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Grief and Healing in Young and Middle Age: A Widower's Journey

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Abstract

The experience of grief is both uniquely personal and universal. Our personality, our relationship with the deceased, the manner in which the deceased died, our life stage, and many other contextual factors matter and impact grief, and yet there are many experiences, phases, stages of grief that are universal. Those who are grieving deeply or who are farther along in their healing are often trying to understand grief and its realities. It has been said that people die but relationships do not. As a widower twice, once at age 25 and then again nearly 30 years later, I agree with that sentiment, and it is the profound relationships with my wives Becky and Susan that propelled me to share my experiences and reflections on grief and healing. As a clinical psychologist and gerontologist I examined the grief and gerontology literature, learning new things that were useful and not as useful.

Keywords: Bereavement, Cancer, Death and Dying, Life course/Life span, Widowhood

Gamino and Sewell (2004) and Neimeyer and Holland (2015) describe one major grief conceptualization that of personal narrative and how the themes of the mourner's personal narrative affect their adaptation during grief. Having been widowed twice, once at age 25 and again at age 55, I decided to write my own narrative (to read the complete narrative, see Lichtenberg, 2016). In this article, I will attempt to tell enough of my story for the readers to understand my personal context and to draw on a variety of lenses used to examine the aging process: life course, stress, religion and spirituality, as well as positive and optimal aging.

I was widowed first in November 1984 and the second in February 2014. It's not only that I lost both of these women to an early death but also that these relationships were once-in-a-lifetime love affairs. Becky and Susan were everything to me: friend, colleague, lover, and confidante; the person I most wanted to have fun with and the one I wanted beside me in a crisis. These grief experiences were so different and yet similar: one informed by the other, yet

each a whole new chapter in my life. How did these experiences shape me as a clinical psychologist? What theories of grief and healing was I exposed to and how did this affect me? What do I think the field of gerontology understands correctly about grief and what is still lacking? This article will examine those questions, grounding my experiences in rich literature.

My research into widowhood revealed that the odds of being widowed once before age 25 are extremely small. In his book on the biology of aging, *Time of Our Lives*, Tom Kirkwood (1999) writes about how, during the 20th century, the likelihood of dying in the first 25 years of life dramatically declined. He found that if you were born in the 1880s, 7%—or 1 in 14 people—would die between the ages of 5 and 25 years. By the 1960s, that rate had dropped to less than 7,000 per million or 1%—1 in 142 people. Even fewer of these deaths would leave widowers behind. Even at age 55, when I was widowed a second time, the percentage of widowed men aged 50–54 years was less than 5%.

“Entering the Adult World” With Becky

In the fall of 1980, I fell in love with a Washington University senior, a beautiful, boisterous woman whose laugh rang out like a silver bell on a crisp day. Becky made everyone feel at ease, with her humor and good nature, and she was a friend to so many. She was a swimmer—a vibrant, healthy woman—and I loved her as I had loved no one else before.

I asked her to dinner, then convinced my roommate to make his special pecan pie. After we had eaten, Becky and I spent the next 5 hr talking and laughing, on and on. Our friendship blossomed: We shared interests in literature, hiking, and the zoo. St Louis became our wonderland, and we explored its seasons and sights as we explored one another. The spring and summer after graduation were a celebration of closeness. We swam, went for long walks, attended ball games, watched movies, shared dinners, and even took a 2-week trip to the Atlantic Ocean. Although we mostly played and laughed that summer, we also forged a deep bond and yearned to share our lives.

Becky came to West Lafayette, Indiana, where I had started graduate school at Purdue University in December 1981. We were married in Elkhart on June 19, 1982—a beautiful, sunny day. Two years later, in the fall of 1984, we were busy planning our future: I was applying for an internship for the following year, after which I would finish my PhD, and Becky, who had decided to pursue a career in medicine, was getting ready to start medical school. Our lives were full of change and transitions that united and invigorated us.

