Spousal Bereavement in Late Life

Deborah Carr

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Editors

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Edited by
DEBORAH CARR
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Dedication

To the women and men who participated in the "Changing Lives of Older Couples" study. They selflessly shared their concerns, fears, sorrows, and triumphs, so that we would have a richer understanding of late life bereavement.

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Camille B. Wortman (Ph.D.) is Professor of Psychology at the State University of New York at Stony Brook. She is head of the department's Social and Health Psychology Program. Her research focuses on bereavement, with a particular emphasis on how people react to the sudden, traumatic death of a loved one. She has received the Distinguished Scientific Award for an Early Career Contribution in Psychology from the American Psychological Association for this work.

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Foreword

Early in June 2002, I eagerly set off from Europe to attend a small conference/workshop at the University of Michigan in Ann Arbor, Michigan. I had been invited to participate in a meeting entitled "Changing Lives of Older Couples (CLOC): Exploring Bereavement among Older Adults." I knew that the CLOC study—on which this edited volume is based—was one of the largest investigations of its kind ever to have been conducted, incorporating features that make it not only ambitious but also methodologically sophisticated. Unlike nearly all previous investigations, the CLOC design was prospective: pre-bereavement data were available, to enable comparisons before and after spousal loss. The study also included carefully matched non-bereaved controls, a feature that was lacking in much of the earlier bereavement research. Furthermore, the study focused on couples. Previous work had typically focused only on the bereaved individual, failing to take relationship factors into account. In the absence of data from couples prior to the death, researchers were forced to rely on the bereaved person's memories of the deceased. Clearly, couple-related factors are critical in determining the course and consequences of bereavement.

Fascinating publications based on this study were already appearing with increasing frequency in the top academic journals back in 2002. However, the conference permitted the opportunity to learn much more, firsthand, about the whole project. Presentations by the team of scholars associated with the CLOC study provided fresh insights into cutting-edge issues in aging and bereavement. Then, with the guidance of the research team, participants were encouraged to initiate their own analyses of the CLOC data set during the conference week, delving into topics of personal interest. In fact, this summer workshop marked the public release of the data set, such that scholars from all over the world would have access to it. What better way for researchers to go about the collection and dissemination of scientific knowledge!

Understandably, having been introduced to the CLOC study in this manner, I have kept closely in touch with further developments. It is my sense that the publication of this volume, *Spousal Bereavement in Late Life,* edited by Deborah Carr, Randolph Nesse, and Camille Wortman, marks a "coming of age" of the

project itself. The volume is timely and comprehensive. It fills an enormous gap in the scientific literature.

This project raises the standard in the field, with respect to methodological rigor in the study of bereavement experiences among the elderly. For example, previous research has frequently made only superficial comparisons between samples of older and younger bereaved persons with respect to adaptation. Many researchers concluded from such research that younger persons are actually at greater risk, resulting in a diminished attention to the unique nature and context of bereavement in later life. Research also failed to keep up with changing social contexts and cohort differences likely to influence what it means to become widowed in later life in contemporary society. For example, late life is a time when the loss of loved ones becomes a more frequent event, causing multiple occasions for grief, each of which can diminish one's emotional and social network, increasing risk for emotional and health problems, financial difficulties, and so on. At the same time, despite their loss experiences, many older bereaved persons emerge as resourceful and adapt well to their changed circumstances.

In conclusion, this volume provides insightful analysis and—unusually—theoretical interpretation of factors that contribute to a range of adjustment patterns among bereaved persons in late life. It places the experience of widowhood in late life squarely within the context of contemporary society and explores a remarkable range of associated issues. The volume is destined to become a classic; it will set the standard for future empirical investigation of the experience of bereavement among older adults.

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Preface

Why do people grieve the loss of a spouse? How long does their grief last? What, if anything, is wrong with those who experience little or no grief after their long-time spouse has died? Can widows and widowers—even those in their 70s, 80s, and older—experience personal growth and take on new challenges after their spouses die? What about those who were highly dependent on their late spouses? How will they manage alone, after years of relying on their spouse? Does *how* one's spouse died matter for older adults' adjustment? How important is social support for older bereaved spouses? Can friends and children fill the social and emotional void left by the death of one's spouse?

Spousal Bereavement in Late Life is an attempt to answer these and many other questions about the distinctive experiences of older bereaved spouses in the United States today. This volume was born when three social scientists from very different walks of life: a social demographer, a social psychologist, and a psychiatrist with expertise in evolutionary medicine, discovered that a one-of-a-kind data set, the Changing Lives of Older Couples (CLOC) study, might just provide some answers to their ever growing list of questions about bereavement. But the aim of this volume is to do more than simply answer empirical questions about grief. Rather, we hoped to push forward new theoretical perspectives on grief and loss. We wanted to revisit widely-accepted theories of grief and bereavement, and ask whether they can really be substantiated with rigorous empirical analysis. And, we wanted to move beyond theories and statistics. We hoped to offer practical information for women and men on the front lines; the social workers, clinical psychologists, clergy persons, grief counselors, hospice workers, and the many others who counsel and provide important social services to bereaved older adults. We hope that we have succeeded in these aims.

Specifically, the volume has three innovative themes. First, we maintain that late-life (age 65+) widowhood is the most common form of spousal loss, yet most theories of bereavement do not take into consideration the unique risk factors and resources of the elderly. Second, we argue that widowhood is being re-invented in the 21st century. Demographic shifts and advances in medical technologies have changed the way that older adults live and die;

widowhood today happens largely to women, and happens at the end of a long period of spousal illness (and accompanying caregiving demands). Sweeping changes in family and gender roles over the past five decades mean that what is lost upon widowhood has changed for recent cohorts of bereaved adults. Third, we suggest that therapies, policies, and practices to help the older bereaved must be based on empirically sound state-of-the-art research findings, and we provide advice to practitioners based on the research findings uncovered in our analyses.

The book's chapters provide a comprehensive portrait of late-life widowhood in the United States. The chapter authors document the social, psychological, and economic consequences of late-life spousal loss, and identify the factors that protect against (or that increase one's susceptibility to) the stressors associated with widowhood. Most chapters present new research findings, based on sophisticated research methods and a unique data set—the CLOC—which allow us to avoid many of the methodological pitfalls of past studies. We were fortunate to have assembled a stellar group of authors representing a broad array of academic and professional disciplines; each shares his or her own distinctive perspective on the challenges and triumphs of older bereaved spouses in the United States today.

We recognize that *Spousal Bereavement in Late Life* is not the final word on the ways that older adults mourn the loss of their spouse. In fact, our wish is that this volume sparks new research and triggers new questions about older widows and widowers. Important technological, economic, demographic, and cultural developments in the 21st century will once again reshape the experiences of marriage and widowhood, living and dying. We hope that the ideas presented in this volume inspire new empirical investigations and theoretical innovations in the coming decades.

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INTRODUCTION

A History of the Changing Lives of Older Couples Study

Randolph M. Nesse, Camille B. Wortman, and James S. House

The Changing Lives of Older Couples (CLOC) study is now entering its third decade and fifth life stage. The study was born out of a collaboration initiated by Camille Wortman, Ronald Kessler, and James House in the mid-1980s. Phase two was the collection of data for the CLOC, one of the largest prospective studies of grief ever undertaken. Phase three involved assembling a research team and securing funding for the first substantial analyses of a large complex data set. This edited volume—a collection of studies and essays based on these analyses of the CLOC data—represents the fourth stage in the study's history. We hope that this book will inspire an enduring fifth stage, in which researchers from all over the world use this one-of-a-kind data resource to answer important questions about spousal bereavement in late life. We also hope that this brief history of the CLOC study will provide readers with an informative glimpse into the motivation for and content of the study, as well as an understanding of the challenges of making such a study possible.

STUDY ORIGINS

The CLOC study was initiated by psychologist Camille Wortman in collaboration with sociologists Ronald Kessler and James House. Wortman has conducted a comprehensive program of research on bereavement for nearly

two decades (e.g., Wortman & Silver, 1989, 2001). Wortman's research was and continues to be guided by two overarching goals: to delineate the processes through which people come to terms with the loss of a loved one, and to clarify the theoretical mechanisms through which loss events can have deleterious effects on mental and physical health (Kessler, Price, & Wortman, 1985). This research program was guided initially by three theoretical models: classic psychodynamic models of bereavement; the "stage models" of grief, both of which have had a profound influence on the ways the grief process is understood; and the stress and coping approach, which has been influential in the study of life events more generally.

In the late 1970s, Wortman and her collaborators initiated a program of research designed to clarify the processes of coping with loss. Over the next decade, they completed several studies focusing on distinct subpopulations who had endured particular types of loss such as the loss of an infant from Sudden Infant Death Syndrome (SIDS) (Downey, Silver, & Wortman, 1990), or the loss of a spouse or child in a motor vehicle accident (e.g., Lehman, Wortman, & Williams, 1987).

As their data accumulated, Wortman and colleagues discovered that their findings were not consistent with what most classic theoretical models would have predicted: an inevitable period of distress following loss. Wortman and her colleagues' data showed that a substantial percentage of bereaved persons did not seem to experience intense distress following a loss. These seemingly counterintuitive results prompted myriad questions. For instance, could a lack of grief symptoms be indicative of denial or a lack of meaningful attachment to the deceased? Would bereaved persons who showed little distress initially go on to experience "delayed grief," as psychodynamic models would suggest? Further analyses led to the answer "no"; bereaved persons who were doing well initially also continued to fare well at subsequent time points (see Wortman & Silver, 2001 for a review).

These early studies also hinted that the process of "grief resolution" might unfold very differently than classic psychodynamic or "stage models" would have predicted. Data from these studies cast doubt on the belief that most survivors gradually come to terms with the loss. In the motor vehicle study, for example, approximately 70% of the respondents were unable to make sense out of the loss, even after a period of several years. Further, if people were going to be able to resolve what had happened, they did so within the first few weeks following the loss. The major research question that emerged from these studies was quite simple: Who are those people who go through a major loss unscathed? It became increasingly clear to

Wortman and her colleagues that a study beginning after the loss could not adequately address such a question. Only a prospective study could both identify the precursors of one's psychological adjustment to loss, and one's ultimate adjustment to loss (Osterweis, Solomon, & Green, 1984). The prospect of carrying out such a study was daunting, however. Such a project would entail conducting interviews with thousands of people, and then following them long enough into the future so that a sizeable proportion would become bereaved, thus yielding a sufficient sample of bereaved individuals to interview further.

THE AMERICANS' CHANGING LIVES (ACL) STUDY

While Wortman was wrestling with how to conduct a prospective study of bereavement, she was invited by two colleagues from the University of Michigan's Institute for Social Research (ISR), Robert Kahn and James House, to participate in the design of a large national study of health and well-being. Kahn, a psychologist, is widely recognized as one of the world's leading experts on healthy aging (e.g., Rowe & Kahn, 1998). House, a sociologist, had been conducting research for nearly two decades on the impact of social stress and social relationships on health (e.g., House, 1981; House, Landis, & Umberson, 1988). In response to the National Institute on Aging's (NIA) growing interest in the role of psychosocial factors in the maintenance of health and effective functioning in middle and later life, Kahn and House brought together an interdisciplinary group of scholars at ISR who had overlapping research interests: psychologists Toni Antonucci, Regula Herzog, and James Jackson; sociologist Ronald Kessler; biostatisticians Graham Kalton and James Lepkowski; and economist James Morgan. Kessler, in particular, shared with Wortman and House a long-standing interest in the impact of and adaptation to stressful life events, and a recognition of the need for further prospective study of these issues (Kessler et al., 1985).

This team of researchers designed a large-scale study of stress, health, and adaptation across the life span called Americans' Changing Lives (ACL), and obtained a Program Project grant (PO1 AG05561-01, James S. House, Principal Investigator) from the National Institute on Aging (NIA) to support two initial waves of data collection. The ACL is a large, nationally representative sample of 3,617 Americans aged 25 and over (with oversampling of African Americans and persons aged 60 and over) who were first interviewed face-to-face in 1986, with 2,967 survivors re-interviewed in 1989.

Subsequent grants from NIA have funded follow-up interviews in 1994 and 2001–2002.[1]

Teams of investigators designed four research projects, each of whom would use the core ACL dataset to address questions in their area of interest and expertise. Wortman, in collaboration with Kessler and House, designed a component which focused on widowhood. From Wortman's perspective, one of the most intriguing aspects of the ACL study was the opportunity it provided to conduct a truly prospective study of widowhood, since it involved interviewing thousands of people and following them over time. The challenges inherent in designing such a study and analyzing the data were daunting to Wortman, who had never before been involved in such a large-scale project. She approached Ron Kessler, who shared her interest in understanding the impact of stress on health and functioning, and whose talents in research design and analysis were legendary. Although Kessler did not have a particular interest in bereavement, he was excited about the prospect of studying stress and coping processes using a truly prospective design.

Wortman and Kessler obtained funding within the overall Program Project grant to conduct a national bereavement study using the ACL database; their study would have both a cross-sectional and a prospective, longitudinal component. The cross-sectional component involved studying the 800 participants from the original ACL study who had lost a spouse anywhere from a few months to 60 years prior to interview (e.g., Umberson, Wortman, & Kessler, 1992). For the prospective component, they proposed to monitor death records among the ACL respondents, and to conduct interviews with an estimated 150 to 200 persons who would become widowed during the course of the study. Specifically, they planned to re-contact the bereaved ACL respondents 6, 13, and 18 months following their loss.

This proposed procedure was feasible for some states including Michigan, where centralized death records were readily available. In other states, however, the study investigators would need to monitor deaths on a county-by-county basis, making the national prospective design impossible to conduct at a reasonable cost. Kessler, in consultation with Wortman and House, then proposed an ingenious way to study bereaved persons prospectively, using

[1]In 1994 and 2001–20002, 2,562 and 1,788, respectively, of the surviving respondents from the original group of 3,617 interviewed in 1986 participated in follow-up interviews. The current ACL research team hopes to extend the data collection to a fifth wave in 2007–2009. All data from the ACL survey are being deposited with the Inter-University Consortium for Political and Social Research (ICPSR), with the first three waves now available and the fourth expected to become available in 2006.

funds available in the Program Project grant. The proposed design involved reallocating the financial resources budgeted for the prospective widowhood component of the ACL towards a brand new sample of older adults in the Detroit area. By conducting initial baseline interviews with married couples in which the husband is 65 or older, the research team could accrue an adequate sample of older bereaved respondents in just a few years from a reasonable number of baseline interviews. If the study began with a sample of older adults, and oversampled older women who are at greatest risk of losing their spouses, then the likelihood was high that sample members would become bereaved in the relatively near future. Because the study would focus on the Detroit area only, the researchers could monitor spousal loss in an effective and timely fashion. From this innovative new design, the Changing Lives of Older Couples (CLOC) study was born. NIA project officer Dr. Ron Abeles enthusiastically provided approval that allowed the project to move forward.

THE CHANGING LIVES OF OLDER COUPLES (CLOC) STUDY

The proposed CLOC study had many strengths and could achieve many goals that might not have been accomplished with the earlier study design. First, ISR had a large and very capable interviewing staff already available in the Detroit area. Second, the investigators could design a new baseline interview that more fully targeted their own research questions about spousal bereavement, while retaining sufficient overlap with ACL and its cross-sectional study of widowhood. As a result, the CLOC study included a more thorough and comprehensive assessment of many constructs related to coping with loss, including pre-loss indicators of spouse's health, the role the spouse plays in the performance of household tasks, and the nature and quality of the marriage. Other expanded areas in the new baseline survey included personality factors, religious beliefs, attitudes toward death, and worldviews. Important outcome indicators for studying grief, such as depression, anxiety, and positive indicators of psychological well-being, were also expanded in the CLOC study. In the follow-up interviews, held 6, 18, and 48 months after a study participant's spouse died, the investigators made an effort to carefully assess grief and a number of related constructs including indications of continuing attachment, grief behaviors such as crying, and indicators of "working through" the loss (e.g., frequency of thoughts and conversations about the deceased).

Another strength of this design was the collection of data from married "matched controls" at the follow-up interviews. Bereaved spouses were "matched" with still-married persons of the same age, race, and sex in the

CLOC sample. The married controls were re-interviewed at approximately the same time as their widowed "match," thus enabling researchers to compare bereaved and non-bereaved persons, and hence better ascertain the effect of widowhood on health and well-being outcomes.

During this period, Kahn and House worked with John W. Rowe, leader of the MacArthur Foundation's Research Network on Successful Aging, of which Kahn was a member, to obtain funding through the MacArthur Network to collect additional data on biomedical, physical, and cognitive functioning for a subset of the CLOC sample. The resulting component, called the MacBat study, involved a separate biomedical assessment among sample members who were ages 70 and older. This assessment included measures of cognitive functioning, mobility, and blood pressure; blood and urine samples also were obtained. Assessments were done at baseline, and at 6 and 18 months post-loss for respondents who became widowed and their corresponding matched controls. These data would allow investigators to explore important questions about physiological, physical, and cognitive changes following the stress of spousal loss.

The collaborative process of designing the interview schedules and collecting the data was satisfying, moving, and exhausting. The process involved working out arrangements with the State of Michigan to identify widows by matching study participants and their spouses to death records; and developing seven different interview schedules—the baseline interview, and widowed and control schedules for the 6-month, 18-month, and 48-month follow-up interviews. The investigators also had to develop procedures for collecting the biomedical assessments. Each of the interview schedules was pre-tested at least twice and revised based on the feedback received during the pre-tests. The complexities of the project presented the investigators with seemingly endless design challenges, which Kessler particularly handled with great skill.

The overall quality of the data set was augmented by two groups of contributors. First, Wortman and Kessler set up an advisory panel of experts on bereavement who provided guidance on such issues as how to maximize response rate and how to assess key constructs. This panel included Drs. Gay Kitson, Arthur Schulman, Mary Vachon, and Robert Weiss. They also set up an advisory council of bereaved individuals who served as informal advisors to the project. Input from the council was invaluable in developing the procedures and measures for the study. For example, the council members prepared a letter endorsing the study, which was sent to potential respondents along with the letter that was sent from ISR. They were asked

to read and comment on the interview schedules and to identify questions on which wording was unclear, or where it was potentially offensive or upsetting.

The research and design team held frequent meetings to support interviewer morale, wrote respondent newsletters and thank you letters, and initiated a variety of other activities to maintain the quality of the sample. During the course of the study, new and challenging problems arose regularly. For instance, the State of Michigan stopped sending death tapes for three months, so an army of undergraduates were hired to scan the obituary pages in dozens of local newspapers. Other difficulties were posed by funding issues. Repeated and inescapable budget cuts made it almost impossible for investigators to fully carry out their data collection plans. The investigators spent enormous amounts of time writing letters to reinstate the budget and to obtain supplemental funding. Some important aspects of the project had to be eliminated, including proposed telephone interviews with two members of the bereaved person's support network. The planned 1,800 baseline interviews were cut back to just over 1,500 and funds for interviewing control respondents at the 6-month follow-up were slashed.

Wortman and Kessler knew they would not be able to complete all waves of data collection for the CLOC project before the end of the ACL collaborative grant. They submitted a grant proposal to NIA in 1990 requesting 5 years of support for the CLOC project; 3 years for data collection and 2 years for analysis. House and James Lepkowski, a biostatistician, were also collaborators on the new grant. Lepkowski's strong skills in statistics and in organizing and managing large data sets were essential to the project's success. The NIA review panel offered high praise for the CLOC study, calling it "the most comprehensive assessment of conjugal bereavement to date." But funding was provided only for the three years of data collection, not for the two additional years it would take to analyze the data.

Shortly before this new proposal was submitted, however, Wortman was invited to head the Graduate Training Program in Social and Health Psychology at the State University of New York at Stony Brook. She accepted the new position, but negotiated with her new employer so that she could take frequent trips back to Michigan. Upon Wortman's departure to Stony Brook, House and Lepkowski agreed to take responsibility for day-to-day operations of the fieldwork and data processing. The last interview was completed in June of 1994, with all laboratory analyses completed and all data coded and entered by August 1995. The initial process of cleaning the data, constructing variables, imputing missing values, creating indices, and constructing a user-friendly

data file started shortly thereafter. Lepkowski coordinated the initial management and analyses of the CLOC data and supervised the staff members who produced the original study documentation. A description of the final CLOC data and design is provided by Carr in chapter 2 of this volume.

THE PRIMARY DATA ANALYSIS

By the time the CLOC data were ready for analysis, Wortman had relocated to Stony Brook, Kessler had moved to Harvard University, and House had become director of the Survey Research Center at ISR. The logical next step was to apply for additional funding to move forward with data analysis, but with the original investigators absorbed with new responsibilities and duties, it was difficult to launch this next effort. A new team of researchers and collaborators were about to enter the picture, however, and would go on to work with Wortman and House on empirical studies based on the CLOC.

In 1996, Randolph Nesse began work at ISR after 2 decades on the faculty in Psychiatry at University of Michigan. When House, as SRC director, asked him what project he would want to do if he could do anything he wished, Nesse said that he wanted to understand the evolutionary origins and functions of grief. He believed that the best way to achieve this aim was not to study only those bereaved individuals who expressed grief, but also to study those who did *not,* and to identify for the latter what deficits they might have experienced in their relationships before and after the loss. House, with a sly smile on his face, asked, "What would you say if I told you that just such a study has already been done, and the data are all in a database just waiting to be analyzed?" Nesse replied, "That would be unbelievably good luck." Indeed, it was, from both perspectives. With enormous help from House, Wortman, Kessler, and Lepkowski, and a small grant from the Pritzker Foundation, Nesse was able to organize a research group to begin preliminary analyses of the CLOC data.

With Nesse at the helm, the newly assembled research team of faculty, post-doctoral fellows, and graduate students began to conduct preliminary analyses of the data. As they began their analyses, they had myriad questions about the structure and content of the data. The research team began to construct a frequently asked questions (FAQ) file, to record answers to the questions that arose repeatedly, an exercise eventually posted on the project's website—to the benefit of many future data users. One of the most important accomplishments during the early days of the data preparation and analysis phase was the receipt of a grant from the NIA, awarded to Nesse, with Wortman, House, and ISR sociologist Deborah Carr as co-investigators. This cru-

cial grant allowed Nesse, Wortman, and their collaborators to move forward with analysis and data dissemination.

Many ISR faculty members contributed to these efforts, including Deborah Carr (now at Rutgers University), Jim House, and Amiram Vinokur. The role of Carr, a young sociologist, was critically important. She brought extraordinary conceptual skill and analytic sophistication, along with energy and productivity that inspired the entire group. The research team held a weekly research meeting which involved an invigorating exchange of ideas about grief and bereavement. Carr, House, and Nesse provided advice to graduate students who made excellent use of the data to advance what we know about bereavement among older Americans. Post-doctoral fellows Stephanie Brown, Daniel Kruger, and John Sonnega, and graduate students Jung-Hwa Ha and Rebecca Utz also played an important role in doing early analyses of the CLOC data. Utz took on another critical role; she organized a summer workshop to introduce researchers from throughout the United States and Europe to the CLOC data. The team also expanded to include esteemed researchers from outside of ISR. To the great benefit of the project, Camille Wortman invited George Bonanno, an experienced and respected grief researcher from Columbia University, to join the group as an advisor and collaborator.

Disseminating the data to the larger academic community was the final step in a very long and tedious preparation process, spanning nearly three years. During that time, members of the research team continued the process of cleaning and coding the data, merged respondent and spouse files, constructed code books, and did dozens of other tasks to make the data user-friendly upon public release. The group gradually came to be in awe at what Jim Lepkowski and his team had accomplished as they prepared the initial data. Mike Shove and Peter Granda provided a crucial liaison with the Inter-university Consortium for Political and Social Research (ICPSR), where the data were prepared for dissemination to researchers worldwide. The CLOC summer workshop, held in Ann Arbor, Michigan, in 2002, was an important turning point in the project's history. Internationally renowned scholars of grief and bereavement including Robert Neimeyer and Margaret Stroebe joined a group of researchers and students from around the world for a week of intensive analysis of CLOC data. This workshop also marked the official "release" of the CLOC data to the wider academic community.

Social Bereavement in Late Life

Both the weekly meetings of the Michigan-based CLOC research team and the discussions and debates held at the Summer 2002 CLOC summer

workshop made it clear that the CLOC data were well-suited to address important yet unresolved questions about late life spousal loss and grief. Deborah Carr believed that the original CLOC researchers and their rapidly growing circle of collaborators and affiliates could provide important answers to these questions. She proposed that the team members produce a monograph using the CLOC study as the basis for an overview of new research on bereavement in older Americans. The envisioned goal of this book was to familiarize researchers with the CLOC data set, and also to help the CLOC research team to share their ideas with others scholars and practitioners who work with older bereaved spouses. Nesse and Wortman agreed that this was a wonderful idea, but counseled that such an enterprise would consume huge amounts of time. Carr pushed on ahead, organized the chapters, invited the authors, negotiated with the publisher, and cheerfully but persistently did all the onerous things one needs to do to get researchers to contribute their chapters on time. She coordinated the process of critique, obtained comments from co-editors Nesse and Wortman on selected chapters, and then edited each and every chapter herself again. This book exists thanks to her vision and energy. It is not, however, a conclusion, but a beginning of the next phase of a long-lived project. We hope that this volume will not only provide up-to-date information about CLOC analyses conducted thus far, but will also encourage more scientists to use the CLOC data to pursue their own studies of bereavement in elderly spouses. If some do, this book will have been well worth the effort.

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Part I

Studying Bereavement: Methodological Innovations and Contextual Influences

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CHAPTER 1

Understanding Late Life Widowhood

New Directions in Research, Theory, and Practice

Deborah Carr, Camille B. Wortman, and Randolph M. Nesse

Research on death, dying, and bereavement has flourished in the past decade (Bryant, 2003). The U.S. population is older than ever before, and scholars, practitioners, and laypersons need to understand how to best meet the challenges facing older widows and widowers. More than 900,000 adults are widowed each year in the United States, and nearly three-quarters of them are over the age of 65 (Federal Interagency Forum on Aging-Related Statistics, 2004; Moss, Moss, & Hansson, 2001). Given both the high prevalence and emotional impact of spousal loss, it's not surprising that social scientists and medical researchers have devoted tireless efforts to finding answers to their questions on spousal bereavement and grief.

More than 5,000 articles on grief and bereavement have been published in the past 10 years, so researchers and practitioners now have a thorough understanding of the short-term emotional consequences of spousal loss. Scholars also have identified important risk and resilience factors, including gender, social support, and preexisting mental health problems; these research findings help practitioners to distinguish among those persons who will experience relatively few psychological symptoms and those who will be devastated by the death of their spouse. We also now know that most people are resilient following a loss, and that interventions are often unnecessary and may even worsen the psychological consequences of widowhood.

Despite this progress, fundamental questions about the experiences of older bereaved spouses remain unanswered. Why does grief arise after the loss of a spouse? What, if anything, is wrong with those who experience little or no grief? What kinds of initial responses to the loss of a spouse are most likely to portend subsequent difficulties? Is grief best thought of as a temporary upheaval that lasts for a year or two, or does it instead lead to enduring changes in outlook or personality? How common is it for people to show personal growth following the loss of a spouse, and under what conditions is this growth most likely to occur? Will individuals involved in a long period of caregiving for their spouse experience more grief and distress than those who are not involved in caregiving? Or will such losses be easier for them to bear? How does grief interact with other age-related changes such as chronic illness or disability? What brings about the resolution of grief? Is it the passage of time that heals, or certain processes or events that occur during this time? What interventions best help older bereaved spouses, and which ones might cause harm? The answers to these questions remain unresolved not due to a lack of effort, but rather because answers require longitudinal data that are not often available to researchers.

As noted in the Introduction ["A History of the Changing Lives of Older Couples (CLOC) Study"], social scientists Camille B. Wortman and Ronald Kessler set out nearly 20 years ago to gather prospective data that would answer a vast array of questions about the bereavement experience in late life. Soon joined by James S. House and James Lepkowski, the team accomplished their aim. The resulting CLOC study offers extensive prospective data on a large sample of older bereaved spouses and matched controls, and tracks bereaved spouses for up to four years following their loss. The CLOC data are now publicly available for all scholars to use; new and cutting edge analyses of the CLOC data provide the foundation for this volume.

AIMS OF THE VOLUME

Since its inception, the CLOC project has been truly interdisciplinary, bringing together sociologists, social and clinical psychologists, psychiatrists, and experts in quantitative research methodologies to conduct innovative and methodologically rigorous research on bereavement. This edited volume continues and extends that tradition. Our aim was to bring together scholars working in diverse disciplines, and with non-overlapping yet complementary research interests and agendas. We also sought to merge three often disparate areas of scholarship—theory, research, and practice—in order to produce a volume that would be valuable to researchers and

practitioners from many disciplines. Each of the authors contributing to this volume shares our belief that advancements in theory, research, and practice are mutually dependent and that advances in one domain cannot occur without strides in the other two.

For example, many clinical interventions targeted toward bereaved individuals today are based loosely on psychoanalytic models of grief (e.g., Adler, 1943; Freud, 1917/1957; Lindemann, 1944). According to this perspective, in order for bereaved persons to adjust psychologically to loss, they must confront and review their thoughts and feelings about the deceased. This process, referred to by Freud as the "work of mourning," is viewed as painful and as requiring considerable time and energy. In contrast, attempts to keep thoughts of the deceased loved one out of mind through avoidance, distraction, or the use of prescription drugs, are believed to delay the onset of painful symptoms. Failure to experience grief was traditionally viewed as a sign of one's denial, lack of attachment, or emotional immaturity. Conversely, persons who experience the most difficult or "chronic" grief were believed to have had an ambivalent or conflictual relationship with the deceased. This psychoanalytic view of the grieving process has dominated the bereavement literature for much of the past century, and has only recently been called into question (Bonanno & Kaltman, 1999; Stroebe, 1992–1993; Wortman & Silver, 1989, 2001). For example, empirical studies based on CLOC reveal that persons who had negative or ambivalent relationships with their late spouse experience less rather than more severe grief symptoms (Carr et al., 2000), and that "absent" grief is a normative rather than a pathological response to loss (Bonanno et al., 2002). These empirical findings may help to refine both theoretical approaches and practical interventions targeting grief.

The chapters in this volume are guided by three overarching themes. First, we argue that late life (age 65+) widowhood is the most common form of spousal loss, yet most theories of bereavement do not take into consideration the special risk factors and resources of the elderly. Second, we maintain that the widowhood experience has been transformed over the past century. Demographic shifts and advances in medical technologies have changed the way that older adults live and die; spousal loss today happens largely to women, and happens typically at the end of a long period of spousal illness (often with accompanying caregiving demands). At the same time, sweeping changes in gendered social roles over the past 50 years continue to alter the way that widowhood is experienced. For example, the ways that husbands and wives allocate household and financial responsibilities has important implications for how they manage daily life after spousal loss. Finally, we argue that therapies, policies, and practices to help the older bereaved must be

based on empirically sound state-of-the-art research findings. Many current practices designed to assist the grief-stricken are based on dated theoretical models that have not withstood empirical scrutiny. We suggest that rigorous empirical research is a necessary prerequisite for the development and refinement of theories; these newly refined theories of bereavement, in turn, are critical for the establishment and implementation of effective practices to help the bereaved.

Taken together, the book's chapters provide a comprehensive portrait of late life widowhood in the United States today. Specifically, the authors document the social, psychological, and economic consequences of late life spousal loss, and they identify the factors that protect against (or that increase one's susceptibility to) the stressors associated with widowhood. We present new research findings, based on a unique data set—the CLOC—which allow us to avoid many of the methodological challenges of past studies. Finally, we suggest specific ways that findings from recent scientific studies might guide the development and refinement of therapies, policies, and practices targeted specifically toward bereaved older spouses.

The chapters in this volume are presented in four parts. Part I provides an overview of the methodological challenges facing bereavement researchers and offers a sociohistorical context for understanding the distinctive experiences of older widows and widowers in the United States in the late 20th and early 21st centuries. Part II focuses on the personal consequences of spousal loss, and illustrates the diverse ways that spousal loss affects the psychological, physical, social, spiritual, and economic well-being of older widows and widowers. Part III proposes innovative new theoretical frameworks for understanding late life grief and bereavement. Finally, Part IV weaves together theory, data, and practice and suggests ways that new empirical findings on spousal bereavement—generated from the CLOC study as well as other large-scale studies—can be used to inform both therapeutic interventions and public policies.

CHAPTER SUMMARIES

Studying Bereavement: Methodological Innovations and Contextual Influences

"Methodological Issues in Studying Late Life Bereavement" by Deborah Carr (chapter 2) provides a comprehensive overview of methods used to study spousal loss, and discusses the reasons why studies of late life spousal loss often offer equivocal or conflicting findings. Carr's chapter begins with a discussion of the strengths and weaknesses of commonly used data sources for

the study of bereavement, including help-seeking, bereaved, and community samples. She then elaborates the reasons why findings obtained from cross-sectional and self-selected samples may offer an incomplete or inaccurate characterization of the bereavement experience. She also points out the advantages of using large-scale, random sample, prospective, and longitudinal data sets for exploring the short- and longer-term consequences of spousal loss. The most important contribution of the chapter, however, is Carr's discussion of the ways that methodological innovations—including the use of multi-wave prospective data, and the consideration of a broad array of outcome, mediator, and moderator variables—foster theoretical developments and refinements. For example, she argues that subgroup differences in the bereavement experience, such as gender differences, may be "masked" in studies that fail to consider a broad array of bereavement outcomes, or that fail to consider the distinctive pathways that link spousal loss to distress (or resilience) for widows and widowers.

The chapter concludes with an overview of the content and structure of the CLOC study and a discussion of how the unique design of the CLOC makes it an ideal data set for exploring the long-term consequences of spousal loss. For example, one of the most difficult challenges facing bereavement researchers is causal inference. Cross-sectional studies often cannot ascertain whether spousal loss causes distress, or whether distressed persons are more likely to become widowed due in part to earlier stressors and adversities. Moreover, studies based on single point in time observations cannot ascertain whether the quality of a spouse's death or the quality of a couple's marriage affects adjustment to loss, or whether one's psychological state following loss affects one's recollections and reconstructions of their late marriages. The CLOC data set is designed expressly to address these methodological challenges; Carr offers myriad examples of the research questions that can be addressed effectively using the multi-wave, quasi-experimental CLOC data.

A guiding assumption of this volume is that social, cultural, technological, and historical contexts influence how, when, and where older adults die; these contextual factors, in turn, shape the experience of bereavement. In "How Older Americans Die Today: Implications for Surviving Spouses" (chapter 3), Deborah Carr, Camille B. Wortman, and Karin Wolff argue that the widowhood experience has been transformed in the 20th century. Death today is a slowly unfolding process: death typically strikes older adults and often occurs at the end of a long, distressing, and debilitating illness. The transition from "spouse" to "widow(er)" is gradual rather than sudden, and the transition often is accompanied by difficult caregiving responsibilities, and wrenching decisions about the type, site, and intrusiveness of end-of-life

medical care that one's spouse receives, as well as painful moments of watching one's long-suffering spouse battle physical pain, cognitive impairment, and anxiety. During this difficult time, the caregiving spouses also may neglect their own physical health symptoms or psychosocial needs. The authors argue that the stressors experienced during the days and weeks preceding the death may have critically important implications for older adults, both before and after their spouse dies.

This chapter provides an in-depth review of classic and cutting-edge studies on death context and its implications for widows' and widowers' well-being. The chapter opens with a historical overview of how cultural practices surrounding death and the epidemiology of death have changed over the past 3 centuries. The authors then focus on four specific influences on widows' and widowers' adjustment to loss: whether the death was sudden or anticipated, the extent to which the surviving spouse provided care, the place of the death, and the quality of care received by the dying spouse at the end of his or her life.

Studies of death forewarning and survivor well-being date back to the classic Coconut Grove studies, where Lindemann (1944) concluded that sudden death is the most distressing death because it robs survivors of their final moments with their loved one. Anticipated deaths were long considered less distressing, because they offer individuals the opportunity to achieve closure and to resolve emotional "unfinished business" with their dying spouse (Blauner, 1966). Carr and colleagues point out that the forewarning period also may be filled with difficult strains—particularly for older adults—and these strains may compound the harmful impact of spousal loss. The authors highlight the complex and often surprising ways that caregiving strain affects surviving spouses, including the potentially beneficial impact of caregiving for grieving spouses. They also describe the ways that innovative approaches to end-of-life care, including hospice, may benefit bereaved spouses as well as the dying patients. The chapter concludes with recommendations for caregiver services and advances in end-of-life health care that may protect against physical and emotional strain among bereaved older spouses.

Personal Consequences of Spousal Loss

Spousal loss has long been considered one of the most distressing events that older adults will experience (Holmes & Rahe, 1967), yet recent research counters that widowhood is not universally distressing. Bereavement researchers have moved away from asking *whether* widowhood is distressing, and instead ask *for whom* and *for how long* is spousal bereavement distressing? Answer-

ing these questions is a daunting task, given the proliferation of research on bereavement throughout the past four decades. Karin Wolff and Camille B. Wortman offer a detailed and integrative answer to such questions in their chapter "Psychological Consequences of Spousal Loss Among Older Adults: Understanding the Diversity of Responses" (chapter 4). Wolff and Wortman take as their point of departure the observation that some older adults exhibit intense and prolonged distress following the loss of their spouse, while others manifest remarkable resilience. They provide a nuanced discussion of the individual, intrapersonal, and social factors that protect against—or exacerbate—intense and prolonged distress. Wolff and Wortman recognize that men and women experience widowhood very differently, largely because they experience marriage and interpersonal relationships very differently, and they highlight the distinctive risk factors and protective resources of widows and widowers.

Wolff and Wortman also demonstrate the complex interplay among theory, research, and practice. They challenge two theoretical assumptions that have guided research and practice: the expectation that most bereaved people will react with intense distress that diminishes over time, and the assumption that it is necessary for people to "work through" their feelings in order to recover from the loss. Wolff and Wortman review recent research findings that call into question such taken-for-granted assumptions; recent studies—many of which are based on the CLOC—reveal considerable variability in whether intense distress is experienced and whether "working through" the loss is beneficial. The authors conclude by offering suggestions for grief interventions and therapies; these practical suggestions derive directly from both recent empirical analyses and the theoretical refinements that resulted from the analyses.

Bereavement researchers have made tremendous strides in recent years, particularly in documenting the short- and long-term psychological and emotional reactions of older bereaved spouses. However, much less is known about the physical health consequences of spousal loss. Fictional and anecdotal accounts of "death of a broken heart"—where bereaved spouses die shortly after their loss—have intuitive appeal yet have garnered little empirical support. If physical health does decline among newly bereaved spouses, are the effects best understood as short-term responses to a stressful event, or more persistent adversities that bereaved persons must manage? And, if health suffers, what underlying mechanisms are involved? Amy Mehraban Pienta and Melissa M. Franks set out to find answers to these questions in their chapter "A Closer Look at Health and Widowhood: Do Health Behaviors Change After the Loss of a Spouse?" (chapter 5).

Pienta and Franks set forth an intriguing hypothesis: that widowhood may entail either the loss of a person who fostered positive life-sustaining health behaviors, or the loss a partner who brought potentially harmful health behaviors—such as poor diet or smoking—into the couple's home. The authors examine whether and how health behaviors change following spousal loss. They focus on smoking, alcohol consumption, weight change, and exercise, and track these behaviors up to 4 years after the loss. In doing so, they pinpoint whether such changes are a short-term response to the initial strains of widowhood, or whether such changes are enduring responses to the loss of one's helpmate and nurse (or co-conspirator in unhealthy behaviors). Pienta and Franks take full advantage of the prospective design of the CLOC data; they control for pre-loss characteristics that may influence both one's own health behaviors and one's likelihood of becoming widowed. By carefully considering selective pressures into widowhood and the ways that one's health behaviors change following spousal loss—whether for better or for worse—they uncover important new findings about the ways that some bereaved spouses compromise their health following the death of loved ones. Their findings carry important implications for policy and practice; Pienta and Franks outline possible interventions to foster positive health behaviors among older adults struggling with the illness and eventual death of their spouses.

Stephanie L. Brown, James S. House, and Dylan M. Smith explore a new and rarely studied dimension of spousal loss: the interpersonal and spiritual connections maintained and altered after the death of one's spouse. In chapter 6, "Interpersonal and Spiritual Connections Among Bereaved Older Adults," Brown and colleagues uncover what widowed persons *do*, both in terms of relating to others and modifying their patterns of religious behaviors and beliefs. Although past studies examine the extent to which social support or religious beliefs buffer against the strains of widowhood, Brown and her coauthors take this line of inquiry an important leap further. They document the ways that bereaved older adults rearrange or readjust their social and spiritual worlds in order to meet their new psychic and interpersonal needs.

They find that increasing one's reliance on religious coping and increasing one's level of social integration by giving support to others are two independent ways of coping with loss. For instance, they find that bereaved persons who become more intensely involved in religion after spousal loss are more psychologically resilient and bounce back from depression more quickly than those who do not intensify their religious beliefs. Yet they also find that giving social support to others—rather than receiving support—is a critically important step on the path to resilience. For example, they find

that the linkage between early grief symptoms and later depressive symptoms weakens as widows and widowers increase the amount of social support they give to others. These findings challenge and call for re-conceptualizations in how bereaved persons are treated by family members and social service providers. Although widows and widowers clearly benefit from others' assistance, Brown and colleagues show persuasively that widowed persons also benefit from giving to others. By taking control over their spiritual and interpersonal lives, they may feel energized and empowered to manage the myriad other challenges posed by spousal loss.

In chapter 7, "Economic and Practical Adjustments to Late Life Spousal Loss," Rebecca Utz rounds out the exploration of the ways that older widowed persons readjust to spousal loss. Utz, drawing on the Dual Process Model (Stroebe & Schut, 1999), argues that successful readjustment to loss requires that widows and widowers cope with both emotional aspects of the loss (i.e., loss-oriented coping), and practical challenges and "secondary stressors" that result from the death (i.e., restoration-oriented coping). Following the death of a spouse, even seemingly mundane activities such as keeping house, preparing meals, paying bills, and driving to a doctor's appointment can be a source of distress and anxiety to older bereaved persons. Utz argues further that the daily and practical challenges associated with spousal loss may be particularly acute for current cohorts of older men and women, such as those participating in the CLOC study. Men and women born in the early 20th century were socialized to hold rigidly gender-typed social roles. Men were socialized to be breadwinners, and to leave homemaking and child care tasks to their wives. Women, in contrast, were raised to be mothers and homemakers rather than paid workers or financial managers. This gender-typed specialization leaves both widows and widowers ill-equipped to manage the tasks once performed by their now deceased spouse.

Building upon the Dual Process Model and theories of changing gender roles, Utz documents the ways that widows and widowers manage housework, finances, and home maintenance tasks after their spouse dies. Like Wolff and Wortman, Utz finds tremendous heterogeneity among bereaved spouses; for example, she finds that both the needs of and practical adjustments made by recent widows and widowers vary based on the conditions and timing of their spouses' death. For instance, older adults who had advanced forewarning that their spouse was dying often learned to master the household tasks that their ailing spouse had performed even when the spouse is still alive, ensuring a smoother transition to widowhood. Utz concludes that interventions and practices to help bereaved spouses should not focus solely on emotional distress, but should also provide practical support. Programs that assist

widowed women with financial management tasks or that help widowed men with home making tasks may effectively mitigate some of the stressors that cause the most anxiety and distress for newly bereaved spouses.

New Perspectives on Grief and Bereavement

Randolph Nesse and Robert Neimeyer offer two very different—yet surprisingly complementary—new perspectives on grief. In chapter 8, "An Evolutionary Framework for Understanding Grief," Randolph M. Nesse brings an evolutionary perspective to the study of grief. Nesse recognizes that the idea that grief may be a "useful" biological trait may seem cold-blooded. After all, most of us are more interested in how to relieve the pain of grief than in knowing why it exists. Yet Nesse elaborates that grief is a special kind of sadness shaped to cope with the challenges posed when a loved one dies. Central to Nesse's evolutionary approach is the notion that the capacity for sadness must be useful. Drawing together traditional research on grief with animal studies and cross-cultural work, he argues that some aspects of the anguish associated with grief can be useful in some circumstances, at least for our genes. Nesse reviews evidence indicating that the depression associated with grief can foster a necessary reallocation of effort away from options that are no longer possible. Bereaved persons who experience anguish are also more likely to take action to prevent additional immediate losses, and to avoid similar situations to reduce the likelihood of subsequent losses. Both the experience of pain and the anticipation of such pain should increase one's motivation to prevent the deaths of other loved ones.

This framework has important implications for how we think about, study, and treat grief. As Nesse illustrates, an evolutionary prospective provides a fresh lens from which to view current research on grief and loss. For example, this perspective can help account for seemingly maladaptive behaviors revealed among bereaved persons, such as ruminating about the loss or blaming oneself for what has happened. In an evolutionary framework, such behaviors can be conceptualized as automatic responses that help to prevent future losses. This approach also helps to explain the empirical finding that grief is powerfully influenced by degree of kinship. Grief responses to the loss of close relatives are stronger, on average, than responses to the loss of a spouse, and grief is more intense following the loss of one's twin than the loss of another sibling. An evolutionary approach helps to clarify other empirical results that otherwise seem puzzling, such as the intense grief often shown when a relative dies, even if there has been little emotional closeness. These

findings are difficult to explain using traditional models of the grieving process, such as attachment theory.

Yet Nesse also shows how advances in evolutionary thinking are beginning to influence attachment theory. He argues that the mechanisms that underlie close relationships between spouses, particularly among older couples, may be quite different from those that underlie mother-child relationships. The generous behaviors in such relationships, such as caring for an ill spouse, can be understood in terms of a framework he calls "commitment." This refers to a situation where people develop an understanding to help one another even in the absence of any immediate payoff. The special value of such commitments helps to explain much of what is lost when a long-term, intimate relationship comes to an end.

Drawing from the CLOC data, Nesse addresses some of the problems inherent in attempting to test hypotheses regarding the usefulness of grief. He concludes by proposing that an evolutionary framework has important implications for the treatment of grief. He notes, for example, that if there were a drug that would block the pain of grief, an evolutionary approach suggests that it might not be a good idea to administer it routinely to everyone. As he points out, we still do not know nearly enough about such important issues to conclude whether routine treatment of bereaved people with antidepressant drugs would be wise or not.

In chapter 9, "Widowhood, Grief and the Quest for Meaning: A Narrative Perspective on Resilience," Robert A. Neimeyer illustrates the value of applying a narrative constructivist approach to the study of bereavement. In essence, he maintains that there is much to be gained by viewing widowhood as a quest for meaning and continuity. As he points out, there has been a groundswell of interest in narrative processes from many disciplines, including cognitive science, social and developmental psychology, neuropsychology, and psychotherapy. Drawing from the burgeoning interdisciplinary field of narrative studies, he offers a new and valuable framework for understanding widowhood.

Neimeyer observes that significant losses challenge the self-narratives of survivors. He suggests that such losses have the potential to disrupt survivors' personal sense of autobiographical continuity, as well as their social construction of their post-loss identity. In recognition of the diversity of responses to bereavement, he notes that narrative disorganization is limited and transient for some widowed persons, but sweeping and prolonged for others, who are left with a world that is fragmented and incoherent. In an insightful analysis, he suggests a narrative elaboration of each of the five major bereavement

trajectories identified by Bonanno and his colleagues (Bonanno et al., 2002; Bonanno, Wortman, & Nesse, 2004). Neimeyer proposes, for example, that resilient individuals are able to successfully assimilate their loss experience into their existing life narratives, which is why they show only transient distress and report relatively little need to search for meaning. He suggests that the self-narrative of chronic grievers is seriously disrupted by the loss, which is why they remain preoccupied with an intensive search for meaning even a year and a half after the death. According to Neimeyer, people in the "depressed-improved" group can best be understood as having been released by bereavement from the narrative of a caregiver, or of a partner in an oppressive marriage which had sharply constrained their identity.

The author concludes the chapter with a provocative and timely discussion of the implications of his analysis for research and clinical work. He identifies both quantitative and qualitative research methods that could greatly enhance our study of meaning reconstruction following loss. Regarding clinical implications, he draws from a narrative perspective to illustrate why the vast majority of people who experience loss do not require treatment. As Neimeyer points out, however, therapy may be indicated for the 15 to 20% of bereaved whose grief remains chronic. For such individuals, a narrative approach offers a treasure trove of therapeutic procedures that can facilitate the reconstruction of meaning following loss. These include systematic writing about the loss or its most troubling aspects, biographical techniques, poetic expression, and a host of other strategies that hold considerable promise, both for self-help applications and as homework assignments in professional grief therapy.

Implications for Practice, Policy, and Future Research

One of our most important aims in assembling this volume is to provide potentially useful research findings to clinicians, counselors, social workers, gerontologists, and policy makers who work directly or indirectly with bereaved older adults. Two chapters, in particular, helped us to achieve that aim. In chapter 10, "Clinical Interventions with the Bereaved: What Clinicians and Counselors Can Learn from the Changing Lives of Older Couples (CLOC) Study," Anthony D. Mancini, David L. Pressman, and George A. Bonanno offer a state of the art review of clinical interventions for bereavement, with an emphasis on the experiences of older bereaved spouses in the CLOC study. They summarize studies showing that most grief interventions are generally not useful and may actually be harmful. However, they also note that a subset of bereaved persons can benefit from treatment, and that

scholars and practitioners are beginning to understand how to identify the appropriate treatments for members of that subset. Their chapter is a must-read for clinicians working with older bereaved spouses.

Mancini and his collaborators also review recent studies that reveal variations in the grief experience. For example, they report that nearly half of the bereaved subjects in the CLOC study were "resilient" and experienced few symptoms, while only 16% became depressed after the loss and stayed depressed for months afterward. Only one-tenth of the sample displayed the supposedly "typical" pattern, with significant grief symptoms 6 months after loss, and recovery shortly thereafter. Roughly the same proportion showed an improvement in psychological well-being after the loss, probably because the death represented the end of a bad marriage, onerous caregiving responsibilities, or both. These results underscore the importance of both recognizing and respecting the many different ways that widows and widowers grieve, instead of expecting everyone to conform to an essentialized bereavement prototype.

Mancini, Pressman, and Bonanno also argue persuasively that there is no sound empirical evidence for the concept of "delayed grief." Nor do they find any evidence for the hypothesis that the loss of ambivalent or conflicted relationships causes more grief than the loss of more close and loving relationships. Instead, they find that grief is more intense for individuals who were more loving and dependent on each other. Perhaps the authors' most important finding is their observation that for some individuals, much of the depression that follows grief is present even before the loss occurs. Often, this pre-loss depression is a long-standing condition, and one that makes bereavement all the more difficult. The authors urge clinicians to recognize the difference between depression and grief, and to make appropriate treatment decisions based on this differentiation. The authors conclude by noting that many of the problems experienced by bereaved older adults are not a result of the loss per se, but are problems associated with the aging process. These findings have important implications for treatment recommendations, as well as the public policy issues addressed in the next chapter.

In chapter 11, "Implications for Public Policies and Social Services: What Social Workers and Gerontology Professionals Can Learn from the Changing Lives of Older Couples (CLOC) Study," Virginia E. Richardson provides a comprehensive review of treatment options, social service organizations, and public policies that serve bereaved older adults. In particular, the hospice movement has extended its contributions in a natural way to services for the bereaved. The National Hospice Organization has written and adopted practice guidelines, as has the National Association of Social Workers. Richardson

notes that these guidelines draw heavily on prior bereavement research, but that professional organizations can gain much from considering new methodologically rigorous research. Secondary prevention efforts also have grown so that widow support groups and widow-to-widow programs are now available to many. Tertiary prevention has become more specialized and sophisticated, moving from the offices of individual clinicians into organized programs to help those whose grief becomes prolonged or disabling.

Even experienced social workers will learn from this chapter about the remarkable array of government programs that provide practical resources for the bereaved, many funded via the Older Americans Act, others via Social Security, Medicaid, Medicare, and the Family Medical Leave Act. Many of these resources are underutilized and her summary table should help social workers provide more effective help for their clients. Richardson wisely notes that while many of these programs were not designed expressly to help bereaved older adults, they nonetheless offer an array of services for widows and widowers.

Richardson observes that currently available services and policies still are not sufficient to meet the needs of many older bereaved spouses, and that some practices, are wrong-headed or incomplete because they are based on dated notions about loss. Moreover, many of the most challenging problems faced by the bereaved—such as medical expenses, loneliness, and transportation difficulties—are the very same problems faced by many older people who are not bereaved. She offers a series of welcome recommendations for specific policy changes that would greatly help older bereaved spouses. For instance, increasing Social Security benefits by just 5% for the impoverished elderly would help a great deal at a feasible cost. Whether or not such sensible advice will influence policy makers in the current political climate remains to be seen. The chapter concludes with a plea for improved training for those who provide services to the elderly, and those who make public policies. One can only hope policy makers read her important and comprehensive chapter.

The volume concludes with a series of recommendations for future research, and speculations about how future cohorts of older adults will cope with the challenge of spousal loss. In chapter 12, "The Future of Late Life Spousal Bereavement," Deborah Carr reviews some important social and demographic trends that are occurring in the United States today; each of these patterns has potentially important implications for how older adults adjust to the loss of a loved one. As the United States population becomes increasingly diverse in terms of race, ethnicity, and religion, ways of coping with death may change accordingly, and new interventions and therapies may be

required. She also suggests ways that changing family patterns, including divorce, childlessness, and increasing acceptance of gay and lesbian relationships, shape the ways that bereavement is experienced. In the 21st century, widowhood and the personal experience of bereavement may once again be transformed.

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CHAPTER 2

Methodological Issues in Studying Late Life Bereavement

Deborah Carr

The death of one's spouse is considered one of the most distressing, yet also one of the most common, transitions that older Americans face. Although studies of spousal bereavement have flourished in recent years, researchers have not reached a consensus on important issues related to loss. Scholars continue to debate important policy-relevant questions, such as: Who suffers more, men or women? Why do men and women respond differently to spousal loss? How do characteristics of the spouse's death affect the bereaved survivor's adjustment? Is "absent" grief indicative of a healthy or pathological reaction to loss? Conclusive answers to these questions require well-designed rigorous studies that are free of sampling, measurement, and other methodological limitations that may lead to biased or inconclusive findings.

This chapter reviews the methodological challenges that researchers must address in order to make sound contributions to the bereavement debate. I first review the strengths and weakness of commonly used data sources, including help-seeking, bereaved, and community samples. Second, I compare the attributes of cross-sectional versus prospective and longitudinal data sets as appropriate sources for studying bereavement. Third, I underscore the value of using a diverse range of outcomes in bereavement research. Fourth, I describe the purposes and potential contributions of both mediational and moderational analyses. Fifth, I describe the ways that developmental and age-related changes may affect adjustment to loss, and the implications of these patterns for researchers who rely on age-heterogeneous samples. Finally, I describe the

Changing Lives of Older Couples (CLOC) data set, and discuss the distinctive strengths of this study as a resource for studying late life bereavement.

RESEARCH DESIGN AND SAMPLE ISSUES

Help-Seeking Samples

The data and methods available for studying spousal bereavement have undergone important transformations over the past 5 decades. Early studies of bereavement drew subjects from patient populations, usually those seeking psychiatric treatment (e.g., Parkes, 1965). Comparison groups rarely were considered; when control groups were used they typically included non-bereaved patients seeking treatment (Hyman, 1983). Although some recent studies draw subjects from clinical populations (Arbuckle & deVries, 1995), or persons participating in self-help groups (e.g., Silverman, 1986; Wheeler, 2001), findings from these studies cannot be generalized to broader bereaved populations. By definition, patient and self-help group samples include those already seeking help. Findings based on these data may overstate the negative consequences of loss because persons with the most difficult readjustments are overrepresented in help-seeking samples.

Bereaved-Only Samples

Other early studies of widowhood relied on small community-based samples of bereaved persons only; a main objective of such studies was to identify those bereaved persons at greatest risk of developing emotional or physical health problems following loss (e.g., Berardo, 1970; Lopata, 1973; Marris, 1958). Although these studies often produced path-breaking insights into the bereaved spouses' experiences, their conclusions were based on small, non-representative, or volunteer samples, and they often were drawn from specific geographic areas (e.g., Lund, Caserta, & Dimond, 1989). The overwhelming majority focused on women only (Lopata, 1973; Hyman, 1983; Morgan, 1991; O'Bryant, 1991), although a handful documented the experiences of widowers only (e.g., Berardo, 1970; Campbell & Silverman, 1996). Single-sex samples are problematic because they do not allow researchers to assess gender differences in responses to loss.

Moreover, studies based on samples of the bereaved cannot evaluate systematically the *consequences* of spousal loss because they do not include married persons as a comparison group. For example, studies based on samples of widows and widowers cannot evaluate whether the event of widowhood affects men and women differently (e.g., Dimond, Lund, & Caserta, 1987;

Lund, Caserta, & Dimond, 1986). Although these analyses may reveal gender differences in depression rates among the bereaved, they cannot necessarily attribute this to gender differences in the effect of widowhood. Rather, this difference may reflect gender differences in psychological health *in general.* Women have rates of depression that are roughly twice that of men's, while men have significantly higher rates of alcohol use, drug dependence, and antisocial behavior disorders than women (Rieker & Bird, 2000). Thus, in order to ascertain whether spousal loss affects women's and men's mental health differently, researchers cannot simply compare widows and widowers. Rather, they must examine the direct effects of both widowhood and gender on mental health separately, as well as the combined effects of the two. The evaluation of interaction terms allows researchers to ascertain whether widowed women differ from married women, and whether the event of spousal loss affects men and women differently.

Sample Surveys

Over the past 25 years, the development of large sample surveys, including the Epidemiologic Catchment Area (ECA) studies (Robins & Regier, 1990), Americans' Changing Lives (ACL) studies (House, 1986), and National Comorbidity Survey (Kessler et al., 1994) has enabled researchers to compare widowed persons and married persons in terms of important psychological, social, and economic characteristics. Empirical findings based on such large-scale sample surveys are more generalizable than findings from clinical or help-seeking samples, and they allow for comparisons between bereaved and non-bereaved persons. However, most were designed to study health and well-being in the general population and not for the explicit purpose of studying spousal bereavement (Hatch, 2000). Consequently, these studies often do not include detailed information on the circumstances of the loss, such as the length of time since spousal loss, the cause of death, or the extent to which the survivor provided care to the now-deceased spouse (Stroebe, Hansson, & Stroebe, 1993).

Most survey-based bereavement research has relied on cross-sectional rather than longitudinal data. That is, most studies have been based on single point-in-time "snapshot" data rather than on multiple observations over an extended time period. Cross-sectional data pose important obstacles to establishing causal influences; researchers cannot necessarily ascertain whether the differences observed between widowed persons and married persons are attributable to the event of widowhood per se or to differences that existed prior to the loss. In other words, cross-sectional data cannot resolve whether

an observed statistical relationship reflects causation, correlation, or a spurious relationship (see Dohrenwend, Levav, & Shrout, 1992 for a review).

Selective Pressures into Widowhood

A common strategy for examining the effect of widowhood is to compare bereaved and married persons in a cross-sectional sample, then to assume that data from married respondents can be used to represent the behaviors, attitudes, and experiences of widows and widowers prior to their loss (Ferraro & Barresi, 1982). The assumption that married and widowed persons are similar on important attributes is problematic; however, because both *becoming widowed* and *remaining widowed* are selective processes. Not all persons are equally likely to become (or remain) widowed, and factors that increase one's likelihood of becoming widowed also may increase susceptibility to loss-related problems, such as depression, anxiety, financial distress, poor health, or risky health behaviors. For example, persons with limited economic resources are more likely to die prematurely than are wealthier individuals (McDonough, Williams, House, & Duncan, 1999; Preston & Taubman, 1994). Given that the survivors of these early decedents shared their spouses' disadvantaged socioeconomic position, they are more likely to experience economic deprivation (and accompanying psychological distress) *even in absence* of the widowhood event (Kessler, 1979; Dohrenwend et al., 1992). That is, the observed statistical relationship between widowhood and economic distress may be spurious rather than causal.

Considering one's psychological characteristics prior to loss is particularly important in studies exploring affective and emotional responses to widowhood. For example, depressive symptoms prior to loss are a powerful predictor of the most severe and long-lasting grief reactions following loss (e.g., Gilewski, Farberow, Gallagher, & Thompson, 1991; Zisook & Shuchter, 1991). However, researchers cannot distinguish loss-related depressive symptoms from preexisting depression in studies based on cross-sectional data. In sum, it is critically important to evaluate the *precursors* of the widowhood experience if researchers hope to properly specify and interpret the consequences of spousal loss, including the possibility that some of the observed effects of widowhood may instead reflect a spurious relationship.

Selective Pressures Out of Widowhood

Just as *becoming widowed* is a selective process, *exiting widowhood* via either remarriage or death also is a selective transition. Persons who remain widowed for the longest durations (and thus are most likely to be identified as "currently

widowed" in a cross-sectional survey) may differ significantly from those who have exited the "widowed" category. The healthiest, wealthiest, and happiest bereaved spouses are the most likely to remarry (Mastekaasa, 1992; Peters & Liefbroer, 1997). Cross-sectional studies that compare currently widowed with currently married people may thus *overstate* the deleterious consequences of loss; the average well-being of persons remaining widowed is lower than for those who "exit" the widowed state via remarriage. In contrast, the least healthy, wealthy, and happy widowed persons have an elevated risk of mortality (e.g., McDonough et al., 1999; Preston & Taubman, 1994). As a result, studies that compare the widowed with the married also may *understate* the deleterious consequences of loss: the average well-being of persons who survive is higher than for those persons who die during the study period. Whether the effects of spousal loss are over- or understated in a given study may reflect the composition of the study sample; if a high proportion of sample members remarry (e.g., a sample including many young widowers), then the deleterious consequences of loss are overstated. Conversely, if many sample members die shortly after loss (e.g., a sample including many older or ill persons), then the harmful consequences of bereavement may be understated.

Prospective Studies

The challenges posed by social selection can be addressed effectively by using a quasi-experimental prospective research design. Under such a design, data collection begins prior to the time that individuals experience the critical event or transition, such as spousal loss. Subjects are then tracked over time, and persons who eventually become bereaved are then matched with a non-bereaved "control" person who also participated in the baseline interview and who shares important pre-loss characteristics. Differences between bereaved persons and matched controls at subsequent interviews can be attributed to the event of widowhood.

In general, quasi-experimental designs are considered one of the most effective methods for establishing causation in studies where the key independent variable (such as "becoming widowed") cannot be randomly assigned (Campbell & Stanley, 1966). A further strength of the prospective design is that it allows researchers to obtain *timely measures* of important pre-loss characteristics. For example, cross-sectional studies may ask respondents to recall events, conditions, and personal characteristics from the distant past. Prospective studies, in contrast, are superior to cross-sectional studies because the problems introduced by retrospective recall bias are minimized. Retrospective recall bias is a particularly serious concern when studying older

adults. Errors in recalling past experiences increase with age; the longer the recall period, the less reliable are the retrospective reports (Dex, 1995). Age-related cognitive and physical impairments also may increase recall errors (Schwarz, Park, Knauper, & Sudman, 1999; Simon & Von Korff, 1992).

For all age groups, however, recent experiences may affect the way that past experiences are remembered (Scott & Alwin, 1998). In general, current positive mood leads to positive (and often unrealistically rosy) evaluations of the past, whereas negative mood leads to more negative evaluations of one's past experiences and relationships (Futterman, Gallagher, Thompson, Lovett, & Gilewski, 1990; Hirschfield et al., 1989). This mood-induced recall bias may threaten the validity of studies linking retrospective accounts of spousal death with the survivor's current psychological adjustment. Bereaved persons who experience the highest levels of anger and anxiety may, in retrospect, overestimate the extent to which unsatisfactory medical care contributed to their spouses' deaths (Carr, 2003). Moreover, widowed persons who yearn most for the deceased may give unrealistically positive evaluations of their late spouse and late marriage (Bonanno, Wortman, & Nesse, 2004). This process of retrospectively "sanctifying" the memory of one's spouse (Lopata, 1973) may bias investigations linking marital quality with psychological adjustment to spousal loss (Carr et al., 2000). Prospective studies that evaluate characteristics such as marital quality and quality of spouse's medical care prior to loss are less susceptible to the threats to validity imposed by retrospective recall bias. The Changing Lives of Older Couples study (CLOC) is based on a prospective quasi-experimental design; the study details will be elaborated later in this chapter. A further strength of the CLOC study is that it obtains longitudinal data, which enables researchers to explore important and unexplored research questions about the course of bereavement.

Longitudinal Data

Longitudinal studies, or studies that track individuals over time and obtain data at multiple time points, offer important advantages to bereavement researchers. First, longitudinal studies are vastly superior to cross-sectional studies in revealing causal influences because they can better pinpoint the temporal ordering of events and experiences (Alwin & Campbell, 2001). Multiple data points are particularly important when exploring the consequences of stressful life events, such as widowhood. Widowhood typically is conceptualized as a discrete, observable event believed to trigger significant life changes (Holmes & Rahe, 1967). However, most discrete events take time to come to fruition and often occur after a long period of prior stress (Avison

& Turner, 1988; Wheaton, 1999). For example, widowhood may occur at the end of a long period of stressful caregiving. Researchers seeking to evaluate the effect of an event also must consider the social context and conditions that precede that event.

Second, because longitudinal studies obtain data at several time points, researchers can study *change over time*. This is an important concern for bereavement researchers. Many bereavement practitioners operate on the assumption that grief unfolds in stages and that most bereaved persons experience a generally similar set of symptoms in a generally similar order (Heinemann & Evans, 1990; Kubler-Ross, 1969). The development of new statistical methods in recent years, including latent growth curve modeling, provides tools for analyzing longitudinal data and thus enables researchers to directly evaluate claims about the duration, course, and patterning of grief symptoms. For instance, Bonanno and Kaltman (1999, 2001) use longitudinal data to document three distinctive courses of grief symptoms among older bereaved adults: a minimal grief response, a recovery pattern, and a chronic pattern. These dynamic patterns could not have been detected using cross-sectional data only.

Third, longitudinal studies that span extensive time periods allow researchers to document the long-term consequences of an event or transition. Identifying the distinctive characteristics of those persons for whom grief persists is an important objective for clinicians and practitioners. Moreover, studies that offer a long-term time horizon can document important transitions that may not occur until several years after a distressing event. For example, Lehman, Wortman, and Williams (1987) showed that persons who lost a spouse or child in an automobile accident were more likely than matched controls to experience premature death, divorce, and psychological distress, although these problems often did not occur until as late as 7 years after their loved one's death.

Longitudinal studies do have several important limitations, however. The cost of collecting data at multiple time points can be prohibitive. Moreover, attrition—or the loss of subjects over the course of the study—bias the study's findings if the subjects who are lost share certain characteristics (see Mott, 2002 for review). Selective attrition is a particularly important concern in studies of older populations. Older, less healthy, poorer, and more residentially mobile persons are most likely to drop out of longitudinal studies. The selective attrition of persons with the fewest protective resources may lead researchers to underestimate the potentially harmful consequences of spousal loss if those who are the most depressed and sick drop out of the study due to either death or ill health. Researchers should thus take appropriate steps

to identify and acknowledge both the sources and possible consequences of sample attrition. More sophisticated strategies, such as weighting adjustments, imputation (Little & Rubin, 1987; Little & Schenker, 1995), and the estimation of two-stage selection models (e.g., Heckman, 1979; Heckman & Singer, 1984) also are effective ways to address the issue of selective attrition.

IMPORTANCE OF MULTIPLE OUTCOMES IN BEREAVEMENT RESEARCH

The majority of research on spousal bereavement focuses on psychological adjustment among the bereaved. This emphasis is consistent with the widely acknowledged assumption that widowhood is among the most stressful of all life events and as such has important psychological ramifications (Holmes & Rahe, 1967). However, researchers may develop a richer understanding of how older adults adjust to loss by considering a fuller range of psychological, social, and behavioral outcomes, including social engagement and participation (Utz, Carr, Nesse, & Wortman, 2002), social support from family and friends (Ha, Carr, Utz, & Nesse, 2005), physical health (Wilcox, et al., 2003), strategies for managing daily activities (Umberson, Wortman, & Kessler, 1992; Utz et al., 2004), and personal growth in the face of loss (Carr, 2004).

The importance of considering multiple outcomes in stress research has been elaborated elsewhere (e.g., Aneshensel, Rutter, & Lachenbruch, 1991; Horwitz, 2002). The main reasons for considering multiple outcomes are: (a) to identify the *diverse array of consequences* that widowhood may have for older adults, (b) to identify *important subgroup differences* in how newly bereaved persons respond to loss, and (c) to recognize that commonly used *global* measures of adjustment may mask more *specific* adjustments to loss.

Multiple Consequences of Spousal Loss

Most bereavement research focuses on negative mental health indicators and psychiatric complications including depressive symptoms, major depressive disorders (MDD), anxiety-related disorders such as posttraumatic stress disorder (PTSD), and grief (e.g., Bruce, Kim, Leaf, & Jacobs, 1990; Jacobs, Hansen, Berkman, Kasl, & Ostfeld, 1989; Lund et al., 1985–1986; Stroebe et al., 1993; Zisook, Paulus, Shuchter, & Judd, 1997; Zisook & Shuchter, 1991). The two most commonly used outcomes are depression and grief. Depression typically is measured as either a categorical variable signifying

that one has experienced a 2-week spell of depressed mood and somatic and behavioral symptoms in the year prior to interview, or with a continuous measure of depressive symptoms such as the Center for Epidemiologic Studies Depression (CES-D) scale (Radloff, 1977). Grief typically is measured either as an overarching scale that may comprise more specific symptom subscales (Jacobs, Kasl, & Ostfeld, 1986; Singh & Raphael, 1981; Zisook, DeVaul, & Click, 1982), or as a categorical indicator of a specific "type" of grief, such as "complicated" grief (Barry, Kasl, & Prigerson, 2002; Prigerson et al., 1995) or "traumatic" grief (Prigerson & Jacobs, 2001; Prigerson et al., 1999).

On one hand, this emphasis on negative aspects of psychological adjustment and the presence or absence of pathology is justifiable. Distress and depression are relatively common reactions to loss; most studies find that 15 to 30% of older bereaved spouses experience clinically significant depression in the year following their spouse's death (Jacobs et al., 1989; Stroebe et al., 1993; Zisook & Shuchter, 1991). The widespread emphasis on dichotomous outcomes (i.e., the presence or absence of a diagnosis) also is consistent with medical and psychiatric practices (Horwitz, 2002). Psychiatrists, clinicians, and counselors are trained to treat pathology; the decision to treat is contingent upon whether or not one has a formal diagnosis (Kessler, 2002). Moreover, a formal diagnosis may be necessary if a patient seeking treatment hopes to receive reimbursement from Medicare or most HMOs (e.g., Rost, Smith, Matthews, & Guise, 1994).

An alternate perspective among many bereavement researchers is that the consequences of loss should be conceptualized more broadly. Outcomes should be considered both as continua and as discrete categories. Studies focusing only on discrete outcomes, such as MDD or complicated grief, may underestimate the harmful consequences of loss; distressed individuals who barely fail to meet the criteria for the diagnosis are disregarded (Mirowsky & Ross, 2002). The pervasive emphasis on psychological disorder also is problematic in that it identifies only the *presence of negative* mental health rather than the *absence of positive* mental health (e.g., Jahoda, 1958). Ryff and Singer (1998) have argued that persons who score extremely low on indicators of positive psychological adjustment, such as self-esteem, personal growth, or mastery, may find themselves at an elevated risk of major depression if confronted with additional life stressors.

An emerging body of research calls for the exploration of positive mental health in the face of adversity. As noted earlier, most studies find that 15 to 30% of bereaved older spouses experience clinically significant depression in the year following spousal death (Jacobs et al., 1989; Stroebe et al., 1993; Zisook &

Shuchter, 1991); however, this statistic also suggests that the majority of older bereaved spouses experience the widowhood transition without major depression. Several recent studies conclude that spousal loss may have direct positive consequences for some older bereaved persons: Frantz, Farrell, and Trolley (2001, p. 191) observe that, "grief leaves in its wake many positive outcomes." A rapidly emerging body of research has sought to identify the personal and contextual characteristics that may facilitate psychological resilience (Bonanno, 2004), "benefit-finding" (Nolen-Hoeksema & Davis, 2001), personal growth (Carr, 2004), and posttraumatic growth (Nolen-Hoeksema & Davis, 2004; Wortman, 2004) after spousal loss.

In sum, both negative *and* positive indicators of adjustment to loss should be considered, and these reactions should include a full range of readjustment indicators. A focus on psychological dimensions only may perpetuate and reify the assumption that grief is pathological, rather than a normative response to a distressing life event. For older adults, in particular, spousal loss may require important behavioral, economic, social, and psychological readjustments. For women, loss-related distress may be a consequence of financial difficulties, loss of income, lack of experience in managing their household finances, and perceived financial distress (Umberson et al., 1992). For older widowers, in contrast, difficulty in managing household tasks, such as meal preparation, is associated with both physical and psychological declines following loss (Lee, DeMaris, Bavin, & Sullivan, 2001; Umberson et al., 1992). It is thus critically important that practitioners, social workers, and outreach workers identify those persons at risk of a wide array of challenges following loss so that appropriate interventions may be developed.

Subgroup Differences in Bereavement Experience

Studying single outcomes, such as depression or grief only, is a serious liability to researchers who are interested in documenting the distinctive consequences of spousal loss for specific subgroups. Different gender, age, socioeconomic status, and ethnic groups may respond to spousal loss in distinctive ways (e.g., Aneshensel et al., 1991; Horwitz, White, & Howell-White, 1996). To the extent that different groups have distinctive reactions to loss, then studying a single outcome may mask meaningful group comparisons (Stroebe & Stroebe, 1983).

For instance, emotional reactions to loss are shaped by age, gender, and cultural norms. "Feeling rules" or "emotion rules" provide guidelines for which feelings should be revealed (and suppressed), by whom, and in which contexts (Hochschild, 1979). Social norms may encourage men's experi-

ence of anger, but not sadness, while reverse norms are applied to women (Ross & Mirowsky, 1995). Empirical studies that compare the psychological adjustment of men and women after marital dissolution (including both divorce and widowhood) show that women manifest depressive symptoms while men evidence alcohol problems (see Umberson & Williams, 1999 for a review). Age-related emotional and cognitive changes also may affect the ways that individuals adjust psychologically to spousal loss. Older adults are less likely than younger persons to report symptoms of extreme distress or depression (Carstensen & Turk-Charles, 1994). Consequently, studies that focus on single outcomes only may hide the specific consequences for different subgroups.

Importance of Symptom Subscales

Bereavement research also has focused largely on *general* outcomes, such as depression or grief. However, studies based on these broad measures only may fail to reveal the *specific symptoms* experienced in the face of loss. Depression scales, for instance, comprise such subscales as depressed affect, motivational loss, cognitive evaluations, and somatic complaints (Radloff, 1977). Older bereaved adults with clinical depression may not exhibit a dysphoric or "sad" mood, but instead may show elevated somatic concerns and irritability (Blazer, 1996). Research focusing only on one overarching depression scale score may mask these important distinctions.

Grief also comprises complex cognitive and emotional reactions (Bonanno & Kaltman, 1999). Grief may encompass symptoms including normative responses to loss, such as short-term sadness (Raphael, Minkov, & Dobson, 2001), yearning for the deceased (Wortman & Silver, 2001), or anxiety and fear about surviving on one's own (Martin & Doka, 2000). The precise symptoms expressed may be closely linked to the nature and context of the loss. For instance, persons who experience the sudden loss of a spouse are particularly susceptible to intrusive thoughts (Carr, House, Wortman, Nesse, & Kessler, 2001; Bonanno & Kaltman, 1999; Zisook, Chentsova-Dutton, & Shuchter, 1998). Intrusive thoughts occur when unprovoked painful thoughts about the deceased haunt the survivor. In contrast, persons who experience the loss of a spouse following a long period of forewarning have been found to report elevated anxiety symptoms, perhaps a result of a lengthy and exhausting period of spousal caregiving prior to loss (Carr et al., 2001). These distinctive (and potentially competing) effects of anticipated versus sudden death may cancel out one another when an aggregated scale, such as grief only, is considered as an outcome measure.

UNEXPLORED PATHWAYS: IDENTIFYING THE "BLACK BOX" OF WIDOWHOOD

Bereavement researchers often observe that empirical studies are replete with discrepant or equivocal findings. An important example is research on gender differences in reactions to loss. Several studies report that widowed women are more depressed than men (e.g., Farnsworth, Pett, & Lund, 1989; Schuster & Butler, 1989; Thompson, Gallagher, Cover, Galewski, & Peterson, 1989), whereas many others find widowhood to have a more adverse effect on men than women (e.g., Lee, Willetts, & Seccombe, 1998; Lee DeMaris, Bavin & Sullivan, 2001; Umberson, Wortman, & Kessler, 1992). A third group finds no gender differences in psychological health following loss (e.g., Gerstel, Riessman, & Rosenfeld, 1985; Lund, Caserta, Dimond, & Shapper, 1989; Zisook & Shuchter, 1991). The inconclusive findings may be due, in part, to three important methodological issues: (a) variable time periods between spousal loss and follow-up, (b) limited attention to the potential "pathway" variables that may account for different reactions to spousal loss, and (c) an emphasis on the "who suffers worse" approach (Stroebe & Stroebe, 1983), which typically contrasts the post-loss experiences of two subgroups, such as men and women. This approach neglects the possibility that there may be greater *within-group* than *between-group* variation in responses to loss.

Consequences of Loss Are Time Dependent

The effects of spousal loss are conditional upon time since loss, where the severity of one's reaction declines as time elapses. Most studies concur that psychological functioning returns to "normal" or pre-loss levels within 24 months following loss (Bonanno & Kaltman, 2001). The consequences of loss may be masked in heterogeneous samples that include both persons who have long since recovered from loss and those who experienced loss very recently.

Lack of attention to time since loss also may have implications for specifying subgroup differences in reactions to late life loss. On average, men are widowed for shorter time periods than women, because they are more likely to exit the "widowed" state via either remarriage or mortality (Lee et al., 2001). At any given time, then, a higher proportion of widowers than widows are recently bereaved, and the recently bereaved tend to have poorer psychological and physical adjustment. Thus, researchers should stratify their samples based on the time elapsed since loss. Otherwise, the effects of loss will be either overstated or understated, depending on the composition of the analytic sample.

Identifying Why and How Widowhood Matters

Studies that simply evaluate the effect of widowhood (or other stressful life events) on well-being find surprisingly modest effects (e.g., Rabkin & Streuning, 1976; Thoits, 1983). Important questions about the meaning and consequences of widowhood may remain unanswered unless a broad range of potential pathway variables are taken into consideration. Pathway or mediating variables are the variables that transmit the effect of a purported causal variable, such as widowhood (Baron & Kenney, 1986).

One important set of pathways are secondary stressors, or those difficulties triggered by a stressful life event. In the case of spousal loss, secondary stressors may include a distressing period of financial insecurity, loneliness, or anxiety about managing household responsibilities. Importantly, most secondary stressors are *modifiable factors* and carefully targeted interventions may eliminate or mitigate the potentially harmful consequences of these stressors. For example, the linkage between spousal loss and psychological distress has been attributed to post-loss financial strains among women (e.g., Umberson et al., 1992) and to the lack of social support (Carr, 2004), the loss of their late spouse's health monitoring and support efforts (e.g., Umberson, 1987), and difficulties managing household and meal preparation tasks among men (e.g., Lee et al., 2001; Umberson et al., 1992). Thus, practitioners could develop programs to target women's financial needs and men's instrumental and household needs if they hope to mitigate loss-related distress.

Identifying Within-Subgroup Variations in Bereavement Experiences

Mediation analyses are an important strategy for uncovering the reasons why two subgroups, such as men and women, experience loss differently (Baron & Kenney, 1986). However, studies based on mediation analyses seldom take into account the fact that there is considerable *within-subgroup variation* in terms of most pathway variables (Carr, 2004). An alternative strategy, moderation analyses—or the evaluation of theoretically guided two-way interaction terms—allows researchers to answer questions such as: Are gender differences in psychological adjustment to loss still evident, even when we compare women and men who share similar levels of some attribute, such as social support or financial stability? Recent moderation analyses have revealed that when widows and widowers have similar levels of social support, they adapt equally well to spousal loss (Carr, 2004; McCrae & Costa, 1993).

Identifying the sources of within-gender differences in adjustment to loss may have important implications for understanding future cohorts of older

widowed persons. Although current cohorts of older adults have generally adhered to a strict gender-based division of labor in their marriages, future generations are less likely to adhere to such rigid arrangements and are less likely to abide by gender-typed social roles at every stage of the life course. Future cohorts of married women are less likely to be highly dependent upon their husbands for their economic well-being, whereas future cohorts of married men are less likely than current cohorts to depend on their wives for instrumental and expressive support. As gender-typed boundaries blur over time, the ways that older adults adjust to spousal loss may become less differentiated by gender (Carr, 2004). Studies that simply contrast men and women may be less informative (and less relevant) than studies that explore within-gender sources of adjustment.

The Special Case of Older Bereaved Spouses

Past research and theory suggests that widowhood may have a profoundly different meaning and set of consequences for older and younger persons. On one hand, spousal loss may be *less strongly linked* to subsequent distress among older adults compared to younger adults. Older adults are more likely than younger persons to have experienced the death of a significant other prior to spousal loss, and may be better equipped to make sense of and cope with their most recent loss (Thompson et al., 1989). Additionally, with advanced age, spousal loss may be at least somewhat expected (Neugarten & Hagestad, 1976). Roughly 50% of women over the age of 65 are widowed (Fields & Casper, 2001); older women, in particular, may anticipate the deaths of their husbands as they observe their peers experiencing widowhood (Fooken, 1985; Neugarten & Hagestad, 1976). Most older adults today die of long-term chronic illnesses, such as cancer or cardiovascular disease (U.S. Bureau of Census, 1996); older married persons may recognize that their ill spouse will die in the near future (Carr et al., 2001). In contrast, deaths to younger adults are more likely to occur suddenly, unexpectedly, and under particularly distressing circumstances such as murders or accidents (Calhoun & Allen, 1991; Reed, 1998; Rynearson, 1984). Given that predictable, anticipated life transitions are less stressful than unexpected ones (George, 1993; Pearlin, 1982; Pearlin & Lieberman, 1979), older bereaved spouses may experience a less difficult readjustment than younger widow(er)s.

The purported weak relationship between widowhood and psychological distress among older adults (relative to younger adults) also may reflect age-related declines in emotional reactivity. Compared to younger adults,

older adults have a greater capacity to manage or "regulate" their emotional states (Lawton, Kleban, Rajagopal, & Dean, 1992); consequently, they report less extreme levels of both positive and negative affect, and less variability in their emotional responses to stress (Gaitz & Scott, 1972; Mroczek & Kolarz, 1998; Stacey & Gatz, 1991). Grief reactions also are less intense and shorter lived among the elderly bereaved, compared to the younger bereaved (Nolen-Hoeksema & Ahrens, 2002; Sanders, 1993; Sherbourne, Meredith, Rogers, & Ware, 1992). Emotional reactivity may decline in later life because of a variety of factors: (a) biological decrease in autonomic arousal, (b) the greater habituation of older adults to emotional life events, (c) adherence to cultural expectations that the elderly should not be "too emotional," and (d) shifts in the relative salience of emotion versus cognition in late life (Carstensen & Turk-Charles, 1994; Diener, Sandvick, & Larsen, 1985). Older adults are also believed to have wisdom, which may help to minimize loss-related distress; they may accept adverse life events with equanimity and acceptance (Baltes, Smith, & Staudinger, 1992).

Research on stress over the life course suggests, conversely, that spousal loss may be *more strongly* linked to subsequent distress for older adults, given that older adults are more likely to experience prior, co-occurring, or subsequent stressors that may overwhelm their ability to cope (Kraajj, Arensman, & Spinhoven, 2002). Older adults are more likely than younger persons to experience cognitive declines, financial pressures, the deaths of friends and loved ones, and the loss of physical strength and abilities (Arbuckle & deVries, 1995; Norris & Murrell, 1990; Zautra, Reich, & Guarnaccia, 1989). For these reasons, research on the consequences of widowhood should either examine separately the experiences of older adults versus younger adults, or should investigate systematically whether different patterns emerge for different age groups. Studies based on age-heterogeneous samples that simply control for the bereaved person's age cannot reveal the specific consequences of loss for older versus younger adults, and they may fail to show the distinctive risk factors for loss-related distress among older versus younger bereaved spouses.

THE CHANGING LIVES OF OLDER COUPLES (CLOC) STUDY

Sample Characteristics

Many unresolved and unexplored questions about late life widowhood can be addressed with the Changing Lives of Older Couples (CLOC) study, a large multi-wave prospective study of spousal bereavement. The CLOC study

is based on a two-stage area probability sample of 1,532 married men and women from the Detroit (Michigan) Standardized Metropolitan Statistical Area (SMSA).[1] To be eligible for the study, respondents had to be English-speaking members of a married couple where the husband was age 65 or older. All sample members were non-institutionalized and were capable of participating in a 2-hour face-to-face interview. Women were over-sampled in order to increase the likelihood that sample members would become bereaved during the study period; this decision was based on the widely documented finding that men have a higher risk of mortality than do women. Consequently, many analyses presented in this volume use weighted data in order to adjust for unequal probabilities of selection and differential response rates at the initial interview.

Baseline face-to-face interviews with the married older adults were conducted June 1987 through April 1988. The response rate for the baseline interview was 68%, which is consistent with the response rate from other Detroit area studies in that period. Spousal loss was monitored subsequently using monthly death record tapes provided by the State of Michigan and by reading the daily obituaries in Detroit-area newspapers. The National Death Index (NDI) and direct ascertainment of death certificates were used to confirm deaths and obtain causes of death. Of the 335 respondents known to have lost a spouse during the study period, 316 were contacted for possible interview (19 persons, or 6% had died during the interim). Of the 316 contacted, 263 persons (83%) participated in at least one of the three follow-up interviews conducted 6 months (Wave 1), 18 months (Wave 2), and 48 months (Wave 3) after the spouse's death. Each widowed person was "matched" with a same-age, same-sex, non-bereaved person from the baseline sample, and this matched control also was interviewed at each of the three follow-ups (see Table 2.1 for adjusted and unadjusted sample sizes, by gender and widowhood status, across all waves of data collection).[2]

As with all multi-wave surveys, the issue of selective attrition warrants attention. If persons who failed to participate in the follow-up interviews are significantly different from those who did participate, then the study find-

[1]The 1,532 married persons interviewed at baseline include 423 married couples, or 846 persons for whom complete data were collected from both self and spouse. This design feature enables researchers to undertake couple-level analyses, as well as to explore spousal concordance in terms of their evaluation of the marriage and both own and spouse's health.
[2]The variation in the number of controls interviewed at the 6- and 18-month follow-up interviews is due solely to the availability of funding.

TABLE 2.1

Unweighted and Weighted Sample Sizes, by Widowhood Status and Gender, Changing Lives of Older Couples

	Unweighted Sample				Weighted Sample			
	Baseline	Wave 1 (6 mos.)	Wave 2 (18 mos.)	Wave 3 (48 mos.)	Baseline	Wave 1 (6 mos.)	Wave 2 (18 mos.)	Wave 3 (48 mos.)
Total Sample	1,532	333	411	208	1,532	297	370	160
Male	474	46	60	20	725	87	109	25
Female	1,058	287	351	188	807	210	261	135
Widowed		249	198	106		210	168	85
Male		35	29	10		59	51	15
Female		214	169	96		151	117	70
Matched Control		84	213	102		87	202	75
Male		11	31	10		22	58	10
Female		73	182	92		65	144	65

Notes: The weighted sample adjusts for unequal probabilities of selection and differential response rate at baseline.

ings should not be generalized to the overall population of older widowed persons. In past analyses, researchers estimated logistic regression models to identify the correlates of nonparticipation in the Wave 1 and Wave 2 interviews, given that one participated in the prior interview (e.g., Carr, 2004). Gender differences in the sources of attrition also were explored, because widowhood is believed to increase the risk of mortality more for men than women (Kaprio, Koskenuvo, & Rita, 1987). Consequently, men who survive until (and participate in) the CLOC follow-up interviews may have better emotional and physical health than their female counterparts.

The attrition analyses evaluated potential predictors of Wave 1 nonparticipation, including baseline demographic and socioeconomic characteristics, pre-loss marital and nonmarital social support, physical and mental health, and spouse's health. Only three variables were statistically significant predictors of attrition, and these effects did not differ significantly by gender. Age and baseline anxiety increased the odds and home ownership decreased the odds of attrition. In models predicting Wave 2 nonparticipation (given that one participated in the Wave 1 interview), not one variable was a significant predictor ($p \leq .05$) of attrition at Wave 2. Nonetheless, caution should be taken in generalizing CLOC findings to the population at large because older, more anxious, and residentially mobile persons may be underrepresented.

Strengths of the CLOC Study

The CLOC study has several desirable properties that make it an ideal data set for studying the consequences of late life widowhood. First, all interviews with widowed persons (and matched controls) were conducted 6, 18, and 48 months following the death; thus all analyses hold constant the duration of time that has passed since the loss. Second, because the data are prospective and include rich information on the widowed persons, their spouses, and their marital relationship *prior to* the loss, researchers are able to study prospectively changes in psychological and social well-being after the loss. Moreover, it is possible to investigate and identify those factors that both increase one's risk of (or "selection" into) widowhood and that affect adjustment to widowhood. Third, all widowed persons are assigned a same-age and same-sex "matched control" from the baseline sample; therefore, the true effects of widowhood can be differentiated from those related to aging or the passage of time.

Fourth, the CLOC study was designed expressly to explore psychological, behavioral, cognitive, and financial consequences of loss. As such, it includes a wide array of important outcome measures, as well as rich data on the cause,

timing, and circumstances surrounding the late spouse's death (see Table 2.2 for a synopsis of substantive areas included in the study). Fifth, the sample includes both men and women, thus allowing the exploration of gender differences in the experience of widowhood. Finally, the CLOC study includes rich data on both *global* aspects of psychological and social adjustment, such as depression and anxiety, as well as specific *loss-related* outcomes, such as yearning and loss-related anxiety. As noted earlier, specific symptoms and

TABLE 2.2
Changing Lives of Older Couples Content: Selected Demographic, Psychosocial, and Physical Health Measures

Demographics: Age, gender, race, ethnicity, education, immigrant status, place of birth.

Spouse Characteristics: Demographic, health, and employment characteristics.

Living Arrangements: Housing tenure, household roster.

Children: Number, ages, and gender of children; physical proximity, frequency of contact, emotional support, instrumental support, perceived support given, perceived support received, changes in relationships after spousal death.

Occupational History: current employment status, work history, job satisfaction, retirement status, reason for retirement, satisfaction with retirement.

Finances: Income, perceived financial stress, direct costs associated with spousal death, insurance and estate settlement information.

Marital Quality: Marital closeness, conflict, dependence, decision-making.

Social Support: Frequency of contact, emotional support, instrumental support, perceived support given and received, changes in social support after spousal death.

Psychological Assessments: Depression, anxiety, self-esteem, personality, world views.

Religion and Spirituality: Religious affiliation, degree of religiosity, frequency of attendance at services, use of religion for coping, beliefs about the afterlife.

Physical Health: Self-rated physical health, symptoms, illnesses, history of hospitalization, functional limitations with basic and intermediate daily activities, sleep problems, health behaviors (including smoking, exercise, and alcohol use).

Characteristics of Spouse's Death: Age at death, death forewarning, level of pain, spouse's awareness of and understanding of death, perceived attribution for cause of death, degree, intrusiveness and stressfulness of care giving before spouse's death.

Psychological Responses to Death: Grief, anxiety, depression, crying, intrusive thoughts, yearning, despair, perceived personal growth and improvement, meaning-making, attitudes about life and death, loneliness, help-seeking.

Biomarkers and Physical Assessments: Balance, gait, waist-hip ratio, medications checklist, cognition, memory, blood pressure, peak expiratory flow, biomarkers (including creatinine, cholesterol, epinephrine).

behaviors may respond in very different ways to specific aspects of the widowhood transition, and these (potentially) competing effects may cancel out one another when only an aggregate scale is used as an outcome variable.

Other widely used grief scales, such as the Bereavement Index (Jacobs et al., 1986), Present Feelings about Loss (Singh & Raphael, 1981), and Texas Revised Inventory of Grief (Zisook et al., 1982), typically comprise several symptom subscales, such as anger or yearning (see Table 2.3). These subscales respond differently to different aspects of spousal loss, thus the use of an overarching grief scale may conceal patterns among more precise symptoms. Moreover, the CLOC obtains measures of loss-related psychological outcomes at three time points (i.e., at 6, 18, and 48 months following loss), and general psychological outcomes at four time points (i.e., baseline, and at 6, 18, and 48 months following loss). These multiple observations allow researchers to model *trajectories* of psychological symptoms (e.g., Bonanno et al., 2002).

TABLE 2.3
Summary of Items That Contribute to the Grief Scale and Subscales, Changing Lives of Older Couples

Anxiety (α = .71)	Afraid of what is ahead Felt anxious or unsettled Worried about how you would manage your day to day affairs
Despair (α = .64)	Life seemed empty Felt empty inside Felt life had lost its meaning
Shock (α = .77)	Felt in a state of shock Couldn't believe what was happening Felt emotionally numb
Anger (α = .68)	Felt resentful or bitter about death Felt death was unfair Felt anger toward God
Yearning (α = .75)	Longing to have him/her with you Painful waves of missing him/her Feelings of intense pain and grief Feelings of grief or loneliness
Intrusive Thoughts (α = .66)	Difficulty falling asleep, thoughts of him/her kept coming into your mind Tried to block out memories or thoughts of him/her Couldn't get thoughts about him/her out of my head
Grief (α = .88)	[All 19 items above]

The chapters presented in this volume take advantage of the unique design features of the CLOC, and explore questions such as how, why, and for whom does spousal loss affect physical health? What is the time course of grief symptoms experienced by the recently bereaved? To what extent do psychological reactions to loss reflect adjustment to secondary stressors, such as financial strain, or changes in one's social roles and relationships? The answers to these questions have important implications for policy and practice, and will provide the foundation for future generations of research on spousal bereavement in late life.

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CHAPTER 3

How Older Americans Die Today

Implications for Surviving Spouses

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Shifts in the timing and causes of death over the past 2 centuries have created a new context for living and dying. This chapter provides an overview of shifting mortality patterns in the United States over the past 2 centuries and describes how changes in the leading causes of death have created a context where death tends to occur at the end of a long chronic illness rather than quickly after the onset of an acute or infectious disease. Death today also strikes older persons more so than younger people, and men more so than women. How people die has important implications for how late life widowhood is experienced. Death is now a *process* rather than an *event,* and the dying process may pose multiple chronic stressors for the ailing patient's spouse, including difficult caregiving activities, problematic interactions with health care providers, witnessing a loved one's pain and physical and cognitive demise, and making difficult decisions about the type of care that the dying patient should receive. Yet chronic illness and anticipated death also may provide opportunities that sudden deaths do not; older couples can discuss and prepare for the impending death. This process of seeking closure can help to ensure a meaningful transition between life and death, marriage and widowhood.

HOW AMERICANS DIE: A BRIEF HISTORY OF MORTALITY

The experiences of widows and widowers are linked inextricably to how, when, and where their spouses died. Both the demography of death and cul-

tural practices surrounding death and dying in the United States have shifted drastically throughout history. In the 18th and early 19th centuries, death tended to occur at a relatively young age, and due to infectious diseases that could not be "cured." The dying person's final days often were spent at home, surrounded by family and friends. The loss of a loved one was expressed by dramatic displays of grief among survivors and elaborate efforts to memorialize the deceased (Aries, 1981).

Throughout the late 19th and most of the 20th century, death became "invisible" (Aries, 1981) and "bureaucratized" (Blauner, 1966). Physicians and hospitals assumed control over dying and death; mourning became private; the handling of dead bodies and funeral rites were transferred from private homes to funeral parlors; and people were encouraged to "deny" death and believe in medical technologies (Blauner, 1966). Treating dying persons in isolation was believed to help smooth the transition beyond death for both the dying person and the community. Reducing the social status and connectedness of those who were about to die was thought to minimize disruption of ongoing social and economic relationships (Aries, 1981).

The epidemiology of death also has changed dramatically (Omran, 1971). In the 19th and early 20th centuries, deaths occurred primarily because of infectious diseases, including diphtheria, tuberculosis, and pneumonia. Infectious diseases were a threat from the day of birth, and infants and young children were most susceptible to these conditions. In 1900, more than half of the reported deaths involved persons ages 14 and younger. Infectious diseases were remarkably egalitarian, and their onset was not stratified by social class or gender (Preston & Haines, 1991). As a result, men and women, rich and poor, were equally likely to become ill and die, and death often occurred relatively quickly after the initial onset of symptoms. By the mid-20th century, however, improvements in sanitation (including water purification system and sewage treatment improvements), nutrition, and medical interventions (such as immunization programs) helped to conquer infectious diseases (Omran, 1971). Infant, child, and maternal mortality rates dropped dramatically and life expectancy increased as late life deaths replaced infant and childhood deaths. Today, fewer than 3% of deaths each year occur among people ages 14 and younger. (National Center for Health Statistics, 1996).

In the latter half of the 20th and early 21st centuries, in contrast, death occurs overwhelmingly due to chronic diseases that strike late in the life course, such as cancer and heart disease. Today, nearly two-thirds of all deaths in the United States occur annually to persons ages 65 or older. Americans are now living longer than at any point in history. Between 1900 and 2003, life expectancy at birth increased from 46 to 74 years for men, and from 48 to

nearly 80 years for women. Shifts in the leading causes of death over the past century also have created a context where death is highly stratified by gender, social class, and lifestyle choices. Omran (1971) has characterized the current era as the age of "man-made diseases," because conditions such as heart attack, cancer, and stroke are linked closely to personal risk factors, such as smoking, drinking, substance use, work stress, and environmental stressors.

The gender gap in mortality also is a relatively recent phenomenon; gender differences in lifestyle, including men's elevated levels of smoking, alcohol use, and physical strain exerted at work, contribute to men's mortality disadvantage relative to women. As a result, older women currently outlive their male peers. In 2001, life expectancy at age 65 was 19 years for women and 16 years for men, while at age 85 women can expect to live another seven years and men can anticipate living another six years. This gender imbalance in mortality has led to the current gender imbalance in widowhood status. Today women over age 65 are three times as likely as their male peers to be widowed (44 versus 14%). Among persons age 85 and older, 78% of women and 35% of men are widowed (Federal Interagency Forum on Aging-Related Statistics, 2004). (See Wolff & Wortman, chapter 4, for a discussion of gender differences in late life bereavement experiences.)

The ways that dying persons experience their final months (or years) also have changed drastically throughout the 19th and 20th century. Because most deaths today occur at the end of a long, debilitating, painful, and progressive illness, the dying patient's final days are typically spent in a hospital or nursing home, and at least some life-sustaining technologies are used. Life sustaining technologies and medical innovations have increased the length, though not necessarily the quality, of older adults' lives. For many older adults, the final years are spent with at least some physical symptoms, and during their final days most dying elderly are short of breath, unable to eat, and have limited mobility, cognitive functioning difficulty, pain, and difficulty recognizing family (Brock & Foley, 1998).

Some researchers have argued that morbidity, or health symptoms and conditions, have come to overshadow mortality as an index of a society's health (Olshansky & Ault, 1986). The leading causes of death today among persons ages 65 and older are heart disease, malignant neoplasms (cancer), cerebrovascular disease (stroke), chronic lower respiratory disease, influenza and pneumonia, and diabetes mellitus. Each of these is typically accompanied by enduring symptoms and disability. An estimated 20% of older adults today struggle with chronic disability; these conditions typically include arthritis, osteoporosis, and senile dementia (Olshansky & Ault, 1986). Not surprisingly, significant proportions of older adults require assistance with

daily activities during their final years and months of life. Wiener, Hanley, Clark, and Van Nostrand (1990) estimate that roughly 5 to 8% of non-institutionalized older adults need help in bathing, dressing, getting up out of a chair or out of bed, toileting, or eating. Other studies offer higher estimates of the proportion of older adults who are classified as "functionally dependent." Hing and Bloom (1990) found that one-third of older women and one-fifth of older men could be classified as "dependent," defined as those who require assistance with at least one of seven activities of daily living (ADLs) such as eating, bathing, and toileting, or one of seven instrumental activities of daily life (IADL) including preparing meals or managing personal finances.

Bolstered by data on physical disability and cognitive decline at the end of life, death researchers now agree that dying is a process rather than an event (Kastenbaum, 1986). The dying process may follow one of several trajectories, however, with each having distinctive consequences for both the dying person and spouse. Glaser and Straus (1968) proposed that dying typically follows one of several trajectories, including "lingering" and "unexpected quick." The lingering trajectory is one in which a person gradually declines over a long period of time. Comfort care rather than aggressive treatment is the usual mode of medical intervention. In contrast, the unexpected quick death, when death comes suddenly and with little forewarning, is generally considered the most distressing for both health care providers and surviving family members (Glaser & Straus, 1968).

DEATH TIMING AND BEREAVED SPOUSES' WELL-BEING

The proposition that sudden "unexpected quick" deaths are more difficult for family members to cope with than anticipated deaths first received empirical support in Lindemann's (1944) classic study "Symptomatology and Management of Acute Grief." Wives of the men serving in World War II experienced grief-like symptoms (or "anticipatory grief") before their husbands died but managed to disengage emotionally in anticipation of their deaths, and they did not appear to be highly grief-stricken upon the actual death. In contrast, the relatives of young adults killed suddenly in a nightclub fire suffered severe grief symptoms (Lindemann, 1944).

Building upon this seminal work, many bereavement scholars have concluded that individuals who anticipate their spouse's death will use the forewarning period to prepare psychologically and practically for the transition to widowhood. Although spouses may exhibit grief-like symptoms during the pre-death period, their post-loss adjustment is believed to be better than

those who experienced a sudden loss (Gerber, 1974, p. 27; Rando, 1986; Vachon et al., 1982). The forewarning period may be used for the resolution of conflicts with the dying person while he or she is still alive. Moreover, couples who use the time between diagnosis and death to resolve emotional "unfinished business" (Blauner, 1966) may find their relationships strengthened in the final days. Practical plans for the survivor's economic and social adjustment also can be made during the forewarning period, and this may enable an easier adjustment to the loss (Rando, 1986).

Early studies examining the effect of death forewarning on widowed persons' psychological adjustment are inconclusive, however. Many studies suggest that sudden spousal death is associated with poorer psychological adjustment among the widowed (Ball, 1977; Carey, 1979–1980; Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Glick, Weiss, & Parkes 1974; Hill, Thompson, & Gallagher, 1988; Jacobs, Kasl, & Ostfeld, 1986; Lundin, 1984; O'Bryant, 1990–1991; Smith, 1978; Vachon et al., 1982; Wells & Kendig, 1997; Willis, Thomas, Garry, & Goodwin, 1987; Zisook, Shuchter, & Lyons, 1987). A smaller group of studies finds the reverse—that advanced forewarning is linked to poorer adjustment among the widowed (Fengler & Goodrich, 1979; Gerber, Rusalem, Hannon, Battin, & Arkin, 1975; Sanders, 1982–1983; Schwab, Chalmers, Conroy, Farris, & Markush, 1975). A third group of studies finds no relationship between death forewarning and survivors' psychological adjustment (Bowling & Cartwright, 1982; Clayton, Halikas, Maurice, & Robins, 1973; Hill et al., 1988; Maddison & Walker, 1967; McGloshen & O'Bryant, 1988; Roach & Kitson, 1989; Sanders, 1982–1983).

These inconclusive findings may reflect the fact that most studies of death forewarning have not explicitly considered the distinctive ways that older and younger adults experience the "sudden" versus "anticipated" deaths of their spouses (Stroebe & Schut, 2001). If death timing affects young and older adults in different ways, then these competing effects may cancel out one another in studies based on mixed-age samples. Moreover, most research has focused on premature or "off-time" widowhood among young and midlife adults (Ball, 1977; Glick et al., 1974; Lindemann, 1944; Lundin, 1984; Sanders, 1982–1983; Vachon et al., 1976). Other studies have focused solely on sudden deaths occurring under particularly horrific circumstances such as murders (Rynearson, 1984) or suicides (Calhoun & Allen, 1991; Dunn & Morrish-Vidners, 1987; Reed, 1998; van der Wal, 1989–1990). Because deaths of young persons and violent deaths are considered the most difficult to cope with (Archer, 1999; Parkes & Brown, 1972; Reed, 1998; Roach &

Kitson, 1989; Smith, 1978; Vachon et al., 1976), it is not clear whether the deleterious effects of sudden losses are due to suddenness, life stage, or a combination thereof (i.e., sudden and premature death).

For older adults, the stressors associated with death forewarning may cancel out the gains presumably provided by the period of forewarning (Rando, 1986; Siegel & Weinstein, 1983). For instance, while prolonged forewarning periods may allow spouses to prepare psychologically and practically for the loss (Kalish, 1981; Rando, 1986), the warning period may also be accompanied by difficult caregiving duties (Aneshensel, Pearlin, Mullan, Zarit, & Whitlach, 1995; George & Gwyther, 1984; Norris & Murrell, 1987; Wells & Kendig, 1997), emotional isolation from family members and friends (Kramer, 1996–1997), and the neglect of one's own health (Fengler & Goodrich, 1979; Rosenblatt, 1983; Sanders, 1982–1983; Siegel & Weinstein, 1983; Sweeting & Gilhooly, 1990). The dying patient also may be subject to physical pain, problematic medical care, and difficult decisions about future medical treatments (Carr, 2003); each of these conditions may be distressing to a spouse who is watching the events unfold. The stressors related to the "extended death watch" period (Gerber et al., 1975) may be particularly difficult for older adults who are suffering from their own health problems, or from the deaths of their friends, siblings, and parents (Averill & Wisocki, 1981; Fengler & Goodrich, 1979; George & Gwyther, 1984).

Research based on the Changing Lives of Older Couples (CLOC) study has investigated whether and how death forewarning affects older bereaved spouses' adjustment to loss (see Carr, chapter 2, for detail on the CLOC study). Carr, House, Wortman, Nesse, and Kessler (2001) evaluated the psychological impact of three types of spousal deaths: sudden deaths, deaths where the survivor had fewer than 6 months' forewarning, and deaths where the survivor had at least 6 months' forewarning. A diverse array of bereavement-related symptoms were measured as outcomes, including anxiety, depression, grief, intrusive thoughts, and yearning; these outcomes were evaluated both 6 and 18 months following the loss. Importantly, the researchers controlled for other death characteristics that may be confounded with forewarning, including intensity of spousal caregiving and whether the dying patient and spouse discussed the impending death. The analyses showed that neither sudden nor anticipated deaths are uniformly distressing for older adults; rather, the psychological consequences vary across outcomes. For instance, older adults whose spouses died suddenly had elevated levels of intrusive thoughts 6 months after the loss, although the effect faded by the 18-month follow-up. Intrusive thoughts, or painful, unprovoked thoughts about the deceased, are a symptom of posttrau-

matic stress disorder. Such thoughts frequently plague survivors of sudden, shocking losses, such as accidents, suicide, or homicide (Archer, 1999; Zisook, Chentsova-Dutton, & Shuchter, 1998; Kaltman & Bonanno, 1999). However, their incidence has rarely been studied among the elderly bereaved.

Sudden death affected men's and women's yearning (or longing for their deceased spouses) in different ways. Sudden death was associated with lower levels of yearning among widowers, yet higher levels of yearning among widows. Widowers yearned most for their deceased wives when they died after a long forewarning period. This gender difference may reflect the ways that men and women relate to their spouses during marriage. For men, the forewarning period may be a time when they experience increased closeness with their spouse and isolation from others. During this time, men may become even more emotionally bonded to their spouse, at the expense of relationships with others. Given gender differences in mortality, men may have few same-sex peers who are also awaiting an ill wife's death. In contrast, women may rely on their female friends' direct experience with spousal illness to help them through the difficult dying process and thereafter (Fooken, 1985).

Prolonged forewarning (i.e., more than 6 months' warning) was associated with elevated anxiety levels among widows and widowers both 6 and 18 months following the death. These effects could not be explained away by stressors such as caregiving demands. This pattern may reflect the fact that elderly patients dying slowly may be suffering from long-term cognitive impairment. Unlike other anticipated deaths which may allow time for discussions and closure, dementia and Alzheimer's disease may prevent the dying patient from communicating with loved ones during their final days, and from finding meaning in the dying process. However, this hypothesis could not be evaluated because the CLOC sample does not include detailed data on Alzheimer's or severe dementia among the decedents. Overall, research by Carr and colleagues (2001) suggests that for older adults, even "sudden" deaths may be anticipated and viewed as timely (Neugarten & Hagestad, 1976). As a result, sudden spousal loss among older adults may be less distressing than it is among younger and midlife widows and widowers.

THE STRAINS OF THE DYING PROCESS

A prolonged dying process may impose multiple strains on the dying patient's spouse and other family members. For older adults, these strains may include the depletion of economic resources, burdensome caregiving,

dissatisfaction with or disagreements over appropriate medical and/or palliative care arrangements, and guilt or psychological distress following decisions about end-of-life care.

Financial Strains

The costs imposed by protracted illness, long-term care, and acute medical care present a substantial financial threat to most older adults, their families, and the federal government (Field & Cassel, 1997; Lynn & Adamson, 2003; Warshawsky, 2000). Annual health care expenditures for individuals ages 65 and older in the last year of life are estimated to range from roughly $25,000 to 30,000 (e.g., Emanuel et al., 2002; Hogan, Lunney, Gabel, & Lynn, 2001; Hoover, Crystal, Kumar, Sambamoorthi, & Cantor, 2002), with Medicare financing the bulk of these expenses (Hogan et al., 2000). Roughly 30% of all Medicare expenditures are for care during the last year of life. Still, family members bear a considerable burden; nearly one-third of recently bereaved older adults say that they have lost most or all of their family savings due to direct costs associated with caregiving (Hogan et al., 2000). Family members also experience indirect costs; caring for one's ailing spouse may preclude full-time or part-time paid employment, which leads to lost income. Roughly one in five family caregivers reports that they must quit work or make a major change in their daily activities (Covinsky et al., 1994). These financial strains may persist after the spouse dies, creating anxiety for the surviving spouse. For bereaved spouses, particularly older widows, financial problems are an important influence on one's overall psychological well-being (e.g., Umberson, Wortman, & Kessler, 1992; Utz, chapter 5).

Caregiving Strains

The most widely studied stressor associated with the dying process is spousal caregiving, and the ways that caregiving affects older adults both before and after their spouse dies (e.g., Wells & Kendig, 1997). For older adults caring for terminally ill spouses, the management of health symptoms and treatment regimens can be particularly distressing. As noted earlier, chronic illnesses now account for the majority of deaths to persons ages 65 and older, with heart disease and cancer accounting for roughly 60% of those deaths and diabetes accounting for another 3%. New medical technologies and therapies have extended the length of ailing patients' lives, but adherence to treatment programs and survivorship regimens can negatively affect the quality of life for both the dying and their family members. Treatments for many life-threatening diseases are now carried out on an ambulant basis, so

the provision of care is often the responsibility of patients and their families (Schachter, 1992).

For example, advances in cancer care now require that family members manage complex medication regimes, including parenteral infusion, or parenteral and intraspinal medications. Moreover, cancer patients' treatments are being administered increasingly on an outpatient basis and may continue for years (Lynn & O'Mara, 2001). Even less severe health conditions may pose challenges for a caregiving spouse. For instance, older adults often must manage difficult and restrictive dietary regimes when their spouse has diabetes or high blood pressure. Adherence to these regimes may cause distress, or may distract an older adult from attending to his or her own health symptoms.

Even persons who are caring for relatively healthy yet frail spouses may find that caregiving is a time-consuming activity that encompasses giving assistance in activities of daily living (e.g., dressing, eating, walking, toileting, or hygiene) and/or instrumental activities like shopping, housework, bill paying, food preparation, or transportation assistance (Prigerson et al., 2003). Caregivers not only experience the burdens of providing direct care to loved ones, but they also may witness their loved ones in physical or psychological distress. As a result, multiple studies document that caregiving has a deleterious effect on health and well-being (e.g., Chentsova-Dutton et al., 2000; Patterson & Grant, 2003). Caregivers show greater vulnerability to physical illness than do non-caregivers, as evidenced by their poorer self-rated health, poorer immune function, and elevated use of health care services (Schulz, Visintainer, & Williamson, 1990; Vitaliano, Zhang, & Scanlan, 2003). Highly stressful caregiving may even heighten one's risk for mortality. In a prospective study controlling for sociodemographic factors and physical health status, caregivers who both provided support to their spouse and reported caregiving strain were 63% more likely to die within 4 years than caregivers without strain, or matched controls who were not providing care (Schulz & Beach, 1999).

Caregiving also is associated with decrements in psychological well-being (Bookwala, Yee, & Schulz, 2000; Patterson & Grant, 2003). Pinquart and Sörensen (2003) conducted a meta-analysis of 84 articles on differences between caregivers and non-caregivers. They found that caregivers were more stressed and depressed, and had lower levels of subjective well-being, self-efficacy, and physical well-being than non-caregivers. The differences between caregivers and non-caregivers were greater for mental health than for physical health outcomes (see also Schulz, O'Brien, Bookwala, & Fleissner, 1995).

The psychological consequences of caregiving vary with the intensity of one's caregiving activity. Depressive symptoms increase as the number of

hours one engages in caregiving increases (Schulz et al., 2001). This finding is important because caregiving is often a very time-consuming activity for older adults. Older adult caregivers report spending at least 46 hours per week in informal care for loved ones with dementia (Schulz et al., 2003), 70 hours per week caring for Alzheimer's patients (Max, Webber, & Fox, 1995), and 120 hours per week caring for end-of-life care patients with lung cancer and dementia (Haley, LaMonde, Han, Narramore, & Schonwetter, 2001). More than half the caregivers in a study by Schulz et al. (2003) reported that they felt they were "on duty" 24 hours a day. Consequently, these demands often impinge on caregivers' well-being: they may not get enough rest when sick, may forget to take medication, and may not have enough time to go to the physician or to eat well and exercise (Schulz et al., 2001). Intensive caregiving also may prevent older adults from participating in leisure and social activities that improve their own quality of life (Beery et al., 1997, Seltzer & Li, 2000).

Caregivers' Adjustment to Widowhood

The high levels of stress experienced by caregivers suggest one of two courses of adjustment once their ill spouse dies. On one hand, the death may come as a relief from distressing caregiving activities. On the other hand, the caregiver's already compromised physical and emotional well-being may be overwhelmed by the new stressor of widowhood. Qualitative data show that both responses are common. Koop and Strang (2003) conducted open-ended interviews with bereaved persons who had provided home-based caregiving for family members with advanced cancer. Most caregivers reported mixed feelings; they reported positive reactions, including feelings of accomplishment and improved family relationships, as well as negative reactions such as haunting images and feelings of failure.

Koop and Strang's (2003) study raises two important questions: What happens to bereaved spouses when caregiving ends? What characteristics distinguish those caregivers who experience resilience versus distress in the face of loss? Scholars have proposed two competing models that characterize caregivers' adjustment to spousal death—the Relief Model and the Complicated Grief Model (see Bernard & Guarnaccia, 2003). The Relief Model suggests that persons who perceive caregiving as stressful will experience some relief when their spouse dies, because care responsibilities end (Bass & Bowman, 1990). At the same time, these caregivers have had the opportunity to "work through" their sense of loss during the lengthy caregiving period, and to detach themselves psychologically from their dying spouse. The alterna-

tive Complicated Grief Model posits the opposite: Greater care-related strain is associated with greater distress during bereavement, possibly because coping resources were used up in the long caregiving period.

Empirical studies offer support for both models. In a study that tracked the experiences of widowed persons who had been caring for a spouse with Alzheimer's, Robinson-Whelen, Tada, MacCallum, McGuire, and Kiecolt-Glaser (2001) found support for the Complicated Grief Model. Although former caregivers experienced decreases in stress and negative affect after the loss, they did not improve on several measures of psychological well-being. Specifically, their scores on depression, loneliness, and positive affect did not rebound to levels comparable to non-caregivers, but instead remained similar to those of *current* caregivers for up to 3 years after caregiving had ceased. The authors concluded that adjustment following a long period of caregiving for a spouse with dementia may pose distinctive challenges that persist long after the loss. Similar results were found by Bodnar and Kiecolt-Glaser (1994). In general, the association between caregiving and post-loss distress increases as one's retrospective rating of caregiving strain increases (Bass & Bowman, 1990). Bernard and Guarnaccia (2003) tested explicitly whether caregiving strain results in relief or in further difficulties following the death of a loved one, in a sample of caregivers of breast cancer hospice patients. They found that husband caregivers' reactions were consistent with the Complicated Grief Model, where greater caregiver role strain predicted more difficult adjustment to loss.

However, other studies provide support for the Relief Model. In a prospective, population-based cohort matched-control study, Schulz and colleagues (2001) assessed the effect of bereavement on family caregivers. They compared pre- versus post-death health outcomes among elderly persons who had been providing varying levels of care prior to their spouse's death. Three groups were compared: caregivers with strain, caregivers with no strain, and non-caregivers. The respondents were assessed for changes in depressive symptoms, antidepressant use, and health risk behaviors. During the pre-bereavement caregiving period, the strained caregiver group reported higher levels of depressive symptoms and poorer health practices (e.g., neglecting to take medication, not exercising) than caregivers with no strain or non-caregivers. Following the death of their spouse, the strained caregivers displayed no further increases in depressive symptoms or antidepressant use, but instead reported improved health practices. Bereaved non-caregivers and non-strained caregivers showed increased levels of depressive symptoms after the loss, but no important changes in their health behaviors.

More recently, Schulz and his collaborators (2003) studied family caregivers providing care for loved ones with dementia, and the caregivers'

responses to the death of the patient. They found that caregivers exhibited high levels of depressive symptoms while providing care. After the death, they were remarkably resilient, and showed a dramatic decrease in depressive symptoms. Over 90% of the caregivers said they believed that the death came as a relief to the patient, and 72% said that the death was also a relief to them.

These results are similar to those reported by Bonanno et al. (2002) based on the CLOC data. These investigators found that bereaved persons showing a dramatic and lasting improvement in depressive symptoms following their spouse's death were more likely to have had an ill spouse than those respondents who showed chronic grief symptoms following the death. The latter respondents were more likely to have had a healthy spouse. If they did provide care, they typically did not report caregiver strain. Other studies have shown that caregivers' psychological resilience occurs relatively quickly after their loss. For example, Chentsova-Dutton et al. (2002) found that the relatively high levels of depressive symptoms reported by caregivers prior to loss continued shortly after the loss (i.e., at a 2-month follow-up). However, by 7 months after the loss, these caregivers rebounded and reported depressive symptom scores that were no higher than non-caregivers and non-bereaved persons.

Most studies assessing the Relief and Complicated Grief models conceptualize caregiving as a stressor, and typically focus on the presence, absence, or intensity of this purported stressor. However, a new and emerging body of research focuses explicitly on positive aspects of the caregiving experience, and the implications for bereaved spouses (Haley et al., 2001; Hunt, 2003). Recent studies suggest that the caregiving experience may increase closeness between patient and caregiver (Hinrichsen, Hernandez & Pollack, 1992; Vachon et al., 1982; Wilson, 1990), and may provide a lasting sense of purpose to the caregiver (O'Bryant, Straw, & Meddaugh, 1990; Richards, Acree, & Folkman, 1999; Richards & Folkman, 1997; Wright, 1991).

Boerner, Schulz, and Horowitz (2004) recently examined how positive aspects of caregiving affect adjustment to loss among older men and women who had been caring for a loved one with dementia. The study's focus was on the effect of caregiving "benefit," where benefits included beliefs such as caregiving made them "feel useful," or made them "appreciate life more." Boerner and colleagues (2004) found that pre-loss caregiving benefit was associated with higher levels of post-loss depression and grief, even after controlling for caregiving burden and other contextual factors. Their findings underscore the often counterintuitive linkages among caregiving, bereavement, and survivor well-being. Although bereaved caregivers may experience "relief" when

their ailing spouse dies, those who found meaning and solace in caregiving often have a more difficult adjustment to loss. Taken together, these studies suggest that practitioners should recognize that those who are at the greatest risk of distress during the dying process may fare relatively well in the post-loss period, and vice-versa.

LIVING ARRANGEMENTS AND MEDICAL CARE AT THE END OF LIFE

When older adults are no longer able (or willing) to provide informal care to their dying spouses, these spouses may require formal care from physicians, nurses, hospice workers, or home health aides. The quality and type of care that patients receive varies based on where they spend their final days. Whether the patient dies at home, in a hospital, in hospice, in a nursing home, or elsewhere may have important implications for their spouse's well-being, both prior to and after the death. Place of death, like cause of death, has changed drastically throughout the past century. Whereas death typically occurred at home in past centuries, older adults dying of chronic illnesses today are much more likely to die in an institution than in their own home. The majority of older adults today die in hospitals (57%). Roughly equal proportions die in nursing homes (17%) and in their own homes (20%). This experience departs starkly from most adults' preferences: 70% of Americans report that they would like to die at home (Brock & Foley, 1998).

The increase in institution-based deaths reflects several important social and contextual factors. First, advancements in medical technology mean that dying persons often require care that cannot be offered in the home. Second, life expectancy is higher than ever before, and even relatively healthy older patients may be frail enough that they require care from a nursing home or long-term care facility. Third, shifts in residential patterns and family structure have occurred. Geographic mobility, declines in birth rates, and increasing rates of divorce mean that the number of relatives or long-term friends available to care for an individual at the end of life are declining. Thus, the end of life is often spent in an institution, and not in one's home—as most dying patients and their loved ones had hoped for.

Place of Death and Survivor Adjustment

Evidence is mixed as to how the place of death affects the bereaved spouse's adjustment. As noted above, multiple studies reveal that most adults would prefer to die at home, and prefer that their loved ones spend their final days

at home (e.g. Brock & Foley, 1998). There is suggestive evidence that at-home deaths may be less distressing for the surviving spouse as well as for the patient. Bereaved persons who were by their ailing spouse's side at the moment they died, and who were able to say "good bye," tend to cope better with the loss than those who did not reach such closure (Bennett & Vidal-Hall, 2000; Fiewiger & Smilowitz, 1984–1985; Hinds, 1985). These two scenarios may be more likely to occur at home than at a hospital or nursing home, given that continued co-residence enables the patient and spouse to spend continuous time together.

Other studies suggest, conversely, that a death occurring in an institution may be less distressing for surviving spouses. The institutionalization process has been characterized as "quasi-widowhood," because older adults have considerably reduced daily contact and communication with their spouse, may emotionally detach from their spouse, and are spared the daily stresses of direct caregiving (DeSpelder & Strickland, 1992; Rosenthal & Dawson, 1993). As a result, these spouses may be better prepared for the impending loss. Grant et al. (2002) offer empirical support for this perspective. In a prospective study, they examined the psychological and physical consequences of moving one's spouse from the home to an assisted living community or long-term care facility. All study participants were spouses who were providing care at home when the study began. Both caregivers who placed their spouse in long-term care facilities and caregivers whose spouses died showed improvement in depressive and physical symptoms, compared with continuing caregivers and non-caregivers. The authors conclude that this improvement may reflect the older adults' relief from chronic worry and the emotional and physical demands imposed by caregiving. This reprieve, they argue, may outweigh the psychological costs incurred from guilt over placement, or from the death of their spouse. However, the protective effects of nursing home placement were limited to psychological health outcomes. After caregiving responsibilities ended, former caregivers showed physiological stress responses (i.e., heightened systolic blood pressure) that persisted for up to 12 months after either spousal death or placement of one's spouse in a nursing home. Overall, however, Grant et al. (2002) offer compelling evidence that caregivers may benefit psychologically from placing their loved one in a care facility prior to his or her death.

New and mounting research suggests that not all institutions are equal; rather, some sites of care are more conducive to a "good death" for the patient, and consequently, his or her surviving spouse. Hospice care, in particular, may help ease older spouses' transitions to widowhood. Hospice care provides an alternative to the medical, scientific model of dying, and can be

offered either in-hospital or at home. Pain management, open communication among family, patient, and care providers, and a peaceful accepted death are the core goals of hospice (National Hospice and Palliative Care Organization, 2001). This mode of care began in the United States in the early 1970s to promote palliative care at the end of life, and its use has increased markedly over the past 2 decades, particularly among the dying elderly (National Hospice Organization, 1995). To date, roughly 300 of the nation's 6,000 hospitals have palliative care programs in place, and an additional 200 have plans to establish such a program (Pan, Morrison, & Meier, 2001).

Several recent studies suggest that family members report both better psychological adjustment after loss and more positive evaluations of their spouse's quality of care at the end of life when their loved one spent his or her final weeks using in-home hospice services, compared with those who were cared for in nursing homes, hospitals, or at home with home health nursing services (Teno et al., 2004). Families of patients who had used hospice care were less likely to say that their loved one had unwanted pain and were more likely to say they were satisfied with their medical care and with physician communication about medical decisions.

Similar findings have been reported by other investigators. For example, Miller, Mor, Gage, and Coppola (2000) found that bereaved older adults report fewer anxiety symptoms prior to the loss and fewer depressive symptoms during bereavement when they and the patient used hospice care. Moreover, in a recent matched cohort study with a population-based sample of nearly 200,000 respondents in the United States, Christakis and Iwashyna (2003) found that hospice use may reduce the increased mortality risk associated with bereavement. By 18 months after the loss, there were significantly fewer deaths among wives whose husbands had received hospice care than among those whose husbands received other types of care (typically a combination of home care with occasional hospital stays). Mortality was also lower for husbands whose wives received hospice care, but the effect fell short of statistical significance.

Although these results are encouraging and suggest that expanded use of hospice services may help older adults as they transition to widowhood, such a solution would be difficult to implement. Fewer than 20% of Americans who die today use hospice care (NHPCO, 2001). Both current health policies and social context factors may prevent some from using hospice, even if they would like to. Medicare reimbursement for hospice requires that two physicians certify a six-month prognosis for the dying patient. Prognosticating life expectancy is a challenging task for physicians, and accurate prediction is rare for patients other than those dying of cancer (Christakis & Lamont,

2000; Fox et al., 1999). Moreover, hospice usually requires that the dying patient has a close family member or friend to participate in their care.

Hospice care, especially home-based hospice—which accounts for nearly three-quarters of all American hospice patients—is most viable when a relative who can be primary caregiver lives in the home and can assume responsibility for care. Persons who are widowed, or whose spouse is too ill to provide care may not be able to take advantage of hospice. In fact, some estimates show that roughly half of hospice programs do not admit patients who have no primary caregiver (National Hospice Organization, 1997). Although hospice provides benefits to the dying and their spouses, not all have equal access to this benefit. Finally, several studies suggest that even caregivers who turn to hospice or who place their spouse in a long-term care facility still face difficult caregiving duties; many still feed, groom, and shop for the dying patient, and some take on new tasks such as interacting with administrators and becoming an advocate for the dying (e.g., Keefe & Fancey, 2000).

A "Good Death"?

The place of a spouse's death, and more important, the type of medical and personal care that he or she receives at the end of life, not only affects the "quality" of the patient's death, but also may affect the surviving spouse's adjustment. In the past 10 years, scholars, ethicists, and policy makers have sought to define a "good death" and to identify those aspects of the "good death" that are most important for surviving spouses' adjustment to the loss. Conceptualizations of the "good death" typically include the following attributes: dying persons should be aware of and at peace with their impending deaths; the dying should be surrounded by loved ones; death should occur at the end of a long and full life; the dying process should not be burdensome to others; the death should be relatively pain- and distress-free; and the dying (or their families) should control decisions about end-of-life treatment (Field & Cassel, 1997; Hospice Education Institute, 2001; National Hospice Organization, 1997; Pierce, 1999; Singer, Martin, & Kelner, 1999; Steinhauser et al., 2000).

Late life deaths typically meet at least one of the critical criteria for a "good death"; by definition, late life deaths are generally considered "timely" and occur at the end of a long and full life. Callahan (1993) has observed that deaths to young persons are retrospectively described with regret, while deaths to older persons are described as sad but expected and acceptable events. To what extent do late life deaths comply with the other widely agreed upon criteria for a "good death"? Two recent studies have sought to answer

this question, and to specify whether death "quality" affects survivor well-being. Prigerson and colleaguges (2003) evaluated the quality of life among dying patients; evaluations were based on the reports of 76 hospice-patient caregivers (32% of whom were spouses). The caregivers had cared for their relatives for two years, on average, before the hospice admission. More than three-quarters reported that they had witnessed the patient in severe pain or discomfort, and 62% of them said they witnessed this daily. Nearly half reported that the patient was unable to sleep, or unable to eat or swallow on a daily basis. More than 40% thought the patient had "had enough."

Research based on the CLOC study also asked recently bereaved spouses to evaluate the "quality" of their spouse's death on a variety of indicators; these evaluations were measured 6 months after loss (Carr, 2003). The study revealed that there may be two paths to the "good death," one sudden and one anticipated, with each requiring different interventions and practices to ensure survivor and patient well-being. The proportion of bereaved spouses reporting that their spouse was in pain, received inappropriate care, or had psychological or social difficulties at the end of life varied widely based on whether their spouse died suddenly or after some forewarning.

Sudden deaths (versus anticipated deaths) were found to spare the decedent of two negative aspects of the dying process: physical pain (18 versus 47%) and high levels of dependence on their spouse for care. Spouses of those who died suddenly provided only 12 hours of care per week prior to the death, compared to 34 hours per week among survivors whose spouses died after a forewarning period. Those who died suddenly, however, were far less likely to have accepted the idea of dying (as evaluated by their surviving spouse). Persons who died suddenly were less likely to have been at peace with the idea of dying (11 versus 50%), to be aware that they were dying (16 versus 64%), and to have discussed their impending death with their spouse (3 versus 37%). Both sudden and anticipated deaths were equally likely to have occurred at the end of "a full life" (84%), and to have occurred with their spouse by their side (44%). Only 7% of bereaved spouses reported that their late spouse received negligent medical care at the end of life.

One important finding that emerged from both studies (Carr, 2003; Prigerson et al., 2003) is that perceived quality of end-of-life care is linked to survivors' adjustment. Carr (2003) found that bereaved spouses who believe that their loved one's medical care was negligent reported elevated anger symptoms, while those who reported that their loved one was in severe pain had elevated levels of yearning, anxiety, and intrusive thoughts. Similarly, Prigerson and colleaguges (2003) found that higher exposure to patient distress was associated with negative consequences for the caregiver such as depression.

Studies that explore the linkage between death quality and survivor's adjustment tend to share an important methodological limitation, however. The bereaved person's post-loss psychological health may bias their retrospective evaluation of the death process. For instance, angry persons may be particularly likely to "recall" that their deceased spouse's physician was unresponsive to the patient's needs, while a highly depressed survivor may perceive that he or she did not provide adequate care to their dying spouse. However, we believe that such recollections and perceptions are important in their own right. The ways that a bereaved spouse makes attributions (or causal explanations) for their loved one's death has important implications for their adjustment to loss (Bennett, 2004; Field & Bonanno, 2001). Attribution theory generally predicts that persons who blame themselves for a negative outcome are likely to experience psychological distress and guilt, while those who blame an external source tend to report higher levels of anger (Weiner, 1985). One's attributions for their spouse's death and the emotions that either gave rise to or result from these attributions may portend the bereaved spouse's future adjustment to loss. Anger typically follows from an event that violates or challenges one's values, whereas guilt typically follows events where the "wrongdoer" holds him or herself accountable and blameworthy for some moral violation (deRivera, 1984). Anger, in turn, is considered a particularly problematic bereavement symptom, because it is linked to social isolation and rejection of social support (Parkes, 1970). Guilt, in contrast, may motivate a futile desire to make things right with the deceased spouse (deRivera, 1984; Field & Bonanno, 2001). Practitioners working with older bereaved persons may develop more effective interventions by considering the surviving spouse's beliefs about how and why their spouse died; these interpretations may provide important insights into their future adjustment to loss.

End-of-Life Decisions

Another critical component of the "good death" is whether the patient's and family members' preferences for end-of-life care were met. Concern among patients, family members, and care providers about costly, painful, futile, or unwanted end-of-life care (e.g., Field & Cassel, 1997; SUPPORT, 1995) has sparked a number of policies and practices geared toward placing control of the dying process in the hands of patients and their families. The most sweeping reform was the passage by Congress (1990) of the Patient Self-Determination Act. This Act requires all government-funded health care providers to give patients the opportunity to complete an advance directive when they are admitted to a hospital. (An advance directive, sometimes called a "living will," is

a formal document that specifies the medical treatment a dying patient would like to receive in the event that he or she is incapacitated.)

Although the American Medical Association (1996) and the American Geriatric Society (1995) have urged older adults to complete an advance directive, only 2 to 15% of Americans have done so (Ott, 1999). Even persons with written advance directives have no guarantee that their treatment preferences will be adequately transmitted, understood, or followed (SUPPORT, 1995). There are many conditions under which the advance directive may not effectively transmit the patient's wishes: if the content is unclear, the specific preferences stated are not relevant to the dying patient's condition, the physician does not have access to the document at the critical decision-making moment, and/or if family members do not know or support the content of the document (Coppola, Ditto, Danks, & Smucker, 2001; Ditto et al., 2001; Field & Cassel, 1997; Miles, Koepp, & Weber, 1996). Recent research on family members' and physicians' knowledge of dying patients' preferences offers a discouraging glimpse into end-of-life decision making. The main reason why older persons do not have a living will is that they feel that they can rely on family members to make health care decisions for them (Elpern, Yellen, & Burton, 1993; High, 1994).

