Chapter 1

GRIEF, GRIEVING AND BEYOND:
LIVED EXPERIENCE AMONG SPOUSES/COHABITANTS OF PERSONS WITH BIPOLAR AFFECTIVE DISORDER

Oscar Tranvåg
Department of Nursing Education, Faculty of Health Sciences, Oslo and Akershus University College, Norway
Department of Public Health and Primary Health Care, Faculty of Medicine and Dentistry, University of Bergen, Norway

ABSTRACT

Grief, one of oldest forms of suffering in recorded history, is a normal manifestation of human anguish, differing from other forms of suffering by way of origin; an experience of loss. Since loss is a natural consequence of being human, so too are suffering and grief natural aspects of living. The first part of this chapter is dedicated towards illuminating crucial aspects of human grief. Within the literature we find contrasting theoretical perspectives concerning what grief is and what grieving entails. Positivism and phenomenology are two scientific traditions with contrasting views on the nature of grief. While these traditions emphasize seemingly incompatible and contradicting perspectives, we shall discuss how each of them can enrich our understanding of the nature of grief. Then, we will consider how new
insight may be gained by combining these two paradigms join to form a double optic in an effort to reveal a holistic understanding of grief, beyond what either paradigm alone can accomplish. The second part of this chapter will review the findings of a study exploring the grieving process experienced by a group of family caregivers, namely spouses/cohabitants of persons with bipolar affective disorder. The study reveals how suffering caused by grief over loss was found to be a part of a cumulative process over an extended period of time. Over the years, each spouse/cohabitant experienced various illness-related challenges. Persons living together with their ill partner over the longest periods of time found their process of grief over loss helped them move forward towards dawning acceptance, solace of reconciliation, and finally, a new hope. Gestalt therapy theory was applied to develop a theoretical base of understanding for this cumulative process bound within the psychology of this particular form of sadness. Spouse/cohabitant suffering from grief over loss was attributed to an inner imbalance provoked by the lack of insight and meaning, counteracting their normal organic equilibrium. This imbalance was caused by incomplete intrapersonal and interpersonal gestalts, or patterns. In time, new insight and renewed meaning reduced burdens of grieving over loss, as new and holistic gestalts immerged towards dawning acceptance, reconciliation and a new hope. Inner imbalance was reduced, new foundations established and equilibrium restored. Nurses and allied healthcare professionals can play important roles in the empowerment of spouses/cohabitants. Humane and empathetic care, health-promoting guidance and insight enriching dialogues were found to be important factors towards encouraging grieving spouses/cohabitants to moving forward beyond suffering, towards dawning acceptance, reconciliation and a new hope.

**INTRODUCTION**

Grief, one of oldest forms of suffering in recorded history [1-3], is a normal manifestation of human anguish, experienced as the deepest form of human sorrow. Grief differs from other types of suffering by origin, namely the experience of loss over a part of life with great individual meaning [4, 5]. But what characterizes this inner suffering? How do human beings experience grief over the loss of someone or something very precious to them? And how do we understand the nature of grief? Surprisingly perhaps, there is no simple or all-encompassing answer to these questions. Several attempts have been made in literature, including nursing literature, to identify and describe variables and their working interrelationships encompassed in the process of
grieving. A conceptual definition associated with these variables however is missing [4], and to date there is no existing theory which can fully explain grief as a human experience [6]. While some authors argue that certain universal characteristics are present, others maintain that grief is a complex, individual, contextually founded phenomenon. Most agree however, that grief is a normal experience in the life-world of human beings [7].

The first part of this chapter will attempt to illuminate some important aspects often found in the grieving process. Two scientific traditions with contrasting approaches concerning the nature of grief are positivism and phenomenology. The first focuses on physical and psychological signs, diagnosis and treatment. The second attempts to learn through first hand lived experiences of individuals who have suffered grief, and how their process of grieving developed. Here, the question may be asked: Would it be possible to learn more about the nature of grief and the process of grieving by considering both the positivistic and phenomenological perspectives at the same time, forming a double optic? Can so doing give us a more holistic understanding of grief, beyond that which either paradigm alone can offer? The second part of the chapter reviews the findings of Tranvåg & Kristoffersen [8], a research study exploring grief, the process of grieving and beyond, as experienced by a sample of family caregivers, namely eight spouses/cohabitants of persons with bipolar affective disorder. Gestalt therapy theory [9, 10] was initiated to illuminate their grieving processes. Previous studies on individuals with mental disorders indicate that family members often experience their role as every-day caregiver as stressful and burdensome [11, 12]. Alarming, in this context many family caregivers of persons with mental disorders develop physical and/or mental disorders of their own [8, 13, 14]. In addition, persons who care for family members with mental illness often experience grief over loss [8, 12, 15]. Research underscores the urgent need for healthcare authorities to promote preventative caring intervention for the health and well-being of family caregivers. For this reason, the present chapter also addresses current perspectives on nursing and allied healthcare practice related to grief. But first, a review of the existing literature on the human experience of grief and the grieving process attributed to loss.

