

**“AND THERE’S ALWAYS THIS GREAT HOLE  
INSIDE THAT HURTS”: AN EMPIRICAL STUDY  
OF BEREAVEMENT IN LATER LIFE<sup>1</sup>**

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**ABSTRACT**

Stage theoretical approaches to bereavement have long been used in both academic and clinical work. Their impact has been so great that they have permeated lay understanding of bereavement, to become, as Tony Walter puts it, the “clinical lore” of bereavement. This paper examines this clinical lore from the perspective of older women’s narratives of widowhood. We suggest that, though these widows experience the sorts of emotions stage theories predict, there is little evidence to support the notion of steady progression from one stage to another. Nor is there evidence to support the idea that widows “recover” from their loss in the sense of surrendering their attachment to the dead, nor that “renewal” equates with a fully restored sense of wellbeing. The widows themselves argue cogently that the idea of “recovery” is an inappropriate (and indeed insensitive) aim for them to strive for. They feel uncomfortable with the pathologizing of lasting grief; they also express strong views about those who try to “help” them. It concludes that, though stage theories are useful in identifying some of the physical effects and emotions associated with bereavement, they do not adequately reflect the experiences of women widowed in later life.

<sup>1</sup>Some of this material appeared in G. Bennett and K. M. Bennett, Bereavement, Witnesses, and the Sense of Presence, Chapter 3 of *Alas, Poor Ghost!: Traditions of Belief in Story and Discourse*, by G. Bennett (1999).

## INTRODUCTION

Over the last century, academics and physicians have been attempting to understand the process of grief following bereavement. The earliest of these was Freud in 1917. He saw mourning as the process whereby survivors overcame their grief by withdrawing from the deceased emotionally and learning to redirect their affection elsewhere (Middleton, Raphael, Martinek, & Misso, 1993). Another early influential study was that conducted by Erich Lindemann in 1944. His model treats grief as a psycho-medical condition, the symptoms of which needed to be “managed.”

Broadly speaking, this sort of approach underlies the work of many who use other mainstream approaches such as attachment theory or medical/social transition models (see, for example, Bowlby, 1961; Hoyt, 1980; Parkes, 1972; Weiss, 1982). As Robert Weiss puts it: “Phases of grieving have been reported to occur with some reliability in all grieving that eventually moves to recovery” (Weiss, 1993, p. 279). The assumption is that grief has recognizable emotional, behavioral, and psychological characteristics, and that grieving people will “recover” from it in due course, passing through a number of observable stages. They will move from a period of desolation and chaos, through withdrawal from the lost loved one, to the ability to make new ties. They will, and must, learn to slacken the bonds of love, to readjust to an environment in which the dead person is missing, and to form new relationships. The signs of a “pathological” grief reaction is that the mourner gets stuck in one of the early destructive phases and fails to move on at the appropriate time to the later reconstructive phases.

Recent scholarly work has begun to move away from these sorts of approaches (see, for example, Lopata, 1996). Tony Walter sees a “revolutionary” phase as beginning in the late 1980s (Walter, 1996) and Margaret Stroebe speaks of the emotion-centered “grief work” model as coming into “disrepute some years ago” and being replaced with a cognitive model (Stroebe, 1997). In her earlier work with Wolfgang Stroebe and Robert Hansson, she noted that there have recently been “significant advances” from clinical models and that it “seems evident now that a narrow interpretation of grief as a form of mental or physical illness or debility, or as a matter of clinical concern alone . . . is no longer viable” (Stroebe, Hansson, & Stroebe, 1993, p. 458; see also Charmaz, 1980; Stroebe & Schut, 1998). Indeed, Stroebe and Schut have been developing the Dual Process Model of Coping with Bereavement (Stroebe & Schut, 1998; Stroebe, Schut, & Stroebe, 1998). They argue that there are two processes involved in the bereavement experience: loss-oriented experiences, including what others have called “grief work,” and restoration-oriented experiences, including attending to life changes. They argue that bereaved people oscillate from loss- to restoration-coping.

