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**BLACK URBAN WIDOWS: THEIR EXPERIENCES OF AND COPING WITH  
BEREAVEMENT IN A TRANSITIONAL SOCIETY**

by

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## DECLARATION

I, Puseletso Masebolao Dlukulu, hereby declare that the work on which this thesis is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree at this or any other university, institution for tertiary education or examining body.

A handwritten signature in black ink on a light blue background, reading "Puseletso M. Dlukulu".

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Puseletso M. Dlukulu



## ABSTRACT

Death is a drastic event in one's life. Through grief, mourning and bereavement, people heal the hurt of their loss of a loved one. Little research exists on bereavement in Black transitional societies of South Africa. As such, the objective of this study was to explore how widows in South African transitional societies, whose husbands have died of terminal illnesses, experience bereavement, and how they cognitively process and cope with the loss. The Participants' bereavement process was defined as starting when they become aware of their husbands' anticipated death (anticipatory bereavement). Unstructured and structured interviews were conducted with 10 widows from the community under study and a thematic analysis was performed on the data. Five themes emerged concerning the Participants' personal characteristics, their challenges and how they dealt with them, their experiences of stressors, and coping. Although the Participants responded to the news of the deaths of their husbands in a similar manner, there were differences in other responses, reflecting individual differences in coping strategies. Some Participants seemed more adaptive, with greater openness and flexibility in social cognition and greater problem-focused coping, while others showed more negative emotions in social interaction, greater loneliness, and expressed relatively closed and inflexible social cognition. However, positive or negative responses and coping did not necessarily determine whether bereavement would be functional or dysfunctional. It was found that the Participants' anticipatory bereavement did not ease or shorten their sense or period of bereavement after their husband's death. A model of the cognitive-affective-motivational-behavioural network of bereavement was developed, taking into account the role of culture and how each Participant's cognition, affect, and the kind of attachment to their husbands motivated their behaviours in particular ways in coping effectively or ineffectively with their bereavement.

**KEY WORDS:** Terminal illness, death, widowhood, bereavement, death rituals, urban society, coping, cognitive theory, transitional society, attachment theory



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## CHAPTER 1

### INTRODUCTION TO THE STUDY

#### 1.1 INTRODUCTION

Through grief, mourning and bereavement, people attempt to heal the hurt of their loss of a loved one. This universal human experience is shaped by, amongst others, the culture within which people function. Grief, mourning and bereavement are used as co-concepts in this study, which focuses on how Black urban widows in South African transitional societies, whose husbands have died of terminal illnesses, experience and cope with bereavement.

The Participants' bereavement process is defined as beginning when they become aware of their husbands' anticipated death, that is, anticipatory bereavement. The bereavement process is also linked to the pressure of making decisions about how to care for their dying husbands.

In this chapter the global experience of loss is discussed and a background to the development of the Black urban South African transitional society is provided. This is followed by the justification for the study, the aim and objectives of the study, contribution of the research to the advancement of science, and an overview of the study.

#### 1.2 THE GLOBAL EXPERIENCE OF LOSS

Death is a drastic event in one's life (Vess & Arndt, 2008), and brings a need to repair the wounds caused by loss. Given that this is an emotionally devastating event, as early as 1967, Holmes and Rahe, in their Social Readjustment Rating

Scale, ranked the death of a spouse on the life event scale as the most stressful of all possible losses, a sentiment that was later confirmed by Scannell-Desch (2003) and Silverman (2004). Gow (1999) and Van Praagh's (2000) view of grief as being composed of a variety of physical, emotional and spiritual sensations could explain spousal death as the most stressful loss.

As bereavement is the emotional state that one experiences during loss (Ong, Bergeman & Bisconti, 2004; Zautra, Berkhof & Nicolson, 2002), for people to move on they need to let go of those they love who are no longer with them. Through the bereavement process they gradually accept the loss, allowing the dead to be gone from their lives. At the end of a functional bereavement process, sadness still exists, but is tempered by happy memories of the deceased, which remain.

One of the many factors that contribute to the devastating impact of the loss of a loved one is that a considerable period of time passes before one is once again able to live without being preoccupied with what has happened. Carr, House, Wortman, Nesse and Kessler (2001) state that grief is an intense, preoccupying, depleting and multifaceted experience that affects one's emotions, body and life. This is due to the many facets of life involved in the loss of a spouse.

The grief experience affects people as a mixture of raw and conflicting feelings, and is an exhausting physical experience. It is the experience that overwhelms the ordinary human adaptations to life (Higgins & Glacken, 2009). Daily life is affected at all levels, for example, getting ready for bed, waking up in the morning, discussing the children, planning the future, and other related issues. The emotional pain involves missing the deceased, sleeping in a half-empty bed, craving the scent of the deceased's body, longing for his embrace, and so on. The widow might also wonder what life could have been like had her husband



survived. Additional emotions include a sense of insecurity, fears of abandonment, and enormous vulnerability. Life is thrown out of balance, forcing adjustments with uncertainties. The bereaved are often confronted with the possibility of their own death – something most people would rather not think about (Carr et al., 2001).

The feelings that accompany the grief experience include feeling some degree of disorientation, and feeling devastated as the experience represents not only the departure of a partner, a friend and a breadwinner, but also a radical change in a woman's social status and lifestyle. These changes are dealt with as cognitive responses to grief, mourning and bereavement, such as questioning and trying to make sense of the loss, and attempting to keep the deceased present (Higgins & Glacken, 2009).

The social nature of human beings means that people spend remarkably long periods of their lives growing, living in and being supported by their social environment. This environment moulds its members from early childhood to integrate life and death events into their human experiences. The social nature of human beings also relates to the forces that draw people to each other. These forces are deeply entwined in culture and the experience of falling in love, and longing for each other's love. As such, Ong et al. (2004) and Zautra et al. (2002) view mourning as the socially prescribed way of going through the grief emotion. Mourning can thus be viewed and interpreted as imposed by society to be expressed in diverse ritual forms to reinforce the identity of society and strengthen its bonds. These bonds make people depend on each other, and occupy special places in each other's heart, becoming part of each other. Given these deeply rooted feelings, mourning encourages people to help and protect each other, as and when needed.



When a husband suffers from a terminal illness and dies, as is the case in this study, the Participants' security of daily existence is affected. The intensity and persistence of the pain associated with the loss can then be thought to occur as a result of the emotional detachment of the wife from her husband, despite the difference in each couples' strength of attachment (Holmes & Rahe, 1967). The relationship ends, although the relational bonds arising from the attachment persist. However, for people to appreciate these positive feelings, to be fully human they also need to experience the negative feelings that accompany bereavement (Van Praagh, 2000). Although the death of a spouse ends the relationship, it does not end all relational bonds because the sense of being that is connected to the late husband persists. At times, a widow may experience a sense of having been abandoned as she still continues in a relationship with an absent partner (Holmes & Rahe, 1967).

Functional bereavement should therefore not be seen as an illness or condition from which we must recover, or even an intellectual process; rather, it is a life event and a human process of feelings and physical conditions. Putting it differently, bereavement should be viewed constructively as an experience that evokes negative feelings that are just as relevant and important as positive feelings (Van Praagh, 2000).

### **1.3 BACKGROUND TO THE DEVELOPMENT OF THE BLACK URBAN SOUTH AFRICAN TRANSITIONAL SOCIETY**

In this section, two aspects of Black urban societies are discussed. These provide a background to the changes in the Black urban South African community under study, and explain how the changes came about. The first part of this section examines the Black urban South African community before 1994, and the second part considers community life after 1994.

### 1.3.1 Black urban South African communities before 1994

In the heyday of apartheid, Black communities in urban areas were only allowed to live in the townships developed for this purpose and to rent the houses that belonged to municipalities. They could thus not own property. A socialist culture of equality was created, where the community belonged to the same social class (Donaldson, 1996b). This engendered a feeling of collectiveness with a communal element of being there for each other. A culture of “ubuntu”, namely, essence of humanity, could have been strengthened by this context, forming the core of what Black South African culture is today. In traditional African culture, the community comes first whereas in Western culture, it is the individual who is important (Donaldson, 1996b; Mojapelo-Batka, 2005).

Furthermore, in the townships, houses were allocated on the basis of tribe (defined as a particular language group). For example, in the community in which I grew up, the Zulu-speaking people of the community was separated from the Sotho-speaking people, and the two sections were referred to as the Zulu section and the Sotho section. I experienced this as creating a sense of boundary between “us and them” in the same community. Members developed common interests that were expressed collectively, dividing communities into impermeable sub-communities (Bahr, Jurgens & Donaldson, 2005; Donaldson & Van der Merwe, 1998).

Division along tribal lines had its own advantages and disadvantages. Just as much as it created an idea of shared tribal affinity and a sense of belonging based on a belief system of collective ancestry and a notion of distinctiveness, it also created social competition with great violence and viciousness between the tribes. This division was based on common language, history and physically bounded territories where Zulu-speaking residents would feel unsafe in Sotho sections and vice versa. This phenomenon extended to ethnically differentiated

schools and universities, which in turn, discouraged intertribal marriages. If a woman married into a different tribe, she was bound to experience problems with her in-laws and the community (Donaldson & Marais, 2002). Despite Donaldson and Marais' argument (2002), the spirit of ubuntu may still prevail in Black townships (Mbigi, 1997).

### **1.3.2 Black urban South African communities after 1994**

During the demise of legislated apartheid, which culminated in the 1994 elections, heterogeneous communities gradually developed. With actions such as the abolition of the Immorality Act, Influx Control Act and Group Areas Act a few years before the democratic elections, the nation as a whole became permeable. With this, some members of different communities found it easier to marry across the lines of race and tribe (Donaldson & Marais, 2002; Kotze & Donaldson, 1996).

After the abolishment of the Group Areas Act in South Africa, Bodibe (1993) notes that some members of township communities who could afford to move to historically White residential areas did so. These individuals soon realised that these residential areas had a different culture from theirs, making it difficult for them to perform some of their cultural rituals (Donaldson, Bahr & Jurgens, 2003; Donaldson & Van der Merwe, 1999). These rituals included the slaughtering of animals to appease their ancestors, which was perceived by their White neighbours as cruel to the animals and as a barbaric practice, and created conflict in those neighbourhoods. In some cases, Black people in previously White communities felt insulted, and White people felt that their neighbourhood standards were being lowered. Night vigils the night before the funeral also contravened with the laws of the local authorities in those areas (Donaldson & Marais, 2002; Kotze & Donaldson, 1998). However, in many areas, even in Black

townships, night vigils may be held for shorter periods rather than the whole night or until the morning hours of the day of the funeral.

Black people in historically White residential areas gradually changed the nature of their culture in different ways (Donaldson & Kotze, 1994). For example, the slaughtering of animals to appease their ancestors as it is practised in traditional African culture could only take place at abattoirs instead of their homes, losing the essence of the flowing of blood in the yard of the deceased. The singing and preaching at the night vigils was stopped as it was regarded as disturbing public peace. These reflect the changes in traditional Black culture and its changing practice in transitional societies. Although some practices were retained, individual families as opposed to the community determined those changes. The deep psychological functions of the rituals, which formed the essence of dealing effectively with bereavement in African societies, were then partly or entirely lost to the generation that followed (Donaldson, 2001a).

Another change was that the new Constitution entrenched gender equality. Women experienced greater freedom to move into the labour market. The traditional nature of couples' relationships changed, where some wives now played provider roles, with common legal codes and equality. Prior to 1994, women could not rent a municipality house without a husband but after 1994, they were given social and political rights of ownership (Marais & Donaldson, 2002).

Black urban township communities also experienced changes; social interaction and marriage now became based on shared beliefs, values and norms to a greater extent. These shared values included a set of interrelated roles and socio-economic status as opposed to ethnicity only, as in the past. This broke down barriers between tribal and racial categories, which enabled further

transition of cultural barriers. Cross-cultural cooperation and understanding, including respect and tolerance for other cultures, rapidly developed (Donaldson & Van der Merwe, 2000). Although the members of the new South African society maintained loyalty to and identification with their individual culture, they were also assimilating into the greater community: one that was urban and Westernised (Donaldson, 2001b). The strong relationship between one's identity and self, which is tied to culture, is explored further in chapter 2.

#### **1.4 JUSTIFICATION FOR THE STUDY**

Although grief, mourning and bereavement are generally regarded to be amongst the most stressful events in adulthood, health professionals and society as a whole still know relatively little about its influences on life in the urban South African context that is characterised by rapid transition. Research done on bereavement of widows in South Africa so far has focused almost exclusively on widows in rural traditional communities who function in a different context to that of widows in transitional communities.

For example, Demmer (2006) conducted an exploratory study on professional caregivers in rural Kwazulu-Natal focusing on AIDS-related loss and grief. Demmer (2007) also focused on bereavement with regard to HIV/AIDS related loss among the rural poor in South Africa. Other studies include those of Brysiewicz (2008) about the lived experience of losing a loved one to a sudden death in rural KwaZulu-Natal, and Manyedi, Koen and Greeff (2003) who focused on experiences of widowhood and beliefs about the mourning process of the Batswana people. Ngubane (2004) studied traditional burial practices of Zulu people in South Africa. Rautenbach (2002) developed guidelines for social workers in ethnic sensitive mourning counselling for Xhosa speaking persons, and Selepe and Edwards (2008) studied grief counselling in African indigenous churches in Venda.

All these studies were conducted in rural areas in South Africa where bereavement practices tend to be traditional. Only one study by Rosenblatt and Nkosi (2007) could be found that examined differences in bereavement experiences between Zulu-speaking widows living in a Zulu homeland in rural Kwazulu-Natal, and those living in urban Soweto. The widows' experiences in rural communities were generally that their language, culture and social practices are maintained in a more traditional form than is true for Zulus living in urban areas. It is evident that there is a paucity of research that sheds light on the developing culture of bereavement in transitional societies in South Africa today. As such, this study hopes to contribute to the body of knowledge of the challenges that grieving widows in transitional societies face in an environment that is often different from the one they were brought up in.

Through my own involvement and observations in Black urban societies in South Africa, it has become evident to me that the plight of widows often remains invisible in daily life and to people around them, although it is always there, hidden just beneath the surface. Anecdotal evidence from widows that have been clients in my clinical practice suggests that transitional societies may consider bereavement to be an inconvenience due to its demands even though, as human beings, we still need others' acknowledgement of our pain and sorrow. For example, a widowed nurse has to wear her uniform to work even though her in-laws expect her to wear black clothes. Cultural norms also require her to be home before sunset, which may not be accommodated by her working hours. These highlight some dilemmas faced by families and widows in transitional societies. One may then wonder what happens to the rituals that have determined bereavement practices in the past, for example, are traditional rituals adapted to accommodate the practicalities of societal demands, and if so, does this lead to the extinction of significant cultural practices?

People's tendency to feel uncomfortable with ambivalence is another factor that motivated this study. Feelings of ambivalence are problematic during the grieving process because the widow often experiences conflicting feelings which, based on my experience and perception, are functional in helping the widow go through the process bereavement with greater comfort. It is common, for example, to experience resentment and guilt towards the deceased but because it is not socially expected and accepted, a woman may not share those feelings with people around her. Bereavement should be seen as an important part of one's journey through life, and emotional honesty is important in fully resolving this process. Conflicting feelings are functional in helping people to acknowledge their bereavement and to accommodate their sorrow. From a psychological perspective, unexpressed pain does not dissolve by itself. An inability to express the feelings associated with bereavement can lead to pathology (dysfunctional bereavement), such as possible emotional and physical problems, inhibiting functional grieving and mourning, leading to prolonged bereavement and possibly depression.

Depression and bereavement require different treatments although their clinical symptoms often overlap. This overlap tends to lead to misdiagnosis by medical practitioners in private practice. Medical practitioners tend to overlook bereavement when it is presented, diagnosing it rather as depression and treating it accordingly with medication (Ayers, Baum & McManus, 2007). The health professionals' misdiagnosis of bereavement provided a further motivation for this study, as about 80% of the cases I have seen in my practice were referred by medical practitioners only after a long period of unsuccessful drug therapy. Bereavement is sometimes diagnosed as depression because individuals may present with symptoms of severe headaches, sleeplessness, lack of appetite and forgetfulness, which are characteristic of depression as well as grief, mourning and bereavement. Social factors associated with loss that may contribute to symptoms include loneliness, reduced income, loss of status, and fear of the future alone. If a widow emphasises these factors to the exclusion



of the issue of her bereavement, medical practitioners' awareness of her situation would be limited to a consideration of her socio-economic situation and not her loss.

Functional bereavement concerns the widow's ability to achieve equilibrium by allowing new information in her schema of loss, with positive emotions acting as a motivating factor. Dysfunctional bereavement entails attributing loss to both intrapsychic and interpersonal processes that lead to negative feelings and failure to allow new information in the schema. A widow's inability to let new information into her existing schema, her rigidity, together with a lack of comprehension of the changes in society, its implications and impact are additional factors that motivated this study. The urban widows' dysfunctional bereavement might be attributed in part to the fact that bereavement is not as shared and public as it is in traditional societies. Selepe and Edwards (2008) assume that the reason behind this could be, amongst others, the lack of empathy and support for widows compared to what is available in traditional societies. Traditional societies seem to understand grief as a multi-layered phenomenon with emotional, physical, cognitive and behavioural effects, and seem more attuned to accompanying widows through the initial stage of shock and disbelief, allowing them a period of healing, and ultimately helping them to complete their mourning.

The literature discussed thus far and my own observations seem to indicate that in some cases traditional death rituals and practices have been modified due to the practical realities of transitional societies. This study hopes to contribute insight into and awareness of the challenges faced by the widows of this study and, as a result, sensitise people to their challenges.

Widowhood in other African countries is discussed in chapter 2 to provide a comparison between bereavement experiences in those communities and the society examined in this study, including how the latter society has transcended its cultural boundaries. In the following section, the rationale for focusing on women and the reason for choosing terminal illnesses as the mode of death is explained.

#### **1.4.1 The rationale for focusing on women**

Despite the urbanised nature of transitional societies, it seems that community members still respect important cultural values and mourning rites to some extent. This suggests that some cultural beliefs and practices surrounding widowhood ceremonies and rites have survived the transition in Black urban societies. Even though bereavement practices in traditional societies have a healing function, rituals tend to have more to do with exalting the position of the deceased (the husband) than allowing an outlet for the widow's grief (Mojapelo-Batka, 2005).

Emotional distress differs according to the different situations that widows find themselves in, and because of individual uniqueness. People may find themselves in the same situation with similar challenges, but will deal and cope with those challenges in different ways (Carr et al., 2001). For example, Ng (2008) views problem-focused coping strategies as attempts to modify the source of a problem, while emotion-focused coping strategies are efforts to reduce emotional distress. Frey (2000), Ninot et al. (2009) and Shu-Chuan, Chia-Hsiung, Hsueh-Chih and Thomas (2008), take it further when they observe that men tend to use more problem-focused coping and women are more likely to use emotion-focused coping. Brantley, O'Hea, Jones and Mehan (2004) and Ng (2008) explain the gender difference in coping strategies structurally within the context of the different demands that men and women often have. For example, men are

more likely to have control over solutions, which fits with problem-focused coping, while women are more likely to have fewer control opportunities, making emotion-focused coping more suitable.

However, Zivotofsky and Kolowsky (2004) found no gender differences in coping strategies, arguing that people of both sexes who occupy similar social roles tend to have similar coping strategies, suggesting that coping styles may be a product of sex-role stereotypes, including the exceptions that will always exist. For example, social roles corresponding to gender often change when people reach middle age, where men become more dependent and women more independent and assertive (Zivotofsky & Koslowsky, 2004). Ng (2008) took this idea further finding that the two coping styles sometimes work together and are useful for most stressful events, depending on the nature of the event. Her argument was based on the view that problem-solving coping is an attempt to do something constructive about the stressful and harming conditions, when emotion-focused coping is an effort to regulate emotions experienced because of the stressful event.

Widows and widowers in Black South African society tend to be treated differently where bereavement rituals are concerned. The performance of rituals is emphasised more for women than for men. This difference in treatment is due to patriarchy and gender relations, which define males as having authority over females and also as being superior to females (Guzana, 2000). This is reflected in a relative lack of taboos on a man's mourning of his wife. The mourning period is shorter for men than women (Mojapelo-Batka, 2005), and unlike women, men are considered to be free to remarry soon after they have buried their wife. Bereaved men are more likely to remarry and have greater freedom to socialise because their movements are not restricted by taboos (Magudu, 2004). Widowhood is also considered more traumatic for women than for men, which influences the way widows are viewed by society.



Other examples of gender inequality in bereavement rituals are plenty. For example, widows have to wear clothes that symbolise their widowhood and their respect for the deceased. Sexual activity amongst widows who are mourning the loss of their husbands is prohibited (Magudu, 2004). Social ostracism is also prevalent where a widow is not welcomed in a neighbour's house until the mourning period prescribed by her in-laws is over. This includes ritual seclusion where the widow is not supposed to be outside her house after sunset, and the general isolation that takes place for a certain period in the community, and other related issues (Magudu, 2004). Anecdotal evidence from my clients suggests that the duration of widowhood rites differs from family to family in transitional societies due to, amongst others, the cause of death, specific common beliefs of each family, and the age of the widow at the time of her husband's death. For example, in some families in transitional societies, based on my experience in my practice as a clinician, if the widow was not coping well during her husband's illness, was sick, or had just lost her loved one, her in-laws may decide that she should not wear clothes that signify her widowhood.

The restrictions dictated by tradition and cultures seem to put far greater restrictions on widows than widowers. As a result, more information could be gathered from widows to shed light into their individual experiences of bereavement than widowers, and for this reason women were selected to participate in this study.

Another motivating factor for the choice of women is based on my experience in my clinical practice, where I found widows to be more emotionally expressive than men, probably as a result of socialisation, and maybe because I am a woman my clients felt freer to express their feelings and share their experiences with me. Also in my experience in my clinical practice, widowers tend to be less expressive and guard against being tearful. Those who become tearful will often be embarrassed by it, because they are expected to look tough and never to cry

in public. As a result, it was easier to recruit widows who were willing to participate in the study than it was to involve widowers.

Another observation from my practice was that a sizeable number of widows (about 80%) reported to me that their in-laws blamed them for the deaths of their husbands with the objective of gaining financially from their deaths. For example, in-laws tended to suspect widows of having extra-marital affairs and that as sole heirs to the family home and payouts of insurance policies, widows and their boyfriends (assuming that the widows had extramarital relationships) had played a role in the deaths of their husbands. This deprived them of the opportunity to grieve the loss of their husbands and instead forced them to focus on the conflict with their in-laws. This blame, accompanied by feelings of guilt, anger and hurt, often lead to increased vulnerability. The widows I consulted with often felt unsupported and bitter, which delayed the bereavement process and promoted dysfunctional bereavement. For example, the widows' in-laws would not be supportive to the widow during her husband's illness, and would not help in caring for him. Some widows were blamed for not having cared enough for their husbands and the in-laws therefore considered her to have caused the death of their brother or son.

My clients tend to attribute the motivation for the conflict to greed, where the in-laws' interest is the wealth left behind by the deceased. They expect the widow to share with them everything she would inherit after her husband's death. Some in-laws may even demand all the couple's assets, assuming that what the couple accumulated belongs to the deceased and not to her. In my practice I have observed that if widows succeed in asserting themselves and ensuring that things are done according to their wishes and those of the deceased, this gives comfort to the widow, and allows her to grieve in her own preferred ways.

### 1.4.2 The rationale for focusing on terminal illnesses

As early as 1972, Parkes advocated that, to a certain extent, the mode of death, together with other factors, plays a role in whether one's bereavement is functional or dysfunctional. In this study, terminal illness was chosen as the mode of death of the husbands for various reasons.

Terminal illness as the mode of death was chosen as I anticipated that it would shed more light on the bereavement experience than other modes of death, as it also includes anticipatory bereavement. An exploration of terminal illness as a mode of death may also shed light on the multifaceted nature of the illness, the couples' belief systems and the in-laws' interpretation of the illness.

Transitional society, by its nature, goes through a paradigm shift during change. This causes discomfort to those who were brought up in a traditional manner. It is common practice that women in these societies play the dual role of providers and homemakers. This can create conflict and tension between the partners because the role of provider is traditionally reserved for males (Shope, 2006). The nature of the couples' relationship affects how the couple deals with the challenge of the anticipated death after diagnosis. The nature of the relationship may also determine factors like the widows' attitudes to caring for their dying husbands, how the couples deal with the anticipation of death during the period following diagnosis, and the process of acceptance or non-acceptance of the illness by both husbands and wives (Bonanno & Field, 2001; Colfman, Bonanno & Rafaeli, 2006). The impact of these factors on the widows' bereavement process was therefore considered in the choice of bereavement following terminal illness as a condition of participation in this study.

## 1.5 THE AIM AND OBJECTIVES OF THE STUDY

The overall aim of the study is to answer the research question: *How do Black urban widows in transitional South African societies, whose husbands have died of terminal illnesses, experience, process information about and cope with bereavement?*

As mentioned earlier, there is a lack of literature about Black widows' bereavement processes in transitional South African societies. The current study was thus exploratory as it is inductive and deals with uncertainty and ambiguity, with constant interplay with the data and deep involvement with the research context (Demmer, 2006).

The study explores widows' experiences of anticipating their husbands' deaths, the actual death and how they responded to it, support structures available and how they dealt with the lack of support, how the in-laws behaved towards the widows, and how they coped with all these issues. The research question is answered by describing, amongst others, how Black urban widows cope with bereavement in a transitional society. The study includes women whose husbands died of terminal illnesses to allow the focus on coping with anticipated and actual loss. Coping is explored from a cognitive theoretical perspective. Cognitive theory, according to Fritscher (2009), attempts to explain human behaviour by understanding the thought process and it assumes that humans are logical beings that make choices that make the most sense to them. Sternberg (1999) elaborated on this by viewing cognitive theory as a process through which people perceive, learn, remember and think about information in their environment. In the process, the thoughts determine one's emotions and behaviour.

An additional objective is to describe the changes that are taking place in traditional African beliefs and values related to bereavement in the context of transitional, Western-influenced beliefs, values and ways of living. Finally, I wish to describe how widows experience bereavement in a transitional society.

## **1.6 CONTRIBUTION OF THE RESEARCH TO THE ADVANCEMENT OF KNOWLEDGE**

As far as can be determined, grief, bereavement and mourning have not been comprehensively studied amongst Black urban widows in South Africa. This study may shed light on how these phenomena present and how the Participants (widows) experienced and coped with them. It may shed light on Black South African ways of dealing with bereavement, especially now that these ways are changing. It is hoped that the study will clarify how people move between these two worlds (traditional and transitional), and also help to create understanding of changes in these experiences, their impact and how they are dealt with cognitively.

The dynamics of widows in urban transitional societies can be expected to be different from rural societies (Rosenblatt & Nkosi, 2007). It includes the challenges of coping in those areas where important scripts may not be followed anymore.

A further contribution may be to improve health professionals' understanding and awareness of this often hidden condition, which may help them in understanding the nature of bereavement in a specific context. Through this study, a systematic bereavement model will be developed and presented to help demystify bereavement. The model could be built into the therapeutic programmes that



relate to grief, mourning and bereavement, and in the process, contribute to our knowledge about factors that affect coping with loss.

It is hoped that the findings will increase people's understanding of bereavement in general and therefore promote its acceptance as a normal and an inevitable part of life. Although grief, mourning and bereavement are generally regarded to be the most stressful events in adulthood, we still know relatively little about the influence of grief on life even though there is much literature about death and loss. This may be because people often feel uncomfortable talking about death and therefore lack knowledge about the process of bereavement. As a result, when a family is confronted by a meaningful loss, confusion is intensified. It is this avoidance of talking about death that leads to the lack of knowledge about it and, in the process, increases fear, feelings of despair, hopelessness and helplessness when one is faced with a major loss in her life. Also, when the intense and powerful emotions of bereavement are heightened, they are made out to be inappropriate, and are often denied by societies in transition. This denial of mourning is damaging as it blocks feelings that may eventually surface later in our lives, with possible serious psychological and physical problems (Parkes, 1972).

Increasing people's understanding of bereavement in general and therefore its acceptance as a normal and an inevitable part of life, could contribute to a reduction of fear and anxiety of people's experience of loss. This may help them recognise the spectrum, types, degrees and different experiences of loss across people, time and place. When people develop a philosophical attitude to approaching life, they tend to recognise and normalise the common losses, and in the process, understand their responses to them. Their experience of loss may become less frightening and less overwhelming (Worden, 1996).

However, making friends with loss will not protect one from experiencing the myriad of often intense reactions that accompany loss. However, it may help people feel less overwhelmed by it when those experiences do occur. This may help people to view loss and the resulting bereavement as natural parts of life. It may also help people to understand loss to be a result of being deprived of one's loved one, and accept bereavement as a personal experience (Kubler-Ross & Kessler, 2005). In the process, this may hopefully encourage greater empathy amongst people in their experience of loss.

## **1.7 OVERVIEW OF THE STUDY**

Chapter two explores the literature on bereavement and the transitions in society. The overall theoretical framework informing the study is cognitive psychology because it provides a framework for understanding how the widows process information about bereavement in a transitional society.

Chapter three deals with the methodology of the research that was conducted for this study. Interviews were conducted with ten widows and the data were analysed by means of thematic content analysis.

Chapter four presents the findings of the study. The sample that participated in the study is described and the themes and sub-themes that were generated during data analysis are discussed.

Chapter five contains the conclusions drawn from the study, and presents the model developed from the findings. It also includes a discussion of the implications of the findings, a critical review of the study and recommendations for future research.



## 1.8 CONCLUSION

This chapter provided a background on how traditional Black South African society is in the process of transcending its traditional way of life. It provides the context in which the Participants of this study function. The choice of focusing on women and the reasons for choosing terminal illnesses as the mode of death were justified. The motivation, aim and objectives of this study, together with its potential contribution to the body of knowledge, were addressed. A brief overview of the chapters concluded this chapter.

The following chapter focuses on the literature relevant to the topic. This forms a context according to which the research question may be addressed. In addition, the chosen theoretical framework, cognitive theory, is presented.

## CHAPTER 2

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### 2.1 INTRODUCTION

This study deals with how Black urban widows in South African transitional societies, whose husbands have died of terminal illnesses, experience and cope with bereavement. The focus of the study includes anticipatory and actual bereavement. In addition, different practices and beliefs within the African context pertaining to the topic of investigation are described and discussed. Some of these descriptions and discussions are based on my observations in the community and my participation in various facets of death and bereavement. In cases where the information was gleaned from my own observations, the source will be indicated by the acronym *r.o.s* (researcher's own observation). This is necessary because of the lack of academic literature to refer to on this topic.

This chapter consists of three parts. Bereavement forms the central construct around which the chapter is structured. Firstly, literature about bereavement is presented. Secondly, theoretical approaches relevant to studying bereavement, which include cognitive theory, attribution theory, coping strategies, attachment theory, Schachter and Singer's two-factor theory of emotions, systems theory, cultural perspectives on bereavement, and other selected theories are discussed. Lastly, the relevant constructs from the selected theories are integrated in a unified approach.

In the section that follows, bereavement, as the core construct of this study will be discussed by focusing first on its definition, followed by its conceptualisation, diagnostic issues, etiological issues and the differentiation from mood and anxiety disorders.

## 2.2 BEREAVEMENT

### 2.2.1 Definition of bereavement

Ong et al. (2004) view bereavement as the emotional state of having suffered a loss. Moody and Arcangel (2001) see it as a state of being deprived after loss. Kubler-Ross and Kessler (2005) also regard it as an experience during the period following a death when mourning occurs. On the basis of these views, bereavement can thus be described as an emotional state of deprivation after suffering the loss of a loved one that occurs during the period of time following a death.

Bereavement can be seen as an overarching psychobiological state, which encompasses grief and mourning. The affective system is also composed of defined structures, namely, the affective schemata that produce affect when activated. Bereavement can also be seen as an affective reaction and an integral part of psychobiological strategies concerned with survival (Beck, 1996; Dyregrov, 2004). It is a state that activates cognitive, affective and behavioural schemata and manifests as grief and mourning. During this state, feelings of loss often grow in intensity and are associated with feeling alone.

A bereavement process does come to an end, although the memories of the person lost remain. Once the loss loses its overpowering effect with time, closure is achieved in different ways. This occurs for example during the burial itself, viewing the corpse, when the coffin is slowly lowered into the grave, the cleansing ceremony, and the unveiling of the tombstone. These practices differ between cultures as every culture, including transitional societies, has developed unique ways for the living to pay tribute to the dead. In African culture, for example, memorial tombstones and graves serve as a powerful source of

comfort and support for the living. A grave provides a specific place for the family to visit, as opposed to cremation where there may be no visible marker (r.o.s).

Although there are human universals, each individual is also unique, family background, the manner in which cultural heritage is internalised, and genetic makeup (Malkoc, Kay & Webster, 2002). Accordingly, each individual responds differently to bereavement, its expression, and the coping mechanisms that are required. Although similarities are found across individual experiences, there is naturally a wide range of personal bereavement experiences (Kubler-Ross & Kessler, 2005).

Psychologically speaking, it is impossible to predict the course of one's bereavement. This said, the burden of emotional pain usually lifts, with people eventually regaining meaning and purpose in life even in the midst of feeling the loss. On this basis, bereavement can thus also be seen as a process of meaning construction that evolves throughout the life of the bereaved. In the section to follow, concepts that are relevant to bereavement will be looked at.

### **2.2.2 Conceptualisation of bereavement**

Grief, mourning and bereavement are related terms signifying reactions to the loss of a loved one. Mourning and grief are complementary as mourning without grief and grief without mourning; rarely occur (Ong et al., 2004). The conceptualisation of bereavement is intended to represent mourning as a normal phenomenon. However, an important limitation of the Diagnostic and Statistical Manual's DSM-IV-TR's vagueness on this point is that it does not provide a means of distinguishing between individuals who show common grief reactions from those who do not (American Psychiatric Association, 1994).

### **2.2.2.1 Functional and dysfunctional bereavement**

What is functional bereavement for one individual may be dysfunctional for another, as loss may produce profound and lasting changes in physical arousal, emotions, cognition, and may sever these normally integrated functions from one another. The ordinary human response to loss is a complex, integrated system of reactions, encompassing both body and mind (Higgins & Glacken, 2009). It is inevitable that some kind of reaction to the loss of a husband will occur in a woman's life. Loss tends to focus the widow's attention on the immediate situation, may alter her ordinary perceptions, and evoke intense feelings of fear and anger. However, changes in arousal, attention, perception and affect implicit in these reactions are normal, adaptive reactions.

In the sections that follow, the cognitive equilibrium model (CEM) (Malkinson, 2001) is used together with Bowlby's (1963) phases of bereavement to provide a framework for understanding people's general response of bereavement following a loss.

#### **2.2.2.1.1 Functional bereavement**

Functional bereavement develops through a number of phases. Although these phases, ranging from initial disbelief and the ultimate acceptance of the death, have been described in the literature, because of people's individual uniqueness, these different phases do not unfold in the same manner for all people (Carr et al., 2001). These phases are discussed in this thesis with the purpose of using them in the conclusion chapter as a reference to a functional process of bereavement in Western culture and also to see if they are relevant in transitional Black South African culture.

As the widow adjusts or accommodates to the loss, cognitive structures become modified, signalling the final phase of the bereavement process (Gow, 1999). This is the period of relocating the relationship with the deceased within one's life in a new perspective, as one adapts on emotional, behavioural, physical, spiritual and social levels. This is the phase of letting go of the ambivalence that is associated with the change in the widow's life brought about by the death of her husband. It involves the widow's cognitive processes of assimilation and accommodation. At a cognitive level, cognitive structures rearrange and establish a new equilibrium. The widow's perspective of her relationship with the deceased is renegotiated and relocated within her life. She then finds and creates different ways of remembering the deceased, and finds an appropriate 'holding-place' for the loss, which enables her to function optimally in her environment (Gow, 1999).

A functional bereavement process seems to revolve around the widow's ability to achieve equilibrium, which implies a balanced and homeostatic mental state (Fredrickson, Mancuso, Branigan & Tugade, 2000). The process of equilibration helps in the forward-backward movement between equilibrium and disequilibrium for the development of more adaptive cognitive schemata after each bereavement phase (Ayers et al., 2007). This view assumes an innate constant tendency to organise one's experiences with the environment, leading towards adaptation and a state of internal equilibrium. This motivational tendency to create a balanced relationship between the self and the external environment is of central importance to understanding bereavement from a cognitive perspective.

Milbrath et al. (1999) observe that conjugal loss might also initiate a process that can lead to dramatic growth or a quiet reorientation. Eckstein, Leventhal, Bentley and Kelley (1999) describe a process of moving from being a wife to being a widow to being a woman. This means that a widow must first accept the reality of the loss, signifying that she is no longer someone's wife. Growth will only occur



when the widow gives up her view of herself as partnerless and strives to enhance her sense of individuality.

In summary, in functional bereavement, when the widow experiences her husband's loss, she responds with cognitively adaptive efforts to help her return to or exceed her previous level of psychological functioning, which involves various cognitive processes.

#### **2.2.2.1.2 Dysfunctional bereavement**

Nolen-Hoeksema (2000) talks about rumination, i.e. the tendency to respond to distress by focusing on the causes and consequences of your problems without moving into active problem solving. She found that people who ruminate in response to difficult circumstances have more severe and prolonged periods of depression and anxiety. Furthermore, Boelen, van den Bout and van den Bout (2003) also find that behavioural and cognitive avoidance strategies were significantly related to the severity of traumatic grief and depression. Stroebe et al. (2007) argue for a reconceptualisation of ruminative coping with the death of a loved one as an avoidant rather than a confrontation strategy. They find ruminative coping to be characterised by a persistent, repetitive and passive focus on negative emotions and symptoms. This way of coping was theoretically described and empirically shown to be a maladaptive process of grieving, and thus dysfunctional, as it may occur when action is of no avail (Stroebe et al., 2007). This may take place when neither resistance nor escape is possible, and the widow becomes overwhelmed and disorganised. She may experience intense emotions, but without clear memory of the loss, or may remember everything in detail without knowing why. Symptoms of loss may become disconnected from their source and take on a life of their own (Higgins & Glacken, 2009). Rumination then seems to exacerbate negative thinking, interfering with good problem solving, where ruminators are more likely than non-

ruminators to engage in impulsive, escapist behaviours, for example, binge eating.

Field, Bonanno, Williams and Horowitz (2000) and Kissane, Bloch, McKenzie, McDowall and Nitzan (1998) describe various characteristics of dysfunctional bereavement. These include a lasting loss of interest in social interactions, or furious hostility against specific people. Poor judgement (for example in handling finances), overactive behaviour combined with sadness, and bitter self-accusation are also common. Upsetting memories and yearnings for the deceased on a daily basis over a long period of time, long-term efforts to avoid reminders of the deceased, and difficulty acknowledging the deceased also play a role in dysfunctional bereavement. In some cases widows may develop physical symptoms similar to the medical illness of the deceased, or develop psychogenic symptoms like headaches that are not related to any physical problems or illness. Carr et al. (2001) suggest that dysfunctional bereavement might not show until long after the loss, and may be characterised by prolonged suffering and interruption of normal activities, preventing life from being lived to the maximum.

The most basic cause of dysfunctional bereavement is not completing the bereavement process (Carr et al., 2001). This means that the widow becomes stuck in a state of complicated bereavement (Archer, 1999), where she stops progressing in her recovery from the death. This makes dysfunctional bereavement a disruption in the normal bereavement process, and prohibits healthy closure and healing for the affected people. According to Ong et al. (2004), the disruptions to normal attachment sequences of numbing, yearning and searching, disorganisation and despair, and reorganisation, contribute to dysfunctional bereavement (Blatt & Luyten, 2009).

The extent of support received from the widow's environment is important, as in African culture a human being should never be alone when confronted with a loss (Selepe & Edwards, 2008). The widow forms part of a network of people who can support, encourage and help her. This social support can contribute to the widow's appraisal of feeling less powerless, disturbed and discomforted, therefore resulting in fewer negative outcomes. A lack of support from family and friends can contribute towards difficulty in progressing fully through the bereavement process (Manyedi et al., 2003).

Within the South African context, dysfunctional bereavement may occur, among others things, as a result of changes in the impact of the community on the widow. This relates specifically to the emerging individualistic nature of Black urban societies and the associated unsupportive tendency of the community, as well as unrealistic expectations of the widow to show courage (Carr et al., 2001), and to heal within a certain period of time due to the demands of urban society (e.g. compassionate leave from work is of limited duration). Despite that, different widows may have different experiences of support from their families and community, which could just be a matter of degrees when compared with practices in rural areas. For example, some widows may have supportive employers who may or may not understand the practices expected from the widow and respect social and cultural expectations, when other employers may not.

In addition to the lack of support from family and friends, people's attachment styles can contribute to their progression through the bereavement process. For example, a widow with a secure attachment style, who experiences more positive and less negative emotions, more adaptive responses, greater openness and flexibility in social cognition, and more problem-focused coping with threatening situations, is likely to deal with her bereavement more effectively than a widow with an insecure attachment style who experiences emotional swings, more

negative emotions in social interaction, greater loneliness, and a tendency to have a relatively closed and inflexible social cognition (Ong et al., 2004). Despite that, widows carry this identity throughout their lives, even if they remarry or have new partners, where their identity in the eyes of the Black community does not change. The widow remains her late husband's wife.

What dysfunctional bereavement is to one person may be functional to another person, due to, amongst others, age, gender, marital status, quality of the marriage, social support, socio-economic status, culture, and so on (Schmidt & Joiner, 2004; Shen & Tran, 2009). These authors argue that the influence of depression on the processing of personal attributes is due to the disorganisation of the self-schema in depression.

As mourning is influenced both by the culture in which people grow up and by the culture in which they live as adults (Archer, 1999), a conflict between one's self-schema and culture may contribute to dysfunctional bereavement. This is because the development of the self and hence the development of self-knowledge as an active learning process, may be in conflict with the way of doing things in the social environment (Lalonde, Hynie, Pannu & Tatla, 2004).

People's bereavement depends on their cognitive interpretation of the loss, the shared scripts of their culture, attachment styles, and other related factors. The severity of the loss and duration of bereavement, including the necessity for professional help, among other things, can vary substantially, depending on the influence of various social characteristics of the widow (Bernard & Guarnaccia, 2004).

### 2.2.2.2 Determinants of bereavement

According to Parkes (1998), the nature of the bereavement is determined by three factors: (a) a persons' gender, age and relationship with the deceased; (b) the mode of death, and (c) one's personal vulnerability. These factors are discussed briefly in this section.

In some marriages, companionship consists only of sharing daily routines and outings. In other marriages, the relationship is characterised by an intense sharing of the couple's intimate lives. In all cases, the death of a spouse necessitates finding a substitute companion or tolerating a lonelier life. The loss of a spouse who had been a best friend represents additional impoverishment, including the loss of a sexual partner. According to Klass and Walter (2001), some widows totally lose interest in sex as one aspect of bereavement and become celibate for some time after their husbands' deaths. With time, however, at least some may report a renewal of sexual interest and unsatisfied yearnings.

Age also plays a role in determining the nature of the widow's bereavement. Sources of stress and coping styles probably vary with age. Most widows, depending on their ages, have to face major social adjustments in their lifestyles (Bernard & Guarnaccia, 2004). The loss of the husband may mean the loss of the main income producer, imposing on the widow not only the sole responsibility of managing the family's finances, but also the problem of compensating for the husband's absent contribution. The sudden need to manage the finances may be stressful for older widows who have no understanding of money matters, and who lack practical job skills that would enable them to find employment. In cases where there are growing children, the widow must carry the total responsibility for raising them and fulfilling the roles of both mother and father to satisfy the children's instrumental and emotional needs (Rosenblatt & Nkosi, 2007).

A young widow may remind others of the fragility of life and be seen by other women as a threatening sexual rival. She may also no longer have access to previously available social support. Widows are often referred to as “someone’s wife”, implying that their identities depend on that of their husbands. Widowhood therefore thrusts upon widows a new need for different identities (Rosenblatt & Nkosi, 2007).

The mode of death strongly influences the bereavement process (Archer, 1999). The different modes can be categorised as sudden death, violent death, and anticipatory death. The bereavement process in *sudden unexpected death* is often more intense because there is no warning that the event is going to happen. The situation is so normal, so self-evident, yet suddenly something happens which makes the world look totally different (Vess & Arndt, 2008). Common responses to sudden death are denial and disbelief. This form of denial assumes varying degrees of intensity. For example, the widow may behave as if the deceased is still alive. The impact of a sudden and *violent death* is similar as they are both sudden and not anticipated.

Death comes as no surprise in *anticipatory death*. In this case, caregivers are often emotionally and physically exhausted because they look ahead, predicting, expecting or preparing themselves for an impending loss. They go through three stages, namely, the anticipation stage before the death, the waiting stage when waiting for the death to happen, and the period after the death (Neimeyer, Stewart & Anderson, 2004). During each stage of the process, they experience conflicting emotions and states of mind, and typically use a combination of problem-focused coping and emotion-focused coping at every stage.

### **2.2.2.3 Misconceptions about bereavement**

Misconceptions about bereavement often lead to dysfunctional bereavement as they impact the cognitive reality of death. According to Bernard and Guarnaccia (2004), most people fear that if bereavement is allowed to take place, then it will go on indefinitely and have a negative impact on their motivational schema. The truth is that the only bereavement that does not end is the kind of bereavement that has not been fully dealt with, as bereavement that is experienced does dissolve. Another contributing factor, according to Carr et al. (2001), is the misunderstanding of tears as 'breaking down' when in fact weeping affords people a necessary release of intense feelings.

Another misconception is the idea that continued bereavement is a testimonial to one's love for the deceased. The widow may honour her late husband more through the quality of his or her continued living rather than by constantly remembering the past (Fredrickson et al., 2000; Gerjets, Scheiter & Tack, 2000).

### **2.2.2.4 Emotions**

Each emotion has its own structure, much in the same way that each individual is structured differently with a unique purpose in life (Shaver & Tancredy, 2001). Walsh, King, Jones, Tookman and Blizard (2002) describe an emotion as a subjective feeling that affects and is affected by one's thoughts, behaviour and physiology. These thoughts, behaviour and physical processes form the basis of affective schemata. For example, bereavement serves the purpose of transition and growth (Ong et al., 2004). According to Walsh et al. (2002), people are also aware that they are likely to feel sad when they are separated from their loved ones, and to feel angry when they are unfairly treated. Affect related to pleasure and pain plays a key role in the mobilisation and maintenance of behavioural patterns. This explains why individuals can experience a full range of feeling from

positive and pleasant emotions (for example, love, happiness, joy, and affection) to negative and unpleasant emotions (for example, fear, sadness, hate, and anger) (Walsh et al., 2002). Although functional bereavement includes the experience of negative emotions, it can be hypothesised that widows who also often experience positive emotions would more often experience functional bereavement.

According to Walsh et al. (2002), emotional mechanisms serve to reinforce behaviours directed towards survival and bonding through the expectation and experience of both negative and positive emotions. Affective schemata produce different feeling states through automatic thoughts and the meanings attached to events, contributing to the arousal of an emotion concerned with survival (Colfman et al., 2006). An emotion can thus be explained as the process that starts when something is perceived, appraised and developing an attitude. Mikulincer, Hirschberger, Nachmias and Gillath (2001) view bereavement as an affective reaction and an integral part of psychobiological strategies concerned with survival. Bonanno and Field (2001) hypothesise that a dysfunctional attitude acts as a general psychobiological indicator. As such, the attitudes of bereaved individuals become their personal coping resource.

According to Colfman et al. (2006), the affective system produces different feeling states, shadings and combinations. This variation of emotions is also evident in cultural differences in affective experiences. For example, the range of emotions associated with bereavement and which are allowed social expression differs from culture to culture. In some societies, both sexes are allowed the release of tears in public and some even expect an open show of emotions at funerals and encourage the expression of bereavement during mourning.



#### **2.2.2.5 Emotional pain**

The pain of bereavement is an affective schema of a psychological pain, which seems to have no clear physical location, but entails the experience of damage to the self (Archer, 1999; Zautra, Smith, Affleck & Tennen, 2001). Holm and Severinsson (2008) support this by viewing emotional pain as a subjective psychological experience. This suggests that a negative affective schema could be experienced even in the absence of bodily damage. It does not, however, imply a total absence of physical processes. The pain of bereavement is an affective reaction, which is an integral part of psychobiological strategies concerned with survival. It is an inevitable experience during the bereavement process.

The perception of emotional pain can also be determined by individual socialisation experiences, and the relative degree of individual extroversion or introversion (Bonanno, 2001). In this case, the expression of emotional pain may be associated with how one presents herself. Open and flexible social cognition, for example, may allow a woman to express emotions in a manner that will be functional in her bereavement. Personal vulnerability also plays a major role in people's mental, emotional and spiritual health, and in determining how they cope with loss. People differ in terms of their vulnerability because of individual differences in emotion, which reflects differences in cognitive appraisal and coping at any given stage of a stressful situation (Shaver & Tancredy, 2001).

#### **2.2.2.6 Grief**

The DSM-IV-TR explicitly avoids the categorical distinction of complicated versus uncomplicated grief. However, Parkes (1965) proposed one of the earliest expositions of complicated versus uncomplicated grief. Parkes distinguished uncomplicated grief from three forms of atypical grief based upon interviews with

patients who had been hospitalised for psychiatric illnesses within six months following the death of a parent, spouse, sibling or child. He identified chronic grief as the most common form of grief in the interviewed sample, defined as an extended variant of typical grief in which symptoms are particularly pronounced. The reaction is always prolonged and the general impression is one of deep and pressing sorrow. In contrast to chronic grief, Parkes defined inhibited grief when a bereaved person evidenced little overt reaction to the loss. He highlighted inhibited grief as an atypical grief reaction that is present primarily in children. He described delayed grief as occurring when a typical or chronic grief reaction follows a period in which grief is inhibited.

People's attachments to others are amongst the most intense and influential of human experiences (Shaver & Tancredy, 2001). Zautra et al. (2002) view grief as an instinctive response to loss within attachment relationships, and agree that it involves bodily and psychological reactions. From a cognitive psychological point of view, grief involves a cognitive-affective-motivational-behavioural network. The perception of loss (i.e. a cognitive schema), and feelings such as anxiety, insecurity, abandonment and vulnerability (i.e. affective schemata) form an integral part of psychobiological strategies concerned with survival. This is related to Archer's (1999) and Parkes' (1972) view of grief as complex processes of detachment where the affective schemata serve to reinforce behaviours directed towards survival and bonding which, in the process, trigger automatic and spontaneous motivational-behavioural schemata. This spontaneous process becomes activated, and is followed by the behavioural schemata (scripts), for example, crying out the hurt of the loss. Vess and Arndt (2008) summarise grief as a biologically founded pattern of physical and psychological reactions developing along setlines.

The cognitive-affective-motivational processes related to grief usually lead to recovery and healing, and eventually adaptation (Forgas, Baumeister & Tice,

2009). This offers the opportunity for growth, because these processes disrupt and sometimes shatter one's established way of viewing or making sense of the world, and provide for a new integration. Grief has evolved to encourage the human species to maintain social bonds and make attachments that are critical for survival, as one cannot survive alone (Ong et al., 2004). Attachment is thus of central importance and it could be expected that people with different attachment styles would deal with their grief differently. A widow with a secure attachment style may evaluate this experience with more frequent positive emotions and less negative emotions due to her tendency to having greater openness and flexibility in social cognition, and may therefore adjust better than a widow with an insecure attachment style.

In the sections that follow, diagnostic issues of bereavement are explored.

### **2.2.3 Diagnostic issues of bereavement**

According to the American Psychiatric Association (1994), the DSM-IV-TR views the death of a close friend or relative as a stressor with generally normative and predictable consequences. According to this approach, bereavement is used diagnostically when the focus of clinical attention is a reaction to the death of a loved one. In this section, diagnostic issues of bereavement are discussed.

#### **2.2.3.1 Differentiation between bereavement and depression**

Regarding the relationship between bereavement and bereavement related depression (BRD), the current DSM concept of uncomplicated bereavement is not confirmed because the sleep pattern of people who develop a depressive syndrome in the context of bereavement is also not confirmed. As such, people with either bereavement or BRD have sleep patterns identical to those found in

major depressive episodes (Byrne & Raphael, 1999). However, Ayers et al. (2007) differentiate BRD from complicated grief where BRD includes apathy, insomnia, extreme sadness, low self-esteem, including suicidal thoughts. In contrast, complicated grief as opposed to uncomplicated grief includes searching and yearning for the deceased, crying, feeling stunned by the death, not believing that the loss occurred, and being preoccupied with thoughts of the deceased. While depression needs a psychopharmacological approach, bereavement needs moral support. Reynolds et al. (1999) find symptoms of complicated grief to probably be distinct from depressive symptoms and appear to be associated with enduring functional impairments deserving of specialised treatment. Based on the prevailing evidence, Zisook and Kendler (2007) conclude that there are more similarities than differences between BRD and SMD (standard major depression).

A study by Cox, Stabb and Hulgus (2006) comparing anger and depression between boys and girls found that girls are more likely than boys to suppress anger due to socialisation in their development of gender identity. Girls are thus socialised to be more comfortable with depression than anger. However, Cheng, Mallinckrodt and Wu (2005) found that in Taiwan, the expression of anger and depression was either neutral or positively associated with depression symptoms. However, the inability to experience and express this anger openly and directly could give rise to it being inwardly directed, resulting in possible depression. This can take the form of an exaggerated bereavement reaction, which occurs when feelings of fear, hopelessness and depression, become so excessive that they interfere with the daily existence of the bereaved (Zautra et al., 2001). Although depression and bereavement are different, they are inextricably linked, and may also overlap.

Depression and bereavement share similar symptoms such as loss of appetite (and thus weight loss), difficulty falling asleep (and as a result, low energy or

extreme fatigue), excessive sleep, and mood swings. At times individuals may feel the pain and weep; at other times they may feel emotionally detached from their environment emotionally (Archer, 1999; Parkes, 1972).

Withdrawal and the inability to relate to others are common reactions, although not everyone may experience all these feelings as they vary from person to person. Additional experiences that are characteristic of both bereavement and depression include physical symptoms such as dizziness, shortness of breath, headaches, heartburn, psychosomatic pains, and chronic colds (Turvey, Carney, Arndt, Wallace & Herzog, 1999).

Functional bereavement symptoms may also consist of a longing for the deceased, a lack of acceptance of the death, memories that occur suddenly at any time or any place (intrusive memories), frequently thinking of the deceased (preoccupation), tearfulness, sensing the presence of the deceased, and other related psychological experiences. It can also involve chest pains or a racing heart, digestive problems, and hair loss. Depression, on the other hand, is indicated by prolonged physical lethargy and fatigue, or emotional distress for reasons other than the death (Turvey et al., 1999).

Clinical depression is different from bereavement in that depressed persons experience life as meaningless and find nothing pleasing or positive in it. They experience deep despair with no prospect of relief and no sense of a future; they struggle function in everyday life and may have persistent thoughts of ending their own life (Kendler, Myers & Zisook, 2008). This is different from the deep sorrow that naturally results from losing someone you love. Whereas bereavement is an emotion, depression is a condition (Archer, 1999; Parkes, 1972).

The difference between mood disorders and anxiety disorders will be discussed next, as they share some common features. As emotional states, however, anxiety and depression can be differentiated within mood disorders (McWilliams, Cox & Enns, 2001).

### **2.2.3.2 Differentiation between mood and anxiety disorders**

A clinically depressed person has symptoms daily for at least two weeks, severe enough to interfere with function. Anxiety disorder, for example, panic attack, is a horrifying experience, typically starting suddenly with physical symptoms. The symptoms of depression include sadness, emptiness, reduced pleasure in daily activities, weight change, change in sleep patterns, physical slowing down, loss of energy, feelings of worthlessness, helplessness, hopelessness and guilt, indecisiveness and suicidal ideations. Those of anxiety are shakiness, sweating, palpitations, nausea, and shortness of breath. These go with an intense feeling that something awful is going to happen. It will usually last for a few minutes before fading away. Usually, if one had panic attacks, one may develop a persistent anxiety about having future attacks and may begin to avoid situations in fearing that an attack will happen. However, problems associated with disorder-based analyses need to be supplemented by examining relations among the specific symptom dimensions within these diagnostic classes (Watson, 2009).

Depressive disorders, but not anxiety disorders, constitute risk for suicide. Moreover, the differentiation between a depressive and an anxiety disorder as the principal diagnosis, as well as the assessment of anxiety-level symptoms with major depressive episode and dysthymia, seems of special relevance when assessing suicide risk (Chioqueta & Stiles, 2003).

## **2.2.4 Cultural perspectives on bereavement and related concepts**

The DSM-IV-TR emphasises culturally determined forms of mourning and grief behaviour, and that the duration of expression of normal bereavement differs considerably among different cultural groups (American Psychiatric Association, 1994). In this section, how culture impacts on the Participants' bereavement and how they deal with it will be explored.

### **2.2.4.1 Culture**

As this study uses a cognitive theoretical framework, the discussion of culture in this thesis is presented from this perspective, referring to culture as the social heritage of a community, with socially shared cognitive representations in the minds of individuals. It also involves the activity of learning so as to extend cognitive structures (Church, 2001).

Culture is a shared, learned, symbolic system of values, beliefs and attitudes that shape and influence perception and behaviour of its members. It is shared by members of a society, living and thinking in ways that form definite patterns, which are mutually constructed through a constant process of social interaction. Within culture, language and thoughts are based on symbols and symbolic meanings created by members of society and perceived as natural (Kashima, 2000), for example, scripts. These symbols assume their meanings in relationship to other symbols within a broader context of a meaning system. Members use this system of shared beliefs, values and customs to cope with their world and with one another; and those are transmitted from generation to generation through learning (Figlio, 2001). As a result of its complexity, it is a social, multidimensional construct comprising judgemental or normative, cognitive, affective, skill, and technological dimensions (Li & Karakowsky, 2001).

According to Li and Karakowsky (2001) people develop expectations that are greatly affected by all kinds of shared experiences. These expectations are formulated from previous experiences that were guided by their communities around them, giving them a frame of reference for later experiences. People learn from those experiences and then process and evaluate new experiences in light of them. As members of a community reflect on the meaning of their life experiences and adapt to the circumstances, they further come to have similar perspectives on their situation. This reflection and their response to their circumstances usually lead to a generalisation of what the world must be like and so, in the process, determine the nature of human culture (Mkhize, 2004). Culture and cognition then become inseparable, where the different schemata, including scripts, together define a belief system that forms part of culture in a particular community.

Figlio (2001) finds cultural codes to be a useful way of referring to share meanings through which people can interact and communicate. Codes are the systems of organising signs and the relation of signs to each other. Learning to live in a culture therefore means learning to use the signs, symbols, metaphors and codes available within that culture (Kashima, 2000).

According to Kashima (2000) and Ogarkova, Borgeaud and Scherer (2009), language makes culture a communication system, which establishes the boundaries of the discourse, and is the interpretative framework that defines the cultural group. A cultural group shares a common language, making language one of the significant experiences of the community and a strong identifying and unifying factor, both as an expression of common perspectives and as a factor in the development or change of common perspectives. As such, for outsiders to communicate effectively and to operate within a particular society or culture, they need to share at least the most significant aspects of the society's culture as expressed in language. In this way their worldview can include significant



aspects of the insider's worldview. This involves a process of adapting to the environment and, at the same time, adapting the environment to the self (Christopher & Bickhard, 2007; Kashima, 2000). At the core of this process is the frame of structures through which people make sense of and act appropriately towards experienced actualities.

Mkhize (2004) believes that the analysis of culture entails a search of the material vehicles of perception, affect and comprehension, which are significant symbols, clusters of significant symbols, and clusters of clusters of significant symbols. Metaphors and symbols are fundamental to the understanding of experiences as they imply a way of thinking and perceiving that pervade how people understand their world and experiences (Kashima, 2000; Zittoun, Gillespie, Cornish & Psaltis, 2007). This also explains why people use metaphors whenever they seek to understand one element of experience in terms of another, as these metaphors frame people's understanding in a distinctive way. By using a variety of metaphors, symbols and frames to understand the complex and paradoxical character of social experiences, people are able to achieve much more multidimensional, penetrating and useful analyses and understandings of others, times and places (Zittoun et al., 2007). For example, mourning and its accompanying rituals are based on the scripts that guide people's views and the understanding of their daily behaviour. These cognitive artefacts within the cultural context are the symbolic objects that embody humanly interpretable meanings, socially shared meanings, and other related issues.

Just as much as culture is not static, symbols such as language, core values, certain cognitive schemata and so forth, are resistant to change. As such, sharing a common language is a strong identifying and unifying factor, both as an expression of the shared worldview of a cultural group, and as a factor in the development or change of its members' common perspective (Kashima, 2000).

Gow (1999) views schemata as being built in interaction with people's surroundings, where objects and events are assimilated into existing schemata and thus expand people's existing frameworks of knowing. Gow adds that when this is not possible because people's existing schemata are inadequate to deal with new experiences, they will accommodate. This means that people undergo structural change in their schemata to enable them to expand their understandings and see objects and events in different ways. This view helps us to comprehend the nature of a transitional society where boundaries and frameworks of culture are not rigid. Culture provides a basis for reframing and establishing new boundaries, using different perspectives and legitimising new relationships and values, so that cultures are dynamic and continuously changing (Kashima et al., 2004).

Keller and Greenfield (2000) view cognitive problems as bounded by the cultural definition of the problem to be solved and its culturally defined methods of a solution, even though there are variations in cultural scripts where members of the same culture may behave in different ways within the same script. Thomson and Tulving (2002) further contend that culture defines not only what its members should think or learn but also what they should ignore or treat as irrelevant aspects. These authors term this acceptable ignorance or incompetence, and it is an aspect that applies to the transitional societies examined in this study. One possible reason for this could be that traditionally accepted scripts change as a result of the influence of other cultures. Hofstede (1997) and Kashima et al. (2004) suggest that a contradiction between individual scripts and society's scripts, in other words, weak scripts, are characteristic of a transitional society, where there are few clear scripts to follow.

#### **2.2.4.2 Ethnicity**

Ethnicity is found to be an “almost unmanageable” category for determining group boundaries. According to Church (2001), people from different racial groups could belong to the same ethnic group, whilst those from different ethnic groups need not belong to different racial groups. For example, different racial and ethnic groups may, with time, lose their distinctive language, culture, customs and even their biological distinctiveness over many generations.

According to my observations, ethnicity in societies in transition does not necessarily play the most important role in determining how culture should be practised. Acculturation that occurs in urban residential areas, work contexts, schools and other educational institutions, and churches also leads to a blurring of ethnic boundaries. In this study, I do not attempt to define ethnic boundaries, as the focus is on Black South African women in transitional societies. Although I was part of the Sotho section of a township during apartheid and am Sotho-speaking, the kinds of divisions between Black South Africans encouraged by the previous regime (Bahr et al., 2005) are not emphasised in this study.

Religion and cultural practices will be discussed next in an attempt to highlight the literature that may explain the dynamics between Christianity and the traditional African context.

#### **2.2.4.3 Religion and cultural practices**

Scholars of religion, according to Kritzing (1999), Mbiti (1991) and Uka (1999), agree that the term “religion” denotes a complex set of phenomena comprising, for example, publicly observable behaviours, publicly proclaimed beliefs and ethical systems, etc. As such, it is impossible to generalise about concepts in

African religions because each ethnic group on the continent formulates its own understanding (Burrow, 2000; Strandsbjerg, 2000). For example, in South Africa, religion varies widely (Cumes, 2004), with different customs among a number of South African Christian churches due to the influence of the religious missionaries. About 80% of the population of South Africa are members of the Christian religion, where most are Catholics and Protestants (Cumes, 2004).

According to Chitando (2000) and Greene (1996), religion and African culture are intertwined. They base this assertion on the fact that most rituals are appropriated into culture and as such, shape and influence the religious philosophy and practices of the community.

Mbiti (1991) advocates that Africans regard ancestors as an integral part of their religious and cultural worldview. For example, ancestors are believed to be angels of God to serve and protect the living. Setiloane (1989) confirms this, advocating that ancestors are accorded a special status in African religion, based on the fact that they lived among us and enter God's sacred space and as such, they are regarded as beings that have assumed a higher degree of divinity. Because they know our plight, they are best suited to act as intermediaries between the living and God. That assigns respect to them among Africans, but they are not worshipped (Mbiti, 1991; Setiloane, 1989). As such, Shorter (1978) argues that attempts to dichotomise African spirituality into the sacred and the secular, the physical and the spiritual, distorts and misconstrues theology and its praxis. Africanness, according to Maluleke (1994), can then be viewed as a legitimate host and home of Christ. For example, pre-funeral day-night vigils, foot stamping when singing, repetitive choruses, the peculiar African preaching style, and the belief that ancestors are the angels of God, are accepted as valid African appropriations of Christianity. These reflect how African culture responds to Christianity (Maluleke, 1994).