**GRIEF OVER LOSS**

As a baseline for understanding, grief is recognized as “experiencing an intense inner reaction over en immense external loss [16, p. 16]. This
experience of forfeiture will vary in meaning and intensity according to the value of each relationship is question. There are numerous losses which may lead to grief. In the literature a majority of authors discuss grief as a reaction to death and the loss of a significant human being [4]. Grief however can follow many instances where changes in valuable relationships occur [6] or when a valuable object is withdrawn from one’s life [17]. This is an indication that grief may arise in a variety of circumstances, for example, following the loss of a beloved pet [18] or the deprivation of a limb, bodily function or normal development [16]. Physical impairment or dysfunction, eroding health or chronic illness, often leads to grief as well [19, 20]. Family members may share in the grieving process over the loss of loved ones memory, deviation of personality or others changes which make normal communication and meaningful interaction strenuous or impossible [16]. It is not unusual that individuals experience grief due to loss resulting in increased dependency on others [21] or in connection with the forfeiture of employment or the onset of retirement [4]. Heart wrenching is the loss of hope felt by the woman who knows she can never experience giving birth to her own child due to involuntary infertility [22]. Equally devastating is divorce related loss [23], none the least, that of a grieving child experiencing for the first time a broken heart over the loss of companionship to a beloved parent [24]. The loss of one’s home can also initiate a process of grieving [25].

In general terms, grief can be understood according to the nature of privation, for example, the forfeiture of material goods, erosion of relationship, or systemic loss, in other words, the loss of shared experiences of members of the same group. Additional categories of loss include intrapsychic loss, referring to painful, subjective recognition of one’s limitations, resulting in declining self-esteem due to a realization that future dreams or plans may never reach fruition [26]. Grieving may also coincide with symbolic loss, such as lost hope over future possibilities [16, 26]. Gender [27, 28] and age [29] may also influence the grieving process. Moreover, previous life experience, including encounters of previous loss [30] and cultural or religious devotion can impact individual processes of grieving [31]. In this perspective, grief over loss can be seen as a normative process since the socio-cultural context defines the boundaries for what is attributed an expected, appropriate or “normal” grieving reaction [4]. However, categorizing factors leading to grief can never be exhaustive. Thus, the findings of Stroebe, Stroebe and Hansson [6] and Worden [17], suggesting that grief often follows changes in valuable relationships or withdrawal of valuable objects in life, may serve as a basis for our understanding of grief over loss.
Intense sadness leading to grief can influence an individual’s life function, shading his or her interpretation of that which has true meaning in life [16]. Grieving is a pervasive experience which affects the person in all aspects of life [4]. Emotional reactions such as an inability to experience happiness or pleasure are not unusual. Feelings of helplessness, anger, frustration, sadness or depressive moods are common. The process of grieving can also result in problems with concentration or preoccupation of thoughts related to the experienced loss. Social withdrawal from others is not uncommon. Reduced capacity to perform activities of daily living due to physical and behavioral changes such as sleeplessness, feeling lethargic, constant crying, change in blood pressure or heart rate, gastrointestinal problems and weight changes are also seen in grieving individuals. In addition, the grieving persons’ spiritual and existential foundations can suffer as well, resulting in growing ambivalence towards religion and faith, leading to despair over the path for a meaningful future [4].

**PERSPECTIVES ON THE NATURE OF GRIEF**

Research shows how the experience of grief varies from person to person, and according to the context of one’s life. Grief can therefore be seen as a unique and personal experience in which an individual undergoes his or her own grieving process [7, 16]. At the same time, the literature emphasizes for generalities and universal aspects of grief in the human experience [32, 33]. In an effort to shed light on this polarization I will draw upon both positivistic and phenomenological paradigm to open our understanding of grief within these diverse scientific traditions;

Grief can be perceived as a universal process developing over several phases over time [4]. We can understand grief symptomatically, relating to certain expressions, signs and developmental phases utilizing a positivistic perspective on stress, depression [7] and crisis [16]. Within this paradigm grief is viewed as an object for classification, quantification and utilization of diagnoses according to pathogenesis. According to the positivistic tradition, necessary treatment can be prescribed and initiated [7]. An example of a theory concerns phases experienced due to separation and grief is John Bowlby’s attachment theory. This theory has greatly influenced our understanding of this phenomenon. His theory is founded upon biological-, cognitive psychological- and system theory, in close association with object-relation theory as well. According to Bowlby, the human experience of grief
can be seen in the following phases: numbness with shock and denial; anger, protest and a search for answers; disorganized despair; depression and lack of energy; reorganizing and accept. According to this perspective it is possible for the grieving individual to overcome the dependency of a deceased loved one by enduring the mentioned five phases. Characteristics of beneficial grieving are seen as an individual acknowledgment and acceptance of the death of a loved one and as adjustments to move from dependency to independence [16, 34]. However, it is accepted within the positivistic paradigm that some individuals never experience a normal or beneficial grieving process. Founded on a positivistic scientific diagnosis, some grieving processes may be seen as “pathologic grief” [32, p.51]. According to Bowlby, pathologic grief has four characteristics: A constant, unconscious longing for the lost person or object; an intense and constant anger accompanying an attitude of reproach towards certain individuals or organizations; uses of substitute and alternative objects for grieving; denial over the fact that that which is lost is gone forever [32]. In pathologic grief there is no personal relinquishing of the lost object. The longing for reconnection with that which is no more represses a healthy and normal process of reconciliation [35].

Within a positivistic paradigm, a prolonged and complicated grieving process may eventually lead the development of pathologic conditions such as depression, anxiety, phobia, psychosomatic ailments, sleep disorders, anorexia and social isolation [35]. Some express concern that symptoms of grief can be mistaken for major depressive condition [21]. A recent study of Newson et al. [36] illustrates the ongoing discourse within this paradigm on the characteristics of grief, distinguishing it from all other forms of suffering. In their study, Newson and her colleagues found that among 5741 older participating adults, 1089 individuals reported current grief and 277 (25, 4 %) were diagnosed with complicated grief combined with inflated anxiety and depression rates. The vast majority of those experiencing complicated grief remained free from these two most common co-morbid psychiatric diagnostic disorders of ageing. Thus, in line with some previous studies [37-39], Newson et al. [36] indicate that complicated grief is a separate condition with symptoms not attributable to other mental health disorders, thus emphasizing the “need for prevention, diagnosis and treatment options” including the “recognition of complicated grief as a distinct diagnosis” [36, p. 231].

