THE EXPERIENCE OF BEREAVEMENT AMONG OLDER BLACK WIDOWS: A PHENOMENOLOGICAL STUDY

By

Laura S. Rodgers

A Dissertation

Presented to

Oregon Health Sciences University

School of Nursing

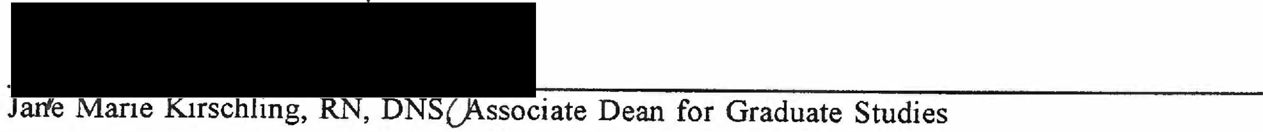
in partial fulfillment

of the requirements for the degree of

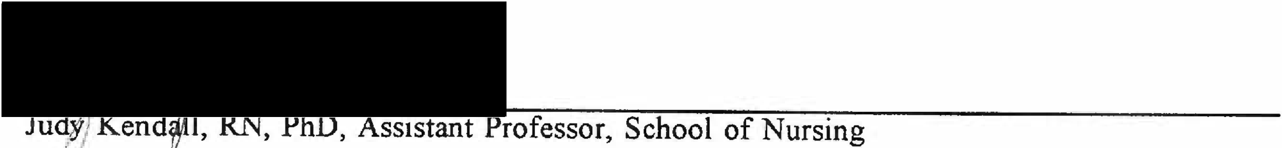
Doctor of Philosophy

May 17, 1995

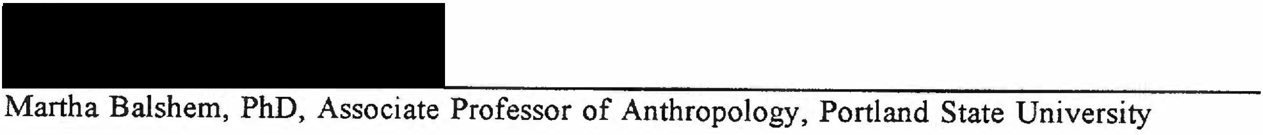
APPROVED:



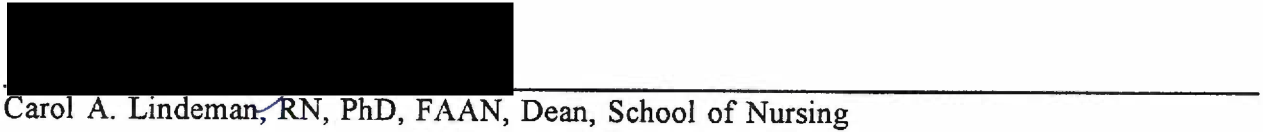
Jane Marie Kirschling, RN, DNS, Associate Dean for Graduate Studies



Judy Kendall, RN, PhD, Assistant Professor, School of Nursing



Martha Balshem, PhD, Associate Professor of Anthropology, Portland State University



Carol A. Lindeman, RN, PhD, FAAN, Dean, School of Nursing

This study was supported, in part, by grant NR07048, Institutional Research Service Award, Nursing Care of Older People, School of Nursing, Oregon Health Sciences University.

ACKNOWLEDGEMENTS

I would like to thank my family for their unending support, encouragement, and patience...So, thank you Bob, Althea, Darren, Michelle, and Linda. An even bigger thankyou to my typist and cheerleader — my mother.

My dissertation committee was a rich source of support, guidance, and helpfulness. Jane Kirschling provided thoughtful criticism and gentle nudging during my research project. Her high academic standards and genuine caring kept me motivated and focused. Thank you Jane for being an excellent role-model and mentor! Judy Kendall's enthusiasm and knowledge provided direction and insight with my data collection and analysis. Martha Balshem enabled me to think more globally through her creative insight of the research background.

ABSTRACT

TITLE: The Experience of Bereavement Among Older Black Widows: A Phenomenological Study

AUTHOR: Laura S. Rodgers

APPROVED:
Jane Marie Kirschling, DNS, Associate Dean for Graduate Studies

This descriptive phenomenological study resulted in the essential structure of bereavement among older Black widows. The essential structure of bereavement emerged from the data and was not translated or defined by external criteria. A purposive sample of 11 older Black widows from a midsize city in the Pacific Northwest were interviewed. No structural interview guide was used. The interviews were transcribed verbatim and then analyzed according to Colaizzi's (1978) methodology. Seven themes emerged from the data analysis. Storytelling emerged as a distinct theme from the grief experience of the participants. There were six themes identified from the participants' description of their grief experience. The six themes were awareness of death, caregiving, getting through, moving-on, changing feelings, and financial security.

The results of this study increases our understanding of bereavement among older Black widows. These findings can enable nurses to interact more efficaciously and sensitively to older Black widows. The importance and role of family in the experience of bereavement among older Black widows needs to be especially emphasized. It is logical that the best

ABSTRACT (continued)

source of information about a client is the client. Phenomenological research in nursing can help nurses understand what is real about the lived experiences of our clients. These understandings could be directly related to the development of a body of knowledge and the design of effective nursing care.

TABLE OF CONTENTS

CHAPTER PAGE

I. INTRODUCTION

Background 2

Clarification of Descriptive Terms 6

Problem Statement 8

Research Question 9

Implications for Nursing 9

II. REVIEW OF THE LITERATURE

General Overview 11

Nursing Research 12

III. METHODS

Overview of Phenomenology 18

Phenomenology as a Philosophy 19

Historical Perspective 19

Phenomenology as an Alternative Movement 21

Phenomenology as a Research Method 27

Design 29

Setting 29

Study Participants 30

Data Collection Procedures 34

Data from the Researcher 35

Data from the Participants 37

TABLE OF CONTENTS (continued)

CHAPTER PAGE

Data analysis 39

Validity 40

Protection of Human Subjects 43

IV. ANALYSIS AND RESULTS

Colaizzi's Seven Steps of Analysis 44

Step 1: Review of Protocols 44

Step 2: Extracting Significant Statements 44

Step 3: Formulating Meanings 45

Step 4: Cluster of Themes 45

Step 5: Exhaustive Description 45

Step 6: Statement of Essential Structure 46

Step 7: Final Validation 46

Storytelling 46

Grief Experience 49

Awareness of Death 50

Caregiving 54

Task-oriented 55

Problem-solver 55

Decision-maker 56

Learner 56

Getting Through 57

TABLE OF CONTENTS (continued)

CHAPTER PAGE

Moving-on 61

Positive Memories 65

Personal or Self-growth 66

Strength-seeking 67

Using Support 67

Life-oriented 68

Changing Feelings 69

Financial Security 74

Essential Structure 78

Final Validation 85

V. DISCUSSION AND IMPLICATIONS

Validity of Findings 87

Comparison of Findings with Previous Studies 90

Strength and Limitations of Study 93

Strength and Limitations of Method 93

Implications and Recommendations for Nursing Research and Practice 94

Personal Reflections 97

Summary 98

References 100

TABLE OF CONTENTS (continued)

Appendix

Verbal Consent Form 115

LIST OF TABLES

TABLE PAGE

1. Representative Significant Statements of Awareness of Death 52

2. Awareness of Death Formulated Meanings 53

3. Representative Significant Statements of Caregiving: Task-oriented 58

4. Caregiving Formulated Meanings: Task-oriented 59

5. Representative Significant Statements of Getting Through 62

6. Getting Through Formulated Meanings 64

7. Representative Significant Statements of Moving-on: Connectedness 70

8. Moving-on Formulated Meanings: Connectedness 71

9. Representative Significant Statements of Changing Feelings 73

10. Changing Feelings Formulated Meanings 74

11. Representative Significant Statements of Financial Security 76

12. Financial Security Formulated Meanings 77

CHAPTER 1

INTRODUCTION

One out of eight Americans are 65 years of age and older (Harper & Alexander, 1990). By the year 2030, it is projected that older persons will comprise 21.8% of the total population (American Association of Retired Persons, 1988). The ethnic older population is growing faster than among Whites (Harper, 1990). It is estimated that by the year 2025 the numbers will triple. Consequently, ethnic elderly will constitute over 15% of the entire older population in 35 years (Watson, 1990). More specifically, older Black Americans are the fastest growing portion of the total population with Black women 80 years of age and older growing the most rapid among this population of elderly people (Johnson, Gibson, & Luckey, 1990). This increase in numbers of older persons, and especially older Black persons, will have a significant impact on social and healthcare services.

Older women are more likely to be widowed than older men (U.S. Bureau of the Census, 1989). While the general issue of loss is a widespread occurrence among the older person (Burnside, 1988; Dimond, 1981; Rigdon, Clayton, & Dimond, 1987), one of the more profound losses is the death of a spouse (Barrett & Scott, 1989; Holmes & Rahe, 1967). The older bereaved person is susceptible to an increase in health problems (Gerber, Rusalem, Hannon, Battin, & Arkin, 1975; Glick, Weiss, & Parkes, 1974; Parkes & Brown, 1972; U.S. Bureau of the Census, 1984) as well as higher mortality risk (Jacobs, Kasl, & Ostfeld, 1977; Kaprio, Koskenvuo, & Rita, 1987; Osterweis, Solomon, & Green, 1984; Thompson, Breckenridge, Gallagher, & Peterson, 1984). In addition, the impact of a spouse's death affects the survivor's

social, economical, and emotional status (Bass, Bowman, & Noelker, 1991; Breckenridge, et al., 1986; Gass & Chang, 1989; Lund, 1989; Shucter & Zisook, 1986). Several studies suggest that widowed survivors over the age of 50 grieve more intensely than younger survivors (Gerber et al., Sanders, 1980-1981) thereby accentuating the potential deleterious effects of grieving the death of a spouse.

Background

Using the age of 65 as a benchmark, Harel, McKinney, and Williams (1990) describe the present elderly Blacks as a group with a rich "heritage of survival knowledge and skills" (p. 22). This group of elderly were born prior to the Depression, were grandchildren of former slaves, witnessed the peak of migration of Blacks from the South to the North and "have been scarred by a history of discrimination and racism" (Harel et al., p. 73). The greater percentage of African Amercans live in the Southeastern states (59%) (Harper, 1990) which reflects the "second great migration" of Blacks to the South (McDonald, 1987). Over 20% of the Black elderly live in rural communities.

While there is recognition that each person has a unique life experience, much information is available regarding general health and social issues of the Black elderly. Padgett (1989) differentiates between young-old and old-old because members of non-White ethnic groups have not only shorter life spans than Whites, but may well be functionally old before the age of 55. She also contends that many ethnic elderly may consider themselves "old" by age 55. Black elderly tend to suffer earlier in their life courses from debilitating chronic illnesses.

Harper (1990) suggests several characteristics which are unique to Black

elderly. First, she states that Black elderly tend to not report or underreport illness and physiological changes to health care providers. Secondly, Black elderly consider certain physiological changes, such as edema in the legs, as part of the natural aging process. And finally, sickness is perceived as a sign of weakness. In support of these findings, Harper revealed that not only do Black elderly get infrequent routine physical examinations, but that when health care is sought their condition is usually in a late and advanced stage.

It has been hypothesized that being older and a member of a minority ethnic group places one at a double disadvantage related to health in later life. For this double jeopardy theory to exist, it would need to be shown that the health differential between elderly Whites and Blacks increases with age. Ferraro (1987, 1989) found several reasons why the double jeopardy hypothesis may be false. He stated that previous measurements used to assess the existence of double jeopardy utilized cross-sectional studies rather than longitudinal studies. Moreover, a crossover effect in racial mortality exists at about the age of 75. Black elderly have a higher mortality rate than White elderly until the age of about 75 which at that time there is a reversal in mortality. At that time Black elderly outlive White elderly. This phenomena not only raises the possibility that Blacks and Whites age physiologically at different speeds as well as puts into serious question the validity of the double jeopardy theory. Overall, life expectancy and health of the Black population has not improved since 1984 (Harper, 1990).

The Western Africa from which most elderly Black came consisted of families living together in communities. The extended family was very strong and relatives

commonly lived together (Satcher & Thomas, 1990). In addition, the elderly occupied a special place of leadership and honor in the family. In America, the Black extended family continues to provide economic and emotional support to its members while also providing a source of protection and strength against societal pressures and social isolation (McDonald, 1987).

While family members are prominent in the support networks of Black elderly, Taylor, Chatters, Tucker, and Lewis (1991) observed that regional location influenced the size of the network. They found that Southern Black elderly had larger and more diverse networks. Elderly Blacks tend to prefer to receive assistance, care and support from a daughter, followed by a son, spouse, sister, brother, friends, neighbor, and finally parents (Baressi & Menon, 1990). Thus, care among Black elderly tends to be more acceptable from immediate family members and other relatives than non-kin members or formal supports.

Participation in the church and religious activities is an extension of family life for older Blacks (Brown, 1990) as well as a source of social integration (Johnson & Barer, 1990). Church membership groups are significant sources of support and help to older Blacks during sickness (Taylor & Chatters, 1986) but are still secondary sources of support sought by Black elderly when compared to family or kin or kin groups (Watson, 1990). Church attendance has been associated with a decreased risk of mortality among Black elderly but this association was not found with kinship or friendships (Bryant & Rakowski, 1992; Chatters & Taylor, 1990).

Black elderly women have been and continue to be a major source of support and nurturance to their families (Angelou, 1969; Gibson, 1989a, 1989b). The older

Black person, and especially the grandmother, occupies a special place of leadership and honor in the family (Satcher & Thomas, 1990). Hill-Lubin (1991) found that the older Black grandmother is a model and source of empowerment for the future generation of Blacks. More specifically, the grandmother uses stories to teach skills of survival to her family. She is also the retainer and transmitter of values and ideals that supports her family (Hill-Lubin). This last function emphasizes her spirituality. Consequently, because of the prevalence of widowhood among older Black women and their vital role in the family, it is important for nurses to research and increase their understanding of bereavement among the older Black widows.

Most of the older Black women are in the lower socioeconomic class and throughout their lives have not been able to afford to take the sick role (Edmonds, 1990). They were usually not employed in jobs that had fringe benefits such as sick pay or prepaid health insurance plans. When they did not work, they did not get paid. Being the main support of themselves and their families forced many Black women to work regardless of their health status. Consequently, while the work history of each Black woman was diverse, they shared a focus on the importance of work in order to promote family survival (Allen & Chin-Sang, 1990).

Other factors besides economics influence the health of elderly Black women. Fatalism is a common feature among many Black elderly women which may explain some of their attitude toward health care. They perceive that one must "bear the cross" or suffer illnesses secondary to poverty and life circumstances because after one dies there is a better life in heaven.

Clarification of Descriptive Terms

There are three distinct ethnic groups in the Black community: American-born, Caribbean-born, and African-born (Davis, 1993). Because of this ethnic diversity Blacks should no longer be considered a single ethnic group (Portes & Jensen, 1989). Both history and identification are important in determining ethnicity. There has been a disparate historic past for these three groups. The American-born and Caribbean-born were part of the African diaspora, even so these groups have had very different experiences since then (Davis). For example, the African-born Blacks do not have the history of North American slavery, segregation, and racism like the Caribbean-born and American-born blacks. Likewise, African-born Blacks have experiences of apartheid, colonialism, and political instability. Davis eloquently states that "to assume a common cultural bond among these three groups strains scientific credulity. It is far more like that they represent three distinct cultural traditions" (p. 32).

In spite of the differences between the three Black ethnic groups, there is a worldview or paradigm which links the groups with African history and culture. This paradigm has been called Afrocentricity.

Afrocentric scholars describe Afrocentricity as a philosophy, a life-style, a worldview, a perspective, a movement, an analytical approach, and a cultural orientation (Asante, 1988; Keto, 1989). Asante believes that Afrocentricity includes every element of human orientation such as perception, religion, interpersonal relationships, philosophy, communication, language, and fashion. For instance, the African-American oratory, used by pioneers of the Civil Rights movement, illustrated the power of the spoken word through sermons, lectures, gospel songs and poetry. This

rhetorical power is a carryover of the ancestral practice of oral expression from Africa which used drumming, storytelling, and praise singing.

Another example is that an African-based culture emphasizes the centrality of the family and personal integrity (Mbiti, 1970) as compared to a European-based culture which emphasizes the idea of survival of the fittest and individuality. The African-American family includes the extended family in that they believe that all aunts and uncles are responsible parents of all their nephews and nieces. There is also a great respect for age (Allen, 1978). Consequently, any study of African-American experience should include the African heritage and the American experience (Jackson, 1983; Oyebade, 1990).

There are two terms used in America for Blacks, "Black" and "African-American." Davis (1993) uses the term "Black" for three reasons. First, there is a tradition in using that term that is reflected in the writings of Frederick Douglas and W.E.B. DuBois. Secondly, Davis asserts that using one term over the other is "tantamount to taking a political stance on a matter that is not at issue" (p. xi). And finally, he contends that it remains unclear as to what exactly these terms mean. Others use the term African-American in order to reject objectifying language as well as to convey a heritage (Avery, 1992; Hale, 1992).

It is not my intention to make a case to use either term, "Black" or "African-American". In order to be consistent in this study I will describe the study participants as older Black widows who were born in America. However, I will use the terms "Black" or "African-American" to reflect accurately from sources of original authors.

Problem Statement

In the past 20 years, there has been an increase in bereavement research, especially regarding widowhood among the older population. Despite this accumulating knowledge, researchers have either failed to include ethnic elderly in their study samples or neglected to address the impact that ethnicity may have on the bereavement process or outcome. Unfortunately, the trend in elderly, spousal bereavement research has been to discuss en masse all elderly populations in assuming all elderly have similar bereavement experiences. Harel, McKinney, and Williams (1990) poignantly comment that "researchers, policymakers and human service professionals have tended to regard the elderly from a monolithic viewpoint. By so doing, they ignored the distinctiveness and/or uniqueness of the life experiences of groups such as the Black elderly" (p. 20).

Since older Black Americans are a rapidly growing segment of the older population, the significance of ethnic diversity becomes especially relevant (Dimond, 1981). The majority of Black women aged 65 years and older are widowed (57.7% as compared to 51.1% for older White women) (Harper & Alexander, 1990; Murray, Khatib, & Jackson, 1990; Satcher & Thomas, 1990). Also, the tendency for Black women to be widowed early is increasing (Satcher & Thomas). Yet in spite of this increase in older Black widows, the process of bereavement among these widows has not been adequately studied. Generalizing and applying the current knowledge of bereavement through nursing interventions among older Black widows may be premature.