Other authors have discussed the ways in which the living continue to maintain bonds with the deceased (see, for example, Klass, Silverman, & Nickman, 1996). Shuchter and Zisook (1993, p. 25) have admitted that “several features of grief, particularly those related to attachment behaviours . . . continue several years after the loss . . . some aspects of grief work may never end for a significant proportion of otherwise normal bereaved persons”; they now prefer to speak of “dimensions” rather than “stages” of grief (Shuchter & Zisook, 1993; for a discussion, see Lopata, 1996, pp. 101-103). Even more liberally, Marcia Kraft Goin has argued that some people maintain a “timeless” emotional involvement with the deceased, and this is often a “healthy adaptation” to loss (Goin, Burgoyne, & Goin, 1979). Margaret Stroebe has noted too that, though Bowlby’s work tends to stress the need for detachment, “it is not hard to find evidence in his writing that continued links with deceased persist throughout bereavement” (Stroebe, 1997, p. 257). Silverman and Klass (1996) outline the ways in which people maintain a relationship with the deceased throughout their lives, for example in dreams, conversations with the dead, and in remembering (see also, Shuchter, 1986). Others have examined the sense of presence of the dead and argue that it is both a common and a normal experience (Bennett & Bennett, 2000; Conant, 1996).

Nevertheless, it has to be noted that the concept of a progression from desolation through detachment to “recovery” (particularly Lindemann’s phrase “grief work”) persists in much of the literature aimed at self-help or counseling (see, for example, Bowling & Cartwright, 1982; McLaren, 1998; Moorey, 1995; Sanders, 1989). Tony Walters aptly calls this the “clinical lore” of bereavement counseling (Walters, 1996, p. 7 *et passim*).

This paper aims to contribute to the discussion of models of bereavement and “clinical lore” by presenting some preliminary findings from an ongoing study of the experiences of widowed women in their later years, as told in their memories, narratives, and reflections. We present the women’s accounts, and use them to try to draw some conclusions about whether conventional models of grief and healing provide an adequate understanding of bereavement for a substantial proportion of the bereaved population—that is, women who lose their partners in late life.

## METHOD

### Participants

The respondents were all members of a club for widowed women which meets on Sunday afternoons in the UK city of Leicester. These interviews were part of a larger study conducted by Kate M. Bennett (KMB), investigating changes in lifestyle, morale, and social participation following spousal bereavement in later life. The data consists of tape-recorded interviews with 19 widows aged between

60 and 76 years old who had been widowed between 2 and 26 years. Two women had been married and widowed twice.

The women were from the city and suburbs of Leicester, an industrial town in the English Midlands. While information on occupation was not routinely asked for, information was given in the majority of interviews. Most of the women (18) had worked while they were married: eight had worked part-time in unspecified occupations; six had worked full-time in a variety of traditional female occupations; and four had worked but gave no further information. There had been 21 husbands (since 2 women had been married twice). Occupations were known in 16 cases and these were primarily in social classes III and IV (14), with two in social class II. In 10 cases the husbands had already retired (either because of their age or ill-health) before they died and seven of women had also retired or stopped working to be with their husbands. Very few women talked about going to church (2).

### **Procedure**

The Chair of the Leicester Widow's Sunday Club was approached and asked if she and her members would be interested in taking part in the study. She discussed this with the ladies at their next meeting and they agreed to allow us to invite them to participate. The members were sent an information pack which included a letter of introduction, an information sheet, an "expression of interest" form, and a stamp-addressed envelope. The Chair distributed between 40 and 60 packs and 21 widows expressed interested (one of which we couldn't trace later, so 20 interviews took place). Nineteen of these were coherent enough for transcription and coding. The widows were interviewed in their own homes over a 6-month period during 1997-98. The interviews lasted from one to four hours, the average being about an hour-and-a-half. Interviews were conducted by KMB and by another interviewer. In addition to the individual interviews, a group interview took place with 20 widows and this was conducted by KMB. The interviews were then transcribed.