Each and every ethnic group and even clan has myths that make an attempt to create the origins of humanity and its destiny. For example, the Batswana of Southern Africa believe that humanity came out of a hole in the ground (Setiloane, 1989). This is also reflected in the different names when referring to God. Mbiti (1970; 1991) finds that myths across Africa point to the belief that humans, male and female, were created by God to take care of God's creation, that they were made perfect and that God's intention was for them to live forever. Africans that were converted from traditional African religions either had their birth names changed to those of European origin or new ones added. New converts were named after saints of the church and other biblical figures.

As indigenous African religion bases its philosophy on ancestral spirits, African religion and its cultural practices have ways of mediating between people and ancestors. Traditional African religion involves medicine people who are highly prized and much respected, using herbs to heal. The elders, priests, mediums, sangomas (who are predominantly women), and nyangas run religion (Kale, 1995; Mbiti, 1970, 1991; Pityana, 1999). A sangoma, for example, is a practitioner of herbal medicine, divination and counselling in traditional Black religion (Kale, 1995).

A training sangoma is trained by another sangoma for about a year, whilst still performing humbling service in the community. After training comes the graduation where a ritual sacrifice of an animal is performed, a chicken, goat or a cow. The spilling of the animal's blood is meant to seal the bond between the ancestors and the sangoma (Kale, 1995). Sangomas perform a holistic and symbolic form of healing, which is embedded in the beliefs of their culture that ancestors in the afterlife guide and protect the living. They are called to heal, and through them ancestors from the spirit world can give instructions and advice to heal illnesses, social disharmony and spiritual difficulties.

The relationship of African Christians and their ancestors is, according to Strandsbjerg (2000), an important factor. Strandsbjerg bases this importance in African traditional thinking of ancestors as an essential link in a hierarchical chain of powers, which stretches from this world to the spirit world, making the cult of the ancestors its most common and essential activity. Mbiti (1970) takes this relationship further by reporting that though the spirit world is radically different, it is believed to be a copy of the society in which ancestors lived in this life, where ancestors are believed to remain as part of the family, sharing meals and maintaining an interest in family affairs just as they did before death. The difference is that they are thought to have advanced mystical powers, which enable them to communicate easily with both the family and God and, as such, are considered to be indispensable intermediaries, and integral to the traditional African social structure. Bodiako (1995) and Dickson (2006) confirm this relationship of African Christians and their ancestors by stating that in a culture where tribe, clan and family are important, ancestors are the most important and respected members of the family. The family perceives their ancestors to reflect its identity.

Based on the relationship of African Christians and their ancestors, African Christianity can be seen to represent a projection of a new Christian identity, one that takes seriously the African holistic view of life, steeped both in the cultural values and traditional religious practices of the people. This is because in African traditional thinking and belief, death is not thought to end human relationships but instead, heralds the entrance of the dead into the spirit world (Bodiako, 1995; Dickson, 2006). Pratt (2003) brings in another factor in the relationship of African Christianity and ancestors when he argues that for the family to be cut off from relationships with its ancestors is for it to cease to be a whole. This is based on the idea that the ancestors sanction society's customs, norms and ethics, and that, without them, Africans would be left without moral guidelines or motivation, making society powerless to enforce ethics. This explains why African culture often acknowledges the presence of ancestors, particularly at meals or when

drinking brewed beer, where small portions are set aside or spilled on their behalf. Ancestors will again be referred to in sections 2.2.4.5. (Marriage rituals), 2.2.4.6 (Death), and 2.2.4.7 (Death rituals), signifying the importance of ancestors in African culture and religion in everything they practice.

Strandsbjerg (2000) acknowledges that a dichotomy of the soul has arisen, in which believers assent to orthodox Christian belief and join in the denunciations of the ancestral rites, but privately retain their loyalty to the tradition, especially in times of serious misfortune or death. They believe that with Christ as the bridge that binds the living and the dead, Christians can pray for their ancestors and plead that the sacrifice of Christ may be effective in their case also.

As identity is anchored in a particular social context or in a specific set of social relations, the identity formation process involves a dialectical relationship between the individual and society. It implies that we become who we are as a result of a particular form of socialisation in which there are always competing claims of meaning and power relationships. It is in this context that one begins to appreciate the political significance of the conflict of interpretations about the nature of social reality. This conflict also takes place within religious communities as they seek to be faithful to the imperatives of the gospel. The question now is whether authentic Christian faith can flourish in every culture (Maluleke, 1994).

This introduces the issue of cultural differences between Black and White South Africans. Maluleke (1994) argues that the African interpretation and practice of religion is different from that of the West and is based on the spiritual truth of African traditional culture. He argued that pre-colonial Black South African traditions and culture were not recorded except orally. On the basis of this argument, African culture may have defined the experience of Christianity in its own unique way, rather than merely adopting Western religious doctrine.

Religious and cultural practices of a given community might not necessarily be the product or consensus of all its members, as some families may practice some of the rituals and not others. Maluleke (1994) argues that cultural differences have been either exaggerated or environment-induced to a large extent. As a result, African Christianity must be understood to refer to how Black South African Christians receive and proclaim Christianity (Maluleke, 1994). It may then seem that multi-cultural Christianity depends very much on what one wishes to convey by it, and the use one wishes to make of it (Maluleke, 1994).

Despite the fact that Christianity is known through incarnation, Christian gospel has always been wrapped around a culture. When Christ is interpreted as a rabbi or priest in Western culture, in African culture, He is interpreted and comprehended as the healer, the ancestor and the master of initiation (Maluleke, 1994). It is in this context that the Christian faith is not foreign to Africans but speaks to the very heart of the Christian community. This does not only promote a new sense of African Christian identity, but is also the core of the new kind of spirituality in the African context, especially in transitional societies. As such, Black South African Christians' faith and identity is rooted in their religious experience (Strandsbjerg, 2000).

Africans, according to Mbiti (1970), have always attributed some sacredness to certain geographic places. From the cognitive theory perspective, this can be explained as a shared set of schemata where, for example, Christianity dilutes racial and ethnic boundaries, for religions transcend cultures as people from many groups may share them. Some people prefer to be buried where they were born and brought up, in their *gae* (Tswana word for home), which in South Africa is often a rural area. The importance and meaning of *gae* to Black South Africans is to have their resting place next to their ancestors (Mbiti, 1970), bringing us to the next section of place identity.



#### 2.2.4.4 Place identity

However, the concept of *gae* is weakening in transitional societies, as more and more people move to urban areas for employment, start a family and settle. They tend to prefer to be buried where they have settled with their nuclear families as opposed to their rural place of origin. This suggests *place* to be an aspect of one's identity. There is an attachment to place, which has become woven into the individual's personal identity. In view of this, place identity needs to be accounted for (r.o.s).

Goodings, Locke and Brown (2007) explain place identity in a psychological context as people's attempt to regulate their environments, based on their ability to create and sustain a coherent sense of self, and reveal their selves to others within the social, cultural and biological definitions and cognitions of place. Every individual has an environmental past that consists of places, spaces and their properties, which have served instrumentally in the satisfaction of one's biological, psychological, social and cultural needs, and which serve as part of the socialisation process during which self-identity is developed (Goodings et al., 2007).

According to Verkuyten and Poullasi (2002), the self-identity develops in the spaces and places in which individuals are found. Goodings et al. (2007) summarise place as a unifying concept of self and society, making place an essential factor in the production of self. As a result, place becomes an embodiment of one's identity that gives meaning to one's existence. In this conception, people play the role of agents with the ability to appropriate physical contexts to create a place of attachment and rootedness, and a space of being. It would seem that, amongst Africans, the concept of *gae* or home is organised and represented in ways that help individuals to maintain self-coherence and self-esteem (Relph, 1976). Smaidone, Harris and Sanyai (2005) describe place

identity further by explaining it as a “pot-pourri of emotions, conceptions, interpretations, ideas and related feelings about specific physical settings and types of settings” (p. 60). Through experience and activity, each self has its own unique pattern, much of which is as a result of one’s perception of self. The past in people’s minds becomes embedded in their selves as a sub-structure of their self-identity that consists of cognitions about the physical world. This cognitive sub-structure is unique to each individual as each person records and retains memories in different ways. Those memories form the basis of needs and desires (Smaidone et al., 2005).

Fried (2000) suggests the concept of sense of “insidedness” in an attempt to explain the concept of place within physical settings. “Social insidedness” refers to tacit knowledge of the physical details of place, and “the sense of connection to a local community and recognition of people’s “integration within the social fabric” (p. 302).

It is clear that belonging to processes of self-definition is a central feature of place identity (Cuba & Hummon, 1993). Smaidone et al. (2005) also view a sense of belonging as the core of place identity, where subjectivity and place cannot be separated without comprehending the located subject and identity of place (Verkuyten & Poullasi, 2006). This means that “place belongingness” is not the only aspect of place identity, but is a necessary basis for it, where place identity can then serve as personal identities, define appropriate social behaviour and activities intelligibly, express tastes and preferences and mediate efforts to change environments (Gerjets et al., 2000).

In summary, it seems that the capacity and expression of rootedness in place is the foundation of both the individual identity and social membership in one’s community. People’s perception of place will determine how they interpret and

react to it. The acquisition of a place identity is not a uniform process but rather a combination of memories, conceptions, interpretations, ideas and related feelings about specific physical settings as well as types of settings (Smaidone et al., 2005). This makes place identity an attachment for place (Rowles & Ravdal, 2000) that points to people's shared representations, unifying self and society. At the time of loss, one's interpretation of the event and self-schema together will be a reflection of society's shared representations.

#### **2.2.4.5 Marriage rituals**

The death of a husband cannot be fully understood if the meaning of marriage and the rituals that go with it are not accounted for. The meaning of marriage can partly be inferred from marriage rituals. Marriage rituals in some African cultures have the meaning of integrating the families of the bride and groom together with their ancestors (Mbiti, 1991).

The groom-to-be must inform his uncles from his mother's side of the family that he intends committing to a marriage with a particular bride-to-be. The uncles, together with the chosen elders of the family, will have a meeting to discuss the date and time of meeting the other family. A letter will then be drafted and sent to the bride's family specifying their intention to come for negotiations of lobola (the money paid by the groom to the bride's parents, thanking them for bringing up their daughter to be his wife), with the intention of having their daughter as their daughter in-law. On the decided date and time a meeting will be held where the bride's uncles and chosen elders are present. In some instances the bride-to-be will be called to meet her future in-laws. After the negotiations and payment of lobola, appointed members from each side sign for the payment and agreement, and the date is set for the marriage ritual, which will bring the two sides of ancestors together as one. The unification of the couple and the families'

ancestors has the purpose of protecting the couple and their children from evil spirits (Mbiti, 1991).

#### **2.2.4.6 Death**

The idea of immortal ancestors dominates African thought about death and the afterlife (Mojapelo-Batka, 2005; Wiredu, 1995). This is so as the world of an African consists of the living and the dead sharing one world in which they share one life and one vital force, i.e. the world of the living-dead (Kasoma, 1996). The spirit, which does not die, is the vital force, which gives life to both the living and the dead. What dies, according to Kasoma, is the body in its physical form although the spirits of the dead have bodies too but these bodies are spiritual and not physical. Kasoma advocates that the dead are not actually dead but merely transfer to another life, where the living needs the dead to carry out a normal and full life. The dead, in turn, need the living to enjoy their life to the full. This then explains sacrifices by the living to the dead.

Magesa (1997) takes it further by advocating that when a person dies, it is believed to be the whole person who continues to live in the spirit world and receive a new body identical to the earthly body with enhanced powers to move about as an ancestor. This suggests that the concepts of life and death are not mutually exclusive and there are no clear dividing lines between them (Okwu, 1979), and also that there are culturally defined schemata associated with death.

According to Okwu (1979), in the African belief system life does not end with death but continues in another realm. Idowu (1973), Mbiti (1969) and Mojapelo-Batka (2005) confirms the idea that death does not alter or end the life of an individual, but only causes a change in its condition where it is expressed in the concept of ancestors, i.e. people who have died but continue to live in the

community and communicate with their families. Idowu (1973) and Okwu (1979) then suggest that Africans welcome reincarnation, i.e. the soul of a dead person is reborn in the body of another, where the world is a living place to which the dead are only too glad to return from the darkness and coldness of the grave, forging a relationship between birth and death. An ancestor may also be reincarnated in more than one person at a time.

There are many different ideas about the place the departed go to, a land, which in most cases is believed to be a replica of this world. In most cases, it is believed to be an extension of what is known at present, although for some people it is a much better place without pain or hunger. This is based on the fact that most African people believe that rewards and punishments come to people in this life and not in the hereafter. This then makes the African concept of death to be perceived as the beginning of one's deeper relationship with all creation, where life is complemented and is the beginning of communication between the visible and the invisible worlds (Mbiti, 1969; Mojapelo-Batka, 2005).

What happens in the land of the departed happens irrespective of a person's earthly behaviour, provided the correct burial rites have been observed. However, according to Mbiti (1969), the deceased may be subjected to a period of torture according to the seriousness of his or her misdeeds, much like the Catholic concept of purgatory. The individual who had been very bad in his lifetime will be unable to live properly after death and become a danger to those he or she leaves behind, becoming a wandering ghost. Among Africans, to be cut off from the community of the ancestors in death is equivalent to the concept of hell (Mbiti, 1969).

Funeral rituals for transition are performed so as to elevate the deceased to successively higher spiritual planes and stages of greater integration into a

spiritual world, assisting the deceased with his or her journey to the ancestral body (Mbiti, 1969; Mojapelo-Batka, 2005). For that to happen, the deceased must be detached from the living to make as smooth a transition to the next life as possible because the journey to the world of the dead has many transitions (Strandsbjerg, 2000). There are two traumatic experiences that would affect a widow and her late husband in the same way. For the deceased, the traumatic experiences involve the wrenching of the spirit from the human body, and its separation from the visible society. For the widow, it involves the loss of her husband, which she has to learn to accept and adapt to. For both the deceased and the widow, life after death and bereavement mean a period of uncertainty, adjustment and contemplation (Mojapelo-Batka, 2005).

In travelling along the purification journey, the spirit of the deceased is believed to be alone in the dark and the wilderness. It is also believed that it can only be assisted by the support of the living kin through their mourning observances. This they do by sharing a sense of loneliness and withdrawal from the pleasantries of life together as a couple. In so doing, the widow helps the deceased's spirit to reach its destination as an expression of her companionship with him. This is partly achieved through the widow's duty to perform rituals to promote the ancestral status of the deceased in achieving his position in the ancestral realm together with the rest of the ancestral spirits so as to start protecting her from the evil spirits (Mojapelo-Batka, 2005).

It is also believed that if the widow does not follow the rituals during the deceased's purification journey properly, her husband's spirit may never reach the desired ancestral realm. According to the African belief system, the spirit will continue wandering in the valley of spiritual wilderness without end. This emphasises the importance of the sets of rituals to be performed by the widow to help the deceased's spirit to become part of the ancestral realm. This, in the

process, will reassure the widow of the well being of her late husband (Mbiti, 1969; Mojapelo-Batka, 2005).

#### **2.2.4.7 Death rituals**

Although information on death rituals is more often associated with anthropology than with psychology, the concept of death rituals was found to be relevant in this study as it plays an important part in informing widows' psychological experience of mourning. Ritualistic behaviours, according to Nurs (2006), are often associated with ceremonies for the deceased.

Death rituals have an important psychological significance for African people. They are meant to facilitate the process of healing rather than delaying it. For example, most African rituals include the use of incense called "impepho" used to expel evil spirits and to invite positive energies during particular rituals. Impepho, according to Tlhagale (2004), has a calming effect both emotionally and spiritually. In passing the rituals from generation to generation, however, the meaning may be lost. From my observation of the transitional society of which I am a member, it is unfortunate to realise that some people comply with traditional death rituals without necessarily understanding their symbolic meaning.

According to an elder from the Participants' community with whom I spoke during the study, death rituals arose from the strong sense of community between the living and the dead. This strong sense of community makes those who had passed on (ancestors) and those who are still alive mutually interdependent such that what affects the living adversely or favourably also affects the ancestors in precisely the same manner. If the burial and its rituals have been satisfactorily respected and completed, it is believed that balance and security, which death

has sought to overcome, will be restored (M. Mfelang, personal communication, November 3, 2004).

In the section that follows, death rituals in traditional and transitional societies are described. This discussion illustrates some of the fundamental changes that have taken place in transitional societies.

#### **2.2.4.7.1 Death rituals in traditional societies**

In traditional communities, the culturally prescribed rituals have a symbolic meaning and a therapeutic effect, with the purpose of remembering the deceased and for closure. As such, people in these communities tend to practise and live according to the tenets of their traditional culture. As a result, participating in bereavement ceremonies and rituals tend to help the widow in her bereavement process (Mojapelo-Batka, 2005; Tlhagale, 2004).

Members of traditional communities tend to be closely involved with the family members in caring for the dying person. As such, family members of the dying person come to perceive death as a natural part of the life cycle. This explains the common trend for people to die at home in traditional societies (Tlhagale, 2004).

An important ritual that the widow is expected to follow from the moment her husband passes away is to stay indoors, in the couple's bedroom (Mojapelo-Batka, 2005). All windows are smeared with ash, all pictures in the house are turned around and all mirrors, televisions and all reflective objects are covered. The beds are removed from the deceased's room, and the bereaved women sit on the floor, usually on a mattress (Strandsbjerg, 2000). Female relatives from



both sides of the family will sit on the mattress on the bedroom floor together with the widow until the morning of the day of the burial (Mojapelo-Batka, 2005).

During the time preceding the funeral, family, friends and neighbours show sympathy in different ways, such as visiting the widow or buying groceries for the bereaved family, where visitors are usually directed to the couple's bedroom. This is done to give the bereaved family moral support and comfort, reflecting the communal nature of African culture (Mojapelo-Batka, 2005).

The day before the burial, just before sunset, the corpse is brought home for the night, and remains in the couple's bedroom together with the surviving spouse and the female elders. This allows the deceased to say goodbye to his or her family and worldly possessions. The whole of that evening and night, the widow sits at the head of the coffin whilst the deceased's mother sits at the foot to symbolise the two significant women in his life (Okwu, 1979).

A night vigil then takes place, often lasting until the morning. The night vigil is a time for pastoral care with the singing of hymns and a sermon (Chitando, 2000). That very night, a ritual killing (called *go phasa badimo* in South Sotho), is often made for the ancestors, as it is believed that the blood from the animal that is slaughtered must be shed at this time to avoid further misfortune (Mojapelo-Batka, 2005). In the case of the death of a husband, a male animal is slaughtered to symbolise the death of the head of the family that represents an attempt to communicate with the ancestors. In the case of a wife, a female animal is slaughtered. The first blood from the neck of the slaughtered animal, which is regarded as the delicacy of the ancestors, needs to flow onto the ground, which is a significant part of any ritual in African culture. It also includes prayers, snuff for the ancestors, and African brewed beer for the ancestors to quench their thirst (Magesa, 1997). The hide of the slaughtered beast is often

used to cover the corpse or placed on top of the coffin as a blanket for the deceased.

The following morning the corpse is prepared by bathing it. If the deceased is a woman, women will prepare the corpse; if it is a man, men will prepare it. Another elder in the community under study explained the bathing of the corpse as symbolising the sacred quality of a human being that exists in the soul and spirit. As such, the body is perceived as a temple for the spirit during life, which deserves decent and respectful treatment. He further explained the soul as being the pre-existing, rational and immortal part of humans, with the spirit developing and growing as an integral part of the living being. The spirit denotes that which separates a living body from a corpse, implying consciousness and sensitivity (Magesa, 1997).

The elder further explained the purpose behind the bathing. This, according to him, is based on the belief that there is a long journey between this world and the next, and that death is a continuation of life and not an ending. The bathing and dressing of the body is done in a manner that is based on beliefs concerning the preparation of the deceased for a long journey. For example, utensils are sometimes put in the coffin or on the grave for the deceased to use throughout his or her journey. In the morning, before the sermon starts, family and friends come to the house to view the corpse for the last time and to take leave of the deceased (Strandsbjerg, 2000). Traditionally, the funeral takes place in the early morning (often before sunrise) and not late in the afternoon, as it is believed that witches move around in the afternoons looking for corpses to use for their evil purposes. Because witches are asleep in the early morning, this is a good time to bury the dead.

At the cemetery, the *diphiri*, the young men who dig the grave early in the morning of the funeral in rural areas, are the authority, together with the religious leader. Everybody, including the bereaved, complies with the priest or *diphiri*'s authority, insisting on a particular dress code for the funeral proceedings. Those who do not comply are not allowed at the funeral. The important task of filling the grave is done by the *diphiri* when everybody is still present to make sure that nobody interferes with the corpse. In some communities children and unmarried adults are not allowed to attend the funeral. During the burial itself the immediate family of the deceased is expected to stay together on one side of the grave at a designated place. They are forbidden from speaking or taking any vocal part in the funeral (Mojapelo-Batka, 2005).

From the cemetery, people are invited to the deceased's home for the funeral meal. Many people follow a cleansing ritual at the gate of the deceased's house, where everyone must wash off the dust of the graveyard before entering the house. Sometimes pieces of cut aloe are placed in the water, and this water is believed to remove bad luck. Churches that use holy water sprinkle people to cleanse them from impurity at this time (Chitando, 2000). The following morning, blankets and anything else that was in contact with the deceased are wrapped up in a bundle and put away for a year or until the extended period of mourning has ended, after which they are distributed to family members or destroyed by burning (r.o.s).

In traditional societies, widows are respected and given time to heal, and not necessarily kept away from in a negative sense. This accepted pattern of behaviour would be explained by cognitive theory as shared scripts that guide people's interpretation and comprehension of their daily experience (Magudu, 2004). Accordingly, in traditional societies communities tend to prescribe the widow's behaviour in churches, public transport, in the neighbourhood, within their own families, and at the workplace.

#### **2.2.4.7.2 Death rituals in transitional societies**

As there is virtually no published information about death rituals in Black South African transitional societies some of the descriptions in this section were gleaned from the researcher's clients in therapy over the years, and to a lesser extent, from the researcher as a member of the community under study. As such, this description is therefore specific to the researcher's and her community's experiences and cannot be generalised to other transitional societies. It is not meant to provide factual information about the rituals, but to present some context to the reader about the community under study. This confirms the researcher's motivation for this study to be taken further and encourage others to research urban transitional societies.

It would seem that Black urban societies in South Africa still maintain some of their cultural practices, although they have integrated aspects of widowhood and religion from Western societies into the structure of their transitional societies. Some families participate in traditional death rituals while functioning in a transitional community, while others follow Christian bereavement rituals; this may differ from family to family. Still others do not practise any rituals at all. The eclectic nature of adherence to rituals creates the impression that the healing power of the traditional rituals has become watered down or is nonexistent in transitional societies. This may create a bewildering and confusing mixture of traditional African practices and practices borrowed from Christianity and Western traditions. This includes changes in the way rituals are practised, which seem to be based on the families' traditions instead of on community norms. This can sometimes create problems in situations where women become members of a family through marriage, which follow different practices from her family of origin, when her late husband's rituals are supposed to act as "glue" that brings family members together, including the daughter in-law.



Traditional practices that are still respected are sometimes practised in different ways. For example, while the hide of the slaughtered animal is used to cover the coffin in traditional societies, some modern families in transitional societies use a new blanket to cover the coffin, while others put flowers on the coffin. Also, in traditional societies people often die at home whereas in transitional societies they often die in hospital.

There are some extreme practices in transitional societies that are not the norm. At times the mattress is still put on the floor, although some families will receive visitors in the lounge and respect the privacy of the deceased's bedroom, especially if the corpse is not coming home overnight. In some families night vigils are not conducted. Another new variation is for the undertaker to prepare the corpse. Some families may allow the corpse to be viewed while others may not. Also, some families may give away the deceased's possessions while others will not.

The most common traditional rituals that still seem to be maintained by families in urban transitional societies are the slaughtering of an animal, the cleansing ceremony, and the home coming of the deceased before the funeral when the corpse is brought home before sunset and placed in the main bedroom (Okwu, 1979). The cleansing ritual involves the widow drinking boiled herbs, washing with the mixture of the slaughtered animal's stomach contents and shaving all body hair. Shaving the hair is based on the belief that, because life is concentrated in the hair, shaving it symbolises death, and its growing again indicates the strengthening of life (Eyetsemitan, 2002).

The practicalities of transitional societies demand that bereavement should be brief and intense, and that one should resolve bereavement quickly and return to normal activity (Archer, 1999), something that is perceived to be unAfrican. As

such, there are rituals that are not generally practised in transitional societies for practical reasons. For example, although there are widows who still wear black clothes, many will wear blue or some other colour. It is clear then that some modifications seem to have been made. The widows' in-laws are often the ones to prescribe the manner in which the ritual is practised. For example, while some in-laws may insist that the widow wears black clothes, others may prefer blue or any other colour, and still others may decide that the widow should wear her usual clothes. This illustrates how transitional societies have adopted Western practices to a certain extent, characterising those societies as unAfrican.

Another practical reason for the widows in transitional societies not to practice some rituals may be financial as, for example, they may have to return back to work as soon as possible. Regarding that, Archer (1999) argues that the issue of a brief and prescribed period of bereavement is misleading. Archer bases this on the fact that some aspects of bereavement are life-long and reflect a positive continuing attachment to the deceased. Outdated as this source may be, its understanding of mourning seems to remain relevant to the practices of current transitional societies.

The workplace is another area where widows in transitional societies potentially face discrimination, especially when one is from a family that still practises the tradition of wearing black clothes or a black band. This practice is supposed to be part of the healing process and is often determined by the widow's in-laws. However, colleagues, who are supposed to support the widow, might behave in the same way towards her as others as in her community, for example, refusing to use the same utensils that she uses, possibly obliging her to bring her own utensils, not sitting on the widow's chair, and so on. Some widows' families may also require the widow to use a different set of utensils in her own house and do her washing separately from the family's since no one except the widow is supposed to touch the mourning clothes.

Some churches, which the widow looks to for support, alienate her when she needs them most. For example, there is often a special place, usually at the back row of the church, where widows are supposed to sit and not mix with the congregation, implying that they are different from the rest based on their widowed status. Even the members of the congregation may behave in a manner that tells the widow that she must stay away from them. For example, people may move away from the widow if she happens to sit next to them.

The unveiling of the tombstone is another example of an area of change due to Western influences. Unveiling the tombstone signifies closure, helping the widow in the final stage of bereavement to achieve closure (r.o.s). In transitional societies, people are invited for the unveiling ceremony and as such, one is not expected to come uninvited. This is unlike traditional societies where people are not invited, but rather are expected to attend the ceremony. For the unveiling of the tombstone to be done, the widow should have gone through the cleansing ceremony, signifying the end of the mourning period. However, in transitional societies, a tombstone is sometimes erected and unveiled at the burial ceremony for economic purposes even though it is traditionally believed that the spirit of the deceased has to join the ancestral body (a transition that takes some time) before the tombstone can be unveiled. The ceremony is the final service that the widow can perform for her late husband. The tombstone itself symbolises that the widow has built a house for the deceased who would by then be part of the ancestral body.

The unveiling of the tombstone ceremony is, to a certain extent, similar to the funeral ceremony. Slaughtering will take place on the night before the day of the unveiling and food would also be prepared. In some cases a night vigil is held. In traditional African culture the ceremony is only done in winter, very early in the morning before sunrise. However, in transitional societies, it is sometimes performed in summer and sometimes in the afternoon. The practice in



transitional societies is for the priest to conduct a short service, with a scripture reading done at home or at church. The procession will then move to the graveyard. The grave has to be covered with a white cloth the day before the ceremony, and will be removed when the tombstone is unveiled. At the graveside, the priest will read a second scripture and conduct a second, longer service.

The ceremony involves the removal of the white cloth that had covered the stone overnight by, more often, the deceased's grandchildren. One of the grandchildren will then read the inscription to the crowd. Thereafter the priest will bless the stone, an elder in the family will give a vote of thanks, and the people will be asked to walk round the grave to see and admire the tombstone. The crowd will then drive back to the family's home for a meal.

It has for many years been customary to have funerals over weekends in Black communities. This is done because people are better able to attend a funeral over the weekend and because relatives may need to travel long distances to attend the funeral. In transitional societies, due to the volume of people dying through illnesses, non-accidental deaths, and HIV/AIDS, it has become impractical and inconvenient to conduct funerals only on weekends with the result that more funerals are being held during the week.

In transitional societies, it is believed that the size of the crowd at one's funeral is a reflection of how involved the deceased was with people around him or her. The bigger the crowd, the more prominent it is believed the deceased was in the community. This includes the social class the deceased belonged to, and the lifestyle he lived, as reflected by friends and family at the funeral.



The dress code at funerals in transitional societies is not prescribed as it is in traditional societies, i.e. in the former, a woman can wear pants with a jacket and without covering her head as opposed to the latter where pants for women and not covering your head is not allowed. Also, the grave is dug by the local municipality and is paid for. The covering of the grave is one of the rituals that is still maintained albeit with a blanket instead of the traditional animal skin. From the cemetery, the mourners will go back to the deceased's house for a meal as a token of appreciation by the family for the support they received from the mourners, as is also the case with the unveiling of the tombstone ceremony.

The seating arrangement at funeral services in transitional societies has changed from earlier times. In traditional society, men and women sat separately, whereas in transitional society males and females sit together. That may suggest that males and females now view each other as equals and partners to a greater extent than before.

Support from friends and neighbours seem to have become, to a certain extent, impersonal, as opposed to traditional societies, where the death of a community member affected the whole community. For example, people may send sympathy cards or communicate support via the obituary column of newspapers (Malkoc et al., 2002) instead of visiting the home of the deceased daily for moral support. Also, from my observations and experiences, some members of transitional societies treat widows in an unsupportive manner, perceiving them as a curse, probably because of their fear of being infected by the widows' tragedy.

Such attitudes and accompanying behaviours towards the widow are sometimes seen in different contexts. For example, some neighbours would not allow the widow into their homes, and would also not come to visit as they might have done in a traditional society. Another response from some communities can be

seen in public transport where the widow is not be allowed to queue with other people but must stand aside and wait for a sympathetic taxi or bus driver to allow her in. Even then, there may be other passengers who do not want to sit next to her, and she may be forced to sit at the back of the taxi, or find herself sitting on her own in the bus. Some taxi drivers do not want to touch her taxi fare because of *sefifi* (misfortune). This behaviour by the community can negatively affect the widow's self-experience, and is often accompanied by feelings of rejection. In an attempt to compensate for this lack of support, forums have been established in the communities where the widows live where the widows will meet and share experiences and advice.

Generally, in African culture, the bride is socialised into the culture of her future husband's family immediately when she joins her family of marriage. She practices the new cultural norms through observing others, imitating them and receiving feedback from others. It is believed that this is the culture that should be shared by all generations, from their ancestors to the present generation. The bride is expected to assimilate into this culture. Later on she is also expected to socialise other new family brides and her children into the same culture and practices. As such, the widow's difficulty in observing her in-laws' way of practising rituals may have serious consequences as ritual practices prescribe that the "*makoti*" (daughter in-law), her husband and their children observe family norms and beliefs. This is not a matter of choice as there are serious consequences for deviation. However, in transitional societies this seems to occur to different degrees.

The rituals that a widow is used to in her family of origin may be different from those in her husband's family, and this can also complicate the widows' bereavement. A couple may, for example, have met at a tertiary educational institution as students, having similar ways of looking at life, the world and their future together. After getting married, their different upbringings could create

conflicts in their relationship. One of these differences may concern the death rituals that are practised by the two families. The widow may be expected to practise rituals that she never grew up practising, making it difficult and uncomfortable for her. This can counter the intended purpose of healing, creating intense feelings of resentment. In this regard, the widow's relationship with her in-laws plays an important role in whether she will receive support from the in-laws or not. The in-laws' participation or non-participation in the last death ritual of the unveiling of the tombstone, for example, may also have an impact on the widow's bereavement as this ceremony serves as closure to the mourning process. For example, the in-law's participation will give the widow an opportunity to arrange a ceremony that she believes befit her husband, thus giving a sense of having done the best for him.

A power struggle may develop between the late husband's family and the widow. In some cases, the in-laws may feel that they invested in the deceased, struggled to educate him so that he could be able to educate his younger siblings, and take care of his family of origin. When he passes away, the widow's in-laws may expect the widow to carry on his duty of educating her late husband's siblings when she herself has to educate her own children (r.o.s).

Also, from the researcher's observations in the community, when a husband passes away, it may be suspected that his wife is implicated in his death. This may be due to financial considerations such as insurance payouts, and the widow now owning the house as opposed to it being a shared property. Implicating a widow in the death of her husband could be one of the causes of dysfunctional bereavement as it may cause anger, which may impeded the natural process of bereavement.

Kasoma (1996) advocates that weak scripts of transitional societies exist because the communal approach of African culture is conspicuously lacking. He advises that individualism in Africa today should be discarded since it is unAfrican. If one were to subject transitional societies' death rituals to a scrutiny of how rooted they are in African values and traditions, the likely outcome would be that they are foreign bodies in the cultural fabric of Africa (Traber, 1989).

#### **2.2.4.8 Mourning**

People come to understand who they are by virtue of cultural scripts, symbols, stories, images, sayings and ways of doing things that surround them (Zittoun et al., 2007). Cultural and traditional practices signify people's life cycles, marked and symbolised in a certain way to give meaning, helping people to adapt to their environment, and giving them a sense of continuity with their past (Gerjets et al., 2000; Moody & Arcangel, 2001; Worden, 1996). These practices also help incorporate loss into an already established cognitive system (Worden, 1996).

As early as 1974, according to Daneel (1974), some Christian churches have a night vigil at the home after the bringing the corpse home. Daneel describes the ceremony in some Zimbabwean churches at that time, where the living believers escorted the spirit of the deceased relative to heaven through their prayers, after which a mediating role could be attained. The emphasis was on transforming traditional rites, while providing consolation to the bereaved family. This example shows how these churches try to eliminate an old practice without neglecting the traditionally conceived need that it had served (Chitando, 2000).

The first phase of mourning is usually when relatives and friends surround the widow immediately after the death of her husband. The purpose of the activities preceding the funeral is to comfort, encourage and heal those who are hurting. It

is a period of support with varying forms of tradition, culture, social and religious practices, including the group's interpretation of its supportive function (Magudu, 2004). About a month or two after the funeral the grieving family slaughters a beast and then goes to the graveyard. They speak to the ancestors to allow the deceased to return home to rest. It is believed that at the graves the spirits are hovering on the earth and are restless until they are brought home – an extremely dangerous situation for the family because the family may have misfortunes. The family members take some of the earth covering the grave and put it in a bottle. They proceed home with the assurance that the deceased relative is accompanying them to look after the family as an ancestor (Magudu, 2004).

In the amaHlubi tribe of South Africa, for example, the death of a person is symbolised by a tradition called “*ukuzila*”, which is defined as showing respect to the deceased by avoidance of certain behaviours and places (Magudu, 2004; Ngubane, 2000). During this period, for example, the widow respects the custom of *ukuzila* by wearing black as a symbol of mourning with varying forms (Magudu, 2004; Mojapelo-Batka, 2005). Historically among the Nguni tribes of South Africa, mourning widows do not attend social gatherings until after the cleansing (Magudu, 2004). Mojapelo-Batka (2005) refers to this period as the seclusion period, where the widow shelters her bereavement, and becomes the object of special care and concern to help her deal with a disrupted life of pain, suffering and loneliness. This script is part of a process to help the widow experience and incorporate sadness into her life. It reflects the recognition of the widows' pain and sorrow, and as such, society acknowledges the new life of the widow as she goes through the phases of bereavement.

During *ukuzila* the women's feelings are ignored as they are expected to follow the instructions that are laid down for them by men (Magudu, 2004). This is so as, according to Daber (2003) and Sossou (2002), cultural rites of mourning and

cleansing are gendered, discriminatory and life threatening for women in most African societies. The widow is escorted whenever she leaves home and, should the widow fail to comply; she is subjected to a fine imposed by the tribal court council (Daber, 2003). Also, as ukuzila is finalised by cleansing, during the ceremony a widow is expected to bath in cold water mixed with “*muthi*” (away from home or in a river) every evening for the whole mourning period. This may be detrimental to the widow’s health if practiced during a cold winter. This cleansing is done because widows are regarded as impure and unlucky and they are believed to carry darkness from the death of her husband, which can only be eradicated through a series of purification ceremonies (Daber, 2003; Mojapelo-Batka, 2005).

The major purification ceremony is performed after a year at the widow’s family of origin (Magudu, 2004). All these rituals symbolise the widow’s breaking off from the past. When it is believed that this purification phase is completed, the widow may begin readjusting to life without the deceased. At the same time, the rituals complete the purification of the deceased’s spirit to enable it to be integrated with the body of the ancestors. The purification period is measured according to the family responsibilities that the deceased undertook whilst alive. If the deceased were the head of the family, he would take longer to be purified than a child. This suggests that the spirit of an adult takes longer to integrate with the body of ancestral spirits than that of a child (Mojapelo-Batka, 2005).

Some people, however, associate ukuzila with colonisation and others associate it with industrialisation when men were working away from their homes. In the latter case black clothes would distinguish widows from other women so that they could be respected and men would stay away from them (Magudu, 2004). Some people, however, argue that ukuzila was introduced after the Second World War to identify women whose husbands had died so that they could be compensated by the government.

Vestiges of traditional mourning practices that venerate the ancestors still prevail at African Christian funerals and traditional societies to a certain extent, especially the ritual killing rites. Because the funeral is pre-eminently a community affair in which the church is but one of the many role players, the church does not always determine the form of the funeral. Some indigenous rites have indeed been transformed and given Christian meanings (see 2.2.4.3), as it seems to be the case in transitional societies, which both Christians and those with a traditional orientation can relate. Sometimes there are signs of confrontation and the changing and discontinuance of old customs to such an extent that they are no longer recognisable in that context (Daneel, 1974).

#### **2.2.4.9 Widowhood practices in other African countries**

Examining widowhood practices in other African countries further demonstrates some of the differences between transitional and traditional societies in South Africa and some of the death and bereavement practices in other parts of Africa. As African culture is not monolithic, there are those societies that treat widows and widowers the same (Mintz, 1998), and those that do not (Sossou, 2002) and as such, this study does not pretend to describe the totality of women's experiences of bereavement in African societies, but focuses on one aspect, namely, a transitional community in South Africa. The experiences of widows from other African countries are viewed socially, economically and psychologically within the cultural and historical context of their communities.

Widowhood practices in West Africa, according to Sossou (2002), are characterised by a period of hardship and deprivation with varying degrees of physical seclusion and a state of ritual contamination that calls for purification. Unlike birth, death is seen as a great and unredeemed tragedy, regardless of age, as it is never seen as natural. What complicates the issue of death is the fact that it is attributed to or associated with witchcraft. When it is a young

person's death, explanation is sought in witchcraft, creating an atmosphere charged with superstitions and denials (Sossou, 2002). As a result, among the matrilineal Akan of southern Ghana, for example, the widow is forced to remain constantly with the body of her dead husband until burial. This is because it is believed that if the spirit of the deceased returns and has sexual intercourse with the widow, she will be forever barren (Magudu, 2004).

During the mourning period, the widow is expected to wear a particular dress, and contribute food and gold. In the polygamous northern part of Ghana, where the deceased has left widows and children, the widows stay inside alone, and are stripped naked with leaves placed on their private parts. They are not allowed out of the house unless they carry a calabash, which symbolises the deceased. In the case of polygamous relationships an elderly woman would take all the deceased's widows to drink a special brew. After the burial, each widow is asked to choose the man she would like to marry as, if she has sex with another man outside of wedlock, she will embarrass her in-laws. However, if it is discovered that she did have sex with a man, she will be given to that man as his wife, even if he was not her choice (Owen, 1996).

In the Ivory Coast in West Africa there is a certain indifference to gender regarding widowhood practices (Mintz, 1998), where observances for widows and widowers are identical. A one-year mourning period, which was practised in earlier times, has now changed to three months during which the surviving spouse wears special clothing and fasts during the day, weeping each day at sunrise and sunset. This ritual is practised in confinement in the conjugal compound. In there, a widow has to abstain from contact or conversation with anyone except a previously widowed person. The widower also maintains sexual abstinence even if he has other wives. Both the widower and the widow submit to evening visits from relatives who will insult them, and the bereaved person is



expected to weep loudly to appease the relatives. Any property belonging to the deceased is taken back to his or her family of origin (Mintz, 1998).

After the three-month mourning period, there are rites that have to be completed. Thereafter, the surviving spouse can resume normal sexual relations, but only after having a sexual encounter with a stranger (Mintz, 1998). However, the widow's remarriage into the deceased's family is not allowed, as, according to their belief, one does not marry twice into the same family.

Among the Igbo of south-eastern Nigeria, widowhood rites and rituals are in part characterised by greed and superstitious sanctions structured to oppress the widow. Among this tribe, according to Sossou (2002), patrilineal sisters of the deceased, both married and unmarried, have power over everybody, which is displayed during the death of their brother. They are highly respected by others, and their role is significant, especially during funerals. Korieh (1996) views the widowhood rites as either administered with vengeance and out of spite for the widow by the deceased's patrilineal sisters, or widowhood rites are genuinely based on the belief that it is the only way to maintain the necessary ritual balance for the good of the deceased and the living. The role of the sisters-in-law is to establish whether the widow did not kill their brother and take his wealth for her family. Before the burial, for example, the widow is locked up with the corpse for three hours and, after the burial, sleeps in the cemetery for two days to confirm or disconfirm that she killed their brother (Sossou, 2002).

The early part of the mourning period is usually the most rigorous. According to Sossou (2002), during the first twenty-eight days, the widow is not allowed to do anything until certain rituals are performed and she can then resume her normal activities. During the seclusion period, and before the burial, she is expected to refrain from washing herself and sit on the ground. Her food is prepared

separately and is fed to her by another widow from either a broken or old plate because they are thrown away after the seclusion period (Sossou, 2002). The second part of the seclusion begins after the first twenty-eight days and runs for a year. During this period, the widow should refrain from sex and any pregnancy during this period represents a serious breach of taboo, which calls for its own purification. However, widowhood rites end by some form of cleansing rituals, for example, shaving the widow's hair and washing her with herbs, which is believed to wash away the deceased spirit and the general bad luck associated with the loss of a husband.

In Southern Africa widowhood practices vary to a certain extent based on ethnicity. Amongst the Batswana tribe of Southern Africa, for example, the widow is subjected to isolation due to stigmatisation of widowhood, and as such discriminated against (Manyedi et al., 2003). This is based on the belief of the community, where the isolation of a widow is meant to protect her and the community, as widowhood is associated with misfortunes.

With about 80% of the South African population following the Christian religion (Cumes, 2004), widowhood practices tend to be influenced by a number of South African Christian churches and religious missionaries. Amongst members of the Zion Apostolic Church in Venda, South Africa, bereavement is a shared experience, with the understanding of the grief of a widow as a multi-layered phenomenon (Selepe & Edwards, 2008). Although the Venda community of the Zion Apostolic Church allows the widow a period of healing in a collective manner, social isolation is still part of the mourning process.

## **2.3 THEORETICAL APPROACHES FOR STUDYING BEREAVEMENT**

Cognitive theory, as the chosen theoretical framework for this study, is discussed in the next section of this chapter. Its key concepts will be examined to lay the foundation for understanding how information from the environment is processed. Other theoretical approaches for studying bereavement are outlined in the sections of the chapter that follow the discussion of cognitive theory.

### **2.3.1 Cognitive theory**

Cognitive theory was chosen as a theoretical framework for this study since it is useful to clarify how widows attend to information, perceive, encode and retrieve, analyse and interpret information pertaining to the anticipated and actual loss of their husbands through death. Cognitive theory is also useful in understanding whether the experience of caring for a terminally ill husband and his subsequent death is either functional or dysfunctional. In the sections that follow key concepts in cognitive theory are discussed; attribution theory will form part of the discussion of cognitive theory as a basis for later explanation of Participants' behaviour.

#### **2.3.1.1 The nature of schemata**

Cognition involves the processes through which information from the senses is transformed, reduced, stored, elaborated upon, retrieved from memory and used (Willingham, 2007). Central to these mental processes are cognitive structures called schemata.

As early as 1932 and 1958 Bartlett, through conducting studies on the recall of Native American folktales, suggested that people have schemata (unconscious

mental structures), which represent one's generic knowledge about the world. Bartlett's schema-concept (Gerjets et al., 2000; VanLehn, 1996) assumes that individuals' knowledge about their world is represented in their memory as a total sum of organised units called schemata. He also suggested that memory takes the form of schema which provide a mental framework for understanding and remembering information. In other words, it is through schemata that old knowledge influences new information. Schemata are thus the building blocks of cognition (Gerjets et al., 2000), and the fundamental elements upon which information processing depends, as they are employed in the process of interpreting sensory data, in retrieving information from memory, in organising behaviour, in determining goals and sub-goals, in allocating resources, and, generally, in guiding the flow of information processing in the system (Gerjets et al., 2000). As a result, dysfunctional schemata and maladaptive strategies will make individuals susceptible to life experiences that impinge on their cognitive vulnerability, based on schemata that are extreme, rigid and imperative.

Carroll (2006) and Gerjets et al. (2000) have further developed the schema-concept. Schemata are also considered to be important components of cultural differences in cognition (Suizzo, 2004), which was confirmed by Bartlett when he advocated that just as schemata are acquired through learning, some primitive schemata derive through cultural experiences. Gerjets et al. (2000) describe schemata as a series of interrelated cognitive contents that develop as a result of the interaction between individuals and their environment. Pratch and Jacobowitz (1996) regard schemata as inner structures and integrated ways of representing the environment, thereby organising our world. Schemata are thus units of organised information that interconnect concepts, attitudes, cognitive content and skills that govern information processing and associated behaviour.

Pratch and Jacobowitz (1996) describe schemata as varying considerably in the amount of information they contain. They are organised according to a hierarchy

that assigns progressively broader and more complex meanings at successive levels (Pratch & Jacobowitz, 1996; Walsh et al., 2002). Schemata thus have different levels of complexity and abstraction. One could have an abstract schema of objects (for example, a chair schema) and a concrete schema of one “specific chair”, schemata of people (for example, a teacher schema), schemata of a state of affairs (for example, a peace schema), schemata of abstract concepts (such as a capitalism schema), and schemata of relationships between objects. These schemata are the result of cognitive processing of information input (Gerjets & Scheiter, 2003). Any important element that does not fit in the schema can cause confusion. For example, if one’s chair schema is a chair with four legs and a back, any chair without those elements can cause confusion even though it can be used as a chair.

According to Beck (1996), cognitive schemata are concerned with abstraction, interpretation and recall; affective schemata involve feelings; motivational schemata deal with wishes and desires; instrumental schemata prepare for action; and control schemata are involved with self-monitoring and inhibiting, or directing action. These schemata represent an integrated cognitive-affective-behavioural network, which Beck (1996) says produces a synchronous response to external demands and provides a mechanism for implementing internal dictates and goals. In this network, affective states may influence cognitive performance, and cognitive appraisals may in turn influence emotional experiences. Similarly, cognitions and emotions may influence behaviour, and the latter in turn may influence the former. In terms of this network the death of a spouse may, for example, be regarded as a perceived threat to the widow (cognitive schema), accompanied by feelings of anxiety and sadness (affective schema), creating a response to act in accordance with the customs and norms of the community (motivational schema).

### 2.3.1.2 Changes of schemata through the processes of organisation and adaptation

As the child interacts with the world and acquires more experiences, these schemata are modified to make sense of the new experience. New information interacts with pre-existing schemata through processes called assimilation and accommodation (Fredrickson et al., 2000). Piaget's developmental model for children is based on adaptations children need to make to their schemata so as to fit into and function within their environment. When new information is modified to fit the pre-existing schema, the process is defined as assimilation. Assimilation is taking new experience and fitting it into an already existing schema. In this process, information from the environment is selected, explored, worked through or ignored, consistent with one's unique way of interpreting events. This takes place before information is translated into habitual behaviour, adding the information to one's existing body of knowledge (Fredrickson et al., 2000). This suggests that assimilation is the individual's attempt to incorporate new information from the environment into his or her existing cognitive structure, attributing meaning to it, attaching a feeling to it, or preparing one to behave in a particular manner. Mourning can thus be viewed as involving assimilation since loss is incorporated into an already established repertoire.

Fredrickson et al. (2000) and Gerjets et al. (2000) refer to *accommodation* as the adjustment of one's view of the world, and of existing cognitive schemata, as a result of an assimilated experience. During accommodation new information is allowed into and thereby changes existing schemata, resulting in new cognitive structures that enable one to cope better with new experiences and the environment (Gerjets et al., 2000). This means that accommodation can be equated with changing existing schemata, whereas assimilation can be equated with fitting new information with existing schemata.

For individuals to survive in an environment, they must adapt to physical and mental stimuli, where both assimilation and accommodation are part of the adaptation process (Gerjets et al., 2000) and occur simultaneously as interdependent and complementary processes. This means that something has to be partly assimilated before accommodation can take place. According to Piaget, adaptation and organisation guide intellectual growth and biological development (Bhattacharya & Han, 2001; Gerjets et al., 2000). Piaget also believed that human beings possess mental structures that assimilate external events, and convert them to fit their mental structures. These mental structures accommodate themselves to new unusual and constantly changing aspects of the external environment (Bhattacharya & Han, 2001).

The schema is the simplest level, which is a mental representation of some physical or mental action that can be performed on an object, event or phenomenon (Bhattacharya & Han, 2001). Although schemata are relatively stable, they can change through a process referred to as organisation. Organisation refers to the nature of adaptive mental structures (assimilation and accommodation), where the mind is organised in complex and integrated ways. Organisation is the gradual developmental process of building cognitive structures through direct interaction with the environment in an attempt to achieve a better fit between cognitive representation of an individual and the environment (Gerjets et al., 2000). In this process, newly changed cognitive structures rearrange to reach a new interconnected and intellectually coherent whole state of equilibrium, so as to make sense of one's experience. An example of this would be the reorganisation phase of the bereavement process.

### **2.3.1.3 The self-schema**

Mahoney (1995) refers to the self-schema as the construing of the self that differs among different age groups. This suggests that the self-schema involves

the individual's development over the course of life events, and includes the activities and meanings that derive from them. Gerjets et al. (2000) define the self-schema as a composite image of what we think we are; what we think we can achieve, what we think others think of us, and what we would like to be. It also implies the self-schema to be one's self-image that is comprised of multiple schemata, in other words, various cognitive structures about the self.

The cognitive structures suggest that during the development of the self-schema a person distinguishes the self from other environmental elements, since the self is construed via the bipolar construct of "self versus others". A person's representation of his or her awareness of the self, and thus the self-schema, is developed in the course of interaction with the environment, and specifically with significant others. This interaction forms the basis of the self-experience, where a part of the individual's experience becomes differentiated and symbolised in an awareness of one's own being and functioning (Lalonde et al., 2004). The implication is that one's development of self, and hence of self-knowledge, is an active learning process.

There are different self-schemata. The *ideal self* is the self-schema that people desire to achieve and the kind of person one would like to be, and reflect, for example, one's hopes and aspirations. The extent to which the ideal self is achieved will determine the quality of one's self-schema. The *ought self* deals with the facets of the self-schema that should exist, for example, duties, obligations and responsibilities. The *possible self* is how one thinks one could possibly become. The *social self* is how one perceives oneself in terms of social expectations (Lalonde et al., 2004).

The death of a spouse has an impact on the widow's self-schema. It affects her social self where she changes from being a married woman to a widow without a



husband, her ought self where she now has to be both a ‘father and a mother’ to her children, and her possible self where she may be unsure of whether she can possibly become what she needs to be (Alexander, 1997).

#### **2.3.1.4 Scripts**

Schemata are acquired through learning, and are used to internalise experiences, make analogies, and indulge in the intricacies of higher-level thinking, including representing concepts, situations, events, and actions (Pratch & Jacobowitz, 1996). According to Wagner (1998), people come to produce and share similar sets of representations, called social representations, through discursive processes of internalisation and externalisation. This means that stimuli from the environment are interpreted and given meaning that play a role in the representations that people form. This, according to Wagner (1998), only occurs when there is interaction between personal experiences and the collective, and shared experiences of socially and culturally similar others. This suggests social representations to be inherently social in nature because they are shared by a number of people (Farr, 1998). These social representations are interpreted as shared cognitive schemata. They can be related together to form systems, even though they are not mutually exclusive packets of information but can overlap (Pratch & Jacobowitz, 1996), and are called scripts, i.e. a schema of an event. For example, a schema for a picnic may be part of a larger system of schemata including meals, outings and parties.

Kashima et al. (2004) view scripts as commonly experienced social events which, according to Fujii and Garling (2003), can only be interpreted by bringing in a great deal of additional information. They are essential ways of summarising common cultural assumptions to help understand text and discourse, predict future events and how one should behave appropriately in given social situations. They also contain the sequence of actions one goes through when carrying out

stereotypical events, serve to provide meanings to guide behaviour and make inferences about events when there are gaps in the available knowledge about acts that occurred in an event (Kashima et al., 2004; Rubin, 1995).

Attribution theory is the next theory to be discussed in the section.

### **2.3.1.5 Attribution theory**

According to Gagne, Yekovice and Yekovice (1993) and Thomas, Meyer and Johnson (2009), attribution theory is based on a cognitive approach and proposes that every individual attempts to explain behaviour, such as success or failure of self and others, by making certain attributions. Attribution theory assumes that people try to determine why they do what they do, i.e. attribute causes to behaviour (Zuckerman, 2006), based on a three-stage process. One must first perceive or observe a behaviour, one must then believe that the behaviour was intentionally performed, and then determine if one believes the other person was forced to perform the behaviour (in which case the cause is attributed to the situation, for example death of a spouse), or not (in which case the cause is attributed to the other person).

The theory is relevant in this study because it could explain that Participants' perceptions, event perceptions and attitude change can impact on their self-esteem and their levels of anxiety (Heider, 1958; Tesser, Crepez, Collins, Cornell & Beach, 2000). Heider also believes that individuals act on the basis of their beliefs. Also, the Participants' past experiences could have affected and contributed to how they dealt with their bereavement. However, not all behaviour can be accounted for by attribution theory, but the theory can be used as one way of identifying and explaining how behaviour (negative or positive) may be related to other events that have occurred in the past.

According to Thomas et al. (2009), people constantly make attributions and judgements about their own and others' behaviour. In doing so, situational influences tend to be underestimated, and dispositional influences are overestimated when understanding other people's behaviour. This tendency leads to fundamental attribution errors. Attributional judgements are influenced by many factors, including cultural differences (Thomas et al., 2009). They also include ability, effort, task difficulty and luck (Mayer, 2003), i.e. internal and external attributions. Effort relates to an internal and unstable factor over which one can exercise a great deal of control. Ability relates to an internal and relatively stable factor over which one does not exercise much direct control. Level of task difficulty relates to an external and stable factor that is largely beyond one's control. Luck relates to an external and unstable factor over which one exercises very little control (Mayer, 2003).

External attributions (situational attribution) relate to causality, which is assigned to an outside factor, agent or force, for example, if a Participant in this study perceives herself as having no choice. Internal attributions relate to when causality is assigned to an inside factor, agent or force where one can choose to behave in a particular way or not, i.e. when behaviour is not influenced. For example, while a widow transitioning to Western culture is more likely to emphasise people's freedom of choice and not situations, a rural African widow's locus of control is more likely to be external. Her behaviour would more likely be interpreted in terms of situational attributions, and she then conforms to the traditional process of bereavement, which entails externalising behaviours. The two widows maintain different sets of perceptions and beliefs because they are provided with information from different points of view, with different available information that is processed differently (Rosenblatt & Nkosi, 2007).

Differences in attribution mean that some widows may think that strategies for coping with the loss of their husbands reside within them, while others might

think of dealing with their loss as residing outside themselves. In other words, while some widows might perceive their behaviours as being driven by inner causes, others might attribute their behaviour to situational factors.

The formation of impressions of others depends on the activation of appropriate categorical knowledge, the ability to attend to relevant aspects of behaviour, and the efficiency with which attributes are encoded. Attribution theory also sheds light on depression that is associated with bereavement, as people who experience depression tend to have a particular attribution style where failures and negative events are attributed to internal, stable and global causes (Zuckerman, 2006). This style could contribute to a dysfunctional bereavement experience.

## **2.3.2 Coping strategies**

### **2.3.2.1 Coping styles**

Neimeyer et al. (2004) state that coping strategies can be divided into two broad categories according to their primary functional focus. The first is problem-focused coping that is used to manage the sources of stress, and is directed at making the stress-inducing circumstance less stressful. This coping strategy helps one to reduce the demands of the situation or expand the resources to deal with it. It is also related to, among other things, stronger feelings of self-efficacy (self-esteem and personal confidence) and mastery (Greenglass, 1995). In summary, problem-focused coping strategies are attempts to modify the source of a problem (Neimeyer et al., 2004).

The second category is emotion-focused coping, which is used to manage emotions (Neimeyer et al., 2004). They view emotion-focused coping strategies

as directed primarily at controlling the emotional response to the stressful situation by regulating distressing emotions associated with stress-inducing circumstances. These strategies are efforts to reduce emotional distress.

Grossi (1999) and Strongman, Mclean and Neha (2007) observe an overlap between the two strategies where men tend to practise more problem-focused coping than women, and finding women to use more emotion-focused coping than men. This is further explained by Neimeyer et al. (2004) structurally within the context of the different demands that men and women often have. For example, men are more likely to have control over solutions, which has a fit with problem-focused coping, when women are more likely to have fewer control opportunities, making emotion-focused coping more suitable. However, Kabbash, El-Gueneidy, Sharaf, Hassan and Al-Nawawy (2000), Mah et al. (2008) and Torkelson and Muhonen (2004) find no gender differences in coping, arguing that people of both sexes who occupy similar social roles tend to have similar coping strategies.

Aspinwall (1997) views proactive coping strategies as strategies that people employ to prevent future stressors. Ouwehand, Ridder and Bensing (2008) confirm Aspinwall's view that people who have the tendency to be planners and are concerned about their future undertake more efforts to prevent potential stressful changes in health, social relationships and personal finance to prevent future threats to their goals. Ouwehand et al. (2008) associate proactive coping with individual differences. Schwarzer and Luszczynska (2008) also find proactive coping to involve future challenges that are seen as self-promoting and as such, saw it as bridging the gap between the constructs of coping and the constructs of action and volition. Sohl and Moyer (2009) view proactive coping as predictive of positive affect and subjective, due to optimism, where its unique association with well being-being is explained by the competent use of resources and realistic goal setting. This is confirmed by Fiksenbaum, Greenglass and

Eaton (2006) who advocate that social support (resource) is associated with fewer daily hassles and also indirectly related to daily hassles by increasing proactive coping.

Coping with feelings of loss while providing care for the dying member can be a challenge. In coping with the anticipated death of a husband, the caring wife would experience pain, and may need assistance in dealing with this pain. For some widows, family and friends may be of assistance; some may seek professional help, while some may receive assistance from community organisations such as church and support groups.

The goals of coping are to alter the relationship between self and the environment, or to reduce emotional pain and distress. Neimeyer et al. (2004) view psychological stress as a relationship between individuals and their environment, which is interpreted by individuals menacing their own resources and endangering their well-being. Coping refers to one's attempt in dealing adaptively with stress (Neimeyer et al., 2004). Should coping not be adaptive, the menacing situation will endure and the person will remain under stress.

Coping resources can be broadly divided into personal, environmental (Taylor & Stanton, 2007), and physical (Mak & Mueller, 2000). Personal coping resources involve traits and characteristics, attitudes and beliefs. Social coping resources involve intimate relationships including family, and extended networks including friends. Physical coping resources involve health and personal energy, and practical resources.

Social support, as a coping resource, can be cognitive, affective, motivational and behavioural, with the objective of helping to reduce the probability that an event will be viewed as stressful. It buffers the impact of stress by providing

actual assistance in problem solving or in feelings of attachment to others for emotional support. This is confirmed by Brougham, Zail, Mendoza and Miller (2009), who classify a social support seeking strategy as containing both problem and emotion foci.

Another factor that plays a role in coping is the beliefs and values that one has. These beliefs and values are important because they may lead one to appraise events as less stressful. For example, in some African cultures the ancestors can be a source of support in, for example, appearing through reassuring dreams. This also applies to societies in transition where ancestral beliefs are still frequently held, as expressed in communicating with the dead through rituals such as “*go phasa badimo*” meaning “to remember and please the ancestors” (Mojapelo-Batka, 2005).

In my experience support structures in my transitional society has become impersonal to a certain extent. An example of this is signing up with a funeral undertaker and contributing monthly payments for a package that one can afford. Some of these packages cover all aspects of the funeral, including the mortuary, preparing the corpse, the coffin, the animal to be slaughtered, and catering. The undertaker’s services replace the responsibilities that would traditionally be taken up by family, friends and one’s community.

#### **2.3.2.2 Sternberg’s problem-solving cycle**

Sternberg’s problem-solving cycle explains how different couples deal differently with the anticipation of death based on their abilities to solve the problems facing them, both as individuals and as couples. According to Sternberg (1999), problem solving is a cycle that involves seven steps. These steps are problem identification, the definition of the problem, constructing a strategy for problem

solving, organising information about a problem, allocating resources, monitoring problem solving, and evaluating problem solving. It is important that people have the ability to allow new information into their schema in following the different steps of the cycle and attempting to solve the problem. Tolerance of ambiguity on how best to proceed in solving the problem is also required.

In the problem identification step, failure to recognise the goal and its path may lead to an unworkable solution. Even if the problem can be identified, it is important to define and represent it well enough to comprehend the process of solving it. If not, the ability and the planning of the strategy to solve it will be limited. The strategy includes breaking down the problem into manageable elements (analysis), and putting together the different elements into something useful (synthesis). Another strategy involves an attempt to generate diverse possible alternative solutions, namely, divergent thinking; and narrowing down possibilities to converge on a single best answer or most likely solution, namely, convergent thinking.

The available information then needs to be organised and reorganised strategically to implement the strategy. This includes identifying resources needed, deciding which resources to allocate and when to do so. During this process, the person or couple must continue to monitor the problem solving process to assess if the goal is nearing achievement. The evaluation of the solution during the process or after the completion of the process is also important as new problems may be identified or redefined, and new strategies implemented, which may in turn need new resources.



### 2.3.2.3 Factors that mediate the impact of loss and an individual's coping

In addition to the effectiveness of one's coping strategies, other factors affect the intensity and duration of one's bereavement process (Martin & Doka, 1998). Due to the far-reaching effects of bereavement on the psychosocial, physical and emotional levels, Naidoo's (2005) study was designed to identify the influence of how one presents herself, and sense of coherence on coping with bereavement, i.e. how the two correlate with coping and non-coping characteristics of human behaviour and, specifically, the bereavement experience. This author suggests that the two factors are the result of the different ways in which people prefer to use their cognitive processes. Naidoo includes sense of coherence, which comprises of comprehensibility, manageability and meaningfulness. Naidoo further advocates that the extent to which these three components are present in one's life determines an individual's global perception of life. The suggestion is that as each individual's bereavement is determined by his or her unique combination of psychological, physical and social qualities, factors like one's experiences, the nature of the relationship with the deceased, and mode of death play a role. The findings of Naidoo's study showed that coping individuals displayed a significant preference for feeling, judging and a high level of coherence. Non-coping individuals showed preferences for intuition, perceiving and a low level of coherence. However, no significant differences were found for introversion, extroversion, sensing and thinking.

The nature of the relationship with the deceased includes kinship, the role the deceased occupied, the strength of attachment, security of the attachment, the length of the relationship, degree of dependency, the intensity of ambivalence in the relationship, and the unique nature and meaning of the loss (Martin & Doka, 1998). These authors add that mode of death involves the circumstances surrounding the loss, when in the life cycle the loss occurred, previous warnings, preparation for bereavement (anticipatory bereavement), the widow's perception

of preventability, the perception of the deceased's fulfilment in life, and the unfinished businesses that were present in the relationship with the deceased.

Martin and Doka (1998) distinguish between affective and cognitive modalities as two different forms of bereavement on the continuum. The affective modality is generally associated with women and the cognitive modality is generally associated with men. The affective modality of bereavement consists primarily of profoundly painful feelings, which are spontaneously expressed through crying. One would tend to respond favourably to traditional, affect-intensive interventions, such as group support. The cognitive modality converts most of the bereavement energy into the cognitive domain, where goal-oriented activities are often the behavioural expression.

