Death of One’s Partner: The Anticipation and the Reality

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The loss of a chosen partner is, for many people, one of the most tragic events that can occur. The severity of the sense of loss and grief is contingent on length of marriage/relationship, age of partner and of their children, whether the partner’s death was sudden or followed a long illness, socioeconomic status, existence of a support network, and whether the relationship was predominantly happy or discordant. This article explores the fear about and reactions to death of a partner. It is based on over 35 years of clinical practice and draws on myriad observations about how family, friends, and patients perceive and cope with this life-altering event. Case illustrations are used, and interventions are highlighted to provide a possible template for clinicians.

“Till death do us part.” This statement of commitment has long been and still is a cornerstone of the marriage vows taken by the majority of couples entering what they hope will be long-time connubial bliss. The covenant of matrimony is sacrosanct to many as they embark on their life’s journey together.

If the couple is young, they soon tend to focus on the creation of new life and either bringing children into the world or adopting a child that needs a home (Babb, 1999; Schwartz & Kaslow, 2003). They tend not to be concerned about their partner’s eventual death in the early years of being together. Their savings are for purchasing cars, a home, and consumer goods, taking vacations, and providing for their children’s education. Little thought is given to the senior years, retirement, or the ultimate death of each other in this stage of the life cycle, especially if each partner is relatively young and healthy, physically and emotionally. With life expectancy now extended into one’s 70s and 80s, death seems a long way off—barring a fatal accident or a natural or people-made disaster. Optimism tends to run high as couples are in their expansive building years. Worries about the end of life are more apt to be centered on what is happening to their respective parents. However, with the passage of the years and the approach of retirement or onset of arthritis, chronic illness, or other problems associated with the normal aging process, and the increasing number of deaths of their own peers, concerns about the inevitability of their own deaths are likely to surface, perhaps to be ignored, only to return to consciousness periodically.

Occurrence of Prolonged Illness

However, for some, their optimistic dreams (Seligman, 1991) all too soon can be darkened by various shadows. Their partner can be diagnosed with multiple sclerosis, muscular dystrophy, or Lou Gehrig’s disease. He or she may be incapacitated by a serious stroke, have cardiac failure or require quadruple bypass surgery, need kidney dialysis, have some kind of cancer, or be seriously injured in an accident. All of these conditions tend to have some life-altering consequences and to be very sobering occurrences.

Relevant Family Systems Concepts

Family systems theory has numerous basic precepts that have evolved and been refined and elaborated in the past approximately 60 years since the emergence of the family psychology/psychiatry/therapy field. I present those principles most pertinent for the purposes of this treatise on the death of a spouse, viewed within a family systems perspective, which I have updated and synthesized, with a brief explanatory comment added for each.

1. All members of the family system are interconnected and interdependent, and the behavior of each affects all of the others. (This particularly applies to the nuclear family unit, and often to the extended and intergenerational family as well [Bowen, 1988].) Because of this interconnectedness, therapists can encourage the surviving spouse to turn to other members of the nuclear and close extended family unit so they can reminisce and grieve together, for emotional support, to help with tasks that need to be executed immediately, and to plan for the future.

2. Families strive to maintain their homeostatic balance and to resist major challenges to their values, lifestyle, and overall equilibrium. A patient can be reassured that not wanting to make drastic changes immediately, like moving into smaller living quarters, is normal and that decisions to undertake such actions probably can be postponed until one feels more ready to consider these.

3. When one member of the family experiences pain (or distress), all members of the family experience some form of pain (Satir, 1964, 1967), discomfort, or anxiety. These feelings may provide the leverage for getting the significant others of the originally identified or index patient into family treatment. Children are also affected by the death of a parent and, if the family is close, will resonate to the surviving parent’s grave sense of loss, as well as experiencing their own. Sharing the pain and bewilderment about the future can provide solace and mutual comfort and should be encouraged.

4. Each member of the family has their own narrative to tell (White & Epstom, 1990) and should be listened to empathically. It is their version of their family’s story, and their place, role, and...
status within their family. Each person in treatment, or assembled anywhere, should be encouraged to tell his or her story and share memories with one another, which can have a curative effect in the opportunity reminiscing provides for catharsis; this can also optimize feelings of “bonding” and attachment.