### **The Interview**

The interviews were tape recorded and undertaken in the respondents' own homes; they were semi-structured and lasted between 0.75-1.5 hours. One respondent was interviewed twice, on both occasions between 1-1.5 hours. Before beginning the interview, the respondent was given an information sheet to read and asked to sign a consent form; confidentiality and anonymity were assured. The interview was not prescriptive; the aim was to learn from the widows what was important to them. The approach was "We are the novices and you have the experience."

The interviewer began with an introductory formula to the effect of: "Thank you for agreeing to talk about your experiences of widowhood. I am interested in your

personal experience, and it may be different from other people's, so tell me what it has been like for you. The interview will last between one and one-and-a-half hours. I would like to tape record the conversation with your permission. We will be able to arrange an opportunity for you to hear the tape if you would like. Should you wish to stop the interview at any time, or take a break, please tell me."

The interview schedule consisted of five parts: first factual questions concerning age, length of marriage, widowhood and family relations; then four sections inquiring about the widow's life at various times.

The first of the middle sections asked about what the marriage had been like. Questions included what hobbies they had pursued together, what the division of labor had been, what had they done separately, whether they had argued, and so on. The second section asked about the time around the death of their husbands. For example, they were asked to describe what a typical day had been like after the death, whether they went out, what support they had had from family and friends, and how they had felt, and what emotions they had experienced. The next section asked them what they did and how they felt one year later. They were asked how their lives had changed by then, what a typical day was like at that stage, whether they were now doing anything new, and whether anything had changed with regard to work around the home. They were asked had their feelings changed, whether they were lonely, or whether they enjoyed being able to spend time alone. The last section asked about what their lives were like at the present time: what did they do with their time, how did they feel about their widowhood, how had their lives changed, what their emotions were, and how they felt now about being alone.

## FINDINGS

While the Leicester study was not designed to test theories of grief, it does provide snapshots of three periods in the course of a bereavement. During the interview the widows were encouraged to talk, first about the time immediately following their husband's death, then what it was like a year later, and finally what it is like now. The technique was to invite narratives rather than to ask very specific questions and expect snappy replies, so it is sometimes difficult to tell how long after the death of their husband some of the events and feelings they are describing took place. Nevertheless, it is interesting to note that the Leicester widows gave a very vivid picture of what it feels like to be bereaved in the early weeks or months corresponding perhaps to Stroebe's loss-orientation coping. Likewise, restoration orientation coping is observable in the narratives, at least in the very broad sense that there comes a time when the widow is able and ready to start to rebuild her life.

Among the effects the Leicester widows report in the early days, those attributed to shock are very common. They say they felt "dazed," "in a complete fog," "numb," "shattered," "lost," "on automatic pilot," "like a zombie." Many report

that they cannot remember the early days at all. Some say “I didn’t know where I was really,” or “I don’t think I knew what I was doing.” Some cannot believe, or will not accept, the death. Some say they were indifferent to life, they did not eat, they “gave up,” lost interest in everything, could not concentrate. One said she felt betrayed and “let down” by her husband; another was angry because her husband “didn’t deserve” to die. Among emotions often reported in the first weeks and months were: anxiety and nervousness, guilt, loneliness, confusion, emptiness, tearfulness, feeling “ragged and drained,” exhausted, withdrawn, mutilated (“like half a person”), and resentful (“why me?”). Some brooded over the death; some were afraid to go to bed at night, while others lost all sense of fear (one lady reports taking cycle rides through the city at 3 am, another says she “did a lot of mad things”), three became very dependent on their children; one became “hard and bitter”; two were physically ill; one had panic attacks; and one could not cope at all. Three could not bear to be in the house and literally wandered the streets, two sold their houses right away, four immediately went on vacation with family or friends or fled to a relative’s house, eight displayed the classic “flight into activity” pattern, filling the day with hasty and ill-considered activity, decorating the house, changing the furniture, digging the garden, anything to take their mind off their sorrow. Many withdrew from social contact:

I didn’t want to talk to anybody [said Mrs. P], and, I mean, you’ve probably gathered, I’m a fairly outgoing person, but I wanted to shut myself away. On the bus, I used to take a book, and if I saw anybody I’d say, “I hope you don’t mind, I’m going to have a cigarette upstairs and I’m reading something important.” I couldn’t bear to talk about the weather and casual things. It was too trivial, after what had happened (Transcript, p. 7).

