto eqhelekileyo ngokwendalo yethu; kulungil'ukuyiqhela...*" (Participant 163: female)
>
> 'It is possible to accept death, especially that it is a common phenomenon that is part of our nature; it is something to be used to.' (Author's translation)

Theorising death in such a secularised manner, therefore, could be understood as an unconscious attempt to compensate for the meaning-making 'deficits,' which an appeal to religion as a sole means of explaining, understanding – as well as coping with – the loss, may not have adequately addressed.

In the expressions outlined above, what became evident was the participants' perception of social and instrumental support being *readily available* at their disposal as having been critical in facilitating the coping process.

Instances existed, however, of concerted efforts participants actually made to seek social support as a means of coping with their loss, wherein sharing the problems with the significant others was perceived to have had a healing effect on the emotionally distraught state.

> "*[Kuthe kwakubanzima ndabona ukuba mandiyithethe ingxaki yam] nabany'abantu... abangabahlobo bam..., bandiduduza ke, bathi mandiyiyeke le nto, kuzakuba* right." (Participant 118: female)
>
> 'When things became difficult, I resorted to talking about my problem with other people who are my friends; they comforted me by assurances that things are going to turn just right.' (Author's translation)

The power of sharing problems with others, coupled with the curative role it plays in relieving the emotional burden associated with spousal death continued to dominate the discussion, in which participants continuously

expressed their desire for using social contact as a medium through which they could 'ventilate' stressful feelings induced by grief.

> "*Ndiye ndizame okanye ukukhupha into engaphakathi, [ngokuthi] ndizame ukudibana nomny'umntu, ndimbalisela [ngembilini yam]...*" (Participant 158: female)
>
> 'I often try to express my inner feelings by going to talk with someone with whom I could share my troubles.' (Author's translation)

At times avoidance of being alone, the latter being a potential trigger for feelings of loneliness, was revealed as a motivating factor in the participants' company-seeking propensities.

> "*Ndiyakoyika ukuba ndibendodwa, kangangokuba ndiye ndifune ukuba abantwana babekhona ekhaya xa engekho umazala... Umazala ngoyena mntu undixhasa kakhulu, nanjengoko ndihlala naye; usoloko endomeleza, endithuthuzela ngelithi mhlawumbi kuzakuba ngcono ekuhambeni kwexesha.*" (Participant 80: female)
>
> 'I get scared when I am alone, such that I always need children to be around when my mother-in-law is not available; she is one person who is supportive since I live with her. She always comforts and consoles me by assuring me that with time things may turn out for the better.' (Author's translation)

As the above expressions illustrated, social support received from significant others could be of maximal value in mitigating the stress associated with the death of a spouse. Hence, it would be crucial for individuals undergoing grief, particularly conjugal grief, that they received the necessary support if they were to successfully adapt to the critical phase of widowhood.

5.2.2. Avoidant coping

Despite the evident benefits of social support, it appeared that not all participants found social support-seeking coping as a mode of coping with conjugal loss entirely appealing, as a trend was revealed in which avoidant forms of coping were often utilised. These comprised shying away from social support structures as well as internalising emotions associated with conjugal loss.

The inclination to 'keep busy' by means of constantly engaging with the household tasks (as a way of coping with grief associated spousal death), found expression as a medium through which participants voiced reluctance to succumb to the emotionally debilitative grief state.

> "*Ndisuke ndihambe ndiy'ehlathini, ndenz'ukuchith'isithukuthezi..., kuba xa ndihlel'aph'ekhaya, noko sikhon'isithukuthezi sokuhlala ndingenzi nto... Kufunek'ukuze kube ngcono, ndisukume ndenz'into...*' (Participant 164: female)
>
> 'I would go to the forest *to collect firewood* just to while away time, because sitting around at home doing nothing may induce immense loneliness. For me to cope better, I should keep busy.' (Author's translation, *emphasis added*)

Moreover, the power of distraction as a means of coping grew in significance as this sought to represent an open defiance of a potentially disempowering nature of conjugal bereavement, wherein participants' assertion of their coping capabilities became manifest.

> "*[Ubukhulu becala] ndiye [ndizixakekise], ndisebenze, ...[khon'ukuze] kube ngcono ke...*" (Participant 159: female)
>
> 'Mostly, I keep busy by doing the *household* work, so that the situation *of being emotionally distraught* gets better.' (Author's translation, *emphases added*)

At times participants openly challenged the notion of social proximity as having an incremental coping value, wherein 'glorified' solitary life found more expression.

> *"...Andinasithukuthezi [nje tu]. Andikwazi nokuphuma ndithi ndiyobutha kangangokuba iindaba zelali ndiye ndizive sele zidlulile... kuba kaloku ndisoloko ndizihlalel'aph'ekhaya, ndisenza ...umsebenzi wam..."* (Participant 101: female)
>
> 'I do not feel lonely at all. I cannot even make time to visit *the neighbours*, such that I am always outdated with community affairs because I always stay at home, doing the work.' (Author's translation, *emphasis added*)

However, expressions like the one just cited above could be interpreted in twofold: on the one hand, as an indication of the attempt at which participants sought to reconcile with the cultural prescriptions that dictated solitary life as the definitive widowhood characteristic, something which participants had neither say nor control in constructing. On the other hand, it could be construed as symbolically representing a subtle protest against cultural norms under which solitary widowhood life was subsumed. Viewed from both vantage points, the expression cited above underscored the detrimental effects loneliness associated with solitary life during widowhood had on the psychological well-being of the recently conjugally bereaved participants.

For some participants the preference for internalisation of feelings associated with their grief was unequivocally expressed, albeit with no clearly identified underlying causative factor, as illustrated in:

> "*Andikakwazi nokuyithetha le nto... [yokushiywa ngumyeni wam]... hayi andika[thandi] kuyithetha [okwangoku]...*" (Participant 144: female)
>
> 'I just cannot talk about the loss of my husband at all. I do not like to share it *with other people* just yet.' (Author's translation, *emphasis added*)

At times, however, the perceived curative effect of emotionally disengaging with the loss was revealed as the motivational factor for participants' internalisation of grief.

> "*...Indiphathe kakubi ke [into yokuba kuthethwe ngokuswelekelwa kwam], ngoba bayandithunuka... Kungcono xa kuse kuvele kungasathethwa ngayo...*" (Participant 159: female)
>
> 'Talking about the death of my husband usually takes a big toll on me; it immensely provokes emotional pain. More often, I prefer not to talk about it.' (Author's translation)

The power of 'distracted' conversations also found meaningful expression, in which participants' engagement in activities not related to spousal loss was perceived as having ameliorative effect in the experience of grief.

> "*[Eyona nto ndidla ngokuyenza xa ndifun'ukuziva bhetele kukuba] ndibekhona nje iincoko ezahlukileyo... Mandithi mhlawumbi kukuncokola nje izinto ezi-*general..." (Participant 163: female)
>
> 'One thing that I usually do that makes me feel better is talking... about other unrelated things; I mean, talking about general issues.' (Author's translation)

The above expressions highlighted that, for some participants, avoidant coping was beneficial in coping with bereavement-induced stresses, as avoiding confrontation with the stress provided participants with a psychological 'cooling-off' opportunity (respite) in which they could disengage mentally and emotionally with the stress at hand in order to make it manageable.

5.2.3. Problem-solving coping

It appeared that practical and concerted efforts aimed at solving the problems secondary to the death of a spouse were utilised by participants, these being attempts of rendering the bereavement-induced stress manageable.

In this respect, the reported determination to engage in tasks that facilitated solving problems resultant from conjugal loss could be seen as an attempt through which participants asserted both their potential and capacity for competency notwithstanding the loss.

> "*...kuyo yonk'into, ndiyayizama into yokuba mandi...zimele... Ndiyazama... ukuba ndizimele kuba ndiyayiqond'ukuba ndindedwa...*" (Participant 118: female)
>
> 'In everything [that I do], I strive for independence; I try to be independent because I am well aware that *with my husband's absence* I am on my own *with virtually no one else to rely upon.*' (Author's translation, *emphases added*)

Furthermore, participants' display of open defiance against the potentially incapacitating grief state found expression, wherein bereavement became conceptualised as presenting opportunity for exerting psychological resilience resultant from solving day-to-day problems, as illustrated in:

> "*[Emva kokusweleka kukatata wekhaya] ndaphila ngokufundis'abantwana bam, ngokuba ndiqonde ukuba, hey, yinqalo le: ndathengisa impahla...*" (Participant 101: female)
>
> 'After my husband's death, I resorted to sending my children to school *so that they get education* as I had realised that this [*conjugal loss*] is not something to consume myself into; I should rather start selling clothes...' (Author's translation, *emphases added*)

Moreover, the overt resoluteness to fight odds became a medium through which the participants' intense want for a sense of control over challenging widowhood life circumstances found expression.

"*Nokuba kukubi nje kodwa nam ndiyazizama... [ewe, kona kunzima], kodwa... zikhona... iindlela zokuzinceda...*" (Participant 144: female)

'Although things are worse, I do try to make the situation better; indeed, it is a challenge, but there will always be ways of helping myself *out of the quagmire.*' (Author's translation, *emphasis added*)

Furthermore, striving for access to limited resources served to highlight the participants' need for sustenance of life within the inherently disempowered socio-economic circumstances.

"*...ndiye ndithi xa ndithe ndabamba amatorho (apho ndiye ndifumane imali), kubabhetele... Xa ndithe ndafumana loo madlana [kuza umahluk'omkhulu]...*" (Participant 2: female)

'When I hold some temporary jobs, which provide me with a source of income, I usually feel better; getting money brings a significant difference.' (Author's translation)

In this instance, the pursuit of monetary power, seen here as a means of making amends for the financially deprived widowhood state, could be interpreted as representing the desperate efforts in which participants sought to cope with the stress embedded in conjugal bereavement. Moreover, the latter view resonates with the established view that having a paid work identity has ameliorative effects on the stresses that stem from the loss of a spouse (Aber, 1992; Lindstrøm, 1999; McCallum, Piper & Morin, 1993).

As illustrated in the above expressions, measured efforts were made by participants to practically deal with the stresses induced by the loss of the spouse. These served to highlight that coping as a process was not merely contingent upon participants as passive recipients, but that active steps were taken that were aimed at ameliorating the stressful conjugal bereavement state.

5.2.4. Other factors facilitating adjustment to loss

5.2.4.1. Competencies and activities of daily living

An important aspect that gained significance in facilitating coping, for some participants, was the subjective perception of their activities of daily living being rampant, notwithstanding the spousal death – something which could be seen as indicative of better psychological adjustment to the loss.

> "*Zikhona izinto... [endisakwaziyo uku]...zenzela, kuba kwangeliya xesha ebekhona... bendizenzela izinto ezininzi...*" (Participant 164: female)

> 'There are many activities that I'm still able to perform general tasks; even at the time my spouse was still alive, I used to be able to them *and nothing has changed much.*' (Author's translation, *emphasis added*)

Viewed from the above perspective, functional independence coupled with competency in performing activities of daily living could be interpreted as a self-esteem booster, which in turn rendered participants to be better equipped to cope with the stress induced by loss.

5.2.4.2. Psychological immunisation

For some participants, psychological immunisation was revealed as a factor characteristic of their widowhood experience, and this could be seen as an embodiment of the participants' propensity for resilience, wherein the potential for 'recovery' in the face of adversity found overt expression.

> "*Kusazakubangcono.... [nakuba ndilahlekelwe] akukho bunzima ndizakubuqala, bendivele ndibuthwele kakade...*" (Participant 6: female)

> 'The situation will still turn out for the better. Despite my loss, hardship is not something I will be encountering for the first time; it is something I am used to.' (Author's translation)

The reported immunization that pervaded the above expression could also be seen as representing an open challenge to the notion of grief as inherently detrimental to the psychological well-being of the individuals undergoing bereavement.

5.2.4.3. Improved communication with children

The power of the personal relationships with offspring following spousal death dominated the participants' accounts of their interpersonal relationship domain, wherein such relationships were subjectively perceived as positively attuned and emotionally rewarding. Such perceptions could be interpreted as indicative of participants' better adjustment to loss – one of the prerequisites for adaptive coping.

> *"Izinto ezindizisela ulonwabo, ndiphawula intlonipho apha ebantwaneni – abandihlonipha ngayo... ebendingayiboni kakuhle... ngexesha ebesekhona [umama wabo]... iqhina lobudlelwane lomelele ngoku, [yaye] siyanxibelelana."* (Participant 16: male)

> *'One of the* things that bring me happiness is noticing the level of obedience and respect my children have towards me, which I hardly experienced when their mother was still alive. The bond *I have with them* is stronger now, and we communicate *much* better.' (Author's translation, *emphases added*)

Moreover, it was noteworthy that central to the participants' adjustment to loss were perceptions of children's progress, which served as a glimmer of hope in the face of adversity.

> *"...Ndingathi indizisela uvuyo into yokuba abantwana bapase... [esikolweni]... [Into yokuba bafunde, inika ithemba lokuba ekugqibeleni kungabhetele]..."* (Participant 118: female)

> 'It brings happiness to see that my children are doing well and passing the grades at school. To have them get education is a source of hope that the situation may get better some other day.' (Author's translation)

At times participants openly acknowledged the extent to which their coping was contingent upon both their relationship with children and interpersonal relationships in general.

> "*Undisokolisile ke lo omdala [umntwana]; ngalo lonke ixesha ubesoloko endibuza ukuba uphi na utata wakhe... - yaye indiphathe kabuhlungu le into, ndinga...zi ukuba ndizakuyithini... Abantu... bandicebisa ukuba mandimxelele xa aleleyo (ukuba utata wakhe wasweleka...); ndalizama... kwabakanye elo qhinga. Ndingatsho ukuba lasebenza, kuba akazange aphinde andibuze ngotata wakhe...*" (Participant 80: female)

> '*Since my husband's death* I have had trouble with the older child; she would repetitively inquire about her father, and this induced profound emotional pain in me as I did not know how to deal with it. People advised me to tell her whilst she was asleep that her father had died. I tried this only once, and I can now say it worked as she never again asked me about her father.' (Author's translation, *emphasis added*)

The latter expression illustrated that, although the coping process occured, and enhanced through interaction, within a social context in which the individual operated, it may be seen as representing participants' inability to completely assert their individuality in an inherently socialised milieu, from which escape posed a challenge. Thus, each individual's actions and mannerisms were largely governed by a set of predetermined socially crafted rules. The latter point was particularly illustrated in:

> "*[Ngamany'amaxesha ndiye ndiye ndi...] fumanise ukuba kunzima nokuba ungasa isandla emntwaneni... genxa yemiqathango ekhoyo (evela eburhulumenteni)... Kwameko le yokuphila kwabantwana bethu izakwahluka kwimeko yokuphila kwethu sisakhula...*" (Participant 163: female)

> 'Sometimes I find that it poses a challenge to instil discipline in children, because of the prevailing government regulations governing the application of discipline. Our children's way of life seemingly will differ from our own childhood years *because of these restrictions*.' (Author's translation, *emphasis added*)

In this expression, the ostensible disdain towards authoritatively prescribed set of rules, which were seen here as hindering self-regulated predisposition to life, could shed light into the underlying frustration participants genereally experienced over having to abide by the societal prescriptions that governed actions and behaviours, of which stress and coping formed part. As such, this may be seen as symbolically representing a subtle protest against those societal prohibitions that often deny the expression of individual differences with regard to the experience of bereavement-induced stress and the choice of coping endeavours.

5.2.4.4. Continuing bonds with the deceased

Participants' account of their experience with conjugal loss also revealed a pattern in which they still felt connected emotionally and spiritually to the deceased spouse, wherein such continuing bonds were experienced as having a curative effect on grief.

> "*[Ndidla ngokuba nemibono ngomyeni wam] – uyavele ndithandaza ndodwa... futhi avel'enxibile... eyona nto engathethi... Ndiye ndizive ndingcono kakhulu... futhi ndingamoyiki ...ndingazi ukuba yintoni...*" (Participant 159: female)

> 'I usually experience vision for my *deceased* husband; *often* he appears when I engage in solitary prayer, appearing fully dressed but not speaking. That usually makes me feel much better, and I somehow do not fear him *when he suddenly appears*' (Author's translation, *emphases added*)

Although this expression may be seen as marked reluctance to acknowledge the current widowhood status (wherein the irrevocability of the loss is thus denied), the power vested in the bond attaching the participants to the deceased could be interpreted as a symbolic representation of the pursuit for solace in the context of grief.

Moreover, the apparent normalisation of reported hallucinatory experiences pertaining to the bonds with the deceased, served to underscore the participants' preparedness to incorporate such bonds as truly characteristic of the conjugal bereavement period, as illustrated in:

> "*...Ndiye ndingathethi [xa evela]... ngoba kaloku kufanele ndiphendule into ayithethayo... [Eyona nto] ndimoshwa kukungathethi [kwakhe]...*" (Participant 159: female)

> 'When *my husband* suddenly appears I usually do not talk *to him* as I am supposed to only respond to what he says. The frustrating thing, however, is that he never utters a word.' (Author's translation, *emphases added*)

From the above expression it is noteworthy that the ostensible *ego-syntonicity* (that is, the acceptability to the ego) of the hallucinatory experiences was consistent with the social construction of grief, which assigned the griever to a more passive, uncritical and submissive role. In addition, the expression also revealed the extent to which the societal prescriptions pertaining to the manner in which grief ought to be experienced and expressed appeared to be internalised. The readiness to respond only to the 'instructions' as presumably given by the husband (as envisioned) highlighted the hierarchical gender stereotyping, which assumed an inferior feminine role – to which participants were 'willing' conformists.

At times the continuing bonds participants felt towards the deceased spouse gained omnipotent assumptions, wherein the deceased spouse was perceived to possess cumulative power, knowledge and influence over the participants' lives.

> "*...Njengokuba sekweliyaa cala ke ngoku, mhlawumbi amandla... okuzisa iintsikelelo – mhlawumbi uwabona ngcono kweliyaa cala. Ingase ndicele zona nje ukuthi andicelel'iintsikelelo kuThixo uba mandi...benento [endi]yifumanayo yokuphila...*" (Participant 16: male)

> 'As *my wife* is now on the other side *of life*, maybe she is better equipped to bring us blessings. In that case, I would request her to ask God's blessings for me so that I have a better life.' (Author's translation, *emphases added*)

It was also intriguing to note that the continuing bonds served as the medium through which the gratification of participants' immediate needs could be sought. Herein, the causal relationship between the deceased's presumed spiritual powers and the sustainability of life's demands found overt expression.

> "*...[Ndiye] ndicele ukuba makasikhusele kweli khaya. Nokuba... kudingeka into... ndiye ndi...cele [uncedo kuye lwento ethile ephelileyo mhlawumbi],...ndithi ndiyabona sele zikhona...*" (Participant 2: female)

> 'I usually ask that he protect us in this family. Even if we have run out of the basic needs, I often pray to him to ask that he provide; and *since he helps us find a way of providing for ourselves* things start falling in place and I then see the basic needs being readily available *through others' help*.' (Author's translation, *emphases added*)

Also noteworthy from the above expression was the marked reluctance to relinquish the 'protected status' that previously had been characteristic of the married life. Thus, the conceptualisation of the deceased as a 'protective' being may be seen as open defiance of the notion of inherent psychological vulnerability as embedded in conjugal bereavement.

At times, the pattern of continuing bonds with the deceased assumed quasi-didactic undertones, in which participants' advice seeking became the medium through which the presumed attachment to the deceased found expression.

> "*Xa ethetha mhlawumbi usenokundicebisa uba mandenze njani na... ndize ndibe ndivuke... malunga ne mfuyo... ukuba andicebise ukufumana yona... Ndingase ndibambe [loo] macebiso, [ndize ndilandele] wona...*" (Participant 119: male)
>
> 'If *my wife* were to speak, maybe she would advise me on how to regain wealth through rearing livestock. I would follow *whatever* advice she may give me *in this regard*.' (Author's translation, *emphases added*)

Also noteworthy was the conceptualisation of the bond with the deceased as encompassing an ever-binding 'marital contract' in which participants' own actions and wishes were regarded as contingent upon the deceased's presumed approval.

> "*...Bendingathi nje ...makandikhombise umntu endingase ndimthathe. Into endinexhala layo yile yokuba ndibuyise umntu [nengase imchukumise, angathandi... njengokuba ebevele engumntu onekhwele... [Leyo yinto] endingathandi ukuthi ndingayenza engakhululanga yena.*" (Participant 16: male)
>
> 'I would like a situation where *my deceased wife* could show me the right woman to marry. My gravest worry is re-marrying and upsetting her in the process. My wife was very jealous, hence I would not want to do anything without her express approval.' (Author's translation, *emphasis added*)

The expressions as outlined above illustrated an underlying reluctance to renounce the ties that bound the relationship to the deceased spouse, while simultaneously attempting to find solace through re-definition of the spouseless life as re-kindled by the emotional and cognitive memento held towards the lost spouse. Moreover, this served to reinforce the notion that, notwithstanding the

physical absence of the deceased spouse, the bond that tied the participants to the deceased was perceived to be still intact.

5.2.4.5. Unveiling ritual

The power assigned to the upcoming, and yet much-anticipated, traditional, cultural unveiling rituals that would mark the culmination of the one-year mourning period, continued to manifest itself in the participants' account of their experience with conjugal bereavement. The participants' discourse surrounding the rituals revealed an inextricably linked relationship between the experience of grief and the personal significance the rites had to their psychological well-being, wherein the cumulative adaptive value of the rites to a spouseless life found overt expression.

> "*...Ndinethemba kona, kodwa ke [nakuba ndingʃazi – [kubaʃizinto ziyatshintsha; [kona], ndilindele ukuba kode kufike elaa xesha lokuba ndakhulula [iimpahla ezimnyama]...*" (Participant 164: female)

> 'I have hope *for the better.* Although I can never be sure *about what future holds for me* – given the sudden change of circumstances, all I am looking forward to is the time for the *cultural* shedding of the black mourning veil.' (Author's translation, *emphases added*)

An idea covertly illustrated in the above expression was the conceptualisation of the unveiling ritual as symbolically representing a sense of 'closure' to the socially prescribed phase of mourning, which could explain the pervasive anticipation for the ritual. The resonance with which the sense of anticipation for the unveiling ritual carried may be seen not solely as a completion of the mourning cycle, but also as a reinforcing point of recognition for the irrevocability of the loss.

It was also noteworthy that rituals had generally come to be viewed as the indispensable phenomena for the sustenance of the participants' lives at post-loss, wherein their well-being was deemed contingent upon the appeasement of the 'spirits' of the deceased, as illustrated in:

> "...[*Njengokuba elele*] *phaya samngcwabela khona [umyeni wam], ...akazi ngoku ukuba seza ngapha... Bathi abantu ...kufuneke sixhel'ibhokhwe... simxelel'uba siza apha ngoku...*" (Participant 159: female)

> 'As my husband lies in his grave, he does not know that we have since moved *to the new homestead.* People *we occasionally talked to* pointed out that we should slaughter a sacrificial goat as a gesture of notifying him about our relocation.' (Author's translation, *emphases added*)

The centrality of the unveiling ritual to the participants' conceptualisation of the resolution of grief also revealed marked reluctance to succumb to the financial pressures exerted by adherence to the very practice of such rites. Herein, participants found themselves unable to repudiate the standards set as 'truly reflective' of mourning resolution.

> "*...[Ndiyafuna] uba ndijong'uba umsebenzi lo awufumaneki [kusini] na... Ngoba andikembulwa, [ndifun'ukwenza amalungiselelo]... kwenzel'uba ke ndembulwe...*" (Participant 119: male)

> 'I am determined to finding out about the possibility of getting a job. As I have not yet undergone a cleansing ritual *following my wife's death*, I want to make preparations for it in order that I get cleansed accordingly.' (Author's translation, *emphasis added*)

At times the notion of the unveiling ritual as both phenotypical of the participants' worldview and of being the medium through which their identification with their traditionally established norms could be channelled,

did find expression – notwithstanding the apparent frustrations over the financial limitations in executing the rites.

> "*Nangokuna njengokuba kukho laa [mcimbi] kuthiwa ngumembulo, bekufanele ukuthi mandibe ndombuliwe, endingazi ukuba ndizakuqala phi, ndi[ze]... ndithini [xa] ndilungiselela... akukho namali [yoneleyo, esinokuthi siyisebenzisele loo mcimbi]...*" (Participant 101: female)

> 'Even now, I am supposed to undergo the unveiling ritual *once the mourning period is over*, I do not know where I will start in preparing for such ritual. There is just not enough money to use to conduct the ritual.' (Author's translation, *emphasis added*)

It was intriguing to note in the above expression that the juxtaposition of material deprivation (that is, lack of money) and the dire need for a realisation of a self-fulfilling 'prophecy' (the ritual), yielded a poignant ironic twist to a potentially distressing bereavement state. On the one hand, the message communicated in the specific expression outlined above served to 'beckon' the audiences to deepen their empathic understanding of the vicissitudes of conjugal bereavement. On the other hand, it could be seen as a means of accentuating the intense want for 'emancipation' from the psychologically debilitating effects of grief.

Furthermore, the fact that the inherently costly unveiling ritual '*should*' mark the end of an already financially strenuous mourning phase, may be seen as symbolically representing the protest against the very rationale behind which the phenomenon (unveiling ritual) had been socially constructed.

As illustrated in participants' expressions outlined above, the significance the unveiling ritual held for participants was that it served as a medium through which the sense of 'closure' could be brought about for the

active mourning phase of their conjugal bereavement. However, financial strain appeared to be a complicating factor that undermined the very execution of the cleansing ritual.

To conclude, although the qualitative data analyses offered a limited contribution towards a contextual understanding of the participants' subjective experience of conjugal bereavement, it nevertheless provided rich and meaningful insight into how individuals undergoing spousal bereavement specifically interpreted their spouseless lives and generally decoded their world. Moreover, the data rendered a deeper understanding of the manner in which the conjugally bereaved rural black populations experience the loss of their spouses, the manner of their coping with grief and secondary problems arising out of loss as well as ways they seek to reconstruct their lives without the deceased spouse.

CHAPTER 6: DISCUSSION OF FINDINGS

6.1. STRESS: DEPRESSION AND ANXIETY

6.1.1. Depression

The findings from the present study supported the hypothesis that the depression levels of the rural Black South African widows and widowers would be high; it was revealed that an alarming 87.88% of the participants presented with at least mild depression and 78.28% with moderate to severe depression. Consistent with this pattern of the prevalence of depression following spousal death, numerous studies conducted previously in this specific field have found that people encountering the loss of a spouse through death experience heightened levels of depressive symptomatology (Bornstein, Clayton, Halikas, Maurice, & Robins, 1973; Carnelley et al., 1999; Clayton, 1990; Clayton, Halikas, & Maurice, 1972; Futterman, Gallagher, Thompson, Lovett, & Gilewski, 1990; Gilewski, Farberow, Gallagher, & Thompson, 1991; Harlow, Goldberg, & Comstock, 1991; Jacobs, Hansen, Berkman, Kasl, & Ostfleld, 1989; Lee, Willetts, & Siccombe, 1998; McHorney & Mor, 1988; Pasternak et al., 1991; Spangenberg & Somhlaba, 2003; Stroebe, Stroebe, & Domittner, 1988; Thompson et al., 1991; Zisook, 1993; Zisook & Shuchter, 1991; Zisook, Shuchter, Irwin et al., 1994; Zisook, Shuchter, Sledge et al., 1994).

