Crisis of mate loss in the elderly

The crisis of mate loss in the elderly has severe implications for the physical and mental health of the surviving spouse. During the dying process of the mate, the spouse experiences an imbalance in needs and resources. The nurse is in a unique position to facilitate the resources of the spouse, particularly during the mate's dying process. The conceptual model for crisis of mate loss in the elderly describes the dynamics of nursing intervention and facilitation of resources such as interpersonal support, religious-spiritual belief, and intrapersonal coping.

Judith M. Richter, RN, PhD
Assistant Professor
School of Nursing
University of Northern Colorado
Greeley, Colorado

WHEN ASKED to describe the reactions to the loss of her husband, a recently widowed woman responded, "To lose a child is like losing the limb of a tree. To lose a mate is like losing the trunk of a tree." It has been said that the loss of a mate through death is the most catastrophic event that American men and women experience.[1,2] Following the loss, some survivors may maintain their health or show improvement. Research has indicated, however, that in the first year following the loss of a mate, there is an increase in morbidity and mortality rates of widows and widowers.[3] The aged bereaved are particularly at risk for physical and emotional problems. The surviving spouse is expected to accomplish complex tasks requiring time and resources. For example, the spouse is expected to resolve grief and resume a normal life.

OVERVIEW OF CRISIS THEORY

Crisis theory is the conceptual framework used in most studies of loss.

Although this theory has some limitations in describing the total bereavement process, crisis provides a useful framework in understanding the experiences of the spouse during the dying process of a mate.

Crisis refers to the person's emotional reaction to a hazardous event and not to the event itself. Eliot[4] indicated that crises can be characterized by emotional excitement and efforts on behalf of the organism to respond in a way that will relax the unpleasant state of tension. Typical behaviors observed in response to the loss of a loved one include rejection of the facts, shock, temporary dissociation, repression, or blame of self or others. The crisis of loss is part of a transitional period with the opportunity for growth or increased vulnerability to physical or mental disorder.

Grief has been described as a normal emotional and physical process that accompanies the crisis of loss. The classic paper by Lindemann[5] described the symptoms of normal grief, based primarily on observations of bereaved disaster victims of the Coconut Grove fire in Boston. The four major characteristics are preoccupation with the image of the deceased, somatic distress, hostile reactions, and guilt. Distortions of normal grief, described by Lindemann as morbid grief reactions, include delay of reaction, which may involve years, and symptoms such as alterations in relationships with friends and relatives or agitated depression. These findings were later contradicted by Gerber et al,[6] who found that it is normal for grief reactions in the elderly to be delayed or prolonged. All researchers agreed, however, that effective intervention with persons experiencing grief reactions could prevent serious and prolonged pathological alterations in the client's social adjustment as well as potential physical disease.

Erikson's[7] developmental theory included a discussion of crises or periods of cognitive and affective upset. Crises occur developmentally as a person makes the transition from one phase of development to another or accidentally when the individual is confronted with a novel situation such as the death of a loved one. Life hazards involving the sudden loss of resources or the threat of loss or challenge associated with the opportunity for increased resources usually range from a few days to a few weeks in duration. The personality may suddenly change in unexpected ways during periods of crisis, and these changes may be toward increased health and maturity or toward reduced capacity to deal effectively with life's problems. The notion of crisis as a turning point offers the hope that effective interventions during the disequilibrium of the crisis could increase the possibility of a healthful outcome.

The critical factor influencing the occurrence of a crisis is an imbalance between the importance and difficulty of a problem and the resources available to deal with it. The usual problem-solving mechanisms are unsuccessful, and tension caused by frustration of need rises, leading to difficulty in maintaining the integrity of the organism. Caplan[8] developed a conceptual model for crisis intervention with loss. He indicated that not all problems can be solved by removal of the threat to need satisfaction; however, even in these cases, a positive outcome, accompanied by an act of relinquishing this avenue of need satisfaction and replacing it by alternatives, can

be differentiated from problem avoidance in which no conflict is resolved. For example, in the crisis of bereavement from the death of a loved one, the individual must accept the impossibility of ever satisfying his or her needs through interaction with the deceased.