Despite widespread reliance on family members at the end of life, one of the most disheartening findings repeated across clinical studies of end-of-life decision making is family members' limited knowledge and understanding of the dying patient's preferences (e.g., Coppola et al., 2001; Field & Cassel, 1997; Miles, Koepp, & Weber, 1996). Moreover, patients who do not make their wishes for treatment known are more likely to be overtreated than undertreated. These (often) futile and unwanted life-extending treatments may prolong the patient's pain and suffering, and subject their families to medical costs that far exceed the costs of palliative care (Field & Cassel, 1997; Teno, McNiff, & Lynn, 2000). Medical care that has been deemed futile is estimated to account for roughly 4% of Medicare expenditures (Emanuel & Emanuel, 1994). However, patients who do desire aggressive medical care also might have their preferences neglected; this may be particularly true for those with the fewest economic and social resources. Life-sustaining treatment for patients without decision-making capacity may be foregone if the patient's surrogate relates that this was the patient's actual wish, if family members disagree with the patient's desire for aggressive treatment, or if the patient's current financial resources or insurance coverage are not sufficient to cover their needs (Field & Cassel, 1997; Meisel, Snyder, & Quill, 2000).

The extent to which family members plan for the dying person's end-of-life care may have important implications for both the dying and their

surviving spouse. A clearly formulated plan for end-of-life care will protect the dying person from unwanted and potentially futile care and may even enhance the quality of his or her final days. The dying process has been described as an experience that strips patients of the traits that make them a "whole human person" (Sulmasy, 2002). Careful end-of-life planning may enable the dying person to maintain positive relationships with family members, and to enact important aspects of the self throughout the course of their illness. For instance, specifying their precise preferences for end-of-life treatment is one way that religious adults may ensure that their medical care accords with their religious and spiritual views. Moreover, persons who have formal written instructions for late life medical treatments may be better able to focus on their spiritual, existential, and interpersonal concerns—rather than symptom management—during their final weeks. Clearly articulated plans also spare family members from making difficult and distressing decisions in cases where the dying person becomes incapacitated and cannot make such decisions for himself or herself.

To date, however, little is known about the ways that end-of-life planning affects the bereavement experience of surviving spouses. Making decisions about a loved one's care without the dying patient's input are potentially distressing. Spouses who decide to withhold treatment may suffer from guilt and family discord following their decision, whereas those who decide to sustain treatment no matter what may face financial strains, as well as the realization that their loved one is in pain (Field & Cassel, 1997). We know of no studies that have explored fully the ways that older widows' and widowers' decisions about their loved one's end-of-life care affect their emotional and social well-being in bereavement. This is an important line of inquiry; we urge researchers to study prospectively the ways that end-of-life planning affects the "quality of death" for both patients and their spouses.

CONCLUSION AND OUTLOOK

In past centuries, Americans typically died at home surrounded by loved ones. Death struck young persons, and came relatively quickly after the onset of an infectious disease. Death and dying have been transformed in the late 20th and early 21st century. Medical care has become more specialized and technological advances now facilitate a society-wide desire to prolong life. Most older adults spend their final days with at least some physical and emotional distress and impaired cognitive functioning, and most spend their final hours in health care institutions. These transformations have created a new widowhood. Spousal bereavement overwhelmingly strikes older women who have devoted much

time and energy to caring for their dying spouses. The ways that older adults adjust psychologically to the loss of their spouse, consequently, is inextricably linked to how, when, and where their spouse died.

Pre-loss experiences like caregiving and quality of medical care at the end of life should remain priority areas for continued research and theoretical clarification. Bereavement researchers have shown persuasively that clinical depression is an exception rather than the rule among older bereaved spouses (e.g., Bonanno et al., 2002). Identifying who is at elevated risk for distress both during and after the dying process is critically important. Researchers also must further refine their core concepts, such as caregiving strain. Recent research reveals that the linkage between caregiving and bereavement adjustment is complex. While stressful caregiving is associated with poor psychological adjustment when the spouse is alive, overly taxed caregivers tend to rebound to relatively high levels of psychological functioning after loss (e.g., Schulz et al., 2003). In contrast, those who are most energized by their caregiving role may suffer the greatest loss when their spouse dies (e.g., Boerner et al., 2004).

Research on death quality shows, similarly, that very few aspects of death "quality" are uniformly positive for either patients or loved ones. For instance, while most Americans prefer to die at home and to avoid spending time in a nursing home (e.g., Brock & Foley, 1998; Steinhauser et al., 2000), bereaved persons sometimes adjust better to their loss when their loved one died in a care facility (Carr, 2003). Taken together, the research reviewed in this chapter suggests that support, resources, and training be readily available for spousal caregivers before and after their loss. Caregivers may need bereavement support through structured support groups, individual or peer supervision, and through formal "relief" programs that give them time off to tend to their own mental and physical health demands. Through interactions with other caregivers or participation in family caregiver support groups, they may have opportunities to ask questions and share their fears; they can learn how to administer medications, deal with their guilt when they cannot fulfill the roles they feel they should be fulfilling, and ask questions about the pre- and post-loss challenges associated with the caregiver role.

High-quality medical care for dying patients is also critically important for the well-being of their spouses—both before and after the death occurs. When dying patients are in pain, or receive inadequate care at the end of life, their loved ones experience significant distress. Improved end-of-life care and pain management programs may help ensure a smoother transition to widowhood. However, access to pain management programs such as hospice is often limited. As noted earlier, federal requirements for Medicare reimbursement

state that a dying patient must have a 6-month survival limit in order to receive reimbursement for hospice. Health care providers and professional organizations could react to these constraints by developing consensus statements about appropriate end-of-life care, or by improving the regulatory monitoring of end-of-life care. Such efforts may help to shift physician efforts to pain management rather than medically futile attempts at prolonging life (Teno et al., 2000). Scholars widely agree that comfort should be a primary goal of end-of-life care, with efforts that focus on pain management, the minimization of distress, and meeting the psychological, spiritual, and interpersonal needs of the patient (Bradley, Fried, Kasl, & Idler, 2000; Miller et al., 2000; Teno et al., 2000). Such efforts may enhance the well-being of older bereaved spouses, as well as the dying patient.

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Part II

Personal Consequences of Spousal Loss

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CHAPTER 4

Psychological Consequences of Spousal Loss Among Older Adults

Understanding the Diversity of Responses

Karin Wolff and Camille B. Wortman

This chapter's primary goal is to enhance scholars' and practitioners' understanding of the diversity of responses to conjugal loss among older adults. Some older adults exhibit intense and prolonged distress following the loss of their spouse, whereas others manifest remarkable resilience. First, we provide an overview of research on how older men and women are affected by the loss of a spouse. Next, we discuss two assumptions that have guided research in this area: the expectation that most people will react with intense distress which diminishes over time, and the assumption that it is necessary for people to "work through" their feelings in order to recover from the loss. Research suggests that these assumptions need to be reexamined and that bereaved persons show considerable variability in whether intense distress is experienced and whether "working through" the loss is beneficial. Next, we turn our attention to risk factors that can help to clarify why some older persons are far more devastated by the loss of a spouse than others. We then focus in depth on one factor believed to be especially important for how older adults adjust to spousal loss: gender. Finally, we discuss future research priorities in this rich and complex area.

LATE LIFE SPOUSAL LOSS

More than 900,000 people are widowed each year in the United States, and nearly three-quarters of them are over the age of 65 (Moss, Moss, & Hansson, 2001; U.S. Department of Health and Human Services, 1996). Among older married couples, spousal loss is a ubiquitous experience; the only way to avoid such a loss is to die first (Miller & Wortman, 2002). Most studies concur that successful mastery of this transition is an important feature of the aging process (Baltes & Skrotzki, 1995).

Despite the prevalence of conjugal loss among older adults, there has been a paucity of research examining how elderly persons are affected by the death of a spouse (Lund, 1989; Moss, et al., 2001). This dearth of research may stem from assumptions and beliefs regarding how older persons react to conjugal loss. Because widowhood is a "normal" and expected part of life among older adults, spousal loss is presumed to pose less of a coping challenge to older adults, compared to the loss of a spouse in early adulthood or at midlife (see Wortman & Silver, 1990 for a more detailed discussion). As Neugarten (1968, p. 86) has maintained, death of a spouse among the elderly is "rehearsed, the 'grief work' completed, the reconciliation accomplished without shattering the sense of continuity of the life cycle." Since older adults expect to be confronted with the death of their spouse, they may anticipate and plan for the challenges that lie ahead (Brim & Ryff, 1980). Moreover, most elderly persons lose their spouse following a chronic illness, and thus have the opportunity to resolve any "unfinished business" and convey what they have meant to one another. Older bereaved spouses also have more opportunities to interact with and learn from their widowed peers than do those who lose a spouse earlier in life. This is particularly the case for women, since by the age of 65, over 50% of women are widowed (Rosenzweig, Prigerson, Miller, & Reynolds, 1997). It is also widely believed that the death of a spouse will cause less upheaval among the elderly because they are less emotionally reactive to, and more accepting of, stressful life experiences (see Moss et al., 2001 for a review). Baltes and her associates (e.g., Baltes & Skrotzki, 1995) have maintained that older persons have learned from experience how to manage life's difficulties, and that such wisdom-related knowledge facilitates coping with the death of a spouse.

However, there are many reasons why the elderly may find it particularly difficult to cope with the death of a spouse. Older persons' social networks are often narrowed by the deteriorating health and death of their peers. Moreover, there is evidence that people become more selective in their choice of social partners as they grow older, reducing contact with people

who provide fewer emotional rewards (Carstensen, Isaacowitz, & Charles, 1999). In highly mobile societies like the United States, families are often dispersed geographically, so older persons may have few children or other close relatives in the vicinity to provide support. Many elders were raised in tight-knit communities and consequently may have little experience in developing new supportive relationships outside of the family (Lopata, 1996; Moss et al., 2001). For these reasons, spousal relationships often assume increasing importance among older men and women.

Over the course of their marriage, many couples have formed strong and deep attachments. It is also common for older couples to develop a highly interdependent relationship that is based on interlocking roles, commitments, and traditions (Moss et al., 2001). For these reasons, older spouses are often highly dependent on one another for companionship. In fact, loneliness has been identified as the single greatest difficulty for older bereaved spouses (Lund, Caserta, & Dimond, 1993). Elders may also rely on their spouse for assistance with the tasks of daily living, particularly if they are ill themselves. Hence, the loss of a spouse may be accompanied by a loss of independence. Because of the centrality of the spousal relationship at this point in the life course, the loss of this relationship is likely to result in a profound disorganization of one's life patterns and roles. Indeed, older couples may have such closely interwoven lives that the death of one partner may cut across the very meaning of the other's existence (Raphael, 1983).

Moreover, older persons are likely to experience spousal loss against the backdrop of age-related changes such as diminished physical stamina or cognitive impairments (Lund, 1989) and other stressful life events, such as the onset of chronic illness, disability, and/or involuntary relocation (Moss et al., 2001). The accumulating loss of friends and family members not only leads to an erosion of social support, but possibly to a "bereavement overload" which could further deplete adaptive resources (Stroebe & Schut, 2001). Socioeconomic status and income level typically decline with age as well. These resources can play an important role in coping with spousal loss, since they allow for greater freedom in choosing living arrangements and purchasing services that may have been performed by the spouse, such as household maintenance (Wortman & Silver, 1990). In addition, elderly persons may have experienced many role losses prior to the death of their spouse, such as the loss of employment. The accumulating role losses that occur in late life can rob people of their social identity and result in feelings of uselessness and futility (Rosow, 1973). Older persons are also far less likely than their younger counterparts to remarry (Lopata, 1996), and the

course of widowhood can extend for many years (Hansson, Remondet, & Galusha, 1993).

In sum, the loss of a spouse in young adulthood or at midlife may be more likely to disrupt the continuity of the life cycle, and shatter the surviving spouse's hopes and dreams for the future. But for many reasons, spousal loss may also be very difficult in later life. Moreover, the loss may require considerable coping efforts at a time when social, financial, and adaptive resources are declining. Perhaps for these reasons, research suggests that younger people are initially more devastated by the loss of their spouse, but that the emotional distress associated with grief declines more slowly among older persons (Saunders, 1981).

What are the consequences of the loss of one's partner in late life? Numerous studies have documented an increase in physical health problems and emotional disorders, especially depressive symptoms and anxiety, in the surviving spouse in the months and years following bereavement (e.g., Bennett, 1998; Clayton, 1998; Jacobs, 1993; Thompson, Gallagher-Thompson, Futterman, Gilewski, & Peterson, 1991). The bereaved exhibit higher rates of symptoms and illnesses (Palmore, Cleveland, Nowlin, Ramm, & Siegler, 1979; Thompson, Breckenridge, Gallagher, & Peterson, 1984), experience more severe pain (Bradbeer, Helme, & Yong, 2003), consult physicians more often (e.g., Parkes, 1964; Prigerson, Maciejewski, & Rosenheck, 2000), and report higher health care costs than do their married peers (Prigerson et al., 2000). Bereaved persons also consume more alcohol and tobacco, and they utilize more prescriptions and medications than do married persons (Charlton, Sheahan, Smith, & Campbell, 2001; Clayton, 1990; Thompson et al., 1984). In their review of research on physiological functioning among bereaved persons, Hall and Irwin (2001) maintain that changes in multiple physiological systems take place during bereavement. The bereaved are more likely to experience disturbed sleep, including more early morning awakening and poorer sleep efficiency (Reynolds et al., 1992). Bereavement can also have a detrimental effect on the immune function of survivors (Hall & Irwin, 2001). Perhaps the most severe consequence of bereavement is that the loss of a spouse has been found to be associated with increased mortality (see, e.g., Bowling, 1987; Lehman, Wortman, & Williams, 1987; Stroebe & Stroebe, 1993; see Miller & Wortman, 2002 for a review) Although this effect is most pronounced for young men, some research indicates that older men are at heightened mortality risk, particularly during the first six months after the loss (Bowling & Windsor, 1995). Among older persons, threats to immune status, physical health, and mortality are compounded if the bereaved

are also depressed (Hall & Irwin, 2001; Schulz, Drayer, & Rollman, 2002; Stroebe & Stroebe, 1993).

ASSUMPTIONS GUIDING PRIOR RESEARCH

Past research on the impact of conjugal loss has been guided by certain assumptions about the grieving process that are pervasive in our culture (Wortman & Silver, 1989, 2001). Because there is little scientific evidence to support these assumptions (Bonanno & Kaltman, 1999, 2001; Wortman & Silver, 1989, 2001), we have come to label them "myths of coping with loss" (see Wortman & Silver, 2001, or Wortman & Boerner, in press for a more detailed discussion). One assumption is that following the death of a spouse, the surviving spouse will exhibit intense distress, which will gradually subside over time. As Shuchter (1986) expressed it, "virtually everyone whose spouse dies exhibits some signs and symptoms of depression" (p. 170). The most influential theories in the area, including classic psychoanalytic models (e.g., Freud, 1917/1957) and Bowlby's (1980) attachment model, are based on the assumption that at some point, the bereaved will go through a period of distress and depression as they confront the reality of the loss. Historically, failure to exhibit distress following a major loss has been regarded as problematic. Most clinicians maintain that "absent grief" (i.e., a lack of grief or depressive symptoms following loss) stems from denial or inhibition, and that it is maladaptive in the long run (Middleton, Moylan, Raphael, Burnett, & Martinek, 1993). It is often assumed that if the bereaved fail to experience distress shortly after their loss, then problems or symptoms of distress will erupt at a later time as "delayed grief" (see, e.g., Worden, 2002). As Mancini, Pressman, and Bonanno (Chapter 10) discuss in more detail, many clinicians have maintained that people who have *not* begun grieving would benefit from clinical intervention designed to help them work through their unresolved feelings (see, e.g., Bowlby, 1980; Deutsch, 1937; Jacobs, 1993; Lazare, 1989; Rando, 1993; Worden, 2002). Failure to exhibit distress has also been viewed as a sign of character weakness in the survivor, with those showing few signs of grief labeled as "narcissistic" or "developmentally immature" (see, e.g., Horowitz, 1990, p. 301; Raphael, 1983). People who show little distress following the death of a spouse have also been portrayed as cold and uncaring people or as only superficially attached to their spouse (Fraley & Shaver, 1999; Rando, 1993).

Another pattern that has been discussed widely by both bereavement scholars and practitioners is "chronic grief," which is generally regarded as

the most common type of pathological grief (Jacobs, 1993). Instead of showing a decline in distress as time passes, chronic grievers become "stuck" in their grief and continue to experience intense distress for a lengthy period of time. There are no firm guidelines regarding how long distress must continue in order to be considered pathological. However, it is generally assumed that within a year or two, the bereaved will recover from the loss and return to normal functioning.

Clinicians have frequently argued that persons who have conflictual or ambivalent relationships with their spouse will be most likely to experience chronic grief (see, e.g., Freud, 1917/1957; Parkes & Weiss, 1983; Rando, 1993). Other purported risk factors for chronic grief include excessive dependency on one's spouse, deficits in coping resources, and low levels of social support. However, there is some debate in the literature regarding whether chronic grief is best understood as an intense or prolonged reaction to the loss, or whether it merely reflects pre-existing psychopathology (Bonanno et al., 2002).

With few exceptions (e.g., Levy, Martinkowski, & Derby, 1994; Middleton, Burnett, Raphael, & Martinek, 1996), bereavement researchers have studied grief and depression by aggregating data across respondents, examining "average" levels of symptoms, and identifying specific risk factors that are associated with more or fewer symptoms. This standard regression approach makes it impossible to determine what percentage of respondents shows particular patterns of reaction over time (i.e., normal, "absent" or minimal, delayed, or chronic grief). However, there is growing research interest in learning more about these specific patterns of grieving. Several studies have assessed depressive symptoms or other forms of distress in the early months following the death of a spouse, and then reassessed symptoms again anywhere from 13 to 60 months after the loss (see Bonanno et al., 2002, Wortman & Boerner, in press for reviews). Moreover, we have recently conducted a study based on the Changing Lives of Older Couples (CLOC) data, which was specifically designed to examine the prevalence and the antecedents of these patterns of grief. In the CLOC study, older married adults participated in a baseline interview. As the original sample members became bereaved, they were re-interviewed 6, 18, and 48 months after the loss of their spouse. At roughly the same time, still-married matched controls participated in a similar follow-up interview. For bereaved persons, the baseline interview occurred three years prior to the death of their spouse, on average (Boerner, Wortman, & Bonanno, 2005; Bonanno et al., 2002; Bonanno, Wortman, & Nesse, 2004). Grief, depressive symptoms, and other indicators of processing the loss and role functioning were assessed at each interview conducted post-

loss. The prospective design of the CLOC study provides the opportunity to identify bereavement patterns that cannot be assessed in studies beginning after the loss (e.g., improvement in depression). The design also makes it possible to determine what percentage of those who show a prolonged grief response were in fact depressed prior to the loss, and what percentage were doing well prior to the loss. Results from this research provide compelling evidence that many of the assumptions about widely-accepted patterns of grieving may need to be reexamined.

It is now clear that the so-called normal grief reaction, in which people experience significant depression that decreases over time, is not as widespread as earlier models would have predicted. The percentage of respondents showing initial depression, followed by improvement over time, is typically shown by far less than half of the respondents (Wortman & Boerner, in press). In three studies focusing specifically on older bereaved respondents, the proportion showing "normal" grief is far lower than would be expected, given past studies suggesting that "normal" grief patterns are among the most common reactions evidenced by the bereaved: 29.3% (Bournstein, Clayton, Halikas, Maurice, & Robins, 1973), 9.4% (Lund, Caserta, & Dimond, 1986), and 10.7% in the prospective study based on the CLOC data that was described above (Bonanno et al., 2002). In fact, there is compelling evidence that a substantial proportion of bereaved respondents do not show clinically significant distress or depression following spousal loss (57% in Bournstein et al., 1973; 78% in Lund et al., 1985–1986). In the prospective study conducted by Bonanno and colleagues (2002), nearly half of the sample (45.6%) showed low levels of depressive symptoms prior to the loss and at 6 and 18 months following the loss, whereas another 10.2% showed improved mental health following the loss, scoring high in depressive symptoms prior to the loss but low at 6 and 18 months after the death.

The prevalence of this "minimal grief" reaction alone calls into question whether such a reaction is pathological, as prior theorists have suggested. Even more surprising than the pervasiveness of "minimal grief" is the recent spate of studies documenting that most conjugally bereaved elders do not even show mild dysphoria following a loss. For example, in a study by Zisook, Paulus, Shuchter, and Judd (1997), respondents were assessed 2 months after their spouse's death. Twenty percent evidenced major depression, 20% were classified as exhibiting minor depression, 11% evidenced subsyndromal depression (i.e., they endorsed any two symptoms from a symptom checklist) and 49% were classified as evidencing no depression (i.e., they endorsed one or no items from a symptom checklist; see also Bruce, Kim, Leaf, & Jacobs, 1990; Cleiren, 1993). Research also fails to support the hypothesis

that "delayed grief" will emerge among those who fail to show a grief reaction initially (the rate is typically around 2%) or that physical health problems will emerge. This has not turned out to be the case even in studies following the bereaved for as long as five years after the loss (Bonanno & Field, 2001).

The data presented in the study by Bonanno and colleagues (2002) suggests that a pattern of consistently low distress, beginning before the loss and still evident at 6 and 18 months following the loss, is best understood as resilience in the face of loss (see Bonanno, 2004 for a more detailed discussion of the resilience concept). Consistent with this argument, individuals classified as resilient also exhibited low levels of grief symptoms, such as yearning. The data provide no support for the idea that failure to exhibit distress is a form of denial, because respondents classified as resilient made no effort to avoid reminders of the loss (Bonanno et al., 2004). These data also fail to support the hypotheses that those who fail to show distress are emotionally cold or distant, or were not emotionally attached to their spouses. In fact, these respondents scored high on several prebereavement measures indicative of resilience, such as acceptance of death and availability of instrumental support. The depressed-improved group, rather than the resilient group, expressed negative and ambivalent feelings toward their spouse prior to his/her death. Interestingly, those in the depressed-improved group were also likely to have a spouse who was ill prior to loss. As noted above, members of this group showed a dramatic decrease in depressive symptoms following the loss, and these symptoms remained low as time passed. Like the resilient group, "depressed-improved" persons showed few grief symptoms. The results suggest that for this group, the spouse's death represented the end of a chronic stressor rather than the onset of a new acute stressor (Wheaton, 1990). In a recent study examining these patterns over a 4-year period (Boerner et al., 2005), respondents in both the resilient and depressed-improved groups continued to do well. These findings add to the growing body of evidence challenging the notion that "delayed grief" will emerge among those who initially show little distress.

Empirical research also has shown that the chronic grief pattern is far less prevalent than the minimal or resilient pattern, particularly among older adults (see Wortman & Boerner, in press for a review). In studies by Bournstein and colleagues (1973) and by Lund and collaborators (1985–1986), the proportion of respondents showing high levels of distress shortly after the loss, and again several months later, was 13% and 7.7%, respectively. In the prospective study by Bonanno and collaborators (2002), 15.6% of the respondents showed a chronic grief trajectory, manifesting low distress prior to the loss but high distress at both 6 and 18 months after the loss. Another

7.8% of the sample showed a trajectory more closely resembling chronic depression: they scored high in depressive symptoms prior to the loss and again at 6 and 18 months following the loss. In contrast with the assumption that chronic grief is most likely to occur among those with negative or ambivalent marriages, we found that persons showing chronic grief were more likely to be involved in a strong marriage to a spouse who was healthy. Respondents in the chronic grief group were most likely to report intense feelings of yearning, to search for meaning in the loss, and to think and talk about their lost loved one. These results suggest that chronic grief stems from an enduring struggle with cognitive and emotional distress resulting from a devastating loss. It was the chronically depressed respondents whose marriages were described as negative or ambivalent. Those in the chronic depression group were also most likely to report experiencing day-to-day problems as a result of the loss, such as trouble keeping up with things around the house, dealing with financial agencies, or making decisions on their own. These results suggest that chronic depression results more from enduring emotional difficulties that are exacerbated by the loss. Both the chronic grief and chronic depression groups scored high on dependency on their spouse, and on interpersonal dependency. Interestingly, long-term follow-up data on these groups revealed that while the chronic grief group showed highly elevated depression scores at 18 months post-loss, they showed an improvement in depression by the 48-month time point. In contrast, the chronically depressed group demonstrated long-term problems, with little indication of improvement between the 18-month and 48-month assessment (Boerner et al., 2005).

Another widespread assumption among practitioners in the field of grief and loss is that in order to recover following a loss, it is necessary to "work through" the thoughts, memories, and emotions associated with it. The term "grief work" was originally coined by Freud (1917/1957), who maintained that "working through" grief is critical for recovery from the loss. Although scholars have debated precisely what it means to "work through" a loss, most grief theorists assert that it involves an active, ongoing effort to come to terms with the death. Attempts to deny the implications of the loss, or block feelings or thoughts about it, are generally regarded as maladaptive. This view of the grieving process has dominated the bereavement literature for the past half-century (Bonanno, 2001), and only recently has been called into question (Bonanno & Kaltman, 1999; Stroebe, 1992–1993; Wortman & Silver, 1989, 2001).

"Working through" has been operationalized in many ways, including thinking about the loss, confronting versus avoiding reminders, or expressing one's feelings verbally, through facial expressions, or through writing. On the

whole, however, little empirical evidence supports the necessity of "working through" the loss. Available evidence suggests that thinking about one's relationship with the loved one is associated with worse long-term adjustment (Nolen-Hoeksema, McBride, & Larson, 1997). Verbal expression or facial expression of negative emotions is likely to portend subsequent difficulties, and not facilitate the resolution of grief. Moreover, those who express negative emotions run the risk of driving away members of their support network (see, e.g., Bonanno & Keltner, 1997). Similarly, studies that have examined the impact of confronting versus avoiding reminders of the loss consistently show that it is not necessary to confront the loss, and that avoiding or minimizing one's feelings of distress may be an effective means of coping with the loss (Bonanno, Keltner, Holen, & Horowitz, 1995). In the prospective study described above, respondents in the two groups showing the best adjustment (i.e., the "minimal" or "resilient," and depressed-improved groups) scored lower on a measure of processing the loss by thinking about the loved one, talking about him or her, and confronting reminders. In contrast, those in the two groups showing the poorest adjustment (i.e., the "chronic grief" and "chronic depression" groups) scored higher on processing the loss. In studies using writing tasks among bereaved respondents, results have been inconclusive (see Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002, or Wortman & Boerner, in press for reviews).

The current thinking on "working through" loss is that many people may not need to "work through" a loss. It is possible that "working through" a loss can be beneficial for certain kinds of people—for example, those who have difficulty expressing their emotions (e.g., Lumley, Tojeck, & Macklem, 2002; Norman, Lumley, Dooley, & Diamond, 2004), or for certain kinds of events—for example, loss events that are particularly traumatic (Jordan & Neimeyer, 2003). Future research should help to clarify those conditions under which older adults will benefit from "working through" feelings associated with the loss of their spouse.

VARIABILITY IN RESPONSE TO CONJUGAL LOSS: THE ROLE OF RISK FACTORS

Though a majority of older individuals appear to show considerable resilience following the loss of their spouse, a significant minority shows enduring effects. As Lund and colleagues (1993) have indicated, some elderly bereaved "described themselves as being socially active, independent, helpful to others, involved with hobbies, and motivated to make the best of a very bad situation, whereas others reported being despondent, angry, miserable, and sick of

living" (p. 245). The evidence reviewed above shows considerable variability in response to major losses; researchers have responded with increasing interest in identifying those factors that may promote or impede successful mastery of conjugal bereavement. Studying risk factors can advance bereavement theory by helping to clarify the mechanisms through which spousal loss influences subsequent mental and physical health. Moreover, knowledge about risk factors can aid in the early identification of individuals who may benefit from bereavement interventions before their difficulties become entrenched.

Five broad categories of risk factors have been studied in the literature (see Archer, 1999; Sanders, 1993; and Stroebe & Schut, 2001 for reviews). These include *demographic factors* such as age, gender, and socioeconomic status; *background factors* including whether the respondent has experienced prior losses or traumas, or has a history of mental health problems; factors describing the *nature of the marital relationship,* such as marital quality and dependence on the spouse; *personal and social resources* including personality, religiosity, and social support; and the *context in which the loss occurs,* which refers to whether the loss was sudden, whether the surviving spouse was involved in caregiving, the type and quality of death, and the presence of concomitant stressors such as ill health of the surviving spouse. A comprehensive review of these risk factors is beyond the scope of this chapter (see Carr, Wortman, & Wolff, chapter 3, for a discussion of death context and its implications for bereaved older spouses). However, we wish to highlight those risk factors that have particular relevance for understanding reactions to conjugal loss among the elderly. Below, we first provide a brief overview of selected factors. We then identify one important personal characteristic that we believe to be particularly significant in understanding bereavement reactions among the elderly: gender.

Nature of the Marital Relationship

As noted above, early theoretical writings on loss maintained that chronic grief results from conflict in the conjugal relationship, or arises out of ambivalence toward the spouse (Bowlby, 1980; Freud, 1917/1957; Parkes & Weiss, 1983). Some early studies concluded that marital conflict is linked with chronic grief (see, e.g., Parkes & Weiss, 1983). Other studies, however, have found no relationship between quality of marriage and adjustment to conjugal loss (see, e.g., Lund et al., 1993). However, most researchers now recognize that it is not possible to obtain an accurate assessment of a person's marriage after the spouse has died because of the tendency to idealize or "sanctify" one's spouse, in retrospect. Moreover, people who are highly

distressed following the loss may recall their marriage as more conflictual than was actually the case (Bonanno et al., 2002). Two recent analyses of the CLOC data, in which marital quality was assessed prior to the loss, indicate that those with the happiest marriages experience more intense and prolonged grief (Bonanno et al., 2002; Carr et al., 2000). Consistent with these studies, Prigerson and colleagues (2000) found that persons who became widowed following a harmonious marriage had subsequent health care costs that were 32% higher than did widowed respondents who had conflictual marriages. Relatively few studies have focused specifically on ambivalence, but the available data provide no support for the view that this is a risk factor for chronic grief (Bonanno, Notarius, Gunzerath, Keltner, & Horowitz, 1998; Bonanno et al., 2002).

It is also widely believed that chronic grief is linked to excessive dependency on one's spouse (Lopata, 1979; Parkes & Weiss, 1983; Raphael, 1983). Taken together, available research evidence suggests that excessive dependency on the spouse is indeed a potent risk factor for poor outcome (Bonanno et al., 2002; Carr et al., 2000; Parkes & Weiss, 1983). However, more recent analyses from the CLOC data indicate that those who are most dependent on their spouse may also ultimately experience the greatest benefits. Carr (2004a) found that women who were most emotionally dependent on their spouses had the poorest self-esteem while still married, but evidenced the highest levels of self-esteem following the loss. Similarly, men who were most dependent on their spouses for home maintenance tasks experienced the greatest personal growth following their spouse's death. According to Carr (2004a), these results suggest that "widowed persons who were once highly dependent upon their spouses reap psychological rewards from the recognition that they are capable of managing on their own" (p. 220).

Personal and Social Resources

Personality

In the CLOC study, we assessed dimensions of the five-factor model of personality (Costa & McCrae, 1990): *emotional stability or neuroticism, agreeableness, openness, extraversion,* and *conscientiousness* prior to the spouse's death. *Emotional stability* was the only personality trait to show a relationship to patterns of grieving; respondents showing a pattern of chronic depression scored low on this personality indicator. In contrast, those in the chronic grief group did not score low, and in fact scored as high as respondents in the common grief and resilient groups in terms of emotional stability (Bonanno

et al., 2002). An earlier study by Vachon and collaborators (1982) also suggests that those who are emotionally unstable may have difficulty adjusting to the loss. Taken together, however, these results suggest that people who show no signs of maladjustment prior to the loss can exhibit intense and prolonged distress if other factors are in play—for example, if they were involved in a close and interdependent relationship.

Although the research evidence is not entirely consistent (e.g., Stroebe & Stroebe, 1987), there is some evidence to suggest that *self-esteem* may be an important coping resource among older bereaved spouses. In their program of research on how the elderly cope with the death of their spouse, Lund and colleagues (1993) found self-esteem to be one of the most important predictors of the course of adjustment (see also Reed, 1993). These investigators have suggested that those with high self-esteem are more motivated to take charge of the situation, and persist until they have more favorable outcomes, relative to their low self-esteem counterparts. A related personality variable identified by Lund and collaborators (1993) as being very important was *personal competencies*. According to this study, those who are married for many years may lack specific skills for managing the tasks of daily life. Older adults who were assessed as most competent in social, interpersonal, instrumental, and resource identification skills made the most favorable adjustment to the death of their spouse.

Research by Nolen-Hoeksema and her colleagues (Nolen-Hoeksema, 2001; Nolen-Hoeksema & Larson, 1999) has suggested two additional personality variables that may influence coping with conjugal loss: *dispositional optimism* and *a ruminative coping style*. She found that respondents who scored high on dispositional optimism, or the tendency to be optimistic in most circumstances, showed greater declines in depressive symptoms between the time of initial interview (1 month after the loss) and the 13- and 18-month post-loss interviews. Moreover, dispositional optimists were more likely to find meaning or something positive in the loss than were pessimists.

A ruminative coping style involves a predisposition to "engage in thoughts and behaviors that maintain one's focus on one's negative emotions and on the possible causes and consequences of those emotions" (Nolen-Hoeksema, 2001, p. 546). Nolen-Hoeksema has reported that those who engage in rumination following a loss show little decrease in distress over time. Interestingly, bereaved ruminators believe that their ruminations will help solve their problems but this is not the case: they are significantly less likely to become actively engaged in effective problem-solving behaviors than non-ruminators.

Religious and Spiritual Beliefs

In recent years, there has been increasing interest in the role that religious or spiritual beliefs may play in coping with the death of a loved one. Religious beliefs may ease the sting of death, and facilitate finding meaning in the loss, by providing a ready framework of beliefs for incorporating negative events (Pargament & Park, 1995; Park & Cohen, 1993). Specific tenets of one's faith, such as the belief that the deceased is in a better place, or that the survivor and deceased will someday be reunited, also may mitigate the distress that can be evoked following the death of a spouse. It would be wise to include this variable in studies of conjugal loss among the elderly, as there is evidence that religion becomes increasingly important with age (Koenig, 1994).

However, empirical evidence on the value and efficacy of religion for coping with loss is mixed, and the majority of studies to date are characterized by serious methodological shortcomings (see Stroebe & Schut, 2001 for a review). A handful of recent studies employing sound methodological designs do suggest that religious beliefs are beneficial in coping with loss. For example, some studies suggest that religious beliefs facilitate finding meaning in the death of a loved one (McIntosh, Silver, & Wortman, 1993; Murphy, Johnson, & Lohan, 2003), that those with strong spiritual beliefs are more likely to resolve their grief successfully (Walsh, King, Jones, Tookman, & Blizard, 2002), and that those who hold spiritual beliefs are more likely to use positive reappraisal and effective problem-solving and coping than those who do not (Richards, Acree, & Folkman, 1999; Richards & Folkman, 1997). However, none of these studies have focused on elderly samples. Hopefully, future research will help to clarify whether religious beliefs can facilitate adjustment among elders who lose a spouse (see Brown, House, & Smith, chapter 6).

Social Support

As noted above, the number of social relationships that one maintains tends to diminish with age. Therefore, social support may be a particularly important resource for older bereaved persons. Research has suggested that low levels of social support are particularly damaging for the physical functioning of older adults irrespective of bereavement (Sherbourne, Meredith, & Rogers, 1992). Social support is perhaps the most frequently studied modifier variable in the bereavement literature (Norris & Murrell, 1990). Numerous studies have concluded that social support may mitigate the negative effects of bereavement (e.g., Clayton, 1998; Cleiren, 1993; Dimond, Lund, & Caserta, 1987; Stylianos & Vachon, 1993), especially among older age groups (see Stroebe & Schut, 2001 for a review). Researchers have recognized that social

support is a complex construct encompassing many different kinds of assistance, including material support, emotional support, and opportunities for the expression of feelings (see Nolen-Hoeksema & Larson, 1999). Moreover, the ability to mobilize support is an important form of coping that may be more likely to be carried out by people with certain personality characteristics and personal predispositions (Filipp & Aymanns, 1987).

Research suggests that in addition to studying potential benefits of social support, it is important to examine the impact of negative social interactions, or "social negativity" (Finch, Okun, Pool, & Ruehlman, 1999). This may include interactions characterized by anger or hostility, or remarks that are critical, demanding, or lacking in sensitivity (Rook, 1984, 1997). Available evidence indicates that exposure to negative social exchanges has an adverse effect on older adults' physical health (Kiecolt-Glaser et al., 1993) and their emotional well-being (Reinhardt, 2001). Negative interactions are likely to be particularly deleterious among people who are experiencing stressful life events. Perhaps for this reason, it is common for people to express dissatisfaction with the emotional support received following the loss of a spouse (see Wortman, Wolff, & Bonanno, 2004 for a review). Lund and colleagues (1993) have described the disappointment, frustration, and anger expressed by the elderly bereaved as a result of comments from friends and family members that were "judgmental, avoidant, inconsiderate, pushy, and demanding" (p. 251).

GENDER DIFFERENCES

Conjugal bereavement is far more prevalent among older women than men. Among Americans who are 65 and older, 46% of women are currently widowed whereas 42% are married. In contrast, 75% of American men who are 65 and older are married and only 14% are widowed. This ratio becomes increasingly skewed with age (U.S. Bureau of the Census, 2002); among individuals over 85 years of age there are 15 widows for every widower (Schneider, Sledge, Shuchter, & Zisook, 1996). One reason for this disparity is that men have higher mortality rates than women, and thus older women are more likely than their male peers to outlive a spouse. In fact, after 30 years of marriage, women have more than three times the risk of becoming widowed than do men (Novak & Campbell, 2001). However, the skewed ratio also reflects the fact that widowed men are far more likely than widowed women to remarry after their loss. But does this mean that women also suffer more psychological distress from widowhood? In recent years, there has been increasing interest in gender differences in grieving

(see, e.g., Wortman, Wolff, & Bonanno, 2004) and specifically in how men grieve (see, e.g., Martin & Doka, 2000).

Who Suffers More?

Regarding gender differences, there are several reasons why women might be expected to be more vulnerable to partner loss than men (see Miller & Wortman, 2002 for a more detailed discussion). First, women have traditionally been financially dependent on their husbands. This is certainly the case for current cohorts of older women. On average, women's income decreases by nearly one-third after they are widowed, while men do not typically experience a similar drop in income (Bound, Duncan, Laren, & Oleinick, 1991; Holden & Smock, 1991). Women also experience considerable strain when they lose financial resources through widowhood (Umberson, Wortman, & Kessler, 1992). Second, women's identities are closely tied to their relationships, while men tend to define themselves in terms of their jobs. This is particularly true for women born in the early decades of the 20th century; most channeled their time and energy toward family responsibilities rather than careers (e.g., Carr, 2002). Third, widowed women are much less likely than widowed men to become involved in subsequent romantic relationships or to remarry (e.g., Lee, Willetts, & Seccombe, 1998; Schneider et al., 1996). As pointed out earlier, the gender gap in remarriage is particularly large among older men and women.

Several early studies supported the hypothesis that women experience more intense grief and depression following conjugal loss than men (see Miller & Wortman, 2002). However, these studies had serious methodological limitations. For example, most early studies failed to include a control group of married men and women. It is well known that women are generally more depressed than men. Therefore, a study showing significant differences between men and women on an indicator like depression does not necessarily mean that there are gender differences in adjustment to loss. Instead, it is necessary to compare the risk of depression among bereaved women relative to married women with the risk of depression among bereaved men relative to married men. Recent studies using such control groups have demonstrated that men do worse following bereavement (see, e.g., Miller & Wortman, 2002; Stroebe, Stroebe, & Schut, 2001 for reviews). (For a further discussion of methodological challenges facing bereavement researchers, see Carr, chapter 2.)

Most recent, well-controlled studies have found higher levels of depressive symptoms among widowed men than widowed women, compared to same sex married controls (e.g., Fry, 2001; Lee et al., 1998; Umberson et al.,

1992; Van Grootheest, Beekman, Broesse van Groenou, & Deeg, 1999). In a sample of elderly persons, Lee, DeMaris, Bavin, and Sullivan (2001) found that widowhood had a more adverse effect on the psychological well-being of men than that of women. Few studies have examined the physical health status of widows and widowers, but the evidence suggests that when compared with their respective married counterparts, widowers are more vulnerable than widows. For example, Goldman, Korenman, and Weinstein (1995) reported that widowers experienced more physical limitations, and required more assistance with tasks of daily living than did widows.

While several studies have found increases in mortality for both widowed men and women (see Goodkin et al., 2001 for a review), mortality rates for widowers (versus married men) are relatively higher than for widows (versus married women). For example, Christakis and Iwashyna (2003) examined mortality among elderly respondents who had placed their spouse in hospice care. By 18 months after the death, around 5% of the bereaved wives had died, compared to more than 13% of the bereaved husbands. The duration of mortality risk may be longer for widowers than for widows. Among women, the elevated mortality risk is limited largely to the first year after the loss, whereas for men, the risk was found to be still elevated for as long as 15 years after the loss (e.g., Schaefer, Quesenberry, & Soora, 1995). This finding led the authors to conclude that death of a spouse represents a chronic as well as an acute stressor for widowers.

Gender Differences in the Cause of Death Among Bereaved Spouses

Relatively few studies have collected data on the cause of death among the bereaved. Widowers' high mortality rate has been attributed to causes including alcohol-related illnesses (e.g., cirrhosis of the liver), accidents and violence, suicide, and chronic ischemic heart disease (Kaprio, Koskenvuo, & Rita, 1987; Li, 1995; Martikainen & Valkonen, 1996; Rogers, 1995). A study of suicide among older adults yielded a consistent finding: the relative risk of suicide for widowers was five times higher than that of married men, whereas the relative risk of suicide among the widows was near zero (Li, 1995). Miller and Wortman (2002) argue that such patterns may reflect a pattern where bereaved husbands lose their sense of meaning and purpose, give up hope, and lose their will to live.

Possible Explanatory Mechanisms

An early review of the literature suggested that the gender differences in adjustment to loss stem from higher levels of social support received by widows

compared to widowers (Stroebe & Stroebe, 1983). Women typically have many more close social relationships than men and are likely to be the ones to nurture and sustain the couple's social relationships with others. Men often rely heavily on their wives for support, and their wives are often their main and sometimes only confidants (e.g., Umberson et al., 1992). There is clear evidence to indicate that supportive relationships with others can protect people from the deleterious effects of stress (e.g., House, Umberson, & Landis, 1988; Schwarzer & Leppin, 1989; Stroebe & Stroebe, 1996), while the absence of such relationships is associated with poorer health and higher mortality rates (e.g., House, Landis, & Umberson, 1988). However, there is little empirical support for the hypothesis that social support is a decisive factor contributing to gender differences in bereavement outcome (Stroebe, Stroebe, & Abakoumkin, 1999). Rather, evidence suggests that support from family members and friends can be helpful, yet it is unlikely to fill the void left by a partner's death (Stroebe et al., 1999). Even if the conjugally bereaved receive support, they may nonetheless experience intense loneliness.

Gender Differences in the Stressfulness of Widowhood

Another possible explanation for the gender differences is that following the death of a spouse, men experience more stress than women do. Some investigators have argued that men benefit more from marriage than women do, and are therefore more adversely affected when the marriage ends. Available evidence indicates that married men benefit more than women from the instrumental support provided by their spouses.

Historically, women have done much more housework and childcare than their husbands (see Miller & Wortman, 2002 for a review). But important changes in gender roles have occurred over the past few decades (Douthitt, 1989). For example, is it now relatively common for a woman to be a working mother instead of a full-time homemaker, and it is becoming more and more common for husbands to be involved in the performance of household tasks and childcare responsibilities (Barnett, 2004; Gershuny & Robinson, 1988). Even today, however, a majority (58%) of women who are part of a couple say they do all or most of the household chores, including cleaning and laundry (The Shell Poll, 2000). It will be interesting to see whether gender differences in reactions to the loss of a spouse persist in coming decades, as gender roles become less tied to traditional sex stereotypes over time.

Several empirical studies have supported hypotheses that gender differences in reaction to spousal loss are partly caused by gender differences

in social ties and household responsibilities following the loss. In a large community-based study of older people in the Netherlands, Van Grootheest and colleagues (1999) found that widowed men spend more time on household chores than married men, while widowed women spend less time on housework than married women. This trend has also been found in the data from the CLOC study (Utz, Reidy, Carr, Nesse, & Wortman, 2004).

Taken together, the evidence suggests that being married may be more beneficial to men than to women, and the loss of this role may be more stressful for men than for women. But Miller and Wortman (2002) also draw attention to the fact that relatively little variance in the relationship between widowhood and depression is accounted for by such variables as social ties and household responsibilities. This suggests that other factors likely play an important role in the gender differences in response to spousal loss.

Gender Differences in the Social Control of Health Behavior

Umberson (1987, 1992) has advanced the intriguing hypothesis that gender differences in morbidity and mortality following widowhood may be caused by gender differences in the roles married men and women play in facilitating health preserving behavior in their spouses. She found evidence for the hypothesis that women take greater responsibility for the couples' health care than do men. For example, married women are usually the ones who schedule doctor appointments and regular checkups for themselves and their spouses. They may also take more responsibility for such factors as their and their spouse's diet, nutrition, and exercise. Wives are more likely than husbands to monitor whether their spouses are taking prescribed medications and to offer reminders if necessary. Moreover, women place constraints on risky behaviors such as problem drinking, and drinking and driving, which are more common among men. Men also are more likely than women to react to the loss of their spouse with feelings of helplessness and hopelessness (Miller & Wortman, 2002), and these feelings may undermine any motivation they previously had to keep themselves fit and healthy. Indeed, these feelings of hopelessness may lead them to make choices that are comforting in the short run but ultimately destructive. Umberson (1987, 1992) found evidence that the transition from marriage to widowhood (or divorce) was associated with more negative changes in health behavior for men (e.g., greater increase in tobacco use and alcohol consumption). Additionally, widowed men's daily routines, such as eating and exercising regularly, were more disrupted than widowed women's. Umberson concludes that men are hurt more by widowhood because with the loss of their wives, widowed men have lost a social

agent who is concerned with the preservation of their health. (See also Pienta & Franks, chapter 5.)

Gender Differences in Coping Strategies Following Conjugal Loss

Gender differences in depression and mortality following conjugal loss may stem from gender differences in coping with the death. Unfortunately, to date, few studies have focused specifically on gender differences in grieving processes (Stroebe et al., 2001). In general, when dealing with stress, women tend to express their feelings and confide them to others (e.g., Derlega, Metts, Petronio, & Margulis, 1993), whereas men generally prefer avoidant coping strategies (e.g., deRidder, 2000), such as distraction (Stroebe et al., 2001; Vingerhoets & Van Heck, 1990). Unfortunately, they may distract themselves in ways that are detrimental to their health, such as excessive drinking (Umberson et al., 1992).

Another possible explanation is that because of men's mortality disadvantage, women may go through a "rehearsal" for widowhood as they observe their peers experience the loss of their spouse, and may therefore be better prepared for the death. Because women are more likely than men to be widowed, they may be better prepared for the transition—even if the loss occurs suddenly. As noted earlier, older widows can also rely on their widowed friends' direct experience with partner loss to help them cope with the loss.

A new theoretical model of coping with loss, the dual process model (Stroebe et al., 2001), also suggests reasons why men may be more affected by the loss of a spouse than women are. One of the most important features of the dual-process model is that it provides an alternative to the view that grief is resolved solely through confrontation with the loss (Archer, 1999). According to this model, it is actually the oscillation between confrontative (toward the task of loss) and restoration-oriented (avoidance) coping that is most effective. Stroebe and colleagues (2001) argue that women are prevented by external constraints from exclusively engaging in their preferred style of coping (confrontative). Social roles require women to become involved in daily activities (restoration oriented) as well. Men focus primarily on restoration oriented coping, and are generally not required by external constraints to express their feelings.

REMARRIAGE

Following partner loss, how common is it for people to become involved in new intimate relationships? And is it a sign of recovery when widowed

individuals express interest in dating or remarriage, or is it merely an attempt to avoid the pain that widowhood brings?

There is evidence that not all widowed individuals seriously consider remarriage, and fewer still actually remarry (Lopata, 1979). The interval to remarriage lengthens with age for both men and women (Wilson & Clarke, 1992). Generally, a person's age at the time of their spouse's death is consistently related to the likelihood of remarriage (e.g., Cleveland & Gianturco, 1976; Gentry & Shulman, 1988). The older the widowed person, the lower the probability of remarriage. Gentry and Shulman suggest several possible reasons why remarriage may be influenced by age. They emphasize that age could be a proxy for a number of social, psychological, or biological constructs. They also suggest that age may simply represent the differential availability of potential spouses, and may thus signal to women that they are "too old" to remarry. Interestingly, when asked for their subjective assessments on this issue, only 7% of the widows in their study reported that they thought they were too old to remarry. Although the frequency of this reason did increase with age; it was not a major reason for not remarrying until after age 65, and even then it was only the third most frequently given reason for why a person would not remarry.

Men Are More Likely to Remarry

Studies of remarriage after widowhood consistently show that women are more likely than men to be widowed, yet they are less likely to remarry after their loss (Cleveland & Gianturco, 1976). Men who become widowed are more likely than women to become involved in subsequent romantic relationships or to remarry (Lee et al., 1998). In a sample of middle-aged bereaved people, Hustins (2001) found that only 7% of women had become involved in some type of sexual relationship by the end of the first year of bereavement, compared to 54% of the men. In a study of older widows and widowers (over age 65), 31% of the widowers developed a new romantic relationship within two years compared to only 4% of widows (Davidson, 2001). In a study using a sample of bereaved individuals with a mean age of 61, by 25 months after the loss 61% of the men became involved in new romantic relationships and 25% remarried, whereas only 19% of the women became involved in new relationships and 5% remarried. Those women who remarried took twice as long to do so as the men did (Schneider et al., 1996).

Why Do Men Tend to Remarry More Often?

The gender gap in remarriage may reflect more general patterns of how men and women cope with loss. Some authors (e.g., Gentry & Shulman, 1988)

suggest that the reason for this asymmetry in remarriage rates may be the longer lifespan of women paired with the tendency of women in our culture to marry men who are older than they are. This results in a larger pool of potential spouses for widowers. Men typically become involved with women younger than themselves, and consequently have an even larger pool of women to choose from. In fact, the ratio of widows to widowers is at least 5 to 1 among older adults (Schneider et al., 1996) and this ratio becomes increasingly skewed with age (the ratio in people over 85 is 15 to 1). Thus, men have greater opportunity to find a suitable partner and pursue new relationships.

As we have discussed earlier, men are more devastated by conjugal bereavement, possibly because the marital role is more beneficial to them than to women, as far as household chores and emotional support are concerned. Do widowers remarry primarily to "replace" functions previously provided by the wife (Davidson, 2001), or because they are so dependent on marriage for their emotional well-being?

Recent evidence from the CLOC study suggests that the major reason why men form new relationships is to re-establish emotional closeness: men who were most emotionally reliant on their wives reported the greatest desire to date and remarry (Carr, 2004b). For women, this pattern was reversed: the more emotionally reliant women were on their husbands, the less interested they were in pursuing subsequent relationships. Moreover, among bereaved individuals with very high levels of social support from friends, widowed men were no more likely than widowed women to say that they were interested in remarrying (Carr, 2004b). This finding suggests that bereaved men want and need social support; those who receive support from friends and family may be less motivated to find a new wife and confidante.

Why Are Women Not as Interested in Remarriage as Men Are?

Interestingly, widows almost never mention the shortage of available men when they are asked to provide reasons why they have not become involved with someone new. Available research suggests that they have come to value the independence associated with widowhood and do not want to give it up. Gentry and Shulman (1988) asked 612 widows who had not remarried whether they had ever considered remarriage, and why they had or had not considered remarriage. Although 192 widows had considered remarriage but had not yet remarried, more than twice as many widows (n = 420) reported that they had not considered remarriage. When asked why they had

not remarried, 40% of the widows said that they had not found anyone as nice as their deceased husband, and 37% indicated that they liked being single. Only 8% of the total sample said that they were too old for remarriage (among the widows older than 66 years, 15% felt they were too old). Even among the oldest widows, lack of potential spouses was not reported as the major reason for not remarrying. Only about 3% of the widowed women in the total sample reported a lack of eligible men as the reason why they had not yet remarried, and this did not vary with age. Gentry and Shulman suggest that even though in reality there is a scarcity of men, the widows apparently do not *perceive* that to be the reason they do not remarry. However, the authors concede that the 40% of the widows who said that they could not find anyone as nice as their deceased spouses are indirectly reflecting the demographic situation. Possibly, older women find the perception that they have "chosen" their single state empowering and affirming, rather than viewing their singlehood as a sad consequence of the skewed gender ratio. This feeling of control over their destiny may make adjustment to their situation easier for them.

In a qualitative study, Davidson (2001) found that 92% of the elderly widows, but none of the widowers, said that the reason they had not remarried was that they didn't want to look after another person. Fifty-six percent of the widows mentioned that they were enjoying their freedom, whereas none of the widowers mentioned this factor. The widows in Davidson's study were well aware that because of prevailing norms, they would probably end up with a man older than they were. They found this unappealing because they recognized that older men are more likely to require caregiving. In addition, the elderly widows had reservations about becoming sexually involved with an older man: "I'm 70. Who wants to marry a man about 75? Oh, I couldn't go to bed with an old man like that. I couldn't bear the thought of it" (Davidson, 2001, p. 312). The elderly widows in the study also perceived that there were too many "strings attached" in becoming involved in a new relationship, meaning that they would have to do household chores again even thought they felt they had "paid their dues" already in the last marriage. One widow in the study said, "First it's the 'home cooked meal,' then it's the shirt that needs ironing. No . . . Not any more . . . I've done my bit" (Davidson, 2001, p. 311). Another widow said, "You know, if you get 'life' [in prison] you only do 25 years. I did 50!" (Davidson, p. 311). Interestingly, in a study of elderly widowers who lost their spouse roughly three years previously, those widowers who had taken care of their wives and felt burdened by caregiving were less likely to consider remarriage (Vinick, 1984).

Is Remarriage Adaptive or Maladaptive?

After bereavement, others often bring up the topic of remarriage in an attempt to encourage recovery. There is evidence that discussions of this topic are often initiated within a few days or weeks of the spouse's death (Wortman & Lehman, 1985), and that such early suggestions are viewed as unpleasant or even jarring by a sample of widows (Glick, Weiss, & Parkes, 1974). But what about later on? Is it possible that the encouragement of remarriage by others is justified because the formation of a new relationship can be viewed as an adaptive way of coping? Should interest in dating be regarded as an indication of recovery and healing, or as a sign of trying to avoid the pain of bereavement?

Available evidence suggests that involvement in a new relationship may be healthy and adaptive. Schneider and colleagues (1996) found that widowers and widows who were involved in a new romance 25 months after their spouse's death were more likely to rate their adjustment to widowhood as good or excellent and were significantly less depressed. Similar results have been reported by Lund and collaborators (1993). Of course, it is not clear from these studies whether romantic involvement influences adjustment or whether good adjustment enhanced the likelihood of romantic involvement.

Gentry and Shulman (1988) examined whether remarriage can be viewed as a way of coping with the concerns and stresses of widowhood, and if so, whether it represents an effective means of coping. They found that remarried widows reported fewer current stressors (such as finances or social roles) than widows who had not considered remarriage or those who had considered remarriage but had not actually remarried. Additionally, the remarried widows were the only group to report experiencing fewer stressors at the interview than they recalled experiencing in the period immediately after the death of their husband. The authors concluded that some of the problems that arise from the death of a spouse, such as loneliness, finances, and home maintenance, may be lessened or resolved by remarriage, so that it can be considered an effective means of handling such concerns. But because a retrospective design was employed in this study, these results are merely suggestive.

CONCLUSIONS AND IMPLICATIONS

Although spousal loss is a ubiquitous experience among older married couples, there has been a paucity of research on the psychological sequelae of such losses. In this chapter, we have reviewed studies on how older adults are affected by the death of a spouse. While such losses are often associated

with an increase in physical health problems and emotional distress, it is clear that there is great diversity in how older Americans respond to the loss of a spouse. Data from several studies, including the CLOC study, indicate that a substantial percentage of elderly bereaved do not show significant distress at any point in time following the loss of their spouse. Moreover, a significant minority shows an improvement in mental health after their spouse's death. Taken together, available data provide strong support for the notion that such a response is indicative of resilience in the face of loss rather than denial or lack of attachment to the spouse. Data from the CLOC study, reviewed in this chapter, provides important information about the antecedents of resilience. The findings that resilient individuals are more accepting of death, and more likely to believe in a just world, suggest that pre-loss world views may play an important role in adaptive coping with the loss. It is our hope that subsequent research will provide further information regarding how resilient individuals are able to assimilate such a major loss.

The data reviewed in this chapter also illustrate that a significant percentage of elderly bereaved individuals show intense and prolonged distress following the loss. By clarifying the antecedents of this response, the CLOC study has shown that those who are happily married to a healthy spouse are most likely to show a chronic grief reaction. These findings underscore that all spousal losses are not the same. People who were involved in unsatisfying marriages and who lost a spouse who was ill actually showed an improvement in mental health following the spouse's death. Taken together, these findings highlight the importance of examining the context in which a loss occurs.

Another important finding to emerge from the CLOC study is that some respondents who show intense and prolonged distress following the death of an elderly spouse were in fact depressed before the loss occurred. In contrast to the chronic grievers, this chronically depressed group rated their marriages as relatively unsatisfying. In subsequent research, it will be important to determine whether these groups might benefit from different sorts of interventions. For example, chronic grievers may be helped by cognitive and behavioral interventions that provide a context for them to "work through" their feelings about losing a loved spouse. In contrast, chronically depressed individuals may benefit more from interventions that are specifically focused on their depressed mood, (e.g., pharmacologic interventions) and on helping them handle tasks of daily living.

One of the most intriguing aspects of the research reviewed in this chapter concerns the gender differences that were reported. It will be interesting to see whether gender differences in reaction to partner loss, desire

to remarry, and remarriage rates will continue to occur as men and women become more equal partners in marriage as far as household tasks are concerned. At the moment, women seem to be less interested in remarriage than men are. Available studies (e.g. Davidson, 2001; Vinick, 1984) suggest that it might not be gender per se that affects one's interest in remarriage. Rather, the interest in remarriage may be determined by the current organization of gender roles in the family. In the future, if more men take on roles in the family system traditionally held by the female homemaker, such as caregiver and cook, these men might also wish to avoid remarriage.

It would also be worthwhile to study the nature of the relationships that widowed women have with men, given their lack of interest in remarriage and the low frequency with which they do remarry. Do they initiate contact with men as confidants, friends or social companions, or do they increase their social contacts with females? Hopefully, subsequent research will help to resolve these issues.

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CHAPTER 5

A Closer Look at Health and Widowhood

Do Health Behaviors Change After Loss of a Spouse?

Amy Mehraban Pienta and Melissa M. Franks

Deaths to older adults in the late 20th and early 21st centuries result primarily from chronic illness. Chronic illness, including cancer, heart disease, and diabetes, are closely linked to the lifestyles and health behaviors maintained over the life course (Topp, Fahlman, & Boardley, 2004). Late life disability also is linked to prior health behaviors, including exercise, smoking, diet, and alcohol consumption (Vita, Terry, Hubert, & Fries, 1998). Positive health behaviors, then, serve as an important buffer against late life health declines and disability. Evidence indicates that married persons are healthier than their unmarried peers at least in part because spouses tend to encourage each other's healthy behaviors—a health-promoting advantage that may diminish after the death of a spouse (Kiecolt-Glaser & Newton, 2001). We propose that changes in health behavior following spousal loss are a potentially important yet under-researched risk factor for health decline and mortality among bereaved spouses. Researchers' neglect of this topic reflects the scarcity of data on older adults' health behaviors both *prior to* and *after* the loss of their spouse that would reveal patterns of health behavior *changes*. The design, breadth, and depth of information available in the Changing Lives of Older Couples (CLOC) study, however, now enable researchers to explore more fully the health behavior pathways linking widowhood and physical health among older adults.

In this chapter, we describe research documenting the relationship between widowhood and health among older adults in the United States. We review past empirical analyses, discuss why past studies have yielded equivocal results, and identify potential mechanisms for the relationship between widowhood and both health and health behaviors. We then present new empirical findings, based on the CLOC study, that indicate specific ways that lifestyle factors mediate the relationship between widowhood and physical health.

DOES HEALTH DECLINE AFTER SPOUSAL LOSS?

The relationship between marital status and health has been documented across a broad range of health measures, including mortality, self-rated health, and health behaviors. Research conducted over the past 5 decades documents a mortality disadvantage among bereaved spouses, compared to their married peers (Gove, 1973; Hu & Goldman, 1990; Kraus & Abraham, 1959; Lillard & Waite, 1995). Recent studies suggest that widowed men and women have higher mortality rates than married persons, with the strength of this relationship attenuating over time since the loss (Lichenstein, Gatz, & Berg, 1998). However, some ambiguity remains about whether spousal loss affects mortality in similar ways for women and men (Mineau, Smith, & Bean, 2002) and across all cultural settings (Nagata, Takatsuka, & Shimizu, 2003).

Evidence is less clear about the relationship between marital status and health outcomes other than mortality. One cross-sectional study comparing older married women with women who were widowed in the previous 12 months found self-reported health to be poorer among those who had lost a spouse (Byles, Feldman, & Mishra, 1999). Another cross-sectional study found no relationship between self-reported health and widowhood status (Wolinsky & Johnson, 1992). These equivocal findings can be attributed partly to the reliance of past studies on samples and data sets that: (a) were designed for purposes other than studying the consequences of widowhood, and thus do not include indicators of important pre-loss characteristics of the bereaved; (b) typically focused on one gender only; (c) varied in length of time passed between spousal loss and follow-up interview; and (d) had only a limited set of health measures.

Past studies also have not considered fully the range of potential pathways linking widowhood status to health. One key pathway may be health behaviors, and past research has not resolved whether or to what extent health behaviors change following spousal loss. Widowhood may create a loss of structure in the surviving spouse's daily life, which may lead to erratic

sleep patterns, poor diet, and other health-compromising behaviors (Perkins & Harris, 1990). However, we know of few studies that have examined systematically the extent to which health behaviors change for men and women following the loss of spouse (for a recent exception, see Williams, 2004). For example, health behavior changes may be transient; these changes may be associated with psychological distress in the months immediately following a loss, yet have no long-term impact on health. Moreover, the health behaviors of men and women may be affected in different ways by widowhood. Because women and men differ in their propensity to adopt risky health behaviors, such as drinking and smoking, and because bereaved women and men may respond differently to the loss of spouse, it is plausible that men's and women's health behaviors also would change in different ways following the loss of a spouse.

Following is an overview of research that has investigated the relationship between widowhood and the health behaviors of sleep, diet and body weight, smoking, and alcohol use.

Sleep Problems

Sleep is an important determinant of physical health, especially for older adults. According to recent estimates, over half of all adults ages 65 and older experience sleep problems (Kryger, Monjan, Bliwise, & Ancoli-Israel, 2004). Among older adults, a lack of restful sleep at night is associated with excessive daytime sleepiness, attention and memory problems, depressed mood, falls, and poorer quality of life (Kryger et al., 2004). One cross-sectional study found that older widowed adults experienced more sleep problems than their married peers, where sleep problems encompassed insomnia, difficulty falling asleep, and early morning waking (Foley, Monjan, Simonsick, Wallace, & Blazer, 1999). However, because this study did not control for how long a person had been widowed, it did not reveal whether sleep disturbances are a short-term response to loss, perhaps due to depressive symptoms in the early weeks after loss, or a more persistent problem that continues months or years after the loss.

Diet

Empirical studies have been fairly consistent in reporting the harmful effects of widowhood on diet and body weight (Quandt, McDonald, Arcury, Bell, & Vitolins, 2000; Rosenbloom & Whittington, 1993; Wilcox et al., 2003). These negative effects are thought to stem from changes in daily routines that reduce nutrient intake (Rosenbloom & Whittington, 1993), decrease fruit

and vegetable consumption (Wilcox et al., 2003), and increase fat consumption (Wilcox et al., 2003). The types of dietary routines that appear to change following spousal loss include more frequent meal skipping, less home food production, and less dietary variety (Quandt et al., 2000). Such changes might lead to weight loss following widowhood (Umberson, 1992); although weight loss often is viewed positively by older adults, it may threaten one's health if the weight reduction results from a compromised diet. In general, nutritional problems are more common among elderly persons than younger adults (Pirlich & Lochs, 2001), and inadequate nutrition has been associated with increased risk of morbidity and mortality among the elderly (Pirlich & Lochs, 2001). Thus, weight loss in old age is considered a marker of frailty (Chin A Paw et al., 2003).

One limitation of previous dietary studies is that many did not explicitly examine gender differences. Because most studies of bereavement are based on samples that include more women than men, it is possible that the harmful effects of spousal loss on weight and diet are understated. Wives (particularly those in current cohorts of older adults) tend to do more meal preparation than their husbands, thus the loss of a spouse may be more harmful to the dietary practices of widowers than widows. Also, past dietary studies relied mainly on small samples and included single follow-ups; as a result, it is not clear whether the compromised nutrition of bereaved spouses is a short-term or persistent consequence of loss (Wilcox et al., 2003 is an exception to this). Our work builds upon past studies by presenting data on dietary changes spanning the four-year period following spousal loss, and by exploring gender differences in dietary changes following loss.

Smoking

The empirical evidence is mixed regarding the effect of widowhood on smoking behavior. Although some scholars have argued that smoking might increase as a way of coping with spousal loss, especially among smokers and former smokers, Wilcox et al. (2003) find that widows actually smoke fewer cigarettes per day than married women. Other studies show no difference in the smoking and quit rates of widowed and married persons over a 2-year period (Franks, Pienta, & Wray, 2002). For women, in particular, smoking may be a social activity that decreases when one's spouse dies. Research on smoking, like research on other health behaviors, could offer clearer and more persuasive findings by examining women and men separately, and by tracking widowed persons over time to see how smoking behavior might change as time passes since the loss. Our work addresses these issues by ex-

ploring gender differentials in smoking behavior changes among widowed older adults, and by extending the period of examination to 4 years following spousal loss.

Alcohol Consumption

Research on the association between widowhood and alcohol consumption also has yielded mixed results. Wilcox and colleagues (2003) find no differences between widows' and married women's alcohol consumption over a 3-year period. However, using longitudinal data from the Health and Retirement Study, Perreira and Sloan (2001) find that spousal loss is related to increased alcohol consumption. Byrne, Raphael, and Arnold (1999) report that widowers drink with greater frequency and in larger quantities than older married men.

These mixed results may reflect different underlying reasons for alcohol consumption. On one hand, the loss of a spouse (and drinking partner) may decrease alcohol consumption, because people who drink alcohol tend to be married to those who also drink alcohol (Graham & Braun, 1999), and because spouses may drink socially with each other more often than they would drink alone. On the other hand, alcohol consumption may increase following spousal loss; drinking may be viewed as a means of reducing stress and coping with the loss of one's spouse, especially in the initial months of widowhood.

The equivocal findings on alcohol consumption also may stem from the same research challenges facing studies on the relationship between spousal loss and sleep, diet, and smoking behaviors. First, most previous work investigating the link between widowhood and health behavior relies on data sources that were not designed explicitly to investigate the consequences of spousal loss. Also, cross-sectional data are sometimes used, with measurements of married and widowed persons at a single observation point used to represent health changes resulting from widowhood (e.g., Byles et al., 1999). Some studies rely on small sample sizes, reflecting the infrequent incidence of widowhood in general population samples (e.g., Franks et al., 2002). Wilcox and collaborators (2003) note too that, given these small sample sizes, some studies do not differentiate widowhood from divorce, although they are very different processes. Another challenge of studying widowhood and health is that even with longitudinal data, follow-up times vary and are often quite long—a critical limitation given that behavioral changes may be transitory. Also, a number of studies include women only, in part because widowhood is much more common among women.

Because of these limitations, past studies provide an inconsistent overall picture of whether and how widowhood affects health behaviors among older adults. Our study seeks to remedy this by building upon past work in four ways. First, we examine health behavior changes following spousal loss using longitudinal data from CLOC, a study designed specifically to investigate the course and predictors of bereavement among older adults. The data allow us to examine changes over time using relevant measures on a large sample of widowed adults. Second, the CLOC sample includes matched controls, allowing us to specify the effects of spousal loss through comparisons made with married male and female control samples. Third, we examine health behavior changes among both women and men, allowing us to identify gender differences in reactions to loss. Finally, we evaluate health behavior changes that occur shortly after the loss of one's spouse (6 months after loss), and also explore the extent to which these changes persist or attenuate over time. The longitudinal data allow us to distinguish between short- and longer-term changes occurring following loss of a spouse.

How Does Marital Status Affect Health?

Scholars have offered two competing perspectives on why widowed persons have poorer health than married persons: social causation and social selection. The social causation perspective proposes that the marital context itself promotes good health. Individuals embrace healthier lifestyles once they are married (Sherbourne & Hays, 1990), and spouses also provide each other emotional, financial, and instrumental support that may foster better health. The social selection perspective posits, in contrast, that healthier people are more likely than unhealthy persons both to marry and to remain married. Thus, the better health of married people reflects benefits they had prior to marrying.

The social causation perspective views conjugal or spousal support as an important pathway linking marriage and health. Conjugal support is believed to be a particularly important source of social support as couples age (Ducharme, 1994), conferring benefits for both psychological (Sherbourne & Hays, 1990; Ducharme, 1994) and physical health (Ducharme). Older adults often experience chronic disease and functional limitations, declines that make emotional and physical spousal support all the more important. An older adult who loses his or her spouse may not only lose their primary source of emotional and physical support, but a partner who monitors their health and encourages and facilitates healthy behaviors (Umberson, 1987, 1992). A recent meta-analysis of studies across a broad spectrum of chronic illnesses

reveals that social support enhances patients' adherence to their treatment regimens, and thus may serve as an important mechanism in the established linkage between social support and health (DiMatteo, 2004). Notably, spousal support is particularly important for married older adults in the United States today, where immediate family members play a much more active role in day-to-day life than do extended family members (McNally, 2003).

Marriage also offers women and men a shared environment or a shared lifestyle; as a result, one's own health may benefit (or suffer) due to the choices made by one's partner. For example, although women typically earn less money than men in the workplace, wives may benefit financially from their husbands' earnings, and thus may afford a life style that fosters better health. Conversely, a nonsmoker who is married to a smoker may be subjected to second-hand smoke, which in turn takes a toll on both the smoker's and spouse's health. Because spouses have access to the same food in their household, households that focus on healthy eating and provide healthy food choices may be beneficial to both spouses—even if one spouse has a personal preference for unhealthy food. Thus, in marriage the shared environment may affect health above and beyond one's own individual choices and actions. Yet when one's spouse dies, the environment inevitably shifts. For example, a newly bereaved person who prefers unhealthy food may revert to his or her own personal preferences, when faced with making independent decisions about food choices at the grocery store.

The social selection explanation for the observed association between marital status and health is based on the idea that individuals prefer to marry persons with good mental and physical health, as well as positive health behaviors. As a result, healthier people are more likely to marry and to remain married than their less healthy counterparts. This means an observed association between marital status and health reflects the influence health on one's marital status, rather than the health-promoting aspects of marriage (Lillard & Panis, 1996). As men and women select their romantic partners, psychologically or physically "robust" individuals are more often selected (Goldman, 1993), resulting in a remaining pool of relatively frail persons who are unmarried. Various other selection arguments have been made as well. Socioeconomic background may influence both who marries and who is in good health, for example. Similarly, individuals with relatively stable lives may tend to both marry at higher rates and have healthier lifestyles than their counterparts with riskier lifestyles. Thus any observed relationship between marriage and health may simply reflect a spurious relationship, a consequence of pre-marriage characteristics. While the social selection hypothesis is a useful and thought-provoking framework for comparing the

health of married versus never married individuals, the selection argument is not generally favored for predicting why widow(er)s are less healthy than married persons (Joung, Mheen, Stronks, Poppel, & Mackenbach, 1998).

Nonetheless, selective pressures may certainly affect the likelihood and timing of one's transition into widowhood. Persons with fewer economic and social resources may be more likely to become widowed (because mortality is inversely related to socioeconomic resources), and more likely to have poor health behaviors following loss. Also, because spouses often have similar lifestyles, they may share health problems as well. For example, a widow whose husband died of heart disease may be more likely to be battling heart disease herself because she and her husband engaged in similar high-risk health behaviors. Thus, widowhood itself may be an indication of underlying health or economic problems shared with the deceased spouse.

Why Does Widowhood Matter?

The loss of the marital relationship may have particular meaning in the context of health when the marriage ends because one spouse dies. Because marriage may act as a buffer against daily life stressors, losing a spouse to death is considered highly stressful and may have negative health consequences. Further, widowhood in itself can be a very stressful life event, and a large literature reveals that such events may trigger psychological or physical health problems. A number of studies have linked widowhood to certain types of stress-related health outcomes including high cholesterol and LDL levels (low-density lipoprotein) among younger adult women (Kushnir & Kristal-Boneh, 1995), heart disease among older women and men (Carr, 2001), and deaths from ischemic heart disease among adult women and men (Jones, 1987). However, other diseases that are not typically associated with stress are also more prevalent among the widowed, which suggests that factors other than stress are at work. For example, Carr (2001) has argued that heart disease may be more prevalent among the widowed in part because of changes that occur during the period preceding spousal death, especially extensive caregiving, institutionalization of one's spouse, or the neglect of one's own health symptoms. Moreover, in an effort to sooth the emotional pain associated with spousal loss, some bereaved persons may "self-medicate" with substances such as alcohol or tobacco. By tracking changes in health behavior following widowhood, the present study helps clarify mechanisms in the relationship between widowhood and health.

Widowhood is also frequently accompanied by financial loss, especially for women. Economic deficits may lead to less than optimal health care utilization. Although widows tend to visit physicians more frequently and spend

more days in nursing homes that married women (Prigerson, Maciejewski, & Rosenheck, 2000), there is evidence that widowed persons seek care at lower quality hospitals (Iwashyna & Christakis, 2003), which may have negative health implications. Moreover, because very few older widows and widowers remarry, few restore the financial or emotional resources that were lost when their spouse died.

The extent to which widowhood affects one's health also may be contingent upon how one's spouse died (Carr, House, Wortman, Nesse, & Kessler, 2001; Carr & Utz, 2002). Some persons experience the sudden loss of a healthy spouse, whereas others experience the loss of a terminally ill spouse after a long period of intensive caregiving. The way that one's spouse dies has important implications for the survivor's adjustment. On one hand, caring for a chronically ill spouse may provide a period of forewarning that allows easier adjustment to widowhood than does sudden loss. On the other hand, the stress and strain associated with pre-loss caregiving may prove to be an important reason that health problems are more prevalent following loss of spouse (Carr, 2001). For example, one recent study has shown that sleep problems are particularly problematic for widows who were caregivers prior to losing their spouse (Wells & Kendig, 1997). Both of these possible effects of the anticipated loss of a spouse—the adjustment afforded by prior knowledge versus the stress involved in caregiving—have important implications for late life widowhood because chronic disease-related deaths are most common in later life.

The loss of a spouse to death is certainly linked directly to feelings of sadness, depression, and grief, with these emotions being sharpest immediately following the spouse's death (Umberson, Wortman, & Kessler, 1992). Older men appear to be particularly vulnerable to depression following the loss of their spouse (Umberson et al., 1992; Lee, DeMaris, Bavin, & Sullivan, 2001). Grief symptoms have been shown to affect morbidity and mortality (Helsing, Szklo, & Comstock, 1981; Jones, 1987; Kaprio, Koskenvuo, & Rita, 1987), suggesting that at least part of the relationship between widowhood and health operates indirectly through the experience of grief. Studies by Yalom and Vinogradov (1988) and Lieberman and Videka-Sherman (1986) have reported that the more recently widowed are especially prone to increased incidence of poor physical health for a year or more after a loss.

Complicated or traumatic grief receives considerable attention in the bereavement literature. Traumatic grief refers to feelings and symptoms of distress stemming from the loss of one's partner and is defined by observable symptoms such as yearning, preoccupation with thoughts of the deceased, feeling disbelief, and feeling stunned at the loss. Many have argued

that widowed persons experiencing traumatic or complicated grief may be most vulnerable to declines in physical and psychological health—more than widows not experiencing traumatic or complicated grief. Widowed persons suffering from traumatic grief are often observed to also have elevated rates of cancer, hypertension, and heart problems (Prigerson et al., 1997). Traumatic grief, which tends to be associated with sudden/unexpected death, is more common among younger than late life bereaved persons, and thus may have less relevance as a health factor in late life spousal loss. This study extends previous cross-sectional research on bereavement and health by evaluating whether and how health behaviors change in response to widowhood, whether these changes differ for women and men, and whether such changes persist beyond the months immediately following spousal loss.

DATA AND METHODS

We use prospective data from the Changing Lives of Older Couples (CLOC) study in our investigation of the relationship between losing a spouse and health behaviors. The design of the CLOC study and its sample are described elsewhere (see Carr, chapter 2). The CLOC study is ideal for examining whether health behaviors change following loss of spouse because: (a) widowed persons (and matched controls) are studied prospectively over time; (b) baseline (preloss) characteristics are available, enabling us to control for potential confounding variables; and (c) it includes indicators of multiple health conditions and health behaviors. These features allow us to clarify the causal relationship between widowhood and health.

We use data from the bereaved sample and the married control sample (matched on age, sex, and race) at the baseline interview and the three interviews following the death of a spouse. Our analytic sample comprises all widowed persons (n = 250) and matched married controls (n = 83) participating in the 6-month interview, the 18-month interview (210 widowed persons and 199 married controls), and the 48-month interview (106 widowed persons and 101 matched controls). Controls are not available for all bereaved subjects at the 6-month follow-up because funding for the control sample was cut from the proposed budget, and was reinstated halfway through the data collection for the 6-month follow-up.

MEASUREMENT OF DEPENDENT VARIABLES

We focus on five aspects of health behavior that may be affected by spousal loss: sleep patterns, alcohol consumption, smoking, body weight, and physi-

cal activity. We focus on two specific dimensions of sleep: *daily sleep* (typical hours of sleep per day) and *sleep medication* (number of days per month one uses sleep medication). Respondents were asked: "How many hours of sleep do you get in a 24-hour period, including naps?" Responses ranged from 2 to 16 hours of sleep per day, with an average of 7.5 hours. Second, respondents reported the number of days over the past 30 days that they took medication to help them sleep. Responses ranged from 0 to 30 days, with an average of 2.3 days in the past month. Daily sleep was measured at baseline for the full sample and at each follow-up interview for widowed persons and matched controls (i.e., at 6, 18, and 48 months following spousal loss). Use of sleep medication was measured at baseline and at the first two follow-up interviews only.

Alcohol use was assessed with two measures: *number of days one drank in the past month* and *number of drinks per day.* Respondents were asked to report the number of days in the past month they drank beer, wine, or other alcohol. Responses ranged from 0 to 30 days, with an average of 5.9 days over the past month. Respondents who reported drinking at least one day in the past month were then asked, "On the days that you drink, how many cans of beer, glasses of wine, or drinks of liquor do you usually have?" Responses ranged from 0 to 15, with an average of less than 1 alcoholic drink per day (mean = .9). Both alcohol use measures were obtained at baseline and at each follow-up interview.

Smoking behavior was assessed using two measures. First, respondents were identified as non-smokers or *current smokers*, with the latter comprising roughly 13% of the sample at baseline. *Number of cigarettes smoked per day* also was reported. Responses ranged from 0 to 60, with an average of 2.4 cigarettes per day. Both smoking measures were obtained at baseline and at each follow-up interview.

Ideally, our examination of health behaviors would include indicators of dietary quality and nutritional intake. The CLOC does not obtain these measures, so we use a measure of body mass index (BMI) to approximate changes in diet that could produce weight gain or loss following the loss of a spouse. BMI is a measure of body weight based on height and weight that applies to both adult men and women. To calculate this index, height reported in inches (converted to meters squared) is measured at baseline and used in conjunction with weight reported in pounds (converted to kilograms) to calculate BMI (kg/m^2) at each time point in the CLOC study. The National Heart, Lung, and Blood Institute (NHLBI) has established BMI cut points to assess individual risk for obesity-related chronic disease. A BMI score under 18.5 classifies one as underweight; BMI scores of 25 and above

indicate that a person is overweight, and scores over 30 indicate that a person is obese. The mean BMI of the CLOC sample at baseline is 26.4. The measure is based on self-reported weight and height at each of the three follow-up interviews.

Physical activity and exercise reflect one's responses to questions on walking and participation in vigorous activities/sports. Respondents were asked: "How often do you take walks for exercise or pleasure?" Response categories were: often, sometimes, rarely, never. This measure was collapsed into *walks regularly* (1 = often or sometimes) and does not walk regularly (0 = rarely or never). Over half of the baseline sample reported walking regularly (56.1%). Respondents also were asked: "How often do you participate in active sports or exercise?" Response categories were: often, sometimes, rarely, never. This measure was collapsed into *exercises regularly* (1 = often or sometimes) and does not exercise regularly (0 = rarely or never). Just over one third of the baseline sample reported exercising regularly (35.3%). Using responses to both of the previous questions, we constructed a third measure that indicates whether one maintains a *sedentary lifestyle* (1 = never walks and never exercises; 0 = walks or exercises). Only 18% of the baseline sample reported a sedentary lifestyle. We construct each of these physical activity measures from data obtained at the baseline interview and three follow-up interviews.

INDEPENDENT VARIABLES

The central independent variable is *loss of spouse* contrasted with married persons (reference category) from the matched control samples. *Gender* also is evaluated in the present analysis (1 = female; 0 = male). Other control variables include: *age* (measured in years), *education* (measured in years), and *race* (1 = white; 0 = non-white). Baseline health is defined as *self-rated health* ranging from excellent (= 1) to poor (= 5), to capture any potentially confounding health declines that precede any changes in health behaviors.

ANALYSIS

We compare health behaviors of widowed persons and married matched controls at the 6-, 18-, and 48-month follow-up interviews. For continuous outcomes (e.g., daily sleep) we compare means for the two groups using two-

tailed *t*-tests. For categorical outcomes (e.g., smoking status) we compare frequency distributions for the two groups using the chi-square statistic. We then estimate multivariate models (OLS for continuous outcomes and logistic regression for dichotomous outcomes); we regress health behavior on widowhood status and introduce other baseline characteristics as control variables. We control for age, education, race, self-rated health, and baseline health behavior. All multivariate models also control for time (in years) elapsed between the follow-up interview and the baseline interview. This is important because length of time to first follow-up differs depending on the amount of time elapsed between baseline and death of a spouse. For instance, although all Wave 1 follow-up interviews were conducted 6 months following spousal death, the duration between the baseline and Wave 1 interviews ranges from nine to 76 months due to variation in the timing of spouse's death. Thus, baseline assessments are more temporally distant for those who lost their spouses at later dates.

All analyses are weighted to account for unequal probability of selection into the sample and response rates at baseline. Because of the substantial sample attrition across the follow-up interviews and the concomitant concern about sample selectivity biasing the results, selectivity analyses were conducted. Participation at the 6-month follow-up was predicted, based on characteristics obtained in the baseline interview. Results indicated that while study participation was related to age, anxiety level, and home ownership—with age and anxiety decreasing the likelihood of participation and home ownership increasing it (Carr, 2001)—neither baseline health nor health behaviors predicted subsequent study participation. Also, participation in the 18-month follow-up was unrelated to health or health behavior at the 6-month interview, although persons with lower levels of education were less likely to participate. Thus, we are confident in the generalizability of our findings for the health and health behavior outcomes.

RESULTS

Health behaviors of widowed persons and married controls are compared in Table 5.1, which summarizes the health behaviors for the full sample, for men only, and for women only, by both widowhood status and interview wave. Shaded cells represent values that are significantly different for widowed persons and matched controls, based on *t*-tests (for comparison of means) and chi-square analyses (for comparison of frequency distributions).

TABLE 5.1

Descriptive Statistics for Health Behaviors (at 6-, 18-, and 48-Month Follow-Ups) by Widowhood Status and Gender

		Wave 1—6 Months		Wave 2—18 Months		Wave 3—48 Months	
		Bereaved	Control	Bereaved	Control	Bereaved	Control
	Unweighted *n* =	250	83	210	199	106	101
Hours of sleep/night (mean)	Total	7.1	7.6	7.3	7.5	7.5	7.5
	Women	7.1	7.8	7.3	7.3	7.3	7.5
	Men	7.2	7.3	7.5	7.9	—	—
Days/month sleep medication (mean)	Total	1.9	1.2	2.0	2.1	—	—
	Women	2.1	0.6	2.4	2.5	—	—
	Men	1.2	3.1	0.9	1.0	—	—
Number of drinks (mean)[a]	Total	0.9	1.4	1.1	1.2	0.9	3.0
	Women	0.8	0.9	1.1	1.1	0.8	3.0
	Men	1.4	2.6	1.2	1.6	—	—
Days/month drink alcohol (mean)[a]	Total	6.0	9.4	7.4	7.6	5.9	8.8
	Women	4.1	5.8	7.1	7.0	5.5	8.5
	Men	1.4	19.1	7.8	8.8	—	—
Smokes (%)[b]	Total	21.5	9.6	25.1	10.8	23.5	27.1
	Women	31.7	14.4	36.2	17.0	34.0	31.1
	Men	8.7	4.5	10.3	4.1	—	—
Number of cigarettes/day (mean)[b]	Total	3.3	0.8	3.9	1.6	2.7	3.5
	Women	4.7	1.5	5.8	2.6	3.9	3.7
	Men	1.5	0.0	1.5	0.6	—	—

TABLE 5.1 *(continued)*

		Wave 1—6 Months		Wave 2—18 Months		Wave 3—48 Months	
		Bereaved	Control	Bereaved	Control	Bereaved	Control
	Unweighted *n* =	250	83	210	199	106	101
BMI (mean)	Total	25.5	26.6	25.9	27.2	25.0	25.4
	Women	25.7	26.9	25.4	27.0	24.8	25.3
	Men	24.5	25.5	24.9	27.9	—	—
Walks (%)	Total	52.8	52.7	52.7	54.0	51.1	60.3
	Women	52.1	49.9	53.8	50.3	52.4	58.4
	Men	60.5	54.5	49.7	62.5	—	—
Vigorous activity (%)	Total	31.7	31.1	30.0	33.4	25.6	32.9
	Women	26.1	26.8	25.5	35.5	23.9	31.0
	Men	46.2	44.3	41.2	28.4	—	—
Sedentary lifestyle (%)	Total	24.5	26.7	20.0	25.6	25.9	23.7
	Women	27.4	22.4	24.4	24.4	24.2	23.2
	Men	17.1	40.0	9.2	28.3	—	—

[a]Calculated for respondents who ever drink alcohol.
[b]Calculated for respondents who have ever smoked in lifetime.
Shaded cells indicate statistical significance $p < .05$ (*t*-test for difference of means and Chi-Square for categorical variables).
Results are not weighted.

At the 6-month follow-up, bereaved persons report less daily sleep than their married peers (see Figure 5.1). Married women get 7.8 hours of sleep per day whereas widows sleep only 7.1 hours, a difference that declines at the 18-month mark and disappears completely by the 48-month follow-up. Married men report virtually the same amount of daily sleep as widowed men at the 6-month follow-up (7.3 hours vs. 7.2), a difference that increases by the 18-month follow-up. At the 6-month follow-up interview, widows report more frequent use of sleep medications in the previous month than their married peers, a difference that attenuates by the 18-month interview and does not hold for men who have lost a spouse.

Although alcohol consumption patterns change very little following spousal loss of spouse, smoking behavior appears to change, at least among women. A greater proportion of bereaved women report smoking at the 18-month follow-up (36.3%) than their married peers (17.0%). At the 6-month interview, widows also smoke more cigarettes (4.7) per day than the married women controls (1.5) (see Figure 5.2), a difference that persists at the 18-month follow-up but virtually disappears by the 48-month follow-up.

At the 6-month interview, BMI does not differ by widowhood status. By the 18-month follow-up, however, there is a difference in BMI, with bereaved women and men weighing less than married men and women controls (see Figure 5.3). This gap is most pronounced among widowed and married men

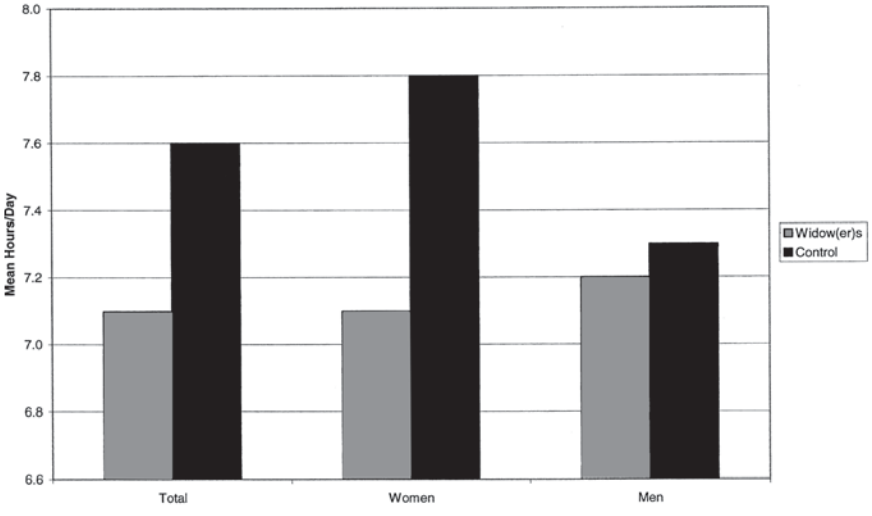

Figure 5.1 Widowed Persons and Married Controls at 6-Month Follow-Up: Hours of Sleep per Day.

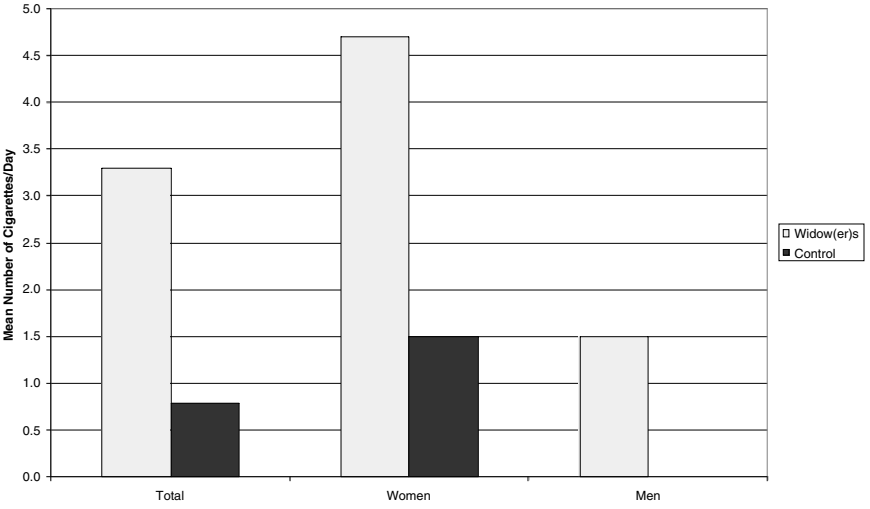

Figure 5.2 Widowed Persons and Married Controls at 6-Month Follow-Up: Number of Cigarettes per Day.

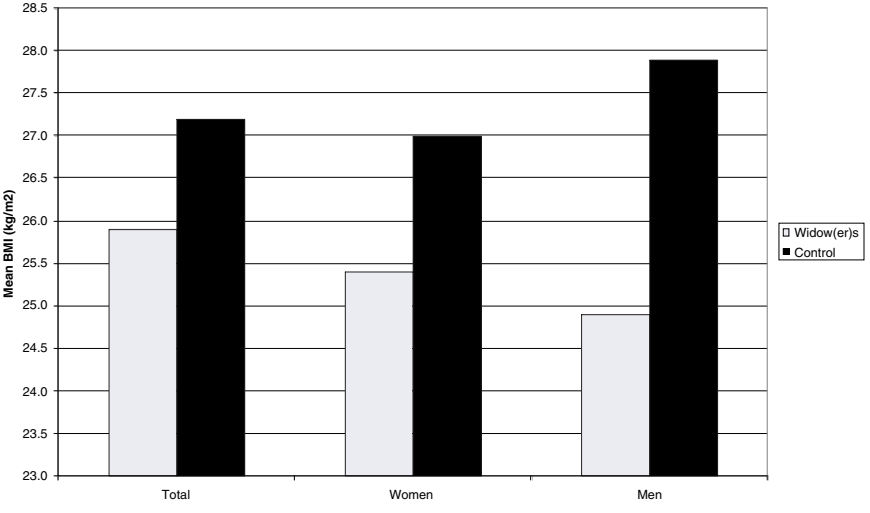

Figure 5.3 Widowed Persons and Married Controls at 18-Month Follow-Up: Body Mass Index.

at the 18-month follow-up, with BMIs of 24.9 and 27.9, respectively. The difference attenuates by the 48-month follow-up. Such differences in BMI likely reflect changes in dietary behavior and possibly changes in physical activity. Among women, physical activity does not change following widowhood. Among men, however, there is a large gap in the proportion of widowed and married men who are sedentary at the 6-month follow-up. Only 17.1% of widowed men are sedentary 6 months after losing a spouse whereas 40% of married controls report sedentary lifestyles (see Figure 5.4). This means that over 80% of the widowed men report that they walk or do some type of exercise or vigorous activity at the 6-month follow-up. This difference also is observed at the 18-month follow-up, but is no longer statistically significant by the 48-month follow-up. Thus, men may adopt or resume a more active and less sedentary lifestyle after spousal loss, which in turn is associated with a lower and healthier BMI.

We now explore the extent to which the findings uncovered in our bivariate analysis persist when we control for salient pre-loss characteristics. In Table 5.2, we present the effects of widowhood on health behaviors, net of age, gender (for the full sample), race, education, baseline self-rated health, baseline health behavior, and time elapsed since baseline interview. Our multivariate analyses reveal that sleep problems (i.e., sleeping fewer hours per day and frequency of taking sleep medication) are more common among

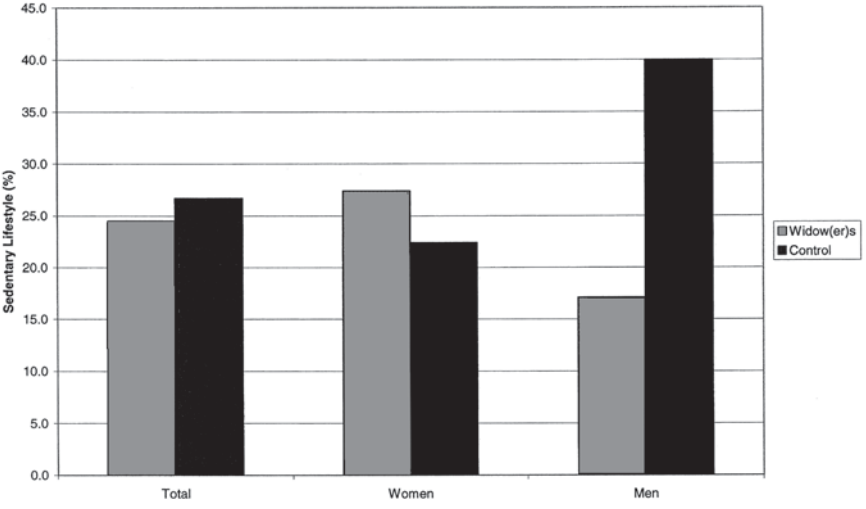

Figure 5.4 Widowed Persons and Married Controls at 6-Month Follow-Up: Sedentary Lifestyle.

TABLE 5.2
OLS and Logistic Regression Predicting Health Behaviors at 6- and 18-Month Follow-Ups

		Wave 1—6 Months		Wave 2—18 Months	
		B	SE B	B	SE B
Hours of sleep/night (OLS)	Total	−0.501	0.172	0.219	0.229
	Women	−0.525	0.181	−0.032	0.219
	Men	−0.669	0.477	−1.023	1.026
Days/month sleep medication (OLS)	Total	1.119	0.861	2.268	1.035
	Women	1.442	0.910	2.808	1.225
	Men	−0.080	2.269	0.497	0.725
Number of drinks (OLS)	Total	0.021	0.101	0.022	0.143
	Women	−0.019	0.085	−0.077	0.143
	Men	0.158	0.414	0.542	0.439
Days/month drink alcohol (OLS)	Total	−0.310	0.739	0.086	0.990
	Women	−0.594	0.739	−0.898	1.035
	Men	0.331	1.834	2.883	2.983
	Men	—	—	—	—
Number of cigarettes/day (OLS)[a]	Total	0.131	0.973	2.491	1.368
	Women	0.169	1.278	3.651	1.710
	Men	0.369	1.464	1.361	1.371
Smokes (Logistic)[2]	Total	−0.088	0.873	3.255	1.52
	Women	−0.384	1.045	3.685	1.69
	Men	—	—	—	—
BMI (OLS)	Total	−0.115	0.290	0.074	0.432
	Women	0.090	0.327	0.496	0.488
	Men	−0.938	0.688	−1.788	1.062
Walks (Logistic)	Total	−0.167	0.322	−0.221	0.462
	Women	−0.110	0.378	−0.014	0.504
	Men	−0.160	0.642	−2.367	1.761
Vigorous activity (Logistic)	Total	−0.618	0.379	−0.038	0.491
	Women	0.176	0.445	−0.952	0.545
	Men	−1.676	0.797	—	—
Sedentary (Logistic)	Total	0.007	0.376	0.298	0.494
	Women	2.015	0.399	1.162	0.605
	Men	−1.054	0.785	−4.687	2.090

Notes: For OLS models betas and standard errors are presented. For logistic regression models log-likelihood coefficients and standard errors are presented. All models control for age, race, education, baseline health status, baseline health behavior in same domain, and time passed since Baseline interview. Shaded cells indicate statistical significance at $p < .05$.
Data are weighted in all models.
At the 6-month follow-up interview; unweighted n is equal to 333 (total) 287 (women), and 46 (men).
At the 18-month follow-up interview; unweighted n is equal to 240 (total) 212 (women), and 28 (men).
[a]Calculated for respondents who have ever smoked.

widows than married women net of baseline characteristics. Also, widowed women sleep less than married women at the 6-month interview, and this difference is not explained by sleep patterns observed at baseline or other pre-loss characteristics.

On the other hand, the decreased alcohol consumption observed among bereaved persons at the 6-month interview is explained by baseline characteristics. Widowed persons may drink less on average compared to married controls, but this difference is explained by pre-loss factors. Smoking rates, in contrast, are elevated among widowed persons, particularly women. At the 18-month follow-up, widowed women are much more likely to smoke than married women. Further, widows smoke more cigarettes per day at the 18-month follow-up than married women. Pre-loss characteristics (smoking status, health, and education) do not explain why widows smoke more than their married counterparts.

Interestingly, when pre-loss characteristics are included as controls, BMI is no longer lower among bereaved persons than among married controls. This suggests that dietary patterns, physical activity changes, and weight loss may be altered before one actually loses a spouse. Physical activity differences among men are robust even after pre-loss characteristics are accounted for. Widowed men are much less likely to be sedentary at the 18-month follow-up than married men controls ($b = -4.687$), net of pre-loss characteristics. Table 5.2 also shows that at the 6-month follow-up, widowed men are less likely to participate in vigorous activities ($b = -1.676$). Widowed men appear to be physically active, although their physical activity entails less taxing activities. Widowed women, in contrast, are more sedentary than married women at the 6-month followup. ($b = 2.015$).

CONCLUSION

Evidence regarding excess mortality among older bereaved spouses has generated scores of studies examining the relationship between widowhood and health. Past studies have focused primarily on short time horizons following loss, and few considered pre-loss indicators of health behaviors. This chapter examined whether recently bereaved spouses and married controls differed in terms of sleep behavior, alcohol use, cigarette use, body weight, and exercise. We used data from the CLOC study; these prospective, multi-wave data offer a corrective to many of the aforementioned methodological limitations in the widowhood literature.

The CLOC data show that widowhood is related to health behavior changes that may have important health implications in the long run. Be-

reaved women are more likely than married women to experience a health behavior change, especially at the 6-month point following a spouse's death. Specifically, bivariate results show that compared to their married peers, widowed women sleep less, use sleep medication more frequently, are more likely to smoke, smoke more cigarettes per day, and lose more weight. Multivariate models reveal that widowed women's increased prevalence of negative health behaviors remain even when baseline characteristics are controlled. Widowers, on the other hand, make two health behavior changes: they adopt more active lifestyles and lose weight. These changes are robust even when baseline characteristics are controlled.

Health behavior changes in the face of spousal loss do not persist in the long-term. At the 48-month follow-up, widowed persons are no different from married persons with respect to sleep, alcohol use, smoking, body weight, and exercise. It is possible that some widowed persons engaging in the least healthy behaviors may have left the study due to death, institutionalization, poor health, or some other reason. However, attrition analyses revealed that selection issues were quite modest in the sample. Thus, it appears that the data presented here lend support to the idea that, like health changes (Lieberman & Videka-Sherman, 1986), lifestyle changes may be transient, with widowed persons being affected most dramatically in the months immediately following death of spouse. These findings lend support to the idea that bereaved spouses may in fact be resilient in the face of loss. After a period of adjustment, widowed persons appear to resume their previous lifestyle. While health behavior changes may lead to some deterioration in health in the months following a spouse's death, it is unlikely that negative health behaviors are adopted among the bereaved long enough to have long-term implications for health.

Interesting gender differences emerge from these analyses. Most notably, we find that men may be less likely than women to alter their health behaviors following spousal loss. This finding contradicts a number of studies showing that widowhood is particularly detrimental to men (Umberson et al., 1992). Thus, our lack of significant differences for men regarding health behavior changes may simply be an artifact of the small number of men who become widowed. Another explanation for this finding may be that because widowers are more likely to remarry and date than widows, a new spouse or partner may play a role in curbing poor health behaviors. Or, perhaps children and other family and friends rally support around a bereaved father. Men may even be more likely to reside in nursing homes or assisted living facilities, where their health behaviors are under surveillance. It is also possible that widows provided care to their dying husbands, and may have neglected

their own health or engaged in poor health behaviors during and after the dying process. The data presented here point to the need for more careful investigation of the specific ways that widows and widowers alter their health behaviors both during and after the process of losing a spouse to death.

Pre-loss characteristics played an important role in explaining health behavior changes following widowhood. It is possible that the dominance of disabling chronic disease in the aging in the United States has changed not only the experiences of dying persons but the process and experience of widowhood. We suspect that stress associated with caregiving may alter health behaviors in the months leading up to a spouse's death. Also, widows and widowers are more likely to come from economically disadvantaged groups. Lower socioeconomic status (SES) is associated both with one's risk of becoming widowed, and with one's risk of engaging in negative health behaviors. Thus, the lower educational attainment of widowed persons (compared to married controls) may partly explain why widowed persons engaged in riskier health behaviors (Hayward, Pienta, & McLaughlin, 1997).

Although the CLOC data have many strengths for studying the consequences of spousal loss, the present study still has several limitations. Because the control group is small at the 6-month follow-up, our sample of married controls, especially married men, is quite small. Also, despite encouraging results from an attrition analysis, one should not overlook the fact that the sample size declines over time. Although it appears that sample attrition was not related to key variables of interest, the power to detect statistically significant differences was greatly reduced. Thus, the absence of significant differences in health behavior at the 48-month interview may be related to the underpowered sample. Lack of dietary and nutritional data leaves us with an unclear interpretation of what it means to lose body weight following a loss of spouse. Because most of the sample was overweight at baseline, it should suggest that weight loss is a positive outcome. However, when weight loss results from a compromised diet, it may be an indicator of negative health behavior change. Information about dietary habits from food diaries might have contributed to more persuasive and clear-cut results. Also, it should be noted that the CLOC data include a set physiological and biological measures for a subset of the widowed and married sample members. Future research might consider how these biomarker data (including cholesterol levels) might be used to illustrate the physiological consequences of health behavior changes. Although we do not include indicators of psychological health in our analyses, it likely that depressive symptoms may contribute to health behavior change among widowed persons.

Finally, our findings may be cohort specific; aging baby boomers could reveal different patterns than the CLOC cohort. Women and men in the CLOC sample were born in the early part of the 20th century. Many of these women and men entered young adulthood during the years of the Depression, which has been characterized as a time of economic distress. Children who experienced the economic hardship of the Depression grew up to place a great deal of importance on stable family life as they became adults and parents (Elder, 1974), perhaps contributing to a rigid gender differentiation in work and family roles. Whereas women of the CLOC cohort devoted most of their adult years to childrearing and family responsibilities, women of the large baby boom cohort entered the labor force in large numbers, and most worked while raising their children. Thus, it is possible that many of the patterns observed in the CLOC sample may change in the future, given that future cohorts of older women and men will have held less highly gender-differentiated work and family roles. For example, among more recent cohorts, women may be less apt to fill traditional family roles such as caregiver and meal preparer. Thus, gender differences noted in this chapter may erode as the boundaries demarcating "men's roles" and "women's roles" start to blur. Also, women and men of the baby boom cohort will be less likely than prior cohorts lose a spouse from a first marriage to death. High rates of divorce and remarriage may have important consequences for the meaning of marriage and widowhood, even with respect to health and health behaviors. Thus, future studies of aging women and men of the baby boom generation are warranted.

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CHAPTER 6

Interpersonal and Spiritual Connections Among Bereaved Older Adults

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Over the past century, the nature of widowhood has changed substantially, probably even more so than in previous centuries. In the United States through the middle of the 20th century, marriage was almost universal and divorce was rare, so widowhood was the main way that marriages ended. Spousal loss was almost equally likely to befall men as women and usually occurred while one or both spouses were still of working age, especially in the early decades of the 20th century. By the end of the century, when the Changing Lives of Older Couples (CLOC) study was conducted, widowhood was only one of the ways in which marriages ended; divorce and separation having become much more prevalent. The widowed were increasingly likely to be women as the gender gap in life expectancy grew from about 2 to almost 7 years. Due to the almost 30-year expansion of life expectancy in America over the 20th century, the vast bulk of widowhood occurred in later life after one or both spouses were retired or out of the labor force. This transformation has made widowhood an expected, though still very painful and stressful, event in the lives of older married women.

The CLOC study and sample reflects these changes. The sample of couples in which the husband was age 65 or older yielded a sample that is almost 80% women. So in many ways, the results reported here are specific to women widowed in later life in a society in which an increasing number

of older women are unmarried for several different reasons. This may in part be why we find that for most people the psychological impact of widowhood follows a course characterized by intense sadness that peaks 6 to 18 months after widowhood and then abates, leaving the person in much the same psychological state as prior to being widowed (see Mancini, Pressman, & Bonanno, chapter 10).

Yet there remains considerable variation in the degree to which widowhood produces intense sadness or grief and its precipitation of more general and enduring psychological problems, such as depression. This chapter seeks to identify the ways that social relationships and religious behaviors and beliefs—two of the most commonly available and utilized resources for adapting to stress—affect the psychological impact and course of widowhood in terms of both grief and depressive symptoms. We argue that it does so in ways that reflect the changing nature of our understanding of widowhood and modes of adapting to it. In particular, our approach is informed by the recognition that widowhood, like other stressful "events," is a *process* that unfolds over time. Hence, understanding the role of social relationships or religion in adapting to widowhood involves understanding how *changes* in these phenomena, in response to widowhood, relate to subsequent *changes* in grief and depression.

Moreover, we recognize that the social position and context of widowed individuals has changed over time. Due especially to the increasing tendency for older adults to live independently, often at some distance from their children, and in communities different from those in which they grew up or spent most of their work and child-rearing years, widowed individuals increasingly construct and reconstruct their lives, including their social relationships and religious beliefs and behaviors, rather than merely being embedded in and responding to preexisting networks of social relationships or systems of religious beliefs and behavior patterns. Thus, our focus is on what widowed persons *do* in reaction to widowhood in terms of relating to others or modifying patterns of religious behavior and belief, rather than on what is done to or for them by other individuals or institutions.

COPING WITH LOSS: THE ROLE OF INTERPERSONAL AND SPIRITUAL CONNECTIONS

The ability to form and maintain interpersonal and spiritual connections constitutes much of what it means to be human. We take for granted that these connections directly influence our well-being and help us to successfully navigate the experience of widowhood. However, the fluid boundar-

ies and broad scope of close social bonds (whether between individuals or directed toward God) makes them complex to study directly. In the absence of well-established principles generated from empirical research, we often take for granted that interpersonal and spiritual connections are beneficial for widowed individuals because of their presumably supportive quality. Thus, one common assumption is that receiving support (whether social or spiritual) facilitates coping with loss during widowhood. This is especially true for efforts to prevent or reduce depressive symptoms that accompany bereavement.

Social Support and Bereavement-Related Depression

Numerous studies have demonstrated that widowhood is a risk factor for subsequent depression (Silverstein & Bengston, 1994). One study of stressful events found that widowhood was the only one of eight major life events to be associated with depression 3 years after the event (Chou & Chi, 2000). Despite the fact that widowhood may be a risk factor for more serious complications, such as depression, many of the normal reactions to spousal loss often include depressive symptoms that are not associated with pathology, or the subsequent development of a depressive disorder (Bonanno, 2001).

For example, in the immediate aftermath of spousal loss, depressive symptoms and symptoms of grief may be one and the same (Stroebe & Stroebe, 1987). Common reactions to the loss of a spouse such as sadness, loss of appetite, sad mood, sleep disturbances, suicidal thoughts, and fatigue are also considered to be symptoms of depression (Zisook & Shuchter, 2001). However, grief symptoms, or the "pangs of bereavement" (Zisook & Shuchter, p. 786), are often triggered by thoughts of the loved one and generally lessen in intensity over time. Thus, depressive symptoms that are part of the grief experience also lessen in intensity over time (Bonanno et al., 2002). On the other hand, there is some consensus that extreme stress, when prolonged over time, can cause depression (Brown, Harris, & Hepworth, 1994; Frank, Anderson, Reynolds, Ritenour, & Kupfer, 1994; Ingram, Miranda, & Segal, 1998). Thus, depression that emerges from a grief experience may be considered to be distinct from grief once the grief reaction has settled and been allowed to run its normal course. Some evidence suggests that cognitive and emotional difficulties that follow bereavement typically subside within 2 years after the loss (Bonanno, 2001; Sonnega, Nesse, & Utz, 2004).

To prevent the development, or reduce the intensity, of persistent depressive symptoms among older widowed persons, research has often focused on the protective power of close relationships (Hainer, 1988) and

spiritual connections (Walsh, King, Jones, Tookman, & Blizard, 2002). Social support has been provided to victims of stressful life events, in part to prevent depression (U.S. Department of Health and Health Services, 1999). These intervention efforts take the form of emotional types of support (e.g., family therapy and support groups) and instrumental support (e.g., tangible forms of support, such as helping individuals to develop social networking skills). Widowed individuals who maintain spiritual connections appear to also benefit from their religious involvement (Frantz, Trolley, & Johll, 1996; Gallagher, Thompson, & Peterson, 1982; Glick, Weiss, & Parkes, 1974; McIntosh, Silver, & Wortman, 1993; Smith, 2002). These benefits include milder grief symptoms (Walsh et al., 2002), reduced depression (Azhar & Varma, 1995), and lower levels of anger, guilt, and death anxiety (Bohannon, 1991).

Despite the intuitive appeal of providing social and spiritual support to promote recovery after widowhood, the overall research picture is mixed and demonstrates that widowed individuals do not benefit invariably from their spiritual connections, from receiving support, or from having supportive social relationships that predate the loss of their spouse (Arling, 1976; Pargament, 2002; Wortman, Silver, & Kessler, 1993). Such findings may reflect methodological weaknesses or conceptual ambiguities that interfere with the study of social support, religious coping, and bereavement. As mentioned above, social support studies often are based on the assumption that benefits of social contact are due to support that is received from others, despite evidence to the contrary (Smith, Fernengel, Holcroft, & Gerald, 1994). Moreover, conclusions about the benefits of social support and religiosity are often based on the results of cross-sectional rather than longitudinal data. This chapter begins with an overview of the methodological strengths of the CLOC data set; we then describe how the data set can be used to address contradictory findings and overcome methodological and conceptual challenges to the social (and spiritual) support literature. Next, we highlight the results from two CLOC studies that inform our understanding of the benefits of spiritual and social support for coping with the loss of a spouse. In particular, we present evidence that providing support to others and increasing one's religious beliefs each promote recovery from widowhood.

Advantages of the CLOC Project for the Study of Social (and Spiritual) Support

One of the main methodological challenges facing researchers of social (and spiritual) support is that past studies are largely cross-sectional and thus suffer from a variety of design issues that make it difficult to determine the

nature of the observed relationship between support and depression. For example, support might only appear to be beneficial because the resources one takes from a relationship partner, a social network, or God are associated with a number of factors that are correlated with well-being, but that do not influence well-being directly. This possibility cannot be ruled out within a cross-sectional design. Alternatively, social support or a relationship to God might falsely appear harmful if the most distressed individuals are soliciting or receiving the most support. Without a longitudinal follow-up it would not be possible to observe that support helps these individuals to subsequently feel less distressed. Thus, the results from cross-sectional studies might either be misleading about the benefits of support, or these results might lead to an inaccurate conclusion that support is harmful.

One of the primary advantages of using the CLOC data set to investigate support and coping following widowhood is that the data set contains multiple measures of demographic, personality, health, mental health, and relationship concepts that are measured prospectively (before the loss) and at three time points after the loss. The CLOC study also provides a non-widowed control group for assessing comparisons at each time point. Thus, the data set is particularly valuable for studying factors such as interpersonal or spiritual support in which the direction of causality is unclear or may be confounded with multiple other features of the individual or interpersonal relationship.

A New Look at the "Giving" Side of the Equation

People who have regular social contact with others are generally healthier and happier than those who are more socially isolated, and this relationship has been documented in both cross-sectional and prospective data sources (House, Landis, & Umberson, 1988). Researchers have tended to attribute these benefits to social support that is received from others. Despite the intuitive appeal of the assumption that receiving is good for our well-being, tests of the hypothesis that receiving is beneficial have produced contradictory results (Smith et al., 1994) and have even demonstrated, in some instances, that receiving emotional support (e.g., feeling loved and cared for) can be harmful (Brown & Vinokur, 2003). For example, older adults who report receiving instrumental support from their children reported higher levels of depression (Silverstein & Bengston, 1994). Arling (1976) observed that widows who reported receiving emotional support from their children did not necessarily report a higher sense of well-being; in fact, they were just as likely to feel lonely or to worry. Finally, Wortman et al. (1993), examining

data from a longitudinal study of a national sample of older adults, found that social support received prior to widowhood was unrelated to depression after the loss.

For widowed individuals, these apparently contradictory findings may be, in part, a product of the previously mentioned difficulty in separating clinical complications, such as depression, from the normal experience of grief. That is, if the symptoms of grief in the immediate aftermath of bereavement represent a normal response (Bonanno, 2001), the benefits of supportive interventions may be difficult to observe, especially if individuals who are likely to desire and benefit from forming interpersonal relationships are the very ones who are most upset by the loss of a spouse. In fact, Futterman, Gallagher, Thompson, Lovett and Gilewski (1990) demonstrated that higher ratings of retrospective marital adjustment were associated with more severe levels of depressive symptoms among bereaved elders. It is plausible that individuals with better marital relationships also have better quality relationships with others, but experience more severe grief over the loss of their spouses compared to those who had less satisfying marital relationships (as confirmed by Carr et al., 2000).

Adding more complexity to this picture is the fact that significant others can exacerbate as well as buffer adverse symptoms that accompany the grief experience (Lund, Caserta, & Dimond, 1993). As Lund and colleagues (1993) describe:

> Findings about the benefits of social support networks need to be tempered with numerous qualitative examples about negative effects of support persons. Our interviewers heard detailed accounts of disappointment, frustration, anger, and sadness expressed by the bereaved because some friends and family members were judgmental, avoidant, inconsiderate, pushy, and demanding. (p. 251)

Other investigators have also noted that there is a "dark side" of close relationships and have shown that there are adverse effects of receiving high levels of social support. For example, de Catanzaro (1986) and Brown, Dahlen, Mills, Rick, and Biblarz (1999) have demonstrated that feeling like a burden to a loved one puts one at risk for mental health problems such as depression, anxiety, and suicide. If receiving support makes some people feel like a burden, then receiving could actually be harmful to the well-being of the recipient. This perception of burdensomeness may be especially problematic for older adults who may be motivated to avoid encumbering children and grandchildren.

The Benefits of Providing Support to Others

The inconsistencies across studies of received support suggest other possible unidentified benefits of social contact. One possibility is that the benefits of social contact may be due to giving support, rather than receiving it. This idea can be derived from evolutionary theories of altruism and is consistent with social psychological studies of helping and pro-social behavior. Evolutionary theories of altruism propose that there can be considerable adaptive advantages to making a contribution to others' well-being (Hamilton, 1964; Trivers, 1971). Like other species, humans would not exist without tendencies to provide for and protect others, including children. The motivation to give away resources has been suggested to be the evolutionary function of social bonds (Brown, 1999; Brown & Brown, in press), and a consequence of forming emotional commitments to others (Nesse, 2001). Although the behavior of helping others has been a mystery to some scientists, it seems likely that helping others brings evolutionary benefits. Some benefits are conferred via the successful reproduction of common genes (Hamilton, 1964), and others come from the exchange of favors (Trivers, 1971). These benefits may well have shaped a mechanism that gives us an experience of well-being when we help others.

This possibility is consistent with research findings in several disciplines. For example, sociologists note the widespread practice of giving to others (Rossi, 2001) and specific links to well-being (Melia, 2000). Many studies show that volunteering has beneficial effects for volunteers, including improved physical and mental health (Musick, Herzog, & House, 1999; Omoto & Snyder, 1995; Wilson & Musick, 1999). Moreover, emerging life span perspectives on volunteerism and service emphasize the importance of giving for feeling useful, especially in later life (Omoto, Snyder, & Martino, 2000). For example, dialysis patients who provided support to their friends and family had a lower risk of mortality (McClellan, Stanwyck, & Anson, 1993). Among elderly populations, providing support to others improves physical functioning, after controlling for health status (Avlund, Damsgaard, & Holstein, 1998; Hays, Saunders, Flint, Kaplan, & Blazer, 1997). Also, evidence links emotions that may be associated with giving such as a sense of meaning, purpose, belonging, mattering, self-efficacy, and self-esteem to happiness and reduced depression (Baumeister, 1991; Taylor & Turner, 2001). Finally, a growing body of research demonstrates that individuals benefit from helping strangers and relationship partners, in terms of reduced distress, improved physical health, and improved relationship satisfaction (Cialdini, Darby, & Vincent, 1973; Midlarsky, 1991; Schwartz & Sendor, 2000; Van Lange, Rusbult, Drigotas, Arriaga, Witcher, et al., 1997).

Recently, the CLOC data were used to systematically evaluate the benefits of giving support, versus receiving support, for reducing mortality risk (Brown, Nesse, Vinokur, & Smith, 2003). When both giving and receiving were controlled simultaneously, only the indicator of "giving" emerged as a significant predictor of reduced mortality risk, not receiving. A similar, independent benefit was found for giving practical forms of help (instrumental support) to friends, relatives, and neighbors.

FURTHER EVIDENCE FROM THE CLOC PROJECT

Brown, House, Brown, and Smith (2004) directly tested the hypothesis that giving support to others would buffer widowed individuals against the risk of depression following bereavement. This hypothesis was tested using the data from the CLOC project. Analyses focused on data from widowed respondents who participated in baseline (pre-loss), 6-month (Wave 1), and 18-month (Wave 2) follow-up interviews, and controlled respondents who provided data at baseline and at roughly the same time as their matched widowed persons' Wave 1 follow-up. For widowed respondents, depressive symptoms at Wave 2 were examined as a function of reports of giving and grief at Wave 1. Because the CLOC data contains measures of multiple variables that may be related to giving, receiving, or grief, it was possible to control for many confounding personality, health, and interpersonal factors in the analyses.

Because grief is a normal reaction to the loss of a loved one, giving was not expected to directly reduce the intensity or severity of the grief reaction or of depressive symptoms that occurred immediately after the loss. Rather, Brown, and colleagues (2004) examined whether providing support to others at Wave 1 would buffer widowed individuals against that chance that their grief at Wave 1 would be associated with an increase in depressive symptoms at Wave 2. "Giving" was assessed in the following way: respondents indicated whether they gave instrumental support (tangible forms of help) to friends, neighbors, and relatives other than their spouse in the last 12 months, with the stipulation that the recipient did not live in the same household and the respondent did not receive monetary compensation. Respondents indicated (yes/no) whether they helped with (a) transportation/errands/shopping, (b) housework, (c) child care, and (d) other tasks. A composite measure was created by summing the number of "yes" answers to these questions. Participants who scored "0" reported providing no help for each category.

Brown and colleagues (2005) first compared widowed participants to non-widowed participants on their reports of interpersonal contact, including

TABLE 6.1
Mean Levels of Interpersonal Support Among Widow(ers) and Controls, 6-Month Follow-Up[a]

	Give Instrumental Support	Receive Emotional Support	Informal Social Integration (Z scores)	Formal Social Integration
Widowed participants	1.32	3.86	.10	1.38
Controls	1.29	3.88	−.11	1.05

[a]Results of a 2 (widowhood status) ×4 (social support outcome) MANOVA: $F(4, 327)=2.50$, $p < .05$; Univariate ANOVA conducted on social integration: $F(1,330)=7.58$, $p < .01$.

giving and receiving social support. Table 6.1 shows the mean values of giving, receiving emotional support from others, and informal and formal social integration (frequency of contact with others by phone or in person; participation in formal activities) for widowed and non-widowed respondents. As shown in Table 6.1, there was a significant main multivariate effect of widowhood on social support and social integration. Widowed individuals had higher levels of informal and formal social integration. Note, however, that widowed individuals did not appear to differ from controls in their levels of giving and receiving social support. Table 6.2 illustrates the zero-order correlations among the giving measure and other measures of support. As shown in Table 6.2, giving was only weakly associated with receiving emotional support from friends and family.

The main hypothesis that giving would reduce the association of grief at Wave 1 with later depressive symptoms (Wave 2) was tested using multiple regression. As reported by Brown and collaborators (2005), the association of grief at 6 months with depressive symptoms at 18 months was much stronger for widowed participants who did not provide support to others (33% of widowed participants). On the other hand, participants who reported either

TABLE 6.2
Zero-Order Correlations Among Social Support and Social Integration Indicators, 6-Month Follow-Up

	Give Instrumental Support	Informal Social Integration	Formal Social Integration
Informal social integration	.25*		
Formal social integration	−.03	.12†	
Receive emotional support	.19**	.35**	.12†

*Significant at $p < .05$. **Significant at $p < .01$. †Significant at $p < .10$.

providing support in only one helping category (22% of the sample) or providing support in 2 or more categories (43% of the sample) showed virtually no relationship between their grief symptoms at 6 months after the loss and depressive symptoms 1 year later (see Figure 6.1 for a display of the results of this analysis). The interaction of grief at Wave 1 with the amount of giving at Wave 1 was significant. Consistent with the pattern of findings from prior work (Brown, Nesse, Vinokur, and Smith, 2003), receiving support did not buffer the grief experience. Participants who reported receiving high amounts of support from others were just as likely to have their initial grief lead to later depression as participants who reported receiving less support. None of the health, personality, or other relationship characteristics available in the CLOC data were able to account for, or reduce, the mental health benefit of giving (Table 6.3 lists these control variables). In a separate analysis, conducted on the non-widowed control sample and controlling for the same potential confounding factors, giving support was predictive of reduced depressive symptoms over time.

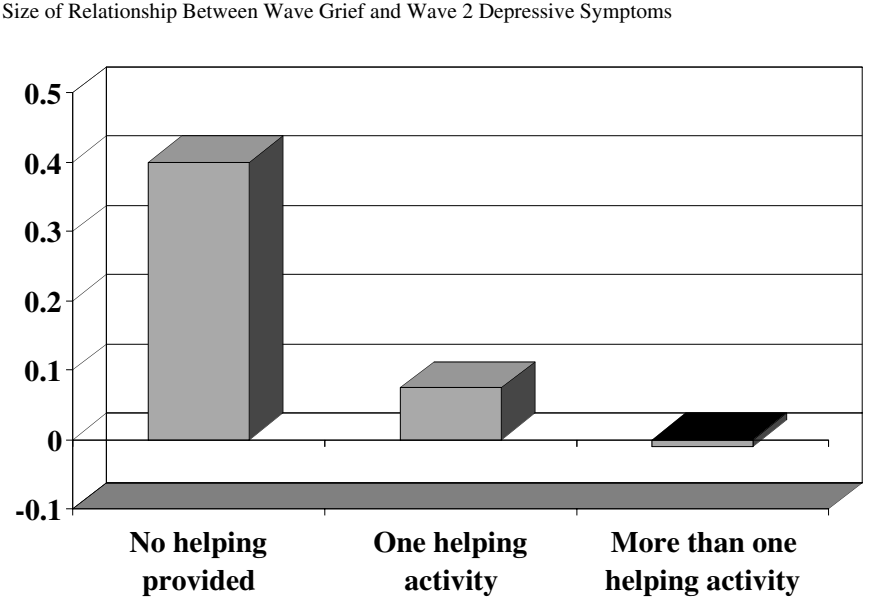

FIGURE 6.1 Association between Grief Symptoms at 6-Month Follow-up and Depressive Symptoms at 18-Month Follow-up for Participants Who Reported Providing No Help, Low Levels of Help, and High Levels of Help at 6-Month Follow-up (net of depressive symptoms at 6-month follow-up).

TABLE 6.3
Independent Variables Controlled in Multivariate Analyses

Baseline Depression	
Demographic variables	Gender
	Age
	Total income
	Education
	Ethnicity
Social support variables	Received support from all sources
	Informal social integration
	Formal social integration
Health variables	Functional health
	Satisfaction with health
	Physical activity
Personality variables	Internal control
	Interpersonal dependency
	Extraversion
	Agreeableness
	Conscientiousness
	Neuroticism
	Openness to experience

Taken together, these results from the CLOC data provide new insights into the relationships among social support, bereavement, and coping with loss. In particular, the results suggest that those bereaved individuals who provided support to others may navigate the grief experience much better. Providing support buffered widowed individuals against the increase in depression that can accompany the experience of high levels of grief. Although it remains possible that our measure of giving support taps some preexisting mental or physical robustness that influences both giving and coping with loss, the possible confounding effects of physical health, socioeconomic status, age, gender, personality variables, and other support variables were considered and found to be inconsequential.

The findings extend previous work on the link between social contact and mortality from the CLOC project (Brown et al., 2003). This study demonstrated that giving emotional support to a spouse and giving instrumental support to friends, relatives, and neighbors were each associated with a significant decrease in the risk of mortality (Brown et al.). There was no similar benefit for receiving support. Although it is premature to conclude that giving support is the aspect of social contact that accounts for the protective

effects of social relationships, the results from the CLOC studies thus far are consistent with this possibility.

God as a Compensatory Attachment Figure: Spiritual Connections and Widowhood

The results presented thus far highlight the healing power of maintaining and contributing to close relationships with partners. However, as aging adults are increasingly confronted with losses of friends and family relative to younger adults (Carstensen, 1995), they may also benefit from religious involvement (Koenig, 1994; Musick, Traphagen, Koenig, & Larson, 2000). As McFadden (1996) writes: "For many older persons, religion provides meaning that transcends suffering, loss, and the sure knowledge that death looms somewhere on the horizon" (p. 163). In fact, for older adults religious involvement (a multidimensional concept, including religious beliefs and behaviors) is associated with higher subjective well-being (McFadden, 1995), improved morale (Koenig, Kvale, & Ferrel, 1988), and better adjustment to widowhood (Gass, 1987). In the section that follows, we describe the results of studies of religious coping that have assessed aspects of the religious experience such as the importance of religious beliefs, and religious behaviors such as church attendance. We note the limitations of these studies and describe how a theory of interpersonal relationships (i.e., attachment theory, Bowlby, 1958, 1969) can be used to elucidate the features of religious involvement that are likely to provide benefits for navigating the grief experience.

Relatively few studies have examined the benefits of religion for the bereaved, and empirical investigations of coping have produced mixed findings regarding the benefits of religiosity (Balk, 1991; Pargament, 2002; Park & Cohen, 1993; Rosik, 1989; Sherkat & Reed, 1992). Moreover, past research is inconsistent in the conceptualization and measurement of religiosity. Some studies focus on extrinsic religion (i.e., religion as a means to some other end such as socializing with church members), whereas others focus on intrinsic aspects of religiosity (religion as an end in and of itself, such as the importance of religious or spiritual beliefs). For example, in a survey of 159 elderly widowed individuals, Rosik (1989) found that religiosity was associated with increased distress for both men and women when it was characterized by an extrinsic orientation. Park and Cohen (1993) surveyed 96 college undergraduates about their reactions to a recent death of a close friend, and found that although intrinsic religion was indirectly related to personal growth and decreased dysphoria in their study, it was also directly related to increased event-related distress. Sherkat and Reed (1992) found that religious behavior

was not associated with reduced depression, although it was associated with increased self-esteem among suddenly bereaved individuals.

These inconclusive findings also underscore the difficulty in using cross-sectional data to study the consequences of bereavement. As Pargament (2002) describes: "A preponderance of cross-sectional designs . . . leaves us unable to determine whether religion is the cause or effect of well-being" (p. 169).

Several studies have used longitudinal data to examine the relationship between religion and bereavement, but most of these assumed that religious beliefs are a stable, unchanging trait and thus researchers did not attempt to assess whether religious preferences, beliefs, and participation changed following significant life experiences (Hettler & Cohen, 1998; Walsh et al., 2002). For example, in one of the only prospective studies of religion and bereavement, 135 close friends and relatives of individuals with terminal illness were asked about their grief symptoms 1, 9, and 14 months after the loss (Walsh et al.). The results indicated that individuals who held strong religious beliefs prior to the loss were better able to resolve their grief over time, but post-loss measures of religious beliefs were not obtained. Thus, although past studies have documented that pre-loss religious preferences and practices may help individuals to cope with loss, these studies do not show whether people changed their religious beliefs as a result of the loss. A prospective design, in which religious beliefs are assessed repeatedly, is needed to investigate possible effects of loss on reported religious beliefs. The CLOC data makes such an exploration possible.

Theoretical Considerations

To explore why spousal loss might trigger changes in religious beliefs, we turn to Bowlby's (1958, 1969) attachment theory. Bowlby originally proposed the notion of attachment to describe the evolutionary advantages conferred when infants form an affectionate bond to a caregiver. Prominent among these advantages was the idea that maintaining proximity with a caregiver could help protect an infant from threats such as predation. Forming an attachment to a primary caregiver would also lead to a feeling of security, so that an infant could comfortably explore his or her world (the "secure base" phenomena) and feel protected during times of threat. Bowlby further suggested that the attachment between caregiver and infant would create an internal working model of intimate relationships that would form the affective basis for future interpersonal relationships. As such, people with secure early attachments would come to expect that others would be generally trustworthy and would be responsive to their needs (Belsky, Steinberg, & Draper, 1991).

Recent applications of attachment theory to spousal relationships in adulthood have noted a striking resemblance between the defining criteria for secure attachment (i.e., proximity-seeking, secure-base phenomena, safe haven in times of threat) and religious phenomena, such as relying on God for comfort during times of threat or hardship and seeking proximity with God (in the form of prayer; Kirkpatrick, 1992). Thus, for those individuals who are bereaved or who are otherwise socially isolated, a personal relationship with God may function as a secure attachment, may provide safety and security, and may, in part, compensate for the loss of a love relationship. Recent research has shown that the absence of a loving relationship has been linked to higher degrees of religious beliefs and behavior (Berardo, 1967; Granqvist & Hagekull, 2000). A study of 156 undergraduates at a Swedish university found that "singles, compared to lovers, were . . . more religiously active, perceive a personal relationship with God, [and] have experienced changes implying increased importance of religious beliefs" (Granqvist & Hagekull, p. 111).

Further support for the hypothesis that religious beliefs provide emotional compensation in the face of loss comes from investigations of the link between religiosity and attachment style (Ainsworth, Bell, & Stayton, 1972). Specifically, people who have an "insecure" type of attachment history (i.e., those whose felt they could not reliably depend upon the responsiveness of a primary attachment figure and who are now insecure about the trustworthiness of relationship partners), as opposed to people with a more secure attachment history, show greater instability in their religious beliefs in the face of stressful circumstances (Granqvist, 2002; Granqvist & Hagekull, 2000, 2001; Kirkpatrick, 1997, 1998). Insecure individuals—who are unable to derive felt security from a relationship (maybe get rid of "relationship") partner may instead turn to God during hard or stressful times; in effect, they use God as a compensatory attachment figure. Thus, religious beliefs among persons with insecure attachments styles are less stable, and change as threatening circumstances occur. It is not surprising that insecurity in attachment style has been frequently associated with emotion-based religiosity—using God and religion to regulate emotion (Granqvist, 2002; Granqvist & Hagekull, 2000, 2001). If a relationship with God helps to regulate emotion, then such a relationship may be particularly valuable to older adults who may be more focused than younger adults on the socio-emotional goal of reducing emotional upset (Carstensen, 1995). That is, according to Carstensen's socio-emotional selectivity theory, older adults have an explicit motive to reduce emotional upset—a personal relationship with God may aid in achieving this goal.