Phenomenology on the other hand, offers another approach for understanding the human experience of grief. Within this scientific-philosophic paradigm the positivistic approach is inappropriate for understanding and describing human experience. The positivistic tradition is
defined as having reductionist and objective perspectives of humankind. As formulated by Skjervheim [40] reducing an individual to an object, dependent on general laws of nature, is within the phenomenological paradigm understood as an *instrumental mistake* and an injustice to humankind [40]. Since phenomenology looks at people as intentional, self-interpreting and non-reducible, this scientific tradition does not accept what is perceived as positivistic minimization of humankind and society at large, as one does with nature sciences in considering what is right and what is not [41]. From the perspective of phenomenology, human life-phenomena must be understood as pre-cultural aspects of humankind [42]. As pre-cultural lived phenomenon [42] grief leads to experiences which are particular and typical at the same time. This implies that the process of grieving carries with it inner meaning, both particular to the individual, while at the same time typical for human process of grieving [7]. Grief over loss represents a lived experience over something important and meaningful is lost [7]. This human experience is expressed within the cultural context the individual is a part of. However, from a phenomenological perspective, the grieving individual can never be placed within a normative standard for characterizing grief or expressions of the same. As a lived experience, grief cannot be categorized or defined in plain terms as this would imply a reduction of living beings and the process of grief into something less than the living phenomenon they are [43].

As underlined by the Husserl [44], the methodological founder of phenomenology, this scientific tradition emphasizes the gaining insight into the phenomena of human existence, by attempting to uncover how the lived experience reveals itself for the person experiencing it. This approach entails turning to “the matter itself”, by investigating how this is experienced by the person herself/himself [7, p. 273]. Seeking insight into human grieving processes through experiences from within the grieving individual's life-world is an example of how phenomenology turns towards “the matter itself”, as formulated by Furnes & Martinsen [7, p. 273]. In other words, one must seek out and meet the phenomenon as *it is for the one experiencing it*. Phenomenology understands grieving as a natural human experience and not as a pathological form of illness. The variety of expression and intensity found in grief, show the phenomenal range found in this human experience. The content of the grieving process, its strength and duration, all depend on the circumstances surrounding its origin, the environment and relational context the grieved party find themselves in, as well as individual circumstances of the grieving person themselves [16]. The experience of grief offers the grieving individual opportunities to develop new insight concerning the *meaning* of
life. Finding meaning in suffering implies individual discoveries and acknowledgements towards forming new and invaluable understanding for what it means to be human. The nature of this insight is mature life knowledge, a maturity the individual will carry with them in here-and-now situations as well as during future experiences in life [7, 45].

**Contradicting Views or “Double Optic”?**

For lack of a consensus on the nature of grief one may be inclined to obtain a dualistic understanding where the contrasting scientific perspectives involved are considered as opposite and mutually foreclosed. Time and energy can be utilized for arguing how one’s own perspective is the right frame of reference. However, researching diverse and contrasting perspectives may ultimately lead to the formation of new foundations of understanding from which new questions and new insights may arise. Or as Karl Popper, the well-known theorist of scientific theory and research methods concluded, "I may be wrong, and you may be right, therefore, if we cooperate we may come closer to the truth" [46, p. 255]. When concerning grief as our phenomena of investigation in this chapter, perhaps the following questions may be relative: Is it possible that contrasting or polarized views can enrich one another and contribute to a holistic understanding of the grieving process? Are the perspectives concerning the two scientific traditions positivism and phenomenology non-compatible in absolutely each and every circumstance? Can the fusion of these paradigms form a contrasting double optic, a holistic understanding of grief, beyond the either or dichotomy? Can researchers, despite differences in epistemological and ontological principles, identify perspectives which may serve as “bridge builders” between these scientific bastions? For example: Can the grieving individual’s search for meaning, or in other words, his or her search for meaning as a health-promoting perspective be acknowledged both from a phenomenological perspective as well as positivistic theory perspectives related to stress, depression and crisis?

We often declare certain themes or experiences as meaningful out from the circumstances surrounding us. Experience we considered meaningful are far more important than those with meaningless substance. Despite being widely used, the concept of meaning is often vague, defined in various ways by different authors. Derived from the German word meinen, and interpreted “to think”, meaning can be seen as the substance of our understanding, the foundation of how we make sense of our experience and the “significance we
seek in living” [26, p. 75]. From a positivistic viewpoint, the experience of grief initiated by loss can be understood as a psychological wound, while the healing of such a wound is accomplished through various methods of grief adaptation [32]. One form of this adaptation may involve psychological treatment or therapy. As stated previously, within the positivistic tradition, grief is connected to theories of stress, depression and crisis. From this perspective the grieving person’s search for meaning in the meaningless is apparent. Also the phenomenological tradition views the grieving individuals need for new insight and meaning in suffering made visible [7]. In other words, grief is an inner form of suffering which requires and makes possible new insight, meaning and an expansion of the human experience. Recent studies concerning grief illuminate the fact that a grieving individual’s search for meaning is essential to the healing process [47-49].