5. As any one member of the family system changes, this will trigger changes in the other members of the system, as they will ultimately have to respond differently. As the surviving parent regains composure and starts to function more competently and independently, this sets grown children free to deal with their own changed world and worry less about their parent. If the children are young when their Mom or Dad dies, the remaining parent will have to tend to their needs, also, so their rates of reequilibration will be intertwined.

6. Each person is responsible for his or her own behavior and should be held accountable for changing it in accordance with the tasks to be mastered and goals set in treatment. Clinically, despite their recent tragedy, each person should be expected to treat in an age- and stage-appropriate way and gently guided to resume responsibilities. For example, children should be expected to return to school after a lapse of time devoted to active grieving, and adults to work, or their other activities after sufficient time has been allotted for the first phase of the mourning process. Yet they should be reassured that periods of being sad, lonely, teary, or angry will recur for a while to come, and they should allow themselves to feel what they feel while still attempting to resume their normal activities. (These principles are alluded to later in the Z case summation.)

Bentovim (1992) talked about trauma-organized systems, that is, how the family organizes itself differently than before the illness set in, or the accident or other traumatic event(s) occurred, to deal with the immediate crises or series of events. Initially, the majority of families shift into a crisis mode, which first entails dealing with what must be done immediately, like getting someone to the doctor or hospital, arranging for surgery, visiting daily, or setting up nursing, physical therapy, rehabilitation, or other needed services. They may also be confronted with the need to reappportion roles in the family, like chauffeuring children to activities and making meals. Filing insurance claims may be another time-consuming task with which the partner may be unfamiliar, yet that needs to be done. Financial concerns may mount, driving everyone’s stress level higher. The sick person needs empathy and understanding and is likely to get it, at least initially, from family and friends. However, the well partner, who is often on overload and feeling distraught in the caregiver and general manager roles, may get little of the sympathy and support he or she requires, especially if the illness becomes chronic and drawn out. The needs of all change over time, so it is important that the system continue to be flexible and make new adaptations (Olson, 1996) and long-range plans, rather than stay in the crisis mode that was appropriate in the beginning and acute phases of the illness. Children may be baffled and frightened, their sense of security threatened by one parent’s plight and possible diminished accessibility at the same time the other parent has become preoccupied and therefore also less available.

**Death Following a Long-Term Illness**

As an acute illness becomes chronic and then is viewed as terminal, the anxiety level is likely to escalate, and if death seems to be hovering near, everyone’s dread may mount. Under these circumstances, fear of death may exact as much of a toll as the illness itself, and the caretaker/partner may feel overwhelmed by the burden of all the responsibilities and resentful or saddened by the multiple losses devolving from no longer having a capable, cheerful, and contributing partner (Rainer & McMurry, 2002). When a person dies after a prolonged illness, the remaining partner, if still young and with children at home, often feels an admixture of new apprehensions about managing as a single parent and relief that the ordeal has ended.

If the person is in a financially solvent position, it is likely to be easier to pay attention to the children and their dilemmas about the loss and other needs, as well as do their own mourning and subsequent reequilibration. If they are impoverished or financially strapped, their grief and often a sense of aloneness are complicated by yet another layer of serious concerns about mounting bills and having to earn a living, thus not being available to the children much of the time. For many, this is a bleak scenario for an extended period of time, and the comfort of neighbors, family, and friends is essential during the most difficult months following the death. If they can be guided to enter individual or family therapy or go to a support group with others who are also dealing with bereavement issues, they can receive assistance for coping with the grief and exhaustion and planning for the present and future. Their coping capacities and sense of well-being can be enhanced. For those who have a strong religious or spiritual faith, talks with their minister, priest, or rabbi, as well as prayer and church attendance, may help them regain strength, courage, and perspective and to find a way to move forward (Close, 2002b).

In older couples who have been together for many decades and who still like being married to each other, the bonds of friendship, companionship, and love deepen over the years (Sharlin, Kaslow, & Hammerschmidt, 2000). They become interdependent, and although they may maintain separate and well-individuated identities, their couple identity is vitally important and significant to their sense of being and well-being. While they are still well, it is advisable that future threats to this vital bond be discussed and tentative plans made, including the preparation of advance directives stating each one’s wishes in the event one becomes seriously ill (Rainer & McMurry, 2002). However, many couples harbor a silent fear of the demise of their spouse that neither cares to broach in open discussion. Both hope the inevitable end to life will not come for many years. The Z case, which follows, is illustrative of the second type of older couple.