Research Question

The purpose of this study was to describe the experience of bereavement among older Black widows. This research contributes knowledge to the nursing profession that enables nurses to more effectively provide bereavement support and interventions to this ethnic group. The essential characteristics of bereavement were extracted from the widows' experiences by phenomenological analysis. The research question addressed was as follows: From the perspective of the older Black widows, what are the lived experiences of their grief/bereavement after the death of their husbands?

Implications for Nursing

Nurses are the largest group of health professionals who provide care for the ill as well as aged in institutions and the community (Dimond, 1981). Nurses deliver care to clients in a variety of settings such as the hospital, long term care facilities, public community clinics, physician's offices, hospice, and even religious settings such as churches in the role of consultants/advisor. Nurses are the logical providers of bereavement support for the older bereaved spouse and their family and friends (Dimond, 1981; Martocchio, 1985). Nurses have the opportunity to work with bereaved spouses and their families when they are most likely to benefit from effective interventions. Consequently, it is critical that this care be based upon a scientific data base.

The grief experience has been described as a unique and personal phenomena which includes each person's own perceptions of the death as well as one's culture, personal history, ethnicity, and family dynamics (Carter, 1989; Clavon, 1986; Detmer

& Lamberti, 1991; Karl, 1987). Nurses need to be prepared to provide quality care in a pluralistic society. The significance of this study to nursing is that it can sensitize nurses to the bereavement process of older Black widows. This study can be helpful in developing and implementing nursing interventions that are more consistent with the unique needs of this particular population.

Providing comfort and minimizing the many threats to the physical and mental health of the bereaved widow is one of the goals nurse educators try to teach their students. It is imperative that nurse educators incorporate cultural awareness and sensitivity into the nursing curriculum. This study helps in developing an understanding of bereavement among older Black widows through understanding their perceptions of bereavement.

CHAPTER 2

REVIEW OF LITERATURE

The purpose of this literature review was to justify the need for this exploratory study. This review of the literature was not done to identify nor operationalize terms. Empirical studies which addresses the bereavement process among older Black women are nonexistent. This review of the literature includes a general overview of the history and development of bereavement theories, and a review of nursing research studies of bereavement which include any percentage of ethnic older persons.

General Overview

Lindemann's classic study (1944) was the first systematic study of bereavement. He described acute grief as a four to six-week crisis with specific psychological and somatic symptoms. Bowlby (1961) outlined a theory regarding loss after a significant attachment. He described three phases of the mourning process: the urge to recover the lost object, disorganization, and reorganization. Drawing on Bowlby's work on separation, Parkes (1972) delineated seven phases of mourning: (1) initial denial and avoidance of the loss, (2) alarm reactions, (3) searching, (4) anger and guilt, (5) feelings of internal loss, (6) adoption of traits or mannerisms of the deceased, (7) and acceptance and resolution.

Raphael (1977) conducted an experimental study in which she found that high risk clients were similar to low risk clients after treatment in a group of widows under the age of 60. Another intervention study (Vachon, 1976) examined the efficacy of a widow-to-widow program and found the intervention group adapted faster than the

control group. Silverman (1987) developed a widow-to-widow program which can provide widowed spouses with much needed resources and support to facilitate a positive bereavement outcome.

A number of empirical studies investigating bereavement among older spouses (Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Jacobs, Hansen, Berkman, Kasl, & Ostfeld, 1989; Kitson & Roach, 1989; Nuss & Zubenko, 1992; Roach & Kitson, 1989; Siegel & Kuykendall, 1990; Thompson & Gallagher-Thompson, 1991; Zisook & Shucter, 1991a, 1991b) included ethnic elderly in their studies, however, the vast majority of subjects were White, middle-class, and well-educated. Neither ethnicity or race was discussed as having any significant influence on bereavement outcomes in these studies. It is interesting to note that these studies were fairly recent in chronology even though the review of literature included a 10 year time span.

Nursing Research

Nurses have conducted numerous studies on bereavement in the elderly. The nursing studies reviewed in this section will be divided into three categories. Those studies which had no focus or reference to ethnic groups will be reviewed first. Next, while some studies included a small percentage of ethnic people in their study samples, no consideration to ethnicity was included in their findings. And finally, those studies which focused primarily on a specific ethnic population will be examined.

Dimond (1981) developed a model for grieving among the elderly. She identified concepts of support networks, concurrent losses, and coping skills as

intervening factors for adaptation.

Cowles and Rodgers (1991) did a systematic and thorough review of the current and classic literature concerning grief within the nursing and medical fields. Their study was designed to methodically identify a conceptual definition of grief as it has been utilized in the nursing and medical literature. The concept of grief underwent little change over time. Their analysis revealed that nursing knowledge concerning grief emanated from other disciplines, primarily the medical field (Rodgers & Cowles, 1991).

Martocchio (1985) examined grief responses and factors influencing them. She described the wide range of behaviors and responses associated with normal bereavement but made no reference to the specific population regarding age or ethnic characteristics. She distinguished grieving from bereavement. Bereavement is a subjective state which occurs as a response to loss through death. Grieving is the total response which includes thoughts, feelings, and behaviors which includes internal processes and observable reactions.

A comparative study of perceived social support among widows and widowers during the first year of bereavement was conducted by Warner (1987). She found widowers relied more on professionals for support and widows valued advice support more than widowers. Her sample was predominantly Norwegian and German, Lutheran or Catholic, and from North Dakota and northwestern Minnesota. She stated her results were not generalizable given the ethnic and geographic limitations of her sample.

Gass (1987) studied the coping strategies of older widows. She found that instead of developing new roles, most widows returned to activities they had little time

to do when their spouse was ill. Keeping busy, prayers, and participating in social groups were helpful coping strategies. Her sample consisted of primarily Catholic and all White (N = 100) subjects.

Gass and Chang (1989) tested a model based on a stress-coping framework on a widowed person's psychosocial health dysfunction after conjugal bereavement. Their findings supported the premise that higher threat appraisal will cause more stress which will be manifested in poorer health functioning. Their subjects were all White (N = 157) and primarily Catholic.

Hegge (1991) conducted a qualitative retrospective study examining the effects of anticipatory grieving on the caregiver before the spouse's death. The most frequent and troubling problems reported by the subjects (N = 26) were loneliness, social isolation, disruption in eating and sleeping patterns, and independent decision-making.

Jones and Martinson (1992) described the bereavement experience of caregivers (N = 13) of family members with Alzheimer's disease. Their findings neither supported nor refuted the phenomenon of anticipatory grief.

Aber (1992) examined the paid work role as a predictor of widow's health following the death of her husband. She found that a woman's work history and work attitude were significant predictors of health during spousal bereavement. Her study consisted of widows aged 55-75 (N = 157). The previous nine studies either make no mention as to the ethnicity of their study samples or they included only all White study samples. Ethnicity was not discussed in the conclusions of these studies.

On the other hand, several studies included ethnic populations in their study sample. Valanis and Yeaworth (1982) found that subjective ratings of health among

older conjugally bereaved spouses (ages 59-83) were primarily positive and significantly better than the objective ratings. Of the total subjects (N = 60), there was 1 Black male and 7 Black females, the remainder were White. They concluded that the number of Black subjects was too small to allow for much more than speculation.

Prevalence of alcohol use among the bereaved is higher than among nonbereaved older persons (Valanis, Yeaworth, & Mullis, 1987). Their sample included White (85%) and Black (15%) older persons ranging from 54-83 years. There was no relationship between age, race, education, social resources, mental health, physical health, or economic resources and drinking patterns prior to bereavement.

Kirschling and McBride (1989) examined the effects of sex and age on the experience of widowhood. This nonexperimental exploratory study utilized a convenience sample (N = 82) of primarily Caucasian subjects (88.9%). No mention is made as to the ethnic background of the remaining 10.1% of the subjects. This study found that the age and sex of recently widowed subjects were important variables on social support, attachment, grief, and coping.

Herth (1990) found a significant positive relationship between the level of grief resolution and level of hope among her sample of 75 conjugally bereaved spouses. While her sample included older Black persons (16%, N = 12), she suggested that the study needs to be replicated with subjects from various cultural subpopulations in order to broaden the generalizibility and potential implication. The above four studies included small percentages of ethnic populations in their study samples. However, the studies provided no serious consideration as to the application of their findings to different ethnic groups.

Portillo (1990) examined the process of bereavement for Mexican American widows using a grounded theory approach among 18 widows age 35-83 (mean age = 62). She identified a basic social process, Reorganizing a New Me, as the continuous process used by Mexican American widows in order to adjust and adapt to widowhood. She also identified coping strategies utilized by this population.

A comparison of grief responses and physical health changes in Caucasian (N = 34) and African-American (N = 34) women following a third trimester stillbirth was studied by Willis (1991). She found no major differences in overall physical health following the stillbirth due to their response to grief.

Rosenbaum (1991) described the grief meanings and experiences of older White Greek-Canadian widows. Her findings did not support Lindemann's (1944) final stage of mourning. Instead of accepting death, she found the widows did not fully accept their husband's death, but rather became resigned to the death as she became reintegrated into the Greek community. The previous three studies were conducted on specific ethnic populations with only two of the three examining grief among widows.

In summary, in recent years nurse researchers have begun to study the bereavement experience among different ethnic groups (Portillo, 1990; Rosenbaum, 1991; Willis, 1991). However, there still remains a large gap in the current bereavement literature addressing the concerns or experiences of bereavement among the older Black widows. Bereavement is a social, cultural, and psychobiological phenomenon (Osterweis, Solomon, & Green, 1984). In order to explain cross-cultural

variations in specific health consequences of bereavement, systematic research is needed to determine bereavement process and cultural norms for the ethnic group.

> Until better data are available on variation in grief responses among the members of ethnic and minority groups, health professionals should be aware that the phases, timing, and significance of grieving by individuals of different backgrounds may vary from those reported in studies of persons in the mainstream population (Osterweis et al., 1984, p. 287).

CHAPTER 3

METHODS

Overview of Phenomenology

Research methods, as described by Polkinghorne (1989), are blueprints or maps which guide researchers in their quest for knowledge. Currently, the two major methodological domains, qualitative and quantitative methodologies, are based on differing philosophical assumptions "about the nature of reality and the processes of human understanding" (Polkinghorne, p. 41). To understand my rationale for using phenomenology as my choice of research method, I will provide an overview of phenomenology in three areas. First, I will discuss the origin and evolution of phenomenology as a philosophy and a methodology. I cannot discuss the historical background of phenomenology without also distinguishing between the two major philosophical perspectives of research. The major assumptions and concepts of phenomenology will be identified and explicated. Secondly, phenomenology as a research method will be described according to the essential elements and assumptions inherent in the method. Also, a distinction will be made between the phenomenological method and other qualitative methods.

It is important to understand what is meant by world view prior to discussing phenomenology as a philosophy. The concept of world view was developed by Redfield (1953) to provide a useful analytical basis upon which to argue for the congruency between science and philosophy. World view was characterized by Redfield as the way individuals or cultures perceive or know their world about them. This outward look upon the universe or world includes forms of thought as well as

attitudes toward life (Ray, 1985).

Phenomenology as a Philosophy

The nature of the phenomenon being investigated as well as the paradigm from which the phenomenon occurs determines which research method an investigator uses (Parse, Coyne, & Smith, 1985). Qualitative and quantitative methodologies, being the two major domains of research methods, have major philosophical differences. These differences will be addressed from a historical perspective, including the background of natural science, how it evolved, and the major philosophical assumptions. Then, I will describe how phenomenology emerged as an alternative philosophical movement. Within each of these discussions, major concepts will be identified and clarified.

Historical perspective. The history of the modern scientific movement can be traced to the Greek philosophers (Carter, 1985). There was an intense desire among these early philosophers to understand the logical order and organization of nature (Carter). Mathematics and deductive reasoning were incorporated in the early development of this philosophy of nature. The bonding of mathematics and evolution of the scientific method was intensified over the next several centuries. Early mathematicians and philosophers, such as Thales, Aristotle, and Archimedes, created a world view of nature that consisted of irreducible parts or atoms (Carter). These early Greek scientists focused on discovering the existence of all the different types of atoms in the world. Very little emphasis was focused on whether or not interrelationships existed between various and different atoms.

Scientific advances occurred rapidly during the 17th century, secondary to the advancement of mathematics and the advent of algebra. Atoms were still considered to

be the basic irreducible parts of nature, only now these atoms were linked to each other in an orderly yet independent mathematical relationship. Human beings could now be divided into a body and mind "as though these were two separate parts of the same whole, and a set of relationships could be expressed to show the interdependences" (Carter, 1985, p. 28).

During the 18th and 19th centuries the scientific worldview came into a dramatic centrality in scientists' thinking. Quantification via precise measurement and deductive reasoning became the significant essentials of the scientific method. As a result, scientists began to devalue the human experience of living. Personal experience could not be quantified and consequently any dealings with personal experience was deemed unreliable, untrustworthy, naive, and insignificant (Colaizzi, 1978). The scientific or empiric-analytic method toward knowledge development via experimentation allowed the researcher to utilize methodological techniques to sift out subjective elements, such as bias and feeling, thereby facilitating objectivity.

Empiric-analytic research focused on the empirical and objective analysis of predetermined variables in order to ascertain whether there was a causal and measurable relationship among the studied variables (Patton, 1990). For centuries, science was concerned only with inanimate objects or the depersonalized aspects of human existence (Colaizzi, 1978). Wilhelm Wundt in 1879 developed scientific psychology and in order to have it viewed as a legitimate science he studied psychological phenomena according to the scientific method, thereby deleting the inclusion of human experiences in his studies because they were neither quantifiable nor observable (Valle & King, 1978).

The philosophic fundamentals of the scientific method is referred to as logical positivism (Polit & Hungler, 1989). One epistemological assumption of empiric-analytic research is that variables to be studied can be controlled and manipulated into objective forms of measurement. An epistemological assumption of this research method is that variables can be studied selectively and objectively by a controlled experimental design (Leininger, 1985). There is also an ontological assumption about the nature of reality. This assumption of determinism contends that phenomena have preceding causes and random causes do not occur (Polit & Hungler, 1983). The researcher is not to be influenced by extraneous factors in the study and consequently objective measurable data is the goal for empiric-analytic research. Valle and King (1978) identified three criteria that are fundamental assumptions of the scientific method which are phenomenon must be observable, measurable, and verifiable via other observers.

Phenomenology as an alternative movement. In the 19th century, sociologists and psychologists addressed the concern of how to structure the study of humans (Davis, 1973). Behaviors which were observable, measurable, and verifiable (Valle & King, 1978) were the only data acceptable to the scientific method. There was a growing criticism toward the inappropriate application of this methodology in seeking to understand human behavior (Cohen, 1987). Phenomenology was developed by Edmund Husserl as an alternative to the scientific method (Knaack, 1984). Husserl described phenomenology as the study of human experience as it is lived from the perspective of an individual (Colaizzi, 1978; Knaack; Oiler, 1986; Omery, 1983; Taylor & Bogdan, 1984).

Spiegelberg (1994) wrote a well documented history of the "Phenomenological Movement." He used the term "Movement" to demonstrate that this is not a stationary philosophy (Cohen, 1987). Furthermore, he said the philosophy has changed and been revised both across different philosophers as well as within each philosopher. Spiegelberg divided the history of phenomenology into three phases. I will provide a brief historical background of the philosophical development of phenomenology and will elaborate on key concepts as they emerge.

Franz Brentano and Carl Stumpf were involved in the first phase known as the Preparatory Phase. Brentano was the first, in this line of scholars, to propose the value of inner perception (Cohen, 1987). Inner perception was described as a recognition of one's own psychic phenomena. Also, he was the first to propose the concept of intentionality. Intentionality (Ray, 1985) is a quality of acts that are always directed toward an object. For example, consciousness is always intentional because if one is conscious then one must be conscious of something. Both of these concepts were important to the later evolution of phenomenology.

Stumpf, a student of Brentano, created experimental phenomenology. He conducted experiments combining reality and imagination. Scientific rigor of phenomenology was demonstrated by Stumpf, this being his most influential and lasting contribution to the development of phenomenology.

Edmund Husserl and Martin Heidegger were the two prevailing philosophers of the second phase of the phenomenological movement, known as the German Phase. Husserl, a former student of Brentano, has been identified as the central figure of the development of phenomenology. Husserl's philosophy changed over time and has been

divided into three distinct phases. It is his second phase which I will expand.

Husserl's son died in action during World War I. He redirected his work after the war. Husserl, like other existential-phenomenological philosophers, were becoming more disenchanted with the traditional approach that pervaded scientific philosophy at that time. He did not agree that the mind and body should be separated into two different entities (Polkinghorne, 1989). Rather, he believed that science needed a philosophy that would reestablish contact with deeper human concerns (Cohen, 1987). His marked departure from traditional empiric-analytic methods was demonstrated in his famous appeal "to the things." "'To the Things' signified that philosophy must begin with the phenomena and problems themselves" (Cohen, p. 22).

In direct contradiction to the scientific philosophy of his time, Husserl strongly contended that the mind contributes to an understanding of the world through experience and that "experience consists of the reception of worldly objects by the processes of consciousness to constitute what presents itself in awareness" (Polkinghorne, 1989, p. 42). In other words, experience exists with the interaction between a person and the world. Further, experience cannot be reduced to either a physical or mental dimension but rather is a result of human awareness to the world (Polkinghorne). Husserl acknowledged that experiences have meanings which remain constant. For example, Polkinghorne provides a poignant example to demonstrate this concept. I can have different experiences regarding the concept of "triangle". For instance, I can observe a triangle drawn on a blackboard, outlined on beach sand, or even marked on a dog. These are three different experiences I can have with the concept of triangle. However, there remains a constant structure or meaning of

"triangleness." Husserl used the terms eidos or essence to refer to these essential structures of experience.