This new paradigm for grief theory, research and practice is anchored in the postulate that “meaning reconstruction in response to a loss is the central process in grieving” [49, p 4]. Despite difference in epistemological and ontological foundations, one can claim that both positivism and phenomenology provide worthy perspectives, while shedding light over the value of meaning for the grieving person. An understanding of his or her process of grieving will be a valuable lesson for the persons also later in life [7]. Finding meaning in grief can assist towards alleviating existential pain and help the suffering individual move on in life [45], leading him or her towards developing new foundations of understanding, new realities and a new scope for defining self-identity [30]. To nurses and allied healthcare professionals meeting individuals in their personal grieving process, this is an important perspective to reflect on, although challenging to explore. Understanding another person’s process of grieving or even the nature of grief is a challenging task. Gaining understanding from contrasting theoretical and scientific philosophies can be demanding. However, a search for knowledge through divergent traditions for a better understanding of grief, beyond one’s own paradigm utilizing a double optic can be a fundamental and necessary initiative for healthcare professionals claiming to hold a holistic view of humankind. In order to improve future healthcare practice there is a need for increased understanding of grief [50] and on the reconciliation of grief [5]. Professional caregivers have a responsibility for both the grieving patient and their patients’ family. The professional nurses’ responsibility for helping also patients’ family to find meaning is emphasized in nursing theory [45] as well as in international obligations and regulations concerning nursing ethics [51]. Therefore, as part of a caring and health promoting perspective, nursing
science and scientific works of allied health professions play an important role in the development of scientific knowledge, as a fundament developing caring interventions and practices towards alleviating family caregivers’ suffering from grief as well.

Tranvåg and Kristoffersen [8] explored experience of grief in the lives of spouses/cohabitants with a partner suffering from bipolar affective disorder. In this phenomenological hermeneutic study we found that after many years of struggling with various illness-related challenges, spouses/cohabitants experienced a grieving process due to loss. The findings suggest that grief formed part of a larger, cumulative process. Several reciprocal experiences were identified and described as interrelating concepts. The following chapter will portray this cumulative process showing how it helped grieving individuals slowly towards dawning acceptance, solace of reconciliation, and eventually, a new hope based on a more holistic meaning and understanding of that which is most important in life. In addition, a theoretical framework anchored in gestalt therapy theory [9, 10] was utilized to shed theoretical light on their grief-, grieving- and beyond-processes. However, to understand these processes, we first must gain insight into their personal experiences and losses during their pre-grieving lives. Therefore, let’s first observe how previous illness-related experiences formed part of a cumulative process and set a foundation for the development of grief over loss in spouses/cohabitants of persons suffering from bipolar affective disorder.

**SPouses/COHABITANTS’ SUFFERING EXPERIENCING PARTNERS’ STRUGGLE WITH MENTAL ILLNESS**

Eight spouses/cohabitants of individuals with bipolar affective disorder participated in the study (see Table 1). Two Norwegian psychiatric hospitals assisted the researchers with participant recruitment. A strategic selection prioritized participants of different ages to obtain a wide variety of experience within the research focus. The main research question asked was: *What experiences have you had in life with your partner, who has a bipolar affective disorder?* The duration of their shared lives together with their respective partner varied from 6 to 51 years after onset of the illness. A phenomenological hermeneutic method was utilized [52-54], a qualitative approach emphasizing the methodological movement between phenomenological attitude and hermeneutic interpretation throughout the
Table 1. Study participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Civil status</th>
<th>Number of years married/cohabitant</th>
<th>Partner’s age</th>
<th>Number of joint children and the children’s age</th>
<th>Number of years since the spouse/cohabitant first became sick</th>
<th>Number of times the partner had been institutionalized</th>
<th>Range of severity among the spouses/cohabitants: Study findings: Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>85</td>
<td>Married</td>
<td>51</td>
<td>59</td>
<td>1 (45)</td>
<td>59</td>
<td>&gt;20</td>
<td>1-0, 11-14</td>
</tr>
<tr>
<td>Female</td>
<td>74</td>
<td>Married</td>
<td>50</td>
<td>59</td>
<td>4 (52, 64, 48, 30)</td>
<td>40</td>
<td>4</td>
<td>1-22</td>
</tr>
<tr>
<td>Male</td>
<td>77</td>
<td>Married</td>
<td>50</td>
<td>73</td>
<td>3 (58, 43, 48)</td>
<td>40</td>
<td>3</td>
<td>1-4, 11-12</td>
</tr>
<tr>
<td>Female</td>
<td>53</td>
<td>Cohabitant</td>
<td>6</td>
<td>54</td>
<td>0</td>
<td>18</td>
<td>3</td>
<td>1-22</td>
</tr>
<tr>
<td>Male</td>
<td>31</td>
<td>Cohabitant</td>
<td>9</td>
<td>50</td>
<td>2 (5, 7)</td>
<td>8</td>
<td>3</td>
<td>1-8</td>
</tr>
<tr>
<td>Female</td>
<td>49</td>
<td>Married</td>
<td>25</td>
<td>49</td>
<td>2 (20, 23)</td>
<td>9</td>
<td>2</td>
<td>1-22</td>
</tr>
<tr>
<td>Male</td>
<td>38</td>
<td>Married</td>
<td>41</td>
<td>68</td>
<td>2 (16, 38)</td>
<td>34</td>
<td>2</td>
<td>1-3, 4</td>
</tr>
<tr>
<td>Female</td>
<td>61</td>
<td>Married</td>
<td>41</td>
<td>68</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The participant with 38 years of marriage did not want information about him or his family to be included in the table and has therefore been excluded here [8].

research process. Qualitative research interviews were applied to gain access to the participants’ life-world [55]. Two interviews were held with each spouse/cohabitant. The first interview lasted 100–120 minutes and was tape-recorded so the dialogue could be transcribed verbatim. 160 pages of transcribed text were available for analysis. Structural text analysis based on Ricoeur’s phenomenological hermeneutics, as described by Lindseth and Norberg [54] was carried out.