One thing to emerge quite clearly from these accounts (this is something which the clinical lore plays down) is that people might choose to cope with their loss by dying themselves. A famous epigraph by Sir Henry Wotton (1568-1639) makes the point very poignantly (‘Death of Sir Albertus Moreton’s Wife’):

He first deceas’d: she for a little tri’d  
To live without him, lik’d it not, and di’d.

Nowadays, of course, grief is not recognized as a cause of death (except perhaps in fiction); nevertheless, men in particular do often opt for this way out (see Lopata, 1996). Sanders, too, notes that “the decision to die” is a “choice [that] is seldom discussed . . . but is selected far more often than realised . . . Sometimes this is not a conscious decision but is more an unconscious desire, and death results from illness or accidents” (Sanders, 1989, p. 82).

A number of studies have shown that morbidity is significantly higher among recently bereaved people than among the general population, and that illnesses around the anniversary of the death were common (see for example, Bennett, 1998; Parkes, 1964, 1986; Sanders, 1989; Stroebe & Stroebe, 1993). Other

studies have shown significant levels of mortality following the death of their spouses (see, for example, Bowling & Windsor, 1995; Jones & Goldblatt, 1986). The Leicester study supports these findings. Almost half the widows reported physical or mental conditions which—at the least—show that, in the early days of their bereavement, they were careless whether they lived or died. Two overtly state that they didn't want to live (“it don't matter if you die anyways, because life doesn't matter anymore”; “no, I didn't want to live”); three became fearless to the point of “madness”; many lost their appetite or “gave up”; two suffered from a series of physical ailments; one broke down; and one became preoccupied with thoughts of death; some suffered several of these effects. These experiences of “carelessness for life” cannot be seen as equivalent to suicidal ideation (in a pathological sense). They appear more to be a “normal” and understandable reaction to a serious loss.

Despite illness, carelessness, and thoughts of death, however, the Leicester widows were all survivors. Even those who expressed the wish to die chose life eventually. Initially most of them seem to have had high levels of support from family and friends in those early, difficult days. But that soon dropped off, leaving many socially isolated. Old acquaintances were embarrassed by their own inability to find anything appropriate to say and hurried by them in the street; married women friends began to avoid them, or so they thought. Being with couples was difficult, seeing people in pairs in the street was overwhelmingly painful. One lady said:

I can always remember in the early days I used to say, “Even the birds are in twos!” I can always remember saying to myself, “Oh, the birds are flying about in twos” and I used to really sort of resent being on my own to begin with (Mrs. F., Transcript, p. 23).

Everything upset them—photographs, memories, the behavior of others—and life was extremely difficult.

Among the 20 interviews there is one particularly graphic account of the aftermath of a death and the subsequent gradual rebuilding of a shattered life:

. . . the awful thing about bereavement is, other things are reparable . . . you can build . . . You can cope with just about everything else, but death is so final . . . Nobody can change it. So it's handling that. That's the difficult bit [. . .]

I didn't paint for six months after Stan died [Mrs. A. is accomplished amateur artist]. I just couldn't, I just couldn't bring myself, and then one day . . . one morning I woke up and I said, ‘Do you know, Stan would want this. He'd want you to paint, Stan would—he knew you were painting. He gave you a lot of encouragement.’ And I picked up a brush again and I was away [. . .]

I can't tell you how long ago that was, but suddenly I remember that—feeling when I was single, “This is me. This is June. Nobody else is doing this” . . . I remember thinking this. I thought, “This is not Stan. This is not anybody else. It's June doing this. It's a ‘me’ and it's a something I can do and I

CAN be me . . . It's me." So that was—my independence was there. I'd found something that was totally I could handle on my own (Mrs. A., Transcript, pp. 21-22 and 32).