### **2.3.3 Attachment theory**

Some individuals emerge from the stress of bereavement relatively unharmed, while others suffer severe psychosocial problems. The reason for the inclusion of attachment theory in this study is to identify the characteristics of the bereaved or the bereavement situation that are associated with a functional or dysfunctional bereavement outcome.

Attachment theory has its basis in psychodynamic theory. The psychodynamic attachment theory focuses on interpreting unconscious fantasies and motivations (Meissner, 2000). It is also guided by the assumption that the same motivational system that gives rise to the close emotional bond between an attachment figure and the child is also responsible for the bond that develops between adults in emotionally intimate relationships. That is, one's attachment style is a partial reflection of early childhood attachment experiences (Rutter, 2008). In this study, an attempt is made to re-interpret attachment in terms of concepts from cognitive

theory, as the underlying framework for this study. Juffer, Stams and Ijzendoorn (2002) study, based on the case of adopted children and their biologically unrelated parents, finds that infant attachment and temperament in early childhood predict adjustment in middle childhood. John Bowlby's theory of attachment also indicates how attachments from childhood continue into adulthood, which is interpreted here in terms of cognitive theory.

John Bowlby developed an interest in evolutionary adaptation (Bowlby, 1997), focusing on the adaptation of organisms to the environment. He pays attention to physical surroundings and circumstances, and social relatedness and social processes, with the survival of the organism through the process of natural selection as his ultimate objective. This includes the protection and defense of the organism against danger or threat.

Bowlby (1997) focused on the influence of "the environment of adaptation" (p. 47) on the activation and termination of instinctual behaviour patterns. He gained ideas from behavioural patterns in animal behaviour, including specific patterns of courtship, mating, feeding, locomotion and care of the young. These behaviours helped him identify similar forms of the bond present between mothers and children across cultures (Kochanska, Forman & Coy, 1999), and within the context of caretaker-child relationship.

According to Bowlby's theory, the human infant starts out with five reflex-like and stereotyped instinctual attachment behaviours that include sucking, crying, smiling, clinging and following (Kochanska et al., 1999). These behavioural systems are not initially learned and are not influenced by environmental feedback. These five modalities are interactional: eye contact and smiling occurs between mother and child, the infant's sucking has, as its corollary the mother's feeding, the infant's clinging is reciprocated by the mother's holding, there is

mutual touching of mother and child, and there are vocalisations of mother and child to each other (Beebe et al., 2007). At a later stage, due to the maturation of the child, these instinctual responses become meaningful and goal-directed, forming part of a behavioural pattern. However, this behavioural pattern is not inherited; it has only the innate potential to develop (Kochanska et al., 1999). This is so as both internal and external conditions are necessary for the activation and termination of the child's behavioural system.

Bowlby (1997) defines attachment as follows: "To say that of a child that he is attached to, or has an attachment to someone, means that he is strongly disposed to seek proximity to and contact with a specific figure and to do so in certain situations, notably when he is frightened, tired or ill" (p. 371). According to Bowlby (1997), infants form strong attachments to one figure, usually the mother or primary caregiver, suggesting that infants are monotropic. Although infants tend to remain closely attached to one figure, the attachment becomes more elaborate as they grow older, where attachment is formed with other people, such as friends and a life partner. This suggests a change in attachments along a continuum of development, and attachment is considered a healthy feature of human interrelatedness. Even though attachment behaviour may not always be evident, it does not necessarily indicate a lack of attachment (Kay Hall & Geher, 2003).

In reference to a study done by Moore in 1971, Bowlby indicates the persistence of the early attachment styles throughout life, although it is possible that some events in the course of development (for example, death of a mother) may alter the attachment pattern (Bowlby, 1997). Early attachment styles seem to lay a foundation for further relationships (Lopez & Brenan, 2000).

Myers (2002) conducts a study where it was found that about seven in ten infants, and nearly that many adults, exhibit secure attachment. Secure attachment infants become distressed when their mothers or caregivers leave and, when the figure returns, they run to her, hold her, then relax and return to explore and play (Cole, 2005). Secure attachment adults tend to get close to others with ease, are not afraid of being abandoned or being dependent. Within the context of continuing intimate relationships, they enjoy sexuality and, as a result, tend to have satisfying and enduring relationships (Myers, 2002).

About two in ten infants and adults exhibit avoidant attachment (Myers, 2002). Avoidant attachment infants, although internally aroused, reveal little distress during separation from the attachment figure or clinging behaviour upon reunion. Avoidant attachment adults tend to be less invested in relationships and are more likely to leave them, suggesting individuals who avoid closeness.

About one in ten infants and adults exhibit insecure attachment that is characterised by anxiety and ambivalence (Myers, 2002). Insecure attachment infants are more likely to cling anxiously to their mothers or caregivers in strange situations, due to the situation. If left by themselves, they are more likely to cry but when the figure returns, they are more likely to be indifferent or hostile. With age, these consistent, faulty or incorrect appraisals of situations may create dysfunctional thoughts that cannot be reasoned out as they become readily attached to a range of stimuli (Baer & Martinez, 2006; Rachman, 1998).

In adulthood, insecurely attached individuals are more often anxious and ambivalent with less trust, and they are therefore more possessive and jealous. They are likely to repeatedly break up with the same person, probably due to consistent, incorrect and subjective perceptions and interpretations of the relationship that they perceive as emotionally stressful. This is due to the

underestimation of their ability to cope in an emotional challenging relationship (Baer & Martinez, 2006). Their incorrect appraisal of a conflict also explains their tendency to be emotional and angry when engaged in a conflict (Myers, 2002).

The different attachment styles can clearly be attributed to parental responsiveness where sensitive, responsive mothers who instil a sense of trust in their infants' environment are more likely to have securely attached infants. If their mothers were involved and nurturing with them as infants, they tend to have warm and supportive intimate relationships as adults (Rosenblatt, Hinde, Beer & Busnell, 1979). Bowlby (1980) hypothesises that a securely attached person is more likely cope appropriately with the loss of a loved one, due to the internal working model he or she possesses. A secure attachment style can thus be considered as a buffer in the experience of bereavement.

Attachment theory links with other theories in this study by attributing meaning in terms of the parent-child interaction, and later the bond between partners in an intimate relationship. How the widow interprets the loss of her loved one (a cognitive process), while the kind of relationship they had (attachment) will determine the intensity of her bereavement experience, depending on her attribution of the meaning of the loss experienced.

#### **2.3.4 Schachter and Singer's two-factor theory of emotions**

Emotions are a subjective experience as there can be different causes for feelings and everyone reacts slightly differently to situations. Schachter and Singer's two-factor theory explains how emotions are experienced upon the perception of a stimulus. The fact that people tend to be more sensitive to information that matches their current mood (Zuckerman, 2006) suggests a relationship between cognition and affect. As a result of this relationship,

cognition may serve to minimise or aggravate the experience of certain affective reactions.

Schachter and Singer (1962) believe in a cognitive and physiological view of emotions in which people search their beliefs in an attempt to understand the emotional aspect of their bodily reactions. They believed that emotions are controlled through a very close interrelationship with and interaction between physiological arousal and cognitive appraisal. Keltner and Haidt (1999) provide further support for the link between cognition and affect.

According to the Schachter and Singer's two-factor theory of emotions, when we try to understand the kind of people we are, we first watch what we do and feel, and then deduce our nature from this. Physiological arousal and its cognitive label will depend on the way one processes information, in other words, the process of receiving, encoding, transforming and organising information. This comprises both content, namely, developed thoughts of reality such as beliefs, attitudes, opinions, and so on, and processes such as attribution, perception, and memory (Zuckerman, 2006). The first step is to experience physiological arousal of the autonomic nervous system. It is then followed by cognitive appraisal of the physiological arousal where we then try to find a label to explain our feelings, usually by looking at what we are doing and what else is happening at the time of the arousal. The physiological arousal associated with an emotional experience thus becomes cognitively labelled. This theory suggests that people do not just feel, but experience feeling and then decide what that feeling means through a sequence that starts with an event, being arousal, followed by reasoning, and then experiencing an emotion (Schachter & Singer, 1962).

The two-factor theory suggests that emotion comes from a combination of a state of arousal and a cognition that makes the best sense of the situation the person

is in. The theory argues that when people become aroused they look for cues as to why they feel the way they do. The state of physiological arousal results from environmental conditions, and people look to their environment to gain an explanation of their feeling. This explanation is based on current cognitions, past experiences, the present environment and its social significance. An emotion may be aroused through a conscious appraisal of the environment (Schachter & Singer, 1962).

The two-factor theory proposes that if a person experiences a state of arousal for which he or she has no immediate explanation, he or she will describe his or her emotions in terms of the cognitions available to him or her at the time. It also proposes that if a person experiences a state of arousal for which he or she has an appropriate explanation, then he or she will be unlikely to describe his or her emotions in terms of the alternative cognitions available. This theory thus presumes that in order to experience an emotion one needs both a physiological arousal and cognition, where the cognition explains the physiological arousal in terms of the current events or thoughts. Again, if a person is put in a situation, which in the past could have made him or her feel an emotion, he or she will react emotionally or experience emotions only if he or she is in a state of physiological arousal (Schachter & Singer, 1962).

The explanations for people's increased arousal is often obvious, and they do not need to do much cognitive searching for understanding their increased arousal; however, at other times there may not be obvious explanations for the increased arousal. In the latter case, cognitive theory predicts that people then cognitively search their environment for an explanation and label their feelings based on what is going on around them. When cognition clashes with another unpleasant state of arousal it results from the inconsistency of these dissonant conditions. Human beings are motivated to reduce this unpleasant state of arousal as much as possible, even if it means changing formerly held cognitions. Incongruent



cognitions will then have a motivational function, where motivation, according to Keltner and Haidt (1999), is an internal state that activates behaviour and gives it direction.

In this thesis the nature of emotions during bereavement, such as grief and sadness, are explored using Schachter and Singer's two-factor theory. Attention is given to how functional and dysfunctional bereavement can be understood from this perspective. People look at their environment for explanations of arousal; and this environment includes culturally based thought patterns and symbolism. The role of culture in labelling certain emotions is also explored. The latter discussion includes the transition in shared social schemata, which form part of the cognitive processes of Black urban widows.

As Schachter and Singer's two-factor theory of emotions can be considered dated, it is complemented with more recent literature, including a study by Jarymowics and Bar-Tal (2006), which focuses on fear and hope. The study was found to be relevant to the transitional society within which the Participants of this study functioned. Jarymowics and Bar-Tal advocate that fear and hope can become a collective emotional orientation, and can organise societal views to direct behaviour.

Emotions serve as mediators and data for processes of feeling, judgement, evaluation and decision making that may lead to a particular behaviour (Rafaeli & Hareli, 2007). As a result, emotions play an important role in decoding the meaning of stimulation through perception and learning to which individuals respond with the same emotional reactions as when they encounter similar events (Bargh & Chartrand, 1999). This may occur either consciously or unconsciously (LeDoux, 2002). Emotions evolved as an adaptive function in dealing with basic external challenges (Carroll, 2006), and as modes of relating

to the changing demands of the environment (Garling, 1998). However, they can lead to maladaptation by eliciting dysfunctional reactions in certain situations, which are characterised by irrationality and destructiveness.

Where there is fear, there is mindlessness and misery; where there is hope, there is rationality and progress (Jarymowics & Bar-Tal, 2006). According to Vaes, Paladino and Leyens (2006), primary and secondary emotions, including positive and negative emotions, function differently due to their different origin.

Primary emotions are emotions that provide information about current situations and get us ready or motivate action in some way, responding to a pleasant or unpleasant stimulus. For example, one is late for a meeting and as a result, experiences frustration. These emotions happen as a result of an external cue that affects us emotionally, doing what they are supposed to do (Damasio, 2003). Secondary emotions afford the ability to reason about current events in the light of experiences and expectations. They are emotions we have in response to a primary emotion not being recognised or expressed. They can be analysed by listening to our dialogue (Damasio, 2003). Secondary emotions are secondary because they are not necessarily related to an adaptive response in a given situation. They are complicated, non-adaptive patterns of emotions about emotions. They come to us through a filter of thought processes that go by automatic thoughts, judgements, assumptions or irrational beliefs. They are learned responses that often come from role models, usually in our family of origin, and afford the ability to reason about current events in the light of experiences and expectations. Crucial to understanding our emotional reactions and how we behave, either in a healthy and self-actualising way, or conversely in an unhealthy detrimental way, is being aware of our primary emotions and that they all have value. Not allowing the expression of primary emotions, we at best fail to thrive and live a meagre detached existence, and at worst, when the

primary emotions become secondary, we cause damage to others and ourselves (Spradlin, 2003).

The functioning of primary emotions is spontaneous, fast, uncontrolled and unintentional (LeDoux, 1996). Often, emotional reactions are unconscious as they occur through automatic information processing without perception and conscious experience (Killgore & Yurgelun-Todd, 2004). Fear is a primary emotion that is spontaneous and automatically activated, is consciously and unconsciously processed, and is based on past and present experiences to determine one's behaviour without mediation of cognitive appraisal (Damasio, 2003). It is only under certain conditions that stimulations generate conscious emotion (Damasio, 2004). When this process takes place, it may override secondary, more complex, positive affective components of emotion, such as hope. Hope is a secondary emotion, which needs anticipation as it is cognitively processed for new ideas, and requires creativity and flexibility. People may be spontaneously immobilised by painful situations, leading to anticipated hostility. People's response to this provocation may determine their ability to cope in stressful and demanding situations such as bereavement. In addition, maladaptive functioning may sometimes be maintained and reinforced by social factors like culture.

Conscious processes of positive secondary emotions are to a certain extent also spontaneous (Bargh, 1997). Even though they are connected with the appraisal of one's environment, they are strongly influenced by primary emotions (Garling, 1998). In these processes, emotions automatically guide attention to particular cues and information, influence the organisation of memory schemes, give differential weight to specific stored knowledge, activate relevant associative networks in memory, influence the order of cognitive processing priorities, provide interpretive frameworks to perceived situations and, on those basis, and pull towards certain objects, individuals and situations while abstaining from

others (Mayer, Salovey & Caruso, 2000). However, only some human emotional processes are part of the sequence of recognition and understanding (Petrides & Furnham, 2002). As such, evaluation based on an appraisal process is related to deliberate thinking and intellectual operations; and the use of cognitive evaluative processes is relatively independent of basic primary affective mechanisms (Piaget, 1970). Such evaluations are linked with secondary emotions.

The different functioning of primary and secondary emotions is more evident in situations of perceived threat, such as death. In such instances, primary emotions may dominate over secondary ones; negative emotions may override positive ones. Hope is often preceded, dominated, controlled and inhibited by spontaneous, activated fear (LeDoux, 1996). This is because the connections from the affective system to the cognitive system are more numerous than those in the opposite direction, from the cognitive to the affective system (LeDoux, 1995; 1996). As a result, fear floods consciousness and leads to automatic behaviour, preparing one to cope with the threatening situation. Damasio (1999) further distinguishes between primary and secondary emotions when he views primary emotions to be innate, and secondary emotions to be feelings which allow people to form systematic connections between categories of objects and situations on the one hand, and primary emotions on the other.

### **2.3.5 Systems theory**

In this section, family systems theory is integrated with general systems theory in an attempt to gain a better understanding of how the parts of a system are integrated into a whole within the context of the Participants in this study. These theories together help clarify how the system and subsystems interact with one another. They also help clarify how patterns are created through this process of interaction within the family context (Wendt & Zake, 2006).

According to Wendt and Zake (2006), a system is a bounded set of interrelated elements exhibiting coherent behaviour as a trait. According to Bausch (2001), general systems theory could also be called a 'science of complexity' since it "stresses studying natural phenomena of all sorts as heterogeneous wholes composed of multiple different but interrelated parts rather than studying each part in isolation" (p. 10). Wendt and Zake (2006) define a system as any two or more parts that are related to each other, such that change in any one part changes all parts.

A family system has components that involve interrelated elements and structures, patterns of interaction, and open or closed boundaries. Each system has subsystems, which consist of subgroups of members. Each subsystem has its own rules, boundaries, and unique characteristics, and membership of a subsystem can change over time (Wendt & Zake, 2006). These components have subsystems, and function according to the Composition Law, using messages and rules (Wendt & Zake, 2006).

According to Whitchurch and Constantine (1993), Composition Law states that the whole is greater than the sum of its parts. When applied to the family, this means that the family as a whole is greater than simply adding individual member characteristics together. The whole becomes greater than the sum of its parts because the whole includes elements that cannot be broken down and applied to individual members. It is possible then for the system to have characteristics, which no individual element possesses except when they are put together in an interactional context. The family images and themes are reflected in this holistic quality, as the members' unique behaviours cannot be explained outside the context of the entire system. Families can then be considered to be systems as they are made up of interrelated members who exhibit coherent behaviours in their regular interactions and are interdependent on one another (Whitchurch & Constantine, 1993).

As families comprise interrelated elements and structures, in the context of the present study this means that family members (i.e. the widow, children and the dying husband/father, in-laws and extended family), have relationships which function in an interdependent manner, creating the sum total of interrelationships amongst members (Wendt & Zake, 2006). Understanding these aspects of the family system may contribute to a comprehensive understanding of the family system's behaviour as a whole (Kern & Peluso, 1999).

A family system uses messages and rules to shape its members. These messages and rules are relationship agreements, which prescribe and limit members' behaviour over time. They are repetitive, implicit, and perpetuate themselves through reproducing (Wendt & Zake, 2006). They form predictable patterns of interaction that emerge in a family system. These patterns of interaction help maintain the family's equilibrium, and determine how members should function.

In achieving patterns of interaction, the system needs to have boundaries, which can either be open or closed (Wendt & Zake, 2006). This is achieved by the system's ability to define its own boundaries by either including or excluding members. When boundaries are established, it is done so that the relational whole is retained, where change in one part causes change in all (Wendt & Zake, 2006). In order to maintain the dynamic structure of the system and its boundaries, a network of feedback loops, for example, communication amongst family members, needs to be established (Kern & Peluso, 1999).

Just as there are functional and adaptive family systems, there are also dysfunctional family systems. These include chaotically enmeshed and chaotically disengaged family systems. An adaptive level of family cohesion is one in which family members work together. Chaotically disengaged families feel

disconnected from one another, allowing unrestricted external influences to impinge on the family. Boundaries are predominantly blurred, and the family's interaction is unpredictable and marked by limited and/or erratic leadership and discipline. Negotiations are endless with dramatic role shifts and rule changes. Chaotically enmeshed families present themselves as extremely close with high loyalty demands and little tolerance for privacy, separateness or external influences. A family with permeable and vague boundaries is considered an open boundary system, allowing elements and situations outside the family to influence it. A closed boundary system isolates its members from the environment, and seems isolated and self-contained (Wendt & Zake, 2006).

Cognitive, attachment and family systems theories will be unified to link the theories discussed above. This is done in an attempt to consider their combined influence on the Participants in this study.

### **2.3.6 A unified integration of bereavement concepts and theories**

In this section a unified integration of bereavement concepts and theories will be presented. In achieving this, the different phases of both functional and dysfunctional bereavement will be looked at, and cognitive, attachment and family systems theories and bereavement will be compared.

#### **2.3.6.1 Integrated phases of bereavement (functional and dysfunctional)**

Whereas functional bereavement allows the widows to identify, acknowledge and integrate the loss of their spouses, dysfunctional bereavement prolongs suffering, interrupts normal activities, and as such prevents life from being lived to the maximum. A widow whose bereavement is functional experiences a naturally progressions through the process of bereavement, while a widow who

experiences dysfunctional bereavement becomes fixated, sliding into an unhealthy and prolonged withdrawal, remaining stuck at one point (Moody & Arcangel, 2001).

In functional bereavement, denial serves as a coping mechanism to protect the psyche of the widow from an initially intense crisis and as such, enables her to absorb and filter the blow. Just as denial is functional at the early stages of bereavement, it can also be dysfunctional if prolonged. This is because denial distorts reality, and involves forgetting, escaping, and disbelieving reality (Moody & Arcangel, 2001).

The initial phase of bereavement is to experience a shock reaction. This shock reaction represents a general reaction of the body's defense system brought about by the activation of cognitive disequilibrium in reaction to awareness of the loss. Shutting off some of the pain with temporary numbness which is associated with shock helps in managing the overwhelming experience of the severe emotional crisis (Carr et al., 2001). However, exaggeration of these feelings, denial of their existence, extending their duration – getting stuck in this phase – may be dysfunctional.

Anger may occur as part of the first phase. When the anger experienced serves as an outlet, accepting it as natural makes it functional, especially in widows with secure attachment styles. Anger can, however, also be viewed as a masked bereavement reaction, contributing to a dysfunctional bereavement in those with insecure attachment styles, as inability to express feelings may inhibit the bereavement process. Anger can also be as a result of the widow's inability to recognise her experiences as being related to her loss. A securely attached widow would, however, interpret this phase as the beginning of the bereavement



process with the awareness of the loss as a changing reality, making her shock and numbness functional (Carr et al., 2001).

The second phase of bereavement, yearning and searching, is also a function of the cognitive disequilibrium that results from the loss. It involves an attempt to deal with the cognitive impact of the loss (Archer, 1999; Parkes, 1972). It is characterised by disbelief, confusion, and denial. Widows with secure attachment styles tend to deny the loss as a defense while they get used to the loss; here, denial becomes functional. Widows with an insecure attachment style may tend to use denial as the only coping mechanism, which, in the process, makes them resistant to accepting the loss. This will prevent adaptive cognitive change, leading to repeated frustration and disappointment, making the bereavement dysfunctional. Whether bereavement is functional or not is thus partly determined by the widow's inner conflict between resisting (denying) information about the loss, and accepting the change incurred by the loss (Archer, 1999; Parkes, 1972).

The third phase of bereavement, disorganisation and despair, is characterised by depression and difficulty planning future activities (Carr et al., 2001). The widow who feels isolated, bitter, angry, or guilty due to, for example, her exaggeration of the negative and positive aspects of her relationship with the deceased (Carr et al., 2001), may have a dysfunctional bereavement. Since having these feelings is difficult to acknowledge to oneself, they can lead to temporary low self-esteem, as a result of the doubts the widow may have about her ability to cope. The low self-esteem is associated with a disruption of the role schema that the widow was used to.

In the study done by Kubler-Ross and Kessler (2005), the authors attempt to find the meaning of grief through the five stages of loss. The authors find that the

reorganisation of a new life period to be the fourth phase during which the relationship with the deceased is placed in perspective. The widow will start to carry on with life. According to Carr et al. (2001), one may be ready to start a more active social life to close the gap created by the loss, especially widows with secure attachment who have greater openness and flexibility in social cognition. However, a need to express one's self emotionally remains. One risks facing the accompanying emotional pain. There will, however, be a shift from resisting change, to letting go of the hold of the past, to facing the reality of the present and the resulting emotional pain of the loss. This is the period of allowing new information in the schema to start effecting change. The coming and going of the feelings associated with bereavement is combined with a decrease in intensity as time goes on (Carr et al., 2001). However, the widow may feel a prolonged sense of guilt, where she feels that she is abandoning her husband. This may become dysfunctional, depending on her attributions around this feeling.

### **2.3.6.2 Comparison between cognitive theory, attachment theory and family systems theory**

#### **2.3.6.2.1 Cognitive and attachment theories**

Cognitive theory and attachment theory depend on each other to interpret the diversity of emotional reactions and overt behaviours during the bereavement process. Cognitive theory is concerned with conscious meanings and external events (Beck, 1996). In the context of difficulties in life, it consists of all the approaches that alleviate psychological difficulties through the medium of restructuring one's schemata by, for example, helping to allow new information in (Beck, 1996), and by accessing people's emotions through their cognitions, with the purpose of altering excessive and inappropriate emotional reactions.

Attachment theory describes a phenomenon proposed by Bowlby (1969) as a process where people create affectional bonds with other people, usually a loved one. This theory may be useful in uncovering the meanings people attach to their environment, to others, and to internal experiences, particularly when it concerns the loss of a loved one. It helps to conceptualise widows' bereavement as the disruption of an attachment bond through loss. This disruption offers a plausible explanation for several characteristics of functional bereavement, which are often difficult to understand. These include searching for the lost attachment figure, and anger towards the deceased because of feeling permanently abandoned. These can thus be understood as natural reactions to separation.

Whereas cognitive theory helps to identify and examine spontaneous cognitive responses and the underlying belief system at the conscious level, the psychoanalytic attachment theory focuses on interpreting unconscious fantasies, motivations and resistance to insight (Beck, 1996). As it is proposed in this thesis that attachment theory can be interpreted from a cognitive perspective, attachment will be regarded as a schema that is developed by a child and carried over into adulthood about the nature of the relationship between the self and significant others. The two theories complement each other in explaining the widow's bereavement process, and thus provide a theoretical framework appropriate for this study.

#### **2.3.6.2.2 Comparison between attachment and family systems theory**

Family systems theory and attachment theory have important similarities and complementarities, converging in two areas. Family systems theory attempts to describe the unique characteristics of a family system, which are defined by the unique interaction between individual members. The mother-child dyad, as the subsystem of a family system, is characterised by the interaction between the

mother and child within the family system, which eventually defines the nature of the attachment.

At a broad conceptual level, both theories deal with relationships and what draws people together, what drives them apart, and how those people deal with conflict. At a more specific level, it deals with the correspondence between attachment classifications of secure and insecure relationships on the one hand, and the family systems categories of adaptive, chaotically enmeshed and chaotically disengaged relationships on the other hand. There are also differences between the two theories. Whereas attachment theory focuses on the dynamics involving protection, care, and security, family systems theory is concerned with family dynamics involving structures, roles, communication patterns, and power relations.

Furthermore, attachment theory focuses on the dyad, with much of the action occurring between a mother and a child, whilst family systems theory has a broader focus that includes other family members, focusing on the triad, where much of the action occurs within groups. The family systems theory revolves around family members and their interaction with each other. Attachment theory, in this study, revolves more around the couple subsystem, their patterns of interaction and communication.

#### **2.3.6.2.3 Family systems theory and bereavement**

The family systems theory explains how the family, as a system, responds to the dying member of the system. This study does not focus on the family as a whole but rather on the couple as a subsystem of a family system. According to Whitchurch and Constantine (1993), the interactions between different

subsystems within the main system add characteristics to the whole that make it qualitatively different from each individual member of that system.

A family system has components that involve interrelated elements and structures, patterns of interaction, and open or closed boundaries. Each system has subsystems, which consist of subgroups of members. Each subsystem has its own rules, boundaries, and unique characteristics, and membership of a subsystem can change over time (Wendt & Zake, 2006). These components have subsystems, and function according to the Composition Law, using messages and rules (Wendt & Zake, 2006).

According to Whitchurch and Constantine (1993), Composition Law states that the whole is greater than the sum of its parts. When applied to the family, this means that the family as a whole is greater than simply adding individual member characteristics together. The whole becomes greater than the sum of its parts because the whole includes elements that cannot be broken down and applied to individual members. It is possible then for the system to have characteristics, which no individual element possesses except when they are put together in an interactional context. The family images and themes are reflected in this holistic quality, as the members' unique behaviours cannot be explained outside the context of the entire system. Families can then be considered to be systems as they are made up of interrelated members who exhibit coherent behaviours in their regular interactions and are interdependent on one another (Whitchurch & Constantine, 1993).

A family system uses messages and rules to shape its members. These messages and rules are relationship agreements, which prescribe and limit members' behaviour over time. They are repetitive, implicit, and perpetuate themselves through reproducing. They form predictable patterns of interaction

that emerge in a family system. These patterns of interaction help maintain the family's equilibrium, and determine how members should function. Just as there are functional and adaptive family systems, there are also dysfunctional family systems. These include chaotically enmeshed and chaotically disengaged family systems. An adaptive level of family cohesion is one in which family members work together (Wendt & Zake, 2006).

Chaotically disengaged families feel disconnected from one another, allowing unrestricted external influences to impinge on the family. Boundaries are predominantly blurred, and the family's interaction is unpredictable and marked by limited and/or erratic leadership and discipline. Negotiations are endless with dramatic role shifts and rule changes. Chaotically enmeshed families present themselves as extremely close with high loyalty demands and little tolerance for privacy, separateness or external influences. A family with permeable and vague boundaries is considered an open boundary system, allowing elements and situations outside the family to influence it. A closed boundary system isolates its members from the environment, and seems isolated and self-contained.

## **2.4 CONCLUSION**

This chapter consisted of three parts where bereavement formed the central construct around which the chapter was structured. The first part discussed literature about bereavement, the second part presented theoretical approaches relevant to studying bereavement, and the final part integrated relevant constructs from the selected theories into a unified approach. Bereavement was defined and conceptualised, including its determinants and misconceptions. Emotions, as an affective schema that dominates bereavement, its diagnostic issues, African cultural perspectives of bereavement and its constructs were discussed. Cognitive theory, as the central theory around which the study revolves, schemata as unconscious mental structures, and scripts were looked

at. Relevant theories were used to complement cognitive theory. Those theories were attribution and systems theories, coping strategies and Schachter and Singer's two-factor theory of emotions in an attempt to explain the cognitive-affective-motivational-behavioural network of the participants in response to the deaths of their husbands.

In the chapter that follows, the methodology of this study is discussed.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 INTRODUCTION

The research methodology used in this study is outlined and discussed in this chapter. This is done to substantiate the choice of the research method, the data collection process and the implemented data analysis.

The methodology used in this study was qualitative, with an interpretive, naturalistic approach being followed. As cognitive theory typically uses quantitative research designs, a section that attempts to reconcile the theoretical framework with the methodology follows the description of qualitative research.

Data were collected in different ways and forms. These involved interviews (structured and semi-structured), Participant observation and consultation with the elders of the community under study. The tape-recorded data collected from the interviews were transcribed into electronic format. Data were analysed using Miles and Huberman's (1994) method of data reduction, data display, conclusion and verification.

Ethical considerations such as the protection of the Participants' interest and well-being, their emotional safety and identity were deemed important. A discussion of how the integrity and consistency of the data analysis and interpretation were established concludes the chapter. Qualitative research, as used in this study, is discussed in the following sections.



## **3.2 DESIGN**

Denzin and Lincoln (1994) state that qualitative research uses a number of methods "as it involves an interpretive, naturalistic approach to its subject matter" (p. 2). The choice of a qualitative research design in this study was based on the need to acquire in-depth understanding of relatively unexplored phenomena that are value-laden, and to situate the findings within an integrated theoretical perspective.

### **3.2.1 Qualitative research**

Qualitative research is characterised by an attempt to understand the meanings that people give to social phenomena. As one cannot understand human behaviour without understanding the framework within which the Participants interpret their thoughts, feelings and actions (Marshall & Rossman, 1980), qualitative researchers enter into the natural settings of the Participants whom they study. They physically go to the people, interview setting or site, to observe or record behaviour in its sociocultural context. This they do as human behaviour is significantly influenced by the sociocultural and the interview settings in which it occurs. As such, researchers are able to study behaviour to gain an understanding of norms, traditions, roles and values, which are crucial for contextual variables (Cresswell, 1994; Marshall & Rossman, 1980).

The objective is to look for answers to questions about the way the Participants create and interpret social experience (Denzin & Lincoln, 1994). For example, when the researcher conducts interviews with the Participants, the researcher obtains an idea of how the Participants feel and think about their situation, what sort of limitations they experience, how they deal with conflicts within themselves

and their environment, the rules they have to deal with, their strengths and weaknesses.

The researchers use themselves as the primary instrument for data collection and would, for example, conduct face-to-face interviews with their Participants with the objective of looking for answers to questions about the way social experience is created and interpreted (Denzin & Lincoln, 1994). According to Merriam (1988), the meaning that qualitative researchers are interested in revolves around how people make sense of their lives, experiences and the structures of the world. This is explored through fieldwork that focuses on processes and finds meanings of events situated in the sociocultural natural setting of the Participants (Marshall & Rossman, 1980). This setting includes the past experiences and personalities of the researcher (Peck & Secker, 1999). The fact that qualitative researchers' ultimate objective is to understand the meanings that people give to social phenomena makes qualitative research descriptive in that the researcher is interested in process, meaning and understanding gained through words. In achieving this, the research process becomes inductive in that the researcher builds abstractions, concepts and theories from details (Creswell, 1994), in an attempt to observe and interpret meanings in context (Patton, 1990).

This study was conceptualised, designed and conducted by the researcher who used her as an instrument and is also a member of the culture under study (Creswell, 1994). The research focused on the context, perspective, experience and meaning of the Participants with the objective of describing and understanding the subject matter. A naturalistic and emergent design was applied. A naturalistic design is one that views reality as multiple, constructed, holistic and understood within its context (Lincoln & Guba, 1985). In an emergent design, the researcher seeks to observe and interpret meanings in context (Patton, 1990).

Qualitative research therefore involves interpreting non-numerical data in a particular perspective and context. It stresses the socially constructed nature of reality, the relationship between the researcher and the subject matter, the situational constraints and the value-laden nature of inquiry. Both the research and the researchers look for answers to questions about the way social experience is created and interpreted with a set of interpretive practices (Denzin & Lincoln, 1994). This is based on the understanding that different people from different groups have different contexts and perspectives, creating many different meanings in the world, where no one meaning is necessarily more valid than the other (Gay & Airasian, 1999).

In summary, qualitative research relies on first-hand accounts and tries to describe what it sees in rich detail (Terre Blanche, Durrheim & Painter, 2006). It stresses the socially constructed nature of reality by taking into account individual uniqueness where each person is an individual with a different perspective of the world, with different reactions to occurrences, and different opinions on how the world should be (Putney & Green, 1999).

The ontology is a categorisation of all the concepts in some field of knowledge, including the objects and all of the properties, relations, and functions needed to define the objects and specify their actions. It specifies the nature of reality that is to be studied, and what can be known about it. The researcher who uses an interpretive qualitative approach holds the ontological belief that the reality to be studied consists of people's subjective experiences of the external world (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004). It also assumes that people's subjective experiences are real and as such, should be taken seriously (Lincoln & Guba, 2000). This study aimed to understand the subjective experiences of loss and bereavement among Black South African women in transitional societies.

Epistemology refers to the assumptions about knowledge and how it can be obtained (Myers, 2009). It studies the nature of knowledge, in particular its foundations, scope and validity, specifying the nature of the relationship between the researcher and what can be known. It assumes that people can understand others' experiences by interacting with them and listening to what they tell us while adopting an epistemological stance towards reality (Terre Blanche et al., 2006). Researchers who use an interpretive approach uses methodologies that rely on a subjective relationship between themselves and the Participants, for example, interviews and Participant observation, with the objective of explaining the subjective reasons and meanings that lie behind social action (Terre Blanche et al., 2006; Thorne et al., 2004). This is done to specify how the researchers may go about practically studying whatever they believe can be known, as qualitative research techniques are assumed to be best suited to this task (Terre Blanche et al., 2006).

### **3.2.2 Advantages and disadvantages of using qualitative research**

The advantages and disadvantages of using qualitative research in this study are included here, and are relevant to the reflection on the strengths and weaknesses of the study in chapter 5.

#### **3.2.2.1 Advantages**

Putney and Green (1999) identify the following advantages of qualitative research:

- It expands the range of knowledge and understanding beyond the researchers themselves.
- It provides ways of a) transcribing and analysing the discursive construction of everyday events, b) examining the nature of the subject

matter within and across events, c) exploring the historical nature of life within a social group or setting.

- It provides insight into the Participants' way of life so that the researcher can behave appropriately without offending the Participants.
- It provides information about why and how miscommunication occurs between people, especially when people are members of different groups.
- The approaches and theories that guide qualitative researchers raise awareness of different voices; and awareness of the need to consider whose voice will be represented, how, in what ways, and for what purposes.

### **3.2.2.2 Disadvantages**

- The research may be costly because it is a time-consuming exercise in relation to the data collection, and because the process of analysis involves continual movement between the data and emerging themes to adapt. This includes the verification of the analytical framework being developed.
- The conclusions are typically disseminated through academic publications and papers, which people unfamiliar with the academic repertoire can find difficult to access and follow.
- Researchers have their own experiences and views and it is therefore important for them to be aware of these when carrying out inductive reasoning processes.
- Data is collected from a few cases or individuals and as such, findings cannot be generalised to the larger population.



- The quality of the research is heavily dependent on the individual skills of the researcher.
- Rigour is more difficult than quantitative research to maintain, assess and demonstrate.
- It is not as well understood as quantitative research and is therefore more difficult to convince others of the importance of its contribution.

Cognitive theory was chosen amongst other psychological theories as the most appropriate to theoretically explain the collected data. The fact that it studies the mental processes underlying mental activity i.e. perception, learning, problem solving, reasoning, thinking, memory, attention, language and emotions motivated its choice amongst all other theories and approaches. Its focus on an individual's thoughts, and the belief that these thoughts determine one's emotions and behaviour and as such strengthened its choice. Also, people cannot have emotions and behaviours without thoughts as thoughts come before any feelings and actions, even though behaviour can at times be learned. On the basis of this argument, how one thinks can determine how situations are perceived and, changing feelings and behaviours can only change if thoughts are changed (Bowlby, 1997).

In the following paragraphs I attempt to reconcile the qualitative research design with cognitive theory.

### **3.3 RECONCILIATION OF THE QUALITATIVE DESIGN WITH A COGNITIVE PSYCHOLOGICAL THEORETICAL FRAMEWORK**

In this study, the theoretical framework relied on cognitive psychology and theory that was developed through positivistic science (Lincoln & Guba, 1985). As research is about creating new social realities, what researchers seek to describe

is the social world. This world consists of factual statements, knowledge claims, and moral judgements that refer to an empirical reality while simultaneously setting up the conditions through which the reality can be known (Terre Blanche et al., 2006). This makes the background knowledge or paradigms of the subject matter important to tell us what exists, how to understand it, and most importantly, how to study it (Bryman, 2006a).

According to Terre Blanche et al. (2006), paradigms are all-encompassing systems of interrelated practice and thinking that define the nature of their enquiry along three dimensions for researchers, namely, ontology, epistemology, and methodology. Their function is to help determine the questions that the researchers ask about constructs and how they go about answering them (Bryman, 2006b). When epistemology specifies the nature of the relationship between the researcher and what can be known, methodology specifies how researchers may practically go about studying whatever they believe can be known (Terre Blanche et al., 2006). These dimensions of paradigm exist simultaneously and constrain each other at the same time (Bryman, 2006a).

As I became familiar with the research topic, I decided on a theoretical framework that would enable me to gain an understanding of the phenomenon under investigation (Bryman & Cassell, 2006). Although Lincoln and Guba (1985) perceive qualitative and quantitative methodological approaches as incompatible based on the underlying philosophical nature of each paradigm (Bryman, 2006a), others believe that the skilled researcher can successfully combine approaches (Glesne & Peshkin, 1992) based on the apparent compatibility of the various research methods (Bryman, 2006b).

The positivistic approach has influenced psychology with linear cause and effect models using quantitative designs. In this study a design that is circular in nature

is used that creates tension between the ontology, epistemology and (qualitative) methodology that is used. In the following paragraphs I attempt to reconcile the qualitative research design with cognitive theory (Bryman, 2006b).

A quantitative approach assumes social facts with an objective reality, primacy of method, and variables that can be identified and relationships that can be measured, and has an outward point of view (Bryman, Becker & Sempik, 2007). Conversely, a qualitative approach assumes a socially constructed reality, primacy of subject matter, with complex, interwoven and difficult variables to measure (Bryman et al., 2007). While a quantitative approach aims at generalisability, prediction and causal explanations, a qualitative approach aims at contextualisation, interpretation and understanding the Participants' perspectives (Glesne & Peshkin, 1992).

A quantitative approach begins with hypotheses and theories, manipulation and control, and uses formal instruments and experiments (Glesne & Peshkin, 1992). It also uses deductive and component analysis in an attempt to reduce data to numerical indices, and uses abstract language in writing up results (Bryman, 2006b). Qualitative approaches might, however, end with hypotheses and grounded theory, with emergence and portrayal. Researchers use themselves as an instrument (Bryman, 2006b). The approach is naturalistic and inductive in search of patterns, and might describe what the person feels, reminiscing about experiences relating to the feeling, and embracing pluralism and complexity with descriptive write-up, and makes minor use of numerical indices (Glesne & Peshkin, 1992).

In contrast, researchers interested in what allows people to perceive apply cognitive theory to understand the life-world. This, according to Roth (2004), emphasises two complementary parts to the cognitive phenomenological



(qualitative) method in overcoming the subjective/objective divide. They involve the articulation of the structures that characterise the life-world which include objects and events, patterns of behaviour, and changes in those objects, events and behaviour (Agre & Horswill, 1997).

However, Scott (2007) argues that qualitative and quantitative research designs are irreconcilable. The argument is based on the idea that approaches and ways of reconciling quantitative and qualitative methods are still deficient in relation to the development of an overarching and correct view of ontological and epistemological matters; and concludes that reconciliation occurs at the ontological level. The suggestion was that positivist and interpretive ontologies underlie quantitative and qualitative methods respectively, and represent different ways of approaching real phenomena that are not predicated on them.

According to Lincoln and Guba (2000), “naïve realism” underlies positivism, which holds that reality is both “real” and “apprehendable”. Interpretive ontology assumes that it is impossible to separate the researcher from the researched (Guba & Lincoln, 1989). It also assumes that the researcher and the researched are interlocked in an interactive process in which each influences the other (Mertens & McLaughlin, 1995). Based on this understanding, the qualitative research design aims to elicit rich experiential data about the phenomenon within the everyday context in which it is negotiated and made meaningful (Bryman, 2006b). According to Thorne et al. (2004), relativism underlies interpretivism with the belief that knowledge is relative to the observer while reality is determined by the experiences, social background and other factors of the observer, which become the raw data. These factors are not a constant, but represent rather a relationship between changing variables. This, together with cognitive phenomenology, constitutes real life experience as a proper field of phenomena that cannot be reduced to other approaches but require a rigorous method and pragmatics of inquiry, i.e. exploration and analysis. This is so as cognitive

phenomenology seeks mutual constraints between the phenomenal field as revealed by the researcher's experience and careful life-world analysis, and the associated field of phenomena as studied by cognitive science (Roth, 2004).

Researchers who use a positivist approach believe that their subject matter consists of a stable and unchanging external reality. As such, they tend to adopt an objective and detached epistemological stance towards how reality can be known. At face value, this means that the observer is separate from the observed, and that findings are "true" (Bryman, 2006b). Durant and Cashman (2003) confirm this view by arguing that the social order exists independently of social scientific inquiry, suggesting therefore that reality exists independently of a particular community. However, Roth (2004) argues that qualitative research assumes that the study of a particular experience leads to the recognition of generative structures that are common to people more generally. He continues to see qualitative research as an attempt to establish a scientific method that explicitly deals with experience and structures that give rise to it and as such deal with the hard problem of cognitive science to relate personal experience and mental/cognitive events. The implication is that, even when individuals and communities may construct interpretations of events that reflect relative values and interests, the underlying phenomena do not rely on them for existence (Bryman, 2006b).

A comparison of the beliefs and assumptions of the two approaches suggests that while the quantitative nature of reality is single, tangible and fragmentable, the qualitative nature of reality is multiple, constructed and holistic (Lincoln & Guba, 1985). From a cognitive phenomenological perspective, a continuously developing perception creates the perceived world in a constructive or generated process, i.e. what we perceive is a function of what we do (Roth, 2004). In a quantitative approach, the knower and known are independent (a dualism), while the relationship of the knower to the known in a qualitative approach is interactive

and inseparable (Lincoln & Guba, 1985). While inquiry is considered value-free in the quantitative approach, in the qualitative approach it is value-bound (Lincoln & Guba, 1985).

Even though qualitative and quantitative research designs ontologically specify the nature of reality to be studied, they achieve similar results from different perspectives. According to Lincoln and Guba (2000), positivism's ontology, termed "naïve realism", holds that reality is "real". Cognitive phenomenology argues that different people inhabit the same physical environment and take this environment as shared, but simultaneously inhabit different life-worlds. As such, it is as wrong to assume that perspectives are completely unique as it is to assume that they are all the same (Corno et al., 2002). As such, Bryman (2006b) emphasises that reconciliation must begin with a shared notion of social phenomena in the world and therefore what is "real". Just as people can share the "facts" of everyday "reality", even when differing in the interpretations of their meaning, the "realities" of the different paradigmatic dimensions are not necessarily foundationally incompatible.

Bryman (2006b) also views the positivist and interpretivist paradigms to be complementary and not dominant, despite the fact that the two approaches differ in assumptions, purpose, approach, and researcher's role (Glesne & Peshkin, 1992). However, this does not mean that the positivist never uses interviews, and that the interpretivists never use a survey, as researchers tend to adhere to the methodology that is most consonant with their socialised world (Bryman, 2006b). Also, different approaches allow researchers to know and understand different interests about the world (Bryman, 2006b).

Terre Blanche et al. (2006) suggest that positivist researchers employ a quantitative methodology to access reality by relying on the control and

manipulation of reality. This is done with the objective of providing an accurate description of the laws and mechanisms that operate in social life. It can also be inferred that attention is needed to see anything specific, which arises from access to and control over one's perceptual activity (O'Regan & Noe, 2001), when applying a cognitive phenomenology. However, researchers who use a qualitative approach believe that the reality to be studied consists of people's subjective experiences of the external world, and may adopt an intersubjective epistemological stance towards that reality. They would thus use methods that rely on the subjective relationship between themselves and the Participant, for example, interviews and Participant observation, with the objective of explaining the subjective reasons and meanings that lie behind social action (Terre Blanche et al., 2006). This is confirmed by cognitive phenomenology as a method of studying the knowing, learning and instruction through the employment of first-person methods, which study human activities not merely by taking the perspective of the Participant, but strive for categories that explain why and how experiences are experienced (Roth, 2004).

The other employed method is the third person, which is a scientific process that distinguishes between researchers and the researched. In this process, the line of rigour and lack of it does not lie between first- and third-person accounts but on whether descriptions are based on clear methodological grounds leading to a communal and intersubjective knowledge (Graumann, 2002). As such, qualitative research can be reconciled with the theoretical framework of cognitive psychology.

Qualitative and quantitative research methodologies also offer a complementary view of the social world because the richness of the combined approaches can enhance the precision of the findings. When an in-depth account encompasses more information, focus on precision can lead to a clarification of basic concepts. The rich descriptive data produced by qualitative research can shape the choice

of variables. Reciprocally, the effects derived from experiments can help reframe the problem and provide a new focus for in-depth descriptive study (Bryman, 2006b). This is so as cognitive phenomenology understands that a continuously developing perception creates the perceived world in a constructive or generative process as, what we perceive is a function of what we do (O'Regan & Noe, 2001). The potential interplay between these two approaches implies that they share many qualities as part of the research enterprise. In a very positive way, therefore, the two approaches are both constructive because they create data, and are mutually constitutive, reflecting the challenging interplay between words and variables (Smith & Heshusius, 1986).

Although it has been argued that qualitative (interpretive) design and cognitive science are irreconcilable, it is now clear that even though each paradigm has a different look and feel, researchers' choice of a paradigm depends on what fits in with the kind of things that they can identify with, and not because the one paradigm is better than the other (Bryman, 2006a). For example, researchers who require objective facts would prefer positivism, and interpretive research would be better suited to those who are curious about the meanings people attach to such facts (Terre Blanche et al., 2006). Both research designs are therefore engaged, though they responsibly endeavour to develop principles and accounts that are not restricted by arbitrary biases (Durant & Cashman, 2003).

As approaches to gaining access to reality, cognitive phenomenology and qualitative methodologies also share something in common when it comes to examining these phenomena. However, they are deconstructive when it comes to disturbing the fabric of naturally unfolding episodes in the social world (Bryman, 2006a). The flow of events in everyday life is segmented and turned into a subject of inquiry, and the subject of inquiry and selectivity becomes an immediate source of bias and distortion (Durant & Cashman, 2003). Both

approaches deal with data, meaning that they break the flow of events in the social world and selectively focus on that behaviour of individual Participants.

Regarding the issue of complementarities between the two approaches, it has generally been assumed that qualitative research precedes a cognitive hypothesis-testing phase. The notion of the qualitative-cognitive sequence is best replaced by a position that views them as complementary (Rennie, 1998). This is because the process of research is recursive, and one approach feeds back into the other. Whereas natural history involves the rich and in-depth description of observed phenomena, including observed patterns and relationships, empirical science involves an attitude in which selected variables are abstracted from the overall phenomenon, and their interaction is carefully observed (Rennie, 1998).

Even the concept of validity need not isolate scholarly communities. In both approaches, validity expresses a concern for ecological validity, which is a type of external validity, which looks at the testing environment and determines how much it influences behaviour. It is the extent to which a finding meaningfully reflects an event or process in the world, and both paradigms bear the burdens of their doctrinal commitments (Bryman, 2006a). In many studies, there may be a trade off between internal and external validity. External validity, according to Mitchell and Jolley (2001), is the validity of generalised or causal inferences in scientific studies, which are usually based on experiments as experimental validity, and where threats to external validity interact with the independent variable. Internal validity is the approximate truth about inferences regarding causal relationships and as such, relevant to studies that try to establish a causal relationship. It can be used when there is evidence that what is done in the study caused what is observed (outcome) to happen (Shadish, Cook & Campbell, 2002).

According to Shadish et al. (2002), external validity and ecological validity are closely related in the sense that causal inferences based on ecologically valid research designs often allow for higher degrees of generalisability than those obtained in an artificially produced laboratory environment. However, some findings produced in ecologically valid research settings may hardly be generalisable, and some findings produced in highly controlled settings may claim near-universal external validity. This then makes external and ecological validity independent. Within the qualitative research paradigm, external validity is replaced by the concept of transferability, which is the ability of research results to transfer to situations with similar parameters, populations and characteristics (Lincoln & Guba, 1986).

Cognitive psychology tends to adopt a positivist approach to researching phenomena. However, as the above discussion suggests, it does not exclude the use of a qualitative methodology. In the case of positivism, precise operational definitions can deplete a phenomenon of its richness and texture so that it all but disappears in the rush of actual prediction. For example, measurement can transform meaning into nothingness (Wallner, 1994). According to Bryman (2006a), the two schools of thought therefore have different problems from their epistemological perspectives. Bryman suggests that reconciliation must begin with a shared notion of social phenomena in the world, and therefore, a sense of what is “real”. As such, cognitive phenomenology, together with qualitative research, seeks mutual constraints between the phenomenal field as revealed by the researcher’s experience and careful life-world analysis, and the associated field of phenomena, as studied by cognitive science (Roth, 2004). This is based on the fact that phenomenology assumes that the study of particular experience leads to the recognition of generative structures that are common to human beings more generally. It attempts to establish a scientific method that explicitly deals with experience and structures that give rise to it and thereby deal with the hard problem of cognitive science to relate personal experience and cognitive events (Roth, 2004).

### **3.4 PARTICIPANTS IN THIS STUDY**

#### **3.4.1 Access to potential Participants**

The Participants of this study were drawn from women who formed part of an established support group for widows in Soweto. The phenomenon of support groups for widows is a new development in Black urban South African society. Participant one of this study started this support group under the auspices of the local Catholic Church in the community under study, which explains why a number of Participants were Catholics. The Participant started the group after the death of her husband, as she became more aware of the struggle of widows in the community, and after considering how fortunate she felt compared to most widows she came to know.

I initially joined the group as an observer, with the aims of understanding the members' motivation to join the group, the dynamics within the group, and also to introduce myself and invite potential Participants to join in my study. In attempting to win the Participants' confidence, I asked if I could present a topic about bereavement to the forum. The justification and objective of the study was then put forward, together with the criteria for participation. As a result of these efforts a number of widows were willing to be interviewed as Participants of this study.

#### **3.4.2 Sampling method**

According to Devers and Frankel (2000), sampling methods in qualitative research can be thought of as a rough sketch to be led in by the researcher as the study proceeds. Purposive sampling was used to select the Participants. This method of sampling in qualitative research is essentially strategic to the sampling



of cases based on interviews with an attempt to establish a good correspondence between research questions and sampling where the researcher samples on the basis of wanting to interview people who are relevant to the research questions (Bryman, 2008).

The following inclusion criteria were used:

- The Participants had to be in the stage of middle adulthood, between 45 and 55 years old. The assumption made was that there was a good chance that widows in this age category would have been married for longer than 10 years (see criterion below) and so that couples who lived together that long would have had a better understanding and knowledge of their spouse than younger couples.
- The Participants must have been married for not less than 10 years, to include the probability of the task of bringing up children and possibly experiencing an empty nest.
- The mode of death included an anticipatory phase where the late husband died of terminal illnesses, for example, cancer, and HIV/AIDS. This was necessary to obtain enough data about how the Participants coped with the anticipation and real loss.
- All the Participants had to live in an urban area previously classified as a Black township, where the transition from traditional culture to modern life is evident. Although two Participants would have been classified as Coloured by the previous regime they would currently be classified as Black (Lodge, 1983), and resided in the type of area required for the study.
- Lastly, they must have been widowed for six months to a year-and-a-half. This was necessary to ensure that the widows were more or less at the same level of bereavement. However, the fact that bereavement related depression within the first two months after the loss of a loved

one resembles non-bereavement related depression (Zisook, Shear & Kendler, 2007) was taken into account. Also, it was noted that Participant 3 was the only one who did not mention the duration of her widowhood but that was established after the interview with the gatekeeper (8 months).

The exclusion criteria included mentally and physically handicapped women or those who were undergoing treatment for a psychosis (loss can trigger a psychotic episode). The exclusion criteria eliminated the involvement of additional dimensions in bereavement, which were not necessarily relevant to this study.

One Participant was attending psychotherapy sessions during the time of the interview with her. Another Participant became emotionally upset during the interview, which necessitated a therapeutic interview. Both were included in the study, however, and after the interview they were referred for further therapy.

No final decision was made at that stage regarding the number of people to be interviewed. It was envisaged that at least ten people would be interviewed, but the interviews continued until saturation point was reached in the information obtained, meaning that the themes and categories contained in the data obtained stability, and the research question was adequately answered (Terre Blanche et al., 2006). Ten interviews were conducted with Participants who met the criteria and were willing to be interviewed.

### **3.5 METHODS OF DATA COLLECTION**

In this study, data was collected in different ways and forms, using as many diverse sources as possible. In other words, the sources were triangulated.

Triangulation refers to the use of different data sources in a study (Terre Blanche et al., 2006). These sources included interviews (structured and semi-structured) and Participant observation, where I made observations at the funerals that I attended. As a member of the community under study, I also examined my own background to contribute to the study as objectively as possible without imposing my beliefs onto the study. I also consulted with the elders of the community under study. All the methods that were used in this study are discussed next.

### **3.5.1 The qualitative interview and its value**

Kvale (1996) regards the research interview as a way of obtaining scientific knowledge about the social world, and the one form of the conversations of daily life in which the Participants formulate conceptions of their lived world in a dialogue. Its objective, according to Kvale (1996), is to understand the world from the Participants' point of view, to unfold the meaning of their experiences, and to uncover their world before scientific explanations. As such, qualitative researchers collect data through interviews, among other things, so that they have an opportunity to get to know Participants quite intimately (Bryman & Cassell, 2006). In this study, it enabled me to better understand how the Participants attended to information, perceived, encoded and retrieved it; and how they analysed and interpreted their experiences of the anticipated and actual death of their husband.

A face-to-face dialogue allowed the interviewer, who in this study was myself, to generate and develop questions according to the Participants' responses. Extensive probing and open-ended questions were used, in accordance with the recommendations of Bryman and Cassell (2006). The objective was to increase understanding and elicit data, detailed material and new insights that could be used in analysis (Denzin & Lincoln, 1994). To achieve that, framework within

which the interviewees could respond in a way that represented accurately and thoroughly the Participants' points of view about their bereavement was provided.

The open-ended responses to questions provided me with the main source of data. In line with Patton's findings of 1987, interviewees' responses revealed their levels of emotions, the way they organised their worlds, their thoughts about their situations, their experiences and basic perceptions.

Interviews were conducted in two phases. The initial phase was an unstructured interview, which was initiated by an open-ended, non-threatening question, requesting Participants to describe how they had previously and how they currently experienced and were coping with their bereavement? This allowed them the opportunity to express their experiences and feelings in some depth. The second phase of the interview was a semi-structured interview in which topics uncovered in the first phase were addressed.

### **3.5.2 Unstructured interview**

The choice of an unstructured interview was decided on because it provides information that is closer to the Participants' perspective. When detailed interviewing and observation of Participants' behaviour are included (Denzin & Lincoln, 1994), this form of investigation provides more depth than other types of interviewing. Unstructured interviews are therefore an appropriate and powerful way of interacting to collect and analyse empirical material in this study.

The appropriateness of the unstructured interview helped me to avoid following a rigid form. The subject matter was understood without imposing a predetermined set of questions on the conversation (Bryman & Cassell, 2006). It helped me to understand the complex behaviours of the Participants without imposing prior

categorisations that might limit the study. Instead, it reflected the Participants' experiential reality (Denzin & Lincoln, 1994).

I was a careful listener and clarified where I did not understand so as to obtain a thoroughly tested knowledge. Clarification was requested when the meaning of what the Participants said was unclear. That allowed the Participant to explain or help clarify an idea, to increase the likelihood of providing useful response, and to communicate the meaningfulness of the experience (Burgess, 1991). This served as a window into the Participants' lives (Bryman & Cassell, 2006), as the purpose was to understand how the Participants experienced their bereavement process.

The interdependent human interaction between the Participant and myself went beyond a spontaneous exchange of views, making the interview an interchange of views between researcher and Participant, conversing about a theme of mutual interest (Kvale, 1996). This was done with the objective of obtaining the meaningful statements based on interpretations of events. As a result, the research interview allowed me to capture the perspectives of the Participant (Burgess, 1991).

The quality of the information obtained largely depends on the interviewer's skills as a researcher (Patton, 1990). An in-depth, one-to-one interviewing technique may develop an understanding of how Participants translate their experiences into meaningful explanations about themselves. Gutman (1982) calls this a laddering technique. To achieve this, an interviewer needs to be a good listener and questioner, sensitive and empathic; and should have the ability to establish a non-threatening interview setting in which interviewees may feel comfortable, with adequate knowledge of the interviewees' culture and frame of reference.

This may motivate the Participant to respond, with a series of directed probes in this discovery process.

Kvale (1996) also considers the value of the research interview to be that the interview is conducted in the Participants' natural habitat. This also provides an understanding of the Participants' world from their points of view; helps to unfold the meaning of their experiences, and uncover their lived world prior to scientific explanation. In this way, knowledge about the Participants and their conditions may develop effectively without manipulating their behaviour. The strength of the research interview helps to capture the multitude of the Participants' views on a theme, and in the process, provides a picture of a multifaceted human world.

During the interviews in the current study, the Participants and I talked freely (Burgess, 1991) to facilitate free and open responses. This helped me to capture the interviewee's perception in her own words. I became an attentive listener, shaping the process into a familiar and comfortable form of social engagement. That allowed me flexibility in conducting interviews with particular interviewees or circumstances. It also provided an opportunity to explore topics in depth, affording me the opportunity to experience the affective and the cognitive aspects of responses (Burgess, 1991).

Unstructured interviews have their own disadvantages (Denzin & Lincoln, 1994), including that they are time-consuming. In this study I conducted all the interviews to avoid possible inconsistencies across interviews due to the flexible nature of unstructured conversations. Another disadvantage is that the volume of the information tends to be very large, making it difficult to transcribe and reduce data.

### **3.5.3 Semi-structured interview**

After the unstructured interview phase, semi-structured interviews were conducted with the same Participants. These interviews allowed for focused, conversational two-way communication, where the objective was to give and receive more information and obtain clarity on the responses from the first phase of interviews. My focus was on themes that were not covered in the unstructured interview. To create a framework for the interview, I commenced with general questions and topics that were guided by uncovered themes, some of which were created during the interview. That allowed both the interviewee and myself the flexibility to probe for details. As a result, specific and general information relevant to issues was obtained to gain a range of insights on those issues.

The semi-structured interview process confirmed what I had already learnt from the unstructured interview, but also provided me with the opportunity to learn more from the interviewee by providing not only answers, but also reasons for those answers, as the interviewees more easily discussed sensitive issues. The interviewees were also able to ask questions.

### **3.5.4 Interview guides**

A list of topics was compiled for the unstructured interviewing phase based on the literature reviewed as well as my experience of dealing with widows from Black urban areas. In accordance with Bryman's (2008) suggestion, an unstructured interview was also conducted with one of the Participants for the purpose of compiling the list of topics. The first unstructured interview served as a pilot study with the objective of collecting preliminary data, identifying potential practical problems, and so increase the likelihood of the success of the study in preparation for the semi-structured interviews (De Vaus, 1993).

After the pilot interview the list of topics for the unstructured interviews was finalised as follows:

- The Participants' relationships with their late husbands
- The mode of death
- How society responded to the widow before the death of the spouse
- How society responded to the widow after the death of the spouse
- The widow's personal emotional experience of society before the death of her spouse
- The widow's personal emotional experience of society after the death of her spouse
- How the widow interprets society's response
- The widow's personal emotional experience and interpretation of self
- How the widow copes with her bereavement
- Support structures for the widow
- Reasons for joining the support group
- How the support group is experienced
- Rituals the widow performed and what they meant to her, including the scripts she followed during the mourning period

Once I had completed the unstructured interviews and reflected on the responses, I developed an interview guide for the semi-structured interviews with the purpose of probing deeper and more extensively into certain topics (Bryman & Cassell, 2006).

The semi-structured interview guide covered the following topics:



- The personal characteristics of the couples – 1. The nature of the couples' relationships (a. patterns of communication and cooperation b. perceptions and attributions) 2. The couples' knowledge and understanding of the illness 3. The different roles played by the Participants and their husbands 4. Strengths and vulnerabilities
- The Participants' challenges and how they dealt with them – 1. Past significant losses in the widows' lives 2. Stressors 3. Caring and treatment regimen of the dying husbands (a. non-compliance and other unique challenges b. the attitudes towards and responses to the illnesses and its ramifications)
- The Participants' experiences of stressors – 1. Physical symptoms 2. The widows' response to the news of their husbands' deaths 3. Emotions experienced
- Coping – 1. The couples' resources 2. The Participants' approaches to their challenges 3. The Participants' coping styles 4. Participation in African death rituals

The abovementioned topics helped determine whether each Participant's bereavement process is either functional or dysfunctional, how it came to be, and why this was, especially in comparison with the other Participants – in other words, how the Participants perceived, encoded and retrieved, analysed and interpreted their loss.

### **3.5.5 Interview procedure**

The appointments with the Participants were made by Participant one of this study. She arranged a time that suited the Participants and invited them to her home where the interviews were conducted individually by the researcher in a quiet, private room. Each interview lasted about an hour-and-a-half to two hours.

All the interviews were conducted in the Participants' first languages, namely, Sotho, Tswana or Zulu as the interviewer is fluent in all three languages.

I attempted to create a sense of involvement and caring in the interview so as penetrate beyond the Participant's superficial reasons and rationalisations of behaviour to discover more fundamental patterns underlying each Participant's perceptions and behaviour (Gutman, 1982). As in the unstructured interview, it was also critical for me to establish rapport before the actual in-depth probing, and to maintain it during the course of the interview to instil confidence in the Participants for them to express their opinions (Gutman, 1982).

Interviews were recorded on tape with the permission of the Participants. This allowed me to keep a full record of the interview without having to be distracted by detailed note keeping (Bryman, 2008). However, I took note that tape-recording might detract from the intimacy of the encounter, with both the researcher and the Participants in part performing for the tape-recorder rather than really talking to each other (Terre Blanche et al., 2006).

In striving to achieve a good interview, I listened more and talked less, followed up on what the Participant said, asked questions when she did not understand without interruptions, asked to hear more about a subject for concrete details, and explored the Participant's responses. I allowed the interview to flow spontaneously while in the process, covering the scheduled themes.

During the process and in accordance with the recommendations of Terre Blanche et al. (2006), I made brief notes of important events that might not be obvious from listening to the tape recorder. Scribbling questions and thoughts that occurred to me during the interview also helped. However, for that to be effective, I had to know my interview guide well in an attempt to avoid constant reference to the format, or interrupt what is a crucial characteristic of a good

interview, namely, the flow of the interview (Terre Blanche et al., 2006). In this way, the Participants became co-enquirers, changing the interview into a conversation between the interviewer and the interviewee, instead of a question and answer session.

At the end of the interview the Participant was asked if she had anything more to say. At that moment it was important for the interviewer to be aware of what the Participant was saying after the recorder had been switched off. Sometimes interesting understandings only emerge then (Terre Blanche et al., 2006). It was therefore important to select a private setting for the Participants (Bryman & Cassell, 2006).