**Clinical Vignette 1: The Z Case**

Mrs. Z was referred to me by her primary care physician. She and her husband had been married about 45 years and lived an affluent lifestyle in Palm Beach, Florida. They had been on vacation in Europe when Mr. Z suffered a moderately severe stroke. He was flown back to the United States and provided with the best care available. Mrs. Z felt terribly stressed and agitated; she was accustomed to her husband being a competent, take-charge kind of person, and she rarely had had to make major decisions. Seeing

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1 All case illustrations have two or more similar cases intertwined. Nonetheless, all identities have been carefully camouflaged to protect the privacy and confidentiality of the actual patients.
him unable to ambulate easily and hearing his slurred speech were initially incomprehensible. She had been somewhat pampered and enjoyed their country club existence; now he could no longer handle their daily affairs, play golf, or go to social functions with her. She had little understanding of their complex investments and other aspects of their finances. She knew it was important to him that he be treated with dignity and respect and to remain at home.

Her physician recognized her confusion and depression, and thus the referral to me. She was pleased to have someone to talk with who empathized with her plight and who could provide support and guidance. She was able to form a strong therapeutic alliance, which she sustained over many years. Over time she expressed strong resentment and great anger (not unusual reactions) that her husband’s stroke had interferered with their wonderful lifestyle and that she felt adrift. Because her husband’s mind was still functioning well at this point, I suggested she ask him to set up meetings with their accountant, banker, lawyer, and stockbroker so she could become better acquainted with these key people who affected her life and could learn to understand the trusts and will he had set up, how to monitor their investments, and what it was she had to manage. A bright woman, she followed through on this and learned fairly rapidly so she became well versed in their financial affairs.

Friends, as well as her husband’s brother and sister-in-law, visited and sometimes went out to dinner with them the first few months after his initial stroke. However, in the next year he suffered several mini TIAs (transient ischemic attack), and his condition deteriorated visibly. People stopped calling and were reluctant to accept her invitations to come visit and play bridge (he still could) or meet them for dinner. He was using a walker and slobbered when he ate. I sympathized with how cruel this “desertion” by long-time friends must feel and then explained that being around a dear friend who is declining forces others to face their own vulnerability and mortality, and many shy away from situations that serve as a reminder. In addition, I indicated that some of their friends had already decided life for them was short and they wanted to have fun, which may have excluded being exposed to the unhappy sight of a friend who was debilitated. She protested, disliking this idea, but after pondering it, realized she would not like to go out with someone in his condition either, if she did not have to.

One day she came into her therapy session quite sheepishly, which was unusual for her. She said she was afraid and ashamed to say what she was thinking and feeling and yet to talk about anything else seemed trivial. I asked if she wanted help in articulating her feelings, and with tears in her eyes, she nodded. I asked if, after 4 long years of living with her husband while his condition worsened and her own existence revolved increasingly around his illness, she wished the end would come quickly. She nodded again, and asked if she were a terrible person for wishing this for the husband she had once loved so much and who had been so good to her. I provided the reassurance she needed that feeling this way when one has been the caretaker for a person who is chronically ill and is not expected to improve is frequent and that it did not make her a horrible person. She heaved a sigh of relief, and we were able to proceed with discussing other issues during the session.

About a month later she was able to finalize arrangements for her husband to enter a nursing home and for private duty nurses, when needed. He had become incontinent, and she and the at-home nurses could not change his diaper or move him easily. This fact helped her justify “breaking” the promise she had made years earlier not to place him in a nursing home. His residing outside of the home allowed her more free time, so she felt less confined and resentful, and she knew he was getting good care. She visited daily and then did whatever else she wanted to.

With encouragement from her therapist and some preparatory role rehearsals on how to do so before he died a few months later, she was able to say her goodbyes and thank him for what he had contributed to their life together, and for their children. She had kept them apprised of their father’s declining health, but both had come to visit from their homes up north infrequently, indicating they were just too busy.

In treatment we processed her feelings of abandonment and her regrets that they had not paid more attention to their father (as sometimes happens). Her son, daughter, and grandchildren did come to Florida for his funeral, and did find time to fly down again when his will was being probated (Klein, 2000) to see what personal items, like jewelry and cars, they might be getting and could take back with them. She was disappointed by their selfishness and calloused behavior. Yet in many ways, relief was her predominant emotion, and she was ready for the closure death brought.