Phenomenological reduction is another fundamental attribute to Husserl's philosophy. Phenomenological reduction or structured reflection, is the attempt to describe "with scientific exactness the life of consciousness in its original encounter with the world" (Ray, 1985, p. 83). According to the philosophical assumptions of logical positivism, reduction is the attempt to explain complex phenomena, such as the human experience, by simplifying or reducing the experience to only a few preconceived concepts under investigation (Polit & Hungler, 1989). In direct contrast, Husserl's purpose of reduction was to obtain pure untouched phenomena which could only be obtained via the "naive" or "natural" experience of living from an individual's everyday human experience (Cohen, 1987; Knaack, 1984). Husserl felt that in order for a researcher to critically examine a particular phenomena of human experience, the researcher must suspend one's own personal beliefs and put in abeyance those elements of the phenomena that are irrelevant to the phenomenon under study (Cohen, 1987; Polkinghorne, 1989; Ray, 1985). This personal examination of an investigator's preconceptions, prejudices, and bias is known as bracketing.

Another meaningful aspect of Husserl's philosophy is the concept of phenomenological intuition. It is logical or perceptive insight into the understanding of a phenomenon based on representative examples of the phenomena. According to Husserl, phenomenological intuiting can occur, not only in the real life experience, but also within one's memory and imagination (Cohen, 1987).

Two important concepts emerged from Husserl's students and colleagues:

Intersubjectivity and Life-World. Intersubjectivity declared that given a researcher's frame of reference, another person could come to a similar interpretation of the phenomena (Parse, Coyne, & Smith, 1985). Life-World is the world of lived experience. This concept surmised that people take for granted their every day experience of living, and that this experience of daily living is not "immediately accessible to us in our 'natural attitude'" (Cohen, 1987, p. 33). Consequently, access to the every day living experience may be possible through phenomenological studies.

Heidegger became the assistant to Husserl. He was primarily interested with Being and Times and his philosophy of phenomenology began to emerge with the philosophy of existence (Polkinghorne, 1989). Heidigger viewed phenomenology as a new means for a solution, but it was never intrinsic to his philosophy. The term "phenomenology" is not used in his later writings. Some say his greatest contribution to the Phenomenological Movement was the inspiration he imparted to the French phenomenologists (Cohen, 1987). Phenomenology ended in Germany with the Nazi years during World War II. Heidegger and Husserl had many philosophical differences, not the least being the fact that Heidegger was actively involved in the Nazi Movement and did nothing to help Husserl, a Jew, during that time period (Cohen).

Prominent philosophers of the third phase of the Phenomenological Movement, known as the French Phase, were Gabriel Marcel, Jean-Paul Sartre, and Maurice Merleau-Ponty. Marcel had a great influence upon Merleau-Ponty. Sartre was more interested in the practice of phenomenology than the theory or science (Cohen, 1987).

Merleau-Ponty expanded the philosophy of phenomenology. He contended that

since the world and one's consciousness intermingled, then all acts of consciousness, such as remembering, judging, and dreaming are possible only because of one's presence within the world (Munhall & Oiler, 1986). He referred to a person's view of the world as one's "gaze" (Merleau-Ponty, 1956, 1962). He believed that a person experienced the world through one's body, and that the body was one's natural access to the world, which he termed Embodiment. He believed that lived experience was reality. "Lived experience and the perceived world are terms that communicate the indivisible experiencing subject and experienced object" (Munhall & Oiler, 1986, p. 54). Ultimately, it was Merleau-Ponty's goal to demonstrate that a rigorous science of human beings was possible (Cohen, 1987).

It becomes apparent that there are some major fundamental philosophical differences between logical positivism and phenomenology. One of the more basic philosophical assumptions of phenomenology is that the human experience is not viewed as an object in nature but rather coexists with the world (Valle & King, 1978). Another assumption underlying the philosophy of phenomenology is that all data are accepted as they occur. These data are not changed or manipulated to fit into a preconceived theoretical framework (Omery, 1983). The goal of phenomenological research is to understand human experience from the individual's perspective (Knaack, 1984).

Nursing began to use phenomenology in the early 1980's to explore phenomena related to nursing. The phenomenological method explores the meaning and perceived structure of a human experience (Omery, 1983). Understanding a patient's perspective of an experience is central in providing appropriate nursing care (Leininger, 1985;

Paterson & Zderad, 1988). The application of phenomenology to nursing research and clinical practice fits well conceptually (Knaack, 1984). Since the 1980's, there has been an increase in the use of phenomenological approach in nursing research (Haase, 1987; Price, 1983; Ray, 1987; Riemen, 1986; Swanson, 1990; Swanson-Kaufman, 1986; Swanson-Kaufman & Schonwald, 1988). Benner and Wrubel (1989) used a Heideggerian phenomenological approach to examine the lived experience of human illness and the relationships among health, illness, and disease. Diekelmann, Allen, and Tanner (1989) also used the Heidegerian phenomenological approach to analyze the National League for Nursing's Criteria employed in the accreditation process of baccalaureate programs. Paterson and Zderad (1988) proposed a theory and practice of humanistic nursing which included a phenomenological description of the art/science of nursing. Phenomenological methods have been invaluable in discovering the meanings of clinical nursing situations and their relationship to nursing practice (Leininger, 1985).

The above historical overview of phenomenology reflects its origin and evolution. My intention was not to suggest that either philosophical perspective, logical positivism, or phenomenology is superior to the other but rather to highlight specific differences between the two perspectives. In summary, the goal of phenomenological research is to understand human experience from the individual perspective. This study of human experiences is possible because of the philosophy underlying phenomenological research (Knaack, 1984).

Phenomenology as a Research Method

In this section I will describe the basic characteristics of the phenomenological

research method. I will then identify several specific methodologies currently being implemented by phenomenologists.

Phenomenology is an approach and philosophy to human inquiry which attempts to study the complexity of human experience holistically as it is lived (Omery, 1983; Polit & Hungler, 1989). Research methods are steps, strategies or procedures utilized to gather and analyze data in a research study (Polit & Hungler, 1989) in the pursuit of knowledge (Polkinghorne, 1989). Research methods are based on fundamental philosophical assumptions, and consequently a research method depends upon philosophy (Colaizzi, 1978).

The goal of the phenomenological research method is to "describe the total systematic structure of lived experience, including the meanings that these experiences had for individuals who participated in them" (Omery, 1983, p. 50). In order to achieve this goal, the phenomenologist employs an inductive, descriptive method to investigate human experiences (Colaizzi, 1978). Focusing on an individual's experienced meaning rather than on descriptions of an individual's overt behavior distinguishes phenomenological research from other descriptive approaches to research (Polkinghorne, 1989).

The phenomenological method has five main characteristics. Ray (1987) identified these characteristics from writings of Leininger (1985), Parse, Coyne, and Smith (1985), and van Manen (1984). The characteristics are:

1. Focusing on the nature of the lived experience.
2. Holding in abeyance one's scientific presuppositions about a phenomenon.
3. Conducting intensive dialogues with people about the meaning of an experience.

4. Developing themes from recorded dialogues.

5. Reflecting deeply on the meaning of the whole of an experience.

(Ray, p. 169).

Design

The purpose of my descriptive study was to describe the experience of bereavement among older Black widows. Data were collected using in-depth interviews with eleven older Black widows. Data was analyzed using Colaizzi's (1978) seven step method (see pages 44-46 for a description of the steps). Field notes were taken to increase my awareness of pre-reflective attitudes and to gain further insight into the data.

Setting

This study was conducted in a middle-size city in the Pacific Northwest. The participants selected both the time and location for the interview. All interviews took place in the privacy of the participant's home.

After each interview, I drove several blocks from the participant's home and wrote brief descriptions of the interview setting, observations of the participant and my feelings and thoughts. These field notes became part of my research journal. Examples of three such entries in regards to the setting are provided below.

> . . . when I drove up, it's real cloudy day. On my way there, I noticed five or six signals were out and when I got to her neighborhood it looked like it was still dark and anyway, when I got to the neighborhood it was pretty dark. When I walked into the house, she was wearing a jogging suit and . . . turning on the heater . . . her power had been cut off briefly. She showed me a bunch of things. She took me downstairs to her basement to show me the awards Mr. ______ had been given by the community. . . She showed me around the rest of the house, too. I saw lots of pictures of she and her husband. When we had

the interview she sat, we both sat in rocking chairs, cloth chairs with a small little table between us.

I'm getting ready to go in the house and visit with Mrs.______ . She lives in ______. The inside of house looks similar to ______ house. She is wearing an outfit she wore bowling . . . she was sitting at the dining room table when I came in and she was doing her bookkeeping for her _____ . She greeted me at the door, turned off the TV and we sat down on the sofa in her living room.

. . . she sat in her rocking chair the whole time, rocking back and forth . . . her house was beautiful, very ornate with lots of colorful objects. Every shelf was covered with pictures or beautiful little items and things . . . (I got lost) by the time I got there she was expecting me and met me at the door . . . she sat in a chair that faced the entire living room and I sat just inside the door, a chair that really faced the sofa, so I had to sit sideways the entire time to talk with her.

Neither grammar nor syntax was a concern of mine when making these field notes. Some field notes were more inclusive than others. In general, however, the participants' homes had a "I like where I live" demeanor. Each home had many pictures of family prominently displayed on walls and furniture. All interviews were done either in the living room or at a dining room/kitchen table. Only three interviews were done with background noise, such as the radio or television.

After reading through my field notes and reflecting on the content, I realized midway through the investigation that I wrote observations which were laden with many of my personal values. For example, I wrote, "her house was well-kept, very clean, and neat." These are also my personal values. As soon as I realized what I was doing, I tried to put aside my values and write my observations more reflectively.

Study Participants

Criteria for participant selection required that the individual have personal experience with the particular phenomena under study as well as the ability to

communicate or share that experience with the investigator (Colaizzi, 1978; Omery, 1983). It is felt that Blacks may age physiologically sooner that Whites (Padgett, 1989; Taylor & Chatters, 1986). To be considered as a study participant the individual had to meet four criteria: (a) They had to be Black, (b) 55 years or older, (c) a widow, and (d) able to verbally describe and share her bereavement experience.

Participants were recruited through my personal contacts and acquaintances in the Black community. One of my assumptions, discussed in the following section, was that the church and religion were important and had meaning to older Blacks. Consequently, I contacted via telephone, local Black ministers, and actually interviewed with two. I obtained potential names of participants from the two ministers. In addition, three participants were obtained through the technique of "snowballing." I personally contacted all potential participants by telephone. After a brief description of the study, all participants agreed to be interviewed.

Thirteen participants were interviewed, ranging in age from 63 to 94 years. Only 11 interviews were transcribed and analyzed. When I arrived at one participant's home, she told me was not a widow. She had had multiple losses throughout her life and wanted to share those experiences with me. During another interview, malfunctioning of the tape recorder precluded me from transcribing and analyzing her interview. I was unable to return to the participant and obtain another interview because she had moved to another state to live with one of her children. Of the remaining 11 participants, the length of marriage ranged from 11 to 57 years.

All participants identified an affiliation with a church (Baptist, $\underline{n} = 6$; Catholic, $\underline{n} = 2$; Methodist, $\underline{n} = 2$; Pentecostal, $\underline{n} = 1$). Most participants described the church as

a place to obtain, not only spiritual nurturance, but also maintain important social contacts. I obtained rich descriptions from the participants regarding the significance of religion to older Blacks. Below is a brief excerpt from my journal which clearly demonstrates how my analysis of the data was an emerging and ongoing process.

> . . . Both [participants] have emphasized religion and faith and I find that very intriguing and I'm really wondering how important religion was for Black older people. And after I had finished my interview and taped it with my second interviewee, Mrs. ______ , I asked her, "It [church and religion] seem to be very important to older Black people." And she made the comment that I found very interesting. She goes, "Yes, I think to older Black people, it is more important. It means more to us than it does to some of the other White folks." She said, "I moved to ______, and I've been involved in all types of churches." She said that she felt that "the Black churches -- people who belonged to those churches---were more committed and that families and <u>everybody</u> participated in it."

All the participants had busy and active lives. Several belonged to various organizations, such as bridge clubs, sororities, and bowling leagues. A number of the participants continued volunteer involvement in community activities, such as tutoring grade school children or working in senior citizen centers. One participant had her own business and continued to work part-time. Traveling was an activity many participants enjoyed. I heard stories about their trips both when their husbands were alive, as well as after their husbands died. Many traveled overseas such as to China, Russia, and Kenya. Others traveled throughout the United States. Several participants described how their travel experiences changed over the years in conjunction with civil rights changes. Fishing, sewing, and crafts were other activities the participants enjoyed.

Family and friends were extremely important to each participant. Nine

participants had children. Several regularly babysat their grandchildren and offered advice to their children. All participants maintained regular contact with family and close friends.

The participants educational and vocational backgrounds varied. The educational level varied from master's preparation ($\underline{n}$ = 2) to less than sixth grade ($\underline{n}$ = 2). Their occupational backgrounds included teachers, a nurse, social worker, business owner, housewives, and factory workers.

I very much enjoyed interviewing and getting to know each participant. Perhaps the most intriguing observation I noted about the participants was the manner with which they willingly and colorfully described their life stories. I was told story after story about their husbands, families, marriages, travels, and other significant life experiences. The participants used dialogue to convey their stories and imitated the voices including accent changes of the person they were talking about. The participants did not merely provide factual accounts of their life experiences, but rather, incorporated complete conversations into their descriptions. For example, one participant's husband became seriously ill while at home one night. She knew her husband was sick and wanted him to go to the hospital. Below is an example from this participant's protocol of how she was finally able to get her husband to a hospital.

> (takes breath) he [husband] would not let me (hesitates) call (softer) or get at that phone (takes breath). I said, "Well, ______ , [husband's name], if you don't let me get at the telephone" (hesitates). I said, "I will have to call emergency an' just dial emergency by myself" (pause). An' he says, "Sa-rah! [not real name]," finely he said, "Well you just call him [the doctor] and tell him I'm not feeling good." . . . I said, "OK." I called Dr. ______ ," I said, "I think ______ is having another stroke" (louder). The doctor said, (slower), "I am sending an amilance after you (hesitates, takes breath) . . . [her husband said] "No! No! No!

> (louder) No! No! No! No ambuh-lance!" (normal tone) so Dr. ______ spoke to me . . . .

The above also provides a good example of how the participant's told their stories. This particular participant changed the way she said the word "ambulance." She said the word differently several times and I transcribed the word to reflect phonetically the way she said it. The transcribed interviews reflected as closely as possible the actual words used by the participants. The use of stories is discussed further in the analysis and results section, see page 46.

Data Collection Procedures

The purpose of data gathering in an investigation utilizing the phenomenological method is to collect rich descriptions of the lived experience being studied (Polkinghorne, 1989). In phenomenological research, the investigator must be dialogically conversant on an equal level with the participants (Colaizzi, 1978; Knaack, 1984; Polkinghorne, 1989; von Eckartsberg, 1971). This concept of co-researcher is a basic premise to this methodological approach based on the underlying epistemological assumption that knowledge is developed through an interactive and subjective transaction between the researcher and the phenomenon being studied because only then can the investigator understand the human experience being studied from the participant's perspective (Reinharz & Rowles, 1988). The two sources I used to collect data were self-reflection and verbal participant interviews. A research journal was maintained throughout the entire study. All field notes, personal assumptions and reflections, conversations with dissertation committee members, demographic data, and coding strategies were maintained in this journal in chronological order.

Data From the Researcher

Phenomenological reduction or bracketing is setting aside or suspending one's preconceptions and presuppositions (Knaack, 1984; Parse, Coyne, & Smith, 1985). According to Colaizzi (1978), bracketing is one of the preparatory tasks that the researcher must do prior to collecting data from the participants.

I began keeping a chronological list of my assumptions two years prior to beginning any interviews. I bracketed these assumptions in my research journal. My assumptions were grounded upon my personal and professional background. Personal assumptions were those which I identified as arising from my every day life experiences. Professional assumptions were those that I obtained from my studies and practice as a registered nurse. I recognized 10 assumptions which will be expounded.

First, many older Blacks belong to the lower socioeconomic group. Ever since grade school, I have been integrally involved with a Black community. I have tutored Black children at Black churches, coached a predominantly all Black girls high school basketball team, and had a young Black teenager live in my home for a year. Many Blacks I met through these activities were poor.

Another assumption is that older Blacks are very polite and thoughtful of others. I have met many older Blacks in the four different states I have lived. My personal experience was that they treated me with kindness and consideration. Likewise, in my professional encounter with older Blacks, I have observed them to be polite to their families and other professionals.

My next four assumptions are interrelated. Older Blacks are nurturing to their families, have large extended and fictive kinship networks, are generally religious, and

provide practical, useful advice to younger family members. Again, I have had personal experiences with older Blacks and observed all of the above. I have visited many Black churches, most of which were Baptist. Moreover, a significant portion of my minor coursework for my doctoral studies was Black studies. The readings from these studies also influenced these preconceptions.

A seventh assumption is that older Blacks underutilize health care facilities and health promotional activities. Prior to conducting the interviews for this study, I had read numerous books and articles regarding the health status of aged Blacks. See "Background to the Research Problem" page 2 for further elaboration. Another assumption is that Blacks are more emotionally demonstrative in expressing their feelings than Whites. I personally am very hesitant in sharing my emotions with friends let alone casual acquaintances. On the other hand, during this study I found myself taking an older Black lady to an emergency department in the middle of the night. A good friend of this lady, whom she considered as close as a daughter, had been severely beaten during a robbery. I watched this lady and her friends sharing their concerns regarding the particulars of the situation in the waiting room.

I had an assumption that Blacks experience grief differently than Whites. I had no specific preconception about what that difference might be, if indeed it existed. One reading in particular made a significant impression on me. Stanford (1990) proposed a conceptual framework with which to study Blacks. He suggested a framework that would highlight the many positive aspects of the Black experience as well as would emphasize the uniqueness of the older Black person's experience. I read his proposal many times about a year before I actually started to collect the interview data. After

thoughtful consideration of his framework, I then arrived at the assumption that Blacks experience grief differently than Whites.

My final assumption, also a methodological assumption similar to my ninth assumption, was that the world view of current research practices represents Western European ideology and may not necessarily be appropriate for all ethnic groups. After studying the concept of Afrocentricity (Asante, 1988), I realized that in order to study a particular group of people, serious considerations of the studied people's world view should perhaps influence the world view utilized in the research process. I reviewed my assumptions frequently throughout this study with the intention that I would not intentionally impose my preconceptions upon the findings of this study.