As tension rises to a climax in crisis, the person begins to use available resources. The individual is more susceptible to influence by others during the disequilibrium of crisis than at times of stable functioning. Help offered during this time will ultimately influence the health outcome.

In recent years, Caplan[9] and Parkes[10] have expanded the early work with crisis theory to incorporate the notion of psychosocial transition. Although episodes that could be termed crises occur at various stages of the bereavement process, the overall process is more completely described by the comprehensive concept of psychosocial transition. Psychosocial transitions have been described as dramatic changes in life that are lasting in their effects, which take place over a relatively short period of time and which have an impact on significant aspects of a person's life.

According to Dimond,[11] the question of why some older people manage bereavement more successfully than others is, at least in part, a matter of access to adequate and appropriate resources. Dimond developed a nursing model for understanding bereavement in the elderly. She identified coping strategies, support networks, and concurrent losses, as particularly important intervening variables following the death of a mate.

Another alternative to the medical model perspective inherent in much of the crisis literature has been proposed by Narayan and Joslin,[12] who described crisis as depleted health potential. According to these authors, when a person experiences a crisis in reaction to the loss of a mate, there is an alteration in need-resource dynamics. The extent to which internal and external resources are available and used can have an impact on health outcome potential. A significant variable in regulating the capacity to maintain or improve health during and following the crisis of loss is availability and ability to respond to resources.

Most deaths still occur in the hospital, where the nurse has the opportunity to facilitate the resources of the spouse of the dying patient. Historically, nurses have primarily intervened in problem situations, with the intent of correcting or changing the problem. The spouse of a dying patient is likely to feel helpless and bewildered during the final week of the patient's life, and the nursing care provided at this time is more likely to be palliative than curative. The spouse of the dying patient and the hospital staff are more likely than the patient to be aware that death is impending.[13]

Nursing interventions that allow the spouse to use available resources could have a positive impact on the health of the spouse after the mate has died. If nursing is to reinforce existing strengths and

Nursing interventions that allow the spouse to use available resources could have a positive impact on the health of the spouse after the mate has died.

resources as an effective intervention in crisis of loss, an increased understanding of the experiences of the surviving spouse is necessary.

MATE LOSS IN THE ELDERLY

Crisis

The ending of a marriage relationship through death is a profound loss. The elderly are likely to be affected most severely by the loss for a number of reasons. Those who are aged 50 and over are likely to have been in the same relationship for 30 to 40 years. Whether the relationship was satisfactory or not, it certainly was significant and, therefore, the loss is significant. Persons who are over 50 are also more likely to have experienced other losses, such as loss of career or loss of health.

Stern et al[14] described reactions to bereavement among 25 subjects between the ages of 53 and 70. One of the participants in the study was a man and the rest were women. Of the 25 subjects, 23 attended a counseling service for the elderly. The data from this study were taken from several interviews with each subject, as well as the history recorded by the social worker. Despite the small, biased sample and unstructured data collection, the results were significant because this was the first investigation with older people. The findings of the study were that elderly persons:

- showed a tendency to replace emotional reactions with somatic complaints;
- had minimal conscious guilt;
- had a tendency to hostility toward friends and family; and
- demonstrated behavior of self-isolation.

Agee[13] theorized about some of the problems facing elderly persons who experience loss. For example, there is less opportunity to reinstate the lost object or to compromise and replace some of the lost gratification from other sources.

Recent studies have indicated that widowed people over the age of 50 experience grief more intensely than younger spouses.[6,11,16] Gerber et al[6] suggested in their research findings that since the majority of all deaths in American society occur with the older population, health professionals should be alerted to their special needs. Poor medical adjustment was observed in their sample of elderly bereaved. There may be a significant incongruity between anticipated living patterns and actual events during the period of bereavement. Unfulfilled plans for living arrangements and financial assistance as well as daily social needs could lead to added stress during bereavement. These authors suggested that the focus on preventive crisis intervention should be on helping to structure viable social plans before death.