In the 1970s, psychologist Daniel Levinson wrote about men’s adult development in the bestselling *The Seasons of a Man’s Life*. He viewed the transition to adulthood as occurring across a 15-year period, from 17 to 32, and within that span he described three stages. Ages 22–28 he termed “Entering the Adult World,” during which the man’s major task is to create a new home base that is truly his own. Two key components are required to do that effectively: (1) forming a dream and (2) forming a love relationship(s). Levinson also asserted that a man who is particularly happy during this stage has formed an especially close love relationship with a woman who shares his dream. Becky and I fit right into Levinson’s description of development and adult transition.

The Loss

On a Tuesday night in November, Becky and I talked late into the night, laughing and looking ahead. Even though it was late, I knew that Becky would still be out jogging before dawn; she was disciplined and rarely missed her workout. I kissed her, rolled over, and fell into a sound sleep. But at 6:47 a.m. I awoke with a start. I was alone—and before I was conscious, I knew: Becky was dead. I felt it: My chest was tight, my arms numb, and my head and heart wouldn’t stop throbbing. A minute later I heard an ambulance, its siren screaming, and somehow I knew that it carried Becky’s body. My love, my life, my young and

beautiful Becky had died suddenly, without warning, of a cardiac arrhythmia.

It was November 14, 1984. We had been married for 2 years and 5 months. I would later learn that Becky had a condition known as idiopathic hypertrophic subaortic stenosis (IHSS), which is a form of myocardial hypertrophy of the left heart ventricle. The death rate from IHSS is no different from that of the general population, but strenuous exercise is strongly discouraged.

Later that morning, I am sitting in the emergency room, about to dial the phone to tell Becky’s parents that she is dead. The hospital priest, who was sitting with me, gently advised me how to introduce the topic. “Ask if there is someone with them—that you have some very bad news to share.” I did the best I could, and we got through the call. About 3 hr later, her parents and their minister descended on West Lafayette. There was no support, solace, or consolation for me; I was frozen in the moment of devastating loss and shock, and they were determined to control what would happen next. “We have to have the service in Elkhart, and we cannot wait,” they told me. And so Becky’s funeral was set for a quick 48 hr later, with no time to absorb or reflect on the tragedy.

At the funeral home, the night before the service, I stood on one side of the room, weeping with every person who approached me, and Becky’s family stayed on the other. I was irrelevant to them; I was an intruder. Then came perhaps the worst blow of all, a tidbit tossed like a grenade. Her father, a physician, told me that no one with Becky’s heart condition (which she had described to me as a minor congenital abnormality) should ever be jogging. He had learned this a full month earlier. Why hadn’t he told her? Why hadn’t he told us? I should have wondered what was wrong with her parents, to keep critical information from her and treat me with such disdain. But in my shock, grief, and depression, I thought, “What is wrong with me that her family dislikes me so much?” All in one moment my identity, my dreams, my sense of self, and purpose were gone, and after making and delighting in a deep commitment and marriage to Becky, it was over just like that. My best friend, my biggest support, my anchor, my love—all gone in one devastating moment.

I became depressed by the time I left Indiana to go back to my parents’ home (just 60 hr after Becky’s death) and I couldn’t process and use the support and love offered by others. Of course my family and friends tried to reach out to me, but it didn’t register. Everyone wanted to talk to me about the future (either how I might never get over this or wondering who I might date next). I hated that anyone felt like they had the right to talk to me about the future. Becky was my world and that had not changed. After Becky’s death the physical symptoms of grief were so powerful and confusing. I couldn’t swallow hardly at all, barely ate, wept, and felt engulfed in shock and despair, alternating so quickly it was hard to predict when things would come or change. The physical symptoms of depression (eg, tearfulness, sleep,

and lack of energy) and grief overlap, particularly during the first month of grief. The amount of self-criticism, loss of self-esteem may indicate who is likely to continue to struggle with depression as the months and/or years after a loss go by.

I found no descriptions in the grief literature that described my grief and it wasn't until I read Doris Kearns Goodwin's (2006) highly acclaimed *Team of Rivals*, about Lincoln and his cabinet members, that I found a description I could relate to. She describes the devastating effect of losing one's spouse or love interest during the "entering adulthood" phase of life. Salmon Chase, Lincoln's Secretary of State, lost his wife during childbirth when he was 23. He wrote to friends, "I feel loneliness the more dreadful, from the intimacy of the connection which has been severed." For months he would walk around his house muttering to himself devastated by his loss.

An Academic Approach

In the spring of 1983, I had taken a "Death and Dying" course from the well-known gerontologist Victor Cicirelli, one of my graduate advisors at Purdue University. I tried to use academic knowledge to help me grieve. Most modern grief literature recalls the Coconut Grove fire of 1944 and Lindemann's research with the grieving survivors. As I read this, I recognized in myself the same early reactions to loss; somatic distress; I could barely eat and it was a strain even to speak. Preoccupation with the deceased and guilt were vivid descriptors of how I felt.

I was given more popular books on grief and loss such as Tatelbaum's *The Courage to Grieve* (1980), which described the stages of grief: shock, searching, suffering, and recovery. These were helpful in understanding such new phenomena as believing that I heard Becky talking in my apartment. In that era of grief and mourning, there was also a focus on being able to finish grieving. Kubler-Ross' (1969) work in her famed book *Death and Dying* described the acceptance stage and Worden's *Grief Counseling and Grief Therapy* (1991) conceptualized the grief process as the tasks of grief. Worden described healing as "relocating the deceased and moving on with life" (ie, being able to recall the deceased without pain). Tatelbaum termed it "finishing" and "letting go." These grief models would eventually be challenged and one current model, the two-track model (Neimeyer and Holland 2015), now exists in which the relationship to the deceased is not only viewed as surviving well past the death but a central component to the well-being of the mourner. The impact of the relationship one has with the deceased reveals itself over time, and over time, the meaning of the relationship can affect the well-being of the surviving spouse.

Vulnerability and a Destructive Decision

Eight months after Becky's death, I moved to Gainesville, Florida, for my clinical internship—and the worst year of my life. Nothing even comes close to it, and yet I refused to

seek help or change course. After I went away during the summer, first on vacation and then to move to my internship in Florida, all of the facade of doing okay came apart and the depression took over. It all came crashing down on me in Florida. I cried; I was incredibly sad. I would drive into work in the morning, park on the gravel lot where the interns parked, sit looking at the chicken coops that were surrounding the lot, and it would take at least 5 min each day before I could will myself to get out of the car and go inside.

Despite the pain in my life, I discovered that my skills as a clinical psychologist were being enhanced by my experiences. My internship yearlong rotation was in a Veterans Administration Nursing Home. Several of the residents had been there for several years, but now a group of men were actively dying. My supervisor recognized that her friendships with these men might get in the way of her clinical treatment of them and asked me to work with each of them one-on-one. I found during that internship what would be a clinical strength of mine; working with the dying and their families.

Due to loneliness and vulnerability I stumbled into a new long distance relationship that would ultimately lead to an unhappy union and marriage. Despite knowing that things were "not right," I barreled forward with the relationship. Writing about this period now, I had to admit to myself that my downfall was allowing my fear of remaining alone to overcome my certainty that the marriage would be a mistake.

Stress and the Life course

Pearlin and Skaff (1996) wrote a seminal article in which he examined the intersection of stress research and the life-course perspective. The life-course perspective, he noted, was more focused on positive aging and new opportunities for growth across time. The stress literature, he stated, was more focused on negative outcomes and mental health difficulties. Perlin noted that stress is a process that interacts across time with other stressors and with the life course. Coping, in which a major task is meaning making and mastery, is less effective after "off time" transitions, often leading to less social support and to mental health challenges. Perlin's description is a useful way to conceptualize my widowhood after 1984. It would require another developmental transition—a normal one in the life-course perspective—to lead to my real first steps in positive coping and mastery.

In considering widowhood as a specific stress, Gamino and Sewell (2004) analyzed narratives of widows and widowers in order to better understand what factors led to more complicated grieving. Gamino and Sewell concluded that more difficult grief experiences occurred with unexpected deaths, widowhood at a younger age, and when losses were viewed as preventable. The narratives of these widowed individuals were more pessimistic, self-deprecating, and filled with less gratitude.