Z Case Summation

Mr. Z’s illness led to a change in the Z’s marital interaction; it necessitated Mrs. Z becoming much more self-sufficient and taking on the major decision-making and caretaking roles. Their grown children’s neglect of both of them during this time, while they continued to expect their usual annual tax-free $10,000 checks per person, plus other major gifts, forced Mrs. Z to recognize that she and her husband had indulged their children and had failed to teach them appreciation and mutuality. My psychodynamic therapeutic interventions facilitated ventilation and catharsis and promoted greater insight into herself, her husband, and their children. Cognitive–behavioral techniques used for goal-oriented planning (Kaslows & Patterson, 2002), plus systemic and narrative approaches, were included. (The principles alluded to herein were explicated earlier in this article.) These included the following:

- Encouraging Mrs. Z to tell their life story; listening attentively, sympathetically, and empathically; and interjecting responses as she related her memories and interpretations. (Principle 4: Retelling one’s personal narrative.)

- Helping her become aware of her strengths, which included her intelligence (previously underutilized), her astuteness and perceptiveness, her competence to learn about and later to manage their affairs, and her considerable energy. (Principle 6: Encouraging independence, responsibility, and mastery.)

- Giving “permission” to her to find ways to resume enjoying her own life, including taking occasional mini vacations, without feeling guilty once she had devised and implemented good plans for his care in the nursing home. (Principle 1: Helping her extricate slightly from feeling too interconnected and losing any sense of being a separate self.)

- Encouraging her to articulate her thoughts and feelings about him to her husband, thank him for their life together, and say her goodbyes—while he was still coherent and could respond and give her loving feedback, too. As they had not been prone to being emotionally expressive of deep sentiments, engaging in this kind of behavior had seemed alien to her, and yet she knew intellectu-
ally that it was something she would like to do. We did several role enactments to ready her for what proved to be a very dramatic and touching interaction. (Principle 2: Here we attempted to disrupt a long-term homeostatic balance that had had negative consequences.)

- Gently guiding her to assess her children and grandchildren more realistically so she was not repeatedly disappointed in and hurt by their inattentiveness and lack of concern. (Principle 5: As Mrs. Z changed, it was anticipated there would be a concomitant change in the reactions and behaviors of her children and grandchildren.)

- Once Mr. Z had died, and she had had time to mourn, I refocused treatment on what she wanted to do with her life in the immediate future, and she was able to ponder this and make some decisions, like how much she wanted to move back to a beachfront condominium, increase her travel, renew neglected friendships, and take appropriate actions to implement her plans. (Principle 6: In using this type of intervention, I encouraged Mrs. Z to take charge of her own life—in the present and for the future—and free herself of her husband’s remaining vestiges of control, which she had abhorred.)

- Suggested bringing many years of therapy to closure, as she was capable of managing quite well on her own, thereby supporting her recently acquired sense of her own self-sufficiency. (Principle 6: She had achieved her goals and needed to be off on her own, by mutual agreement. It was an excellent, liberating final session, like a graduation.)

Sudden, Unanticipated Death

This scenario is quite different from what is apt to occur when someone is confronted with the sudden, (almost) instantaneous death of their partner. This can result from an airplane or car crash, a drive-by shooting, a hurricane or flood, a fatal coronary, or a horrendous event like the terrorist attack of 9/11 that quickly destroyed thousands of lives. All of these occurrences seem inexplicable and incomprehensible and are overwhelming to deal with. There is no time for emotional preparation, no time to work through problems, no time to say goodbye and bring any sort of emotional closure to the relationships, and no time to ask for or offer forgiveness (Close, 2002a). Instead, there probably is disbelief, shock, incredulity, numbness, grief, rage, and bewilderment about how this happened, and myriad questions that one may obsess over such as: Did he or she suffer? What could I have done to prevent it? How am I going to go on? What is going to happen to me, the children, and his/her (dependent) parents? Given the quandary and quagmire in which they may perceive themselves to be caught, and all of the uncertainties that beset them, it is not unusual for people to try to give some meaning to their terrible loss by seeking someone to blame. It can be the doctors (in the case of a partner’s fatal coronary or not being able to save their life after an accident), God for allowing such a disaster to occur, or the airline or government for not properly protecting its passengers or citizens.