The empirical work reviewed above suggests that spousal loss may arouse increased religiosity, which could help compensate for the lost marital attach-

ment, especially among persons with a history if insecure attachment style. However, none of these studies have incorporated all three design features necessary to adequately test the hypothesis that increased religious or spiritual beliefs help older individuals to cope with widowhood. These three features are (a) prospective data, (b) presence of a non-widowed comparison group, and (c) multiple measures of religiosity obtained over time. Even the best designed studies, those that have examined changes in religion over time (Granqvist, 2002; Kirkpatrick, 1997, 1998), have typically not examined religious change as a *consequence* of bereavement. Data from the CLOC study were used to examine whether religious beliefs and participation increase after widowhood, and whether these changes facilitated personal adjustment to spousal loss (Brown, Nesse, House & Utz, 2004). Because religion is a multifaceted construct, Brown and colleagues (2004) examined two aspects of religious involvement: the personal importance of one's religious and spiritual beliefs, and also the frequency of attendance at religious services. Because religious beliefs may be more likely than church attendance to be a direct product of a personal relationship with God, benefits of religious involvement were expected to be rooted in the importance of religious beliefs, as opposed to church attendance which may be influenced by other factors such as the desire (or lack of) for social support, social anxiety, or even symptoms of depression such as lethargy.

Empirical Evidence from the CLOC Study

Brown and colleagues (2004) examined the ways that spousal loss affects change in religious beliefs and church attendance. CLOC sample members classified themselves as Protestant (49 %), Roman Catholic (42.8%), or Jewish (5 %). Across all four waves of data collection, the correlations between the importance of religious and spiritual beliefs and church attendance were significant, but moderate, ranging from $r = .51$ (Baseline) to $r = .58$ (Wave 3). See Table 6.4 for the correlations among religious importance, church

TABLE 6.4
Zero-Order Correlations among Religion, Social Support, and Social Integration Indicators, 6-Month Follow-Up

	Give Instrumental Support	Receive Emotional Support	Informal Social Integration	Formal Social Integration
Religious beliefs	.07	.10	.07	−.05
Church attendance	.19**	.02	.08	−.08

*Significant at $p < .05$. **Significant at $p < .01$. † Significant at $p < .10$.

attendance, and social support variables. Note the low correlation between support and religiosity, suggesting that these are independent phenomena.

Widowed participants were more likely than control participants to report an increase in both the importance of their spiritual beliefs and their frequency of church attendance 6 months after the loss (see Figures 6.2 and 6.3 for a graph of the change in spiritual beliefs and church attendance for widowed and control participants). Although the increase in church attendance remained elevated up to 18 months after the loss (Figure 6.3), widowed participants appeared to return to their baseline levels of religious beliefs at 18 months post-loss (Figure 6.3).

Multivariate analyses indicated that participants who reported an increase in the importance of their religious/spiritual beliefs between Baseline to Wave 1 (n = 21) also had fewer grief symptoms 18 months after the loss compared with those who did not report increased importance of religious beliefs (n = 82) (The mean values of grief at each wave as a function of religious increase are presented in Figure 6.4.). Note, however, that the benefits of religion for reducing grief were specific to grief symptoms and did not influence other indicators of psychological adjustment such as depression and anxiety. Moreover, the benefits of religious change were limited to beliefs only and did not extend to increased church attendance between Baseline and Wave 1 (Figure 6.5).

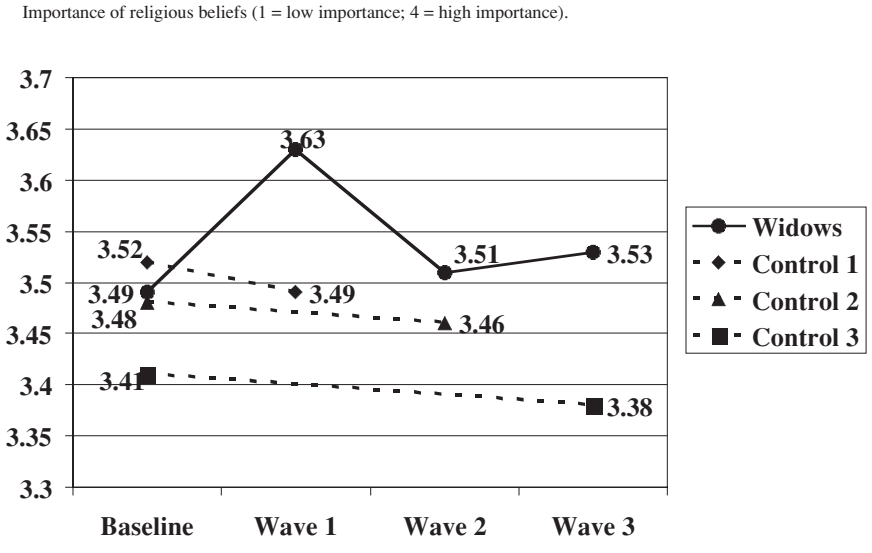

FIGURE 6.2 Mean Values of Religious Beliefs at Baseline, Six-Month, 18-Month, and 48-Month Follow-ups, for Widowed and Control Samples.

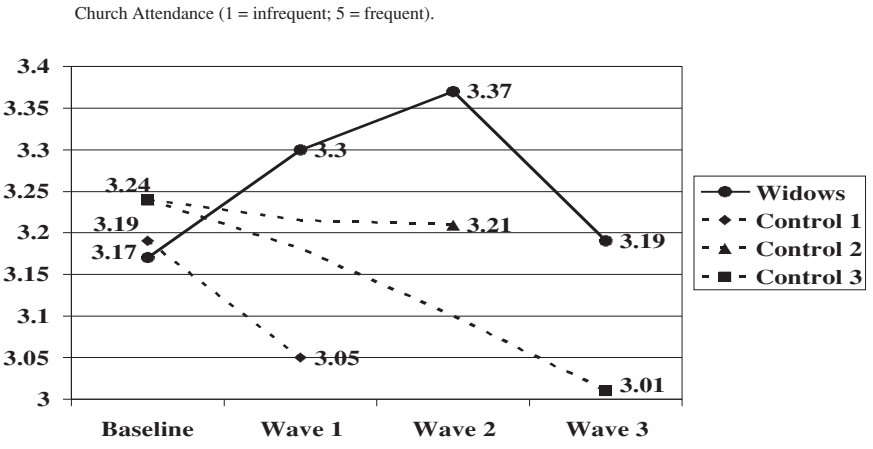

FIGURE 6.3 Mean Values of Church Attendance, at Baseline, Six-Month, 18-Month, and 48-Month Follow-ups, for Widowed and Control Samples.

Finally, the results of the Brown, Nesse, et al. (2004) study were consistent with the emotional compensation hypothesis, as the benefits of increased beliefs on grief were strongest for individuals categorized as having an insecure attachment style (see Figures 6.6 and 6.7 for the association of religious increase and grief for participants categorized as "insecure" and "secure"). Results such as these underscore the need to consider how different components of religious involvement may influence the bereavement experience,

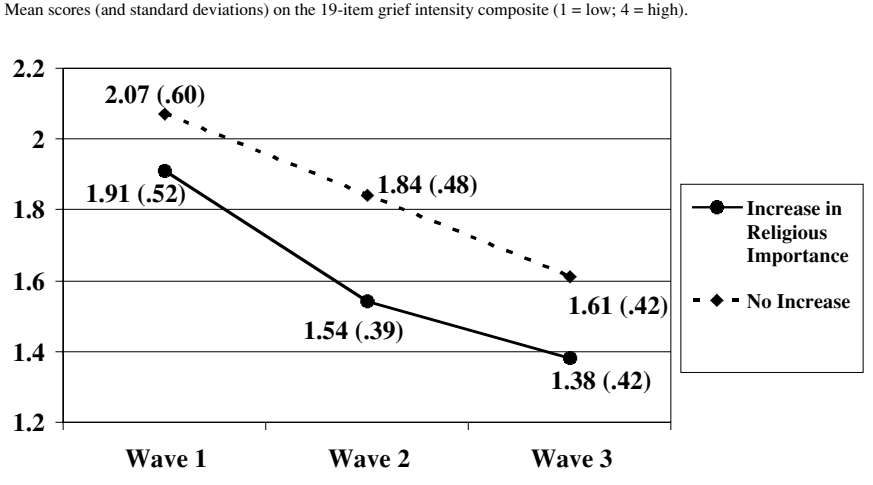

FIGURE 6.4 Grief Symptoms, as a Function of Increased Importance of Religious Beliefs, Six-Month, 18-Month and 48-Month Follow-ups.

Mean scores (and standard deviations) on the 19-item grief intensity composite (1 = low; 4 = high).

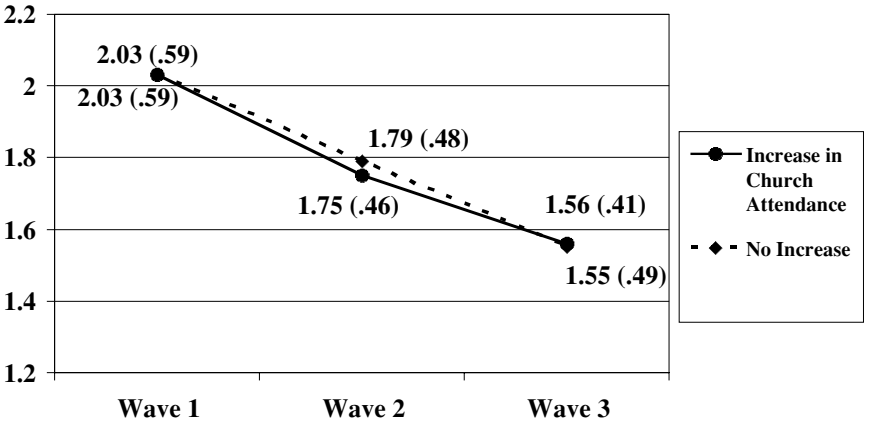

FIGURE 6.5 Grief Symptoms, as a Function of Increased Church Attendance, Six-Month, 18-Month and 48-Month Follow-ups.

and how the effects of religious involvement may be different for different personality types.

Taken together, these results help to reconcile contradictory findings about the effects of religion on coping with widowhood. They suggest that the widowhood transition *does* influence religiosity, and that religious involvement can be beneficial. However, these benefits are more closely related to religious

Mean scores (and standard deviations) on the 19-item grief intensity composite (1 = low; 4 = high).

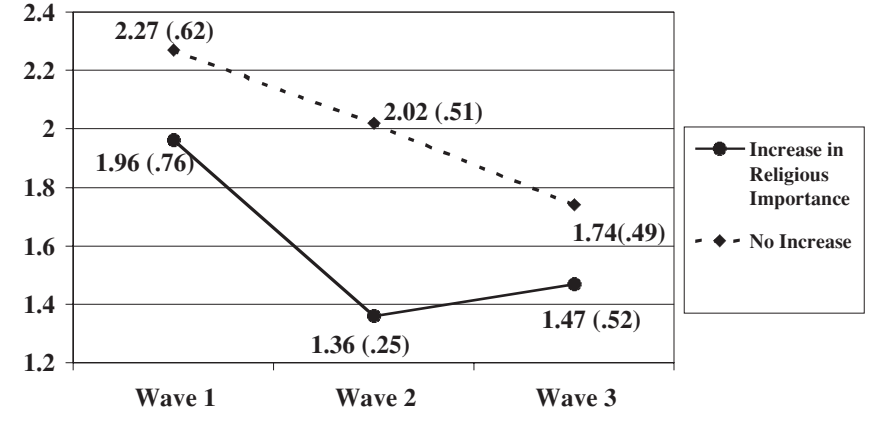

FIGURE 6.6 Grief Symptoms, as a Function of Increased Importance of Religious Beliefs (from Baseline to Six-Month Follow-up), For Participants Categorized as "Insecure."

Mean scores (and standard deviations) on the 19-item grief intensity composite (1 = low; 4 = high).

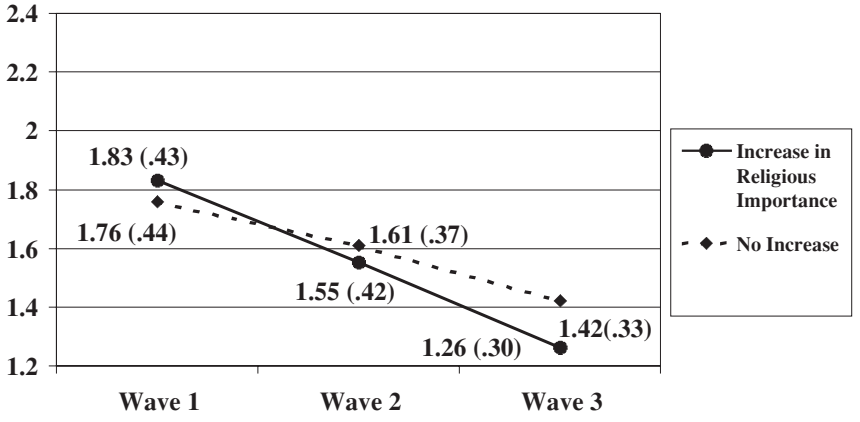

FIGURE 6.7 Grief Symptoms as a Function of Increased Importance of Religious Beliefs (from Baseline to Six-Month Follow-up) for Participants Categorized as "Secure."

beliefs than church attendance. Moreover, the benefits are specific to grief, and may not extend to adjustment in general. Finally, the benefits of religious beliefs may depend on factors related to personality, such as attachment style.

DISCUSSION AND CONCLUSION

As life expectancy increases, most marriages that end in widowhood will do so relatively later in life. There remains, however, substantial variation in the experience of widowhood and the degree to which individuals regain pre-bereavement levels of psychosocial functioning. The variation may reflect how well individuals are able to construct a new life for themselves after losing their spouse and as an adaptive interpretation and coming to peace with their loss.

The findings reported in this chapter suggest that increasing reliance on religious coping and increasing engagement with others via giving support, are two relatively independent ways in which individuals enable themselves to construct a new life and gradually put the sadness of widowhood behind them. The linkage between early grief symptoms and later depressive symptoms weakens as individuals increase the amount of social support they give to others. Commitment to religion also weakens the linkage between early grief symptoms and later depression. Those who intensify their religious beliefs in the face of loss return to pre-loss levels of depressive symptoms more quickly after loss compared to those who do not intensify their religious beliefs. Thus,

the active fostering of social and religious connections, where the bereaved give as well as receive, may help to resolve grief and help the bereaved return to pre-bereavement levels of functioning. And this is probably becoming increasingly so as relatively independent older adults confront and transcend widowhood at some distance from the family, especially children, and friends with whom they were most proximally connected earlier in their lives.

As noted in the discussion of each of the studies above, further research is needed to explicate how and why both giving and receiving interpersonal support and religious beliefs and behaviors promote adaptation to widowhood among bereaved elderly. However, studies based on the CLOC data suggest that these are issues and processes worthy of further exploration for both the scientific and practical insights they may provide into perhaps the most ubiquitous social stressor of older age.

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CHAPTER 7

Economic and Practical Adjustments to Late Life Spousal Loss

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Bereavement entails more than just longing for one's deceased spouse. The bereaved also must cope with changes that occur in everyday life. Such changes may include the loss of financial security, disruptions in how household chores are completed, and other routine stressors that arise when one's spouse is no longer available to share the tasks of daily life. The majority of bereavement research focuses on the emotional consequences of spousal loss, whereas relatively few studies examine how the death of a spouse transforms day-to-day routines and responsibilities. This chapter explores how older adults cope with the economic and practical challenges of spousal loss, and how these daily readjustments and challenges contribute to the overall experience of bereavement. The discussion draws upon the theoretical assumptions of the Dual Process Model (Stroebe & Schut, 1999), and empirical support is provided by the Changing Lives of Older Couples (CLOC) study. This under-researched dimension of bereavement is particularly important because it suggests new directions for how to offer care and support to the recently bereaved.

MARITAL TRANSITIONS: FROM SINGLE TO MARRIED TO SINGLE AGAIN

To understand more fully how individuals cope with the day-to-day stresses of spousal loss, it is instructive to first step back and consider what happens when marital unions are formed and then broken.

Union Formation

When two persons say "I do," they vow to love, honor, and cherish one another, and also to uphold the socially prescribed roles and responsibilities associated with being married (Berger & Kellner, 1970). To do so, the newlyweds shed their identities as a "bachelor" and "bachelorette" in exchange for the new titles of "husband" and "wife." Symbolic interactionists (e.g. Cooley, 1964; Mead, 1934/1967) suggest that newlyweds consciously alter their lifestyles to comply with the social expectations that accompany the roles of husband or wife. Couples begin to function as a unit or team rather than as two separate individuals. They develop a shared social reality in which each spouse assumes some responsibility for the other's well-being as well as for the couple's overall functioning. For example, consider the ways husbands and wives divide the tasks and responsibilities that must be performed on a routine basis: one spouse may prepare dinner, while the other washes the dishes. One spouse may work for pay, while the other stays at home with the children. One does chores inside the home, the other yard work.

By dividing the social and instrumental roles of daily life between two people, couples are able to capitalize on each of their strengths, while not duplicating either of their individual efforts (Waite, 1995). The allocation of chores between husband and wife often parallels traditional gender role expectations. As a result, women have traditionally taken the lead on homemaking and child-rearing tasks, whereas men have been primarily responsible for the family's economic well-being (Becker, 1965, 1991; Milkie & Peltola, 2000). This arrangement is particularly common among current cohorts of older adults, who came of age in the years prior to the gender-role revolution of the 1960s and who were likely to maintain the traditional male-breadwinner and female-homemaker division of social roles. This gendered specialization of tasks is believed to be both rational and cost effective for the couple, because men typically have higher earnings than women and women are socialized to be more nurturing than men (Parsons, 1954).

Although the boundaries demarcating men's and women's social roles have become more fluid and permeable in recent eras, empirical evidence reveals that wives still perform the majority of household tasks (Hochschild, 1989) and husbands continue to earn higher salaries in market-based work (Budig & England, 2001). These persistent inequities suggest that traditional gender role expectations, although becoming less rigid in contemporary American society, still permeate the daily lives of most married couples and guide the allocation of tasks between husband and wife.

In theory, the formation of a marital union is an attempt to create a well-oiled machine that allows both husbands and wives to be more productive

and efficient than they could have been without the other. This well-oiled machine quickly breaks down and begins to malfunction when the marital union is broken.

Union Dissolution

When marriages end, either through death or divorce, the individuals must undergo a significant amount of adjustment, just as they did upon entering the union. With this transition, each individual assumes a new label, that of "divorcee" or "widow(er)," and also tries to comply with the normative expectations associated with the new identity label (Berger & Kellner, 1970). The formerly married person must learn to live as a single individual again and begin to manage and perform all the tasks and roles of daily life, even those that had previously been performed by the individual's late (or former) spouse.

Those who fail to develop the requisite new skills or who find it difficult to live independently after marital dissolution are at an elevated risk for long-term mental and physical health problems (Caserta, Lund, & Rice, 1999; Powers & Wampold, 1994; Wells & Kendig, 1997). Common reactions include feeling overwhelmed by the tasks that must be completed or experiencing anxiety or fear that one will not succeed in his or her new role (Stroebe & Schut, 1999). At least some of these emotional reactions are attributable to one's lack of confidence, experience, or familiarity with performing the social roles and routine responsibilities that the other spouse had previously managed (Lund, Caserta, Dimond, & Shaffer, 1989).

Because many older couples have allocated the tasks of daily life according to traditional gender roles, men and women often experience very different sources of stress following spousal loss (Lee, DeMaris, Bavin, & Sullivan, 2001). For example, an important source of stress for both widowed and divorced men is related to their limited experience in cooking or cleaning for themselves (Berardo, 1970; Lee et al., 2001; Umberson, Wortman, & Kessler, 1992). Women, on the other hand, are more likely to experience financial strain at the time of union loss (Holden & Smock, 1991; Zick & Smith, 1991a, 1991b). In each case, the distress felt by the newly "single" person is a consequence of how the couple divided the roles and responsibilities of daily life. Those couples that maintained a rigid division of labor were generally more dependent on one another, thus the surviving spouse may encounter considerable stress when forced to live independently.

This need for readjustment may be particularly difficult for older adults, especially those born in the early 20th century (i.e., members of the CLOC

cohort). This particular birth cohort has maintained a strict gendered division of labor throughout the life course. For example, in 1960, fewer than 10% of married women with young children worked for pay, whereas fathers of this era reported nearly universal full-time employment (Hayghe, 1990). This rigid task specialization has created a cohort not accustomed to performing the tasks typically assigned to the opposite gender. Those born in the 1920s and 1930s also had relatively low rates of divorce (with the exception of a spike in divorces immediately after World War II), making their marriages quite long lasting. In the CLOC sample, the median duration of marriage is 44 years. As the duration of the marriage increases, the couple's daily routines become so well established that the stress of losing them is magnified. Moreover, older adults—regardless of their birth cohort—have solidified a lifetime of behaviors, attitudes, and preferences (Atchley, 1985), which makes the adjustment associated with spousal loss all the more difficult to confront during the later stages of the life course.

Although both divorce and widowhood entail a significant amount of readjustment and stress at any stage of the life course, the transition from married to widowed has been identified as the most distressing of all life transitions (Holmes & Rahe, 1967). This is perhaps because widowed persons must reconfigure their social roles and routine responsibilities, just as they would have done in the case of divorce, but they must also grieve the death of an intimate life partner (Bowlby, 1980). These intense feelings of grief may interfere with the ability to readjust daily activities, and, conversely, anxiety about performing the essential tasks of daily life may exacerbate psychological distress (Caserta et al., 1999). As a result, widowed persons may perceive themselves as helpless, incapable, or inadequate (Horowitz, 1985), which can make the experience of union dissolution all the more distressing for widows and widowers. Nothing can change the fact that one's spouse died; however, properly designed interventions may be able to help minimize the secondary stressors that are associated with spousal bereavement (Caserta & Lund, 1993).

This chapter focuses on how older widowed persons cope with the practical and economic adjustments associated with spousal death. I also argue that spousal bereavement is not purely, or even primarily, an emotional experience. Instead, the death of the spouse affects nearly every facet of daily life, forcing the bereaved to readjust activities and renegotiate social roles. The Dual Process Model of Coping (Stroebe & Schut, 1999) provides a theoretical framework for understanding the practical challenges facing newly bereaved older adults, and data from the CLOC study provides

important empirical evidence documenting the ways the spousal loss affects the daily experiences of older widows and widowers.

THE DUAL PROCESS MODEL OF COPING

The Dual Process Model of Coping (Stroebe & Schut, 1999) proposes that in order to adjust successfully to bereavement, the bereaved must oscillate between two styles of coping: *loss-oriented* and *restoration-oriented coping.* Both coping styles are necessary because the stresses of widowhood fall into two distinct categories—the stress associated with losing an intimate life partner and the stress associated with losing the instrumental arrangements that allowed the married couple to operate efficiently.

When the bereaved adopt a *loss orientation,* they are doing the traditional "grief work" that clinicians and counselors often emphasize (Worden, 2002). Grief work requires that the bereaved concentrate on and resolve the broken bond (Bowlby, 1980). Widowed persons often ruminate and yearn for their deceased spouse. They may feel despair and loneliness knowing that their spouse is not going to return and that they must manage on their own. In general, adopting a loss-oriented coping style allows the bereaved to come to terms with the emotional dimensions of the loss. (See Wolff & Wortman, chapter 5, and Mancini, Pressman, & Bonanno, chapter 10, for critiques of the "grief work" perspective.)

On the other hand, a *restoration-oriented* approach acknowledges that the bereaved must cope with the disruptions in social roles and routine responsibilities that occurred when the spouse died. This coping style is critically important for managing the secondary stressors of widowhood (Cook & Oltjenbruns, 1998; Pearlin, Menaghan, Lieberman, & Mullan, 1981; Thoits, 1983). Secondary stressors are those practical problems that arise from the death of a spouse, including coping with fewer economic resources after the spouse's income is no longer available and managing all the household chores including those that the deceased spouse had previously performed. The goal of restoration-orientation is not to "restore" one's previous life; rather, the goal is to "readjust" one's daily activities to match the new reality where the spouse is no longer present.

Widowed persons oscillate between these two coping styles. They confront one dimension of the loss, while (temporarily) avoiding the other, and then change their coping style when emotional resources allow or when the situation demands. The Dual Process Model's emphasis on *oscillation* recognizes how overwhelming and all-consuming the experience of bereavement

can be. Its emphasis on *duality* recognizes that bereavement is more than just the emotional reaction caused by the loss of an intimate life partner. For these reasons, the Dual Process Model is a useful theoretical framework in considering how the tasks of daily life impact the overall bereavement experience.

THE CHANGING LIVES OF OLDER COUPLES STUDY

The Changing Lives of Older Couples (CLOC) study is an ideal data source from which to explore this topic because it has collected information on the daily activities and psychological well being of widowed persons both before and after their loss. Analyses of the CLOC data reveal the ways that older adults adjust to two types of restoration-oriented tasks after spousal loss: (a) the *economic consequences* of widowhood and (b) the *practical consequences of spousal loss* (which refer primarily to the performance of routine household chores).

These specific tasks of financial and household management have been chosen because they represent essential functions of daily life that must be confronted, regardless of one's emotional state, and regardless of one's past experience in performing such tasks. Furthermore, these two specific tasks represent the traditional domains of male and female household labor and, therefore, have the potential to show how gender-typed allocation of social roles within marriage affects the overall bereavement experience (Hatch, 2000). Finally, because the stress associated with financial and household management can be ameliorated with proper intervention, it is important to understand who is most at risk for experiencing practical or financial stresses after spousal loss.

The Economic Consequences of Widowhood

Multiple studies suggest that economic resources are threatened when marriages end and that unmarried persons have fewer economic resources than married persons (Burkhauser, Holden, & Feaster, 1988; Holden, Burkhauser, & Feaster, 1988; Hyman, 1983; McCrae & Costa, 1993; Meyer, 1990; Morgan, 1981, 1989; Zick & Holden, 2000; Zick & Smith, 1986, 1988, 1991a, 1991b). Most studies concur that women experience economic hardship more than men because they have traditionally dedicated themselves to homemaking tasks rather than breadwinning roles (see Holden & Smock, 1991 for a review).

Although age-based programs such as Social Security do provide a basic level of economic support for older Americans (Crystal & Shea, 1990; Hungerford, 2001; Richardson, chapter 11), many older widowed persons are still economically vulnerable at the time of their spouse's death. Older

widowed persons are four times more likely to experience a year living below the poverty line, compared to their married counterparts (Smith & Zick, 1986). An important pathway out of poverty for the younger widows is remarriage. However, demographic realities make this option less viable for older persons because after age 65, women outnumber men roughly 1.5 to 1. Finally, since older adults usually are retired from the paid workforce and rely on a fixed income, the expenses associated with the funeral, end-of-life care, or estate-distribution of the deceased spouse may overwhelm the fixed budget of an older adult (Covinsky, Goldman, & Cook, 1994).

According to data from the CLOC study (see Figure 7.1), widowhood heightens one's economic vulnerability but rarely causes complete financial devastation for older adults (Utz, 2002). Nearly two-thirds of widowed persons (63%) expect that their income will decline after their spouse's death, but less than 1 in 10 (6%) report having serious financial problems 6 months after the death. Only 3% report serious problems 18 months after their loss. The relative infrequency with which bereaved persons report "serious" financial problems may reflect the fact that few of the CLOC participants (i.e., persons over the age of 65) were working for pay or were married to paid workers even prior to their loss, thus relatively few could have experienced an appreciable drop in earned income. Moreover, age-based entitlement programs, such as Social Security or Medicare, may provide a safety net that protects older adults from major economic hardship after widowhood (Hungerford, 2001).

As expected, the CLOC data showed that the negative economic consequences of widowhood were more severe for women than for men. About three-quarters (72%) of women expected their income to decline after spousal loss, but less than a third (29%) of men held this expectation. Likewise, 7% of widows, compared to 2% of widowers, reported serious financial problems after widowhood. Future generations of older women may be less likely to experience these reported financial hardships because a greater proportion of them will have worked outside the home and contributed to the family's economic needs, perhaps making them more financially independent and secure than women of previous generations. The women of the CLOC cohort have typically embraced traditional homemaking roles throughout their married lives (Carr & Utz, 2002), and thus may be more economically dependent on their husbands than would future generations of older women.

The CLOC data also document how widowhood changes one's perceptions of their current financial strain (Utz, 2002). Perceived financial strain refers to the perceived adequacy of one's income in relation to one's preferred standard of living. It also captures a person's ability to manage financial

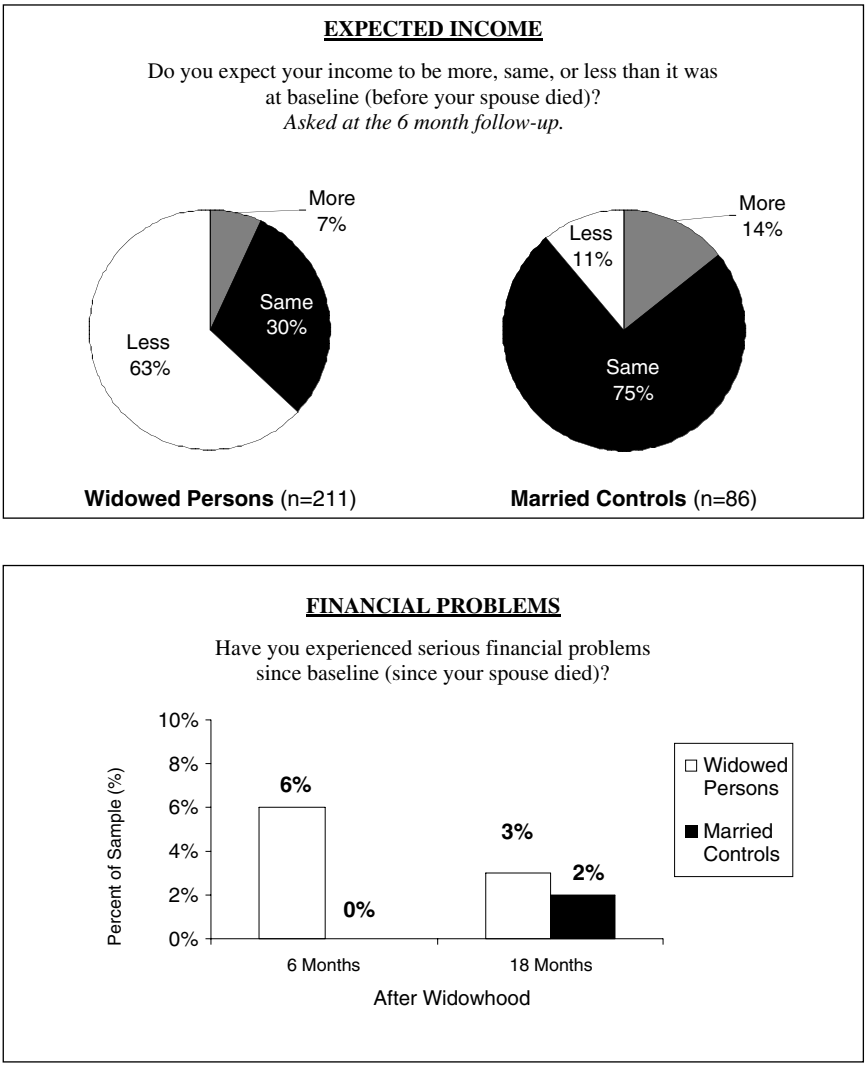


FIGURE 7.1 The Economic Consequences of Late Life Widowhood, Changing Lives of Older Couples (CLOC).

resources (Mendes, de Leon, Kasl, & Jacobs, 1994). Documenting and understanding the sources of perceived financial strain is important for two reasons. First, it provides an important alternative to studies that merely document absolute changes in income and wealth; the latter two measures are problematic because survey respondents often fail to answer such questions, or offer inaccurate reports of their financial resources. Second, and more important,

perceptions of financial strain are meaningful in their own right because increased levels of perceived strain may exacerbate feelings of anxiety or create a sense of economic uncertainty among widowed persons. Although perceived financial strain is highly correlated with actual economic resources, it also captures important non-pecuniary dimensions of economic life, such as reliance on others for financial management tasks. For example, if the deceased spouse was responsible for the major financial and legal decisions for the household, the surviving spouse may report higher levels of financial strain given that person's lack of confidence in performing these types of tasks.

The CLOC data show that perceived financial strain is higher among widowed persons than married controls. Women are more likely than men to report financial strain after the death of a partner (41% of women versus 16% of men at the 6-month follow-up; 35% of women vs. 18% of men at the 18-month follow-up). Furthermore, perceived financial strain is highly correlated with measures of depression and anxiety.

The effect of spousal loss on perceived financial strain declines as time passes, suggesting that the bereaved initially experience a heightened level of financial strain (perhaps in response to a decline in actual economic resources or costs associated with the funeral and end-of-life health care), but then adjust to their new economic circumstances. That is, they may shift their consumption or money management practices as time passes. Selective attrition also may explain, in part, why perceived financial strain levels off over time. Mortality rates are highly correlated with socioeconomic status, where people with fewer economic resources tend to die younger. If the poorest bereaved persons tend to die earliest, then the more financially stable and less emotionally distressed are more likely to participate in the later waves of the study.

In general, the CLOC data show that older adults who experienced a change in economic resources—a loss, most typically—were also more likely to exhibit heightened psychological distress, as measured by depressive symptom and grief scores (Utz, 2002). Women who were highly dependent on their husbands for help with financial tasks were far more distressed than the men who had depended on their wives for these tasks. On the other hand, men who experienced serious financial problems or who reported a particularly high level of financial strain had far worse psychological outcomes than the women who had experienced similar circumstances. In both cases, changes in economic resources appear to threaten a core dimension of the bereaved person's identity. For women, psychological distress is likely when the instrumental arrangements that they had come to depend on are severed or terminated. For men, perceived financial strain may threaten

their identities as breadwinners, and may consequently cause psychological distress.

The economic consequences of spousal loss may necessitate additional changes, such as re-entering the workforce or selling one's home. These changes, which are stressful in their own right, may help explain the psychological distress that is so common after spousal loss (Munton, 1990). However, these types of adjustments were relatively rare among members of the CLOC sample, after controlling for physical or functional health status. Only 10% of widowed persons changed residences within the first 6 months after loss, and just 3% moved between 6 and 18 months after the loss. Similarly, very few bereaved persons re-entered the workforce. Six months after spousal loss, only 12 of the 250 bereaved spouses had experienced a job change since widowhood, and most of these job changes were the result of retiring from the workforce. A few residential relocators said that they moved "to save money"; however, they also gave explanations such as "to be closer to family" and "because the house was too big" for a single person.

In general, neither residential relocation nor employment changes were very common in the CLOC sample, nor did these transitions appear to be triggered by financial necessity. Therefore, these findings suggest that neither residential relocations nor job changes are the primary mechanisms through which economic resources disrupt the psychological well-being of older widowed persons.

The Practical Consequences of Widowhood

An examination of routine household chores also reveals the ways that older adults cope with the day-to-day disruption caused by spousal loss. Housework is a task that is typically shared—though perhaps unequally—by the married couple (Thompson, Breckenridge, Gallagher, & Peterson, 1984). More than 9 in 10 older adults live independently, and more than 3 in 4 (77%) are homeowners (U.S. Department of Housing and Urban Development, 1999). Thus, household chores are a necessary daily activity for the vast majority of the non-institutionalized older population.

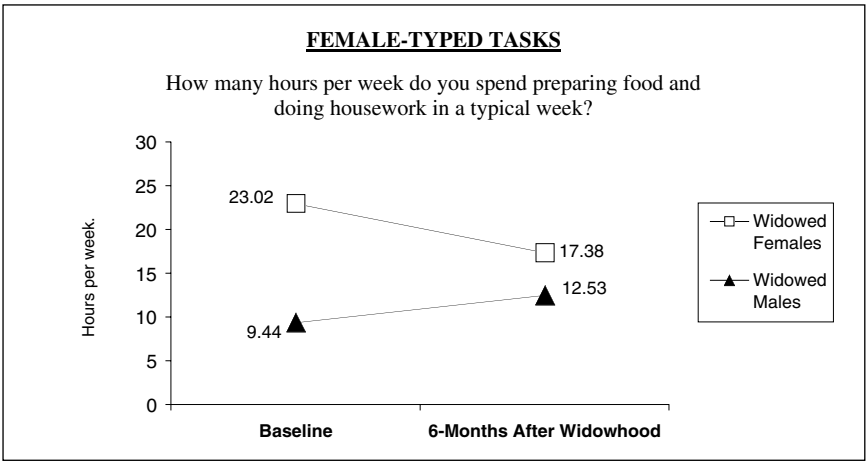
Housework consists of two sets of tasks. *Female-typed tasks* include daily chores such as cooking, cleaning, and laundry, whereas *male-typed tasks* include major household repairs and yard work. The former tend to be performed daily, whereas the latter need to be completed sporadically. The labels "male-typed" and "female-typed" are, of course, an indication of how the tasks traditionally have been allocated between husband and wife (Blair & Lichter, 1991; Starrels, 1994). (This labeling convention is used for brevity

only; such labels may perpetuate cultural beliefs about the suitability of one gender to perform a given task [Coltrane, 2000].)

According to the CLOC data, the average older adult spent 15 to 19 hours per week doing housework and preparing meals, while the majority (50% at baseline and 75% at the 6-month follow-up) spent less than 20 hours a year doing household maintenance and repairs. Clearly, older adults do not perform male-typed tasks as frequently or as regularly as female-typed chores and, therefore, an analysis that focuses on male-typed tasks would not reveal the process of daily-life adjustment as readily as an analysis of female-typed tasks. It is important to consider how widowhood affects *both* types of housework because together they can illuminate how a traditional gender-based division of labor may impact the overall bereavement experience.

Consistent with past research (Coltrane, 1996; Herzog, Kahn, Morgan, Jackson, & Antonucci, 1989; Orbuch & Eyster, 1997; Robinson & Godbey, 1997), the CLOC data suggest that husbands did more maintenance and repairs than their wives, and women spent disproportionately more time on household-related chores than their husbands, regardless of their age or disability status (Utz, Reidy, Carr, Nesse, & Wortman, 2004). In fact, women did two to three times more housework than men did. Although a rigid gender-typed division of household labor may make sense earlier in the life course, the economic motivation for it no longer exists as couples reach retirement age and no longer have children living in the home. These gender inequities may be attributable to the long-term influence of socialization experiences (Ha, Carr, Utz, & Nesse, 2006; Hareven, 1982; O'Rand, 1996). Early in the life course, men and women learn appropriate gender-specific behaviors, which are maintained throughout the later stages of the life course, perhaps simply out of habit.

Given this division of labor, the performance of male-typed and female-typed tasks is inevitably altered when a spouse dies. As shown in the top panel of Figure 7.2, female-typed tasks remain relatively stable over time for the nonwidowed sample (married men do slightly more than 5 hours per week, while married women do about 21 hours per week). In contrast, widowed persons exhibit significant changes between the two time points. Widows do considerably fewer hours of housework after spousal loss (a 25% decrease from 23 hours to 17 hours), while widowers do significantly more (a 33% increase from 9.5 hours to 12.5 hours). After controlling for potential confounding factors, widows do 3.5 hours less than their married counterparts per week, while widowers do nearly 7 more hours of housework than married men (Utz et al., 2004). Although men do consistently fewer hours



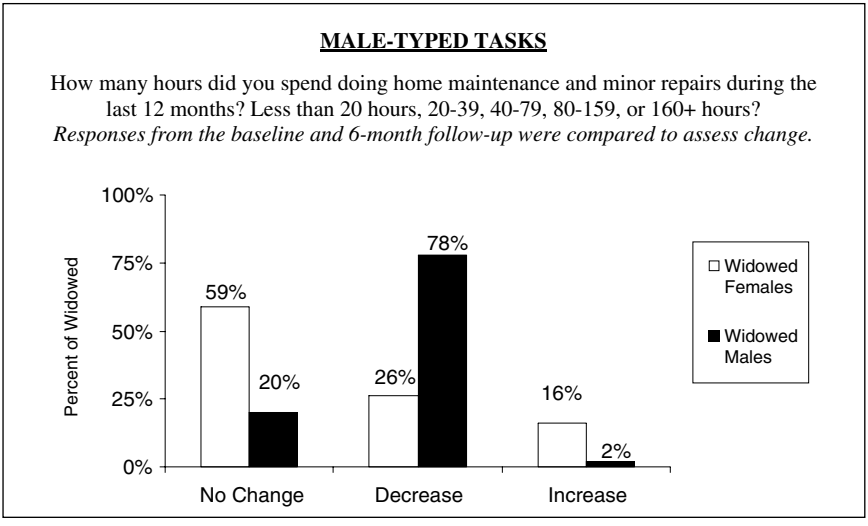


FIGURE 7.2 Changes in Household Tasks after Widowhood, Changing Lives of Older Couples (CLOC).

of housework than women, they also report increases in female-typed tasks when they were forced to—this includes when the wife became ill and when she died.

Changes in male-typed tasks are presented in the bottom panel of Figure 7.2. Because this variable was measured with aggregated responses, rather than with discrete time units, data can only illustrate whether someone is doing more, the same, or less maintenance tasks than he or she was doing

at baseline (pre-loss). Interestingly, most older adults, both married and bereaved, exhibited a decline in the performance of male-typed tasks over time, suggesting that these tasks become increasingly more difficult as people age. Therefore, with age and decreased physical stamina, older adults may become more reliant on the goodwill or service of others to complete these necessary tasks of household management.

The majority of widowers (78%) followed this general pattern of declining effort as time passed. Women, on the other hand, were less likely to decrease their efforts after widowhood. Three of five women (59%) performed the *same* number of maintenance tasks after widowhood, while an additional 16% actually *increased* their efforts after widowhood. Women's tendency to maintain or increase their workload may reflect their need to get the job done now that their spouse is no longer available to perform or assist with those tasks.

This need to readjust household chores can be quite stressful for the bereaved. Roughly half of the bereaved men (54%) and half of the bereaved women (51%) reported feeling overwhelmed by the need to perform basic tasks such as meal preparation. However, some of this distress may be related to eating without a companion rather than preparing the meal itself. Additional analyses reveal that those persons who reported the greatest change in task performance exhibited the highest levels of anxiety, depressive symptoms, and grief. In contrast, continuity in one's roles was associated with more positive psychological outcomes (Rhee & Utz, 2003; Utz, Carr, Nesse, & Wortman, 2002; Utz et al., 2004). This suggests that an individual's distress may be related directly to the amount of readjustment he or she is required to do.

Restoration-Oriented Coping and Psychological Well-Being

Consistent with past research (e.g., Umberson et al., 1992), the CLOC data have illustrated how the financial and practical readjustments of widowhood are associated with short-term increases in depressive symptoms, anxiety, and grief. However, a handful of influential studies show that stressful life situations may actually turn out to be an empowering or psychologically positive experience (Lieberman, 1996; Lopata, 1973; O'Bryant, 1991). For example, managing the restoration-orientation tasks of widowhood actually provides an opportunity for personal growth and increased self-esteem for many of the CLOC respondents (Carr, 2004). Fully three-quarters (76%) of widowed persons reported that they had become more self-confident as a result of having to manage on their own. They perhaps developed a sense of self-worth or

self-confidence after realizing that they were capable, and even successful, at handling the tasks and responsibilities that they had previously lacked experience, time, or interest to perform. Although the need to readjust daily routines can produce a significant amount of stress for the recently bereaved, the fact that most older adults derive long-term psychological benefits from enduring and overcoming this period of readjustment should not be minimized.

THE INDIVIDUAL EXPERIENCE OF BEREAVEMENT

Classic theories of bereavement propose that grief is a universal phenomenon that typically follows several stages (Bowlby, 1980; Kubler-Ross, 1969), more recent research calls such assumptions into question, however. Current research reveals marked heterogeneity in the bereavement experience. For example, each individual may experience the secondary stressors of spousal bereavement in a slightly different way, depending on a host of individual, dyadic, and contextual factors (Carr & Utz, 2002). Although gender has emerged as an important influence when investigating the types of economic and practical adjustments widowed persons may face (Hatch, 2000; Lee et al., 2001; Lee, Willetts, & Seccombe, 1998; Umberson et al., 1992), other risk and resilience factors should also be considered. Individual variation in bereavement outcomes may also reflect differences in: (a) how the couple allocated tasks and responsibilities during their marriage, (b) whether the bereaved has access to formal or informal sources of instrumental and economic support, and (c) whether the bereaved had any forewarning about their spouse's death. These three factors are especially important when studying how older adults cope with the restoration-oriented tasks of widowhood and which tasks they will encounter.

Prior Allocation of Tasks and Responsibilities

As noted earlier, husbands and wives share the essential tasks of daily life in order to improve their efficiency as a couple (Becker, 1965, 1991). As a result, the newly-single bereaved person often has to learn how to manage those tasks or roles for which he or she is ill equipped or unprepared. Although gender has been an important risk factor that explains a significant portion of the variation in the response to conjugal loss (Hatch, 2000; Lee et al., 2001; Lee et al., 1998; Umberson et al., 1992), the desire to perform new roles may also heighten one's susceptibility to psychological distress after the death. Therefore, researchers should broaden their focus beyond gender-based explanations and instead explore what types of compromises spouses

made earlier in their marriage and how these decisions affect adjustment to spousal loss. Prior experiences may influence how well the bereaved take on new roles and responsibilities at the time of widowhood. A life course perspective, which considers how previous events influence current and future trajectories (Elder, 1998), is essential in broadening our focus away from traditional gender-based explanations.

This alternative focus may be particularly appropriate for understanding the ways that future generations of bereaved adults will manage the restoration-oriented tasks of widowhood. Important social and economic changes over the past 4 decades, including a blurring of traditional gender roles and expectations, rising divorce rates, delayed marriage and childbearing, and frequent job changes, have created a context where future generations will have greater opportunities to "try out" social roles that have traditionally been held by the opposite gender (Axinn & Thornton, 1993). Because members of more recent birth cohorts may have a greater diversity of experiences to draw upon when coping with widowhood, they may find their daily readjustments to be less stressful than earlier-born cohorts who maintained a more rigid gender-typed division of labor throughout the life course.

Nevertheless, assuming that couples will continue to allocate tasks in order to maximize their efficiency, future generations may still endure stress, which is related to performing the roles and responsibilities that the deceased spouse had fulfilled while alive. One possibility is that as young women increasingly perform male-typed roles in the home—and as men perform more female-typed tasks—both men and women may encounter difficulties performing the "traditional" gender-typed role in the future, if those tasks had been relegated to their spouse. For example, stay-at-home fathers may struggle with financial matters, whereas career women may encounter stress when forced to do laundry and cook for themselves. Regardless of whether the tasks are allocated according to traditional gender lines or some other dimension, loss-related distress will continue to reflect earlier experiences that may have heightened or hindered the development of the skills needed to manage on one's own.

Receipt of Instrumental Assistance

Another important influence on bereaved persons' ability to cope with secondary stressors is the extent to which they receive formal or informal assistance from others. Practical support, financial assistance, and or simple companionship can help minimize the restoration-oriented stress associated with widowhood. Older adults, in general, receive increased assistance

during times of stress, such as one's own prolonged illness or the death of a spouse (Hogan & Eggebeen, 1995; Lopata, 1996; Mancini & Blieszner, 1989; Ward, Logan, & Spitze, 1992). Assuming that widowed persons accept this support, they may be able to minimize the stress of widowhood by reducing the workload associated with the death of the spouse.

According to CLOC data, widowed persons receive an outpouring of support from friends and family that extends to at least 6 months after the loss (Utz et al., 2002). Widowed persons also become more dependent on their children for emotional and instrumental needs after the spouse dies (Ha et al., 2006). As well, adult children assist their grieving parents with basic activities of daily life, such as cooking, cleaning, and running errands (Utz et al., 2004). Increased support, including the receipt of instrumental assistance, is quite common across all members of the CLOC sample, yet women report significantly higher levels of support than men. In fact, widowed men often receive *less* support after widowhood than they do beforehand. These gender inequities may reflect the tradition whereby women play the role of kin keeper or social coordinator for the couple (Hagestad, 1986). The couple's children and other family members maintain that strong social tie even after the woman's husband has died.

If the bereaved cannot draw upon an informal social support network, they may have the option to purchase formal services that could minimize the increased workload associated with widowhood. Clearly, though, the resources needed to purchase such services are not equally available to all widowed persons. Those with more financial resources will be better equipped to purchase assistance, whereas those with closer ties to family and friends may be more likely to rely on the informal assistance provided by a support network. Regardless of whether the support is given or purchased, the availability of informal social support or formal instrumental assistance is a critical factor in determining how widowed persons cope with the restoration-oriented tasks of bereavement.

Nature of the Death

The nature and context of the spouse's death also may influence how well the surviving spouse manages the practical and economic shocks of widowhood. In the late 19th and early 20th centuries, acute and infectious illnesses prevailed as the leading causes of death (Omran, 1982). Today, the most common causes of death are related to chronic, degenerative diseases that typically occur in the later stages of the life course. This historical shift in the cause and timing of death has redefined the nature and process of bereavement (Ball, 1977;

Carnelley, Wortman, & Kessler, 1999; Rando, 1986, 1988). In essence, it has allowed widowed persons to prepare for widowhood before it actually occurs. Approximately two-thirds of the CLOC sample reported having at least some warning time prior to the death of their spouse. One-quarter of the sample had more than 6 months of warning time prior to their spouse's death.

Couples who are aware that one spouse is dying can use the forewarning period to prepare emotionally, economically, or practically for the impending death. They are given the opportunity to readjust their daily activities and responsibilities while both spouses are still alive. For example, they may re-allocate certain responsibilities or begin teaching one another their specialized tasks. They may also make arrangements to help ensure the financial security of the surviving spouse.

As Table 7.1 shows, soon-to-be widowed persons report significantly lower levels of spousal dependence than persons who remain married across

TABLE 7.1
Anticipatory Coping: Do Older Couples Renegotiate Instrumental Arrangements Prior to the Death of a Spouse? Changing Lives of Older Couples

	How Much Do You Depend on Your Spouse For			
	Meal preparation	Household repairs	Bill paying	Financial decisions
	(Higher values represent greater dependence.) [a]			
Married Persons (n = 83)	2.84	3.09	2.90	3.34
Widowed Persons (n = 250)	2.31	2.37	2.37	2.84
Widowers (n = 35)	3.19	1.64	2.49	2.49
Widows (n = 215)	2.00	2.64	2.35	3.10
Sudden Death (n = 93)[b]	2.35	2.40	2.60	3.23
Some Forewarning (n = 92)[b]	2.44	2.37	2.22	2.86
Prolonged Forewarning (n = 65)[b]	2.08	2.34	2.34	2.68
Mean Differences[c]	*/**	*/**	*	*/**/†

[a]Dependence was assessed prior to loss on a four-point scale. Response categories were 1 "not at all" to 4 "a lot."
[b]Six months after the death of the spouse, respondents were asked, "How long before your spouse's death did you realize that s/he was going to die?" "Sudden Death" refers to people who had no forewarning or only minutes warning prior to the death of their spouse (37% of sample). "Some Forewarning" includes persons had less than 6 months warning (37% of sample). "Prolonged Forewarning" refers to those who had more than 6 months of warning (26% of sample).
[c]Unadjusted means are reported in cells. Mean differences were assessed with two-tailed t-tests and one-way ANOVAS.
*denotes a significant difference between the married and widowed samples, $p \leq .05$.
**denotes a significant difference between widow and widower samples, $p \leq .05$.
†significant difference between the no/some/prolonged forewarning samples, $p \leq .05$.

waves of data collection. This is true in the case of preparing meals, household chores, paying bills, and making financial decisions. These data reveal that older adults have effectively utilized the forewarning period to prepare for their inevitable transition into widowhood. Therefore, because the readjustment to widowhood may actually begin before the actual death, widowhood must be considered an unfolding *process* rather than a discrete *event* (defined by the death), or an individual *identity* (defined by marital status) (Utz et al., 2002). According to the CLOC data, married individuals may start to prepare for spousal loss when their spouse becomes sick, rather than at the actual moment of their spouse's death.

Furthermore, the soon-to-be widowed person who was highly dependent on the spouse—for emotional, instrumental, or economic needs—also is more likely to report high levels of anxiety and psychological distress following the loss (Carr et al., 2000; Utz, 2002). This suggests that being more self-sufficient (i.e., less dependent on one's spouse) may be associated with better psychological outcomes after the loss. While anticipatory coping will not eliminate the later disruption and stress altogether, it may enable older persons to enter the widowhood role with the skills and knowledge necessary to live alone.

REVISING OUR ASSUMPTIONS ABOUT BEREAVEMENT

Widowhood represents the loss of an intimate life partner, a friend, and an emotional confidant. Yet this chapter has reminded us that widowhood also represents a different type of loss—the loss of daily routines and functional arrangements that were shared by both members of the couple. Spousal loss may also mean the loss of a social coordinator, a personal chef, a handy person, a laundry service, a landscaper, a financial advisor, or whatever specific role a spouse may have played. Therefore, in order to successfully cope with the unfortunate experience of widowhood, the bereaved must adjust simultaneously to the emotional and instrumental voids that have been created by the death of their spouse.

Most interventions designed to assist the newly bereaved are based on theoretical models that emphasize only the emotional aspects of the loss (Bowlby, 1980; Lindemann, 1944; Parkes, 1996; Raphael, Middleton, Martinek, & Misso, 1993 for example). Therefore, the most common methods of intervention focus primarily on loss-oriented coping or on treating the psychological symptoms of the bereaved. While this perspective is valuable, it does not address the full array of challenges that older bereaved spouses face. Conceptual models of bereavement must move beyond the limited scope of attachment-based models (e.g., Bowlby, 1980) and begin to emphasize the broader array of

challenges that are associated with spousal loss (e.g., Stroebe & Schut, 1999; Worden, 2002). Such theoretical developments will be critical for devising effective intervention practices that seek to reduce the stress of widowhood.

Proposed Theoretical Model

Figure 7.3 synthesizes the major conceptual themes that have been presented throughout this chapter. The proposed theoretical model, which builds upon the Dual Process Model (Stroebe & Schut, 1999), illustrates the two main types of stress that result from the death of a spouse: the stress of losing an emotional attachment (loss-oriented stress) and the stress resulting from the disruption in the economic and practical arrangements that the couple shared and maintained (restoration-oriented stress). According to this model, psychological reactions to loss are not merely the result of just one aspect of loss; rather, anxiety, sadness, or other bereavement-related symptoms reflect the confluence of both dimensions of stress. The full extent of bereavement outcomes cannot be understood fully without equal attention to both the practical and emotional aspects of the loss.

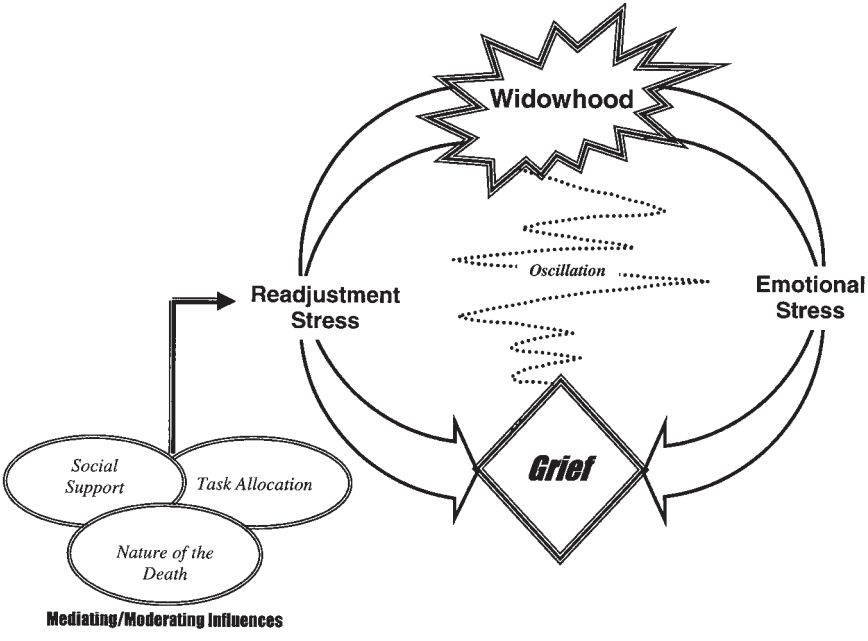


FIGURE 7.3 Theoretical Model of Spousal Bereavement. The dual process model has been adapted here to depict how older adults cope with the restoration-oriented tasks of widowhood and how these tasks contribute to an individual's unique experience of bereavement.

The proposed theoretical model also captures another important aspect of bereavement: how the experience varies across individuals and social contexts. These analyses have shown how a bereaved person's well-being and ability to cope are associated with important risk factors such as how the couple allocated social roles and routine responsibilities (Carr, 2004; Carr et al., 2000; Utz, 2002), whether the bereaved had anticipated the spouse's death (Carr, House, Wortman, Nesse, & Kessler, 2001), and whether he or she had received assistance to help reduce some of the post-widowhood workload (Ha et al., 2006; Utz et al., 2004). Though Figure 7.3 provides a useful framework for identifying which risk factors may potentially account for some of the variation in bereavement outcomes, each widow and widower should be considered a unique case and their expression of grief to be the result of their individual experiences and resources. This theoretically guided approach to studying individual-level variation may be particularly important for clinicians who are trying to provide personalized care to help the bereaved effectively cope with the stresses of spousal loss.

Proposed Intervention Strategies

Interventions based on the principles of restoration-orientation address the modifiable aspect of the loss (i.e., the practical and economic consequences), while the interventions focused on loss-orientation help the bereaved come to terms with the fixed aspects of the loss (i.e., the death). Although both types of coping are important, even essential, the following discussion highlights interventions that address the secondary stressors of widowhood, since that has been the main focus of this chapter. Given the stress associated with daily-life readjustment, targeting the secondary stressors of widowhood may be a critical first step for identifying and treating bereaved persons at risk of psychological distress.

For example, assistance programs could ameliorate financial strain by assisting widows or widowers in their search for appropriate employment, helping them change their spending behaviors, offering subsidies to compensate for any declines in income, or providing basic skills training so they can confidently navigate the intricacies of financial and legal institutions. Further, community service organizations could assist widowed persons with basic tasks of household management such as cooking, cleaning, or household repair. Because peers or laypersons (i.e., persons without formal clinical training) could administer these types of support programs, interventions based on the principles of restoration-orientation might be a cost-effective way to support the bereaved.

Teaching the bereaved practical coping strategies or providing peer counselors who can help individuals master basic tasks such as cooking, cleaning, and routine bill paying have been found to significantly reduce the distress and improve the health and well-being of the bereaved (Caserta et al., 1999; Schut, Stroebe, Keijser, & Bout, 1997). Although the documented benefits of these programs underscore the utility and importance of a restoration-oriented approach, an intervention that provides *only* restoration-oriented support is as limited as one that attends *only* to the emotional needs of a grieving individual. According to the conceptual model outlined in this chapter, intervention strategies should target the diverse range of practical and emotional challenges associated with spousal loss, but also be flexible enough to fit each person's individual resources and experiences. (See Richardson, Chapter 11, for a detailed discussion of both existing and proposed programs that target the specific needs of bereaved persons.)

CONCLUSION

This chapter has drawn on both theoretical writings and empirical analyses in order to redefine bereavement as an experience that permeates nearly every facet of daily life, rather than solely a set of emotional reactions that occurs within the minds and hearts of widowed persons. The thesis of this chapter is that the death of a spouse is a multifaceted experience, which reflects the loss of an enduring emotional relationship, as well as the loss of the daily practices and routines that gave stability and purpose to the couple's lives. Moreover, this chapter has illustrated how grief and the process of adjustment vary considerably across individuals, depending on the particular resources and experiences an individual possesses. Accordingly, theoretical models of bereavement should adopt both a *multidimensional* and *individualistic* perspective on bereavement. The conceptual framework depicted in Figure 7.3 clarifies both how older adults cope with the practical and economic consequences of loss, and how these secondary stressors contribute to the individual experience of spousal bereavement.

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Part III

New Perspectives on Grief and Bereavement

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CHAPTER 8

An Evolutionary Framework for Understanding Grief

Randolph M. Nesse

The idea that grief may be a useful biological trait that is shaped by natural selection seems both preposterous and somewhat cold-blooded. The overwhelming pain and the inability to carry on with daily life after the loss of a loved one seem to be sufficient evidence that grief is useless. Also, the idea that the capacity for grief may exist because it somehow increases Darwinian fitness is deeply disturbing. Whether the grief is one's own or that of a loved one, most people do not care why it exists; they just want to know how to relieve the pain.

From another vantage point, however, grief is not only normal, it is an essential aspect of our humanness. Imagine, for a moment, that scientists discovered a drug that safely prevents grief and all its pain. If grief were just an abnormality or some useless evolutionary accident or social construction, then presumably it would be sensible and humane to encourage wide use of the drug to eliminate grief. To many, such a world would seem inhuman indeed. Vast suffering would be eliminated, but at what cost? We do not know, but most people instinctively recognize that grief is intertwined with the meaning of our relationships and our lives.

The intensity and centrality of grief in human life have motivated many scientific studies about its nature. We now know a great deal about the symptoms and course of grief, who experiences it, and its complications. We are learning more about how grief varies across individuals and cultures. Many pervasive, but questionable, assumptions about grief are gradually giving way

in the face of mounting evidence that not everyone experiences grief, grief work is not always necessary, and delayed grief is rare (Bonanno & Kaltman, 1999; Wortman & Silver, 1989). The recent publication of a millennial *Handbook of Bereavement Research* describes a field chock full of data and theory from scores of fine researchers (Stroebe, Hansson, Stroebe, & Schut, 2001). These leaders in the field agree on the facts but they also agree that we lack, and badly need, a unifying framework for understanding grief.

This chapter argues that an evolutionary understanding of why grief exists will eventually provide the foundation for building such a framework. So far, however, agreement remains elusive even about how to pose the question about why grief exists. The straightforward approach is to assume that the capacity for grief is, like physical pain, a useful trait shaped by natural selection. This approach fits nicely with tendencies to assume that grief is a monolithic phenomenon and that grief after the loss of a spouse late in life is fundamentally the same as grief after the loss of a child. However, these assumptions may be incorrect. Whether natural selection directly shaped our capacity for grief is unknown, but there is no doubt that selection shaped the mental mechanisms that give rise to grief. If we understand them, we will better understand grief in general and grief among older bereaved spouses in particular.

Readers unfamiliar with ethology and behavioral ecology may have difficulty following this line of thought. The crucial idea is that natural selection shapes brains that give rise to adaptive behavior in much the same way that it shapes physical traits such as the shape of the finch's beak. The process of natural selection is simple. For instance, when a drought eliminates all but the toughest seeds, the individual finches with larger beaks will get more food and have more offspring. Because beak size is passed on to offspring, the average beak size will become progressively larger in each generation when only tough seeds are available. When the environment is more stable, individual finches will be at a disadvantage if they have beaks much larger or smaller than average. There is no such thing as an optimal trait except with reference to a certain environment. For instance, if a new predator appeared, finches with greater tendencies to avoid risks would do better and natural selection would gradually shift the population to a lower tendency to take risks. Such behavioral tendencies are shaped by natural selection in the same way as more tangible traits.

Though it initially seems preposterous to think that the capacity for grief might have some useful function, many useful traits are aversive and disabling. Pain is the exemplar. It might seem wonderful to eliminate pain, but the few people born with an inability to experience pain are unfortunate in-

deed; they are all dead by early adulthood. This is not to say that all negative experiences are somehow useful. Seizures, paralysis, jaundice, and cancer are utterly useless. The challenge is to distinguish useful responses shaped by natural selection from abnormal or useless responses that arise only because for some reason natural selection has not been able to make the body better. This is the core question for grief.

The fundamental question addressed here is, *What selection forces shaped the brain mechanisms that give rise to grief?* Finding an answer to this question is not only of theoretical interest; the gap in knowledge also holds back research, treatment, and even diagnosis. For instance, enormous effort has been dedicated to determining when grief is "normal," when it is "abnormal," and when it is "traumatic" (Prigerson et al., 1997). At the extremes, the distinction is easy—ordinary grief after loss of a close loved one is recognized as normal (if only because it is the typical response), while extremes of grief are recognized as pathological because of their severity, duration, and complications. However, without understanding why the mechanisms that give rise to grief exist, all criteria for separating normal from abnormal grief are essentially arbitrary. Defining the boundaries of pathology requires an answer to the core question.

Understanding what grief is will also advance treatment. Controlled studies reveal that treatment for ordinary bereavement is not very effective and can be harmful (Schut, Stroebe, Van den Bout, & Terheggen, 2001). Why don't interventions work reliably, and how do they sometimes make things worse? Is it sometimes a mistake to interfere with grief? Treatments for extremes of grief can be effective, but why are some individuals so vulnerable to grief? How do different loss circumstances influence grief? Are these differences epiphenomena, or do grief regulation mechanisms adjust grief depending on the circumstances? An answer to the fundamental question about the origins and possible functions of grief is important in seeking answers to each of these more specific questions. Furthermore, if pharmacologists do discover drugs that block the experience of grief, answering the core theoretical question becomes an urgent practical necessity.

The hope that an evolutionary perspective can help provide a framework for understanding grief is justified by the experience in every other area of biology, where the need to understand evolutionary origins and functions is taken for granted (Alcock, 2001). Researchers who study fever know that it is useful during infection. They use this knowledge to determine when fever is normal and when it is abnormal or useless (Kluger, Bartfai, & Bartfai, 1999). Seeking evolutionary explanations for behavioral regulation mechanisms is

equally essential (Alcock, 2001). For instance, anxiety is useful in the face of danger, but the selection forces that shape the regulation mechanisms make us prone to useless phobias (Marks & Nesse, 1994).

There is no shortage of theories about grief (Weiss, 2001). Despite the human tendency to emphasize the differences between new theory and old, the field seems to have avoided the balkanization that characterizes some areas of psychology. Most authorities on grief applaud the plurality of approaches, even as they note the need for an integrating framework (Bonanno, 2001; Shaver & Tancredy, 2001). However, no amount of integration of diverse perspectives can substitute for an evolutionary understanding of what grief is and why it exists at all. To arrive at this basic understanding of grief requires a fundamentally different approach.