Data from the Participants

The purpose of phenomenological research is to describe the structure of a particular experience rather than the characteristics of a group (Polkinghorne, 1989). I selected participants who would be willing to verbally share in detail their bereavement experience following the death of their husbands. I tape recorded each interview and had them transcribed. The length of interviews varied between 1 to 3½ hours. In general, I used open-ended questions.

Recognizing that the way I posed my questions could influence a participant's descriptions of an experience (Taylor & Bogdan, 1984), I developed a brief list of questions which I felt would facilitate and encourage the participant to describe specific aspects of her experience. After approval from my dissertation committee, the following questions were asked of each participant:

- Describe the way you felt following the death of your husband, include

your thoughts and feelings as you remember experiencing them.

- What was it like for you after your husband died?
- What is it like for you now?
- Please continue until you feel you have shared as much as you would like.

I kept a written list of these questions and reviewed them in my car immediately prior to each interview and occasionally referred to this list during the interview. Each participant was told that she could end the interview any time. I asked questions throughout each interview in order to clarify what a participant was saying. Occasionally, I refocused a participant's conversation to the topic being studied.

As themes and concepts emerged, I modified my interview questions in order to obtain the most data I could about the participant's experience. For example, it became apparent after the second interview that a participant's faith was an important aspect of her bereavement experience. Consequently, I included the question, "How do you see religion helping you?" in subsequent interviews.

As I continued the interview process, I realized that stories told from the participants provided some of the richest and most descriptive data about their bereavement experience. I then added another open-ended question "Tell me a story about . . . (like when he died)?" to obtain additional data. Several clarification statements or probes were used throughout the study, such as "Tell me what you mean by ______", or "You used the word ' ______ '. Tell me what you mean by that." The interview guide was developed in order to probe the participant's experiences in their fullness.

Data Analysis

van Kaam (1959) conducted the first study that utilized the phenomenological approach as a defined methodology. He used five steps in his study "really being understood." Giorgio (1975) implemented a phenomenological study which consisted of six steps in their study of "what constitutes learning for ordinary people." Colaizzi (1978) described seven steps, see pages 44-46, in his study of "being impressed by reading something to the point of modifying one's existence." There is no definitive phenomenological method. Colaizzi contends that "each psychological phenomenon, in conjunction with the particular aims and objectives of a particular researcher, evokes a particular descriptive method" (p. 53).

Nevertheless, the three studies cited above utilized three similar steps (Polkinghorne, 1989). In the first step, the original protocols transcribed texts were divided into units. Next, the researcher transformed the units into meanings expressed in phenomenological concepts. The researcher then linked together these transformations and composed a general description of the investigated experience. Each of the above studies attempted to produce clear and accurate descriptions of a particular human experience utilizing a phenomenological research method based on phenomenological philosophy.

The method of data analysis varies among phenomenological researchers (Colaizzi, 1978; Knaack, 1984). The purpose of data analysis is to "derive from the collection of protocols, with their naive descriptions to specific examples of the experience under consideration, a description of the essential features of that experience" (Polkinghorne, 1989, p. 50).

I analyzed my data using Colaizzi's (1978) seven step method. A number of nurse researchers have used his method of analysis (Haase, 1987; Knaack, 1984; Price, 1993; Riemen, 1986). The procedural steps will be explained in detail in the next chapter. Because I generated massive quantities of data from my interviews, I used the computer program, "The Ethnograph" Data Analysis Program, version 3.0 (Seidel, Kjolseth, & Seymour, 1988), as a convenient way to store and sort my data. This program does not substitute for the rigor or analytic imagination of the researcher (Swanson-Kaufman, 1986).

Validity

The concept of validity determines whether or not the findings of a research study can be trusted and consequently used as the basis for actions or even policy decisions. The validity of a study is never definitely established, but rather it is the investigator who must present evidence to support the validity of the study (Messick, 1980). It is as important for the phenomenological researcher to address the issue of trustworthiness as it is for the quantitative researcher (Patton, 1990). However, there is some confusion in the literature about how to apply the notion of validity to phenomenological research (Knaack, 1984; Polkinghorne, 1989; Ray, 1985, 1987; Wertz, 1984).

It becomes imperative for the phenomenological researcher to persuade readers that the inferences made from their findings were supported by soundtransformation of the raw data into informed expressions. Also, there must be accuracy in the synthesis of the transformed meaning units into a general or essential structure of description (Polkinghorne, 1989). Ultimately, the reader must be able to follow the thinking

(Polkinghorne, 1989). Ultimately, the reader must be able to follow the thinking processes that led to the conclusions and to accept them as valid.

Colaizzi (1978) stated that face and content validity can be achieved and accepted based on the assumption that the participants have indeed experienced the phenomena studied and can communicate those lived experiences. Polkinghorne (1989) stated that "the validity of phenomenological research concerns the question, 'Does the general structural description provide an accurate portrait of the common features and structural connections that are manifest in the examples collected?'" (p. 57).

Polkinghorne (1989, p. 57) described five doubts which need to be addressed and included when attending to the validity of phenomenological research. It is the following five questions which were used to establish the validity for my study:

1. Did the interviewer influence the contents of the subject's descriptions in such a way that the descriptions do not truly reflect the subject's actual experience?

2. Is the transcription accurate, and does it convey the meaning of the oral presentation in the interview?

3. In the analysis of the transcriptions, were there conclusions other than those offered by the researcher that could have been derived? Has the researcher identified these alternatives and demonstrated why they are less probable than the ones decided on?

4. Is it possible to go from the general structural description to the transcriptions and to account for the specific contents and connections in the original examples of the experience?

5. Is the structural description situation-specific, or does it hold in general for

the experience in other situations?

I addressed these five questions of validity. First, I bracketed my preconceptions prior to beginning any interview in order to minimize my biases from influencing an accurate interpretation of the findings. I used open-ended questions during the interview and frequently used clarifying statements to understand a comment from a participant. I continued to modify my interview questions in order to obtain specific aspects of the participant's experience.

Prior to data analysis, the participant's descriptive responses were collected. I audiotaped the participant's description of their bereavement experience following the death of her husband. Each description was transcribed verbatim. I listened to each tape two or three times to verify accurate transcription. Each interview was transcribed into the computer program Ethnograph (Version 3.0) in order to facilitate ease of analysis. I listened to the taped interviews while simultaneously reading each transcribed protocol.

I addressed the final three questions posed by Polkinghorne in several ways. My dissertation committee consisted of two nurses and an anthropologist. One nurse was an expert in grief and the other nurse had personal experience in conducting phenomenological research. I met regularly with my committee through the analysis phase. As I extracted meanings and clustered themes, I had direct feedback from my committee. I used drawings and lists to demonstrate my thinking process during the analysis phase so that another researcher could understand my rationale for the decisions I made. And finally, I returned to the participants and read my final structural description of the experience. New information was incorporated into a

Protection of Human Subjects

Protection of human rights was satisfied in several ways. This study received approval from the Oregon Health Sciences University's Committee on Human Research (Appendix). Written consent was not required from the Committee on Human Research, rather verbal consent from the participants was suggested. Each participant gave verbal consent to participate in this study. Confidentiality was assured each participant and she was also told she could withdraw from the study at any time.

There were no known risks involved. Mental distress may have occurred because of the nature of the topic, spousal bereavement. I told each participant that I was a registered nurse. Had a participant become emotionally distraught during an interview, I would have stayed with that participant until I felt comfortable leaving. Then, I would have debriefed with my dissertation chairperson, a mental health nurse with expertise in grief, within 36 hours of the interview to determine the need for follow-up with the participant. Several participants became tearful at moments during the interview, however, none became so emotionally distressed that the above plan had to be initiated.

The taped interviews, verbatim transcriptions and research journal did not contain the participants' names. Instead, each participant was identified by a code number. The data was kept in a secure locked environment during the investigation. The tapes were destroyed upon completion of the study.

CHAPTER 4

ANALYSIS AND RESULTS

This chapter is organized into three major sections. First, I will list and describe the seven steps of data analysis according to Colaizzi's (1978) methodology. Next, I will discuss storytelling as a major theme which emerged from the data. And finally, I will discuss the grief experience of the older Black widow.

Colaizzi's Seven Steps of Analysis

Colaizzi (1978) described seven procedural steps used to analyze data phenomenologically. He emphasized that his method of data analysis is neither the absolute nor definitive way to analyze data phenomenologically. He asserted that the seven steps were developed with considerable overlapping between the steps and that the following sequential procedural steps should be viewed flexibly and freely by each researcher. Colaizzi also recommended that the steps should be modified by the researcher as needed. The seven procedural steps of analysis I used will now be listed and explicated.

Step 1: Review of Protocols

Reading each participant's description was the first step of analysis. Each transcribed description is called a protocol, according to Colaizzi (1978). The purpose for reading each protocol was to obtain a "feeling" for them or a "making sense out of them."

Step 2: Extracting Significant Statements

Next, sentences or significant phrases or statements that directly pertained to

the phenomenon under investigation were extracted from each protocol. At this step of analysis, Colaizzi (1978) recommended that repetitious phrases or statements could be eliminated and instead have the resulting list of significant statements reflect the broadest scope of the phenomenon as it was described by all participants.

Step 3: Formulating Meanings

Formulating meanings for each significant statement was the third step. These meanings were formulated based on thoughtful insight by the researcher. The researcher moved beyond the specific protocol statements and assigned meaning to those statements. The researcher needed to be careful not to sever connection with the original statements but rather to assign and bring out meanings hidden in the context of the phenomenon (Riemen, 1986) that were present in the original protocols.

Step 4: Cluster of Themes

The aggregate of formulated meanings were then organized into clusters of themes. This step was done in order to allow for an emergence of themes evolving from the participant's protocols. The clusters were validated by referring back to the original descriptions to ascertain whether any data had been inadvertently omitted or erroneously included. Contradictory themes were not discarded. Colaizzi (1978) contended that contradictory themes, should there be any, may be a real and valid experience.

Step 5: Exhaustive Description

A narrative integration of the significant statements, formulated meanings, and clustered themes resulted in an exhaustive description of the phenomenon. This procedural step provided insights into the structure of the participant's lived

experience.

Step 6: Statement of Essential Structure

The final analytical step resulted in the finding of research which was called the essential structure. The essential structure was formulated from the exhaustive description. The essential structure was the basic or fundamental structure of the participant's description of their grief experience. This essential structural definition needed to be stated as clear and unambiguous as possible.

Step 7: Final Validation

The last step of analysis was validation. The researcher re-contacted the participants and asked if the final analysis accurately described her grief experience. New relevant data was worked into the final product or final statement of essential structure.

Eleven participants' protocols were analyzed according to Colaizzi's (1978) methodology. From the analysis of the data, seven themes emerged. Six of these themes are subsumed under the grief experience. One theme, storytelling, emerged as distinct from the grief experience in that it provided the vehicle by which the participants shared their life experiences. The themes are described below. The names, factual places, and dates were changed in all of the following examples in order to protect the privacy of the participants.

Storytelling

Storytelling was one of the major themes identified in this phenomenological study of bereavement among older Black widows. Storytelling was at the heart of every participant's description of their bereavement experience.

Storytelling emerged as a theme after the second interview. Every participant related stories to me. These stories were rich with details of the participant's life history. Storytelling involved more than merely relating a particular incident to me in a chronological and narrative fashion. Rather, through storytelling the participant took on the various roles and languages of the persons who were part of the story. For example, via storytelling, participants changed voices and accents to imitate the voices of the people involved in the event. Not only did the participants' voices change, but their demeanor changed by becoming actively involved in the storytelling. Participants used their hands, body language, and facial expressions to share stories.

Storytelling occurred throughout the entire interview. Different experiences of grief were related via stories. Participants recalled pleasant memories of their husbands via stories. For example, one widow had gone shopping one afternoon and when she returned she found her husband dead on the floor. He had had a heart attack while she was gone. His death was sudden and a surprise to everyone. This particular widow found it difficult to tell people of her husband's death. His death was so sudden and unexpected that many of his friends called or dropped by the house to see him because they were unaware of his recent death. Below is an example of a brief excerpt from this participant's actual protocol in which she is telling one of her husband's friends that her husband had just died. This friend found it hard to accept that the husband had died because this particular friend had just seen her husband the day before.

> . . . then he went on to tell this he said, "When I asked them [friends of the widow] is Mr. Smith there? An' they says gone, it didn't occur to me (laughs) that he was gone forever, that he had died that way. I just thought he was out of the house." Another convincing thing I had to do was [tell] some close friends that he had, uh (hesitates and clicks

> tongue) at a shop he [husband] used to go to all the time [to meet] fellows his age an' so on. He [husband] had this open bed truck an' we had a little dog who was a (hesitates), an' he used to take Sally [the dog's name] with him all-l the time. An' so then we [widow and her family] called to tell him [husband had died] . . . he didn't believe it. He called back, (hesitates), an' I answered, he said, "I, they, just told me some . . .", he said, "I'm callin' you to see if it's true?" I says, "What is it, Tom?" He says, (higher voice and clicks tongue), "Did John Smith die?" (pause) I said, "Yes, Tom, he did, and they've taken him away." (shouts) "NO!, I, I'm talkin' my (hesitates) John Smith!" (laughs) I said, "Well, Tom, I ought to know (half cough, half laugh, hesitates) he's gone, he really is." He said, "Well, he was just here." I said, "I know." An' I had to tell him [what happened] . . . so it was re-telling that was kind of har-d (hesitates). They [friends] wouldn't believe what you tol' them. They thought I was just kidding. An' there's some others you try to tell them, well, "You mean that man with the little black dog? The little black dog with the truck?"

The above example reflects several dialogues and conversations she recalls while describing this event.

Stories were told regarding the husband's death event. Below is another example of how a participant used dialogue to describe her husband's death. Her husband had been ill years earlier with prostate cancer and recently had become seriously ill again. Her husband had requested he die at home and that no heroic measure be done to extend his life. His wife supported his decision. The protocol below is the widow's description of her husband's moment of death.

> . . . well, a he, um, Tuesday, see I worked in a dress shop, an' I noticed he wasn't feelin' too well but he would get up every morning an' sit on that chair an' get his coffee an' breakfast, an' that morning he did. An', he, um, he doesn't look good, but I went on to work an' the nurse came in just before I left an' I said, I said, "I called my niece to come over, an' she'll be here in just a few minutes an' stay with him 'til I get back." The nurse said, "I'm not in a hurry, I'll stay 'til she gets here." So, when I got to work, the nurse called me an' say he had a seizure, which he hadn't had nothin' like that before. An', an' I rush here. By the time I got here, it [the seizure] was over with, you know. An' then the head nurse came out and checked him and said, "I don't know, his heart's

> beating good an' everything, so not sure why [he had the seizure]. So, she called the doctor an' asked if he would like for her to put him in the hospital an' he said, "No. Let him die in peace." An' then she hollered an' "really!" Then it was very comical, they [friends and hospice team] would come in groups. They'd look at TV, an' say, "you want to go to the hospital?" He say, "No, I don't an' if my heart stops, I don't want you startin' it." An' the nurse said, "Oh, everything seems like, well, can I order you a hospital bed?" An' I said, "Oh, yes! You can order me a bed." Which they did an' they delivered it that evening, an' we put it right across that window over there. An' then, um, then we put him in the bed. The doctor came out an' gave special medicine at night so, an' then that put him in kind of sleep most of the time . . .. He [the doctor] said he would last about three more days. Now as to the question, I say, "I notice lately when his he sleeps his eyes are not completely closed." He had large eyes, I thought that maybe was the reason. The nurse said, "No, he's dyin'." Just like that. But, when he did pass, I was glad I was in this chair. I jumped up to go to the bathroom an' I run back by an' check him an' when I looked at him his eyes was completely closed. His mouth was open a bit, an' I felt his hand--it was coolin' off. I says, "Oh, he's gone." His daughter was here with me an' I didn't know she was out on the porch gettin' a cigarette. An' she heard me, she said, "Mamah, who you say? What you say?" An' then naturally, she carried on, she was tryin' to bring him back an' I say, "He's gone, honey." So, then I had to call the other nurse in the hospice program . . .

Again, the overarching theme of storytelling occurred throughout each participant's description of their bereavement experience. The stories were not limited to any particular topic nor aspect of their bereavement experience. In the next section, grief experience, there are six themes identified. Storytelling, as an overarching theme, permeated all six grief experience themes in that the participants shared their grief experience with me via stories and their chronological narration of events.

Grief Experience

Six themes emerged from the participant's description of their grief experience after the death of their husbands. The six themes were: awareness of death, caregiving, getting through, moving on, changing feelings, and financial security. I will discuss

each theme and provide its exhaustive description. For each major theme, an original protocol is presented. For themes that have subthemes, one subtheme was selected as an example to illustrate significant statements and formulated meanings which will be placed in tables. Finally, the essential structure of the phenomenon and final validation will be discussed.

Awareness of Death

Awareness of death was the participant's realization of her husband's impending death. This occurred when widows actually knew and could verbalize that their husbands were going to die very soon. This awareness of death occurred at home or in the hospital or convalescent home. The participants described this awareness in different words. Below is an example of an original protocol depicting the awareness of death theme. This widow's husband had died two months prior to my interview. He had been seriously ill for years and had only recently been hospitalized for an exacerbation. This widow had only six months earlier provided terminal care for a parent. She recognized that her husband was dying and wanted him to die at their home.

> . . . No, I knew any any day he would [die]. Any, any minute 'cause they had [told] me, the nurses (hesitates) Uh, he was on this, what is it--hospice? An', us, they had prepared me that (hesitates) any day, any time he could go . . . you know if you don't drink and don't eat--you gotta go. I don't care who you are--you gotta go . . . I, I knew he was gonna pass. I said, "I wanta take him home (hesitates softer) and let him pass at his own house 'cause he built the house." And I say, "I want to take him home [from the hospital] no matter what, what condition he in." I say, "I'm gonna take him home." So, I brought him home and I called workman's compensation an' (hesitates), uh, (hesitates), they told me, "we'll send you out some help." An' they did. They sent somebody out and they gave me all kind of supplies . . . but I know he wasn't gonna make it, but I did want him to go at home. I didn't want him to

be out there in one of them old rest homes.

Table 4-1 provides representative examples of significant statements reflecting this. Table 4-2 provides the formulated meanings for the significant statements found in Table 4-1.

