Gender, age and widowhood

Gender differences in adaptation in the medium and long term



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There is a perception that men, specifically ageing men, are more emotionally distressed than ageing women by their spouse's death. The few studies carried out on widowers indicate that it is the loss of the person whose care allowed them independence, and the need to take on the role as self-carer that requires the greater psychological adjustment. However, the difference men and women experience when bereaved is reflected in the strategies they utilise to adapt to solo living, rather than the intensity of their distress.

There has been a considerable body of research based on the psychological processes dealing with the early stages of bereavement and adaptation, usually covering a period of time up to two years after loss[1, 2]. This type of investigation involves the more short-term consequences of bereavement and focuses primarily on adjustment as the outcome.

It is not intended here to provide a comprehensive review of bereavement studies other than to point out that a substantial number have been carried out by psychiatrists and psychologists. Perhaps unsurprisingly then, grief tends to be categorised into 'stages' exhibiting normal and abnormal behaviour and the 'abnormal' translated into 'illness'[3]. Prolonged grieving is considered dysfunctional, or atypical behaviour. Colin Murray Parkes[4], for example, cites Queen Victoria as an individual who epitomised atypical grief: she continued to have Prince Albert's pyjamas put out nightly and his shaving water made ready every morning for the forty years of her widowhood.

There is a consensus, however, that somewhere around the second anniversary of the death of a spouse, there is a diminution of the degree of distress experienced[5].

GENDER DIFFERENCES IN PSYCHOLOGICAL ADAPTATION

Early research carried out by Felix Berardo[6, 7] concluded that the precariousness of widowhood appeared to be experienced more by the older male than by the female. Numerous social factors, he contends, aid the adjustment of widows but impede the satisfactory transition for widowers: continuity of domestic role for a widow provides a buffer but proves problematic for a widower. Also, a widow is more likely to be involved in kin and friendship networks and will continue to participate in these relationships. Lopata[8], arguably the most prolific author on widowhood, states:

> The support systems of men also undergo disorganisation with the death of their wives, particularly in our 'person-oriented' form of marriage and our focus upon the nuclear family in its own housing unit. In fact, several social scientists ... find that widowers exhibit more severe symptoms of disorganisation than do widows[8].

The relatively greater isolation of the older widower is related to and probably aggravated by his retirement. Removed from his chief sources of self-identity, his occupation and his partner, the widower often experiences unhappiness, low morale, mental disorders, high death rates and high suicide rates[7]. The primary social role of a man is not as husband and father: his sense of self-identity is derived from his occupational status rather than his marital status[9].

For the cohort of married women born in the first three decades of the 20th century, there is empirical evidence that social identity is typically derived from the husband's occupation and their role as wife[10]. Therefore, the widow has to contend not only with the physical loss of her spouse, but the loss of her primary source of identity.

Feinson[11] disputes Berardo's[6, 7] conclusions by finding that there is little evidence to support the contention that widowers suffer worse symptoms of emotional stress than widows:

> ...the studies of psychological distress clearly do not provide any support for the perception about aging widowers. Indeed the data available at this time suggest that there are no gender differences[11].

She argues that widows and widowers have more experiences in common than is generally perceived. The issue of 'who suffers more?', widowers or widows, is shown to be contentious.

Lubben[12] reveals that both widows and widowers were found to have lower psychological well-being than their married counterparts. Health status and social networks were major predictors of psychological well-being. Among women, close female friends contributed more to psychological well-being than family contact, while among men, family contact was more important.

Martin Matthews[10] sees the transition from 'status' to 'process' as involving the (re)construction of reality, and the meaning of this new way of life for individuals as active creators of their social worlds. She states that widowhood is not static. There is a continuous

EDITOR'S NOTE

'You can't teach an old dog new tricks' is a truism which explains many of the problems of bereavement in old age. Fortunately it is not entirely true. The remarkable thing about most old people seems to be their ability to cope with not one, but many losses and changes in their lives. In this paper Kate Davidson outlines the range and complexity of the adaptations required of older widows and widowers. She recognises the 'chaos' that results in the lives of those who fail to make the grade.

renegotiation of roles as parent, kin member, friend and participant in society. Under investigation is the 'how and why of things', because the answers change with circumstances: how and why do older widows and widowers interpret and give meaning to their life experiences?