Biologists distinguish between "proximate" questions about *how* organisms work, and "evolutionary" questions about *why* organisms are the way they are. Ernst Mayr's (1974) essays introduced this idea to most biologists and Tinbergen's (1963) classic article "On the Aims and Methods of Ethology" defined the four different questions that must all be answered to explain any trait fully. He describes two kinds of proximate explanations. The first is *mechanism*, that is, explanations based on anatomy and physiology and learning. Mechanistic explanations are about the organism's devices and how they work at all levels of organization, from the neuron to psychological mechanisms. The second is *ontogeny*, the sequence and forces that develop a zygote into a mature form. Tinbergen also described two separate kinds of evolutionary explanations. One explains the selection forces that shaped a trait, often described in terms of the trait's evolutionary function. The other examines the phylogenetic history of a trait. These four questions are not alternatives; answers to all four are necessary for a complete explanation of any trait, including grief. Many current theories of grief provide answers to more than one kind of question without always distinguishing the separate questions addressed.

For instance, many aspects of grief are recognized as emotions, so knowledge about emotions generally is useful in understanding grief (Bonanno, 2001). This knowledge includes an understanding of how emotional capacities develop, cues and cognitions that regulate emotions, brain mechanisms that mediate emotions, individual differences in emotional experience, and the evolutionary origins, phylogeny, and functional significance of emotions. This plurality is needed, but not recognizing the separateness of each question leads to much confusion (Plutchik, 2003).

Much grief research has also been organized around the vulnerability-stress-coping paradigm (Bonanno & Kaltman, 1999). However, as Shaver

and Tancredy (2001) note, stress has become a "garbage can" for all manner of more specific negative emotions, and researchers would do well to attend separately to each of the 15 or so emotions aroused in grief.

The Dual Process Model proposed by Stroebe and Schut (1999) has been particularly successful in organizing grief phenomena with its emphasis on separating attempts to cope with the emotional loss from attempts to reorganize the instrumental aspects of life after a loss. While primarily descriptive, we will see that this distinction maps nicely onto a functional model of different sources of emotion and concern after a loss.

Of the several traditional perspectives on grief, two are so influential they deserve detailed consideration: attachment theory and studies of relationships (Weiss, 2001).

ATTACHMENT THEORY

Most research on grief is based on Bowlby's attachment theory (1969, 1973, 1980). His evolutionary perspective on social bonds and loss initiated a long and influential tradition of considering the functional aspects of grief (Belsky, 1999). Researchers' acceptance of this paradigm has been so uniform that few have proposed critiques or expansions despite substantial modern evolutionary advances in understanding attachment, relationships, and emotions.

Taking his cue from conversations with the ethologist Konrad Lorenz, Bowlby recognized that infants who develop strong attachments to others will be more likely to survive than those who do not; staying close to mother is generally wise. Especially useful are the reactions to broken attachments—protests and then despair. However, Bowlby's evolutionary explanation for universal patterns of attachment is inextricably entangled with his developmental explanations for individual differences and pathology. Like other psychoanalysts, he was convinced that differences in adult behavior resulted mainly from differences in early childhood experiences. For instance, a child might develop an anxious and dependent attachment style because of experiences with an unempathic mother. Along with Ainsworth, Blehar, Waters, and Wall (1978) and Main (2000), Bowlby described the variations in terms of several categories: secure, avoidant, or anxious/ambivalent. As many as half of the children in some studies showed avoidant or anxious patterns of attachment, yet only the secure form of attachment was recognized as "normal."

Three aspects of attachment theory deserve comment here. First, Bowlby's evolutionary view of attachment and reactions to its disruption is fundamentally correct and far ahead of his time. Offspring who stay close to their

mothers are more likely to survive, so natural selection preserves genetic tendencies to respond to separation with distress and motivation for reunion. Maternal attachment tendencies do not benefit the mother directly, however, so they require a different explanation. As many have noted, Bowlby had no access to newer models of how selection works; he tended to think in terms of benefits for the species, instead of benefits to individuals who increased the frequency of genes for a trait (Belsky, 1999). Hamilton's (1964) discovery of kin selection was a landmark advance in understanding animal behavior that is just now being integrated with attachment theory. In simple terms, genes that induce organisms to do things that shorten their own lives, such as taking risks for the safety of their offspring, can nonetheless persist in the gene pool because half of their genes are identical to those in their children. Because children share only 50% of a parent's genes, sacrifices for offspring make evolutionary sense only when the benefit to the offspring is at least twice as great as the cost to the parent. Such situations are common. Evolutionary explanations based on kin selection have replaced previous explanations for such behaviors that were based incorrectly on benefits to the group or species.

The principle of kin selection highlights the different selection forces that shape the mother's attachment to offspring versus the offspring's attachment to the mother. Attachment behavior in offspring benefits them directly, but maternal attachment behavior benefits the mother only via kin selection. Obviously, such factors can influence fathers as well, but the mother-offspring attachment is overwhelmingly the observed phenomenon in most species, and for the good evolutionary reason that mothers know who their offspring are, but males often do not (Low, 2000). I will use the phrase "genes for attachment" as shorthand for wordier expressions that indicate that the genes in question interact with environments to result in behavioral tendencies toward attachment behavior.

The importance of this for studies of bereavement in elderly spouses is profound. The attachment between spouses may have phenomenological similarities to attachments between mothers and children, but the origins and functions of these attachments may be quite different. The principles of mother-infant attachment may prove relevant for understanding marital attachment and grief, but it is essential to recognize the leap involved and to address the question of whether these behaviors in adulthood were themselves shaped because they are useful and whether they arise from the same mechanisms as childhood attachment.

Another advance in evolutionary thinking has also begun to influence attachment theory. Attachment theory, as applied in a clinical context,

tied notions of normal attachment closely to happy relationships free from psychopathology. It has become increasingly clear, however, that aversive emotions are as useful as positive ones, otherwise they would not exist (Nesse, 1990, 1991). In addition, warm, mutually supportive, secure relationships are wonderful and desirable, but they are not always the best route to reproductive success so it is not surprising to find many other patterns in nature. Several researchers have suggested that so-called abnormal patterns of attachment may offer selective advantages in certain circumstances (Belsky, 1999; Chisholm, 1996). The baby of an uninterested mother may do better by being clingy, or by being so distant that the mother must take responsibility for maintaining proximity. Whether or not infants actually discern maternal inclinations and adapt their attachment patterns, and whether these patterns give a selective advantage that could shape them and such a regulation system, is still up in the air. The conclusion for now is that we should not assume that secure attachments are normal and optimal in all circumstances.

One final issue is whether the phenomena in adult close relationships are best understood in terms of the same attachment mechanisms characteristic of childhood (Hazan & Zeifman, 1999). Much research now demonstrates that early attachment patterns are correlated with adult beliefs about relationships (i.e., schemas, or working models) and that variation in adult relationship patterns are a function of childhood attachment patterns. The same mechanisms that mediate childhood attachment to parents may also mediate adult close relationships. It is possible, however, that somewhat different mechanisms mediate these similar appearing phenomena. The continuity of individual attachment tendencies across the life span could reflect general personality or emotional tendencies instead of the persistence of the same mechanism. As is so often the case for such biological tendencies, the complexity of what actually happens may be hard to describe in the crisp categories and simple causal models that our minds prefer.

What are the implications of these advances for understanding grief? They move us away from the simple view that all normal attachments have the same form, origin, and function. The attachment of mother to infant is shaped by fundamentally different selection forces than the attachment of infant to mother. Patterns of non-secure attachment may be alternatives, not abnormalities. Moreover, attachments between mothers and children are not necessarily mediated by the same brain and psychological mechanisms as attachments between spouses. These differences suggest that the global response to loss of an attachment is an insufficient explanation for grief and we may need to seek different explanations for grief arising from different kinds of losses.

RELATIONSHIP LOSS

Grief is caused by loss of relationships. Consequently, understanding the meaning of grief must be based on an understanding of relationships (Weiss, 2001) and how they give a selective advantage (Fiske, 1991). Lack of such an evolutionary understanding has stymied grief research. The attachment model offered a good start by interpreting the utility of grief responses in adults as analogous to the benefits attachment offers to mothers and offspring. However, an evolutionary understanding of relationships has advanced rapidly in recent decades and now has much more to offer grief research. The original breakthrough, Hamilton's (1964) recognition of kin selection, offered an explanation for why close relatives tend to offer each other generous help that may harm their individual interests. It quickly became apparent, however, that altruism in non-kin relationships needed a different explanation. The answer came from Trivers's (1971) insight that the exchange of favors often offers a net benefit to both parties. Since studied in exhaustive detail using models based on the Prisoner's Dilemma, the benefits of such reciprocal exchanges are now recognized even more clearly than they were by the early Utilitarian philosophers as the bedrock of social life (Axelrod & Dion, 1988).

When Trivers wrote his seminal paper, the study of the evolution of communication signals was flourishing, with a focus on the many strategies of deception and manipulation found in nature. In conjunction with continuing preoccupation about how to explain altruism, this led to an emphasis on modeling short-term exchanges among strangers in which the maximum advantage comes from cooperating when it is necessary and defecting or deceiving others when that gives a maximum payoff (Krebs & Dawkins, 1984). This model matches many observations from everyday life and the expectations of individuals whose internal working models are not based on basic trust. What it leaves unexplained are generous behaviors in close relationships where costs are high and tangible payoffs are low or absent, such as caring for a sick parent or a disabled spouse.

Scholars continue to flesh out our understanding of how intimate relationships work, but one perspective is particularly germane here. In relationships characterized by what economists call "commitment," individuals will have an advantage if they can convince others that they will offer help even in the absence of a guaranteed payoff (Frank, 1988; Hirshleifer, 1987; Nesse, 2001a). The advantage is that the other is likely to make the same commitment, thus giving both parties access to help at the times when it is most needed, to say nothing of a genuine friendship that does away with the record keeping and negotiations that drain energy from exchange relationships.

Whereas noncommitted partners are keeping score and ensuring that they do not allow the other to go too deeply into debt, committed partners are helping each other in various ways irrespective of the circumstances. These relationships are a lot like those based on kinship and the psychological tendencies that make them possible may well have originated to manage kin relationships. Also, social groups, especially religious groups, often promote such relationships with ideology and sanctions that require helping other members of a close-knit group that is costly to join and even more costly to leave. The close-knit group that best exemplifies commitment in our society is marriage. The care provided by a spouse at the end of life is not explained by reciprocity or kinship, but by something more like commitment.

The special value of such commitments explains much of what is lost when intimate relationships end. If an exchange partner is lost, a replacement is often available. If a commitment partner is lost, however, the investment needed to establish trust in that relationship is gone and it may be years (or never) before another such relationship can be established. These different kinds of relationships are very close to the distinction between relationships based on attachment and those based on affiliation (Weiss, 2001), and the distinction between communal and exchange relationships (Fiske, 1992; Mills & Clark, 1994). After the loss of a loved one, the bereaved spouse cannot just start up again with someone else, because the entry costs are high and long experience is essential to establish trust. Trust is an expensive social resource. It is not replaceable without another similar huge investment.

JOHN ARCHER'S ASSESSMENT

The psychologist John Archer (1999) has undertaken the task of integrating Bowlby's discoveries with modern evolutionary perspectives on human behavior to create a comprehensive model of grief. He includes much relevant information to support his thesis that grief has not been shaped by natural selection but is an epiphenomenon of the capacity for attachment. He argues that grief has such high costs that it is implausible to think that natural selection shaped it. He explains the persistence of grief despite these fitness costs by arguing that attachment offers enormous benefits and natural selection has not been able to shape mental mechanisms that offer the benefits of attachment without the costs of grief. He sees the specific adaptive function of attachment bonds as maintaining "the persistence of social bonds when the other is absent," (p. 555) and he emphasizes the phylogenetic continuity of human grief and the searching exhibited by animals looking for lost kin (Archer, 2001a). We humans know that death is

permanent, but we nonetheless persist in reactions that are fundamentally similar to this searching behavior in other animals.

Archer offers by far the most careful and comprehensive assessment of the evolutionary origins of grief, but I am not at all sure that he is correct (Nesse, 2000b). One misgiving is the weight he gives to evidence that grief is costly to fitness via effects on physical health. First, there is continuing controversy about the strength of this evidence. Although some studies find earlier death after loss of a loved one, it is not at all clear that this effect is robust; a correlation between experiencing loss and shortened life span can be accounted for by many factors other than the mediating effects of the grief response (Martikainen & Valkonen, 1996). There is also a significant risk that negative or equivocal findings on this question remain unpublished. Furthermore, most of these studies are of elderly people where the effect of natural selection would be weak in any case, although there is some indication of small increases in mortality in younger populations (Bowling, 1987; Kaprio, Koskenvuo, & Rita, 1987). Similar criticisms apply to studies that show decreased immune responses, more sickness, and so forth in the bereaved.

Definitive confirmation of Archer's hypothesis would require evidence that people who do not experience grief experience significant Darwinian fitness advantages compared to those who do. Such evidence would be hard to come by, and the relevant environment would be that of hunter-gatherers in the Paleolithic. If grief is a disadvantageous epiphenomenon, however, this predicts that those who have a tendency to experience grief will have advantages from better attachments but selective disadvantages from the impairment imposed by experiencing grief. There is little evidence to support this. The evidence that grief disrupts life and causes depression is strong, however, and these costs do require some kind of explanation of grief, either as an epiphenomenon selection cannot eliminate or in terms of some kind of benefits.

Another problem is Archer's emphasis on costs and his neglect of possible benefits. Ignoring the benefits of painful responses is a common problem in medicine as well as in psychology (Nesse & Williams, 1994). For instance, doctors routinely treat fever because it is uncomfortable and may cause seizures. These costs make it hard to see the utility of fever in fighting infection. The costs of diarrhea are even more dramatic. It is the leading cause of death in children worldwide, so this would presumably select against any capacity for diarrhea. The mechanism persists, however, because the benefits of having a capacity for clearing infection from the gastrointestinal tract are greater, on the average, than its sometimes-fatal costs. Pain offers yet another example. People who experience pain, especially chronic pain, are disabled, and this would certainly decrease their ability to survive and reproduce. This

does not, however, support the conclusion that the capacity for pain was not shaped by natural selection; it instead means that the benefits of pain must be so substantial that they outweigh its costs. The usefulness of pain is clear from the tragic cases of individuals born without any capacity to experience pain; almost all are dead by early adulthood (Sternbach, 1963). Below I argue that individuals born with no capacity for grief experience analogous disadvantages.

IS GRIEF A SPECIALIZED KIND OF SADNESS?

The power of the attachment paradigm has made it difficult to consider alternative explanations for grief. In particular, many aspects of grief make sense as aspects of sadness, either generic sadness, or sadness that has been specialized to cope with loss of a close relationship. Emotions such as sadness, joy, fear, and rage are special states that are useful only in certain situations. There has been a tendency to seek evolutionary explanations for emotions by describing their possible functions. Emotions do serve functions such as focusing attention, communicating, and making certain behaviors more likely, but describing such functions does not offer a full evolutionary explanation. A more complete explanation comes from considering how natural selection shaped the capacity for emotions. They adjust physiology, motivation, perception, and behavior in ways that increase the ability to cope with certain situations. The situations are those that were repeatedly important to fitness over the evolutionary history of a species, such as being threatened by a predator or being near an attractive potential mate. Each emotion is shaped by natural selection to cope with the adaptive challenges of the situations. The correct question to ask about an emotion is not, "What is its function?" but is instead: "In what situations have the changes characteristic of this emotion given a selective advantage?" (Nesse, 1990).

Positive emotions, such as love and joy, seem useful while negative emotions, such as anger and anxiety, seem maladaptive. This is an illusion, the same "clinician's illusion" that makes it hard to see the utility of bodily defensive responses such as fever and pain. The high costs of negative emotions and body defenses demonstrate not that they are useless, but the opposite: their high costs confirm that they offer substantial benefits in certain situations. They will sometimes be expressed in situations where they are maladaptive, and the systems that regulate defenses make mistakes (Nesse, 2001b; Nesse, 2005), but overall they give an advantage.

Although it is harder to see the utility of negative emotions, most people readily recognize the utility of anxiety. In the face of a potential danger,

protective responses prevent damage or loss. Sadness, however, typically occurs after a loss. The horse is already out of the barn, as it were, so how can any kind of response be helpful now? However, an evolutionary view highlights different questions: Is the loss of a valuable resource an event of adaptive significance? To put it more specifically, are there things an organism can do after a loss that might increase its fitness? There are many, including attempting to undo the loss, trying to prevent future losses and warning others. (For a more complete list, see Table 8.1.)

This list in Table 8.1 is not exhaustive, but it does describe responses that could be useful after the loss of any valued resource. The list of possible ways that general sadness could be useful applies to any loss, but is especially germane for situations in which a loved one has died. To make this all horribly vivid, imagine a mother whose child has just drowned. She will immediately search for her child, call for help, get her other children out of the water, and warn others. In the future, she will avoid exposing her children to the same danger, and will think endlessly about what she might have done to prevent the tragedy. Mothers without these tendencies may suffer less and live longer, but their children will be at risk. Later in life, a person who anticipates the pain of grief will take care to protect his or her spouse. This will not result in more children, but it will make life much better and both members of a couple will do better at taking care of children and grandchildren who share their genes.

TABLE 8.1
Sadness: Behaviors That May Be Useful After a Loss

1. Search for what was lost, or otherwise try to undo the loss.
2. Stop any actions that were associated with the loss to prevent additional immediate losses.
3. Take other protective actions to prevent further immediate losses.
4. Escape from the situation to prevent more immediate losses.
5. Warn kin about the danger.
6. Signal a need for help.
7. Come together with close relatives and friends for mutual protection.
8. Avoid the situation and actions that preceded the loss to avoid future similar losses.
9. Experience mental pain after the loss, and when thinking about situations that caused it, to motivate avoidance of the situation and to find ways to prevent future losses.
10. If the lost object can't be found, search for a replacement.
11. If no replacement is available, adjust life strategies to cope with the absence of the resource.

Selection also shapes mechanisms, such as learning, that allow individuals to cope with the kinds of threats and losses prevalent in their particular environment. An evolutionary approach to emotions does not view organisms as robots responding to cues. Human emotions arise from cognitive appraisals of the meaning of a cue or event for an individual's ability to reach important personal goals (Ellsworth & Smith, 1988). Thus, discovering a pregnancy may arouse joy in a married woman who wants to have a baby, but anxiety and guilt in a single woman for whom the news may mean being rejected by her community. Likewise, loss of a spouse may give rise to different responses depending on exactly what is lost and the details of the individual's life situation after the loss.

Sadness differs from low mood and depression. A discrete loss that does not block long-term goals will arouse sadness that soon fades. If, however, the loss makes it impossible to reach important goals, continued striving toward an unreachable goal gives rise to low mood, that is, mild depression. Klinger describes how low mood can be useful in disengaging effort from unachievable goals and how persistence in pursuit of such goals could escalate ordinary low mood into full-fledged depression (Klinger, 1975). This paradigm has now developed so it is widely recognized that mood is influenced by events that indicate a change in expected rate of progress towards crucial goals (Carver & Scheier, 1990, 1998) although recognition of the relevance of these discoveries for psychiatry is still nascent (Nesse, 2000a).

Generic emotional responses were shaped into partially differentiated subtypes to cope with specific kinds of situations. There are specialized kinds of anxiety, for instance, to cope with heights, predators, and social threats. Different kinds of losses arouse different negative emotions. Tissue damage arouses pain. Loss of a friendship arouses guilt and motivation for reparations and reconciliation. Violation of a minor group norm arouses embarrassment that signals respect for the group and motivates future conformity. Failing to live up to a performance expectation arouses shame that signals recognition of the failure and motivates avoidance and striving to improve (Gilbert, 1998; Keltner & Busswell, 1996). The aversiveness of each of these reactions is useful to promote escape and future avoidance, and as a guide for future mental planning.

Evidence that natural selection has differentiated emotions to cope with specific situations highlights a crucial question: *Is grief a special kind of sadness shaped to cope with the adaptive challenges posed by loss of a close relative or loved one?* This hypothesis can explain much of what we know about grief. It is very different from the hypothesis that grief arises only from broken attachments and it can explain some phenomena that are otherwise mysterious such as

the grief aroused by loss of a relative who is genetically close, but emotionally distant—say, a brother who has been overseas for many years. It also predicts that the reaction to loss of an intimate companion, such as a spouse, may be quite different from the reaction to loss of a relative. The hypothesis that grief is a specialized kind of sadness also nicely matches the well-established "dual-process model" of grief, which recognizes the need to both adjust the instrumental aspects of life to the absence of the loved one, and to also make the emotional adjustment to the loss (Stroebe & Schut, 1999). The next challenge is to examine what we know about grief to see how past research and theory fits with the predictions of models based on attachment as compared to specialized sadness.

ASSESSING POSSIBLE EVOLUTIONARY EXPLANATIONS OF GRIEF

Precipitants

The single most salient fact about grief is its precipitant: the death of a close relative or other loved one. People also experience sad feelings when a close loved one moves to a distant place where he or she will not likely be seen again, but these feelings are not the same as grief. This seems very important. Grief is aroused not by simple separation, but by knowledge that the person has died. Even learning about a death that occurred in a distant place months previously can set off intense grieving. This was taken to an extreme in a scene from a science fiction movie about intergalactic explorers who travel toward a distant galaxy for 3 million years, then turn back and retrieve mail that has caught up with them. One man gets the news that his father has died and begins to weep bitterly. His companions are incredulous, saying, "Why are you crying, he has been dead for 3 million years? They all have been dead for 3 million years!" "I know," replies the man, still weeping, "but I just found out now."

The other core fact about grief is that it is aroused more by the loss of close blood relatives than other close relationships. The loss of a longtime spouse or friend certainly arouses grief, but the exemplar precipitant is the loss of a child or parent. Moreover, the percentage of genes shared in common with the lost relative predicts the intensity and duration of grief (Crawford, Salter, & Jang, 1989; Littlefield & Rushton, 1986; Segal, Sussman, Marelich, Mearns, & Blozis, 2002). When teenagers die at that point in life when they are maximally surly and distant, the parent's grief is by no means lessened. One can attribute this to the persistence of the bond despite con-

flicts. But this raises the question of why such bonds should exist when there is little emotional support or mutual helping. One answer is that relatives have shared genes. When other factors are held constant, it appears that grief is maximal when the lost person is at the age of maximum reproductive value (the age of first reproduction), which is just what might be expected from an evolutionary view (Crawford et al., 1989; Littlefield & Rushton, 1986).

The degree of estimated grief even appears proportional to the percentage of genes in common (Littlefield & Rushton, 1986), and grief responses to loss of close relatives are estimated to be greater, on average, than responses to loss of a spouse (Segal & Bouchard, 1993; Segal et al., 2002). Grief at the loss of a co-twin is greater than loss of another sibling, although it is hard to argue that selection would shape a mechanism to detect and respond to the rare circumstance of having an identical twin. More likely, the experience of being a twin draws on the mechanisms that usually regulate feelings of kinship (Segal & Bouchard, 1993).

Much more research and theorizing is needed to determine exactly how grief is influenced by different aspects of relationships, but the data to date suggest that grief is influenced most by the degree of kinship, considerably by degree of emotional closeness and commitment, and some by the degree of close everyday contact and the degree of instrumental exchange. The phenomenon of intense grief that individuals feel for famous people they never met, such as Princess Diana, is important but not easy to explain. Media images seem somehow to be able to create emotional connections whose disruption creates full-fledged grief.

Grief Phenomena

The most prominent characteristic of grief is its painfulness. The pain of depression is similar to grief as are other depressive symptoms such as low energy, inward turning, preoccupation, guilt, and self-criticism. However, grief is less often characterized by low self-esteem, pessimism, and hopelessness. The significance of emotional pain is most likely parallel to that of physical pain. People who respond to tissue damage with physical pain escape damage now and avoid danger in the future. Losses of resources, including health, material resources, territory, status, relationships or kin, cause comparable emotional pain. People who experience emotional pain in response to such losses have a better chance to prevent further losses now and in the future. Conversely, individuals who lack negative emotions are at a disadvantage parallel to the disadvantages experienced by people who cannot experience

physical pain. Those who do not experience anxiety may take unjustified risks. Those who have no capacity for low mood may have difficulty reallocating their efforts from unreachable to more achievable goals.

In this framework, pain following the loss of a relative has a straightforward interpretation. Few other events harm one's reproductive success as much. The experience of pain and the anticipation of such pain should motivate intense efforts to prevent death of relatives. Genes associated with this response tend to become more common via kin selection—the relatives who benefit share some of the exact same DNA sequences including those that shape tendencies for pain after a loss. This is supported by evidence that grief intensity is proportional to the degree of genetic relatedness. Whether grief in response to loss of friends or others arises from the same brain mechanisms is uncertain, although it seems likely that they do.

The shock and denial of a loss, and the intensity of searching for the lost loved one, are exactly what one would expect from a useful specialized form of sadness. If there is any chance that the person might still be alive, the search should go on. In the ancestral environment, such losses occurred regularly and such searches might often have paid off. Individuals with relatives who searched long and hard would have an advantage. It is interesting to note the public's deep emotional engagement with news reports of a child lost in the woods, even if the woods are a thousand miles away. Something about such situations grabs our emotions. None of this proves, however, that searching for the deceased is always useful. When people search for someone they know is dead, it seems preposterous. This is a good example of a behavior whose regulation remains crude perhaps simply because selection cannot make it better. In modern times, the concealment of death, such as funerals with closed caskets, may foster excessive searching. This is extreme and poignant in the relatives of prisoners of war (POWs), still hoping after decades.

Many people report "seeing" or "hearing" a deceased relative (Baethge, 2002), a phenomenon that gives rise to belief in ghosts. Similar phenomena are encountered in searches for other objects. A vivid search image facilitates recognition but results in many false positives. A sound or image that vaguely resembles one associated with the deceased is interpreted as indicating his or her presence. Sometimes such experiences are true hallucinations, not just illusions based on misinterpretation of similar stimuli. Experiences of the presence of the deceased are unlikely to have any direct utility, but they strongly indicate the presence of a search image and thus reinforce the above interpretation of the value of searching.

Rumination over whether something could have been done to prevent the death is thought to exemplify pathological grief (Nolen-Hoeksema, 2001).

This common reaction seems abnormal because it is often obvious that survivors could not have prevented the loss and should have no reason for guilt. In an evolutionary framework, however, such ruminations may be automatic; major losses may trigger a cognitive process examining every minute action or inaction that could have prevented the dire outcome. This may be another example of an evolved mechanism that remains somewhat crude.

Not often highlighted, but commonplace, are personal fears aroused by a death. Few eat steak at the funeral dinner for a man who died from a heart attack. Indeed, much of people's preoccupation with a loss is related to their own fears and fears of mortality have inspired the whole area of "terror management" (Nolen-Hoeksema, 2001; Pyszczynski & Greenberg, 1987). As Gerard Manley Hopkins put it in his poem *Spring and Fall* (Hopkins, Gardner, & MacKenzie, 1967),

> Margaret, are you grieving
> Over Goldengrove unleaving?
> . . .
> Now no matter, child, the name:
> Sorrow's springs are the same.
> Nor mouth had, no nor mind, expressed
> What heart heard of, ghost guessed:
> It is the blight man was born for,
> It is Margaret you mourn for.

Personal fears are but one part of loss, however. The loss of a spouse takes away the very structure of daily life (Utz et al., 2004). All the everyday rituals, and the overarching goal of caring for and pleasing the other, are yanked away. Bereaved spouses often attempt to continue old habits. They set the table for the lost spouse, they converse even though the person is not there, and they think automatically about what the individual would like. Such habitual behaviors sometimes are rudely interrupted by the sudden realization that the spouse is deceased. Such behaviors are habits, but they are also efforts to continue to pursue goals that are no longer reachable. The low mood, lack of incentive, and general moroseness of grief are characteristic in general of situations in which motivation is being disengaged from wasted efforts (Wrosch, Scheier, Miller, Schulz, & Carver, 2003).

This brings up a central question. If grief exists to foster the transition after a loss, why is it so enduring and so impairing? Why not just get on with it? One might even predict that after a major loss the optimal reaction would be to experience optimism about new possibilities, to move on with gusto.

That is not what people do. To understand why, consider how we react to people who do move on with nary a backwards glance. We think there is something wrong with those who do not grieve, and our reaction is not just curiosity, but critical condemnation. This moral reaction may help to explain the preoccupation with absent grief. From the beginning of organized studies, grief researchers have believed, and have believed that they have found evidence for, the pathological nature of absent grief. In the era when Freud's ideas dominated psychology, absent grief was thought to indicate denial and the repressed affect was presumed to return later to cause symptoms not easily traced to the loss. Alternatively, absent grief has been thought to arise from lack of attachment and associated personality pathology. Prolonged grief, conversely, is hypothesized to arise from unconscious ambivalent feelings about the deceased, with depression explained by these hostile feelings turned against the self.

Data from prospective studies such as Changing Lives of Older Couples (CLOC) study challenge early claims about the uniform necessity of grief. A large proportion of people carry on relatively unfazed after the loss of a spouse, often reporting mild short-lived symptoms (Bonanno et al., 2002). Delayed grief is so rare as to be nearly nonexistent. Also, these data show that more ambivalent relationships give rise to milder grief reactions (Carr, House, Wortman, Nesse, & Kessler, 2001). None of these findings are evidence against the complexity of reactions, including psychodynamic defenses, after a loss. However, they do pull attention back to more straightforward interpretations of grief as a special kind of sadness.

A period of low mood, low initiative, and pessimism is characteristic after losses in general, not just losses of loved ones. Loss of a job, a house, or even loss of a garden mowed down by a woodchuck can kick motivation in the solar plexus. After such losses people often withdraw and do little except thinking, sometimes ruminating, about what was lost and why and what to do now. Gut (1989), in her book *Productive and Unproductive Depression*, describes such reactions as a necessary and useful reallocation of effort to planning instead of action, a chance to consider options, weigh them, and reorganize one's ventures and values before plunging on ahead. This makes perfect sense. However, a simpler advantage may arise for individuals who tend, after a loss, to stop activities that might lead to more losses, and to pause to consider what to do in a new situation.

Overall, considerable evidence suggests that natural selection has partially differentiated generic sadness into a special state that facilitates coping with the loss of a loved one. As noted above, prolonged searching, self-blame,

ruminating about what could have prevented the loss, coming together with close friends, and withdrawal from the routines of everyday life may all be useful responses to loss, on average. However, because selection can never start afresh and merely tinkers with previous patterns, such as generic sadness, there is no expectation that every aspect of grief should be useful or even that generally adaptive aspects of grief are always useful. Selection leaves many rough edges that give rise to suboptimal patterns of behavior, such as months of useless rumination or the persistence of clinical depression.

Thinking about the deceased has been seen as a hallmark of useful "grief work," or the process of reorganizing mental life to cope with absence of the loved one. However, a growing body of evidence suggests that emotional outcomes are not influenced much by the amount or quality of thinking about the deceased (Bonanno & Kaltman, 1999). It is also unclear why such reorganization could not take place without such suffering and disability, although Archer (1999) suggests that ruminations about the deceased may be nonadaptive products of a system that is useful to maintain social bonds despite absences.

Grief also usually includes much crying, often agitated. This is certainly a signal, but to whom, meaning what? The reactions of others tend to be sympathy and wishes to help. It could be as simple as that—expressions of grief bring needed help from relatives just as the crying of infants brings help from parents (Zeifman, 2001). Or, crying could be simply a manifestation of the pain, with no specific adaptive significance for grieving adults, a hypothesis that is consistent with much crying that is kept secret.

Expressions of public grief also testify to the bereaved person's character. They signify an ability to have relationships based on emotional commitment, not just instrumental convenience. Such expressions differ vastly in different cultures, perhaps in part because the nature of close relationships differs, as well as because of related differences in social norms. Failure to express grief may be dangerous to a person if others interpret it as a lack of ability for genuine caring. For instance, Wortman and Silver (2001) describe a man convicted of murdering his wife based mainly on his lack of expression of grief on learning about her death.

Guilt after a loss is often as incomprehensible as it is powerful. It is often the most doting parent or the most committed spouse who is paralyzed by ruminations about what could have been done to prevent the loss. A tendency to ruminate over any oversights that could perhaps have prevented the loss is useless for the loss already incurred, but may be invaluable in preventing future losses. Here again the adaptive mechanism seems quite crude—guilt

arises routinely after a loss, often with little correspondence to actual culpability. Even if grief is a specialized form of useful sadness, many of its aspects in many individual instances are cruelly unnecessary.

The Course of Grief

While stage theories of grief have been rightly discredited, some phenomena, such as looking for a replacement, necessarily follow earlier stages of looking for the lost object. Likewise, giving up on finding the lost person comes only after the search.

Many studies have investigated the course of grief. The purported duration of grief has steadily lengthened, from the figure of a few weeks cited in Lindemann's (1944) classic Coconut Grove study, to recent work emphasizing that people do not get over losses, they gradually get used to them and move on even while retaining a continuing relationship with the deceased (Klass, Silverman, & Nickman, 1996). Despite some variation, however, it is clear that grief is most intense in the first weeks after a loss and that it continues for months, with some aspects of grief (not just the relationship) persisting for a year or so in many individuals (Bonanno & Kaltman, 2001). This is useful information in seeking its utility; whatever grief does must require extended, but not indefinite, processing.

Animal data

Grief-like reactions observed in animals can offer useful clues to the functions of grief, especially by correlating the reactions to loss with typical patterns of relationships in the species. Data on reactions to loss in animals are sparse. Simple reactions to loss of kin can be found even in insects. The death an ant, for instance, triggers a fixed action pattern response in other ants who dispose of the body. This response was shaped by selection to cope with loss of related individuals, but it is nothing like grief. Archer reviews evidence on reactions to the loss by death of related individuals in chimps, elephants, and dolphins (Archer, 1999, 2001b). In each case, the exemplar is a mother who stays with or continues to carry an infant who has died. This behavior is easy to explain as an aspect of normal attachment. Giving up too soon would be such a serious error that the system is designed to maintain proximity even long after an infant is dead. The reverse situation, death of the mother, also gives rise to profound reactions of the sort described originally by Bowlby (1980). Jane Goodall reported of the death of Flint, an 8-year-old chimpanzee who died, apparently of grief, after the death of his mother Flo (Goodall, 1986). In broad summary, in many species mothers show distinct reactions

to death of an offspring, but it is difficult to tell if this is a special response or just a continuation of previous attachment behavior.

Cultural Influences on Grief

The profound cultural differences in grief are becoming clearer thanks to better summaries of ethnographic data (Rosenblatt, 1988). There is no doubt that cultures have strictly enforced expectations that shape the expression of grief, just as social norms influence diet, marriage, child care, and other important aspects of social life. In this sense, manifestations of grief are socially constructed. However, it is an elementary mistake to think that evidence for strong social influence on the nature of grief is evidence against the hypothesis that grief was shaped by natural selection. The universality of special social rules about how to behave after a loss testifies to a universal underlying phenomenon despite the wide variation in the nature of the social expectations.

Are cross-cultural differences in grief experience and expression correlated with differences in the nature of relationships in those cultures? It would be very interesting to compare the results of independent surveys of grief and relationship patterns in dozens of cultures to test this idea. The above speculations about the role of grief in commitment versus exchange relationships predict that grief among close friends is much more intense in cultures where friendships are mediated more by commitment than exchange.

Individual Variation in Grief Responses

Individual differences in reactions to loss should offer additional clues about the origins and functions of grief. Emotional closeness is associated with grief intensity. Though it seems likely that the closeness leads to the grief, it is also possible that a tendency to experience pain after interpersonal losses may result in closer relationships or that people who develop closer relationships tend to be people who experience more negative emotion in general. The exact aspects of a relationship that influence the intensity of grief remain uncertain. In addition to emotional closeness, other factors include the amount of time people spend together, the daily disruption the loss causes, the availability of other supports, or personality factors such as dependency that influence relationship patterns and emotional experience more generally.

It is also becoming clear that much suffering after a loss arises not from the loss itself but from the instrumental changes in life (Utz, Carr, Nesse, & Wortman, 2002; Utz et al., 2004). A loss may disrupt a supportive circle of friends, may cut income dramatically, or may require moving or accepting

unwanted help from others. Such sequelae of loss create symptoms, but perspective comes from data showing that most people do well and that there are gains as well as losses after a death. Social support, for instance, goes up, not down, after a loss.

Within-Individual Variation in Grief Responses

There is no good way to study the distinctive effects of different kinds of actual losses experienced by the same individual, but studies that estimate grief intensity offer useful information (Littlefield & Rushton, 1986). Useful information is also available from studies of individual differences in grief as a function of age of the deceased, genetic relatedness, emotional closeness, situation of death, or other characteristics. The most important conclusions, as mentioned already, are that grief is highest if there is a high genetic relatedness and emotional closeness with the lost individual, and if the individual is just entering adulthood.

Assessment

Many aspects of grief appear to be aspects of the generic sadness response that were shaped by natural selection to deal with any loss, but it seems likely that natural selection differentiated generic sadness into a special pattern to deal with the special aspects of loss of kin. Losses of close emotional attachments reliably arouse grief, but the strength of the attachment is not the whole story. Evidence includes the intensity of grief after loss of a relative with whom there is little emotional closeness, and the peak of grief intensity for losses of children at the age when they are just becoming adults. The loss of an unrelated relationship partner gives rise to grief that may be less or different. Attachment bonds are so strongly correlated with degree of genetic relatedness that it is difficult to determine the relative contribution of the degree of relatedness, the loss of emotional support, and the loss of instrumental factors.

This evolutionary perspective on grief as a specialized form of sadness predicts several factors that should influence grief. Grief intensity should be a function of characteristics of the person lost, including the coefficient of relationship (percentage of genes in common), reproductive value, nonreplaceable instrumental value, and strength of an irreplaceable committed relationship. All of these will be influenced by individual, group and cultural variations. Of course, such a summary does not do justice to the profoundly individual nature of the grief experience, nor does it incorporate the psychodynamic defenses so powerful they can turn unconscious hatred and love into

the opposite conscious experience. Also, it says nothing about religious beliefs and other cognitive factors that change the meaning of a loss. Nonetheless, data on differences in grief remain useful in helping us toward a first approximation of a framework for understanding why we experience grief at all.

Does grief exist simply because natural selection cannot shape a mechanism that gives the benefits of attachment without the extraordinary costs of grief? No mechanism of the body is perfect, and trade-offs are ubiquitous, such as those that sustain the mechanism for clearing toxins from the gut despite the costs of diarrhea. While trade-offs account for some aspects of grief, such as a chimpanzee mother carrying an infant for days after its death, no global trade-off can explain the existence of grief. Attachment bonds maintain a cognitive representation of absent others, but exactly how this gives benefits is hard to make explicit. Knowledge about others can be maintained with cognitive mechanisms that do not involve much emotion, and we maintain clear memories of absent others whether or not we are attached to them. The special values of committed relationships could foster special attention to the absence of these individuals and perhaps mechanisms to allow such relationships to pick up in their special way upon reunion. However, this does not seem sufficient to support an argument that grief is maintained by such trade-offs.

Other suboptimal designs result from constraints on what selection can accomplish. For instance, because of a happenstance in phylogeny, the nerves to the retina run on the inside of the eyeball and create a blind spot at their exit. Similarly, the mechanism for relationship bonds could be so rigid and crude that it simply cannot be turned off after a loss. However, this is a bit like suggesting that selection could not create a mechanism to turn off pain after an injury heals or that it could not turn off fever after the threat of infection has passed. I see no reason why the benefits of attachment cannot be dissociated from the many costly aspects of grief. Furthermore, in many cases the loss of a close bond does not lead to intense grief, so it is obviously possible. In animals, where attachments are as significant to fitness as in humans, there are few reports of grief responses that decrease fitness compared to the many common situations in which attachment serves its function well and a loss of an attachment results in only temporary disability.

Implications

This framework and its tentative conclusions have implications for how we think about grief, how we study it, and how we treat it. However, it is once again essential to emphasize the difficulties, emotional as well as scientific, of

attempting to understand the origins of grief. It is upsetting to think about the origins of grief. If it is simply a nasty epiphenomenon of the brain mechanisms that make loving attachments possible, grief has no meaning except as a defect in design that we may well and justifiably try to overcome with pharmacological or genetic engineering. The view that grief exists in part because it benefits our genes is disturbing in a different way. In this view, grief at least has meaning and a significance that helps to explain it, but the meaning offered is very different from the spiritual and personal significance that so many people seek.

Much in this overview coheres with recent developments in grief research, in particular, Stroebe and Schut's dual-process theory (1999). Bereavement requires both dealing with the emotional loss and coping with the changed everyday realities of life. This maps well onto the distinction between aspects of grief that arise from kin selection and committed relationships and those that arise from losses of resources and the benefits of exchange relationships. To greatly oversimplify, sadness is about what we lose that was useful for us, but much of the pain of losing a relative is useful only for our genes.

IMPLICATIONS FOR RESEARCH

An evolutionary framework may help grief researchers to distinguish more explicitly between proximate and evolutionary questions and to use data to test predictions from an evolutionary view. For instance, they should determine how much of the association between strength of grief and strength of bonds is accounted for by degree of relatedness and vice versa. Is the peak of grief for one's children at their age of maximum reproductive value an artifact of the emotional closeness at that age? Nearly every question in grief research can be reexamined in an evolutionary perspective and existing data can be useful in better understanding the origins of grief. Data on absent grief should be particularly useful. In the CLOC study, I had hoped to find a group of people who lacked the "normal experience" of grief so I could determine how their lives were impaired by the absence of this response. The experiencing was chastening.

More than a quarter (28.3%) of bereaved spouses interviewed 6 months after the loss reported experiencing no "painful waves of missing your (husband/wife) in the past month" and 7.9% reported them, "Yes, but rarely." When asked if they had "EVER experienced painful waves of missing," 13.2% reported never experiencing such feelings.

When asked if they had experienced "feelings of intense pain or grief over the loss" in the past month, 36.6% said, "No, never" and 10.2% said, "Yes, but rarely"; the other half of the sample reported sometimes or often experiencing such feelings. When asked if they had "at any time" experienced feelings of intense pain or grief, 17.0% answered, "No, never." When asked if they had experienced "feelings of grief, loneliness or missing your (husband/wife)" in the past month, only 5.7% said, "No, never," with 4.9% saying, "Yes, but rarely."

Overall, 5.7% reported experiencing no feelings of grief, loneliness, or missing at all, 13.2% reported no "painful waves of missing" the deceased, and 17.0% reported no "feelings of intense pain or grief" in the first 6 months after the loss. Of 250 widows, 58 reported no symptoms ever on one of the three questions. But of the six who reported never experiencing "feelings of grief, loneliness or missing" since the loss, three reported "painful waves of missing" within the past month, and one reported some "painful waves of missing" in the past 6 months. Of the 35 subjects who reported never experiencing "painful waves of missing" since the loss, 18 reported "feelings of grief loss or loneliness" in the past month. The good reliability of the data set in almost all respects argues against transcription and coding errors; it is much more likely that some subjects simply gave inconsistent answers.

Subjects who reported little grief were, at baseline, in most respects the same as the larger subject pool. They showed no tendency toward social isolation, no obvious mental disorders, and they had less of a tendency to depression than others. They could not be distinguished by their age, race, sex, or religion. Their relationships with their partners at baseline were comparable to those of other couples. After the loss, they seemed to adapt well, not demonstrating any particular pathology.

Concurrent with my analysis of the CLOC data, I had occasion to talk with a number of people who were in the midst of coping with loss of a loved one, some of whom I saw in my psychiatric practice. Their reports illuminated the empirical data, and lack of results, from the numbers in the database. One woman had been dissatisfied for years with a husband who was uncaring and even abusive. But now, her adaptation to widowhood was associated with fond memories about his few tender moments and how she had provoked his temper outbursts. Another woman was very depressed after the loss of her husband, but her thoughts were rarely about him. Instead, she worried incessantly that she would have to move from the home and neighborhood where she had spent her whole life, and she feared that no one would ever take care of her again. A man who lost his wife felt sad for a

few days after her loss, after which he found himself besieged by attractive women who offered him anything and everything. He took up with one after another in a sequence that seemed not to be a defensive reaction but more of a grand time. Finally, a woman who was depressed and aloof her whole life became more so after her extraverted husband died.

As I tried to put these stories together with the CLOC data, I realized how amazing it is that any patterns emerge from aggregated survey data obtained from random samples of individuals. Their individual hopes and fears are stirred not only by what happens but by their assessments of what events mean for their peculiar personal goals. There is just enough consistency in the goals of defined groups of people—say, white, healthy, middle-income, Presbyterian widows in their 70s, for example—to make some generalizations valid. However, the observed consistencies in their reactions to loss are likely to arise mainly because they are correlated with consistencies in their relationships, personalities, goals, and strategies of social influence.

I began by asking if it would be wise to use an imaginary drug that blocked the pain of grief. With the previous paragraph in mind the answer is, unsurprisingly: "It depends on the person and the situation." However, my interpretation of grief's possible utility to our genes joins with Archer's (1999) thesis to suggest no personal disadvantage to use of such a drug. If grief is important for protecting relatives, however, widespread use of such a drug could well change the very social structure, dissolving family feeling even further. Such a drug might undermine useful aspects of sadness that occur after the death of a loved one. There is a good analogy to pain. Even though the capacity for pain is normal and useful, it can be blocked safely or reduced an overwhelming proportion of the time. This is because the systems that regulate pain were shaped to ensure that pain was sufficient every time it was needed even if they quite often were excessive at other times.

The most valuable contribution of an evolutionary foundation for a framework of understanding grief may be its heuristic value in suggesting new questions and the kinds of data that can answer them. Some examples include:

1. Do types or intensities of grief symptoms differ depending on coefficient of relatedness with the deceased, after controlling for emotional closeness?
2. Do kinds or intensities of grief symptoms differ depending on the reproductive value of the deceased, controlling for relatedness and emotional closeness?
3. Do kinds or intensities of grief symptoms differ depending on the instrumental losses controlling for relatedness and emotional closeness?

4. Is the intensity and duration of grief arising from death of a friend greater for relationships based on commitment rather than exchange?
5. Is grief more intense, prolonged and public in groups and cultures where relationships are based more on commitment than exchange?
6. How do outcomes differ in bereaved people treated and not treated with antidepressant medications?

Therapy

Therapeutic recommendations should be based on controlled studies, not theory. In the real world, however, analysts try to help their patients get in touch with anger turned inwards, cognitive therapists try to channel thoughts in different directions, and biological psychiatrists prescribe drugs. Although an evolutionary framework for grief does not suggest a specific kind of therapy, it reminds all therapists that grief is normal and natural and some aspects are probably useful, albeit perhaps not for the grieving individual. Furthermore, the wide range of intensities and content of grief experiences does not necessarily represent a small middle with much pathology at each extreme. The system itself may vary considerably among individuals just as people's tendency to get a fever varies. In addition, some of the variation may arise from facultative mechanisms shaped to detect and respond differently to different circumstances. At this point, we are far from being able to dissect such mechanisms. Even worse, behavioral regulation systems often do not have the crisply outlined inputs, processors, and outputs that would satisfy our wishes for a simple comprehensive explanation. We may have to discipline ourselves to accept the fuzzy margins and multiple connections of an evolved system. Nonetheless, much work remains to flesh out these systems in order to understand the origins of grief.

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CHAPTER 9

Widowhood, Grief, and the Quest for Meaning

A Narrative Perspective on Resilience

Robert A. Neimeyer

> My husband Jack has been deceased for 6 months, and I'm still trying to process the whole thing. . . . I went to a cancer support group for two years when he was in treatment, and I think that really prepared me for his *death*, if you can be prepared at all for such a thing. But it didn't prepare me for life from that day on. I'm at loose ends. . . . More than anything, I keep thinking, I have to get a *new life*. That's the thing—there's kind of like a big hole missing in your life. I have a couple of friends who are widows, and they seem to have just gone along, doing the same things they always did, but without their husbands. But for me I keep thinking, I have to have something new, something to *feel* about, maybe a new life. And I think his death too made me more aware of my own mortality, and the number of years I have left. . . . I'm not sure yet what direction I want to go, but at least I can adopt his positive attitude. —*Mary, age 56*

> Work is a life-line right now—a place where I recognize myself. In so many other aspects of my life I don't seem to know who I am without Vance—and that is a great and painful surprise since we lived so fully as independent people. I am learning that our independence depended so much on the absolute and dependable loyalty of the other. —*Judith, age 65*[1]

[1]Judith Koltai Peavy, the author of this and later quotations in the chapter, prefers to acknowledge her authorship of these words. I personally appreciate her contributing her reflections, as I do Mary's similar generosity in giving us an inside glimpse of some of what the loss of a beloved spouse means to those who have suffered it. This chapter is dedicated to Vance, Jack, and the memory of others who continue to teach us something of value beyond their deaths through the lives of their partners.

In their accounts of their bereavement experience, Mary and Judith touch on many of the subtler themes of widowhood, beyond the sometimes searing pain of sundered attachment to a partner they loved. These themes—too easily missed in the preoccupation with bereavement-related stress and symptomatology—turn on such issues as the need to process a disequilibrating life-transition, to grieve not only the death of the loved one but also the changed life of the survivor, and to reestablish a new life worthy of passionate reinvestment. In particular, both women draw attention to the way in which profound loss can disrupt the continuity of the fabric of a life thoroughly and perhaps surprisingly interwoven with the strands of another, even when those lives were apparently self-sufficient. Each account also speaks to the quest to reinforce a sense of identity that has been undercut or eroded by the loss. As the accounts further imply, this is as much a social process as it is a personal one, one that seeks validation for a recognizable self in the ongoing world of work and relationships as well as in identification with the positive characteristics and purposes of the deceased husband. And yet, there is also acknowledgment of alternative pathways through the terrain of bereavement, including some that are straightforward and continuous with life before loss. In sum, the testimony of Mary and Judith resonates with a conception of grief as entailing an attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss (Neimeyer, 2002a, 2001b).

My intention in this chapter is to underscore and extend this account of widowhood as a quest for meaning and continuity by drawing selectively from the burgeoning interdisciplinary field of narrative studies, with particular attention to how this perspective is coming to inform and transform conceptions of bereavement. Thus, although my emphasis will be on the experience of bereavement in later life, I am ultimately interested in contributing to an integrative perspective on loss that encompasses the death of a partner at other points in the life cycle, and indeed losses of other kinds (Neimeyer, 2001a). Moreover, in keeping with the provocative findings originating in the Changing Lives of Older Couples (CLOC) study (Bonanno et al., 2002; Bonanno, Wortman, & Nesse, 2004), I will review some constructivist concepts and findings that might have relevance to a deeper understanding of the various trajectories through bereavement, suggesting fruitful avenues for additional research and promising methods for pursuing such questions when possible.

THE NARRATIVE DIMENSION OF HUMAN LIFE

As human beings, we live our lives in stories. At one level, we are steeped daily in the stories of our time and place in the form of films, plays and televi-

sion dramas, comedies and news reports, not to mention stories encountered in their most literal versions in newspapers, magazines, short stories, and novels. Likewise, and perhaps more vitally, we are caught up in an endless web of telling and hearing, as we relate stories of the events of our days or of our lives to associates, friends, family members, and sometimes therapists, and serve in turn as responsive audience to the storytelling of others. Less tangibly, but no less important, the plots and themes of our lives are shaped and constrained by mythic stories of our historical moment and geographical situation, whether these take the form of scriptural parables exemplifying moral virtues or canonical tales of heroism that concretely crystallize a nation's ideals. Thus, at every level from the spoken or whispered stories of our private lives to the grand "culture tales" that provide broad parameters for valued social identities, human consciousness seems to be embodied in narrative form (Howard, 1991; Neimeyer & Levitt, 2001).

How and why this should be so is becoming clearer as a result of basic research on the narrative nature of the mind. Cognitive scientists, for example, have documented the inveterate human tendency to structure events in terms of "story schemas" or "extendures" that assimilate even apparently unrelated events into canonical plot structures, conferring on experience a sense of meaningful progression from the past, through the present, to the future (Barsalou, 1988; Mandler, 1984). Likewise, developmental psychologists have chronicled the gradual emergence of narrative capacities in children, from the rudimentary attempts of 2-year-olds to construct a meaningful "landscape of action" in their stories to the insights of older children as they grasp the "landscape of consciousness" reflected in the thoughts, feelings, and motivations of different characters (Bruner, 1990; Nelson, 2003). For their own part, social psychologists have emphasized the interpersonal dynamics of narrative, from the way in which we recruit witnesses to our personal accounts of suffering (Harvey, 2000) to the means by which we subtly position ourselves as characters of moral worth in the stories we tell to others (Wortham, 2001). And finally, neuropsychologists and brain scientists are beginning to map the widely distributed neural structures that subserve autobiographical memory and narrative reasoning, processes that are surprisingly difficult to disrupt even in the presence of significant brain lesions and disorders (Demasio, 1994; Rubin & Greenberg, 2003). The result is a burgeoning interdisciplinary interest in narrative, as scholars seek out the relations between phenomenological, psychological, neurobiological, and even literary analyses of narrative and consciousness without privileging or diminishing the value of any of these approaches (Flanagan, 1992).

NARRATING THE SELF: FROM COGNITIVE SCIENCE TO CLINICAL SIGNIFICANCE

Given the groundswell of interest in narrative processes, it is not surprising that the significance of stories has been increasingly recognized by clinical theorists and therapists, especially by those animated by a broadly "postmodern" emphasis on the role of language in shaping the realities to which we respond (Neimeyer & Bridges, 2003; Neimeyer & Stewart, 2000). This is nowhere clearer than in the field of constructivist psychotherapies (Neimeyer & Mahoney, 1995; Neimeyer & Raskin, 2000), which have from their very outset been oriented to the personal and social means by which we phrase and punctuate life experiences in order to create an interpretable and predictable world (Kelly, 1955/1991). In narrative theory, constructivists have encountered and extended a trove of useful concepts for understanding the construction of a semi-stable, semi-permeable self in the crucible of intimate relationships (Guidano, 1991) and in response to the sometimes constraining discourses of the cultural domain, which often define personal identities in a restrictive fashion (White & Epston, 1990).

Central to this strain of constructivist theory is the recognition that identity is itself a narrative achievement, an ongoing attempt to construct a life story that is recognizable across time as one's own, despite the emotional and circumstantial vicissitudes of living. The result of this ongoing dialectic between concrete experience and its abstract explanation and elaboration is a unique *self-narrative,* defined as "an overarching cognitive-affective-behavioral structure that organizes the 'micro-narratives' of everyday life into a 'macro-narrative' that consolidates our self-understanding, establishes our characteristic range of emotions and goals, and guides our performance on the stage of the social world" (Neimeyer, 2004b, p. 53–54). Viewed in this light, one's sense of self emerges from an ongoing effort to integrate discrepant life experiences in a way that preserves the continuity of one's autobiographical memory, and continues to project one toward a recognizable future. As Kelly (1955/1991) noted, the goal of such integration is not so much the preservation of an unchanging identity as it is "novelty moderation" (Mancuso, 1977), a gradual modification of existing structures in the face of optimally, but not overwhelmingly discrepant life experiences. This formulation is compatible with the neo-Eriksonian model of adult identity development formulated by Whitbourne and Connelly (1999), which focuses on the individual's effort to maintain a sense of self-consistency through selective assimilation of life events into cognitive and affective structures, and necessary changes in the person's identity in order to accommodate the self-image to identity-discrepant events. In keeping with this model, Sneed and Whitbourne (2001) studied the ex-

tent to which 242 middle-age and older adults dealt with age-related developmental challenges through an assimilative strategy (e.g., minimizing their importance and carrying on as before), an accommodative strategy (e.g., being overwhelmed and struggling to change their sense of who they were), or a balanced style (e.g., using the change as a stimulus for psychological growth). Significantly, results indicated that people who adopted a predominantly assimilative style or one that balanced assimilation and accommodation enjoyed higher levels of self-esteem. Conversely, those who worked to accommodate their identities to life events experienced greater threat to their self-esteem, even though such accommodation might ultimately be a harbinger of personal development.

GRIEF AND BEREAVEMENT IN NARRATIVE PERSPECTIVE

What does the forgoing discussion of narrative psychology have to do with the experience of widowhood? In a word, everything. Recent decades have witnessed a revolution in bereavement theory, calling into question time-honored formulations of grief predicated on presumably universal symptoms (Lindemann, 1944) or stages (Kubler-Ross, 1969) and offering in their place a range of models that emphasize the variations of grieving as a function of the unique attachment histories (Bowlby, 1980), coping styles (Stroebe & Schut, 1999), gender (Martin & Doka, 2000), and ethnic heritage (Irish, Lundquist, & Nelsen, 1993) of bereaved persons. Equally important, a resurgence of empirical research on the causes, correlates, and consequences of grief has contributed to an increasingly refined view of how bereaved persons actually negotiate the landscape of loss, as data undermine older models that emphasize universal patterns of response to bereavement (Center for the Advancement of Health, 2004; Stroebe, Stroebe, Hansson, & Schut, 2001). A central theme to emerge from much of this work concerns the role of meaning reconstruction in response to loss (Neimeyer, 2001a; Neimeyer & Anderson, 2002), a perspective on bereavement to which narrative theory makes integral contribution.

In narrative terms, significant losses—whether associated with the death of a loved one; traumatic exposure or injury to the self; or loss of home, cherished possessions, or statuses—challenge the self-narratives of survivors, both in terms of their personal sense of autobiographical continuity and the social construction of their post-loss identity. Such disruptions, however, can take multiple forms (Neimeyer, 2000a, 2004c), as a threatened *disorganization* of the previously scripted life story can be compounded by narrative *dissociation* or *dominance*, as summarized and illustrated below.

Disorganized narratives arise when life events perturb the basic structure of the bereaved individual's life story, at the level of its *plot* (the *what* of the story, or the events to be integrated), *characterization* (the *who* of the story, focusing on the intentions and motives of significant actors), *setting* (the *where* of the story, its circumstances or context), *theme* (the *why* of the story, its implicit principles and premises) and *fictional goals* (the *wherefore* of the story, its basic "telos" or projected conclusion). For example, Mary, whose description of the impact of the death of her husband, Jack, opened this chapter, initially struggled to accommodate the changed plot of her life upon diagnosis of Jack's cancer, as well as to revise her short and long-term life goals in light of his ultimate death. Although significant, the disorganization of Mary's self-narrative was both relatively circumscribed and temporary, ultimately yielding to a new stability and reorganized social identity as a widow who sustained connections to her family and to her husband's memory, while finding new validation for her sense of self in an expanded circle of friends.

This favorable accommodation to widowhood contrasts with that of Denise, who returned home from work one day to a silent house. She discovered the lifeless corpse of her young husband, Mark, suspended by his neck from a pipe in the basement ceiling, his face purple and contorted, his pants around his ankles, his hands cuffed, and the stool on which he was standing kicked over among the myriad pornographic magazines laying open on the floor beneath his dangling feet. Not surprisingly, the horrific discovery of Mark's apparently accidental death during an act of autoerotic asphyxiation ruptured Denise's assumptive world (Janoff-Bulman, 1989), calling into question fundamental themes of trust, benevolence, and predictability on which her self-narrative was grounded, as well as many of the specific themes pertaining to her 4-year marriage to a man she thought she knew. Thus, in addition to the struggle to assimilate such a horrifying loss into the plot structure of her life, Denise was forced to reconstrue the story of her marriage at the level of the characterization of her husband's motives and needs, as well as to reorganize the larger goal structure of her life in light of her traumatic bereavement. Even the setting of her life narrative took on new and frightening significance, as every step that took her past the door leading to the basement of her home triggered reactivation of the trauma imagery. Narrative disorganization can therefore range from relatively limited and transient for some widowed persons to sweeping and chronic for others, who struggle with a sense of self and phenomenal world that remains continually fragmented, anguishing, and incoherent (Neimeyer, 2004c).

Dissociated narratives can compound the challenge of post-loss meaning reconstruction by introducing "silent stories" in the form of autobiographi-

cal accounts that are denied acknowledgment in the presence of others, or perhaps even to the self. As such, the loss is potentially dissociated in two senses, disrupting the bonds of sociality that secure affirmation of our life stories with an audience of relevant others and in extreme cases threatening full integration of the micro-narrative of the event into the macro-narrative of the person's own conscious history. Both processes were evident in Denise's case as she carefully edited the account of Mark's death given to others to portray it as a "simple" suicide, at times even questioning her own interpretation of the surreal event as something still more perverse. Dissociated narratives in both the interpersonal and intrapersonal senses can arise in connection with many stigmatizing losses, ranging from the death of a loved one from drug overdose to non-death-related losses associated with a history of sexual abuse or marital deceit (Neimeyer, 2004b, 2004c).

Finally, *dominant narratives* represent oppressive ascriptions of identity, constricted definitions of the survivor's sense of self, world, and future that foreclose the quest for a more meaningful engagement in life. Though often implicitly enforced by local communities, these more preemptive scripts for organizing who one is and might be typically draw on powerful cultural discourses that circumscribe the identity options of those whose lives they "colonize" (Foucault, 1970; White & Epston, 1990). For example, following a tragic murder/suicide in which his wife killed their daughter before turning her gun on herself, Barry found himself uniformly condemned by his family and community for having instigated his spouse's violent meltdown through a marriage that was widely regarded as dysfunctional, disloyal, and perhaps even abusive. The resulting pariah status into which he was cast immensely complicated his post-loss adjustment as he struggled painfully with the isolation, guilt, and rage into which his catastrophic loss had thrown him (Neimeyer, 2000a). But losses need not be dramatic in order to foster dominant narratives of one's post-loss identity; indeed, they can even be culturally normative. To choose but a single example, the traditional Chinese characters for widow, pronounced *mei mon yan* in Cantonese or *wei wan ran* in Putonghua (Mandarin), translate literally as "not yet" "die" "person," or "she who is not yet dead." Interestingly, the sense of foreclosure of social identity implied by this conception of widowhood contrasts with the identity ascribed to the subsequent wife of a widower, *tin fong* in Cantonese, *tien fang* in Putonghua, which translates as "fill" "room," referring to his need to find a woman to fill the room, or to replace the previous one. Not surprisingly, these linguistic distinctions are reflected in broader social practices and expectations, such that widowhood tends to become a permanent (and marginalized) status for bereaved women, whereas bereaved men typically remarry quickly and

without corresponding social marginalization (Chan & Mak, 2000). As in all cultures, these statuses continue to evolve in response to cross-fertilization with societies offering different identity options to the bereaved, and as a result of the efforts of Chinese women themselves to claim enlarged post-bereavement self-narratives.

Although in their extreme forms all three types of narrative disruption can be destructive in their consequences, it is worth noting that in more limited degree they can play a valuable role in positive adaptation to bereavement. For example, moderately disorganizing discrepancies between the pre-loss and post-loss worlds (Parkes, 1996) may drive the "restoration orientation" (e.g., experimenting with new roles, developing new skills) that serves as a critical counterpoint to the "loss orientation" (e.g., grief work, confiding) in the Dual Process Model of coping with bereavement (Stroebe & Schut, 1999), ultimately leading to the personal growth reported by many bereaved persons (Hogan, Greenfield, & Schmidt, 2001; Neimeyer, Prigerson, & Davies, 2002). Likewise, selective silence regarding features of their loss experiences can be adaptive for some grievers who anticipate social censure, and indeed research indicates that the bereaved are adroit at identifying and perhaps avoiding unhelpful communications from would-be support figures (Marwit & Carusa, 1998). Even dominant narratives, in their less extreme form, can serve a function, as when traditional funeral rituals confer a new, communally sanctioned "reinscription of identity" upon widows and widowers (Romanoff & Terenzio, 1998) who are expected to comply with norms of propriety (e.g., refraining from new romantic involvements) for an explicit or implicit period of time. Such socially constructed roles provide a provisional self-narrative that essentially functions as a bridge between one identity status and another.

The forgoing description of the dynamics of narrative disruption hint at the considerable variability in adaptation to bereavement because widowed persons differ in their efforts to assimilate successfully the sequelae of separation into their existing self-narratives, or accommodate these same life scripts to be adequate to what they have suffered and what they must now struggle to change. It is to the different bereavement trajectories implied by this diversity that I now turn.

PATHWAYS THROUGH BEREAVEMENT

One of the great values of the CLOC study is the longitudinal lens it focuses on quite distinct pathways through bereavement. Drawing on analyses of these data that identify five major trajectories from pre-loss to 18 months

post-loss (Bonanno et al., 2002; Bonanno et al., 2004), I will suggest a narrative elaboration of each, citing illustrative findings on their distinctive meaning-making processes where relevant.

Resilient Coping

One of the striking findings of the CLOC study is that over 45% of the sample of older widowed persons displayed little depression prior to the death of their spouse, and continued to report remarkably little symptomatology 6 and 18 months after the death. Because pre-bereavement data provided no evidence that these individuals were maladjusted or emotionally disengaged from their spouses (Bonanno et al., 2002), and post-bereavement scores indicated they were low in avoidance and regret (Bonanno et al., 2004), the researchers were justified in their interpretation that this low-symptom profile represented an adaptive pattern of coping with loss, rather than a dysfunctional form of detachment, denial, or delay in the grieving process.

How might these resilient widowed persons be understood in narrative terms? Perhaps the most plausible interpretation is that they were able successfully to assimilate the loss experience into their existing life narratives in such a way that it triggered only moderate and transient perturbation in their meaning systems (Viney, 1991). This explanation is compatible with the data of the CLOC study itself, which reported that most depressive symptoms in this subsample had abated by 6 months and that resilient spouses felt relatively little need to search for meaning in the death; presumably, if one's prior life narrative provided an adequate philosophic or practical resource in dealing with the loss, few anguishing existential issues would be triggered for such grievers. Moreover, resilient survivors reported the greatest comfort from positive memories of their partners, suggesting that they spontaneously preserved a strand of continuity in their sense of connection to their spouse. In short, such individuals seemed able to integrate the experience of their spouse's death into their existing self-narrative in a way that did not profoundly challenge the plot structure, thematic underpinnings, or other key features of their previously viable life story.

Data on other bereaved samples beyond the CLOC study add credence and detail to this interpretation. Davis and his colleagues, for example, have summarized the results of their programmatic research on the loss of loved ones through sudden infant death syndrome (SIDS) as well as motor vehicle accident (MVA), relating the process of searching for and finding meaning to bereavement symptomatology at 6 and 18 months post-loss (Davis, Wortman, Lehman, & Silver, 2000). If a search for meaning were triggered by a

violation of one's assumptive world, then one might expect the percentage of bereaved persons undertaking this urgent pursuit of sense-making to be highest among those groups whose losses were least expected, such as those that were violent or "off-time" in the family life cycle (Walsh & McGoldrick, 1991). Comparing the results of these studies with those of the CLOC research, this is precisely what was found: whereas over 70% of the older widowed sample from the CLOC study reported no search for meaning by 6 months into their bereavement, only 30% of those spouses widowed in an MVA were exempted from such a search. Moreover, the death of a child was even *less* likely to be taken in stride without an emotionally excruciating effort after meaning: only 21% of parents losing a child in an MVA, and merely 14% whose infant died of SIDS, failed to seek answers to earnest questions of why such tragedy had befallen them. Moreover, in the case of the Davis et al. (2000) studies, those who sought meaning and found it, even if only provisionally, reported less distress across a wide range of symptom areas than those who searched for significance in vain.

