Cause & Effect — Dealing with the Loss of a Spouse

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INTRODUCTION

Satisfying marriages buffer spouses from psychological distress and negative life events.[1] For this and many other reasons, perhaps the most stressful experience for anyone to face over the continuum of a lifespan is the death of a spouse. This loss has great impact because of the intensity with which the dyadic relationship is held and the core themes the marriage represents in a person's existence.[2] This is especially true for those women who have assumed dependent, supportive roles, acting as primary child-care givers, and maintaining the home. In some cases, women have sacrificed opportunities to develop careers, or to generate substantial income. Irrefutable evidence for this loss-related distress is evidenced by self-reports of widowed individuals who placed the death of a spouse at the head of lists of stressful life events,[3] and is manifested by the significant increase in widowed individuals of depression, physical illness, and suicide.[4]

The cardinal symptoms of bereavement[5] are crying, depressed mood, and sleep disturbance; complicated mourning can include somatic complaints of palpitations, anorexia, headaches, fatigue, problems with concentration, memory impairments and loss of interest in pleasurable activities. This negative impact of bereavement on mental and physical health has been referred to as the *loss effect*.[6] Widows who experience additional major loss in the first year following the death of a spouse are at increased risk for suicide, especially when they self-soothe with verbalized fantasies of reunions with the deceased. The stressors of widowhood are often 2-fold, characterized by intense emotional aspects, such as grief, mourning, intense yearning for and idealization of the lost spouse[7] and by the existence of pressing, reality-based needs, such as finances, child-rearing issues, and social roles.

MARRIAGE DYNAMICS AND GRIEF

Innate to the issues surrounding conjugal loss can be the demise of the surviving spouse's identity, whether it is whittled away over time, or is demolished directly upon the moment of a beloved's death. Where or when conjugal loss occurs on the timeline of the marriage can determine how the bereaved partner will adjust in either optimizing or disregarding life opportunities that inevitably emerge. The attachment that develops in the context of a reciprocal, satisfying relationship, consists of bonding that occurs over time, the nature of which is partly predetermined by enduring aspects of each partner's relationship history and styles of relating learned within the family of origin.[8] Bowlby's theory of attachment[9] suggests the nature of the first close relationship between infant and primary caretaker will determine the lifetime quality of individual intimacy and attachment. Ainsworth's object relations perspective on attachment[10] identifies 3 major styles of early attachment: secure attachment, described as ideal; anxious/ambivalent attachment, describing the primary caretaker as inconsistently responsive to the infant, creating a circumstance where the child both craves and resents the caretaker; and the anxious/avoidant attachment, describing a caretaker who is not responsive to the infant, resulting in a child who avoids contact with the parent, and is not distressed by parental separation.

These childhood learned patterns of relating may, in fact, have defined the functional quality the marriage had held for each partner, as mutual dependencies often symbolize interlocking dynamics, such as the fulfillment of sadistic-masochistic drives often manifested in bitter verbal exchanges that occur between partners. The presence of an interpersonally ambivalent relating style between spouses is correlated with the development of a melancholic, rather than a successful, resolution of the grief process. Widows who display an ambivalent attachment within the intimate context have most likely been exposed to a psychologically unavailable attachment figure. Individuals who have been forced to rely on emotionally unreliable caregivers in childhood often demonstrate a relating style typified by heightened anxiety combined with anger and hostility,[11] thus becoming ambivalent partners in the intimate setting.

In an ambivalent relationship, the characteristics of anger and anxiety define major interactions, and serve as a venue to convey the wife's need for comfort, or to reproach the husband for being emotionally unavailable.[12] As a result, at the time of her spouse's death, when his emotional unavailability is total, the

wife's maladaptive coping resources which had been strongly reinforced by her husband's responsiveness to her needs, greatly inhibits her ability to negotiate feelings of grief, isolation, abandonment, and intense sadness regarding his death. In addition, her baseline anxiety is exacerbated, further impeding her ability to regulate arousal and to process cognitively.

AGE AT LOSS AFFECTS RECOVERY

Despite its relevance to understanding relatedness among couples, attachment theory only begins to provide insight into the complexity of the emotional transaction that occurs in marriages.

Marriages undergo transitional changes: Relational attachment characteristics develop with the couple, and are defined by the compatibilities and differences uncovered as intimacy, and mutual learning deepens. Aside from the development of actual life memories, connections among couples become highly evolved, as psychological comfort and communication become fluent on the nonverbal level: through the recognition of subtle physical cuing, olfactory messaging, and through affective and physical memory. Similar to the acquisition and mastery of any complex skill, these different aspects of the conjugal relationship require the passage of time and the challenges of the activities of daily interrelated living to branch and season the relationship as the couple potentialize.