To date, a number of studies have been conducted to determine the prevalence of depressive phenomena in widows following the death of their spouses. For example, Clayton et al.'s (1972) study revealed that 35% of the 109 participants had a collection of depressive symptoms similar to those common in psychiatric depressed patients. Also noteworthy, in Jacobs et al.'s (1989) study it was found that 32% of participants who had been conjugally

bereaved for a period of 6 months (from a pool of 61 participants), and 27% of those who had been bereaved for 12 months (out of 116 participants), evinced high rate of depression. Furthermore, in their study comparing the depressive symptomatology in married women and widowed women, Harlow et al. (1991) found that 40% of the elevation in widows' depression scores at 12 months following spousal death was potentially attributable to bereavement. Also, Gilewski et al.'s (1991) study of 393 conjugally bereaved elderly adults revealed that at one month post-loss 28.7% of the participants scored in the depressed range on the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), with 36% of these scoring in the moderate to severe range. Yet another study (Zisook, Schut, Sledge et al., 1994) found that the depressive symptoms in women 13 months post-loss ranged from mild depression (for 26% of participants), moderate (13%) to severe (4%). In contrast, Carnelley et al. (1999) found 10.5% of participants in their study to be presenting with depressive phenomena that warranted a clinical diagnosis of a major depression at one year post-loss.

The reason for the apparent discrepancy between the findings of above-cited studies and the findings of the extremely high prevalence of moderate to severe depression in the present study is not clear-cut, and merits further investigation. A possible explanation is that since black people in South Africa have been found to be experiencing a lot of psychological distress emanating from numerous psychosocial stressors such as undesirable life changes, recurring life events as well as continuous life events (Spangenberg & Pieterse, 1995), the death of a spouse, for the participants in the present study, could have been an additional stressor to the ones already experienced. Moreover, it is

possible that poverty served as an exacerbating factor for this group of widows and widowers. The latter points are significant when considering the idea that the presence of additional concurrent crisis-situations becomes taxing for the individual to the extent that the coping requirements are likely to be beyond the adaptive capacities of most people (Maddison & Raphael, 1975). To this effect, Parkes (1996) has also made a compelling point when asserting that the additional crises that are in close temporal relationship to a bereavement may be associated with a poor grief outcome. In similar vein, Sanders (1993) has asserted that additional debilitating stressors during bereavement may result in overwhelming situation for the bereaved. It stands to reason, therefore, that the high depression as experienced by the conjugally bereaved individuals in the present study may have been attributable not only by grief, but also to the already overwhelming mass of other life problems encountered that also demanded continual attention and solutions.

Moreover, as evident from the qualitative data, the spousal death triggered a constellation of feelings of sadness, dejection, and diminished self-esteem, coupled with difficulties with adjusting to the loss as well as 'erosion' of the status of being married. A heightened sense of despair and helplessness resultant from the material deprivation due to the loss of income, could also explain the heightened depression levels. This particularly applied to women participants who, prior to the husbands' death, had played the 'traditional' role of a homemaker. They experienced difficulty dealing with the absence of the material provider of their families.

For the present study, the psychosocial factors cited above also emerged as salient indicators of participants' high depressive symptomatology arising

out of the loss. Evidence from the literature also points to the idea that the loss of a spouse is accompanied by difficulties with adjustment to widowhood (Bowling & Cartwright, 1982; Cook & Oltjenbruns, 1998; Lindstrøm, 1997; Littlewood, 1992; Lord, 1987; Parkes, 1993; Richardson & Balaswamy, 2001; Van Baarsen et al., 2002), diminished self-esteem (Lund, Caserta, Dimond, & Shaffer, 1989), loss of income (Bowling & Cartwright, 1982; Cook & Oltjenbruns, 1998; Gass, 1987; Littlewood, 1992; Lopata, 1996; Lord, 1987; Parkes, 1975, 1993; Sossou, 2002; Zick & Smith, 1988), single-handed responsibilities (Nadeau, 2001; Lord, 1987; Parkes, 1975) and 'erosion' of status and social benefits of being married (Gallagher, Thompson, & Peterson, 1982; Hanson & Hayslip, 2000; Kalish, 1985; Lopata, 1996).

Furthermore, the alarmingly high incidence of postpartum depression (64.9%) recently found in Spangenberg and Lacock's (2001) study of rural black South African women, pointed to numerous psychosocial factors that were deemed to have a detrimental effect on the women's psychological well-being. These factors included being married, experiencing relationship difficulties with partner or husband, having had an unplanned pregnancy, financial problems, and dissatisfaction with the social support system.

These findings cited above therefore support the idea that the participants in the present study may have been experiencing ongoing psychosocial stressors in addition to the loss of a spouse, hence the heightened depressive symptomatology.

Since the prevalence of depressive symptomatology was found to be very high, the results of the present study point to the necessity of psychological help for the conjugally bereaved men and women in the rural areas to cope with

the death of their spouses. It is therefore imperative that psychotherapeutic support systems should be put in place for black people in rural areas.

6.1.2. Anxiety

Data from the present study supported the hypothesis that anxiety levels of the sample of widows and widowers would be high. At least 69.19% of participants presented with mild anxiety symptomatology, while 27.27% evinced moderate or severe anxiety. The latter pattern of heightened anxiety symptoms following the death of a spouse has been corroborated in numerous studies conducted previously (for example, Jacobs et al., 1990; Lindstrøm, 1995a; Sable, 1988, 1991; Prigerson et al., 1996; Spangenberg & Somhlaba, 2003; Zisook, Mulvihill, & Shuchter, 1990), which found that the loss of a spouse is both a fear-inducing and anxiety-provoking experience for many bereaved spouses.

Pertaining to the prevalence of anxiety symptoms in wake of spousal death, Sable (1988) found that anxiety related to grief was reflected in reports of 58% of the respondents who reported experiencing worry, panic and fear after the husbands' deaths. In a study conducted by Jacobs et al. (1990), 25% of participants reported symptoms that qualified for a diagnosis of at least one type of anxiety disorder within the first six months after spousal death, and this figure increased to 44.4% during the second half of the first year of bereavement. Furthermore, and more consistent with the findings of the present study, a South African study of 70 rural women recently conjugally bereaved (Spangenberg & Somhlaba, 2003) revealed that an alarming 78.57% of the participants experienced anxiety at above average levels on the S-scale of

the Stait-Trait Anxiety Inventory (STAI; Spielberger, Lushene, Vagg, & Jacobs, 1983).

Moreover, the results yielded by the qualitative data that pointed to the pervasive pattern of uncertainty about their future as well as hopelessness and helplessness in wake of spousal bereavement, served to underscore the participants' anxiety symptomatology at post-loss. Due to the high prevalence of anxiety symptoms reported by participants in the present study, bereavement treatment programmes in rural areas are warranted in order to help recently bereaved men and women cope with conjugal loss.

6.2. RELATIONSHIP BETWEEN DEPRESSION AND ANXIETY

Significant positive correlations were found between anxiety and depression. The findings that participants in the present study presented with high incidences of both depression and anxiety were not surprising, primarily for two reasons. Firstly, it is the increasingly emerging view that the loss of a spouse is one of the most severe traumas a human being is likely to experience in his or her lifetime (Casement, 2000; Daggett, 2000; Gass, 1989a; Holmes & Rahe, 1967; Lindstrøm, 1997; Marris, 1974; Norris & Murrell, 1990). Secondly, the number of such stressors as difficulties in adjusting to the loss of partner, 'erosion' of the marital status of being married, material deprivation due to loss of income, having to face challenges single-handedly as well as uncertainty about the future – all which were identified by participants as complicating factors in their experience of conjugal bereavement – point to the stressful nature of spousal death. Moreover, the universality of the grief reactions after the loss of a significant other, in which the bereaved tries to adapt to such a

loss, has also been noted by some authors (for example, Botha & Pieters, 1987; Wright, 1993), which serves to underpin the notion of the death of a loved one, particularly spousal death, as inducing symptoms characteristic of both clinical depression and anxiety.

It must also be kept in mind that both anxiety and depression are inherent aspects of psychological distress, and measures of both anxiety and depression have often been used in research as indications of the emotional manifestations of stress (Spangenberg & Theron, 2001). Furthermore, it has to be noted that a clinical overlap between anxiety and depression, as also evident in the findings of the present study, has been documented by numerous other researchers to date (for example, Clark, 1989; Dobson, 1985; Lazarus, 1993; Lovibond & Lovibond, 1995; Stavrakaki & Vargo, 1986; Watson & Kendall, 1989).

The findings of the overlap between anxiety and depression in the present study point to the relevance in bereavement intervention programmes of recognising depression and anxiety as characteristic features of grief and bereavement, in order that treatment of grief-induced depression runs in tandem with treatment of grief-induced anxiety, and *vice versa*.

6.3. RELATIONSHIP BETWEEN ANXIETY AND COPING STRATEGIES

The surprising findings from the present study, which was also sharply contrasted to the hypothesis that there would be a significant relationship between stress levels and coping strategies, were that no significant relationships were found between anxiety and the participants' use of each of the three kinds of coping styles.

For example, the negative correlations found between the participants' scores on the Beck Anxiety Inventory (BAI) and their scores on the problem-solving coping strategies scale of the Coping Strategy Scale (CSI) were not significant. Moreover, the regression analyses demonstrated that the problem-solving coping strategy was not a significant predictor of anxiety. This was inconsistent with three previous South African studies done on recently detoxified alcoholics (Spangenberg & Campbell, 1999), patients with systemic lupus erythematosus and rheumatoid arthritis (Venter et al., 1999), and recently widowed rural black women (Spangenberg & Somhlaba, 2003), which all found significant negative relationships between anxiety and a problem-solving coping strategy.

The negative correlations found between the participants' scores on the BAI and their scores on the social support-seeking coping strategies scale of the CSI were not significant. Moreover, the regression analyses demonstrated that the social support-seeking coping strategy was not a significant negative predictor of anxiety. Inconsistent with this finding is Spangenberg and Somhlaba's (2003) study of recently widowed women, which found significant negative relationship between anxiety and a social support-seeking coping strategy.

Furthermore, the negative correlations found between the participants' scores on the BAI and their scores on the avoidant coping strategies scale of the CSI were also insignificant, and the regression analyses demonstrated that the avoidant coping strategy was an insignificant negative predictor of anxiety. This finding is highly inconsistent with the findings of previous South African studies (for example, Spangenberg & Campbell, 1999; Spangenberg & Theron, 1999), which all found an avoidant coping strategy to be an attributable factor

in increased anxiety levels. Also puzzling was to note this finding to be inconsistent with the findings of the study of recently widowed women (Spangenberg & Somhlaba, 2003), in which significant positive relationship between anxiety and avoidant coping strategy was found.

The reasons for the above findings are unclear and merit further investigation. However, it is to be argued that rather than interpreting these findings to be suggestive of irrelevance of the coping process in the experience of grief-induced anxiety, this should be seen as an indication of the need for more research in the specific area of coping with anxiety following grief, especially spousal death. Moreover, the data that the interviews with the participants in the present study yielded indicated conjugal bereavement as anxiety-provoking experience. Therefore, the manner in which individuals experiencing conjugal loss cope with the anxieties embedded therein, warrants priority in bereavement research.

6.4. RELATIONSHIP BETWEEN DEPRESSION AND COPING STRATEGIES

A significant positive correlation was found between the participants' scores on the Beck Depression Inventory – Second Edition (BDI-II) and scores on the problem-solving coping strategy scale, which suggests that an increase in utilizing a proble-solving coping strategy was associated with higher depression scores and *vice versa*. In addition, regression analysis indicated problem-solving strategies to be predictive role of bereaved spouses with increased depressive symptoms. This finding was consistent with findings from international studies that have pointed to problem-focused coping as neutrally- or positively related to emotional distress (Baum et al., 1983; Bolger, 1990; Carver & Scheier, 1994;

Coyne & Gottlieb, 1996; Marrero, cited in Aldwin & Revenson, 1987; Watson & Hubbard, 1996).

The findings of a positive relationship between problem-solving coping strategy and depression were also inconsistent with findings from previous South African studies that highlighted the negative relationship between problem-solving coping strategies and depressive symptoms (for example, Spangenberg & Campbell, 1999; Spangenberg & Somhlaba, 2003; Spangenberg & Theron, 1999). Also noteworthy, the finding was sharply contrasted to the evidence from the literature that had derived a consistent relationship between problem-solving coping and positive affect (Coyne & Racioppo, 2000; Coetzee & Spangenberg, 2002; Folkman, 2001; Gass & Chang, 1989; Ptacek et al., 1992).

A plausible explanation for the relationship between depression and the problem-solving coping strategy in the present study was that the use of the problem-solving coping strategies may be interpreted as a reflection of the underlying depression symptoms, to the extent that the dimension of uncertainty coupled with a heightened hopelessness and helplessness following spousal death, may have triggered concerted efforts aimed at ameliorating the inherently distressing situation. To this effect, problem-solving efforts may be seen as *following upon*, rather than contributing to, depressive symptoms. Moreover, it is worth noting that the analyses of qualitative data revealed the participants' determination to gain some measure of control over in the context of helplessness and a total lack of control following spousal death, albeit with pervasive feelings of emotionally overwhelming conjugal bereavement.

The 'complementary' nature of the relationship between problem-solving coping strategy and depression in the present study seemed to be relevant to

the debates surrounding the efficacy of the coping strategies in general in mitigating stress. For example, Lazarus and Folkman (1991) have acknowledged that the *best* coping effort an individual can make is the one that changes the person-environment relationship for the better, although this does not necessarily translate to the idea that coping will result to a positive outcome. Related to this, Coyne and Racioppo (2000) have noted that in the domain of coping research, the effectiveness of coping has come to be evaluated in terms of the association between coping and psychological distress, with the assumption that a negative association between the two represents coping effectiveness. Coyne and Racioppo further maintain that such narrow focus on the presumed goal of reduction of psychological distress tends to ignore the likelihood that people approach different situations with multiple goals.

Considering these views, it is likely that the positive relationship between the problem-focused coping strategies and depression in the present study highlights the idea that problem-solving coping strategy and depression are both representations of the behavioural and emotional reactions of a broader facet of conjugal grief, and the expression of each is to be conceptualised as occurring in the context of a confluence with the other. Related to this, Zeidner and Saklofske's (1996) conceptualisation of stress and its outcome is relevant for consideration, insofar as the associations between the two (stress and outcome) are deemed to be "*...mainly concurrent; ...[and that] it is not clear whether coping influences adjustment, or whether coping and distress are mutually intertwined reflections of yet some other human condition or characteristic*" (p. 525).

Since cumulative evidence exists from literature that links problem-solving strategies with psychological adjustment (Coyne & Racioppo, 2000; Coetzee & Spangenberg, 2002; Folkman, 2001; Gass & Chang, 1989; Ptacek et al., 1992), and that in the present study there was a positive relationship between the two, it becomes incumbent upon community psychologists involved in bereavement treatment programmes to identify 'problem-solving' coping efforts that are maladaptive to psychological adjustment. Clearly distinguishing the maladaptive problem-solving coping efforts from those efforts that enhance a successful grief resolution, in order to psycho-educate the conjugally bereaved populations about the importance of recognising and making use of more adaptive problem-focused coping strategies, should occupy the central focus of such bereavement treatment programmes.

Moreover, basic support groups should be aimed at fostering interpersonal transactions that are channelled towards exchanging problem-focused aid in order that the conjugally bereaved individuals cope better with problems secondary to grief, which have the potential to undermine successful adjustment to bereavement.

A significant positive correlation was found between the participants' scores on the BDI-II and scores on the social support-seeking coping strategy scale, which suggests that the more participants were depressed, the more likely they were to use social support-seeking coping strategies and *vice versa*. However, the regression analyses indicated the social support-seeking strategies played no predictive role in the manifestation of depression.

Evidence from the literature exists that pits social support behaviours against psychological adjustment following spousal loss (for example, Greene &

Feld, 1989; Kalu, 1990; Rook, 1984; Talbott, 1990), as well as that which highlights negative effects of social interaction in times of stress (Fiore et al., 1983; Revenson et al., 1991). However, no studies could be traced from literature that found the social support-seeking coping strategies to be positively correlated with depression. Notably, the findings from the present study were inconsistent with the South African study of coping with widowhood among 70 rural black women of Bizana in the Eastern Cape (Spangenberg & Somhlaba, 2003), which revealed social support coping strategies to be negatively correlated with depression.

A plausible explanation for the positive correlations between social support-seeking coping strategies and depression in the present study could be made by taking into consideration that, when overwhelmed by heightened levels of dejection, sadness, and loneliness in the wake of conjugal loss, participants may resort to seeking social support as a means of compensating for their depressed mood states. In fact, numerous studies have long documented the idea that the widowhood period is characterised by intense isolation (for example, Babchuk & Anderson, 1989; Berardo, 1970; Maddison & Raphael, 1975; Morgan, 1984; Wilson, 1971).

Therefore, the use of the use of social support-seeking coping strategies in the present study may be interpreted as indicative of the deep-seated desire for the company and support from social networks amidst emotionally debilitating effects of the depressive state of grief. Given that social support received adds value to the psychological well-being only if it is *subjectively appraised* as beneficial by the recipient (Bankoff, 1983; Dakof & Taylor, 1990; Fiore et al., 1986; House, cited in Vachon & Stylianos, 1988; Jacobson, 1986;

Morgan, 1989), the implication for the finding of the positive relationship between depression and social support-seeking coping strategies in the present study, is the importance of continuously evaluating the social support structures in order to determine their usefulness.

Thus, it would be critical for the conjugally bereaved population to solidify connection with the social ties that enhance sustenance of both social and emotional support in times of bereavement, this being a way of moderating depressive symptomatology.

A negative correlation between avoidant coping strategy and depression was insignificant. However, regression analyses indicated that avoidance played a predictive role in a decrease in depression. The latter finding was inconsistent with previous South African findings in which avoidant coping strategies were positively associated with depression (for example, Spangenberg & Campbell, 1999; Spangenberg & Somhlaba, 2003; Spangenberg & Theron, 1999, 2001).

A possible reason for the above trend could be that participants' use of avoidant coping may have served as a 'shield' from the reality of the trauma of grief following spousal death. To this effect, psychological distancing from the circumstances surrounding the loss may have taken a central stage in coping with the death, thus mitigating the deleterious effects of depressive symptoms following such loss. In fact, this trend is sharply contrasted with the evidence pervading coping literature (Coetzee & Spangenberg, 2002; Holahan et al., 1996), in which the passive coping style of avoidance is closely associated with symptoms of psychological distress.

Notably, in a South African study of 30 HIV positive patients, Stein (1996) found that avoidant coping strategies functioned as protective buffer

against negative thoughts and related beliefs of hopelessness and helplessness. Stein's findings thus posed a vigorous challenge to the generally accepted notions about the preferability and desirability of problem-solving and social support-seeking coping strategies over the avoidant coping strategy for the individual to cope effectively with the crisis at hand. Stein further maintained that in an African setting, where the emphasis is not on the personal or individual process - but rather on the socio-cultural context within which the individual functions - avoidance coping ought to be generally viewed as adaptive (Stein, 1996).

Furthermore, the view of the benefits of avoidance in reaction to a stressful encounter is also contained in Sue's (1986) contention that the use of denial, while often regarded as a less desirable strategy, may be a much more widely efficacious means of coping with stress than many mental health professionals are willing to admit. Also related to this is Boden and Baumeister (1997) view that, when confronted with negative affective stimuli, some people seem to be able to use a repressive strategy that involves turning their attention away from the distressing stimuli and toward pleasant thoughts and memories that are apparently unrelated to the distressing stimuli.

Therefore, the use of avoidant coping strategies for the participants in the present study may have served as a buffer against depressive symptoms following spousal death. Related to the latter view, Shuchter and Zisook (1993) pointed to the adaptive value of being able to regulate the emotional pain of a loss. Similarly, in an American study of 42 conjugally bereaved participants, Bonanno, Keltner, Holen, and Horowitz (1995) found that emotional avoidance during bereavement might serve adaptive functions. Moreover, as it emerged

from the qualitative data in the present study, specified forms of avoidant coping, such as 'keeping busy', cognitive distraction and emotional disengagement from the pain induced by grief, internalisation of emotions, as well as seeking to glorify solitary widowhood life, served to voice participants' reluctance to succumb to the emotionally debilitative states of grief and to represent an open defiance of a potentially disempowering nature of conjugal bereavement.

Thus, the negative association between depression and the avoidant coping strategy in the present study highlights the need to re-consider the generally held ideas of the preferability and desirability of certain coping styles. It would thus seem that avoidance, notwithstanding its categorisation as representing negative coping, could be beneficial in a stressful encounter – a view apparently postulated by numerous coping researchers to date (for example, Boden & Baumeister, 1997; Shuchter & Zisook, 1993; Stein, 1996; Sue, 1986).

6.5. RELATIONSHIP BETWEEN PERCEIVED SOCIAL SUPPORT AND STRESS

The negative correlations found between the depressions scores on the BDI-II and scores of participants' perceived social support on the Social Support Appraisals (SSA) scale were negligible and not significant. However, regression analyses revealed that depression played a predictive role in the increase in participants' perceived social support levels. As also noted in the significant positive correlations found between the participants' scores on the BDI-II and scores on the social support-seeking coping strategy scale, the positive relationship between perceived social support and depression in the present

study was partially consistent with findings from previous international studies that found social support to be contra-indicated to psychological adjustment following spousal loss (for example, Greene & Feld, 1989; Kalu, 1990; Rook, 1984; Talbott, 1990). Also notably, some authors have highlighted the negative effects of social interaction in stressful encounters (Fiore et al., 1983; Revenson et al., 1991).

It remains unclear whether the positive relationship between perceived social support and depression was due to depression leading to more help-seeking behaviours, or to the notion that seeking help from others contributes to depressive symptoms (due to the less 'egalitarian' nature of power relations resultant from constant support-seeking, to the point of this eliciting feelings of stress). However, a plausible explanation for the relationship between these two variables was that, owing to expectations of social support being perceived as 'unmet', these may have generated a heightened sense of despondency over the lack of support from the subjectively abundant social networks. It is also possible that the pervasive depressive symptoms stemmed from the participants' difficulties with successfully re-arranging their social ties in order that these meet their support needs.

To this effect, in an American study of 44 caregivers of spouses with a diagnosis of Alzheimer's disease, Fiore et al. (1983) found a positive relationship between depression and social network interactions. The latter study cited unmet expectations of support or negative input from significant others as the possible reasons for the association between participants' depressive symptoms and social support interactions.

For the present study, it would thus seem that, rather than translating the availability of social support to the satisfaction derived from social networks, such interactions may have not adequately met the participants' psychological needs, hence the exponential increase in the experience of depressive symptomatology. As also noted in other research findings (for example, Mutran & Reitzes, cited in Morgan, 1989), it is possible that the loss of independence involved in receiving support from others posed a threat to the participants' overall self-esteem, as this invariably translated to a series of role reversals that produce a loss of authority and respect previously enjoyed within such social networks.

It is also possible that the participants' '*dysphoric*' mood states, which had initially propelled support-seeking 'coping' behaviours, significantly interfered with the participants' responsiveness to the social contacts to the extent that the support rendered had no mitigating effect to the experienced distress. To this effect, the perceived unhelpfulness of the social networks, and the resultant failure of the networks to mediate in the stress encounter, could have served to accentuate the manifestation of depressive symptoms. Bankoff (1983) has also espoused the idea that due to psychological apathy and general unresponsiveness to human relationships many social network interactions are empirically unrelated to both the psychological well-being and good adjustment outcomes for recent widows. Similarly, Fiore et al. (1983) as well as Greene and Feld (1989) have attributed the positive associations between social network interactions and stress to the fact that individuals in distress often respond to support networks with a negative response set – a factor that makes social support to be unhelpful under stressful encounters.

The present finding highlights the positive value of re-arranging the social support networks in order that they respond to the psychological needs of the conjugally bereaved populations. Moreover, as the qualitative data showed the participants' quest for continued social contact in the wake of spousal death, it becomes important that the community psychologists directly involved in bereavement treatment programmes should direct the bereavement intervention to emphasise the need for their clientele to constantly evaluate the social relationships by strengthening ties with those that help mitigate grief-induced depressive symptoms and enhance adjustment to loss. This is especially significant when considering cumulative evidence from literature that suggests that the quality and source of social support rendered determines how the recipient of such support adjusts to conjugal loss (Babchuk & Anderson, 1989; Bankoff, 1983; Dakof & Taylor, 1990; Fiore et al., 1986; House, cited in Vachon & Stylianos, 1988; Jacobson, 1986; Lund, 1989; Morgan, 1989; Morgan et al., 1997; Rook, 1987; Schuster & Butler, 1989; Silverman, cited in Bankoff, 1983; Stroebe et al., 1996).

Furthermore, findings in the present study confirmed the hypothesis that the correlations between participants' perceived social support and stress levels would be significant. A significant negative correlation emerged between anxiety scores on the BAI and scores on the perceived social support scores on the SSA, which suggested that the more participants perceived to have received social support from the significant others, the less were their anxiety scores and *vice versa*. Moreover, regression analyses revealed that anxiety was a significant negative predictor of the participants' experience of perceived social support. This finding was in line with evidence from literature that points to the benefits

of social support in attenuating the effects of stress following spousal death (Faletti et al., 1989; Farberow et al., 1992; Gallagher-Thompson et al., 1993; Greene & Feld, 1989; Hall & Irwin, 2001; Krause, 1986; Norris & Murrell, 1990; Stroebe & Stroebe, 1993; Stylianos & Vachon, 1993; Vachon & Stylianos, 1988).

It thus seems as if social support can mitigate anxiety symptoms, and this reinforces the idea that social support networks are helpful in mitigating anxiety and loneliness emanating from widowhood. Moreover, when considering the socio-cultural context in which the participants in the present study resided, which was characterised by a collectivist worldview and mutually supportive interpersonal relationships, it stands to reason that, for the conjugally bereaved, reaching out for social ties served to moderate their anxiety symptoms. Related to this finding, Spangenberg and Henderson (2001) found that a collectivist, supportive world-view, often termed *ubuntu*, had a buffering effect against stress among black South African adolescents. The implication this finding has for the widowed is the importance of continuously connecting with their social ties for the sustenance of both social and emotional support in times of duress – this being a way of moderating anxiety symptomatology.

6.6. RELATIONSHIP BETWEEN PERCEIVED SOCIAL SUPPORT AND COPING STRATEGIES

A significant positive correlation was found between the problem-solving coping strategy scores on the CSI and scores on the perceived social support scores on the SSA. This finding was inconsistent with the results of the South African

study of 70 rural black women recently conjugally bereaved (Spangenberg & Somhlaba, 2003), in which no significant associations were found between problem-solving coping strategies and participants' subjective perceptions of social support received from the significant others in wake of spousal death.

A plausible explanation for the positive associations between perceived social support levels and problem-solving coping strategy in the present study is that the participants' responsiveness to subjectively supportive social networks served as a protective buffer against depleting effects of grief-induced stress, to the extent that this increased the magnitude for practical problem-solving behaviours. This is particularly significant when considering that support networks are helpful if they offer instrumental assistance, which in turn makes options available for handling the problems as they arise (Gass, cited in Farberow et al., 1992; Rook, 1987). As was also evident in the participants' accounts obtained from the qualitative data in the present study, perceived social support from significant others functioned as a mechanism of solving problems embedded in participants' experience of conjugal grief, to the extent that such support appeared as an 'indispensable' factor in the adjustment to loss.

