

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 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.

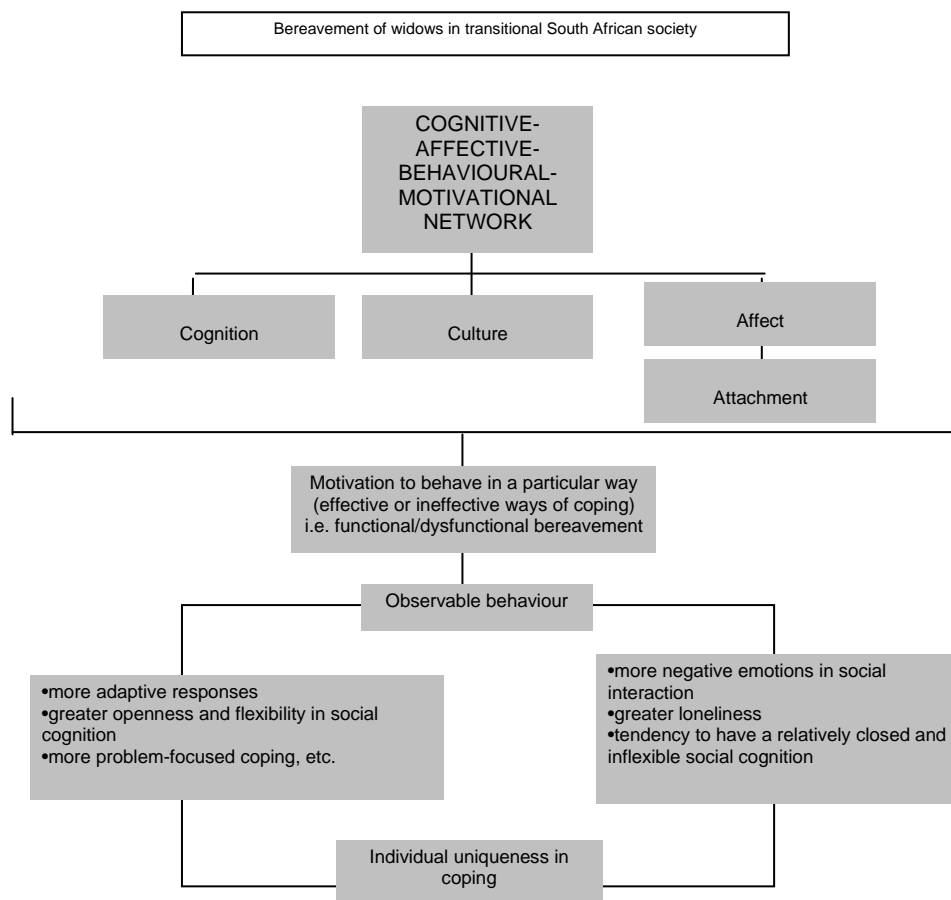


Figure 1 Model of cognitive-affective-behavioural network of bereavement of widows in transitional South African society

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.