Levinson's Age 30 Transition

Levinson's second stage of adult development is "the Age 30 Transition," during which finding a mentor is important—and although I didn't realize it at the time, when I met Jeff Barth in March 1986, I had embarked on the next stage of my development. I now had a direction and a future. Jeff was the Acting Director of Psychology at Western State Hospital in Staunton, Virginia, where they had an opening for a director of geriatric psychology. Within the first 10 min of my interview, I knew that I wanted to work with him and benefit from his wisdom and experience. So I did: I moved to Virginia, and I threw myself into work. Jeff mentored me, and, by his example and dedication to his craft, he showed me what it took to become a professional and advance in the field. When I first came to work for him, Jeff believed in me much more than I did in myself. Then he did what mentors, if they're really good, do: He broke it all down so that I would know, on a tangible level, who I was and what I could accomplish.

My first research effort was on grief in spouses who were caregivers. This work was published in the *Clinical Gerontologist* (Lichtenberg and Barth, 1989) and received almost no attention, but it helped me understand better the power of loneliness and the role of grief in family members when their loved one entered long-term care. As a clinician, I created several education and peer-mentoring programs over the years to help family members become integrated in caring for their loved one in long-term care (Lichtenberg, 1994). My experience of grief and coping set the stage for my work with vulnerable older adults and my ability to see how I could communicate openly and honestly with older adults but never take away hope and never give up on helping them pursue their own goals. My experience of grief sensitized me as an administrator as well and heightened my awareness of how easily people can feel underappreciated or even invisible.

Healing my Personal life

In January, 1991, I left small-town Virginia for the gritty city of Detroit, which was a perfect fit; it felt a lot like my hometown of Philadelphia. My career took off in my new job, and my ambitions soared. My marriage, in contrast, floundered. One part was a success: We had a daughter, Emily, whose arrival brought me great joy. I also had the good fortune of living close to my lifetime friend John, who was in graduate school in nearby Ann Arbor. Between my times with him and my love for Emily, I began to want more than just a career; I began to want a full life. I did not know what that would look like, but I was becoming more distant from my wife as I focused on myself and on Emily. I decided that I might need a new job, but instead of taking any of the out-of-town offers—none of which suited me—I decided to stay put and focus on my own personal growth. I also decided to separate from my wife.

When I moved out in April 1997, Becky had been dead for a little more than 12 years—and yet I knew that I was, in a large part, moving out so that I could finish

the healing process and finally get on with my life and my dream. I was working with Susan MacNeill, a Clinical Neuropsychologist, and our relationship grew from friendship to love. Susan and I began hiking together regularly after I separated, and after a few of those hikes we began to date. My pictures of Becky were still in their places on my roll-top desk and remained for a few months after Susan and I had been dating regularly. I told her that I was finishing the healing process, and she smiled and said that that was fine with her.

When I finally felt that it was time to remove the pictures, Susan asked me why. I was finished, I told her, with that part of healing. I was also ready for *her* pictures and *our* pictures to adorn my desk. I was astonished by how much Susan understood my healing—and how easy it would have been for her to feel threatened or assume that I was not ready to date her. Instead, as she told me later, she knew that I was totally in our relationship—totally present, loving, and never veering away from her.

I felt as if Becky had handed me to Susan and given her blessing to our life together. My dream had truly resumed, with a life and home full of love and friendship. My mother particularly loved Susan and supported my new relationship the way she had supported my relationship with Becky. Susan and I played tennis, went running, watched movies, shared novels, and reveled in the companionship and love that fulfilled our every sense. We also worked together, which drew us even closer. We were a great team: We published many articles, and our research yielded findings about and approaches to the assessment and treatment of older adults in medical rehabilitation settings.

We married on a sunny day in late September 1999. People rarely saw us when we weren't caught up in talking together. I was exposed to so much through Susan—the opera, old and new movies, and her favorite musicians. She was a loving stepmother. A decade passed, and in addition to Emily, we had a son and daughter together.