Conceptual model of crisis

A person who experiences the dying process of a mate has an alteration in needs and resources. The extent to which needs will outweigh resources or vice versa will depend on a number of factors including age, sex, developmental level, previous losses, and self-concept. The role of the nurse is to apply the art and science of nursing in a caring way. The client in this model is the elderly spouse of the dying patient. The nurse determines with the

Fig 1. Conceptual model of crisis of loss in the elderly.

spouse the impact of the crisis with respect to intervening variables. There is also an assessment of the degree to which resources are operating for the spouse. Three resources that have a significant influence on health outcome are interpersonal support, religious-spiritual belief, and intrapersonal coping (Fig 1).

Interpersonal support

Interpersonal or social support can be described as personal contacts that individuals perceive as providing emotional support, information, material aid, and services.[17] According to Caplan,[9] persons with good support systems have decreased incidence of physical and mental disorders when confronted with acute or chronic stress. Maddison[18] studied differences between 20 widows who were coping well versus those ($N = 20$) who had a bad outcome 15 months after the death of their spouses. In semistructured interviews, subjects were questioned about interpersonal relationships. Widows who were doing well reported helpful interactions with other persons in the 3-month period following their loss. Support provided during the crisis of loss, is important in a number of ways. The spouse is likely to feel cared about and has the opportunity to express feelings about the impending loss. Those who are available for support during the crisis can empathize about the loss as it is occurring.

Family members have been considered the most appropriate primary support group for the bereaved.[19-21] They have been described as a valuable resource, especially if the communication in the family has been open and the family has been closely knit. Nurses can facilitate family interaction, answer questions, and provide needed information so that family members feel more in control of the situation.

Other sources of support during the dying process include friends, neighbors, physicians, the funeral director, nurses, and chaplains.[22] If the nurse recognizes that support is not available to the spouse, support from nursing staff and referral to appropriate community agencies becomes very important. Irwin and Meier[23] were among the first in nursing to look at needs of family members when a spouse is experiencing the stress of fatal illness. An exploratory study was done using the Q-technique to operationalize the concept of support for relatives of fatally ill patients. In addition, a comparison was made between what helping persons considered

to be supportive and opinions of those who needed support during the crisis of fatal illness of a close relative. Nursing behaviors described as most supportive were honesty, clear explanation of what was being done, interest in answering questions, and making the patient comfortable.

Interpersonal or social support is not always welcomed by family members. Receiving support from others requires the spouse to perceive self as needing support. To maintain a strong image, some spouses may exhibit social detachment and not disclose information about themselves. The spouse may believe that the costs of self-disclosure to the social network are greater than the benefits. Rather than demand too much attention from the support group, the spouse may refuse all assistance. Unfortunately, this social alienation may have the result of isolating the person from social support, thereby limiting future interactions.[24] Unhealthy outcomes in bereavement have been described as failure to find adequate expression and support in the social network.[25]

Religious-spiritual beliefs

Religious and spiritual beliefs of the spouse of a dying patient can be described as faith in a power or powers outside of self that are perceived as resources because of being associated with meaningful death or belief in a life after death. Fatalistic beliefs or belief in the will of God can also be perceived as religious-spiritual resources. Religious-spiritual beliefs may be supported with meditation, ritual, or prayer.

In her study of hope in cancer patients aged 18 and older, Stoner[26] found that religiosity was associated with higher hope and was an important aspect in the lives of 87% of the people interviewed. Her findings suggested that nursing interventions that recognize the importance of religion would help maintain hope and, ultimately, coping ability. Nighswonger[27] indicated that the family's hope for cure will shift ideally to a concern for the meaningfulness of death. This belief is a means of accepting the appropriateness of the loss of a loved one. Ability to find meaning in the anticipated loss of a loved one can make the difference between acceptance and resignation, fulfillment and frustration.