Given that social support received aids in attenuating stress embedded in bereavement (Gallagher-Thompson et al., 1993; Stroebe & Stroebe, 1993; Stylianos & Vachon, 1993; Vachon & Stylianos, 1988), and that the benefits of problem-focused coping in reducing threat have long been emphasised (Coetzee & Spangenberg, 2002; Folkman, 2001; Gass, 1987; Gass & Chang, 1989; Ptacek et al., 1992), the implication for this finding is that bereavement treatment programmes should prioritise strengthening ties with interpersonal

relationships that enhance practical problem-solving coping strategies. As Folkman (2001) has also alluded, problem-focused coping would give the conjugally bereaved individuals a sense of control in a context of bereavement that usually makes people feel completely helpless. Furthermore, the therapeutic support groups, which serve as an effective intervention in decreasing stress in bereaved individuals (Davis, Hoshiko, Jones, & Gosnell, 1992), would be indicated, as such groups would serve to psycho-educate the conjugally bereaved in ways of establishing relationships that facilitate adjustment to loss.

The finding that the social support-seeking coping strategy was found to be a negative predictor of perceived social support is in line with cumulative evidence from literature that points to social isolation emanating from the loss of a primary attachment figure (Babchuk & Anderson, 1989; Berardo, 1970; Maddison & Raphael, 1975; Morgan, 1984; Wilson, 1971) accompanied by the need of social support from their significant others. For the present study, the finding suggests that participants sought social support in reaction to perceived dearth of support from their networks. Data obtained from participants' subjective accounts also pointed to active, social support-seeking behaviours as a means of warding off pervasive feelings of loneliness subsequent to the loss. Therefore, it becomes necessary for community psychologists to direct bereavement support groups towards providing the 'platforms' in which the conjugally bereaved individuals can expand their social network as a means of mitigating feelings of social isolation. Psychoeducating these populations about

solidifying social ties that enhance sustenance of both social and emotional support in times of bereavement should be a basic tenet of the intervention programmes.

6.7. RELATIONSHIP BETWEEN PRE-LOSS MARITAL RELATIONSHIP AND STRESS

Significant positive correlations were found between scores of the pre-loss marital relationship on the EMS and anxiety scores. Although no study could be traced from literature that revealed a similar pattern between these two variables, it is worth noting that the finding appeared to be partly consistent with some authors' emphases on the quality of the pre-loss marital relationship as having a pivotal role in determining the subsequent adjustment to spousal death. For example, Freeman (1984) has alluded to this effect when she opined that the manner in which spousal death gets experienced is contingent on the different marital roles played by the lost spouse. Similarly, Kalish (1985) has cited the centrality of the relationship with the lost person as a strong determinant of the extent and duration of grief, such that grief becomes more intense for survivors for whom the death led to the loss of important roles and relationships. Ryan (1989) has echoed the latter view by asserting that the extent of grief is proportional to the extent to which the grieving individual valued the lost person.

It would make sense, therefore, to suggest that the manifestation of anxiety symptomatology in the present study represented an expression of the threats and uncertainty at having lost the spouse with whom participants had shared most of their married lives. In this regard, participants' elaborate

accounts of their subjective experience of spousal loss highlighted the pervasive feelings of threats, fears, and uncertainty about the future without the deceased spouse, with whom they had a mutually supportive and satisfactory relationship. The loss of a spouse as an experience that induces fear and provokes anxiety for many bereaved spouses throughout the first few years of their bereavement (Lindstrøm, 1995a; Sable, 1988, 1991) has long been the subject of bereavement research arena.

The notion of anxiety symptoms as characteristic of conjugal bereavement is consistent with Bowlby's (1973, 1980) concept of 'separation anxiety', which is viewed as a reaction to the separation from an attachment figure that is characterised by the bereaved individual's wish to remain physically and psychologically close to the lost figure. Bearing in mind Bowlby's 'separation anxiety' phenomenon, the pattern of anxiety for the present study should be conceptualised as essentially participants' fear response to separation from a significant other (that is, the deceased spouse) as well as the acknowledgement of a severed intimate relationship, from which they had derived validation and a sense of belongingness.

Another plausible explanation for the positive correlation between anxiety and pre-loss marital relationship, when considering the participants' expressions in the interviews, is the ambivalent feelings held towards both the pre-loss marital relationship and their deceased spouses. Unmet expectations in the form of deviation from acceptable norms of a marital relationship (marital infidelity) and heightened sense of 'desertion' by the deceased spouse, featured prominently in the participants' accounts of an ambivalently reminisced marital relationship with the deceased. Therefore, it could be inferred that the

ambivalence towards the pre-loss marital relationship and the deceased played a significant role in the manifestation of anxiety symptoms. In fact, the idea of ambivalent interpersonal relationships at pre-loss as having a compounding effect on grief, has received corroboration from numerous researchers to date (for example, Carr, 1975; Cleiren, 1993; Parkes, 1998b; Parkes & Weiss, cited in Kalish, 1985; Raphael, cited in Lopata, 1996; Raphael & Dobson, 2000; Sanders, 1983). Moreover, Switzer (1970) has also long cited subjective experience of desertion by the deceased as a possible pattern of grief in the context of ambivalence towards the deceased.

The finding of the positive associations between pre-loss marital relationship and anxiety in the present study highlights the need of the bereavement treatment programmes to focus their therapeutic interventions on the "working through grief" as a form of coping with conjugal loss. Grief work should facilitate cognitive and emotional processes of confronting the loss, through going over the salient events of the pre-loss marital relationship, focusing on memories (both good and bad) about the relationship with the deceased spouse at pre-loss, and processing the emotions associated with the deceased. Processing these aspects of the relationship with the deceased would enable the mitigation of grief-induced anxieties as well as resolution of potential ambivalence towards the lost relationship – thus enhancing the 'detachment' from the deceased and hence a successful adjustment to the loss. To date, numerous researchers have cited the benefits of grief work in the resolution of grief and bereavement (for example, Lindemann, 1944; Stroebe & Schut, 2001b; Wortman & Silver, 2001).

6.8. RELATIONSHIP BETWEEN PRE-LOSS MARITAL RELATIONSHIP AND COPING STRATEGIES

A significant negative correlation was found between scores on the pre-loss marital relationship and scores on the problem-solving coping strategy scale. This implied that the lower was their adaptability and satisfaction with most of the aspects of their pre-loss marital relationship, the more participants made use of problem-solving coping strategies, and *vice versa*. No studies could be traced from literature that revealed a similar relationship between pre-loss marital relationship and problem-solving coping strategies. However, it is worth noting that the quality and emotional nature of the marital relationship has been found to be a determining factor in such consequences of widowhood as the bereaved individual's overall self-worth and self-esteem (Carr, 2004), which invariably have a bearing on the individual's problem-solving coping propensities.

One plausible explanation for the negative relationship between pre-loss marital relationship and problem-solving coping strategies is that, for participants who derived minimal gratification from their married life, the inclination for problem-solving coping in wake of spousal death may have represented the pre-existing coping behaviours. Owing to the low levels of marital satisfaction, and hence the decreased emotional dependence on the spouse at pre-loss, such participants may have long relied unto themselves pertaining to carrying out household and other responsibilities to the extent that upon spousal death, their (problem-solving) coping styles generally reflected their usual style of coping with daily stress. The latter point is relevant when considering the data obtained from interviews with the participants,

wherein practical problem-solving efforts emerged as a means of maintaining some measure of control in the context of helplessness evoked by widowhood. It was also noteworthy that expressed ambivalence with the pre-loss marital relationship yielded no indication of intention to surrender from the responsibilities for household chores and parenting. This pattern served to underscore the participants' open defiance of widowhood as an inherently incapacitating experience, regardless of the low-level satisfaction with the pre-loss marital relationship.

The implication of these findings points to the importance of community psychologists to shape their interventions towards equipping the conjugally bereaved individuals with the skills necessary for solving daily practical problems emanating from their bereaved state. This would enable the bereaved to regain control in their lives and hence to assert their independence at post-loss. Irrespective of the level of pre-loss marital satisfaction, the acquisition of skills necessary for practical problem solving following spousal loss would serve as the self-esteem booster, which could in turn equip the individuals with psychological hardiness in the event of subsequent potential stressors.

6.9. DEMOGRAPHIC VARIABLES

The following is the discussion of certain participant characteristics that appeared to have influenced the experience as well as expression of the stress-coping relationship in wake of spousal death, and thus shaped the subjective retrospective appraisals of pre-loss marital relationship and social support received from significant others following conjugal loss. The prominence of these demographic variables ties on the conceptualisation of the stress-coping

model of grief and loss, which emphasises the role played by the contextual factors in the experience, expression, and manifestation of the response to loss (Richardson & Balaswamy, 2001; Wortman et al., 1993). The discussion of the demographic variables, therefore, served as a means in which the present study accounted for the variability in the stress-coping relationship in the context of conjugal loss.

6.9.1. Age

Findings from the present study revealed that perceptions of social support received from the significant others were significantly higher for younger participants (aged between 21 and 49 years), when compared to their older counterparts (aged between 50 and 99 years). Although no study could be traced in literature that revealed a similar relationship, it is worth noting that numerous studies to date have documented a pattern in which younger widows are presumed to be at greater risk than older widows for psychological and health problems following spousal death (Cook & Oltjenbruns, 1998; Hansson & Hayslip, 2000; Hansson, Remondet, & Galusha, 1993; Lopata, 1996; Parkes, 2001; Wortman et al., 1993). The reason cited for such a trend is that for older widows and widowers the death is seldom unexpected and that it is not considered premature or untimely, while for their younger counterparts the death is usually unanticipated and few, if any, preparations have been made for its eventuality.

The loss of spouse for younger participants in the present study was probably viewed in the society as defying the 'natural order' of life and death (the assumption of which is that marriage to their spouses would sustain them

through to the old age). It is, therefore, possible that losing a spouse too early in their married lives had generated necessary social support and sympathy from the significant others who viewed the young widows and widowers as having greater psychological vulnerability following spousal death.

Another plausible explanation for the younger participants to have higher perceptions of social support from significant others is that since the loss experienced was largely 'unanticipated' as it occurred rather early in marriage, they were motivated to garner support and solidify the already existing ties within their social networks. The latter idea that is analogous to findings in literature that point to the human tendency for seeking social support as a means of coping with chronic life stress (for example, Amirkhan, 1990; Fiore, et al., 1983; Fiore, et al., 1986; Hall & Irwin, 2001; Krause, 1986; Norris & Murrell, 1990; Stroebe & Stroebe, 1993; Stylianos & Vachon, 1993).

The implication for this finding is that it highlights the need for bereavement treatment interventions to focus on the psycho-education of bereaved individuals, especially younger widows and widowers whose lives become disorganised at the unexpected loss of their spouses, to continuously re-define their social support structures for continued social and emotional support if they are to successfully adjust to widowhood period.

6.9.2. Sex

The variation of participants' sex in the sample merits some in-depth discussion; with 170 females (85.86%) when compared to 28 males (14.14%) who participated in the study, the conclusion seems almost inescapable that widowhood experience affects more women than men. Evidence from research

literature also suggests that studies investigating the pattern of widowhood tend to have few widowers than widows in their sample. For example, Stroebe and Stroebe (1983) have pointed out that most studies of conjugal bereavement have concentrated on widows only, primarily due to the relative scarcity of adequate samples of widowers. And pertaining to the scarcity of widowers in the conjugally bereaved populations, Jackson (1977) has long held the view that that the life expectancy for men is sixty-eight years while that of women is seventy-six. Also related to this, Cook and Oltjenbruns (1998) have pointed to the longer life span of women and their tendency to marry men older than they are as contributing factors to the reality that the widowed spouse is typically a woman.

In similar vein, Hansson and Hayslip (2000) have revealed that the population figures indicate that women tend to outlive men, that they (women) are three times to more likely than men to become widowed, are less likely than men to remarry, and are more likely to spend their later years living alone. Since Hansson and Hayslip's (2000) view is that forty-six per cent of American women aged 65 years or older as opposed to sixteen percent of men in the same age group tend to be widowed, it is hardly surprising that the number of widowed women is always greater than that of widowed men. The idea of the life expectancy as relatively higher for women when compared to their (male) spouses, has recently found the corroboration of McGoldrick (2004) who maintains that women in the United States of America die on average seven years later than men. Considering these points of view, it would thus seem that widowed women would always outnumber widowed men virtually in any given

population. In African societies, Sossou (2002) has also recently acknowledged that widows make up a large proportion of female population.

For the present study, a plausible explanation for the greater number of widows when compared to the widowers is that since men in traditional setting usually assume the role of breadwinners for their families (Lopata, 1996), some widowed men may have been inaccessible due to work commitments that necessitated that they leave their homes immediately after the wife's funeral. For most working men in this rural setting, staying away from their families for extended periods of time, while earning a living in mostly distant workplaces, makes them see their families only once in a couple of months. Such long absence from the families has to date become an inherent characteristic of the migrant labour system for many black South African people's lives (Crush, Jeeves, & Yudelman, 1991; Moodie, 1994; Ramphele, 1993). In contrast, the widows usually play the role of the 'homemaker', and this makes them readily available for catering for their children's immediate needs as well as receiving visitors and guests into their homes. Given this set of living conditions and social circumstances, the widows may have been identifiable and readily available for participating in the present study.

There is also a possibility that, since most widowed men tend to remarry after the wife's death (Hansson & Hayslip, 2000; Lopata, 1996), identifying the '*recently re-married*' men for inclusion in the present study may have proved difficult, as their attachment to the 'new' wives could have easily blurred their widowhood status.

Another related factor that is partly related to the latter view, and which may have thwarted identification of widowers for inclusion in the sample of the

present study is the possible involvement of some men in polygamous marriages, especially when considering that three women participants in the present study (1.76%) reported to have been in a polygamous marriage with their deceased husbands. Since polygamy features in some marriages in traditional, rural African societies (Sossou, 2002; Speizer, 1995), it is possible that conjugally bereaved men from such marriages were excluded from participating in the study because they could not easily be identified for participation since they represented a category of widowed men that did not fit the conventional description of a "widower" as a '*spouseless man whose marriage culminated in his wife's death*'.

Pertaining to the sex differences in relation to the main variables, the finding that widows evinced depressive symptoms significantly more than widowers, was consistent with findings from numerous studies to date (for example, Carey, 1977; Gilbar & Dagan, 1995; Jacobs et al., 1989; McGoldrick, 2004; West & Simons, 1983), which revealed that widows are more susceptible to psychological vulnerability after the death of their spouses than widowers. It is also worth noting the present findings were not consistent with previous other research findings that revealed widowed men as more prone to bereavement-induced depression than their female counterparts (for example, Freeman, 1984; Lee et al., 1998; Stroebe & Stroebe, 1983, 1993; Stroebe, Stroebe, & Schut, cited in McGoldrick, 2004; Umberson, Wortman, & Kessler, 1992; van Grootheest, Beekman, Broese van Groenou, & Deeg, 1999).

One plausible explanation for the finding in the present study (that widows evinced depression more than widowers) is that, for widows, the loss of a husband – mainly the sole breadwinner and father figure for the children –

had left them not only with the difficulties adjusting to the loss of spouse, but also with a multiplicity of responsibilities, some of which were the husband's, and all which proved challenging to assume. Qualitative data obtained from interviews with the participants also highlighted single-handed responsibilities in household chores and loss of income as additional stressors to the loss of their spouses. Pertaining to this, Wortman et al. (1993) have stressed the idea the women's vulnerability following widowhood arises from an increase in financial strain. Also related to the latter view, Kalu (1990) and Sossou (2002) have cited financial deprivation as the main attributing factor in heightened distress levels in the post-burial period for many African women.

The finding that widows presented with anxiety symptoms at significantly higher levels when compared to their widowers in the present study was consistent with findings from Chen et al.'s (1999) study of 150 widowed persons (92 widows and 58 widowers), in which anxiety levels were significantly higher for widows.

A plausible explanation for the findings of the present study (higher anxiety symptomatology for widows) can be traced by considering the socio-cultural, traditional, rural context in which participants resided; wives often play the role of the homemakers who rely on their husbands for economic survival (Kalu, 1990; Sossou, 2002). In such settings, the death of a male spouse leaves the wife with distress, with the compounding factors being heightened uncertainty and hopelessness about the future as she no longer has the protection and related privileges previously accorded in her one-time marriage with the deceased (Manyedi, 2001). Data obtained from the interviews with the female participants in the present study also revealed the 'erosion' of

social status as a married woman, the loss of a family's protective father figure as well as hopelessness about the future as attributing factors in the participants' experience of high anxiety following spousal death.

It is also possible that widows in the present study were under great strain as they found themselves 'caught up' in a double-bind of having to single-handedly carry out household tasks, while simultaneously attempting to project the image of an idealized widow. The idea that being burdened by household tasks has an effect on the manifestation of anxiety reactions following spousal death has been documented in Carr et al.'s (2000) recent study that investigated the relationship between the marital quality of 1,532 married individuals and their psychological adjustment to subsequent widowhood. Findings from the latter study revealed dependence on a spouse for male-type tasks as a stronger predictor of anxiety for women at post-loss (Carr et al., 2000).

The idea that cultural prescriptions, regarding what is considered acceptable widowhood behaviour, influence the manner in which a widow conducts herself in relation to her community, is consistent with Sossou's (2002) synoptic account of African widowhood practices, wherein she has opined that widowhood cultural rites place more restrictions on African widows than on widowers. Echoing the latter view, Kalu (1990) and Manyedi (2001) have revealed that since the woman is regarded as a property of the husband, she is expected to submit to the dictates of his extended family and kin network following his death. Therefore, for widows in the present study, the difficulties in maintaining a balance between pursuit of personal needs and meeting societal expectations without the necessary support and protection previously

accrued from the marital relationship with their (now deceased) husbands could have placed them at greater emotional strain following spousal death.

The findings that women were more depressed and anxious than males in the present study have important implications for community psychologists and bereavement counsellors. Such findings identify a population of the conjugally bereaved as being at higher risk for depression and anxiety, and thus highlighting the importance of bereavement treatment programmes to give special attention to widowed women as a way of helping the latter to manage depressive and anxiety symptoms arising from their grief. Such programmes need also to psycho-educate the conjugally bereaved individuals about ways of acquiring skills necessary for practical problem-solving endeavours, which would enable them to find solutions to additional problems generated by widowhood, thereby boosting their morale, self-esteem and self-reliance.

The alleviation of anxiety induced by single-handed responsibilities, should take the form of provision of instrumental support and assistance in practical tasks and household chores. This would help the widowed to regain control of important aspects of their lives, thus enabling adjustment to their widowhood period with minimal distress. Pertaining to this, Sossou (2002) has stressed the need for empowerment and transformative approaches involving both individual women and collectives of women groups to fight the hindrances and potentially disempowering, and hence alienating, widowhood practices inherent in African traditional approach to death, mourning, grief and bereavement.

Findings from the present study also supported the hypothesis that significant differences would exist between widows and widowers in terms of the

subjective retrospective appraisals of the nature of pre-loss marital relationship. The data revealed that the widowers' levels of adaptability and satisfaction with most aspects of their pre-loss marital relationship were significantly higher than for widows. Although no study of note revealed a similar patter, a plausible explanation for the present finding can be made by considering Waite's (1995) idea that marriage, especially in situations where tasks between the spouses are allocated according to traditional gender roles, has greater protective effects for men than for women.

Given the latter view, it is possible that widowers had derived gratification from their pre-loss marital relationships as these relationships, by virtue of their very 'traditional' nature, were tailored more towards their needs than to their wives' needs. In corroboration of the above viewpoint, cumulative evidence from literature suggests that men receive substantially more instrumental advantages from marriage than women do, particularly when it comes to household tasks (Carr, 2004; Hartman, cited in Carr et al., 2000; Miller & Garrison, 1982), and this particularly applies in the traditional African communities (Sossou, 2002; Speizer, 1995). Noteworthy, data obtained from interviews with male participants in the present study also revealed the lamentation about the loss of the central marital relationship with their deceased wives, from which they had derived satisfaction as the wives had been very instrumental in the execution of most household chores prior to their death.

Considering the above-cited viewpoints, for the present study the loss of relationships that had put men at such an advantageous position could explain the widowers' higher levels of satisfaction and adaptability with their pre-loss

marital relationships. As men's greater vulnerability following spousal death stems from marked difficulty in assuming tasks previously handled by their wives (Wortman et al., 1993), the present finding has important implication for community psychologists. The finding needs to be understood as conscientising community practitioners about the possibility that beneath the higher levels of pre-loss marital relationship satisfaction among widowers lies deep-seated distress that can significantly interfere with the widowers' adjustment to widowhood. Special provision for support networks that would aid widowers insofar as rendering instrumental assistance in daily household tasks and chores should alleviate potential distress induced by the loss of central relationships previously enjoyed with their wives.

6.9.3. Number of people in the household

The social milieu of participants in the present study played a critical role in the choice of a coping strategy. Participants living with fewer people in their households (5 people or less) made use of the avoidant coping strategies significantly more than participants who lived with a sizeable number of people (more than five people in the household). Although no study of note revealed the similar pattern, the finding raises the question of whether avoidant coping served as a reaction to the subjectively inaccessible or inadequate social support (coping deficiency), or that it was indicative of the coping efforts that were compatible with the individuals' psychological well-being (functional coping). The latter part is significant when considering the emerging view accentuating the benefits of avoidant coping in handling stressful encounters (Boden & Baumeister, 1997; Bonanno et al., 1995).

A plausible explanation for the finding that participants living with fewer people in their households (5 people or less) made more use of the avoidant coping strategies is that, unlike in contexts of bigger social convoys that would necessitate active and reciprocal social interaction, the minimal number of people may have limited the availability of "agents" of help and support. Resultantly, the limited options of available for handling bereavement-induced stress, and also given that widowed individuals experience a substantial decrease in the number of visits during bereavement (Morgan, 1984), could have propelled participants to turn 'inward' and resort to passive, emotion-focused coping that minimised direct contact with the outside world.

The implication of the latter finding highlights the need for community psychologists and bereavement practitioners to consider the use of avoidant coping by conjugally bereaved individuals from households with fewer people as an indication of coping difficulty. Considering the high levels of distress (depression and anxiety) in the present study, the use of avoidance by participants from households with fewer participants served to highlight the hidden costs of limited social support networks in the context of conjugal bereavement. Establishment of supportive structures that would facilitate the bereaved individuals' adjustment to widowhood should form part of the bereavement intervention programmes.

6.9.4. Family monthly income

Middle-income home earners reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship significantly more than the low-income home earners. This finding was consistent with the emerging view

that having a stable source of income has the mediating factor in the expression and manifestation of distress following the loss of a significant person (Aber, 1992; Gass, 1987; Lindstrøm, 1999). In fact, to date many researchers have cited problems emanating from the loss of income as a complicating factor following death of a major attachment figure (Bowling & Cartwright, 1982; Cook & Oltjenbruns, 1998; Lopata, 1996; Parkes, 1975, 1993; Sossou, 2002; Zick & Smith, 1988).

A plausible explanation for the finding that the levels of pre-loss marital relationship for middle-income home earners (MIHE) were higher when compared to the low-income home earners (LIHE) is that a substantially greater family income for the MIHE group could have served as a buffer against stress generated by the loss of such a central relationship. In this regard, the high levels of pre-loss marital satisfaction for the MIHE group could be interpreted as indicators of low distress levels. The fact that the MIHE group had financial resources that potentially enabled them to meet the daily demands of the family in the period following the death of a spouse meant that the grief-induced distress (arising out of economic deprivation) was minimised to the extent that their subjective account and ratings of the lost relationship were more positively toned.

The finding that the middle-income home earners' levels of pre-loss marital satisfaction were significantly higher than for those with low-income, has important implications for bereavement intervention. It points to the need for bereavement practitioners to consider the bereaved populations who lack economic resources necessary for sustenance of their livelihoods as the group that is particularly at risk for distress. It is a general view that pre-loss marital

quality influences grief reactions to the subsequent loss (Carr, 2004; Carr et al., 2000). Therefore, an evaluation of the bereaved individuals' subjective experience of pre-loss marital relationship as well as the resultant financial resources and their sustainability following the loss should form a focal point of the support intervention that seeks to mediate or minimise the stress induced by material deprivation.

6.9.5. Level of education

A significant negative relationship was found between educational level and the problem-solving coping strategy. The semi-literate participants (no formal education and Standard 6 or below) made more use of the problem-solving coping strategies when compared to the literate participants (high school education when combined with teacher's- or nursing college of education). No previous study of note revealed a pattern that could compare with this finding. This finding could suggest that the semi-literate participants, with little exposure and encounter with other resources of coping, may have limited their coping efforts to practically solving the problems they faced in wake of spousal death, this being a reflection of helplessness that they found themselves in as they sought to adjust to their bereaved state.

A significant negative relationship was found between level of education and the use of social support-seeking coping strategy. The semi-literate participants made more use of the social support-seeking coping strategy when compared to their literate counterparts. This was consistent with findings from Spangenberg and Somhlaba's (2003) study of 70 recently widowed rural black women, in which social support-seeking coping strategies were strongly

associated with relatively lower levels of literacy. Inconsistent with the present finding was Lopata's (1996) idea that widows with higher education and socio-economic lifestyle, and with less limiting health, tend to have the broader support networks, and that they are less dependent on any one person.

A plausible explanation for the finding that the semi-literate participants made more use of the social-support seeking coping strategy when compared to the literate group can be made by considering the socio-cultural, rural context in which participants lived. This context is characterised by the collectivist and mutually supportive view of the world – often referred to as *ubuntu*. This pattern of reciprocally supportive relationships has been noted by Spangenberg and Henderson (2001) as an inherent characteristic in most black communities. In such settings, the *semi-literate* individuals often lead exclusively 'subsistence' livelihoods and, with minimal contact with the outside world, their lives are defined mainly by inter-dependent relations with extended family members (Spangenberg & Somhlaba, 2003) as well with members of the community in general, who become available for problem sharing and social support in times of need. Therefore, it is possible that the conditions were more conducive for the semi-literate participants in the present study to establish social ties from the readily available support networks in wake of spousal death. This is in contrast to the literate participants whose work- and other commitments probably dictated that they spend most of the time away from the community activities, thus limiting their contact with the potential sources of social support.

Since support from extended family members and broader kin group is a characteristic feature of interpersonal relations in the rural areas, the

implication of the present finding is that basic support group programmes, which also include the educated widowed men and women, are indicated in order to facilitate the bereaved individuals' adjustment to the loss of their loved ones.

A significant positive relationship emerged between literacy and pre-loss marital relationship. The literate participants reported adaptability and satisfaction with most of the aspects of the pre-loss marital relationship more than their semi-literate counterparts did. Although no study could be traced from literature that revealed a similar pattern, a plausible explanation for the present finding is that the literate participants, owing to the possible career paths they led, had held the contemporary view of the institution of marriage, which espoused more 'liberal' gender role ideology for both partners – thus viewing marriage not merely as a means for reproduction of the offspring (procreation) but also as contributing to the aesthetic and spiritual growth of the individuals involved. Viewed from this perspective, the levels of pre-loss marital relationship were higher for the literate participants since they perceived their marriage as both emotionally rewarding and heightening their sense of validation.

The finding has an important implication; it behoves the bereavement practitioners to evaluate bereaved individuals' subjective accounts of pre-loss marital relationships, irrespective of the levels of literacy, in order to determine whether such accounts harbour any distress symptoms that pose a potential hindrance to an adjustment to widowhood.

6.9.6. Participants' job status

Significant negative relationships were found between participants' employment status and the manifestation of anxiety symptoms. The finding that unemployed participants' anxiety symptoms were significantly higher than for their employed counterparts bears on the findings in literature that highlight the benefits paid work identity as having an ameliorative role in the distress following spousal death (Aber, 1992; Gass, 1987; Lindstrøm, 1999; McCallum et al., 1993).