It is advisable to make notes about the interview as soon as possible after the interview as well, writing down anything that might not be obvious from the recording. For example, how the interviewer felt at a particular point in time during the interview so as to give clarity to the content and mood of the interview setting. Interview notes also included interesting issues that were discussed after the recorder were switched off, ideas that occurred during the interview, and additional questions the researcher would have liked to ask (Terre Blanche et al., 2006). Notes were also taken during the interview to help recall the comments that might be garbled or unclear on the tape (Bryman & Cassell, 2006).

From the above, it seems clear that the method of interviewing was an appropriate choice for this study. My flexibility, expertise and interpersonal skills allowed the interviewee to describe what was meaningful to her, using her own words in a relaxed atmosphere (Bryman, 2008). That allowed me to probe for more details and ensured that the interviewees were interpreting questions in the way that was intended.

### 3.5.6 Participant observations

Observations were another powerful tool in the data collection process, which focused on the actual behaviour of the Participants during events related to the topic of research, for example, death rituals. This technique was used to supplement interviews and gain access to the context of the Participants, understand their everyday subjectivity, and grasp meaning attached to those observations. This was considered important as the meaning of human creations - words, actions and experiences - can only be ascertained in reaction to the contexts in which they occur, including both personal and societal contexts (Terre Blanche et al., 2006). As a member of the community under study, these were my observations over time.

In an attempt to take advantage of the first-hand experience of the subject matter in Participant observation, I chose (a) the “Participant as observer” and (b) “observation only” approaches, depending on the situation (Terre Blanche et al., 2006). In the former, I made my presence and role as a researcher known, and behaved in accordance with accepted custom of the community. I did this to minimise the effects of my presence on the community's usual behaviour and social processes, while resisting being drawn into relationships and patterns of behaviour that were not conducive to my research. In the observation only approach, I merely watched and recorded what happened (Harper, 1994). The death rituals I observed included the period between the arrival of the body at the deceased's house the afternoon before the burial and the ceremony following the burial. I noted the deep emotional pain that the deceased's loved ones experienced, some crying, and the silence and respect showed at that time where everybody stopped what they were doing until the coffin was in the bedroom. I noticed how the overall mood changed in the course of the evening, the night vigil, and the sermon at home the following morning before attending the church burial ceremony. I also observed and noted that when the deceased

was male, a male animal would be slaughtered, and when it was a female, a female animal would be slaughtered.

Even though I am a member of the community under study, I am not part of the elders and also not part of the support group. I was also not necessarily aware of most of the death rituals, and there was no need for me to conceal my lack of experience and knowledge in the setting. Also, in taking advantage of the first-hand experience of the subject matter, I chose to reveal my identity to Participant one during a death ritual ceremony by introducing myself, expressing interest, and requesting more information and clarification regarding the procedure. That helped me to gain access to a setting where I may not have been accepted otherwise, including informal discussions with elders in the community to help clarify the meanings of the events. In keeping the setting as natural as possible, I blended in with the environment, with the purpose of sharing in the daily experiences of the people involved and to minimise the social distance that might have existed between the Participants and myself. This helped me to gain an intimate qualitative understanding of the complex social phenomena from the perspective of the community that the Participants live in (Harper, 1994).

I kept note of ideas that I developed about the phenomenon under study, my reflections on ethical issues for conducting the research, and the points of uncertainty that I needed to clarify as data collection continued. I also noted my behaviour, emotional reactions, thoughts and plans, as they are an important source of data. I minimised the effects of my presence on a community's usual behaviour and social process by becoming one of the crowd in participating in social events, adopted the language and dress of the group, and striking a balance between too much participation and too little (Bryman & Cassell, 2006). This is in line with Harper's (1994) view, which is that Participant observers collect data with more tentative and less detailed hypotheses than in quantitative research. Participant observers take advantage of the first-hand experience of

the subject matter, so as to develop, revise and test hypotheses while learning more about the Participants' setting.

My observations at funerals in the community revealed descriptions of the Participants' behaviours in context, allowing me to identify recurring patterns of Participants' behaviours that might not have been recognised by either the Participants themselves or myself. This provided rich data that included nonverbal and physical behaviour.

### **3.6 ETHICAL ASPECTS**

Ethical considerations are very important in any study (Eide & Kahn, 2008). The protection of the Participants' interest and well-being was a central ethical concern in this study. As the interviews were expected to elicit intense emotional discussions on the death of the Participants' husbands, emotional safety was essential. As a result, provision was made for referrals to relevant health professionals should Participants experience emotional difficulties.

Qualitative data, by its nature, is highly accessible. It consists of verbal descriptions which can be easily be read by anyone (Flick, Kardoff & Steinke, 2001). It is therefore important to maintain the confidentiality of the source of data and the anonymity of the Participants. This requires that all records be such that there is no possibility that the source of the information can ever be identified. This makes confidentiality and anonymity important requirements for credible research (Flick et al., 2001).

Confidentiality and anonymity of the interviews of the Participants was maintained throughout the study. The Participants gave permission to tape record the interviews. To achieve this, the researcher communicated clearly and

directly the confidentiality of the interviews to the Participants in an attempt to reassure them, and tape-recorded data was kept in a safe place (Bryman & Cassell, 2006). This was important, as some Participants would not willingly express their most private details, opinions and emotions knowing that their identity would be published. In some cases, the researcher further concealed the Participants' personal details where necessary, without distorting the important elements of the data, to ensure that Participants could not be identified from their responses quoted in the presentation of the findings.

The identifying information of the Participants was removed from the data as soon as it was no longer necessary. The cassettes used for tape-recording the interviews were destroyed on completion of the study. The Participants were also assured that the tapes would be labelled anonymously, using numbers. Their names were also replaced by with randomly chosen letters of the alphabet. The brief and general biographies of the Participants are reported in such a manner that confidentiality was maintained.

### **3.7 DATA ANALYSIS**

The data analysis process of this study was based on Miles and Huberman's (1994) method with other sources providing additional detail. The process started with managing the data, which is discussed next.

#### **3.7.1 Data management**

The tape-recorded collected data were transcribed verbatim. Interview transcripts were used to arrive at a contextual understanding so as to reconstruct for the reader the emotional journeys undertaken by the Participants. As interviews were conducted in Sotho, Tswana and Zulu, they were translated into English

during transcription because this thesis is written in English and also to make them accessible to more readers.

In addition to the verbatim transcriptions of the raw data, I included descriptions of the Participants' characteristics, enthusiasm, body language and the overall mood during the interview. The transcription method was used to prepare the material from the interview for analysis (Bryman, 2006a; Terre Blanche et al., 2006). Quotes were extracted and rendered in a written style and linked to the text they were related to with a clarification of the context of the quotes. The collected data were in written up transcriptions of interviews, and included notes made during Participant observation as well as notes made subsequent to the interviews. The notes of the interviews were used to recall the comments that were garbled or unclear on the tape for detailed comparison with the transcriptions.

Miles and Huberman's (1994) data reduction, data display, conclusion and verification then followed. The qualitative interviews and their transcripts used in this study produced a large volume of material, which needed to be condensed, categorised, interpreted and made meaningful. For this reason, the Miles and Huberman method was considered the most appropriate.

### **3.7.2 Data reduction**

According to Miles and Huberman (1994), data reduction is the process of selection, focus, simplification of data. In the process, the data are abstracted and transformed. As too many data were generated in this study for meaningful interpretation, they were condensed during a data reduction process, where sections were highlighted with a marker pen, and a list of codes generated. The



meaningfully reduced data were then transformed and organised to help make sense of the subject matter.

In initiating the data reduction process, data selection focused on distilling the different experiences expressed by different Participants. The differences and similarities between personal observations, informal discussions and data collected from the interviews were then set out without diluting the richness of the data. Specific content of the Participants' views was explored, while taking note of the relative frequency with which the different issues were raised, including the intensity with which they were expressed (Miles & Huberman, 1994).

These aspects of the reduced data were meaningfully categorised with the main objective of avoiding a large volume of unassimilated and uncategorised data, using a combination of deductive and inductive analysis. While shaping the initial categorisation it was important for me to remain open to new information so as to induce new meanings from the available data. In this way I arrived at a preliminary understanding of the meaning of the data by the time the data analysis commenced. The data were analysed by taking all the material and immersing myself again in it, working with interview scripts and field notes. By the time I had finished, I knew the data well enough to know more or less what could be found where, what sorts of interpretation were likely to be supported by the data and what would not to be supported (Terre Blanche et al, 2006).

In a qualitative study, there is no clear point when data collection stops and analysis begins; rather, the one gradually fades into the other (Terre Blanche et al., 2006). As a result, I stayed close to the data to interpret it from a position of empathic understanding and to place real life events and phenomena into perspective. This is possible as qualitative analysis deals in words and is guided by few universal rules and standardised procedures (Terre Blanche et al., 2006).

In this study, data were analysed before the data collection had been completed, applying the “principle of interaction between data and analysis” (Erlandson, Harris, Skipper & Allen, 1993, p. 114). This occurred especially in situations where analysis of the Participants’ statements occurred during the interview itself (Holstein & Gubrium, 1995; Shaw, 1999). The qualitative modes of analysis provided ways of discerning, examining, comparing and contrasting, and interpreting meaningful patterns or themes. Data were analysed and synthesised from different angles to achieve meaningfulness through a systematic and intensely disciplined qualitative analysis. Through a loop-like pattern of multiple revisits of the data, additional questions emerged, new connections unearthed, and more complex formulations developed with a deepening understanding of the subject matter (Terre Blanche et al., 2006).

Throughout the course of analysis, the patterns and common themes emerged. During the process, the data were repeatedly revisited to redefine and regroup categories until the results reached stability. How the patterns, themes and emerging stories helped illuminate the broad question of study was examined. Deviations from these patterns and any factors that might explain the typical responses were noted. The broad study question needed revision where the emerged patterns or findings suggested additional data that needed to be collected (Terre Blanche et al., 2006).

Patton (1990) states that each qualitative study is unique, which suggests a unique analytical approach. The human factor was both the greatest strength and fundamental weakness of this qualitative inquiry and analysis because the inquiry depends at every stage on the skills, training, insights, and capabilities of the researcher, so that the findings ultimately depend on the analytic intellect and style of the researcher (Miles & Huberman, 1994).

Data were further broken down into labelled meaningful pieces or codes, so that the bits of coded material could later be clustered together under the code heading. The coded headings were further analysed both as a cluster and in relation to other clusters. This suggested a blend of thematising and coding between categories. This process helped to break up the sequence so that different events and remarks could be associated, and parts of the text that appear to belong together could be carefully compared (Terre Blanche et al., 2006).

In comparing parts of the text that appeared to belong together, implicit assumptions were recognised and addressed. The answers relied on a combination of observations during interviews, transcriptions, the researcher's observations of society, and theory. Miles and Huberman (1994) state that researcher's ability to listen for and be receptive to the unexpected differing patterns of interconnection in data lead to the discovery and manipulation of those informative patterns that might have presented fresh analytic insights or challenges for further elaboration and verification of an evolving conclusion.

Sub-issues and themes surfaced during this phase, capturing the finer nuances of meaning that were not captured originally. This process was repeated until no further significant new insights appeared to emerge (Terre Blanche et al., 2006). The interpretation of the Participants' experiences and how they coped with them were combined in a written account, using thematic categories from analysis as sub-headings. In the process, ambiguous points and contradictions were included in the interpretation, instances of over-interpretation, including researcher's prejudices (Terre Blanche et al., 2006).

### **3.7.3 Data display**

Data display went a step beyond data reduction, with the purpose of providing an organised and compressed assembly of information that allowed conclusions to be drawn. This helped to extrapolate enough data so as to start discerning systematic patterns and interrelationships (Miles & Huberman, 1994). At this stage, additional higher order categories and themes arose naturally from the data that went beyond those discovered in the data reduction stage, which at the same time had a bearing on the research question (Terre Blanche et al., 2006).

In this study, all Participants went through the bereavement process. However, their experiences because of personal characteristics, culture and demographics, relationship with family members, attachment style, and support structure. As a result, patterns of interrelationships between Participants' data were discerned to determine the differences and similarities. Themes and sub-themes generated were displayed in tabular format and described (see the section on drawing conclusion and verification below). A model of the cognitive-affective-behavioural network of bereavement was developed based on the findings, literature and theory and is set out in chapter 5.

### **3.7.4 Drawing conclusions and verification**

According to Miles and Huberman (1994), the meanings emerging from the data need to be tested for their plausibility, sturdiness and confirmability. The meaning of the analysed data and the assessment of its implications for the research question were considered in the conclusion drawing stage. This stage was a way of arranging and thinking about the textually embedded data. As verification is integrally linked to drawing conclusions, it involved revisiting the data as many

times as necessary to verify the emergent conclusions. Attention was given to the stability and credibility of the results (Miles & Huberman, 1994).

Data were systematically examined and re-examined to generate meaning. Themes that had a bearing on the research question arose from the data. These themes were induced to infer general rules or classes from specific instances. Terre Blanche et al. (2006) advise that the researcher reads through her texts many times over in an attempt to try and work out the organising principles, which naturally underlie the material. Tactics like identifying patterns and themes, clustering cases, making contrasts and comparisons, partitioning variables, and subsuming particulars in the general were employed simultaneously and iteratively. Themes were rearranged for a smaller number of the main themes, with several sub-themes under each. Broader overarching themes were used to incorporate sub-themes (Miles & Huberman, 1994).

In summary, it is quite clear that analysis is not just the end product but also the repertoire of processes used to arrive at a particular stage (Kvale, 1996). This relates to the researcher's skilful, artful and persuasive way of crafting an argument, how and why she drew certain conclusions and on what bases she excluded other possible interpretations. It also includes how logical the analysis is and how it makes sense in relation to the study's objectives and the presented data (Terre Blanche et al., 2006).

### **3.8 CONSISTENCY AND INTEGRITY OF THE STUDY**

The consistency and integrity of the data analysis and interpretation is important in qualitative research (Kvale, 1996). The way in which the trustworthiness of the data was established in this study discussed in the sections that follow.

### **3.8.1 Trustworthiness**

According to Lincoln and Guba (1985), the notion of trustworthiness of the data ensures the quality of data in qualitative evaluation in four different ways, namely, credibility, transferability, dependability and confirmability. In this study, the trustworthiness of the data was crucial so that the evaluation report could effectively communicate research findings. As a result, trustworthiness was enhanced in different ways.

#### **3.8.1.1 Credibility**

Credibility is analogous to internal validity. It relates to the way the researcher co-constructs the generated knowledge and the views the Participants express in the process of the inquiry (Guba & Lincoln, 1989). Credibility involves a correspondence between the way in which the Participants perceive certain issues, and the way in which the researcher portrays their viewpoints (Guba & Lincoln, 1989). Stable, trustworthy and credible knowledge is initiated during the establishment of the relationship between the researcher and the Participants.

In this study, the purpose of the study was explained to the Participants and their cooperation was sought. In this sense, credibility was more personal and interpersonal than methodological (Reason & Rowan, 1981). Prolonged engagement also enhanced credibility. This refers to "the investment of enough time to achieve certain purposes, for example, learning the culture of the participants, testing for misinformation introduced by distortions either of the researcher or of the participants, and building trust" (Lincoln & Guba, 1985, p. 301).

The Participants were seen as individuals in their own right, and their uniqueness was respected. Through frankness and honesty, I endeavoured to establish a position of trust with the Participants, and I attempted to create a climate of freedom so that the Participants could express their true feelings and opinions without fear of disapproval. A relationship of mutual respect was established to facilitate the revelation of information.

To further establish credibility, *peer debriefing* was used. Peer debriefing is the process of "allowing a peer who is a professional outside the context and who has some general understanding of the study to analyse, test working hypotheses and emerging designs, and listen to the researcher's ideas and concerns" (Erlandson et al., 1993, p. 140). In this study, the researcher's initial promoter (Prof. Johan Schoeman) served as a peer who challenged the researcher's thoughts and experiences where necessary. The research process, research situation and context were also described in detail so that the reader may ascertain if and to what extent the research results are trustworthy and credible.

### **3.8.1.2 Transferability**

Transferability, as one of the elements of trustworthiness, refers to the possibility that what was found in one context by a piece of qualitative research is applicable to another context (Lincoln & Guba, 1985). In the present study, this was accounted for through Miles and Huberman's data analysis process, and depended on the presentation of solid descriptive data to improve analysis (Patton, 1990). Transferability was confirmed through Participant observation and talking to people in the community.

### **3.8.1.3 Dependability**

According to Guba and Lincoln (1989), dependability is the equivalent of the term “reliability” which, in quantitative research terms, means that the same tests should produce the same results across testing situations. In qualitative research terms, this is impossible to realise because of the flexibility of the research design, and the production of research findings by constant changes in interactions between the researcher and Participants. Each researcher interprets differently with different conclusions. Guba and Lincoln (1989) consider these changes to be an indication of a maturing and successful inquiry in qualitative research. The researcher established dependability by consistently examining the research process as it occurred.

### **3.8.1.4 Confirmability**

Confirmability is the equivalent of objectivity, which is concerned with establishing that the data and interpretations of an inquiry were not just figments of the researcher's imagination (Schwandt, 1997). To address the truth-value, confirmability and consistency of the results, the Participants' first-hand experience of their life-world formed the focus, rather than speculative explanations of it.

According to Miles and Huberman (1994), the meanings emerging from the data need to be tested for their plausibility, sturdiness and confirmability. Analytic confirmability in this study encompassed a broader concern of whether the conclusions drawn were credible, defensible, warranted and able to withstand alternative explanations. Confirmability was achieved by trying to determine the extent to which Participants' experiences reflected trends in the broader society (Schwandt, 1997).



Lincoln and Guba (1985) suggest that confirmability and dependability can be determined through one properly managed audit, and are realised by similar techniques in qualitative research, for example, through auditing by the research supervisor. According to Schwandt (1997, p.6), this is "a procedure whereby a third party examiner systematically reviews the audit trail maintained by the inquirer". In this study, the audit trail included recorded materials such as cassette tapes, interview transcripts, details of Participants, notes about research procedures, interviews and discussions. The researcher's initial promoter served as the auditor for this study, reviewing the data, methodology and analysis process for consistency and applicability, and making suggestions for changes and improvements. Suggested reconsiderations were negotiated until agreement was reached on the consistency and applicability of the process.

However, reanalysis through auditing may invade the Participants' privacy with the potential of harming them (Miles & Huberman, 1994). This was avoided by removing any identifying information about the Participants before discussing the data with the auditor.

As a member of the community under study, I also examined my own background to contribute to the study without imposing my beliefs to the study. This was done through applying reflexivity, which is discussed in the section that follows.

### **3.9 REFLEXIVITY**

Ellingson (1998) states that reflexivity refers to the researcher's awareness of self in relation to the research process, which, according to May (1998), is a process of self-examination. The fact that qualitative researchers use themselves as research instruments for both data collection and analysis makes qualitative

research evaluations contingent on the subjectivity of the researcher (May, 1998). This then makes it important to cultivate reflexivity, and to document personal reflections (Ellingson, 1998). In this way, qualitative methods account for themselves to satisfy the demands of scientific method (May, 1998). Later in this section some personal reflections are presented. My subjectivity is checked by confirming my experiences and knowledge of both traditional and transitional African ways of dealing with death and its rituals with some elders of the community under study. Furthermore, I attempted to remain focused on the Participants' first-hand experience of their life-world as it was without imposing my own experiences and beliefs on the data.

Reflexivity has two dimensions, namely, endogenous and referential (May, 1998). Endogenous reflexivity is the examination of the processes by which communities constitute their social reality. For example, this would examine how the experiences of the widows are constructed within the broader community. This is based on Garfinkel's (1967) argument that actions and statements within any field can only be fully understood from within the context that they were produced.

Referential reflexivity, according to Bourdieu (1988), is the study of the relations between the researcher and the researched. The problem of referential reflexivity is that communities have their own ontological structures of great subtlety and sophistication and that they are often not sufficiently appreciated (Worsley, 1997). Also, it is not just the immediate relations between the researcher and the researched that must be brought into question, but much deeper questions of cultural and class affiliation should be considered if findings are to be more accountable and accessible, culturally specific, and open to local evaluation (Harding, 1991). Researchers therefore run the risk of imposing ontological structures arbitrarily from their own already dominant culture.

I applied a reflexive approach to help me to avoid the illusion that I did not have illusions (Bourdieu, 1988). In fact, awareness of reflexivity offered the possibility that, in unveiling the determinants surrounding the research, I acquired a relative freedom from such determinants (Bourdieu, 1996). It also made methodologies more transparent and accountable.

To achieve this, emphasis was placed on developing stable, trustworthy and credible knowledge (see also section 3.4.9) during the establishment of the researcher-Participant relationship. Achieving a relationship of mutual confidence and respect also facilitated information sharing. For example, the purpose of the study was explained to the Participant and co-operation was requested to make credibility personal and interpersonal. Potentially speculative explanations of the Participants' first-hand experience were systematically challenged by the study's promoter where necessary for extensive periods of time, questioning the researcher's views with the idea of generating understanding of the meaning of data and so enhancing the stability and credibility of the data. My own background and experiences, as the third data source, were examined with the purpose of determining how this could influence the interpretation of data.

During the data collection phase, I developed excessive high blood pressure, and I felt threatened by my health problems. Reflecting on my experience helped me gain a better understanding of people who are seriously ill. My experience helped me to understand what the dying partner of the women I interviewed might have gone through. For example, seeing his family doing their best to make him feel comfortable might have made the husband feel simultaneously guilty for causing his family trouble and yet appreciative of their care. However, none of the Participants of this study expressed feelings of resentment towards their husbands for the burden of care they may have carried. This may be because the interviews were conducted some time after the death of the husbands and as such, the Participants may have been focusing more on their current emotions.

### **3.10 CONCLUSION**

This chapter introduced and made explicit the assumptions underpinning the research design. The chosen methodology, qualitative research, was reconciled with the theoretical framework of cognitive psychology, which tends to favour quantitative methods. The selection of the 10 Participants using purposive sampling was described. Data collection methods included in-depth interviews (unstructured and semi-structured) and Participant observations. Miles and Huberman's data analysis process includes data management, data reduction, data display and conclusion drawing and verification. The ethical issues of the protection of the Participants' interest and well-being, maintaining the confidentiality of the source of data and the anonymity of the Participants, and concealing the Participants' personal details and identifying information were addressed. Ways of ensuring the consistency and integrity of the data were discussed, included credibility, transferability, dependability and confirmability.

The chapter that follows presents the description of the Participants and the themes generated from the data analysis.

## CHAPTER 4

### PRESENTATION OF THE FINDINGS

#### 4.1 INTRODUCTION

As shown in the literature chapter the experience of the loss of a loved one depends on the perception and interpretation of the loss by those who experience it. The couple subsystem, as part of the family system within which it functions, was the focus of the analysis of data and presentation of the findings of this study.

The chapter starts with a description of the Participants based on their biographical background. Four themes were identified from the analysis and are presented with sub-themes and direct quotations from the interview transcripts in the sections that follow. The four themes that were identified are: the widows' experiences of stressors; personal characteristics; the Participants' challenges and how they dealt with them; and coping. These themes will give the reader a better understanding of the Participants' challenges regarding their husbands' conditions and what was to come (anticipatory bereavement). The chapter also describes how the widows experienced their bereavement and their different coping styles, both in the time prior to the bereavement and following their loss.

The following section describes the Participants of the study.

## 4.2 DESCRIPTION OF PARTICIPANTS

Ten Participants were interviewed for this study. The Participants are described in terms of the following biographical characteristics: age, level of education (Participants), level of education (husbands of the Participants), duration of marriage, diagnosis, duration of illness, mode of death, and duration of widowhood. The widows who participated in the study were all from Soweto in Johannesburg, and belonged to the widows' forum, which was established by one of the Participants (Participant one). Their ages ranged between 45 and 55 years. The level of education of the Participants and their husbands is included as a context to explore how education may have played a role in how the Participants experienced bereavement. All the Participants were married in the Western legal system.

Most of the Participants' husbands died of socially acceptable illnesses such as heart problems, cancer. Participant four's husband died of tuberculosis. Only one Participant (Participant nine) admitted that her husband died of an AIDS-related illness. It was not possible to recruit more Participants whose husbands had died of AIDS-related illnesses as people are reluctant to disclose their or their loved ones' HIV status. Table 4.1 below summarises the Participants' different contexts based on their developmental stages. The reasons for including the Participants' age, level of education and duration of marriage are that older Participants might have perceived their challenges differently from the younger ones; the couple's level of education could have affected the intensity of the challenges facing the couple; and the duration of the marriage could have had an impact on the anticipation of what was to come.

Table 4.1 Description of the Participants



Participant	Age (years)	Level of Education* (Participants)	Level of Education* (Husband)	Duration of Marriage (Years)	Diagnosis	Duration of Illness	Possible Mode of Death	Duration of Widowhood (Months)
1	Estimated 55	Tertiary education (nurse)	Tertiary education (teacher)	20	Cardiomyopic	14-18 years	Heart failure	18
2	50	Tertiary education (teacher)	High school level with no Matric	25	Cardiovascular disease	5 years	Heart failure	16
3	45	Primary education	Tertiary education (middle adulthood)	+20	Cardiovascular disease	Not mentioned	Heart failure	8
4	46	High school level with no Matric	High school level with no Matric	14	Tuberculosis	18 months	Tuberculosis	8
5	Not mentioned	Tertiary education (nurse)	High school level with no Matric	15	High blood pressure and diabetes	3 years	Heart failure	12
6	45	High school level with no Matric	High school level with no Matric	15	High blood pressure and diabetes	10 years	Heart failure	12
7	47	High school level with no Matric	High school level with no Matric	30	High blood pressure and diabetes	5 years	Heart failure	15
8	55	Tertiary education (nurse)	Tertiary education (Senior executive)	20	Tumour of the spine	2 months	Cancer	16
9	45	Primary education	Primary education	20	HIV/AIDS	2 months	AIDS-related illnesses	6
10	45	Primary education	High school level with no Matric	18	Cancer of the throat	1 month	Cancer	15

\* Matric as an education level refers to the final year of formal schooling in the South African education system

### 4.3 THEMES

The table below provides a summary of the four themes and their sub-themes. This provides an overview of the analysis scheme prior to a reading of the detailed description of each theme. In the case of theme 1, sub-theme 1.1 three additional themes were evident (referred to as sub-sub-themes).

Table 4.2 Summary of themes and sub-themes

Themes	Sub-themes	Sub-sub-themes
<b>1. Personal characteristics</b>	1.1 The nature of the couples' relationships before and during the illness 1.2 The couples' knowledge and understanding of the illness 1.3 The different roles played by the Participants and their husbands 1.4 Strengths and vulnerabilities	1.1.1 Patterns of communication and cooperation 1.1.2 Perceptions and attributions
<b>2. The Participants' challenges and how they dealt with them</b>	2.1 Past significant losses in the widows' lives 2.2 Stressors 2.3 Caring and treatment regimen of the dying husbands 2.4 The attitudes towards and responses to the illnesses and its ramifications	2.3.1 Non-compliance and other unique challenges
<b>3. The Participants' experiences of stressors</b>	3.1 Physical symptoms 3.2 The widows' response to the news of their husbands' deaths 3.3 Response of the widows' in-laws to the widows	



	3.4 Emotions experienced	
<b>4. Coping</b>	4.1 The couples' resources 4.2 The Participants' approaches to their challenges 4.3 The Participants' coping styles 4.4 Participation in African death rituals	

Direct quotations from the interviews are included to illustrate the researcher's interpretation while attempting to keep a balance between the quotes and the text (Kvale, 1996).

#### **4.3.1 Theme 1: Personal characteristics**

A description of the personal characteristics of the Participants and their husbands is based on the nature of the couples' relationships before and during the illness. The relationships are based on the couples' patterns of communication; perceptions and attributions; and strengths and vulnerabilities. The Participants' previous losses of significant others are also presented.

##### **4.3.1.1 Sub-theme 1: The nature of the couples' relationships before and during the illness**

In this theme, the couples' patterns of communication and cooperation, perceptions and attributions, and strengths and vulnerabilities are presented to promote a clear understanding of the nature of the Participants' relationships before and during the illness.

#### 4.3.1.1.1 Patterns of communication and cooperation

Some couples seemed to have had open and healthy patterns of communication. There were, however, differences amongst some of the couples. Those couples with healthy patterns of communication were open, clear and direct with each other, encouraging cooperation. This was evident with Participant couples one, two, six, nine and ten.

Participant couple one, for instance, prayed together, and was also able to talk about the anticipated death. As the widow said, “Even when he was about to pass on we were able to talk about his death. He would tell me that he realised that he had reached the end of the road.” Participant two experienced her relationship with her husband as open as, according to her, they realised that they only had each other and, as a result, appreciated each other. According to Participant two, “We were very close.” Also, “He used to tell me at the hospital that our late son always talked to him, and promised to come and fetch him.”

Participant six’s dying husband would communicate his wishes to the Participant, expressing a wish that when he passes away he would like her to put on black clothes. Participant nine’s dying husband would also share his wishes with the Participant, and she reports, “He asked me to sell it (his flock) all after his death, and move from the Eastern Cape where we had a house with the children to the Vaal area because he did not trust his family of origin and would not be there to protect us.” He felt that his wife and children needed protection from his family’s potential claims on his assets.

Participant ten appreciated the close relationship with her husband that was characterised by respect. She related how, when they disagreed, he would try to show her his point of view with respect. However, when he went to the hospital

for the last time, he asked their elderly neighbours to look after the Participant and his children, but did not communicate this to her.

Participants four, three and seven couples' patterns of communication came across as indirect, which unfortunately created misunderstandings at times. For example, Participant four failed to understand her husband when he told her sister and not her that he was going back home where he came from, meaning that he was going to die. Participant seven's dying husband once told the Participant that on the day he dies, he did not want to bother anyone, and would just go into a deep sleep. The widow did not seem to comprehend what her husband was communicating.

Participant three also did not comprehend the message behind her husband's comment about the short week ahead. Regarding that he said to her, "On Monday when I was about to go to work, he said to me that it was surprising how short life can be, especially the coming week because he had to go. I left like that, and round about two o'clock that day I got a call that he was admitted to hospital, but I did not believe it. He passed away the next day."

Couple five had a partially open pattern of communication. According to Participant five, her husband was scared of death because every time she suggested that they should draft a will, he would refuse, and walk away. At times he would share his wishes with the Participant, asking her that if he died before her she should erect the tombstone on the day of the funeral.

Participant couple eight used sensitivity as a way of avoiding to share their feelings about the anticipated death, which the dying husband was aware of as his doctor had confirmed it. That was evident when he was given a weekend pass from the hospital to be with his family for the last time, and did not

communicate the reasons behind his visit, which was the last before his death. According to Participant eight, “All that he said was that he would be given weekends home until he got better and discharged.” Also, “On our way home, we stopped at a petrol station, and I started crying. He was not sure what was wrong with me and I explained it by telling him that I was crying because my sister was also sick and I could not take it any longer.” There were, however, wishes that were shared, probably before the illness took hold of their lives. For example, he shared a number of wishes where he stated that he did not want her to put on black clothes, did not want the furniture in his house to be moved around when he had passed on, and did not want the windows of his house to be ashed and made dirty.

There was a difference between Participant couples two and eight regarding sensitivity. Participant couple two used sensitivity to save each other the pain and panic of the anticipated death. The Participant said the following: “I would sometimes ask him where the problem was and he would just tell me that it’s not that bad but I could tell that he was suffering. He didn’t want to worry me. Instead, he would joke about his illness.”

Couple nine’s pattern of communication was complicated by the conflict between them as a couple and between them and the husband’s family of origin. The couple did not see each other for four years, during which the husband did not return home for the summer holidays as he had previously used to. They were, however, open in their communication, probably because the widow was aware that they did not have much time together.

#### 4.3.1.1.2 Perceptions and attributions

The Participants had different perceptions and attributions about their husbands' anticipated deaths. When Participant three's husband did not involve her in his illness, she attributed that to his usual way of distancing himself from her. She perceived him as not part of the family. As a result, she said that she found it difficult to be there for him when he needed her but, according to her, she had no choice.

Participant four perceived her environment as supportive, attributing that to the good relationship the couple had with people in their surrounding environment. She illustrated this by saying, "Those (the relatives that helped her with the burial of her husband) were the people who lived with us and knew Pat for his goodness. They bought him the coffin."

Participant one attributed her lack of support from her in-laws to the misinterpretation of her situation and long-standing conflicts between her and them. She said, "...they just thought that I have money and I'm working. Nobody helped me with that shop except my children and other children that I brought up."

Participant two may have attributed the struggle to deal with her husband's death to the repeated sense of abandonment she experienced in her life when she lost males she was close to. This included the loss of her father at an early age, her son, and subsequently also her husband.

Participant five perceived her sister-in-law's negative behaviour towards her as spite, letting her brother drink as much as he did without eating any food.

Participant six perceived her in-laws as discriminating against her husband as,

according to her, “When I joined my husband at his mother’s house, I came to realise that he alone had been providing for his mother and brother’s family, when both the brother and his wife were employed. Despite all of that, they would not give him food.” As a result, she perceived herself as being the only person her husband could rely on.

Participant seven attributed the deterioration of her dying husband’s condition to his stubbornness and irresponsibility, perceiving it as his way of wanting to stay away from work. Participant eight attributed her challenges of not dealing effectively with the death of her husband to the fact that she stayed home after his death for too long, with his memories around her. As a result, she decided to go back to work to avoid those memories. For example, “Mind you, I stayed home for six weeks. I really wanted to go back to work because at home I used to struggle because I would smell my husband’s body smell and all the things that would be reminding me that he is no more.”

Participant nine perceived some of the people around her to be dishonest. This was illustrated by her saying, “I even thought that maybe they also saw me as infected with HIV but could not ask me.” She attributed this to the perception that people in her social environment believed whatever her mother in-law was telling them. She also attributed her sister in-law’s behaviour to her belief in witchcraft. Participant ten perceived her in-laws as unsupportive and as a result, did not expect much support from them.

#### **4.3.1.2 Sub-theme 2: The couples’ knowledge and understanding of the illness**

The Participants’ knowledge and understanding of their husbands’ illnesses is explored in this sub-theme to determine how they interpreted their dying husbands’ conditions, what it meant to them, and how they dealt with it.

Participants one, two, five and eight had tertiary education, Participants one, five and eight were professional nurses, and Participant two was a teacher.

The nurses tended to talk in medical terms when they explained their husbands' conditions, reflecting their level of knowledge and understanding of the illnesses. Participant one, for example, knew and understood her husband's condition to be cardio-myopic, explaining it as the enlargement of the heart. Participant five talked about seeing concentrated glucose in the toilet bowl, which she knew and understood to be a bad sign of her husband's high insulin level. Participant eight knew and understood her husband's condition as cancer where the primary lesion was the lung. He also had a kind of pneumonia that she found unusual because, according to her, that kind of pneumonia is only found in birds. Participant eight further showed her knowledge and understanding of her husband's condition by saying, "What scared me was the location of the tumour."

Although Participant six did not have any tertiary education, she knew and understood her husband's condition to a certain extent, as she attributed the cause of her husband's condition to heredity. She showed her need to know and understand by saying, "He would have gout but when he went to the doctors he would be told that it was not that. As a result, we concluded that he inherited his illness from his mother because she had the same problem."

While some Participants knew of their husbands' conditions, they did not always understand them. Some of the Participants understood that their husband's lifestyles contributed to the condition, while some were neither familiar with nor understood their husbands' conditions. Participant three knew about her husband's condition but did not understand its implications. According to her, she only knew that her husband had a heart problem, and although he was in and out of hospital, he continued working. Participant seven understood the appropriate

diet for her husband's condition although it was unclear if she understood the reasons for this, as she made no mention of his diagnosis. All that she knew was that her husband was in pain and would vomit. His legs would swell and he would not be able to urinate properly.

Although Participant ten came to know about her husband's condition towards the end of his life, she did not seem to understand it. Regarding her husband's condition she said, "He went to consult with a general practitioner because he could not swallow and had to drink water to help the food go down his throat." Participant four had no understanding and no knowledge of her husband's condition as she said, "When he first got sick, we were told that he was suffering from tuberculosis. He did get better and started getting sick again. I don't know why because he lacked appetite and complained about his aching body. We ended up not knowing because he also complained about chest pains."

#### **4.3.1.3 Sub-theme 3: The different roles played by the Participants and their husbands individually**

After the death of her husband, Participant four became the provider for her children, selling clothes to make a living. She said, "I am now selling stuff to make money for my children and not the house that should have been paid off." Participant ten's husband was retrenched prior to his illness. After the death of her husband, her roles included being the sole provider and caregiver for her mentally disabled children.

The husbands of Participants six, seven, eight and nine were still employed at the time of their death, and as such, were providers for their families until their death. However, the husbands of Participants six and seven wanted to retire because of ill health. Participant six illustrated her husband's reluctance to continue working by saying, "Despite all of that, he was still able to go to work



even though he then wanted to retire because of ill health.” After the death of her husband, her roles included providing for her children, and continuing to be there for them. After the death of Participant seven’s husband, her role was to provide for herself, as her two daughters were already financially independent. As Participants one, two, three, five, seven and eight were employed; they spent most of their time away from home and their sick husbands.

For a short time before their death, the husbands of Participants eight and nine were on sick leave. Before they died, the couples’ roles remained the same. Participant eight continued working and looking after her daughters as her husband provided financially for the family. After his death, she became the sole provider of her one child as the other daughter was already married by then. Participant couple nine’s roles also remained the same, where the Participant looked after the well being of the family, and her husband provided financially for the family. After the death of her husband, she did not have to assume economic responsibility for her children because her late husband had provided for them after his death, which was also the case with Participant eight.

The husbands of Participants one, two, four, five and ten were unemployed when they died. Participant three’s role did not change as she had always been the sole provider for her children, while her husband had cared only for himself.

In summary, those Participants who were employed, and those whose husbands were on sick leave at the time of their deaths, did not experience as much change in providing for their families as their husbands had made provision for them after their death.

#### 4.3.1.4 Sub-theme 4: Strengths and vulnerabilities

There were a number of couples whose strengths were based on team spirit between them as partners. The couples' strengths were shown in different ways. Participant couple one's strength was the awareness and understanding of the dying husband's condition and, as a result, his anticipated death. Regarding this, Participant one said, "One day at home we started talking about his death and he expressed his wishes." However, no vulnerabilities were shared with the researcher.

Participant couple two's strength was the close relationship they had, relying on each other for support and as a result, working together as a team. Their vulnerability was the loss of their son two years before the dying husband passed away. In this situation, the husband became sick before the son, and the wife expected to lose her husband first, and not her son (see section 4.3.1.2).

Participant couple four's strength was their interdependent relationship: the widow was dependent on her husband financially as she was unemployed and her husband depended on her emotionally as he had a distant relationship with his family. Participant couple five's strength was that while the dying husband was unemployed, the Participant was employed and so they could manage financially. Their vulnerability was the dying husband's failure to deal with his sister's interference in the couple's relationship.

Participant couple six's strength was that the dying husband was still employed with a long service record with his employer. As a result, he received moral support from his employer and so the family not experience financial problems. The couple's two main vulnerabilities were the inability of the Participant's husband to open up to her, and his non-compliance with his treatment regimen.

Participant couple seven's strength was that the dying husband remained employed (she was unemployed), and that their two grown daughters were living independently on not reliant on them for support. However, this last strength also became the Participant's vulnerability, as she found herself alone at home before and after her husband's death, and felt unsafe. The couple's other vulnerability was the husband's refusal to comply with his treatment regimen.

The strengths of Participant couple eight and ten was the fact that their husbands were diagnosed at a late stage of their illnesses and the Participants did not have to go through the difficult process of caring for the dying husband as much as the other widows interviewed. However, this may also have been the couple's vulnerability as they did not experience anticipatory bereavement and the couple did not get an opportunity to come to terms with the husband's anticipated death. Participant couple ten's strength was their close relationship, but vulnerability was the fact that they were sick at the same time.

Participant couple nine's strength was the realisation of the short time they had left before the death of the husband. Her husband got an opportunity to share with her his wish that she and the children could move as far away from his family as possible. Their vulnerability was the fact that as a couple, they had lived apart all of their married life: in the twenty years that they had been married, the husband only came home for the Christmas holidays. The couple's other vulnerability was the widow's in-law's interference, which prevented her from caring for her sick husband.

In Participant couple three's situation, the death of the husband did not seem to make a great financial impact on the widow, as she had always provided for the family. This could have functioned both as strength and vulnerability, as it left the widow financially secure, but feeling bitter and angry with the deceased.

In conclusion, common vulnerabilities were lack of financial security, non-compliance with medical treatment and interference by the widows' in-laws. Common strengths were the open nature of some of the couples' relationships and the Participants' financial independence. In situations where the husbands were diagnosed late in their illness, the couples did not experience the challenges of nursing as much as those whose illnesses were diagnosed early; however, this meant that they also did not experience anticipatory bereavement.

The next section focuses on how the Participants dealt with their challenges.

### **4.3.2 Theme 2: The Participants' challenges and how they dealt with them**

#### **4.3.2.1 Sub-theme 1: Past significant losses in the widows' lives**

Participants one, three, five, seven, eight and ten were already married and not staying with their families of origin when their parents passed away. It was not clear if Participant four lost her father before or after her marriage. Participant two lost both her parents at an early age. According to her, "I lost my father at a very young age, and we were very close. I was still at primary school. My mother passed away when I was in Standard five (about age twelve)." She also lost a nephew and a son two years before the death of her husband. At the time of the interview, she was still struggling to deal with her son's death. There was no mention of any past significant losses by Participants six and nine.

#### **4.3.2.2 Sub-theme 2: Stressors**

The stressors physically affected the widows in more or less the same way. Some Participants did not report any physical experiences, which may have been because they were taking medication, which would target the symptoms. These

physical experiences are discussed in more detail in the section that follows. Particular stressors experienced by Participants included previous losses of significant others through death, conflict with in-laws, financial problems, providing emotional support to children and dealing with society's reaction to the husbands' deaths. Some of these stressors are described in depth in sub-themes of this theme as the data allowed a rich description of the Participants' experiences.

Having experienced the loss of significant others in the past became an additional stressor for Participants two and three when their husbands passed away. Participant two had lost a son two years before the loss of her husband. At the time of her husband's death, Participant three was still struggling with the loss of her father whose funeral she did not attend as her mother had divorced her father and they had not been told about his death. Hearing about the death of people she knew also affected Participant four. She said, "Hearing that somebody I know passed away, it really affects me." The impact of multiple losses on the Participants is explored in more detail in a later section.

The bad treatment that Participant four received from her in-laws after the death of her husband was another stressor. She illustrated this by referring to the in-law's fight over her husband's possessions, "furniture and all. In the first place, they wanted Pat to be buried in the Free State so that they could claim everything in his name, including the car." The widow was also bothered and stressed by what had been done to the body of her husband by male elders the morning of the funeral when she and female elders in the room were ordered out. In this regard she said, "What preparation I did not know, and could not ask because all those people were related to him and not me. If it were my relatives, I would have asked because I did not even understand why I, as his wife should also walk out. I was very unhappy with that. What was it, as his wife, I did not know about him? In fact, I should have been the one person who should have

been preparing him. Besides, what was to be prepared that I should not do myself?”

Participant five’s main stressor was her sister in-law’s negative attitude and behaviour towards her, at a time when they should have worked together to help her husband, with both of them being professional nurses. Participants five and seven were stressed by the fact that they had to follow rituals that they were not brought up with. Both these Participants were classified as Coloured by the Apartheid regime and, because of the separation of people during this time, they were not familiar with and did not understand their participation in African death rituals. Participant seven illustrated this by saying, “I do not believe in that.”

Participant four was stressed by the fact that she could not afford to bury her husband in the way she would have wanted to. Another stressor was her in-laws insistence that she wear black clothing, whether she liked it or not. This was confirmed when she said, “They were just being spiteful because even before the day of the funeral, they were busy saying that whether I like it or not I will put them on.”

Other stressors experienced by Participants varied. Participant three was stressed even before her husband’s death by having to provide financially for the family, and feeling unsupported by her husband who she felt was not reciprocating her efforts in their marriage. She said, “Once he recovered he would forget that I exist. He only cared about his car and himself (clothes).” Participant six was stressed by the fact that she had to present a strong face for her children. Participant nine had to deal with the stigma of her husband’s cause of death (HIV/AIDS), and the suspicion of people in her environment that she was infected and living with the disease. She said, for example, “They (the neighbours) never came when my husband was sick. I did not even know how to

respond to them. I did not appreciate their support. People know me to be infected.”

#### **4.3.2.3 Sub-theme 3: Caring and treatment regimen of the dying husbands**

In this study, all of the Participants' sick husbands received adequate medical care because they had access to it, which helped alleviate the problem of caring from the Participants. This also reflects the way of life in transitional societies as opposed to traditional societies where the widows would be expected to care for their dying husbands at home until their death.

The widows had different challenges when it came to caring for their dying husbands. Participants five and six mothered their dying husbands in their caring for them, defining their relationships as mother-son relationships instead of husband-wife relationships. For example, Participant five said, “However, my husband promised that he would never take alcohol again, because his liver was also getting affected.” This could have been a son apologising to his mother. This was also the case with Participant couple six, with the Participant reporting, “He had promised me that he would never ever drink again. When he got into the house, the first thing he said to me was that he could not stop drinking although he tried for weeks and stayed clean. He had even lost his spectacles.” The nature of her caring was reflected when she said, “I would always rub him, sometimes before he got out of bed, and sometimes before he went to bed.”

When Participant seven's husband did not comply with his treatment regimen, the widow gave up and let him continue with the lifestyle that was aggravating his condition. In this regard Participant seven said, “He was the kind of person who would not be persuaded when he had decided to do something.” As a result, she was used to taking him to hospital each time his condition deteriorated.

Although Participant five's husband was not cooperative at times, she was always supportive of him. For example, she related how her sick husband woke up one morning and they brushed their teeth, she poured him a soft drink, and they had breakfast.

Participant two related how her sick husband was admitted to hospital because he was struggling to breathe, and he later died there. She said, "He would usually struggle and would often ask us to take him to the hospital." Participant three, however, resented having to nurse her dying husband as, according to her, nursing him made her feel unappreciated and used. The care of the husbands of Participants eight and nine was totally taken over by the hospital as they were diagnosed towards the end of their lives. As a result, no opinion about their caring could be made.

In conclusion, it seems that the nature of the couples' relationships determined the kind of caring the dying husband received. For example, the closer the couples' relationships, the more caring the Participants were. The nature of the Participants' relationships with their husbands before the actual death also determined, to a certain extent, how the Participants would cope afterwards.

#### **4.3.2.3.1 Non-compliance to the medical treatment and other unique challenges**

Participant nine, whose husband died of an AIDS-related illness, had the additional challenge of dealing with the stigma of the illness. To illustrate her challenge she said, "You know the stigma associated with AIDS is unbelievable and hurting. You won't understand that until you experience it." Participant ten and her husband were both sick and had to take care of each other. According to her, "When my husband died, I was sick. He would take me to hospital when he himself was also sick."



Some Participants had to deal with the issue of their husbands' non-compliance with treatment, making it difficult for them as couples to function as teams. Regarding non-compliance Participant five said, "I then asked his sister to explain to me why, as a nurse, she could let a diabetic keep on taking alcohol without food." Participants six and seven also experienced a similar challenge. Participant six said, "He would talk about death when he was in a happy mood because he was smoking and took alcohol." Participant seven said, "I knew that his condition did not allow him to take alcohol but he insisted and I gave up on persuading him to live a healthy lifestyle." Participant three did not mention anything regarding her sick husband's compliance or non-compliance.

#### **4.3.2.4 Sub-theme 4: The attitudes towards and responses to the illness and its ramifications**

Due to the advanced nature of his illness, the physical deterioration of Participant one's husband might have shaped his considerate response to the Participant as she said, "Then the same night he suggested that it would be better for him to sleep in the room with a male family member because he felt that I should take time out and rest instead of taking him to the bathroom the whole night. I did not mind as long as it made him happy. He felt that he was bothering me."

The couple understood that he was reaching the end of his life and decided to discuss the practicalities thereof. For example, the wife helped him with his spiritual baptismal wishes, as, according to her, "he was desperate to be baptised". She also said, "It was on a Friday when he asked me to pray for him and I told him and reassured him that I always prayed for him. But I also told him to pray for himself. The two of us knelt down and he prayed and when he finished he said Amen."

Participant two's husband became physically weaker over time, although he could still function independently when his wife was away at work. This was illustrated when she said: "It was worse because I expected my husband to die first and not my son." The dying husband did not show any emotional strain.

Participant three had a negative attitude towards her husband and so experienced an ambivalent response to his illness and subsequent death. She reported that she cared for him with mixed feelings, and also missed him after his death.

Participant four's attitude was characterised by confusion. According to her, "When he first got sick, we were told that he was suffering from tuberculosis. He did get better and then started getting ill again. I don't know why because he lacked appetite and complained about his aching body. We ended up not knowing because he also complained about chest pains. He was in and out of hospital for eighteen months."

Participant five made sure that her husband kept to the lifestyle that was most suitable for his condition. Her husband, however, seemed to have been careless about his health, and complied only when the widow insisted. Despite her husband's carelessness, she said, "I also knew that my husband appreciated me". Her husband thanked her for what she did for him in his life when they left the house with his sister to go to the hospital.

When Participant six's husband seemed not to appreciate the implications of his lifestyle on his illness, such as being careless with his diet, the Participant would monitor her husband's health all the time, and was instantly aware of a change in him. She said, "His health was not of the best that day, I cleaned the house and asked him to sit down and watch me clean." She monitored his health to the

extent that she would take responsibility for his compliance with medication. For example, she stated that “He asked me for his tablets, and he sat up on the bed.” Her attitude was also confirmed by this quote, “Tuesday he went to work and later that day it started raining and I was worried that he would get wet and his condition would deteriorate.” Participant seven dealt with her husband’s non-compliance with both acceptance and understanding.

Participant couple eight responded to the illness with consideration for each other. The Participant illustrated this when she said, “Normally he would have insisted (that the widow should not fall asleep) but he did not and did what I was suggesting. He commented about how tired I should be and we must sleep, saying that he would sleep after I had fallen asleep. I immediately fell asleep because I was tired and had to wake up at night to test his insulin. He would wake up at night and want to go to the toilet and it would be then that I would test his insulin. It was cold and he would tuck me in when I thought he was asleep.”

Participant nine’s attitude and response to her dying husband’s condition was that of understanding; and at the same time she wanted them to focus on themselves as a couple as she was aware that they did not have much time left. According to her, “I told him because I believed that with a CD-4-count of seventeen, he did not have much time to live, and we must focus on us as a couple, my future with the children when he had gone, and what he expected me to do for him.” The dying husband needed forgiveness. The widow said, “We would talk and he would ask for forgiveness. How could I not forgive him?”

Participant ten couple was unaware of the seriousness of the dying husband’s condition as he was only diagnosed with a terminal illness a month before his death. According to the widow, “It was cancer. He was only sick for a month. You would not tell that he was sick. He was not aware of it himself.”

Compromise and peacekeeping was a theme in the narratives of Participants. Participant seven agreed to sit on the mattress with her mother-in-law even though she was against it, so as to avoid unnecessary conflicts. Participant three nursed her husband when he got sick as was expected of her by custom. Participant five agreed to drink the boiled water of herbs even though she did not believe in it. She said, “My sister brought me herbs to drink, telling me that people advised her that it was a way of cleansing me internally. She bought them at an Indian shop. I just drank. The taste was horrible. I do everything for peace sake.” Participant six illustrated her compromise by saying, “His two uncles from his father’s side prepared him. For peace sake I agreed to everything.” Participant one also illustrated compromise by saying, “...my grandfather’s daughter told me that I needed to drink herbs. She bought them, gave me instructions and I listened to her but after she left I threw them away.”

### **4.3.3 Theme 3: The Participants’ experiences of stressors**

#### **4.3.3.1 Sub-theme 1: Physical symptoms**

Physical experiences reported by the Participants included headaches, sleeplessness or sleep disturbances, and lack of appetite. Participant one did not share any physical effects she experienced before or after her husband’s death. She dealt with her bereavement using cognitive strategies: “I did not tell myself that I’m diabetic and widowed, feeling pity for myself; I had the support structure and I participated actively in the community.”

At the time of the interviews, Participant two was still bothered by excruciating headaches that woke her up at night, and feeling down all the time. Participant three experienced terrible headaches and sleeplessness. She said, “I can’t deal with this terrible headache that wakes me up at night, and I struggle to fall asleep. I always fall asleep in the early hours of the morning.”

Participant four experienced sleep disturbances. She reported sitting up the whole night wide-awake with headaches, and being constantly preoccupied with thoughts of her late husband. Participant six could not fall asleep at night. According to her, she was only able to sleep well the first three months after her husband's death because she was emotionally tired from thinking about life without her husband the whole day. The fourth month after her husband's death happened to have the same dates and days, which affected her sleep and appetite. For example, she said: "I could not eat except soft porridge."

Participant seven missed her husband after his death, feeling lonely and often tearful. She said, "I experience sleeplessness, lack of appetite, social withdrawal, and prefer to be on my own. Sometimes I would not wake up and just be in bed the whole day." Also, "So far I still do not understand myself because some days I would be fine when other days I would be depressed. I only sleep well at my daughter's place but not at home. I never eat well, and suffer with continuous headaches."

Participant eight experienced chest pains, could not breathe, and had severe back pains. As a result, she was in and out of hospital. She was unsure of whether her condition was because of the loss of her husband or not, She feared that she would have a heart attack, and needed answers about whether she really had a medical condition or not. As a result, she would be hospitalised over and over again. Later she understood her physical experiences to be as a result of her husband's loss. According to her, "It then dawned on me that the problem was not the back pain, and I wasted so much time away from work." In explaining that she said, "I behaved like I was psychotic."



Participant ten also struggled to fall asleep, and was in need of psychological help. She would often worry about her deteriorating health, including arthritis. There was no mention of physical symptoms by Participants five and nine.

#### **4.3.3.2 Sub-theme 2: The Participants' response to the news of their husbands' deaths**

The Participants responded to the news of their husbands' deaths with similar pain. While some experienced numbness, others experienced shock, disbelief, and denial. This section explores their reactions in detail.

Participant one responded in a religious manner, thanking God for having given her the kind of husband that she had. Participants two, three, four and five responded to the news of their husbands' deaths with disbelief and confusion. In addition, Participant five experienced shock, bitterness, blame and anger. Participant six responded to the news of her husband's death by breaking down, blaming God for taking her husband, and her husband for leaving her. She was overwhelmed and confused by the news. Participant seven responded to the news of the death of her husband with confusion, numbness and helplessness. Participant eight responded to the news of her husband's death with disbelief, denial, confusion and crying. Participant nine responded to the news with numbness, anger and blame. Participant ten responded to the news by collapsing, suggesting that she felt overwhelmed.

#### **4.3.3.3 Sub-theme 3: The response of the Participants' in-laws to the Participants**

In this study, the support of the Participants' in-laws differed. Participant five's conflict with her sister in-law seemed to have been in existence for a long time. For example, this Participant interpreted her sister in-law's behaviour towards her

as fighting her, and using her husband as a weapon against her. The Participant's attitude towards her sister-in-law was also negative, discouraging any kind of support from her and any attempts to work together as a team. To illustrate that she said, "I feel that his sister, because her mother left her with her house when she died, does not know what to do with her money and ends up spending it on liquor". The tension between them was reflected when the Participant's church leader asked the Participant's sister-in-law and her relatives to leave the room when church members came to give their condolences. Also, the negative attitude they had towards each could have made it difficult for the dying husband, explaining why he decided to go and spend Christmas day with his sister without his wife to avoid unnecessary tensions.

Participant seven related how her relatives and her husband's siblings protected her from her mother-in-law who wanted to move furniture around and manhandled her curtains. Participant three felt that her brother-in-law and his wife were never there for her before or after the death of her husband. She felt unsupported, as she had expected some reciprocation from them after she had supported them when their teenage child committed suicide. Her disappointment was illustrated when she said, "I thought, as a result, they would relate to what I was going through. I gave them all the support needed but when it came to me, the next time I saw them was a day before the funeral."

Participant nine knew that her husband was living with a woman who was very close to her mother-in-law, and from the same area in which they lived. Because her mother-in-law and his family had never approved of her, she believed that they had spread rumours that she had bewitched her husband. The fact that most of the interview revolved around her in-laws reflected the deep-seated hurt she felt about them. She also related how they convinced her son of 18 to turn against his parents and take the family's side in arguments. She said, "My son was so disrespectful towards his father and me. I could not believe it when he

argued with us.” Also, “I did not even want to talk to my son because he disappointed me, letting him be used by my in-laws as a weapon against me. He could not even protect his own father.”

Participant four experienced and interpreted her in-laws as spiteful and cruel when they forced her to wear the black clothes of a widow. Participant eight questioned her in-laws’ distance after the death of her husband, and felt suspicious about this. She said, “Before then, they were commenting that they need answers regarding my husband’s death. They were then suggesting that we must go to a witch doctor to know what really happened.”

When Participant ten was insulted by her in-laws, her mother advised her to keep quiet and not answer them but focus instead on the loss of her husband. She said, “My mother was also insulted. I was also accused of hiding my husband’s insurance payout, and I refused to slaughter an ox for my husband.” She was also accused of hiding her husband’s money for the burial, and they tried to evict her the house she had been living in with her husband. She said, “After my husband’s death I extended the house and that was when problems started, my husband’s nephews and nieces fighting with me and wanting my children and I out of the house.”

The relationship with the in-laws of Participants one and two did not have a great impact on them. Participant one arranged her husband’s funeral without her in-laws, as both she and her in-laws were aware of their strained relationship. As such, her in-laws kept their distance. Participant two had no conflict at all with her in-laws, probably because her husband came from a small family and found it easier to deal with a few people than the different opinions of a larger family.



#### 4.3.3.4 Sub-theme 4: Emotions experienced

Participant one went through the anticipatory phase of her bereavement with some element of acceptance of what was to come. The Participant planned the funeral and burial with her husband. To illustrate this she said, “Rich and I had planned the whole funeral, even what I would wear on that day.”

Acceptance was evident in Participant one’s behaviour immediately after her husband passed away. This is what she said: “When the undertaker came to fetch the corpse I walked up to the door (behind the corpse). I just felt one of Rich’s aunts grabbing me roughly, saying I should not walk Rich out. I was too depressed to say much but just my look said it all.”

The sense of fulfilment and closeness the couples experienced prior to the death could have contributed to the widow’s feelings following their bereavement. For example, Participant ten expressed a sense fulfilment when she thought of how her husband had called the house every evening when he was alive to check if the family was safe. However, she faced different challenges from Participants one and two, such as a lack of financial support, raising mentally ill children, and unsupportive in-laws.

Participant couples four and eight shared feelings of anxiety and sadness during the period of anticipatory bereavement. Participant couple four experienced anxiety about the debt of the house that they could not afford, and Participant four felt sad about the lack of support from her in-laws when her dying husband was still alive. She said, “He (her husband) ended up not caring about whether they (his family of origin) come to see him or not.” Besides her financial difficulties, she also experienced anxiety the morning of the day the corpse was to come home overnight. Regarding this she said, “I felt very anxious, only to

realise that it was because he was coming home that evening. I was very down spirited the whole day.”

Participant couple eight experienced anxiety and uncertainty when they were in the same room, and were not talking to each other. Two of the Participants (four and eight) experienced the same feelings even after the deaths of their husbands. Participant four again experienced anxiety during her cleansing ceremony and when her black clothes were to be burnt. In this regard she said, “When they were burning them, I became emotional like I was abandoning my husband. I felt like that although I was happy to know that I will be back to my old self. Before then I was anxious and did not know how I will feel about it. The ashes were taken and thrown into the river nearby.” Participant eight felt her late husband’s presence in the room and felt anxious and uncertain. According to her, “It was like he came as a supernatural being and mind you, the corpse is cold. I even talked to myself saying to him that if he wanted to visit me he must help me not to be scared.”

Mistrust was experienced by Participants four, five, eight and nine towards their in-laws. Participant four related how, when the corpse was brought into the bedroom, his sister sprinkled water in the bedroom, something she did not understand and approve of. She also resented the fact that she was not asked permission for the sprinkling. That was illustrated when she said, “My family of origin and I were disapproving and did not trust her because according to tradition, she should have asked permission from me. We never practised such things in our house.” Also, “When I bathed, my sister was there with me. Whatever I ate, my sister had to dish up for me and nobody else. I did not trust his family but mine.”

Participant five only found out later that her sister in-law and her cousins had been at the undertaker earlier to do something to the corpse. She said, “I never knew and understood what they did.” Participant eight avoided interacting with her friends because she felt that they disapproved of their husbands’ sympathy and desire to help. She avoided them because, according to her, “I read something from their wives, or maybe I was just paranoid that they did not approve of their husbands’ need to help. I thought they would not trust me, although they would call.”

Participants six and nine felt used by their dying husband’s families of origin. Participant six related how, when she joined her husband at his mother’s house after they got married, she realised that he was the only one providing for his mother and brother’s family, even though both his brother and his wife were employed. Participant nine understood her mother in-law’s dislike of her because her husband had a child with a woman in the area before he met her, and suspected that her mother in-law was disappointed that he had not married that woman. As a result she felt that her mother in-law punished her by making sure that she (the Participant) did all the house chores.

Participant three also felt used. She illustrated this by saying, “It started when we both stayed with our husbands’ parents and the other daughter in-law was favoured against me. I was the one who nursed our mother in-law who had a stroke and could not do anything for herself and her husband. Nothing was expected from the other daughter in-law. She moved out of her in-laws’ house without her husband who stayed behind with his parents”. She added: “My husband then forced me to move back with his parents, saying that they have no one to look after them. That made me feel like a slave, unappreciated and used. I understood him when he pushed for us to move in with his parents again because he was not prepared to buy a house for his family but instead, take over his parents.”

Couples three, four and eight were not in touch with each other's emotions. For example, Participant eight related how, on their way home from the doctor who had just told them of the terminal nature of the husband's illness, they never shared their feelings about it.

Participants who were wearing black clothes at the time of the interview experienced self-pity. Participant four felt sorry for herself when one taxi driver told her in front of everybody to go and sit right at the back of the taxi. When she sat down, the person next to her moved as far away from her as possible, and that hurt her. Also, when she had to pay her fare, some passengers and the driver did not want to touch her money. One taxi driver told her that he was doing her a favour to let her in his taxi because nobody else would. Participant five's in-laws sewed her a black dress that was too long and big for her, telling her that she would put it on whether she liked it or not, and laughing about it in front of other people in the room. She said, "My children saw that and started crying."

Participant seven, who was wearing blue clothing and not the traditional black, related how she was made to feel at the taxi rank by other passengers. She said, "People would be staring at you, some moving away from you, some telling me to stand next to the person in front of the queue, and that person would not want you next to him or her. I felt like an outcast. The queue marshal would scream at me. In the taxi, I was expected to sit at the back seat. There was this short queue marshal who would usher everybody a seat and tell the passengers that I must go in first without ushering me a seat. They would all be looking at me not knowing whether they feel pity for what or me. During that incident, I would bow my head and cry when I get home, blaming my husband for that. When I walk and decide to turn my head I would find people looking at me. That was terrible." Participant nine did not share her experience of people's reaction to her black clothes.

All the Participants, except Participant one experienced frustration. Participant two was irritated by a phone call from someone from the hospital who had to tell her about the death of her husband, but did not get to the point immediately. She said, “That irritated me because I already sensed that something was wrong and that person was going round in circles.”

Participant three would often feel irritated by her husband when she had to care for him when he got sick. At times, she would cry in private, asking God to take him, and would feel guilty about that although she knew that when he recovered, he would not reciprocate the support she had given him. Participant five was frustrated by her in-laws when she realised that they had changed the coffin she chose for her husband for a more expensive one so that she should struggle to pay for it.

Participant six was frustrated by her husband's non-compliance with medical treatment, as well as his failure to share his feelings with her. Participant seven's frustration concerned her husband's lack of compliance with medical treatment and his insistence on a lifestyle that worked against his health.

Participant eight became frustrated when her husband tried to talk to his aunt and could not: “He wanted to say something to his aunt but could not. That was really frustrating.” Participant nine was frustrated by seeing her husband helpless against his family, asking her to tell his family of origin that he did not want to go with them but preferred to stay with her. She again experienced frustration when she went to the hospital to move his body to a private undertaker provided by his employer, and she found that her in-laws had already moved the body and did not want to tell her where they moved it. To illustrate this she said, “I was hurting, frustrated and helpless.”