Rather than seeking someone to blame, others turn to their faith for comfort and believe that somehow what happened is part of God’s plan and they must accept it and pray for guidance, strength, humility, and understanding. They may turn to family, friends, and the community for succor and solace. Still others dull the pain with antianxiety or antidepressant medication, illegal drugs or alcohol, gambling, or overeating. But sooner or later they must face the loss and its implications and attempt to deal with the present and future—for at least a while—alone, as a widow or widower. Loneliness may be pervasive and paralyzing. It may be many decades since they lived alone and were not part of a couple. The solitude and emptiness can cause despair and a feeling of not knowing where to turn, what to do, how they will survive, and whether they want to go on without their partner. Clinically, we see a myriad of other feelings also, such as guilt and remorse expressed in such statements as “I should have been a better husband [or wife].” “I did not realize how much I cared for him [or her].” “I’m so sorry for all the missed opportunities.”

Here attentive listening, loads of support and encouragement, and “permission” to grieve, to be angry, and generally “feel what you feel” can be given. Later, suggestions can be made about how to pick up the pieces. Discussion about whether to move or stay put in the marital home, how to reach out to old and new friends, and resuming activities may be warranted. The therapist should pace interventions to the rhythm of the patient’s ability to hear and perhaps use the suggestions.

The therapeutic approaches and strategies recommended earlier are also applicable when death has been sudden. But first a safe sanctuary or holding environment (Winnicott, 1986) must be provided by the therapist so the person can do his or her grieving. Occasionally, we hear relief expressed when a fatal accident occurs. This seems to be particularly true where a situation has been abusive and the partner’s death sets the spouse free, when divorce was perceived as untenable or dangerous to pursue.

Clinical Vignette 2: The C Case

Bob C was 39 years of age. His wife, Lira, was 35 years old, and they had twin daughters, age 3. Bob, a CPA, worked hard and put in long hours at the office and with clients. Although he was devoted to his family, he saw his main role as providing well for his family financially, just as his dad had done. Lira agreed, since she wanted to be a stay-at-home mom and devote her time to raising the children. Both considered the marriage and their life together quite happy and fulfilling, until tragedy struck suddenly.

One day when Lira had a babysitter she went to do some shopping in the nearby mall. While she was driving, another car rammed into her and she was thrown out onto the road. By the time the paramedics came and got her to the hospital, she was pronounced dead on arrival. Her injuries had been fatal.

When Bob received the phone call at his office telling him there had been an accident and he should come to the hospital immediately, his heart began to pound. With barely a word of explanation, he raced out of his office. When he got to the hospital and was told the horrific news, he went into a state of disbelief saying, “It can’t be true; you must have the wrong person.” But when they showed him her wallet and identification and described her mangled car, the truth became undeniable.

What he later described to me in therapy (which one of the nurses had urged he seek right away) was that disbelief turned to shock, horror, fury, and then uncontrollable tears. His whole life had changed instantaneously, and he had no idea of what to do or where to turn. A social worker in the emergency unit suggested that the few things he needed to do immediately were (a) call his office, tell them what had occurred and arrange for others there to cover his accounts and paperwork for the next week; (b) notify his
wife’s parent and his, and see who could help with the children immediately and until other arrangements could be made; and (c) think about funeral arrangements and decide if he wanted to handle these or delegate them to someone else. Through his tears, he nodded, but he was so dazed he felt like a “dead man walking.” He realized he had to decide quickly whether to take the twins to the funeral, which he was reluctant to do. In the initial emergency therapy session, I suggested that even though the twins might not understand what death and a funeral really signified, it was probably better to take them, for them to symbolically say goodbye, and conveyed that this memory probably would become increasingly important as they got older.

For weeks afterward, he went through the motions of conducting his life, handling what seemed most pressing at the moment. Both sets of parents set up a schedule of shifts to help with the children when he was not available and agreed to do this for 4 to 6 weeks, and thereafter when other arrangements could not be made. One of the greatest dilemmas for him was how to tell the children that their mommy was not coming back and to communicate how fatal accidents occur without frightening them so that they would still be willing to go in a car. We dealt with this in his second and third therapy sessions, as this was a pressing matter. Despite having gone to the funeral, the girls kept asking, “Where is mommy?” “Why isn’t she coming back?” He explained about death as best he could and found that their longing for their mommy and anger at her disappearance just added another huge layer of despair to his own distress. The demands of his daily life felt overwhelming; he could not concentrate; he could not show his grief and upset to the child who loved him. They needed reassurance of his continued love, but that much as he would pour out his heart, get some sincere empathy for his pain and plight, and also receive some rational help with step-by-step procedures for accomplishing the tasks that needed to be done. He was able to follow through and implement the plans and actions we had devised jointly.