Mrs. A. has plainly made what models of bereavement would call a successful adjustment, rebuilding her life as an independent person after the destructive desolation of loss. Similar processes can be found in many other accounts. Just over half of the Leicester widows speak of new confidence and independence, new friends and hobbies and skills, an active social life and holidays abroad. They claim they have a good quality of life and sometimes speak of the pleasures of what they call "selfishness" (in other words, pleasing themselves). Though it is difficult to detect an ordered progression through several distinct phases in their stories, as traditional stage models predict, one can usually see a movement from numbness and disorder, through a purposeful reconstruction or rediscovery of self, to functional competence.

Nevertheless, we think the Leicester narratives show that stage theories have weaknesses which are currently often overlooked. The first, and perhaps most obvious, is that the models assume a uniformity of experience—that everyone is the same and feels the same. A moment's reflection shows that this cannot be the case. Parkes (1993), while himself using stage theories in his early work, has cogently observed that grief is not a unitary phenomenon and that the experiences of women who have lost their husbands cannot be the same.

The Leicester accounts show this very clearly. The women's responses to bereavement run the whole gamut from breakdown to gladness. Whereas, for example, Mrs. A. pines for her lost mate for many years, another widow said, "I'd shed all my tears in those two years I'd been taking care of him, and it was a relief to me [when he died], because life was so hard." Asked what was the first thing she did after her husband died, she said she took a bath. It had been a pleasure denied during her husband's last months.

Another problem is that stage models measure adjustment by the degree of independence and reintegration into the community which the bereaved person can achieve. Actually, however, social engagement is a poor measure of quality of life, as Mrs. A.'s testimony, otherwise so positive-sounding, reveals. Though, she says, after a few months "You've lost all that feeling that, you know, that you want to die [and] you seem to find that you could—cope with being alive," it is coping as opposed to enjoying: "It's a battle to survive." The rediscovery of self, the independent persona, the creative activity are, for her, a protective carapace over a gaping wound:

. . . there's always this great hole inside that hurts, and I felt, you know, it didn't matter what you did, it's there, it was there. So I felt all these things I was doing, as if I was building a pattern, a life round it. I couldn't—you can't ever fill it, but you build a life round [. . .]

Now this might sound like I'm bragging but I'm not. People have said to me, "I wish I could handle it like you" and I think, "Well, I don't know [laughs], I don't know that I'm handling it that well. They don't know how I feel inside" (Transcript, p. 30).

In general, in the Leicester study, it is the very same women who have apparently reintegrated themselves successfully and become independently functioning members of society who nevertheless speak of a continuing sense of loss. All these widows have been alone at least two years, some of them for 20 years or more. According to most stage theories, they should be "over" their grief. Nevertheless, 89 percent (17/19) of the women are holding onto their husbands in a variety of ways: 6 of them still miss their husband or are lonely without him; 13 or 14 still sense his presence; 5 still talk to him as if he were alive; 5 still keep a few of his clothes or possessions; 2 attend spiritualist meetings; 2 still harbor destructive emotions; 1 is envious of the still-married; 1 says nothing has changed from the first days of her bereavement; and others wake up and think their dead husband is in bed with them. Some have very limited aspirations, content to be "coping," "living from day to day," refusing to plan ahead for fear of disappointment. Mrs. P., for example, who has been widowed 13 years and has suffered several illnesses since, summed up her hopes for the future thus: ". . . so that's all I really want out of life, to feel well and to cope, and to see my family when I can. My expectations aren't very great but I'm satisfied" (Transcript, p. 19). The overwhelming impression is that these widows have not "recovered" from their loss as if it were a bout of chicken pox, but rather have decided, in the popular phrase, that "life goes on." So social engagement and functional competence, though worthwhile in themselves, are not necessarily a sign of adjustment from bereavement or a measure of the quality of the widow's life.

Other studies support this observation. The Nottingham Longitudinal Study of Activity and Ageing (NLSAA), for example, found that while levels of social participation remained stable following a bereavement, depression increased and morale decreased for up to eight years (Bennett, 1996; Bennett & Morgan, 1992). Other researchers have queried other assumptions of the model. Prosterman has noted that: "Social interaction is not synonymous with social support" and that "it must not be assumed" that the development of new relationships is always necessary or even "beneficial for widows" (Prosterman, 1996, p. 195); Rook has suggested that social engagement can sometimes create more problems than it solves (Rook, 1984; see also Rook, 1989); and Talbott has questioned whether social support itself is always beneficial for widows (see, for example, Talbott, 1990).