Participant ten was frustrated by having to take care of her mentally disabled children without support from anyone. She said, “My uncle’s son was the one person who would think of my children and me. He would bring us groceries because I am unemployed, but he also passed away.”

The following section focuses on how the Participants coped with their challenges.

#### **4.3.4 Theme 4: Coping**

##### **4.3.4.1 Sub-theme 1: The couples’ resources**

Resources can be social, moral, emotional, and financial, with the latter being an instrumental resource in transitional societies. Participants one, two, five, six, seven, eight and nine did not experience financial problems before or after their husbands' deaths. However, there were other challenges that they faced at the time.

The resources that assisted Participant couple one in meeting their needs were both tangible and intangible, for example, financial and friendships. According to the Participant, “When Rich died, I did not even think about it (the support that his cousin promised and did not fulfil) because I was organised (financially stable).” Participant couple two’s resources were both tangible (financial) and intangible (sense of mastery), which helped the Participant, for example, in arranging her husband’s funeral by herself with ease. The couple also received spiritual support from the church.



The difference between Participants one and two was social support. Friends supported Participant one, while Participant two had no one but her children, and her siblings who could support her morally but not financially. Also, because Participants one and two had been providing for their families on their own from the time their husbands were boarded, their husbands' deaths had less of a financial impact on them. It is possible that their financial self-sufficiency increased their degree of confidence, especially for Participant two, despite a lack of support from her neighbours, and helped her to find the strength needed to face the demands of making her husband's funeral arrangements.

Participants six and seven also received support from the children. Participant six said, "It went well with the support from the church, and my children." Participant seven said, "I went home and called my children to tell them about their father. My eldest daughter came and we left together."

Participant eight also experienced her children as a source of support. That was evident when she said: "My children would take me to the hospital in the middle of the night." She also received support from her family of origin, much like Participants two and three, except for the fact that she also received support from some of her in-laws, unlike Participant two who was married into a small family. Participant eight said, "Some of my husband's relatives supported me. Those were the ones that my terrible sister in-law does not like." Her financial stability gave her strength and independence in the arrangement of her husband's funeral, saying, "I did not need their financial help because I could bury my husband without a problem." Also, some of her other sisters in-law were supportive, and her youngest sister in-law contributed money and was angry with her eldest sister for not supporting the Participant.

Participants five, six and seven were all financially stable and had supportive neighbours and employers. That was evident when Participant five's neighbours heard her scream when she heard the news of her husband's death from his doctor on the phone, and they came running to help her. Participant six's neighbours supported her immediately after they heard the news of her husband's death, helping her to calm her hysterical daughter, who had been very close to her father. One of Participant seven's neighbours took her in his car to help her look for her husband after she was told that he had been taken to hospital. The difference between the three Participants was that there was no mention of friends by Participant five, while Participants six and seven received additional support from their friends.

Other Participants who received support from neighbours were Participants four, nine and ten. Participant four reported that her neighbours were supportive because of her husband's helpful and reliable nature. She said, "He was very sociable and warm. He used to help people." Her neighbours showed their support by protecting her against her in-laws. One neighbour offered her the use of his car for her to make arrangements for the funeral, so that she would not need to use her car, which her in-laws wanted for themselves.

When Participant nine arrived at her house for her husband's funeral (her husband passed away in another province), her friends were already busy preparing food for the funeral the following day. Participant ten appreciated the support of her neighbour. In this regard she said, "I do not know what could have happened to me. My neighbour really helped me because I was like a zombie."

Although Participant three was earning her own money, she struggled financially to bury her husband, although not as much as Participant four, who was unemployed. It seems likely that her neighbours helped reduce the impact of the



loneliness she felt at the time. She said, “My neighbours were there for me, before and after the death of my husband. They made me feel that I was not alone.” Participant ten experienced significant support was from her neighbour. She added, “One of my brother in-law’s uncles would bring us groceries as and when he could afford to. I really appreciated that.”

Participant six’s widowed friends would often reassure her about her experiences and how normal they were. She said, “She (a friend) reassured me that with time, I would be myself again.” Participant seven’s friends also played a significant role in providing support. This was evident when the Participant had conflicts with her mother-in-law and her friend intervened: “A friend of mine even intervened in the conflict because even when I sat on a chair because I felt tired of sitting on the mattress, she (the mother-in-law) would fight with me.”

In terms of support from the Participants’ employers, Participant five experienced her colleagues and employer to be supportive. Her boss contributed R10 000 for her husband’s funeral. Her boss would also call her to check how she was doing. Participant six’s husband’s employer convinced her husband to continue working, giving him all the support he needed, such as time off when he was unwell. Participant seven’s boss suggested that she should stop working to look after her husband. When the Participant’s boss heard about her husband’s death, she called her and suggested that she should come back to work. According to the Participant, “That helped me a lot because when I interact with people I stop thinking about my husband all the time although, at times, I do feel like being on my own.”

Participant nine received support from her family of origin, some neighbours, her daughter, her husband’s employer and some of her husband’s relatives. She left her eldest daughter with the younger one at her house in the Eastern Cape

Province because they were still at school. Fortunately they were old enough to look after themselves and the house. She received a great deal of moral and financial support from her husband's employer: "I called his employer two days later because I had to arrange with his relatives who were supporting me to move him from the hospital to the private mortuary... The employer then gave me ten thousand rands for the burial, and asked me to come back for the rest."

#### **4.3.4.2 Sub-theme 2: The Participants' approaches to their challenges**

Participant one came across as an individual who could make decisions for herself without relying on others' opinions. She showed her strength of character when she told her in-laws that her maid of honour at her wedding would stand beside her at the funeral. She did this to avoid the cultural practice of being covered with heavy blankets as a widow at her husband's funeral in the middle of summer. She also continued with her daily commitments whilst looking after her dying husband, something which is not usually socially expected of her; wives are socially expected to stay with their dying husband and to spend all of her time caring for him. This reflects some of the changes in a transitional society. She could have been perceived as neglecting him. She travelled provincially when her husband was still alive and sick, and used to go overseas once or twice a year. As she said, her husband never complained or felt neglected. When her husband had passed away, she insisted that respects be paid in the lounge instead of the main bedroom as is traditionally practised, and that she should spend time with her friends in the main bedroom, fulfilling her husband's wishes. Even during his illness, they would continue with the lifestyle they were used to as a couple: "But when he was out of hospital you would be surprised because we would go to jazz festivals and all. When he relapsed, he would relapse (laughing)".

Participants two and three shared similar traits of reacting through withdrawal, although they expressed them in different ways. For example, Participant two had the support of her husband, unlike Participant three. Participant three said, “Maybe staying at his parents’ house with them made him not to realise that he was a father and husband. Even my children are used to that.” The two Participants also seemed to understand that their siblings were not as able to support them as other people were. They both accepted that their siblings had problems of their own and could not support them as much as they would have wanted to. Participant three understood that since most of her siblings were unemployed, their support was limited to helping clean the house and being physically present with her. She said, “I could see that they would really want to help but did not have much. Just the thought of helping was enough for me.”

Participant four understood the manner in which her black clothes impacted others, sharing how one man reacted to her with shock by saying: “Maybe he did not expect to see a widow in black. Maybe it was because most people do not put on black anymore, or maybe someone close to him like his mother wore it and is no more. Maybe he thought he was seeing his late mother, I do not know.” However, Participants five and seven interpreted people’s negative responses to their black clothes differently. They felt alienated by their social environment and felt hurt as a result.

After the deaths of their husbands, some Participants’ social interaction changed for the better, while others’ did not. Participant two, who would never interact with people around her when her husband was still alive, interacted more with other widows than before when she joined the support group. She found the support group helpful because she found herself to be stronger than most widows in the group, supporting them morally and emotionally. Participant three’s social interactions did not change significantly, as she could not stand the noise around her after the death of her husband, and preferred to be by herself. She withdrew

more than when her husband was still alive, saying, “I am more at peace when I am on my own.”

Some Participants came across as unforgiving. Participant eight said that she used to find it difficult to forgive her husband when he had hurt her. She said, “He would often apologise but not me.” As a couple, they would reflect on how others dealt with bereavement. For example, she said, “We had a friend who lost her husband and she put on black clothes. At night she would take them off and put on her fancy clothes, and would go and enjoy her nightlife. I really do not see the significance of those black clothes. That was when we realised that black clothes meant nothing.”

Participant three also showed an unforgiving side, which is illustrated by the following quotation: “That heart problem I think started after his car was stolen. It did not bother me because he never provided for the family, but owned a car (he could afford a car).” Participant five was also unforgiving towards her sister-in-law, saying, “You know, I even thought that after my cleansing, I would open a case of murder but because that is not me, I will leave it the way it is. She will pay in God’s own way.”

Participant six showed forgiveness and maturity in different ways. She forgave and tried to understand when her husband became impatient with their children, screaming at them for no reason, which was unusual for him to do. Later, after his death, she understood his behaviour as his having realised that he was nearing his death and was struggling to deal with it. This is illustrated in her saying, “You know, I was able to forgive him.” Even though her mother-in-law had previously evicted them from her house, Participant six showed her maturity in the following way: “We never knew how she (mother-in-law) knew that we then

had a house. I welcomed her and she stayed with us. She even died staying with us and we buried her without assistance from my brother in-law and his wife.”

Participants two, eight, nine and ten found comfort and meaning in some of their experiences. Participant two consoled herself with the fact that she was the last person to be with her husband before he died at the hospital. Participant eight appreciated her doctor for being hard on her when he told her to go home and deal with the loss of her husband or consult with a psychologist. She said, “The way he said it made me strong although I cried and he was there for me at the time.”

Participant nine felt appreciative towards her husband after his death in a different way. He had not seen her for four years prior to his death and afterwards, she interpreted his disappearance as a way of avoiding infecting her with HIV. She said, “I really appreciated that because he showed me how much he loved and cared for my well-being.” (See also the theme on patterns of communication.)

Participant ten appreciated her husband for having been a good provider when he was still employed. She also remembered how, when he was working night shifts, he would always call from work to check that she and the children were safe.

Participant five tended to accept her situation for the sake of peace. For example, her sister in-law brought her herbs to drink, telling her that people advised that it was a way of cleansing herself internally. Despite not wanting to, she drank the herbs.



Some Participants were suspicious of people around them. Participant eight would lock the door to people who would come to see how she was doing, and did not want to interact with them. This was because she suspected that just as much as her friends' husbands were sympathising with her, their wives did not approve of their husbands' help. She said, "I thought they would not trust me, although they would call. I used to suspect that they were not comfortable with me." Participant four dealt with the neighbours' wives differently. When she realised that her female neighbours were alienating her she felt pity for them as she said, "...the poor husbands would sometimes avoid greeting me because of their wives."

Participants four and five were suspicious of their in-laws. Participant four refused to give them her husband's car keys which her in-laws demanded because she suspected that they would steal the car parts, do something to the car or even take it away while she was still trying to deal with her loss. Participant five overheard her in-laws talking, thinking that she was asleep, saying that they must force her to go and wash her husband's body at the undertaker so that she would also die; and she refused then to do this.

Some Participants showed control in their difficult situations. Participant two took control of managing her husband's funeral arrangements on her own even though it is not customarily expected, which again reflects the changing dynamics in transitional societies. She chose to do this despite the fact that people would come to show their respects during the day and they would not find her at home. In traditional societies, the widow is expected to stay at home, in the main bedroom, until the burial.

Just as much as the Participants sometimes showed control, at other times they would lose it. Participant four was more in control after the burial of her husband

than before her husband was buried, because, as a couple, they were financially dependent on others. Her in-laws took advantage of this and insisted that the couple's possessions were theirs and not the widow's because the couple did not have children together. The widow showed control after the burial when she told her sister in-law not to come to her house anymore, and telling her sister in-law that she disliked her.

Participant five could not control her sister-in-law's interference in her marriage. However, arranging her husband's tombstone ceremony put her back in control as she ran it by herself and did what her husband would have wanted. Unfortunately she could not do everything as he had wished, as the family took over the funeral preparations. As such, although her husband had wished her to erect the tombstone on the day of the funeral, this was not possible.

While Participants one, four, nine and ten were self-reliant in different ways, Participant three and nine felt helpless. Participant one was able to open a "*spaza shop*" (community-based convenience store) so that her husband could keep himself busy during the day, and also compensate for his share of the budget. Participant four still managed to be a homemaker after her husband's death despite the fact that she was unemployed. She sold various things to make money for her children. After her husband's death, she also instituted legal proceedings against the builder of her house who was not keeping to his promises.

Participant ten was able to rationalise issues. For example, when people would tell her about what her in-laws were saying about her, she would rise above it. She would tell her husband's nephews and nieces that they were her children and if anything happened to them, they were her responsibility. When Participant nine was accused of bewitching her husband, she realised that her husband did

not have long to live and focused on talking to him about his wishes and accepting his apology about having a mistress.

Participant three was self-centered in that she perceived that things were done to her without doing anything about it, and as a result, evoking self-pity. This is illustrated in her statement: “The fact that I was born poor, grew up poor, married poor, and would even grow old poor. I was unable to live the life I want. Maybe it was meant to be.”

Some Participants dealt with their challenges with bitterness and anger. Participant one’s feelings of anger and bitterness were directed at her in-laws, with whom she had never had a good relationship. As a result, she did not expect anything good from them.

Participant two was angry and bitter with her husband’s friends and her church. She was supported spiritually by her husband’s parish, which she joined after her husband’s death. Regarding her parish, she said, “I would send a message to my parish and priest, but no one would come. When I needed them most they were not there.” Long after her husband’s burial, she met her previous priest who asked her why she did not attend church anymore. Her bitterness resurfaced as, according to her, “I told him (her priest) straight that when I needed him he was not there and I did not see any compelling reason to still continue at his parish.” The following quote reflects a lack of support from friends: “His friends who were not there for him when he needed them, waiting outside (the hospital ward). I told them that he was no more.” Also, “If he was helpful, he should not have expected the same from others.”

Participant three showed her anger and bitterness in different situations. Of her brother in-law she said, “When you have everything in the world, you will have



hangers-on. My brother in-law and his wife never supported me in their lives.” Of her husband, she stated: “He was a very quiet person who would only answer what he was asked. Even if I could talk about what could be done in the house, he would never answer.” The Participant felt that her husband had failed to provide for the family and was never there for her. She said, “That is why I am so bitter and angry with him at times because he refused to take responsibility and provide, maybe we would not be struggling the way we are if he did.”

Participant five was angry because her husband’s sister was a qualified nurse who should have known the needs of a diabetic, and what needed to be done when he was sick. Participant seven’s bitterness towards her in-laws was evident when they forgot about her after the funeral. She felt that they only gave her the necessary support during the funeral week. She did, however, tell them of her feelings. Participant eight felt uncomfortable when she returned to work after her husband’s death, not knowing how to deal with her colleagues because of her frequent admissions of struggling to breath at her workplace (professional nurse), thinking that her colleagues would have perceived her as having over reacted.

The individual reactions of the Participants manifested in different ways. Participant seven showed her assertiveness when she told her mother in-law that she had enrolled for Matric at a night school and would attend at night. This was not culturally acceptable because as a widow, she was not supposed to be out of the house after sunset. Participant eight also showed assertiveness when her in-laws suggested that they needed to go with her to a witch doctor to determine what had killed their brother. She refused because as a couple, they did not believe in witch doctors. They then gave up, although they were unhappy that she rejected everything they were suggesting.

Participant four showed empathy when she said, "...it felt like they were killing my father (at her mother's cleansing ceremony when an animal was slaughtered)." This memory caused her to consider how her mother may have experienced her father's death. Participant eight also showed empathy in becoming more sensitive and considerate towards her children. For example, "When I got home I realised that I was depressing my children."

#### **4.3.4.3 Sub-theme 3: The Participants' coping styles**

Participant one related how her husband coped by being solution-focused and communicating openly with the Participant. The way she carried herself also helped him cope with his anticipated death. She said, "Even when he was about to pass on we were able to talk about his death. He would tell me that he realises that he had reached the end of the road." Also, "He even told me that he had a man-to-man talk with his physician, and told him that he wanted to go home."

Before and after the death of her husband, Participant one coped by continuing with her daily routine and making extra money as the sole provider despite what was socially and culturally expected of her. Her refusal to compromise in what she believed also helped her to cope with the challenges she was faced with. As a couple, they coped by opening a convenience store so that the husband could keep himself busy and bring in an income: "During that time, I had a spaza shop to keep Rich busy." Another coping strategy was their ability to enjoy life, even when the husband was not well enough to go out.

Participant two's husband coped by being independent. She said, "His independence really helped me cope because I would leave him by himself and go to work, run my errands, and would find him comfortable and looking after the house." Before and after the death of her husband, Participant two coped by

accepting that she was on her own in looking after the family, by becoming financially independent, looking after the family's nurturance and economic well-being; and trusting the hospital treatment. As a couple, their interdependence and openness, including their spiritual belief, helped them cope.

Participant three's husband coped by distancing himself from the Participant. She described her husband as self-centred, focusing on himself only. Before the death of her husband, Participant three tended to accept whatever demands were facing her, which to a certain extent helped her to adjust to life after her husband's death. She wanted very much not to be bothered by her husband's treatment. She coped by withdrawing from her environment and keeping to herself after the death of her husband.

Participant couple four anticipated having a mortgage problem with their lack of income. They therefore considered the most appropriate and effective way to overcome this to be the purchase of a cheaper house. Participant five's husband coped by keeping his feelings and experiences to himself, and by acting like a son to the Participant. After the death of her husband, Participant five avoided her in-laws. She said, "After the funeral, my sister in-law called me asking for forgiveness. I asked her forgiveness regarding what? She said forgiveness for being irresponsible by drinking liquor with my husband and I did not answer her but dropped the phone because I told her that I would never ever talk to her." As a couple, they coped with the impact of the illness in their own different ways. When the dying husband kept the impact of his anticipated death to himself without sharing his feelings with the Participant, she nursed him as if she was caring for her son, probably because it is easier to provide for and mother a son than a husband. This is illustrated in her words, "He did not sound sober on the phone and I discouraged him from coming over. He later called, telling me that he wanted to go home and I advised him to sleep over at his sister's place, for his own safety."



Participant six's husband coped by keeping to himself, and not complying with medical recommendations. The Participant illustrated that by saying, "He would talk about death when he was in a happy mood because he was smoking and took alcohol. That was all that we would fight about. Sometimes he would argue that when I met him he was taking alcohol and I never had a problem with that, and I would tell him that he was older and alcohol was now affecting his health. He did not understand." Before and after the death of her husband, Participant six coped by praying and asking advice from friends who had been widowed.

Participant seven's husband coped by continuing to live the life that he was used to living before his illness, which worked against his condition. The Participant disagreed with him as she said, "I believe that one should live life to the maximum, but should also be responsible. That is a good value in life." After the death of her husband, Participant seven used her spirituality to cope although her husband did not approve: "...whenever I felt down I would open my Bible and he would scream at me for that."

Participant eight's husband coped by avoiding talking about his illness and what was to come. This was evident when I asked her if there was anything of importance in their life together that her husband would talk about. She replied, "Not really. It would be about issues of the family, meaning the children. He would ask me about the children and how they were doing. That time he was admitted to hospital." After the death of her husband, Participant eight coped in different ways. She avoided contact with people, preferring to go through the deceased's belongings on her own, as a way of reminding herself of him. She also coped by reassuring herself of their shared beliefs and values that she respected after his death. When she felt overwhelmed by the loss, or struggled emotionally, she would drug herself with sleeping tablets to deal with the situation in the most comfortable way possible.

Participant nine's husband would often apologise for his unfair treatment to her as a way of coping with his guilt, and she would routinely forgive him. She said, "How could I not forgive him?" After the death of her husband, the Participant coped by reminding herself how her dying husband had provided for her all along. To illustrate that she said, "He provided for the family. That I cannot complain about. However, in the past four years, he stopped coming home until last year for the Easter holidays, and was sick. I did not know what the problem was then." She also interpreted his long disappearance as his way of protecting her from being infected with HIV. She said, "Mind you, the last time I saw him, which was four years ago, he was a healthy man. What was unusual then was that he avoided intimacy with me, but I just took it like that. It is only now that I appreciated that because he was avoiding infecting me. I really appreciated that because he showed me how much he loved and cared for my well-being." Coping as a couple was not possible as they lived in different provinces.

Participant ten's husband coped by being there for the Participant despite his condition, expressing concern about her well-being, and showing that he cared. She said, "When my husband died, I was sick. He would take me to hospital when he himself was also sick." After the death of her husband, Participant ten coped by always remembering how good her dying husband had been to her and their children. At the time of her husband's death they were both unemployed and her difficulty in dealing with her loss was reflected when she said, "I just could not cope without my husband because he was a good provider, although by the time he passed away he was on ill health pension." As a couple, they functioned as a team: when they were both be sick they would still nurse each other.

#### 4.3.4.4 Sub-theme 4: Participation in African death rituals

In table 4.3 below a summary of the Participants' participation in African death rituals is presented, as it seems that participation or non-participation in these rituals may have had some effect on Participants' experience of bereavement. Participants who were comfortable with the prescribed rituals seem to have coped better than those who felt uncomfortable with the rituals and did not believe in them. Being brought up within a particular culture allows for an understanding and appreciation of the implications of rituals, which may aid in the therapeutic benefit thereof. For example, a widow who was brought up knowing that observing, respecting and participating in death rituals is not only designed to ease her path but also to help her late husband to smoothly complete his purification journey may make her feel like they are still working together as a couple. Participation in five of the main rituals is indicated.

Table 4.3 Participation in African death rituals

Participant	Mattress on the floor in the main bedroom	Corpse home overnight	Black clothes	Drinking herbs for cleansing	Cleansing ceremony
1	No	Not mentioned	No	No	Yes
2	Yes	Yes	No	Not mentioned	Not mentioned
3	Yes	Yes	No	Not mentioned	Yes
4	Yes	Yes	Yes	Yes	Yes
5	Yes	Yes	Yes	Yes	Yes
6	Yes	Yes	No	Not mentioned	Not mentioned
7	Yes	Yes	No (Blue)	Yes	Yes
8	Yes	Yes	No	No	No
9	Yes	Yes	No	Yes	Yes
10	Yes	Yes	Yes	Yes	Yes

#### 4.4 CONCLUSION

During the course of this chapter, four themes were presented. It seems that the Participants who had positive relationships with their husbands also cared for them in a positive manner and vice versa. It was also found that past losses of significant others with whom the Participants did not live did not have a significant impact on the Participants' experience of bereavement. The Participants experienced similar physical responses, and reacted to the news of their husbands' deaths in a similar way. Financial resources seemed to have played a large role in the funeral arrangements, where those Participants who were financially independent buried their husbands in the best way they could without depending on others for help. Although the Participants had similar experiences they dealt with their challenges in their own unique ways.

In the chapter to follow, the findings are interpreted and discussed. A theoretical explanation of the data is provided. This section describes how Black urban widows in a South African transitional society, whose husbands had died of a terminal illness, experienced and coped with bereavement. The chapter also includes the model of bereavement in a transitional society developed for this study.

## CHAPTER 5

### DISCUSSION, RECOMMENDATIONS AND CONCLUSION

#### 5.1 INTRODUCTION

In chapter 3 an outline of the process of gathering and analysing data from Participants who were members of a widows' support group in Soweto was presented. Chapter 5 provides a discussion of the findings presented in chapter 4. The aim of chapter 5 is to provide a theoretical explanation of the findings. The interpretation and detailed discussion of the findings presented in chapter 4, leads to an answer to the research question, which is: How do Black urban widows in South African transitional societies, whose husbands have died of terminal illnesses, experience, process information about, and cope with bereavement? In addition to the discussion, recommendations for future studies conducted within the context of bereavement in transitional societies are made. The limitations of this study are also examined.

The discussion in chapter 5 highlights the contribution made by the study to the body of knowledge. In this respect, the discussion provides literature to the under-researched topic of ways in which Black South African widows in transitional societies deal with bereavement, and their experiences of rituals of loss and change. It is hoped that this information will contribute to health professionals' understanding and awareness of bereavement in this sector of South African society, including its functional and dysfunctional aspects. The description of these issues is based on the changes that are taking place in traditional African beliefs and values related to bereavement in response to modern, Western-influenced beliefs, values and ways of living.



## 5.2 DISCUSSION OF THE PARTICIPANTS' BACKGROUND HISTORY

Before discussing the findings of this study, the Participants' background history is interpreted based on the theoretical framework and literature used in chapter 2. This discussion includes the Participants' age, level of education of the Participants and their husbands, duration of the marriage, diagnosis, duration of the illness, mode of death and duration of widowhood.

The Participants' anticipation of what was to come depended on their cognitive interpretation of the anticipated loss, the shared scripts of their culture, attachment styles, and other related factors. In addition, the duration of the couples' marriages, which in this study ranged from fourteen years to thirty years, could have played a role in how the Participants cognitively interpreted the anticipated death of their husbands. As mentioned in section 2.2.2.6 of chapter 2, grieving people tend to develop an integrated cognitive-affective-motivational-behavioural network in response to the death of a loved one. Most of the Participants in this study experienced anticipatory grief prior to the anticipated death of their husbands. This anticipated experience might be regarded as a perceived threat to the Participants (cognitive schema) with feelings of anxiety and sadness (affective schema). Some of the responses included acting in accordance with the customs and norms of the community (motivational schema). These customs and norms derived from the Participants' culture, which is a social multidimensional construct that comprises judgemental or normative, cognitive, affective, skill, and technological dimensions (Li & Karakowsky, 2001).

Chapter 4 showed that companionship in some of the Participants' marriages consisted only of sharing daily routines, while in others, the relationship was characterised by an intense sharing of the couple's intimate life. It seems that neither of these two possibilities occurred in the case of Participant three. This Participant failed to spontaneously mention the duration of her dying husband's

illness, how long they were married, or the duration of her widowhood. This may suggest that, as a couple, they shared neither daily routines nor intense intimate lives. The Participant's emotions might have been aroused through a conscious appraisal of her unfulfilling marriage, which might have created a negative attitude towards her marriage.

Cultural scripts also played a significant role in Participant three's experience of bereavement. Her husband was expected to provide for the family while the Participant looked after the emotional aspect of the family. Her husband behaved differently from what his cultural script dictated, which created problems for the Participant, who was cognitively bounded by her subculture's definition of the problem to be solved and its definition of proper methods of a solution (Li & Karakowsky, 2001). This finding is confirmed by what Thomson and Tulving (2002) term acceptable ignorance or incompetence in culture: what the couple may ignore or treat as irrelevant aspects was ignored only by the Participant's husband and not by her.

The couples' level of education, the nature of the husband's work (whether skilled or unskilled), and whether both the Participants and their husbands were employed or not, did not necessarily play a role in preparing the Participants for their husbands' death, and probably did not influence their experience of bereavement after the death. Whether or not the Participants expected the husband's death, they all responded to the news in a similar manner. This reflected how cognitions and emotions influenced behaviour in a similar manner, and how their cognitive appraisals might in turn have influenced their emotional experiences (Beck, 1996).

In this study, the Participants' ability to cope effectively with their bereavement depended partly on their financial status, as they had to face major social

adjustments in their lifestyles in the transitional society within which they functioned. That made financial independence an important factor. For instance, Participant four was unemployed during her husband's illness, and had to depend on others for financial support. That included the stressor of a house that could have been repossessed. Couple ten had a similar vulnerability to that of Participant Couple four in that they were both unemployed. An added vulnerability was that both Participant ten and her husband were sick, creating an added problem. The couple lived in a family house, which subsequently created problems for the Participant after the death of her husband as the house belonged to the Participant's in-laws and could be claimed by any of her late husband's nephews, niece or extended in-laws. Participants four and ten were also faced with the issue of raising children, and found themselves solely responsible for raising them and fulfilling the roles of both mother and father to satisfy their instrumental and emotional needs. This contrasts with Bernard and Guarnaccia's (2004) finding that age is a determining factor in coping during the illness and death of a husband.

Both Participant couples two and ten, however, had the advantage of healthy relationships. The two couples were also unaware of the seriousness of the husbands' illnesses, which meant that they presented with similar cognitive appraisal and coping strategies as neither of them anticipated the loss. Both Participants four and ten had problems with retaining their family homes, and after the deaths of their husbands, also had to cope with incorporating new information from the environment into their existing cognitive structure, namely, becoming sole providers for their children.

According to Parkes (1972; 2001), the mode of death seems to strongly influence the bereavement process. In this study, most of the Participants anticipated the deaths of the husband. These Participants were often emotionally and physically exhausted by the strain of looking ahead, predicting, expecting and preparing

themselves for their husbands' anticipated death. Relevant here are the circumstances surrounding the anticipated death, previous warnings through hospital admissions, and the forward-backward movement between hope and despair, which provided the equilibrium and disequilibrium for the development of more adaptive cognitive schemata (Martin & Doka, 1998). Neimeyer et al. (2004) support this idea in their description of a three-stage process in preparing for death: the anticipation stage, the waiting stage, and the period after the death.

Neimeyer et al. (2004) argue that people experience conflicting emotions and states of mind during the anticipatory process, and as such, develop a preferred coping style. Parkes and Weiss (1983) and Turvey et al. (1999) confirm this by arguing that a good death is a prepared death, whereas a bad death is untimely and unprepared. However, although the emotional impact of the Participants' dying husbands on the Participants could not be measured, the anticipation of their loss seems likely as painful and stressful as the actual experience of loss through death. This was evident in this study as all the Participants, despite their different ages, level of education, duration of the marriage, diagnosis, duration of the illness, possible mode of death and duration of widowhood, responded in a similar manner to the news of their husbands' death.

### **5.3 DISCUSSION OF THE FINDINGS**

During the course of the literature search for this study it was found that little is known about bereavement of Black widows in transitional societies (see chapter 1 section 1.4). When reviewing the literature included in the discussion on this specific issue, a consistent theme kept emerging, i.e. the fact that grief, mourning and bereavement are generally regarded to be amongst the most stressful events in adulthood, and that relatively little is known about its influences on life in the urban South African context that is characterised by rapid transition. This is so as most bereavement studies in South Africa were conducted in rural areas

where bereavement practices tend to be traditional. Only one study by Rosenblatt and Nkosi (2007) could be found that examined differences in bereavement experiences between Zulu-speaking widows living in a Zulu homeland in rural Kwazulu-Natal, and those living in urban Soweto. This theme pointed to the need for research to be conducted in order to answer the research question of this study, i.e. *How do Black urban widows in transitional South African societies, whose husbands have died of terminal illnesses, experience, process information about and cope with bereavement?*

As was highlighted in chapter 1 (section 1.6), the research findings of this study led to the development of a systematic bereavement model for widows in transitional societies that could contribute to our knowledge about factors that affect coping with loss in the community under study. The discussion of the findings follows the structure of the themes presented in chapter 4. This is followed by an explanation and presentation of a model of the cognitive-affective-behavioural network.

### **5.3.1 Theme 1: Discussion of the findings in respect of personal characteristics**

The Participants exhibited different constructs with regards to their bereavement, where some were shared, and some not. This discussion on personal characteristics focuses on the nature of the couples' relationships before and during the illness which includes the couples' patterns of communication, and their perceptions and attributions. The couples' personal characteristics also involve their knowledge and understanding of the illness, the different roles they played as couples, and their strengths and vulnerabilities.

### **5.3.1.1 Sub-theme 1: The nature of the couples' relationships before and during the illness**

As was mentioned in chapter 1 (section 1.2), the loss of a partner causes grief (Archer, 1999), which Parkes (1972) views as a consequence of the way people form personal relationships. Wendt and Zake (2006) advocate that a couple's relationship functions in an interdependent manner, creating the sum total of an interrelationship between the partners. As such, the intensity of grief tends to follow the closeness of the couples' relationship. Parkes further suggests that the product of how people form relationships involves representations of the loved one, which affect every aspect of people's lives, and which are resistant to attempts to change them. As such, one may, for example, want to maintain contact with the deceased. This then makes bereavement the cost that people pay for being able to love in the way they do, and suggests that the intensity and experience of bereavement will vary according to the strength of the lost relationship.

Participant three had a distant, anxious and ambivalent relationship with her late husband. She experienced her marital relationship as unfulfilling with unresolved issues. Anger might have occurred, serving as an outlet. Those Participants with secure attachment styles seemed better able to accept the loss of their husbands as a natural occurrence, and so experienced a more functional bereavement process. For Participant three, the loss of her husband and their unfulfilling relationship could have contributed negatively to her bereavement. She could not express her feelings due to her inability to recognise her anger experiences as being related to her loss, which inhibited her bereavement process. Participants with secure attachment styles, however, interpreted their emotions during anticipatory bereavement as marking the beginning of their bereavement processes, and were aware of the loss of their husbands as a changing reality, making their emotions functional (Carr et al., 2001).

The nature of the couples' relationships revolves around the dynamics involving protection, care, and security, including the couples' relationship structures, roles, communication patterns, and power relations. The following section focuses on the couples' patterns of communication, including perceptions and attributions of the couples.

#### **5.3.1.1.1 Patterns of communication and cooperation**

Communication between individuals in couple relationships establishes the boundaries of the discourse and the interpretative framework that defines the nature of those relationships (Kashima, 2000). An open and healthy pattern of communication may be partly attributed to the secure attachment style of the individual partners. These couples are more likely to have satisfying and enduring relationships with warm and supportive intimate relationships and greater cooperation. As a result, they are more likely to cope effectively with loss due to the internal working model they possess (Bowlby, 1980). This model might, to a certain extent, help the Participants through the actual bereavement phase. However, this could not be confirmed in this study as other factors such as individual personalities could also have played a role.

Those couples who were able to cooperate seemed to have achieved this through shared meanings in their relationships (Figlio, 2001). This helped the husbands through their dying processes and, at the same time, also helped the Participants to go through their bereavement feeling that they were available to their husbands. It seems that the dynamic structure of their relationships and its boundaries were maintained through a network of feedback loops (Kern & Peluso, 1999).

This sense of team spirit represents interdependence between partners, who are able to protect and appreciate each other. As a result, the Participants seemed better able to accept their husbands' condition with commitment and appreciation. This encouraged the couples to share their needs and wishes, giving them an opportunity of realising and sharing similar fears and uncertainties. This was possible despite the confusion, frustration and hopelessness they felt. This was reflected in the way the Participants tended to talk positively about their late husbands. Participant three, however, still had unfinished business with her late husband and still felt bitter towards him for not taking care of the family. This attitude was unusual compared to the rest of the Participants who talked fondly about their late husbands. As already mentioned, she did not spontaneously mention the duration of her husband's illness, or duration of her marriage and widowhood, which could suggest a lack of interest in her relationship with her late husband.

It is then clear that securely attached couples had the potential to experience functional bereavement and cope better than insecurely attached couples. Securely attached couples were more likely to be dependent on each other, and yet not be afraid to be abandoned. They were thus better able to enjoy their relationships. These partners tended to attribute their behaviour to inner causes, while insecurely attached couples are more likely to attribute their behaviour to situational factors, which in turn heightens their risk of experiencing dysfunctional bereavement and failing to cope with the loss.

The strength and the security of the attachment seem to play a role when death is anticipated. In couples with insecure attachment styles such as Participant couple three, where the dying husband had an avoidant attachment style and the Participant had an anxious and ambivalent attachment style, the relationship was characterised by loneliness and resentment. In the case of this couple, the dying husband's avoidant attachment style tended to make him less invested in the



relationship, and he created his own life outside of the couple's relationship. The Participant's anxious and ambivalent attachment style made her less trusting, more possessive and jealous and, as a result, likely to withdraw from her husband due to her consistent and subjective perception and interpretation of her relationship as being emotionally challenging. This made it difficult for the Participant to adapt to her new environment and to adjust the environment to self. As a result, she became angry and resentful when she had to care for her dying husband. This partly explains how some Participants were able to care for their dying husbands better than others.

Some couples' relationships were characterised by too much sensitivity and avoidance. These couples deprived themselves of the opportunity to reassure each other and share each other's fears. In these relationships, one partner did not know how the other felt.

Also, whether the dying husbands shared their fears and wishes with the Participants seemed to have depended on how the dying husbands understood the Participants' strengths and weaknesses. This brings us to the question of how functional and open a relationship should be to view it as healthy, even though what could represent dysfunctional bereavement for one Participant may be functional bereavement for another Participant, due to, among other things, individual uniqueness. The husbands' discussion of their own anticipated death may have been informed by their knowledge, learnt over the years, of what their wives were capable of hearing. If the husband spoke directly and clearly about his death, would his wife be able to deal with it, or would she feel helpless and make it difficult for him? It was clear that oversensitivity, avoidance, and withdrawal prevented open communication at times and deprived some couples of an opportunity to share their feelings and experiences. These behaviours might be a reflection of the couples' previously established patterns of communication.

Whether relationships were open or not, all the husbands communicated their anticipation of death in different ways to the Participants, even though in some cases the Participants did not understand what their husbands were communicating. This may have been due to the Participants' denial of the inevitable, whereas the husbands might have accepted their anticipated death. Also, frequent hospital admissions of the husbands could also make Participants lose hope that their husbands will survive.

#### **5.3.1.1.2 Perceptions and attributions**

According to Schachter and Singer's two-factor theory of emotions discussed in chapter 2, section 2.3.4, physical arousal and its cognitive label depend on the way one processes information, comprising both the content such as beliefs and attitudes, and processes like attributions and perceptions. Also, there are shared cognitive schemata, which become part of one's individual perceptions. These shared views become activated during bereavement. The Participants' perceptions of their husbands' illnesses, and the meaning they attributed to the illness contributed significantly to how they interpreted and dealt with the anticipated death of their husbands. This could also have determined the intensity of their anticipated and actual bereavement experiences and how they coped.

Attribution judgements are also influenced by factors such as cultural differences (Gopalan & Thomson, 2003). The analysis of culture searches out significant symbols, clusters of significant symbols, and clusters of clusters of significant symbols, which are the material vehicles of perception, affect and comprehension. For example, a progressive widow in a transitional society may be more likely to emphasise freedom of choice over lack of control in situations, while a conservative widow's locus of control in traditional society is more likely to be external (Rosenblatt & Nkosi, 2007). Participant three's behaviour, for

example, is more likely interpreted in terms of situational attributions. Progressive and traditional widows' different sets of perceptions were maintained because they were provided with information from different points of view, and with different available information that was processed differently (Detweiler, 1978).

Those Participants who were able to incorporate their husbands' impending death into their existing cognitive structure, attribute meaning to it, and attach a feeling to it, were better able to prepare themselves for the challenges to come and, as a result, mourned appropriately and effectively. Such an approach was more effective in ensuring that the widows received support from the environment and these Participants were thus more likely to feel cared for, reassured and protected.

For those Participants who could not incorporate their challenges into their existing cognitive structures, attributing meaning to events could have had a negative impact on their environment, and as a result, they were more likely to feel unsupported, alone and lost without their husbands. These Participants tended to be more suspicious of their environment and to withdraw from it, which in turn deprived them of the comfort that came with support. This is because people constantly make attributions and judgements about their own and others' behaviour (Thomas et al., 2009), and these Participants would have consistently made the same attributions and judgements.

### **5.3.1.2 Sub-theme 2: The couples' knowledge and understanding of the illness**

Despite their knowledge and understanding of their husbands' condition or the lack thereof, all the Participants went through similar experiences of anticipation before the death of their husband. For example, the professional nurses, who had extensive knowledge and understanding of their husbands' conditions,

responded to their deterioration in a similar way as the rest of the Participants. This may be because human beings are motivated to reduce unpleasant states of arousal as much as possible, even if it means changing formerly held cognitions (Keltner & Haidt, 1999) as discussed in section 2.3.4 of chapter 2.

Some of the professional nurses even dealt with the deterioration of their husbands' conditions in a more confused way than the rest of the Participants. This illustrates that the Participants' cognitions and emotions might have influenced behaviour, and that their behaviour in turn might have influenced their cognitions. Consequently, it may be assumed that knowledge and understanding of the illness does not necessarily play a role in preparing people either for the death of a spouse or the actual bereavement. It can furthermore be assumed that knowing and understanding the condition can at times work against helping the Participants to cope effectively with the challenge of the anticipated death due partly to the emotional pain of knowing and understanding. On this basis, knowledge and understanding of the condition does not necessarily play a role in alleviating the challenge of anticipating death. This then suggests that education does not necessarily translate into better knowledge and understanding of the condition. For example, Participant six, who had less knowledge and understanding, managed her dying husband's condition better than those Participants who had sufficient knowledge and understanding of their husbands' conditions.

### **5.3.1.3 Sub-theme 3: The different roles played by the Participants and their husbands individually**

The anticipated deaths of the Participants' husbands was traumatic for some Participants and was often associated with bouts of sorrow when the couple acknowledged that one of its partners would die in the near future. Nonetheless,

it did not prepare the Participants for the final loss and the expected changes in their roles.

The husbands were perceived by the Participants as having been good providers, good husbands and companions to the Participants, with the exception of Participant three, who perceived her husband as self-centred and felt that he never fulfilled his socially expected role of provider. The Participants of the husbands who had been medically boarded by the time they died prepared themselves earlier during the illness of their husbands to the play dual roles of both provider and homemaker.

Some husbands were still employed at the time of their deaths and, as a result, their wives continued to fulfil the socially expected role of the homemaker until their husband's death. These Participants only assumed the dual roles of providing for the family and homemaking after the husband's death.

Role shift took place when the role schema that the Participants were used to changed. There were no negotiations regarding the role changes, probably because the scripts of the couples' culture expected them to function as a team, especially in transitional societies.

#### **5.3.1.4 Sub-theme 4: The couples' strengths and vulnerabilities**

The nature of the bereavement is determined by, among other things, one's relationship with the deceased and one's personal vulnerability (Parkes, 1972). This is related to people's mental, emotional and spiritual health and helps shape the way they cope with loss. Also, the Participants' difference in vulnerability because of individual emotional differences reflected differences in cognitive appraisal and coping at every stage of the anticipatory grief process (Neimeyer et

al., 2004). Together, these factors determine the intensity of the bereavement experience, depending on the Participants' attribution of meaning to their husbands' deaths.

The nature of the couples' relationship was found to function as either a strength or vulnerability. Despite their distant relationship, Participant couple nine was motivated by the realisation that they did not have much time together to function as a team. That forced them to deal with the anticipated death in a mature manner. Their ability to assimilate or incorporate the anticipated death into their existing cognitive structures, attribute meaning to it, and attach a feeling to it prepared them to behave in a mature manner. This then became the couple's strength.

Just as the anticipated death of the Participants' husbands was a vulnerability to most couples; there were other unique vulnerabilities that affected each couple separately. These factors include interference from the husbands' families, stigma attached to one husband's HIV status, and non-compliance with the treatment regimen. All of these issues deprived the couples of an opportunity of realising and sharing possible similar fears and uncertainties that they might have had. These vulnerabilities are discussed further later in this chapter.

It seems that the nature of the couples' relationships played a significant role in how the couples dealt with the challenges of the illness, the physical deterioration of the husband, and his ultimate death, which some couples expected, some denied, and some did not expect. It also seems that the strength of attachment security, the length of the relationship, degree of dependency, and the meaning of the possible loss played a role in how each Participant approached the challenges and coped after her husband's death.

The Participants' cognitive processes of assimilation and accommodation also played a role in their ability to rearrange and establish a new equilibrium to be able to function effectively. Those who were able to respond to the anticipated death with cognitively adaptive efforts, such as renegotiating their relationships within themselves, were able to exceed their previous level of psychological functioning. As a result, intense sharing in the couple's intimate lives was maintained, and these Participants were more likely to tolerate a lonely life after the death of their husbands. This achievement assumes an innate, consistent ability to organise their experiences in accordance with the challenges facing them, leading towards adaptation and a state of internal equilibrium, and creating a balanced relationship between themselves and the reality of their lives (Beck, 1996).

However, those Participants who tended to be bitter and angry, such as Participant three, experienced greater difficulty coping with the loss. As a result, these Participants experienced dysfunctional bereavement and possible low self-esteem. Participant three's low self-esteem was reflected in her belief that she was born poor, grew up poor, married poor and would die poor. Her subjective perception and interpretation of the relationship was that it was emotionally stressful, and she underestimated her ability to cope in an emotional challenging relationship (Baer & Martinez, 2006). Her lack of self-esteem promoted anxious and ambivalent feelings, and contributed to less trust in her relationship with her husband. This may have led to possible depression and difficulty planning future activities (Carr et al., 2001), as well as dysfunctional bereavement, in which she exaggerated both the negative and positive aspects of her relationship with her late husband.

In conclusion, how the Participants cognitively interpreted the loss of their husbands, together with the kind of relationship they had (attachment), determined the intensity of their bereavement experience, depending on the

attribution of the meaning of the loss they experienced. Just as loss tended to focus the Participants' attention on the immediate situation, altered their ordinary perceptions, and evoked intense feelings of fear, their belief in the relationship between the dead and the living gave them a certain level of relief. This was within the context of knowing that their husbands, as ancestors, are accorded a special status based on the fact that they live among the living (Setiloane, 1989), serving and protecting them as the living (Mbiti, 1970, 1991). Death is not thought to end human relationships, but instead, heralds the entrance of the dead into the spirit world. Also, the African belief of the spirit world to be a copy of the society in which ancestors lived in this life, where ancestors are believed to remain as part of the family (Idowu, 1973; Mbiti, 1969; 1970; Mojapelo-Batka, 2005; Okwu, 1979), helps widows to maintain the relationships with their late husbands who will continue maintaining an interest in family affairs just as they did before death. The deceased are considered to be indispensable intermediaries, and integral to the traditional African social structure, where the dead are in a much better place without pain or hunger. Pratt (2003) argues that for an African family to be cut off from relationships with its ancestors is for it to cease to be a whole, the reason why African culture often acknowledges the presence of ancestors, particularly at meals or when drinking brewed beer, where small portions are set aside or spilled on their behalf.

The theme that follows addresses the challenges of the Participants where the focus is on their experiences of those challenges. They include how past significant losses in the Participants' lives impacted on the loss of their husbands, the stressors they encountered, their experiences of caring and treatment regimen of their dying husbands, and their attitudes towards and responses the illnesses and its ramifications. These are the challenges they dealt with.



### **5.3.2 Theme 2: Discussion of the findings in respect of the Participants' challenges and how they dealt with them**

#### **5.3.2.1 Sub-theme 1: Past significant losses in the Participants' lives**

It seems that past losses of significant others had less of an impact on the Participants if they were living apart from the person at the time of death. This finding may be due to the shift in focus on the part of the Participants, whose nuclear families may have been their primary concern after leaving the family of origin. This suggests that even though attachment behaviour may not always be evident, this need not indicate a lack of attachment, but rather a change in the attachment pattern (Bowlby, 1997; Kay Hall & Geher, 2003).

Participant two, who showed a secure attachment style and Participant three, who indicated an insecure attachment style, had experienced multiple losses by the time their husbands died. Participant two had lost her eldest son two years before, while Participant three was still struggling to come to terms with the loss of her father prior to her marriage, and whose funeral she did not attend. Participant two's grief could have been functional as her son had died only two years before the death of her husband, and her reported grief was therefore within normal parameters. Participant three, however, lost her father more than twenty years before the death of her husband, and she was still struggling with that loss, suggesting a prolonged bereavement which could have also affected her bereavement process following the death of her husband.

#### **5.3.2.2 Sub-theme 2: Stressors**

Most of the Participants' stressors revolved around their in-laws in different ways. Chapter 2 section 2.2.4.4 stated that marriage rituals in African culture have the meaning of integrating the two families (the families of the bride and groom)

together with their ancestors, where the death of a husband cannot be fully understood if the meaning of marriage and the rituals that go with it are not accounted for. However, the two families may have different ritual practices. The couples can also have different practices from those that were practised in their families of origin and, as such, create conflict (a stressor) at the time of the Participants' husbands' deaths. This is so as people develop expectations that are greatly affected by all kinds of shared experiences and are formulated from previous experiences that were guided by their communities around them, giving them a frame of reference for later experiences, and further come to have similar perspectives on their situation (Li & Karakowsky, 2001). This then defines the couples' belief systems, which form part of the subculture of a particular family.

Mourning is also a culturally prescribed script that moves mourners through the bereavement process and helps them adapt to their loss (see chapter 2, section 2.2.4.8; Kubler-Ross & Kessler, 2005; Moody & Arcangel, 2001). In this case then, in-laws should have played a major role in supporting the Participants in adapting to their loss. In line with new developing ways of living in transitional societies, however, it seems that the Participant couples may have had their own ways of doing things that were different from the rituals practised by their families of origin. This may explain why all of the Participants experienced conflict of some sort with their in-laws. It also suggests that transitional societies could have what Kashima et al. (2004) refer to as weak scripts, which are a contradiction between individual scripts and society's scripts. Due to a contradiction between individual scripts and society's scripts, there are few clear scripts to follow. This is discussed more in Theme 4, sub-theme four (participation in African death rituals) later in this chapter.

An added factor is the emerging nature of Black urban societies where the focus tends to be on the individual and support from the community is somewhat different to that in traditional societies. There are also unrealistic expectations of

the Participants to show courage (Carr et al., 2001), and to heal within a certain period of time due to the demands of urban society when affective schemata produce different feeling states through automatic thoughts and the meanings attached to events, contributing to the arousal of an emotion concerned with survival (Colfman et al., 2006). In the process, the Participants' attitudes developed because an emotion is the process that starts when something is perceived, appraised and developing an attitude (Walsh et al., 2002).

Each emotion has its own structure, in much the same way that each individual is structured differently with a unique purpose in life (Malkoc et al., 2002). This should also be taken into account in considering the Participants' reactions. The Participants' cognition could have served to minimise or aggravate their experience of certain affective reactions, as mentioned in section 5.5. The differences in the lack of support provided by the family in-law produced different feeling states, with different shadings and combinations (Beck, 1996). This is also evident in the affective experiences of different societies, where the range of emotions associated with bereavement and which allow social expression differs. For example, in some societies, males and females are expected to cry openly at funerals while amongst Africans, only females are expected to be openly tearful.

Participant seven's response may be explained as her emotions evolving for adaptive functions in dealing with the loss of her husband. Her mother in-law's emotional pain at losing her son seems to have lead to a maladaptive, dysfunctional irritation towards the Participant. Another explanation may be that the two individuals (Participant and mother in-law) had different perceptions of emotional pain, due partly to different socialisation experiences (Holm & Severinsson, 2008). The two women's different roles, as mother and wife, also influenced their experience of their loss and affected the status of their relationship with each other.

Martin and Doka (1998) find that the experience of death is influenced by childhood experiences, other recent losses, their resolution, or changes prior to the loss. However, those Participants who had experienced previous losses of significant others did not seem to have been affected by their husbands' deaths any differently from other Participants. Rather, the Participants' perception of emotional pain was mainly determined by the relative degree of individual extroversion or introversion (Holm & Severinsson, 2008). Participant two lost significant males in her family at an early age and lost her son two years prior to her husband's death. Her childhood losses seemed to have less impact than the loss of her son, suggesting that her nuclear family was more significant to her than her family of origin. Participant three lost her father after she was married, but did not attend his funeral and was emotionally inexpressive when asked about her father's death. Participant three's negative experience of the death of her father (paternal relatives not telling her family of her father's death) could have contributed to her negative feelings with regards to the death of her husband. In contrast, Participant two was emotionally expressive, showing open and flexible social cognition and a functional approach to her bereavement.

Participant three was less emotionally expressive, with a different cognitive appraisal style and coping strategies. Participant three seemed to have maladaptive strategies based on her extreme, rigid and imperative schemata (VanLehn, 1996). These may have rendered her more susceptible to life experiences that impinged on her cognitive vulnerability. This was evident in the nature of her relationship with her husband, which was characterised by distance.

It was mentioned in section 2.2.4.8 of chapter 2 that sociocultural factors define mourning, influencing the experience of loss through socially determined rules. As such, the observation of cultural mourning rituals will always accompany mourning. However, some Participants were obliged to follow rituals that they

were not brought up with, which became a stressor to them. Participant nine had to deal with the stigma of her husband's cause of death (HIV/AIDS) and suspicion from her community that she had been infected and was living with the disease. She anticipated hostility and was spontaneously immobilised, as her suspicions provided her with an interpretive framework that determined her level of coping with her suspicions (Mayer et al., 2000).

The Participants reported being physically affected in more or less the same way in response to these stressors. According to Schachter and Singer's theory of emotions, physical arousal and cognition are both needed to experience an emotion so that the cognition can interpret physical experience according to the event that is taking place (Bowlby, 1997). The fact that some Participants did not report any physical experiences may be due to their taking medication for symptoms. These experiences are discussed in more detail in the section that follows.

### **5.3.2.3 Sub-theme 3: Caring and treatment regimen of the dying husbands**

The degree of caring the Participants gave their dying husbands seems to have depended partly on the nature of the couple's relationship. Among couples who had a close relationship, the Participants showed commitment to the care of their husbands, which was largely accompanied by cooperation from their husbands.

For example, Participant couple three had a distant relationship and the Participant felt irritated by having to care for her husband. She also came across as having a traditional view of life, with a more external locus of control, which meant that she felt obliged to adhere to the traditional social expectations of caring for her sick husband despite her resentment at having to do this. Her behaviour could be interpreted in terms of situational attributions based on her

culture. She could not recognise the fact that culture is not static and that her existing schemata were inadequate to deal with her new experiences. She was unable to accommodate and undergo structural change in her schemata due to her self-schema, which developed in the course of her interaction with her environment. This prevented her from comprehending the nature of a transitional society where the boundaries and frameworks of culture are not rigid. She was also unable to evaluate her new experiences of the transitional society within which she functioned and could not adapt to develop alternative perspectives such as those expressed by other Participants (Mkhize, 2004). This could also be a reflection of poor adaptation to the dominant culture on her part. This is so as caring for others is part of the spirit of ubuntu in African culture, where non-compliance can be perceived as a deviation from the norm. This then confirms the inseparable nature of culture and cognition where scripts, including other schemata, together defined the Participant's belief system, which was different from the community within which she functioned.

There was no mention of nursing their husbands by some Participants. This might suggest that the Participants took their dying husband's caring as a socially expected norm, confirming the influence of shared scripts that allowed the Participants to make inferences about the appropriate behaviour (Kashima et al., 2004). For example, socialisation, culture and the expectations imposed by society, community and individual families within which the Participants grew up would also have played a role. It would seem that care-giving and care-seeking systems are combined as most Participants' relationships contained both, making care-giving an integral part of, and an outgrowth from the care-seeking system.

#### **5.3.2.4 Sub-theme 4: The attitudes towards and responses to the illness and its ramifications**

The dying process can be viewed as a process not too dissimilar to growth and maturation. Just as maturation entails physical changes and their recognition, the dying process brings with it new ways of thinking about one's self, one's future and aspirations. The recognition and adjustment processes in both scenarios are similar (reference). In the current study the couple's attitudes and responses to the husband's illness ranged from awareness, confusion, frustration, commitment and appreciation to hopelessness.

The physical deterioration of some of the husbands in the advanced stages of illness may have affected the couple's emotional state. According to the participants some husbands did not make their wives aware of their struggles even though their relationships were open and healthy, probably because they realised that they were reaching the end of their lives. Instead, they showed consideration and expressed appreciation of their wife's efforts. For example, one husband suggested that an assistant should be found to nurse him so that the Participant could rest. Despite the husbands' attempts to minimise their discomfort, the threat of the anticipated death as a cognitive schema, and feelings of anxiety as affective schema, the Participants' behavioural attitudes were reflected in their commitment to caring for their husbands, and their reciprocation of their husbands' consideration. The couples' motivational schema helped them deal with their wishes and desires. It can be concluded that those Participants accepted their husbands' physical deterioration to the extent that death was expected.

It is clear that the couples with secure attachment styles were better at dealing with the illnesses and the anticipation of death. Their individual secure attachment styles helped them to hold more positive and less negative emotions

and beliefs about each other and their situation. Their secure styles made their responses to their challenging situation more adaptive.

Couple three did not conform to this picture. Participant three had a negative attitude towards her husband, and responded with ambivalence and irritation. That may explain why her husband did not make the Participant aware that he was struggling and needed to go to hospital, and the Participant often only discovered later that her husband had been hospitalised. There was also no mention of her taking him to hospital, even though she was familiar with the nature of his illness. She never showed concern for her husband during the interview, which could explain why her husband never talked about his illness with her. Her non-involvement could be explained by the fact that the Participant felt used because she perceived her husband as being interested only in himself and nobody else.

Some couples' attitude to the illness seemed constituted in a combination of a lack of understanding of the husband's condition and confusion about it. Some seemed unaware of the seriousness of the illness and its consequences. As such, the Participants reported no specific attitudes towards the illness and its ramifications. This group largely comprised the widows who only learned of the husband's illness very close to the end.

The findings of this study confirm Beck's (1996) view of bereavement, which, in the case of this study would be anticipatory, as an affective reaction and an integral part of psychobiological strategies concerned with survival where Bonanno and Field (2001) hypothesise that a dysfunctional attitude acts as a general psychobiological indicator. As such, the Participants' attitudes become their personal coping resource.



The next theme focuses on how the Participants experienced stressors that they were faced with, which are, physical symptoms, their responses to the news of their husbands' deaths, how their in-laws responded to them, and the emotions they experienced.

### **5.3.3 Theme 3: Discussions of the findings in respect of the Participants' experiences of stressors**

#### **5.3.3.1 Sub-theme 1: Physical symptoms**

The fact that there were Participants who did not report physical symptoms after the deaths of their husbands does not imply a total absence of physical processes, as a negative affective schema could be experienced even in the absence of bodily damage (Holm & Severinsson, 2008). Emotional pain is an inevitable experience during the bereavement process. Walsh et al. (2002) confirm this in their description of emotions as subjective feelings that affect and are affected by one's thoughts, behavioural and physiological processes that form the basis of affective schemata.

Some Participants experienced physical symptoms that were similar to the characteristics of clinical depression. These included headaches, sleeplessness or sleep disturbances, and lack of appetite. Zuckerman (2006) notes that depression may be associated with bereavement, arguing that people experiencing depression tend to have a particular attribution style where failures and negative events are attributed to internal, stable and global causes. Such an attribution style could contribute to dysfunctional bereavement. This may explain how bereavement is usually diagnosed and treated as depression by health professionals. Despite similarities in the physical symptoms of depression and bereavement such as dizziness, shortness of breath, headaches, heartburn, psychosomatic pains, and chronic colds, there are noteworthy differences

between them as depression is a condition, whereas bereavement is an emotion (Parkes, 1972).

### **5.3.3.2 Sub-theme 2: The Participants' response to the news of their husbands' deaths**

The feelings and responses exhibited by the Participants upon hearing the news of the deaths of their husbands are a reflection of the way that they cared for and valued their husbands. Their responses heralded the end of an important relationship, which triggered a synchronous and integrated cognitive-affective-behavioural network. This network was similar for all the Participants.

The steady physical decline of some of the Participants' husbands may have raised their wives' awareness of their suffering and the seriousness of their illness (Rafaeli & Hareli, 2007). This may have evoked an emotional process in the Participants, starting with when they perceived and appraised their husbands' deterioration. Also, the seemingly adequate medical care that was provided in the transitional society under study, with repeated discharges home, may have given them false hope about the condition of their dying husbands. Jarymowics and Bar-Tal (2006) state that where there is hope there is rationality and progress. This may partly explain the response of shock and disbelief that was common to all the Participants to the news of their husbands' deaths.

It seems that the Participants' experience of their husband's illness and their physical deterioration did not prepare the women for their death. However, the different levels of intensity of their experiences and responses could be explained by, among others, the attachment they felt to their husbands, which triggered an instinctive and spontaneous response to their husbands' loss in terms of the couple's relationship.

According to Shaver and Tancredy (2001), the Participants' experiences of their husband's illness and their physical deterioration are among the most intense and influential of human experiences. This experience prompted the Participants to respond in accordance with the customs and norms of the transitional community within which they functioned, and this response was directed towards survival. They responded to the news of their husbands' deaths in a more or less similar manner. This can be explained by Damasio's (2003) explanation of secondary emotions, which are not necessarily related to an adaptive response in a given situation but are learned responses, usually in our families of origin, and afford us the ability to reason about current events in the light of experiences and expectations of events.

As previously mentioned, just as the Participants had different experiences of their husband's illness and the associated stressors, so they responded to the news of their husbands' deaths in a similar manner. For example, those Participants with secure attachment styles were most likely to look at their experiences with more frequent positive emotions and fewer negative emotions due to their tendency to having greater openness and flexibility in social cognition. They were therefore better able to adjust than those Participants with insecure attachment styles.

Theme 4 discusses how the Participants coped with their situations which involve their resources, how they approached their challenges, how they coped with them, and their participation in African death rituals.

### **5.3.4 Theme 4: Discussions of the findings in respect of coping**

#### **5.3.4.1 Sub-theme 1: The couples' resources**

Resources and support also played a role in coping. The couples whose children were independent were at an advantage, as they did not face the challenge of concern and care for their children before and after their father's death, and needed only to focus on themselves as a couple.

In my private practice I have often come across cases where a woman's in-laws blame her for her husband's death. Commonly, one finds that the deceased used to provide for his family of origin before marriage where the family of origin are then deprived of this support after his marriage. That often creates resentment towards the new wife, with hostility present in the relationship between the daughter in-law and the husband's family of origin. A similar situation arose with one of the Participants in this study. The in-laws' lack of support for the Participant suggests a long-standing hostile relationship between them. In the case reported here, resources were social, moral, emotional and financial, with the latter representing an instrumental resource.

All of the Participants of this study but one received spiritual support from their church, and believed that their husbands were with God. It seems that spirituality, as a connection with a higher power or a sense of meaning, can provide tremendous comfort and support. Spiritual support reflects the spiritual nature of transitional societies, which, to a certain extent, may have replaced society's form of a communal way of life that has been lost from traditional societies. The formation of support groups is also a reflection of a different form of communal life that transitional societies have defined. This relates to the dynamic nature of culture discussed in section 2.2.4.1, where schemata are built in interaction with

people's surroundings and in the process, assimilate objects and events into existing schemata, and expand people's existing frameworks of knowing.

The moral support that Participants received from their families of origin and neighbours also reflects a part of the traditional way of life that is retained by transitional societies. The fact that some Participants received additional moral support from their in-laws, suggested that not all families in-law respond to widows in an unsupportive manner. Some couples' children were also acknowledged by some Participants, reflecting how the different couple subsystems' rules, boundaries, and unique characteristics change over time. This is noted in section 2.3.5 of chapter 2. For example, the child subsystem changes from dependence on parents to supporting the parental subsystem (Wendt & Zake, 2006).

The couples' resources differed among the Participants to a certain extent. Some couples were financially stable because both the Participants and their husbands were employed, while in other couples, only one partner was employed. In some cases, both partners were unemployed, which caused additional financial strain when money needed to be found to pay for the burial.

Some Participants' personalities also acted as a resource for the couple. Those Participants with a sense of autonomy, commitment, and the ability to think ahead, and who had developed proactive ways of dealing with challenges, could manage the emotional challenges of their losses better than those who did not have those traits. This is clearly explained by Gerjets et al. (2000) who consider self-schema to be one's self-image that is comprised of various cognitive structures about the self.

In contrast to this picture were the Participants whose dying husbands continued to live the unhealthy life that they followed before their illness and failed to comply with the treatment regimen. These couples avoided talking about their illnesses and what was to come. As a result, they lost out on an opportunity to share their views and needs with each other.

It was evident that the Participants of this study were adequately socially integrated in their social support networks like churches, friends and support groups. However, it is highly likely that the Participants who were dependent on their husbands for male stereotyped tasks such as financial support would be at higher risk for struggling to come to terms with their loss. Naidoo (2005) argues that how individuals prefer to use their mind (cognitive processes) is unique to an individual. He maintains that these processes are based on comprehensibility, manageability and meaningfulness, which together comprise a sense of coherence. He further showed that coping individuals tend to display a significant preference for feeling and judging with a high level of coherence, while non-coping individuals tend to show preferences for intuition and perception with a low level of sense of coherence.

#### **5.3.4.2 Sub-theme 2: The Participants' approaches to their challenges**

Section 2.2.4.4 of chapter 2 mentioned that the death of a spouse has an impact on the Participant's self-schema and so affects her social self. When this event takes place, the Participant changes from being a married woman to a widow without a husband. The development of the Participant's self and self-knowledge is thus an active learning process. As a result, her *ought self* changes to being both a 'father and a mother' to her children. In the process, the uncertainty of her *possible self* may be affected, and she may become unsure of whether she could possibly become what she should be (Alexander, 1997). In this network, the death of her husband can be regarded as a perceived threat to the Participant

(cognitive schema), with anxiety (affective schema), and creating a response to act in accordance with social expectations (motivational schema).