A plausible explanation for the unemployed participants to evince higher anxiety levels is that the death of a spouse, with whom they shared the financial needs of the family, could have left a constellation of uncertainties surrounding the future without the other partner, especially with the lack of material prowess necessary for the sustenance of the family living. Qualitative data yielded by the interviews with the unemployed participants also highlighted the latter view, wherein the anticipated challenges of single-handed parental and related household responsibilities without a stable income emerged as triggering factors in the experience of anxiety.

The implication for the present finding is that community psychologists working with the conjugally bereaved populations need to consider the unemployed bereaved individuals as the high-risk group for the manifestation of stress following the death of a spouse. Therefore, support that involves examination of alternatives that the affected individuals have at their disposal, of finding ways to generate income, should become central in the intervention programmes if distress induced by material deprivation following major loss is to be minimised. Moreover, psycho-educating the vulnerable individuals about

the need to augment social ties and interpersonal transactions that are channelled towards exchanging problem-focused aid should be the focus of bereavement intervention.

Significant positive relationships emerged between job status and social support appraisal. The finding that the employed participants' perceived social support levels were significantly higher when compared to the unemployed participants partly bears on Lopata's (1996) idea that the higher socio-economic lifestyle of the conjugally bereaved individuals is directly related to the broader social networks. Resultantly, the bereaved whose social network is broader has access to many support structures and people to garner necessary support when in need.

A plausible explanation for the participants with steadier and more secure employment to perceive that they received social support from significant others more than their unemployed counterparts is that, in addition to the support presumably received from family members, relations with other people in the workplace could have exponentially increased their social networks. Subsequently, the number of people with whom the employed participants relate to both at home and at work meant that many options were available insofar as determining who would respond positively to their needs, which in turn contributed to the employed participants' self-worth. Regarding the latter point, Aber (1992) and Lindstrøm (1999) have cited social support interactions in the workplace as additionally beneficial in fostering individuals' independence and autonomy as well as providing necessary respite from the sad thoughts and emotions following spousal death.

The present finding has important implications for the practitioners involved in the bereavement intervention programmes. It highlights the need to consider the individuals with no steady job following bereavement as a particularly high-risk group, given that there is a potential lack social support networks that would help mitigate the deleterious effects of grief. Support programmes aimed at expanding the social networks of the unemployed participants should be a priority for the bereavement intervention programmes.

6.9.7. Period of bereavement

Significant negative relationships were found between period of conjugal bereavement (number of months post-loss) and anxiety. The anxiety scores of the *most recently bereaved* participants (within one month) were higher than for both the *intermediately bereaved* (between 1 and 6 months) and the *distantly bereaved* participants (between 7 and 12 months).

The latter finding partly bears on the idea long espoused by Peretz (1970a), which is that the period of bereavement immediately following the loss of a loved one is a greater risk in the precipitation of pathogenic reactions to loss. In similar vein, Richardson and Balaswamy's (2001) recent study of 200 widowed men categorised participants into two groups: those who had been widowed for less than 500 days ("recently bereaved") and those whose period of bereavement was more than 500 days ("later bereaved"). Although the duration of the categories of the 'period of bereavement' for the latter study was markedly longer when compared to that of the present study, Richardson and Balaswamy's (2001) study highlighted a higher negative affect in recent bereavement, and that time since widowhood is one of the most significant

predictors of well-being among the bereaved individuals. Moreover, studies that noted a significant decline of anxiety symptoms at follow-up interview, when compared to the baseline levels (Chen et al., 1999; Prigerson et al., 1996), also served to highlight a positive relationship between recent bereavement and the manifestation of anxiety symptoms.

A plausible explanation for the finding that the *recently bereaved* participants in the present study evinced anxiety symptoms at levels higher than the other groups is that the persistent shock resulting from the *recent* death of a spouse still served as a hindrance to their adaptation to the loss. To this effect, the prospects of life ahead without the deceased spouse could have been anxiety provoking, to the extent that the recently bereaved participants may have interpreted the adjustment to loss as an insurmountable challenge. Moreover, because bereavement is understood to be progressing through different discrete phases, of which the first phase entails shock and disorganization (Botha & Pieters, 1987; Hodgkinson, 1984; Kübler-Ross, 1981, 1989), it can be inferred that it was natural for those who were recently bereaved to evince higher anxiety levels.

This finding highlights the importance of bereavement practitioners to give special attention to the recently bereaved individuals as the latter represent a group that is at high risk for developing anxiety symptoms meeting the diagnostic criteria for anxiety disorder. Given this, more support groups aimed at facilitating the grief process and giving the bereaved an opportunity for a shared experience with others, are indicated in order to mitigate the deleterious anxiety symptoms in the early phases of conjugal bereavement.

Furthermore, support interventions need to focus on helping the recently bereaved populations identify and 'work through' aspects of the loss that serve as the triggering factors in the manifestation of anxiety symptoms, this being a way of minimising the perceptions of threat that undermine the successful adjustment to loss.

6.9.8. Deceased spouse's job status

Significant positive relationships were found between deceased spouse's job status and participants' levels of social support appraisals. The finding that participants whose spouses were employed at the time of death perceived to have received social support from their networks significantly more than participants whose spouses were unemployed partly bears on the emerging view that a work environment provides a constellation of social networks that impact positively on the individuals' psychological well-being (Aber, 1992; Lindstrøm, 1999).

A plausible explanation for the latter finding is that the deceased spouses' workplaces could have provided the surviving spouses with an additional avenue, in addition to family and friends, through which their grief and loss received recognition and a sense of validation. It is possible that such surviving spouses had derived solace from receiving messages of support and condolences from the deceased spouses' workplace, this being a factor that, in turn, could have influenced their perceptions that their loss of a life partner – this simultaneously being the co-workers' felt loss of their colleague – was thereby overtly acknowledged, and hence a shared 'pain'. Another possibility exists that, in facilitating the provision of the worker's death benefits, a

concerted level of support would typically be rendered by the company that had employed the deceased.

The present finding has important implications for community psychologists involved with bereavement intervention programmes. Support intervention aimed at facilitating a successful adaptation to widowhood needs to emphasise the establishment, broadening, and strengthening of social support networks for the bereaved populations in order that the experience of loss becomes a shared experience. Pertaining to the latter point, Krause (1986, p. 519) has also cited the benefits of social support in resolving a "*mutually shared, common problem*" of conjugal bereavement. Morgan (1989) has also maintained that, since no single relationship is likely to cater for all support needs, it is ideal that the support networks provide the individuals with access to different types of relationships at different points in the period of transition to widowhood.

6.9.9. Age of deceased spouse

Significant negative correlations were found between age of the deceased spouse and participants' levels of social support appraisal. The perceptions of having received social support from the significant others in wake of spousal death were significantly higher for participants whose deceased spouses were younger at the time of spousal death (aged between 23 and 49 years) when compared to participants whose deceased spouses were older (50 and 98 years). Although no study of note revealed a similar pattern, the latter finding partly bears on the emerging view that younger widows and widowers are at higher risk when compared to their older counterparts in terms of psychological vulnerability

following spousal death (Cook & Oltjenbruns, 1998; Hansson & Hayslip, 2000; Hansson, et al., 1993; Lopata, 1996; Parkes, 2001; Wortman et al., 1993).

There is a possibility that the extended family and society had interpreted the younger spouses' death as 'ill-timed' or 'premature' since the death translated to the obliteration of hopes and aspirations for the future as married couples. Since the death could have been perceived as serving to defy the 'natural order' of life and death – which assumes that married people live long enough to reach old age – the loss of a younger spouse could have evoked sympathetic reactions, supportive behaviours, and positively toned messages of support from the significant others. This could have influenced such participants to respond positively to the behaviours of others, which in turn significantly shaped their perceptions of received support from their social milieu.

This finding highlights the importance of bereavement intervention programmes to consider individuals bereaved early in their marriage years, and who have minimal support structures, as representing a high-risk group for the development of psychological problems emanating from grief. The finding also identifies the need to 'not neglect' older bereaved individuals as they may also require structural support. Such programmes need to prioritise the strengthening of supportive social ties for the bereaved in order to help mitigate the deleterious effects of loneliness triggered by the loss of a loved one.

6.9.10. Status of pre-loss marriage

Significant negative relationships were also found between status of marriage and depression. The levels of depression were higher for participants whose pre-

loss marriage status with their deceased spouse was characterised by maximal cohesion, co-existence and mutual sharing (less physical distance), when compared to participants whose status of pre-loss marriage was defined by greater physical distance. The latter finding is partly consistent with Futterman et al.'s (1990) study that included 212 bereaved adults (113 women and 99 males), who were compared with 162 nonbereaved individuals; it was found that the severe ratings of marital depression for bereaved individuals were associated with higher ratings of pre-loss marital adjustment. In attempting to explain the finding of the associations between high depression ratings and higher ratings of pre-loss marital relationship, Futterman and associates opined that the bereaved individuals tend to view their marriage more positively if they are depressed about it (Futterman et al., 1990).

A plausible explanation for the present finding that participants whose marriage was less physically distancing evinced more depressive symptomatology, is that the loss of a spouse with whom they had spent most of their married lives could have proved difficult to deal with. The loss of such a central relationship could have meant that that these participants had to simultaneously grieve over the loss and adapt to the life without the deceased spouse, upon whom they had relied for continued companionship, advice and mutual intimacy. The latter view is relevant when considering Bugen's (1979) long-held, and Carr's (2004) recently articulated, notion that the closeness of the relationship previously formed between the bereaved individual and the deceased directly influences the intensity of the subsequent grief reaction.

Still pertaining to the above-cited relationship between the status of pre-loss marriage and depression, the finding that participants whose marriages

were characterised by greater physical distance (estrangement, separation or divorce) evinced less depressive symptoms was surprising. Given that evidence from literature exists, which suggests that marital disruption negatively affects the individual's psychological well-being (Bookwala, 2004; Dehle & Weiss, 1998; Johnson, 2002; Roy, cited in McLeod & Eckeberg, 1993), the levels of depressive symptoms for the participants whose marriages were experiencing estrangement, separation or divorce at the time of spousal death were expected to be even higher. The latter point is relevant when considering that the loss of a generally disruptive marital relationship could trigger a multiplicity of unresolved marital issues – with depression as a characteristic feature, all which serve as a potential hindrance to the successful resolution of grief.

A plausible explanation for the lesser depressive symptoms among participants from the latter group (that is, estrangement, separation and divorce), is that the potential stresses embedded in greater levels of physical distance that characterised the marriage could have psychologically immunised them from the deleterious effects of subsequent loss. Accordingly, their "customary exposure" to potentially stress-inducing marriage circumstances meant that, at the time of spousal death, they were *already* relatively accustomed to responding to major life stresses that had emanated from 'losing' their primary attachment figures through estrangement, separation and divorce. Related to the above vantage point, it is also possible that the lower depressive symptoms for the latter group, following spousal death, were reflective of the adaptive coping efforts that constituted their general response pattern to stressful encounters. Pertaining to the general coping with stress, Williams and colleagues (Williams, Wiebe, & Smith, 1992) have opined that

hardy individuals have the ability to behave in adaptive manner in the event of experiencing stress, and that hardiness positively influences that individual's general strategies for managing the experienced stress.

Another explanation for the latter finding (of less depressive symptoms among participants whose marriages were characterised by greater physical distance) is that the loss of a disruptive marriage had resulted in relief from the realisation that the marital stresses experienced were giving way to the new life full of hope and new challenges. Closely tied to the latter view is Wortman and Silver's (2001) assertion that some people would show little distress following their loss, especially if such loss signalled relief from a relationship that had inherently been stressful. Studies of divorce have also highlighted the lower susceptibility to depression among individuals leaving marriages characterised by dissatisfaction and conflict (Aseltine & Kessler, 1993; Kitson & Sussman, cited in Carr et al., 2000).

The implication for the latter finding is that the conjugally bereaved individuals whose pre-loss marital relationships with the deceased were characterised by closeness are generally a high-risk group for the manifestation of depressive symptoms following loss. Therefore, support intervention programmes need to target the latter group in order to alleviate the potential 'depressogenic' effects of grief.

A significant negative relationship was also found between status of marriage and pre-loss marital relationship. The finding that participants whose pre-loss marriage was less physically distancing (cohesive) reported more adaptability and satisfaction with aspects of their pre-loss marital relationship when compared to participants whose marriage was characterised by more

physical distance, partly bears on the marriage studies that emphasise the strong and protective effects of marriage on psychological well-being (Kim & McKenry, 2002; Sacco & Phares, 2001; Waite, 1995).

A plausible explanation for the latter finding is that the death of the spouse had translated to the 'erosion' of the privileges associated with the companionship the marriage had afforded participants who had enjoyed an intimate, cohesive and mutually rewarding marriage marked by the constant physical presence of the spouse. Therefore, the sudden change of the circumstances arising out of the absence of a spouse could have influenced the participants to report the aspects of pre-loss marital relationships in positive terms.

Data obtained from participant interviews also pointed to the heightened distress following the loss of a subjectively rewarding and close marriage. Moreover, the fact that participants whose pre-loss marriage was less physically distancing were also more depressed about the loss points to a 'triangular' relationship between the three variables: depression, cohesive marriage status and pre-loss marital relationship. To this effect, inference is made that the loss of a cohesive marriage heightened their depressive symptoms to the extent that this reinforced their perceptions of pre-marital relationships as having been satisfactory. Phrased differently, the participants' subjective retrospective appraisals of the aspects of pre-loss marital relationships were higher because they were depressed about the loss of a cohesive marriage they had with the deceased. Futterman and colleagues (Futterman et al., 1990) have also observed that depression about the loss triggers positive appraisals of a pre-loss marital relationship.

The present finding has important implications for bereavement intervention practitioners. The finding aids to identify a conjugally bereaved population that is at risk for debilitating effects of grief. Social support programmes need to make it a priority to render basic support-group therapeutic interventions to bereaved spouses who depended on their deceased spouses for the sustenance of self-esteem and emotional validation. The provision of such support groups may help mitigate the depressive symptoms that arise out of the loss of such central relationships.

Finally, the social support appraisals were higher for participants who were filing for divorce at the time of spousal death when compared to participants from other categories. Although no study of note emerged to be consistent with the latter finding, it is worth noting that evidence from literature points to the proliferation of social support from significant others as positively correlated to psychological adjustment among people encountering marital separation or divorce (Smerglia, Miller, & Kort-Butler, 1999; Stone, 2002; Waggener & Galassi, 1993).

It is possible, therefore, that for participants who were in the process of filing for divorce at the time of spousal death could have already been receiving support from others amidst the marital problems that had necessitated their 'exit route' from such marriages. The number of people readily offering sympathy could have exponentially increased following spousal death as others possibly saw this group of bereaved spouses as having suffered "enough already", and thus deserved more understanding and support. Such availability of supportive persons and networks in their social milieu could in turn have

shaped the perceptions of significant others' receptive behaviours as inherently supportive.

The implication of this finding is that strengthening of social ties for individuals whose conjugal bereavement is preceded by marital relationship troubles, should be a focal point of bereavement support intervention. Garnering necessary support would help alleviate depressive symptoms that act as potential hindrance to the successful adaptation to widowhood.

6.9.11. 'Hypnagogic' hallucinations

First and foremost, the variation of participants' hallucinatory experience following spousal death in the present study merits some in-depth discussion. One-hundred-and-thirteen participants (57.07%) reported hallucinatory experiences ranging from "none of the time", "a little of the time", to "some of the time" (*mild reactions*) when compared to 85 participants (42.93%) whose hallucinatory experiences ranged from "a good part of the time" to "most or all of the time" (*severe reactions*). The above variation bears testimony to the idea that the hypnagogic hallucinations (Parkes, 1998b; Sanders, 1989) are common experiences during the widowhood period – an idea that has found resonance in numerous other studies to date (for example, Bennett & Bennett, 2000; Grimby, 1998; Hoyt, 1981; Rees, 1971, 1975; Simon-Buller, Christopherson, & Jones, 1989).

Second, and pertaining to the relationship between hallucinatory experiences and other main variables in the present study, a significant positive relationship was found between hypnagogic experience and depression. The depressive symptoms for participants who experienced severe hallucinatory

experiences in the wake of conjugal loss were significantly higher when compared to participants whose hallucinatory experiences were mild. This finding was consistent with previous findings that also reported a relationship between experience of sensing the presence of the deceased person and the severity of the grief reactions (Lindemann, 1944; Lindstrøm, 1995b). Also notably, the present finding, which pointed to an association between severity of hallucinations and depression, did not correspond with Rees's (1971, 1975) conceptualisation of hallucinatory experiences following loss as having no associations with morbidity that would suggest that they are abnormal features.

A plausible explanation for the participants' hypnagogic hallucinations in the present study to be positively correlated with depression is that the hallucinatory experiences could have triggered distressing memories of the deceased spouse, which, when coupled with an intense feeling of yearning for the deceased, had confronted participants with the painful reality of the loss. Thus, the hallucinations could be understood as representing deep-seated desire of the bereaved to search for and find, as well as to re-establish contact with, the deceased spouse. Pertaining to this, Parkes (cited in Sanders, 1989) has noted that the hallucinations of bereavement are maintained as a way of clinging to the lost person. It therefore becomes evident that the severe hallucinatory experiences for the participants in the present study were directly related to the manifestation of depressive symptomatology.

However, a noteworthy result from the qualitative data was the expressed associations between hallucinatory experience and positive affective states, wherein the hallucinations were experienced as providing participants with solace. Herein, the hallucinations served as an affirmation of the bond that

subjectively bound the bereaved to the deceased spouse. Thus, the latter pattern could be seen as representing participants' reluctance to give up the valued lost relationship – an idea also long espoused by Freud (1925). Also recently, the positive psychological states in the context of hallucinatory experiences in widowhood have been evident in Lindstrøm's (1995b) study of 39 recently bereaved widows, wherein it emerged that the widows expressed their sensing of the deceased spouse's presence as having a comforting effect. This trend highlights the importance of interpreting the hallucinations of widowhood as the medium through which participants get temporary respite from the psychologically debilitating effects of grief, particularly in light of the cumulative literature evidence that emphasises the adaptive value of grief hallucinations in the process of mourning (Baethge, 2002; Goin et al., 1979; Klass, 2001a, 2001b; Moss & Moss, 1985; Rees, 1971, 1975).

Yet another important consideration of the 'comforting' nature of the participants' hallucinations in wake of spousal death, in the present study, was the socio-cultural context of the communities in which participants resided. The apparent inherent acceptability (ego-syntonicity) of the hallucinatory experience offered a 'glimpse' of the participants' belief system and worldview, which both had bearing on the experience of bereavement and subsequent adjustment to their widowhood state. Their belief in the life after death – that the deceased person joins the ancestral world that oversees the daily lives of the bereaved relatives (Jali, 2000) – could be an attributing factor in the positive association between hallucinations and positive affective states. To this effect, participants could have interpreted the sensing of deceased spouse's 'presence'

as indicative of the strong ties that characterised their relationship with both the deceased and the entire world of the ancestors.

The ostensible social construction of grief in the manner that the participants' bond to the deceased was perceived as 'intact' served to defy the potentially debilitating effects of spousal death, wherein participants' readiness to embrace aspects of grief that offered some measure of 'continuity' in the context of loss defined the expression of conjugal bereavement. Also noteworthy, the personal significance in the participants' grief experience of the anticipated unveiling ritual, and the meaning such ritual held as it symbolically represented 'closure' to the socially prescribed phase of mourning, served to highlight the socio-cultural context in which grief and mourning processes occurred. Given the influence of the participants' belief system, it behoves the bereavement practitioners working with the rural conjugally bereaved individuals to shape the intervention to be congruent with the frame of reference of the particular populations they are working in. As also advocated by Swartz (1987, 1998), background knowledge of the social and cultural factors in mental and related illnesses should form an integral part of the promotion of mental health and prevention of mental disorders in South African communities.

A significant positive relationship emerged between hypnagogic hallucinations and problem-solving coping strategy. Participants who reported experiencing severe hypnagogic hallucinatory experiences made more use of problem-solving coping strategies in wake of spousal death. No previous study of note revealed a similar relationship between these two variables.

A plausible explanation for the positive relationship between hallucinatory experience and problem-solving coping strategy can also be made by considering the socio-cultural context in which participants lived. Through 'sensing' the presence of the deceased spouse, participants could have translated their experience as representing a 'message' of what the deceased spouse would require them to do during their adjustment to widowhood. This is particularly relevant when considering the significance of the presumed communication between the bereaved relatives and the dead, which is recognised and upheld as a guiding force for the behaviours and actions of the bereaved (Walter, 1999). The latter view also underscores Jali's (2000) emphasis of the deference to the dead as a truly characteristic feature of the continued 'communication' between the living and the ancestral world in the African setting. The present finding serves to highlight the need to recognise the socio-cultural aspects of the bereaved rural populations as central in both the experience and expression of grief. Bereavement practitioners should consider these aspects as prerequisites for assisting the rural bereaved individuals adapt to widowhood.

Significant positive relationships were also found between hypnagogic hallucination and avoidant coping strategy. Participants who experienced severe hypnagogic hallucinatory experiences made more use of the avoidant coping strategy in the wake of conjugal loss. Although no study could be traced from literature that revealed a similar pattern, it is worth noting that that evidence from previous research suggests that hallucinations of widowhood are indicative of the reluctance to give up the lost relationship (Freud, 1925; Parkes, cited in Sanders, 1989). It is therefore possible that the experience of

the hallucinations became the medium through which participants sought to 'revive' the lost relationship with the deceased, thus emotionally distancing themselves from the painful reality of the loss.

The implication for the latter finding is that bereavement practitioners would need to focus their grief intervention on guiding the bereaved individuals who experience hallucinations following widowhood to re-visit the unresolved aspects, should there be any, of the pre-loss relationship with the deceased, which serve as a potential hindrance to the successful adaptation to loss. Therapeutic work should also focus on helping the bereaved integrate the experience and meaning of their 'sensing' of the deceased into the awareness of themselves in relation to the lost relationship, as well as the manner in which their reaction to these hallucinatory experiences could be channelled towards adjustment to the loss.

Significant positive relationships emerged between hypnagogic hallucinations and social support appraisal. The subjective perceptions of social support received from significant others in wake of spousal death were higher for participants with severe hallucinatory experiences. No study of note revealed a similar pattern. The latter finding is partly consistent with findings from Simon-Buller et al.'s (1989) study of 294 Arizona widows, which revealed accessibility to neighbours in times of need as one of the factors that increased the susceptibility for the sensing experience.

A plausible explanation for the present finding (of significant positive relationships between hypnagogic hallucinations and social support appraisal) can be traced by considering the socio-cultural context of the participants' area of residence. It is a documented evidence that the collectivist, interdependent,

mutually supportive and humane interpersonal relations – often termed *ubuntu* – are a characteristic feature of the lives of South African black people (Spangenberg & Hendersen, 2001), this being particularly prevalent in traditional rural settings (Spangenberg & Somhlaba, 2003). Since the belief in ancestral worship is deep rooted in many African settings notwithstanding the competing Christian faith (Jali, 2000), it is possible that the collectivist, mutually supportive nature of their environment had enabled the significant others to be positively responsive to the participants' sensing experience. The latter point is relevant when considering that the surviving spouse, who is often regarded as the 'chief mourner' following death (Jali, 2000), could have been generally regarded as having assumed the role of the medium of communication between the extended family members and the ancestral world. Moss and Moss (1985) have also espoused the idea that societal values and social networks tend to reinforce the widowed individuals' tie to the deceased spouse, and this influences the surviving spouse to rekindle memories about the deceased spouse and seek to fulfil the latter's presumed expectations.

Therefore, since the social networks tend to view the identity of surviving spouse and the latter's manner of expression as intricately linked to the deceased spouse, it is possible that others had interpreted participants' hallucinatory experience as a symbol of respect for, and continued allegiance to, the deceased spouse – a highly esteemed virtue that, in such settings, may have strongly influenced the social networks to be more receptive and readily available for the participants in times of need.

The implication of the latter finding is that the bereavement support groups should be directed at incorporating the bereaved individuals' sensing

experience with the meaning they make of such experience as well as translating these into solidifying social ties would render support necessary for a successful adaptation to widowhood.

6.9.12. Concurrent bereavement

Significant negative relationships were found between concurrent bereavement and depression. Participants who had not lost any other family member or close relative besides the deceased spouse (*non-concurrently bereaved*) evinced more depressive symptoms when compared to participants who had lost other family members or close relatives in addition to the deceased spouse (*concurrently bereaved*). This was inconsistent with the emerging view in bereavement literature that the loss through death that happens in the context of other significant losses detrimentally affects the individual's adjustment to the current loss (Heikkinen, cited in Freeman, 1984; Maddison & Raphael, 1975; Sanders, 1993; Smith, 1978).

A plausible explanation for the latter trend is that the non-concurrently bereaved individuals were still recovering from the shock and despair and their relative 'unfamiliarity' with the loss situation itself could have made them to engage in ruminative coping over the loss (Nolen-Hoeksema, 2001; Nolen-Hoeksema et al., 1994), which interfered with the problem-solving and heightened distressed mood states as well as pessimistic thinking about themselves and their lives.

Since the non-concurrent bereavement is a potential risk factor for the depressive symptoms, support group intervention needs to focus on finding ways for the bereaved populations to strengthen the social ties that facilitate

problem-solving efforts, thus enabling the bereaved individuals to regain control of their lives.

Significant positive correlations also emerged between concurrent bereavement and anxiety. The anxiety levels were significantly higher for the concurrently bereaved participants when compared to their non-concurrently bereaved counterparts. This is partly concordant with the view that the stress that is subsequent to, or co-occurs with, major losses may serve to sustain the distress of widowed persons, which in turn interferes with the adjustment to bereavement (Kalish, 1985; Norris & Murrel, 1990; Peretz, 1970b; Sanders, 1993).

It is possible that the loss of a spouse in the context of other losses had evoked heightened fears as well as uncertainty about the future, as the concurrently bereaved participants had lost other significant people in their lives who were potential sources of support and solace, and pillars of strength. Equally plausible is that the loss of significant others within a relatively short period could have triggered anxiety that stemmed from the participants' fear of their own death. The latter view has found resonance in Elizabeth Kübler-Ross's (1981, 1989) conceptualisation of anxiety surrounding death and dying as indicative of fear triggered by the prospects of the one's own demise – an idea also later echoed by Kalish (1985).

Therefore, the implication for psychologists working in bereavement intervention programmes need to consider the concurrently bereaved individuals a high-risk group for the proliferation of anxiety symptomatology following major losses. Support groups need to be directed at both solidifying social support ties for the bereaved and equipping the concurrently bereaved

individuals with practical problem-solving skills, which would enable them to manage aspects of their lives that, owing to the 'simultaneous' losses, are subjectively insurmountable. Moreover, 'working through grief' in evaluating the meaning and personal significance the losses have for the concurrently bereaved individuals should be the focus of bereavement intervention programmes. This would help the bereaved to regain control of their lives, thus facilitating mitigation of the anxiety symptoms that have the potential to undermine a successful adjustment to conjugal bereavement.

Significant negative relationships were also found between concurrent bereavement and the problem-solving coping strategy. The non-concurrently bereaved participants made more use of the problem-solving coping strategies when compared to the concurrently bereaved participants. No study of note revealed a similar relationship between the two variables. It is possible that the death of a spouse had left the non-concurrent bereaved participants bearing the identity of the 'primary' survivors to loss, which meant that they single-handedly had to keep mechanically busy with more urgent problems to attend to without the instrumental assistance and support previously occasioned by their deceased spouses.

