

THE BEREAVEMENT EXPERIENCE IN ELDERLY WIDOWS: A CLINICAL-QUALITATIVE STUDY

Adriano Luiz da Costa Farinasso¹
Renata Curi Labate²

This study aims to understand the significance of grief in the elderly by the death of the spouse/husband. This is a clinical-qualitative study that was conducted with an intentional sample, composed of six elderly widows. Data was collected through unstructured interviews and observation. After data analysis was conducted the following categories were listed: 1) grief and longing, 2) history of losses and resilience, 3) denial as a defense mechanism in mourning, 4) mourning mediated by guilt, and 5) depression as a reaction to loss. We emphasize the importance of these findings as a foundation for the practice of health professionals working with bereaved elderly.

Descriptors: Grief; Aged; Qualitative Research.

¹ PhD, Adjunct Professor, Universidade Estadual de Londrina, Londrina, PR, Brazil.

² PhD, Professor, Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, WHO Collaborating Centre for Nursing Research Development, Ribeirão Preto, SP, Brazil.

Correspondence

Adriano Luiz da Costa Farinasso
Universidade Estadual de Londrina. Centro de Ciências da Saúde
Departamento de Enfermagem
Av. Robert Koch, 60
Vila Operária
CEP: 86038-350, Londrina, PR, Brasil
E-mail: adriano_farinasso@hotmail.com

A VIVÊNCIA DO LUTO EM VIÚVAS IDOSAS: UM ESTUDO CLÍNICO-QUALITATIVO

Este estudo objetiva compreender os significados da vivência do luto em idosas, pela morte do cônjuge/marido. Trata-se de um estudo clínico-qualitativo, realizado em uma amostra intencional, composta por seis viúvas idosas. Os dados foram coletados por meio de entrevista não estruturada e observação. Após análise de conteúdo foram elencadas as seguintes categorias: 1) luto e saudade; 2) histórico de perdas e resiliência; 3) negação como mecanismo de defesa no luto; 4) luto mediado pela culpa; e 5) depressão como reação à perda. Ressalta-se a importância destes significados como alicerce para atuação do profissional de saúde que trabalha com idosos enlutados.

Descritores: Pesar; Idoso; Pesquisa Qualitativa.

LA EXPERIENCIA DEL LUTO EN VIUDAS DE LA TERCERA EDAD: UN ESTUDIO CLÍNICO-CUALITATIVO

Este estudio tiene como objetivo comprender los significados de la experiencia del luto en personas de la tercera edad, por la muerte del cónyuge/marido. Se trata de un estudio clínico-cualitativo, realizado en una muestra intencional, compuesta por seis viudas de la tercera edad. Los datos fueron reunidos por medio de entrevista no estructurada y mediante la observación. Tras el análisis de contenido fueron enumeradas las siguientes categorías: 1) luto y melancolía; 2) histórico de pérdidas y superación; 3) negación como mecanismo de defensa en el luto; 4) luto condicionado por la culpa; y 5) depresión como reacción a la pérdida. Se destaca la importancia de estos significados como base para la actuación del profesional de la salud que trabaja con ancianos guardando luto.

Descriptores: Pesar; Anciano; Investigacion Cualitativa.

Introduction

The aging population is increasing more rapidly in Brazil when compared to developed countries, which has important consequences for all sectors of society⁽¹⁾. This increase in proportion of older people does not happen equally between men and women; with advancing age the number of women in relation to men is higher. In addition, many of them are widows and are in a fragile position, vulnerable to physical illness, as well as mental and developmental disabilities⁽²⁻³⁾.

In an epidemiological context, where the majority of the elderly population are women, widows, living in nuclear families, with comorbidities and often with impaired functional

capacity⁽¹⁻³⁾, a husband's death may exacerbate these problem, causing mourning to occur differently, many times it is more complicated than in the non-elderly⁽⁴⁾.