Notably, however, the minority of bereaved persons who never undertook such a search performed as well as, and in some cases better than, the "finders" across outcome measures. Such results accord well with the argument that (a) bereavement can powerfully challenge the narrative coherence of survivor's lives, triggering a quest for meaning; (b) a subset of bereaved persons are resilient in the face of this disruption, assimilating the loss with only moderate and transitory distress; and (c) the percentage of the bereaved manifesting this resilience dwindles when the losses are tragic, sudden, or off-time. Further support for the assimilation hypothesis comes from qualitative studies of bereaved parents, some of whom display remarkable resilience even in the face of objectively devastating loss. For example, Braun and Berg (1994) conducted a careful grounded theory analysis of detailed interviews with parents whose children had died from a variety of causes, documenting their characteristic phases of meaning reconstruction, which they described as involving discontinuity, disorientation, and eventual adjustment. The crucial determinant of bereavement outcomes was found to be the "prior meaning structure" of these parents, defined as "the parent's descriptions of the collection of beliefs, assumptions, values, and norms that characterized their reality or their knowledge of life before their child's death" (Braum and Berg, p. 114). Those meaning structures that failed to account for a child's death (e.g., those that assigned to the child the central role in the parent's purpose in life or that viewed life as basically good) underwent the greatest discontinuity and produced the greatest disorientation for bereaved parents, whereas those who permitted the death to be assimilated in some fashion—perhaps in terms of a

deeply held set of religious convictions—were less likely to be overwhelmed by loss. Parallel findings have been reported by other qualitative researchers, who have demonstrated that even secular meaning systems that acknowledge the role of injustice in the world but that take affirmative action to mitigate it can be a resource supporting resilience in the face of loss (Milo, 1997).

Other evidence suggests, however, that the roots of resilience are anchored as much in the social system as in the solitary self. Death and funeral rituals, for example, can give impetus to the social reconstruction of meaning by providing symbolic and communal validation of the changed reality of the bereaved, helping recast their "internal working models" of both self and the deceased (Romanoff & Terenzio, 1998). Likewise, analyses of specific ritual elements such as eulogies suggest that they can promote coping by changing how reality is perceived (Lazarus, 1993) through re-narrating vivid characteristics of and experiences with the deceased, and in this way fostering continuity with that person's memory (Kunkel & Dennis, 2003). Ethnographic research demonstrates that communal rituals are by no means only the province of established institutions such as the church, state, or funeral industry, however. Bereaved parents' groups are especially adept at fashioning ceremonies (e.g., candle lightings, butterfly releases) and narrative practices (e.g., story circles, newsletter memorials) that systematically assist parents in transforming the narratives of lives shared with their children, ultimately maintaining a continuing bond at a more representational rather than tangible level (Klass, 1999).

Finally, it bears emphasis that the preponderance of the social reconstruction of loss occurs in informal, spontaneous exchanges in local networks, and perhaps especially in the family. The formative power of the family system is reflected in the finding that family communication and cohesion early in a shared bereavement is far more predictive of subsequent grief than early grief is of later family functioning (Traylor, Hayslip, Kaminski, & York, 2003). Moreover, qualitative analyses have documented the intensely interactive co-construction of meaning within couples (Hagemeister & Rosenblatt, 1997) and larger family units (Nadeau, 1997) as members support and contest one another's narratives of the death, typically forging a partially shared and partially individual story of the loss and its impact on their collective identity.

Common Grief

One implication of the above research is that although many of the bereaved are resilient, especially in the face of normative loss, others struggle mightily, and sometimes successfully, to accommodate their self-narratives to the harsh

reality of a loved one's death. Indeed, this pattern of struggle followed by successful adaptation defines the "common grief" trajectory in the CLOC study, where it was found to characterize the pathways followed by approximately 11% of older widows and widowers.

If the pattern of self-narrative development among resilient grievers is typically *evolutionary,* displaying gradual and measured modification to assimilate the realities of loss, then that of common grievers is more often *revolutionary,* requiring substantial overhaul in their worlds of meaning following a profound rupture in their sense of coherence. Of course, in the personal as well as political sphere, revolutions can lead to either a *progressive* or *regressive* restructuring of prior systems. This was illustrated in the finding that although 12% and 15%, respectively, of a large sample of bereaved persons reported becoming more open to others and stronger or more mature in the wake of their loss, 6% and 12%, respectively, reported the contrasting trends of finding it harder to be close to others or becoming more sad and fearful (Neimeyer, 2001b). Paradoxically, the frequency of both outcomes, positive and negative, is likely to be higher as the losses become more traumatic, posing greater disorganization to the existing self-narrative and requiring more substantial reorganization.

Although profound loss commonly poses the task of "relearning the self" and "relearning the world" (Attig, 1996), and research suggests that personal growth in the wake of bereavement is relatively common (Frantz, Farrell, & Trolley, 2001; Neimeyer et al., 2002), the extent and character of such reconstruction invites closer scrutiny. For example, a long series of studies by Tedeschi, Calhoun, and their associates suggests that a struggle with life crises, including the death of a spouse, frequently leads to a keener appreciation of life, more meaningful relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual perspective (Tedeschi & Calhoun, 2004). However common such reports might be, it is important to bear in mind that positive reconstruction of life stories, where it occurs, is often counterbalanced by negative developments as well, forming a subtle, sometimes ironic blend. This is well illustrated by the reflections of Judith, whose comments on her husband's death introduced this chapter. She further writes:

> People speak to me now of their own suffering, of which they have never spoken before—I am astounded at the vastness of the hidden world of grief that exists all around me and of which I never knew before. And I understand my own reasons for often wanting to isolate and hide. . . . I have said so many "thank-yous" to so many people these last 6 months. I

> realize the meaning of that. On the one hand it confirms the great amount of help and support offered to me, on the other it reveals the great void that has opened and which no amount of help or kindness can even touch, at least for the time being.

Paraphrasing Judith, there are both interpersonal gains and losses entailed in her reconstruction, surprising intimacy as well as retreat, gratitude for the extension of concern and the simultaneous recognition of its insufficiency. The result for Judith, as for many widowed persons, is a self-narrative that is more complex, more sophisticated, but not necessarily more unambivalently positive than that which preceded the loss.

In addition to considerations about the extent of posttraumatic growth within cohorts of bereaved persons or within individuals, more attention needs to be given to the explanation of apparent positive change when it occurs. Janoff-Bulman (2004), for instance, questions whether personal growth among survivors can be entirely explained in terms of rebuilding assumptive worlds and engaging in existential reevaluation. In her view, other factors that are less accessible to self-report, such as developing enhanced psychological preparedness for future adversity, could be equally important, though harder to assess. Unfortunately, testing competing explanations for reported gains from losses has received less attention than straightforward documentation of the reports. More skeptically, Wortman (2004) raises the question of whether reports of gain might not often be positive illusions arising from the cognitive dissonance of survivors of great adversity. Ultimately, as she points out, longitudinal studies like the CLOC project are in an excellent position to reveal whether measurable gain from pre-loss functioning has occurred, or whether it represents a form of wishful thinking on the part of the bereaved. Although the documentation of pre-loss/post-loss gains would indeed be valuable, from a constructivist standpoint anything defined as real is real in its consequences, such that attributions of meaning or enhanced self-efficacy, even if invalid in an objective sense, may be consequential for those who make them and deserve study in their own right to determine their possible contribution to bereavement adaptation.

Chronic Grief

Whereas the resilient and common grievers identified in the CLOC study by definition adapted positively to loss in the short or longer term, this favorable outcome was not observed for the 16% of participants labeled "chronic grievers," who failed to return to pre-loss levels of positive adjustment at any point in the 18-month follow-up period. The extent of their struggle to

assimilate the loss of their partner was reflected in their high likelihood of engaging in an ongoing intensive search for meaning, even a year and a half after the death, as well as in their elevated levels of yearning, ruminating, and regret regarding the relationship, and their self-reported difficulties coping with bereavement (Bonanno et al., 2002). These findings accord closely with estimates of the incidence of chronic grief across several studies, in which between 15% and 20% of bereaved persons manifest serious long-term difficulties adjusting to life without their loved one (Prigerson & Jacobs, 2001).

In recent years research on complicated grief has undergone considerable refinement, largely as a function of improved and empirically informed criteria for its diagnosis. Current consensus criteria identify grief as complicated when it is debilitating (associated with serious impairments in functioning in work and family roles), chronic (with marked symptomatology persisting for 6 months or more), and characterized by intensive symptoms of separation distress (e.g., intrusive thoughts and yearning for the deceased), as well as a cluster of pronounced cognitive and emotional symptoms (Prigerson & Jacobs, 2001). Significantly for the present argument, many of these symptoms refer specifically to the direct or indirect effects of the decimation of the bereaved person's self-narrative: difficulty assimilating the reality of the death, detachment, the sense that life is without meaning, purposelessness, feeling that a part of the self has died, and a shattered world view (Neimeyer et al., 2002). Research by independent investigators has confirmed the long-term deleterious physical and mental health outcomes associated with this condition (Ott, 2003; Prigerson et al., 1997) and linked ongoing grief acuity to a disrupted sense of coherence and inability to find meaning in bereavement (Uren & Wastell, 2002).

Although attempts to identify precursors to complicated grief are in their infancy, converging lines of evidence suggest that problematic attachment styles are implicated in difficulties in reaffirming or reconstructing a livable self-narrative following significant loss. The CLOC data themselves confirm that chronic grievers were more likely to display high degrees of dependency prior to the loss (Bonanno et al., 2004), in keeping with the contention that people with a history of insecure attachment are especially prone to experience the death of an identity-stabilizing other as deeply threatening to their fulfillment and basic self-narrative (Neimeyer et al., 2002; Stroebe, 2002). Further evidence supporting this reasoning derives from research linking a history of childhood loss of an attachment relationship with vulnerability to complicated grief in adulthood, whereas a history of adversity in adult life was linked to vulnerability to posttraumatic stress disorder (Silverman,

Johnson, & Prigerson, 2001). As attachment relationships provide the critical crucible in which models of self and other are forged (Guidano, 1991), it is hardly surprising that fractures in the historical foundation of a person's self-narrative leave the individual more vulnerable to complicated bereavement in the wake of subsequent loss. Nonetheless, it is probable that social as well as individual factors are at play in many circumstances of bereavement complications, as when "empathic failure" on the part of families and larger communities deprives the grieving of the validation of their experience that reconstruction of meaning may require (Neimeyer & Jordan, 2001). The result can be a dissociated narrative of the loss or one of its more problematic aspects, which can impede subsequent attempts to assimilate the experience.

Chronic Depression

A unique advantage of the longitudinal perspective afforded by the CLOC data is the ability to distinguish chronic grief and chronic depression trajectories, with the latter showing elevated levels of depressive symptoms even before the loss—often in the context of historical problems in coping and in the marriage (Bonanno et al., 2002). Further analysis of these data also disclosed distinctive features of the 8% of the sample that showed chronically depressive courses, including greater difficulties during bereavement, poorer coping in general, and less comfort from positive memories of the spouse (Bonanno et al., 2004). In contrast, other research suggests that chronic *grievers* find solace in cultivating a continuing bond with their loved one's memory, even if they do so more frequently than their more resilient counterparts (Field & Friedrichs, 2004). The failure of chronic depressives to find comforting connection, as well as their failure to pursue a clearly identifiable search for meaning in bereavement, both suggest that chronic depression and chronic grief are distinguishable conditions, a conclusion that is reinforced by their differential responsiveness to pharmacological treatment (Reynolds et al., 1999).

In narrative terms, chronic depression in the widowed might therefore be viewed less as a response to disorganization of the individual's identity as a function of bereavement than as a stable but suboptimal meaning system characterized by cognitive constriction, impaired problem solving, and other relatively well-studied processes (Beck, 1993; Neimeyer & Feixas, 1992) that antedate widowhood. This implies that rather different interventions might be necessary for depression exacerbated by loss, as opposed to chronic grief per se, a topic to which I return below.

Depressed Improved

Finally, CLOC investigators identified 10% of their widowed sample who reported high levels of depression when the spouse was living, but whose depression remitted and who seemed to be functioning well on essentially every index 6 and 18 months after the loss (Bonanno et al., 2004). In constructivist terms this group might be understood as having been released by bereavement from a dominant narrative of caregiver, or alternatively, partner in an oppressive marriage, which had sharply constrained their identity. Rather than representing a disruption in a previously satisfying sense of self, the death of the spouse, for them, seemed to have opened the door to a long-awaited elaboration of new possibilities. Still, it is worth cautioning that, at least for those caretakers who loved the chronically ill family members for whom they cared, release from an exhausting but nonetheless intensely meaningful role can itself occasion a poignant sense of loss, as qualitative research on bereaved mothers of disabled children suggests (Milo, 1997).

RESEARCH AND CLINICAL IMPLICATIONS

If a constructivist, narrative formulation of widowhood is to make more than an integrative heuristic contribution to the field of bereavement, its implications for research and clinical work require concrete explication. My goal in the present section is to hint at its fertility, directing readers to sources that offer more detailed treatments of both areas.

At the level of research, interest in narrative theory has burgeoned in fields as diverse as psychotherapy, neuropsychology, cognitive science, developmental psychology, personality and social psychology, literature, communication, and sociology (Fireman, McVay, & Flanagan, 2003). This suggests the availability of a vast array of relevant tools to analyze the structure and function of meaning systems and their transformation in the wake of loss. Because bereavement is an experience that both reaches down deeply into our individuality and branches out widely into our social world, it calls for interdisciplinary study using complementary concepts and methods (Neimeyer et al., 2002). From this perspective, the broader contexts that shape and constrain human meaning making in the face of death deserve closer attention. This might range from studies of the developmental pathways by which children construct models of death as a state that is universal, nonfunctional, and irreversible (Speece & Brent, 1992) to discourse analysis of the way in which cultures construct death and widowhood (Seale, 1998; Walter, 1999).

Even within the relatively narrow ambit of the social and clinical psychology of bereavement, the degree of constriction and simplification of typi-

cal methods and research strategies is remarkable. For example, most studies of meaning reconstruction in bereavement rely upon a few face-valid ratings of items concerning whether the bereaved person ever sought or found meaning in the loss, which are then used to distinguish different groups, trajectories, or outcomes. Although helpful in providing a rough sketch of the terrain to be mapped, the astonishing limitations of these methods become clear when one contemplates the probable yield of cognitive psychology if it were reduced to simply asking people whether they had ever thought about a topic or had come to any conclusions! Although obvious ethical and practical considerations set limits on the use of experimental methods in the field of bereavement research (except perhaps in the more adequate implementation of clinical trials of grief therapy interventions [Neimeyer, 2000b]), more refined assessment of relevant narrative structures and meaning making processes is surely both desirable and feasible.

What form might such assessment take? First, as with the field of grief research in general, studies of meaning reconstruction would benefit from a greater appreciation of both quantitative and qualitative research strategies, either of which can be used well or poorly (Neimeyer & Hogan, 2001). Thus, on the one hand, there is a need for the development of more psychometrically defensible measures of key constructs that focus on meaning making in the face of loss, supplementing current scales that bear at least indirectly on this domain (Antonovsky, 1993; Tedeschi & Calhoun, 1996). But these measures need not be restricted to conventional questionnaires, per se, as such methods as repertory grids (Neimeyer, Keesee, & Fortner, 2000; Sewell, 1996) and the self-confrontation method (Hermans, 1995) have been adapted to provide sophisticated structural representations of meaning systems into which individuals assimilate loss. More consistent use of such techniques to operationalize key features of self-narratives prior to and following bereavement or relevant clinical interventions could yield a more adequate understanding of meaning reconstruction and its relation to other factors that shape grief outcomes.

In contrast, qualitative methods can make a distinctive contribution to the study of reconstructive processes in bereavement, inasmuch as their central focus is on issues of meaning. Taking narratives as their subject matter, a range of phenomenological, hermeneutic, ethnographic, content analytic, and grounded theory methods have been applied to the study of trauma and loss, yielding genuine insights into the human attempt to find significance in profoundly perturbing events (Glaser & Strauss, 1969; Klass, 1999; Pennebaker, Mayne, & Francis, 1996; Rosenblatt, 2000; Viney, Henry, Walker, & Crooks, 1992). Unfortunately, although disciplined applications of such

methods can illuminate the intricacies and variations in meaning making in a way that quantitative studies typically do not, qualitative research on bereavement is cluttered with simplistic studies and duplication of effort, with too little attempt to integrate and extend the mini-theories generated by the study of innumerable small samples. Perhaps the most progressive approach to preserving the nomothetic and idiographic advantages of quantitative and qualitative research strategies, respectively, would be to articulate them within the same research program, using each to strengthen the other (Hogan et al., 2001).

From a clinical standpoint, the non-pathologizing, strength-oriented focus of constructivist theory mitigates the risk of overzealous attempts to regard all bereaved persons as in need of professional intervention, as quantitative and qualitative reviews of the literature on grief therapy provide little evidence of its benefit for the majority of those who suffer a loss (Jordan & Neimeyer, 2003). As suggested by the CLOC data, resilient responders, those grievers who show a gradual accommodation to their changed lives over the early months of bereavement, and those who actually thrive following the ending of an insufferable burden are likely to require no formal support beyond that available in their indigenous family and community networks. Even in the wake of devastating community trauma such as terrorist attacks on civilian populations, a prudent perspective would advocate for widespread screening coupled with selective service delivery to needy individuals over a period of several months rather than immediate and indiscriminate debriefing interventions for whole populations (Neimeyer, 2002b). In keeping with what might be termed a *resilient systems approach,* efforts would be directed toward mobilizing the collective healing forces in existing cultural institutions (e.g., faith communities, mutual support organizations, neighborhoods) rather than preempting them with professional therapeutic interventions for individuals.

However, for the 15% to 20% of widowed persons whose grief remains chronic and debilitating and who lack adequate social support (Ott, 2003), professional therapy might clearly be indicated. Here a meaning reconstruction approach can make a distinctive contribution, in light of its anchoring in the multifaceted field of constructivist and narrative psychotherapy (Angus & McLeod, 2004; Mahoney, 2004; Neimeyer & Bridges, 2003; Neimeyer & Mahoney, 1995; Neimeyer & Raskin, 2000). At the most literal level, narrative interventions that make use of systematic writing about trauma and loss can help promote expression and integration of such experiences, as meta-analyses of these methods have demonstrated (Pennebaker, 1997). Extensions of this approach that sharpen its relevance for reconstructing meaning in bereavement

include the use of metaphoric stories, biographical techniques, life imprint methods, loss characterizations, unsent letters, epitaphs, poetic expression, and a host of other strategies that hold promise in both self-help applications and as homework assignments in professional grief therapy (Neimeyer, 2005). Proactive variations on therapeutic writing, in which a terminally ill person records his or her "ethical will" to bequeath cherished life stories, lessons, and values to loved ones (Baines, 2002), could also reinforce the strands of continuity of the self-narrative of the dying with the life stories of those who will go on living, in a way that could assist the subsequent reconstructive efforts of the latter.[2]

In the interactional setting of constructivist psychotherapy, narrative methods and metaphors offer a considerable trove of therapeutic procedures. At the most fundamental level, these may involve "re-membering conversations" within families, in which the therapist invites each person's stories of the living legacy of a loved one who, though physically absent, remains very much a "member" of his or her life (Hedtke & Winslade, 2003). In keeping with a narrative emphasis on resilience, such conversations tend to deconstruct dominant narratives of grieving as a painful process of "letting go" of those we love, instead celebrating "sparkling moments" of personal hardiness, joy, and continued connection.

Other specialized therapeutic strategies complement this emphasis on the construction of a preferred self-narrative for the griever by accessing and "re-storying" disorganized and dissociated accounts of loss. For example, carefully constructed group formats for "retelling violent death" have been found to help survivors of especially stigmatizing losses by suicide and homicide (Rynearson, 1999), just as reflective group formats have fostered greater shared sense-making about other traumatic experiences (Stewart, 1995). However, not all accounts of loss are easily accessible in storied form, as the most traumatic often exist in a fragmentary, inarticulate, and pre-narrative state that undermines a more coherent declarative memory of events (van der Kolk & van der Hart, 1991). In such cases, careful sifting of such stories by slowly replaying relevant micro-narratives of the event, "zooming in" on problematic particulars (e.g., the incongruous expression of a family member in a deathbed scene) and then "zooming out" to place new awarenesses in the broader context of the event or one's life can promote greater experiential continuity (Guidano, 1991; Neimeyer, 2000a). Even in relatively "normal"

[2]I allude to ethical wills here because of their continuity with other narrative methods, even though by definition their use would not be confined to those who subsequently contend with complicated grief.

circumstances such as grief over the terminal illness and death of a child, clients can benefit from assistance in symbolizing, articulating, and "dialoguing with" difficult emotion states as a step toward their narrative integration, as demonstrated in videotapes of constructivist psychotherapy (Neimeyer, 2004a).

This emphasis on written or spoken narration of experience, however, should not be taken to suggest that stories are purely verbal affairs. Indeed, the most dramatic stories may be those that are enacted, whether on the stage of a literal theater or on that of everyday life. Extending this concept to the therapeutic arena, the performance of loss narratives in the form of empty chair or two chair dialogues with the deceased (Greenberg, Watson, & Lietaer, 1998) has proven diagnostically useful in pinpointing postmortem problems between self and other that require clinical attention (Field & Bonanno, 2001). Similarly, therapeutic enactment methods in group settings (Westwood, Black, & McLean, 2002), in which traumatic life experiences are performed and re-scripted with the participation of a supportive audience, hold promise as a method for re-authoring loss narratives (Neimeyer & Arvay, 2004). These and other meaning-making methods deserve broader attention on the part of the clinical and research communities concerned with bereavement.

CONCLUSION

In this chapter I have tried to argue that a narrative constructivist approach provides a valuable theoretical framework for integrating many of the subtler features of widowhood, beyond the traditional preoccupation with presumably universal signs, symptoms, and stages of readjustment in the wake of significant loss. In particular, it accords well with prospective studies of bereavement, which are beginning to reveal the variegated trajectories by which the bereaved lose, preserve, reestablish or enlarge the structure of their previous self-narrative, occasionally struggling painfully to find new meaning in the face of profound disruption. I have tried to suggest further that such a perspective, making contact as it does with broad and deep developments in psychology and the human sciences, offers an expanded repertory of concepts and methods for both studying the personal experience of bereavement and fostering its assimilation or accommodation.

Having begun these reflections with the voices of widows themselves, it seems appropriate to allow them the last word as well. Speaking on behalf of many who have known this poignant, if normative loss, Judith writes of the difficulty of finding others who can hear and respond to the "secret," private meanings of bereavement:

> There are so many aspects now to being alone. Sometimes, indeed, it is the only choice and even a comforting one. "Company"—as is offered sometimes—can enhance the suffering. But there is the rare solace in the quiet, gentle shared presence of those who know secret things or yearn to know secret things. . . . Anything written or spoken that witnesses of an understanding, or even a wholehearted attempt to understand, is much-needed solace. As a matter of fact there is a strange kind of insatiable feeling about that—as if one never believes that anyone can understand this experience, or truly wants to, unless they have lived it, no matter what they say.

Ultimately, a narrative perspective on loss and resilience invites us to be a responsive audience to these stories of transition, in whatever ways the bereaved want and need to tell them.

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Part IV

Implications for Practice, Policy, and Future Research

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CHAPTER 10

Clinical Interventions with the Bereaved

What Clinicians and Counselors Can Learn from the Changing Lives of Older Couples Study

Anthony D. Mancini, David L. Pressman, and George A. Bonanno

Coping with the death of a spouse is consistently listed among the most highly stressful experiences a person might endure (e.g., Holmes & Rahe, 1967). However, as is the case with acute stressors generally (e.g., Lucas, Clark, Georgellis, & Diener, 2003), individuals who endure the loss of a spouse tend to vary greatly in the duration and severity of their grief reactions (Bonanno & Kaltman, 1999, 2001; Wortman & Silver, 1989, 2001). Some bereaved individuals, usually ranging from 10% to 20%, tend to suffer from chronic distress and depression for years after the loss. However, others suffer more acute reactions and then gradually return to baseline or pre-loss levels of functioning, while still others show surprisingly short-lived reactions and a relatively rapid return to their own previous normal levels of functioning (Bonanno & Kaltman, 2001). The range of reactions people exhibit when a spouse dies has led to considerable controversy in the bereavement literature about what might be the "normal" course of bereavement, and who might need or benefit most from a grief-focused clinical intervention (Bonanno, 2004).

Bereaved individuals who evidence a chronic profile of elevated distress and depression would be obvious candidates for clinical intervention. Chronically grieved individuals are often so overwhelmed with the psychological pain of bereavement that they are unable to maintain their previous

levels of performance at work and in caring for others; they suffer increased physical illness and health problems and require more frequent medical attention (Bonanno & Kaltman, 1999; Prigerson & Jacobs, 2001; Thompson, Breckenridge, Gallagher, & Peterson, 1984), and evidence greater incidence of mortality (Kaprio, Koskenvuo, & Rita, 1987; Stroebe & Stroebe, 1993), including an increased risk for suicide (Luoma & Pearson, 2002). Although these negative health effects tend to be less pronounced in relatively older bereaved samples (Lichtenstein, Gatz, Pedersen, Berg, & McClean, 1996; Nolen-Hoeksema & Ahrens, 2002; Sherbourne, Meredith, Rogers, & Ware, 1992; Zisook, Shuchter, Sledge, & Mulhvihill, 1993), the issue of chronic grief is nonetheless an important public health concern among the elderly bereaved.

What about bereaved individuals who show little or no prolonged disruption in their ability to function following the death of their spouse? Traditionally, bereavement theorists have viewed the absence of distress during bereavement as both rare and pathological (Bowlby, 1980; Deutsch, 1937; Jacobs, 1993; Lindemann, 1944; Osterweis, Solomon, & Green, 1984; Rando, 1993; Worden, 1991). Bereavement theorists also have tended to assume that bereaved individuals who do not exhibit overt signs of grieving will eventually manifest delayed grief reactions (for a review see Bonanno & Field, 2001). And, as would be expected given these assumptions, bereavement theorists have historically viewed the absence of grief as a form of denial that also necessitates clinical intervention (Bowlby, 1980; Deutsch, 1937; Jacobs, 1993; Lindemann, 1944; Osterweis et al., 1984; Rando, 1993; Worden, 1991). Indeed, in a recent survey of self-identified bereavement experts (Middleton, Moylan, Raphael, Burnett, & Martinek, 1993), a majority (65%) endorsed beliefs that "absent grief" usually stems from denial or inhibition, and that it is generally maladaptive in the long run. Thus, a critical task of bereavement researchers is to better understand the nature of chronic grief and whether absent grief is indeed maladaptive in the long run.

EVIDENCE FOR THE EFFICACY OF CLINICAL INTERVENTIONS WITH THE BEREAVED

Given the strength and pervasiveness of these assumptions, it is not surprising that a variety of interventions have been targeted specifically at persons suffering from bereavement. What is surprising, however, is that *existing clinical interventions for bereavement have proven to be generally inefficacious* (Jordan & Neimeyer, 2003). For example, two recent meta-analytic studies compared randomly assigned grief treatment and control groups. In contrast to the generally robust effect sizes typically observed for psychotherapeutic outcomes,

grief-specific therapies produced only small and relatively inconsequential effects (Kato & Mann, 1999; Neimeyer, 2000). Importantly, in one of these analyses an alarming 38% of the individuals receiving grief treatments grew worse relative to no-treatment controls (Neimeyer, 2000). As seems to be the case with psychotherapy in general, those individuals who self-selected grief therapy benefited more from the intervention than did participants recruited by investigators (Allumbaugh & Hoyt, 1999). The clearest benefits were evidenced with bereaved individuals experiencing chronic grief reactions, although the effect size in this case was still smaller than is normally observed for psychotherapy outcomes (Neimeyer, 2000).

The lack of efficacy found for grief therapy has surprised clinicians and researchers (Jordan & Neimeyer, 2003). One reason why individuals who ostensibly exhibit complicated bereavement may not always fare well in grief-focused therapy is that some bereaved persons' difficulties are in fact the result of a pre-existing depression. Thus, it may be that a grief-focused intervention is inappropriate for bereaved individuals with a standing history of clinical depression. Indeed, because depression and grief present many similarities, clinicians might fail to recognize the depression, opting instead to focus exclusively on issues related to the bereaved person's grief. This approach would likely prove particularly ineffective for bereaved persons whose depression predated their loss. Perhaps for this reason, Zisook and Shuchter (2001) have suggested that bereavement interventions should treat both depression and grief simultaneously, employing a balance of insight-oriented and behaviorally focused interventions, as well as psychopharmacology when warranted. Indeed, there is evidence that psychopharmacological interventions alone are reasonably effective in lifting post-loss depression in the elderly (Oakley, Khin, Parks, Bauer, & Sunderland, 2002). This conflation of grief reactions and depressive symptoms following a loss will be discussed throughout the chapter.

Another, and perhaps even more compelling, reason for the lack of efficacy found for grief therapies is the over-inclusion of bereaved individuals who either show resilience, and thus have relatively little need for treatment, or who would recover naturally on their own. As will be described later in the chapter, there is now solid evidence that many, if not the majority of, bereaved individuals demonstrate resilience in response to a loss (Bonanno et al., 2002; Bonanno, Moskowitz, Papa, & Folkman, 2005a). Inclusion of such individuals in treatment would certainly contribute to low effect sizes for that treatment.

Despite their overall poor track record, grief therapies have shown some effectiveness for the small subset of bereaved persons who evince the most

severe and enduring grief symptoms (Schut, Stroebe, van den Bout, & Terheggen, 2001). However, it is perhaps most puzzling that grief therapies have still shown such modest effects even for this group. Later in this chapter, we discuss problematic aspects of traditional grief counseling models, identifying some subtle modifications that might result in better outcomes.

COMMON CLINICAL ASSUMPTIONS ABOUT BEREAVEMENT

Despite the failure of grief therapies to prove efficacious for the majority of persons who experience bereavement, there is a virtual cottage industry devoted to such therapies, purveying widespread assumptions about bereavement. Indeed, a brief glance at most monographs on grief counseling would acquaint the reader with some surprisingly common beliefs about bereavement (e.g., Jacobs, 1993; Rando, 1993; Worden, 1991) and would even permit one to construct a prototypical grief reaction that might be deemed appropriate for clinical intervention as depicted in the grief counseling literature.

For example, such a grief reaction might be represented by the widowed husband, who, though saddened by the loss of his wife, does not evince overt signs of distress and whose level of functioning is largely unimpaired. Nevertheless, well-meaning friends and family members, concerned that he is repressing feelings of anger and sadness about the loss, would perhaps encourage him to see a professional and "work through" the loss. Perhaps the bereaved husband would feel guilt at appearing insufficiently distressed and would accede to the urgings of his family members that he undergo grief counseling, though unsure of its usefulness. Through a professional intervention aimed specifically at feelings toward his lost wife, he might uncover ambivalent feelings toward her, particularly unresolved anger and sadness at being abandoned. In the absence of therapeutic intervention, these negative feelings might have slowly simmered over time, eventually boiling over into a full-blown grief reaction marked by powerful feelings of anger and sadness years down the road. As it is, the cathartic experience of expressing these feelings in grief counseling allows him to resolve the grief, relinquish his attachment to the deceased, and move past the loss, inoculating him from a more devastating experience of grief at some future point.

This narrative description of a grief trajectory and its correlates embodies important assumptions contained in both our clinical and cultural understandings of bereavement. For example, one common assumption is that active efforts are required to cope with loss, a process called "grief work" (Stroebe & Stroebe, 1991). This notion of grieving traces its lineage

to Freud's (1917/1957) historic conceptualization of grieving as an effortful process in which the bereaved person reviews "each single one of the memories and hopes which bound the libido" to the lost person (p.154), and it is widely endorsed in the bereavement literature. Indeed, later theorists have emphasized even more strongly the critical necessity of confronting negative thoughts, feelings, and memories associated with the loss (e.g., Rando, 1992). Furthermore, models for grief counseling frequently employ specific procedures to promote the bereaved person's efforts to work through the loss. For example, bereaved persons are implored to accept the reality of the loss, to review specific memories and express feelings (particularly negative ones) associated with the lost loved one, and to make active efforts to relinquish their attachment (Rando, 1993; Worden, 1991).

A related clinical assumption is that the absence of overt distress in response to bereavement is itself indicative of pathology because it suggests that the person is inhibiting or dissociating from negative feelings (Middleton et al., 1993) or lacked a strong attachment to the deceased (Fraley & Shaver, 1999). When individuals don't display overt distress, they may be presumed to be avoiding the "tasks" of grieving, opting instead to repress the emotional pain that might otherwise be experienced (Worden, 1991). Such responses to loss have often been thought to portend later and much more severe difficulties that could be avoided by engaging in "grief work" processes.

Despite widespread endorsement of the "grief work" perspective (and the concomitant pathologizing of those who fail to evince grief symptoms), startlingly little empirical evidence exists to support these assumptions about bereavement (Wortman & Silver, 1989). Indeed, there is increasing consensus among bereavement theorists that *traditional models of coping with loss are not supported by the empirical data* (Bonanno, 2001a, 2004; Bonanno & Kaltman, 1999; Lindstrom, 2002; Murphy, Johnson, & Lohan, 2003; Wortman & Silver, 1989, 2001). This leaves the bereavement field in something of a theoretical vacuum (Bonanno, 2001a; Bonanno & Kaltman, 1999). Of greater potential concern, there is growing evidence that not only is "grief work" incompatible with the evidence, but engaging in practices that promote grief work may even exacerbate grief reactions (Bonanno & Kaltman, 1999). The alarming number of people who actually appeared to worsen as a result of receiving grief counseling demonstrates its potential for harm and indirectly supports the notion that engaging in practices to enhance "grief work" are potentially deleterious (Jordan & Neimeyer, 2003; Neimeyer, 2000). Rather than recommending that all persons should focus on intensive grief work, it appears that grief work may be appropriate at best for only a subset of bereaved individuals who demonstrate the most severe

grief symptoms (Bonanno, Papa, & O'Neill, 2001). However, in a recent test of the grief work hypothesis, even more severely grieved individuals did not benefit from extensive focusing on the loss (Bonanno, Papa, Nanping, & Noll, 2005b).

It is possible that promoting "grief work" as a therapeutic procedure is most indicated for persons prone to internalizing their grief symptoms. Internalizing difficulties, such as self-recrimination, hopelessness, and dysphoric mood, are thought to be more responsive to therapeutic procedures that focus on insight, while externalizing symptomatology, such as substance use and acting out behaviors, are thought to be more responsive to skill- and symptom-focused interventions (Beutler, 2000). Indeed, there is evidence that internalizing responses to bereavement may predispose a person to a more severe grief reaction (Nolen-Hoeksema, Parker, & Larson, 1994), further supporting the idea that "grief work" may only be indicated for a small subset of bereaved persons. We will revisit this possibility in our discussion of clinical interventions with the bereaved.

Given the general lack of empirical support for the grief work perspective, it has nevertheless demonstrated surprising currency in the grief counseling literature and among clinicians generally. What has accounted for the durability of the grief work perspective? One germane factor is that the grief work perspective has an illustrious pedigree deriving, first, from Freudian perspectives on loss (Deutsch, 1937; Freud, 1917/1957) and, later, from Bowlby's (1980) highly influential theorizing on attachment.[1] Moreover, grief work's precepts—its emphasis on internal representations of the lost loved one and the central importance of expressing affect associated with the loss—mirror more recent developments in psychodynamic thought that have also enjoyed wide influence (namely, object relations theory: Greenberg & Mitchell, 1983). Finally, the grief counseling literature has been dominated by adherents of the grief work perspective (e.g., Rando, 1993; Rich, 1999; Worden, 1991), leaving little space for competing views. In the absence of such competing perspectives, the field may have preferred grief work to no theory at all, although a number of cogent alternatives have recently been offered by bereavement investigators (see Bonanno & Kaltman, 1999 for a review).

[1]Investigators have pointed out that Bowlby's later writings fail to endorse one central contention of the grief work perspective: that continued attachment to the lost person is inherently maladaptive (Fraley & Shaver, 1999).

BASIC GRIEF OUTCOME TRAJECTORIES

Historically, the bereavement field has been plagued by confusion and controversy regarding the prevalence and characteristics of chronic or complicated grief reactions (Hansson, Carpenter, & Fairchild, 1993), with bereavement theorists proposing a number of different taxonomies (e.g., distorted grief, Belitsky & Jacobs, 1986; Rando, 1992; exaggerated grief, Worden, 1991). One theorist (i.e., Rando, 1992) proposed as many as seven unique types of complicated bereavement. However, a thorough and critical review of the available empirical literature (Bonanno & Kaltman, 1999, 2001) suggests a much simpler picture: the available evidence indicated three clear and encompassing grief outcome trajectories—a *minimal grief* response; a *recovery pattern,* in which normal functioning is temporarily disrupted followed by a gradual return to baseline lasting for one or two years; and a *chronic pattern*, in which normal functioning is disrupted for several years or longer. What's more, recent empirical studies further indicate that chronic grief need not be considered a unique syndrome that manifests itself in multiple forms, but rather that chronic grief is best understood in terms of prolonged symptoms of distress and depression, and in some cases posttraumatic stress disorder (Bonanno & Kaltman, 1999; Bonanno et al., 2002; Kaltman & Bonanno, 2003).

Although chronic grief's underlying pathology appears to reflect clinical syndromes of distress and depression, some investigators have argued that the phenomenonology of grief is distinct from depression and other forms of clinical distress (Neimeyer & Hogan, 2001; Prigerson et al., 1995). Depression is a diagnostic category signifying painful dysphoric affect or loss of interest in things combined with eating or sleeping problems, lack of energy, or self-reproach—symptoms that must persist for 2 weeks to qualify for a diagnosis. In contrast to depression, grief comprises a complex set of negative and *positive* emotional responses (Bonanno & Kaltman, 1999), is a normative response to loss usually undeserving of clinical attention (Raphael, Minkov, & Dobson, 2001), and may entail significant challenges to existing meaning structures (Bonanno & Kaltman, 1999; Shuchter & Zisook, 1993), potentially altering a person's character permanently. Other characteristics of grief, such as yearning for and reviewing memories of the lost loved one, in addition to more enduring potential sequelae, such as painful feelings in response to thoughts about the lost loved one (Wortman & Silver, 2001), mark grief as distinct from depression in obvious ways.

Nevertheless, it is equally clear that grief and depression are related phenomena, and estimates of the proportion of bereaved spouses who re-

port clinically significant levels of depressive symptomatology in the first few months after the loss are significant, from 20% to 40%[2] (Bruce, Kim, Leaf, & Jacobs, 1990; Zisook, Paulus, Shuchter, & Judd, 1997), and these percentages may be higher for other types of losses, such as the loss of a partner to AIDS (Folkman, Chesney, Collette, Boccellari, & Cooke, 1996) or the death of a child (Murphy, 1997). Of primary clinical concern, a subset of bereaved persons will go on to experience persistent distress, sometimes for years after the loss. However, it is often unclear whether this distress results from a grief reaction or is an extension of an unresolved depression that preexisted the loss. Indeed, from a clinical standpoint, grief and chronic depression present many similarities, complicating efforts to distinguish them and target appropriate interventions. However, as we discuss later in this chapter, a number of factors, both pre- and post-loss, distinguish chronic grievers from those suffering from chronic depression, with clinical implications for both groups.

BEREAVEMENT IN OLDER ADULTS

Up to this point, we have considered grief therapy and grief trajectories in general. The majority of bereavement studies and grief therapies are geared toward a middle-aged adult sample. However, the bereavement experience for older adults may be quite different from the rest of the adult population. As opposed to the experience of a younger adult, the older adult is more likely to experience the death of significant others prior to the loss of a spouse or adult child (Thompson, Gallagher-Thompson, Futterman, Gilewski, & Peterson, 1991). Also, reactions to a specific loss in the elderly are most likely to occur in the context of additional ongoing stressors particular to late life, such as financial pressures, low levels of social support, and chronic health problems (Arbuckle & deVries, 1995; Norris & Murrell, 1990; Zautra, Reich, & Guarnaccia, 1990). Moreover, older adults, when compared with younger adults, appear to rely to a greater extent on their spouse as a social resource: loneliness is one commonly cited consequence of bereavement in late life (Lund, Caserta, & Dimond, 1993). In addition, the loss of a spouse would likely signal a more pronounced change in day-to-day activities and a more difficult adjustment to independent life for older persons than for younger persons

[2]The obverse of those percentages (60% to 80%) demonstrates that the majority of bereaved persons do not experience significant levels of depressive symptomatology directly following the loss.

(Norris & Murrell, 1990). For these reasons, bereavement appears to present distinct adaptive challenges to older persons.

Despite these adaptive challenges, older adults' grief reactions are generally less intense than those of younger adults (Nolen-Hoeksema & Ahrens, 2002; Sanders, 1993; Sherbourne et al., 1992), perhaps because loss is viewed as a normative experience of late life (Neugarten, 1979). Indeed, other common stressors of late life may have more deleterious effects than bereavement. For example, when bereaved persons were compared to persons who had suffered a significant functional disability from illness or accident, psychological distress related to the event persisted 14–16 months later in the disability group, while it had largely resolved in the bereaved group (Reich, Zautra, & Guarnaccia, 1989).

Another important consideration is that older bereaved persons are more likely to have provided high levels of care to a disabled spouse, and the strain of caregiving may have represented an acute stressor in itself. Indeed, Schulz and colleagues (2001) found that elderly bereaved persons who experienced stressful caregiving reported *declines* in psychological distress following the death of a loved one. This finding demonstrates that bereavement is not invariably experienced as a stressor and can sometimes result in improvements in psychological functioning, a notion that we develop in greater detail later in this chapter. Indeed, earlier investigators (e.g., Arbuckle & deVries, 1995) have urged researchers to evaluate adaptive coping strategies and the meaning and interpretation of the loss in the bereaved individual's life, rather than merely focusing on the presumed difficulties of coping with loss.

What other more general factors might be relevant to grief and depression in old age? One relevant finding is that positive affect appears to increase and negative affect to decrease as people grow older (Mroczek & Kolarz, 1998), and, in a complementary finding, older adults are less likely to endorse dysphoria in standard symptom inventories of depression, leading to the suggestion that diagnostic criteria for depression may be inappropriate for older adults (Newmann, 1989). Further evidence of older adults' capacity to manage their own emotional states is found in a body of research that shows a linear age-related increase in the capacity to regulate emotional states (Lawton, Kleban, Rajagopal, & Dean, 1992) and in the complexity of emotional experience itself (Labouvie-Vief, DeVoe, & Bulka, 1989). Moreover, the generally less intense grief reactions seen in older adults may be in part attributable to this increased capacity for emotional regulation and complexity. Together, these age differences in the regulation and complexity of emotion suggest that older persons are particularly competent managers of their emotional states

and that the prevalence of chronic grief and chronic depression is likely reduced in old age,[3] underscoring the importance of careful assessment of the severity and nature of difficulties prior to clinical intervention.

FINDINGS FROM THE CHANGING LIVES OF OLDER COUPLES STUDY: IDENTIFYING THE VARIETIES OF GRIEF REACTION

It is now widely recognized that there are marked individual differences in people's responses to the loss of a loved one (Wortman & Silver, 1989, 2001). However, methodological limitations in prior bereavement studies, in particular the absence of pre-loss data, have hampered the ability to test hypotheses about these divergent reactions to loss. For example, prior psychopathology is a strong predictor of chronic grief reactions (Zisook & Shuchter, 1991), but without data on pre-loss levels of functioning, it has not been possible to distinguish chronic grief from pre-existing depression. Furthermore, the absence of distress has commonly been viewed as maladaptive, despite evidence that this response to loss is very common (Bonanno & Kaltman, 2001). Prior to the Changing Lives of Older Couples (CLOC) study, no research has identified a group of individuals with low levels of distress prior to and following the loss. Rather than being seen as denial or a reflection of poor attachment to the spouse, which are the most common explanations for absent grief, low levels of distress prior to and following loss can be viewed as evidence of resilience.

The CLOC study used a prospective design to obtain data prior to and following spousal loss. A large representative sample of older couples was surveyed at baseline, and researchers monitored obituaries and death notices to identify bereaved spouses who had been part of the baseline sample, conducting follow-up interviews at 6, 18, and 48 months after the loss. Using these pre- and post-loss data, Bonanno, Wortman, Nesse, and their colleagues (Bonanno et al., 2002; Bonanno, Wortman, & Nesse, 2004) were able to test hypotheses regarding divergent patterns of grief reaction.

Several important findings emerged from this research design. First, based on pre- and post-loss depression scores, the researchers were able to validate five distinct grief trajectories, including: (a) *chronic grief* (15.6%: low pre-loss depression and high post-loss depression at 6 and 18 months); (b) *common grief or recovery* (10.7%: low pre-loss depression and high post-loss depression at 6 months that improves at 18 months); (c) *resilience* (45.7%:

[3]However, depression tends to increase in very old age (Newmann, 1989), and data on grief reactions in very old age are sparse.

low pre- and post-loss depression at 6 and 18 months); (d) *depressed-improved* (10.2%: high pre-loss depression and low post-loss depression at 6 and 18 months); and (e) *chronic depression* (7.8%: high pre-loss depression that persists at 6 and 18 months post-loss). Second, chronic grief could be clearly distinguished from chronic depression based on levels of pre-loss depression, but without pre-loss data, these two grief reactions would have been virtually indistinguishable.

Third, a small minority of persons fell into the common grief category, a finding that calls into question its widespread endorsement as the appropriate response to bereavement. Fourth, the large number of persons (nearly half) in the resilient pattern, who demonstrated minimal or low levels of depression at 6 and 18 months following bereavement, signifies compelling evidence that this pattern of grief is not anomalous or pathological but rather a typical response to loss. Fifth, two other patterns of grief reaction, which had received some mention in the literature but had not previously been examined empirically, were found: (a) a significant decline in depression from pre-loss to 6 and 18 months post-loss, which was labeled as "depressed-improved"; and (b) high levels of pre- and post-loss depression, which was labeled as "chronic depression." Finally, no evidence for a delayed grief pattern was found, adding to mounting evidence that disconfirms the existence of delayed grief. Importantly, a number of these core patterns of grief reaction could only be distinguished from one another using pre-loss data.

Further evidence for the validity of these divergent patterns of grief reaction was found in their relationships to a variety of pre-loss factors. For example, it had been previously thought that persons with minimal grief symptoms were in denial, emotionally distant, or lacked a close attachment to their spouse. In fact, persons in the resilient pattern showed no evidence of these traits and instead evidenced a number of traits suggestive of genuine resilience in the face of loss. For example, the resilient group reported high levels of belief in a just world, acceptance of death, and generally satisfying marriages. In addition, the group reported low levels of talking about and searching for meaning in the loss. Moreover, they derived relatively high levels of comfort from thoughts about the spouse (Bonanno et al., 2002; Bonanno et al., 2004). These findings provide strong evidence that individuals in the resilient pattern of grief are not emotionally distant or in denial but are in fact well-adjusted individuals responding to loss in a healthy way.

In like fashion, bereavement theorists have tended to associate chronic grief with a host of negative factors, including marital conflict and ambivalence, excessive dependency on the spouse, deficits in coping resources,

low levels of social support, and feelings of vulnerability to highly stressful events. In fact, most of these antecedent variables were found to bear no relationship to chronic grief (Bonanno et al., 2002). Moreover, chronic grievers reported the highest levels of satisfaction with their marriages. The negative trait most clearly associated with chronic grief was excessive dependency both on one's spouse and dependency as a general personality variable. This characteristic of dependency most clearly distinguished chronic grievers from other participants who were not depressed in the years prior to the death of their spouse. More to the point, a number of variables hypothesized to be associated with chronic grief were instead related to chronic depression. For example, the chronically depressed group reported low levels of marital satisfaction, greater difficulties in managing emotional states, and little faith in their capacities to cope with stressful events, as well as belief that negative events were often uncontrollable.

Other factors further distinguished chronic grief from chronic depression. For example, chronic grievers were more likely than those with chronic depression to report searching for meaning in the loss, underscoring its potent impact on the chronic grief group (Bonanno et al., 2004). Indeed, these findings provide strong evidence that the emotional difficulties evidenced by chronic grievers are primarily due to the upheaval prompted by the loss, whereas persons suffering from chronic depression appear to have more enduring problems in coping and managing emotions that likely were exacerbated by the loss.

Perhaps the most intriguing grief pattern identified by Bonanno, Wortman, and their colleagues (Bonanno et al., 2002; Bonanno et al., 2004) is the depressed-improved group. These persons had high levels of pre-loss depression, negative and ambivalent views of the marriage, low levels of instrumental support, high levels of introspection and emotional instability, as well as particularly dark views of the world. Surprisingly, their post-loss profile, which showed low levels of depression, grief symptoms, and avoidance of the loss, is consistent with psychological health. Taken together, these findings suggest that persons in the depressed-improved group were not engaging in emotional inhibition or denial about the loss, as is suggested by traditional theorists who viewed the absence of grief as a form of denial; rather, it appears that bereavement served as the end of a chronic stressor. Indeed, an interpretation far more consistent with the data is that this group consisted of persons who felt trapped in a bad marriage with a seriously ill spouse and that widowhood offered relief and escape from the chronic stress associated with this circumstance.

CLINICAL IMPLICATIONS OF THE CHANGING LIVES OF OLDER COUPLES FINDINGS

The findings from the CLOC studies have a number of important implications for treatment of bereaved persons. Previously, much of the clinical literature on grief has identified the failure to "work through" the loss as the primary cause of chronic grief (Rando, 1993). A possibility often ignored is that persons who exhibit symptoms of apparent chronic grief may instead be experiencing a chronic depression that existed before the loss. This distinction is of critical importance. Because the etiology of chronic grief and chronic depression is starkly divergent, so are the implications for their treatment, despite the apparent similarities in their symptom profiles. This similarity, in fact, suggests one very clear implication of the CLOC findings for treatment interventions: the necessity for thorough assessment of bereaved persons who present for treatment. Indeed it is essential for the grief counselor to assess whether a bereaved person's depression is a direct consequence of the loss or whether more enduring psychological difficulties lie at the root of his or her symptoms.

Moreover, findings from the CLOC study suggest some important avenues of clinical inquiry in the assessment of the bereaved. For example, although high and persistent levels of depression are characteristic of both chronic grief and chronic depression, persons with chronic depression—when compared with chronic grievers—have greater perceived deficits in coping efficacy, more difficulty managing troubling feelings, and less positive affect, as well as more negative views of the marriage (Bonanno et al., 2002). In addition, those suffering from chronic depression experience, by definition, higher levels of pre-loss distress than chronic grievers. On the other hand, chronic grief—when compared to chronic depression—is associated with more active efforts to understand the loss, including higher levels of processing and searching for meaning during the first 6 months of bereavement. These differences suggest a number of fruitful areas of inquiry when conducting a clinical assessment of a bereaved person.

However, one caveat is that information obtained from the bereaved person may be biased by their current affective state (Safer, Bonanno, & Field, 2001), though this difficulty is not unique to the treatment of grief. It is well-established that depressed persons often overestimate the extent to which they have experienced depressive symptomatology in the past, complicating efforts to assess pre-loss levels of functioning (Clark & Teasdale, 1982). This tendency suggests that additional sources of information about the bereaved person's pre-loss level of functioning may provide important insight into

the history and the nature of the individual's difficulties. These sources may include medical charts and perhaps close friends or family members. Of course, prior histories are not always available in clinical settings, and the bereaved person may not wish to involve family members or close others in treatment or to reveal that treatment is taking place. Nevertheless, a full assessment is of paramount importance before embarking on treatment with bereaved persons, ensuring that the treatment is appropriate to the nature of the difficulties.

Indeed, the contrasting profiles of chronic grief and chronic depression suggest sharply different treatment implications. Those suffering from chronic grief, for example, appear most appropriate for therapeutic procedures that might focus on the meaning of the loss. Because chronic grievers report high levels of processing the loss, interpersonal dependency, and a more positive relationship with the deceased (Bonanno et al., 2004), they would likely benefit from treatment that enhances insight into the loss (which appears to have been particularly shattering for this group), fosters meaning construction, and provides a safe context for emotional disclosure. Indeed, the internalized nature of the distress manifested by those with chronic grief is well-suited to generic therapeutic techniques designed to promote insight and focus on relationships (Beutler, 2000). On the other hand, empirical research has failed to support, and in some cases even contradicted, many of the more specific therapeutic prescriptions associated with grief work, including expressing negative emotions (Bonanno & Keltner, 1997), the necessity of confronting feelings of anger or sadness (Bonanno, Keltner, Holen, & Horowitz, 1995), and excessive focus on emotions associated with the loss (Nolen-Hoeksema et al., 1994). Indeed, it is the expression of positive feelings, and the avoidance of negative ones, that appears to portend a more rapid resolution of grief symptoms for many bereaved persons (Keltner & Bonanno, 1997). These findings suggest that one principal focus of traditional grief work therapies—the guided expression of negative emotions associated with the loss—is unlikely to facilitate the resolution of chronic grief.

In a more speculative vein, grief work models of therapy may also promote a directive treatment style that is less compatible with the coping patterns of chronic grievers. That is, grief work's prescriptive nature would likely lend itself to a more directive treatment style. When one considers that directive therapies are often less effective for persons with internalizing symptoms (Beutler et al., 1991; Calvert, Beutler, & Crago, 1988) and that chronic grievers may be prone to internalizing their distress (Nolen-Hoeksema et al., 1994), there is the intriguing possibility that grief work therapies are inherently poorly matched with the coping styles of persons with chronic grief.

Based on these considerations, we offer a more limited endorsement of the principles of grief work in the treatment of chronic grief, one that is compatible with the research on the costs of expressing negative feelings and the benefits of verbal disclosure. For example, ample research has identified the adaptive consequences of talking about acute stressors or trauma (e.g., Pennebaker, 1993), a process that appears to promote important processes of cognitive integration and restructuring (Greenberg, Wortman, & Stone, 1996). In the context of bereavement, however, the positive effects have been less clear (Kelly & McKillop, 1996). Indeed, Stroebe, Stroebe, Schut, Zech, and van den Bout (2002) recently examined the effects of written and verbal forms of emotional disclosure during bereavement and found no evidence that the disclosure of grief-related emotion improved adjustment. Given such findings, it is worthwhile to consider an important moderating factor in disclosure, demonstrated by Lepore and colleagues (Lepore, Silver, Wortman, & Wayment, 1996): the extent to which others are seen as available and willing to listen to expressed feelings. Without a supportive environment, the benefits of disclosure are diluted (Lepore, Ragan, & Jones, 2000).

Taken together, these findings suggest that, rather than seeking to promote the disclosure of negative feelings about the loss and discount the expression of positive ones, clinicians should adopt a neutral, non-directive stance with regard to the content of the bereaved person's disclosures, and instead focus on providing a safe environment in which disclosure is supported and insight and meaning construction is enhanced. That is, the clinician who places a greater priority on the negative emotions associated with the loss and grief generally may convey the message that some emotions and topics of concern are preferred over others. If the bereaved person wishes to express positive feelings regarding the lost love one, for example, but perceives the clinician as unreceptive to those emotions, the benefits of disclosing such feelings would likely be negated. Indeed, the bereaved person might experience shame for even wishing to express positive feelings.

Alternatively, it may be just as useful to focus less fully on the grief reactions for this group and instead to address their broader emotional difficulties in treatment. Recall that of the individuals in the CLOC study with low pre-loss depression, the group that went on to struggle with chronic grief and depression after the spouse's death (i.e., the chronic grief group) had significantly higher levels of both general interpersonal dependency and also dependency specific to the conjugal relationship. Our research team also has provided convergent evidence from other studies indicating that chronically grieved individuals suffer from an anxious-ambivalent attachment to the deceased spouse. In a recent study, for example, Fraley and Bonanno (2004)

found that chronically grieved individuals scored highly on a measure of *anxious attachment* (encompassing both anxious preoccupied and anxious fearful attachment styles). In another study, bereaved participants who showed the highest initial (6-month) levels of grief and distress tended to have increasingly *ambivalent representations of the deceased spouse* (e.g., used more positive and negative terms) over time and to rate the quality of their relationship with the deceased more negatively over time (Bonanno, Notarius, Gunzerath, Keltner, & Horowitz, 1998).

Finally, a third convergent line of research (Field, Gal-Oz, & Bonanno, 2003) indicates that chronically grieved individuals were most likely to report continued attachment to the deceased spouse even 5 years after the death, suggesting they suffer from an *active continued attachment to a deceased spouse as a form of anxious preoccupation*. These findings suggest that chronic grievers' experiences of loss exacerbated preexisting difficulties in forming secure attachments. For this reason, the therapist may wish to moderate the clinical focus on loss and instead consider other areas of concern. For example, the formation of a trusting therapeutic relationship, the development of interpersonal skills and greater assertiveness, and the elucidation of negative views about the self in relation to others might better serve to ameliorate the person's distress than a strict focus on grief.

It is important to note that the chronically depressed sample (i.e., high levels of depression prior to the loss that remain elevated during bereavement) also scored highly on measures of dependency. This finding, in conjunction with the other data from the CLOC study, suggests clearly that therapeutic interventions for chronically depressed persons who have suffered a recent loss should be more symptom- and skill-focused. In fact, therapeutic interventions designed to enhance processing of the loss appear particularly prone to failure with this chronically depressed group, given their lack of interest in finding meaning in the loss (Bonanno et al., 2004). Further, because the depression of this group anteceded the loss, a specific focus on bereavement generally appears unproductive. Rather, consistent with Zisook and Shuchter's (2001) suggestion that depression and grief must be treated simultaneously, we suggest that the clinician put the relative stress on enduring issues that may be implicated in the depression, such as poor coping skills, lack of supportive relationships, and interpersonal dependency, rather than emphasizing psychic processes presumed to be activated by the grief. Finally, chronic grievers also appear most appropriate for psychopharmacological intervention, given the extent and chronicity of their symptoms (Beutler, 2000; Zisook & Shuchter, 2001).

For persons demonstrating what Bonanno and colleagues (2002) termed the resilient pattern during bereavement, findings from the CLOC study, as well as other recent empirical studies (e.g., Bonanno et al., in 2005a), make clear that the relative absence of grief is *not* an appropriate rationale for clinical intervention. Despite suggestions by some theorists (e.g., Worden, 1991), the notion that absent grief is a problem that needs to be solved received no support from the findings in the CLOC studies. It seems clear that persons who show resilience in bereavement are well adjusted and that there is a greater likelihood of harm than good in encouraging treatment for such persons (Bonanno, 2004).

What are we to make of the individuals for whom psychological functioning improved following the experience of the loss? As previously mentioned, these individuals exhibited high levels of depression prior to the loss; yet following the loss, they displayed relatively little depression during bereavement and gave no indication of maladjustment on other indicators. In a follow-up study, Bonanno and collaborators (2004) empirically examined several different possible explanations for this pattern. The results offered the clearest support for the view that for most of the improved group, the spouse's death was experienced as a kind of relief at the end of a chronic stressor: Most of the respondents in this group had a spouse who was suffering from chronic illness, they perceived themselves to have little in the way of buffering instrumental support, and they viewed their marriages as relatively conflicted and unsatisfying. Similarly, another recent study has also shown that family members who provide care for relatives with dementia endorsed high levels of depressive symptoms prior to the loss and exhibited significant decreases in the level of depressive symptoms following bereavement (Schulz et al., 2003). Consistent with this analysis, the individuals in the depressed-improved group from the CLOC study scored higher on the perceived benefits of widowhood, such as pride in coping with adversity and greater self-confidence, than did all other groups (Bonanno et al., 2004). Moreover, the improved group in this study exhibited an unambiguously healthy profile during bereavement and, in fact, was not statistically different from the resilient group on most of the post-loss measures of adjustment. Like the resilient group, the improved group scored relatively low on indices of different types of grief symptoms, and evidenced little searching for meaning or processing the loss. In contrast to the notion that the improved group's healthy profile was due to denial or grief inhibition, this group did report at least occasional grief symptoms in the early months of bereavement and had low scores on measures of avoidance and distraction.

Thus, even the improved respondents seemed to be surprised by how well they did. Finally, although the improved group reported little comfort in positive memories of the spouse at the 6-month point in bereavement, it was the only group to increase significantly on this measure over the course of bereavement, and by the 18th month of bereavement, those in the group had levels as high as resilient individuals.

CONCLUSION

Our review of the findings and clinical implications of the CLOC study clearly underscore, the importance of systematic, prospective research on bereavement among both younger and older adult populations (Bonanno, 2001b). As we argued earlier, the bereavement field now faces something of a dual dilemma. Not only have historically dominant assumptions about the necessity of engaging in grief work consistently failed to generate convincing empirical support, but standard clinical interventions, based largely on this assumption, also have shown a sobering lack of efficacy. Our analysis of the CLOC findings suggests that one underlying reason for this lack of efficacy has been inattention to the distinction between chronic grief and chronic depression. Indeed, future research on clinical interventions should employ rigorous assessment and selection procedures to differentiate chronic grief from chronic depression. Another issue raised by our analysis is the extent to which a thoroughgoing focus on grief is therapeutic for persons with severe and persistent grief symptoms. One way to address this question would be a controlled trial where bereaved participants are randomly assigned to either a grief-focused or a symptom-focused intervention. An alternate approach would be to investigate qualities of the therapeutic alliance in relation to the perceived emphasis and usefulness of a grief-focused intervention. In addition, researchers might profitably employ designs that examine the effectiveness of grief interventions in routine clinical settings, eschewing rigorous controls. In real-world settings, clinicians might rely on more generic therapeutic procedures that are less indebted to grief work and that may be more effective. Indeed, investigators have argued that research on grief interventions should take greater account of the broader literature on psychotherapy outcomes in which nonspecific relational and contextual aspects are widely regarded as the active ingredients in psychotherapy (Jordan & Neimeyer, 2003). In this broader framework, grief counseling would be based less on specific therapeutic procedures and more on generally accepted principles of sound clinical practice (Beutler, 2000). Our analysis of the CLOC findings

and the bereavement literature supports this alternate conceptualization of grief counseling and suggests that it is an important area for future research.

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CHAPTER 11

Implications for Public Policies and Social Services

What Social Workers and Other Gerontology Practitioners Can Learn from the Changing Lives of Older Couples Study

Virginia E. Richardson

Social workers and other gerontological practitioners encounter bereaved persons in many settings including hospitals, hospices, nursing homes, retirement communities, senior citizen centers, and adult day centers. In hospitals, physicians and nurses consult with social workers about dying patients and their families. Social workers conduct assessments and provide care to bereaved persons in hospices. They develop bereavement plans that consider bereaved persons' needs, resources, and goals; identify outcomes and objectives for each service that is provided; and determine the frequency with which the services will be offered (National Hospice and Palliative Care Organization [NHPCO], 2002).

Social workers' knowledge about community services and their involvement on interdisciplinary teams place them in a unique position to link bereaved persons to supportive services and to counsel those who need help. More social workers and other practitioners with training and expertise in bereavement will be needed as the population ages. Unfortunately, most social workers feel ill-prepared to provide bereavement counseling and services (Kramer, Pacourek, Hovland-Scafe, 2003). Kramer and collaborators (2003)

found that only 31 of 50 social work texts reviewed between 1997 and 2002 covered grief, loss, and bereavement, and just 11% of the gerontology texts presented adequate content on end-of-life care. Although several new theories of bereavement emerged during this period, few authors mentioned contemporary models of bereavement; several referred to Kübler-Ross's (1969) stages of dying as grief stages, although they were based on the experiences of terminally ill persons instead of bereaved persons. More recent efforts, such as the National Association of Social Work's "Guidelines on End-of-Life Care," will advance social workers' knowledge in this area (Bailey, 2004).

Social workers and other practitioners must keep abreast of developments in bereavement research as the number of older clients steadily increases. Nearly one-third of all persons over the age of 65 are widowed (14% of men and 44% of women in 2003) and roughly two-thirds of all Americans over the age of 85 are widowed (35% of men and 78% of women in 2003) (U.S. Bureau of the Census, 2004; Federal Interagency Forum on Aging-Related Statistics, 2004). The personal and social costs of bereavement are high; bereaved persons often experience psychological and physical declines that cause work absenteeism and place a burden on friends and family members (Laditka & Laditka, 2003).

A large body of research shows that older bereaved spouses have higher rates of mortality and morbidity, weaker immune systems, more depressive symptoms, more chronic conditions and functional disabilities, a higher number of physician visits and days spent in nursing homes, greater overall health care costs, and higher rates of hospitalization than their married peers (e.g., Goodkin et al., 2001; Hall & Irwin, 2001; Laditka & Laditka, 2003; Prigerson, Maciejewski, & Rosenheck, 2000). The economic and physical costs associated with spousal loss underscore the importance of enhanced training in bereavement care for all health professionals. But, these costs also highlight the need for bereavement programs that address the concrete as well as the psychological issues that older widowed persons confront.

This chapter focuses on two goals: first, to increase practitioners' awareness of programs and services that address the practical and psychological challenges facing older bereaved persons; second, to suggest policies and programs that will offer effective help to bereaved older adults as they cope with these challenges. The rational for (and necessity of) providing both practical and emotional support to bereaved elders is set forth in the Dual Process Model of Bereavement (Stroebe & Schut, 1999).

Stroebe and Schut (1999) propose that bereaved spouses alternate (or "oscillate") between managing emotional or *loss-oriented tasks* and practical

or *restoration-oriented* activities. Specifically, when bereaved persons engage in loss-oriented coping they focus on what they have lost, typically the loss of an enduring and intimate relationship with a spouse. They use restoration-oriented coping, which are secondary processes, when they address the difficulties that arise following (and because of) the loss. This may include attending to life changes, doing new things, distracting oneself from grief, and establishing new roles, identities, and relationships. According to Stroebe and Schut (1999), most older widowed persons oscillate or alternate between loss- and restoration-oriented coping during bereavement.

Practitioners can assist older bereaved persons more effectively when they implement bereavement programs and policies that address both loss-oriented concerns, such as feelings of yearning and sadness, *and* restoration-oriented tasks, such as securing survivor benefits. Although many employers, organizations, and community programs attend to widowed persons' psychological issues, far fewer address the many practical problems that bereaved older adults face. This chapter begins with a review of current clinical interventions, including primary, secondary, and tertiary practices, as well as public policies and programs, such as the Older Americans Act (OAA), the Social Security Act (SSA), Medicare, Medicaid, and the Family Medical Leave Act (FMLA), that directly (or indirectly) target the needs of older widowed persons. Next, I discuss the implications of research findings from the Changing Lives of Older Couples study (CLOC) and other studies for the development and administration of bereavement interventions. Finally, I conclude with recommendations for education and training.