Pertaining to this, Bowling and Cartwright (1982) have highlighted an exponential increase in new practical tasks that surviving spouses have to take following spousal death. The societal perception of the surviving spouse as the primary mourner who has to assume many roles during the period of conjugal bereavement seems to be an essential feature that characterises widowhood (Peskin, 2000), and this is particularly applicable to many rural African settings (Jali, 2000; Manyedi, 2001; Sossou, 2002).

In contrast, participants who had experienced other losses in addition to spousal death made less use of problem-solving coping strategies. It is possible that, for the latter group, finding solutions to problems emanating from the losses was a conjoint responsibility among many relatives who all shared the collective identity as the bereaved or 'survivors' – thus minimising the burden and responsibility on the surviving spouses in seeking practical solution to problems.

The latter finding has important implications for practitioners working with the bereaved populations. Support intervention needs to prioritise the strengthening of social ties that facilitate practical problem-solving efforts in order that the stresses embedded in bereavement are minimized. Rendering assistance in household activities and daily chores is the way in which support networks could be of benefit to individuals battling with multiplicity of tasks during conjugal bereavement.

Significant negative relationships were found between concurrent bereavement and the social support-seeking coping strategies. The non-concurrently bereaved participants made more use of the social support-seeking coping strategies when compared to their concurrently bereaved counterparts. No previous study of note revealed a similar relationship between the two variables. It is possible that the psychological upheavals that stemmed from their only encounter with loss had left this group of participants helpless and in dire need of support, which could have directly influenced them to seek social support from the available social networks at their disposal. Equally plausible is the idea that the latter finding, when viewed from a socio-cultural context, could point to the constant availability of social support structures for

the non-concurrently bereaved individuals (who were more likely to have extended family members to garner support from). Since support from extended family members and kin group is a cherished virtue that promotes kin group cohesion in rural African settings (Spangenberg & Somhlaba, 2003), it behoves community psychologists to set up basic support group programmes that would help widen the social support networks in order for the conjugally bereaved individuals to cope with grief.

Significant negative relationships were also found between concurrent bereavement and the social support appraisal. The levels of subjective perception of social support received from significant others were higher for the non-concurrently bereaved participants when compared to their concurrently bereaved counterparts. Notably, the latter finding partly bears on Vachon and Stylianos's (1988) view that the social support network may be perceived as less helpful if there are concurrent stressors in addition to bereavement.

It is possible that because the non-concurrently bereaved participants' encounter with spousal death was an experience that rendered them as the 'primary mourners' who were directly and uniquely affected by the loss, the social networks could have recognised and responded accordingly to the latter profile by providing necessary support in times of need. Pertaining to this, Jacobson (1986) has espoused the idea that the behaviours offered by others and intended to be supportive, may be seen as helpful if provided at the right time. The possibility that the non-concurrently bereaved group had received social support that was responsive to their dire needs could have influenced their perceptions of social support received to be significantly higher than those of the concurrently bereaved participants. It was a surprising finding, however,

that the concurrently bereaved participants, notwithstanding a multiplicity of potentially supportive networks to garner support from, had lower perceptions of social support received from significant others. This finding sheds light on the idea that the availability of support structures does not necessarily influence the recipient to perceive them as helpful and satisfactory – an idea that has found resonance in some studies to date (for example, Fiore et al., 1986; Greene & Feld, 1989; Rook, 1984).

The implication for the present finding is that the bereavement support programmes need to prioritise the strengthening of social ties for bereaved individuals who experience marked social support deficits following bereavement. The social support structures following the death of loved ones would help compensate for the risks involved in loneliness that has the potential to undermine the successful adaptation to widowhood.

6.9.13. Post-loss intimate relationship status

Significant positive relationships were found between post-loss intimate relationship status and depression. The levels of depressive symptomatology were higher for participants who were not intimately involved post-loss (*sexually inactive participants*) when compared to participants who were involved in an intimate relationship after spousal death (*sexually active participants*). This finding partly bears on Richardson and Balaswamy's (2001) view that the positive feelings following conjugal bereavement improve over time among those who become involved in post-loss intimate relationships.

A plausible explanation for the depressive symptoms to be higher for the sexually inactive participants is that, unlike the sexually active participants,

those who were not intimately involved had no adequate social and instrumental support that the involvement in intimate relationship could possibly offer. Having no one with whom they could share their intimate worries and concerns could have propelled them to 'turn the grief inward' and ruminated over the circumstances surrounding the loss, a factor that is attributable to the depressogenic effects of bereavement (Noelen-Hoeksema, 2001; Noelen-Hoeksema et al, 1994). In highlighting the benefits accrued from post-loss intimate relationships, Weiss (2001) has recently opined that, although entering a new relationship does not end grief for the surviving spouse, support can be found in the new partnership.

The finding highlights the importance of bereavement intervention programmes to help the conjugally bereaved individuals to establish and solidify interpersonal relationships that would serve as buffer against the stress of loneliness, thus minimising the risks for the advancement of the dysphoric mood into a full-blown clinical depression. Having a special confidant, albeit not necessarily the person intimately involved with, would aid to forestall the deleterious effects of grief and hence facilitate a successful adaptation to widowhood.

Significant positive relationships were found between intimate relationship status and problem-solving coping strategy. Sexually inactive participants made more use of the problem-solving coping strategies when compared to their sexually active counterparts. No previous study of note revealed a similar relationship between the two variables. It is possible that being out of an intimate relationship had made the sexually inactive participants to constantly engage in tasks that were necessary for the

sustenance of daily operation of their households, for which they had single-handed responsibility. It has been suggested that most widowed individuals often choose not to be intimately involved following spousal death, either due to fear of another unanticipated death of the new partner (Schulz, 1978) or out of 'respect' for the deceased spouse (Kalish, 1985). Should these be the factors attributable to the latter group's relationship detachment, it could be inferred that constant engagement in practical problem-solving efforts represented both a commitment to the deceased spouse and a quest for independence following the death of a previously relied-upon spouse. In contrast, the sexually active participants had probably shared some of the household tasks with their new partner and this could have reduced the burden of single-handed responsibilities.

The finding highlights the importance of bereavement support groups to be directed at assisting the bereaved individuals to strengthen social ties that facilitate practical problem-solving coping efforts, this being a way of enabling the bereaved to regain control of their lives following the death of their loved ones.

Significant positive relationships were also found between post-loss intimate relationship status and avoidant coping strategies. The sexually inactive participants made more use of the avoidant coping strategy significantly when compared to the sexually active participants. No study could be traced from literature that revealed a similar pattern. It is possible that, due to fact that the sexually inactive participants had virtually no one with whom they could share intimate concerns and worries that stem from having lost a spouse, they had cognitively and emotionally disengaged with the loss and 'kept

busy' with other tasks – these being compensatory behaviours intended to ward off feelings of loneliness. Also noteworthy, the finding that the sexually inactive participants were more depressed when compared to their sexually active counterparts suggests that the prevalent use of avoidant coping strategies among participants who were not intimately involved represented an underlying reluctance to give up the relationship with the deceased spouse. Regarding this, Kübler-Ross (1989) as well as Raphael and Dobson (2000) have noted that the temporary disavowal of reality represents an intense avoidance of giving up the relationship with the deceased person.

Therefore, basic support group programmes for the individuals undergoing spousal bereavement need to emphasise the strengthening of social ties from which the bereaved can garner necessary emotional support that would facilitate adjustment to widowhood.

Significant positive relationships were found between post-loss intimate relationship status and pre-loss marital relationship. The sexually inactive participants reported adaptability and satisfaction with most of the aspects of their pre-loss marital relationship significantly more than the sexually active participants. This finding partly bears on the conceptualisation of post-loss relationship disengagement as stemming from the "undying commitment" to the deceased spouse (Kalish, 1985).

It is possible that being outside the 'ambience' of intimate relationships – itself being a factor that would have shifted the attention and energies to the new partner – could have influenced the sexually inactive participants to rate their pre-loss marital relationships as having been relatively satisfactory, especially that they were still grappling with adjusting to the loss of such

relationships. When considering the finding that the sexually inactive participants were also more depressed following spousal death, their high perception levels of pre-loss marital relationship could be indicative of underlying idealisation (sanctification) of the spouse, which took the form of magnification of the personal qualities of the deceased spouse. Lopata (1979, 1996) has observed that the spouse sanctification is a characteristic reaction of widowed spouses who are battling with adjustment to the loss. Evidence also exists in literature that notes the bereaved individuals' inclination to view their pre-loss marriages more positively if they are depressed about the loss (Futterman et al., 1990).

Therefore, basic support group programmes need to focus on helping the bereaved to establish and solidify social ties from which they can garner necessary support in times of need. Once again, special relationships with people who are willing to be confidantes ought to be encouraged, as these would help create an atmosphere in which the bereaved could continuously reflect on the aspects of the pre-loss marital relationship that serve as potential hindrance to a successful adaptation to widowhood.

6.9.14. Onset of medical illness

Significant differences emerged in the means of onset of medical illness with regard to the manifestation of depressive symptomatology. Participants whose onset of medical illness could be traced only *after* the death of the spouse (*illness succeeding death*) evinced depressive symptoms significantly more than participants whose onset of medical illness preceded the conjugal loss (*illness predating death*). Although no study of note revealed a similar pattern, it is

worth noting that the finding bears testimony to the evidence from literature to date, which draws 'grief reactions' following spousal death as a factor that is directly related to the onset of deteriorating physical health (for example, Ferraro, 1986; Irwin, Daniels, & Weiner, 1987; Maddison & Viola, 1968; Parkes, 1964a, 1972).

The higher depressive symptoms for participants with illness succeeding spousal death may be interpreted as an expression of suppressed emotional reaction to the loss, and the deteriorating physical health as indicative of the underlying 'somatization' tendency. It is possible that grappling with the physical ailments following such major loss, in addition to the difficulties with adjustment to the loss, was too stressful an experience for this group of participants to the extent of exacerbating the already existing grief-induced distress. Data from interviews with the participants also highlighted the detrimental effect of grief on physical health as the physical ailments hindered the execution of daily tasks – this itself being an aggravating factor in participants' psychological well-being.

The expression of grief through physical ailments following the death of spouse ought to be a cause of concern to practitioners directly involved with bereavement intervention. The conjugally bereaved individuals exhibiting physical ailments following the loss of their spouses need to be considered a high-risk group for depressive symptoms. Therefore, relevant referrals to medical practitioners for determination of any physiological basis for the physical complaints need to be central to the intervention process. Moreover, support group programmes need to be directed at creating therapeutic group space that would enable emotional expression for bereaved individuals, this

being aimed at mitigating the depressive symptoms that hinder adaptation to loss.

Significant positive correlations were found between onset of medical illness and problem-solving coping strategy. Participants with illness succeeding death made use of the problem-solving coping strategy significantly more than participants with illness whose onset predated the loss. No study of note revealed similar relationship between the two variables. It is possible that attending to the physical ailments following spousal death (by consulting with either the medical practioners or the traditional healers) had left this group of participants with multiplicity of problems to solve, thus broadening the focal scope that formed part of the adjustment to the loss. Repeated consultations with the medical practitioners in response to physical complaints following spousal death has been reported by many researchers to date (Carr & Schoenberg, 1970; Parkes, 1975a, 1975b; Thompson, Breckenridge, Gallagher, & Peterson, 1984; Wiener, Gerber, Battin, & Arkin, 1975) as ranking among the problems bereaved spouses find themselves having to deal with in wake of spousal death.

The finding highlights the importance of bereavement intervention programmes to equip the bereaved individuals with the necessary practical problem-solving skills that would help them overcome the challenges of adjusting to the loss. The idea that physical ailments serve as potential aggravating factors in the adaptation to bereavement necessitates referral of individuals with these complaints to relevant primary health care centres that would help determine the physiological basis of their illness. Moreover,

therapeutic support would be indicated that sought to facilitate the transition to bereavement.

Significant differences emerged in the means of onset of medical illness with regard to the use of the social support-seeking coping strategy. Participants with illness succeeding death made more use of the social support-seeking coping strategy when compared to participants with illness predating death. No previous study of note revealed a similar pattern. It is possible that the proliferation of physical ailments following spousal death had influenced this group of participants to reach out for social networks that were perceived as potential sources of support.

The implication for the latter finding points to the need of bereavement treatment programmes to make it its priority to direct the intervention at guiding bereaved individuals to strengthen social ties that would serve as buffer against the stresses embedded in bereavement. Social support structures would help mitigate the stress aggravated by the accompanying physical ailments in the context of loss.

6.9.15. Overall physical health

Significant positive relationships were found between participants' subjective ratings of their overall physical health and depression. Depressive symptoms were higher for participants who rated their overall physical health as *'poor'* when compared to those of participants who rated their overall physical health as *'good'*. Moreover, participants who rated their overall physical health as *'average'* evinced depressive symptoms at significantly higher level than participants who rated their overall physical health as *'good'*. The latter findings

were consistent with findings from Smith's (1978) study of 120 widowed women, wherein the depressive symptoms were found to be higher for participants who rated their overall physical health as poor.

It is possible that the participants' subjective ratings of their physical health as poor had adversely affected their mood, which, owing to a pessimistic view of themselves and their lives in general with resultant lowered morale and self-esteem, could have reinforced them to ruminate over both their health and loss. Thus, a persistent and repetitive focus on negative thoughts and emotions surrounding health and loss could have been an attributing factor to heightened depressive symptomatology in this group of participants. Nolen-Hoeksema and associates (Nolen-Hoeksema, 2001; Nolen-Hoeksema et al., 1994) have elaborated on the deleterious effects of ruminating on distressed mood and thinking as significantly interfering with good problem-solving efforts following loss.

Thus, basic support programmes need to equip the bereaved individuals with the necessary problem-solving skills that would serve to boost their self-esteem while instilling morale. Support groups would be effective if they incorporated these aspects into the broader therapeutic intervention aimed at assisting the conjugally bereaved adjust to the loss of their spouses.

Significant positive relationships were also found between participants' subjective ratings of their overall physical health and anxiety. Anxiety symptoms were significantly higher for participants who rated their overall physical health as '*poor*' when compared to both the participants who rated their overall physical health as '*good*' and the participants who rated theirs as

'*average*'. No previous study of note revealed similar relationships between anxiety and subjective ratings of overall physical health.

A plausible explanation for the latter finding is that participants who rated their overall physical health as 'poor' were apprehensive about the impact of their "poor health" on the execution of daily tasks, particularly that they no longer had the partner with whom they had previously shared some of the household tasks. Qualitative data from interviews with the participants also revealed an intricately linked relationship between perceived poor health and anxieties surrounding the loss of status accompanied by being unable to meet the household and societal demands, which set productivity as a yardstick to measure each individual's social worthiness. Pertaining to this, Lund and colleagues (Lund et al., 1989) have cited the lack of competency in tasks of daily living and being functionally dependent upon others as factors that tend to trigger persistent worry for many widowed individuals, which in turn often leads to physical and emotional exhaustion.

The implication for the present finding is that bereavement intervention programmes need to prioritise the strengthening of social ties from which the bereaved individuals could garner the necessary support. Instrumental assistance in daily household chores from the support networks, with the recipient of help being also directly involved throughout, would help the bereaved regain some control of the important aspects of their lives – thus mitigating the anxiety that is triggered by inability to manage the perceptibly 'insurmountable' tasks.

Significant differences were found in the means of participants' subjective ratings of their overall physical health with regard to the use of the

problem-solving coping strategies. Participants who rated their overall physical health as '*average*' made significantly more use of the problem-solving coping strategies when compared to both the participants who rated their overall physical health as '*good*' and the participants who rated theirs as '*poor*'. No previous study of note revealed a similar pattern.

It is worth considering the possibility that, because participants with an 'average' overall physical health had regarded their health as bordering between "normal" health and morbidity, they made concerted efforts to safeguard their physical wellness as their bi-dimensional focus was on averting a potential deterioration of their health as well as striving to reach an optimal health level. Also noteworthy, participants who rated their overall physical health as '*poor*' significantly made more use of the problem-solving coping strategy when compared to participants who rated theirs as '*good*'. No previous study of note revealed similar relationships between the two variables, but it is possible that subjective perceptions of overall physical health as 'poor' influenced participants to do repeated consultations for medical check-ups with the medical practitioners or traditional healers as a way of managing potential risks of their "poor" health – a behaviour pattern documented in numerous studies as characteristic of widowed individuals' concern with their overall physical health (Carr & Schoenberg, 1970; Parkes, 1975a, 1975b; Thompson, Breckenridge, Gallagher, & Peterson, 1984; Wiener, Gerber, Battin, & Arkin, 1975).

Related to the above, is that the more use of problem-solving coping strategies in the context of perceptions of overall physical health as 'poor' could be indicative of underlying hypochondriacal tendencies, especially when considering that the latter group also evinced high anxiety symptomatology. As

per definition outlined in the DSM-IV (APA, 1994), hypochondriasis entails preoccupation with the fear of having, or the idea of having, a serious disease based on the person's misinterpretation of bodily symptoms. Although hypochondriacal preoccupation is not better accounted for by anxiety disorders (APA, 1994), there is evidence in literature that suggests that some patients with hypochondriasis could be classified under anxiety disorders (Noyes, cited in Creed & Barsky, 2004). However, because a period of at least 6 months needs to have elapsed in order to make a clinical diagnosis of hypochondriasis (APA, 1994), further longitudinal exploration of the relationship between subjective ratings of overall physical health and anxiety in the context of problem-solving coping strategies following major losses is indicated. This would help in making an accurate assessment of the impact of hypochondriasis on the adjustment to conjugal bereavement.

The latter finding serves to highlight the need for bereavement treatment programmes aimed at equipping the bereaved individuals with practical problem-solving skills that would help the manage aspects of their lives that would enable them to regain control of their lives. Support groups aimed at facilitating grief process and offering the bereaved an opportunity for expressing fears embedded in their bereaved state, are indicated in order to minimise the anxiety that often serves to hinder a successful adaptation to widowhood.

Significant differences were also found in the means of participants' subjective ratings of their overall physical health with regard to the use of the social support-seeking coping strategies. Participants, who subjectively rated their overall physical health as '*average*', made significantly more use of the social support-seeking coping strategies when compared to participants who

rated their overall physical health as '*good*'. Also notably, participants who rated their overall physical health as '*poor*' made significantly more use of the social support-seeking coping strategy when compared to participants who rated their overall physical health as '*good*'. No previous study of note revealed similar differences.

Viewed from a socio-cultural context of the participants' community of residence, these results could point to the greater availability of social support structures for individuals with poorer health. Therefore, subjective perceptions of the disparities between desirable and preferred health status (*ideals*) and experienced health status (*reality*) could have influenced participants with 'average' and 'poor' overall physical health to seek support from the social networks as they (participants) regarded themselves as more physically vulnerable. Since support from extended family members is a predominant feature of interpersonal relations in the rural settings, the belief and understanding that social networks would respond positively to their expressed health concerns could have reinforced the support-seeking propensities among the latter groups of participants. These findings point to the need of basic support group programmes, which are aimed at buffering the stress associated with the social support deficits following major losses, and which would help the conjugally bereaved individuals cope with the death of their spouses.

Significant differences were also found in the means of participants' subjective ratings of their overall physical health with regard to the use of the avoidant coping strategies. Participants who subjectively rated their overall physical health as '*average*' made significantly more use of the avoidant coping strategies when compared to both the participants who rated their overall

physical health as '*good*' and the participants who rated their overall physical health as '*poor*'. No previous study of note revealed a similar pattern.

A plausible explanation for the latter finding is that subjective perceptions of overall physical health as bordering between 'normal' health and morbidity influenced the latter group of participants to use avoidant coping as a way of 'shielding' themselves from the reality of potential deterioration of their health. Therefore, psychological distancing from the health-related concerns could have served to mitigate the anxieties that stemmed from the prospects of susceptibility to a degenerative medical condition – a factor that would be 'too stressful' to contemplate, especially when they were also grappling with the grief following spousal death. It is also possible that the social interaction with members of the extended family and kin group reinforced participants to turn their attention away from the potentially distressing thoughts and emotions pertaining to their overall physical health. In such settings, the scope of focus in terms of support given to the bereaved participants was probably restricted to the death of spouse itself rather than taking into consideration the bereaved spouse's emotional and physiological *reaction* to the loss. Because they did not want to 'upset' or alienate potential sources of support, and lest others should view them as being unreasonably demanding, these participants could have resorted to 'emotional withdrawal', thus making more use of avoidant coping strategies.

Support group programmes facilitating grief work and offering the bereaved an opportunity to 'ventilate' their fears, concerns and attitudes about the loss as well as their overall subjective experience of the loss of a spouse, are

indicated in order to facilitate the bereaved individuals' successful adaptation to conjugal bereavement.

Finally, significant differences were found between participants' subjective ratings of their overall physical health and the appraisal of the social support received from the significant others following spousal death. Social support appraisals were significantly higher for participants who subjectively rated their overall physical health as '*average*' when compared with both the participants who subjectively rated their overall physical health as '*good*' and the participants who rated their overall physical health as '*poor*'. No previous study of note revealed similar findings.

It is possible that the greater availability of social support structures within a collectivist, inter-dependent family- and group settings that characterised the interpersonal relationships had influenced the perceptions of individuals with subjective ratings of overall physical health as 'average' to have received most support from the significant others in wake of spousal death. Given that the latter group of participants evinced higher depressive and anxiety symptoms, and that they also made more use of social support-seeking coping strategies, this suggests that they were a needier group in terms of receiving social support from their social networks. Therefore, having social support structures readily available for their immediate needs could have significantly reinforced the appraisals of social support received from the significant others following spousal death.

Once more, the latter findings emphasise the need for bereavement intervention programmes to make it a priority to initiate basic support groups that would psycho-educate the bereaved individuals about the importance of

solidifying those interpersonal relationships within their social networks that serve as a protective buffer against the debilitating effects of loneliness following major losses.

The fact that higher stress levels were prevalent despite higher social support appraisals suggests that a renewed look at how the bereaved individuals' support systems operate, and the manner in which these support systems interact with the stresses of grief, needs to be a priority. This would enable community psychologists directly involved in bereavement treatment programmes to make a meaningful contribution towards helping the bereaved cope with major losses.

No significant differences or correlations were found between such demographic variables as the *mode of spousal death* (fatal accidents or death after chronic illness), the *place of spousal death* (home, work, hospital, or other place), *the expectancy of spousal death*, as well as *whether or not participants were present at the time of spousal death*, and any of the main variables of stress, coping strategies, pre-loss marital relationship and perceived social support.

6.10. PARTICIPANTS' OVERALL USE OF COPING STRATEGIES

Findings from the present study did not support the hypothesis that participants would make a predominant use of an avoidant coping strategy. Instead, as the scores on the Coping Strategy Indicator (CSI) indicated, a mere 5% of participants made a high use of avoidant coping strategies, as opposed to 58% of participants who made a high use of the problem-solving coping strategies, and 24% who made a high use of social support-seeking coping

strategies. A surprising finding pertained to the mode of coping for the remaining 13% of participants, which was characterised by an oscillation between both the problem-solving coping strategies and social support-seeking coping strategies.

The percentage of participants who made a predominant use of avoidant coping strategies in the present study (5%) was inconsistent with previous findings from a South African study that investigated coping styles of 70 recently widowed rural black women (Spangenberg & Somhlaba, 2003), wherein an overwhelming 70% of the sample made more use of avoidant coping strategies. The reason for this discrepancy is unclear and merits further investigation. It is possible that, over the progression of years, widowhood is slowly becoming a less 'stigmatised' experience, to the extent that people undergoing spousal loss are increasingly being accommodated to express their emotions, worries and concerns without the fear of being castigated, and hence their need to 'internalise' their ways of coping with conjugal loss gradually diminishes as opportunities for social interaction, albeit still minimal, do get created. This marked a significant shift from the traditional view of widowhood in the African setting, the cultural practices of which confined the widowed individuals to social isolation, particularly as these bereaved individuals were perceived as infected with 'an illness' of grief (Jali, 2000; Kalu, 1990; Manyedi, 2001; Sossou, 2002).

Also noteworthy, the '*Khomanani* (Caring Together) Campaign' advocated by the Department of Health in South Africa, which seeks to promote public willingness to help alleviate the suffering caused by HIV and AIDS, has the reduction of stigma surrounding the illness as its main objective (Department of

Health, 2005). Thus, the influence of public awareness health campaigns on individuals' self-perceptions of overall physical health and how such individuals subsequently cope with the physical ailments as well as with the psychological upheavals following major life transitions (like death of loved ones), should be the focus of further research.

The findings that the majority of participants in the present study (58%) relied more on the problem-solving coping strategies in wake of spousal death, and that there existed positive correlations between depression and problem-solving strategies, were not surprising, given the multiplicity of role responsibilities the conjugally bereaved individuals often find themselves confronted with after the loss of their spouses. As also suggested in literature (for example, Nadeau, 2001; Lopata, 1996; Lord, 1987; Parkes, 1975), widowhood often translates to a proliferation of single-handed household and parental responsibilities, which keep the widowed individuals preoccupied with practical problems and tasks to solve and deal with that are geared towards the sustenance of their livelihoods. It seems that support structures that are geared at problem-focused aid seem indicated if the bereaved spouses are to successfully adapt to their widowhood phase.

The finding that 24% of participants made a high use of social support-seeking coping strategies was inconsistent with the findings from the previous South African study of recently widowed rural black women (Spangenberg & Somhlaba, 2003), wherein 12.9% participants made more use of social support-seeking coping strategies. This significant difference suggests that widowhood as an inherently isolating experience for many bereaved in the rural settings is increasingly redefined as representing an opportunity for the widowed to reach

out for social ties that would serve as a buffer against grief-induced stress. Many researchers to date have emphasised the benefits of social support during bereavement phase (Duran et al., 1989; Gallagher-Thompson et al., 1993; Hall & Irwin, 2001; Krause, 1986; Norris & Murrell, 1990; Schuster & Butler, 1989; Siegel & Kuykendall, 1990; Stroebe & Stroebe, 1993; Stroebe et al., 1996; Stylianos & Vachon, 1993).

Moreover, the significant positive correlations between social support-seeking coping strategies and depression served to highlight the need for a redefinition of the role of social support structures in managing grief-induced distress. To this effect, the value of social ties would be largely determined by their responsiveness to the needs of the individual in distress as well as how they enable that individual to find solutions to the problems encountered following the spousal death.

The mode of coping that saw an oscillation between the problem-solving and social support-seeking coping strategies for the remaining 13% of participants in the present study was surprising. Although no previous study of note revealed a similar pattern, many researchers to date have noted an overlap between what have been understood as distinct coping strategies; for example, between problem-focused coping and emotion-focused coping (Carver & Scheier, 1994; Coyne & Racioppo, 2000; Folkman & Lazarus, 1980, 1985, 1991; Folkman et al., 1986; Lazarus, 2000).

The present finding, in which participants' coping strategies oscillated between problem-solving and social support-seeking coping strategies, highlights the notion of the overlapping relationship between the two coping styles in relation to dealing with the stressful encounter. The latter point is

significant when considering that the behaviour involved in seeking social support in times of stress (bereavement) was, by itself, representative of a tendency in which the individual sought to solve the practical problems subsequent to the loss of a spouse. Put differently, in a stressful encounter of spousal death, the bereaved individuals could have resorted to solving the problems experienced by reaching out for social ties in order to get an opportunity for sharing with others their fears and concerns as well as to enlist others' help, advice or guidance in finding practical solutions to the problem emanating from the loss. The latter viewpoint also bears on Thoits's (1986) distinction between behavioural problem-focused support (exertion of situational control by direct intervention) and cognitive emotion-focused support (reinforcing the individual's own interpretation of his or her condition), which both serve as coping assistance in the context of stressful encounter.