Since the participants shared lives after the onset of the illness varied from 6 to 51 years, this made it possible to gain insight into their experiences over time. Participants who lived with their ill partner for long periods of time had many of the same experiences as those participants with a shorter shared lifespan. Yet, spouses/cohabitants who had lived with their ill partner over the longest periods of time encountered additional illness-related experiences not shared by those with fewer years of shared lives. The study found three major aspects that characterized the spouses/cohabitants’ experiences within this time-dimension: Experience formed part of (A) a cumulative process containing 10 illness-related experiences, followed by up to four cumulative experiences arising from the grieving process. Each experience created pre-understanding that (B) affected how subsequent experiences were perceived. When confronted with a new illness-related challenge, previous experience of burden created presidents for perceiving these as burdensome also. Equally so, good experience in the past, laid a foundation for future beneficial experience as well. In turn, their pre-understanding also affected how they (C) managed to
master new illness-related challenges (see Figure 1). In the following, the spouses’/cohabitants’ 10 illness-related and cumulative experiences will be presented. Thereafter, the following grieving process containing up to four cumulative experiences will be portrayed (see Table 1 for range of severity among the participating spouses/cohabitants):

The spouses/cohabitants’ secure and stable life with their partner took a dramatic turn the first time their partner became ill. They were unprepared for their partner’s considerable behavioral changes. They could not understand what was happening, or what to do, leading to the illness-related experience (1) Fear and the incomprehensible. Their life situation became chaotic, incomprehensible, unpredictable and frightening.

Some experienced that their partner developed a substantial change in activity level, thinking and behavior. Others saw their partner become depressed, withdrawn, desiring only to stay in bed. The spouses/cohabitants often experienced (2) Accusations from their partner, who told them that they were the reason everything that had gone wrong. Their partner attributed hidden, destructive motives to them.

The spouses/cohabitants experienced great uncertainty regarding their own capabilities and judgment, leading to (3) Self-doubt and doubt about one’s own powers of judgement. A frightening, incomprehensible life situation and personal recrimination gave rise to uncertainty about their own power of judgment and handling of the situation.

As closest family member, the spouses/cohabitants experienced (4) Care and information vs. being overlooked or turned away by health personnel responsible for treatment and care of the ill partner. A number of participants experienced not being attended to by the health personnel. They lacked care and information in a difficult life situation. When their partner was discharged from the hospital, the full responsibility was again transferred to them, often without any follow-up by the health service. Some however, did have meaningful experiences, as healthcare personnel help them understand how this mental disorder affected her/his partner, as well as how to better master their own cognitive, emotional and practical challenges.

After their partner became a patient at a “psychiatric hospital” they became the topic of gossip among friends and neighbors, leading to the illness-related experience of (5) Stigmatization and loss of social network. This was an additional, painful burden, as rumors had a negative and sensational content. Their social networks were reduced as former associates ceased to make contact, leading to social withdrawal in the spouses/cohabitants as well.
Many unanswered questions about the illness, its treatment and the future, caused great uncertainty and a sense of powerlessness. Nonetheless, they retained a small hope that everything would someday be restored as it once was. Their burdensome and equivocal experience led to (6) Uncertainty and powerlessness while clinging to hope.

Relationships with their partner changed. Dialogue and cooperation became more difficult and risk of conflicts increased. They often felt a burdensome (7) Loneliness, and longed to be able to share their thoughts and feelings with their partner. The loss of a social network limited communication and socializing with others. They found that other people could not quite understand their situation, so they often found themselves alone with only their own thoughts and feelings.
The sum of burdens sometimes led to emotional reactions as (8) Anger and despair. Uncertainty, insecurity, powerlessness, accusations, stigmatization, loneliness and lack of care on from health personnel, lay foundation for these burdensome experiences.

Recognition that their partner’s mental illness was not a onetime episode, but implied a risk of future episodes of illness as well, was a burdensome experience as the partner’s mental health condition then became (9) The persistent threat. They developed therefore a watchful attitude to changes in behavior or signs of illness in their partners. Experiencing such changes in their marital role was perceived as hard and a constant burden.

Numerous burdens caused a number of spouses/cohabitants to develop (10) Own health problems, such as tension, muscular pain, tiredness, physical fatigue, insomnia and feeling mentally worn down. Two of them also developed diagnosed depression [8].

**GRIEF, GRIEVING AND BEYOND:**
**SPOUSES/COHABITANTS’ EXPERIENCES**

The study [8] found that spouses/cohabitants who had lived together with their partners over the longest period of time shared 10 illness-related cumulative experiences, followed by a grieving process containing up to four cumulative experiences. After suffering many years they experienced an increasing sense of sadness in their lives as an awareness of their partner’s eroding condition evolved and essential aspects of life faded. Over time, this recognition led to a process of grief over emotional and social loss due to their partner’s long-lasting mental illness. Through a demanding and wistful process, previous illness-related burdens were brought forth and worked through over time. This initiated an emotionally demanding process which gradually made it possible for them to let go of that which was lost and irrevocable. Essential aspects of their grieving process will be presented hereafter, illustrated by participant quotations. The spouses/cohabitants’ names have been changed to protect anonymity:

The partner’s illness caused the loss of important aspects of life, leading to the experience of (11) Grief over loss. They experienced grief as they felt the illness took the person they loved away. Gone too was the life they once lived together. They grieved over the loss of security, the future they had envisioned
and friends who had deserted them. Their grief was also related to their children’s loss of security and stability when growing up, as explained by Mary:

I grieved over losing the man I had married, over the children who lost their good, secure father, and over friends who disappeared. I still feel grief over all those who could not stay. I grieved over everything I… we… had lost. It is emotional and leaves permanent scars.