CLINICAL INTERVENTIONS AND PUBLIC POLICIES

Clinical Interventions

Bereavement clinical practices are typically organized around primary, secondary, and tertiary interventions. Primary interventions focus on preventing problems and supporting existing health or healthy functioning, whereas secondary interventions are designed to reduce problems. Tertiary interventions attempt to decrease complications or maladaptive responses, and are usually provided by highly trained mental health professionals (Bloom & Gullotta, 2003).

Primary Interventions

Primary interventions range from strengthening bereaved persons' social support systems to providing crisis intervention shortly after a death. The purpose of such programs is to mobilize bereaved persons' natural support systems

and link them to community services as needed. Hospice care is an example of a primary intervention that supports dying and bereaved persons.

Hospice and End of Life Care. The intent of hospice care is not to prevent death, but rather to provide emotional and spiritual support to dying persons and their families and to facilitate an individual's dying in a way that meets the person's distinctive needs (DeSpelder & Strickland, 2002). Hospices are usually community-based organizations. They offer a range of services from managing care recipients' pain to comforting and counseling family members during bereavement.

Medicare Part A (hospital insurance) covers 100% of hospice benefits if the patient's doctor certifies that the patient is terminally ill with a life expectancy of 6 months or less (Centers for Medicare and Medicaid Benefits, 2004; see Table 11.1 for website addresses). Beneficiaries contribute a copayment up to $5 for outpatient prescription drugs and may be charged 5% of the Medicare-approved amount for inpatient respite care. Medicare pays providers according to fixed prospective per diem rates that are based on service level and setting. Medicare requires that hospices include an organized program of bereavement services under the supervision of qualified professionals. Medicare is the most common source of funding for hospice services, but Medicaid provides hospice coverage in most states, and many hospices receive reimbursements from private companies and other sources. In 1977, there were about 50 hospices in various stages of development, and by 2001 the National Hospice and Palliative Care Organization (NHPCO) estimated that 3,200 hospices were operating in the United States and its territories, serving approximately 775,000 patients and their families (NHPCO, 2003).

The NHPCO, formerly the National Hospice Organization, represents 90% of hospices in the United States. It is committed to enhancing the quality of life for terminally ill persons and their families and is the largest nonprofit organization of hospice and palliative care professionals and organizations in the country. The NHPCO standards for bereavement care, which are outlined in "Guidelines for Bereavement Care in Hospice," require follow-up visits with families for at least 12 months after the patient dies (NHPCO, 2002). The standards also mandate that interdisciplinary teams conduct two bereavement assessments (NHPCO, 2002). Social workers conduct a survivor risk assessment at the time of the patient's admission to evaluate family members' risks for developing complications in bereavement. The second bereavement assessment, which considers family members' physical, emotional, social, spiritual, economic, and intrapersonal needs, concerns, and resources, is completed between 4 and 8 weeks after the patient's death. Social workers also develop

TABLE 11.1
Website Addresses for Programs, Services, and Organizations Meeting the Needs of Bereaved Older Adults

American Association for Retired Persons	http://www.aarp.org/griefandloss
Center for the Advancement of Health	http://www.cfah.org/pdfs/griefreport.pdf
Last Acts at the Robert Wood Johnson Foundation	http://www.rwjf.org/index.jsp
National Association of Social Workers	http://www.socialworkers.org
National Consensus Project	http://www.nationalconsensusproject.org
National Partnership for Women and Families	http://www.nationalpartnership.org
National Hospice and Palliative Care Organization	http://www.nhpco.org
Older Americans Act	http://www.aoa.dhhs.gov/about/legbudg/oaa/oaa_1965.pdf
Older Women's League	http://www.owl-national.org/
Medicare Benefits	http://www.medicare.gov/Publications/Pubs./pdf/yourmb.pdf
Social Security Facts on Women	http://www.ssa.gov/organizations/educationalwomen factsheet.htm
Strengthening Aging and Gerontology Education for Social Work (SAGE-SW)	http://www.cswe.org/sage–sw
The Council on Social Work National Center for Gerontological Social Work Education (CSWE Gero-Ed Center)	http://www.cswe.org/ http://depts.washington.edu/geroctr/

a plan for bereavement care for up to 1 year following the patient's death. Practitioners refer family members who are deemed at risk for complicated grief reactions or who want further assistance to specialists with expertise in bereavement counseling.

Patients' lengths of stay in hospices have decreased over the past decade as physicians try more curative treatments for longer periods of time, but most hospices still provide bereavement care for approximately 1 year (Miller,

Williams, English, & Keyserling, 2002). The care typically involves trained volunteers who visit survivors in their homes and provide them with support, information, and referrals to professional counselors if necessary (Leming, 2003). Unfortunately, these contacts are often brief and inconsistent (Center for the Advancement of Health, 2003). The NHPCO reported in a recent survey of hospices that survivors received a total of about 3.4 bereavement contacts, including home visits and/or telephone contacts (NHPCO, 2003). Despite these limited services, experts found in a recent review of hospice outcomes that elderly spouses of hospice decedents, especially wives, had higher survival rates than older spouses of non-hospice decedents (National Consensus Project, 2004).

The NHPCO recently joined a consortium of national organizations that includes the American Academy of Hospice and Palliative Medicine, Center to Advance Palliative Care, Hospice and Palliative Nurses Association, and Last Acts Partnership (now under the direction of the Robert Wood Johnson Foundation) in order to develop the first national clinical practice guidelines for palliative care. The guidelines have been published in a report entitled, "Clinical Practice Guidelines for Quality Palliative Care" (National Consensus Project, 2004), and are designed to improve access to hospices and palliative care programs, especially for persons deemed ineligible for hospice services because their physicians were unable to certify that they have only six months to live. The intent is to reach people at all stages of illness and to increase the number of deaths that occur at home. Most deaths in the United States occur in hospitals (over 50%) or in nursing homes (about 25%), and the proportion of deaths occurring in institutions is even higher among older persons (Teno, 2003). These statistics are troubling because the vast majority of Americans would rather die at home (Pritchard, Fisher, & Lynn, 1998).

Practice guidelines at all stages are outlined in the consensus report. The bereavement recommendations, which are included in Guideline 3.2, state that bereavement services should include:

1. An interdisciplinary team of professionals with expertise in loss, grief, and bereavement
2. Bereavement services as a core component of the palliative care program
3. Bereavement services and follow-up for the family for at least 12 months or longer if needed, after the death of the patient
4. Routine grief and bereavement risk assessment
5. Clinical assessments to identify people at risk of complicated grief and bereavement associated with depression and comorbid complications

6. Ongoing provision of information on loss and grief and the availability of bereavement support services, including those offered through hospice and other community programs, as culturally appropriate and desired
7. Support and grief interventions in accordance with the developmental, cultural, and spiritual needs, expectations, and preferences of the family
8. Training, supervision, and support for staff and volunteers providing bereavement services
9. Referrals to health care professionals with specialized skills when clinically indicated

The National Association of Social Workers (NASW), the largest membership organization of professional social workers in the world with 153,000 members, also has recently adopted guidelines on bereavement and end-of-life care in a report titled, "NASW Standards for Social Work Practice in Palliative and End of Life Care" (Bailey, 2004). The guidelines emphasize social workers' commitment to biopsychosocial and culturally sensitive practice, interdisciplinary teamwork, and empowerment and advocacy. The authors describe social work services, such as linking families to support systems and participating in interdisciplinary teams, and also recommend individual and family counseling for people who are struggling with bereavement. These guidelines will become an increasingly important resource as more and more social workers work with older widows and widowers in the future.

Other Community Supports. Hospice social workers integrate hospice care with local agencies that promote older persons' independence and enhance the quality of their lives. Most agencies receive funding under the Older Americans Act (OAA), discussed in the next section, but they also obtain financial support from local sources, private donations, and Social Services Block Grants established in 1981 when the Title XX Amendments to the Social Security Act were passed. Although programs vary widely, partly as a result of disparate funding sources, almost all communities provide home-delivered meals (e.g., Meals on Wheels), homemaker and chore services, and other home-based services for older persons and people with disabilities. Many communities also offer escorts or volunteers who travel to older persons' homes and accompany them to the grocery store on public transportation. Grocery delivery programs, in which older persons call in grocery orders that volunteers deliver to their homes, are widely used.

Practitioners have used various strategies to target the most vulnerable older adults, but information and referral services (I&R) are often older persons' first link to aging services. Practitioners working at these I&R services: (a) provide individuals with current information on opportunities and services available to them within their communities; (b) assess older adults' problems and capacities; (c) connect people to the opportunities and services available in the local area; (d) investigate through follow-up whether people were successfully connected to the services they needed; and (e) serve the entire community of older individuals, especially members of minority groups and the most frail elderly persons (AOA, 2004a). The National 2-1-1 Initiative and the National Eldercare Locator, both launched in the 1990s, also will improve older persons' access to services. The National 2-1-1 Initiative, which is supported by disparate funding sources, is a 24-hour telephone hotline that provides information about older adult services. Although the services that are offered through 2-1-1 vary from community to community, most provide information and referrals regarding basic human needs, physical and mental health care, transportation, adult day care, employment, and financial assistance. The National Eldercare Locator is a national toll-free referral that also links caregivers to older adult services in their communities. It is funded by the U.S. Administration on Aging and administered by the National Association of Area Agencies on Aging and the National Association of State Units on Aging.

Secondary Interventions

Secondary interventions, such as individual counseling and mutual support groups, are designed to minimize the negative effects of bereavement. These interventions provide help to older bereaved adults who want additional support to alleviate their distress and to prevent it from escalating.

Widow Support Groups. Widow support groups usually meet once a week for approximately 10 weeks. Participants share information about grief, widowhood, effective coping strategies, survivor benefits, and residential relocation. Community providers and health professionals often refer people who need support to these groups, and although professionals often facilitate them, widows who have previously participated in similar groups sometimes lead them.

Phyllis Silverman developed the "widow-to-widow program" (WTW) at the Harvard Laboratory for Community Psychiatry in the late 1960s (Silverman, 1986). Although professionals directed the program, it functioned as a

mutual-help program. It was originally designed for use by men and women, but Silverman found few widowers who were available to volunteer their time and serve as peer supports. The program is based on her observation that the most effective support for a bereaved person is another widow. These programs also helped to reduce the stigma associated with professional counseling by putting widows in contact with one another.

The WTW eventually added a Widowed Service Line, staffed by volunteers, which substantially improved outreach to bereaved adults (Abrahams, 1972). Although the original program ended in 1971, community agency leaders continued to offer widow support groups. The basic design of Silverman's (1986) program has been replicated and adapted many times, throughout the United States, Canada, and Western Europe.

In 1973, the American Association of Retired Persons (AARP) began a similar program, called Widowed Persons Service (WPS), and AARP continues to act as a resource for widowed persons in the United States and Canada. These groups currently vary from professionally led groups to mutual support groups led by experienced widows. AARP has developed new programs that take advantage of new technology and media; for example, online support groups are now available (AARP, 2004).

Researchers have found that participants in widow-to-widow support groups had fewer depressive symptoms, resumed their activities more quickly, and developed new relationships more easily than nonparticipants (Lieberman & Videka-Sherman, 1986; Vachon, Lyall, Rogers, Freedman-Letofsky, & Freeman, 1980). Raphael and Wooding (2004) concluded that widow support groups effectively provide bereaved persons with social support, advocacy, and practical information, especially regarding identity and role redefinition.

Individual Counseling. Individual counseling is another secondary intervention that is available to most older widowed persons. This counseling, which almost always occurs during face-to-face meetings, varies from supportive and insight-oriented treatments to cognitive behavioral approaches. Insight-oriented counseling focuses on clients' feelings, perceptions, and reactions to bereavement, whereas cognitive behavioral therapies emphasize changing clients' behaviors and thought processes. The latter interventions assume that negative beliefs, expectations, and perceptions about the world and about one's experiences cause anxiety, depression, and general distress. Practitioners encourage clients to substitute positive and constructive statements for irrational and self-destructive cognitions and combine these with behavioral interventions such as relaxation training and pleasant events activities (Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003).

Although many social workers use insight and cognitive behavioral interventions, most implement biopsychosocial interventions that target older clients' biological, psychological, social, and environmental functioning. For example, a social worker might encourage an older client to identify positive aspects of bereavement or to use coping strategies, such as finding meaning, that will alleviate distress (a micro-level intervention) but also concomitantly advocate for more environmental supports or higher survivor benefits (a macro-level approach).

Tertiary Interventions

Most tertiary interventions involve individual counseling for people who are under extreme distress or who have been diagnosed with complicated grief reactions. Although some experts believe that complicated grief exists and should be included in the *Diagnostic Statistical Manual (DSM)* (e.g., Prigerson et al., 1999), others believe these reactions occur infrequently (see Mancini, Pressman, & Bonanno, chapter 10). Researchers who have evaluated the efficacy of clinical interventions for bereaved persons have found only weak empirical support for tertiary treatments (see, for example, Mancini and colleagues, chapter 10; Jordan & Neimeyer, 2003; and Schut, Stroebe, van den Bout, & Terheggen, 2001). Gray, Prigerson, and Litz (2004) concluded that although therapy generally alleviates bereavement-related distress, it typically subsides over time without intervention, and no particular type of intervention for bereavement has yet been proven to be better than any other. Most scholars concur that grief interventions work best for those who are at-risk for complicated reactions and for those who seek help. However, such interventions can be ineffective and create adverse effects when they interfere with normal grieving (Hansson & Stroebe, 2003; Jordan & Neimeyer, 2003; Schut et al., 2001). There is also evidence that treatment is more likely to be successful if is administered after a delay, preferably between 6 and 18 months after the death (Jordan & Neimeyer, 2003).

The most significant problem with tertiary interventions is the lack of consensus about how complicated or traumatic grief should be conceptualized and what criteria should be used for diagnosing it. One difficulty arises from inconsistency in labeling; some investigators refer to complicated grief reactions, but others call them disordered, pathological, or traumatic, and these labels mean the same thing in some instances but refer to different syndromes in others. Standardizing treatments is problematic when different labels are used to describe similar phenomena. In addition, very few investigators have systematically assessed the cultural and social contexts of

disordered mourning. The efficacy of a treatment, for example, may differ when it is used with bereaved persons from different ethnic backgrounds. Finally, methodological issues, self-selected samples, a lack of control groups for comparison, and the absence of statistical controls for confounding factors all help explain the contradictory findings.

Public Policies

Few national policies focus directly on bereavement, although some federal statutory programs, such as the Older Americans Act (OAA), the Social Security Act (SSA), and Medicare, include important provisions for older widows and widowers. The Older Americans Act offers a network of services for older bereaved adults, while Medicare finances health care and hospice benefits for people over the age of 65, and the Social Security program provides economic benefits to retirees, widows, and their dependents. Many policies targeting older adults have emerged over the last 50 years, but these three programs—OAA, SSA, and Medicare—have had the greatest impact on the daily routines, physical and mental health, and economic resources of older widows and widowers (Wacker, Roberto, & Piper, 2002). Medicaid, which provides health care for low-income persons, and the Family Medical Leave Act also will have increasing relevance as more older adults continue to work.

The Older Americans Act

After the White House Conference on Aging in 1961, advocates for older persons developed legislation that ultimately created Medicare and the Older Americans Act (OAA) in 1965. The OAA created a network of agencies dedicated to providing services to older adults, including the Administration on Aging (AOA), state governments, and area agencies on aging. This federal, state, and local partnership, called the National Aging Services Network, consists of 56 State Units on Aging (SUAs); 655 Area Agencies on Aging (AAAs); 244 Tribal and Native American organizations; two organizations that serve Native Hawaiians; 29,000 local service providers; and over 500,000 volunteers. The network serves about 7.5 million older persons under Title III, called the Community-Based Services Program, and over 400,000 caregivers receive services each year under the National Family Caregiver Support Program (AOA, 2004b).

Unlike many federal programs, the OAA created services for all older persons without means testing. Although recent amendments to the Act target those in greatest social and economic need, including the most frail older

persons and low-income and minority elderly persons, all older persons 60 years of age or older are eligible for services. OAA consists of seven titles. Title I of the OAA established 10 broad policy goals geared toward improving older persons' lives that incorporate federal, state, tribal, and local government partnerships. Title II created the Administration on Aging and includes aging network support activities previously funded under Title IV. Title III is the largest program under OAA and has the largest budget; it provides grants to state and community programs on aging and supports mental health and other services for older persons. Under Part B of Title III, area agencies on aging must provide *access services,* such as outreach, case management, escort, transportation, and information and referral, which are usually the first contacts older adults have with the aging network; *community services,* such as senior centers, adult day care programs, congregate meals, nursing home ombudsman services, health promotion, elderly abuse prevention, legal aid, and employment counseling; *in-home services*; and *caregiver services*, such as respite, counseling, and information. The focus of Title IV is Research, Training, and Demonstration, which has resulted in numerous innovative projects, such as the National Eldercare Locator, discussed earlier. Title V funds the Senior Community Service Employment Program, which was created to help low-income persons over the age of 55 find jobs. Title VI provides grants to Native American tribes, and Title VII focuses on rights protections for elderly persons, such as long-term care ombudsman programs.

The programs and services provided under OAA are especially important for supporting older persons' independence and allowing them to continue living at home. Many older bereaved persons benefit from in-home services, such as homemaker services, chore services, telephone reassurance programs, and friendly visitors, which are usually staffed by volunteers (AOA, 2004a). Some local area agencies on aging also offer health promotion services, including screening for depression, information about mental health, and referrals to psychiatric and psychological services under OAA, as well as concrete services that many older widowed persons use, such as home repair and homemaker services (Wacker et al., 2002). The addition of the National Family Caregiver Support Program (NFCSP) to OAA in 2000 added numerous innovative interventions to support family members who are caring for frail elders. For example, the Administration on Aging and various area agencies on aging have created a web page devoted to NFCSP, a listserv to disseminate research, and issues briefs on family caregiving posted on the NFCSP website (AOA, 2003).

Unfortunately, many older adults who could benefit from the OAA programs lack access to them because of transportation problems and other limi-

tations. Cultural barriers and the perception that help-seeking is stigmatizing also prevent many older bereaved persons from using these services. Over the next 5 years, the AOA plans to implement several innovative outreach strategies, such as targeting information about older adults services at low-income, rural, and non-English speaking older persons, that will help these programs reach the most isolated and vulnerable older adults (AOA, 2002).

The Social Security Act

The Social Security Act (SSA) was enacted in 1935 in response to the development of publicly funded pensions for federal workers and the rise in unemployment during the Great Depression. The Act originally provided benefits only to retired workers, and excluded many farm and domestic workers, state and local employees, and the self-employed. Coverage for survivors and dependents of eligible workers was added in 1939, but it was not until additional legislation was passed in the 1950s that benefits were extended to self-employed persons, state and local employees, and farm and domestic workers. Beginning in 1972, benefit levels were adjusted to reflect annual cost-of-living increases.

Although Social Security is an important source of income to bereaved persons, it is not sufficient to eliminate the high level of poverty among older widowed women, which has consistently been three to four times higher than that of their married peers (McGarry & Schoeni, 2003). For example, roughly 11% of the U.S. population aged 65 and older lived at or below the poverty line in 2002; however, this figure was more than 20% for women who are not married (widowed, divorced, or never married), and 40% for black women living alone (Social Security Administration, 2004; U.S. Bureau of the Census, 2004). Moreover, the median household income for widows in 2002 was $12,971 compared to $30,395 among widowers (U.S. Bureau of the Census, 2004). Unmarried women generally rely more on Social Security benefits than their male counterparts (SSA, 2003).

Many factors contribute to high poverty rates among older widows. First, an older widow usually receives only about two-fifths of the benefits that her former spouse received when he was alive. Widows and widowers can receive full benefits (100% of the deceased spouses' benefits) at the age of 65 or reduced benefits at the age of 60. Because a woman (or a man) is entitled to 50% of the benefit her spouse receives upon retirement as her husband's dependent, a couple receives 150% of his benefit. When her husband dies, however, she receives 100% of the deceased spouses' retirement benefit, which results in a one-third reduction in household income. Second,

older men are more likely than older women to have retirement income from other sources, such as pensions and other savings (Older Women's League, 1998; U.S. Bureau of the Census, 2004). Third, many older women outlive their savings or other non–Social Security income. Women who reach age 65 in 2003 are expected to live, on average, an additional 20 years, compared with 16 years for men (SSA, 2003).

Medicare

Medicare was established in 1965, the same year that OAA was enacted, as a program of comprehensive health insurance for Americans who are eligible for Social Security retirement benefits under Title XVII of the Social Security Act. It includes Part A, Hospital Insurance, which covers costs associated with inpatient hospitalization and some post-hospitalization care as well as hospice expenses, and Part B, Supplemental Medical Insurance, which covers costs of physicians, outpatient care, and other medical services. All persons who are eligible for Social Security receive Medicare; eligible persons include persons who worked 10 years or 40 quarters in jobs that contributed to Social Security, and their spouses. Those without coverage can purchase Part A benefits if they also buy Part B coverage.

Mental health services for bereavement are available under Medicare and include inpatient psychiatric care up to 190 days over the course of one's life; outpatient psychotherapy (with a 50% copayment), and partial hospitalization (which requires a 20% copayment) to alleviate acute distress. Partial hospitalization can benefit older persons who need care and structured services during the day. These mental health services are provided by approved community-based mental health centers, hospital-based programs, or free-standing partial hospital programs (AOA, 2001).

Medicare does not reimburse doctors for mental health screening. Some mental health and aging advocates, such as the Older Women's League (OWL, 2004), argue that Medicare should cover the same amount and percentage of mental health services that it covers for physical health services. The most significant limitation of Medicare is its lack of coverage for many health expenditures, such as extended hospital stays and long-term care, which sometimes devastate older widows' savings. Although legislation was recently passed to cover the costs of prescription drugs, many elderly persons who are eligible for this coverage are unaware of, or confused about, these benefits (National Council on Aging, 2004).

Older widows and widowers often struggle to pay medical costs for dying spouses. In an analysis of older bereaved persons using data from the Health

and Retirement Study, McGarry and Schoeni (2003) found that out-of-pocket medical spending escalates just prior to death and frequently contributes to survivors' economic impoverishment; average medical expenditures were approximately $6,000 in the last year of life, which was about 40% to 50% greater than medical expenditures during any other 1-year period. Hogan, Lunney, Gabel, and Lynn (2001) reported similar findings in their study of Medicare beneficiaries; medical expenses of dying persons during their last years account for 27% of all Medicare spending, and one-half of these expenditures were for expenses incurred within the last 60 days of life (McGarry & Schoeni, 2003).

Medicare also does not cover catastrophe expenses, such as hospital or nursing home stays longer than 150 days. Most people must pay for these expenses out-of-pocket unless they are eligible for Medicaid. Many older persons can receive additional help by purchasing Medigap, a supplemental insurance that covers deductibles, copayments, and other expenses that Medicaid does not cover. However, Medigap still excludes coverage for most long-term care costs (McGarry & Schoeni, 2003).

Medicaid

Medicaid was established in 1964 as a federal-state partnership for low-income persons. Each state develops it own eligibility standards and defines the type and amount of benefits, whereas the federal government maintains oversight and sets broad guidelines. In addition to nursing home care, Medicaid covers mental health services, although these vary across states, and all nursing homes must conduct preadmission screenings to determine a patient's need for mental health treatment under mandates of the Omnibus Budget Reconciliation Act of 1987. If a physician approves the treatment, Medicaid will also pay for individual and group therapies; psychosocial services, and physical, occupational, and speech therapies; case management services that assist older persons with medical, social, educational, and other services; services for older persons in institutions for mental or emotional disorders, such as severe brain disorders; personal care services, such as assistance with instrumental activities of daily living; hospice services; and home and community-based services, including Medicaid waiver programs that incorporate programs for individuals with chronic mental illnesses.

The Family Medical Leave Act

The Family Medical Leave Act (FMLA), passed by Congress in 1993, does not specifically provide bereavement leave. It guarantees that people who

work for companies with more than 50 employees can take up to 12 weeks unpaid leave a year to care for a newborn or newly adopted child or for certain seriously ill family members, or to recover from their own serious health conditions. The FMLA was developed largely to address the needs of younger working parents who were grappling with the demands of paid work and child care (or parent care) (U.S. Bureau of the Census, 2004). Although it does not provide bereavement leave, older persons can use the FMLA to care for an ill spouse or deal with their own health problems. Bereaved workers may obtain reprieves from work if they provide medical documentation that they are so incapacitated by grief following the death of a spouse that they are unable to function successfully at work. Companies will need to accommodate more requests for leaves by older persons under the FMLA as increasing numbers of older workers delay retirement and work later in life. People over the age of 65 will account for roughly 20% of the U.S. labor force by 2015 (U.S. Department of Labor, 2004a).

For employees to be eligible for FMLA benefits, they must have worked for a covered employer (with at least 50 employees) for at least 12 months and have worked for at least 1,250 hours over the previous year at a location in the United States. In addition, at least 50 employees must be working within 75 miles of the employer (U.S. Department of Labor, 2004b). Although the FMLA was intended to provide employees time off from work to provide care for family members—a responsibility that typically falls upon women—the firm-size requirement precludes many women from taking advantage of FMLA benefits. The stipulation that FMLA covers only firms with 50 or more employees means that it omits about half the workforce, particularly women and low-income workers who typically work for smaller firms (Lichtman, 2003; Phillips, 2004). The National Partnership for Women and Families (2002) is working to expand the FMLA to cover part-time workers and businesses that have at least 25 employees, which would add an additional 14% of all workers.

Employees of small (and large) companies often turn to employee assistance programs (EAP) for bereavement services. EAP services help employees manage personal or interpersonal problems that may affect their job performance, and counselors are usually licensed and certified in their respective professions (Federal Occupational Health, 2003). These programs were first developed to help employees with substance abuse problems, but they have expanded to provide assistance with mental health issues, family conflicts and stress, and workplace violence. All federal agencies have employee assistance programs, and current, disabled, or retired state employees and their families are eligible for EAP services in most states (Office of Personnel Management,

2004). The Federal Occupational Health (FOH) is an employee assistance program that offers a range of services to federal employees, including 7-day, 24-hour telephone access to professional counselors for assessment of mental health, substance abuse, workplace, and other issues; face-to-face short-term, focused counseling for individuals, couples, and families; referral for treatment and other supportive resources; educational and informational services; and help with returning to work or seeking new employment after an absence for medical or mental health reasons (FOH, 2003).

Despite the number and range of services that EAP provide, few of these programs specifically address bereavement and end-of-life issues. One survey of workplace policies revealed that only 6% of all employers offered comprehensive employee programs on terminal illnesses and bereavement, although this may increase as older workers delay retirement (Last Acts, 1999). Some national organizations have developed guidelines to help employers design bereavement policies. For example, "Grief at Work: A Manual of Policies and Practices" (2000), published by the American Hospice Foundation, recommends that companies offer referrals for bereavement counseling and mental health services and provide educational materials on grief and bereavement to all eligible employees (Fitzgerald, 2000). Last Acts, an advocacy organization for death and dying issues, has also developed a manual, "Helping Employees Deal with End-of-Life Issues: A Toolkit" (2002), which encourages employers to offer paid family leave, flexible work schedules, job sharing, leave sharing, and support groups (Last Acts, 2002).

CRITIQUE OF INTERVENTIONS AND PUBLIC POLICIES

Although the number of programs and the availability of services continue to increase, there is still very little research identifying the interventions that work best for different clients under different circumstances. For example, Schut, Stroebe, van den Bout, and de Keijser (1997) found that the efficacy of a treatment differed for widows and widowers: bereaved men benefited more when practitioners implemented emotion-focused interventions, whereas bereaved women improved more when problem-focused interventions were used. Experts have also inadequately evaluated the impact of community interventions, such as support services for widows who need assistance with yard work, financial matters, and other instrumental tasks. The efficacy of bereavement interventions may increase when clinicians tailor interventions based on clients' gender, ethnic background, and other personal differences.

Bereavement policies and programs serve older widows and widowers on multiple levels, but they are often fragmented and inconsistent and vary

by community, agency, or health professional. As more national organizations develop bereavement guidelines, practitioners will have more up-to-date resources for assessing and treating older widows and widowers. The next section reviews selected findings from the CLOC study and other empirical studies that demonstrate that older widowed persons must adjust to practical as well as psychological issues after their spouses' deaths. In general, the findings from these recent studies underscore the importance of adopting a "dual process perspective" on bereavement, such as Stroebe and Schut's Dual Process Model of Bereavement, that emphasizes both loss-oriented (or emotional) issues and restoration-oriented (or practical) issues that older widows and widowers face.

FINDINGS FROM THE CHANGING LIVES OF OLDER COUPLES STUDY

Most studies of widows and widowers have used cross-sectional research designs (O'Bryant, 1991; Richardson & Balaswamy, 2001), but the CLOC is a longitudinal study that allows researchers to examine older bereaved persons' emotions, behavior, social relationships, and psychological well-being over time. It is ideally suited for studying bereavement because it includes a sample of older married "controls" who are matched with bereaved persons of similar age, gender, and race. The study also obtained a baseline evaluation of older bereaved persons before they lost their spouses and included detailed questions about the context of the individual spouse's death.

Researchers using the CLOC data have provided new insights into bereavement that challenge many practitioners' myths and assumptions about grieving. Taken together, studies based on the CLOC reveal that reactions to spousal loss vary widely depending upon death circumstances, coping styles, and economic and social resources. Bereavement affects people on multiple levels, and in turn, multiple factors influence how people react to it.

Despite the complexity and variability of older persons' bereavement reactions, experts such as Stroebe and Schut (1999) suggest that most people oscillate between loss-oriented and restoration-oriented coping; that is, they focus on their feelings about the loss and concomitantly attend to the secondary stressors associated with bereavement. Recent findings from the CLOC and other studies confirm the importance of loss- and restoration-oriented coping during bereavement (Richardson, in press; Utz, chapter 7). Although many factors influence people's bereavement reactions, two issues have particularly important implications for bereavement policies and programs: the

death context and practical considerations, which affect loss- and restoration-oriented coping, respectively.

Death Context and Loss-Oriented Issues

Research Findings

Research shows that older bereaved persons' adjustments to loss are affected by many aspects of death, including timing, cause, place, extent of caregiving, extent of suffering, and communications about death. Although it depends on what aspect of loss one is measuring, the most salient death context influences include whether the death was sudden or prolonged, violent or peaceful, and painful or uneventful; the amount of caregiving; and the location of death. (See Carr, Wortman & Wolff, chapter 3, for an in-depth discussion of these death context influences.)

Implications for Practice and Policies

Implications for the National Hospice and Palliative Care Organization. The death context—especially where and how a person died—has important implications for hospice and palliative care organizations and carries lessons for both pubic policies and clinical practice. Researchers confirm that survivors are less distressed over losing a spouse when the death occurs at home, but feel more distress if the decedent suffered (Carr, 2003; Richardson & Balaswamy, 2001). Caregiving circumstances also affect bereaved persons' reactions. Survivors often feel relieved when spouses die after long, protracted illnesses, but widowers who became socially isolated during caregiving suffer long-term consequences from lack of interpersonal contact (Carr, House, Wortman, Nesse, & Kessler, 2001; Schultz et al., 2001). These adverse consequences underscore the value of hospice and palliative care and mental health services. Recent data also suggest that people need time to address loss-oriented and restoration-oriented issues during bereavement (Richardson, in press; Richardson & Balaswamy, 2001). For example, Richardson and Balaswamy found that older men who were bereaved for less than 500 days demonstrated significantly more negative affect than those who had been widowed for a longer time period. Similarly, using the CLOC data, Richardson (in press) observed that the scores of older widowed persons and their matched controls on the Bradburn Affect Scale differed most at Wave 1. For example, the scores for overall well-being for the widowed participants were 7.7, 8.5, and 8.6 at Waves 1, 2, and 3, respectively, while the scores for the controls were 10.3, 9.9, and 9.2, respectively, for this same period. The widowed persons and their controls became more similar by Wave 3; however,

this was partly due to a decline in well-being among the non-bereaved. These findings corroborated previous studies that had suggested bereavement is especially stressful during the first year (Wilcox et al., 2003). In addition, although Bonnano and collaborators (2002) found substantial variability in older bereaved persons' patterns of grieving, they also observed that almost all bereaved persons initially exhibited some symptoms of grief that subsided by 18 months after their spouses' deaths.

Implications for Mental Health Policies. Services available under existing programs are insufficient in many respects. For example, many older persons who could benefit from mental health services do not receive them (AOA, 2001). Fewer than 3% of older adults are seeing mental health professionals for treatment, which is lower than any other adult age group (Lebowitz et al., 1997). This figure may reflect generational differences in the perception that treatment seeking is stigmatizing. However, the high cost of this care is also a significant obstacle for many older widows and widowers.

The Mental Health Parity Act. Proposed legislation to enhance the Mental Health Parity Act, originally passed in 1996, would reduce some treatment costs. This Act and the Mental Health Parity Reauthorization Act of 2003 require employer-sponsored health plans to provide equivalent annual or lifetime dollar limits for mental and physical health services (U.S. Department of Labor, 2004c). In addition, 34 states now have legislation requiring parity requirements (National Alliance of Mental Illness, 2004).

The Mental Health Equitable Treatment Act. The Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, which has been introduced in the House and Senate, would increase parity between mental and physical health treatment. This Act would prohibit employers with 50 or more workers from imposing higher out-of-pocket costs for treatment of mental illness than for treatment of physical illness and would require treatment for mental illness on the same terms and conditions as other illnesses. The U.S. General Accounting Office (GAO) estimates that this legislation would increase health premium costs by about 4% (U.S. GAO, 2000).

The Medicare Mental Health Modernization Act. Another proposed bill now pending before the House and Senate, the Medicare Mental Health Modernization Act of 2003, would expand coverage of mental health services under Medicare by eliminating the lifetime limit on inpatient mental health services.

It would also establish parity in treatment for outpatient mental health services, expand coverage of community-based mental health services, and improve beneficiaries' access to Medicare-covered services. The current Medicare benefit structure discriminates against those who suffer from mental illness and continues to endorse outdated approaches biased toward institutionally based programs by underfunding long-term care (National Institute of Mental Health, 1999). Proponents argue that community-based mental health programs could reduce hospitalization rates by 30% to 60% under this Act.

The Positive Aging Act. The proposed Positive Aging Act, which is also pending in the House and the Senate, would improve mental health services for older persons by integrating medical and mental health care, improving older persons' access to mental health care and delivering this care more effectively. The Act would support mental health projects at various levels, including prevention and intervention at senior centers, adult day care programs, assisted living facilities, and primary care settings. Research by Fischer, Wei, Solberg, Rush, and Heinrich, (2003) and Bruce, Ten Have, Reynolds, and Katz, (2004) underscores the need for these policy changes. Fisher and colleagues (2003) compared treatment of older and younger patients in primary care clinics and found that physicians were significantly more likely to ask about depression, offer resources, and refer for mental health treatment when speaking to younger patients. Physicians rarely raised these issues when they met with older patients. Brown and colleagues (2004) reported similar results in a study of home health patients. When Bruce and collaborators (2004) compared the effectiveness of usual care for older persons' depression symptoms with an on-site intervention administered by masters-level clinicians, they found that the on-site approach was significantly better at reducing symptoms. Mental health practitioners who are specially trained to detect depression in older persons can effectively screen and treat older adults for mental health symptoms in these primary care settings, and give physicians more time to focus on older persons' physical functioning.

Restoration-Oriented Issues

When a spouse dies, bereaved persons must cope with more than just feelings of loss for a life long companion. They must also address restoration-oriented issues—which include secondary stresses related to bereavement—that range from concrete matters such as maintaining one's home to obtaining survivor benefits and other economic issues.

Practical Issues

Bereaved persons must perform the same practical chores they have always completed along with those that their deceased spouses once performed. These tasks include preparing meals; doing laundry; making home repairs; managing household duties and finances; socializing; and shopping for groceries, clothes, and other personal needs. Utz (see chapter 7) found that older bereaved adults are often overwhelmed when initially confronted with these additional tasks, although widows are more troubled by home maintenance chores and widowers struggle more with household tasks. Both widows and widowers spend less time on household chores over time, presumably because they have more difficulty performing them as they grow older. Although friends and family members usually assist bereaved persons with instrumental tasks during the early stages of bereavement, these informal supports tend to subside over time, and widows tend to receive more support than widowers (Utz, chapter 7). These analyses suggest that many older widowed persons, especially older widowers, need more assistance later in the bereavement process.

Utz's findings underscore the importance of tailoring services to individuals' practical needs and of reaching out to even the most reticent widowed persons. The priorities articulated in the Administration on Aging's report, *Strategic Action Plan FY 2003–2008*, are consistent with the need to improve older persons' access to community services. The administration's first priority is to increase older persons' access to "an integrated array of health and social supports" (AOA, 2002). The goal is to educate the public, including policy makers, about the challenges older people face when trying to access services and to identify more effective interventions and outreach programs to meet these challenges. Other strategies that the AOA intends to pursue include disseminating information to older persons to increase their awareness about health and social supports, integrating health care and social support programs; promoting innovative community models to implement services, testing new approaches and techniques, and evaluating programs to identify strategies and approaches to support future programs and policy developments (AOA, 2002). The AOA also plans to launch an online version of the National Eldercare Locator (mentioned earlier) to support a greater number of partnerships among organizations and reduce the fragmentation and redundancy in services, and certify and train Information & Referral Specialists to enhance their understanding and sensitivity to the needs of older persons (AOA, 2002).

The AOA's other priorities include helping older people stay active and healthy, supporting caregivers, ensuring older persons' rights, preventing elder

abuse, and promoting effective and responsive management. AOA recently launched a program, the Performance Outcome Measures Project (POMP), which will evaluate the effectiveness of OAA services. The preliminary findings from this initiative are favorable: 95% of people who used information and assistance reported that their call was promptly answered, 80% reported that they would recommend this service to friends, and 94% who left a message had their calls returned the same day (AOA, 2004c). In addition, the most vulnerable and socially isolated older adults appear to be accessing the service. Approximately 69% of those who used homemaker services lived alone, 85% reported incomes under $15,000, 72% were over the age of 75, and 47% indicated that they wanted more social activities. In the general older adult population, by contrast, about 6% are over the age of 75 and 39% have incomes below $15,000 (U.S. Bureau of the Census, 2004; SSA, 2004).

The AOA's role is not limited to the evaluation of services. It also conducts financial audits of OAA programs, which have been consistently underfunded, seeks competitive funding sources, and incorporates feedback from inside and outside the aging network. The 2003 appropriation for OAA services amounted to less than $30 for each eligible American (aged 60 or over) (Richardson & Barusch, 2005). Demands for aging-related services will grow as the number of older Americans increases, and additional funding will be needed to meet those demands.

Economic Issues

Many older persons worry about their finances. Utz (see chapter 7) found that widows reported significantly more financial strain and significantly less income than widowers. These results are consistent with data presented earlier documenting the high poverty rates among older widows.

Experts have considered various strategies to reform Social Security to ameliorate elders' economic difficulties. The most frequently discussed options focus on: (a) increasing Social Security survivor benefits, (b) modifying the eligibility criteria for Supplementary Security Income (SSI), (c) redefining Social Security minimum benefits, (d) eliminating Social Security limits on widows and widowers, and (e) increasing Social Security benefits for people over the age of 80. (See Anzick & Weaver, 2001; Choudhury, Leonesio, Utendorf, Del Bene, & Gesumaria, 2001; and FitzPatrick & Entmacher, 2000 for a more in-depth discussion of these options.) These options would have varying effects on payroll taxes, ethnic groups, future cohorts, and a host of other issues. The potential consequences for widowed persons are considered here.

Increase Survivor Benefits

Both scholars (e.g., Choudhury et al., 2001) and women's advocacy groups, such as the Older Women's League (OWL), have endorsed the first option—increasing Social Security survivor benefits. This option would increase Social Security survivor benefits to 75% of the couple's combined Social Security benefits. As discussed earlier, when a spouse dies, a survivor receives only about two-thirds of what the couple received, which is problematic for most widows. Although this option would affect the largest number of people, Anzick and Weaver (2001) estimate it would reduce the poverty rate among elderly widows and widowers by only 1.8%; if survivor benefits were increased to 85% of the couple's benefits, it would decline by 3.0%. The most serious limitation of this proposal is its inattention to older divorced women, who have especially high poverty rates (SSA, 2004).

Reform Eligibility for Social Security Income

A second option is to change the income requirements and assets test for SSI. Rupp, Strand, and Davies (2003), as well as Anzick and Weaver (2001), conclude that this option would decrease the poverty rate among elderly widows and widowers by 2.1%. Rupp and colleagues (2003) confirm that the poverty rate among elderly women is highest among those who are eligible for SSI based on income criteria but who also have assets in excess of SSI limits. This option would reduce the elderly poverty gap (the amount of money it would take to raise all elderly persons to the poverty threshold) by a larger percentage (8.9%) than any of the other options (Anzick & Weaver, 2001).

Redefine Minimum Benefits

The third option is to redefine minimum benefits. Special minimum-benefit legislation was enacted in 1972 to increase Social Security benefits for regular, long-term covered workers with low earnings and their dependents or survivors (Olsen & Hoffmeyer, 2001/2002). Most (90%) special minimum beneficiaries are female retired workers. Unfortunately, few persons—only 1,122 of approximately 4.2 million new beneficiaries in 2001—receive these benefits (Olsen & Hoffmeyer, 2001/2002). The long-term goal of this proposed legislation is to phase out the need for minimum benefits as regular benefits increased over time; minimum benefits are paid only if they are larger than the benefits that are payable under the regular formula, which grows faster because they are linked to wages which have exceeded inflation. Although this guarantees at least poverty level income and increases the benefit levels of women with low lifetime earnings, the minimum level

is only guaranteed for those who attained the 40 quarters of paid work eligibility criterion for benefits (Calasanti & Slevin, 2001; Sandell, Iams, & Fanaras, 1999). Those with intermittent work trajectories would not be protected by this proposal because the structure of Social Security is linked to earnings histories (Rupp et al., 2003). In addition, this proposal would not reduce the overall gender gap in wages and retirement income because it only applies to a subgroup of older women (Calasanti & Slevin, 2001). This option nevertheless would target the most impoverished older adults and would reduce the poverty rate among elderly widows and widowers by 2.3%. (Choudhury et al., 2001).

Eliminate the Widow and Widower Limit

The fourth option is to eliminate the widow and widower limit, also enacted in 1972, which restricts benefits to the amount that the deceased spouse would be receiving if he or she were still alive (Anzick & Weaver, 2001; OWL, 2002). If the spouse filed for retirement benefits before age 65, the amount the survivor will receive is less than if the spouse delayed retirement until after age 65. The intended purpose of this legislation is to prevent survivors from receiving higher benefits than their spouses would have obtained if they were still alive. About one-third of widow/widower beneficiaries have their benefits limited as a result of this provision (Weaver, 2001/2002). Some argue that the widow/widower limit provisions unfairly penalize survivors, who may not have had input into a spouse's decision to retire early (Anzick & Weaver, 2001; OWL, 2002). In addition, few widows have other retirement resources, such as personal savings or pensions, to compensate for this reduction in Social Security benefits. The Older Women's League contends that widows/widowers should get credit for delayed retirement benefits, receive higher benefit levels, and have their benefits calculated on the age at which benefits begin rather than the age at which a spouse retired (OWL, 2002). However, the impact of these changes in benefits would be minimal, reducing the poverty rate by only 0.6% (Anzick & Weaver, 2001).

Increase Benefits for Persons Over Age 80

Increasing benefits by 5% for persons over the age of 80 is a fifth option (Choudhury et al., 2001). Given that poverty rates tend to increase with age for Social Security beneficiaries, this option would reduce overall poverty levels. However, because this option would only help those over the age of 80, it would not assist many of the lowest income beneficiaries, who are most likely to die prematurely (Preston & Taubman, 1994).

Future cohorts will confront new and different sets of issues as they age. More women are working today than in the past, and they will receive Social Security benefits based primarily on their own work records. This change will benefit mostly women who work at jobs with high earnings, however, and many widows will continue to rely on their husbands' retirement benefits because women's jobs pay less than men. Almost two-thirds of women today have the same kind of low-wage jobs in sales, clerical, and retail that women have traditionally held (OWL, 2002). Estes (2004) estimates that a typical woman with a college degree who is now 25 years old will make about $523,000 less in wages over her lifetime than her male counterpart (see Women's Institute for Secure Retirement (WISER), 2002). The problem is exacerbated because women are more likely than men to work at jobs that lack pension coverage (U.S. Bureau of the Census, 2004), and to work intermittently due to caregiving obligations (Brody, 2004; OWL, 2001; Women's Institute for Secure Retirement (WISER), 2000). OWL estimates that women perform an average of 16 years of unpaid care work for children and 17 years for adults (OWL, 2000).

Caregiving credits would benefit older women and younger working women who must take time off from work to care for others. Many older women's Social Security benefits would be higher if employees were given credits for up to 5 years of work for unpaid caregiving. Their benefits also would increase if older women could disregard up to 5 additional years in which they earned little or no income when calculating Social Security benefits (see OWL, 2002 for a more in-depth discussion of these alternatives). Disproportionate numbers of widows will continue to live in poverty unless policy makers account for their often interrupted work histories when calculating Social Security benefits (Gregoire, Kilty, & Richardson, 2002).

IMPLICATIONS FOR EDUCATION AND TRAINING

The disparities between existing bereavement services and the needs identified by recent research underscore the importance of research-based bereavement interventions. According to a recent report on bereavement and grief research, "Improving care through the alignment of research and practice is an issue of critical concern in relation to bereavement care" (Center for the Advancement of Health, 2003). To close this gap between research and practice, social scientists and clinicians must communicate and keep abreast of developments in each other's domains. Researchers must translate new findings into forms that practitioners can easily use, and clinicians must be able to interpret research and apply it to their practices.

As the population ages, there will be an increased need for practitioners with expertise in gerontology, end-of-life care, and bereavement. Social workers with expertise in aging will be in great demand in the 21st century (Scharlach, Damron-Rodriguez, Robinson, & Feldman, 2000). The National Institute on Aging estimates that by 2020 the aging populace will require between 60,000 and 70,000 full-time social workers (National Institute of Aging, 1987). The U.S. Bureau of Labor Statistics similarly projects a 40% increase in the need for gerontological social workers (U.S. Bureau of Labor Statistics, 1992). The demand will become especially important in medical settings. Many older bereaved persons would rather discuss their mental health concerns with their physicians than with social workers or psychologists (Unutzer, Katon, Sullivan, & Miranda, 1997). Innovative partnerships, such as that implemented by Bruce and colleagues (2004), described earlier, will become important strategies for reaching older widowed persons. Future demands will require social workers with expertise on aging to work on interdisciplinary teams with physicians, nurses, occupational therapists, and other health professionals in primary care settings, such as hospitals, nursing homes, rehabilitation centers, health maintenance organizations, hospice programs, and multipurpose senior services (Damron-Rodriguez & Corley, 2002).

The John A. Hartford Foundation has budgeted more than $22 million to enhance geriatric social work in the United States (Robbins & Rieder, 2002). It is committed to developing faculty leaders in gerontological education, creating aging-rich field placements for social work students, and establishing gerontological resources for clinicians, teachers, and researchers. The Foundation's first social work funding went to the Council on Social Work Education (CSWE), the only accrediting body for social work baccalaureate and master's programs, which subsequently created "SAGE-SW" (Strengthening Aging and Gerontology Education for Social Work), and more recently, The CSWE National Center for Gerontological Social Work Education (CSWE Gero-Ed Center). Numerous resources on gerontological social work have been developed since SAGE-SW began. A survey of social work programs confirmed the need to better educate social workers about aging; the survey showed that few social workers are prepared for the next generation of older clients and few programs offer specializations or certificates in aging or field placements devoted to gerontological practice. The Hartford initiatives aim to attract more students to gerontological social work and to teach them about "best practices" with older persons. The Hartford Geriatric Faculty Scholars Program, the Hartford Geriatric Social Work Doctoral Fellows Program, and the Practicum Partnership Program also will strengthen social workers' resources in aging.

In addition to initiatives that prepare geriatric specialists in social work, Rosen, Zlotnick, and Singer (2002) emphasize that gerontological competence must increase for *all* social workers, who will inevitably encounter older adults in families, prisons, hospitals, and community mental health centers. Thus, content on late life and bereavement should be infused into human behavior, research, and policy courses. Specialized courses that focus on aging, bereavement, and other end-of-life issues are also needed. Accreditation and licensing bodies must also mandate content on aging and end-of-life care to increase all practitioners' understandings of aging and widowhood.

Instructors should encourage practitioners to reflect on their own experiences with dying friends or family members and to consider the ways those experiences can influence their work with bereaved clients. Innovative curricula efforts that integrate didactic and experiential learning will help instructors to train practitioners more effectively. According to the authors of the recent report on *Grief and Bereavement Research*, "Failure to recognize the role of experience as well as the role of formally derived knowledge in guiding practice may therefore make it much more difficult for researchers and practitioners to connect and for research evidence to be used to improve care" (Center for the Advancement of Health, 2003, p. 21).

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CHAPTER 12

The Future of Late Life Spousal Bereavement

Deborah Carr

The research presented in this volume provides a detailed portrait of late life widowhood in the United States. The authors documented the psychological, social, physical, and spiritual consequences of spousal loss for older adults. In addition, they provided important insights into both the etiology of grief and an evaluation of the effectiveness of current policies and interventions for assisting bereaved older adults. However, it is important to recognize that this research describes late life spousal loss as it is currently experienced, and not how it may be for *future cohorts* of bereaved elders. The members of the Changing Lives of Older Couples (CLOC) study were born in the early 20th century, and in many ways their experiences as widows and widowers reflect the distinctive experiences of a generation who came of age during the Depression and World War II years, and who went on to hold traditional gender-typed social roles in adulthood.

The CLOC participants' experiences are broadly representative of White, heterosexual, American-born older adults who had been married only once in their life. Future generations of older adults will be much more racially and ethnically diverse than the CLOC cohort, and will have family and marital histories that are very different from those of past generations. Future cohorts of older adults also will be much larger than current cohorts. Participants in the CLOC study belong to a relatively small birth cohort; during the first 3 decades of the 20th century, roughly 2 to 3 million babies were born per year. During the Baby Boom years of the mid-1940s through early 1960s, in

contrast, 3.5 to 4 million babies were born each year. The oldest members of the baby boom cohort, born in 1946, are on the verge of turning 60; in the coming decades this very large cohort will enter late life.

Due to its size and diversity, the aging baby boom cohort will create unprecedented challenges for policy makers, clinicians, and gerontology professionals. This chapter briefly describes the ways that future cohorts of older adults may differ from members of the CLOC sample, and speculates about how these differences may shape bereavement experiences among future cohorts of older adults. As the elderly population in the United States grows increasingly diverse, scholars and practitioners must develop an understanding of the distinctive ways that different subgroups experience and respond to spousal loss.

DIVERSITY IN THE OLDER POPULATION

The "Aging" of the Older Population

The most rapidly growing segment of the older population is the "oldest old," or persons ages 85 and older. The oldest-old population is expected to increase fivefold, from 4 million in 2000 to 21 million by 2050 (Federal Interagency Forum on Aging-Related Statistics, 2004). The burgeoning "oldest old" population is of particular interest to policy makers because they are much more likely than younger elderly to experience physical disabilities and cognitive impairments. As a result, future generations of older caregiving spouses will include many frail persons, and they may be particularly overwhelmed by caregiving responsibilities and the eventual death of their spouse. Bereavement scholars may need to move beyond contrasting the experiences of older widows and widowers (i.e., persons over age 65) with younger and midlife bereaved persons, and may instead need to identify the distinctive challenges facing the "young" old (i.e., persons ages 65 to 84) and the "old" old (i.e., persons ages 85 and above).

Cultural Differences in Bereavement Experiences

Surprisingly little research has focused on the distinctive sources of distress and resilience among older African American, Hispanic/Latino, Asian American, and Native American bereaved spouses in the United States. How people grieve varies widely across ethnic groups due to cultural differences in how death is understood, beliefs about the possibility for future reunion with the deceased, and ways of communicating about death (Rosenblatt, 2001). Although small qualitative studies have documented the ways that specific

ethnic and religious groups grieve (see Rosenblatt, 2001), little systematic comparative research has been conducted. This omission reflects the fact that few sample surveys include adequate numbers of older ethnic minorities, yet this may soon change in coming decades.

The older population in the United States is more ethnically diverse than ever before, and will become even more diverse as the aging baby boom cohort enters late life. Today, non-Hispanic Whites account for nearly 83% of the U.S. population over age 65. Blacks account for 8% of the older population, Asians make up nearly 3%, and Hispanics (of any race) account for nearly 6% of the older population. Demographers predict that by the year 2050 these proportions will shift dramatically. According to some projections, in 2050 non-Hispanic Whites will account for just 61% of the U.S. population over age 65. Blacks will account for 12%, Asians will make up nearly 8%, and Hispanics (of any race) will account for fully 18% of the older population. In raw numbers, that means that the older Hispanic population is expected to grow from 2 million today to 15 million in 2050, whereas the older Asian population will increase from 1 to 7 million in that same time period (Federal Interagency Forum on Aging-Related Statistics, 2004).

The religious profile of the American population also is changing, due in part to high levels of immigration from Asia and parts of Africa. The U.S. government does not maintain official statistics on religious preference, yet the American Religious Identification Survey (ARIS), a large scale sample survey, reveals that the number of Americans who identify as Buddhist or Muslim has doubled over the past decade (Kosmin, Mayer, & Keysar, 2001). Consequently, programs and services for older people, particularly bereaved older spouses, will require greater flexibility to meet the needs of a more culturally and spiritually diverse population.

Some research suggests that older African Americans have special disadvantages and advantages, relative to Whites, as they cope with spousal loss. At every stage of the life course, African Americans have lower earnings, fewer assets, and lower rates of home ownership than do Whites (e.g., Oliver & Shapiro, 1995). Because the death of a spouse often is accompanied by costly end-of-life medical care and funeral expenses, the transition may be particularly devastating for older adults who already faced economic adversity prior to the loss. Yet research on racial differences in coping suggests that African Americans have several resources that may enable a more successful adjustment to loss. First, older African Americans are more likely than Whites to participate in formal religious activities (such as church attendance) and to rely on their religious beliefs as a strategy for coping with stressful life events (e.g., Levin, Chatters, & Taylor, 1995). The beneficial effects of religion—

particularly for older women—have been widely documented (Koenig, 1998); religion provides social support and a belief system that helps older bereaved persons to cope psychologically with loss.

Second, African American married couples have been found to have lower levels of marital quality, higher levels of marital conflict, shorter marriages, and a more egalitarian division of household labor than do White married couples (Orbuch & Eyster, 1997). Black women historically have been more likely than White women to work for pay outside the home, and the division of labor at home tends to be more egalitarian when both wife and husband work outside the home (Shelton & John, 1996). Because of their reduced dependence on their spouse for performing gender-typed household tasks and more strained emotional ties within marriage, African American widows and widowers may experience less distress and anxiety upon the loss of spouse than Whites. Third, African American elders are less likely than Whites to depend upon and interact with members of the nuclear family only, and instead maintain a more diffuse social network that may include friends, distant relatives, neighbors, and members of their church congregation (Ajrouch, Antonucci, & Janevic, 2001). Given that social support is one of the most important resources for coping with stressful life events, older African Americans' more varied interpersonal relationships and frequent contacts may provide an important source of instrumental and expressive support as they adjust to loss. One study based on the CLOC sample found that African American bereaved spouses reported lower levels of anger and despair than did their White peers, and this advantage was due in large part to their higher levels of social support and religious support (Carr, 2004).

Few studies have explored systematically the ways that older Hispanics and Asians manage the challenges of late life, particularly spousal loss. However, a number of recent small-scale and qualitative studies reveal cultural differences in practices surrounding death and bereavement. For instance, some Latinos experience *ataque de nervios* in response to the death of a loved one (Guarnaccia, DeLaCancela, & Carillo, 1989). The *ataque* is a display of sadness and anger that may involve shaking, shouting, swearing, striking out, and falling to the ground with convulsive movements, or lying still as if one were dead. *Ataques* typically occur in appropriate contexts such as funerals and are generally accepted by members of the community as a normal and appropriate grief response. An understanding of cultural differences in grief reactions can be useful to counselors and practitioners for treating members of ethnic subgroups. For example, a clinician who is aware of *ataque* and its significance in some Latin American cultures may be more likely to recognize

it as a culturally acceptable response, rather than as an indication of delirium or pathological grief (Wisocki & Skowron, 2000).

Identifying ethnic differences in family roles, relations, and customs may also be helpful in developing culturally sensitive interventions to help the older bereaved. For instance, older Chinese bereaved spouses may feel shame in turning to public agencies for support. Confucian principles of filial piety dictate that children (particularly one's oldest son and his wife) should care for their aging parents. Children who neglect their parents are looked upon with shame (King & Bond, 1985) and are believed to have violated a moral imperative (Wei-Ming, 1994). Yet older Chinese parents also may feel shame by turning outside the family for support; such an act would suggest that their children are not fulfilling their responsibilities. If cultural beliefs and traditions pose psychological barriers to help-seeking, then social workers and practitioners need to be fully aware of such barriers.

Partner Loss Among Older Gays and Lesbians

Researchers also know relatively little about how older gays and lesbians adjust to the loss of their long-term life partners. This dearth of research reflects the fact that no official statistics are available for same-sex unions, given the lack of social and legal approval for these relationships. Moreover, current cohorts of older adults (such as participants in the CLOC study) grew up during an historical era marked by limited awareness and acceptance of homosexuality. For future cohorts of older adults, however, gay partnerships may be both more common and more accepted than in past cohorts. Grief counselors and practitioners will need to develop an understanding of the ways that gay bereaved partners are both similar to and different from heterosexual widows and widowers.

Older gays and lesbians face special challenges, yet may also have distinctive advantages as they cope with partner loss. On one hand, bereavement may be particularly difficult. Bereaved gay partners may encounter conflict with their deceased partner's family members, particularly with respect to the dispersion of personal possessions following death (DeSpelder & Strickland, 1992). Lack of institutionalized support compounds the difficulty faced by gay partners. Although there are serious shortcomings in Social Security benefit levels and eligibility criteria for surviving spouses who were married (see Richardson, chapter 11), no benefits are available for surviving partners in gay and lesbian relationships. Other rights extended to heterosexual married couples are not typically available for same-sex couples, including the opportunity to

make health care and end-of-life decisions for ill partners. (The legal rights afforded to gay partners are rapidly evolving, however, with a handful of states now granting gays the right to marry or to form civil unions.) Bereaved partners may not receive sufficient emotional support upon loss, because the end of homosexual relationships may not be recognized or acknowledged in the wider community. Some may receive insufficient emotional support from their families of origin, if these relatives disapprove of their lifestyle or sexual orientation (Friend, 1990).

However, gays and lesbians also may have some resources that may enable better coping with the strains of late life partner loss. They may create their own support networks of friends, significant others and selected biological family members. Lesbians are more likely than heterosexual women to enact flexible gender roles throughout the life course; these roles, in turn, may foster greater adaptability to change and more positive self-identities, particularly upon the loss of one's life partner (Kimmel, 1992). Friend (1990) has argued that older gays and lesbians have had greater freedom than their heterosexual peers to learn skills that are nontraditional for their gender. Because they are not bound to traditional family roles, they may be better prepared for the daily challenges and responsibilities (or "restoration-oriented tasks") faced by the newly bereaved (Stroebe & Schut, 1999).

CHANGING DEMOGRAPHIC AND ECONOMIC CONTEXTS

Shifting Gender Roles

One of the most important social changes to occur in the late 20th century has been the transformation of men's and women's work and family roles. Cohorts of men and women born in the early 20th century, such as participants in the CLOC study, were socialized to maintain traditional gender roles in the home and workplace. Most women channeled their time and energy toward raising children and caring for their families. Relatively few women had continuous or high-paying careers, so most depended on their husbands for their financial well-being (Spain & Bianchi, 1996). Their husbands fulfilled the role of breadwinner and typically spent little time mastering home-making tasks. Moreover, men raised in the early 20th century often were socialized to be independent and self-reliant; many relied nearly exclusively on their wives for emotional support and had few other confidantes (Stevens, 1995).

In contrast, men and women in subsequent generations are much more likely than members of the CLOC cohort to share equally in household responsibilities (Shelton & John, 1996). Baby boom women have higher levels of education, more years of work experience, and higher personal earnings

than do past cohorts of women. While more than one-quarter of baby boom women are college graduates, only 6% to 7% of women born in the first 3 decades of the 20th century have college degrees (Hughes & O'Rand, 2004). Thus, future generations of older women may be less dependent on their husbands for income, as well as for support with male-typed tasks such as home repair and financial management tasks (Spain & Bianchi, 1996). Likewise, each cohort of men is more likely than his father's generation to participate in homemaking and child-rearing tasks (Shelton & John, 1986). As the boundaries demarcating traditional men's and women's roles blur, we might expect that distress and anxiety will be minimized among future cohorts of widows and widowers. Newly bereaved elders will presumably face fewer challenges as they manage the tasks once performed by their late spouses, because they are likely to have shared such tasks while married.

Family Structure Changes

At the same time, adaptation to spousal loss may become more difficult for future cohorts of widows and widowers. Two important demographic trends—increasing divorce rates and declining fertility rates—may have important consequences for how older bereaved spouses adjust to loss. The members of the CLOC sample belong to a cohort who experienced relatively low levels of divorce and separation, given both the social stigma accompanying divorce and the lack of opportunities for women to provide for themselves economically in earlier decades (Cherlin, 1981; Holden & Smock, 1991). Thus, some men and women of this cohort may have remained in marriages that provided relatively low levels of warmth and relatively high levels of conflict. If we believe that current cohorts of married couples are more likely to dissolve dissatisfying marriages, then those who remain married until late life may have higher levels of marital satisfaction and thus may suffer worse following the loss of these close relationships.

Declining fertility rates and increases in geographic mobility mean that older men and women will have fewer children upon whom they can rely for social support, and these children will be less likely than past generations to live close to their parents (Connidis, 2001). Women born in the early decades of the 20th century were largely responsible for giving birth to the large baby boom cohort, with most giving birth to three or four babies. Women born in the 1940s and 1950s, however, have gone on to have just one to two babies, on average (Hughes & O'Rand, 2004). Future cohorts of older bereaved spouses may need to develop more expansive social networks that include friends and family members who are geographically proximate, to

counterbalance the fact that their children are fewer and less proximate than in past generations.

Although future cohorts of older adults will have fewer children than did past cohorts, a growing number of older adults are responsible for the care of their grandchildren. In 2000, nearly 6 million grandparents lived with grandchildren under the age of 18. Of these, 2.4 million co-residential grandparents were their grandchildren's primary caregivers. Nearly two-thirds of these grandparents are women, and roughly one-fifth live in poverty. Researchers have not explored extensively whether co-residential grandchildren are an additional stressor or a source of support when an older adult loses his or her spouse. Some evidence suggests that bereaved spouses who live with their grandchildren may be overwhelmed by the stressor of widowhood, because it is yet another stressor added to their already difficult lives. Many grandparents co-reside with their grandchildren because of a family crisis, such as the death of their child (i.e., the grandchild's parent), or because their child is incarcerated, ill, impoverished, or suffering from substance abuse or mental health problems (Fuller-Thomson, Minkler, & Driver, 1997). Future research should investigate the special stressors facing widowed co-residential grandparents, so that effective interventions may be developed.

Economic Trends

The Social Security Act of 1935 and subsequent amendments have been instrumental in lifting many older adults' incomes above the poverty level (see Richardson, chapter 11). While 35% of older adults lived below the poverty threshold in 1960, this proportion dropped to just 10% by 2002 (Federal Interagency Forum on Aging-Related Statistics, 2004). However, some older adults are much more likely to live in poverty than others, with unmarried (i.e., divorced/separated, widowed, and never married) women—particularly Black and Hispanic women—at greatest risk of poverty. While just 4% of White married couples over age 65 live in poverty, 41% of unmarried Black women and 47% of unmarried Hispanic women are poor (Federal Interagency Forum on Aging-Related Statistics, 2004). This economic disparity between the "haves" and "have nots" is expected to grow even larger among future cohorts of older adults. Inequality in household income has increased dramatically since 1980. Households in the top one-fifth of the income distribution have increased their share of income, whereas those in the bottom four-fifths have lost ground (Hughes & O'Rand, 2004). Rising inequality is an important trend, and one that may easily go unnoticed. Media depictions of aging baby

boomers tend to portray White, healthy, wealthy couples looking forward to their retirement, but the reality is that growing proportions of older adults will not enjoy economic stability in late life. As Utz (see chapter 7) observes, economic strain prior to and after spousal loss is an important and persistent source of distress for older bereaved spouses, particularly widows.

For future cohorts of older adults, even middle-class couples may face an uncertain economic future, and this has important implications for the well-being of the surviving bereaved spouses. Economists have found that older married couples often underestimate the number of years that the wife will outlive her husband, and consequently may not have sufficient savings or pension earnings to support the bereaved wife for an unexpectedly long spell of widowhood (Holden & Kuo, 1996). Moreover, it may be more difficult for future cohorts of older adults to save for retirement and old-age because workers are retiring earlier than in past generations. How long older adults (and eventually, widowed persons) will need to survive on their retirement earnings depends largely upon their age when they leave the workforce. Over the past 4 decades, workers have been retiring at increasingly younger ages. While men in the 1950s spent 3.3 years working per every 1 year they spent in retirement, in the late 1990s men spent 2.1 years working per every 1 year spent in retirement. The combination of longer life spans yet shorter work lives among baby boomers is expected to create a context of economic uncertainty for this generation as they face old age and spousal loss (Gendell, 2001). This uncertainty may be compounded by proposed changes in Social Security benefits. Although the future of Social Security is in flux, current proposals including the privatization of the system; this move could have a dramatic effect on the economic resources available to future generations of older Americans, particularly bereaved older spouses.

CONCLUSION

The central theme running through this volume is that bereaved older spouses are a remarkably heterogeneous group. Some experience severe depressive and grief symptoms after their spouse dies, while others are resilient and show few signs of distress after their spouse dies. Although therapy and interventions can be highly effective for treating the problems of some bereaved spouses, for others, such interventions may actually do harm. Widowhood does not have uniformly negative (or positive) effects on physical, emotional, economic, social, or spiritual well-being; rather, the personal consequences of spousal loss are contingent upon characteristics of the bereaved, characteristics of the late spouse, the context of the death, the

quality of social support available, the nature of the marital relationship, and even the historical time period in which one lives. In the future, researchers will be charged with exploring additional sources of heterogeneity, including the race, ethnicity, religion, sexual orientation, and family characteristics of the bereaved spouse. The CLOC data set has and will continue to answer important questions about bereavement among current cohorts of older adults. We very much look forward to seeing future studies explore the distinctive ways that the aging baby boom cohort experiences spousal loss in the coming decades.

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