Considering that physical frailty in the elderly is seen as a vulnerability to health problems, mourning in the elderly can be experienced as an overwhelming event because in older people there is a risk of multiple and sequential losses of family and friends. Thus, the addition of more events with negative consequences can be expected; because of the immediacy of mourning a wide range of stressful events are associated with aging such as: diseases, environmental changes, financial problems, among others⁽⁴⁻⁵⁾.

The bereavement experience in the elderly may commonly emerge as depression or other anxiety disorders and, as is characteristic of this population, may have various forms and symptomatology⁽⁶⁾. Follow-up studies showed that widowed elderly groups showed high levels of depression, when compared to non-widowed⁽⁷⁻⁸⁾.

On the other hand, the increase of resilience in the bereaved elderly can be considered a facilitating factor in coping with grief⁽⁹⁾. Resilience is shown as a phenomenon, its function, sometimes, is the art to adapt to adverse situations, developing abilities linked to internal resources (intrapsychic) and external resources (environmental); this allows appropriate mental development suitable for social inclusion⁽¹⁰⁾. In other words, overcoming earlier losses can lead to the development of perspective and of the concept itself, facilitating adaptation to further losses⁽⁴⁾.

It is possible to overcome losses, when the individual can count on support, reflection and treatment. The loss of a loved one creates high levels on the stress scale and individuals suffering losses become more vulnerable to diseases, especially at the time of loss, when they rely on internal resources to overcome it⁽⁹⁾.

As previously stated the mourning process in the elderly can be shown as a complex event and has a great impact on both physical and mental health. Thus, the instrumentalization of health professionals who work with this population is necessary, suggesting the need for understanding the specifics of the grieving process. In this context, this study aims to understand the significance of the grief experience in the elderly, by the death of the spouse/husband.

Method

In this research we used the clinical-qualitative method, as a refinement of the general qualitative methods. This method was chosen because its characteristics correspond with the objectives proposed in this study. The clinical-qualitative method allows the researcher to go through bereavement with the person grieving and share the anxiety and anguish arising from the experience of loss; they are able to seek understanding of the issues proposed, and at the same time identify with the other person. This existentialist

attitude, characteristic of the clinical-qualitative method allows researchers to uphold the anguish and anxiety of this, while maintaining a clinical attitude, with qualified eyes and ears for the existential understanding of suffering that affects the other person. The clinical-qualitative method of scientific research searches for interpretations of senses and significations brought by individuals, a phenomena pertinent to the health-disease process, allowing the use of an eclectic framework of theoretical references for discussion within the interdisciplinary team⁽¹¹⁾.

In order to study phenomena that have a complex structure, in a personal setting (intimate) and/or is a subject difficult to verbalize, as in the case of death of the partner/spouse, the clinical-qualitative methodology has been particularly helpful. Thus, this method allows a detailed investigation with intimate and loaded questions about suffering, welcoming the anguish and anxiety of these subjects with a clinical attitude, providing effective parameters for determining the validity of the results.

This research took place within the area of coverage of the Family Health Program (FHP), in a city with approximately 100,000 inhabitants, located north of Paraná state. An intentional sample was studied, with variety, composed of six elderly women who experienced the grief process by death of a spouse, selected from the records of the Family Health Teams. Inclusion criteria were: a) age less than 60 years, b) female, c) living in urban areas with coverage of the FHP, in the city of Arapongas, PR, d) having had experienced the death of her husband for more than one month and less than 13 months before the interview, and e) agree to participate.

Considering the structure of the clinical-qualitative method, the researcher served as the main instrument to collect and record data. Within this concept, their perceptions captured the phenomena and represent their consciousness and work. Unstructured interview technique and observation were used as auxiliary instruments to perform the data collection. Data analysis was performed according to the content analysis techniques, described specifically for the clinical-qualitative method⁽¹¹⁾.

In relation to ethical guidelines, this research was approved by the Research Ethics Committee

of the Northern University of Paraná (UNOPAR) by Protocol PP 0222/08, following the standards and regulatory guidelines for research involving human beings, arranged in Resolution 196/96 National Health Confederation (CNS). Also, it was guaranteed that elderly participants were free to abandon the study at any stage, by signing the Informed Consent Statement.