Some Participants showed their strengths of character in different ways. For example, one woman showed respect by fulfilling her husband's wish that the family did not use the main bedroom to show their respects but did so rather in the lounge. Another did not observe customary death rituals such as wearing black clothes, and another made the funeral arrangements on her own even though it is not customarily expected of her to do so. Some continued with their daily commitments during the husband's illness, leaving him alone at home, something that is not usually socially expected. These women report that their husbands never complained or felt neglected, which suggests cooperation in the relationship.

The above examples illustrate the changes that have occurred in transitional societies, and speak to the Participants' ability to adapt to their environment and, at the same time, adapt the environment to them (Gerjets et al., 2000). Just as much as the self-schema is a composite image of what we think we can achieve (Gerjets et al., 2000), one can never know what this may be until one is confronted by challenges such as those experienced by the Participants of this study.

One Participant felt more in control after the burial than before. Prior to the burial her financial situation put her in a socially dependent role; however, afterwards she showed control by telling her sister-in-law that she disliked her and did not want her to come to her house anymore. Another Participant could not control her in-law's interference in her marriage, but arranging her husband's tombstone ceremony put her back in control as she ran this ceremony by herself and did what her husband would have wanted. The Participants who wore black clothes

dealt with this challenge in different ways. One Participant understood the manner in which her black clothes impacted others, while another interpreted people's response to her black clothes in a way that left her feeling alienated and hurt.

After their husbands' death, some Participants changed for the better, while others did not. One Participant who seldom interacted with people around her when her husband was still alive interacted more with others than before albeit other widows. This occurred when she joined the support group, which she found to be helpful as it made her feel stronger than before, which allowed her to experience empathy with those Participants who were struggling more than her. Another Participant withdrew more after her husband's death than during his life.

Some Participants dealt with their different challenges in an unforgiving manner. One Participant found it difficult to forgive her husband for not having taken care of the family; some were unforgiving of their in-laws for the treatment they received during their husbands' illness and after their death. One Participant discussed her process of forgiveness, and showed maturity by always trying to understand the reason behind people's negative behaviour towards her.

Some Participants dealt with their challenges by finding comfort and meaning in their experiences. For example, one woman consoled herself with the knowledge that she had been the last person to be with her husband before he died at the hospital, and expressing appreciation that the doctor had been hard on her to make her realise that she needed to focus on the source of her struggle. Another expressed appreciation was the fact that he kept his distance and so avoiding infecting her with HIV, and appreciation of her husband for having been a good provider when he was still employed.



Some Participants dealt with their challenges by becoming more self-reliant, while others dealt with their challenges by becoming more helpless. One Participant was able to open a community-based convenient store so that her husband could keep himself busy during the day, and also compensate for his share of the budget. Another one was able to maintain her household after her husband's death despite having been unemployed when he was still alive, selling things to make money for her children, and resolving the problems that they had not been able to resolve as a couple. One Participant responded in a more self-centered way, perceiving herself as a victim who was unable to do anything about her situation. She predominantly reported feelings of self-pity and disempowerment.

Two Participants responded with withdrawal, although they expressed this in different ways. One of these Participants felt that her husband was on her side, while the other Participant felt that her husband was not there for her. The two Participants also reported differences in the support they received from their siblings and support they received from other people. Some Participants dealt with their challenges by accepting their situation for the sake of peace; some avoided people around them; some regarded others with suspicion, discomfort or empathy. Some Participants dealt with their challenges with bitterness and anger, some of which was directed at their in-laws, even though the Participants did not expect anything from them. One Participant's anger and bitterness was directed to her husband's friends and her church. Another Participant directed her anger and bitterness towards her brother in-law and husband.

It seems that the Participants' challenges were primarily emotional. Their need was to develop and employ adaptive functions of coping with their feelings about the loss of their husband while still providing care for him. Such challenges require rational and constructive thoughts. If these are not utilised, maladaptation through the use of dysfunctional reactions may result (Garling, 1998).

#### 5.3.4.3 Sub-theme 3: The participants' coping

What dysfunctional bereavement is to one Participant may be functional to another, due to, among others, learned factors from the environment. The Participants' bereavement depended on their individual cognitive interpretation of the loss of their husbands, the shared scripts of their culture, attachment styles, and social characteristics. Another factor to consider may be the duration of widowhood. This is relevant, as widows who have been widowed longer could come across as coping better than ones who have been recently widowed. However, as widowhood was limited to six months to a year-and-a-half in this study, the duration of widowhood on the type of bereavement could not be explored.

The fact that all the husbands but one died in hospital reflects a changing society. The Participants were therefore exempted from having to deal with the unknown character of their husband's anticipated death, and this may have given them hope of recovery, as the husbands would often come back from the hospital in a better condition than when they were admitted. Jarymowics and Bartal's (2006) study suggests a specific integrated response to external demands and provides an organised way of processing events; however, it is still uncertain if this response had any impact on the Participants' expectations and acceptance of the anticipated death, and how they coped with this challenge. This is based on the relationship between cognition and affect.

The deterioration of the husbands' health decoded the meaning of that deterioration. The Participants perceived their husbands' deterioration as a threat to their health, and gave rise to their fear of losing them. The suggestion that comes out of this is that it is more traumatic to witness the death of a significant other than not witnessing it. At times, the Participants were not certain whether their husbands would survive or not, and experienced only fear. This made it

difficult for them to deal with the challenge of the possible death of their husband. Facing such a possibility involves an element of emotional turmoil, which the Participants had to overcome to function effectively. Whenever a schema of personal loss is activated, there is a consequent activation of an affective schema. As the Participants had created affection bonds to their husbands, this affective schema entailed intense sadness. That suggests that coping requires a complex set of emotional, cognitive and behavioural reactions. The Participants' fear of losing their husbands may have been due to the schema about loss that is associated with negative emotions, with the result that Participants try to avoid those emotions.

Couples with employed husbands or husbands who were on sick leave when their conditions deteriorated eliminated the important issue of financial difficulty, as financial stability seems to be an important factor in coping in transitional societies. This gave the couples an opportunity to focus on other important issues in their lives, knowing that financial stability will continue even after the husbands' deaths, for example, the husbands' employers' pension funds. It helped them to cope better with the anticipated death and the dynamics surrounding it than those couples whose husbands were unemployed.

In dealing with the cognitive impact of the loss of their husband, Participants with secure attachment styles tended to deny the loss only as an initial defense to get used to the idea of the loss. Among these Participants, the initial experience of denial is functional. Participant three, who was insecurely attached, tended to use denial as her only coping mechanism, making her resistant to accepting the loss of her husband who she missed after his death. That could have prevented adaptive cognitive change, explaining the headaches, withdrawal and loneliness, all of which suggest a dysfunctional bereavement.

This sections suggests that the ability of the Participants to cope with the challenges of their husband's anticipated death depends on, among other things, the couples' knowledge and understanding of the illness, the different roles played by the Participants and their husbands individually, past significant losses in the Participants' lives, whether the Participants participated in African death rituals or not, the Participants' attitudes towards and responses to the illness, and the couples' resources. These aspects are discussed in the sections that follow.

#### **5.3.4.4 Sub-theme 4: Participation in African death rituals**

Death rituals are scripts that enable people to interpret the meaning of situations, based on the culture of a particular society (Kashima et al., 2004). They guide behaviour by allowing members of a society to make inferences about what the appropriate actions in a particular situation would be, and also help cope with situations. Just as much as members of transitional societies seem to have some different death rituals from members of traditional societies, which seem to depend on familial instead of societal expectations, those death rituals (weak scripts) seem to be shared by members of transitional societies to a certain extent.

Irish, Lundquist and Nelson (1993) believe that attitudes, beliefs and practices about death and bereavement are characterised and described according to culture. In transitional societies, for example, weekday funerals are conducted where the community attends a church service and those who have to go to work leave when the procession departs for the cemetery. This is something that was unheard of before.

These changes may create the potential for contradiction between individual Participants' intrapersonal experiences of bereavement and their preferred

cultural expression of bereavement (Ong et al., 2004). Failing to carry out expected rituals can lead to an experience of unresolved bereavement for some people.

From the findings of this study it seems as if bereavement and sadness in transitional societies still accompanies the observation of mourning rituals to some extent, suggesting that an element of societal prescription of customs remains. This is evident in the findings, which show that there were rituals that were shared by most Participants' families. These rituals should be thought of as event schemata that are vitally connected to the Participants' lives to provide meaning and value to them (Parkes, 1972), to help them go through their bereavement process. The most common rituals were the cleansing ceremony for the Participants, the corpse coming home overnight, the preparation of the corpse by male relatives, the giving away of the deceased's clothes, and the slaughtering of an animal.

The Participants' compliance with the cleansing ritual, for example, was evident even though some Participants were unsure of their position on participating in African death rituals. This applied to a number of Participants, including some who were unsure of the rituals despite their having been practised in their homes while they were growing up. Those who went through the cleansing ceremony even though they did not believe in the ceremony complied for different reasons. For example, some complied out of respect for their families' belief system, and some because their families of origin insisted on the respect of the ritual. Some did not understand the logic behind the rituals. This reflects the inseparable relationship between culture and cognition, where the different schemata, including scripts, together define a belief system.

The least common ritual was wearing black clothes as a symbol of the Participants' widowhood. Amongst those who did wear black clothes, some resented this ritual. Only one Participant wore the clothes without feelings of ambivalence and conflict, probably because she had grown up in a traditional society. The fact that she had different scripts from most of the other Participants meant that she could assimilate the ritual in the same way as her in-laws, and so incorporated her loss into a different established repertoire from the rest of the Participants in the support group.

Although it is generally accepted in African culture that the deceased become ancestors, during the interviews conducted in this study, none of the Participants referred to their late husbands as ancestors. That could be because the Participants assumed that as a member of their community and culture, I would know, understand and respect that their husbands were ancestors, or perhaps they had not yet processed the loss of their husbands up to that level. Christianity may also have developed as an alternative worldview for the widows, supplying the spiritual strength needed to cope with the loss of their husbands. The participants used the transitional societal system of shared beliefs, values and customs to cope with their loss through learning from their past experiences about death and the rituals that go with it.

In some families, the widows' families of origin conducted the cleansing ceremony. In others, in-laws first cleansed the widow and then her family of origin cleansed her weeks or months later. Eight out of the ten Participants went through the cleansing ceremony. Also, as at least seven of the Participants shared the Christian faith, consolatory services were held at their homes to comfort and encourage the family (Blakely, Van Beek & Thomson, 1994).

In the next section, a developed systematic bereavement model will be presented and discussed.

## **5.4 DEVELOPMENT OF A SYSTEMATIC BEREAVEMENT MODEL**

### **5.4.1 Introduction**

The model presented in this section is based on the cognitive-affective-behavioural network in which the Participants' observed behaviour, and how they coped with the anticipated and actual loss, is interpreted based on cognitive processes that include culture and emotions. Beck's (1996) relationship between cognition and affect, Li and Karakowsky's (2001) advocacy of the relationship between cognition and culture, and Willingham's (2007) views of cognition form the basis of the model. The model is based on the findings of how widows in transitional societies, who lost their husbands through terminal illness, transformed information about the loss of their husbands by reducing, storing, elaborating upon it, retrieving it from memory and using it.

Through the overview and the subsequent discussion of the literature it was determined that attachment styles play a role in determining the Participants' way of coping. From these discussions, it became apparent that in order to fully comprehend the role that each of these constructs played in the Participants' bereavement, an in-depth understanding of the psychological origin of these constructs is required.

The focus is on cognition, affect and cognition (including cognition and attachment), and cognition and culture. From a cognitive psychological point of view, the Participants' bereavement involves a cognitive-affective-motivational-behavioural network. The perception of their husbands' death (cognitive

schema), and feelings such as anxiety, insecurity, abandonment and vulnerability (affective schemata) form an integral part of psychobiological strategies concerned with survival.

Figure 1 below shows the model that developed from the research in this study. It shows how cognition, affect and culture together may determine how the Participants of this study were motivated to behave in a particular way to the challenges they were experiencing.

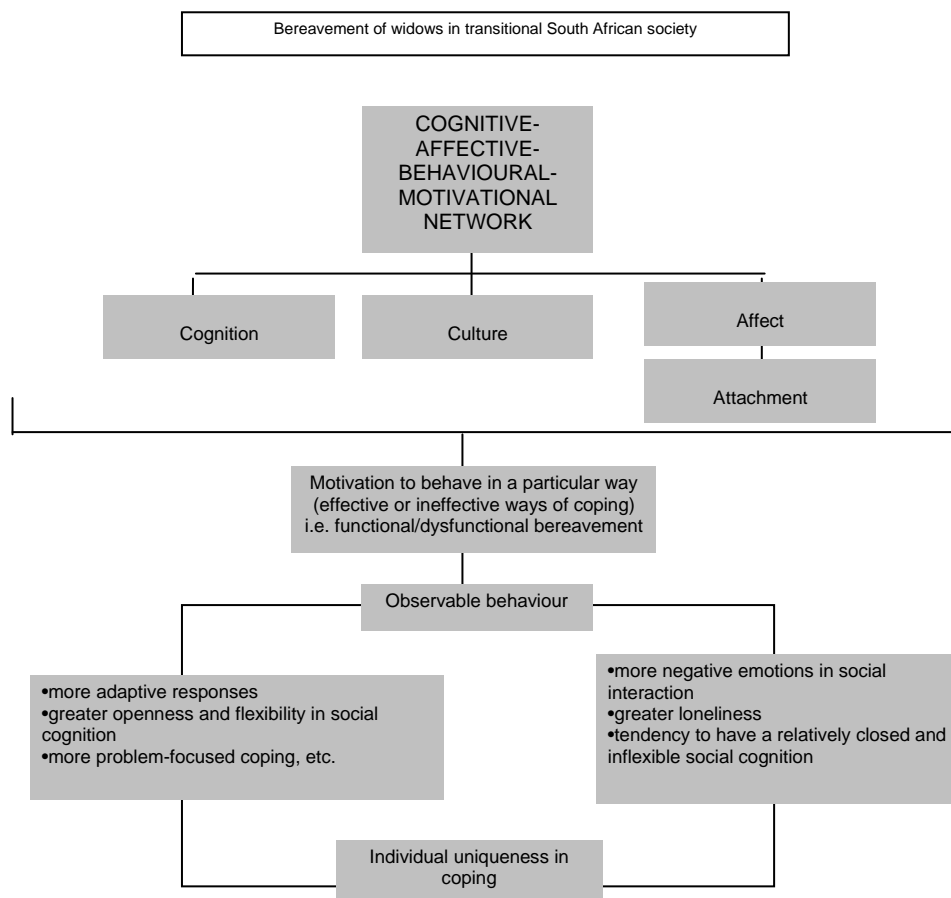


Figure 1 Model of cognitive-affective-behavioural network of bereavement of widows in transitional South African society



The sections that follow elaborate on cognition, affect and cognition, including cognition and culture.

#### **5.4.2 Cognition**

Schemata, which are central to the cognitive process, are also the building blocks of cognition (VanLehn, 1996). As they are a series of interrelated cognitive contents that are acquired through learning as a result of the interaction between individuals and their environment (Gerjets et al., 2000), the Participants' socialisation played a major role in the expectations that were affected by shared experiences in their widowhood, for example, scripts regarding bereavement.

As schemata are inner structures and integrated ways of representing the environment to organise the world (Pratch & Jacobowitz, 1996), cognition played a major role in the Participants' bereavement. Also, the Participants' perception of thoughts pertaining to the loss of their husbands will determine their individual bereavement.

#### **5.4.3 Cognition and culture**

As stated in chapter 2 culture can be viewed as a shared, learned, symbolic system of values, beliefs and attitudes that shape and influence perception and the behaviour of its members (Kashima, 2000) and the analysis of culture entails a search of the material vehicles of perception, affect and comprehension, which are significant symbols, clusters of significant symbols, and clusters of clusters of significant symbols (Mkhize, 2004). Kashima (2000) and Zittoun, Gillespie, Cornish and Psaltis (2007) view metaphors and symbols as fundamental to the understanding of experiences, implying a way of thinking and perceiving that pervades how people understand their world and experiences. However, just as

much as culture is not static, symbols such as language, core values, certain cognitive schemata and so forth, are resistant to change. As such, sharing a common language, for example, is a strong identifying and unifying factor, both as an expression of the shared worldview of a cultural group, and as a factor in the development or change of its members' common perspective (Kashima, 2000).

Culture is shared by members of a society, living and thinking in ways that form definite patterns, which are mutually constructed through a constant process of social interaction. It involves the activity of learning so as to extend cognitive structures (Church, 2001). The Participants in this study learnt from their experiences of bereavement, for example, putting the mattress on the floor in the main bedroom, staying in the house immediately after the deaths of their husbands, and so on. This reflects the Participants' ability to process and evaluate their new experience of widowhood in light of their previous experience of having been married women.

Scripts, as schemata, are formulated from previous experiences that, in the case of the current study, were guided by Participants' communities, giving them a frame of reference for later experiences such as bereavement. However, the weak scripts of transitional societies exist because the communal approach of African culture is conspicuously lacking (Kasoma, 1996). The individualistic approach towards a part of the bereavement of the Participants under study could be discarded since it is unAfrican and not rooted in African values and traditions, and as such, it is a foreign body in the cultural fabric of Africa (Kasoma, 1996; Traber, 1989).

Figlio (2001) finds cultural codes to be a useful way of referring to shared meanings through which people can interact and communicate. As the

Participants reflected on the meaning of their life experiences and adapted to their circumstances, they further came to have similar perspectives on their situation as widows. This reflection and their responses to having lost their husbands would usually lead to a generalisation of what the world must be like and, in the process, determine the nature of their culture (Mkhize, 2004). The Participants achieved this by using codes, which are the systems of organising signs and the relation of signs to each other. That became their belief system, which formed a structure through which the widows of transitional society under study made sense of and acted appropriately towards experienced actualities (Kashima, 2000).

Despite past experience, each self has its own unique pattern, much of which is as a result of each Participant's perception of self. The past in each Participant's mind became embedded in herself as a sub-structure of her self-identity that consists of cognitions about her environment. This explains why the Participants of this study respected some of the death rituals, while others did not. The Participants' cognitive sub-structures were unique to each one as each person records and retains memories in different ways. Those memories formed the basis of their needs and desires as individuals. However, as mourning is influenced by the culture in which people grow up, and by the culture in which they live as adults (Parkes, 1972), a conflict between one's self-schema and culture may contribute to dysfunctional bereavement, as people tend to create a balanced relationship between self and the environment. As a result, the development of one's self and hence, the development of self-knowledge as an active learning process, may be in conflict with one's perception of oneself in terms of social expectations (Lalonde et al., 2004).

Goodings et al. (2007) summarise place as a unifying concept of self and society, making place an essential factor in the production of self. As a result, place becomes an embodiment of one's identity that gives meaning to one's existence.

In this study, all husbands were buried in the communities where they lived, suggesting that the Participants identified with their transitional communities and these new places have become their *gae*. This also confirms the inseparable nature of cognition and culture (Li & Karakowsky, 2001), where scripts defined the Participants' belief system of a transitional society.

#### **5.4.4 Cognition and affect**

The relation between cognition and affect is reflected in people's tendency to be more sensitive to information that matches their current mood (Zuckerman, 2006). Schachter and Singer's two-factor theory of emotions provides support for the link between cognition and affect. This theory proposes two components of emotions: a general physical arousal, and a cognitive interpretation of that arousal, where the physical arousal associated with an emotional experience becomes cognitively labelled, namely, the death of a husband. The Participants would look to their environment to gain an explanation of their feelings based on current cognitions, past experiences, the present environment and its social significance.

Cognitions and affect may influence the Participants' behaviour, and the latter in turn may influence the former (Beck, 1996). However, people differ in vulnerability because of individual differences in emotion, and this will reflect their individual differences in cognitive appraisal and coping at any given stage of their bereavement process (Neimeyer et al., 2004). As a result of this relationship, the Participants' individual cognition could either serve to minimise or aggravate the affective experience of the loss of their husbands, even if it means changing formerly held cognitions (Keltner & Haidt, 1999).

Just as the perception of emotional pain can be determined by individual socialisation experiences, it can also be determined by individual uniqueness (Holm & Severinsson, 2008). In this study, there were participants who expressed their emotional pain with open and flexible social cognition. For example, Participants one and four could express emotions in a manner that was functional in their bereavement. This is based on the fact that personal vulnerability also plays a major role in people's mental, emotional and spiritual health, and contributes to determining how they cope with loss.

#### **5.4.5 Cognition and attachment**

The Participants' attachment styles influenced the way they went through the bereavement process. Malkoc et al. (2002) view the reorganisation of a new life period as the fourth phase of mourning, during which the relationship with the deceased is placed in perspective. The Participants' attachment to their late husbands is amongst the most intense and influential of human experiences (Shaver & Tancredy, 2001). This is related to Parkes' (1972) view of bereavement as complex processes of detachment, where the affective schemata serve to reinforce behaviours directed towards survival and bonding which, in the process, trigger automatic and spontaneous motivational-behavioural schemata.

The spontaneous cognitive-affective-motivational processes process became activated among the Participants after the actual death of the husband. This was followed by the enactment of behavioural schemata (scripts), for example, crying out the hurt of the loss. This process led to recovery and healing for most, and eventually adaptation (Ong et al., 2004). It offered the Participants an opportunity for growth, because it disrupted and sometimes shattered their established way of viewing or making sense of their world. It also provided for a new integration. Their bereavement, as a result, evolved to encourage them to maintain social

bonds and make attachments that were critical for their survival, as one cannot survive alone (Ong et al., 2004).

Attachment is thus of central importance and the Participants with different attachment styles can be expected to deal with their grief differently. Those Participants with secure attachment styles were more likely to show greater openness and flexibility in social cognition. As such, they tended to look at the experience of their husbands' deaths with more frequent positive emotions and less negative emotions, and so adjusted better than Participants with insecure attachment styles. The latter displayed emotional swings, more negative emotions in social interaction, greater loneliness, and were more likely to exhibit relatively closed and inflexible social cognition.

## **5.5 THE THEORETICAL AND PRACTICAL RATIONALISATION OF THE RESEARCH QUESTION**

Chapter 1 stated the research question of this study as follows: how do Black urban widows in South African transitional societies, whose husbands have died of terminal illness, experience, process information about and cope with bereavement? This question was investigated using a cognitive theoretical framework.

Schemata are central to cognitive processes experienced by the Participants in this study. The schemata of culture, affect and attachment played a significant role in determining how they would cope with the anticipated death of their husband. Those schemata revolved around their individual background history, experiences, personal characteristics, the challenges facing them as individuals, and how they coped with them in the transitional society they functioned in.

The Participants' inner structures and integrated ways of representing their environments differed due to individual uniqueness. Their self-schemata involved their individual development over the course of life events, and the activities and meanings that derived from them in organising their environments (Mahoney, 1995). As such, the manner in which they organised information that interconnected the concepts, attitudes, cognitive content and skills that governed their information processing and associated behaviour can be assumed to be different. This was evident in their different attitudes towards similar experiences that they interpreted in different ways; their unique individual personal characteristics; and how differently they approached and coped with their challenges. However, financial independence also played a role in their coping. Many of the widows were financially independent which contrasts with the circumstances of women in rural settings described by Rosenblatt and Nkosi (2007). This situation helped the participants to face major social adjustments in their lifestyles in the transitional society within which they functioned, knowing that their financial future without their husbands is secure. For example, financially independent participants were able to bury their husbands in a manner they saw fit without depending on people around them, their houses were secure, etc.

Participants five, six and seven experienced the similar challenge of their husbands' non-compliance with treatment, but dealt with it in different ways. Participant five blamed her sister-in-law for her husbands' non-compliance to treatment and not her husband. Instead, she smothered him, made sure that he complied, and treated him like a son. Participant six's husband smoked and drank alcohol when he was not supposed to because of his condition. The Participant understood that he did that only when he was in a good mood. Participant seven knew that her husband was not supposed to take alcohol and she gave up trying to persuade him because of his insistence and refusal to change.

Also, Participants two and three both used withdrawal as a way of coping with their husbands' anticipated death, but expressed this differently. While Participant two felt that her husband on her side and that the couple worked together as a team, the relationship of Participant couple three was characterised by distance, creating a dysfunctional schemata and maladaptive strategies on the part of the Participant. As a result, she resented her husband for not having been there for the family. Her schemata represented a negative integrated cognitive-affective-behavioural network that influenced her internal dictates and goals. Despite this difference, the two Participants understood the reasons behind their siblings' lack of support in a similar manner.

A cognitive-affective-motivational-behavioural network of bereavement seems to fully integrate the themes chosen for this study. In this network, the Participants' affective states influenced their cognitive performance. In turn, their cognitive appraisals influenced their emotional experiences. Their cognitions and emotions influenced their behaviour, where their cognition served to minimise or aggravate their experience of affective reactions (Zuckerman, 2006). As such, their emotions played an important role in decoding the meaning of their husbands' possible deaths and their actual loss. They perceived this loss as a threat, and experienced feelings of anxiety and sadness.

Couples four and eight shared feelings of anxiety and sadness. Participant four was anxious about the house that they could not afford, and felt sadness about the lack of support from her in-laws when her dying husband was still alive. Participant couple eight experienced anxiety and uncertainty but did not share their feelings with each other. The two Participants experienced these feelings even after the death of the husband: Participant four was overwhelmed by anxiety at her cleansing ceremony and when her black clothes were to be burnt, she felt guilty that she was abandoning her husband. Participant eight felt the



presence of her husband in the room after his death, felt anxious and uncertain, and coped by asking him to help her to not be scared.

It is evident that the functioning of primary emotions such as fear is spontaneous, fast, uncontrolled and unintentional (LeDoux, 1996). Emotional reactions are largely unconscious, occurring through automatic information processing without perception and conscious experience (Killgore & Yurgelun-Todd, 2004). As a primary emotion, fear overrode the more complex, positive affective component secondary emotion of hope, which needed anticipation as it is cognitively processed for new ideas, and requires creativity and flexibility. That explains why Participant eight felt spontaneously immobilised. This occurred even though the African culture of ancestors and life after death are inseparable from cognition (Mkhize, 2004).

In traditional Black South African society, the event schema of the long and slow process of the husband's death as the termination of life (Carr et al., 2001) is later (after death) seen as a transition (Parkes, 1972). This process involves death rituals that provide assistance to the deceased in journeying to the ancestral body. The transition involves elevation of the deceased to successively higher spiritual planes and stages of greater integration into a spiritual world, where the deceased is understood to continue having an impact on the living and to communicate with them.

As was discussed in sections 2.2.4.1 and 5.4.3 symbols such as language, core values and certain cognitive schemata are resistant to change, and schemata of culture are assimilated into existing individual schemata. When this is not possible because existing schemata are inadequate to deal with new experiences, people accommodate and undergo structural change in their schemata, expanding their understandings and seeing death rituals in their own

different ways (Gow, 1999). This implies that culture is not static; as cultural and individual schemata interact changes take place in its symbols. In this study, the Participants of the same culture behaved in different ways, showing that there were variations in cultural scripts in this transitional society. This confirms Thomson and Tulving's (2002) contention that culture is not limited to what its members should think or learn, but that weak scripts are found in some societies such as the one under study. In this study, Participants confirmed the existence of weak scripts in their transitional society by ignoring/not believing in some death rituals while performing others. Some participants were also not sure about the meaning of certain rituals, although this may have been a natural result of passing rituals from one generation to the next (Nurs, 2006).

Most Participants performed the cleansing ceremony, allowed respects to be paid in the couples' bedroom, and had the body come home overnight. Half of them cleansed internally by drinking the water that boiled the herbs, and half wore black clothes that signified their widowhood. Some widows may have dispensed with wearing black clothes for practical reasons associated with living in a transitional society. For example, a widowed nurse may not be allowed to wear black clothes to work, but may have to wear a uniform as places of employment may not have policies that acknowledge the enactment of traditional Black South African scripts as company culture in South Africa is more often Western in nature and follows different scripts, has weak scripts or no scripts at all. These are some of the factors that contribute to the changes that characterise a society in transition.

Conflict between individual uniqueness versus shared meanings of the community and family may give rise to different perceptions of the community and the family's functional or dysfunctional bereavement. As a subsystem of the community, a family (the Participants, their children and husbands, in-laws and extended family) has its own unique family rules and boundaries with possible

change of membership over time (Wendt & Zake, 2006). For example, Participants of this study, who were members of their families of origin, changed membership through marriage. As such, the characteristics of their family systems were greater than just adding individual family members' (the in-laws and the Participants' families) characteristics together (see the discussion of the Composition Law in chapter 2 section 2.3.5) (Whitchurch & Constantine, 1993).

The belief system of the Participants, their husbands and children is reflected in this holistic quality, as their belief system cannot be explained outside the context of the entire system (community and in-laws). This is because family members of the Participants of this study (i.e. the Participants, their children and husbands, in-laws and extended family) have relationships which function in an interdependent manner, creating the sum total of interrelationships amongst themselves as a system (Wendt & Zake, 2006). A conflict between the individual uniqueness of family members (Participants, their husbands and children) versus the shared meanings of the community, in-laws and extended family as a whole, may give rise to different perceptions of the Participants' bereavement, and may influence whether their bereavement is functional or dysfunctional.

Some Participants complied with death rituals "for the sake of peace", suggesting that they were able to incorporate new information from the environment (traditional bereavement rituals) into their existing cognitive structure (transitional societal scripts). They were able to attribute meaning to this information, attach a feeling to it, and were thus able to respect and comply with the rituals.

Christianity seems to have transcended many of the African traditions, probably because members of transitional societies tend to share the Christian belief system. As such, it provides a basis for members of transitional societies to reframe and establish new boundaries, using different perspectives and

legitimising new relationships and values. As such, their culture is dynamic and continuously changing (Kashima et al., 2004). For example, pre-funeral day-night vigils, foot stamping when singing, repetitive choruses, the peculiar African preaching style, and the belief that ancestors are the angels of God, are accepted as valid African appropriations of Christianity that provide comfort to widows steeped both in the cultural values and traditional religious practices of African societies (Maluleke, 1994). Religion seems to be one of the elements that helped the Participants to comprehend the nature of a transitional society in which the boundaries and frameworks of its culture are not rigid.

Christianity seems to have become a shared set of schemata for most of the Participants and diluted most of the boundaries that characterise transitional societies. Christianity has thus become a unifying factor in the members' constant interaction with their environment. As a result, the spiritual support that the Participants of this study received from their church played a role in their coping, where the beliefs and values of their church were important in leading them to appraise their loss as less stressful.

Despite the influence of Christianity, ancestral beliefs were still frequently adhered to and were expressed by communicating with the dead through rituals like *go phasa badimo* (meaning, to remember and please the ancestors). These beliefs were included as part of the Participants' coping strategies. This reflects how African culture responds to Christianity (Maluleke, 1994), where Black South African Christianity revolves around African forms of Christianity. These forms include a conceptualisation of ancestors as the angels of God, and Africanness as a legitimate host and home of Christ. This belief is evident in pre-funeral day-night vigils, foot-stamping when singing, repetitive choruses, and the peculiar African preaching style, which are all accepted as valid African appropriations of Christianity.

Maluleke (1994) argues that African and Western Christianity should be understood independently to comprehend how African Christians receive and proclaim Christianity. He bases his argument on the notion that African Christians interpret and comprehend Christ as the healer who is the ancestor and master of initiation. According to Maluleke, this reflects cultural differences between African and Western Christianity. As such, African culture may still be a pivotal source of transitional societies' experience of Christianity, rather than merely Western churches. Transitional societies' experience of Christianity could be incorporated into the Participants' way of coping with the loss of their husbands and the feelings attached to that loss. It relates to Parkes's (1972) view of grief as complex processes of detachment, where the affective schemata serve to reinforce behaviours directed towards survival and bonding which, in the process, trigger automatic and spontaneous motivational-behavioural schemata.

From a cognitive psychological point of view, grief involves a cognitive-affective-motivational-behavioural network. Ong et al. (2004) view grief as an instinctive response to loss within attachment relationships, which involves bodily and psychological reactions. This is related to Shaver and Tancredy's (2001) view of attachment as being amongst the most intense and influential of human experiences. This then suggests that the Participants' cognitive-affective-motivational-behavioural network would have had an impact in one way or the other on dealing with the challenge of their loss. Participants with secure attachment styles with more positive and less negative emotions, more adaptive responses, greater openness and flexibility in social cognition, and more problem-focused coping during the anticipatory phase were likely to deal with their bereavement more effectively than those with insecure attachment styles with emotional swings, more negative emotions in social interaction, greater loneliness, and a tendency to exhibit a relatively closed and inflexible social cognition.

## 5.6 CRITICAL EVALUATION OF THE PRESENT STUDY

One limitation of the study was the potential effect of the Participants' different levels of knowledge and understanding of their husbands' illnesses (for example, health professionals like nurses versus housewives) on their ability to cope with their bereavement. From the findings it seems, however, that the Participants' knowledge and understanding of their husbands' conditions was neither a factor in their caring for them, nor influenced their coping and bereavement. This is discussed in section 5.3.4.1 of this chapter.

A methodological flaw in the study was that the Participants were selected from a support group. As such, they might already have been counselled before they were interviewed, which might have affected the intensity of their experience of loss prior to becoming Participants in this study. Furthermore, relying on a convenience sample means that the findings of this study cannot be generalised to the entire population of widows in transitional societies. Drawing Participants from one area only (Soweto) also limits the findings geographically to one transitional society in South Africa.

Although the participants were members of a support group that falls under the auspices of a Catholic church not all of the widows were Catholics or Christians. Even though this study did not set out to explore the link between religion and bereavement some of the findings are related to this topic. Literature on religion and bereavement (see section 2.2.4.5) shows that about 80% of the population of South Africa are members of the Christian religion, where most are Catholics and Protestants (Cumes, 2004). Within this context, Mbiti (1991) advocates that Africans regard ancestors as an integral part of their religious and cultural worldview, where ancestors are believed to be angels of God to serve and protect the living (Chitando, 2000; Greene, 1996).

Another limitation of the study was the difficulty of finding willing Participants whose husbands had died of AIDS-related illnesses, probably because it is still a stigma in their community, or because they themselves may have been infected and were not ready to disclose their HIV status. This issue will be explained further in the next section that contains the recommendations for future research.

## **5.7 RECOMMENDATIONS PERTAINING TO THIS STUDY AND FUTURE RESEARCH**

The recommendations of this study are partly based on its limitations. Additional recommendations based on the elements of the topic that could not be covered in the scope of this study are also presented.

Even though this study did not focus on religion, an in-depth study is needed to investigate how Participants who do not follow a specific religion deal with their bereavement and its challenges, the interpretation of their husbands' loss and their future without them (husbands). The purpose of such a study would be to determine how they cope with their loss without having a religious script to draw on.

A larger study with more Participants is recommended to see if the experiences of the Participants of this study are common in other transitional societies. Also, Soweto as a community may have a culture and lifestyle that is unique, including for example, accessible medical care, greater opportunities for employment of both spouses than in other transitional communities, and so on. As such, the findings may only apply to the participants from Soweto.

A study on bereavement in transitional societies of women whose husbands have died from AIDS-related causes is recommended, particularly with widows



who are also infected with HIV (if they are willing to reveal their status for the purpose of research). Such a study may examine how they deal with their bereavement knowing that they may also die from similar causes, how they deal with the anticipation of leaving their children behind, and the impact of the stigma attached to the illness.

A comparative study between widows with traditional perceptions and practices and those who have transitioned from traditional cultural practices to adopt those of transitional society is recommended. The purpose of such a study would be to determine how the two groups deal with their challenges, and to consider whether adopting transitional practices changes the cognitive processing of the bereavement process. Another purpose would be to determine how similar or different the bereavement processes of these two groups are, and whether traditional death rituals remain applicable and helpful in the bereavement process in transitional societies. Although Rosenblatt and Nkosi's study (2007) dealt with this topic it did not do so from a cognitive theoretical viewpoint.

A study of couples whose husbands are terminally ill but still living is recommended so that data may be collected from both partners in the couple. This would allow the husbands to share their experiences of their anticipated death, the impact on them and how they perceive the impact on their wives. Such a study could include their wives' experiences to compare their versions with their husbands'.

An in-depth study is needed to investigate support of widows by the family in-law, and how this support (or the lack thereof) impacts on the widows' bereavement process. Such a study may include how the death rituals come to be decided upon by the in-laws, and whether those rituals have any impact on the widow's experience of bereavement. The study should also include the couples' children



and their perception of bereavement practices, and how the interactions between the widow and her in-laws impacts on them.

Future research is needed in determining the value of support groups and their implication in transitional societies. Such a study may help improve the structure of support groups in transitional societies for their maximum use.

## **5.8 CONCLUSION**

Bereavement in the transitional society under study is complicated by different factors. For example, bereavement is sometimes perceived as an inconvenience due to its demands. As such, some death rituals tend to be adapted to accommodate the practicalities of societal demands and lead to the extinction of significant cultural practices. The struggle of Black urban widows in transitional societies in finding new scripts to express their feelings associated with their bereavement will thus often remain invisible in their daily lives and to people around them, although it is ever present. In line with new developing ways of living in transitional societies, most Participant couples had their own ways of doing things that were different from the rituals practised by their families of origin. This may explain why Participants experienced conflict of some sort with their in-laws. It again highlights the impact of weak scripts of transitional societies, which affect some aspects of the Participants' mourning negatively.

Ritualistic behaviours are often associated with ceremonies for the deceased although in passing the rituals from generation to generation, the meaning may be lost (Nurs, 2006). The loss of meaning of bereavement rituals was confirmed by some of the participants in this study that still practised certain traditional rituals. The analysis of the interviews conducted for this study revealed that bereavement scripts tend to be familial, unlike in traditional societies, where

scripts are determined by society, suggesting that the cognitive artefacts within the transitional societal cultural context do not exist to the extent that they do in traditional societies. It seems that the participants in this study have compensated for the loss of or non-belief in societal scripts by following spiritual scripts, forming support groups and searching for moral support from family, friends and neighbours to find a platform to share their bereavement. This can lead to dysfunctional bereavement that can be misdiagnosed as depression, as the two have clinical symptoms that often overlap, when depression is a condition, and bereavement a life event. In conclusion, the developed model can be used in therapy giving the therapist the ability to identify and determine whether the client's bereavement process is or will be functional or dysfunctional.



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## APPENDIX A

### TRANSCRIPTS OF INTERVIEWS

In this study, interviews were conducted in Sotho and translated into English. As a result, the translations come across as incorrect English, but were kept that way to maintain the exact, deep and emotional meaning of the Participants as much as possible.

#### PARTICIPANT ONE

**Interviewer:** How did you come to start this group?

**Interviewee:** You know I can't recall but then, I felt that maybe widows are neglected.

**Interviewer:** Was it before or after you were widowed?

**Interviewee:** No it was after. Maybe from my observation but ok, let me give you part of my background. Being a nurse by profession I used to do a lot of work in marriage counselling as a volunteer, when later I got employed as a marriage guidance counsellor and education counsellor as well. So I used to do a lot of sex education, marriage counselling, pre-marital counselling, and other related issues. And then later I found that even at home people would consult with me on various issues. I later found that the counselling skills that I acquired at marriage guidance helped me in that they became applicable in different cases. Especially in conflict resolution, counselling skills really helped me a lot as I understood them very well, including my life experiences.

**Interviewer:** So after your husband's death (Rich), when was it?

**Interviewee:** He passed away in 1994, 20<sup>th</sup> of March, ten years ago. I can't recall. You know what actually happened (laughing), I started thinking about other widows who were not as fortunate as I was. At the same time, a certain white lady (Tony) that I knew from church (Catholic) lost a husband (Chris) much later than mine. I knew her because her parish was our twin parish. We tried to do some activities together between the two parishes, but we found that the white people were boring us. Our parish would visit theirs, have Mass and after, we would have planned to have football between our children and theirs. After Mass most of the white congregation would go and only a few would stay behind, those who still had consciences. So with time we decided to

stop the relationship. Tony contacted me later and asked me to meet with her. I told her about the widows' support group that I had started, and we meet as widows just to share our experiences, and see how we can help each other, because others need more help than others, others cope and others cannot. So Tony suggested that through her firm (Marfam-marriage and family organisation), she would like to do the same. One Sunday we sat down and plan although it was Catholic oriented. Now she wanted to prescribe how it should be conducted. She suggested that it should not be a workshop but each widow should reflect and talk about her experiences and share with others.

**Interviewer:** How can they be so prescriptive?

**Interviewee:** That is something that no one could be prescriptive about. It deals with one's feelings. Like me, Rich was sick for fourteen years or eighteen, I can't remember.

**Interviewer:** What was the problem?

**Interviewee:** Rich passed away in 1994, suffering from the enlargement of the heart and was also diabetic. So he was in and out of hospital, and in and out of ICU. But when he was out of hospital you would be surprised because we would go to jazz festivals and all. When he relapsed, he would relapse (laugh).

**Interviewer:** How did you cope with that?

**Interviewee:** Ok. Even now when I look back, I'm surprised at myself. I think Rich's understanding played an important role because it helped me to cope. I remember then I was the national chairperson of the South African Association of Early Childhood. I was travelling provincially and I used to go overseas once or twice a year and he would never complain or feel neglected.

**Interviewer:** You related well with each other.

**Interviewee:** Very well. Even when he was about to pass on we were able to talk about his death. He would tell me that he realises that he had reached the end of the road. He was on life support machines in hospital. He even told me that he had a man-to-man talk with his physician, and told him that he wanted to go home. The doctor felt like he was giving up on him, and he told the doctor that he had done more than his share, and felt he had to go. One day at home we started talking about his death and he expressed his wishes. He asked me to open his side of the

cupboards, and decided with me which clothes to give away and which ones not. He even suggested how I should look on the day of his funeral. In fact, he had a clothing material that he had planned to make a suit out of and he never came to do it. He suggested that I should make a short skirt and a jacket, and even chose shoes for me. When my suit was ready, I put it on for him and was very pleased.

**Interviewer:** Do you believe that a dying person knows that he is going?

**Interviewee:** Yes. That's what I always tell people. But some people don't say it. Rich did say, he was clear and direct. Rich was then released and he stayed home for ten days and he wanted to be baptised by my Catholic priest. Mind you he was not Catholic but an atheist. He was desperate to be baptised. The next day he forced me to call the priest and he came. Another thing about Rich was that he was always having people around him. As a result even the day he died, he died in the presence of people who were with him in the house. He was baptised in front of a lot of people who witnessed his baptismal. I was pleased with that because people would have complained that he was not a churchgoer but was buried by the Catholic Church. He died soon thereafter. It was on a Friday when he asked me to pray for him and I told him and reassured him that I always prayed for him. But I also told him to pray for himself. We knelt down the two of us and he prayed and when he fished he said Amen. Then the same night he suggested that it would be better for him to sleep with one male family member because he felt that I should take time out and rest instead of taking him to the bathroom the whole night. I did not mind as long as it made him happy. He felt that he was bothering me. He did not sleep well on Saturday. On Sunday, I went to church and made sure that I leave the church as soon as possible. I left and went home, and I found him with his friend. Those days he refused to eat. In the afternoon most of his friends came over to see him and, one of his friends came to call me. He had asked for a glass of water, and he drank very fast and he gasped (he struggled breathing and died). Immediately thereafter the priest walked in.

**Interviewer:** How did you feel?

**Interviewee:** Numb but I had to think quickly because I had already called the priest. I asked the priest if I could pray, and he agreed. In the prayer I thanked God for having given me Rich and the life that we lived together and asked God to carry me through the funeral arrangements. After saying Amen, I asked the priest in front of everybody to burry Chris on Saturday, and leave the church at ten o'clock. The priest agreed to all of that. When it came to his family, I told them when the funeral would be and the time. Rich's mother's family supported me, and his father's did not. I made sure that they should never force me to go through the rituals that I don't believe in,

especially taking anything oral. Rich even asked me not to interfere with his bed where the mattress would be put on the floor. In other words, not just anybody should walk in and out of his bedroom. So that evening I told everybody that I would sleep with my friends in my bedroom and nobody else.

**Interviewer:** What did your in-laws say?

**Interviewee:** When the undertaker came to fetch the corpse I walked up to the door (behind the corpse). I just felt one of Rich's aunts grabbing me rough, saying I should not walk Rich out. I was too depressed to say much but just my look said it all. I told the whole family that my maid of honour at my wedding would be on my side at the funeral (on the day of the funeral), to avoid being covered with heavy blankets in the middle of summer. Rich and I had planned the whole funeral, even what I would put on that day. I even put on those clothes for him the Friday before he died, and he liked the outfit. On the day of the funeral I had a hat on, something I am not used to. From the church to the car I made sure that his family walked far behind me. I did not want to be crowded (did not want too many people around me). I was able to walk and see people around me.

**Interviewer:** Do you have children?

**Interviewee:** Yes, three. When their father passed away they were old enough, say around twenty. The Sunday before the funeral (a day after Chris passed away), I sensed that his family was talking about me. One cousin of Rich came to me and told me that she had her uncle as one of the beneficiaries of her "society" (burial society). I thanked her and left it there. I forgot about it. When Rich died, I did not even think about it because I was organised (financially independent). I strongly believe that some of the family members influenced her against it, saying that I have lots of money. I think that's what they said because she said nothing about it thereafter, and none of them helped. One nasty cousin volunteered to buy two sheep, and one of them died, meaning that Chris did not approve (a belief that the deceased did not want help from him and, in a way, where the dying of the sheep was his way of communicating his feelings and disapproval of help from his cousin). They (the deceased's relatives) did not even tell me that so and so would buy the sheep. They should have told me. During that time, I had a "spaza shop" to keep Rich busy and they just thought that I have money and I'm working. Nobody helped me with that shop except my children and other children that I brought up. The morning after the funeral (burial), I took out all Rich's clothes that he ordered me to give away. He did not want his suits to be given away. On Sunday morning, one cousin of Rich told me that he wants to know about Rich's suits. I told him in front of everybody that his uncle sorted them himself, and the rest that the cousin was



asking about were for my children. Although there was no need to explain, I saw that as an opportunity to tell off the gossiping old fools who were around. It was havoc because they were telling me that I kept my husband's clothes for my family of origin. That cousin demanded all the CD's he bought his uncle and, believe you me, he took all the CD's and left. For me that was not important. Do you know that that cousin lost a wife before Rich died. He did not even have a cent, and I thought he had money. He was and still is working for government. He asked Rich and I to help him burry his wife. He only bought the coffin. But when it was my turn when my husband passed away, it was a different story. The last time that cousin came to my house was the day after the funeral. Things started going wrong for him. Cars (his) were involved in accidents, house burglary, lost four cars at gunpoint, he got sick. Three years later he called me, wanting to come and see me. He came the next day and explaining that he could not come with his children. He looked embarrassed and asked me never to talk about the past, and asked for forgiveness.

**Interviewer:** How is his relationship now with the rest of the family and relatives.

**Interviewee:** It seems as if they don't talk to each other and don't know the others' where about. Their other uncle passed away two-three years after Rich, and this cousin did not even go (did not attend the funeral). A few months after Rich's death that niece of Rich who came to tell me that Rich was one of the beneficiaries in her "society scheme" came to apologise and I had forgotten about it. I told her that she should not worry because I had everything covered.

**Interviewer:** It seems like because of the support you received and your personality you were able to cope.

**Interviewee:** I think so. What also helped me was the fact that Rich and I talked and came to closure. Like when he used to say that he thinks he has reached the end of the road, I would say to him that if you are ready to go, we will accept and let you go. He told me that he is ready but feels guilty to leave me behind. I reassured him by telling him that when he goes he will be our angel and ask God to look after us.

**Interviewer:** How did you experience the support group?

**Interviewee:** We shared and it is therapeutic. I preferred a black only group because of our different dynamics in our societies. I got widows through the church. Some are Catholics and some are not. I mostly identify them with their black clothes in the streets, supermarkets, and I would greet her and invite her, but some would not be interested.

**Interviewer:** Why is it that some would not be interested?

**Interviewee:** I haven't got an answer because they haven't opened up, but those who join benefit a lot. Sometimes I would invite a widow to the Widows Forum, and you'll hear one giving excuses. I would know there and there that she is not interested. There's this specific one, a nursing sister. She would promise to come and would not. One day I saw her peeping in during our group session and left. Why she didn't come in and join I don't know. Maybe she did that because she felt that she was above us, or showed me that she is there and won't come in. I'm not a psychologist but I'm just thinking. She has this tendency of crying because of petty things. She even often causes misery at the church, and a liar. She's got issues.

**Interviewer:** Is your church supportive of widows?

**Interviewee:** Yes, our priest encourages support. It's only that there will be those who will isolate themselves. There's this old lady at the church who would gather all these young widows to the forum.

**Interviewer:** How do you conduct the forum?

**Interviewee:** As I've told you that we used to meet with the widows of the other Catholic Church in the suburbs. We would start with introductions where each widow introduces herself. Then we talk about expectations, what the widows expect from the forum. Then we would divide them into groups, and then have a report back from different groups. It was during the report back that you hear the hurt in them and unbelievable stories. I remember one widow telling us that she buried her husband's corpse without a head. There are a lot of sad stories that do not help one to let go and move on. What complicates matters worse is the fact that the widow's in-laws suspected that their son was murdered by the widow's boyfriends. That is very common. Because we were a diverse group, coloureds, white, black, Portuguese, Greeks, etc. The problem with that was the fact that widows preferred to talk in their own languages, with other widows of similar cultures and dynamics. What I prefer is to introduce myself first because there are always new members, and let them be spontaneous without preparing anything. Now the joint sessions we used to have with our white counterparts been terminated because Tony would come preparing a lecture, running a workshop, which I thought was prescriptive and insensitive because people feel like they do and are told how to grieve. It was boring. Now when it's only us, we start with a prayer and hymn (the African way). Sometimes we would invite speakers with good information. I'm telling you, widows have problems out there. It's very rare to be in the kind of situation that I was in when Rich died.

**Interviewer:** Were there any rituals that you went through?



**Interviewee:** Nothing and I did not even had black clothes on but my grandfather's daughter told me that I needed to drink herbs. She bought them, gave me instructions and after she left I through them away. It was different because it was my sister. My in-laws did not interfere with me. The one ritual that I went through was after about six months when my mother's sister was supposed to take off "sefifi" (the cleansing). They bathed me in the early hours of the morning with cold water, and it was raining that morning. In that water I don't know what it was but something itchy. I even thought to myself that these women who got widowed and remarry and remarry are brave if they have to go through this over and over again.

**Interviewer:** How did you feel about the cleansing ceremony?

**Interviewee:** To me it was not important. It was just a matter of respecting my aunt because she was saying that even if I did not have black clothes on the cleansing I must. What I did not want to be associated with was drinking anything oral. For instance there's grandmother of mine who lost a husband. I was then asked how we do these things in our family and I told them that I don't know. I then suggested that they do as she wished. She got sick thereafter and I told her it could be those herbs she decided to boil and drink the water. She was then told that she took the wrong stuff, and was advised to go to her family of origin to reverse the wrongs and do everything the way her family do them. It is also expensive.

**Interviewer:** Which rituals are followed, the husband's or wife's family rituals?

**Interviewee:** I'm not sure but what is common is "dipitsa" (the water from boiled herbs) that are bought at the herbalist shop, boil the herbs and drink that water. After the death of Rich I didn't do any of those things. Rich knew that I was diabetic and have a problem with my blood pressure. I did not take all those things and am still healthy. It has to do with belief system and attitude. I didn't tell myself that I'm diabetic and widowed, feeling pity for myself. I had the support structure and I participated actively in that.

**Interviewer:** What is common in the widows that you've had contact with?

**Interviewee:** I can't say because their circumstances differ. For example, some let their in-laws control them from the beginning. With me I don't even have contact with Rich's aunts and uncles. My in-laws passed away a long time ago.

**Interviewer:** How long were you married and how old were you?



**Interviewee:** We were married in 1971 and he passed away in 1994. It means we were married for twenty-three years, and then, I was forty-three.

**Interviewer:** Do you have any childhood experience of loss?

**Interviewee:** None

**Interviewer:** How about adulthood?

**Interviewee:** My father passed away before I got married and, because my mother could not do much at that point in time, I had to take over. As a result, I was in control then so as to oversee the running and arrangements of the funeral.

## PARTICIPANT TWO

**Interviewer:** How long have you been widowed?

**Interviewee:** For a year and four months.

**Interviewer:** How long were you married?

**Interviewee:** For about twenty-five years.

**Interviewer:** How old were you then?

**Interviewee:** I was forty-seven with five children but the eldest passed away two years before his father. He was sick for about two months and that was it (he died only after two months). It hit me more than his father's departure. He would always tell me that he went to see his doctor. He used to complain about pains all over the body and was bothering him (pains). His doctor sent him to Baragwanath Hospital, took X-rays and blood samples. They also advised him not to carry heavy stuff, but could not tell what the problem was. One morning I realised that he was really struggling and I took him back to the hospital. The second week at the hospital he wanted to go home. I was not going to see him at the hospital that Saturday but sent his siblings, and promised to come see him during the week. He asked me to leave the nursing staff with my home phone number. On Saturday morning when his siblings were busy preparing themselves to go and see him, the phone rang and it was the hospital. I even thought they were telling me to come get him. The

person on the other side of the phone asked me who I am and if I'm on my own in the house or not. That irritated me because I already sensed that something was wrong and that person was going round in circles. My elder daughter then grabbed the phone and asked the nurse to say whatever was happening. They then told us he passed away the previous night. He died of heart failure, which they could not diagnose. At that time, my husband was also sick. He had been suffering from heart problems for about five years and was even given early retirement because of his condition. Baragwanath hospital was able to manage his condition. Even then, my son's death devastated me then and is still devastating me (she became tearful and there was a long pause). It was worse because I expected that from my husband and not my son.

**Interviewer:** Was your husband bed ridden?

**Interviewee:** No, he was on and off even though you wouldn't see that he was sick. He was very independent although he would struggle breathing. I would sometimes ask him where the problem was and he would just tell me that it's not that bad but I could tell that he was suffering. He didn't want to worry me. Instead, he would joke about his illness.

**Interviewer:** How was your relationship with your husband?

**Interviewee:** We were very close although we didn't have that much support because he came from a very small family. He was the only child. He grew up with his mother and maternal grandmother who, by the time he got sick, they were both dead. He was very close to his grandmother. So we only had each other, and the children.

**Interviewer:** Did you get moral support from outside the home?

**Interviewee:** I don't remember getting support from anybody. I coped by accepting it because even my siblings had their own problems, and both my parents had passed away. He kept himself busy by going to church on Sundays.

**Interviewer:** How did you feel about his condition?

**Interviewee:** You know, because he got sick before my son, I accepted it easier because he stopped working in 1994. His independence really helped me cope because I would leave him by himself and go to work, run my errands, and would find him comfortable and looking after the house.

**Interviewer:** Did your church give you the support you needed?



**Interviewee:** No. I was alone. I got support just before he passed away. We attended two different parishes. His parish really gave us support. I would send a message to my parish and priest, but no one would come. They would only ask me about his condition and it would end there. When you needed them most they were not there. His parish members would come home for prayers and we used to really feel supported. I ended up joining my husband's parish. One time I met my old parish priest and he asked me why I don't come to church anymore. I told him straight (in his eyes) that when I needed him he was not there and I did not see any compelling reason to still continue at his parish. I told him straight where I was and why. He then asked me how my husband was doing and he pretended to be shocked when I told him that he passed away. He persuaded me to come back to his parish but was embarrassed.

**Interviewer:** Did your husband die at home or hospital?

**Interviewee:** He died at the hospital. He was admitted because he was really struggling at that time. He would usually struggle and would often ask us to take him to the hospital.

**Interviewer:** How was he at the hospital?

**Interviewee:** I think he knew that he was going because he told me straight that his time was up. At the hospital he told me to go and collect his money from a friend of his because the children and I would need every cent available. Every time I went to see him at the hospital he would ask me about his money from a friend. I would reassure him but would still complain. He again asked me to tell that friend to come and see him but he did not go. That was his best friend.

**Interviewer:** How did you feel about that?

**Interviewee:** I knew that he was always helpful and should not expect people to be like him. He should have known that people would never be the same, i.e. if he was helpful, he should not have expected the same from others.

**Interviewer:** What happened the last time you saw him alive at the hospital?

**Interviewee:** At the hospital he told me that his time was up. That did not bother me because I did not believe him. The reason was that the first time he was admitted I could tell that he might go, and he did not. But when he told me that his time was up, I just took it as talking. That day I promised to come see him the next day and instead of answering me he started praying and asking God to take him and put him on His chest, and then Amen. Those were his last words. He



was still alive then because the doctors were reassuring me that he could hear me talk although he was not able to answer back. He used to tell me at the hospital that our son always talked to him, and promised to come and fetch him. The next day I went with my children (to the hospital). It was on a Sunday. When I walked into the ward, I saw his friend who owed him money and other people. That was the friend that my husband asked to see before he died and he did not come. When I went to his bed I found a different patient and I got tense. I asked the sister in charge and she just told me to look for him. I looked at her and kept quiet. I got angry. Somewhere along the way she came back and asked for the family. We went into her office with my children. It was then that she told us that my husband passed away the previous night.

**Interviewer:** How did you feel at that point in time?

**Interviewee:** I just stood up and walked out of that office. It was like a dream. I was numb. His friends who were not there for him when he needed them were waiting outside. I told them that he was no more. I consoled myself with the fact that the last time we were together was only the two of us. When we got home we just sat quietly with my children. Nobody was talking. Later my children went out to tell the neighbours. At that time I could not tell whether it was night or day. The church members also came and really made us feel supported. The funeral arrangements went well. Unfortunately, my husband's family is very small. He was the only child, his mother and maternal grandmother. They all passed away except his distant relative, his uncle. Everything went well, and his uncle told me not to wear black clothes. He felt that I nursed my husband all that time and to him (uncle), that was enough.

**Interviewer:** How did you fare after the funeral?

**Interviewee:** I had thought that after his death life will be better knowing that he was now fine and not in pain. Instead it was worse than when he was still sick with me. My love for him overwhelmed me and really felt lonely. My children did not want me to sleep by myself. They always shared a bed with me.

**Interviewer:** Which death rituals did you go through?

**Interviewee:** I was on the mattress the whole week although I was up and about organising this and that, as it was only my children and I. More often people would come to see me during the day and I would not be around. The corpse came home overnight. That was torture although I held on to what we used to talk about when he was no more. At the time of his death, we were planning to erect his mother, son's, daughter's and grandmother's memorials. When we were



busy erecting them, he said to me once that he wanted to be buried on top of his grandmother. Even neighbours knew that. He did not even care if I wanted to be buried on top of him. To him, that was how it was going to be. The erection of the tombstones was stopped the week that he passed away, and we asked the tombstone company to include him on the inscription. That really consoled me. After the funeral (burial), his uncle suggested that I should follow my family of origin's rituals. He suggested the cleansing, which I went through, including the Holy water from church, and the Mass that used to be conducted at home.

**Interviewer:** How did you go through the cleansing ceremony?

**Interviewee:** I could not even ask anybody at home because they all did not know how to go about that. We did not even have parents, they both passed away a long time ago. My eldest sister was worse because she did not know anything. My second eldest sister was a born-again (does not believe in rituals). Coming from a small family can be a problem. Ever since he passed away, I never even thought of a companion. Right now I feel that my son's death is still bothering me. I have not come to terms with it yet. Every time we talk about him, it feels like he passed away recently. What is still bothering me is this excruciating headache that wakes me up at night. My spirit is always down.

**Interviewer:** Did you ever lose somebody close to you in your childhood?

**Interviewee:** I lost my father at a very young age, and we were very close. I was still at primary school. My mother passed away when I was in Standard five. We struggled because my sisters brought me up.

**Interviewer:** What other crises in your adult life did you experience?

**Interviewee:** Everything in my adult life went well until one night, when my family and I went to Sebokeng to bury my nephew. That night IFP supporters came and shot at random. Apparently they wanted the corpse of my nephew because they even demanded it from the undertaker. A lot of people died that night. I don't know how we survived. You know, God is alive. My neighbour's children came along and I ordered them before the shootout to stay at my sister's neighbour's house because I was busy with the elders at that time. My grandson did not want to be with anybody but me that night and I had to carry him on my back. When we were busy, I saw a group of men in black and white clothes walking into the yard holding something. They scattered all over the yard looking into the house, with one looking directly at me. It would seem like they were waiting for the sign to start shooting. I then asked my late son to get me a glass of water so that I





could take a pain killer (I had a terrible headache). He came back and I ordered him to join his siblings at the neighbour's house. As soon as my son left, the one man who was looking directly at me started shooting. Fortunately he shot the door and not me. Everybody was on the floor. Those men were looking for my nephew's corpse, and were under the impression that it was in the house. Apparently they first went to the undertaker demanding the corpse, asking him the funeral arrangements and where the deceased's home is, and which day and time will the funeral start. It was then decided that instead of burying him in Sebokeng, he would be buried in Soweto. We only discovered after the fact that they not only shot but also threw grenades, which did not explode. According to them, the whole house should have been down with the corpse (because they believed that the corpse was in the house). After that they drove away in their mini buses. All my family members were safe except one of my other son's clothes were torn and looked like they were on fire. Apparently he went out of the house just when they started shooting and his clothes caught fire. Some people were already dead, some were dying. It was bad. My nephew was killed and was thrown in the sewerage. Fortunately one municipality worker found him just after that. According to the story, those men tied him with a wire to the car and dragged him. It was then that they through his corpse in the sewerage. They were angry because he was found and was going to get a decent burial.

**Interviewer:** How did you know about this widows' forum?

**Interviewee:** It was easy because I'm Catholic and is run by Catholics at the Catholic Church. I knew about it but did not qualify even if I wanted to join.

**Interviewer:** What were your expectations about it?

**Interviewee:** My objective was to share whatever was difficult for me at any point in time with women who were going through similar experiences as me, making me feel that it was normal and expected to go through that.

**Interviewer:** Did it come to your expectation?

**Interviewee:** It really helped because I found myself to be stronger than most widows in the group, supporting them morally and emotionally. You won't believe how some widows go through. I even came to ask myself at times how they manage.

**Interviewer:** Is there anything that I could have ignored?

**Interviewee:** Not that I can think of.

## PARTICIPANT THREE

**Interviewer:** How did you come to know about the widows' forum?

**Interviewee:** My husband passed away seven months ago. Few weeks after the death of my husband I was approached by the gatekeeper as a neighbour and told me about the forum. I did not know that a forum like that existed, maybe because I'm not Catholic. But I came to realise that it is not only for Catholics but widows.

**Interviewer:** How long were you married?

**Interviewee:** For twenty years. I lived with my in-laws (mother and father) only for all those years. At one point my brother in-law and his wife came to stay with all of us, and it was bad. She did not want to do anything in the house.

**Interviewer:** What was your husband doing?

**Interviewee:** He was a middle manager in a computer company.

**Interviewer:** Was your husband sick?

**Interviewee:** Yes, he had a heart problem, but still working although he was in and out of hospital. The nature of his job allowed him to stay at home if he was not feeling well. That heart problem I think started after his car was stolen. It did not bother me because he never provided for the family but owned a car (but could afford a car). It was very difficult for me but had no choice. When he started getting sick I would nurse him but at times pretend and get irritated, doing everything for him half heartedly, although at the same time feel pity for him, those mixed feelings. Once he recovered he would forget that I exist. He only cared about his car and himself (clothes).

**Interviewer:** Did you feel supported in anyway during that time?

**Interviewee:** I don't want to start lying, I was on my own. Nobody was there for us, including his only sibling (brother). When days are dark, friends are few. I did not have that much support, except from my own siblings although they had their own problems. Most of them were

unemployed but would come and help clean the house, and be there physically with me. I could see that they would really want to help but did not have much. Just the thought of helping was enough for me. It was everyone to himself, even after my husband's death. My neighbours were there for me, before and after the death of my husband. They made me feel that I was not alone. The church also supported me all the time. I felt that warmth because it did not discriminate against me.

**Interviewer:** How did you feel without support?

**Interviewee:** I accepted it because I knew it from long ago that when you need people's help most, they will never be there. When you have everything in the world, you will have hangers-on's. My brother in-law and his wife never supported me in their lives. We are in good terms but distant, although the two brothers had a healthy relationship. If we needed help we would never think of them. I had always been financially independent from the beginning because my husband never provided for his family. Maybe staying at his parents' house with them made him not to realise that he was a father and husband. Even my children are used to that.