For younger women, untimely death of a husband is often experienced as psychologically traumatic because of its unexpected nature. This premature loss of husband is incompatible with a young woman's stage of attachment to her spouse[13]: The wife's expectation is one of future and longevity, and separation is extraordinarily painful because of the hopes and plans that were invested in the relationship.[14] Inherent to the concept of adjustment to the loss of husband is a requirement to surrender the dreams, goals and life expectancies already established through commitment and planning. Death of husband during young adult life is often violent, secondary to murder, suicide, car accidents, work-related accidents, aneurysms, neoplasms, or sudden cardiac death, which further complicates the grief process. The widow experiences her spouse as being abruptly torn away from her. Experiences of this sudden nature are rich in traumatic material, and can subsequently result in recurrent dreams, vivid images, mutilation fantasies, intense guilt, and feelings of helplessness, shock and anger for the widow. In the case of lingering sickness, if the wife is constantly with the sick husband, caring for his changed and dying body, she may have difficulty adjusting after his death. Feelings of guilt and repulsion, mixed with relief, further complicated by delayed mourning of the loss of their earlier, healthy relationship, typically arise.

For older women who have suffered the loss of a spouse, bereavement often takes on the appearance of depression, but with some discriminating differences. Although symptoms of pessimism, sadness, fatigue, and decreased interest in sexual activity are often present after partner loss, the elderly bereaved do not usually manifest feelings of failure, nor do they make self-deprecating statements, or report feeling unattractive or worthless.[15] Nonetheless, elderly bereaved do often struggle with severe socioeconomic constraints and the loss of highly significant social support and compatibility at the death of a husband. Additional factors, such as poor physical health or violent death of spouse by suicide, serve to further complicate elderly bereavement.

In many cases, a bereaved widow's outcome will be affected by the role assumed by her in-laws. Grief-stricken widows who progress into melancholia, may identify profound disappointment in their in-laws who lose interest in them after the death of their son. In-laws who do not maintain a positive connection with daughter-in-laws following loss of their son, often fear the real or imagined assumption of financial responsibility for the widow and her children. These aloof relatives frequently are also not supportive of the widow later on, as she considers forming a new romantic attachment.

RESEARCH SUPPORTS SOCIAL ASPECT OF HEALING

Although a widow's personal resiliency and concrete financial resources play a role in the outcome of her grief process, both family and social support have been demonstrated[16] to be positively correlated with grief recovery after conjugal loss. Widows who perceived themselves as having many more unsatisfied needs in interpersonal exchanges during the bereavement crisis, who needed more encouragement and support in expressing affect (grief and anger) than they received, who needed more opportunity to talk actively about their husband and their life together, who needed more support to talk about the negative and positive aspects of their relationships, demonstrated poorer outcomes in recovery than those woman who reported adequate

social support. Research results revealed that those women told to control themselves, to pull themselves together, or told to minimize their grief by thinking of the grief of others, who were advised to not feel angry or guilty, or told not to cry because she would upset others, who were additionally told to focus on the future, take up new activities, develop new friendships, or consider remarriage, also demonstrated poorer grief resolution outcomes than women whose grief process was supported and accepted by those in her social sphere.

WHEN GRIEF IS PROLONGED

It has been suggested that bereaved widows who demonstrate a prolonged grieving period may be using an avoidant form of coping manifested through a physical attachment to the personal belongings of their deceased partner, maintaining a phenomenon referred to as "sense of presence."[17] This attachment to personal belongings includes wearing spouse's clothes, searching for the deceased partner's scent among his tools and garments, and resistance to suggestions related to the discard of anything that had belonged to the husband. Sense-of-presence widows engage in a cognitive style of continued attachment with the deceased, thinking about him as though he were still alive, setting a place for him at dinner, and mentally talking to him as though he is not gone. Thus, the widow fails to integrate the new reality of life without her husband, due to her use of this comforting sense of his presence that she has developed. This type of coping is grief-specific, the inference being that these patterns of holding on to the old aspects of a permanently changed relationship serve the purpose of rescuing the grieving widow from interacting with overwhelming emotional pain, thereby rendering the grief process immobile.

When bereavement symptoms become overwhelming and life disruptive, many patients turn to their primary care providers for treatment. Despite concerns that medication management of symptoms may serve to inhibit successful resolution of the grief process, some limited research[18] supports the careful use of antidepressants to augment bereaved coping and to decrease the occurrence of cognitive distortions. Research also supports the effectiveness of participation in self-help groups as well as the use of interpersonal therapy. MF

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