Numerous participants said the words "knew he was goin'." I then transformed their phrase into awareness of death. I validated this transformation by returning to the original protocols and made sure that my assigned meaning was true to the participant's original descriptions. This transformation was also corroborated by the dissertation committee.

Many participants had taken care of other close family members who died. These participants were able to use their past experience with their husband's death and were able to recognize that their husbands were dying. Physicians and nurses gently informed some participants that their husbands were dying. These same healthcare workers also taught the participants how to ascertain whether their husband was dying at that moment. For example, one participant tried to clean out her husband's mouth because she heard him gurgling. The nurse informed the participant that the noise was death rattles and that her husband was dying. The participant then said, "it was then that I knew he was goin'." This participant then stayed at her husband's bedside and refused to leave the house. She also began notifying family members and told them to come to the house as soon as possible. Having the husband die at home and having family members present at the husband's deathbed will be elaborated further in the theme expectations.

Table 1 Representative Significant Statements of Awareness of Death

"I knew that it didn't look go-od."

"That was when I realized that, he, uh, probably would [not last the day]."

"I couldn't go bowlin' (hesitates), he was too sick! I said, '(very soft) uhn-nhn' (softer) I said, 'I can't go . . . with him in the condition he's in.'"

"You know that's gonna happen [death], but you really don't know when."

"Oh, (faster and stronger), oh, I knew he was going to go."

"Yes. (softly) But I knew that he was goin'. I kept tellin' my children."

"I was kind of prepared for him goin'. I knew, you know, months ahead. He couldn't hold it. Same way with my Mom; I knew she was goin', too."

"I knew any, any day, any minute [that he would go]"

"I knew he warn't gonna make it."

"'bout ten o'clock on this particular night. I went [in] there. I just (slower) kn-ew, I just knew (takes breath), I could just tell , . . he was dy-in'."

"I guess on the day that he (pause), well, I knew that it was just a matter of time."

"We got there early Monday morning, but we knew Tuesday things were bad."

"The doctor had told me, you know [that he was dying]."

"I knew he was pretty sick, you know, but he [husband] still tried to make it."

Table 2 Awareness of Death Formulated Meanings

After close observation of their husbands, the participants became cognitively aware that their husbands were going to die shortly and they were able to verbalize this awareness to others.

The participants became aware of their husband's impending death through past personal experiences with death of other close family members, health care workers providing information of direct personal observation of husband's physical condition.

The participants changed their daily activities when they became aware of their husband's impending death in order to be at their husband's bedside.

Caregiving

Two participants did no caregiving prior to their husband's death and thus did not provide any data for this theme of the grief experience. One participant's husband died suddenly of a massive myocardial infarction while the participant was shopping. Another participant's husband was living with another woman at the time of his brief illness and death. The remaining participants provided care to their husbands prior to their death. The care provided was both formal and informal. Formal care was provided when the wives solicited professional services from others such as hospice care, nursing home care, or hospital care. Informal care included such things as bathing, feeding, or turning their spouse. For either type of caregiving, the widows were present whenever possible. Below is an example of an original protocol depicting caregiving.

> . . . they [physicians] were going to send him to a hospice house, and uh, (hesitates), they asked him, (hesitates), they called and asked me what I thought about it and I said, "No, I sure he wants to come home." I said, "Let him come! . . . an' so, uh, (faster) he came home. They brought him in a wheel chair (hesitates) by car (hesitates) and he had a big (hesitates) easy chair where he sat all the time (points)--right over there (small laugh, smacks tongue) and he got in that chair and says, (with sigh in her voice) "O-o-o-h, there's not place like home!" . . . the doctor told me, "He has about six months to live." And I says, "O-o-o-h?" I didn't tell hi-i-, [husband], he [physician] told me, "I don't think he [husband] knew that at all . . . the hospeece nurse, she came in and talked to me and told me what was going on and what to expect . . . I got him in bed and the next day I tried to give him breakfast, he didn't want anything to eat . . . by that time the nurse had been here and left the medications that he was to ha-ve (breath, faster and stronger) and we [nurse with participant] went through the whole process of the things I should do . . . the next da-ay, uh, (hesitates on Wednesday (pause) three of the fellows from church called and wanted to come and visit him [and they came] . . . but the next morning, he was-s-s, he didn't re-spond, (hesitates) not too well, an', uh, I began to us (pause) (louder)

> do the things I had to do. I would (hesitates) give a ba-ath, an' uh give him his medication . . . I would turn him quite, quite frequently . . .

Four subthemes emerged from the theme of caregiving. The subthemes were: task-oriented, problem-solver, decision-maker, and learner.

Task-oriented

Task-oriented care included direct hands-on physical care for her husband. This care was preferred to be done by the wife or family and if needed by a professional. For example, personal hygiene care such as brushing teeth, bathing, toileting and grooming, was done regularly. Other tasks included driving the husband to and from physician appointments or the hospital or giving insulin to a diabetic husband. Professionals provided task-oriented care such as changing dressings, doing a physical assessment, or drawing blood for lab work.

Problem-solver

Often the participants encountered a difficult or perplexing situation while providing care to their husbands that required an immediate solution or answer. I called this subtheme problem-solver because the participants described specific situations in which they either directly or indirectly resolved a specific problem. For example, one husband refused to have a hospital bed at home. However, the wife was concerned that with his restlessness he might fall out of bed. She placed four large dining room chairs next to one side of his bed after first pushing the bed against a wall. This same participant also had difficulty getting her husband from his chair in the living room to his bed at night. She herself was not well or too strong. She resolved that problem by having her husband sit on the portable commode chair and

rolled the chair from the living room to the bedroom. Another participant felt uncomfortable providing her husband injections. So, she had some of her daughter's friends, who were nurses, come by the house to give the injections to the husband.

Decision-maker

Another aspect of caregiving entailed making decisions. I called this subtheme decision-maker. For instance, one wife decided whether or not her husband would have a surgical procedure, be admitted to a nursing home, or take medicine. The decision-maker theme also included deciding when to call the physician or nurse for advice, when to call an ambulance, or who to involve in the formal caregiving tasks.

I incorporated a term gatekeeper with the subtheme decision-maker. One vital role of being a decision-maker for their dying husbands was making decisions for the husbands and protecting them from others. Several participants spoke directly with the physicians and nurses regarding the care and medical treatment for her husband but chose not to share that information with him. Some wives kept information from their husbands. Other participants were gatekeepers regarding the care of their husbands in that they monitored who could come to the house and visit her husband.

Learner

The fourth feature of the caregiving theme was called learner. Many participants found themselves learning new things. Participants were frequently learning about their husband's diagnoses and treatments. One participant was taught how to replace a nasogastric feeding tube in the event her husband's feeding tube became dislodged. Three other participants were taught how to give subcutaneous injections to their husbands. Still others were taught what to look for specifically when

the moment of death occurred. They were taught to recognize signs of irregular breathing, cyanosis, mottling, and death rattles which indicated the husband's death was imminent.

There were 84 non-repeating significant statements regarding caregiving and consequently I chose to provide only examples of these statements. Table 4-3 is a representative sample of significant statements of task-oriented caregiving. Table 4-4 provides the formulated meanings of caregiving for the subtheme task-oriented.

Getting Through

The third theme of the grief experience was called getting through. Many widows had vivid recall of how they felt when they knew their husband had only a few hours to live. Below is an example of an original protocol depicting this theme.

> . . . in the mean time, we can, I, we began (hesitates) getting in touch with the family, you know. The doctor had told me that, he said, "You'd better call you family." An, uh, so, I did. They began to come in one by one . . . he [husband] had got to the place where he was not (hesitates) responding at all . . . The nurse told me, she said, "Just keep talking to him, just talk to him, just like (hesitates) he's hearin' you and answerin' you." . . . [we'd] talk about different things and we'd say, uh, "Irene'll be here that afternoon and Johnnie'll be here," you know, tellin' him the name of the grandchildren. [we'd tell him] you hang on there now, one of 'em had come [to the bedside] . . . of course we were standing there at the bed and he [husband] just kinda quieted down, I said, "Oh my God, he's go-one!" just that quick . . .

These participants described this particular time as extremely difficult for them. I labeled this theme getting through because the participants were able to identify and specifically describe the last few hours they spent with their husbands at his bedside. The participants were able to point out specific things that helped them "get through" their husband's dying process.

Table 3 Representative Significant Statements of Caregiving: Task-oriented

"Of course, I would drive [to the doctor's appointments]."

"I would have to regulate each thing that would be going on [medication]."

"I got him to bed."

"I made him comfortable [in bed]."

"An' I'd feed him 'cause he was paralyzed on his whole side . . . "

"I would give a bath, an' give him his medication . . . I would put [the medication] in his cheek, that's the way we were getting his medicine down."

"I would turn him frequently."

"I would help, you know, clean him up, I'd help the nurse [at the rest home]."

". . . and I thought, he needs to have his mouth cleaned out, and I'm in there tryin' to clean his mouth up . . . "

"I did everything . . . I had to do everything for him."

"I took him to the doctor."

". . . then, the next thing, uh, I went in, my sister and I decided, well, 'Let's go and turn him, he's been on that side too long."

". . . and then, when, when I could see he wern't feelin' quite as up, I'd say, "I'll drive, it's OK.' So, he'd, would laugh and call me his chauffeur."

"Yeah, I was real bizzy with my husband . . . we set him up in bed and put a sheet around him to cut his hair."

Table 4 Caregiving Formulated Meanings: Task-oriented

The wives provided direct and indirect physical care to their husband's prior to his death.

Caregiving involved "doing for" their husbands.

Task-oriented care meant the wives were the doers, or they arranged to have another person provide the physical care.

Task-oriented care meant meeting the physiological needs of the dying husband as perceived by the wives.

Task-oriented care included touching the husband (such as bathing), manipulating environmental props (such as beds and medications), or transporting the client (such as from house to hospital or room to room).

Support from others was one of the most helpful ways the participant could "get through" her husband's death. Having family in the room with her provided physical and emotional support to the participant. Also, formal support was helpful. For example, nurses and social workers, either by being present at the bedside or available by telephone, provided emotional reassurance during those moments. Friends provided support by being physically present, telephoning warm thoughts and wishes, or bringing food.

Several participants found keeping busy was beneficial. Recalling and retelling positive memories to others present at the bedside to willing listeners also facilitated the widow getting through those difficult moments. The church provided support through their prayers. The participants said that realizing that others were praying for both she and her husband helped her get through the actual dying process. Four participants clearly stated that knowing everything possible had been done to help her husband both during his illness and the actual dying process provided overwhelming reassurance and comfort to her.

Participants had expectations that certain behaviors or actions of others would occur. The participant's belief that these behaviors would transpire facilitated their ability to get through the difficult time of their husband's dying process. For example, the participants expected that all family members would come home, no matter how far away they lived, before their husband's death, in order to pay last respects. Also, it was anticipated that all family members congregate at the widow's house immediately following the husband's death. Another presumption was that the husband would die at home, if at all possible, with his wife and family at his bedside.

Church members and the minister also were expected to participate actively in the participant's grief experience. Church members were expected to provide food and emotional support after the funeral. Moreover, the minister was to assist with the funeral service as well as visit the family in their home before and after the funeral service.

The participants were expected to provide both formal and informal care to their dying husband. The family was to assist the widows with phone calls immediately after their husband's death to notify all relatives. Again, these expectations were not options but rather proceedings that the participants knew and expected to occur. Table 4-5 provides representative significant statements of getting through and Table 4-6 provides the formulated meanings.

Moving-On

The fourth theme, moving-on, was multifaceted. There were five subthemes identified. After the participant's husband died, the widow described intentional activities or behaviors she did in order to continue living day-by-day. I called this theme moving-on because of the descriptions provided by the widow reflect her moving forward with her life or "putting the next foot forward." All the participants said it was difficult to go on living without their husbands. Below is an example of an original protocol reflecting this theme.

> . . . an' you kind outgrow them [one's parents] and grow into a relationship with a husband that that is if a person gets along with him. You know, he and I had a very, very good relationship . . . that we talked about everything an' anything, an' anybody--whatever, because (takes breath) having been in the church, you know, he'd come home after he'd had a hard day, 'cause he was always pasturing . . . if he had a hard day down at the church office we'd talk about that . . . We shared

Table 5 Representative Significant Statements of Getting Through

"fellows from the church called and wanted to come and visit him."

"we, we talked and we reminisced [about how her husband got many men jobs], and we were reminiscing quite well"

"an' they talked about how long he'd [husband] been singing in the choir."

"[the nurse was providing verbal reassurance at the bedside] the nurse said, 'Food won't do him any good now.' The nurses would come and si-it and talk. We would just go over things."

"I wanted to go into the kitchen and wa-sh dii-shes."

"the nurse told me, she said, 'Just keep talking to him, just talk to him, just like he's hearin' you."

"[my sister and I would] work with him [husband], changin' beds an things like that and he didn't need a lot of changin'. And we would talk to him, talk, talk, talk . . . talkin' 'bout diff'rent things"

"and everybody [family members] was at the house."

"we'd tell [husband] who had been here and who was coming [family members]"

"and so I called the number they [hospice nurses] had given me"

"The minister was there[at the bedside] for all this [dying process]."

"I been BIZ-zy"

"I had all kind of support [friends and nurses], people went beyond the call of duty, they bring us food an' all kinds of things"

Table 5 (continued)

"We stayed [at his bedside], right there with him until he, he breathed his last."

"I'm gonna take him home and let him pass [die] at his home."

"So, there again, that kind of support [family came over] without my going out and asking was a great, great help."

"they [nurses] seemed to have tried to do the best they could to make him comfortable."

Table 6 Getting Through Formulated Meanings

The actual dying process of the participant's husbands was identified and singled out as an especially difficult moment for the participants.

Support, via family, friends, professionals, and the church provided emotional support to enable the participants to get through the difficult moment of when their husbands were actually dying.

The participants were able to draw from personal resources to get them through their husband's dying process, since realizing that they did all they could to help their husband or recalling pleasant memories of their husband and saying them out loud to others at their husband's bedside or even just keeping busy.

Before the participants' husbands died, family members came to gather at his bedside. The family members came to be with the dying man and often traveled great distances to be there.

Family members were notified by telephone of the participants' husband's death and attended the funeral even if the family member traveled great distances.

The church provided emotional support to the participants' family both during the husband's illness and following the funeral service.

The minister participated actively in the funeral service and in providing emotional support to the grieving participant and her family.

The participants were at their husband's deathbed if at all possible.

> a lot of things together. We enjoyed each other's company . . . he and I and things we did together, the joys we had on the trips we made . . . I think about the happy times we had when we were getting ready to go on a trip . . . everybody like Rev. ______, the whole community respected him . . .

I distinguished five aspects of their grief experience in this theme which enabled them to go on living: positive memories or recall, personal or self-growth, strength-seeking, using support, and life-oriented.

<u>Positive Memories</u>

Positive memories or positive recall of pleasant times with their husbands was shared via storytelling. Each participant shared several stories with me about their husbands. One participant described three different vacation trips she had taken with her husband. The stories were full of dialogue and colorful descriptions of the places they had visited. She described in detail the costs of the motels and foods they ate at the restaurants. Another participant described her husband as "Mr. Fixit." She said he could fix anything. She told me about his elaborate workbench in the garage and that he would spend hours out there working on projects. She said she always had another project for him to do. The participants shared these stories with humor and often found themselves laughing at things they had done with their husband. Also, participants occasionally became tearful as they recalled more pleasant times in their past.

Each participant wanted to share positive aspects of their husbands with me. Such comments as "He was such a good man," "Everybody liked David" or "He had a way with the children" was inevitably followed by a story about their marriage.

Personal or Self-growth

Personal or self-growth occurred as the widows began to reformulate their identity. Many widows said that in order to go on with life they had to grow from a personal inward perspective. The widows came to the realization that unless they gained insight into themselves it would be more difficult to cope with daily living. Such comments as "I learned you can't give up," "It's [loss of husband] something you have to learn to live with" or "I knew it was something I had to handle" demonstrated personal insight into the realization of the impact their husband's deaths had on their daily lives.

Participants also had to learn to do new things and assume new roles after their husband's death. One participant had always balanced the checkbook but never paid the bills. She found it difficult at first to figure out which bills had to be paid at specific times. Another participant had to learn to take the garbage out, "he [husband] had done that for over 52 years, I'd never taken the garbage out." Another participant had been married to a minister. She found it difficult to identify herself only as "Mrs. ______" and not "Rev. and Mrs. ______." She found it difficult to lose her role as a minister's wife.

Participants learned new skills not because they had to, such as paying bills, but because they chose to try new things. One participant joined a bridge club in order to learn how to play duplicate bridge. She had always wanted to learn how to play bridge but her husband had not been interested. Learning to play bridge also provided her the opportunity to travel with her bridge club.

Strength-seeking

Seeking-strength from the church, friends, family, professionals, and God was a common means of helping the widow to move-on with her daily living. Praying to God for inner strength was described by the widows as "believing in a higher source of strength" to help them deal with the pain of losing their husbands. Church members and the minister provided strength to the women. One widow said, "I told my friends [church members] 'just remember me in your prayers.' I just kept praying for strength."

The participants also sought strength from family members and professional healthcare workers. The widows said they received strength by being remembered by others such as flowers, telephone calls, food, visits, and going out to dinner, and actively solicited these encounters. This subtheme, seeking-strength, is different from using support even though there are some similarities. Seeking-strength was an intentional act by the participant to receive emotional and spiritual strength from others whereas using support was not an intentional act.

Using Support

On the other hand, the subtheme, using support, was when the widow did not actively solicit support but rather unsolicitously received support from others. For example, family members would come to the house and offer to clean the house or do yard work. Several family members offered advice to the widow in the area of finances. The participants willingly and gratefully utilized the support offered by others to help her go on living.

Using support as described in this subtheme of moving-on is different than using support in the theme getting through. The widows described using support in the

getting through theme as a means to get through the final moments of their husband's deaths. This support was provided in a specific time-frame. However, using support in the moving-on theme is of an indefinite nature in that family friends continually provided encouragement and assistance to the widows on an ongoing basis.

Life-oriented

Life-oriented was the fifth subtheme identified in moving-on. All the participants expressed a desire and need to live life to the fullest inspite of the deep pain they felt for their husbands. The participants oriented much of their daily activities and behaviors toward living life positively. I called this subtheme life-oriented. The widows regularly participated in a variety of activities including bowling leagues, craft fairs, Bible classes, bridge clubs, traveling, reading books, crocheting, and fishing. Comments such as, "I keep active and I go to the Y[MCA] to exercise three times a week" or "I like to fish" were typical.