**Interviewer:** Did your brother in-law and his wife used to come visit before?

**Interviewee:** They used to come but when the last of his family member died, they stopped. My husband and I used to visit them, but it felt more like people that we knew, and not relatives. I last saw them two months after the death of my husband. The reason they came was for my brother in-law to tell me that I must cleanse myself because he was not prepared to touch me (he will not bath her with his hands). It hurt me very much, not what he was saying but how he put it. He told me that I must make sure that my family of origin cleanse me because that had nothing to do with him. The children are supposed to be cleansed by their uncle (malome-their mother's brother), but he told me that he did not want his brother's children to be touched by outsiders. Maybe that's how they do things (the way they conduct their rituals). Then he was suggesting that I must also help him with the money to be able to do all that. I was not interested because that was what he wanted to do. That was all that he said. Even now, he hasn't said anything. It was also clear that they did not discuss that before because the wife was surprised to hear that. It does not look like my children will ever be cleansed although my children are not interested.

**Interviewer:** How was the cleansing supposed to be done?

**Interviewee:** I only came to know that day that according to the way they practice their death rituals, they do not touch a daughter in-law.



**Interviewer:** Did you go through any death rituals?

**Interviewee:** I did not put on black clothes but had to put something on my shoulders all the time for a year, which, according to them, is a sign of mourning the death of my husband. After a year I would be cleansed. The mattress was on the floor in my bedroom, and the deceased came home overnight. That was difficult. Even now when I am on my own I still miss him. I now watch TV on my own, and even laugh by myself. I don't expect my children to understand that. My family of origin cut my hair and cleansed me.

**Interviewer:** Do you believe in death rituals?

**Interviewee:** I can't say yes or no. It is just a matter of conscience and playing it safe. I grew up witnessing those rituals and I never questioned them. For example, when I go to the cemetery, church, and funeral. I would put something on my head as a sign of respect. That's how I was brought up. Even when I'm told to cleanse I oblige.

**Interviewer:** How did you cope after his death alone?

**Interviewee:** Reality hit when the last person left after the funeral. My brother's wife was the last to leave, although my siblings would come to see me. This is the first winter alone without human heater. I can't deal with this terrible headache that wakes me up at night, and I struggle to fall asleep. I always fall asleep in the early hours of the morning.

**Interviewer:** How were his last days with you?

**Interviewee:** He was admitted at the hospital and we talked. In fact, the last weekend with him he was still healthy. From Thursday we were together the whole time, which was uncharacteristic of us. Wherever one went, we were together until Sunday. On Monday when I was about to go to work, he said to me that it was surprising how short life can be, especially the coming week because he had to go. I left like that, and round about two o'clock that day I got a call that he was admitted at the hospital, but I did not believe it. He passed away the next day.

**Interviewer:** How did you feel?

**Interviewee:** I did not understand why because I left him with hope. It felt like a dream. What made it worse was the fact that I went to the hospital with his brother and wife, the people I was not used to and could not cry when I wanted to next to them. It was really difficult. My brother-in-law and his wife lost a teenage child through suicide. I thought as a result, they would relate to

what I was going through. I gave them all the support needed but when it came to me, the next time I saw them was a day before the funeral (burial).

**Interviewer:** How was your relationship with your late husband?

**Interviewee:** He was a very quiet person who would only answer what he was asked. Even if I could talk about what could be done in the house, he would never answer. Nothing was done to that house since his parents got it (a municipal house) without ceiling, flooring, nothing. He grew up in that house, married in it and died in it just the way it had always been. When I asked about the state of the house he would tell me that he does not have money but had a car, and expensive clothes. The only expenses for him were water and electricity, a whole manager (he was a manager but could not look after his family). Me, the cleaner at work, had to buy food, clothe the children and myself, I mean everything. That is why I am so bitter and angry with him at times because he refused to take responsibility and provide, maybe we would not be struggling the way we are. Right now I have to improve the house, get loans to take both my children to tertiary institutions because my daughter matriculated last year and he told her to look for a job because he did not have money. My son matriculated years back and is still at home because his father was not prepared to spend his money for his future.

**Interviewer:** Did he at least provide for his death and funeral?

**Interviewee:** Nothing. When I ask he would always tell me about the two burial societies that would bury him, and I should not bother him.

**Interviewer:** Do you see yourself as different in personality now compared to before the death of your husband?

**Interviewee:** I cannot say but what I am aware of is that lately I can't stand the noise or somebody who talks too much. I prefer to be by myself. I am more at peace when I am on my own.

**Interviewer:** Do you visit neighbours like before?

**Interviewee:** I have not tried because I'm scared to be hurt. Not that they will resent me visiting but I'm just playing safe. Although I don't think they can be funny. Especially now that I'm widowed, I'm not sure if my female neighbours will be comfortable to see me talk to their husbands. They may not trust me with their husbands.

**Interviewer:** Did you ever lose anybody close to you in your childhood or adulthood?

**Interviewee:** I only lost my mother nine years ago. I did not go to my father's funeral because my parents separated a long time ago and when he passed away we were never told about his death. I still don't feel happy about that. I don't remember losing anybody close to me in my childhood. My first experience was with my mother in-law in my marriage.

**Interviewer:** What is it in your life that when you think about it, makes you sad?

**Interviewee:** The fact that I was born poor, grew up poor, married poor, and would even grow old poor. I was unable to live the life I want. Maybe it was meant to be. He left his family poor and was never bothered about that in his lifetime. I am bitter about that, honestly. I was a mother and father in that house even when he was still alive and healthy. Although it does not help to be angry and bitter, there is nothing I can do about it now. I fed him, nursed him, and buried his parents for him. I created all that I'm faced up with today. I'm also worried that out of my eight siblings I'm only left with one sister. I cannot afford to lose her.

**Interviewer:** Do you feel secure staying in his parents' house?

**Interviewee:** So far nothing is showing that his brother can claim it back, but I'm not excluding that. It was never regarded as a family house, especially that the two brothers had a very close relationship. It's just that the two daughters in-law are not in good terms. It started when we both stayed with our husbands' parents and the other daughter in-law was favoured against me. I was the one who nurse our mother in-law who had a stroke and could not do anything for herself and her husband. Nothing was expected from the other daughter in-law. I decided to move out with my husband for peace sake. With time, his brother and wife could not stand our father in-law's complaints about his daughter in-law's laziness, when she tried her best to please them. They also moved out. My husband then forced me to move back with his parents, saying that they have no one to look after them (in-laws). That made me feel like a slave, unappreciated and used. I understood him when he pushed to move in with his parents again because he was not prepared to buy a house for his family but instead, take over his parents'. Even the way we moved back was not right. One day when I came back from work I found everything already moved to his parents' home instead of two people who share a life together sitting down and talk about it. On the other hand, I ended up feeling pity for my helpless mother in-law. That was how I ended up staying in my in-laws' house.

**Interviewer:** Is there anything that I could have left behind?

**Interviewee:** I'm still bitter about the fact that he never provided for the children and I. I even had to take out my money to close the gap of the very "burial societies" that he relied on. I spent a lot. I doubt if he would have buried me the way I buried him. I spent a lot. With my mean salary, I now have to for pay water and electricity that he used to pay, and still continue contribute to his "burial societies" because he put the children and I as beneficiaries. For us to still remain as beneficiaries I have to take over the monthly contributions. If he could have left money for his children for their education and life after he had passed on like most fathers and husbands. Instead of missing him at times and feel sad, I feel angry and bitter, feeling used and unappreciated.

## PARTICIPANT FOUR

### FIRST INTERVIEW

**Interviewer:** How long were you married?

**Interviewee:** Fourteen years. I'm now thirty-eight. We were very close, except those small disagreements that every couple goes through.

**Interviewer:** What was he suffering from?

**Interviewee:** When he first got sick, we were told that he was suffering from Tuberculosis. He did get better and started getting sick again. I don't know why because he lacked appetite and complained about his aching body. We ended up not knowing because he also complained about chest pains. He was admitted at Santa hospital. He was in and out of hospital for eighteen months. The last time he was admitted he died on his third week there. The hospital called home and found my sister. I had gone to town to get this and that for the family. My sister called me and asked me to come back home, which I couldn't understand. I was with my sister in-law and my niece. We then decided to come back home. When we got home, I met my brother with one neighbour of mine, which was funny.

**Interviewer:** What happened then?

**Interviewee:** My brother looked at me in the eyes and I just started crying. When I got home, everybody was quiet. My neighbour then said to me that these things happen. That's how I came to know that Pat is no more.

**Interviewer:** By the way you had a house of your own.

**Interviewee:** Our house had problems and is still having them. When Pat was sick, after some time, he ended up not getting paid, and we could not pay the bond. He was paid off at his work but that amount could not cover the balance of the bond. That was stressful for both of us. It was not helping because it made him sicker. We then decided to buy a cheaper house with what we had. That house was still to be built. We signed the papers and come to an agreement. After that, the bank agreed to sell us the house we occupied and owned for the same amount that we agreed on with the other contractor. Then the other problem arose. That contractor is still refusing to give us our money back yet they agreed to pay it to the bank. I really don't know what is happening.

**Interviewer:** Now what are you planning to do with that?

**Interviewee:** I'm planning to take him to court. It's too long now. He takes advantage of the fact that I am a woman and worst of all, widowed.

**Interviewer:** Are you able to pay the bond now?

**Interviewee:** I'm not. I don't know because I'm supposed to be renting my own house. Can you imagine how much it is a month, but the bank said I shouldn't worry. All that they need is a proof that the money is with that contractor, who agreed with the bank. This is what happened. The contractor bought that house from the bank. I think It is now between the contractor and the bank, I want to believe. This has to be sorted out because it is now a bother to me. I'm not sure right now if I have a house or not. This should be bothering Pat wherever he is. It's not fair. Everything was coming okay; the problem is a human being and money. Money is evil.

**Interviewer:** Tell me, before Pat passed away, were you getting enough support?

**Interviewee:** I used to live with my siblings. His family did not. They would only come when they hear that he is really struggling. But from the time he started getting sick, they only came twice.

**Interviewer:** Was he not in good terms with them?





**Interviewee:** They were in good terms. He ended up not caring about whether they come to see him or not. It's sad. I remember one brother of his came to visit. When he was about to leave, Pat persuaded him to stay another day and he refused. It hurt him. His mother wanted to come and visit but could not because he depended on people to bring her. She was too old to come by herself. She is a good person. The few times she came she fought with everybody to bring her. Apparently she could not even sleep at night. She also used to call and check on us. He never used to, except before he was last admitted at the hospital, he said to my sister that he was planning to go home. We even thought he was talking about his parents' house. He then said he was going to his home where he came from when he came to this world.

**Interviewer:** Where else were you both getting support?

**Interviewee:** The church really supported us. They would come for prayers. Even now on father's day, my priest and his wife will take all the widows out for lunch, and it's nice.

**Interviewer:** What happened immediately after he passed away?

**Interviewee:** I asked myself questions that I could not answer. I was hoping that someone would tell me that it was a joke. I was confused. I would cry, keep quiet; asked myself questions, it was really tough. I could not even fall asleep and, when I stand up, I felt weak like I could fall, and had no energy.

**Interviewer:** Who got him from the hospital?

**Interviewee:** It was his brother and one of his relatives. He died on a Thursday and buried on a Saturday. I was worried about what was happening in the kitchen because I had to stay in my bedroom flat on the mattress. But my siblings were present looking after everything in the house.

**Interviewer:** When did your in-laws come to your house?

**Interviewee:** His sister was there with us when Pat passed away. She left the following day back to the Free State, and came back again on Saturday. It just did not make sense now that she was there already. We were even asking ourselves what she went to fetch back home. I mean she could have called home and asked them to bring her extra clothes. She came back with her mother and brothers. I'm in good terms with one daughter in-law because we once stayed together.

**Interviewer:** How did they help you regarding the funeral arrangements?

**Interviewee:** Nothing, nothing. Knowing very well that Pat was not earning a living. I was actually helped by Pat's local relatives who knew the kind of person that he was. He was very sociable and warm. He used to help people. The only thing that his family of origin was looking at was what they were going to take with them when they went back home.

**Interviewer:** What were they interested in?

**Interviewee:** Furniture and all. In the first place, they wanted Pat to be buried in the Free State so that they could claim everything in his name, including the car.

**Interviewer:** Were you not legally married?

**Interviewee:** We were. Married or not they wanted everything. I did not understand what the main issue was with our car. I heard later that when his sister came before Pat passed away, she was sent to get the car. She can drive. She did not say anything because the day Pat passed away was the day that she was supposed to leave.

**Interviewer:** Why the greed?

**Interviewee:** I don't know but my sister overheard them saying that I don't have children with Pat. I got married with two children of my own, and I miscarried twins in my marriage with Pat. They were saying that outsiders could not inherit Pat's estate. In a way, they were protecting his interests. He loved them very much but his family was very greedy. Pat's brother's wife called me and warned me about them. She advised me to make sure I keep the car keys to myself and locked the garage because they had planned to go back home driving Pat's car. I kept in with me all the time. Fortunately my neighbour offered me his car to run errands with it. I opened the garage to be used for storage but locked the car. In fact, the car was supposed to go for service and Pat's sister came all the way from the Free State with a car mechanic specially to service the car. I refused and it did not sit well with them. I again refused because I suspected that they could even steal the car parts, do something to the car or even take it away when I was still trying to deal with my loss.

**Interviewer:** Did you have a night vigil?

**Interviewee:** Yes, but the service was at home because it was during the Easter weekend and the church was occupied.



**Interviewer:** How did the funeral go?

**Interviewee:** It went well. After the funeral the very day people contribute money for me to do whatever I should and would need afterwards. The usual collection like during the church service. His sister was receiving it and took it all for herself. It's a family tradition for family members to contribute besides the community's. I did not think his sister would take that money for herself, but it's bad luck. If they took the money that did not belong to them, I'm asking myself if they will afford to buy the cow for my cleansing. They were spiting me and leave me empty handed. I will have to buy it myself.

**Interviewer:** Did you go through any rituals?

**Interviewee:** The corpse slept over at home. In fact, late Friday morning, I felt very anxious, only to realise that it was because he was coming home that evening. I was very down spirited the whole day. In no time, I happened to see the undertaker outside with the coffin, and I started crying, thinking to my self that I would never see him alive again. I was told not to cry, can you imagine. He was brought in the bedroom and it was like a dream and seeing him there was a torture. I could not believe that he was in there quiet, and would never talk ever again. I was not sure whether to open the coffin and look at him or not, because when he got home that evening, I did not want to look at him. I was told to sit on his head side and his mother on the feet side, with candles lit around the coffin the whole night. The fact that he laid quietly next to me I could not sleep. We were with other old ladies in the bedroom the whole night. As a result right now, hearing that somebody I know passed away, it really affects me. When the corpse got into the bedroom, his sister sprinkled water in the bedroom. Why, I don't know. She did that again when the coffin left the room. My family of origin and I were disapproving and did not trust her because according to tradition, she should have asked permission from me. We never practised such things in our house. You can't just come into somebody's house and do funny things. It would have been different if they could have explained to me that it is their way of doing things and ask for permission. What is important to me is to erect a beautiful memorial for him. That will help me with closure. I will just tell his family when the unveiling will be.

**Interviewer:** What happened in that room the whole night?

**Interviewee:** Nothing. We sat there awake. I was not even allowed to go to the toilet. When I needed to go to the toilet, I was given a potty and that was it. I could only get out the next morning. Even then it was because all the women who spent the night with me in the bedroom were asked to walk out for the older males to prepare him. That was the time I managed to bath.

What preparation, I did not know and could not ask because all those people were related to him and not me. If it were my relatives, I would have asked because I did not even understand why I, as his wife should also walk out. I was very unhappy with that. What was it, as his wife, I did not know about him? In fact, I should have been the one person who should have been preparing him. Besides, what was to be prepared that I should not do myself? When I bathed, my sister was there with me. Whatever I ate, my sister had to dish out for me and nobody else. I did not trust his family but mine. That's how it's done. You choose who ever you trust to do all that for you.

**Interviewer:** What was it that those men were doing in the room with the corpse?

**Interviewee:** I still do not know even today. What I know is that I was asked to take out clothes that I would like him to be put on and I gave them. I want to believe that they were dressing him. I still don't understand why they were not taken to the undertaker to do all that, especially that I was not allowed in. It was only men from his side of the family, and not mine. I had to wait outside for them to finish. Can you imagine? I felt like I did not own him but his family. We were later allowed in. By then the coffin was open and I was allowed to look at him. I remember peeping and thereafter, I don't know what happened. I remember recovering with people holding me. I had my own clothes on that day. Something funny happened that morning. They showed me their own traditional healer who they say was supposed to wash the corpse himself and take that water to cleanse me. That is witchcraft at its best. I refused and pushed him away. That I was not going to allow because I don't even know him. On top of that allow him to touch my husband. They were angry with me and I did not care.

**Interviewer:** What happened the following day?

**Interviewee:** The morning following the day of the funeral (Sunday) Pat's clothes were given away. Everybody was there, especially his family. I only took two items. The eldest daughter in-law dressed me in these black clothes that you see me with. I just sat there quietly like a sheep, obliging to that procedure. They were just being spiteful because even before the day of the funeral, they were busy saying that whether I like it or not I will put them on. The only thing left now is the cleansing when I take off these black clothes by my family. They did not do anything to me regarding rituals. I am pleased with that because I don't trust them anyway. They did not even cut my hair.

**Interviewer:** What is really done during the cleansing ceremony?

**Interviewee:** I don't know. I will see when I get there. However, I witnessed Pat's aunt's cleansing. She got there on a Friday at her parent's house. She also had black clothes on. She stayed in Soweto. I don't know because some people say you are cleansed in a river, some say



in rural areas you are cleansed in the kraal. I don't know, but she was bathed outside the house and not inside. You first bath like normal in the house. In the water they put herbs and, because my family will cleanse me I will definitely ask. According to the custom, when I take off these clothes, my in-laws are supposed to buy a cow that will be slaughtered and the intestine contents will be used in the cleansing. That will be mixed with the water that I will be cleansed with, including other herbs. They would give me the money for the cow when I go home, and one of them will go with me. They will be waiting for me at my house. I am expected to bring home for them half of the cow that was slaughtered. My worry is I can't leave them alone in my house. I think I will talk to my sister whom they fear to look after the house for me. I will however lock my bedroom and all my valuables. My family of origin is supposed to cleanse me. I wanted to take my husband's car but apparently I can't. My mother will have to hire a car for me, and I will lock my car in the garage so that his family must never come near it. I don't trust them because they wanted it. What should happen is that I can drive home but my car is not supposed to stay there. It has to be brought back home and my mother has to find a way of taking me back home. My cousin will take me and back. I'm not going to stay long. I will be cleansed early on Saturday morning and these black clothes will be burnt. I will then put on brand new clothes and a blanket that my mother would have bought for me. I think those herbs smell and I'm not supposed to bath afterwards, I will stay with that smell the whole day. My hair will also be cut and have no say about it. Then I go back home with half of that cow and the meat will be cooked for his family.

**Interviewer:** Have you ever thought about how you may feel during your cleansing ceremony?

**Interviewee:** Yes I have. Just as much as I don't like these black clothes I'm not keen to take them off because they feel like part of Pat. It may feel like I'm abandoning him, after six months. I'm just thinking, I don't know. I will cross that bridge when I get there. I witnessed my mother going through that with my father. We saw the cow and it was hurting for me and I even cried because when the cow was slaughtered, it felt like they were killing my father. It took us back. It should have been worse for my mother.

**Interviewer:** How did you feel when they were busy taking Pat's clothes for themselves?

**Interviewee:** They were even fighting for them. It was so embarrassing. I was really hurt. One of Pat's sisters called Pat's younger brother to come choose whatever he liked and he refused, saying that he was not Pat's favourite and won't participate in the ritual. They were exposing themselves to everybody that they were not one.

**Interviewer:** What are your experiences of the black clothes?



**Interviewee:** One day I was with one lady in town and there was this man coming towards me. He looked at me and screamed. Maybe he did not expect to see a widow in black. Maybe is because most people don't put black anymore, or maybe someone close to her, like her mother, wore it and is no more. Maybe he thought he was seeing his late mother, I don't know. You learn a lot of things with these black clothes. I would get into a taxi and sit down. The taxi driver would tell me in front of everybody to go sit right at the back. When I sit down the person next to me would move as far away from me as possible. It hurts. When I have to pay, some passengers would not want to pass money forward, and some drivers would not want to touch my money. One even told me that he was doing me a favour to let me in his taxi because nobody would. When I walk around people would look at me, some feeling pity for me. Some people you were used to before distance themselves. Maybe they think that I will take their husbands, when the very husbands are still the same. The poor husbands sometimes avoid greeting me because of their wives. It hurts and always reminds you of your situation. When I have nowhere to go, instead of putting on the black clothes, I stay in my pyjamas to take a break from these clothes. I think it also takes back those who went through this loss before. My in-laws are very spiteful and cruel. They were telling everybody who would listen that I would put on black whether I like it or not. Unfortunately Pat did not tell them his wishes about these black clothes. They even came too early for the funeral. It was expensive for me to feed them especially because they were not even helping in any way. If it was not because of Pat's relatives in helping I don't know what could have happened. Neighbours contributed money for this and that because Pat was very helpful and reliable to others.

**Interviewer:** How did you manage with all the financial problems that you had with Pat?

**Interviewee:** Oh, oh, oh, I was at people's mercy. Maybe that was the reason why my in-laws were so nasty and wanted him to be buried at his parents' home. I refused even though I did not know where I would get the money. But they knew that he wanted to be buried where we stayed. He never even used to stay more than two days at his parents' house. Those people are spiteful. His mother insisted that he be buried where he stayed. She is very sweet and fair. According to her, she would be staying with us it's just that she does not like Johannesburg. His relatives who stayed in Soweto helped me. Those were the people who lived with us and knew Pat for his goodness. They bought the coffin. They just asked me to choose, which was very difficult because I had nothing and could not choose what I like for him. I depended on them and was at their mercy. I was hurting. My sister in-law was also there. Maybe she was sent to see whether I have money to buy my husband a coffin or not. There was no need for her to be there. I was asked to choose and that was difficult because only a person with money could choose. One of them chose one, which to me, was acceptable but not there yet. What would I have said?



**Interviewer:** How do you cope right now?

**Interviewee:** I sometimes sit on my own asking myself whether I would cope better with time without him. I sometimes still cannot believe that he is gone forever and I will never see him ever again in my lifetime. But what I liked about him is that he did not believe in debts. We did not owe anyone. God is great because I've learnt that I can't trust people because they change, although people are not the same. It was tough even before he passed away because he was not working and he never allowed me to work. He believed that it was his role to provide for me. If I work means he was failing me as my husband. We used to live on people's donations. It did not sit well with him. He used to refuse those donations. People used to give me without his awareness. The church is also helping. It's just that when I have to walk into someone's house, I always imagine if I do, and the man of the house dies, I will be blamed. You know, after seeing you for therapy, I can sleep. Before then, I could not. I would sit the whole night wide-awake with headaches, lack of appetite, preoccupied and all. You really helped me. Even one widow at our church two weeks ago was asking me how I manage to function because she sees me as coping. I told her about you and she asked me what you to me. I just encouraged her to come and experience for herself. I gave her your number. The church is also of great help. On father's day, our priest and his wife took three of us (widows) out for lunch. It felt so good because we even shared our experiences. They did not believe that I was coping the way I did. I also told them about you. The following Sunday, the priest talked about psychotherapy at church which, to most people was something new. He asked me to tell the congregation my experiences with you. I also did not know anything about psychologists and what they do. I assumed them to be similar to social workers. There were some who knew you for different issues and think highly of you. I felt so important.

**Interviewer:** Did Pat ever talked about death with you?

**Interviewee:** He never used to, except before he was last admitted at the hospital, he said to my sister that he was planning to go home. We even thought he was talking about his parents' house. He then said he was going to his home where he came from when he came to this world. We laughed about it and left it there. That was a month before he died. At the hospital he looked healthy because I even estimated a week before he would be discharged. I remember that week I slept well looking forward to the following week.

**Interviewer:** Have you ever dreamt him?

**Interviewee:** Yes. He was driving his car, taking visitors somewhere with him.

**Interviewer:** Have you ever lost anybody close to you in your childhood and adulthood?

**Interviewee:** My father at about fifteen, that's all. In adulthood was Pat.

**Interviewer:** How did you meet with Pat?

**Interviewee:** We met in the Free State. I already had two sons then with the same man. What I did not like about him was that he listened to his family too much. I just left him without notice. I then continued with Pat but when he started talking marriage he discouraged me because I was not there yet, as I had children, two years and five. With time, he convinced me and we got married, and he accepted my children although my mother wanted the children. We came to a compromise and she stayed with the older one and I took the baby. We were very close. You know, if he could come back from work and not find me at home, he would be very unhappy and abandoned. He wanted to come home and see me open the door for him. He did not want me to work, saying that he can take care of me. He was very dependent on me. He would always tell me that I'm all that he has.

**Interviewer:** What is your main problem right now?

**Interviewee:** It's my house. The little that I have I think I will have to use it to pay off the house because the bank is now sending people to come and view the house. I see myself taken out of the house. Even last month people came. I'm uncomfortable now because when I'm not home, I get worried about those people. One day I will find my possessions out of the house. I will just have to take the builder who took our money to court. He takes advantage of me now that I'm widowed. I'm now worse than before I came for therapy. I had planned to use the little that I have to pay for my children's school fees. I am now selling stuff to make money for my children and not the house that should have been paid off. This problem really causes me headaches. It is now over year. When I think that my husband did not even enjoy it. Doing that to a widow is all bad luck. When I start thinking about it, I get miserable and people around me become uncomfortable. I will cry the whole day and even start blaming the deceased. It's not fair to people who are supportive to me. I don't like it either. I am now weaker than before because of this.

## **SECOND INTERVIEW**

**Interviewer:** How did the cleansing go?

**Interviewee:** I was cleansed but my in-laws did not do what they were supposed to do. They were supposed to buy a cow for the slaughtering but did not. My family of origin had to do it. A



week before the cleansing my sister in-law called and ask about the arrangements and told me about her money problems. She wanted me to borrow money for the cow when it was supposed to do all of that. She now suggested that my worst enemy should take me to my parents home and I refused, telling her that she must tell that person that I don't want to see her near my house because she will start what she did at my husband's funeral, being rude. I told her that the fact that I dislike her is not a secret and she must tell her just that. Apparently my sister in-law collects her parents' pension grant monthly, and my mother in-law suggested that she put two hundred rands every month in preparation for my cleansing. It would seem like she did not do that but instead, used that money for herself and her family. That person is a professional teacher. It was discovered that that sister in-law used her parents' money for the cow. She then called me and asked me to borrow money for my cleansing because she was expecting a cheque from her employer and had not received it. That really destroyed my mother in-law but still continued to deceive her parents and reassured them that she had the money.

**Interviewer:** What did you do about that?

**Interviewee:** My mother understood the kind of people they are. They were prepared for that. The day I left for my parents' house in the Free State, my in-laws were supposed to be there a day before to burn my black clothes so that I could leave with ordinary clothes on. I could not leave without the burning of my black clothes. I could not go home with them on.

**Interviewer:** Who burnt them for you?

**Interviewee:** Because they were not there, my husband's cousin did. That is supposed to be done at sunset. When they were burning them, I became emotional like I was abandoning my husband. I felt like that although I was happy to know that I will be back to my old self. Before then I was anxious and did not know how I will feel about it. The ashes were taken and thrown into the river nearby.

**Interviewer:** How did you feel in your normal clothes?

**Interviewee:** I asked myself questions. For example, what was the purpose of those clothes? When I put my ordinary clothes, a thought that came to mind was that the last time I had them on was when Pat was still alive. It was painful. Two days before the burning of clothes I went to the grave to tell him about it. When I got to the cemetery, I could not find the grave. I ended up asking help from the caretaker. Remember that the last time I was there was the day of the funeral. They gave me the wrong grave number and I realised that. I called home to double check. I was able to identify it through my mug that was on the grave. It was hurting. I was crying, re-experiencing exactly what I went through emotionally at his funeral. I then went to the Free State. My



husband's cousin drove me there. When we got there, his cousin told my mother that my in-laws did not give him money, and she understood because that was what she was expecting because, on the basis of what she witnessed at the funeral, she did not expect them to do what they were expected to do for me when they could not do for their own family member, meaning my husband.

**Interviewer:** What happened thereafter?

**Interviewee:** I got home Thursday evening. On Friday morning, the cow was there. When I saw it I cried so much because it reminded me the day before the funeral when the cow for the funeral got home. It was slaughtered Friday before sunset. I also realised that black clothes are heavy because they always remind you of the reason why you had them on. When you take them off in the evening you feel light. In the evening I was shown the cow and it felt like it was going to be slaughtered for the funeral. I was so much and saw my mother also crying. It was very difficult. After that I was not allowed into the house. I had to wait there while it was slaughtered. I had to watch the whole process. They then took what was in the cow's stomach, gall and some herbs and mix them all. Then my sister, cousin and aunt took me to the nearby river. They also took the new clothes that my mother bought me. The ones I had on were to be left at home and never wear them again.

**Interviewer:** What happened at the river?

**Interviewee:** When we got there, I had to strip naked and shaved me all the hair on my body. I mean everywhere. Can you imagine standing naked in front of people doing you all that. Apparently they were cleaning me, making me pure.

**Interviewer:** What did the shaving mean?

**Interviewee:** I don't know and I never asked. I was put in the river, in a cold and rainy evening. I was shivering. The stomach contents, gall and herbs mixture was in the bucket. They pour me with that from the head down, whilst still rubbing that on my body and I nearly gasped. They then took the water from the river and washed. It was so itchy and I was not supposed to bath when we got home until the following morning. Just as much as I was relieved, I also felt sad when I think of the reason behind that ritual. I never believed that I could go through that. The following day when I had to leave, I cried and saw my mother crying also, feeling pity for me. My uncle then took me back home in the afternoon. I was given new clothes from every member of my family

**Interviewer:** What happened to the slaughtered cow?

**Interviewee:** I came back with the other half of the cow to give it to my in-laws. When I got home I found my sister in-law. She was so embarrassed and I just told her that she will take their half of the cow to her parents. The cow that they were supposed to have bought. They don't call me anymore. It's even better now that they don't.

**Interviewer:** What happened when you got home?

**Interviewee:** The way it is done, I had to show everybody the clothes that I was bought and give my in-laws their part of the cow. Part of it was cooked for whoever was there to welcome me back home. I found my sister in-law at home and my uncle explained to her that my mother understood that my mother in-law is a pensioner and might not have afforded to buy the cow. I discovered later that my husband's parents waited for her to drive them to my place and she was nowhere to be found. Even today, my mother in-law is sick today because of the way her son's funeral was conducted, and now the cleansing. Anyway I went to see them two months ago because she wanted to see me. Both of them were happy to see me. When she saw me she cried so much. When I left she cried again. Her health is affected.

## PARTICIPANT FIVE

**Interviewer:** What was your husband suffering from?

**Interviewee:** He had high blood pressure and diabetes, but they were all controlled. He was up and about and you would not tell that he was sick. The problem came on Christmas day of 2005. We always used to spend Christmas day with my sister at her house. He used to enjoy himself at my sister's house because it's open and peaceful. That day (Christmas day), he refused to join me and decided to spend it with his sister whom I know that she takes alcohol like a horse. As a result, I did not want him to visit her but he insisted. Unfortunately for him on that day, he had a problem with his car and had to use public transport to go to his sister, and I went to my sister alone. He called me at about six o'clock in the evening to check if I arrived safely at my sister's, and promised to come and get me later. He did not sound sober on the phone and discouraged him from coming over. He later called, telling me that he wanted to go home and I advised him to sleep over at her sister's place, for his own safety. However, according to his nieces, he never slept, never ate but drank with his sister the whole day and night. I was told that she had bought more liquor than food for Christmas day. I called him on my way back home that very evening, and his niece suggested that I should come and see how he was. I called again when I got home

and was told that his sister had locked herself in her bedroom, leaving my husband was sick and vomiting. At that time, I was already at home waiting for him. I was angry because she (his sister) is a qualified nurse who should know the needs of a diabetic, and what needed to be done when he was sick. I however suggested that they rush him to the clinic (private) and would meet them there, but that did not happen. Instead, they only brought him home very late that night. I then asked his sister to explain to me why, as a nurse, could let a diabetic keep on taking alcohol without food and the answer I got was that my husband was not the only diabetic in Soweto who takes alcohol without food. What made me angry and hurting most was that, when my husband got home, he asked for food and I gave him and he went to sleep. I promised him that I would take him to hospital. The following morning I asked him to prepare himself to go to the hospital and he refused, saying that the last time he was there his sister embarrassed him when she screamed at the hospital staff, questioning them about this and that. In a way telling them that she is also a nurse. I feel that his sister, because her mother left her with her house when she died, she does not know what to do with her money and ends up spending it on liquor.

**Interviewer:** It seems as if his sister had no interest in his health.

**Interviewee:** She told me that he is also her brother. I feel that she was using her brother as a weapon against me. However, my husband promised that he would never take alcohol again, because his liver was also getting affected.

**Interviewer:** Was he employed?

**Interviewee:** He had been retrenched for five years by the time he died. I think his being unemployed contributed a lot to his drinking, because not providing for the family bothered him. We had two cars and he suggested that we should sell his to reduce the financial strain because we still had the mortgage to manage. To make him feel supported, I decided rather to sell mine (car). On the 28<sup>th</sup> of December, he woke up very early, in the early hours of the morning, at about three o'clock, switched on the lights, the whole house. Before then, I felt like there was somebody standing next to me while I was asleep. When I woke up I saw him next to me and I screamed, and he asked me if I'm not going to work. I work for a company that manufactures dental equipment, majoring in credit control. I was a nurse before. I told him that I am not going to work. He knew that, and I fell asleep again. Normally I'm a very light sleeper but that morning I deeply fell asleep again. When I woke up, he was fast asleep, and I woke him up asking him if I could make him tea. He answered me with his eyes closed, and every time I looked at him he would close them. He then woke up and we brushed our teeth, poured him a soft drink, and asked for

breakfast. He did not look good that morning and would go to the toilet time and again. He seemed to have urine retention problem, avoiding me.

**Interviewer:** Don't you think that he was scared of something to happen?

**Interviewee:** He was and I did not know why he did not say. My husband was scared of death because every time I suggest that we should draft a Will, he would refuse, and walk away.

**Interviewer:** What happened after breakfast?

**Interviewee:** He went to the bathroom to have a bath, and later called me and asked me to help him bath, which I did although it was unusual. When finished and had to put on his clothes, he put on short pants, and later his pyjamas. In the afternoon, he decided to go to the toilet. Whilst in there, he opened the tap to make noise so that I should not hear him when he urinated. But because that was painful he called me for help. I saw concentrated glucose in the toilet bowl, which was a bad sign of his insulin level. I called his sister to come and take him to hospital, as she was the cause of all that. She came three hours later, slowly coming into the house. At the time, his glucose and blood pressure were very, very high and her sister saw that as not that bad. I was very angry but decided not to show it. She started screaming at her brother, telling him to make it quick.

**Interviewer:** Where were you taking him?

**Interviewee:** His sister decided to take him to her family doctor because most doctors were on holiday. When we got there, she refused me entry, insisting that only her and her brother would go in. She went in with my husband, because I did not want to cause a scene. Hardly ten minutes in, they came out with my husband walking in front. I then asked the doctor what the problem was and, before he could answer, she answered rudely, telling me that my husband was about to get a heart failure. The doctor looked at her, and then me without saying anything.

**Interviewer:** How was your husband then?

**Interviewee:** He was walking by himself without help but what her sister said, and how she said it was to finish his brother. I then suggested that we should take him to a public hospital and the sister screamed and rudely refused. We then went to another private clinic nearby. I also suggested to her that she should get a referral letter from that doctor so that in the meantime, the

doctor could call that clinic to make the hospital and physician aware that we were on our way, and it was an emergency. She again screamed at me and drove away.

**Interviewer:** How did you feel?

**Interviewee:** I was hurting, disrespected and worried about my husband's deteriorating condition. I could tell that he was getting worse and worse. When we got there, I rushed for the wheelchair, put him on it, covered his legs and pushed him in and let her fill in the admission form. I was in the ward when she came and told me that I must go and complete the form because she did not know her brother's date of birth and address. I could not believe it.

**Interviewer:** What happened next?

**Interviewee:** The physician came and wanted to talk to one of us. She told the doctor that she was his sister, she is a nurse and she would not leave the room. The doctor then told us to decide and I walked out. I walked in later and asked my husband how he was feeling, covering his legs. He told me that he felt better than earlier. What was puzzling me was the fact that the previous doctor diagnosed eminent heart failure and the one we were with at the time diagnosed pneumonia. That was a big question mark with pneumonia in mid-summer. He was not coughing, no sputum, nothing. He was only complaining about stomach pains, which I thought to be retention. I was confused but not thinking about death.

**Interviewer:** Where was his sister at the time?

**Interviewee:** She was sitting next to him but giving him her back like she wanted nothing to do with him, let alone me. I even started thinking that she knew something that I did not know, probably poisoning his drink on Christmas day.

**Interviewer:** Was there an element of mistrust from your side?

**Interviewee:** Of course yes, considering her behaviour from Christmas day. Encouraging a diabetic to take alcohol without food the whole day, not responding to him when he was vomiting the following day but instead, locking herself in her room, refusal to me to be present when my husband was consulting with both doctors, and giving him her back at the hospital. I saw all of that as an admission of guilt about something that probably she alone knew. You know, I even thought that after my cleansing, I would open a case of murder but because that is not me. I will leave it the way it is. She will pay in God's own way.



**Interviewer:** How long were you at the hospital?

**Interviewee:** We were there for about three hours. He was asking me for water and not his sister. He was sweating a lot and tried to wipe him. We were told to wait for another physician for second opinion. I was getting impatient and starting to panic, and he was getting restless.

**Interviewer:** What was his sister doing at that time?

**Interviewee:** She stood up and wanted to go home, getting “bored”, standing at the door. I was unsure of what to do then and asked him if I should stay. He suggested that I should go and come see him the following day and asked me to bring him his wristwatch. I then took the hospital telephone number and went home. Fifteen minutes later the phone rang, it was the hospital. The doctor asked me if I was alone and I started to panic. He screamed at me, telling me impatiently that I should not panic and I screamed and fainted. My neighbours apparently heard my scream and came running. One of them picked up the phone and answered. The doctor asked to talk to me again and he told me that he tried to resuscitate my husband but he failed. He was so rude. It was an Indian doctor. You know how Indians are. You know it is funny that when someone is about to die I can tell but that time I just could not. I did not think of death when it came to my husband. I blame my sister in-law for my husband’s death.

**Interviewer:** How can you define you husband and his sister’s relationship?

**Interviewee:** Let me tell you their family history. He grew up in Lesotho with his father and paternal grandmother. Although my mother in-law did not tell me clearly, it seemed as if she was never married to that man although she had two children with him, meaning my husband as the elder one, and then his sister. Both their names are Sotho. He only met his sister when he was nineteen years old. It seemed as if their mother in Soweto brought up the sister. Why their mother gave him away to be brought up by his father I do not know. Their married did get married to another man, and let the two to use her maiden name, which is Zulu. He was using a Sotho surname in Lesotho but his mother changed it when she abducted him from Lesotho. That is why, when their mother made rituals at home, would slaughter a goat (which is a Zulu tradition) for her Zulu family, and a sheep (which is for all other tribes), which in that case, was for her Sotho children.

**Interviewer:** Don’t you think the two siblings, in their own unusual way, were trying to bond and define their relationship? Also, what if there were family secrets that they had which you husband might not have been told about.



**Interviewee:** Maybe, but if my husband knew them, he would have told me.

My mother in-law once told me about how she went to abduct my husband from Lesotho. She told me that she dreamt my husband's grandmother in Lesotho thrice, telling her that my husband had no one to look after because both her (my husband's grandmother) and his father had died. Suggesting that she must go to Lesotho and get him. According to her (mother in-law), she did nothing about that because she was too much into alcohol. Years later she decided to go to Lesotho and found my husband. At the time, he was nineteen, and looking after his late father's flock, and staying in the mountains. She then persuaded him to come to Johannesburg with her because he was not attending school anymore. He refused, saying that he was looking after the flock that his father left him. He left school in Standard nine, when everybody was attending school. She then asked him to go to town with her so that she could buy him clothes. That is how she abducted him, and changed his surname to that of his mother. His mother however, asked us to change our surname to that of his father. It is clear that their relationship (sibling) was distant, and probably tried to be closer through alcohol.

**Interviewer:** What happened after the news of your husband's death?

**Interviewee:** I first called his sister and her daughter picked up the call. Apparently she did not want to come to the phone until she was told that it was I on the line. I told her that his brother had passed away. I think she knew what she had done, because the two of them (brother and sister) sat and drank the whole day. She knew that her brother should not be drinking because of his health.

**Interviewer:** How did you really feel about that?

**Interviewee:** I have no forgiveness for her. What irritated me most was the fact that she did not want to help us with transport. Above all, in the middle of the night, with immediate family, including my sister, we heard a scream in the other bedroom. When people went to check, they found my sister in-law naked in the dark, doing something and wanted to touch my niece's head. She (sister in-law) was so embarrassed, trying to explain to everybody something that was unexplainable. She then explained to me that she was checking if the doors were locked, and I did not respond.

**Interviewer:** Was your sister in-law staying with you in your bedroom?

**Interviewee:** Yes. She would sit at the one end of the mattress and I would sit at the other end. What was scaring me also was that time and again she would have a small packet in her hands,



rubbing her hands with it. I eventually asked her what that meant. She could not answer me. The next thing she would be burning herbs in my bedroom with everybody watching. Burning them on the carpet. My sister suggested that we should pray, and later told my sister in-law off. My carpet and underfeld are burnt.

**Interviewer:** What happened thereafter?

**Interviewee:** We later left to go and choose a coffin and my sister in-law insisted that she wanted to come with us. When we got there, she wanted to choose the coffin and I told her to stay at the reception area. You know, I was at peace with myself when I chose my husband's coffin without her next to me. When I went to my insurance company to pay for the coffin, I was told that the computers were down and, as a result they could not pay out. Fortunately my sister's son had left money for me and I used it for the coffin. My family of origin in Kimberley was struggling to get transport because their car could not start. They tried to get other people to drive them to Johannesburg but failed. Everything was just not working. The day before my husband was to come home, his sister told me that I must go and prepare him at the mortuary. I refused because I know that it is not done. Only males prepare a male corpse. Again, I overheard them (my sister in-law and her cousins) talking, thinking that I was asleep, saying that they must force me to go and prepare my husband so that I would also die. I refused to do that. I was later told that they (my sister in-law and her cousins) were at the mortuary earlier to do something to the corpse. I never knew and understood what they did.

**Interviewer:** I do not understand. Does the undertaker allow anyone to come in and do as they (sister in-law and cousins) like with the corpse?

**Interviewee:** I do not know. Do you know what they did? They changed the coffin and choose the one, which was five thousand rand more expensive just to spite me. Their explanation was that my husband was too big to fit into the coffin I chose, and I must go and pay five thousand rands. I had a mortgage to pay, run the funeral and all. When I went to pay the undertaker she refused to come with me.

**Interviewer:** Did the corpse come overnight at home?

**Interviewee:** Yes. I was alone in that room with the corpse. They (sister in-law and her cousins) refused to join me, because culturally, as my husband is her brother, they should have been there with me. Instead, they decided to stay in one of the bedrooms in which they did not allow anyone. I never knew what they were scared of, and what they were doing in there the whole night.

**Interviewer:** How did you feel when the corpse arrived?

**Interviewee:** That moment is a very silent moment. It was painful. What came to mind was that he left the house to hospital walking without help. When we left home, he looked at me and thanked me for having been there for him. It's only now that I remember some of the things that were happening then, and what they could have meant. Sitting there upright the whole night next to that box with my husband in it was torture. That tradition can come to an end. It is not helping anyone. I am the first in my family to put on black clothes and follow some of those rituals.

**Interviewer:** How did you reconcile what you were ordered to do and how you were brought up?

**Interviewee:** You know, I have now accepted these black clothes, unlike before. Before, I did not know how to be to people and would at times avoid them. It was only after a friend of mine advised me to start getting used to it and interact with people because I would struggle when I have to go back to work. To think that I asked my in-laws if I could have a coloured African traditional material dress and they refused. Instead I was told that my husband was not a boy and whether I like it or not I would put on black. They were even telling their other relatives that my family behave like white people, as they did not practice traditional rituals.

**Interviewer:** They were fighting you.

**Interviewee:** Of course yes. When they came to cleanse my children it was worse. They were insulting me, and I just kept quiet. My sister in-law suggested that we must go to my husband's grave and let him know that his children would be cleansed, and I refused. I refused because during her mother's cleansing none of that was done. She then told one of my neighbours that she was done with me she does not care whether I put that dress for three years it was none of her business. I forgot to tell you something important. After the funeral, my sister in-law called me asking for forgiveness. I asked her forgiveness regarding what? She said forgiveness for being irresponsible by drinking liquor with my husband and I did not answer her but dropped the phone because I told her that I would never ever talk to her. She called again asking for the meat (the left over of the funeral). The way I was stupid, I would give her (sister in-law) money to buy this and that like, for example, five thousand rand to go and buy an ox for the funeral. I discovered late that she bought half of an ox and took the rest for herself without telling me. She used the rest to buy liquor. She just wanted to embarrass me. She was overheard saying that it was her brother's money. She was letting me down.

**Interviewer:** When did you put on the black clothes?

**Interviewee:** I was told by them to put it on just before the funeral service started, about a year ago. The dress was up to the ankles with big arms, telling me that I will put it on whether I like it or not. They were looking at me laughing. The apron was up to my feet. My children saw that and started crying. Now days after the funeral my friends came over and joking about the dress to lighten the atmosphere saying that my dress suggested that my husband had two wives because two people could be comfortable in it together. If I did not hold that dress up I could have fallen. I did not get support from them.

**Interviewer:** Did you walk around with it on?

**Interviewee:** No I did not because when I was in a taxi to work, people would collapse, saying that there was something done to my dress. Five people that I did not even know said that to me. With time it started bothering me and I bought a black material for someone to make a decent dress for me. When she had to give away my husband's clothes, she decided to take them home with her. I asked for my husband's shirts, three of them and I just took them.

**Interviewer:** Why were you succumbing to her like that?

**Interviewee:** I do not know. I think it was because the herb she always had in her hands. I asked her about it and she never answered me but instead, she went outside the house, made fire and burnt the herb. The smell was so overwhelming we had to close the windows, in summer.

**Interviewer:** How do people react to your black clothes?

**Interviewee:** People avoid me and sit as far away as possible from me. Now my family does not know what to do and how to go about cleansing me because we do not cleanse in my family of origin. They asked around and were told that I can only do the cleansing in winter. It will be in March, meaning fourteen months in these black clothes. Apparently I am not supposed to unveil my husband's tombstone with black clothes on. You know my husband always asked me that if he could die before me I must erect the tombstone the same time. It did not happen that way because he died during the festive holidays. Arranging the tombstone ceremony will heal me because I will be running it and doing what I know he wanted. I had planned the unveiling for May. Now my problem right now is how am I going to tell my husband's family about the unveiling ceremony because I have to. I think I will just post them invitation cards. I do not care whether his relatives attend the ceremony or not.



**Interviewer:** How were your colleagues at work?

**Interviewee:** They were very supportive. My boss gave me ten thousand rands for the funeral. When I went to him to arrange the payments, he was surprised because, according to him, giving me the financial support the he thought I needed. He would even when I was still at home just checking on me. The church was also very supportive. The church even ran a memorial service. The church leader even asked my sister in-law and her relatives to go and sit outside.

**Interviewer:** When you saw your husband in the coffin, how did you feel?

**Interviewee:** He had false teeth and there was something unusual with his lips. One could see that something was put into his mouth. I was surprised to hear her sister suggesting that his false teeth must be taken out because she wanted them for herself, and I refused. Another concern that I have is that I dreamt him (husband) twice telling me that he has rested but not in peace. The first time I went to his grave was painful. I could not believe that he was deep into that hole. I found small bottles of funny stuff in them. I did not want to get near the grave. I just told myself that when the tombstone is erected, they would remove all of that.

**Interviewer:** Have you really started grieving his loss?

**Interviewee:** I am not sure because there are a lot of unfinished business. You know, one of my husband's nieces came over and was surprised that I still had black clothes on. She went and asked her mother who told her that she had nothing to do with that she must ask my sister in-law because she did all the wrong things. I do not trust them. My sister brought me herbs to drink, telling me that people advised her that it was a way of cleansing myself internally. She bought them at an Indian shop. I just drank. The taste was horrible. I do everything for peace sake.

**Interviewer:** Was your husband aware of his sister's behaviour and beliefs?

**Interviewee:** He was aware and did not trust her because he would at times tell me that his sister is just the same as his mother, believing in witchcraft. Even when his sister would have ancestor event, he would not go. You know I was told that a week before the funeral my sister bought a goat and gave it snuff. Apparently that goat sneezed and people were laughing at what she was doing. I heard weeks after the funeral from her relatives that she told them that my husband died at home and when she got to my house she found her brother's corpse in the garage. That means I dumped his corpse in the garage. That cousin of hers even told me that she had planned to stab me with a knife. I know that she always walks around with a knife in her chest. She meant what she said. But when I tell her exactly what happened, she got embarrassed. Apparently she



had told herself that she would rather be in prison for that. You could tell that my husband did not grow up with them because he was different. Despite all of that, I really got support from people around me. I also knew that my husband appreciated me.

**Interviewer:** Are your parents still alive?

**Interviewee:** My father passed away before I got married even though I was not staying with them at the time. My mother was still alive when I got married but passed away later.

**Interviewer:** Did any of your parents' death affect your husband's bereavement?

**Interviewee:** Not really because I think the difference was the fact that my husband was one person that I spent my life with and was with him until the end, unlike my parents. I also feel and believe that a husband-wife relationship is totally different from a parent-child one.

## PARTICIPANT SIX

**Interviewer:** When did your husband pass away?

**Interviewee:** It was on the 23<sup>rd</sup> of April 2006.

**Interviewer:** Was he sick?

**Interviewee:** He was sick but functional. He had high blood pressure, diabetes and swollen legs. He would have gout but when he went to the doctors he would be told that it was not. As a result, we concluded that he inherited that from her mother because she had the same problem. His legs would just lock and he would not be able to move. I would always rub him, sometimes before he got out of bed, and sometimes before he went to bed.

**Interviewer:** Did he have a specific treatment that he was following?

**Interviewee:** Yes, he had his own treatment that he got from the local clinic, and then Baragwanath.

**Interviewer:** Were you happy with it?

**Interviewee:** Yes I was because I saw a big difference at the hospital because if he complained about certain tablets, they would be changed to something else. I would even go and get his treatment for him because I wanted him to comply. He also had medical aid and as a result, had his own private doctor but for diabetes and high blood pressure he would get it from the clinic. Despite all of that, he was still able to go to work even though he then wanted to retire because of ill health. However, his employer convinced him to continue working with all the support that the company was giving him, giving him time off when he was not fine. He worked there for eighteen years as a labourer and was by then working as an administrator. He was a good husband, very understanding, very loving and generous. Even the problems we would have at home, he would handle them with love. Also, if he disapproves of something or was hurt by something that I did, he would sit me down and express his feelings. He never used to hold grudges. It would only be me who would worry about what he said and think that it would stay with him. I was, at the time, more sensitive than him because I made sure that I did not hurt him. Around the time that he was about to die, he was really short tempered, just decide to keep quiet and coming across as moody. I just could not understand what was happening. A small irritation by the children would affect him, which was something new. I interpreted that as aging or his illness. What I did not realise then was that it could have been the signs of approaching his death. He would talk about death when he was in a happy mood because he was smoking and took alcohol. That was all that we would fight about. Sometimes he would argue that when I met him he was taking alcohol and I never had a problem with that, and I would tell him that he was older and alcohol was now affecting his health. He did not understand.

**Interviewer:** What about his family of origin. What were their feelings about his drinking?

**Interviewee:** He came from a family that did not care. When I got married into that family, about twenty years ago, I had eighteen months old twins with somebody else but did not get married. He did not have a problem with that and they grew up knowing him as their father. His mother and siblings did not approve of that because they tended to discourage him. His argument was that women that he knew before were drunkards and I was a perfect woman for him. From the beginning his family did not accept me. That affected me but I told myself that I love him and would just have to accommodate my mother-in-law. I did not care about the rest of the family because she was the one I would have to deal with.

**Interviewer:** How many siblings did he have?

**Interviewee:** He had an elder brother who was his only sibling. The rest were relatives. His brother would pretend to be good to me but I could see through him, even his wife. Apparently



they (his brother and wife) were pushing my husband to get married because they were staying with my mother in-law and wanted to get their own house but did not want to leave their mother with him alone. They however did not move out when I got there. When I joined my husband at his mother's house, I came to realise that he alone had been providing for his mother and brother's family, when both the brother and his wife were employed. He was paying water and electricity, buying groceries for the whole family, fees for his brother's four children, I mean everything. Despite all of that, they would not give him food. If they did, his food would be different from theirs. They would have the best food but would give him pap and gravy. He would tell me that he only ate well the first week after buying groceries. His mother would eat the same food as my husband. He also used to give his mother money every month.

**Interviewer:** How did he solve that problem?

**Interviewee:** He then told his mother that he was now married and would from then on give all his salary to me, and I would handle the budget. That's where the problem started, and we were chased out of the house. It then came out that his brother took his mother to the municipality offices and changed the ownership of the house to himself without the knowledge of my husband. In the meantime my husband knew that house to be his, extended the house to accommodate the children and me because they (his brother and wife) were supposed to move out. Above all of that, they still expected that he should improve the house further. He worked there for eighteen years as a labourer and was by then working as an administrator.

**Interviewer:** What happened next?

**Interviewee:** We had to leave and the family met to talk about that. My mother in-law told everybody that since her children were born they never had serious conflicts like that, implying that I was the cause of all that conflict. Just before we left, my brother in-law asked his mother to leave home for some time so that when he chased us out, she should not be present. He chased us out of the house in the evening, in winter and I was pregnant. We then went to my parents' house. Since then, there was tension between them and us.

**Interviewer:** How was their life after you had left?

**Interviewee:** You won't believe this. They (brother in-law and his wife) chased my mother in-law out of the house, telling her that the house was theirs. My sister in-law was claiming that our mother in-law was a witch and could not share a house with her. She forced her husband to

choose between her and his mother. He then threatened his mother with an axe, telling her that he could not stay with a witch in his house. She left to stay with relatives.

**Interviewer:** How long did she stay with those relatives?

**Interviewee:** You know, we moved into our new house and a week later, we saw my mother in-law walking in, crying and asking for forgiveness, pleading to come and stay with us. We never knew how she knew that we then had a house. I welcomed her and she stayed with us. She even died staying with us and we buried her without the assistance of my brother in-law and his wife. Even when I had given her a place to stay despite what she did to my husband, and me she was still negative. She would discriminate amongst my children. She would tell my other children with my husband that the twins were not their siblings. But because we brought them up as a family, they never came to be influenced by her attitude. The only problem was that the twins would always complain about my mother in-law having done this and that during the day when we were not home. I would then tell my husband and we would have a meeting and ask her. She would not deny and ask for forgiveness. That continued happening until she died. I made peace with myself and told myself that she never approved of me but I looked after her and buried her. Even her relatives came to ask me to be patient with her because they knew the kind of person that she was.

**Interviewer:** How did your husband take it?

**Interviewee:** I only realised later that everything that was happening in the family was affecting him but he did not show it. It was only then when he was nearing his death that, when drunk, he would talk about them. It was only after his death that I fully understood how he felt about his family of origin. When he was sober he was an angel. I even asked him to express his feelings about things that he did not like so that they could be resolved as and when they happen. He even started having an attitude to the children, all of them, being impatient with them. He would scream at them for no reason, which was unusual. When I think of it now, he was nearing his death and struggling to deal with it. I wish he could have trusted me and open up to me for moral support. You know, I was able to forgive him.

**Interviewer:** Was he still employed at the time?

**Interviewee:** Yes he was. A week before he died he did unusual things. The Monday during the Easter long weekend, he forced us to go to the cemetery to clean the graves of his father, mother and all. He was so happy that day. His health was not of the best that day, and I cleaned and





asked him to sit down and watch me clean. When we were busy talking, he started telling me how blessed he was to have a wife like me, who understands and cares for him the way I did. In the afternoon we visited my sister who had just moved into a new house and we had supper there. On our way back he decided that we should go and drop the car at home and walk to a supermarket to buy some stuff for the family. Tuesday he went to work and later that day it started raining and I was worried that he would get wet and his condition would deteriorate. At that time I had stopped working. I sent my daughter to go and wait for him at the bus station with an umbrella. I got worried because they took time to get home. When they got home, he was so drunk and had not been drinking for two weeks. He had promised me that he would never ever drink again. When he got into the house, the first thing he said to me was that he could not stop drinking although he tried for weeks and stayed clean. He had even lost his spectacles. I was hurting and did not want to say much because I was trying to nurse his feelings. He ate supper and went to sleep. I then discovered that that day he had been trying to call one of his daughters, something that he had never done before. Our daughter called to find out what his daughter wanted when he called her. On the phone, his daughter could pick up that her father was drunk and he did not want to be long on the phone because he knew that she would be aware of his drinking, and be angry. Just before we went to bed he said to me that sometimes you marry a person thinking that things would change and they do not. Sometimes you stop loving that person. I could not understand because he seemed to be talking to himself. Regretting why he married me. In the morning he could not wake up and later woke up and wanted to go to work. He did not look well and he forced to go to working. He later called to say that he was safe. When he came back from work he still did not look well. He could not even eat well and he went to sleep. Later that week he got paid and gave me money. That morning I woke up with him and asked me not to look at him. He made himself breakfast, which was unusual. He then asked me to tell his brother to come and see him that day. They both drink very much. I then left them and went to a wedding. At the wedding I was very uncomfortable and decided to go home. I found them sitting and enjoying themselves, talking about their late nephew. I then expressed a concern about their relatives with whom they have distant relationships, and do not even know where they stay. His brother then left and we went back to the wedding. As a shy person, he did not want to go to the wedding by himself also because he was drunk. We did not stay long and when we got home he sat on the bed and I made him supper. In the middle of the night he woke up and told me that he was not well. He said he suspected that his food was poisoned. His body was swelling, and he vomited, and felt better and fell asleep. In the morning he woke up before me but did not want to go to the doctor. He forced me to go to the wedding again and promised me that if there could be a problem, he would ask our daughter to go and get me. I became suspicious when he said that and decided to stay with him. He asked me for his tablets and he sat on the bed and sat up. He told me that he wanted to relax and sleep for a while. I went to the kitchen and heard him

struggling to breathe and I tried to help him be comfortable and he took his last breath while I was holding him. I cried so much, asking him why he could do that to me. I called my daughter to come and help me and call neighbours. I was still crying at the time. The children came running and I asked them to call an ambulance. There was such confusion, everybody not knowing what to do.

**Interviewer:** What was going through your mind at that time and how did you feel?

**Interviewee:** At that time I was blaming myself thinking that there could probably be something that I did to him that hurt him. I asked myself questions that I could not answer. Thinking that our children would blame me that I killed their father. Why he did not tell me that he was going to die. Why did God not wake him up, or maybe He wanted me to see him when he died. That was traumatising. His eyes were closed and I closed his mouth and wipe him. I was only grateful that I decided to stay home with him and not go to the wedding because people would be blaming me for leaving him alone at home when he was sick. They would even think that I killed him. His youngest favourite daughter came after the paramedics had left. She came in, saw her father lying there and screamed wanting his father and I did not know what to do. I felt that she was asking for her father from me. Neighbours came and helped to calm her down. My sister came first from the family side, and went to report at the church. At the same time, we called the undertaker to come and get him. I called his brother to make sure that his brother sees him before the undertaker came. Our neighbours were there already for support, still asking my husband why he did that. We put him on the bed covered. His brother came three hours later, crying. He thought maybe his brother bit me up.

**Interviewer:** Did they (brother in-law and his wife) give you the support that you needed?

**Interviewee:** They did not. My husband would always tell me that I must know that his family would not give me the support that I would need because his family was not united like mine and I must not expect them to support me. I must only expect support from my family.

**Interviewer:** Did you go through any death rituals?

**Interviewee:** Not really because my brother in-law's wife is a member of these charismatic churches and as a result, as a couple, they do not practice cultural rituals that they were brought up with. However, my husband always used to express a wish that when he passes away he would like me to put on black clothes. I would always ask him how because when I cleanse, his brother has to foot the bill for all of that because it is an expensive ritual. His brother never has

money; he buys liquor with his money and in Zulu culture, which is his brother's role. He eventually saw my point. He stopped talking about that but instead; he would often ask me if I would remarry if he could die before me. I would reassure him and he would tell me that if I could, he would haunt that man. He would promise me that he would never remarry.

**Interviewer:** How did you deal with the death ritual issue?

**Interviewee:** His corpse was brought home over night. It was painful. During the funeral arrangement week, my brother in-law called me outside to talk about the expected death rituals. He told me that he and my husband talked about it and they decided that their wives would not go through the rituals because they are the only two left in their family. They felt that as they did not know much about it without elders left, they could rather not commit to anything instead of making costly mistakes. He asked me to respect like, for example, be home before sunset, avoid cemetery, etc. He also gave me the choice of whether to respect that for three or six months. I told him that I felt that three months is short, and in six months time would be summer and I could not cleanse in summer because it has to be in winter. I did not mind to respect for a year, after all, he was my husband. The only problem I had was with my grandmother who felt that I should put on black clothes but my brother in-law explained to her and she grudgingly accepted.

**Interviewer:** How did the funeral go?

**Interviewee:** It went well with the support from the church, and my children. The problem came after the burial. My husband's favourite daughter could not just accept that her father was no more. On the other hand, I had to be strong for my other children, presenting a strong face. I could not fall asleep at night. I was only able to sleep well the first three months because I was mentally tired. I would think the whole day. I think the problem was that on the fourth month, that month's dates were the same as the month he passed away. That killed me. Even now, the 23<sup>rd</sup> of every month tortures me, counting months of his death. When the 23<sup>rd</sup> approaches, I get sick, realising that he will never come back ever again. During the fourth month, I got so sick that I decided to go to church for help, asking the congregation to pray for me. The source was that I started feeling scared that my husband would come and get me on the 23<sup>rd</sup>. I did not want to die because of my children. I also had to unveil my husband's parents' tombstones. I just could not die. I even thought that I was not praying enough. I even dreamt that I was dying, struggling to breath. I would really feel depressed. Every time I have a bad dream I would pray, but that time I did not. That really bothered me. The church really helped me because they prayed for me. There is also a friend of mine whose husband died the same way as me. She told me that what I was going through is normal, the sleeplessness, headaches and all. She reassured me that with time,

I would be myself again. I could not eat except soft porridge. There was another neighbour of mine who lost her husband and told me the same as my friend. She discouraged me to take sleeping tablets. So I really had the support.

## PARTICIPANT SEVEN

**Interviewer:** What happened on New Year eve?

**Interviewee:** We were used to having a braai at home with friends and family. It was an annual thing. He was so happy that day because he valued family and friends. He took so much alcohol that night.

**Interviewer:** What happened the following day?

**Interviewee:** He was in pain and vomiting. His legs were swollen and could not urinate properly because he was in pain. I knew that his condition did not allow him to take alcohol but he insisted and I gave up on persuading him to live a healthy lifestyle. He was the kind of person who would not be persuaded when he had decided to do something. I was avoiding unnecessary tensions, although I was not pleased with his way of life. I reasoned it out by telling myself that if it were something that he enjoyed, if I discouraged it, what would I replace it with. I believe that one should leave life to the maximum, but should also be responsible. That is a good value in life.

**Interviewer:** What about his treatment?

**Interviewee:** Because he was employed, he had medical aid although he took a lower option, which could not cover his medical needs. He could only consult a general practitioner. He would sometimes complicate because his diet was not the one he was advised to take, and would be taken to hospital. I was used to taking him to hospital and he would be admitted. I would be very lonely and sometimes angry and sad because if he could have complied with his regimen, he would be alive today. He would braai meat with friends, the food that he was not supposed to eat. He knew that every time he ate braai meat he would be so sick that he would be admitted. Despite all of that, he was still able to go to work even though he then wanted to retire because of ill health.

**Interviewer:** When did he pass away?



**Interviewee:** In 2005 January 14th.

**Interviewer:** What happened to him?

**Interviewee:** That morning he was fine. He did not show any struggle but had high blood pressure and diabetes. I remember that morning we were talking and I expressed a need to further my studies to do Matric. He even laughed at me saying that I would not be admitted because I was too old to study. We were laughing about it. I was even saying to him that nobody is old to study. We were in the bedroom. He then decided to go and check the door that we usually forget to close because he was going to work and I was also going to register for my Matric. He suddenly said something that was out of context to what we were talking about. He said he just felt like dying because of the debts he had. I answered him jokingly saying that those debts are for liquor that nobody asked for but him. I suggested that he must go and pay his debtors and never ever take liquor on credit. He just said he would try to be home early that afternoon.