Results and discussion

The results of the interviews were organized in categories, without hierarchy of data but from the presumed importance or frequency of appearance in the statements. The full scope of categories found were recorded under five categories for presentation. The choice of these categories occurred through the correlation between the developed theme and proposed objectives. No results presented a generalized claim beyond the sample studied, in which the inferences and interpretations developed refer exclusively to the context in which the research took place. However, the reflection of these findings can serve as a theme for understanding the work of mourning in the elderly, in a broader context.

Category 1. The grief and nostalgia

One of the most common characteristics of mourning is not deep depression, but acute episodes of pain, with a great deal of anxiety and psychological pain⁽⁶⁾. In these situations, the mourner feels that they really miss the person who died; they cry or call out to that person. The word “nostalgia” can be defined as a soft and melancholy memory of a missing person, place or thing that you want to see again or possess⁽¹²⁾. Nostalgia offers a historical reference of an individual existence⁽¹³⁾. It resembles a testament to the memory, a reminder of the heritage and presence in the continued existence of the bereaved: *[...] in the beginning it seemed we were more okay with it, right? But like everything, one day passes, it seems worse, right? We are longing, we miss him more and more [...]* (Benedicta).

The nostalgia, a characteristic of the grieving process, is linked to another manifestation: the search or seeking of the deceased⁽⁶⁾. The preoccupation with thoughts of the lost person and the events leading to their death is common in

bereavement. These memories are striking and the dead person can be seen exactly as they were, or in other situations, the bereaved widow can feel the presence or expectation that the husband will “soon arrive”, as if he had just come home from a trip or something similar: *[...] we miss him in the living room, we miss here at the table where he sat. Then there are days when you feel sad, discouraged, there are days when we get excited about little and life goes by so [...]* (Cecilia).

For many bereaved, especially those who have lost lifetime companions, dates such as birthdays, death, Christmas or any other dates that have a strong relationship with the deceased may trigger attention to anniversary reactions. The anniversary reactions are related phenomena linked to mourning, in which the unconscious processes and is elucidated by temporal factors that means the individual relives past situations, in a deformed and masked manner⁽¹⁴⁾. These reactions are explained by a date and make the individual go through several processes: anxiety, sadness, psychotic episodes, somatization, among others: *[...] it is two months still, you have the impression that he is coming back, that he was on a trip. Alas you come to your senses, you come to your senses that he not coming back, then comes the holidays, just like it was on Father's Day, and it is difficult! [...]* (Dulce).

Category 2. History of loss and resilience

It is commonly found in the literature the claim that the more an individual experiences loss in their life, the greater the likelihood of an abnormal grieving process; i.e., the accumulation of previous losses is seen as one of the factors related to the difficulty in mourning^(5-6,15).

Studies show that despite some bereaved elderly exhibited evidence of emotional and physical suffering, many of them are shown to be highly resilient⁽¹⁶⁻¹⁷⁾. In this context, resilience can be linked to overcoming past losses, facilitating the adaptation of further losses, explaining this result. In a prospective study, 46% of the elderly showed a resilient pattern during grief, with low levels of depressive symptoms before the death of the spouse and after 18 months of loss⁽¹⁸⁾.

These results corroborate with findings obtained in this study since there was occurrence of previous losses, although they were verbalized

by most interviewees, it seems to not have contributed to the worsening of present mourning. Although four of the six interviewed mentioned death of family members and very close loved ones, it was not evident that these events caused worsening of current mourning. This is reinforced by the fact that only one widow reported a poor experience of mourning, during the interview, and did not verbalize other previous losses to the death of her husband.

Another important point found in this category concerns the relationship between resilience and religious beliefs: [...] *it means that I've been through the mourning of 3 family members right?, but what can I do about it? ... we have to accept what God does ... everything that God does is good! There are people who mistreat Jesus, that Jesus could not do what he has done, took my son, took my oldest son, I never opened my mouth to complain. He does what he wants to do, right! I still don't know what is going to happen to me, now my sister is in the ICU, I don't know if she is going to die or not, I have put it into the hands of God [...]* (Divine).