6.11. SUMMATION OF MAJOR FINDINGS FROM THE PRESENT STUDY

The alarmingly high stress levels of the rural South African widows and widowers, as illustrated in participants' depression and anxiety scores in the present study, served to highlight the notion that the spousal death, as a specific stressor, tends to trigger a constellation of feelings of sadness, dejection, and diminished self-esteem, coupled with heightened anxiety that stems from uncertainty about the future without the deceased. If unattended to, these factors have the potential to undermine psychological adjustment to conjugal bereavement.

The stress indicators for participants in the present study, namely depression and anxiety, emerged as particularly high in participants

undergoing conjugal bereavement, with significant positive correlations between these two measures of stress. While no significant correlations were found between anxiety and the three kinds of coping strategies, significant positive correlations emerged between depression and both the problem-solving- and social support-seeking coping strategies. Moreover, a problem-solving coping strategy emerged as a significant positive predictor of depression, while an avoidant coping strategy was found to be a significant negative predictor of depression.

Anxiety was negatively correlated with social support appraisal, and anxiety emerged as a significant negative predictor of perceived social support, with depression being a significant positive predictor of social support appraisal. Significant positive correlations emerged between the problem-solving coping strategy and perceived social support, while a problem-solving coping strategy emerged as a significant positive predictor of social support appraisal, and social support-seeking coping strategy being a significant negative predictor of social support appraisal.

It would seem that, following the death of a primary attachment figure like a spouse, depression is immune to supportive behaviours of significant others, while anxiety is inversely related to perceived social support. Support networks that aid coping with grief for the rural, conjugally bereaved, populations are those that provide an atmosphere conducive to social interaction to mitigate feelings of social isolation subsequent to spousal death. Moreover, bereavement intervention programmes need to prioritize setting up basic support groups that would psycho-educate the conjugally bereaved to continuously evaluate their support structures and solidify social ties that

provide needed instrumental assistance and advice. Therefore, the deleterious effects of anxiety and depression arising out of the loss of spouse could be mitigated if interpersonal transactions and support from the significant others are channelled towards exchanging problem-focused aid, which in turn would facilitate a meaningful psychological adjustment to spousal death.

Significant positive correlations were revealed between subjective retrospective assessment of pre-loss marital relationship and anxiety scores, while significant negative correlations were found between a problem-solving coping strategy and pre-loss marital relationship appraisal. While no coping strategies played a predictive role in the subjective perceptions of the nature of the pre-loss marital relationship, higher levels of subjective retrospective assessment of pre-loss marital relationship were strongly associated with such demographic characteristics as middle-income home earnings, the semi-literacy, the sexually inactivity, as well as closeness and cohesiveness of a marriage.

Qualitative data obtained from participant interviews revealed the compounding factors in the experience and manifestation of stress associated with the death of a spouse, such as marked social isolation, loss of 'protective' status of being married as well as single-handed parental and household responsibilities. Moreover, cultural aspects such as continued bonds with the deceased – in the form of hallucinatory experiences towards the deceased spouse – as well as the highly anticipated unveiling ritual that would mark the culmination of the societal prescription of a mourning period, served as ameliorative factors in the experience of grief and coping with the additional stressors secondary to loss.

The study also revealed that certain demographic variables had a significant bearing on the stress-coping relationship in the experience of conjugal bereavement. Depression was particularly higher among widows, the sexually inactive participants, those whose medical illness could be traced after the death of a spouse, among participants who lost no other relative in the past twelve months, those whose marriage was characterized by cohesion and those who were undergoing divorce during spousal death, and those with severe hallucinations and subjective description of physical health as either 'average' or 'poor'. Anxiety was higher for widows, the unemployed participants, those most recently bereaved, for concurrently bereaved, and whose physical health was subjectively appraised as 'poor'.

The use of problem-solving coping strategies were higher for semi-literate participants, those with severe hallucinations, the concurrently bereaved, sexually inactive, those with illness succeeding death and those whose health as described as 'average' or 'poor'. Social support-seeking coping strategies were highly associated with the semi-literate participants, while avoidant coping strategies were more strongly linked to severe hallucinations, sexual inactivity following spousal death, 'average' physical health, and with participants from households with five people or less.

The social support appraisals were strongly associated with younger participants, the employed, those whose deceased spouse was employed at the time of death, with participants whose deceased spouses were younger, those whose marriage was characterized by either divorce or physical distance, with severe hallucinations, with non-concurrent bereavement, with medical condition succeeding spousal death, and those whose physical health was

subjectively appraised as either 'average' or 'poor'. Meanwhile, adaptability and satisfaction with most aspects of the pre-loss marital relationship were reported more strongly by semi-literate, middle-income earning, sexually inactive participants as well as participants whose marriage was characterized by marital closeness and cohesion.

6.12. CONTRIBUTION OF THE PRESENT STUDY

The major contribution of the present study was the finding that the prevalence of both depression and anxiety was high in recently widowed rural black men and women. The extremely high incidence of depression (87.88%) is especially alarming. Although 12.12% of the conjugally bereaved men and women were only mildly depressed and probably merely suffered from dysphoric mood, the finding that 78.28% of them were moderately or severely depressed raises serious concern. Similarly, the extremely high levels of anxiety symptoms following spousal death (albeit applicable to 27.27% of participants in the present study) served to highlight the need to consider conjugal bereavement a risk factor for the manifestation of anxiety symptoms, which, when unattended to, may significantly interfere with adjustment to widowhood.

These findings point to the necessity for bereavement treatment programmes for the populations undergoing conjugal grief in the rural areas, which would help mitigate the depressive and anxiety symptoms emanating from the death of a spouse.

Another meaningful contribution was the finding that the use of an avoidant coping strategy, though widely regarded as representing maladaptive coping, predicted a decrease in depressive symptomatology. The notion of

avoidance as an adaptive coping strategy has received corroboration in research literature to date. For example, Lazarus (1981) has acknowledged that avoidance might be helpful within a limited time frame, although it might also become dysfunctional as time lapses and prevents individuals from fully negotiating the bereavement crisis. Sue (1986) is also of the opinion that the use of denial (also regarded as the "healthy denial"), may be a much more widely efficacious means of coping with stress than generally perceived.

Pertaining to grief, Kübler-Ross (1989) has delineated the phases of mourning, which individuals go through upon the death of their loved one. These phases are conceptualised as ranging from initial numbness, shock and denial, proceeding to anger, bargaining and depression, through to ultimate acceptance. Kübler-Ross has further maintained that a temporary disavowal of reality (avoidance) is a means of getting through the initial devastating early period of loss and threat, before reaching the later stage of acknowledgement and adjustment (Kübler-Ross, 1989). Moreover, Folkman and Lazarus (1991) have viewed the cognitive processes of coping such as denial, repression, suppression as well as intellectualization as efforts that are invoked to reduce anxiety and other distressing emotion states.

Given the points of view outlined above, it was not surprising that the use of avoidance coping strategies was associated with decrease in depressive symptoms following spousal death. Therefore, it can be inferred that during the first few months after the spousal death, participants used avoidance as a temporary adaptive response that allowed them to cope with the initial shock while at the same time "buying" time to make the necessary cognitive and emotional adjustment to their new widowhood status.

Furthermore, a South African study of 30 HIV positive patients conducted by Stein (1996) found that avoidant coping strategies functioned as protective buffer against negative thoughts and related beliefs of hopelessness and helplessness. Stein's findings posed a vigorous challenge to the generally accepted notions about the preferability and desirability of problem-solving and social support-seeking coping strategies over the avoidant coping strategy, for the individual to effectively cope with the crisis at hand. Stein further maintained that in an African setting, where the emphasis is not on the personal or individual process – but rather on the socio-cultural context within which the individual functions – avoidant coping is generally viewed as adaptive.

Stein's (1996) findings seem applicable to the findings of the present study, notwithstanding the high incidence of participants' anxiety and depressive symptomatology. However, since the long-term benefits of avoidance in coping with bereavement have not been corroborated in research (Lazarus, 1991), the effects of temporary 'disavowal' of the reality of the grief experience for the conjugally bereaved populations in rural areas on the subsequent transition to widowhood will remain the subject of further scrutiny by professionals directly involved in bereavement intervention programmes.

A third meaningful contribution was the finding that problem-solving and social support-seeking coping strategies as well as perceived social support predicted increase in depression and thus served to propel this negative emotion. This finding is far from suggesting the non-preferability and undesirability of both the problem-solving and social support-seeking coping strategies as well as perceived social support in mitigating depressive symptoms

following spousal death. Rather, it points out that the two coping strategies were reflective of the underlying stresses surrounding participants' inability to regain a sense of control of their lives and over the perceptions that the available social structures did not adequately respond to their immediate needs, especially in addressing the feelings of loneliness and helping in the management of problems experienced. Therefore, the finding serves to highlight that the social ties would be perceived as supportive and hence mitigate the depressive symptoms following spousal death if they assist the bereaved to find practical solutions to problems experienced.

A fourth significant contribution was the finding that the socio-cultural practices, belief systems, and 'religious' worldview of the participants' community of residence largely determined the experience and expression of grief following spousal death. The finding bears on the notion of grief as *not* an entirely private process (that involves only the individual concerned), but as that which is experienced in the context of human relationships with the external events, systems, and other persons (Bowen, 2004; Neimeyer, 2001; Walsh & McGoldrick, 2004). Borrowing a word of caution from Eisenbruch (1984), serious consideration of cultural practices of a given community in reaction to bereavement is to be given, as hindering these practices can disrupt the necessary grieving process.

A fifth contribution was the finding that the nature of the pre-loss marital relationship was positively correlated with anxiety but also negatively correlated with the problem-solving coping strategies. The positive correlations between pre-loss marital relationship and anxiety served to highlight the need for bereavement intervention programmes to focus 'grief work' as a way of

mitigating of anxiety induced by the loss. The negative correlations between pre-loss marital relationship and the problem-solving coping strategies point to the need for equipping the conjugally bereaved individuals with the practical problem-solving skills necessary for both the self-reliance and independence as they continue their lives without the partner with whom to share daily problems.

A sixth and final contribution of the study was that the use of both the quantitative and qualitative research methods allowed meaningful assessment of both the magnitude of relationships between different variables and the exploration of participants' subjective experience of the conjugal loss, as well as the manner in which their expression of grief influenced their coping efforts in the wake of spousal death. Although the contribution towards a contextual understanding of the participants' subjective experience of conjugal bereavement that qualitative data analyses offered was limited, the analyses nevertheless provided rich and meaningful insight into how individuals undergoing spousal bereavement specifically 'negotiated' the hurdles of their widowhood experience and generally made meaning of their spouseless lives. Moreover, the data rendered a deeper understanding of the manner in which the conjugally bereaved rural black population's experience of conjugal loss brought about means and ways of coping with the secondary stressors arising out of the loss itself, as well the manner in which they sought to reconstruct their lives without the deceased spouse.

6.13. LIMITATIONS OF THE PRESENT STUDY AND SUGGESTIONS FOR FUTURE RESEARCH

The first methodological shortcoming of the study was that its reliance on participants' self-reports of their experience of loss (both through assigning a summary score and giving a descriptive account of the loss circumstances) as representing the manifestation of stress-coping relationship following spousal death, compromised the exploration of those aspects of participants' grief reactions and coping efforts that superseded conscious awareness. Therefore, a more therapeutic based and ongoing assessment of grief that also explores the behavioural, emotional and cognitive aspects of bereavement that may be determining factors of the relationship between stress and coping should form part of future research into the experience of conjugal loss for rural black South African spouses.

A second limitation of the study is that the determination of pre-loss marital relationship from participants' retrospective judgements of the marriage rendered the subjective accounts of the pre-loss marital relationship susceptible to the positive recall bias that was reflective of spouse idealisation or sanctification. The latter point is significant when considering the emerging notion that bereaved tend to view their marriages in more positive terms if they are depressed about it (Futterman et al., 1990; Lopata, 1979, 1996). Therefore, future research needs to find ways of reducing the impact of these intervening cognitive processes in the assessment of marital adjustment to bereavement. As also evident in Carr et al.'s (2000) recent study of Changing Lives of Older Couples (CLOC) in 1,532 married individuals aged 65 and older, one such way would be a prospective (baseline) assessment of the effects of marital quality on

mental health as a departing point for the longitudinal exploration of the effects of pre-loss marital relationship into subsequent adjustment to widowhood.

A third limitation, also tied to the one above, was that self-reports of stress following spousal death left no information as to whether or not participants were depressed and anxious prior to the loss, and whether such depressive and anxiety symptoms subsequently improved or worsened. Pertaining to this, Coyne and Racioppo (2000) have also noted that the retrospective nature of the assessments of stress and coping makes it difficult to make a distinction between the manner in which a stressful encounter gets resolved and the contribution of the individual coping efforts to that particular encounter. Once more, prospective studies of bereavement that assess the progression of depression and anxiety over time would address these methodological pitfalls.

A fourth and final shortcoming was that the very 'explorative' nature of the present study on the assessment of stress-coping relationship in conjugal bereavement limited the investigation of the manner in which participants' reactions to spousal death fitted the model of the 'stages' (phases) of mourning. For example, while the inference drawn from higher anxiety symptoms for participants recently bereaved (within 6 months post-loss) was that this was a 'natural' grief reaction – given the disorganisation and emotional upheaval associated with close temporal proximity to the loss event, this provided little information about the nature of the subsequent progression of this reaction over time.

Therefore, future research would add valuable information if it undertook a longitudinal exploration of grief reactions. This would help determine whether

these reactions follow a universal, orderly progressive pattern (Botha & Pieters, 1987; Hodgkinson, 1984; Kübler-Ross, 1981, 1989), or a not necessarily sequential order (Bugen, cited in Cook & Oltjenbruns, 1998; Osterweis and colleagues, cited in Wortman et al., 1993; Stroebe et al., 1993). Moreover, longitudinal research would also ascertain whether grief reactions are phenomena that are contingent upon available coping resources (Wortman et al., 1993), or are they to be understood simply as representing a set of descriptive guidelines of how grief manifests over time (Parkes, 2001; Stroebe et al., 2001).

6.14. IMPLICATIONS OF THE PRESENT STUDY

Despite the limitations, the findings from the present study have two important implications for both clinical and community psychology as well as research focusing on coping with stress following conjugal bereavement in the South African rural settings.

Firstly, there is increased need for continued bereavement treatment programmes (for example, therapeutic support groups) for recently bereaved men and women in the rural areas, which are aimed primarily at mitigating the stress (depression and anxiety) associated with the death of a spouse. This would be important, given that people in these areas are inevitably confronted with the death of their spouses on an almost daily basis. Such treatment programmes would need to also equip the conjugally bereaved with practical problem-solving skills necessary for managing daily problems emanating from the loss of a spouse. Training the bereaved to learn practical ways of enlisting

practical help from the significant others should form an integral part of such bereavement intervention programmes.

Moreover, basic support groups need to be directed at psycho-educating the bereaved about the need to continuously evaluate their support structures as well as strengthen ties with social networks that readily render needed instrumental assistance and advice. Including spouses of chronically ill patients in such programmes would also serve as a preventive strategy (Raveis, 1999), which would facilitate better adjustment to spousal death and help find ways of coping with the conjugal loss when it occurs. The latter view resonates with Maddison's (1968) long-espoused emphasis on the need for conjugal bereavement to occupy a central point in preventive psychiatry.

Furthermore, the need for urgent preventive programmes in response to conjugal bereavement becomes salient when considering that the loss of spouse has generally long been understood as significantly interfering with overall personal functioning (Arbuckle & de Vries, 1995), a triggering or exacerbating factor for the development of surviving spouse's mental illness (Parkes, 1964b, 1965; Osterweis, cited in Van Zandt et al., 1989), as a risk factor for both the adverse health outcomes and deteriorating physiological function (Hall & Irwin, 2001), and as representing increased risk for mortality for surviving spouses (Bowling & Windsor, 1995; Jagger & Sutton, 1991; Lichtenstein, Gatz, & Berg, 1998; Martikainen & Valkonen, 1996; Mellström, Nilsson, Odén, Rundgren, & Svanborg, 1982; Rees, 1967; Ward, 1976), especially suicide (Bock & Webber, 1972; MacMahon & Pugh, 1965).

A second, and final, implication is that the cross-cultural aspects of bereavement, with specific reference to the social construction and expression

of grief for individuals from the rural setting need to be considered when bereavement intervention programmes are set up. For example, collectivist, interpersonal-, interdependent relations, and mutually supportive networks from extended family members and broader kin groups characterise the mode of communication in the rural areas.

Therefore, community psychologists and bereavement practitioners need to be sensitised about the importance of channelling their bereavement support groups to fit this frame of reference in order to make a meaningful and culturally sensitive intervention aimed at helping individuals cope with spousal death.

REFERENCES

Aber, C.S. (1992). Spousal death, a threat to women's health: paid work as a "resistance resource". *The Journal of Nursing Scholarship, 24*(2), 95-99.

AIDS Foundation of South Africa (2005). *HIV/Aids prevalence: trends and challenges,* p. 1 [Website, selected briefs on line]. Retrieved July 25, 2006 from the World Wide Web: http://www.aids.org.za/hiv.htm.

Aldwin, C.M., & Revenson, T.A. (1987). Does coping help? A reexamination of the relation between coping and mental health. *Journal of Personality and Social Psychology, 53*(2), 337-348.

Allen, R.J. (1983). *Human stress: its nature and control.* Minneapolis, Minnesota: Burgess.

Allport, G.W., & Ross, J.M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology, 5*(4), 432-443.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th Ed.).* Washington, DC: Author.

Amirkhan, J.H. (1990). A factor analytical derived measure of coping: the coping strategy indicator. *Journal of Personality and Social Psychology, 59*(5), 1066-1074.

Amirkhan, J.H. (1994). Criterion validity of a coping measure. *Journal of Personality Assessment, 62*(2), 242-261.

Arbuckle, N.W., & de Vries, B. (1995). The long-term effects of later life spousal and parental bereavement on personal functioning. *The Gerontologist, 35*(5), 637-647.

Aseltine, R.H., Jr., & Kessler, R.C. (1993). Marital disruption and depression in a community sample. *Journal of Health and Social Behavior, 34*(3), 237-251.

Babchuk, N., & Anderson, T.B. (1989). Older widows and married women: their intimates and confidants. *International Journal of Aging and Human Development, 28*(1), 21-35.

Baethge, C. (2002). Grief hallucinations: true or pseudo? Serious or not? An inquiry into psychopathological and clinical features of a common phenomenon. *Psychopathology, 35*(5), 296-302.

Balkwell, C. (1981). Transition to widowhood: a review of the literature. *Family Relations, 30,* 117-127.

Ball, J.F. (1977). Widow's grief: the impact of age and mode of death. *Omega, 7*(4), 307-333.

Bankoff, E.A. (1983). Social support and adaptation to widowhood. *Journal of Marriage and the Family, 45,* 827-839.

Bass, D.M., & Brown, K. (1990). The transition from caregiving to bereavement: the relationship of care-related strain and adjustment to death. *The Gerontologist, 30*(1), 35-42.

Baum, A., Fleming, R., & Singer, J.E. (1983). Coping with victimization by technological disaster. *Journal of Social Issues, 39*(2), 117-138.

Beck, A.T., & Steer, R.A. (1990). *Beck Anxiety Inventory: the Manual.* New York: Psychological Corporation.

Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Beck Depression Inventory – Second Edition.* New York: Psychological Corporation.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J.E., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Beem, E.E., Hooijkaas, H., Cleiren, M.H.P.D., Schut, H.A.W., Garssen, B., Croon, M.A., Jabaaij, L., Goodkin, K., Wind, H., & de Vries, M.J. (1999). The immunological and psychological effects of bereavement: does grief counseling really make a difference? A pilot study. *Psychiatry Research, 85*, 81-93.

Bennett, G., & Bennett, K.M. (2000). The presence of the dead: an empirical study. *Mortality, 5*(2), 139-157.

Berardo, F.M. (1970). Survivorship and social isolation: the case of the aged widower. *The Family Coordinator, 19*, 11-25.

Bierhals, A.J., Prigerson, H.G., Fasiczka, A., Frank, E., Miller, M., & Reynolds, C.F. (1996). Gender differences in complicated grief among the elderly. *Omega, 32*(4), 303-317.

Billings, A.G., & Moos, R.H. (1981). The role of coping responses and social resources in attenuating the stress of live events. *Journal of Behavioral Medicine, 4*(2), 139-157.

Billings, A.G., & Moos, R.H. (1984). Coping, stress, and social resources among adults with unipolar depression. *Journal of Personality and Social Psychology, 46*(4), 877-891.

Biondi, M., & Picardi, A. (1996). Clinical and biological aspects of bereavement and loss-induced depression: a reappraisal. *Psychotherapy and Psychosomatics, 65*(5), 229-245.

Bock, E.W., & Webber, I.L. (1972). Suicide among the elderly: isolating widowhood and mitigating alternatives. *Journal of Marriage and the Family, 34*, 24-31.

Boden, J.M., & Baumeister, R.F. (1997). Repressive coping: distraction using pleasant thoughts and memories. *Journal of Personality and Social Psychology, 73*(1), 45-62.

Bolga, N. (1990). Coping as a personality process: a prospective study. *Journal of Personality and Social Psychology, 59*(3), 525-537.

Bonanno, G.A. (2001). Grief and emotion: a social functional perspective. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 493-515). Washington, DC: American Psychological Association.

Bonanno, G.A., Keltner, D., Holen, A., & Horowitz, M.J. (1995). When avoiding unpleasant emotions might not be such a bad thing: verbal-autonomic response dissociation and midlife conjugal bereavement. *Journal of Personality and Social Psychology, 69*(5), 975-989.

Bookwala, J. (2004). Age, marital processes, and depressed affect. *The Gerontologist, 44*(3), 328-338.

Bornstein, P.E., Clayton, P.J., Halikas, J.A., Maurice, W.L., & Robins, E. (1973). The depression of widowhood after thirteen months. *British Journal of Psychiatry, 122*, 561-566.

Botha, H.C., & Pieters, H.C. (1987). Grief, complicated grief and grief therapy. *Psychotherapeia, 14*(4), 3-9.

Bowen, M. (2004). Family reaction to death. In F. Walsh, & M. McGoldrick (Eds.), *Living beyond loss: death in the family (2nd Edition)* (pp. 47-60). New York: W.W. Norton and Company.

Bowlby, J. (1973). *Attachment and loss: separation, anxiety and anger*. Harmondsworth, Middlesex: Penguin books.

Bowlby, J. (1980). *Attachment and loss. Vol. 3: Loss, sadness and depression.* New York: Basic books.

Bowling, A., & Cartwright, A. (1982). *Life after death.* London: Tavistock.

Bowling, A., & Windsor, J. (1995). Death after widow(er)hood: an analysis of mortality rates up to 13 years after bereavement. *Omega, 31*(1), 35-49.

Brislin, R.W. (1976). *Translation: applications and research.* New York: Gardener.

Brock, A.M. (1984). From wife to widow: a changing lifestyle. *Journal of Gerontological Nursing, 10*(4), 8-15.

Bugen, L.A. (1979). Human grief: a model for prediction and intervention. In L.A. Bugen (Ed.), *Death and dying: theory, research, practice* (pp. 33-45). Dubuque, Iowa: William C. Brown.

Cannon, W.B. (1963). *The wisdom of the body.* New York: W.W. Norton.

Carey, R.G. (1977). The widowed: a year later. *Journal of Counseling Psychology, 24*(2), 125-131.

Carey, R.G. (1980). Weathering widowhood: problems and adjustment of the widowed during the first year. *Omega, 10*(2), 163-174.

Carnelley, K.B., Wortman, C.B., & Kessler, R.C. (1999). The impact of widowhood on depression: findings from a prospective survey. *Psychological Medicine, 29*, 1111-1123.

Carr, A.C. (1975). Bereavement as a relative experience. In B. Schoenenberg, I. Gerber, A. Wiener, A.H. Kutscher, D. Peretz, & A.C. Carr (Eds.), *Bereavement: its psychosocial aspects* (pp. 3-8). New York: Columbia University Press.

Carr, D. (2004). Gender, preloss marital dependence, and older adults' adjustment to widowhood. *Journal of Marriage and the Family, 66*(1), 220-235.

Carr, D., House, J.S., Kessler, R.C., Nesse, R.M., Sonnega, J., & Wortman, C. (2000). Marital quality and psychological adjustment to widowhood among older adults: a longitudinal analysis. *Journal of Gerontology, 55B*(4), S197-S207.

Carr, A.C., & Schoenberg, B. (1970). Object loss and somatic symptom presentation. In B. Schoenenberg, A.C. Carr, D. Peretz, & A.H. Kutscher (Eds.), *Loss and grief: psychological management in medical practice* (pp. 36-50). New York: Columbia University Press.

Carver, C.S., & Scheier, M.F. (1994). Situational coping and coping dispositions in a stressful transaction. *Journal of Personality and Social Psychology, 66*(1), 184-195.

Casement, P.J. (2000). Mourning and the failure to mourn. *Fort Da, 6*(2), 20-32.

Chen, J.H., Bierhals, A.J., Prigerson, H.G., Kasl, S.V., Mazure, C.M., & Jacobs, S. (1999). Gender differences in the effects of bereavement-related psychological distress in health outcomes. *Psychological Medicine, 29*, 367-380.

Clark, L.A. (1989). The anxiety and depressive disorders: descriptive psychopathology and differential diagnosis. In P.C. Kendall, & D. Watson (Eds.), *Anxiety and depression: distinctive and overlapping features* (pp. 83-129). San Diego, CA: Academic Press.

Clayton, P.J. (1990). Bereavement and depression. *Journal of Clinical Psychiatry, 51*(7), 34-38.

Clayton, P.J., Halikas, J.A., & Maurice, W.L. (1972). The depression of widowhood. *British Journal of Psychiatry, 120*, 71-78.

Clayton, P.J., Halikas, J.A., Maurice, W.L., & Robins, E. (1973). Anticipatory grief and widowhood. *British Journal of Psychiatry, 122*, 47-51.

Cleiren, M.P.H.D. (1993). *Bereavement and adaptation: a comparative study of the aftermath of death.* Washington: Hemisphere.

Coetzee, M., & Spangenberg, J.J. (2002). *The role of coping styles in the quality of life of people with HIV/AIDS: a review.* Unpublished manuscript, Department of Psychology, University of Stellenbosch, South Africa.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: complementary research strategies.* California: Sage.

Cohen, S., & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*(2), 310-357.

Cook, A.S., & Oltjenbruns, K.A. (1998). *Death and grieving: life span and family perspectives (2nd Edition).* New York: Harcourt Brace College.

Corna, L.G. (1992). Stress and coping in families with diabetic children. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Corr, C.A., Nabe, C.M., & Corr, D.M. (2000). *Death and dying, life and living.* Belmont: Wadsworth.

Costa, P.T., Jr., Somerfield, M.R., & McCrae, R.R. (1996). Personality and coping: a reconceptualisation. In M. Zeidner, & N.S. Endler (Eds.), *Handbook of coping: theory, research, applications* (pp. 44-61). New York: John Wiley & Sons, Inc.

Coyne, J.C., & Gottlieb, B.H. (1996). The mismeasure of coping by checklist. *Journal of Personality, 64*(4), 959-991.