Another thing to come strongly out of the interviews which is relevant to the debate is that the Leicester widows reject any form of outside "help" or counseling (cf. Walter, 1996, p. 17). Though grieving people are often urged to join support

groups such as the Widow to Widow program in the United States or Cruse in the United Kingdom (for discussions of self-help groups, see Lieberman, 1993; Prosterman, 1996), the Leicester material shows that formal or semi-formal organizations geared to counseling do not suit everyone:

. . . everyone doesn't want Cruse. There's one going in Leicester now. Well, I went to the first meeting, and there was a vicar—Well, I don't know what HE knew about widowhood!—and somebody else that was married, so SHE wouldn't know much about it! And they seemed so—On the committee—they had a committee, and they all seemed to know what was right for you (Mrs. G., Transcript, pp. 23-24).

This problem was also discussed in the Group interview (Transcript, pp. 8-9):

*Widow W.* \* . . felt it was, the idea there, the idea there seemed basically for people who wanted to remarry. That's the impression I got.

*Widow X.* And also, they wanted counseling. Well I didn't want counselling, I wanted friendship.

*Chorus.* Yes, Yes.

*Widow Y.* Cruse was so . . . it was organized by somebody that knew nothing about it. I think it takes a widow to know [words lost].

*Chorus.* Yes, yes. That's what came out of it.

*Widow Z.* You can't, you can't see [indistinct] but you have no idea.

(\*Note. The identity of these women could not be established from the tape)

What they want is friendship and companionship from other people who understand what it is like to be widowed.

The biggest problem with "clinical lore," however, may be the concept of "recovery" itself, which is built in by nature of the analogy to physical trauma. For example, Parkes (1972) argues that the loss may be spoken of as a "blow," which usually, but not always, heals. Parkes himself is not judgmental about "recovery," but a tone of certainty, almost of accusation, sometimes creeps into other discussions (see, for example, Schulz, 1978). This is perhaps because stage models were initially designed to distinguish "normal" from "morbid" grief, so they fall into the trap of pathologizing a deep and lasting grief. This sort of attitude is not helpful. As Lopata (1996) argues, by being judgmental and reinforcing society's ideas of normality, it leads many people to question their sanity if their bereavement experiences do not fit the model. Its effects on American women have been criticized by Helena Lopata, and may be typical of other groups.

Like the data from Leicester, recent research suggests that a reluctance to "move on" is not a sign of "complicated mourning" (see, for example, Harvey & Miller, 1997). Nevertheless, such models persist, and if they are allied to a conception of a grief-stricken person as a "patient" whose condition has to be "managed" by others (see Lindemann's title), the result can be unfortunate. The counselor or other helper is invited, as Walter puts it, to "collude with the rest of Western culture in

withholding permission to hold on to the dead” (Walter, 1996, p. 9).<sup>2</sup> The effect is also to take control away from the griever and invest it in others. Everyone is an expert except the bereaved person him or herself. Sanders’ discussion of the stages of grief concludes, for example, with the comment: “a phasic model of bereavement allows caregivers to determine where each grieving individual is in the overall bereavement process in order to provide the appropriate intervention for each phase” (Sanders, 1989, p. 107). The effect of such assumptions have been poignantly highlighted in a recent article in the British journal *Mortality* (Footman, 1998).

Echoes of the judgmental view of how long it takes to recover from bereavement can be found in the Leicester narratives too. Mrs. G., for example, reflects:

There was too many people telling you what you should do. As I say, widows can’t win. You either get people saying, if you go out, “Oh, she’s getting over that quick!”—you know, the old sort of—[laughs] “You’d have thought she’d have stayed at home a bit longer” and that sort of thing. But if you *do* stay at home and be miserable and that, well, they’ll say, “It’s time she got over that” (Transcript, p. 15).