Participants also did many activities with family members. One important activity participants did with family members was to share stories about their husbands. Also, many participants babysat for their children.

Humor and laughter was linked with the life-oriented subtheme. Recalling past funny events about their husbands frequently caused participants to laugh overtly. One widow stated she had not talked about death with her husband and had not seriously thought about her husband dying before her own death. She was laughing when she said, "I thought we'd go down [die] on a plane together; we didn't talk about dying. We were too busy living!"

Doing for others or having compassion for others is another part of life-

oriented. One participant volunteered at a school to teach reading to young children. Another participant bought groceries for a neighbor who could not drive.

Maintaining a daily routine assisted a widow through her grief experience. One participant said, "I get up at seven every morning, I brush my teeth, I shower, I eat breakfast, and then I get dressed. Then, I'm ready to face the day." Another participant owned her own business. She had worked as much as possible during her husband's illness and after his death resumed her regular work schedule.

Connectedness was identified as another aspect of life-oriented. The widows remained connected to their husbands and the past by sharing stories about their marriage. Sharing stories of the past connected the participants with who they are now to the past. Staying connected to happier times via storytelling provided meaning to the participant's life. She was able to gain self-understanding by reflecting on the past. Table 4-7 provides representative significant statements of connectedness and Table 4-8 provides their formulated meanings.

One final perspective of life-oriented is giving advice. Many participants offered advice to other widows on how to cope with losing their husbands. They offered such advice as "Listen dear, you just do the best you can, keep trying," "you never give up on life" or "when you lose a mate, you should find a meaningful life for yourself."

Changing Feelings

This theme of grief described the feelings and emotions widows felt during and after their husband's death. Changing feelings included the very painful and poignant feelings felt following their husband's death. The early feelings were described as

Table 7 Representative Significant Statements of Moving-on: Connectedness

"We had a very unique relationship. There wasn't a bit of jealousy in our life."

"We had a great relationship."

"We've husband] always been very close."

"My husband just never complained; he was a person who never complained. We were pretty close."

"I felt like we've had a good life together." "He was such a happy person."

"There was nothing unpleasant about our life together."

"the minister at the funeral] had some wonderful things to say about him, that he was loved by everybody."

"[my husband] influenced a lot of people; he was a really good person."

"He went to church every single Sunday."

"Those boys [nephews] thought more of him [husband] than they did their own father." "There was nothin' in the world he couldn't do."

"We had a lot of good years together, you know."

"He had one of the largest funerals of a Black American in this town an' that was gratifyin'."

"He an' I had a very good relationship and he sure could dance, too."

"He was a wonderful husband."

Table 8 Moving-on Formulated Meanings: Connectedness

The widows remained connected to their husbands by recalling and retelling stories of happier times with their husbands.

The widows stayed emotionally linked with their husbands by sharing positive attributes of their husbands and their marriages.

shock, "I just couldn't believe he was really gone" or "I didn't feel anything . . . it just can't be happenin', you know, he couldn't really be gone!" As time passed on, the participants described feelings of emptiness and loneliness, "it's a vacant spot that never really goes away." Events or memories that reminded the participants of their husbands would bring sudden feelings of sadness and occasionally even tears. Participants said they felt especially sad when they ate alone or listened to certain types of music. Eventually, as time passed, the participants' feelings changed from shock and intense sadness to "learning to live with it [the pain]." Below is an example of an original protocol. Table 4-9 provides representative significant statements of changing feelings and Table 4-10 their formulated meaning.

> . . . I'm going through a period, where, you, I'm trying to adjust to, I'd say, uh, um, trying to tell myself "I know he's not coming back" . . . it's hard for me to accept the fact that the other half is gone, you know, an' so . . . I've started a whole lot of things an' finished see where his wheelchair bumped the wal-l, an' that puts me into a kind of [sadness] . . . it, it's hard and sometimes just a song or somethin' will trigger me off an' I kind of lose it for a while, I'll sit down an' cry . . . I guess it's hardest at night when everybody's gone home and I'm here by myself [alone] . . . here I am alone, you know. Some day's I'm fine . . .

Several participants shared that they found it difficult to go places, such as church, where they and their husbands had gone together. Other participants used to travel with their husbands and they found it difficult to go on trips because of their memories of good times with their husbands. The sadness became overwhelming for these participants and they did not go on trips.

Financial Security

The final theme identified in the grief experience was called financial security. The participants shared information about their financial concerns. Several participants

Table 9 Representative Significant Statements of Changing Feelings

"You just figure he's gone to sleep."

"I just didn't feel anything; it just couldn't be happenin'."

"It's just like losing an arm--it still is."

"I was just goin' on, acted like it wasn't, it hadn't happened . . . I found myself walkin' around [the house]."

"It didn't hit me for a couple of days."

"The real shock didn't sink in until later."

"It was a long time before I could get back to church; it didn't feel right the first time [back to church]."

"I don't want to go places where we went together."

"Time don't heal all."

"It's something you bear as long as you live."

"It's, it's just heart-breaking [to lose one's husband]."

"It still feels sad when it comes."

"It [sadness] started coming, just a silent kind of thing and you wonder what it was but it's there."

"I don't know any pain like that."

"I will always miss him; I don't care how good things are going."

"I feel pretty good now."

"You always, you always remember . . . It's something you gotta live with."

Table 10 Formulated Meanings of Changing Feelings

Initially after the death of their husbands, the widows felt disbelief, shock, and numbness.

They found it difficult to believe their husbands were dead even though they knew he was dying.

After the shock, the participants described a heart-wrenching pain that was the worst sadness they had ever experienced.

After a period of time, the participants became resigned to the pain of losing their spouse. The pain, while not as long and intense as before, can still recur at different times such as reminiscing about her spouse. The spouses were able to go on living but realized that they would always miss their husbands.

said, "I was so glad the kids were grown and the house was paid for." Below is an example of an original protocol of this theme.

> . . . he had excellent medical care . . . I could arrange the funeral the same day because money, it, those anxieties, it wasn't a problem about money. I knew that there would be, that the house would be paid off an' all, I don't think I had some of the anxieties [other] people have, when you go in there and there's not money for this and there's not money for that. I knew I had lifetime medical care and I mean it was just not the same kind of usual stress that other people have . . . it was more income when my husband lived. I don't have the income I had when my husband was alive . . . we had enough insurance that we could have kept him [husband] at the hospital. . . .

Many participants said that they worried less about the cost of their husband's illness because they had good insurance or medicare. The family and friends often provided financial support via money trees or directly paying bills for the widow. Several widows disclosed the incomes of their children to me and they expressed comfort knowing that their children could financially assist them if needed. Table 4-11 provides representative significant statements of financial security and Table 4-12 their formulated meanings.

Several participants expressed concern that their income decreased after their husband's death and that "it was difficult to make ends meet now." Each participant owned the home they were living in at the time of the interview. Finances included anything that pertained to money, income, or entities that could be purchased with money, such as insurance.

Table 11 Representative Significant Statements of Financial Security

"We have a big house, it's <u>all</u> paid for--at least I don't have that worry."

"He [husband] had excellent medical care; we had good insurance."

"The house was paid for, we . . . "

"But, I mean, I have enough [money] to live on, I would say. But I have friends that help me with the finance such as gettin' my checks straightened out."

"He had workman's comp and medicine."

"My daughter's got her a good job. She makes sixty thousand dollars a year."

"And they had this money tree [at the funeral]."

"As soon as I'm financially able, I'm going to have the house inside redone."

"My [step son] calls an' asks me for money, I'm trying to explain to him your dad didn't have any money. I can live off of it [pension] but I don't want to take care of nobody else with it."

"I wait on my little check from Social Security, pay my rent, an' buy me some groceries."

"It wasn't a problem about the money; I knew the house would be paid off."

"I knew that I had lifetime medical care and I mean, it was just not the same of the usual stress that that other people may have"

Table 12 Formulated Meanings of Financial Security

The participants had less worries both during and after their husband's death if they had good medical insurance.

The participants' income decreased after their husband's death.

The participants expressed fewer financial concerns if their children were financially secure.

The participants expressed concern about finances but it was not a major impact on their grief experience but rather was a topic that was brought up briefly and then not dwelt on again.

Essential Structure

The purpose of this study was to describe the experience of grief among older Black widows after their husband's death. Identifying the essential structure of the grief experience was derived from the exhaustive description. A pervading and overarching theme of grief experience of older Black widows was their ability to communicate their experiences through stories. At the heart of the participant's description of grief was the theme storytelling. Each participant talked about her grief experience via stories. They provided rich, colorful, and detailed descriptions regarding many aspects of their lives. I heard stories about when their children were born, when the couple bought their first home, and when they had their first grandchildren. Also, I heard detailed descriptions of vacation trips the couple took, family histories, family concerns.

Storytelling involved the participant's ability to artfully describe a particular situation in their past. The participants did not merely describe chronological events of their past but also reenacted and relived the experience through elaborate dialogue. The participants frequently changed their voices to imitate the voices of other people. They used their hands and facial expressions to emphasize certain points. Storytelling appeared to be a natural way for the participants to share their grief experiences with me.

Storytelling was the participants avenue or means of describing the six themes of grief identified in this study. The six themes of grief identified were: awareness of death, caregiving, getting through, moving-on, changing feelings, and financial security.

The impact of the realization of their husband's impending death was called awareness of death. Awareness of death occurred when the widows would say, "I knew he was going to die" or "I knew this particular night, I could tell [he was going to die]." The participants made specific comments addressing the fact that they were able to recognize a change in their husband's demeanor indicating he would die shortly.

Awareness of their husband's death was linked to several other themes of their grief experience. For example, being cognitively aware that their husband was going to die in a short period of time enabled the participants to be with him as well as to assemble the family for support. Being aware that their husbands were going to die shortly caused much pain and sadness to the participants. The participants found emotional support during this time from family, friends, professionals, and the church.

The participants described four aspects of caregiving they provided their husbands during his illness. The four subthemes were: task-oriented, problem-solver, decision-maker, and learner. Caregiving included formal care which was solicited by the widows and provided by professionals such as nurses and physicians. Informal care was provided by the widows, family, or friends, such as feeding or bathing their husbands. For either type of care, formal or informal, the widows were physically present whenever possible.

Task-oriented care involved doing physical activities for the husband. These activities included feeding, turning, bathing, giving medicines, or driving to the doctor's appointments. Doing things to the husband was at the heart of task-oriented care. One widow provided an in-depth description of how she learned to give her

husband liquid medicine, and that she regularly gave him his medicine to keep him comfortable.

The widows frequently described situations when caring for their husbands that required problem-solving. One widow did not feel comfortable giving her husband insulin shots. The widow knew her husband needed the insulin and so she solved the dilemma by asking her daughter's nurse friends to come to the house and administer the insulin. The widows became creative in their ability to solve caregiving problems.

The participants shared stories how they had to make decisions regarding the care of their dying husbands. They determined when the physician would be notified, who could come and visit their husbands, when to bring the husband home from the hospital, as well as what information to share with their husbands. For example, a physician disclosed to a participant that her husband was terminally ill and would die within a few months. This widow chose not to disclose this information to her husband. She said, "He never knew [the diagnosis], he never knew. I just didn't want him to know."

The participants frequently found themselves in the learner role when it came to providing care to their husbands. Nurses taught the participants how to give shots, how and when to administer medicines, how to put down a feeding tube, and how to recognize the signs of imminent death. The widows both solicited this knowledge as well as were passive recipients of new information. The widows learned different ways to provide better care to their husbands. Providing the best care possible was important to the participants.

Caregiving as a theme was connected to awareness of death in that at the

moment of their husband's death, the participants described specific caregiving actions or tasks they did for their husbands. For instance, one participant said, "I turned him and kept him as comfortable as possible." Another participant said she recognized that her husband was dying because she had learned some observational skills from a hospice nurse.

Participants poignantly described their husband's actual dying as an especially difficult time for them. Participants recalled how they felt at that moment. The widows identified actions and behaviors which facilitated their getting through these moments. This theme was consequently called getting through. The widows stated that having family present both emotionally and physically gave them strength to get through the dying process of their husband. Other things which enabled the widows were support from friends, prayers from church members, and visits from the minister. Several participants said, "Keeping busy helped in that it kept their mind off the inevitable." Another important thing that helped the widows at the moment of their husbands dying was the realization and acceptance that everything had been done that could have been done to make their husbands comfortable. Widows stated, "It was reassurance that everything was done that could be done, knowing you did all you could" or "We did the best we could to make him comfortable. . . that helped."

Likewise, retelling stories about their husbands to willing listeners helped the widow get through this difficult time. Also, the widows expected their families and churches would be notified as soon as possible about their husband's impending death. No matter how far the family members had to travel, the participants expected them to come and say good-bye to their husbands and attend the funeral. Knowing family and

church would be present at their particular moment provided reassurance and comfort to the widows and facilitated their getting through this time period.

After their husbands died, the participants described intentional activities and behaviors which allowed them to continue living meaningful lives. Moving-on as a theme of grief had five subthemes: positive memories and recall, personal or self-growth, strength seeking, using support, and life-oriented. The widows recalled many positive stories about their husbands and their marriages. Having warm, pleasant memories provided comfort to the widows. Being able and wanting to verbally share these stories with others helped the widows go on living. One widow vividly recalled the time she and her husband bought some land near the coast. She provided great detail about the cost, how they were able to finance the property. The widow expressed great admiration and pride in the fact that her husband took care of her and wanted her to be able to go to her own vacation place.

The widows described many incidents of personal growth after their husband's death. Many widows learned new skills such as paying bills or changing light bulbs while others chose to learn new things such as using a computer. Several described themselves as more self-efficient "now that he's gone, I'm gonna have to everything myself." Several participants said comments such as, "I've grown" and "I can do a lot now, on my own, it's getting easier."

Widows not only accepted support from others but actually sought strength from outside sources. This subtheme of moving-on was called strength seeking. Participants described informal sources such as friends, family, and church members as resources they would intentionally seek for emotional support. Professional support

was sought by participants from professionals such as ministers, social workers, and nurses. In addition, spiritual support was sought from a Higher Being, God. Praying to God provided support. Several participants said, "believing in a higher source of strength [gave me support]" and "I just kept praying for strength." These comments illustrated the widow seeking strength in an outside source.

Support from others provided the widows incentive and encouragement to continue their daily living. Family members, especially children, would visit or telephone and offer verbal words of encouragement and compassion. The church members offered food and prayers as ways to support the widows. Friends came and visited the participants at their homes or invited the widows to attend different social activities. Participants said, "being remembered" by others was very helpful. Phone calls, flowers, and letters provided support to the participants. One widow described an incident when two neighbor boys came and raked her leaves. She said, "it really made me feel good" to know that others cared for her.

Another aspect of moving-on with one's daily living included orienting one's outlook toward living. This subtheme of moving-on was called life-oriented. The widows described living their lives for others and with others. Many widows were very busy with daily activities such as jazzercise, Bible studies, gardening, bowling, traveling, reading, doing puzzles, and playing bridge. Being involved with their family was also being oriented to the living. The widows described holiday events such as birthdays when they would get together with family members. At these occasions participants recalled positive memories of their husbands, which often included humor, and provided family members with an oral history of the family past.

Being physically active and being concerned for others provided the widows with motivation to go on with their lives even though they missed their husbands. Maintaining a regular routine also helped the participants move on with living. Having a focus and goal for each day made doing things without her husband less lonely and sad. Several participants belong to bowling leagues and went at regularly scheduled times during the week. One participant chose to be the team's treasurer because she wanted something to do that would keep "me busy on a regular routine."

The widows described numerous stories that demonstrated an emotional connectedness to her husband. The widows share stories that allowed them to remain connected to happier times. Positive reminiscing allowed the widows to reflect on the past and give meaning to their present life. One participant said, "he [husband] was a very good person, he was a wonderful husband, everybody loved him." This widow said she took pleasure in recalling good things about her husband. When people affirmed the positive qualities about her husband, it gave her great satisfaction and pleasure.

Many participants found themselves offering advice to other widows who lost their husbands. "You've got to live life to the fullest" or "get on with life" were examples of statements the participants told other widows. Also, the participants offered advice to their children and grandchildren.

The participants described explicit feelings of tremendous sadness, pain, numbness, and shock immediately after their husband's death. As time passed, the participants said they had good days and bad days. One participant said, "the vacant spot never goes away, you have to learn to live with it." This theme of grief was

called changing feeling because the participants emotional feelings changed as time evolved.

Having financial Security provided relief to the participant and allowed them to focus on other aspects of their lives. The widow described financial security as having good insurance or monthly income. Also, participants took comfort from the assurance that if their children had good incomes they would have fewer financial worries.

Final Validation

Colaizzi's (1978) last step of analysis is validation. In this step, the investigator must recontact the participants. The participants are then asked if the final analysis accurately describes their experiences. Colaizzi asks, "how do my descriptive results compare with your experiences?" (p. 62). Any new data which is relevant must be worked into the new product.

Two participants were out of town and I was unable to contact them. I was able to talk with two participants in person. I read outloud the essential structure as well as described the themes of grief identified in this study to these participants. Both participants agreed with the findings. One participant said, "Sounds pretty good to me" and offered no other comments. The other participant provided more stories about her bereavement experience which further corroborated the findings. However, no new information was elicited.

I was able to contact four participants by telephone. I read outloud the essential structure and described the themes of grief. It had been approximately one year since I originally interviewed these participants. Two participants said they had forgotten that I had interviewed them. One participant had been a widow only several weeks when I

had interviewed her a year ago. She had forgotten our interview and said, "I was really a mess back then, things are getting better." Nevertheless, she had no additional comments after I read her my findings. Another participant did not remember my initial interview but with gentle reminders she said, "Oh, I'm remembering now." She had no additional comments. She wanted to talk about a recent trip she had taken overseas. Another participant described the death of her daughter which had occurred several months after the initial interview. She proceeded to describe positive attributes about this daughter, "She was such a strong person." She was demonstrating moving-on via remaining connected to her daughter by sharing positive memories and stories. The last participant contacted said, "I realize I have to accept it . . . I have to move on . . . I'm getting better but I'll always miss him." This participant's husband had died several weeks before the initial interview. Her recent comments are reflected in the six identified themes.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

This chapter will include discussion of the following: validity of findings, a comparison of findings with previous studies, strengths and limitations of the study, strength and limitations of the method, implications and recommendations for nursing research and practice, personal reflections, and a summary.