Coyne, J.C., & Racioppo, M.W. (2000). Never the twain shall meet? Closing the gap between coping research and clinical intervention research. *American Psychologist, 55*(6), 655-664.

Creed, F., & Barsky, A. (2004). A systematic review of epidemiology of somatisation disorder and hypochondriasis. *Journal of Psychosomatic Research, 56*(4), 391-408.

Crush, J., Jeeves, A., & Yudelman, D. (1991). *South Africa's labour empire: a history of Black migrancy to the gold mines.* Cape Town: David Philip.

Daggett, L.M. (2002). Living with loss: middle-aged men face spousal bereavement. *Qualitative Health Research, 12*(5), 625-639.

Dakof, G.A., & Taylor, S.E. (1990). Victim's perceptions of social support: what is helpful from whom? *Journal of Personality and Social Psychology, 58*(1), 80-89.

Davenport, D.S. (1981). A closer look at the "healthy" grieving process. *The Personnel and Guidance Journal, 59*, 332-335.

Davis, C.G. (2001). The tormented and the transformed: understanding responses to loss and trauma. In R.A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 137-155). Washington, DC: American Psychological Association.

Davis, J.M., Hoshiko, B.R., Jones, S., & Gosnell, D. (1992). The effect of a support group on grieving individuals' levels of perceived support and stress. *Archives of Psychiatric Nursing, 6*(1), 35-39.

Dehle, C., & Weiss, R.L. (1998). Sex differences in prospective associations between marital quality and depressed mood. *Journal of Marriage and the Family, 60*(4), 1002-1011.

Department of Health, South Africa. (2005). What is done to provide care and support and to fight discrimination? *Frequently Asked Questions [FAQs]: HIV/AIDS*, pp. 1. [Website, selected briefs on line]. Retrieved February 21 2006 from the World Wide Web: http://www.info.gov.za/faq/aids.htm.

Department of Health, South Africa. (2006). National HIV and syphilis antenatal sero-prevalence survey in South Africa 2005. *Extrapolation of HIV prevalence to the general population*, p. 16 [Website, selected briefs on line]. Retrieved July 25, 2006 from the World Wide Web: http://www.doh.gov.za/docs/hiv-syphilis-f.html.

Department of Transport, South Africa. (2002). Road Accidents. *Road Accident Fund Commission Report, 1*, 58-80 [Website, selected briefs on line]. Retrieved February 05, 2004 from the World Wide Web: http//www.transport.gov.za/library/docs/raf/s2-4.pdf.

DiGiulio, J.F. (1992). Early widowhood: an atypical transition. *Journal of Mental Health Counseling, 14*(1), 97-109.

Dobson, J.S. (1985). The relationship between anxiety and depression. *Clinical Psychology Review, 5*, 307-324.

Doka, K.J., & Martin, T. (1998). Masculine responses to loss: clinical implications. *Journal of Family Studies, 4*(2), 143-158.

Donahue, M.J. (1985). Intrinsic and extrinsic religiousness: review and meta-analysis. *Journal of Personality and Social Psychology, 48*(2), 400-419.

Donnelly, E.F., Field, N.G., & Horowitz, M.J. (2001). Expectancy of spousal death and adjustment to conjugal bereavement. *Omega, 42*(3), 195-208.

Dressler, W.W. (1985). The social and cultural context of coping: action, gender and symptoms in a Southern Black community. *Social Science Medicine, 21*(5), 499-506.

Duran, A., Turner, C.W., & Lund, D.A. (1989). Social support, perceived stress, and depression following the death of a spouse in later life. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 69-78). New York: Hemisphere.

Eckenrode, J. (1991). Introduction. In J. Eckenrode (Ed.), *The social context of coping* (pp. 1-12). New York: Plenum Press.

Eisenbruch, M. (1984). Cross-cultural aspects of bereavement. II: ethnic and cultural variations in the development of bereavement practices. *Culture, Medicine and Psychiatry, 8*, 315-347.

Endler, N.S., & Parker, J.D.A. (1990). Multidimensional assessment of coping: a critical evaluation. *Journal of Personality and Social Psychology, 58*, 844-854.

Engel, G.L. (1994). Is grief a disease? In R.V. Frankiel (Ed.), *Essential papers on object loss* (pp. 10-16). New York: New York University Press.

Faletti, M.V., Gibbs, J.M., Clark, M.C., Pruchno, R.A., & Berman, E.A. (1989). Longitudinal course of bereavement in older adults. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 37-51). New York: Hemisphere.

Farberow, N.L., Gallagher-Thompson, D., Gilewski, M., & Thompson, L. (1992). The role of social supports in the bereavement process of surviving spouses of suicide and natural deaths. *Suicide and Life-Threatening Behavior, 22*(1), 107-124.

Felsten, G. (1998). Gender and coping: use of distinct strategies and associations with stress and depression. *Anxiety, Stress, and Coping, 11*, 289-309.

Felton, B.J., & Revenson, T.A. (1984). Coping with chronic illness: a study of illness controllability and the influence of coping strategies on psychological adjustment. *Journal of Consulting and Clinical Psychology, 52*(3), 343-353.

Ferraro, K.F. (1986). The effects of widowhood on the health status of older persons. *International Journal of Aging and Human Development, 21*(1), 9-25.

Field, N.P., Gal-Oz, E., & Bonanno, G.A. (2003). Continuing bonds and adjustment at five years after the death of a spouse. *Journal of Consulting and Clinical Psychology, 71*(1), 110-117.

Field, N.P., Nichols, C., Holen, A., & Horowitz, M.J. (1999). The relation of continuing attachment to adjustment in conjugal bereavement. *Journal of Consulting and Clinical Psychology, 67*(2), 212-218.

Fiore, J., Becker, J., & Coppel, D.B. (1983). Social network interactions: a buffer or a stress? *American Journal of Community Psychology, 11*(4), 423-429.

Fiore, J., Coppel, D.B., Becker, J., & Cox, G.B. (1986). Social support as a multidimensional concept: examination of important dimensions for adjustment. *American Journal of Community Psychology, 14*(1), 93-111.

Firestone, W.A. (1987). Meaning in method: the rhetoric of quantitative and qualitative research. *Educational Researcher*, 16-20.

Folkman, S. (2001). Revised coping theory and the process of bereavement. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 563-584). Washington, DC: American Psychological Association.

Folkman, S., & Lazarus, R.S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior, 21*, 219-239.

Folkman, S., & Lazarus, R.S. (1985). If it changes it must be a process: study of emotion and coping during three stages of a collective examination. *Journal of Personality and Social Psychology, 48*, 150-170.

Folkman, S., & Lazarus, R.S. (1991). Coping and emotion. In A. Monat, & R.S. Lazarus (Eds.), *Stress and coping: an anthology (3rd Ed.)* (pp. 207-227). New York: Columbia University Press.

Folkman, S., Lazarus, R.S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. (1986). The dynamics of a stressful encounter: cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50*(5), 992-1003.

Folkman, S., Lazarus, S.R., Pimley, S., & Novacek, J. (1987). Age differences in stress and coping process. *Psychology and Aging, 2*(2), 171-184.

Folkman, S., & Moskowitz, J.T. (2000). Positive affect and the other side of coping. *American Psychologist, 55*(6), 647-654.

Frantz, T.T., Farrell, M.M., & Trolley, B.C. (2001). Positive outcomes of losing a loved one. In R.A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 191-201). Washington, DC: American Psychological Association.

Frantz, T.T., Trolley, B.C., & Johll, M.P. (1996). Religious aspects of bereavement. *Pastoral Psychology, 44*(3), 151-163.

Freeman, C.U. (1984). The effects of conjugal bereavement: a comparison between widows and widowers. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Freud, S. (1925). Mourning and melancholia. *Collected papers. Vol. IV* (pp. 152-170). London: Hogarth Press.

Frijda, N.H. (1993). The place of appraisal in emotion. *Cognition and Emotion, 7*(3/4), 357-387.

Fulton, R., & Gottesman, J. (1980). Anticipatory grief: a psychosocial concept reconsidered. *British Journal of Psychiatry, 137*, 45-54.

Fulton, G., Madden, C., & Minichiello, V. (1996). The social construction of anticipatory grief. *Social Science Medicine, 43*(9), 1349-1358.

Futterman, A., Gallagher, D., Thompson, L.W., Lovett, S., & Gilewski, M. (1990). Retrospective assessment of marital adjustment and depression during the first 2 years of spousal bereavement. *Psychology and Aging, 5*(2), 277-283.

Gallagher, D.E., Thompson, L.W., & Thompson, J.A. (1982). Psychosocial aspects affecting adaptation to bereavement in the elderly. *International Journal of Aging and Human Development, 14*(2), 79-94.

Gallagher-Thompson, D., Futterman, A., Farberow, N., Thompson, L.W., & Peterson, J. (1993). The impact of spousal bereavement on older widows and widowers. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp. 227-239). Cambridge: Cambridge University Press.

Gass, K.A. (1987). The health of conjugally bereaved older widows: the role of appraisal, coping and resources. *Research in Nursing and Health, 10*, 39-47.

Gass, K.A. (1988). Aged widows and widowers: similarities and differences in appraisal, coping, resources, type of death, and health dysfunction. *Archives of General Nursing, 2*(4), 200-210.

Gass, K.A. (1989a). Appraisal, coping, and resources: markers associated with health of aged widows and widowers. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 79-93). New York: Hemisphere.

Gass, K.A. (1989b). Health of older widowers: role of appraisal, coping, resources, and type of spouse's death. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 95-110). New York: Hemisphere.

Gass, K.A., Chang, A.S. (1989). Appraisals of bereavement, coping, resources, and psychological health dysfunction in widows and widowers. *Nursing Research, 38*(1), 31-36.

Gerber, I., Rusalem, R., Hannon, N., Battin, D., & Arkin, A. (1975). Anticipatory grief and aged widows and widowers. *Journal of Gerontology, 30*(2), 225-229.

Gibbs, H.W., & Achterberg-Lawlis, J. (1978). Spiritual values and death anxiety: implications for counseling with terminal cancer patients. *Journal of Counseling Psychology, 25*(6), 563-569.

Gilbar, O., & Dagan, A. (1995). Coping with loss: differences between widows and widowers of deceased cancer patients. *Omega, 31*(3), 207-220.

Gilewski, M.J., Farberow, N.L., Gallagher, D.E., & Thompson, L.W. (1991). Interaction of depression and bereavement on mental health in the elderly. *Psychology and Aging, 6*(1), 67-75.

Glick, I.O., Weiss, R.S., & Parkes, C.M. (1974). *The first year of bereavement.* New York: John Wiley & Sons.

Goin, M.K., Burgoyne, R.W., & Goin, J.M. (1979). Timeless attachment to a dead relative. *American Journal of Psychiatry, 136*(7), 988-989.

Gore, S., & Colten, M.E. (1991). Gender, stress, and distress: situational-relational influences. In J. Eckenrode (Ed.), *The social context of coping* (pp. 139-163). New York: Plenum Press.

Greeff, A.P., & Malherbe, H.J. (2001). Intimacy and marital satisfaction in spouses. *Journal of Sex and Marital Therapy, 27*(3), 247-257.

Greene, R.W., & Feld, S. (1989). Social support coverage and the well-being of elderly widows and married women. *Journal of Family Issues, 10*(1), 33-51.

Grimby, A. (1998). Hallucinations following the loss of a spouse: common and normal events among the elderly. *Journal of Clinical Geropsychiatry, 4,* 65-74.

Hall, M., & Irwin, M. (2001). Physiological indices of functioning in bereavement. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 473-492). Washington, DC: American Psychological Association.

Hansson, R.O., & Hayslip, Jr., B. (2000). Widowhood in later life. In J.H. Harvey, & E.D. Miller (Eds.), *Loss and trauma: general and close relationship perspectives* (pp. 345-357). Philadelphia, PA: Brunner-Routledge.

Hansson, R.O., Remondet, J.H., & Galusha, M. (1993). Old age and widowhood: issues of personal control and independence. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research and intervention* (pp. 367-380). Cambridge University Press.

Harlow, S.D., Goldberg, E.L., & Comstock, G.W. (1991). A longitudinal study of the prevalence of depressive symptomatology in elderly widowed and married women. *Archives of General Psychiatry, 48*, 1065-1068.

Hays, J.C., Kasl, S.V., & Jacobs, S.C. (1994). The course of psychological distress following threatened and actual conjugal bereavement. *Psychological Medicine, 24*, 917-927.

Hewitt, P.L., & Flett, G.L. (1996). Personality traits and the coping process. In M. Zeidner, & N.S. Endler (Eds.), *Handbook of coping: theory, research, applications* (pp. 410-433). New York: John Wiley & Sons, Inc.

Hill, C.D., Thompson, L.W., & Gallagher, D. (1988). The role of anticipatory bereavement in older women's adjustment to widowhood. *The Gerontologist, 28*(6), 792-796.

Hill, F. (2002). Subjective perceptions of stress and coping by mothers of children with an intellectual disability: a needs assessment. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Hobfoll, S.E. (1988). *The ecology of stress*. New York: Hemisphere.

Hobfoll, S.E., Dunahoo, C.L., Ben-Porath, Y., & Monnier, J. (1994). Gender and coping: the dual-axis model of coping. *American Journal of Community Psychology, 22*(1), 49-82.

Hodgkinson, P.E. (1984). Abnormal grief and its therapy. *Psychotherapeia and Psychiatry in Practice, 33*, 22-31.

Holahan, C.J., & Moos, R.H. (1986). Personality, coping, and family resources in stress resistance: a longitudinal analysis. *Journal of Personality and Social Psychology, 51*(2), 389-395.

Holahan, C.J., & Moos, R.H. (1987). Personal and contextual determinants of coping strategies. *Journal of Personality and Social Psychology, 52*(5), 946-955.

Holahan, C.J., & Moos, R.H. (1990). Life stressors, resistance factors, and improved psychological functioning: an extension of the stress resistance paradigm. *Journal of Personality and Social Psychology, 58*(5), 909-917.

Holahan, C.J., Moos, R.H., & Schaefer, J.A. (1996). Coping, stress resistance, and growth: conceptualising adaptive functioning. In M. Zeidner, & N.S. Endler (Eds.), *Handbook of coping: theory, research, applications* (pp. 24-43). New York: John Wiley & Sons, Inc.

Holmes, T., & Rahe, R. (1967). The Social Readjustment Scale. *Journal of Psychosomatic Research, 11*, 213-218.

Hoyt, M.F. (1981). Clinical notes regarding the experience of "presences" in mourning. *Omega, 11*(2), 105-111.

Hyrkäs, K., Kaunonen, M., & Paunonen, M. (1997). Recovery from the death of a spouse. *Journal of Advanced Nursing, 25*, 775-779.

Irwin, M., Daniels, M., & Weiner, H. (1987). Immune and neuroendocrine changes during bereavement. *Psychiatric Clinics of North America, 10*(3), 449-465.

Jackson, E.N. (1957). *Understanding grief: its roots, dynamics and treatment.* New York: Abingdon.

Jackson, E.N. (1977). *The many faces of grief.* Nashville, Teneessee: Abingdon.

Jacobs, S., Hansen, F., Berkman, L., Kasl, S., & Ostfeld, A. (1989). Depressions of bereavement. *Comprehensive Psychiatry, 30*(3), 218-224.

Jacobs, S., Hansen, F., Kasl, S.V., Ostfeld, A., Berkman, L., & Kim, K. (1990). Anxiety disorders during acute bereavement: risk and risk factors. *Journal of Clinical Psychiatry, 51*(7), 269-274.

Jacobson, D.E. (1986). Types and timing of social support. *Journal of Health and Social Behavior, 27*, 250-264.

Jagger, C., & Sutton, C.J. (1991). Death after marital bereavement – is the risk increased? *Statistics in Medicine, 10*, 395-404.

Jali, N.M. (2000). *The African perception of death, with special reference to the Zulu: a critical analysis.* Unpublished master's thesis, University of Stellenbosch, South Africa.

Jansen, J.M. (1991). Stress and coping in families with physically handicapped children. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Johnson, D.R. (2002). An empirical test of crisis, social selection, role explanations of the relationship between marital disruption and psychological distress: a pooled time-series analysis of four-wave panel data. *Journal of Marriage and the Family, 64*(1), 211-224.

Kalish, R.A. (1985). *Death, grief, and caring relationships (2nd Edition).* Monterey, California: Brookes/Cole.

Kalu, W. (1990). Bereavement and stress in career women. *Women and Therapy, 10*(3), 75-87.

Kaplan, H.B. (1996). Perspectives on psychosocial stress. In H.B. Kaplan (Ed.), *Psychosocial stress: perspectives on structure, theory, life-course, and methods* (pp. 3-24). New York: Academic Press.

Kessler, R.C., Kendler, K.S., Heath, A., Neale, M.C., & Eaves, L.J. (1992). Social support, depressed mood, and adjustment to stress: a genetic epidemiologic investigation. *Journal of Personality and Social Psychology, 62*(2), 257-272.

Kim, H.K., & McKenry, P.C. (2002). The relationship between marriage and psychological well-being: a longitudinal analysis. *Journal of Family Issues, 23*(8), 885-912.

Klass, D. (2001a). Continuing bonds in the resolution of grief in Japan and North America. *American Behavioral Scientist, 44*(5), 742-763.

Klass, D. (2001b). The inner representation of the dead child in the psychic and social narratives of bereaved parents. In R.A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 77-94). Washington, DC: American Psychological Association.

Klass, D., & Walter, T. (2001). Process of grieving: how bonds are continued. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 431-448). Washington, DC: American Psychological Association.

Kramer, D. (1997). How women relate to the terminally ill husbands and their subsequent adjustment to bereavement. *Omega, 34*(2), 93-106.

Krause, N. (1986). Social support, stress, and well-being among older adults. *Journal of Gerontology, 41*(4), 512-519.

Krohne, H.W. (1996). Individual differences in coping. In M. Zeidner, & N.S. Endler (Eds.), *Handbook of coping: theory, research, applications* (pp. 381-409). New York: John Wiley & Sons, Inc.

Kübler-Ross, E. (1981). *Living with death and dying.* New York: Macmillan.

Kübler-Ross, E. (1989). *On death and dying.* London: Routledge.

Lazarus, R.S. (1966). *Psychological stress and the coping process.* New York: McGraw-Hill.

Lazarus, R.S. (1981). The costs and benefits of denial. In B.S. Dohrenwend, & B.P. Dohrenwend (Eds.), *Stressful life events and their contexts* (pp. 131-156). New Jersey: Rutgers University Press.

Lazarus, R.S. (1991). *Emotion and Adaptation*: New York: Oxford University Press.

Lazarus, R.S. (1993). From psychological stress to the emotions: a history of changing outlooks. *Annual Review of Psychology, 44*, 1-21.

Lazarus, R.S. (1999). *Stress and emotion: a new synthesis.* New York: Springer.

Lazarus, R.S. (2000). Toward better research on stress and coping. *American Psychologist, 55*(6), 665-673.

Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal and coping.* New York: Springer-Verlag.

Lazarus, R.S., & Folkman, S. (1991). The concept of coping. In A Monat, & R.S. Lazarus (Eds.), *Stress and coping: an anthology* (3rd Edition) (pp. 21-35). New York: Columbia University Press.

Lee, G.R., Willetts, M.C., & Seccombe, K. (1998). Widowhood and depression: sex differences. *Research on Aging, 20*(5), 611-630.

Lemming, M.R., & Dickinson, G.E. (1998). *Understanding death, dying and bereavement (4th Edition).* New York: Harcourt Brace College.

Leventhal, H., & Tomarken, A. (1987). Stress and illness: perspectives from health psychology. In S.V. Kasl, & C.L. Cooper (Eds.), *Stress and health: issues in research methodology* (pp. 27-55). New York: John Wiley & Sons.

Levy, L.H., Martinkowski, K.S., & Derby, J.F. (1994). Differences in patterns of adaptation in conjugal bereavement: their sources and potential significance. *Omega, 29*(1), 71-87.

Lichtenstein, P., Gatz, M., & Berg, S. (1998). A twin study of mortality after spousal bereavement. *Psychological Medicine, 28*, 635-643.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychology, 101*(2), 141-148.

Lindstrøm, T.C. (1995a). Anxiety and adaptation in bereavement. *Anxiety, Stress and Coping: An International Journal, 8*(3), 251-261.

Lindstrøm, T.C. (1995b). Experiencing the presence of the dead: discrepancies in "the sensing experience" their psychological concomitants. *Omega, 31*(1), 11-21.

Lindstrøm, T.C. (1997). Immunity and health after bereavement in relation to coping. *Scandinavian Journal of Psychology, 38*, 253-259.

Lindstrøm, T.C. (1999). Coping with bereavement in relation to different feminine gender roles. *Scandinavian Journal of Psychology, 40*, 33-41.

Littlewood, J. (1992). *Aspects of grief: bereavement in adult life.* London: Tavistock/Routledge.

Lopata, H.Z. (1979). Widowhood and husband sanctification. In L.A. Bugen (Ed.), *Death and dying: theory, research, practice* (pp. 205-211). Dubuque, Iowa: William C. Brown.

Lopata, H.Z. (1996). *Current widowhood: myths and realities.* Thousand Oaks, California: Sage.

Lord, J.H. (1987). *No time for goodbyes: coping with sorrow, anger, and injustice after a tragic death.* Ventura, CA: Pathfinder.

Loveland, G.G. (1968). The effects of bereavement on certain religious attitudes and behavior. *Sociological Symposium, 1*, 17-27.

Lovibond, P.F., & Lovibond, S.H. (1995). The structure of negative emotional states: comparison of the Depression Anxiety Stress Scale (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*, 335-343.

Lund, D.A. (1989). Conclusions about bereavement in later life and implications for interventions and future research. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 217-231). New York: Hemisphere.

Lund, D.A., Caserta, M.S., & Dimond, M.F. (1986). Gender differences through two years of bereavement among the elderly. *The Gerontologist, 26*(3), 314-320.

Lund, D.A., Caserta, M.S., & Dimond, M.F. (1989). Impact of spousal bereavement on the subjective well-being of older adults. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 3-15). New York: Hemisphere.

Lund, D.A., Caserta, M.S., Dimond, M.F., & Shaffer, S.K. (1989) Competencies, tasks of daily living, and adjustment to spousal bereavement in later life. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 135-152). New York: Hemisphere.

Lundin, T. (1984). Morbidity following sudden and unexpected bereavement. *British Journal of Psychiatry, 144*, 84-88.

MacMahon, B., & Pugh, T.F. (1965). Suicide in the widowed. *American Journal of Epidemiology, 81*(1), 23-31.

Maddison, D. (1968). The relevance of conjugal bereavement for preventive psychiatry. *British Journal of Medical Psychology, 41*, 223-233.

Maddison, D., & Raphael, B. (1975). Conjugal bereavement and social networks. In B. Schoenenberg, I. Gerber, A. Wiener, A.H. Kutscher, D. Peretz, & A.C. Carr (Eds.), *Bereavement: its psychosocial aspects* (pp. 26-40). New York: Columbia University Press.

Maddison, D., & Viola, A. (1968). The health of widows in the year following bereavement. *Journal of Psychosomatic Research, 12*, 297-306.

Mallach, C.S. (1997). Coping with stress amongst males and females in professional occupations. Unpublished master's thesis, University of South Africa.

Manyedi, M.E. (2001). *Experiences of widowhood and beliefs about the mourning process of the Batswana people.* Unpublished master's thesis, Potchefstroom University for Christian Higher Education, South Africa.

Marris, P. (1974). *Loss and change.* London: Routledge & Kegan Paul.

Marshall, H. (2002). What do we do when we code data? *Qualitative Research Journal, 2*(1), 56-70.

Martikainen, P., & Valkonen, T. (1996). Mortality after the death of a spouse: rates and causes of death in a large Finnish cohort. *American Journal of Public Health, 86*(8), 1087-1093.

Matheny, K.B., Aycock, D.W., Pugh, J.L., Curlette, W.L., & Silva Cannella, K.A. (1986). Stress coping: a qualitative and quantitative synthesis with implications for treatment. *The Counseling Psychologist, 14*(4), 499-549.

Mathison, S. (1988). Why triangulate? *Educational Researcher*, 13-17.

McCallum, M., Piper, W.E., & Morin, H. (1993). Affect and outcome in short-term therapy for loss. *International Journal of Group Therapy, 43*, 303-319.

McCrae, R.R., & Costa, P.T. (1993). Psychological resilience among widowed men and women: a 10-year follow-up of a national sample. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp.196-207). Cambridge: Cambridge University Press.

McGoldrick, M. (2004). Gender and mourning. In F. Walsh, & M. McGoldrick (Eds.), *Living beyond loss: death in the family (2nd Edition)* (pp. 99-118). New York: W.W. Norton and Company.

McGrath, J.E. (1970). *Social and psychological factors in stress.* New York: Holt, Rinehart & Winston.

McHorney, C.A., & Mor, V. (1988). Predictors of bereavement depression and its health consequences. *Medical Care, 26*(9), 882-893.

McLeod, J.D., & Eckberg, D.A. (1993). Concordance for depressive disorders and marital quality. *Journal of Marriage and the Family, 55*(3), 773-746.

Mellström, D., Nilsson, Å., Odén, A., Rundgren, Å., & Svanborg, A. (1982). Mortality among the widowed in Sweden. *Scandinavian Journal of Social Medicine, 10*, 33-41.

Middleton, W., Raphael, B., Martinek, N., & Misso, V. (1993). Pathological grief reactions. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp.44-61). Cambridge: Cambridge University Press.

Mikulincer, M., & Florian, V. (1997). Are emotional and instrumental supportive interactions beneficial in times of stress? The impact of attachment style. *Anxiety, Stress, and Coping, 10*, 109-127.

Miller, S.M., Brody, D.S., & Summerton, J. (1988). Styles of coping with threat: implications for health. *Journal of Personality and Social Psychology, 54*, 142-148.

Miller, J., & Garrison, H.H. (1982). Sex roles: the division of labor at home and in the workplace. *Annual Review of Sociology, 8*(1), 237-262.

Mitchell, R.E., Cronkite, R.C., & Moos, R.H. (1983). Stress, coping, and depression among married couples. *Journal of Abnormal Psychology, 92*(4), 433-448.

Mitchell, R.E., & Hodson, C.A. (1983). Coping with domestic violence: social support and psychological health among battered women. *American Journal of Community Psychology, 11*, 629-654.

Möller, A.T., & Spangenberg, J.J. (1996). Stress and coping amongst South African dentists in private practice. *Journal of the Dental Association of South Africa, 51*, 347-357.

Monat, A., & Lazarus, R.S. (1991). Stress and coping: some current issues and controversies. In A. Monat, & R.S. Lazarus (Eds.), *Stress and coping: an anthology (3rd Ed.)* (pp. 1-15). New York: Columbia University Press.

Moodie, T.D. (1994). *Worker identities: migrant cultures, social networks, and the practice of personal integrity.* Johannesburg: Witwatersrand University Press.

Morgan, L.A. (1984). Changes in family interaction following widowhood. *Journal of Marriage and the Family, 46*, 323-331.

Morgan, D.L. (1989). Adjusting to widowhood: do social support networks really make it easier? *The Gerontologist, 29*(1), 101-107.

Morgan, D., Carder, P., & Neal, M. (1997). Are some relationships more useful than others? The value of similar others in the networks of recent widows. *Journal of Personality and Social Psychology, 14*(6), 745-759.

Morris, S. (1971). *Grief and how to live with it.* London: George Allen & Unwin.