Levinson examined middle age in his book *The Seasons of a Man's Life*, and it is useful to apply his observations to my life with Susan and later my grief over Susan. The Dream remains a central thesis throughout a man's life span according to Levinson. In middle age, men often reexamine the dream; giving up on their idealism of youth especially in their careers. Men also become more psychologically minded, searching for meaning and take on more responsibility. In addition to forming and modifying the dream, there are changes related to family relationships and to occupation.

Finding Susan and developing our relationship was the resumption of my dream; the dream of a partner who was my best friend and most cherished individual, and the one I would turn to first in a crisis and vice versa. Not only did Susan and I work together in clinical work with older adults and research and teaching, but she was also my biggest supporter as I made the huge transition from a clinician/researcher position in a hospital to the Director of a

main campus Institute of Gerontology where the research ranged from basic social and behavioral gerontology to applied work and to policy. Instead of reappraising and contenting myself with more limited career goals, I found myself achieving goals and having professional opportunities I never dreamed of. I also found the joy in parenting with a beloved partner. My joy as a father was so heavily affected by the joy Susan took in parenting.

Living and Dying With Cancer

In the fall of 2009, Susan's oldest sister died, a mere 18 months after being diagnosed with breast cancer. When Susan relayed this news to her doctor, she ordered not only Susan's yearly mammogram but an ultrasound as well. Even though Susan's breast cancer had probably been growing for almost 2 years, no mammogram had detected it. Thus cancer, in the form of metastatic breast cancer, came into our lives suddenly, with a 5-cm tumor in one breast and a 3-cm tumor in the other—and almost no symptoms. Nearly half of all women have dense breast tissue, and the detection of cancer in dense breasts using routine mammography is only 27–30% successful. Despite having tumors in both breasts, as well as her bones and liver, it took an ultrasound to find it.

I could share many things about living your life while stage IV cancer takes its toll on a loved one. I am amazed at how much living we did during those 44 months. How we kept getting closer mentally, physically, and spiritually, and how little it mattered whether Susan had hair, or breasts. All that mattered was the bond that grew stronger and more resilient as Susan's body weakened and began to let go. How did I anticipate grief? Susan and I talked about her dying; and we felt that we had to live in two worlds; the living and the dying. We wanted to live as much as we could in the living world but that required us to do grief work. Susan told me how she wanted to die and what she was most frightened of. One day after her first chemo failed (she endured five different chemotherapies and much radiation too) I fell apart, sobbing into Susan's arms who told me "I am glad you are crying and let me comfort you now for I will not always be here." In these ways, we anticipated Susan's dying.

I also took part in a cancer support group in which each of us was a spouse of a Stage IV cancer patient. At times, the support group provided useful information and perspectives, and at times, it was a little too rosy and optimistic. Staying involved in the support group through the months led to forming important bonds with others who knew all too well the future we were facing.

Work was incredibly important to me through the years of Susan's illness and after her death. I was always trying to decide when the right time would be for a leave of absence but Susan encouraged me to work, and she stayed so physically well despite the treatments that I never did have a leave. I stopped traveling for work and that decision led me

to create, with Susan's involvement, a set of financial decision-making scales, the focus of my recent and future work.

Susan's death came quickly; her heart stopped on February 9, 2014, just 30hr after being hospitalized for some breathing problems. On February 22, 2014—44 months after Susan's cancer had been discovered—I stood at a pulpit before more than 300 people and delivered her eulogy. Toward the end of the eulogy I said "Susan was a cancer survivor," and for the first and only time during the eulogy I stopped, the tears right behind my eyes, and wondered whether I could go on. But after a moment they receded. Here is part of what I said: "Until very recently, if it wasn't for the loss of her hair, you would hardly know she was in treatment. We hiked regularly—6, 8, 10 miles at a time. She volunteered at school, and spoiled us at home. Susan's courage and strength were illustrated in a fall 2012 Free Press newspaper article along with her beautiful picture. She was inspiring to so many. She was inspiring to me."