Validity of Findings

The purpose of this phenomenological study was to describe the lived experience of spousal bereavement among older Black widows. The degree of validity or trustworthiness of the findings of this type of study, depends on its persuasiveness of presentation to convince a reader that the results are accurate. Polkinghorne (1989) listed five questions that could be used to establish validity for a phenomenological study. I will discuss each question individually as it relates to my study.

The first question is as follows: Did the interviewer influence the contents of the subjects' actual experience? I tried to avoid influencing the participants' description in several ways. I dressed in a plain skirt and sweater and wore no lab coat or name tag. I thought that a lab coat or name tag might keep the participant from seeing me as a researcher. Also, I let the participant select the time and place for the interview. All interviews were conducted in the participant's home which was a familiar and comfortable setting for them. I used an unstructured interview guide in order to allow each participant to describe her bereavement experience from her perceived perspective. I tried to be nonjudgemental in my responses to each participant and

maintain a compassionate demeanor. I considered each participant my co-researcher and told her I appreciated her willingness to share her experiences with me.

The second question addressing validity is as follows: Is the transcription accurate, and does it convey the meaning of the oral presentation in the interview? Each participant's interview was audiotaped and then transcribed verbatim. I assured accurate transcription by reading the protocol while simultaneously listening to the taped interview. Each participant described her bereavement experience following the death of her husband. Significant statements were elicited from every participant's protocol and these statements were then transformed into formulated meanings and theme clusters. Similar themes emerged from every participant's protocol. Also, the dissertation committee provided invaluable feedback throughout the entire data collection and analytical process. One committee member had expertise in the topic of grief and another expertise with the methodology.

The third question is as follows: In the analysis of the transcriptions, were there conclusions other than those offered by the researcher that could have been derived? Has the researcher identified these alternatives and demonstrated why they are less probable than the one decided on? Using Colaizzi's analytical procedure, required that I move back and forth between the meaning statements and the successive revised hypothetical exhaustive lists until the themes were accurately reflected in the appropriate clusters. Initially, I thought there would be more than three clusters of themes. For example, I thought that caregiving, life-oriented, awareness of death, moving-on, connectedness, expectations, getting through, and descriptive recall would

be themes of one cluster. However, after teasing out the meanings of these potential themes, it became apparent that several should be collapsed into a more comprehensive theme. For instance, positive memories, personal growth, strength-seeking, using support, and life-oriented eventually was identified as moving-on.

The fourth question is as follows: Is it possible to go from the general structural description to the transcriptions and to account for the specific contents and connections in the original examples of the experience? After writing the final exhaustive description, I went back to the original protocols to determine if there were any discrepancies. I found that the exhaustive description did reflect a direct relationship or connection to the original descriptions. Also, I read the essential structure to six of the participants. No new information or reinterpretation of the finding emerged and consequently, the findings were verified by these six participants.

The fifth and final question is as follows: Is the structural description situation-specific, or does it hold in general for the experience in other situations? The essential structure does not appear to be situation-specific or pertaining only to older Black widows' experiences of bereavement. Osterweis, Solomon, and Green (1984) described similar grief experiences among other people who have had a significant family member, not just spouse, die. For example, intense feelings of emotional pain among the bereaved have been described by other investigators (Osterweis, et al.). The participants in this study also described vivid accounts of feeling pain (e.g., sadness, loneliness, being hurt). Also the following section in this chapter provides further corroboration of this question.

The findings from this study were valid based upon the above responses to the questions of validity posed by Polkinghorne. In addition, Colaizzi (1978) states that if the participants have indeed lived the experience of the phenomenon being studied and can communicate their experiences, then the data that is obtained can be accepted as having face and content validity. Each participant had lost a husband through death and thus had personal experience with the phenomenon of bereavement. Likewise, each participant was able to verbally describe her experiences. Thus, face and content validity was achieved.

Comparison of Findings to Previous Studies

To my knowledge, there has been no reported phenomenological study on the lived experience of bereavement among older persons, no matter what the actual loss may have been. Consequently, I was unable to compare the findings of my study, the essential structure of bereavement among 11 older Black widows, to another phenomenological study on this topic.

Storytelling is rooted in a historical context. Hill-Lubin (1991) found that the Black grandmother used stories to teach skills of survival as well as to transmit ideals and values to her family. Storytelling emerged as a major theme in my study. The participants used stories to share their experiences, not just related to bereavement, with me. The participants all offered advice to their own widowed friends and this information was provided to me via their storytelling.

This study revealed the impact that the family has upon the lived experience of bereavement among older Black widows. Allen (1978) found that the Black

community has a great respect for older persons. This finding was also found in my study. Family members demonstrated their respect to the older widow by honoring her decisions as well as being physically present with her during her husband's dying process and funeral. Family members were expected to be with the widow at these two times no matter how far they might have to travel.

Dimond (1981) identified that support networks among older persons enabled them to cope more effectively. Taylor and Chatters (1991a) observed that family members were prominent in the support of the older Black person. My findings were similar to the above studies. The study participants consistently stated that their family provided support in helping them get through their grief and move-on with their lives.

The death of a spouse can negatively impact the surviving spouse's social, financial and emotional status (Bass, et al., 1991; Gass & Chang, 1989; Lund, 1989). McDonald (1987) asserts that the Black family provides economic and emotional support to each member. Several participants expressed much gratitude for help their families gave them. For example, one widow stated that her daughter would regularly call her by telephone and send her cards by mail. The widow stated that being remembered by her daughter helped her through the sad times. Two widows expressed sincere appreciation for money trees that the family provided after the funeral.

Parkes (1972) delineated seven phases of mourning. I found four of those stages were described by the participants in this study. For instance, feelings of internal loss was repeatedly expressed and one widow eloquently described it as "a vacant spot that will never go away." However, the purpose of this study was not to

identify the stages of bereavement. The above results, nonetheless, are consistent with Parkes' findings.

My investigation supports the findings of Rosenbaum's (1991) study of Greek widows. Her findings showed that widows never fully accept her husband's death but rather become resigned to it. Indeed, the participants expressed this sentiment in 26 significant statements. Some examples are as follows: "You always, you always remember," "time don't heal all," and "it's something you gotta learn to live with."

Gass (1987) found that widows who kept busy, prayed and participated in social groups used these strategies to help them cope with the death of her husband. My findings also supported her claims. The widow described many activities which helped them get on with living. A few examples included bowling, volunteering, playing bridge, going to church, going to parties and praying.

Jones and Martinson (1992) used grounded theory to analyze and describe the bereavement experience of 13 caregivers of family members with Alzheimer's disease. A number of the caregivers, after their spouses had died, were "ready to get on with life." These caregivers indicated that what they needed most after their spouses death was help and encouragement from others to get on with life. This finding is very similar to the theme I identified as moving-on. To move-on, the participants ongoing needed support and encouragement from family and friends. One widow described how helpful it was to her when friends and family "remembered" her via phone calls, cards, or visits.

Again, there were no previous studies of this nature to compare to my findings.

Nevertheless, some relevant comparisons with other studies lended support to my results.

Strengths and Limitations of the Study

This phenomenological study described the bereavement experience of 11 older Black widows. There have been no other studies identified which examined the grief experience of older Blacks.

A limitation to this study is that I validated my findings almost a year after the initial interview secondary to my being a part-time doctoral student. Unfortunately, several participants forgot that I have interviewed them when I recontacted them to validate my findings. Another limitation is the fact that only older Black widows were included in this study and no Black widowers.

Strengths and Limitations of the Method

One of the strengths of using this phenomenological method of research was that the lived experience of bereavement among older Black widows was described. Unstructured interviews allowed the participants to describe richly their experiences from their own perspectives. The participants were not directed to address or speak to any particular aspect of their grief experience. Another strength of this method was that since I bracketed my preconceptions, I was able to analyze the data less subjectively. Likewise, recontacting the participants to have them validate my findings is another strength. Another strength is that I adhered closely to Colaizzi's methods of analysis.

Currently, there is a trend for nurses to use a more interpretive approach when

doing phenomenological research. Colaizzi's (1978) methodology looks less at the full picture and richness of a particular phenomenon but rather focuses more on extracting the meaning from the experience and then formulating the meaning of the experience. This method is constrictive in that paradigm cases and exemplars do not emerge from the data.

Implications and Recommendations for Nursing Practice and Research

The findings from this study have direct and indirect implications for nursing practice and research. Nursing as a profession is concerned with the lived experience of the client as well as the perceived meanings that the client ascribes to their experiences. The results of this study increases nursing's awareness and understanding of the bereavement experience as lived by older Black widows. This new insight into this phenomenon can be used to assist nurses in providing more sensitive and thoughtful care to those involved in this experience.

Nurses have always had an integral role in providing effectual nursing care to clients who are dying. Nurses are in the position to help those persons who have suffered the loss of loved one. The results of this study can assist nurses to be creative about the ways she helps the older Black widow.

Social policy and public action can be influenced by phenomenological studies such as this one. The methods of phenomenological research are designed to investigate the realm of reality that comes into being at the intersection of consciousness and the world which is the human experience. Phenomenological studies are only now beginning to be funded. Social and public policy determines how

research funding is utilized.

Empirical studies which addressed the experience of bereavement among older Black widows are nonexistent. That is why I chose to study this particular population. As I began this research project, I did not know if I would find anything unique to the older Black widow's experience of bereavement as compared to the older White widow's experience. No such specific identifying theme emerged from the data, nor was it my intention to compare the grief experiences of Blacks to Whites. Even so, I was interested in ascertaining how the older Black woman's experience might be different to the older White woman's experience.

I interviewed three Black ministers and one Black funeral director who were in unique positions to provide insight, based on their observations and experiences into the grief experience of older Black persons. The four professionals were unable to directly describe how grief differs for Black and White persons even though they all were confident a difference may exist.

The three ministers clearly stated that they believed the Black church and religion greatly influenced the bereaved Black person. Also, two ministers observed that the lower socioeconomic group of Black people were more outwardly expressive in their emotions at the funeral. One minister commented that Black people "were intuitive about their feelings" and consequently expressed themselves based on that intuition.

I specifically asked four participants if they thought there were any differences in bereavement experiences between Black and White persons. This information was

not included in the data analysis because it was solicited information and structured; leading questions are discouraged in phenomenological inquiry. Their responses were not part of their spontaneous descriptions of their lived bereavement experience. Nevertheless, their responses were similar. One participant summed it eloquently as follows: "I don't think in all sincerity, grief has anything to do with color...whether you're Black, White or Blue--it hurts!"

The purpose of this study was not to identify a unique perspective of bereavement among the older Black widow. However, the above comments from the ministers and several participants suggest there may be only minimal, if any, differences of bereavement experiences between Black and White persons. Historically, public funding in this particular area of research has primarily been limited to the older White person's experience. Additional phenomenological research into the experiences of bereavement among ethnic groups of older people is needed. Currently, there is a tremendous emphasis for researchers to conduct studies which include minorities and ethnic groups. In addition to consequences for public policy (Giorgio, 1975), phenomenological researchers relate their findings to other disciplines which can influence their practices and policies.

This small study included only Black widows in the Pacific Northwest. The results of this study are not intended to be generalizable. However, additional studies using the phenomenological approach will provide a deeper understanding of the phenomena and this knowledge can then be utilized by nurses to create innovative and comprehensive health promotion activities, assessment strategies and interventions to

bereaved older persons.

Personal Reflections

The finding which most impressed me from this study was the theme of storytelling. I was amazed at the richness and details which emanated from their stories. The stories provided a historical context with which the widows were able to share chronological events in a vivid manner. Through their stories, I found myself listening intently as well as in expectation. I would listen to the beginning of each story and found myself looking forward to the outcomes of the stories. The interviews went quickly because I became engrossed with so many stories. The stories about their marriages were my favorites because it seemed as if I was able to get to know ever so minutely who their husbands were.

I also was very impressed with each participant's generosity to so willingly and openly share so many personal experiences with me regarding their feelings of bereavement and stories about their marriages and families. I feel that these 11 women have support from their families and that these women are very much respected by not only their families but their communities and churches. My personal life has been enormously enriched because of the personal contact I had with each participant.

In the future, I anticipate using a more interpretive approach in conducting my research. I would like to study the bereavement experience of older Black widows and

widowers using a more Heidigerrian perspective similar to that of Benner and Wrubel (1989). I would like to see if paradigm cases or exemplars would emerge and then incorporate those findings into ways that nurses could use to provide effective care to this particular ethnic cohort. Also, I would like to explore the use of storytelling among the older Black person and the function it may have in their families.

Summary

This descriptive phenomenological study resulted in the essential structure of bereavement among older Black widows. The essential structure of bereavement emerged from the data and was not translated or defined by external criteria. A purposive sample of 11 older Black widows were interviewed. No structural interview guide was used. The interviews were transcribed verbatim and then analyzed according to Colaizzi's (1978) methodology. Seven themes emerged from the data analysis. Storytelling emerged as a distinct theme from the grief experience of the participants. There were six themes identified from the participants' description of their grief experience. The six themes were awareness of death, caregiving, getting through, moving-on, changing feelings, and financial security.

The results of this study increases our understanding of bereavement among older Black widows. These findings can enable nurses to interact more efficaciously and sensitively to older Black widows. The importance and role of family in the experience of bereavement among older Black widows needs to be especially emphasized. For the nurse researcher the directive is to attend to the whole of the situation which is "to recognize the nurse as a part of the client's world and their

relation to one another, the sole vehicle of care" (Munhall & Oiler, 1986, p. 61). It is logical that the best source of information about a client is the client. Phenomenological research in nursing can help nurses understand what is real about the lived experiences of our clients. These understandings could be directly related to the development of a body of knowledge and the design of effective nursing care (Davis, 1973).

References

Aber, C.S. (1992). Spousal death, a threat to women's health: Paid work as a "Resistance Resource." Image: Journal of Nursing Scholarship, 24, 95-99.

Allen, W. (1978). The search for applicable theories of Black family life. Journal of Marriage and the Family, 40, 117-129.

Allen, K.R., & Chin-Sang, V. (1990). A lifetime of work: The context and meanings of leisure for aging Black women. The Gerontologist, 30, 734-740.

American Association of Retired Persons. (1988). A profile of older Americans. Washington, D.C.

Angelou, M. (1969). I know why the caged bird sings. New York: Random House.

Asante, M.K. (1988). Afrocentricity. Trenton, NJ: Africa World Press.

Avery, B.Y. (1992). The health status of Black women. In R.L. Braithwaite & S.E. Taylor (Eds.), Health Issues in the Black Community (pp. 35-51). San Francisco: Jossey-Bass.

Baressi, C.M., & Menon, G. (1990). Diversity in black family caregiving. In A. Harel, E.A. McKinney, & M. Williams (Eds.), Black aged: Understanding diversity and service needs (pp. 221-235). Newbury Park, CA: Sage.

Barrett, T.W., & Scott, T. (1989). Development of the grief experience questionaire. Suicide and Life-Threatening Behavior, 19, 201-215.

Bass, D.M., Bowman, K., & Noelker, L.S. (1991). The influence of caregiving and bereavement support on adjusting to an older relative's death. The Gerontologist, 31, 32-42.

Benner, P., & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. Reading, MA: Addison-Wesley.

Bowlby, J. (1961). Process of mourning. International Journal of Psychoanalysis, 42, 315-340.

Brown, D.R. (1990). The black elderly: Implications for the family. In M.S. Harper (Ed.), Minority aging: Essential curricula content for selected health and allied health professions (pp. 275-295). Washington, DC: U.S. Government Printing Office.

Bryant, S., & Rakowski, W. (1992). Predictors of mortality among elderly African-Americans. Research on Aging, 14, 50-67.

Burnside, I.M. (1988) Nursing and the aged: A self-care approach (3rd ed.). New York: McGraw-Hill.

Carter, M. (1985). The philosophical dimensions of qualitative nursing science research. In M. Leininger (Ed.), Qualitative Research Methods in Nursing (pp. 27-32). Orlando, FL: Grune and Stratton.

Carter, S.L. (1989). Themes of grief. Nursing Research, 38, 354-358.

Chatters, L.M., & Taylor, R.J. (1990). Social integration. In Z. Harel, E.A. McKinney, & M. Williams (Eds.), Black aged: Understanding diversity and service needs (pp. 83-99). Newbury Park, CA: Sage.

Clavon, A. (1986). The Black elderly. Journal of Gerontological Nursing, 12, 6-12.

Cohen, M.Z. (1987). A historical overview of the phenomenology movement. Image: Journal of Nursing Scholarship, 19, 31-34.

Colaizzi, P.F. (1973). Reflection and research in psychology: A phenomenological study of learning. Dubuque, IA: Kendall/Hunt.

Colaizzi, P.F. (1978). Psychological research as the phenomenologist views it. In R.S. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp. 48-71). New York: Oxford University Press.

Cowles, K.V., & Rodgers, B.L. (1991). The concept of grief: A foundation for nursing research and practice. Research in Nursing & Health, 14, 119-127.

Davis, A. (1973). The phenomenological approach in nursing research. In E. Garrison (Ed.), Doctoral preparation for nurses with emphasis on the psychiatric field. San Francisco: University of California.

Davis, R.A. (1993). The black family in a changing black community. New York: Garland.

Detmer, C.M., & Lamberti, J.W. (1991). Family grief. Death Studies, 15, 363-374.

Diekelmann, N., Allen, D., & Tanner, C. (1989). The NLN criteria for appraisal of baccalaureate programs: A critical hermeneutic analysis. New York: National League for Nursing Press.

Dimond, M. (1981). Bereavement and the elderly: A critical review with implications for nursing practice and research. Journal of Advanced Nursing, 6, 461-470.

Edmonds, M.M. (1990). The health of the Black aged female. In Z. Harel, E.A. McKinney, & M. Williams (Eds.), Blacks aged: Understanding diversity and service needs (pp. 205-220). Newbury Park, CA: Sage.

Farberow, N.L., Gallagher-Thompson, D., Gilewski, M., & Thompson, L. (1992). Changes in grief and mental health of bereaved spouses of older suicides. Journal of Gerontology, 47, P357-P366.

Ferraro, K.F. (1987). Double jeopardy to health for older adults? Journal of Gerontology, 42, 528-533.