Spirituality is revealed as a strong indicator of resilience, especially when acknowledging the joining of the meaning in life, from faith⁽⁹⁾. It is worth noting that, resilience should not be considered as a fixed attribute of the person, but as a process where the family, community and society must provide resources so that the person can develop more fully⁽¹⁶⁾. Whereas, resilience can be learned by individuals, through significant others and role models⁽⁹⁾, this requires that specific strategies are developed to face adversity, as in mourning, and that they address the religiosity and spirituality phenomenon.

Category 3. Denial as a defense mechanism in mourning

Denial can be understood as the refusal to recognize a stimulus that causes anxiety⁽¹⁹⁾. Denial serves to postpone the pain, until reality becomes inevitable, helping the bereaved to prepare for it⁽⁶⁾. The use of denial as a defense mechanism in the grieving process was realized in two of the six interviewed: [...] *that day I'll tell you that I have little recollection [...] my head refused to accept, and I think when the news came to me, I remember little of that day, and I felt very strong, right? with great faith [...]* (Dulce). [...] *I did not cry, I did not complain, it seems that I did everything that looks like it was not me [...]* my niece

who lives in Ourinhos said this: 'Auntie, you haven't figured it out yet! You will still cry a lot too! [...] (Eve).

Dulce recalls exactly the refusal to accept her husband's death on the first day after the loss. Denial, is an unconscious defense mechanism, it is used to avoid contact with a hard to accept event. However, feelings can also be avoided consciously and deliberately⁽²⁰⁾. Nevertheless, dissociation, denial and repression by an individual may be important skills for survival and control of trauma and loss. However, the maintenance of these standards may have dysfunctional consequences, complicating the grieving process⁽²¹⁾.

Category 4. Grief mediated by guilt

Irritability and anger during mourning vary from person to person, family to family and from period to period⁽⁶⁾. Sometimes these feelings are directed to the mourner themselves, as self-accusation or blame [...] *this thing keeps hammering and we lose sleep right?... I'm already bad sleeper ... and then I wake up and wonder this thing is pounding in my head, because we didn't do it? Because we didn't do it? And that is bad for us, right! [...]* (Benedicta).

Assigning blame can be a way for a person to protect themselves from feelings of helplessness, fear of no psychic survival, abandonment and feeling less helpless in the face of loss, and difficulty constructing the meaning of respect⁽²²⁾. In a study of London widows⁽⁶⁾, seven of the 22 surveyed women expressed ideas of self-reproach, focusing on some omission or action that could have caused damage to their husband or disturbed his peace of mind. Often, these events were trivial and suggested that the bereaved sought to punish themselves, accepting the blame and believing in some way, in the reversal of events, to have her lost husband back [...] *we wondered how could we have done this, we could have done it, or the doctor, the doctor who was careless not take care of him, right? but I think we cannot be blaming [...]* So then we talk with one another, we do not have to blame. Then day comes, right, I think we have a day of people, right! [...] (Benedicta).

Category 5. Depression as a reaction to the loss

In the case of normal grief without complications, the search phase of the lost person,

intense in the first weeks and months will gradually decrease giving way to the despair phase, where the bereaved recognizes the immutability of loss, experiencing apathy, lack of motivation and depression⁽²⁰⁾.

One of the interviewees reported that two months after the death of her husband she began seeing problems such as depression, lowering self-esteem, lack of motivation and lack of interest, leading her to psychiatric treatment with antidepressants: *[...] but only over time ... I went in and I [was highly emotional at that time] ... and I am still [...] I have undergone psychiatric treatment, [...] now a week ago I have been taking other medication to see if I react better ... but it is very difficult for me [cry] [...]* (Dulce).

Depression due to unmanageable mourning is widely described in the literature, with a strong association between advanced age and vulnerability to depression^(4,6,23). In a literature review⁽²³⁾ it was found that, depending on the sample and measurement procedures, between 15% and 30% of the elderly showed clinical manifestations of depression within one year after the death of a spouse and between 40% and 70% showed pictures of dysthymia.

The statement of Dulce makes it clear her feelings of sadness, discouragement and low self-esteem, as characteristic of a depression, due to her husband's loss: *[...] I have no desire to go out, I do not feel like dressing up, many days I do not even want to shower, I am just going through the motions. My world is in the little room where I have my computer and TV, there in my world I do not want to talk, I spend the entire afternoon, I just leave to do physical therapy, hydrotherapy [...]* (Dulce).

Within the psychoanalytic point of view, the first approach between grief and depression is the classic text "Mourning and Melancholia" by Sigmund Freud⁽²⁴⁾. In it, Freud points out that melancholy differs from the normal mourning, by the presence of low self-esteem and self-recrimination; unlike normal mourning, where the choice of the object is of a narcissistic nature. This narcissistic object values the subject itself and when lost, it causes the lowering of self-esteem. The criticisms and accusations to themselves, in fact, are directed to the object, expressing the intense emotional ambivalence of the relationship. Thus, the subject does not accept the hostile feelings towards the object and blames herself for losing him, due to the death wishes of the object.

By analyzing harder the story told by Dulce, how she perceived herself is evidence of ambivalence in her relationship with the deceased spouse. Years before his death, her husband began to have health problems and was gradually forming a strong relationship of dependency. According to Dulce's account, while she felt useful and valued in this dependent relationship, feelings of irritability and anger denote the ambivalence of the relationship: *[...] as I was projecting myself, he was shrinking, right. And then he became increasingly dependent on the issues I was supposed to solve, I went as far as for him to call me mother, mother this, mother that, right! So then, I faulted this dependence, you know ... it actually irritated me that dependency "Mother what time it is" ... and so on, and he thought I should know, often I did not know, and thus he irritated me, but at the same time I feel useless ... you know that gap, that absence will get you thinking[...]* (Dulce).

Another element found in Dulce's speech is Stoicism, understood as a way to keep the strong ego, attempting to endure any adversity. The conformation/resignation is a submission, often as a silent rebellion. This defense mechanism is very valued by society of the twentieth century, with strength and silence the pain seen as highly desirable⁽²⁵⁾: *[...] the mother was always wonder woman, and was going, forward, the wonder woman gave a trouble and it was ugly! ... so for me, now, this time is very difficult [...]* (Dulce).

Final Considerations

Among the losses resulting from the aging process, mourning the death of a spouse is in a major event, because of its impact on the social, emotional and health of the elderly. From the findings described above, you can see that longing and the search for the loved one are evident traces of the grieving process, and lead to episodes of much pain, grief and emotional distress.

In this study, the history of previous losses to the current mourning seems to have not contributed to worse preparation with loss. Therefore, the concept of resilience, where the experience of past losses can help overcome further losses, applies to the sample.

It was evident in the interviews that there was denial of loss, anger directed at themselves, taking the blame for the loss or failure to carry out any wishes of the deceased and depression. Although these mechanisms and responses are

part of the normal grieving process, these exacerbations can complicate coping with the loss, and must be acted upon in dealing with bereaved elderly.

Given the high frequency of mourning situations among the elderly and the magnitude of emotional and physical problems that such losses may result in, this emphasizes the importance of considering these implications, as a foundation for performance of health professionals working with the elderly.