Traditionally, religion has had the management of loss as one of its main concerns. The individual can be sustained in a life passage by rituals. Rituals can perform three functions: "support in the expression of grief at the loss, approval of the renunciation of what was lost, and guidance in definition and reinvestment of self".[28(p360)] According to Nolan,[28] properly performed religious rituals include essential aspects of crisis intervention. They maintain the person near the reality of the situation, keep an explicit focus on the crisis, and assist with cognitive mastery of the situation by minimizing guilt feelings and feelings of inadequacy.

In a study of widows, Ball[29] found that religious beliefs or philosophy in life were considered important in the adjustment to loss. Sanders,[16] in her study of bereavement in elderly spouses, also found that religious supports were seen as being particularly important sources of strength.

Although religious beliefs may center around a meaningful death or hope in the life hereafter, perceptions may also involve fatalistic ideas. For example, a widow may

believe that the death of the spouse was meant to be or was the will of God.[30] People have historically blamed spirits, magic, or witchcraft for the death of a loved one, as a means of explaining the cause of death.[31]

Based on a questionnaire from 132 widows, Maddison and Walker[32] found that the height of the bereavement crisis is a poor time to present religion in any evangelical sense. Religious interventions have also been criticized for the assumption that people should rise above loss and sorrow. Reeves[33] noted that modern religion reflects societal norms. It is expected that feelings of fear, anger, and sorrow will be controlled or denied. If this is not accomplished, individuals have failed in faith if they are religious or in reason if they are intellectual.

Religious or spiritual interventions would be introduced inappropriately to those who did not perceive their religious-spiritual beliefs to be a resource. It is important, however, for nurses to be aware that religious-spiritual beliefs are perceived by many to be a resource. To ignore this aspect of a person is to eliminate care of the whole self. If the nurse is uncomfortable discussing the religious concerns of the spouse, an appropriate referral to a spiritual counselor should be made.

Intrapersonal coping

Coping can be described as cognitive or behavioral strategies perceived by persons as resources used during a crisis.

Lazarus[34] has indicated that cognitive processes are the basis of coping activities, which continually develop the emotional reaction by altering the ongoing relationship between person and environment. According to Lazarus, cognitive appraisal is determined by an interplay of personality and environmental factors. A similar set of overwhelming demands may be appraised differently by two individuals. These differences in cognitive appraisal can account for differences in somatic and emotional responses as well as solutions to the precipitating event.

A person is continually reappraising his or her relationship with the environment, and the intensity or quality of emotional reaction will fluctuate with this reappraisal. Feelings about being powerful and in control of the environment will be a factor in determining the personal sense of feeling threatened or challenged by events.

Lazarus[34] makes a distinction between coping and a direct control of emotion. Coping is defined as the use of processes that are intrapsychic or processes that involve direct action, such as attacking or escaping the harmful event. Direct control of emotion is described as those behaviors designed to reduce visceral or motor reactions that accompany a stressful situation. The response-oriented approach deals with the somatic reaction rather than its cause. Alcohol, sleeping pills, muscle relaxants, and diversional activity are in this category.

Fromm[35] described two forms of demands involved in coping with reality: ego active and ego passive. The ego may actively meet the demands from the external world with creative coping and master or transform the demands of a crisis at its own pace. A person who responds to a crisis with ego passivity may act in accordance with the requirements of a situation but do so passively. An example of a

person who responds with ego passivity is one who is helpless in the face of external reality and responds by freezing and not acting at all. Coping responses may be termed successful or unsuccessful based on subjective responses. Fromm defined successful coping as acceptable evidence that the tensions considered to be unpleasant have been reorganized into some tolerable or more satisfactory pattern. Nighswonger[27] described effective coping patterns as indications that the family accepts reality without distortion or avoidance. The nurse can effectively intervene by reinforcing coping strategies that are functional for the spouse. Useful strategies for those who are denying the loss of a mate are honesty, information about the mate's condition, and opportunity for the spouse to express fears and concerns.