Many years passed before the spouses/cohabitants gradually began to accept the consequences of their partner’s mental illness, leading them to a (12) Dawning acceptance. The knowledge and insight they had acquired through long experience made it possible to relate to the burdensome experiences of life in new ways, as reported by Mildred:

Accepting the life situation was difficult. It happened gradually. I got help from a therapist, managed to put things into perspective and re-established my belief in myself. I saw that my husband was growing, and that our life became more stabilized. We have undoubtedly both grown from the experiences, but I’m not exactly grateful that this has happened to us.

Gradual acceptance initiated a process of (13) Reconciliation. Reconciling with life as it was involved a deep and genuine acceptance whereby the spouses/cohabitants finally found peace of mind, as expressed by William:

I have accustomed myself to it, as a part of life. I feel 100 per cent secure now, after all these years. I know the system and know that I will get help when I need it. My wife needs to be admitted to an institution a couple of times a year. Then we get good help, both of us, you could say.

Reconciliation opened a pathway to new goals and realigned ideals for living together. An awareness of the opportunities life offers gave meaning and a (14) New hope, characterized by positive realism, an awareness of what is most important in life and an appreciation of “here and now”, planning only for the immediate future, as reported by John:

After many years, when I finally managed to reconcile myself with how my wife’s mental illness affected our life, I managed to take pleasure in the
Figure 2. The cumulative grieving process in which each experience A) created a pre-understanding that B) affected how subsequent experiences were perceived, and C) how they managed to adjust and move forward in their grieving process.

small glimmers of light in our everyday life. Now I hope that she will be well for the next six months, that we have some good summer months, do some enjoyable things together, go for a little trip, things like that.

GRIEF, GRIEVING AND BEYOND: A THEORETICAL UNDERSTANDING

Theories can shed light on empirical data and can therefore be useful tools for gaining increased insight and understanding concerning the phenomenon under investigation. In this study several theories were considered illuminate spouses/cohabitants grieving processes. Gestalt therapy theory was found to be a meaningful theoretical framework for deeper understanding in this instance. The existential view within this theory strives to explain human experience. According to this theory, the insight and meaning individuals derive from their experiences, are crucial for how their experiences are perceived. High degree of insight in a situation lays foundation for increased understanding and meaning to the person. In terms of gestalt
therapy theory this strengthens a person’s ability to perceive intrapersonal and interpersonal experience holistically, or as a complete gestalt. A gestalt can be seen as a pattern, a structure or an organization of the parts it is composed of. A complete gestalt is seen as a holistic experience, made possible by personal insight and meaningful understanding of the individual parts that together make a whole. A complete gestalt contributes to the equilibrium of the human organism. When a person only partially comprehends a lived experience, an incomplete gestalt is formed, counteracting equilibrium and resulting in an inner imbalance in the human organism [9, 10].

Each experience and how it was perceived by spouses/cohabitants formed a pre-understanding, which laid the foundation for how later illness-related challenges were perceived and mastered. In terms of gestalt therapy theory, the cumulative process can be seen as each experience influences the whole and the whole influences the individual experiences. Thus, the whole amounts to more than the sum of its parts. The degree of insight and meaning gained with experience affected whether the event was perceived as a complete or incomplete gestalt. In turn, this had prominent reverberations on the meaning of subsequent illness-related challenges as well. Furthermore, the perceived meaning affected their ability to cope with these challenges. In sum, the individual’s personal gestalt experience had a crucial influence on the degree of equilibrium within their organism.

Figure 3. The spouses/cohabitants’ grieving process; a theoretical understanding in terms of gestalt therapy theory. The curved arrows illustrate the cumulative process in which each experience created pre-understanding that affected how subsequent experiences were perceived and mastered.
After many years of attempting to cope with up to 10 illness-related challenges in every-day life, they gradually developed an awareness and incremental sadness as they perceived that the partner’s illness led to the loss of important aspects of life. Over time, this recognition developed into grief over loss. Through a demanding and wistful process, previous illness-related burdens were brought forth and worked through over time. This initiated an emotionally demanding process which gradually made it possible for them to let go of that which was lost and irrevocable. In turn, the process initiated dawning acceptance of the partner’s mental illness and the losses they experienced in life. The dawning acceptance was not resignation, but adjusting towards a new perspective which eased their burdens and opened new ways to master their lives. This gave rise to new meaning and increased consciousness of possibilities through emancipation from limitations. According to gestalt therapy theory, grief is the realization of having lost valuable and meaningful gestalt in life. At the same time, their grief over loss was the beginning of a healing process reducing inner imbalance in their organism. New insights into intrapersonal and interpersonal relationships brought new meaning and an increased awareness of the valuable gestalts, in life. The organism’s need for holistic understanding towards restore equilibrium can be seen as the driving force in the process towards dawning acceptance, and a renewed formation of complete gestalts.

This new pre-understanding initiated a process of reconciliation with the partner’s mental illness and its’ consequences. This process included a genuine acceptance of life as it was and life as it can be in the future. Through this process the spouses/cohabitants finally found peace of mind, opening a path to new ideals for living together. They began to appreciate the simple things of life, a change which opened their eyes towards new opportunities. This gave rise to meaningful perspectives and a new hope. Negative experiences of the past were replaced by new pre-understanding obtained through the process of grief over loss, dawning acceptance and reconciliation. Through positive realism, awareness of the important things in life, appreciation of life here and now and planning only for the immediate future, new foundations for courage and joy in the existing possibilities of life together were established. In light of gestalt therapy theory, the equilibrium of the organism was re-established as the reconciliation created harmony within them as well as between them and their surroundings. Previous incomplete gestalts were replaced by a new holistic meaning and recognition of important values in their shared life experiences. A foundation for new hope based on positive realism and their opportunities were established, strengthening their capacity for self-support.
New insight increased their capability to attend to their own personal needs. Reorganizing inner and outer sensory impressions towards more meaningful intrapersonal and interpersonal gestalts helped their organism to regain a state of equilibrium.

**GRIEF, GRIEVING AND BEYOND: PERSPECTIVES ON CARE PRACTICES**

In order to understand spouses/cohabitant’s grief over loss it is important to recognize how crucial experiences from the past contribute towards initiating this inner suffering. Exploring past experiences’ impact on current pre-understanding may help professional caregivers to better understand personal perceptions of each spouse/cohabitant. In this study, up to 10

![Figure 4. The spouses/cohabitant’s 14 experiences as a cumulative process. The model’s x-axis illustrates the duration of life together after the partner fell ill (6–51 years). Along the y-axis a thematic presentation is given of the participants’ 10 illness-related experiences and the up to four consequent grieving process experiences; Grief over loss, Dawning acceptance, Reconciliation, and New hope. The experiences do not always have a clear starting point. Furthermore, the experiences do not always have a final end-point. This is indicated by a broken line for each topic. The spirals illustrates: The experiences cumulative process over time in which A) each experience created a pre-understanding that (B) affected how subsequent experiences were perceived and (C) mastered [8].](image)
previous illness-related challenges formed part of their pre-grieving base of experience. How these experiences were perceived and mastered laid foundation for the later grieving process as illustrated by Tranvåg & Kristoffersen [8], (see Figure 4).

Nurses and allied healthcare professionals should be aware that a cumulative process involving the discovery of meaning in previous illness-related experiences, seemed crucial for generating a meaningful process of grieving. Meaningful grieving processes were predicated on a meaningful pre-understanding, empowering spouses/cohabitants to perceive their experience through a holistic point of view or in other words, as whole gestalts.

Caring for the grieving person involves forming bonds and contributing in a relationship that provides a basis for the growth of trust. Compassion, commitment, empathy, sensitivity and respect will help the relationship to grow [56-58]. Spouses/cohabitants who felt good about their experiences with healthcare personnel perceived caregiver awareness, empathy and the feeling of being understood. They were given an invitation to share their grievances’ with someone who was honestly concerned for their welfare. They were offered information and feedback as to how they had perceived and coped with the situation at hand. The study indicates how grief over loss helped initiate a healing process leading to dawning acceptance, reconciliation and a new hope. These spouses/cohabitants had long shared lives with their partner, and the time aspect could be an auxiliary factor, as working through experiences over time may ease their suffering over loss. However, the time factor alone was probably not an adequate indicator of the magnitude of these experiences. First, the cumulative process of growing insight and meaning led to dawning acceptance, in contrast to dawning resignation. They had gained substantial perspectives making it possible to perceive and master grief over loss in more constructive ways. New and meaningful gestalts seemed to help replace imbalance with growing insight concerning past experiences. A deeper understanding of their current grief, coupled with a realization of their own response to loss, gave increased meaning to their experience [8]. The findings suggest that in helping spouses/cohabitants to understand the foundation of their grief, attributing it to loss, nurses and allied healthcare professionals may contribute towards the easing of burdens, assisting those suffering from grief to move on towards dawning acceptance, reconciliation and a new hope.

Professional caregivers should also be aware of the negative effect of “feeling overlooked or turned away” by health personnel, as this experience may increase the burden, reduce one’s ability to master the strain and lay a foundation for negative pre-understanding of the future [8]. Since grief may
negatively affect a person’s psychic and/or physical condition, even leading to ill health over time [4], this underscores the importance of a research based care from a health-promoting perspective concerning the process of grief initiated by personal loss.

Humane and empathetic care, health-promoting guidance and insight enriching dialogues seemed to help spouses/cohabitants to work through a demanding and burdensome process [8]. The finding suggests too this is important ways to help empower [59-61] grieving spouses/cohabitants. Guidance on how to maintain social networks can for instance help prevent social withdrawal and loneliness. However, informative guidance cannot cover all aspects of their needs. It is important that they are given ample opportunity to work through cognitive and emotional reactions as well. Nurses and allied healthcare professionals can invite each to share their thoughts concerning the past and the future, offering guidance through dialogue on how to deal with current perceptions over both past and future outlooks. Such meaningful experience may reduce one’s sense of hopelessness, gradually making possible letting go of that which is irrevocably lost, helping each to move forward in their grieving process [8].

This study acknowledges the complexity of grief experienced as a holistic and cumulative process. Experience of the past are seen as integrated part of the present, and not as isolated incidents, separated from the context at hand. This perspective also recognizes grief over loss as a normal life-phenomenon, an experience founded on the persons pre-understanding and current understanding bases. The grieving process is understood as a fundamental, pre-cultural aspect of life, a human reaction to the loss of something invaluable and irreplaceable. With this perspective in mind, grief is not considered primarily as an outer manifestation of symptoms for an internal pathological condition, but rather as a normal manifestation of severe human anguish. Nonetheless, the literature does indicate how grief can evolve in the direction of increasingly serious health concerns for the grieving party [4]. Healthcare professionals should therefore have respect for the positivistic paradigm’s perspective of grief, which proposes the possibility that an individual may indeed develop “pathologic grief” [32]. For nursing as a holistic profession as well as allied holistic healthcare professions, an eclectic perspective opens for the cautious application of knowledge derived from a wide variety of professions and scientific paradigms [62]. This generates the possibility for the application of both a phenomenological and a positivistic foundation for understanding. The reciprocation of these contrasting and seemingly contradictory traditions assists in generating possibilities to go
beyond our limit of understanding bound within each paradigm alone, while contributing towards a holistic understanding of the lived-experience of those who grieve. An approach of this nature, utilizing a *double optic* may uncover vital data and make it possible to formulate care interventions which are sensitive enough to assist each spouse/cohabitant, regardless of where they are in their cumulative process of grief.

A holistic understanding also demands thorough insight into how the spouses/cohabitants understand their own lived experiences. This requires a phenomenological attitude as well as professional humility among nurses and allied healthcare professionals as they seek to understand each individual’s personal experience of living with grief, existing in the face of grief. Within this context, a *three-part relationship* [40] involving the grieving individual, the professional caregiver, and their common interests, both in each other as well as towards “the matter itself” [7, p. 273] seems to be crucial. This three-part relationship may lay foundation for a meaningful guidance dialogue, assisting the individual to find meaning in grief over loss, move forward and beyond suffering, towards dawning acceptance, reconciliation and a new hope for the future.

**CONCLUSION**

If our goal is to obtain understanding of the human experience of grief, in all its complexities, one may ask whether or not such an investigation can be limited to just one scientific-philosophic perspective? Will such an approach lead to sufficient understanding of the multi-faceted phenomena inherent in the process of grief? This chapter attempts to cast light upon such questions, drawing on two scientific traditions, positivism and phenomenology. At the onset, these traditions are considered contrasting or even oppositional. It is the role of science however, to ask direct and critical questions. This requires not only an honest investigation of contrasting scientific traditions, but also, an equally demanding investigation of one’s own perspective. With this in mind, we may be permitted to seek the “truth” by allowing contrasting and seemingly contradictory scientific traditions to *communicate with one another* and form a *double optic* towards a holistic understanding of grief, moving beyond what either paradigm alone can accomplish. Doing so may cast additional light towards the discovery of yet unrecognized foundations for knowledge and understanding.
Uncovering “truth” in this way may help the dedicated researcher towards unearthing hither to unknown “realities”. Positivistic and phenomenological perspectives of grief are on the onset contrasting. The one utilizes diagnosis based, symptomatic phases for understanding, far different from a pre-cultural understanding of this phenomenon of lived human experience found in the other. Despite their differences, the foci of both traditions include the human experience of grieving, as well as, finding meaning in experience. This makes it possible to view both perspectives simultaneously using a double optic. Thus, widening the lens on our understanding, we view human grief from a new perspective. This perspective requires having the courage to build bridges of understanding between long established “islands of scientific rivalry”. However, this double optic may be the means to illuminate our view, offering new perspectives towards increased meaning and a holistic understanding of human grief.

A study exploring lived experiences among spouses/cohabitants of persons with bipolar affective disorder found how a cumulative process of up to 10 illness-related challenges experienced over a period of time, initiated a process of grief over loss. Individual processes of grieving led those with longest lives together with their partner through a cumulative process of dawning acceptance, reconciliation and a new hope. In this process past experiences created pre-understanding affecting current perceptions, coping, and ability to adjust to new lived experiences.

As a theoretical frame of reference, gestalt therapy theory was chosen to shed light upon the empirical data of lived experience. Gestalt therapy has its origin in psychology of perception, based within a positivistic paradigm. This approach does not block the understanding of empirical data on grief seen as a lived phenomenon, utilizing a phenomenological hermeneutic method for data collection and analysis. In this study, access to both paradigms helped form new possibilities of understanding, utilizing a double optic in which seemingly contradictory paradigm are encouraged to communicate with one another.

An approach of this nature may be of interest, empowering health care professionals who emphasize personalized- and holistic care for persons suffering from grief over loss. The phenomenological hermeneutic use of gestalt therapy theory as framework for discovery helped create a theoretical understanding of the empirical data. Thus, burdensome experience such as grief over loss can be seen as an inner imbalance in spouses/cohabitants as each of them struggles to find meaning in their experiences. When only part of the whole is perceived, an incomplete gestalt is formed, and the person’s lived experience counteracts equilibrium within the organism. New insight helped
them to find meaning in the lived experience and helped each on their journey through their own grieving process, which also includes dawning acceptance, reconciliation and new hope. In this process, previous incomplete gestalts were replaced by a new holistic understanding, strengthening their capacity towards self-support. New insights enabled each, increasing their capability to tend their own fundamental needs, organize inner and outer sensory impressions into meaningful intrapersonal and interpersonal gestalts, and meet the organism’s need for equilibrium.

Nurses and allied healthcare professionals can play an important role in the empowerment of spouses/cohabitants whose partners suffer from bipolar affective disorder. Humane empathetic care, health-promoting guidance and insight enriching dialogues were found to be important means towards encouraging them to move forward in their grieving process, beyond grief over loss, towards dawning acceptance, reconciliation and a new hope for the future.

Reviewed by Professor Dagfinn Nåden, Oslo and Akershus University College.

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