Moss, M.S., & Moss, S.Z. (1985). Some aspects of the elderly widow(er)'s persistent tie with the deceased spouse. *Omega, 15*(3), 195-205.

Muhr, T., & Friese, S. (2004). *User's manual for ATLAS.ti 5.0, 2nd Edition,* pp. 1-417. [Website manual downloads]. Retrieved July 27, 2006 from the World Wide Web: http://www.atlasti.com/downloads/atlman.pdf.

Nadeau, J.W. (2001). Family construction of meaning. In R.A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 95-111). Washington, DC: American Psychological Association.

Neimeyer, R.A. (2001). Introduction: meaning reconstruction and loss. In R.A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 1-9). Washington, DC: American Psychological Association.

Nieboer, A.P., Lindenberg, S.M., & Ormel, J. (1998). Conjugal bereavement and well-being of elderly men and women: a preliminary study. *Omega, 38*(2), 113-141.

Nolen-Hoeksema, S. (2001). Ruminative coping and adjustment to bereavement. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 545-562). Washington, DC: American Psychological Association.

Nolen-Hoeksema, S., Parker, L.E., & Larson, J. (1994). Ruminative coping with depressed mood following loss. *Journal of Personality and Social Psychology, 67*(1), 92-104.

Norris, F.H., & Murrell, S.A. (1987). Older adult family stress and adaptation before and after bereavement. *Journal of Gerontology, 42*(6), 606-612.

Norris, F.H., & Murrell, S.A. (1990). Social support, life events, and stress as modifiers of adjustment to bereavement by older adults. *Psychology and Aging, 5*(3), 429-436.

O'Bryant, S.L. (1991). Forewarning of a husband's death: does it make a difference for older widows? *Omega, 22*(3), 227-239.

Olson, D.H., Fournier, D.G., & Druckman, J. M. (1982). *ENRICH: Enriching & Nurturing Relationship Issues, Communication & Happiness.* St. Paul: Family Social Science, University of Minnesota, 290 McNeal Hall, St. Paul, MN.

Olson, D.H., Fournier, D.G., & Druckman, J. M. (1983). *PREPARE, PREPARE-MC & ENRICH Inventories.* Minneapolis: REPARE/ENRICH, Inc. P.O.Box 190, Minneapolis, MN.

Pargament, K.I. (1997). *The Psychology of Religion and Coping: Theory, Research, Practice.* New York: The Guilford Press.

Parker, J.D.A., & Endler, N.S. (1996). Coping and defense: a historical overview. In M. Zeidner, & N.S. Endler (Eds.), *Handbook of coping: theory, research, applications* (pp. 3-23). New York: John Wiley & Sons, Inc.

Parkes, C.M. (1964a). Effects of bereavement on physical and mental health – a study of the medical records of widows. *British Medical Journal, 2*, 274-279.

Parkes, C.M. (1964b). Recent bereavement as a cause of mental illness. *British Journal of Psychiatry, 110*, 198-204.

Parkes, C.M. (1965). Bereavement and mental illness. Part 2: a classification of bereavement reactions. *British Journal of Medical Psychology, 38*, 13-26.

Parkes, C.M. (1972). Health after bereavement: a controlled study of young Boston widows and widowers. *Psychosomatic Medicine, 34*(5), 449-461.

Parkes, C.M. (1975a). *Bereavement: studies of grief in adult life.* Harmondsworth: Penguin.

Parkes, C.M. (1975b). Unexpected and untimely bereavement: a statistical study of young Boston widows and widowers. In B. Schoenenberg, I. Gerber, A. Wiener, A.H. Kutscher, D. Peretz, & A.C. Carr (Eds.), *Bereavement: its psychosocial aspects* (pp. 119-138). New York: Columbia University Press.

Parkes, C.M. (1993). Bereavement as a social transition: processes of adaptation and change. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp.91-101). Cambridge University Press.

Parkes, C.M. (1996). *Bereavement: studies of grief in adult life (3rd Edition).* New York: Routledge.

Parkes, C.M. (1998a). Introduction. In C.M. Parkes, & A. Markus (Eds.), *Coping with loss: helping patients and their families* (pp. 1-13). London: BMJ Books.

Parkes, C.M. (1998b). Bereavement in adult life. In C.M. Parkes, & A. Markus (Eds.), *Coping with loss: helping patients and their families* (pp. 14-24). London: BMJ Books.

Parkes, C.M. (2000). Bereavement as a psychological transition: process of adaptation. In D. Dickenson, M. Johnson, & J.S. Katz (Eds.), *Death, dying and bereavement (2nd Edition)* (pp. 325-331). London: Sage.

Parkes, C.M. (2001). A historical overview of the scientific study of bereavement. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 25-45). Washington, DC: American Psychological Association.

Pasternak, R.E., Reynolds III, C.F., Schlernitzauer, M., Hoch, C.C., Buysee, D.J., Houck, P.R., & Perel, J.M. (1991). Acute open-trial nortriptyline therapy of bereavement-related depression in later life. *Journal of Clinical Psychiatry, 52*(7), 307-310.

Pearlin, L.I. (1991). The study of coping: an overview of problems and directions. In J. Eckenrode (Ed.), *The social context of coping* (pp. 261-276). New York: Plenum.

Pearlin, L.I., & Schooler, G. (1978) The structure of coping. *Journal of Health and Social Behaviour, 19*, 2-21.

Pennebaker, J.W., Zech, E., & Rimé, B. (2001). Disclosing and sharing emotion: psychological, social, and health consequences. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 517-543). Washington, DC: American Psychological Association.

Peretz, D. (1970a). Development, object-relations, and loss. In B. Schoenenberg, A.C. Carr, D. Peretz, & A.H. Kutscher (Eds.), *Loss and grief: psychological management in medical practice* (pp. 3-19). New York: Columbia University Press.

Peretz, D. (1970b). Reaction to loss. In B. Schoenenberg, A.C. Carr, D. Peretz, & A.H. Kutscher (Eds.), *Loss and grief: psychological management in medical practice* (pp. 20-35). New York: Columbia University Press.

Peskin, H. (2000). The ranking of personal grief: death and comparative loss. In J.H. Harvey, & E.D. Miller (Eds.), *Loss and trauma: general and close relationship perspectives* (pp. 102-111). Philadelphia, PA: Brunner-Routledge.

Pierce, G.R., Saranson, I.G., & Saranson, B.R. (1996). Coping and social support. In M. Zeidner, & N.S. Endler (Eds.), *Handbook of coping: theory, research, applications* (pp. 434-451). New York: John Wiley & Sons, Inc.

Pine, V.R. (1989). Death, loss, and disenfranchised grief. In K.J. Doka (Ed.), *Disenfranchised grief: recognising hidden sorrow* (pp. 13-23). Lexington, M.A.: Lexington.

Porter, L.S., & Stone, A.A. (1995). Are there really gender differences in coping? A reconsideration of previous data and results from a daily study. *Journal of Social and Clinical Psychology, 14*(2), 184-202.

Prigerson, H.G., Shear, M.K., Newsom, J.T., Frank, E., Reynolds III, C.R., Maciejewski, P.K., Houck, P.R., Bierhals, A.J., & Kupfer, D.J. (1996). Anxiety among widowed elders: is it distinct from depression and grief? *Anxiety, 2*, 1-12.

Ptacek, J.T., Smith, R.E., & Zanas, J. (1992). Gender, appraisal, and coping: a longitudinal analysis. *Journal of Personality, 60*(4), 747-770.

Ramphele, M. (1993). *A bed called home: life in the migrant labour hostels of Cape Town.* Cape Town: David Philip.

Rando, T.A. (1988). Anticipatory grief: the term is a misnomer but the phenomenon exists. *Journal of Palliative Care, 4*(1 & 2), 70-73.

Raphael, B., & Dobson, M. (2000). Bereavement. In J.H. Harvey, & E.D. Miller (Eds.), *Loss and trauma: general and close relationship perspectives* (pp. 45-61). Philadelphia, PA: Brunner-Routledge.

Ravies, V.H. (1999). Facilitating older spouses' adjustment to widowhood: a preventive intervention program. *Social Work in Health Care, 29*(4), 13-32.

Rees, W.D. (1967). Mortality of bereavement. *British Medical Journal, 4*, 13-16.

Rees, W.D. (1971). The hallucinations of widowhood. *British Medical Journal, 4*, 37-41.

Rees, W.D. (1975). The bereaved and their hallucinations. In B. Schoenenberg, I. Gerber, A. Wiener, A.H. Kutscher, D. Peretz, & A.C. Carr (Eds.), *Bereavement: its psychosocial aspects* (pp. 66-71). New York: Columbia University Press.

Revenson, T.A., Schiaffino, K.M., Majerovitz, S.D., & Gibofsky, A. (1991). Social support as a double-edged sword: the relation of positive and problematic support to depression among rheumatoid arthritis patients. *Social Science Medicine, 33*(7), 807-813.

Rice, P.L. (1992). *Stress and health (2nd Ed.).* Pacific Grove, California: Brookes/Cole.

Richards, T.A. (2001). Spiritual resources following a partner's death from AIDS. In R.A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 173-190). Washington, DC: American Psychological Association.

Richardson, V.E., & Balaswamy, S. (2001). Coping with bereavement among elderly widowers. *Omega, 43*(2), 129-144.

Rook, K.S. (1984). The negative side of social interaction: impact on psychological well-being. *Journal of Personality and Social Psychology, 46*(5), 1097-1108.

Rook, K.S. (1987). Social support versus companionship: effects on life stress, loneliness, and evaluation by others. *Journal of Personality and Social Psychology, 52*(6), 1132-1147.

Rosik, C.H. (1989). The impact of religious orientation in conjugal bereavement among older adults. *International Journal of Aging and Human Development, 28*(2), 251-260.

Ryan, D.R. (1989). Raymond: underestimated grief. In K.J. Doka (Ed.), *Disenfranchised grief: recognising hidden sorrow* (pp. 127-133). Lexington, M.A.: Lexington Books.

Sable, P. (1988). Anxiety, attachment, and loss of a husband. *American Journal of Orthopsychiatry, 59*(4), 550-556.

Sable, P. (1991). Attachment, loss of spouse, and grief in elderly adults. *Journal of Death and Dying, 23*(2), 129-142.

Sacco, W.P., & Phares, V. (2001). Partner appraisal and marital satisfaction: the role of self-esteem and depression. *Journal of Marriage and the Family, 63*(2), 504-513.

Sanders, C.M. (1983). Effects of sudden vs. chronic illness death on bereavement outcome. *Omega, 13*(2), 227-241.

Sanders, C.M. (1989). *Grief: the mourning after – dealing with adult bereavement.* New York: Wiley-Interscience.

Sanders, C.M. (1993). Risk factors in grief outcome. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research and intervention* (pp. 255-267). Cambridge University Press.

Schulz, R. (1978). *The psychology of death, dying and bereavement.* California: Addison-Wesley.

Schuster, T.L., & Butler, E.W. (1989). Bereavement, social networks, social support, and mental health. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp. 55-68). New York: Hemisphere.

Schut, H.A.W., Stroebe, M.S., Van den Bout, J., & de Keijser, J. (1997). Intervention for the bereaved: gender differences in the efficacy of two counselling programmes. *British Journal of Clinical Psychology, 36,* 63-72.

Selye, H. (1946). General adaptation syndrome and diseases of adaptation. *Journal of Clinical Endocrinology, 6,* 117-230.

Selye, H. (1974). *Stress without distress.* New York: JP Lippincott.

Selye, H. (1976). *Stress of life* (rev. edition). New York: McGraw-Hill.

Selye, H. (1991). History and the present status of the stress concept. In A. Monat, & R.S. Lazarus (Eds.), *Stress and coping: an anthology (3rd Ed.)* (pp. 21-35). New York: John Wiley & Sons.

Sherkat, D., & Reed, M. (1992). The effects of religion and social support on self-esteem and depression among the suddenly bereaved. *Social Indicators Research, 26,* 259-275.

Shuchter, S.R., & Zisook, S. (1993). The course of normal grief. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp.23-43). Cambridge: Cambridge University Press.

Siegel, J.M., & Kuykendall, D.H. (1990). Loss, widowhood, and psychological distress among the elderly. *Journal of Consulting and Clinical Psychology, 58*(5), 519-524.

Siegel, K., & Weistein, L. (1983). Anticipatory grief reconsidered. *Journal of Psychosocial Oncology, 1*, 61-73.

Simon-Buller, S., Christopherson, V.A., & Jones, R.A. (1989). Correlates of sensing the presence of a deceased spouse. *Omega, 19*(1), 21-30.

Smerglia, V.L., Miller, N.B., & Kort-Butler, L. (1999). The impact of social support on women's adjustment to divorce: a literature review and analysis. *Journal of Divorce and Remarriage, 32*(2), 63-89.

Smith, W.J. (1978). The etiology of depression in a sample of elderly widows. *Journal of Geriatric Psychiatry, 11*(1), 81-83.

Somerfield, M.R., & McCrae, R.R. (2000). Stress and coping research: methodological challenges, theoretical advances, and clinical applications. *American Psychologist, 55*(6), 620-625.

Sossou, M-A. (2002). Widowhood practices in West Africa: the silent victims. *International Journal of Social Welfare, 11*, 201-209.

Spangenberg, J.J., & Campbell, M.E. (1999). Anxiety, depression and coping strategies in recently detoxified alcoholics. *Alcoholism Treatment Quarterly, 17*(3), 55-65.

Spangenberg, J.J., & Henderson, M. (2001). Stress and coping in Black South African adolescents. *Studia Psychologica, 43*(2), 77-90.

Spangenberg, J.J., & Lacock, L. (2001). *Postpartum depression in rural Black South African women.* Paper presented as the seventh Annual Congress of the Psychological Society of South Africa (PsySSA), Johannesburg.

Spangenberg, J.J., & Orpen-Lyall, M.R. (2000). Stress and coping strategies in a sample of South African managers involved in post-graduate managerial studies. *Journal of Industrial Psychology, 26*(1), 6-10.

Spangenberg, J.J., & Pieterse, C. (1995). Stressful life events and psychological status in black South African women. *The Journal of Social Psychology, 135*(4), 439-445.

Spangenberg, J.J., & Somhlaba, N.Z. (2003). *Stress and coping strategies in recently widowed rural black South African women.* Paper presented at the 8th European Congress of Psychology, Vienna, Austria, July 2003.

Spangenberg, J.J., & Theron, J.C. (1999). Stress and coping in spouses of depressed patients. *The Journal of Psychology, 133*(3), 253-262.

Spangenberg, J.J., & Theron, J.C. (2001). Stress and coping in parents of children with Down Syndrome. *Studia Psychologica, 43*(1), 41-48.

Speizer, I.S. (1995). A marriage trichotomy and its applications. *Demography, 32*(4), 533-542.

Spielberger, C.D., Lushene, R.E., Vagg, B.A., & Jacobs, E. (1983). *Manual of the State-Trait Anxiety Inventory (Form Y).* Pallo Alto, CA: Consulting Psychologists Press.

Spilka, B., Hood, Jr., R.W., Hunsberger, B., & Gorsuch, R. (2003). *The Psychology of Religion: An Empirical Approach (3rd Edition)*. New York: The Guilford Press.

Statistics South Africa. (2002). *Causes of death in South Africa 1997-2001: Advanced release of recorded causes of death*. Statistics South Africa: Pretoria.

Stavrakaki, C., & Vargo, B. (1986). The relationship between anxiety and depression: a review of the literature. *British Journal of Psychiatry, 149*, 7-46.

Steele, G., & Edwards, D. (2002). *The development and validation of the Xhosa translations of the Beck Depression Inventory, the beck Anxiety Inventory and the Beck Hopelessness Scale*. Paper presented at the 8th South African Psychology Congress, University of the Western Cape, Bellville, South Africa, September 2002.

Stein, J. (1996). Coping with HIV infection: the theory and the practice. *African Anthropology, 3*(2), 68-85.

Stone, G. (2002). Non-residential father postdivorce well-being: the role of social supports. *Journal of Divorce and Remarriage, 36*(4), 139-150.

Stroebe, M.S., Hansson, R.O., & Stroebe, W. (1993). Contemporary themes and controversies in bereavement research. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp.457-475). Cambridge: Cambridge University Press.

Stroebe, M.S., Hansson, R.O., Stroebe, W., & Schut, H. (2001). Introduction: concepts and issues in contemporary research on bereavement. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 3-22). Washington, DC: American Psychological Association.

Stroebe, M.S., & Schut, H. (2001a). Meaning making in the dual process of coping with bereavement. In R.A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 55-73). Washington, DC: American Psychological Association.

Stroebe, M.S., & Schut, H. (2001b). Models of coping with bereavement: a review. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 375-403). Washington, DC: American Psychological Association.

Stroebe, M.S., & Stroebe, W. (1983). Who suffers more? Sex differences in health risks of the widowed. *Psychological Bulletin, 93*(2), 279-301.

Stroebe, W., & Stroebe, M.S. (1993). Determinants of adjustment to bereavement in younger widows and widowers. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp. 208-226). Cambridge: Cambridge University Press.

Stroebe, W., Stroebe, M., Abakoumkin, G., & Schut, H. (1996). The role of loneliness and social support in adjustment to loss: a test of attachment versus stress theory. *Journal of Personality and Social Psychology, 70*(6), 1241-1249.

Stroebe, W., Stroebe, M.S., & Domittner, G. (1988). Individual and situational differences in recovery from bereavement: a risk group identified. *Journal of Social Issues*, *44*(3), 143-158.

Stroebe, W., Stroebe, M.S., & Hansson, R.O. (1993). Bereavement research and theory: an introduction to the handbook. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp.3-9). Cambridge: Cambridge University Press.

Stylianos, S.K., & Vachon, M.L.S. (1993). The role of social support in bereavement. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research, and intervention* (pp.397-410). Cambridge University Press.

Sue, D.W. (1986). Stress coping: when to use one over the other. *The Counseling Psychologist*, *14*(4), 553-556.

Sue, D., Sue, D., & Sue, S. (1994). *Understanding abnormal behaviour (4th Edition.)*. New Jersey: Houghton Mifflin.

Swartz, L. (1987). Transcultural psychiatry in South Africa. Part II. *Transcultural Psychiatric Research Review*, *24*, 5-30.

Swartz, L. (1998). *Culture and mental health: a Southern African view*. Oxford: Oxford University Press.

Sweeting, H.N., & Gilhooly, M.L.M. (1990). Anticipatory grief: a review. *Social Science and Medicine*, *30*(10), 1073-1080.

Switzer, D.K. (1970). *The dynamics of grief*. New York: Abingdon.

Talbott, M.M. (1990). The negative side of the relationship between older widows and their adult children: the mother's perspective. *The Gerontologist*, *30*(5), 596-603.

Taylor, S.E. (1991). Health Psychology: the science and the field. In A. Monat, & R.S. Lazarus (Eds.), *Stress and coping: an anthology (3rd ed.)* (pp. 62-80). New York: Columbia University Press.

Tharratt, G. (1993). Stress and coping in families of adult cancer patients. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Thoits, P.A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology, 54*(4), 416-423.

Thoits, P.A. (1991). Gender differences in coping with emotional distress. In J. Eckenrode (Ed.), *The social context of coping* (pp. 107-138). New York: Plenum Press.

Thompson, L.W., Breckenridge, J.N., Gallagher, D., & Peterson, J. (1984). Effects of bereavement on self-perceptions of physical health in elderly widows and widowers. *Journal of Gerontology, 39*(3), 309-314.

Thompson, L.W., Gallagher-Thompson, D., Futterman, A., Gilewski, M.J., & Peterson, M.J. (1991). The effects of late-life spousal bereavement over a thirty-month interval. *Psychology and Aging, 6*, 434-441.

Troop, N.A. (1998). Theoretical note: when is a coping strategy not a coping strategy? *Anxiety, Stress, and Coping, 11*, 81-87.

Turk, M. (1991). Stress and coping in families with learning disabled children. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Umberson, D., Wortman, C.B., & Kessler, R.C. (1992). Widowhood and depression: explaining long-term gender differences in vulnerability. *Journal of Health and Social Behavior, 33*(1), 10-24.

UNAIDS (2003). *UNAIDS – National Response Brief,* pp. 1 [Website, selected briefs on line]. Retrieved February 05, 2004 from the World Wide Web: http//www.unaids.org/en/geographical+area/by+country/south+Africa.asp.

Vachon, M.L.S., & Stylianos, S.K. (1988). The role of social support in bereavement. *Journal of Social Issues, 44*(3), 175-190.

Vaillant, G.E. (1971). *The wisdom of the ego.* Cambridge, Mars. Harvard University Press.

Van Baarsen, B., Van Duijn, M.A.J., Smit, J.H., Snijders, T.A.B., & Knipscheer, K.P.M. (2002). Patterns of adjustment to partner loss in old age: the widowhood adaptation longitudinal study. *Omega, 44*(1), 5-36.

Van Grootheest, D.S., Beekman, A.T.F., Broese van Groenou, M.I., & Deeg, D.J.H. (1999). Sex differences in depression after widowhood. Do men suffer more? *Social Psychiatry and Psychiatric Epidemiology, 34,* 391-398.

Van Zandt, S., Mou, R., & Abbott, D. (1989). Mental and physical health of rural bereaved and nonbereaved elders: a longitudinal study. In D.A. Lund (Ed.), *Older bereaved spouses: research with practical applications* (pp.25-35). New York: Hemisphere.

Vaux, A., Phillips, J., Holly, L., Thompson, B., Williams, D., & Steward, D. (1986). The Social Support Appraisals (SSA) Scale: studies of reliability and validity. *American Journal of Community Psychology,* 14, 195-219.

Venter, M.M., Spangenberg, J.J., Hugo, F.J., & Roberts, M.C. (1999). Coping styles and depression in patients with systemic lupus erythematosus and rheumatoid arthritis. *South African Medical Journal, 89*(9), 987-991.

Waggener, N.M., & Galassi, J.P. (1993). The relation of frequency, satisfaction, and type of socially supportive behaviors to psychological adjustment in marital separation. *Journal of Divorce and Remarriage, 21*(2), 139-159.

Waite, L.J. (1995). Does marriage matter? *Demography, 32*(4), 483-507.

Walsh, F., & McGoldrick, M. (2004). Loss and the family: a systemic perspective. In F. Walsh, & M. McGoldrick (Eds.), *Living beyond loss: death in the family (2nd Edition)* (pp. 3-26). New York: W.W. Norton and Company.

Walter, T. (1999). *On Bereavement: the culture of grief.* Maidenhead: Open University Press.

Ward, A.W.M. (1976). Mortality of bereavement. *British Medical Journal, 1*, 700-702.

Watson, D., & Hubbard, B. (1996). Adaptational style and dispositional structure: coping in the context of the five-factor model. *Journal of Personality, 64*(4), 737-774.

Watson, D., & Kendall, P.C. (1989). Understanding anxiety and depression: their relation to negative and positive affective states. In P.C. Kendall, & D. Watson (Eds.), *Anxiety and depression: distinctive and overlapping features* (pp. 3-26). San Diego, CA: Academic Press.

Weiss, R.S. (2001). Grief, bonds, and relationships. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 47-62). Washington, DC: American Psychological Association.

Weiten, W. (1995). *Psychology: themes and variations (3rd Ed.).* Pacific Grove: Brooks/Cole.

Wellman, B., & Hall, A. (1986). Social networks and social support: implications for later life. In V.W. Marshall (Ed.), *Later life* (pp. 191-231). Beverly Hills: Sage.

West, G.E., & Simons, R.L. (1983). Sex differences in stress, coping resources, and illness among the elderly. *Research on Aging, 5*(2), 235-268.

Wethington, E., & Kessler, R.C. (1991). Situations and processes of coping. In J. Eckenrode (Eds.), *The Social Context of Coping* (pp. 13-29). New York: Plenum Press.

Wiehahn, C.T. (1991). Stress and coping in families with allergic children. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Wiener, A., Gerber, I., Battin, D., & Arkin, A.M. (1975). The process and phenomenology of bereavement. In B. Schoenenberg, I. Gerber, A. Wiener, A.H. Kutscher, D. Peretz, & A.C. Carr (Eds.), *Bereavement: its psychosocial aspects* (pp. 53-65). New York: Columbia University Press.

Williams, P.G., Wiebe, D.J., & Smith, T.W. (1992). Coping processes as mediators of the relationship between hardiness and health. *Journal of Behavioral Medicine, 15*(3), 237-255.

Wilson, F.G. (1971). Social isolation and bereavement. *Lancet, 26*, 1356-1357.

Wissing, M.P., & Du Toit, M.M. (1994). *Relations of the NEO-PI-R dimensions (NEO-FFI) to sense of coherence (SOC) and other measures of psychological well-being.* Paper presented at the 23rd International Congress of Applied Psychology, Madrid, Spain.

Wortman, C.B., & Silver, R.C. (1991). The myths of coping with loss. In A. Monat, & R.S. Lazarus (Eds.), *Stress and coping: an anthology (3rd Edition)* (pp. 388-405). New York: Columbia University Press.

Wortman, C.B., & Silver, R.C. (2001). The myths of coping with loss revisited. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: consequences, coping and care* (pp. 405-429). Washington, DC: American Psychological Association.

Wortman, C.B., Silver, R.C., & Kessler, R.C. (1993). The meaning of loss and adjustment to bereavement. In M.S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: theory, research and intervention* (pp. 349-366). Cambridge University Press.

Wright, B. (1993). *Loss and grief: skills for caring.* Edinburgh: Livingstone.

Zeidner, M., & Saklofske, D. (1996). Adaptive and maladaptive coping. In M. Zeidner, & N.S. Endler (Eds.), *Handbook of coping: theory, research, applications* (pp. 505-531). New York: John Wiley & Sons, Inc.

Zick, C.D., & Smith, K.R. (1988). Recent widowhood, remarriage, and changes in economic well-being. *Journal of Marriage and the Family, 50,* 233-244.

Zimmerman, D. (1993). Stress and coping in families with visually handicapped children. Unpublished master's thesis, University of Port Elizabeth, South Africa.

Zisook, S. (1993). Major depression associated with widowhood. *American Journal of Geriatric Psychiatry,* 1, 316-326.

Zisook, S., Mulvihill, M., & Shuchter, S.R. (1990). Widowhood and anxiety. *Psychological Medicine, 8,* 425-430.

Zisook, S., & Shuchter, S.R. (1991). Depression through the first year after the death of a spouse. *American Journal of Psychiatry, 148,* 1346-1352.

Zisook, S., & Shuchter, S.R. (1993). Uncomplicated bereavement. *Journal of Clinical Psychiatry, 1,* 365-372.

Zisook, S., Shuchter, S.R., Irwin, M., Darko, D.F., Sledge, P., & Resovsky, K. (1994). Bereavement, depression, and immune function. *Psychiatry Research, 52*(1), 1-10.

Zisook, S., Shuchter, S.R., Sledge, P.A., Paulus, M., & Judd, L.L. (1994). The spectrum of depressive phenomena after spousal bereavement. *Journal of Clinical Psychiatry, 55*(4), 29-36.

Zohar, D., & Dayan, I. (1999). Must coping strategies be limited during stressful events: testing the interaction between primary and secondary appraisals. *Anxiety, Stress and Coping, 12*(2), 1-16. Retrieved November 27, 2002 from the World Wide Web: http://weblinks1.epnet.com/citation.asp?tb=1&_ug=dbs+0+1n+en%2Dus+sid+DD4D4'...

Zonnebelt-Smeenge, S.J., & DeVries, R.C. (2003). The effects of gender and age on grief work associated with grief support groups. *Illness, Crisis and Loss, 11*(3), 226-241.

****