A STUDY OF OLDER WIDOWS AND WIDOWERS

This article reports on one aspect of a study of 25 widows and 26 widowers over the age of 65, who had been widowed for at least two years, had not remarried and were living independently. The respondents were interviewed in their own homes and asked questions about their history, present lives and future aspirations. The aim of the study was to investigate the medium- and long-term adjustment to solo living and to examine gender differences in coping strategies for the adaptation to living alone, sometimes for the first time in their lives[13].

Bereavement is one of life's foremost stressors and yet there is ample empirical evidence to show that some individuals report that they are coping well, despite the negativity of most research findings[14]. Most of the research is carried out within a medicalised model of 'normal' and 'abnormal' functioning and this polarisation has been challenged by Antonovsky[15] who emphasises the imperative of taking a more holistic approach to social, psychological and physical being. Rather than the static dichotomy between health and illness (a person is considered either well or sick), he talks of a health-ease-dis-ease continuum along which an individual travels in either direction. I developed this concept of a continuum along which widows and widowers travelled in either direction, and termed the poles, coherence and chaos.

In the figure below, the continuous line in the 'acceptance zone' represents where I calculated that most of the widowed people situated themselves, most commonly, two years after the loss of their spouse. The dotted line is where most widows and widowers placed themselves when they were first widowed and a small number of widows and widowers had remained or returned.

There was movement both ways along the continuum – the later slide towards chaos, although more likely to be associated with failing health, was often blamed on the loneliness of widowhood. As these people became less socially active because they were limited by ill health, they were inclined to reflect more on the past, on their marriage and on what they recalled as much happier times.

A SENSE OF COHERENCE AND ADAPTATION

A central element in the construct of selfhood is the notion of agency, the ability of individuals to exercise choice, make decisions and give direction to their lives. In order to extend the analysis of the realignment of self after the loss of an individual's 'understood' role, or life purpose, I turned to the concepts of 'trust' and 'security' and the coping mechanisms for regaining a shattered sense of 'known' self.

Self-identity is not a status, but a continuous process of interpretation informed by the individual's biography. According to Giddens[9], personhood therefore includes a cognitive narrative of self which links past, present and future into a coherent whole. An individual overwhelmed by external events, such as the loss of the most important 'other being' in life, often feels emotionally fractured and loses a sense of biographical continuity. The 'who am I now?' questions answered through the process of redefinition of self, will be different for men and women and the 'who can I relate to now?' and 'how do I fit in?' will differently influence long-term coping strategies in widowhood.

GENDER DIFFERENCES IN REPORTAGE

There was however, a perception, held by both widows and widowers that women were emotionally stronger than men and therefore better able to cope with aloneness and loneliness. In the following quotes, the names are fictitious and the quotes are followed by the gender (Mr or Mrs), their initials, age, length of time married (m) and length of time widowed (w).

> Elizabeth: Women are much stronger, love. They've had to be, to cope with everything that goes on in their lives – all the changes. (Mrs EJ, aged 78, m 49 years, w 4 years)

> Howard: They [widows] seem to cope much better. I suppose they're better equipped. They do seem to be able to do things. (Mr HW, aged 81, m 56 years, w 2 years)

The widows consistently spoke continuously of their psychological strength and resilience in coping with all the changes in their lives, including widowhood, whereas the widowers saw women's practical abilities as contributing towards their greater adaptability. Both widows and widowers spoke of emotional loneliness, but a woman's relative strength is seen to come from her greater ability to cope with the 'aloneness', especially in the private sphere of the home, where she may have spent long hours alone while her husband was in employment.

In a couple-orientated social world, a widow is more likely to feel 'alone' in the public sphere where she had been accompanied by her husband. Her aloneness therefore is more likely to associated with what her husband *stood for*: financial security and social status, for example:

> Elizabeth: Well, you can't really go anywhere on your own, without a husband, can you? We used to go everywhere together, we did all that charity work together after he retired. I miss that, terribly. (Mrs EJ, aged 78, m 49 years, w 4 years)

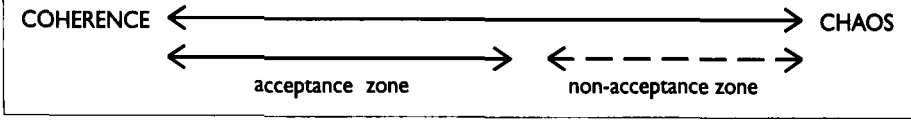
For the widowers, their sense of loneliness and aloneness comes from not only missing the person, but missing what she *did for* him:

> Eric: Widowers lose so much of what they've had over the years with their wives. Being taken care of. (Mr EJ, aged 74, m 38 years, w 13 years)

> Mikail: Man is lost without a wife. I think maybe man is more upset without a wife than the other case. The man misses the home. (Mr MA, aged 84, m 37 years, w 2 years)

Therefore, although both men and women missed the person who has died, how well they coped with solitary living depended on what role that person played and whether it was predominantly in the public or the private sphere. Whilst a vast majority of the sample said they missed the presence of the late spouse ('We were best friends' was a common explanation of the relationship), in instrumental terms the widows reported that they especially missed the social life as enjoyed by a couple, companionate society, whereas the widowers missed the emotional element of

The coherence-chaos continium



the support and care they received from their wives at home. For bereavement counsellors, hearing widowers' account of this gap left in their lives may be helpful in explaining why they value domestic assistance, beyond its sheer practical utility.

This observation supports the findings of Schut *et al*[2], who describe the effectiveness of differing counselling strategies offered to widows and widowers who were continuing to present with elevated levels of distress 11 months after the loss of their spouse. They suggest that for those who do not appear to respond to the perceived gendered counselling needs – that men require more problem-orientated, and women more emotional-orientated intervention – it may be appropriate to offer emotional counselling to men, and problem-focused counselling to women.

The analysis of my interviews revealed that the widows who coped well were the ones who were most likely to be involved in out-of-home activities – in other words those who had found self-identity within the public sphere. With the exception of one widow, whose manifestation of grief was similar to that of Queen Victoria as described by Parkes in the introduction, those widows who reported not coping well at the time of interview had coped well in the past, but were experiencing poor health.

The widowers who coped well were typically under the age of 80 years, and tended to have found emotional support from a cross-gender relationship or had moved into sheltered accommodation. The widowers who were not coping well were more likely to be older, frailer and less domestically competent when they lost their spouse.

CONCLUSION

The death of a spouse is likely, temporarily at least and occasionally permanently, to cause the individual's slide towards chaos. For the vast majority, although by no means all of the respondents, after the disorientation experienced with initial loss, when there seems to be no meaning to life, there was a gradual recovery of coherent existence. In line with well-documented evidence, the widows and widowers in this study said that, generally, they began to come to terms with life on their own after the second anniversary of the death of their spouse[1, 16, 17].

By and large, the adaptation process for the widowers was helped by making new, caring relationships. For the younger men these were typically with an exclusive, but non-resident, female partner: the older men more often formed closer ties with adult children and opted for sheltered accommodation where they maintained independence but had access to support. For the widows, successful adaptation included making a life outside the home, with friends and organisations as well as family.

These findings have implications for early bereavement counselling for both the bereaved person and their family, in particular adult children, in terms of understanding the origin of the gaps in these older people's lives and how they might guide the person in finding ways of filling them. BC

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OBITUARY

Marion (Mollie) Mackenzie

MB BS MRCS LRCP FRCPsych **1907-2000**



Mollie Mackenzie, chairman of the Department for Children and Parents at the Tavistock Clinic from 1968-1972, was a consultant child psychiatrist whose professional life encompassed many of the important developments in her speciality. She was a colleague and close friend of the greatest child psychiatrist of his time, John Bowlby, and became an enthusiastic exponent of attachment theory.

Mollie qualified as a doctor and then married in 1933 but continued to practise, which was unusual for women doctors at that time. One of her junior paediatric hospital posts was with Dr Donald Winnicott and he inspired her with an interest in the mental life of children which was to remain with her for the whole of her life.

During WWII she worked as a single-handed general practitioner while she raised her son, taking a special interest in mother and baby clinics. After the war, she went back to work for Winnicott who had moved from paediatrics to child psychiatry. Mollie underwent a psychoanalytic training – her analyst, Eva Rosenfeld, had herself been analysed by both Sigmund Freud and Melanie Klein – and then joined the Institute of Psychoanalysis; no formal higher qualifications were needed in those days to practise child psychiatry. In 1971 she was made a founder member of the Royal College of Psychiatrists and, soon after, a Fellow.

In 1950 she joined the children and parents' department of the Tavistock Clinic, becoming a consultant child psychiatrist in 1966, and succeeding John Bowlby as departmental chair. It was not easy taking over from such a charismatic and brilliant man, but she held together a difficult department, with its prima donnas, with her usual diplomacy, natural wisdom and toleration of different points of view .

Mollie was essentially a clinician who loved, above all, the face-to-face contact