Fortunately, his parents and in-laws were wonderful to him and the children, and they all loved each other dearly. Their constancy helped the children stay in their prior routine and enabled them to be tucked into bed each night by their daddy or an adoring grandparent. Bob went back to work part time a month after his wife died. He made arrangements to set up a complete office in his home where he could continue to work part time. He found an excellent “nanny/housekeeper” whom he hired for 30 hours a week. The rest of the time he chose to be Mr. Mom, and the two sets of grandparents remained actively involved.

Six months later the household was running smoothly and Bob enjoyed spending more time with his twins. He still desperately missed his wife, and the children still occasionally asked, “When is mommy coming back?” Fortunately, the nanny was reliable, affectionate, and kind. In therapy Bob had asked all of the unanswerable “why” questions, cried over his loss and the enormous changes it had wrought, deliberated over how to handle his children, and decided to take one day at a time. Eventually, it became clear that the “Why did this happen” question has no answer, unless one has deep faith and can accept that the death was God’s will and their loved one is happy in heaven.

The Aftermath

As in the Z case, therapy here used an integrative approach (Kaslow & Lebow, 2002), each strategy tailored to what was most pressing in the moment. Initially I used crisis intervention or critical stress debriefing by “being with him” as Bob sobbed, screamed out in fury at the driver of the car that killed his wife, and poured out his confusion and desperation. Then I structured the interventions to help him focus on:

- What needed to be done immediately regarding the funeral and child care.
- Establishing a longer term plan for the children’s parenting, what to tell them, and how.
- Calling upon and relying on their extended family support system as a key resource network.
- Emphasizing how much the children needed to be able to rely on his resiliency.
- Rearranging his work schedule and setting up an auxiliary office at home.
- How to continue loving and remembering his wife, and yet slowly begin to move on in his life without her presence by renewing friendships and occasionally going out for a social evening.
- Setting a realistic timetable and expectations for his own and the children’s recovery.

Phase 1 of treatment lasted for about 3 months, and then he felt he could “go it on my own.” We agreed to hold a follow-up session every 3 months for a year, and that he could call as needed. He adhered to the plan and actually called only one time for guidance when the twins insisted he had to “make mommy come back.” He was stymied, like most parents would be, posed with this request. I helped him elaborate on what he had originally told the children, to reassure them of her continuing love, but that much as he would like to, he could not bring her back. Such moments are always poignant and highlight the impermanence of relationships and of life itself.

Other Variables to Be Considered

Many variables influence the kind of death that is apt to occur and the grief, mourning, and healing process that ensue. Age is a significant one, and it seems that younger people are more apt to die of sudden, accidental deaths as they are more likely to take such risks as riding motorcycles or driving cars at high speeds, sky diving, bungee jumping, and drag racing. Also, they may serve in the armed forces and may die on the battlefield. Younger surviving partners may go into temporary shock, as Mr. C did, yet recuperate more swiftly because they know their children need them to be healthy and competent, and they have more options available in terms of job opportunities, friendships, and activities in which to participate than their older counterparts usually do. They are likely to have more social resources to call upon and to be more resilient.

It is in the over-65 age range that long-term chronic illness is likely to prove debilitating and culminate in death. In this age cohort, one rarely has healthy parents still alive to turn to, and they will already have lost some of their friends who have relocated for their retirement, or to death. Often their own health is no longer robust, and they view their world as no longer dynamic and expansive but rather as dull and shrinking. In therapy, the components of this pessimistic view needs to be reframed, new alterna-
When the death occurs through suicide (see earlier article in this section by N. Kaslow and Aronson for fuller discussion), it is devastating to the survivor spouse, unless the spouse has long been terminally ill and this action is perceived as a self-chosen “mercy killing.” Given that statistics in the United States show that White men between 75 and 85 years of age have a higher suicide rate than any other age group and that both elderly men and women commit suicide three to four times more than younger adults of the same sex (Saul & Saul, 1988–1989), it is reasonable to assume that a significant portion of these individuals are married and leave behind a bereaved partner. It has been found that elderly people who commit suicide have a strong intent to die (Miller, 1979), and the means they use are more lethal and lead to death more frequently than with younger attempters. A study by Lund and his colleagues (Lund, Caserta, & Dimond, 1986) found that the highest levels of depression and bereavement-related symptoms in the surviving partner were manifested “in the first few months after the loss, and that the symptoms lessened over time”; nevertheless, the loss was often not resolved within 2 years (Balter, 1993).