Ferraro, K.F. (1989). Reexamining the double jeopardy to health thesis. Journal of Geronotology, 44, 514-516.

Gass, K.A. (1987). Coping strategies of widows. Journal of Gerontological Nursing, 13, 29-33.

Gass, K.A., & Chang, A.S. (1989). Appraisals of bereavement, coping, resources, and psychosocial health dysfunction in widows and widowers. Nursing Research, 38, 31-36.

Gerber, I., Rusalem, P., Hannon, N., Battin, D., & Arkin, A. (1975). Anticipatory grief of aged widows and widowers. Journal of Gerontology, 30, 225-229.

Gibson, R.C. (1989a). Blacks in an aging society. R.L. Jones (Ed.), Black development and aging (pp. 389-406). Berkeley, CA: Cobb & Henry.

Gibson, R.C. (1989b). Minority aging research: Opportunity and challenge. Journal of Gerontology, 44, S2-3.

Giorgio, A. (1975). An application of phenomenological method in psychology. In A. Giorgio, C. Fischer, & E. Murray (Eds.), Duquesne Studies in Phenomenological Psychology, Vol..II (pp. 82-103). Pittsburgh, PA: Duquesne University Press.

Glick, J.O., Weiss, R.S., & Parkes, C.M. (1974). The first year of bereavement. New York: John Wiley & Sons.

Haase, J.E. (1987). Components of courage in chronically ill adolescents: A phenomenological study. Advances in Nursing Science, 9(2), 64-80.

Hale, C.B. (1992). A demographic profile of African Americans. In R.L. Braithwaite, & S.E. Taylor (Eds.), Health issues in the Black community (pp. 3-5). SanFrancisco: Jossey-Bass.

Harel, S., McKinney, E.A., & Williams, M. (Eds.). (1990). Black aged: understanding diversity and service needs. Newbury Park, CA: Sage.

Harper, M.S. (Ed.) (1990). Minority aging: Essential curricula content for selected health and allied professions (pp. 3-21). DHHS Publication No. HRS (P-DV-90-4). Washington, DC: U.S. Government Printing Office.

Harper, M.S., & Alexander, C.D. (1990). Profile of the Black elderly. In M.S. Harper (Ed.), Minority aging: Essential curricula content for selected health and allied health professions (pp.193-222). Washington, DC: U.S. Government Printing Office.

Hegge, M. (1991). A qualitative retrospective study of coping strategies of newly widowed elderly. The American Journal of Hospice & Palliative Care, 8(4), 28-34.

Herth, K. (1990). Relationship of hope, coping styles, concurrent losses, and setting to grief resolution in the elderly widow(er). Research in Nursing and Health, 13, 109-117.

Hill-Lubin, M.A. (1991). The African-American grandmother in autobiographical works by Frederick Douglass, Langston Hughes, and Maya Angelou. International Journal of Aging and Human Development, 30, 173-185.

Holmes, R.H., & Rahe, R.H. (1967). The social readjustment rating scale. Journal of Psychosomatic Research, 11, 213-218.

Jackson, A.M. (1983). A theoretical model for the practice of psychotherapy with black populations. Journal of Black Psychology, 10, 19-27.

Jacobs, S.C., Hansen, F., Berkman, L., Kasl, S., & Ostfeld, A. (1989). Depressions of bereavement. Comprehensive Psychiatry, 30, 218-224.

Jacobs, S., Kasl, S., & Ostfeld, A. (1977). An epidemiological review of the mortality of bereavement. Psychosomatic Medicine, 39, 344-357.

Johnson, C.L., & Barer, B.M. (1990). Families and networks among older inner-city blacks. The Gerontologist, 30, 726-733.

Johnson, H.R., Gibson, R.C., & Luckey, I. (1990). Health and social characteristics: Implications for services. In Z. Harel, E.A. McKinney, & M. Williams (Eds.). Black aged: Understanding diversity and service needs (pp .69-81). Newbury Park, CA: Sage.

Jones, P.S., & Martinson, I.M. (1992). The experiences of bereavement in caregiving of family members with Alzheimer's disease. Image: Journal of Nursing Scholarship, 24, 172-176.

Kaprio, J., Koskenvuo, M., & Rita, H. (1987). Mortality after bereavement: A prospective study of 95,647 widowed persons. American Journal of Public Health, 77, 283-287.

Karl, G.T. (1987). Janforum: A new look at grief. Journal of Advanced Nursing, 12, 641-645.

Keto, T. (1989). The Africa-centered perspective of history. NJ: K.A. Publications.

Kirschling, J., & McBride, A.B. (1989). Effects of age and sex on the experience of widowhood. Western Journal of Nursing Research, 11, 207-218.

Kitson, G.K., & Roach, M.J. (1989). Independence and social psychological adjustment in widowhood and divorce. In D.A. Lund (Ed.), Older bereaved spouses: Research with practical applications (pp. 167-183). New York: Hemisphere.

Knaack, P. (1984). Phenomenological research. Western Journal of Nursing Research, 6,107-114.

Leininger, M. (1985). Nature, rationale, and importance of qualitative research methods in nursing. In M. Leininger (Ed.), Qualitative research methods in nursing (pp. 1-25). Orlando, FL: Grune and Stratton.

Lindemann, E. (1944). Symptomatology and management of acute grief. American Jounal of Psychiatry, 101, 141-148.

Lund, D.A. (Ed.). (1989). Older bereaved spouses: Research with practical applications. New York: Hemisphere.

Martocchio, B. (1985). Grief and bereavement: Healing through hurt. Nursing Clinics of North America, 20, 327-341.

Mbiti, J.S. (1970). African religions and philosophy. New York: Anchor.

McDonald, J.M. (1987). Support systems for American Black wives and widows. In H.Z. Lopata (Ed.), Widows: North American, Vol. II (pp. 139-157). NC: Duke University Press.

Merleau-Ponty, M. (1956).What is phenomenology? Cross Currents, 6, 59-70.

Merleau-Ponty, M. (1962). Phenomenology of perception. New York: Humanities Press.

Messick, S. (1980). Test validity and the ethics of assessment. American Psychologist, 35, 1012-1027.

Munhall, P.L., & Oiler, C.J. (Eds.). (1986). Nursing research: A qualitative perspective. Norwalk, CN: Appleton-Century-Crofts.

Munhall, P.L., & Oiler, C.J. (Eds.). (1986). Philosophical foundations of qualitative research. In Nursing research: A qualitative perspective. (pp. 47-63). Norwalk, CT: Appleton-Century-Crofts.

Murray, C.B., Khatib, S., & Jackson, M. (1990). Social indices and the Black elderly: A comparative life cycle approach to the study of double jeopardy. In M.S. Harper (Ed.), Minority aging: Essential curricula content for selected health and allied professions, (pp. 167-187). Washington, DC: U.S. Government Printing Office.

Nuss, W.S., & Zubenko, G.S. (1992). Correlates of persistent depressive symptoms in widows. American Journal of Psychiatry, 149, 346-351.

Oiler, C.J. (1986). Phenomenology: The method. In P.L. Munhall, & C.J. Oiler (Eds.). Nursing research: A qualitative perspective (pp. 69-84). Norwalk, CT: Appleton-Century-Crofts.

Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, 5(1), 49-63.

Osterweis, M., Solomon, F., & Green, M. (Eds.) (1984). Bereavement: Reactions, consequences, and care. Washington, DC: National Academy Press.

Oyebade, B. (1990). African studies and the Afrocentric paradigm: A critique. Journal of Black Studies, 21, 233-238.

Padgett, D. (1989). Aging minority women: Issues in research and health policy. In L. Grau (Ed.), Women in the later years: Health, social, and cultural perspectives (pp. 213-225). New York: Haworth.

Parkes, C. (1972). Bereavement: Studies of grief in adult life. New York: International Universities Press.

Parkes, C.M., & Brown, R.J. (1972). Health after bereavement: A controlled study of young Boston widows and widowers. Psychosomatic Medicine, 34, 449-461.

Parse, R.P., Coyne, A.B., & Smith, M.J. (1985). Nursing research: Qualitative methods. Bowie, MD: Brady Communications.

Paterson, J.G., & Zdered, L.T. (1988). Humanistic nursing. New York: National League for Nursing.

Patton, M.Q. (1990). Qualitative evaluation and research methods (2nd ed.). Newbury Park, CA: Sage.

Polit, D.F., & Hungler, B.P. (1983). Nursing research: Principles and methods (2nd ed.). Philadelphia: J.B. Lippincott.

Polit, D., & Hungler, B. (1989). Essentials of nursing research (2nd ed.). Philadelphia: J.B. Lippincott.

Polkinghorne, D.E. (1989). Phenomenological research methods. In R.S. Valle, & S. Halling (Eds.), Existential-phenomenological perspectives in psychology (pp. 41-60). New York: Plenum Press.

Portes, A., & Jensen, L. (1989). The enclave and the entrants: Patterns of ethnic enterprise in Miami: Before and after mariel. American Sociological Review, 54, 929-949.

Portillo, C.J. (1990). The process of bereavement for Mexican-American widows: A grounded theory approach. (Doctoral dissertation, University of Arizona, 1990). Ann Arbor, MI: U.M.I. Dissertation Services, #PUZ 9025083.

Price, M.J. (1993). Exploration of body listening: Heath and physical self-awareness in chronic illness. Advances in Nursing Science, 15(4), 37-52.

Raphael, B. (1977). Preventative intervention with the recently bereaved. Archives of General Psychiatry, 34, 1450-1454.

Ray, M.A. (1985) A philosophical method to study nursing phenomena. In M. Leininger (Ed.), Qualitative research methods in nursing (pp. 81-92). Orlando, FL: Grune and Stratton.

Ray, M.A. (1987). Technological care: A new method for nursing research. Dimensions of Critical Care Nursing, 6, 166-173.

Redfield, R. (1953). The primitive world and its transformations. Ithaca, NY: Cornell University Press.

Reinharz, S., & Rowles, G.D. (Eds.). (1988). Qualitative gerontology. New York: Springer.

Riemen, D.J. (1986). The essential structures of a caring interaction: Doing phenomenology. In P.L. Munhall, & C.J. Oiler (Eds.), Nursing research: A qualitative perspective (pp. 85-108). Norwalk, CT: Appleton-Century-Crofts.

Rigdon, I.S., Clayton, B.C., & Dimond, M. (1987). Toward a theory of helpfulness for the elderly bereaved: An invitation to a new life. Advances in Nursing Science, 9(2), 32-43.

Roach, M.J., & Kitson, G.C. (1989). Impact of forewarning on adjustment to widowhood and divorce. In D.A. Lund (Ed.), Older bereaved spouses: Research with practical applications (pp. 185-200). NY: Hemisphere.

Rodgers, B.L., & Cowles, K.V. (1991). The concept of grief: An analysis of classical and contemporary thought. Death Studies, 15, 443-458.

Rosenbaum, J. (1991). Widowhood grief: A cultural perspective. The Canadian Journal of Nursing Research, 23, 61-76.

Sanders, C.M. (1980-1981). Comparison of younger and older spouses in bereavement outcome. Omega, 11, 217-232.

Satcher, D., & Thomas, D.J. (1990). Dimensions of minority aging: Implications for curriculum development for selected health professions. In M. S. Harper (Ed.), Minority aging: Essential curricula content for selected health and alliedhealth professions (pp. 23.32). Washington, DC: U.S.Government Printing Office.

Seidel, J.V., Kjolseth, R., & Seymour, E. (1988). The Ethnograph (Version 3.0) [Computer Software], Amherst, MA: Qualis Research Associates.

Shucter, C.M., & Zisook, S. (1986). Treatment of spousal bereavement: A multidimensional approach. Psychiatric Annals, 16, 295-305.

Siegel, J.M., & Kuykendall, D.H. (1990). Loss, widowhood, and psychological distress among elderly. Journal of Consulting and Clinical Psychology 58, 519-524.

Silverman, P.R. (1987). Widowhood as the next stage in the life course. In H.Z. Lopata (Ed.), Widows: North America, 2, (pp. 172-190). Durham, NC: Duke University.

Spiegelberg, H. (1994). The phenomenological movement (3rd ed.). Boston, MA: Kluwer Academic.

Stanford, E.P. (1990). Diverse Black aged. In Z. Harel, E. A. McKinney, & M. Williams (Eds.), Black aged: Understanding diversity and service needs (pp. 33-49). Newbury Park, CA: Sage.

Swanson, K.M. (1990). Providing care in the NICU: Sometimes an act of love. Advances in Nursing Science, 9(2), 64-80.

Swanson-Kaufman, K.M. (1986). A combined qualitative methodology for nursing research. Advances in Nursing Science, 8(3), 58-69.

Swanson-Kaufman, K.M., & Schonwald, E. (1988). Phenomenology. In B. Sarter (Ed.), Paths to knowledge: Innovative research methods for nursing (pp. 97-105). New York: National League for Nursing.Taylor, R. J., & Chatters, L. M. (1986). Patterns of informal support to elderly Black adults: Family friends, and church members. Social Work, 31, 432-438.

Taylor, R.J., & Chatters, L.M. (1991a). Extended family networks of older Black adults. Journal of Gertontology: Social Sciences, 46,(4), S210-217.

Taylor, R.J., & Chatters, L.M. (1991b). Nonorganizational religions participation among elderly Black adults. Journal of Gerontology: Social Sciences, 46, (2), S103-111.

Taylor, R.J., Chatters, L.M., Tucker, M.B., & Lewis, E. (1991). Developments in research on Black families: A decade review. In A. Booth (Ed.), Contemporary families: Looking forward, looking back (pp. 275-296). MN: National Council on Family Relations.

Taylor, S.J., & Bogdan, R. (1984). Introduction to qualitative research methods. (2nd ed.) New York: John Wiley & Sons.

Thompson, L., Breckenridge, J., Gallagher, D., & Peterson, J. (1984). Effects of bereavement on self-perception of physical health in elderly widows and widowers. Journal of Gerontology,39, 309-314.

Thompson, L.W., & Gallagher-Thompson, D. (1991). The effects of late-life spousal bereavement over a 30-month interval. Psychology and Aging,6, 434-441.

U.S. Bureau of the Census. (1984). Current Population Reports, Series P-23, No. 138, Demographic and Socioeconomic Aspects of Aging in the United States. Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. (1989). Statistical Abstract of the United States. (109th ed.). Washington, DC: U.S. Government Printing Office.

Vachon, M. (1976). Grief and bereavement following the death of a spouse. Canadian Psychiatric Association Journal, 21, 35-44.

Valanis, B.G., & Yeaworth, R. (1982). Ratings of physical and mental health in the older bereaved. Research in Nursing and Health, 5, 137-146.

Valanis, B., Yeaworth, R.C., & Mullis, M.R. (1987). Alcohol use among bereaved and nonbereaved older persons. Journal of Gerontology Nursing, 13, 26-32.

Valle, R.S., & King, M. (Eds.). (1978). Existential-phenomenological alternatives for psychology. NewYork: Oxford University Press.

van Kaam, A.L. (1959). The nurse in the patient's world. The American Journal of Nursing, 59, 1708-1710.

van Manen, M. (1984). "Doing" phenomenological research and writing: An introduction (Monograph No. 7). Edmonton, Canada: University of Alberta.

von Eckartsberg, R. (1971). On experimental methodology. In A. Giorgi, W.E. Fischer, & R. von Eckartsberg (Eds.), Duquesnee Studies in Phenomenological Psychology: Vol. I. (pp. 66-70). NJ: Humanities Press.

Warner, S.L. (1987). A comparative study of widows' and widowers' perceived social support during the first year of bereavement. Archives of Psychiatric Nursing, 1, 241-250.

Watson, W. H. (1990). Family care, economics and health. In Z. Harel, E. A. McKinney, & M. Williams (Eds.), Black aged: Understanding diversity and service needs (pp. 50-68). Newbury Park, CA: Sage.

Wertz, F.J. (1984). Procedures in phenomenological research and the question of validity. In C.M. Aanstoos (Ed.), Exploration in phenomenological psychology, Vol. 23, (pp. 29-48). Carollton: West Georgia College.

Willis, L. (1991). A comparison of grief responses and physical health changes in Caucasian and African-still birth. (Doctoral dissertation, The Ohio State University, 1991). Arbor, MI: U.M.I. Dissertation Services, Order number #9120740.

Zisook, S., & Shucter, S.R. (1991a). Depression through the first year after the death of a spouse. American Journal of Psychiatry, 148, 1346-1352.

APPENDIX

Verbal Consent Form

OREGON HEALTH SCIENCES UNIVERSITY
Verbal Consent Form

The Experience of Bereavement Among Older Black Widows:
A Phenomenonological Study

Principal Investigator

Laura S. Rodgers, RN, MS, Principal Inverstigator, (503) 288-3111
School of Nursing, Oregon Health Sciences University

Purpose

The purpose of this study is to describe the experience of bereavement among older black widows. During the interview you will be asked to describe your experiences of bereavement after the death of your husband.

Procedures

If you agree to participate the following will happen. After the verbal agreement, you will be interviewed by the first investigator. The interview will be conducted at a place convenient to you. The interview will last only as long as you wish to describe your experience. The interview will be tape recorded. You may stop the interview and end your participation at any time. After the first interview, the first investigator may contact you be telephone in order to arrange a second interview at your convenience. The second interview will be conducted in order to clarify and verify information you provided in the first interview. The interview will mostlikely be done via telephone.

Risks and Discomforts

There are no risks from this research. However, you may have some emotional discomfort during the interview as you describe your bereavement experience when your spouse died. Some people become uncomfortable and nervous when they talk about themselves and their feelings.

Benefits

Participation in this study may provide some benefits to you. For example, you may experience some emotional reliev after verbally sharing your experience with a person who is genuinely interested in listening to you. Although some people may not feel that they personally benefit from this study, their participation may still contribute to new information which may benefit other widows in the future.

Confidentiality
All tape recorded interviews and transcripts will be kept strictly confidential. No names will appear on any written or recorded data. Data will be identified by code numbers only. Your name and your identity will not be used in any publication from this study.

Costs
There is no cost to participate in this study, nor is there any compensation given to you for participating in the study.

Your Rights as a Participant
Laura Rodgers, RN, MS (503) 288-3111, has offered to answer any questions you may have. Participation in this research is completely voluntary. You may refuse to participate or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University.