Implications for nursing practice

Prevention and health promotion are concepts that are assuming increasing importance in the nursing profession. If spouses of a dying mate could be asked what resources are helping them during the crisis, they are more likely to focus on themselves instead of exclusively focusing on the dying patient. Assistance in recognizing and using available resources enables the spouse to feel in control of the situation. This is especially important at a time when persons are likely to feel helpless and out of control. For those individuals who do not have resources or who appear to have limited resources, nursing intervention could be designed to assist in developing resources according to individual needs, life style, and developmental phase. The crisis of loss in the elderly allows nurses to present caring rather than curing interventions.

In the final phase of life, the nurse can use interventions that express caring to facilitate communication between the partners and to help the spouse gain some closure of the marriage relationship.

In the final phase of life, the nurse can use interventions that express caring to facilitate communication between the partners and to help the spouse gain some closure of the marriage relationship. Many spouses want to assume complete care of the patient during the dying process. The nurse's recognition of the spouse's desire to assume this role can enable the spouse to be a participant in the final phase of the marriage relationship.

Implications for nursing research

According to O'Toole,[36] theory, practice, and research should develop in an interrelated manner. Her suggestion was that observation of a problem in practice leads to systematic study or observation. The next step is hypothesis development to test relationships between variables. To move next to a prescriptive level of theory development, interventions could be developed and tested to determine their impact on the clinical problem. Practice theory is developed through theoretical exploration of the interventions. "Prescriptive studies produce practice theory which feeds back into practice to alter or improve nursing interventions."[36(p14)] The practical becomes theoretical when tested with

research methods and ultimately described as theoretical statements about nursing practice.

A descriptive study exploring experiences of the elderly during the crisis of loss of a mate would be a useful starting point in the research of this topic. Information about resources that helped during the loss would add to the knowledge base in nursing. A longitudinal study providing ongoing information about the elderly bereaved could provide a description of health behaviors in relation to resources available during the crisis of loss.

• • •

For the elderly, the loss of a mate can be likened to the loss of a trunk of a tree. The loss of a long-term relationship represents for many the loss of self, and some persons never recover. Nurses have the opportunity to work with spouses of dying patients at a time when they are most likely to benefit from effective interventions. Resources that are mobilized for the spouse during the dying process of a mate can enable the spouse to be a participant in the closure of the marriage relationship. The spouse is more likely to experience a healthful outcome when resources are available during the crisis of loss.