Grief as a Developmental Process

Levinson's male adult development theory helped me understand my grief at 25 and 55. At 55, I had the experience and confidence to create the type of memorial service I wanted, not just for me but for my children. At 55, I was able to directly ask for and mobilize the support of others that I needed. I was able to capture my gratitude for truly "living the dream" and in my work Susan's influence continued. The biggest change at 55 was the change in my mentoring relationships. Before Susan's illness and later death, I prided myself on giving of myself as a mentor and not asking for much in return. After her death, my grief was so strong that my closest mentee from over 15 years before was one of the people I was most open with and turned to for support. I became more aware of the power of my needs for support and affection from mentees, and our conversations became less about strategic issues at work or the management of ambitions.

My Developmental Psychology colleagues impressed upon me over the years that you can only understand development through longitudinal study. My grief at 25 and 55 were not only the discrete experiences of a young man and a middle-aged man. Rather, the grief I experienced at 55 was shaped in part by the grief I experienced at 25. (Interestingly, Levinson's developmental discussion of men's lives did not continue into one's 50s.) From planning Susan's memorial service and giving her eulogy (which I decided to do a year prior to her death) to having friends stay with me for over 4 weeks after Susan died, to seeking out a writing course to help my healing and keeping Susan close to me throughout my grief, never letting go (but allowing her to become more and more a part of me like my arm and leg are), my grief was much healthier at 55. I did not become depressed, and although I was vulnerable, and a year after Susan's death found myself heading

toward a less than healthy dating relationship, I ended it and healing continued. Although I wish I could have saved Susan—as I wish I could have saved Becky—I did not suffer the guilt or self-blame and anger that I had when Becky died. My grief was certainly present, but it followed a more normative path (see [Neimeyer and Holland, 2015](#)).

I focused more on integrating my relationship with Susan into my current life instead of trying to let go (two-track theory). [Rubin \(1999\)](#) conceptualized the two-track theory as the mourner spending time on both one's biopsychosocial needs (eg, self-care and capacity for work) and time on one's ongoing relationship with the deceased. In this theory, there is a move away from letting go of the deceased and a move toward the ongoing relationship with the deceased as important and changing during the grief process. Another theory, the dual process model ([Stroebe and Schut, 2010](#)) distinguishes between activities that are loss oriented and those that are restoration oriented. In my case, I spent time attending to my grief and to current activities such as parenting, work, friendships (dual process theory), and I hired a writing coach and wrote for a year before deciding to pen my own narrative (meaning through narrative theory). I did not suffer any relapse of depression and functioned extremely well.

Grief and Gerontology

I turned to literature in three subfields of gerontology as they apply to clinical geropsychology to try to understand how the field understands loss and grief. [McFadden \(2015\)](#) highlighted the following in examining spirituality and religion:

As people age, they frequently experience threats to the meanings they've constructed over a lifetime. Vulnerability, limitation, and loss can shake the foundations of meaning and produce considerable suffering. Emotions signal whether the spiritual drive for meaning has been satisfied through a sense of connectedness with others and within the self. Certainly then, we can see grief and loss through the spirituality and religious lens as in part ways to understand and cope with loss.

[Hill \(2015\)](#) examined positive aging in relation to clinical issues. Key tenants include preserving subjective well-being in the face of decline. The task is to construe age-related transitions in a way that preserves psychological well-being while accepting unavoidable loss. Ingredients to accomplish this include gratitude, forgiveness, and altruism.

Finally, [Aldwin's \(2015\)](#) study of optimal aging examines resilience, an individual's capacity for flexible adaptation and wisdom, a focus on meaning. Taken together, one can see how the literature on grief and mental health, meaning making and narrative complement spirituality, positive and optimal aging. Does this help when one is confronted by grief and what lessons are to be shared with fellow gerontologists?

Lessons for Gerontology

I used Levinson's theory of adult development to understand my own life and perhaps it is through that lens that I can offer some lessons in gerontology. One theme in Levinson's work is that the focus on success and ambition earlier in one's career gives way to more realistic appraisal of one's knowledge and impact on the world. Gerontology as a modern field is completing middle age, and although the field has so much to offer, it also faces the same limitations found in middle adulthood. The field of gerontology was not powerful enough to lead to a comprehensive preparedness of society for the graying of America and much of the world. Our impact as a field is modest and we might do well to accept the humility that comes with such a realization and honest appraisal.