Most, if not all, of the great religions have rituals for helping people deal with death, and these involve loved ones in the process for support, comfort, and reassurance. The prevailing rituals may entail prescribed ways of handling the preparations for the funeral, the actual funeral ceremony in a chapel and at the gravesite, and what is to happen after the burial. The rituals serve as road maps that prescribe a structured way that things should be handled, and sometimes even how people should behave. Following these rituals means the grieving and bereaved survivors do not have to figure out the details for themselves; there is a predetermined and widely accepted template for doing so within their personal reference group and community of origin (Imber-Black, Roberts, & Whiting, 1988). Thus, for example, whether one is Catholic and there is a wake and a mass, or is Jewish and is expected to “sit Shiva” for anywhere from 3 days to 1 week followed by, in orthodox Judaism, a mandated, prolonged period of 1 month of heavy mourning and then another 10 to 11 months of lighter mourning until the ceremonial unveiling of the tombstone, the expectations are familiar. This familiarity and link to past and future generations of relatives and mourners provide a modicum of comfort and succor. Friends are also expected to be around to take over to temporarily relieve the bereaved individual (and immediate family) of some pressing chores. In the event that no funeral or burial arrangements have been made, and doing so would be exceedingly stressful for the new widow or widower in the immediate aftermath of their loss, others can execute these tasks. The presence of neighbors, friends, and relatives for the days and weeks following the death not only provides some reassurance and soothing but also can serve as an intermittent distraction from one’s grief and sense of woe. They may also be able to offer some counsel, guidance, wisdom, and assistance in problem solving as to next steps to be taken and the handling of myriad financial concerns.

In a summary of the literature, Balter (1993) found that those who have strong social support networks fare better than those who are isolated and feel lonely, and that they are able to adapt to bereavement without excess physical or psychiatric problems. Clinically, what we see when a senior adult has been widowed by the death by suicide of a spouse is that the living partner goes through the gamut of emotions, from all the self-doubts as to their contribution to precipitating the deadly act to fury that it was committed, leaving them alone and humiliated. They are extremely distressed by what has transpired and its sequelae.

Pitta (2002) and Sanders (1992) have identified tasks that need to be accomplished in the healing and renewal phases of recuperation from grieving the loss of a loved one. These seem applicable to someone mourning the loss of a spouse, and therefore are listed here, with amplifications, because they incorporate and extend what has been discussed earlier in this article and have practical utility for the clinician involved with helping patients heal.

The healing phase—the turning point after recognition of loss and frequent withdrawal:

- Relinquishing roles (particularly that of spouse)
- Forming a new identity (as a widowed person)
- Assuming control (and responsibility for one’s own decisions)
- Self-care (like exercising, eating well, socializing)
- Centering, including self-soothing (perhaps meditating, doing relaxation breathing and exercises)
- Forgiving (the loved one for dying)
- Searching for meaning (in the loved one’s death, perhaps from a spiritual relationship with a higher power)
- Closing the circle (possibly through a ritual or special event, and then embarking on new pathways and opening new circles of friends and activities)
- Renewing hope (remembering both the sad and happy times realistically)

The renewal phase (Sanders, 1992):

- Keeping loneliness in perspective (learning to live without the partner)
- Enduring the anniversaries (and other special couples events, and knowing they may bring about some temporary resurgence of grief and longing)
- Accepting responsibility for and living for oneself (establishing emotional independence and enjoying one’s newfound freedom)
- Focusing (putting one’s energies into meeting new challenges and goals)
- Reaching out
- Understanding the long process of grieving

Smith (2003) cautioned that it is important to differentiate between mourning and melancholia, and to recognize the difference between bereavement and sadness over the loss and clinical depression, which is more serious and longer lasting. The first response of mourning, sorrow and sadness, is normal and reactive. The second is marked by a greater number and more severity of symptoms, plus a sense of worthlessness experienced by the depressed survivor. It is this “sense of worthlessness . . . possibly accompanied by corollary guilt and suicidal ideation, that sets depression apart from grieving” (p. 3). It is imperative that therapists recognize the difference and predicate treatment on an astute differential diagnosis.

References


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