REFERENCES

1. Dracup KA, Breu CS: Using nursing research findings to meet the needs of grieving spouses. *Nurs Res* 1978;27:212–216.
2. Holmes TH, Rahe RH: The Social Readjustment Rating Scale. *J Psycho Res* 1967;11:213.
3. Rees WD, Lutkins SG: Mortality of bereavement. *Br Med J* 1967;4:13–16.
4. Eliot TD: The bereaved family. *Ann Am Acad Political Soc Sci* 1932;160:184–190.
5. Lindemann E: Symptomatology and management of acute grief. *Am J Psychiatry* 1944;101:141–148.
6. Gerber I, Rusalem R, Hannon N, et al: Anticipatory grief and aged widows and widowers. *J Gerontol* 1975;30:225–229.
7. Erikson EH: Growth and crises of the healthy personality, in identity and the life cycle. *Psychol Issues Monogr* 1959;1(1).
8. Caplan G: *Principles of Preventive Psychiatry*. New York, Basic Books, 1964.
9. Caplan G: The family as a support system, in Caplan G, Killelie A (eds): *Support Systems and Mutual Help*. New York, Grune & Stratton, 1976, pp 19–36.
10. Parkes CM: The first year of bereavement. *Psychiatry* 1971;33:444–467.
11. Dimond M: Bereavement and the elderly: A critical review with implications for nursing practice and research. *J Adv Nurs* 1981;6:461–470.
12. Narayan SM, Joslin DJ: Crisis theory and intervention: A critique of the medical model and proposal of a holistic nursing model. *Adv Nurs Sci* 1980;2:27–39.
13. Quint JC: Awareness of death and the nurse's composure. *Nurs Res* 1966;15:49–55.
14. Stern K, Williams GM, Prados M: Grief reactions in later life. *Am J Psychiatry* 1951;108:289–294.
15. Agee JM: Grief and the process of aging, in Werner-Beland JA (ed): *Grief Responses to Long-Term Illness and Disability*. Reston, Va, Reston Publishing Co Inc, 1980, pp 132–166.
16. Sanders CM: Comparison of younger and older spouses in bereavement outcome. *Omega* 1980;11:217–232.
17. Walker K, McBride A, Vachon M: Social support networks and the crisis of bereavement. *Soc Sci Med* 1977;11:35–41.
18. Maddison D: The relevance of conjugal bereavement for preventive psychiatry. *Br J Med Psychol* 1968;41:223–233.
19. Greenblatt M: The grieving spouse. *Am J Psychiatry* 1978;135:43–47.
20. Kerr ME: Cancer and the family emotional system, in Goldberg JG (ed): *Psychotherapeutic Treatment of Cancer Patients*. New York, Free Press, 1981, pp 273–305.
21. Saunders JM: A process of bereavement resolution: Uncoupled identity. *West J Nurs Res* 1981;3:163–173.
22. Carey RG: Weathering widowhood: Problems of adjustment of the widowed during the first year. *Omega* 1979;10:163–173.
23. Irwin BL, Meier JR: Supportive measures for relatives of the fatally ill, in Batey MV (ed): *Communicating*

Nursing Research Collaboration and Competition. Boulder, Colo, Western Interstate Commission for Higher Education, 1973, vol 6, pp 119–128.

24. DiMatteo MR, Hays R: Social support and serious illness, in Gottlieb BH (ed): *Social Networks and Social Support*. Beverly Hills, Calif, Sage, 1981, vol 4, pp 117–148.
25. Hirsch BJ: Social networks and the coping process, in Gottlieb BH (ed): *Social Networks and Social Support*. Beverly Hills, Calif, Sage, 1981, vol 4, pp 149–170.
26. Stoner M: *Hope and Cancer Patients*, dissertation. University of Colorado, Denver, 1982.
27. Nighswonger CA: The vectors and vital signs in grief synchronization, in Schoenberg B, Carr AC, Kutscher AH, et al (eds): *Anticipatory Grief*. New York, Columbia Univ Press, 1974, pp 267–275.
28. Nolan T: Ritual and therapy, in Schoenberg B, Carr AC, Kutscher AH, et al (eds): *Anticipatory Grief*. New York, Columbia Univ Press, 1974, pp 358–364.
29. Ball JF: Widows' grief: The impact of age and mode of death. *Omega* 1977;7:307–333.
30. Kastenbaum RJ: *Death, Society and Human Experience*. St Louis, Mosby, 1981.
31. Krupp GR, Kligfield B: The bereavement reaction: A cross-cultural evaluation. *J Religion Health* 1962;1:226–246.
32. Maddison D, Walker WL: Factors affecting the outcome of conjugal bereavement. *Br J Psychiatry* 1967;113:1057–1067.
33. Reeves RB: The hospital chaplain looks at grief, in Schoenberg B, Carr AC, Peretz D, et al (eds): *Loss and Grief: Psychological Management in Medical Practice*. New York, Columbia Univ Press, 1970, pp 362–372.
34. Lazarus RS: Cognitive and coping processes in emotion, in Monat A, Lazarus RS (eds): *Stress and Coping*. New York, Columbia Univ Press, 1977, pp 145–158.
35. Fromm E: Ego activity and ego passivity. *Int J Clin Exp Hypn* 1972;20:238–251.
36. O'Toole AW: When the practical becomes theoretical. *J Psychosoc Nurs Ment Health Services* 1981;19:11–18.