Gerontology would do well to seek even more input from older adults about research and implications of our results. In academic disciplines, there can be such disconnect between gerontology as beloved field and older adults themselves. Why does society in general and older adults in particular have a gloomier view of aging than do gerontology researchers? Death and dying, the personal experience of it, is likely one reason. I once served on a dissertation committee for a study on the super successful aging adults, the folks who were setting records in athletics, in business, and with their families. The doctoral student expressed his dismay during his defense that every one of his older adult heroes described their own decline, their thoughts of death, and their awareness of their own mortality. It might do us all well to remember that the specific problem we focus on and work to improve (eg, caregiving, frailty, self-regulation, cognitive training, and falling) occurs within a broader life; one that is filled with awareness of our own mortality no matter how hidden or unspoken it is. We might ask more often for the priorities our older adult participants focus on and how our work fits into their life priorities.

Gerontologists' knowledge is often not implemented in settings for death and dying. Despite knowing that preparedness is related to better outcomes, there is often a silence about death. As I sat in my support group and listened to others whose spouses had died from cancer, I observed two things: (1) Death, whenever or however it comes, is still a shock and an insult to most people. A 59-year-old widow bitterly complained about her husband's life being cheated since he was only 64 years old when he died and his father was still alive at 88. That her husband died was a shock and outrage to her. (2) Few people find a way to talk about impending death with their spouse. In my cancer support group, I was the only person who talked to their spouse about death even though all of the spouses had Stage IV cancer. I did it because Susan wanted to discuss it and encouraged us to revisit it. Part of why discussing death was taboo was the belief that to talk about death would be to give up on your spouse, to abandon them and abandon their hope. We have isolated death from the process of life.

There are a few more lessons for gerontologists and clinicians to learn. First, gerontologists must respect what they do not know firsthand. There is no way to duplicate how it feels to live with grief 24 hr a day, day in and day out for months or years on end. The constancy of stressful experiences like grief (or caregiving, chronic illness) is overlooked in the literature. There is a nuance to grief that is never captured in the types of “outcomes research” gerontologists focus on: Did the person recover or not? Function well or remain grief-stricken? Like most phenomenon, my experience is that these outcomes are on a continuum, and there is far more intra-individual variability than gerontologists conceive of. These were two huge, indescribable losses when Becky and Susan died. Coping with those losses never ends. I miss Becky still, 32 years later, and despite the extraordinary relationship I created with Susan. Recently, I attended a string concert in which my daughter Sophie, in fifth grade, and son Thomas, in ninth grade, were playing. From high up in the bleachers I could see both of them across from one another but far across the gym floor. This scene and thinking of how Susan would never see our children playing together for the first time brought feelings of intense grief, as if Susan was absent for the first time. Grief is never fully closed and there should be more recognition of this.

Finally, gerontologists and clinicians should be wary of those who have experienced grief giving advice or telling others how healing occurs. What does it really mean that our statistics relate one characteristic to an outcome? How much of an effect is there? And how crude are our measures? The heterogeneity of healing must be respected; none of us has the surefire answers. I know that I have coped better with my grief the second time around; the things that helped include experience with widowhood before, different inner and outer resources, and much more social support. Yet I know the feelings of grief still run deep when, for example, I yearn to put my arms around Susan and must accept there is simply an empty pillow next to me.

Gerontologists can be as death denying as any other group of professionals. When renowned psychologist Paul Baltes gave a lecture at Wayne State University several years ago, he cautioned against too much “happy gerontology,” the discourse of how wonderful aging is, and his belief that the challenges of aging were downplayed. I see that often in how we discuss research findings. The one that strikes me (and that I have been guilty of using too) is the phrase, “Mortality was predicted by” Isn’t it rather that shortened longevity was predicted by one variable or another? Mortality is best predicted by birth—for we will all die.

As gerontologists, we can strike a better balance between the opportunities in older age and the challenges. It can be difficult to find the right balance so as not to overwhelm or frighten people. Yet my experience as a clinician has taught me that there is almost no topic, including death and grief that cannot be introduced and discussed honestly if it is done with sensitivity and openness.

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