Such attitudes can be very hurtful, as Mrs. A. recalls:

I remember going out once and then somebody was going by, and I was really, really hurt. Because I was doing it for US. And this person turned and said, “Oh, look at you all dressed up again. Where are you gadding off to now?” And I wasn’t gadding ANYWHERE, I was struggling to—I was going out because I couldn’t stay IN, and I’d dressed myself up because I wanted to stay still proud, that I wanted to be Mrs. A. and respect myself again. Because I was always proud that he, he respected how I looked after myself, so no way was I going to let the side down (Transcript, p. 37).

Finally, we should like to observe that it seems to us that the recent empirical data on grief and mourning, including the data from Leicester and the poignant personal accounts recently published in *Mortality* (Footman, 1998; Stroebe, 1997; Walter, 1996) should encourage scholars to update models of bereavement to recognize that “lasting sorrow” may often be a normal outcome of the death of someone who was important in one’s life. The Leicester interviews, in particular, seem to indicate that a measure of grief often persists for a very long time. It may

<sup>2</sup>Another potentially more serious problem is that these approaches can change the focus of bereavement from the bereaved and the deceased to the counsellor him/herself. One, to us, very strange effect of the stress currently laid on the role of the professional attendant can be seen in a discussion by Robert Weiss, in which he lists “four relational bonds” the severance of which results in typical grief reactions. These are pair bonds, parental bonds, “persistence of childhood attachment into adulthood” (by which he means the bond adult children feel for their parents, “an unusual development” he says), and the “transference” bond patients sometimes form with their therapists. Thus he expects adult children to be only “briefly bereft” after the death of a parent but to be potentially seriously distressed by the loss of a therapist (see Weiss, 1993, pp. 274-276).

be come muted, buried, or healed over, but for many people it does not entirely go away. Those of us who have suffered a deep loss must find ourselves chilled by Erich Lindemann's words when he states that successful "grief work" will end in "emancipation from the bondage to the deceased" (Lindemann, 1944, p. 143). Many griever do not consider their love to be bondage nor feel that they need to be emancipated from it. As Mrs. C. said: "You can't spend years with someone and then just cast them aside" (Transcript, p. 12).

We believe that clinical lore which medicalizes grief projects a somewhat distorted picture, especially in that it is underpinned by an analogy to physical trauma from which the successful and expected outcome is a full "recovery." If a medical analogy is to apply, then we suggest that metaphors of "wounds," "blows," or disease should be replaced by that of amputation. Not only does that fit many people's subjective imagery ("I felt like half a person," Mrs. P. said), but it also makes clear that a loss is a loss and it is permanent, however well adapted to or compensated for.

### IN CONCLUSION

The Leicester data has value as evidence of the progress and nature of bereavement because, rather than being theory-based, it is the result of more or less spontaneously volunteered narrative accounts of personal experience. Though it was not designed to test what Walter has called the "clinical lore" of bereavement or to contribute to ongoing academic discussions of stage theory models, nevertheless it can contribute to that debate.

As a result of reading and listening to more than 50 hours of taped testimony, we have been persuaded that, though conventional models have utility in describing large-scale patterns in bereavement, there is danger in regarding them as either universally applicable or as indicative of normative experience. In our opinion, a particular problem may be that they are treated prescriptively. This may lead to some areas of common experience (such as the desire to die) being neglected; others (such as the desire for company rather than counseling) being ignored; others (such as renewed independence and reintegration into society) being overvalued; and others (such as lasting attachment to the dead) being pathologized. After reading the literature, following the debates, and listening to the tape-recorded accounts, it seems to us that there is probably no model of grief that can reliably predict how people are likely to respond to this experience.

It is important to note that the evidence presented here concerns women widowed in later life. It is not wise to generalize these findings to other groups of bereaved people suffering from other significant losses. However, it is equally important that this argument also works in reverse—much of the theoretical work which has been discussed and applied to older people was developed with younger people whose problems, needs, and responses may well be different.

Care, therefore, needs to be taken in generalizing from one group of bereaved people to another.

There is probably no universal experience of bereavement nor one way of dealing with it. Most of us just struggle through it as best we can.

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