References

1. Colss VE, Schwanke CHA. A evolução do índice de envelhecimento no Brasil, nas suas regiões e unidades federativas no período de 1970 a 2010. *Rev Bras Geriatr Gerontol.* 2012;15(3):443-58.
2. Silva VL, Albuquerque MFPL, Cesse EAP, Luna CF. Perfil de mortalidade do idoso: análise da evolução temporal em uma capital do Nordeste brasileiro de 1996 a 2007. *Rev Bras Geriatr Gerontol.* 2012;15(3):433-41.
3. Farinasso ALC, Marques S, Rodrigues RAP, Hass WJ. Capacidade funcional e morbidades referidas de idosos em uma área de abrangência do PSF. *Rev Gaucha Enferm.* 2006;27(1):45-52.
4. Hansson RO, Stroebe MS. Bereavement in late life: coping, adaptation, and developmental influences. Washington: American Psychological Association; 2007.
5. Kovács MJ. Desenvolvimento da tanatologia: estudos sobre a morte e o morrer. Paidéia (Ribeirão Preto). 2008;18(41):457-68.
6. Parkes CM, Prigerson HG. Bereavement: studies of grief in adult life. New York: Routledge; 2010.
7. Lund DA, Casserta MS, Dimond MF. Impact of spousal bereavement on the subjective well-being of older adults. In: Lund DA. Older bereaved spouses: research with practical implications. New York: Taylor and Francis/Hemisphere; 1989. p. 3-15.
8. Carnelley KB, Wortman CB, Kessler RC. The impact of widowhood on depression: findings from a prospective survey. *Psychol Med.* 1999;29(5):1111-23
9. Silva AI, Alves VP. Envelhecimento: resiliência e espiritualidade: história de vida de idosos: superar a adversidades sem perder o senso de integridade. *Diálogos Possíveis.* 2007;6(1):189-209.
10. Laranjeira CASJ. Do vulnerável ser ao resiliente envelhecer: revisão de literatura. *Psicol Teoria Pesq.* 2007;23(3):327-32.
11. Turato ER. Tratado da metodologia da pesquisa clínico-qualitativa. 4ed. Petrópolis: Vozes; 2010.
12. Ferreira ABH. Dicionário Aurélio da Língua Portuguesa. 5ed. Curitiba: Ed Positivo; 2010.
13. Paula B. Corpos enlutados: por um cuidado espiritual terapêutico em situações de luto [tese]. São Paulo: Faculdade de Humanidades e Direito/UMESP; 2009. 370 p.
14. Cassorla RMS. O tempo, a morte e as reações de aniversário. In: Cassorla RMS. Do suicídio: estudos brasileiros. Campinas: Papirus; 1991. p. 107-16.
15. Oliveira JBA, Lopes RGC. O processo de luto no idoso pela morte do cônjuge e filho. *Psicol Estudo.* 2008;13(2):217-21.
16. Laranjeira CASJ. Do vulnerável ser ao resiliente envelhecer: revisão de literatura. *Psicol Teoria Pesq.* 2007;23(3):327-32.
17. Lund DA, Casserta MS, Dimond MF. The course of spousal bereavement in late life. In Stroebe MS, Stroebe W, Hansson RO, editors. Handbook of bereavement: theory, research and intervention. Cambridge: Cambridge University Press; 1993. p. 240-54.
18. Fry PS. Predictors of health-related quality of life perspectives, self-esteem, and life satisfactions of old adults following spousal loss: an 18-month follow-up study of widows and widowers. *Gerontologist.* 2001;(41):797-8.
19. Friedman HS, Shustack MW. Teorias da personalidade: da teoria clássica à pesquisa moderna. São Paulo: Prentice Hall; 2004.
20. Bowlby J. Formação e rompimento dos laços afetivos. São Paulo: Martins Fontes; 1979.
21. Walsh F, McGoldrick M. A perda e a família: uma perspectiva sistêmica. In: Walsh F, McGoldrick M, editors. Morte na família: sobrevivendo às perdas. Porto Alegre: Artmed; 1998. p. 27-55.
22. Mazorra L. A construção de significados atribuídos à morte de um ente querido e o processo de luto [tese]. São Paulo: Departamento de Psicologia Clínica da Pontifícia Universidade Católica; 2009. 253 p.

23. Carr D. Factors that influence late-life bereavement: considering data from the changing lives of widowed couples study. In: Stroebe MS, Hansson RO, Schut H, Stroebe W, editors. Handbook of bereavement research and practice: advances in theory and intervention. Washington: American Psychological Association; 2008. p. 417-40.
24. Freud S. Luto e Melancolia. In: Freud S. Edição standard brasileira das obras completas de Sigmund Freud. Rio de Janeiro: Imago; 1974.
25. Kovacs MJ. Morte em vida. In: Bromberg MHPF. Vida e morte: laços de existência. São Paulo: Casa do Psicólogo; 1996. p. 11-34.