**Interviewer:** What happened that day?

**Interviewee:** On my way back from registering an ambulance went passed and I remember wondering who could be in it. I was even saying to myself that those ambulances just try to exercise power when it is not even an emergency. When I got home a neighbour called me and asked me where I came from. She told me that there was a lady who came looking for me saying that my husband fell on his way to work. I even thought he might have been drunk, fell and broke a bone. A neighbour took me in his car to a place where they said he went for a hair cut before going to work. They expected me to know where he does his haircut, when I knew him to have gone straight to work. We drove to a nearby hostel and asked about a man who was taken to hospital. I was even scared to say his name. They actually said his name and told me that an ambulance took him to hospital with a friend.

**Interviewer:** What happened next?

**Interviewee:** I went home and called my children to tell them about their father. We had planned to meet at the hospital. My eldest daughter came and we left together. I called his brother who is a medical doctor and he left straight to the hospital. When we got to the hospital, we found him at casualty lying on a stretcher. I asked him what the problem was and he told me that he suspected a stroke. He then reassured me that he would be fine. We then waited for a doctor who sent us to the X-ray department. He once told me that the day he dies, he does not want to bother anyone.

He said he would just go into a deep sleep. On our way to the X-ray department I thought of what he once said but I did not say it to anyone, not even to him. His brain was scanned and when he was pushed out, the doctors took him to a room next to where we were waiting but I did not go in. I was scared. Only my daughter and her uncle's wife went in. Apparently they were told that the prognosis was bad, and there was no hope of recovery. He was then taken to the ward and I walked with them. They just told me that the doctor told them that my husband would be fine. I got hope. He was then bathed and we were then told to come and see him. He was so handsome when I looked at him, and I was hopeful. I was even telling my daughter that the following day we would come visit him and then go to their aunt's house because they had a party. We then left.

**Interviewer:** Were you alone at home?

**Interviewee:** Yes I was. In fact I was used to that because we had two daughters. One was staying with my parents who were too old to look after them, and the other one was at a boarding school. When I got home I was so tired. I sat down and watched TV. About two hours later the phone rang and it was my daughter telling me that she was coming over to be with me. I just thought maybe she decided to come over because she knew that I was alone at home. She also suggested that we should change plans and not go to the party the following day. Immediately after her call another call came in and I thought my daughter forgot to tell me something when we were on the phone. It was a white person talking asking me who he was talking to. I told him my name and he me that he was sorry that.... I did not hear the rest of the sentence because I did not know what happened thereafter. When I gained consciousness I called my daughter and she told me that the doctor also called her informing her of her father's death.

**Interviewer:** How did you feel then?

**Interviewee:** I did not feel anything. I was numb and just did not want to believe that I was on my own. I sat down on the chair and could not think. I was overwhelmed. I could not cry. I was confused and to me it was like a bad dream. I was okay.

**Interviewer:** Were you still alone then?

**Interviewee:** My daughter came and started informing the neighbours about the death, and also called the church and his employer. I could not think of all that, and I felt useless and disempowered.

**Interviewer:** How did the funeral arrangements go?

**Interviewee:** I never knew because my daughter and my family did everything, decisions and all. They even chose the coffin.

**Interviewer:** How did the funeral go?

**Interviewee:** I was aware that there were people who came to the funeral but I could not tell who was there and who was not. I was like a zombie.

**Interviewer:** How did you deal with life after your husband's death?

**Interviewee:** You know, before his death, I was busy redoing our bathroom. He used to be proud of me. That used to encourage me. Now that he is no more, I do not have the motivation. It is still incomplete and my daughter decided to take over. I miss him, lonely and would often cry. I experience sleeplessness, lack appetite, socially withdrawn, and prefer to be on my own. Sometimes I would not wake up and just be in bed the whole day. With time I went back to work because when he was still alive, he would be sick more often and that affected my relationship with my boss. Me and I boss decided that I should stop working to look after my husband. After hearing about my husband's death, my boss called me suggesting that I should come back to work. That helped me a lot because when I interact with people and stop thinking all the time although, at times, I do feel like being on my own.

**Interviewer:** Did you go through any death rituals?

**Interviewee:** Not really. I was only given herbs to boil and drink. That was horrible and I pretended to be drinking that water when I was not. I do not believe in that. I did not put on black clothes, and I was not cleansed. My husband's corpse did however sleep over at home. If only I knew how I would feel, I would not have allowed that. It was hurting to see him in that coffin and sitting next to the coffin the whole night. That was not the experience I had of my husband. These rituals are really working against helping widows to go through the loss with ease.

**Interviewer:** How do you feel now?

**Interviewee:** I have no interest in anything. Although I am working now but still I do not feel fulfilled without my husband. It would have been worse. I needed a job to be with my old colleagues.

**Interviewer:** Did you get adequate support?



**Interviewee:** I got the support although after the funeral it was only my two children who still thought of me and would call to check on me. I missed talking to someone because I was used to having my husband with me. They had a system of calling one after the other daily. My in-laws forgot about me after the funeral. They only gave me the necessary support during the funeral week. I did tell them.

**Interviewer:** What role did your in-laws play in all of that?

**Interviewee:** My in-laws did put me on blue clothes as opposed to black. I put them on the morning of the funeral.

A year before my husband his brother passed away, and then mine. Mine was on the fourteen of January and my brother in-law the fifteen of January a year before. My mother in-law then felt that six months would be enough for me with those blue clothes. Her children felt that there was no need to put them on.

**Interviewer:** Did you want to put on those blue clothes?

**Interviewee:** I just accepted whatever they were suggesting. I used to fight very much with my mother in-law during the period between the death of my husband and the funeral. We were both sitting on that mattress but when her children came, she would stop fighting me. The main source of our fight was the fact that whenever I felt down I would open my Bible and she would scream at me for that. She would stop me from reading my Bible, and we would then fight terribly. Whatever I tried to do to avoid crying in front of my children she would fight me. A friend of mine even intervened because even when I sat on a chair because there was a time when I would just feel tired of sitting on the mattress she would again fight me. She then tried to explain to my friend that her son's death had impacted her.

**Interviewer:** Why didn't you take her off the mattress?

**Interviewee:** It was for peace sake. I was helpless. But my relatives were supportive because at one point that mother in-law of mine wanted to move furniture around and just manhandling my curtains. It was terrible. She wanted to destroy my curtains when she did not even have that kind of curtains. My husband's aunts were also so horrible except my husband's siblings.

**Interviewer:** Who was buying groceries like tea for people who came for condolences?





**Interviewee:** My children did that when she with her big mouth was just sitting and criticising. When her in-laws came, meaning my husband's uncles and aunts from his father's side, she would cry so much. My friend even asked her about that, giving the impression that I was treating her bad. She told her to stop that.

**Interviewer:** Did your husband's corpse come home overnight?

**Interviewee:** Yes. It was terrible. I was numb and just thinking about him the whole night, imagining how I was going to be and live my life without him. I however did not regret his presence that night because to me, he was able to spend his last night at his house. That makes me feel good. The family only viewed him, meaning his family of origin and extended family, and mine.

**Interviewer:** Who prepared the corpse?

**Interviewee:** His two uncles from his father's side prepared him. For peace sake I agreed to every thing. The morning of his arrival I was not anxious but looking forward to see him for the last time. When he came in the coffin was too big for the coffin to come in. When they struggled with the coffin it felt like they were hurting him. I don't want to think about that night. I could not sleep the whole night. I wanted to open the coffin the whole night and look at him to make closure but I was not allowed to do that. My bedroom was full of her silly relatives.

**Interviewer:** What happened when you came back from the cemetery?

**Interviewee:** That I could handle at the time, probably because I had cried enough. The people that I attend church with were surrounding me and I even forgot about my mother in-law because they were focusing on me and not her.

**Interviewer:** Who stayed with you after the funeral when everybody left?

**Interviewee:** My mother in-law stayed and left on Monday. My sister and friend also stayed behind. My sister asked her daughter to stay with me for about three months, which really helped.

**Interviewer:** Did you go through the cleansing ritual?

**Interviewee:** Yes I did. According to the Zulu tradition, my in-laws cleanse me first, and then my family of origin. They did that six months later when I took off the blue clothes.



**Interviewer:** What was expected of you in the six months that you had the blue clothes on?

**Interviewee:** Nobody gave me instructions but I followed my own. I told my mother in-law that I had enrolled for Matric at a night school and I would attend with those blue clothes. She did not have a problem with that except that when I leave the house I must make sure that I switch on the lights. I told her that I had already paid for my studies and life must go on because I was preparing for a better life for myself. My only problem was going to be my teachers because I did not know whether they would have a problem with my blue clothes or not. Fortunately they did not have a problem with that. They were very supportive.

**Interviewer:** What happened when they (in-laws) cleansed you?

**Interviewee:** My mother in-law cleansed me, explaining that because the blue clothes were theirs and their son, they (blue clothes) had to be burnt by them. I could not take them (blue clothes) to my family of origin. I was cleansed twice.

**Interviewer:** Did you take anything oral?

**Interviewee:** Oh my God. Those herbs were boiled and I had to drink that boiled water. The taste was horrible. My sister insisted and I was even asking her where she took that tradition from because we did not practice that at my parents' house. They explain it by saying that because I was making love to him and his blood was in me it had to be cleansed. I never understood how his blood could be in me. I never understood that logic because to me it just never made sense. I drank it because my sister would be next to me to make sure that I take it. My mother in-law did not even know that because her other daughter in-law was not given those herbs. For my sister's sake I complied. I had to drink that for the whole six months, morning and evening. After that, I wanted nothing to do with that.

**Interviewer:** How was the taste?

**Interviewee:** It was black in colour and tasted like boiled aloe water. I used to drink it with soft drink. I would feel bilious by just thinking about it. Without soft drink I would not drink it.

**Interviewer:** How did it help you?

**Interviewee:** I somehow appreciated that horrible drink because I had blemishes and they were gone six months later. At least that was the good thing that came out of it. You know when you lose a husband you become everybody's fool (laughing).



**Interviewer:** What was your experience of people with your blue clothes?

**Interviewee:** The worst was at the taxi rank and in the taxi. People would be staring at you, some moving away from you, some telling me to stand next to the person in front of the queue, and that person would not want you next to him or her. I felt like an outcast. The queue marshal would scream at me. In the taxi, I was expected to sit at the back seat. There was this short queue marshal who would take everybody at the back seat telling everybody that I must go in first. They would all be looking at me not knowing whether they feel pity for what or me. At that time I would be facing down and would cry when I get home, blaming my husband for that. When I walk and decide to turn my head I would find people looking at me. That was terrible. Where I used to work was better because that area is full of foreigners from Africa. They did not have that attitude and I was free and happy.

**Interviewer:** Have you unveiled your husband's tombstone?

**Interviewee:** Not yet. Apparently before the unveiling of his tombstone I have to fetch him from his grave and bring his shadow home. It is a ritual before the unveiling ritual. Also, because he died in hospital, his family of origin went to fetch his spirit from the hospital. How they did that I never knew. I have to fetch his spirit from his grave to his house. They would tell you that his spirit is roaming the streets of Soweto and I must bring him back to his house.

**Interviewer:** How do you do that?

**Interviewee:** I should slaughter a bull whether I like it or not. His brother even complained about that saying that it was a waste of money. He told his mother that when he dies, his wife should not be expected to do that. He was very angry, suggesting that I must just buy meat from the butchery, but his mother insisted that I must do it as she suggested, blood must flow. The way it was done, I had to buy that bull but they (in-laws) alone and my children go to the grave and fetch him from his grave without me, to see how their father's family do rituals. How ridiculous. My brother in-law refused to go. He was arguing that that ritual is not going to help me heal but take me back to my husband's death. My sister in-law suggested that for peace sake, we must just comply because with their father and brother, that ritual was done. She even suggested that her brother must write down everything that he wants to be done and not done and take it to his lawyer. That brother in-law even told them he does not want his wife to put on black clothes.

**Interviewer:** Did your husband have any opinion about all of that?

**Interviewee:** Oh, he liked them. He liked everything that his family of origin practised. Slaughtering goat and all.

**Interviewer:** What tribe are you?

**Interviewee:** I don't know because my father even passed away not knowing my origin, even my mother's origin I do not know. I grew up speaking Afrikaans at home. I ended up getting married to a Zulu. That is one complicated tribe with rituals that never make sense with a waste of money. They are so adamant. They also cut me with a razor, something that I never did when I grew up. What that symbolises I do not know.

**Interviewer:** How do you feel so far?

**Interviewee:** So far I still do not understand myself because some days I would be fine when other days I would be depressed. I only sleep well at my daughter's place but not at home. I never eat well, with continuous headaches.

## PARTICIPANT EIGHT

**Interviewer:** What experiences did you go through after the death of your husband?

**Interviewee:** I started having a lot of chest pains, couldn't breath with a severe back pain. I was admitted and attended to by a Neurologist who took me to theatre to manipulate my back. I was discharged after five days. When I got home, the symptoms started again, short breath, and feeling like my house is too small and suffocating. I would cry and people would ask me if it was the death of my husband or not. I would tell them that it was the back pain and would feel that the chest pains may manifest into a heart attack. My children would take me back to the hospital in the middle of the night. That was the second time, and then admitted in ICU, the very unit that I run and have been running for more than ten years at the very same hospital. I was convinced that it was a heart attack. When they check me, they were actually asking me and I ended up supervising them. Nothing was found out of those tests. When I woke up in the morning, I felt so good. Feeling embarrassed that people might think that I was playing sick and seeking attention. I did not want my doctor and colleagues to find me in the unit that morning. Five o'clock that morning I discharged myself and asked my children to come and get me. When I got home, the symptoms came up again. At that time, the back pain had gone but was experiencing more chest pains than the back. When I went to my doctor for the third time, he was hard on me. He said that he had learnt that I recently lost my husband. I think my colleagues told him, and most of his patients were depressed, and probably got the background information from colleagues. He was



hard on me, telling me that I must go home and deal with the loss of my husband or I must go and consult with a Psychologist. The way he said it made me strong although I cried and he was there for me at the time. It then dawned to me that the problem was not the back pain, and I wasted so much time away from work. I was so embarrassed to even face my colleagues because I never wanted to be pitied.

**Interviewer:** When did that stop?

**Interviewee:** When I got home I realised that I was depressing my children, and I had a job to secure although when I go to work my colleagues would be looking at me with pitiful eyes and I hated that. Before I started at work I phoned the matron and my unit requesting them that when I come over, they must pretend like everything was normal and treat me just that way. Mind you, I stayed home for six weeks. I really wanted to go back to work because at home I used to struggle because I would be smelling my husband's body smell and all the things that would be reminding me that he is no more. I behaved like I was psychotic. I remember one night I was asleep and I heard the bedroom door open and felt him slipping into the bed. That side of my body felt so cold. I felt him and was scared. It was like he came as a supernatural being and mind you, the corpse is cold. I even talked to myself saying to him that if he wanted to visit me he must help me not to be scared. Since then I would sleep with the lights on. I think also it was because when he came home late, he would not switch on the lights so that he should not disturb me. That was why I decided to go back to work. I also read a lot of books about bereavement. It seems like I wanted to jump stages of the bereavement process and wanted to get over the process. I felt that I cried enough, nursed him for a long time and buried him the way he would have wanted to. I even asked everybody who decided to stay with me for some time to go because I felt that they were going to delay the process that I was supposed to go through. I just wanted to be with my children.

**Interviewer:** How was your experience of going back to work?

**Interviewee:** I then called my colleagues and my unit informing them that I was coming back and asked them never to mention my husband and just treat me like before. When I went back, it was actually me who was trying to be brighter than them, in a way trying to show them that I was fine. I tried very much to avoid talking about him. At the same time, I could read a lot from their faces, like an indirect pity, and surprised at how I was behaving. When I walk out of the ward, I would meet those who did not know my request and would start with condolences. I ended up staying in my ward from morning until I knock off. I still did feel fine.

**Interviewer:** How different did you experience your house now that you were back to work?

**Interviewee:** The minute I get home I would smell my husband and would want to cry. I would think of people around me and would think of my children. I came to realise that my children were taking cues from me. When they see me in control they tended to be strong, and would not cry in front of me. What hurt me most was the realisation of my children having taken the burden of the loss of their father and carrying me at the same time when I should have been the one carrying them. I was not aware of that. It was only when my daughter broke down at work and her friend called me, telling me that she says that she could not afford to cry her father's loss out when she should have because she was the elder one and had to run around and be strong for me and her younger sister. It was only then that it was hitting her. She said that she could not even cry in front of me. That really affected me. At the time, I did not want to be with people. People would come over and I would not open for them. I would sleep, or read books, or end up opening the wardrobes looking for nothing and would find his photos. I would put them on the dresser and take them away. I thought with time it would be better but it did not although the intensity is getting less and less. I can now do things that I could not do then. For example, then, when a man talks to me, I would feel like my husband was there with me and was disrespecting my husband. It was like that man was saying that he had been waiting for my husband to die so that he could make his move. Sometimes I would think that maybe if I could have had black clothes on, it could have helped me in pushing those men away. The fact that I did not put black clothes on, helped me to be still faithful to my husband even after his death. By the way, he was my first boyfriend; I do not know any other man in my life except him.

**Interviewer:** Why did you not put on black clothes?

**Interviewee:** My husband did not like it. My in-laws were insisting but it was not my problem but theirs. We were going to the mortuary with his sister who commented that I must not forget to buy a black material to sew as my black clothes. I then got an opportunity to tell her about her brother's wishes. I told her that my husband did not want me to put on black clothes, did not want his furniture in his house to be moved around when he had passed on, did not want the windows of his house to be ashed and made dirty. He said when he had passed on he had passed on and that was it. I told my sister in-law to tell the rest of the family my husband's wishes. He also told me not to interfere with his bed and put the mattress on the floor. I never even used to cover my head as a sign of respect. He insisted that I should be as normal as possible. That was how we lived our lives as a family. In both our families of origin, rituals were practised but we decided not to. He even asked his family of origin why they were practising this and that but they could not explain to him convincingly and we decided to have our own norms and values, which I am still carrying. My children are females and when they get married they will follow the practises of their

in-laws if they feel like. When I'm at my in-laws' I join them in what they practise but not in my house. We had a friend who lost her husband and was put on black clothes. At night she would take them off and put on her fancy clothes, and would go and enjoy her nightlife. I really do not see the significance of those black clothes. That was when we realised that black clothes meant nothing.

**Interviewer:** Did you get any support from them?

**Interviewee:** None, zero support but hurts. My husband had three sisters left. The one who talks too much did not even visit her brother at the hospital. She would just call me to check how he was. Not even on weekends. When he passed away, my children first told people who were there for him. She was only told in the morning, and wanted to make it an issue. When she got to our house, the first thing she said was that she would not be able to help me with anything. I did not ask her for help but that was what she said. All I said was that it was okay, and what was important was her presence. When the youngest sister came and gave me a one thousand rands contribution. She asked me how much her sister contributed and I told her the truth. She was very angry and apparently they had a big fight where the youngest told her how ungrateful she was when my husband was her only blood brother who did so much for her. The following day she gave me nine hundred rands. Even her other sister who was unemployed contributed something. I did not need their financial help because I could burry my husband without a problem. What they did was a good gesture.

**Interviewer:** Did the corpse come home overnight?

**Interviewee:** Yes. That was one trauma. When I die I do not want to traumatise my children by coming home overnight although they may perceive it differently. That was one aspect that I did not discuss with my husband. Maybe if we could have discussed it he would not have come home because it is traumatic. It was so traumatic for me to sleep in our bed when he was lying there in that box. I kept asking myself why they were closing the coffin because he was dead. I wanted to see him but again I did not. Not that I did not want him but did not want him to come and lie there cold and dry because it was frustrating as he was there and I could not touch him. It was very traumatic. My children know that I do not want to come home overnight but in the morning.

**Interviewer:** Whose idea was it?

**Interviewee:** That was not discussed but the undertaker did ask me and I just told them to bring him at the time that they usually bring the bodies home. Then I thought I would feel better but



when I heard the hearse siren I just went mad. I was told that I was saying that I did not want, I do not want. I do not remember. I'm told that I talked until I fell asleep because I took antidepressants and sleeping tablets. I did not know how I was going to feel that was why I took the tablets so that I should never have time to wake up until in the morning. I'm told that I slept giving him my back. I even had pyjamas on. I did not want anything because I did not want to sleep with his corpse. I loved my husband and loved him even when he was dead. Even after his burial I regretted burying him and wished he could have been embalmed and be put in a glass frame so that I could look at him as and when I feel like. He was then buried. When he left the house it was terrible. After he was viewed the coffin was closed and locked. It felt like they were suffocating him. They gave me the key and I refused that they should lock the coffin. He looked fine and alive and did not want the locking part. They did not and promised that they would only lock it at the graveside. When we got to the cemetery I got out of the car. They were playing a hymn "Nearer my God to thee" and it really affected me because I thought I was starting to accept. That was so because I was with her terrible sister and she commented that I did a good job in burying her brother. I thought she was repenting and would give her a chance. She even commented about how I nursed him, thanking me. I took tablets again that morning so that I could be strong because I cried enough when he was sick. I wanted to celebrate his life with the best way that I could because he was flamboyant and would have liked to bury him the way I did. Now that hymn that was playing affected me. I did not want to cry. I now overheard the eldest sister saying that in their church they do not practise the right of throwing soil into the grave. I told that man that my children and I would. I told him that for my husband I would do what pleased me. I did that against their will. I think what we did they did not like. They did not say anything. They had already told the larger family that I would not put on black clothes. One of them came to me and advised me to put it on because after six months I would be psychotic or die. I told her that the way I miss my husband I would not mind to die. They also told me that I must be washed with herbs and also drink boiled herbs water. I told them that I did not undermine their practices because even my family of origin practised them. I explained to them that I was allergic to a lot of things and they must analyse everything scientifically because when I complicate and taken to hospital I want to tell the doctors exactly what I took although I knew that I would never take that stuff. I did not even want to see them. They then gave up and were unhappy about the fact that I rejected everything they were suggesting. They forgot that that was my home and we do things in our own preferred way.

**Interviewer:** What happened the following day?

**Interviewee:** The very people who were telling me that they would not be able to help me financially were the ones who had already taken my husband's clothes for themselves and hiding



them in bundles before the ritual. They had taken my husband's best clothes and I was not aware but told. Somebody saw them and put them with the rest. That sister in-law was angry with me for that because she wanted them for her sons. I only chose whatever I wanted as a memory. I could have refused even though we did not have a son but I was avoiding them coming whenever and go through that ritual. I wanted everybody to leave after that and be with my children. It is costly. That was a sore sport for her. Do you know that since my husband passed away they had never been to my house? I then asked that very sister in-law of mine for her son to come and stay with us for some time because I did not feel safe without a male in the house. Six months later she sent another son and I thought she just came for a visit. As time went on I called their mother (sister in-law) complaining about the cost of maintaining two adult males who were unemployed. She told me that they were not supposed to live apart as they are twins. I then told her that if that was the case they must both leave. With time I called again and she told me that they did not want to go. What helped me was that the other one would bring girls in the house and sleep with them. That was how he left. My in-laws, since the death of my husband, had never been to my house. Before then, they were commenting that they need answers regarding my husband's death. They were then suggesting that we must go to a witch doctor to know what really happened. I refused and they apparently went and have not come back to me and I am not interested.

**Interviewer:** Do they suspect that you killed him?

**Interviewee:** Maybe because they have never been to my house since, until we unveiled the tombstone. Even then my terrible sister in-law came a day before the ceremony. That was why we did not inform or involve her in the arrangements of the event. We also had an attitude towards her because she kept on saying things about me to people. She was saying that I wanted her children to leave my house because I wanted to bring a man in my house. My daughter called her and told her that I have the right to do that because it was her house. My children then wanted to know if I would remarry and I told them that my grave is next to my husband's and would not be buried next to their father with a different surname. Even when I can have a boyfriend he would not get into my husband's house. I would be disrespecting my husband. I am not hard up for men, and the man who can suit me is not yet born. I've had my fair share of marriage. You know, I walk the talk. I was not going to prove a point to anyone. My husband was my first boyfriend and I was happy with him. He was not perfect because he was a womaniser. My family of origin really supported me. Also some of my husband's relatives supported me. Those were the ones that my terrible sister in-law does not like.

**Interviewer:** Didn't you get support from friends?

**Interviewee:** Some of them I locked them out and told them to give me my space. I did not want to interact with them because their husbands were sympathising with me and wanted to help. I read something from their wives, or maybe I was just paranoid that they did not approve of their husbands' need to help. I thought they would not trust me, although they would call. I used to suspect that they were not comfortable with me. I then kept to myself because I know that when I go out I make sure that I look good and I feel good. My associates now are new people, more my old friends before I got married. I am not bitter about the ones I had when my husband was still alive. They do not know how difficult this process is (bereavement).

**Interviewer:** When was your husband diagnosed?

**Interviewee:** He was diagnosed with cancer where the primary lesion was the lung. I had guilt feelings because I blamed myself for not detecting it in time, meaning in January. It was in July 2005, and he was coughing again. He was told that his lung had pneumonia but it was funny because that kind of pneumonia is only found in birds. He then started having short breath. I asked him to go and consult with a Physician and it was found that his lungs were affected by a long period of smoking. He was then given puffs to use for that. He had stopped smoking by then but the lung was already damaged and would not recover. With time he developed numbness of the leg and I suspected the compression of the disc because of age. He then went for X-rays and nothing was found and was referred to a Physiotherapist but it got worse. Around July we went to my colleague's funeral and he commented that the next person to be buried would be him. He started limping but what worried me was that after bathing he would not feel that he did not dry himself. He did not feel sensations and I forced him to go for MRI scan. The numbness was progressing up to the chest. I would make appointments for him with doctors and would not honour them. On this particular day he did not feel himself urinating and wet himself. That was then that he went to consult. We went together and was scanned. That took a long time. The doctor told us the bad news of the tumour in the spine. He was overwhelmed and asked me if I understand. I asked him the type of the tumour and it was a serious one and, if operated, he might die on the operating table. What scared me was the location of the tumour. I've seen patients with that kind of cancer being paralysed. The doctor did not promise recovery with the operation. He asked me to decide and I refused because I wanted him to make a decision for himself. That was the one time that he had to decide for himself. He agreed. We were not talking at the time and we were offered coffee and both of us did not feel like coffee. We left and in the car I was trying to reassure him, telling him that doctors know what was best for him. On our way home, we stopped at a petrol station, and I started crying. He was not sure of what was wrong with me and I explained it by telling him that because my sister was also sick and I could not take



it any longer. Since then, he would look at me with those appealing eyes of help like I know what was best for him and I could help.

**Interviewer:** Was there anything of importance in your life together that he would talk about?

**Interviewee:** Not really. It would be about issues of the family, meaning the children. He would ask me about the children and how they were doing. That time he was admitted. At the hospital the doctor called me to explain what they had done so far and their intentions from then on. They found out that the cough he had in January was the source of his cancer and if they had known then, they would have cut that part of the lung that was causing the problem. By then it had metastasised and spread to the spine. He also had prostate cancer. He later became unconscious. He was also oozing fluid from the operation that did on him although it served as an outlet.

**Interviewer:** Emotionally at the time, where was he?

**Interviewee:** He never shared anything with me. He never shared his fears but with other people. Maybe it was because he knew me and how easily tearful I am. He would rather ask the children how I was at home and they would tell him how tearful I was. Maybe if they did not, he would have shared with me. Apparently his doctor told him that he would never make it but he never told me. Even when he was given a weekend pass out and was told that it would be his last time at home he did not say. All that he said was that he would be given weekends home until he got better and discharged. Instead when we got home, he refused the child to go to a party nearby. She insisted that she should stay with him but did go. She died at the end of August, 2005. I only understood after his death that he wanted all of us to be there. The following day he asked his elder daughter to prepare lunch for him but I told my daughter that I would prepare them because I knew the diet that he was on. Time and again he would ask me if our daughter was not home yet to bring him lunch. He eventually gave up and ate mine. Our daughter came later and he looked disappointed. His friends who knew that he was home came to see him. They stayed until late and he was exhausted and I asked him to sleep. He was tired but wanted to watch TV with me and I insisted that he must sleep. Normally he would have insisted but he did not and did what I was suggesting. He commented about how tired I should be and we must sleep, saying that he would sleep after I had fallen asleep. I immediately fell asleep because I was tired and had to wake up at night to test his insulin. He would wake up at night and want to go to the toilet and it would be then that I would test his insulin. It was cold and he would tug me in when I thought he was asleep. The following day he woke up and I bathed him. He was sobbing and I initially thought he was having convulsions. He told me that because he knew that I had a backache he



felt that he was burdening me. I reassured him that I wanted to look after him because I had even arranged some weeks off work to look after him when he got discharged and had already organised a wheel chair. I told him to worry about him. When we left for the hospital in the car, he looked back at the house when the car was moving until it turned the corner. Whatever the doctor told him could have been the source of his behaviour that weekend. It should have been difficult for him because I think he regretted not opening up to me about his last visit, which I suspect the doctor told him about. I suspect the doctor told him to discuss his death with the family, something that he did not do. The way he cried in the bathroom was the first time I saw him cry like that since I knew him. Emotionally I am not a strong person. Every time I was at the hospital I would often walk out of the ward to go and cry. I think he could tell that I was crying because he even told one of his friends that I was crying. Just as much as I wanted him to tell me about his feelings, I also could not ask him. He would not even tell me what his doctor was saying, and could not go and ask the doctor myself. One of my friends did go and ask his psychologist and was told that he would not leave the hospital until he died. The psychologist told me that my husband said he understood that the odds were against him and if he had a choice he would choose to live because there were a lot of things he had to do but he dies then he meant he did not have a choice, and would accept it. I then asked her about his spiritual state and she told me that he was ready because he left everything in the hands of the Lord. He had accepted that if the Lord takes him it was fine and if not it would be a bonus. That really hurt me. The funny thing about death is that I wanted him to rise from the dead and be just the way he was sick and not healthy.

**Interviewer:** What happened when he died?

**Interviewee:** Before then he wanted to see his aunt. She came and when he saw her he stood up and was so excited and hugged her. He wanted to say something to his aunt but could not. That was really frustrating. He asked me to bring him ice cream and he ate it like someone who had not had food for weeks. He said he wanted my ice cream. The following day he could not speak, and would just look at me with tears rolling down his cheeks. I suggested he be taken to theatre for whatever could help. You know I behaved like I was not a nurse. I am sure they were also asking themselves if I was really a nurse. What I was seeing was as a result of the progression of the illness. I even asked them to switch of the morphine, knowing very well the pain that he was feeling. I would wake him up and tell him how much I love him, and tell him that I had forgiven him everything he did to me and he must also forgive me my mistakes. I was recommitting myself to him. It was the first time I very apologised to him, probably because he made more mistakes than I did. He would often apologise but not me. He was suffering but I did not want him to go. I asked him to try and fight. When we got home we got a call to say that he passed away. We went back



to the hospital. By then I had already taken my antidepressant and sleeping tablets. I am told that when I got there I was telling his corpse how much I love him, and I cried holding his hand. I am also told that I did not want to leave the ward when the undertakers came to get him, wrapping him myself and walk him to the hearse. Apparently I had his clean pyjamas, and asked the undertaker to make sure that he put him on those pyjamas and a perfume because I did not want him to have a bad smell and get cold. Apparently when I got home I just fell asleep. When I woke up in the morning, I could not remember and I asked my daughter if it true that her father had passed away. It was then that reality hit. They then told me what I did the previous day.

**Interviewer:** What happened next?

**Interviewee:** When we went to choose the coffin, I asked to see him. I found him with his pyjamas on and he smelled the perfume I gave the undertaker. I had drugged myself and I tried to warm him with my hands because he was cold, and they told me that I was not allowed to stay long in there. I then joined my children to go and talk business. At the time I so wished he could have talked to me and I could have been strong. I thought he was going to be an invalid and when he got discharged I would be there for him. I did not expect that, although I would refuse to consult with him because I was scared to know the truth. I did not expect him to die but as a nurse I should have been aware of his death. I also blame myself that I should have been aware in January of what should be done. I should have consulted with him and asked questions that could have led to his recovery. Even though it is said that God determines one's life and death, I think He is selfish. Sometimes I do feel that way "crying". I thought I was getting better but it does not seem that way.

## PARTICIPANT NINE

**Interviewer:** When did your husband pass away?

**Interviewee:** That was last year 2006 in August. He died of HIV-AIDS, and was mentally disturbed. You know the stigma associated with AIDS is unbelievable and hurting. You won't understand that until you experience it. People coming only after his death and even then, you could see the discomfort in their eyes, and question marks that they are not asking. I even thought that maybe they also saw me as infected but could not ask me. I would even ask myself why they are coming for the supposed support. They never came when my husband was sick. I did not even know how to respond to them. I did not appreciate their support. People know me to be infected.

**Interviewer:** Are you?

**Interviewee:** No I am not. What happened was that from the time we got married, about twenty years ago, my husband was working in another Province and would only come home for the Christmas holidays. I was used to that. He provided for the family. That I cannot complain about. However, in the past four years, he stopped coming home until last year (2006) for the Easter holidays, and was sick. I did not know what the problem was then. What I knew was that he was staying with a woman from my area. That woman was very close with my mother-in-law. The whole township knew that. Can you imagine how I felt? I never had a good relationship with my mother-in-law and she never liked me from the beginning. What I know about my mother-in-law's feelings about me is that my husband has a child with one woman in the area before I met him, and I suspect that she (mother-in-law) was disappointed that he did not marry that woman. She just never approved of me. When we got married, we initially stayed at my mother-in-law's house even though I did not like it. We later built our own house and she told people that I was taking her son away from her, when it was an agreement between my husband and me. I did not care because I wanted to be away from her. Can you imagine living in the same house with a person that you know that she did not want you. Then, she would always want to know how much my husband sent me, and would not answer her. She used to tell people that I was a gold digger.

**Interviewer:** How did the other woman explain his illness?

**Interviewee:** You know, she told his family and not me that he became sick after eating an apricot, and they believed her. His family then spread rumours that I bewitched him. How can I bewitch my own husband? She never supported me.

**Interviewer:** What about her siblings?

**Interviewee:** When I joined that family, I realised that his whole family of origin did not like him. They were not talking to him and he would tell me that they have always been like that to him except his father who was by then, passed away. Apparently, before we got married, he used to give his mother money every month, and school his siblings and even provide for his elder siblings' family, even when they hated him. Maybe that was the reason they perceived me as a gold digger, when my poor husband was just focusing on his wife and children.

**Interviewer:** How did you manage with his nursing at home?

**Interviewee:** Because there are no adequate health facilities where we stayed, I moved him to the Gauteng Province, staying with his relatives who I knew supported me. I left my children at home because they were still at school and still are. Fortunately they are old enough to look after themselves and the house. It was tough caring for him. He was fragile and helpless. Mind you, the last time I saw him, which was four years ago, he was a healthy man. What was unusual then was that he avoided intimacy with me, but I just took it like that. It is only now that I appreciated that because he was avoiding infecting me. I really appreciated that because he showed me how much he loved and cared for my well-being. However, nursing him was a real challenge emotionally and physically. At times I would cry in private, asking God to take him, and would feel guilty about that. It was tough. We would talk and he would ask for forgiveness. How could I not forgive him? He would tell me about his mistress, who did not even come to my husband's funeral and how she used herbs so that he should stay with her. That I told him that I did not believe, and he must not waste our short time together talking about her. I said that because I felt that he was just trying to make himself feel better, and it was irritating me. I told him because I believed that with a CD-4-count of seventeen, he did not have much time to live, and we must focus on us as a couple, my future with the children when he had gone, and what he expected me to do for him. He had a flock of sheep, cows and goat at home and in the Vaal area where I nursed him. He asked me to sell it all after his death, and move from the Eastern Cape where we had a house with the children to the Vaal area because he did not trust his family of origin and would not be there to protect us. He also told me that medically we would be provided for. He insisted that we must be as far away from his family as possible.

**Interviewer:** Was he ever admitted to hospital?

**Interviewee:** Yes he was, with a CD-4-count of seventeen? He was never on antiretroviral treatment before and his doctor suggested that he must wait until he got to a CD-4-count of about fifty, and then he could start the treatment or else, he would die. He was then admitted and when he rose to a CD-4-count of forty-five, the doctor discharged him to gain more at home. By then, he could walk by himself and I had hope that he would recover even though I was aware that he would not go back to work. His mistress and my mother in-law would come to the hospital to see him.

**Interviewer:** Where was his family of origin and his mistress then?

**Interviewee:** You won't believe it. They heard that he was discharged and they came to demand him from me, the very people who hated him. It was his brothers, mother and his mistress. They told me that I bewitched him and they wanted alternative treatment, and also to check if I really

bewitched him. Mind you, his mistress is a witch doctor. My husband was so helpless, asking me to tell them that he did not want to go with them. His relatives, whom I was with, tried to fight them but they overpowered us. I also discovered then that they took his bankcard and had been drawing large amounts of money daily. He received a bonus that month. Also, they convinced my eighteen years old son to be on their side. My son was so disrespectful of his father and I. I could not believe it when he had to fight for his family. They took my husband and left. They told me that I would follow my husband and would make sure that I die exactly the same way that he died.

**Interviewer:** What happened to your husband thereafter?

**Interviewee:** They took him to a witch doctor and was apparently given enema of herbs, which drained him all the strength that he had regained. I understand the thrush that he had in his mouth was scrubbed with herbs, and was bleeding. He further lost weight and they came to get his medical aid card, taking him to another hospital. I gave them because they were aggressive. They did not even tell me to which hospital they were taking him. I was really hurting when I thought of how he needed me, helpless as he was. When I went to check with the bank, I found that they withdrew about twenty-four thousand rands, with the balance of eight hundred rands. I then asked the bank to stop the account.

**Interviewer:** When did you see your husband again?

**Interviewee:** A week later the hospital called to tell me that he passed away. That did not shock me because I expected that. I could not cry, probably because of the anger, blaming his family for their greed to the extent of killing their own blood. As a result, I do not trust them and never will.

**Interviewer:** What happened a week before the funeral?

**Interviewee:** I called his employer (Eskom) two days later because I had to arrange with his relatives who were supporting me to move him from the hospital to the private mortuary. His employer told me that his family had already been there, demanding money for the burial. They could not help them because I was the only beneficiary, and were very angry. I understand they were fighting with the staff, asking why their mother was not getting anything from the employer. They even told the employer that they did not know where I was because I abandoned my husband a long time ago, when their mother looked after my children. They also told the employer that my husband had other children and their mother looked after all those years when I had disappeared. They could not be helped and later came to ask for my husband's death certificate, and I refused to give it to them. The employer then gave me ten thousand rands for



the burial, and asked me to come back for the rest. When we went to the hospital to move his body to a private undertaker provided by his employer, they had already moved it and did not want to tell us where they moved him. I was hurting, frustrated and helpless. Eventually his employer told us where to look for his body and we found it. His family took his clothes and we found him naked. I decided to buy him pyjamas so that he could have something on. His relatives who supported me suggested that I should not go back home alone but would go with me and the body on Saturday and the funeral to be on Sunday. When we were about to leave the undertaker with the coffin, his brother and friends came running with his old clothes to him on. His brother had his clothes on, including his shoes. I could not believe it. That was the brother who hated him most. His relatives told him to go back and tell everybody that the funeral would be on Sunday.

**Interviewer:** When did you arrive in the Eastern Cape?

**Interviewee:** We got there in the evening and my friends were already busy preparing food for the following day. His family insisted that the ceremony be conducted at his parents' house, and it was done just that way. The way it was culturally done, the body had to wait at the gate, and a goat was slaughtered, the coffin spread with the goat's blood and was told that he was now entering his parents' house. We then walked in with his body, and an ox was slaughtered and the skin of the ox was brought in the bedroom, telling him that his blanket was ready. We discovered that his flock was missing, except that goat and ox. His flock in the Vaal was also missing. His cousin is now busy opening a case for theft. His supportive relatives insisted that it should only be my sisters and I in that room. His mother was there, sitting in a corner alone. It was traumatising to sit on the mattress with him next to me the whole night. I felt pity for him, to die with fights and noise when he could be surrounded by people who love him, making him feel loved and supported. He was very unfortunate to have a greedy mother and siblings. As I did not trust them, only my sisters could dish out for me with my own dish from my house.

**Interviewer:** What happened the morning of the burial?

**Interviewee:** He still had the pyjamas I bought him. However, there was a group of old women who were busy sewing a white hat, shirt and pants. I could not understand what that was for. In the morning they put him on those clothes on top of the pyjamas. He looked like a joke in that coffin. That saddened me. I could have done better. I was then given black clothes by my in-laws to put on, which I did. My supportive in-laws suggested that my family should cleanse me in May this year (2007). That would be then that I unveil his tombstone at my house. I will not involve them in that ceremony. We then went to the graveyard and came back. I did not feel anything because there was so much tension around. I did not even want to talk to my son because he



disappointed me, letting him be used by my in-laws as a weapon against me. He could not even protect his own father. Then a meeting was called where everyone said his piece. My supportive in-laws told them off. I then got a chance to tell them what I thought of them, and how they would not get a cent from my husband's inheritance. I showed them my HIV positive results and could tell that they did not believe what they saw. I told them that infected person was my husband's mistress and that they must look after her because they love her.

**Interviewer:** What happened the following morning?

**Interviewee:** His clothes were demanded and they were not there because they took them all. They actually had them on at his funeral. My supportive in-laws decide that I should go back with them so that I should start a new life, look for a house so that I can sell the one I owned with my husband after his unveiling ceremony, and move my children to my new house. My husband's employer is going to give me more money which I would use for the cleansing, the new house and my children's schooling.

## PARTICIPANT TEN

**Interviewer:** When did your husband pass away?

**Interviewee:** In November 2005.

**Interviewer:** What was wrong with him?

**Interviewee:** It was Cancer. He was only sick for a month. You would not tell that he was sick. He was not aware of it himself. He went to consult with a General Practitioner because he could not swallow and had to drink water to help the food down his throat. The doctor was not sure of what his problem was and sent him to the hospital for tests. It came out that he had a problem with his throat but did not feel pain then. It was only after the tests that he started feeling pains in his throat. He underwent an operation and a tube was inserted in his throat and as a result, could not eat solid food. That tube was put in on the ninth of November and he passed away on the twenty-second of the very month. He was given a powder to mix and had it as his food. He could not even drink water with time but ice cubes to quench his thirst. He was later diagnosed with pneumonia and immediately thereafter he passed away in hospital.



**Interviewer:** Were there any signs that he was nearing his death?

**Interviewee:** You know, the day he went to hospital, he told one of my neighbours that he was going to hospital, and asked that couple to look after his family. The couple told him that he would come back and he told them that he would not, the reason why he was asking them to look after his family. He told them he was asking because his family was still young. I just took it like that.

**Interviewer:** How long was he at the hospital?

**Interviewee:** He left on a Tuesday, and on Thursday one doctor called me telling me not to come and visit my husband because he was being discharged. That worried me because the day before I was with him at the hospital and he did not look good. I went to tell the couple he talked to (supportive neighbours) about the call because I was with them at the hospital the previous day. I really relied on that couple because the lady was a retired nurse from that hospital. She then called the hospital to confirm his discharge and the hospital knew nothing about it, and suggested that if he gets discharged they would go and pick him up although I wanted to go to the hospital.

**Interviewer:** What happened that day?

**Interviewee:** In the early hours of the morning I received a call from the hospital telling me that my husband wanted to talk to me, and I must come to the hospital. I called his uncle and my neighbour couple and there was no answer. My daughter and I went to wake up the couple and I went with the lady to hospital. When we got there I left her behind, feeling that she was too slow. I waited for her at the door and she rang the bell and one nurse opened. We got into the lift to his ward and he was not there, only to find that he was moved to another ward. When we got there we were told that he was no more but was still on his bed. I was told to make sure that he was no more.

**Interviewer:** How did you feel?

**Interviewee:** I just saw darkness. If it was not for my neighbour, I do not know what could have happened to me. We were then told to come back the following day to fetch his body to our private undertaker. I refused post mortem that they were suggesting. We then went back home.

**Interviewer:** What happened there after?



**Interviewee:** The following morning my neighbour called the undertaker to pick him up and we went to arrange everything with the undertaker. My neighbour really helped me because I was like a zombie. We chose the coffin and what was needed for the funeral right there. It was bad because I even had to go for psychological help. I was not coping. I stopped those sessions because they called me a mad woman. You know how public hospitals are like.

**Interviewer:** How did you manage with the children in that state?

**Interviewee:** What made it worse was the fact that two of my three children are mentally disturbed. My husband's family have that mental disturbance problem. I just could not cope without my husband because he was a good provider although by the time he passed away he was on ill health pension. One of the twins was born like that and was also hit by cars on two occasions. She is a slow learner and that is really disturbing me. The eldest was fine and is in Matric but last week she was admitted in hospital. I do not know what the problem is but she is sedated all the time because when she gets conscious, she becomes aggressive and the ward staff is scared that she may injure herself. I really do not know what is happening with me and my children. I have high blood problem, and worried about my children if I can die.

**Interviewer:** What is wrong with your eldest daughter?

**Interviewee:** One doctor suspected that she was overwhelmed by the responsibilities she is faced up with. Her studies because she spends the whole night studying and is behind with her studies because sometimes she has to miss school and take his mentally disturbed uncle that I am looking after to hospital. Sometimes she takes me and other times her siblings. I think it is just too much for her to take. She is only eighteen.

**Interviewer:** Did you get any support from your in-laws?

**Interviewee:** Nothing. Instead, they caused me problems. The house that I stay in was my husband's parents' and all of them had died except his mentally retarded brother that I am looking after. After my husband's death I extended the house and that was when problems started, my husband's nephews and nieces fighting me and wanted me out of the house with my children. My couple neighbours helped me with that even though those children do come time and again. They even took me to the municipal offices fighting to get the house, calling me a woman from the rural area, when I was the only person in their family who is looking after their uncle without their help. The house was then officially given to me.



**Interviewer:** What other problems do you encounter?

**Interviewee:** In the past two months I have lost a sister, a brother, uncle and last week was my mother. I was very close to all those people. Every time there is death in my family, it always takes me back to my husband's. My uncle's son was the one person who would think of my children and I. He would bring us groceries because I am unemployed, but he also passed away. I also got support from my uncle.

**Interviewer:** What happened during the period before the funeral?

**Interviewee:** When my husband died, I was sick. He would take me to hospital when he himself was also sick. Even the day he died, I was supposed to go for a check up. Because I did not have money, my supportive neighbour gave me money to go for my check up. I could not talk. It was tough.

I had an insurance, which gave me ten thousand rands, which really helped. I was able to do what needed to be done. People were talking out there but I would know everything my in-laws were saying. My mother advised me to keep quiet and focus on the burial. My mother was also insulted. I was also accused of hiding my husband's insurance payout, and I refused to slaughter an ox for my husband. My supportive neighbour told them to buy that ox if they feel strongly about it. That was because I could only afford meat from the butchery. And then, as they are Zulus, they wanted me to also buy a goat, telling me that it was to welcome him home when the body came home overnight a day before the funeral. They were then told that that goat was supposed to be bought and slaughtered by my husband's family and not me. Those children were badly brought up. I wanted to stay with them but the way they were disrespectful, I could not.

**Interviewer:** Can you share with me your experience of your husband's body coming home overnight?

**Interviewee:** I was not aware of his arrival. I just saw the coffin coming into the bedroom. Since his death; I stayed in the bedroom on the mattress. It was unusual because I realised that he was home after a long time, about two hours later. I am not sure of what was happening with me, because I used to lose consciousness. I was told that I had a mild stroke. You know, I cannot tell you my experience the day of the funeral because I felt like I was in a trance. I do not know how the funeral service went. One of my old madams that I used to work for as a domestic worker heard that I lost my husband, and she sent me oil that I used to sniff and my headache would go away.



**Interviewer:** Did you put on black clothes?

**Interviewee:** No I did not. They told me that I could not because my children and I were sick, and would not be able to take them to hospital as I had to be home before sunset and as a result, it would restrict me. They thought that after the death of my husband I would follow him because of how sick I was. My husband also thought that I would die before him. I even booked a grave next to him.

**Interviewer:** Were there other rituals that you went through?

**Interviewee:** My brother brought me herbs to clean myself from the inside. He is a traditional healer and would bring them personally from home. Even the cleansing ceremony was done by my brother at my mother's house. My in-laws wanted nothing to do with that, probably because it involves money. According to the Zulu culture, they were supposed to have cleansed me first, and then my family at my parents' house.

**Interviewer:** What is the significance of the herbs that a widow has to boil and drink its water?

**Interviewee:** It is a mixture of herbs. You mix "mosetlha", "mosiane" and "motlhoswane", boil them and drink that boiled water. That is to help the widow clean her late husband's blood out of her blood system. That is also done to help the widow to be clean for her possible next husband, or else that man would also die. Those things happen. My priest died because her girlfriend was a widow and did not cleanse herself. His tummy and legs were swollen. That is called "magoma". She came to me for advice but it was too late because the blood of her girlfriend's late husband was flowing in his blood stream. That priest was still married to his first wife, and the two girlfriends that he had were fighting for his corpse until his wife came to fetch his corpse.

**Interviewer:** What does shaving symbolise?

**Interviewee:** The hair that you had before your husband's death is shaven away to clean you of everything on your body when he was still alive. It is another form of cleansing. You do not ask but do what is supposed to be done because we witness some of the after effects of not following tradition. If you do not follow tradition, you encounter problems and have to slaughter unnecessarily, which is costly. You are forced to slaughter an ox that you could not afford when the deceased was still alive.

**Interviewer:** How long did it take before the cleansing ceremony?

**Interviewee:** It was after six months. In rural areas a widow is not supposed to just walk around in the community because people own sheep, goat and all. So, if a widow walk around and an animal walk on her trail trail, it dies. Even a child also dies. It dies of what is called “metlhala”, (trail) where the middle of his head stops moving, constantly vomiting whatever he ate or drink, and its eyes dropping in. In Western culture it is called meningitis. At the hospital a child will be on a drip in its head to help alleviate that. Now black people know how to treat the condition. There are herbs to treat that. Those herbs are boiled and the child drinks the boiled water. Because of the vomiting, the child becomes dehydrated and is given a lot of plain boiled water with sugar.

**Interviewer:** What kind of experiences did you go through after the burial?

**Interviewee:** People always come and tell me what those children are saying and I tell them that they are my children and if anything happens to anyone of them, they are my responsibility. Whether they hate me or not, I will remain their only relative left and I will do what is expected of me. The fight revolves around this municipal house. After the funeral when everybody had left, I was with those nieces and nephews who left one after the other. My couple neighbours would come bring my children and I food to eat, and sit with us. My uncle and mother left later but were there for me. Those nephews and nieces learnt their unacceptable behaviour from their aunt who would always fight me and chase me out of the house. What an ungrateful family. My husband would not know what to do about his sister. She died before my husband. Today I am accused of not looking properly after my mentally disturbed brother in-law when they themselves are far from him. My brother in-law’s problem is that he does not want to bath. I buy him clothes and would tell me that the clothes that I buy him are for people who bath. He is better now because my son from my first marriage now stays with me and forces him to bath.

**Interviewer:** How do you manage financially?

**Interviewee:** My children get government grant, which helps a lot. Also, one of my brother in-law’s uncles would bring us groceries as and when he can afford. I really appreciate that.

**Interviewer:** Do your siblings help you in any way?

**Interviewee:** They have a problem with me, referring to me as a white woman because whenever there is the death in my family, they sit back and expect me to run the funeral. I buried my mother alone. Instead of helping me, they were saying things about me. I had funeral insurance for my mother, which helped me to run the funeral without problems.



**Interviewer:** Do you have any physical problems?

**Interviewee:** I struggle to fall asleep. I would sit and think of my deteriorating health, my small unhealthy children when I am unemployed, and my in-laws who are not united. I am also suffering from arthritis.

**Interviewer:** When are you planning to erect a tombstone for your husband?

**Interviewee:** I do not know because right now, I just cannot afford it. I cannot even afford to pay water and electricity, pay school fees and uniform, all of that. My in-laws have erected tombstones for everybody in the family six months ago except my husband. They did not even know where their graves were and I gave them all the information. My children were hurt by that and did not go to the ceremony.

**Interviewer:** How do you feel now about the loss of your husband?

**Interviewee:** Whenever I am asked that question, tears just drop down. He was a good provider when he was still employed. As he was working shifts, when he did night shift he would always call from work checking on us if we are fine. Even today I would think of him when the time he was used to calling comes. It is painful. He would do that every night. I cannot sleep without a sleeping tablet. Even then I would only sleep for an hour. I always tell my children about how good their father was. He never abused me physically. Even when we disagree, he would try to show me his point of view with respect. He always used to make it a point that when he leaves for work, he made it a point that we are both happy. He would tell me that he did not want to leave and die in an accident when we were not in good terms when he left for work. I miss him and what he used to do for us as a family. He would even give my parents money and buy them clothes. We never used to starve. There are days when my children do not have bread to eat. I sometimes make them dumpling with the flour I buy at times. It is worse now after my mother's death two weeks ago. I still have to go back to hospital because even now that we are talking about my husband, I have a headache on the left side of the head.

### **FR. LIAM (CATHOLIC PRIEST)**

Fr. Liam was interviewed to get a better understanding of the rituals which some of the Catholic Participants of this study practice using, for example, the Holy water, and receiving Sacrament,



etc. Fr. Liam is Irish and did his ministry in Italy. He came to South Africa in 1964 where, before then, he settled in Lesotho to learn the language. He was then based in Sharpeville ever since. His main role in the church is to train new priests, conduct Mass in the neighbouring townships, the roles that he had been playing since 1964. During the old South Africa, he became the target of the ruling party, as his Masses tended to be right wing.

**Interviewer:** From the Catholic perspective, what is death?

**Interviewee:** From the Catholic perspective, death is just simply leaving this life and going to life in heaven or hell as the case may be.

**Interviewer:** For a dying person, how do you interpret that person's experience, as you probably deal with dying people in your profession? What you see, what they go through, how they interpret their feelings, etc.

**Interviewee:** Well, that depends on the individual. There was one lady who died in this parish in the middle of last year (2006). She was a very good Catholic with a very strong faith. She knew she was dying. She had cancer. She had brain tumour and was operated. She thought she would recover but she said that she was always ready to go if the Lord wanted to call her. Because of her faith, she knew that she was going into the next life. She was not afraid and was quite resigned and accepted that situation. As I have said, it depends on how deep one's faith is in the next life. For example, one can sum up the whole attitude towards death, as Franciscans, in the words of St. Francis. During his life he wrote what is called "The Canticle of the creatures", where he praises God for the sun and the moon and the sky he walked on this earth, and so on. As he was dying he wrote another verse, which said, "all praise be to my Lord for sister death, from whose embrace no one can escape. Blessed are those who she finds doing your Will, the second death can do them no harm. Those who die in mortal sin will go into eternal punishment." So, that's more or less the Franciscan and Catholic attitudes to death.

**Interviewer:** Does it mean that belief helps one to go through the fear of the unknown?

**Interviewee:** Yes, with this lady I'm thinking about now, she certainly had no fear of dying. But even if you have a strong faith, the fact that you are facing something unknown I think makes everybody afraid. For Catholics, those who have a strong faith, know that they are going to God if they had lived a fairly good life. St. Francis says, "those who die in mortal sin separate themselves from God and will be punished. It means that they probably came to a point where they lost their faith and as far as they are concerned they do not know where they are going."



**Interviewer:** Can you differentiate between a dying person who is not afraid because of his deep faith and the one who is afraid?

**Interviewee:** In what way?

**Interviewer:** For example, if you know that the dying person has deep faith and, as a result, you expect him not to be afraid. Let's say two people whom you know to have deep faith, but one is afraid and the other is not.

**Interviewee:** I think if you have strong faith you can face death. There would be very few people who would face death as peacefully as this particular lady I told you about because even if you have strong faith there is still the fear of the unknown. You don't really know how this is going to happen and where you are going, etc. So there is always that fear of the unknown. But as I say, with a strong faith one believes in God and knows that he is going to fall into His hands so that no matter how they die they need to go. But it does not eliminate fear completely because human as we are we are afraid of something that we do not know.

**Interviewer:** Don't you think that one's personality also plays a role?

**Interviewee:** Yes, it has a lot to do with it because people who are naturally fearful will obviously be fearful despite their deep faith. However, their faith would calm their fear a bit. If the personality has fear in it, one will not do away with it completely. That is why I say it depends very much on the individual, personality, and the whole conglomeration of things.

**Interviewer:** Now, when you say that, you make me think of the soul and the spirit. What is the difference and what happens during the dying process?

**Interviewee:** I do not know. That is part of the unknown. All we know is that the soul leaves the body and that's it, and the soul goes to be judged by God immediately after death. Then you know if you get a ticket up above, down below or in the middle place.

**Interviewer:** During the dying process of the individual, how do you deal with the family?

**Interviewee:** In actual fact, I have only been present at one death that was this lady I'm talking about. Now, she had dealt with the family herself during the six months whilst she was fairly in good health. She was very resigned to whether she was going to die or get well and so on, and she had more or less prepared them and so, it did not come as a shock. At the same time as I

said I was there at the moment she died and, of course the whole family started crying, the usual reaction to somebody who belongs to you dies. So you just stay there with them, be with them and remind them of what their mother had said.

**Interviewer:** After the death, what role does the church play?

**Interviewee:** Well, after the death, part of the grieving process is the funeral service itself. The family brings the body to church and praying for the person who had died. At the end of the ceremony after Mass we have what is called the final prayer of farewell, just letting go of the person who had died. I think that bringing the body to church, and going through rituals of blessing and the prayer of farewell and accompanying the body to the cemetery really help the grieving process and helps the family to let go of the person who died.

**Interviewer:** what does the holy water symbolise?

**Interviewee:** As you know, when the person is baptised, he is baptised with water. When the body is brought into church, the coffin is blessed with holy water, as a reminder of the fact that this particular person was baptised and through baptismal became the child of God.

**Interviewer:** When you bless the coffin, why the coffin and not the body, why not open the coffin?

**Interviewee:** No, although some people would like that but I have never had the experience of doing that. When the person has died, we bless the body if we happen to be there at the death. When it comes to the church, some families leave the coffin open for viewing, when some do not want that. So, we just take it whichever way the family wants. So when the coffin is brought in, we bless the coffin together with the body that is in it as a reminder that this particular person was baptised with water and became the child of God.

**Interviewer:** What does the incense symbolise?

**Interviewee:** Once again, the body is brought in front of the alter, we say Mass, we do the readings, reminding people from John fourteen when Jesus says do not let your heart be troubled. Believe in God and believe also in me. In my father's house there are many rooms. If not I would have told you. I am going to prepare a place for you, and if I go and prepare a place for you, I will come and take you myself to where I am. That summarises the ceremony. Sometimes we use St. Paul when he said, "I do not want you to grieve like people who have no hope". He is not saying that he does not want people to grieve, but grieve with hope. At the end of

the Mass we have the prayers of commendation, commending the dead person to the Lord, and giving prayer of farewell. While that is going on, we bless the coffin again, and then we use incense. The use of the incense is that this particular person was the temple of the Holy Spirit. In other words, his body was something sacred. So, the incense is just a sign of honour to that person.

**Interviewer:** Still in the funeral service, what other rituals are there?

**Interviewee:** That's basically it in the church.

**Interviewer:** What about the Sacrament received during the funeral service?

**Interviewee:** You mean the Eucharist, i.e. the body of Christ? That is mainly for the people who are at the service and are Catholics.

With the person who is dying, for example, the lady I was talking about, I was there when she died. About an hour before she died, I was called and she received the Sacrament of the sick, which forgives her of her sins. This Sacrament is for someone who is dying and nervous, or who is very sick, this Sacrament brings them a sense of peace and it calms them, and helps them to be more ready for their death. We also give them Viaticum (padkos), food for this final journey. That is all concerning the communion as far as the dying person is concerned. At the end of Mass, nowadays it is becoming more and more common that people are cremated, which is not such a good help for the grieving process. I think it's much a greater help in letting go of the person in going to the cemetery and to have to see the coffin going down. It is a helpful ritual.

**Interviewer:** Now this lady who passed away, what happened after receiving the Viaticum and Sacrament of the sick?

**Interviewee:** She was already unconscious, and was sleeping away, and she was getting weaker and weaker and she died.

**Interviewer:** How did you deal with it?

**Interviewee:** We were reasonably good friends. It would not be the same as let's say burying my mother or my father or my family member. Because we conduct so many funerals, a lot of them are people we do not even know, we get used to it. Now, with this particular lady, we were friendly, but not deep friendship. So for me it was not that difficult.



**Interviewer:** At the graveside, which other rituals are conducted?

**Interviewee:** The coffin is brought in and as soon as the people have gathered together, we bless the grave. These horrible things that lower it automatically then lower the coffin down. I then take a handful of clay and sprinkle it on the coffin and I say to the person that he must remember that he is dust and will return to God until the last day. That's it.

**Interviewer:** Some of the Participants of this study always talk about taking the Holy water home. What is the meaning behind that?

**Interviewee:** The Holy water in the Catholic tradition is for blessing places. Now and again, people will be worried about evil spirits in their houses, and would ask me to come and bless their houses. It is a way of driving out evil spirits. So, quite often people would come to the church and we usually bless water here at the church. I have never been to a place where the Holy water disappears as quickly as it does here. In the prayers we bless the Holy water, we pray that wherever this water is sprinkled it will drive out evil spirit. So people come for the water as a kind of protection for their homes.

**Interviewer:** Before the burial, there is what is called a night vigil.

**Interviewee:** Well, once again that depends a lot on the culture. In Ireland in the old days, we would have what is called a wake, where the body is. Neighbours come to sympathise with the family and console them. Tobacco would be smoked and whiskey would be drunk, to be part of the farewell. Now because there were lots of abuses about that, people getting drunk and so on. Now the custom is that the evening before the funeral, the body is dropped at the church, and they have a short vigil just on prayers, and the people can go home and drink if they want to, leaving the body behind. As you know in the African tradition, the night vigil is very common. It's more an African tradition than a church tradition, but we go there for readings that relate to death, and songs and prayers all during the night. In a way it is a way of Christianising what the family would be doing anyway.

**Interviewer:** There's this ritual of ashing windows during the period between the death and the burial. What does it symbolise?

**Interviewee:** That does not happen anymore but I know that there was a custom of turning mirrors on to the wall and what the meaning of that was I really do not know. It is just popular

customs that people had. It had nothing to do with the church. That does not happen anymore except in very rural areas.

**Interviewer:** What other rituals have you witnessed that families practise?

**Interviewee:** Nothing really. My own family, when my mother died, she died in an old age home, and the body was brought from the old age home straight to the church. There was no wake and we as a family had no rituals to conduct and just followed the way of doing things.

**Interviewer:** Did you run the funeral yourself?

**Interviewee:** Yes, I did. It was not too difficult to deal with because living in South Africa I would see my mother every three years for a month or two. It is difficult but we manage.

**Interviewer:** How does your Black congregation integrate Catholicism and their African culture?

**Interviewee:** You have to ask them because it again depends on the individual. Some are one foot in the Catholic Church and the other in ancestors. They do not work together, but most practise both. The church is trying to help people get rid of their fear of the ancestors and the fact that people are trying to combine the two does not work.

**Interviewer:** Don't you think the church should take into account the context within which their congregation functions?

**Interviewee:** The question of ancestors should be put within the context of what we now believe as Christians. Let's say my grandfather if he was a good man he would probably be in Heaven. If he was a bad man he would be in Hell. So, if he is in Hell there's probably nothing that he can do for me. If in Heaven I can pray for him and he can help me. So you cannot lump all ancestors into one box.

**Interviewer:** It's like saying Virgin Mary is the Catholics' ancestor.

**Interviewee:** We look at St. Francis, St. Anthony, etc. as our ancestors. Some members of my congregations were good Catholics with a deep faith and I have no doubt that they went straight to Heaven, and they are my ancestors.



**Interviewer:** What is purgatory?

**Interviewee:** The doctrine of purgatory is this that when you die you may not be ready to go to Heaven and would have to be put into the washing machine to get yourself ready for Heaven. As Christians, most of us are wishy-washy. We may be living a reasonably good life as Christians but not ready enough to stand in front of Jesus Christ and face him immediately but have to go into the washing machine (purgatory) first, until one is ready. Remember once you die time ceases to exist.