Title: Grief associated with the death of a partner

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Introduction
Current knowledge about bereavement has been derived from experiences of survivors in traditional societal roles of spouses, parent or child. Loss of a spouse/partner is recognized as one of the most stressful losses with the sense of loss intensified because the grief is not only for the person who has died but for the connection to the spouse, as well as for the bereaved person’s plans, hopes, and dreams for a future with the spouse/partner (Walter, 2003). Although all bereaved partners, whether hetero-sexual or homosexual, need to make sense of the loss and fit it into their assumptive world, to date most
research on bereaved spouses has emerged from the heterosexual community. The advent of AIDS in the 1980s witnessed a short-lived surge of research interest in the bereavement experience of the gay community (Murphy and Perry, 1988; Biller et al. 90; Okoneski, 1990; Lenon et al. 1990; Sowell et al, 1991; Neugebauer et al. 1992; Mc Gaffic et al. 1993; Wright and Coyle, 1996. It was evident from the aforementioned research that gay partner loss can be related to the literature on disenfranchised loss (Wallbank, 1992). As Shernoff (1998: 27) explains when a ‘gay man’s partner dies, his trauma is often exacerbated by the lack of mainstream culture’s recognition of his relationship, his loss, and his being a widower’. However, it is clear that not all bereaved gay partners experience disenfranchised grief. Unfortunately, the findings of the research carried out with the gay community at this time are limited in terms of generalisability to the wider gay community for a number of reasons, namely many participants were experiencing multiple losses leading to a chronic state of mourning; experiencing survivors’ guilt and because AIDS often afflicted young men whose life experience was limited in terms of emotions related to the meaning of life, sickness and death thus affecting their response to the loss. Indeed Ferrell (1992) believes that in AIDS related deaths, identification with the deceased is more intense and long lasting because of the survivors’ fear of developing the disease from exposure to the partner. However, there is a dearth of literature exploring the loss of a gay partner to a condition other than HIV related. Similarly, there is a severe lack of literature on lesbian women who have lost their partners through death. There loss is said to be particularly acute as lesbian women tend to establish relatively long term relationships. Indeed, lesbian women who have lost a partner are truly silent grievers (Walter, 2003). This paucity of empirical literature on the bereavement experience of members of the gay community means that palliative care practitioners have no ready source of information available to inform them of the specifics of how gay widows/widowers mourn and what is required for them to adjust to their bereaved state in an adaptive way. Palliative care professionals’ are thus compromised in their ability to provide evidence base care for this population. Given this aforementioned dearth of research and the growing awareness among all palliative care professionals of the needs of this population, the following aim is considered appropriate for exploration at this time.

**Aim:** To identify and describe the bereavement experience of gay/lesbian/bisexual persons following the death of their partner.

**Objectives:**
To discover what processes characterise the course of the bereavement experience of gay /lesbian/bisexual persons.
To determine the factors that influence the bereavement experience.
To explore the psychosocial issues related to the bereavement experiences of gay /lesbian/bisexual persons.
To explore what specific bereavement support structures are required for persons following the death of a same sex partner.
To discover the preferred nature of interventions that could be employed by palliative care professionals to assist the bereaved person.
To determine the perceived critical junctures in the course of the bereavement experience where interventions could be introduced to elicit maximum effect.
References: