

Examining the Role of Social Support on Adjustment to Widowhood

by

Noshin Rafieei

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Graduate Supervisory Committee:

Jennie Kronenfeld, Chair
Steven Haas
Anni Damgaard

ARIZONA STATE UNIVERSITY

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ABSTRACT

Purpose: This study examines the role of social support on adjustment to widowhood. Past research has indicated that the role of social support on adjustment to widowhood remains inconclusive, and needs further examination. This study examines the varying coping trajectories of middle-aged and retired bereaved spouses. Additionally, this study examines how bereavement stage may also influence one's adaptation to widowhood.

Methods: This study used in-depth and semi-structured interviews as a means of understanding the role of social support on adjustment to widowhood. Participants were recruited through two hospice services available in a major metropolitan area in the United States. Convenient and purposive samplings are used in this study; this study will execute a grounded theory approach in order to determine the inconclusive role of social support on adjustment to widowhood. This study is contrasting between two stages- life course stages (middle aged versus retirement aged people) and bereavement stages (a year or less time following the death of a spouse versus three or more years following the death of a spouse). As a means of reducing bias and subjectivity, all data collected during the interview will be transcribed immediately.

Results: Middle-aged bereaved spouses reported higher levels of motivation for adjusting positively and quickly towards widowhood due to their concern for protecting the well-being of their surviving young children compared to retired bereaved spouses. Differences between middle-aged widows and widowers have been found in this study; middle-aged widowers have a higher linkage to negative health behaviors. Retired

bereaved spouses may fare better depending upon their housing location. Living in a retirement center may lower negative effects of bereavement on retired spouses' health.

Conclusions: Types of social support received and expected varied between middle-aged widows and widowers. Gender norms may influence the type of social support widows and widowers receive. Middle-aged widowers are less likely to receive emotional support which may explain their higher linkage to negative health behaviors. Bereavement stage and housing location may be the key factors that influence widowhood trajectories of retired bereaved spouses. Living in a retirement center may lower the negative effects of bereavement on overall health.

DEDICATION

My late father and my beautiful mother.

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Chapter 1

INTRODUCTION

“How am I supposed to get through my daily tasks without bursting into tears every five minutes?” This question was posed to me by my dear friend Martha who had recently lost her husband of twenty-seven years. Martha and her deceased husband were unable to conceive, but were perfectly content being a close-knit family of two. With the first anniversary of her husband’s death fast approaching, Martha confided in me that she has never felt more alone and scared. “I have no children. My parents have passed away. I barely speak to my brothers, and my friends do not really understand the pain I am dealing with.” As a volunteer at the Hospice of the Valley and Homestead Hospice, I urged Martha to spend her retirement days volunteering at the Hospice with me. I suggested that perhaps she would be able to work through her grief by helping others.

As a Hospice volunteer of five years, I constantly challenge myself to determine the most effective way to provide support for bereaved spouses. What kinds of support could I offer bereaved spouses to help mitigate the adverse effects of death? Within the past five years, I have helped bereaved spouses make funeral arrangements, provided instrumental support (assisting with errands), and/or provided emotional support (a shoulder to cry on). Throughout the process of volunteering, I have observed the role of social support on adjustment to widowhood. While some bereaved spouses heavily rely on their children, friends, therapists/professionals, and (extended) family members, some bereaved spouses reported feeling that their family members and friends unintentionally exacerbated their pain and anguish. As a bereaved daughter, Hospice volunteer, and medical sociologist, I find myself intrigued by the role of social support on adjustment to

widowhood. This personal interest and these sets of personal experiences have led me to a decision to study this topic more thoroughly. The goal of this research is to determine the role social support plays on adjustment to widowhood- does it hurt or help?

Baarsen et al (2002) argue that theoretically, “there is no agreement about the role of social support on adjustment to widowhood” (S33). Stroebe et al (1996) add that the role of social support on adjustment to widowhood is inconclusive, and needs further exploration. Why is understanding the role of social support important on adjustment to widowhood? Asai et al (2009) argue that conjugal bereavement may be considered one of the most stressful life events and may be a risk factor for poor health. Holmes and Rahe (1967) agree that widowhood may be the most stressful of all life events, and that widowhood is characterized as one of the most distressing of all life events. Why is widowhood characterized as one of the most distressing life events? “Because the modern nuclear family is expected to be socially and economically autonomous, spouses may have few alternatives sources of social, emotional, or instrumental support” (Carr et al., 1999, p.197). Consequently, when a spouse dies, the bereaved spouse must not only adjust to the loss of a close relationship, but must also handle daily decisions and responsibilities that were once dispersed among two spouses (Wortman, Kessler, & Umberson, 1992; Carey, 1980). Asai et al (2009) suggest that out of all the deaths of a loved one, the most stressful life event may be conjugal bereavement which may increase levels of depression, anxiety disorder, complicated grief, and suicidal ideation.

As a medical researcher and sociologist, understanding what mechanisms may contribute towards a healthy adaptation towards widowhood is important. Because widowhood has been characterized as one of the most distressing life events, it is pertinent to determine what factors contribute towards a positive adaptation trajectory. According to Umberson and Montez (2010), social support/networks may influence health in three ways: behaviorally, psychosocially, and psychologically. “Social support refers to the emotionally sustaining qualities of relationships (a sense that one is loved, cared for, and listened to). Hundreds of studies establish that social support benefits mental and physical health” (Umberson and Montez, 2010, P. S56). Cohen (2004) and Thoits (1995) add that social support may enhance mental health because it may buffer against the impact of stress, and/or it may foster a sense of meaning and purpose in life. Uchino (2006) adds that supportive social networks may reduce blood pressure, stress hormones, and heart rate which may be beneficial to health in addition to minimizing unpleasant arousal which may instigate/trigger risky behavior.

As a Hospice volunteer, I have become acquainted with many bereaved spouses, and developed friendships with a majority of these bereaved spouses. With the consent of my new friends, I collected information regarding their adaptation towards widowhood. Because these bereaved spouses anticipated the death of their spouses and utilized Hospice services, their mortality and adaptation towards widowhood may differ from bereaved spouses who did not utilize Hospice services. For example, Christakis & Iwashyna (2003) found that hospice use reduced surviving wives’ short-term odds of death to 0.92. Furthermore, Christakis & Iwashyna (2003) found that hospice use reduced surviving husbands’ short-term odds of death to 0.95. Said differently, 5.4 percent of

bereaved wives who did *not* utilize hospice care died within 18 months after their husbands' death (Christakis & Iwashyna, 2003). Contrarily, 4.9 percent of bereaved wives who *did* utilize hospice care died within 18 months of their husbands' death- yielding an odds ratio of 0.92 (Christakis & Iwashyna, 2003). For men, 13.7 percent of bereaved husbands who did *not* utilize hospice care died within 18 months after their wives' death (Christakis & Iwashyna, 2003). By utilizing hospice care services, only 13.2 percent of bereaved husbands died within 18 months of their wives' death- yielding an odds ratio of 0.95 (Christakis & Iwashyna, 2003).

As noted above, hospice use might be associated with reducing adverse medical, psychological, and social consequences of bereavement (Christakis & Iwashyna, 2003; Connor & McMaster, 1996). Steinhauser et al (2000) argue that terminally-ill patients fear burdening their family members; as a result, terminally-ill patients reported desiring a "good death." According to Steinhauser et al (2000), "good deaths" may be characterized as deaths that are painless, anticipated, and not too burdensome on family members. Furthermore, hospice care services strive to facilitate "good deaths" by optimizing in pain and symptom relief, enhancing patient and family satisfaction, and providing at-home deaths that are familiar and as comfortable as possible (Steinhauser et al., 2000; Greer et al., 1986; Dawson, 1991). The bereaved spouses that I interviewed are spouses that utilized Hospice services, and anticipated their spouses' death.

Purpose of the study

This dissertation examined the varying coping trajectories of bereaved spouses. The operative word in the aforementioned sentence is: *varying*. The participants in the study varied in their coping trajectories for one or more of the following reasons: gender,

age bereaved, years married, marriage quality, number of children, education level, income level, personality traits, employment, retirement, quality of social network, and amount of time bereaved. What I uncovered is the *current* mental and physical health of the bereaved spouses. More specifically, I wanted to determine the role of social support on adjustment to widowhood; is the role of social support on adjustment to widowhood positive, negative, or inconclusive?

Methods

This study used in-depth and semi-structured interviews as a means of understanding the role of social support on adjustment to widowhood. I used snowball sampling and purposive sampling to recruit participants who have lost a spouse and utilized Hospice care. In this study, I distinguished between two different life course stages and two different bereavement stages. In the former group, life course stages, I discerned between middle age (40-59 years) and retirement age (65 and older) bereaved spouses. In the latter group, bereavement stages, I discerned between one year (or less) following the death of a spouse and three or more years following the death of a spouse. It is important to discern between the life course stage and years bereaved because these factors may or may not influence one's adjustment to widowhood. For example, Raphael (1984) argues that bereavement is expected for older individuals compared to younger individuals. Because older individuals may "expect" bereavement, they may not feel as angry or cheated should their spouse die compared to younger individuals.

On the other hand, Coleman (1990) argues that bereavement for older spouses may be more stressful because they may be in poorer mental and physical health. Additionally, Coleman (1990) argues that older spouses may be more distressed

following the loss of a spouse because they are more likely to be retired, and may have fewer opportunities for contact and support. I interviewed 12 individuals (six males and six females) in the following *four* groups (a total of 48 participants): one year or less following the death of a spouse during middle age (40-59), one year or less following the death of a spouse during retirement age (65 and over), three or more years following the death of a spouse during middle age (40-59), and three or more years following the death of a spouse during retirement age (65 and over).

In conclusion, this project determines the role of social support on adjustment to widowhood. This project examined the following factors on the adjustment to widowhood: age spouse died, gender of bereaved spouse, number of years bereaved, stage of life-course (employed/retired), and quality of social networks/support. As mentioned previously, it may be of importance to examine the age the spouse became bereaved because this may influence one's adjustment to widowhood. For example, an older individual may be more likely to "anticipate" bereavement, and may be more likely to manage his/her emotions more positively following the death of his/her spouse (Raphael, 1984). Sanders (1980) suggests that older and younger spouses may differ in their adaptation towards widowhood due to cohort effects. For example, Sanders (1980) argues that younger spouses compared to older spouses may be more likely to communicate feelings of diminished capacity, fear of emotional breakdown, and uncertainty about their futures (Anderson and Dimond, 1995). Younger spouses may be more likely to seek support compared to older spouses because they may be more likely to communicate their negative feelings and emotions compared to older spouses who may deny these feelings (Anderson and Dimond, 1995; Sanders, 1980). As a result, examining

different age groups and cohort effects may be of particular interest when examining adjustment to widowhood.

In regards to gender differences, men and women may vary in their adaptation towards widowhood. Lilliard & Waite (1995) argue that the “widow/er effect” is especially pronounced in men. Waite (1995) argues that men benefit more from marriage than women; men may benefit more from their marriages because their wives may monitor their health and health-related behaviors (Waite, 1995), may encourage self-regulation (Ross, 1995), and may specialize in the home which would increase married men’s wages (Bianchi, 1995). Furthermore, because this project examined the role of social support on adjustment to widowhood, it is imperative to distinguish between men and women’s social networks. Moore (1990) argues that while men and women generally have similar size networks, or quantity of individuals in their networks, the composition of their networks may vary.

Moore (1990) posits that women’s social networks may be comprised of ties with kin, while men’s social networks may be comprised of non-kin ties. Because the composition of men and women’s social networks may vary, it may be important to discern between the *quality* of men and women’s social networks. While some have argued that women may receive more social support compared to men because their networks are more functional and are characterized as being better in quality (Antonucci, 1990), some have found no differences in the quality of networks and availability of social support by gender (Fischer 1982; Marsden, 1987). As a result, examining gender differences on the adjustment to widowhood is of particular interest in this project.

This project examined the effects of years bereaved on adjustment to widowhood. Because bereaved spouses reported elevated feelings of loneliness, shock, depression, anger, and yearning during their first year bereaved, their adaptation towards widowhood may be more positive as time elapses (Anderson and Dimond, 1995; Asai et al., 2010). Said differently, it may be of particular interest to distinguish between the number of years one has been bereaved. Because bereaved spouses reported lower levels of depression and anguish within three years following the death of their spouse (Asai et al., 2010), this project examined the adaptation towards widowhood between two time frames- one year (or less) following the death of a spouse, and three or more years following the death of a spouse.

Chapter 2

LITERATURE REVIEW

As individuals progress through life stages, at one point or another, they may experience the death of a loved one (Ozer et al., 2003). Some individuals will experience the death of a loved one sooner than others; some individuals may progress through their life cycles without experiencing the death of a loved one and the negative effects of bereavement on their mental and physical health (Ozer et al., 2003). Bereaved individuals cope differently; individuals may have varying coping trajectories depending upon the influence of demographic factors, pre-bereavement personality features, and family backgrounds. Bonanno (2004) suggests that some bereaved individuals may develop acute distress from which they are unable to recover, while some bereaved individuals may cope positively as time passes. Some bereaved individuals may recover quickly-only to experience adverse mental and physical health problems as time elapses (Bonanno, 2004).

Taylor et al (2000) argue that mental health professionals have acknowledged the growing importance and significance of protective psychological factors in the event of experiencing the death of a loved one. According to Taylor et al (2000), protective psychological factors may act as a buffer in protecting the mental and physical health of bereaved individuals. What is of particular importance in this study is determining *how* bereaved individuals may develop protective psychological factors that may shield them from adverse mental and physical health outcomes. What factors contribute towards a positive coping trajectory for bereaved individuals? This literature review will cover the following: the conceptualization of bereavement, the distressing effects of widowhood,

how varying demographic factors may influence one's adaptation to widowhood, and the role of social support on the adjustment to widowhood.

Bereavement

Stroebe et al (2001) suggest that bereavement may be defined as the situation of having lost a significant individual through death. Ringdal et al (2001) argue that the term 'bereavement' "refers to the objective situation of an individual having lost a significant person by death .. bereavement is the cause of both grief and mourning" (92).

Bereavement is a life-event that many people experience, some sooner than later; as such, bereavement may be characterized as a natural human experience that encompasses a period of intense grieving (Stroebe et al., 2007). While many bereaved individuals manage to adjust and readapt to their lives without their loved one(s) over time, some bereaved individuals are at an increased risk of developing negative mental and physical health outcomes (Stroebe et al., 2001; Stroebe et al., 2007).

According to Stroebe et al (2007), the four tasks of grieving are: "accepting the reality of loss; experiencing the pain of grief; adjusting to the environment without the deceased; and relocating the deceased emotionally and moving on" (1964). Stroebe et al (2001, 2007) argue that while the adverse effects of bereavement lessens with time, bereaved individuals do not adapt and/or grieve in a similar fashion. Bereaved individuals may vary in terms of their grieving patterns, amount of time grieving, intensity of grief, and coping trajectories. As such, Elwert and Christakis (2006) argue that examining bereavement-related mortality by subgroups is imperative because there may be subgroup differences to account for. For example, Elwert and Christakis (2006) found that by using a controlled, large-scale study, white bereaved individuals were at a higher risk of

mortality compared to black bereaved individuals. Christakis and Allison (2006) found that sex differences in the mortality of spousal bereavement may also vary. For example, Christakis and Allison (2006) and Waite (1995) found that widowers are more likely to be at a higher risk of mortality compared to widows. Widowers may be at an increased risk of mortality because of an increase in alcohol consumption (Stroebe et al., 2007) and the loss of their 'soul confidante' who would have otherwise monitored their husbands' health status (Stroebe et al., 2001; Waite, 1995).

According to Stroebe et al (2007), sex-difference patterns may vary across types of loss. Li (1995) found that mothers compared to fathers were more likely to experience an increase in excess mortality following the loss of a child. However, with changing sex roles in recent decades, varying sex-difference patterns in bereavement may be altering and should be further examined (Stroebe et al., 2001; 2007). Stroebe et al (2007) suggest that bereavement effects may also vary by age. For example, younger bereaved spouses may be at an additional mortality risk due to the death experienced as compared to their general expected mortality (Stroebe et al., 2007; Schaefer et al., 1995).

Anderson and Dimond (1995) and Sanders (1980) add that younger bereaved spouses may be at an additional mortality risk due to the death experienced (as compared to their general expected mortality) compared to older bereaved spouses because younger spouses are less likely to 'anticipate' and 'accept' the death of their spouse. Stroebe et al (2007) argue that *recently* bereaved individuals are more likely to have physical health problems compared to their longer term bereaved and non-bereaved counterparts. Recently bereaved individuals, according to Stroebe et al (2007) may be defined as individuals who have experienced the loss of a loved one within a year or less; the first

few weeks and months following the loss of a loved one may be the most distressing, and may increase one's risk of mortality (Stroebe et al., 2007). In sum, many researchers have accounted for sub-group differences (age patterns, sex, education, household size, number of children, ethnic origin, socioeconomic status, culture, and personality characteristics) in terms of bereavement effects on health outcomes. It is important to note that even after controlling for subgroup differences in a large-scale study, there is not a "fixed order" process of grieving, and despite controlling for subgroup differences, some bereaved individuals may be at a greater risk of mortality than others (Elwert and Christakis., 2006; Stroebe et al., 2007). As a medical sociologist, it is of particular importance to identify individuals who are at a higher risk of experiencing adverse mental and physical health outcomes as a result of bereavement effects.

Bereavement, grief, and mourning

Ringdal et al (2001) argue that the terms 'grief,' bereavement,' and 'mourning' are often used synonymously. The term 'grief' is characterized as a normal affective response to an overwhelming loss; furthermore, 'grief' includes a number of cognitive, psychological, and somatic reactions that may or may not be expressed by the bereaved individual (Ringdal et al., 2001). The term 'mourning' is characterized as the observable expressions of grief; examples including crying spells, screaming, decrease or increase of appetite, shame, insomnia, emptiness, and fatigue (Ringdal et al., 2001). As mentioned earlier, while most bereaved individuals grieve and mourn differently, it is noteworthy to mention that psychological reactions to bereavement may also vary (Stroebe et al., 2007).

What may also account for varying psychological reactions to bereavement may include the following: affective, cognitive, behavioral, physiological-somatic,

immunological and endocrine changes (Stroebe et al., 2007). Examples of affective reactions may include: depression, anxiety, shock, yearning, anger, and hostility (Stroebe et al., 2007). Stroebe et al (2007) suggest that examples of cognitive reactions may include: suppression, denial, lowered self-esteem, helplessness, and hopelessness. Stroebe et al (2007) suggest that behavioral reactions may include: agitation, fatigue, and social withdrawal. Finally, examples of immunological and endocrine changes may include: susceptibility to disease, illness, and mortality (Stroebe et al., 2007).

In sum, a wide range of psychological reactions may be associated with bereavement; additionally, these psychological reactions may vary by subgroups, cultures, and pre-bereavement personality characteristics. Averill (1979) suggests that researchers have regarded ‘grief’ as an intricate emotional syndrome; while some responses and reactions to grief may be more symptomatic than others, there is not one specific response that is vital to the syndrome (Stroebe et al., 2007; Averill, 1979). Reactions and responses to bereavement may last from a few weeks to a few years, and may range from mild and short-lived to extreme and long-lasting (Stroebe et al., 2007).

Spousal bereavement

“The death of a spouse ranks as the life-event needing the most intense readjustment on the social readjustment rating scale, confirming the status of spousal bereavement as a highly stressful event” (Stroebe et al., 2007, p. 1960). Holmes and Rahe (1967) found that widowhood is characterized as one of the most distressing of life events; furthermore, widowhood may be one of the most distressing of life events “because the modern nuclear family is expected to be socially and economically autonomous, spouses may have few alternatives sources of social, emotional, or

instrumental support” (Carr et al., 1999, p.197). Consequently, when a spouse dies, the bereaved spouse must not only adjust to the loss of a close relationship, but must also handle daily decisions and responsibilities that were once dispersed among two spouses (Wortman, Kessler, & Umberson, 1992; Carey, 1980). Asai et al (2009) suggest that out of all the deaths of a loved one, the most stressful life event may be conjugal bereavement which may increase levels of depression, anxiety disorder, complicated grief, and suicidal ideation. Spousal bereavement may be characterized as a highly distressing life event because it may be related to changes in socioeconomic conditions, emotional conditions, personal relations, and life-style (Parkes, 1985; Kaprio et al., 1987).

Phases of spousal bereavement

Bankoff (1983) suggests that the first phase of bereavement, the crisis loss phase, may be characterized as an extremely chaotic phase. Bereaved spouses have reported feeling that a central, important aspect of their identity died along with their spouse; by losing a sense of self and identity, bereaved spouses also reported feeling that the world has become meaningless and irrelevant during the crisis loss phase (Bankoff 1983; Parkes, 1972; Bowlby 1980). Parkes (1972) argues that during the crisis loss phase, bereaved spouses have yet to accept the reality of their loss, and inadvertently have a propensity to withdraw from reality. Parkes (1972) suggests that during the crisis loss phase, bereaved spouses’ unresponsiveness to human relationships may be characterized as bitter and hostile; Bankoff (1983) suggests that apathy is a common emotional reaction to bereavement during the crisis loss phase. During the crisis loss phase, Parkes (1972) argues that bereaved spouses pay little attention to their role-change issues, secondary

losses, and stigma problems. Their current phase of bereavement, the crisis loss phase, renders bereaved spouses as alienated and isolated (Bankoff, 1983; Parkes, 1972).

In the next stage of bereavement, the transition phase, Bankoff (1983) argues that bereaved spouses may slowly begin to reorganize and rebuild their social relationships. Reorganizing and rebuilding social relationships may be feasible because the intensity of grief has lessened (Parkes, 1972), and bereaved spouses may attempt to revert back to their “normal” lives. “Movement toward a resumption of normal life occurs as the bereaved individual faces the task of building a new life and a new identity as single, rather than a married person” (Bankoff, 1973, p. 829). Bankoff (1983) argues that it is important to acknowledge the various phases of bereavement because the *type, source,* and *amount* of social support needed to mitigate the effects of bereavement may *vary* depending upon one’s bereavement phase.

Are the effects of spousal bereavement less severe if death is anticipated?

While there is no doubt that bereavement is a very distressing life-event, especially among spouses, can the effects of spousal bereavement on one’s health be less severe if death is anticipated? Hansson and Stroebe (2003) argue that in elderly populations (65 years and older), spousal bereavement is extremely frequent, with fifteen percent of men becoming widowed and forty-five percent of women becoming widowed. Raphael (1984) argues that because older spouses may be more likely to “anticipate” bereavement, they may be more likely to manage their emotions more positively following the death of their spouse. Because older spouses may be more likely to “anticipate” bereavement, they may be more equipped to prepare for the onslaught of grief following the death of their spouse (Raphael, 1984). On the other hand, Coleman

(1990) argues that the effects of bereavement may be more pronounced and distressing for older spouses because they may be in poorer mental and physical health. Coleman (1990) argues that older spouses may be more distraught following the loss of a spouse because they are more likely to be retired, and may have fewer opportunities for contact and support.

Sanders (1980) argues that while middle-aged spouses (40-59) may be less likely to “anticipate” the death of their spouse, middle-aged spouses may be more likely to cope positively compared to older spouses because they may be more likely to communicate feelings of diminished capacity, fear of emotional breakdown, and uncertainty about their futures (Anderson and Dimond, 1995). Middle-aged spouses may be more likely to seek support compared to older spouses because they may be more likely to communicate their negative feelings and emotions compared to older spouses who may deny these feelings (Anderson and Dimond, 1995; Sanders, 1980). Examining different age groups and cohort effects may be of particular interest when examining adjustment to widowhood. Because this project is interviewing and focusing on bereaved spouses who *anticipated* their spouses’ death (deceased spouse was terminally-ill and eventually utilized hospice care services), the following section of this literature review will examine the effects of caregiving on the bereaved spouses’ health.

Caregiving burden and “widow/er” effect

Barusch & Spaid (1989) argue that caring for a sick spouse may have adverse health consequences- such as increasing a person’s risk of death; the “caregiving burden” may be more severe among women (Pruchno & Resch, 1989). While women may be more likely to experience the “caregiving burden” compared to men, Lilliard & Waite (1995)

argue that the “widow/er effect” is especially pronounced in men. Waite (1995) argues that men benefit more from marriage than women; men may benefit more from their marriages because their wives may monitor their health and health-related behaviors (Waite, 1995), may encourage self-regulation (Ross, 1995), and may specialize in the home which would increase married men’s wages (Bianchi, 1995). Waite (1995) suggests that marriage provides individuals with a sense of meaning in their lives; because married individuals may feel that they have a “purpose,” they may be more likely to avoid participating in risky behaviors and may be more likely to encourage healthy behaviors. As a result, when a spouse passes, the surviving spouse may experience a diminishing sense of meaning and purpose in his/her life.

Adverse effects of caregiving on the primary caregiver

In this section of the literature review, the following will be examined: the adverse effects of caregiving on a primary caregiver, the unmet needs and challenges primary caregivers may experience, and possible solutions to mitigate the adverse effects of caregiving on primary caregivers (Aoun et al., 2005; Christakis et al., 2003). Aoun et al (2005) define a primary caregiver as an individual(s) who regularly provides “the most assistance with one or more of the core activities of communication, mobility, transport, housework and self-care” (551). Aoun et al (2005) argue that primary caregivers may feel insufficiently prepared for their new role as a caregiver; Aoun et al (2005) suggest that primary caregivers may not only feel insufficiently prepared for their new complex role, but they may also lack adequate resources to fully prepare them for their primary caregiver role. It has been estimated that fifty-seventy percent of terminally ill patients prefer a home death because they desire to be surrounded by familiar surroundings;

spouses and other family members may find themselves insufficiently prepared for the complex role of becoming a primary caregiver to their loved one (Aoun et al., 2005).

Aoun et al (2005) suggest that primary caregivers may experience proliferating levels of stress while performing the caregiving role for the following reasons: uncertainty about treatment, role changes within the family, lack of knowledge about patient care, strained financial resources, physical restrictions, lack of social support, fears of being alone, and lack of transportation for treatment (Aoun et al., 2005, p. 552). Aoun et al (2005) add that emotional strains and disruptions associated with becoming a primary caregiver for a terminally-ill loved one are common; feelings of tiredness, disrupted sleep, isolation, and resentment are commonly reported disruptions and emotional strains reported by caregivers. Caregivers may find themselves adapting to changed family circumstances such as moving to a new location, reducing/increasing employment, and modifying the home to further cater to the needs of the terminally-ill (Aoun et al., 2005). Emanuel et al (2000) found that many caregivers of terminally-ill patients reported feeling anxious and stressed to meet the demands of health care costs. Emanuel et al (2000) argue that many caregivers obtained another job to meet health care costs, sold assets to meet health care costs, took out loans to meet health care costs, and/or spent roughly ten percent of their household income on health care costs for their terminally-ill family member.

Ramirez et al (1998) found that the prevalence of anxiety among caregivers was as high as forty-six percent, and the prevalence of depression was as high as thirty-nine percent the year before the death of their loved one. Ramirez et al (1998) argue that approximately half of the caregivers reported experiencing weight loss, problems

sleeping, and elevated levels of anxiety and isolation. Schulz and Beach (1999) argue that older spousal caregivers were sixty-three percent more likely to experience early mortality compared to non-caregivers. Christakis and Iwashyna (2003) found that utilizing hospice care services mitigated the strains of caregiving on family members; as a result, if the decedent was a recipient of hospice care, the surviving spouse was less likely to fall ill and less likely to experience early mortality compared to surviving spouses who did not utilize hospice care services.

Hospice care services may mitigate the adverse effects of caregiving on spouses' health

As noted above, hospice use might be associated with reducing adverse medical, psychological, and social consequences of bereavement (Christakis & Iwashyna, 2003; Connor & McMaster, 1996). Steinhauser et al (2000) argue that terminally-ill patients fear burdening their family members; terminally-ill patients reported desiring a “good death.” According to Steinhauser et al (2000), “good deaths” may be characterized as deaths that are painless, anticipated, and not too burdensome on family members.

Hospice care services strive to facilitate “good deaths” by optimizing in pain and symptom relief, enhancing patient and family satisfaction, and providing at-home deaths that are familiar and as comfortable as possible (Steinhauser et al., 2000; Greer et al., 1986; Dawson, 1991).

Christakis & Iwashyna (2003) found that hospice use reduced surviving wives' short-term odds of death to 0.92. Additionally, Christakis & Iwashyna (2003) found that hospice use reduced surviving husbands' short-term odds of death to 0.95. Said differently, 5.4 percent of bereaved wives who did *not* utilize hospice care died within 18 months after their husbands' death (Christakis & Iwashyna, 2003). Contrarily, 4.9 percent

of bereaved wives who *did* utilize hospice care died within 18 months of their husbands' death- yielding an odds ratio of 0.92 (Christakis & Iwashyna, 2003). For men, 13.7 percent of bereaved husbands who did *not* utilize hospice care died within 18 months after their wives' death (Christakis & Iwashyna, 2003). By utilizing hospice care services, only 13.2 percent of bereaved husbands died within 18 months of their wives' death- yielding an odds ratio of 0.95 (Christakis & Iwashyna, 2003).

Thus far, this literature review has explored the meanings and conceptualizations of bereavement. Additionally, acknowledging that spousal bereavement may be one of the most distressing life-events motivates researchers to determine what factors may mitigate the adverse effects of bereavement on spouses' mental and physical health. Bereaved spouses may grieve differently, and there is not one "right" or "wrong" way to grieve. Some bereaved spouses may display psychological reactions to loss, while other bereaved spouses do not display psychological reactions to loss.

The time bereaved spouses grieve may vary by weeks or years; additionally, the effects of bereavement may be more pronounced during the first few weeks and months following the death of a spouse. While researchers have found that the effects of bereavement may vary across subgroups, some bereaved spouses may be at a higher risk of mortality compared to other bereaved spouses. Utilizing hospice services and minimizing the adverse effects of caregiving on the surviving spouses' mental and physical health may help mitigate the effects of bereavement on spouses' overall well-being. This project seeks to determine what other factors may help mitigate the effects of spousal bereavement on one's mental and physical health; more specifically, this project seeks to determine the role of social support/networks on adjustment to widowhood.

Does the role of social support/networks mitigate the adverse effects of bereavement or exacerbate the adverse effects of bereavement on spouses' mental and physical health?

Social support/ social networks and health outcomes

This project seeks to determine the role of social support/networks on adjustment to widowhood because the role of social support/networks has not been theoretically agreed upon in the literature (Baarsen et al., 2002). Stroebe et al (1996) add that the role of social support/networks on adjustment to widowhood remains inconclusive, and needs further examining. Stroebe and Abakoumkin (1996) agree that “the bereavement literature suggests that the belief that social support can protect individuals against the deleterious effects of the death of a loved one is theoretically controversial and empirically not well supported” (1241). Bankoff (1983) agrees that the role of social support on adjustment to widowhood is important, yet extremely complex, and needs further examining.

Umberson and Montez (2010) suggest that social networks refer to the web of social relationships surrounding an individual; “in particular, structural features, such as the type and strength of each social relationship” (S55). Umberson and Montez (2010) argue that drawing from prospective studies, much scientific evidence documents that involvements in social relationships may benefit health. According to Umberson and Montez (2010), social networks may influence health in three ways: behaviorally, psychosocially, and psychologically.

According to Vachon and Stylianos (1988), social support includes four components: appraisal support, emotional support, instrumental support, and informational support. Appraisal support, as argued by Vachon and Stylianos (1988), refers to one receiving feedback on one's behavior or views. Emotional support is characterized as support that

enhances one's self-esteem, while instrumental support is characterized as the provision of tangible assistance (Vachon and Stylianos, 1988). Finally, informational support is characterized as support that includes information or advice that enhances/promotes problem solving. "The 'goodness of fit' between donor activities and the need of recipients is governed by the *amount, timing, source, structure, and function* of social support. There must be an adequate balance between the *amount* of support offered and the perceived threat engendered by a particular situation" (Vachon and Stylianos, 1988, p. 176).

Because there are four components of social support, the type and amount of support which may be of much use to bereaved spouses may change over time, and/or may change depending upon the stage of bereavement (Shinn et al., 1984). Personality characteristics and demographic factors may influence the type and amount of support a bereaved individual may need or prefers (Vachon and Stylianos, 1988). As mentioned earlier, bereaved spouses do not cope uniformly to bereavement. Because bereaved spouses do not cope uniformly to bereavement, they may also have different preferences for types and amount of support. Bankoff (1983) argues that the role of social support on bereaved spouses' psychological well-being may depend upon bereaved spouses' adjustment process, stage of bereavement, type of support given, and the source (*who* provides support). These aforementioned factors will be discussed in further detail in the latter section of this literature review.

Umberson and Montez (2010) argue that social networks may influence behavior because it may *control* our health habits. Waite (1995) argues that for example, a spouse may monitor, inhibit, regulate, or facilitate health behaviors in ways which may promote

a partner's health. Ellison and Levin (1998) add that religious ties may influence health behavior through social control. Ellison and Levin (1998) argue that social networks may “instill a sense of responsibility and concern for others that then lead individuals to engage in behaviors that protect the health of others, as well as their own health” (Umberson and Montez, 2010, P. S56). Psychosocial mechanisms-- such as social support, personal control, symbolic norms and meanings, and mental health—may help explain how social networks promote health (Umberson and Montez, 2010).

“Social support refers to the emotionally sustaining qualities of relationships (a sense that one is loved, cared for, and listened to). Hundreds of studies establish that social support benefits mental and physical health” (Umberson and Montez, 2010, P. S56). Cohen (2004) and Thoits (1995) add that social support may enhance mental health because it may buffer against the impact of stress, and/or it may foster a sense of meaning and purpose in life. Uchino (2006) adds that supportive social networks may reduce blood pressure, stress hormones, and heart rate which may be beneficial to health in addition to minimizing unpleasant arousal which may instigate/trigger risky behavior.

Social support may serve a variety of *functions*. Rook (1987) found that bereaved individuals reported highly valuing companionship during their ordeal because it protected them from the despair and emptiness associated with loneliness. Rook (1987) found that bereaved individuals benefited positively, both mentally and physically, when their networks provided support that promoted a sense of well-being. Social support and companionship may provide recreation, humor, companionship, and worthiness- which would positively contribute towards enhancing one's sense of well-being (Rook, 1987; Vachon and Stylianos, 1988).

Umberson and Montez (2010) argue that examining the *symbolic meaning* of social networks may further demonstrate how social networks and health habits are linked. Nock (1998) and Waite (1995) argue that the meanings attached to marriage and relationships with children may promote a greater sense of responsibility to stay healthy—which may in turn promote healthier lifestyles (exercise, dieting, not smoking, and not drinking). Umberson and Montez (2010) argue that the meaning “of specific health behaviors within social contexts may also vary” (S56). For example, racial-ethnic identity may correspond with the meaning of specific health behaviors—which may or may not include the consumption of particular foods or the avoidance of alcohol; the meanings that are attached to specific health behaviors may promote and sustain those behaviors (Umberson and Montez, 2010). Similarly, being involved with large communities, or religious affiliations may foster a sense of meaning and/or purpose in life which may enhance mental health, physical health, and physiological processes (Antonovsky, 1987).

Employment may increase bereaved spouses’ access to social networks and social support

Adler et al (1994) argue that one’s employment (wages and income) may reduce stress in two ways. First, one’s employment (wages and income) may decrease the likelihood of encountering negative financial events (Adler et al 1994). Negative financial events may be translated to “stressful life events,” and a decrease in the exposure and encountering of stressful life events may minimize one’s anxiety and feelings of powerlessness—which should increase one’s mental well-being and health (Dohrenwend & Dohrenwend, 1970). Second, one’s employment (wages and income) may reduce stress should stressful life

events occur because one may have more social and psychological resources to cope with stressful life events—one may be less susceptible to the subjective experience of stress (Adler et al 1994). Employed individuals may be less likely to experience stressful life events, and/or may be more equipped to handle stressful life events should they occur because the labor market may provide an increase in availability of social networks, social support, and/or financial support (Repetti et al 1989).

Social support, as argued by Repetti et al (1989) may be important for employed individuals' mental health because their job opportunities allow for them to come into contact with other co-workers who may form and develop a social network. This social network may provide opportunities for working individuals to receive social support—“which may result in opportunities for enhancing self-esteem and a sense of control” (Repetti et al, 1989, p. 1394). Aneshensel (1986) and Kandel et al (1985) argue that non-employed individuals may be more depressed than employed individuals; employed individuals have an opportunity to increase their social networks which may offer them social support while decreasing feelings of isolation, helplessness, depression, and anxiety (Repetti et al, 1989). In sum, employment may increase one's social networks which may offer and provide social support that minimizes stress and negative psychological well-being; as a result, employed bereaved spouses may be in better mental health and may be more likely to adjust positively towards widowhood compared to retired bereaved spouses.

Dark side of social support/networks

While social networks may be the central source of receiving emotional/social support for most people—social networks and relationships may also be extremely stressful (Umberson and Montez, 2010). Not only may social networks and relationships be stressful, but they may undermine one’s overall health. “It may seem obvious that strained and conflicted social interactions undermine health, but social networks may have other types of unintended negative effects on health” (Umberson and Montez, 2010, p, 557).

While social support systems may be potentially helpful, it is important to note that they may also serve as a source of stress (Vachon and Stylianos, 1988). For example, bereaved spouses may not be adjusting to their ordeal as quickly as others expected; thus, their social networks may respond in a negative manner (Vachon and Stylianos, 1988). Shinn et al (1984) add that support donors may feel frustrated if their attempts at support and assistance are not appreciated and/or acknowledged. Shinn et al (1984) have argued that “negative interactions that derive from supportive efforts are actually additional stressors, not just indicators of a lack of social support. Such negative interactions may also potentiate the effects of other stressors” (64).

A deficit in social support has been linked to poor outcomes in bereavement (Vachon and Stylianos, 1988). Poor outcomes in bereavement is measured by reduced health during the first year of bereavement (Raphael, 1983), increasing levels of distress two years following bereavement (Vachon et al., 1982), an increased use of anti-anxiety medication (Mor et al., 1986), and an increased sense of strain in adjusting to the new role of being a widowed individual (Bankoff, 1986).

Vachon and Stylianos (1988) argue that there is no definitive way in which to measure the effectiveness of a specific support attempt. As a result, the recipient of a specific support attempt is the one who may perceive the support to be helpful or not; social support may be construed or perceived as a property of the recipient. Heller et al (1986) add that the individual who receives support usually determines if the help he/she received during his/her ordeal is effective depending upon the individual's appraisal of network transactions.

Stress in relationships, caused by poor quality of support and networks, may contribute to physiological distress and psychological arousal (increased blood pressure and heart rate) which may lead individuals of all ages to engage in unhealthy behaviors to "combat" the negative effects of stress in relationships (Kassel et al., 2003). For example, in order to "combat" the negative effects of stress in relationships, young adults may consume more alcohol while individuals in mid-life may experience greater weight gain. Relationship stress may also undermine one's personal control; a diminishing sense of personal control may also negatively influence one's level of self-esteem (Umberson and Montez., 2010; Thoits, 2010). Diminishing levels of self-esteem and personal control as a result of relationship stress may augment one's ability to cope with stressful demands and situations (Thoits, 2010).

Are the costs and benefits of social support/networks equally distributed across sociodemographic groups?

"We know little about *how* the benefits and costs of social ties *vary* across sociodemographic groups, but some evidence suggests that there is variation" (Umberson and Montez, 2010). Women tend to have larger numbers of confidants than men, Whites

tend to have more confidants than Blacks, better educated individuals tend to have larger confidants than less-educated individuals, and younger adults tend to have more confidants as well (Umberson and Montez, 2010). Umberson and Montez (2010) suggest that the quantitative (size and diversity) and qualitative (benefits and costs) aspects of social ties may be demographically patterned and socially constructed (p. S58).

Umberson and Montez (2010) argue that most attention has been devoted towards understanding gender differences within a marriage context (in terms of the benefits and costs of social ties); for example, men tend to receive greater health gains compared to women in marriages—partly because men may experience fewer costs from spousal care giving, childrearing, and balancing work/family demands (Spain and Bianchi, 1996). The availability, benefits, and costs of social ties may vary also by race. Blacks are less likely to be married than Whites, and may be more likely to receive fewer economic gains to marriage compared to Whites (Umberson et al., 2005). In sum, “differential access, benefits, and costs to social ties across sociodemographic groups are not immutable; recent work shows that these differentials have changed significantly over time” (Umberson and Martinez, 2010).

Because this project is examining the role of social support on adjustment to widowhood, it is important to distinguish between men and women’s social networks in order to account for gender differences in access to social support. As mentioned above, Umberson and Montez (2010) found that men have smaller social networks compared to women. However, Moore (1990) argues that men and women generally have similar size networks, or quantity of individuals in their networks; what is of particular interest is to examine the varying *composition* of women and men’s social networks (Moore, 1990).

Moore (1990) posits that women's social networks may be comprised of ties with kin, while men's social networks may be comprised of non-kin ties. Because the composition of men and women's social networks may vary, it may be imperative to discern between the *quality* of men and women's social networks. While some have argued that women may receive more social support compared to men because their networks are more functional and are characterized as being better in quality (Antonucci, 1990), some have found no differences in the quality of networks and availability of social support by gender (Fischer 1982; Marsden, 1987). As a result, examining gender differences on the adjustment to widowhood will be of particular interest in this project.

What are policy implications of the current knowledge about the influence of social network/support on health?

Umberson and Montez (2010) argue that much solid scientific evidence has supported the following premises: “1) social networks affect mental health, physical health, health behaviors, and mortality risk, 2) social networks are a potential resource that can be harnessed to promote population health, 3) social ties are a resource that should be protected as well as promoted, 4) social ties can benefit health beyond target individuals by influencing the health of others through social networks, and 5) social ties have both immediate and long-term cumulative effects on health and thus represent opportunities for short-and long-term investment in population health” (S60). The following paragraphs will outline the policy implications that have been documented by Umberson and Montez (2010).

Umberson and Montez (2010) argue that a policy foundation linking social networks and health must do two things: “1) ensure that policies and programs benefit the

populations that need them and 2) maximize health-related benefits for recipients while minimizing costs for providers and recipients” (S60). Umberson and Montez (2010) argue that policy makers should address six fundamental goals while trying to advance population health and reduce social disparities in health: 1) promote benefits of social ties, 2) do no harm, 3) reduce social isolation, 4) reduce harm, 5) coordinate policies and programs, and 6) provide help where help is most needed. Reverting back to the first goal—promoting benefits of social ties—Umberson and Montez (2010) argue that initiatives such as the Healthy Marriage Initiative was designed to enhance positive marriages. Additionally, the initiative was designed to not only enhance positive marriages, but to encourage positive marital interactions which would benefit the mental and physical health of the married couple along with their children.

The second goal, documented by Umberson and Montez (2010), is to “do no harm.” Umberson and Montez (2010) highlight that some programs catered to the sick and elderly may increase caregiving responsibilities for family members; Umberson and Montez (2010) argue that increasing caregiving responsibilities may impose additional stress on caregivers and may negatively influence family relationships. The third goal, “reduce social isolation,” addresses an extremely fundamental finding regarding social networks and health—the most socially isolated Americans may be at greatest risk of poor health and early mortality (Brummett et al., 2001). Umberson and Montez (2010) argue that it may be important for policies to reduce the risk of social isolation in the first place; policies may be able to reduce the risk of social isolation by “enhancing our educational system to impart social-emotional skills, interests in civic engagement, and meaningful employment ... and by ensuring that all communities are economically

developed and contain public places to safely congregate and exercise” (S61). Umberson and Montez (2010) argue that coordinated programs could help locate socially isolated adults; socially isolated adults could be located through physicians, “and they could mobilize local resources to offer social and instrumental support to these individuals” (S61).

The fourth goal, “reduce harm,” has been documented by Umberson and Montez (2010). Umberson and Montez (2010) argue that policies should prevent and alleviate negative aspects of social ties; an example of this may include the acknowledgement of unintended effects on caregivers. The fifth goal, “coordinate policies and programs,” focuses on “improved coordination of services for helping professionals and for citizens seeking services” (Umberson and Montez, 2010, p. S61). The final goal, “provide help where help is most needed,” focuses on specific populations who may be at greater risk for illness than others. For example, Umberson and Montez (2010) argue that populations such as the poor and elderly—which may have a higher risk of being socially isolated—should receive higher priority from policy efforts. Umberson and Montez (2010) argue that policy efforts should also acknowledge that some populations (African American women) may be more likely to experience a burden of caregiving responsibilities. Umberson and Montez (2010) highly encourage policies to acknowledge which populations may be at greater risk for illness and disease than others.

Hypotheses

H1: Because men may benefit more from marriages than women, in terms of overall mental and physical health, perhaps adjusting to widowhood may be more difficult for men than women (Lilliard & Waite, 1995). The composition of men's social ties and networks may not be as emotionally beneficial compared to the social ties and networks of women (Moore, 1990). As a result, widowers may be more at risk of experiencing adverse effects of bereavement on their mental and physical health.

H2: Middle-aged bereaved spouses (40-59) may be less likely to anticipate the death of their spouse compared to older (65 and older) bereaved spouses (Raphael, 1984; Hansson and Stroebe, 2003). However, older bereaved spouses may be less likely to be in "good" mental and physical health compared to middle-aged bereaved spouses prior to bereavement; additionally, older bereaved spouses may be more likely to be retired compared to middle-aged spouses who may be more likely to be employed (Coleman, 1990; Kandel et al., 1985; Aneshensel, 1986; Adler et al., 1994). Being employed may provide middle-aged bereaved spouses the opportunity to come into contact with others which may make them feel less lonely, may help them maintain their finances, and/or may help them develop a sense of purpose in their lives by providing them the opportunity to develop a stable social network (Aneshensel, 1986). Older/retired bereaved spouses may not be as mentally and physically equipped to handle the adverse effects of bereavement on their overall health compared to middle-aged spouses who may be in better mental/physical shape (Coleman, 1990). As a result, older/retired bereaved spouses may be more at risk of experiencing adverse effects of bereavement on their mental and physical health compared to middle-aged/employed bereaved spouses.

H3: Social support/networks have been found to improve one's quality of life and overall mental and physical health; additionally, social support/networks have the propensity to act as a buffer against a stressful ordeal (Vachon and Stylianos, 1988). While the role of social support/networks has shown to positively influence an individual's mental/physical health, the role of social support/networks has also shown to negatively influence an individual's mental/physical health (Shinn et al., 1984; Vachon and Stylianos, 1988; Umberson and Montez, 2010). As a result, perhaps the role of social support/networks may or may not be viewed as effective and helpful depending upon the recipients' perception of the availability, quality, type, source, and appraisal of their social support/networks (Shinn et al., 1984; Vachon and Stylianos, 1988; Bankoff, 1983). In sum, the role of social support on adjustment to widowhood may or may not be effective depending upon the aforementioned factors.

H4: Recently bereaved individuals, according to Stroebe et al (2007) may be defined as individuals who have experienced the loss of a loved one within a year or less; the first few weeks and months following the loss of a loved one may be the most distressing, and may increase one's risk of mortality (Stroebe et al., 2007). Additionally, because bereaved spouses reported elevated feelings of loneliness, shock, depression, anger, and yearning during their first year bereaved, their adaptation towards widowhood may be more positive as time elapses (Anderson and Dimond, 1995; Asai et al., 2010). As a result, recently bereaved spouses may be more at risk of experiencing adverse effects of bereavement on their overall mental and physical health compared to spouses who have been bereaved for three or more years.

Chapter 3

METHODOLOGY

This project will use a qualitative research approach compared to the traditional, quantitative approach (Auerbach and Silverstein, 2003). According to Auerbach and Silverstein (2003), qualitative research is characterized as *hypotheses-generating research* compared to quantitative research which is characterized as *hypotheses-testing research*. Auerbach and Silverstein (2003) define qualitative research as “research that involves analyzing and interpreting texts and interviews in order to discover meaningful patterns descriptive of a particular phenomenon” (5). In order to explain and understand a particular phenomenon through a qualitative approach, Auerbach and Silverstein (2003) argue that researchers should be cognizant that they do not know enough about a particular phenomenon in order to generate hypotheses. Instead, qualitative researchers should generate their hypotheses *after* they have collected their data; more importantly, a key component in qualitative research is valuing the information given by the research participants (Auerbach and Silverstein, 2003).

Auerbach and Silverstein (2003) argue that because the research participants have experienced a particular phenomenon that needs further clarification, it is the research participants that are truly the “experts.” In order to successfully understand a phenomenon that remains inconclusive, qualitative researchers should value the experiences and knowledge of the research participants because they have been directly affected. Generating hypotheses after collecting data is referred to as a grounded theory approach because it places the research participants as the source of knowledge (Glaser and Strauss, 1967; Auerbach and Silverstein, 2003). The original founders of grounded

theory, Barney Glaser and Anselm Strauss (1967), developed grounded theory through their desires to study a social phenomenon from the social interactionism perspective. Glaser and Strauss' (1967) "phenomenon" of interest was examining how individuals prepared for death. According to Glaser and Strauss (1967), using the grounded theory, or inductive theory approach may be most efficient when trying to gather "subjective knowledge" (Auerbach and Silverstein, 2003; Glaser and Strauss, 1967; Belgrave et al., 2002).

Because research participants are considered "experts" regarding the phenomenon being researched, qualitative researchers have an advantage using a grounded theory approach because they can gather "subjective knowledge" (Auerbach and Silverstein, 2003; Glaser and Strauss, 1967). The "subjective knowledge" gathered by qualitative researchers can be put forth towards generating hypotheses about a phenomenon that remains theoretically inconclusive. As mentioned earlier, the role of social support on adjustment to widowhood has not been thoroughly understood (Baarsen et al., 2002). Baarsen et al (2001) argue that while some researchers have found the role of social support to be positive on adjustment to widowhood, other researchers have found the opposite effect; the role of social support on adjustment to widowhood has not been agreed upon theoretically. Because the purpose of this project is to determine the role of social support on adjustment to widowhood, I will be executing a grounded theory approach. As argued by Auerbach and Silverstein (2003), "grounded theory approach uses two basic principles: 1) questioning rather than measuring, and 2) generating hypotheses using theoretical coding" (7).

The phenomenon of interest in this study is examining the role of social support on adjustment to widowhood. As suggested by Auerbach and Silverstein (2003) and Glaser and Strauss (1967), in order to truly understand the role of social support on adjustment to widowhood, I need to place my research participants as the source of knowledge. As a volunteer at the Hospice of the Valley and Homestead Hospice, I will be able to use convenience sampling as a way of recruiting participants. Auerbach and Silverstein (2003) suggest that convenience sampling is referred to as the convenient, or easily accessible way of recruiting participants. Because I have been volunteering over the last five years, one of the main ways I will be recruiting participants is through convenience sampling.

As mentioned previously, the participants in this project will be bereaved spouses who utilized Hospice services. The bereaved spouses in this project anticipated the death of their spouses, and sought the services that Hospice offers. As a volunteer at the Hospice of the Valley in Arizona and Homestead Hospice, I have become acquainted with many bereaved spouses throughout the last five years. As a volunteer, I have helped prepare funeral arrangements, encouraged bereaved family members to seek bereavement counseling, and helped families pack up the possessions of their deceased loved ones. One of the features that Hospice of the Valley and Homestead Hospice offer their patients and families is bereavement counseling; these Hospice services provide bereavement counseling for thirteen months following the death of a loved one. As a volunteer, I have helped family members get into contact with Hospice counselors.

At the Hospice of the Valley, bereavement counseling is catered specifically for bereaved individuals depending upon the role they played in the lives of their deceased

loved ones. For example, bereavement counseling is offered to bereaved adult children, bereaved young children, bereaved parents, bereaved spouses, and bereaved friends; bereaved spouses receive different Hospice bereavement counseling compared to bereaved parents. Since 2010, I have accompanied my mother in receiving spousal bereavement counseling. Throughout the last couple of years, I have not only attended spousal bereavement counseling with my mother, but I have also become acquainted with many bereaved spouses in my mother's counseling sessions.

Being a volunteer at the Hospice of the Valley and Homestead Hospice helped me recruit participants for my project. This project uses in-depth and semi-structured interviews to thoroughly capture the role of social support on adjustment to widowhood. Because I volunteer at the Hospice of the Valley and Homestead Hospice four times a week, I recruited recently bereaved spouses to participate in my study. As mentioned earlier, this project will distinguish between two bereavement stages- recently bereaved (one year or less) and three or more years.

Recruiting bereaved spouses who have become bereaved within the last year or less should be quit simple as a Hospice volunteer; however, recruiting bereaved spouses who lost their spouses three or more years ago may be more difficult. This project also use snowball sampling and purposive sampling to recruit spouses who have been bereaved for three or more years. Because I have made many friends throughout the last five years of volunteering, recruiting spouses who have been bereaved for three or more years will be doable.

Homestead Hospice offers spousal bereavement counseling within a group setting; ten or more spouses gather together and discuss their loss as a group. Hospice of the Valley,

on the other hand, has counselors work one on one with bereaved spouses. Hospice of the Valley counselors meet bereaved spouses at their homes, coffee shops, and parks.

Counselors working at the Hospice of the Valley prefer to offer spousal bereavement counseling privately, whereas Homestead Hospice offers bereavement counseling as a group. Because this project is examining the role of social support on adjustment to widowhood, and participants may not feel too comfortable discussing their experiences in a group setting, each participant is met individually.

To show my appreciation to the participants in this study, I have worked around *their* schedules. I drove to their homes, offered them a ride, and/or treated them to a cup of coffee at a coffee shop. Interviews generally ran between one to two hours. If participants agree, I brought my laptop and typed up notes during the interview. Additionally, a tape recorder was present in order to record the conversation; again, conversations are recorded if participants gave me their permission. Upon completing the interview, notes are transcribed and organized into categories *immediately* following the interview. Notes are transcribed immediately following the interview because maintaining “subjective knowledge” is paramount in order to avoid generating inaccurate theories based on personal experiences (Auerbach and Silverstein, 2003; Belgrave et al., 2002; Matthews, 2005; Glaser and Strauss, 1967).

Belgrave et al (2002) argue that it is imperative for a qualitative researcher to thoroughly explain in detail how he/she plans on deriving categories from the data collected, and how long he/she plans on transcribing data. Interviews ran between one to two hours, and two hours has been devoted towards transcribing the data collected immediately following the interview. For example, if I interviewed three participants in

one day, I spaced their interviews four hours apart in order to devote two hours to thoroughly transcribe data collected from each interview. Matthews (2005) suggests that in order to collect useful data regarding a social phenomenon, a qualitative researcher should be cognizant of the questions he/she is asking. Matthews (2005) argues that qualitative researchers should avoid asking questions that elicit one-worded responses, and should avoid speaking on behalf of the participants. As Glaser and Strauss (1967) and Auerbach and Silverstein (2003) argue, researchers are responsible for generating questions that elicit conversations. If participants agree to participate in the study, then their “role” in the study is to provide data that can assist a researcher in explaining a social phenomenon (Matthews, 2005; Glaser and Strauss, 1967).

As Belgrave et al (2002) suggest, it is imperative for a qualitative researcher to thoroughly and explicitly detail their role in this project. Not only is this project important to me because I lost my father to cancer, and constantly struggle with accepting his death; furthermore, this project is important to me because I have witnessed the adverse effects of widowhood on my mother. As a result, I am devoted and motivated towards understanding the mechanisms that contribute towards a positive adaptation trajectory following the loss of a spouse. More importantly, I want to understand the role of social support on adjustment to widowhood because I have witnessed the role of social support influence my mother’s adaptation trajectory in *both* positive and negative ways. Because the role of social support has not been theoretically agreed upon in the literature (Baarsen et al., 2002), my role in this project is to shed some light on this inconclusive phenomenon. In sum, this project is not only important to me because of my personal loss and sadness, but is also fueled by my quest as a medical sociologist to thoroughly

understand how the role of social support on adjustment to widowhood may be interpreted.

In order to thoroughly understand the role of social support on adjustment to widowhood, I needed to thoroughly transcribe the data collected. As I transcribed the data, I looked for key points to extract from the data collected. For example, how has the role of social support influenced my participants? Was it helpful and/or stressful? What kinds of support did my bereaved spouses receive? Were certain types of social support (financial, instrumental, emotional, and appraisal) more helpful than other types? As I looked for key points as I transcribed the data, I cautiously assigned codes to label the key points that are extracted from the transcribed data. In order to accurately assign codes towards key points extracted from the transcribed data, a qualitative researcher should group similar concepts together (Belgrave et al., 2002; Matthews, 2005).

For example, if participants reported experiencing instrumental social support (friends and family assist with chores, run errands for the bereaved spouse, and/or offer tangible support) following the death of their spouse, then I coded these key findings as “instrumental social support appears to be helpful.” On the other hand, participants have reported that all they needed was for their friends and family to offer a “shoulder to cry on;” however, participants also reported that their friends and family were growing tired of listening to their problems. As a result, I coded these key findings as “emotional support may be necessary for one to adjust positively towards widowhood.” Once I extracted key findings from my transcribed data and coded these findings appropriately and correspondingly, I created categories which are formed from the coded data. Because the coded data is grouped into similar concepts, forming categories from these coded data

should help in generating a theory to explain the phenomenon of interest (Belgrave et al., 2002; Matthews, 2005; Glaser and Strauss, 1967).

Matthews (2005) suggests that a qualitative researcher should disclose all details regarding his/her project to his/her participants and readers. All the participants in this study are informed about the purposes of the study; participants are informed that their participation in the study is voluntary, and they may stop participating at any time. Each participant is assigned a pseudo name in the study, and their full names will not be disclosed. Matthews (2005) suggests that it is pertinent for a qualitative researcher(s) to include details regarding the process of the data collection. It will be important to mention that all of the data will be collected, transcribed, coded, and categorized by myself. By devoting two hours immediately following an interview to transcribe data will hopefully have prevented me from inaccurately generating theories. Once all the data has been thoroughly transcribed, coded, and categorized, I looked for overlapping themes within the categorized data. By neatly organizing my transcribed notes into categories, I spent much time cautiously interpreting the possible themes and meanings given to me by my participants.

As mentioned earlier, I will be distinguishing between bereavement stages and life course stages. For the former group, bereavement stages, I discerned between bereaved spouses who have lost a spouse within a year or less and bereaved spouses who have lost a spouse three or more years ago. In the latter group, life course stages, I distinguished between middle-aged bereaved spouses (40-59) and retired bereaved spouses (65 and over). I also discerned between widows and widowers.

I interviewed 12 individuals (six males and six females) in the following *four* groups (a total of 48 participants): one year or less following the death of a spouse during middle age (40-59), one year or less following the death of a spouse during retirement age (65 and over), three or more years following the death of a spouse during middle age (40-59), and three or more years following the death of a spouse during retirement age (65 and over). This project determined the role of social support on adjustment to widowhood across four various groups in order to accurately capture whether or not the role of social support on adjustment to widowhood is positive, negative, or inconclusive.

Controlling for demographic factors such as age bereaved, employment, and bereavement stage will hopefully help in improving the understanding of the role of social support on adjustment to widowhood. More importantly, this project determined which group of bereaved spouses may be more or less likely to need social support as a way of adjusting to widowhood. As a medical sociologist, understanding whether or not the role of social support positively or negatively influences one's adjustment to widowhood is imperative because spousal bereavement is characterized as a highly distressing life event (Asai et al., 2010). This project seeks to determine what factors contribute towards a positive adaptation towards widowhood; because the role of social support on adjustment to widowhood has not yet been determined in previous research (Baarsen et al., 2002), this project sought to determine whether or not the role of social support on adjustment to widowhood is indeed positive, negative, and/or inconclusive.

In order to properly begin the process of collecting data, I spoke to bereaved spouses at the Hospice locations. Because I come into contact with fatally ill patients and family

members, recruiting *recently bereaved* spouses was not be difficult. As mentioned earlier, this type of grounded theory approach is known as convenience sampling. Recruiting bereaved spouses who lost a spouse three or more years ago was not as “convenient,” and required patience and time. This grounded theory approach, also known as snowball and purposive sampling, required making many attempts in order to reconnect with “older” friends (bereaved spouses) I met volunteering three or more years ago.

Once I was able to locate spouses who have been bereaved for three or more years, I asked them for their cooperation in my study. After all, what I am seeking to understand is how these spouses are holding up three or more years later. If they were coping “positively,” I wanted to understand what factors contributed towards this positive adaptation- more specifically, did their social networks and support systems influence this positive adaptation? On the other hand, some bereaved spouses reported coping “negatively” towards their loss. As a result, I wanted to understand what would help mitigate the adverse effects of death on their health- could a functional support system improve one’s adaptation positively?

In order to understand the effects of social support on adjustment to widowhood, I asked the following questions (a detailed list of questions is available in the appendix of this project): “Are your friends and family able to sympathize and/or empathize with your loss? Are they emotionally supportive (do they give you a shoulder to cry on, allow you to vent indefinitely, and hold your hand)? Do your friends and family provide instrumental support (assist financially, assist with chores that the deceased spouse used to accomplish, and/or offer to drive you around)? If it were not for your friends and family, could you adapt to the loss of your spouse on your own? Do your friends and

family inadvertently exacerbate some of your pain and anguish; for example, do your friends and family make insensitive comments regarding your adaptation trajectory ('get over your loss already, life goes on, move on, let it go')? Do your friends and family make you feel as though you are burdening them with your pain? Would you rather keep your emotions bottled up inside rather than communicating with your friends and family out of fear that you are frustrating them? Do you ever feel as though your friends and family are not trying hard enough to understand exactly what you are going through? Was the support you received from your friends and family consistent? Did the support you received from your friends and family slowly lessen or increase as time elapsed since the death of your spouse?"

In sum, this project used a grounded theory approach to thoroughly capture the role of social support on adjustment to widowhood. Convenience sampling and snowball/purposive sampling were used to recruit bereaved spouses who have lost their spouse within a year or less, and spouses who have lost their spouse three or more years ago. By conducting semi-structured interviews and asking in-depth questions, I captured how the role of social support influenced my bereaved participants. As suggested by Auerbach and Silverstein (2003), it is imperative for qualitative researcher to assign their participants as the "experts" regarding their particular phenomenon of interest. After all, if it were not for the participants who were affected by the phenomenon, how would researchers make sense of inconclusive findings?

Chapter 4

RESULTS

Middle-aged bereaved spouses- bereavement stage one year or less

Six middle-aged widows who have been bereaved for one year or less provided me with ample information regarding their feelings and attitudes after bereavement- both mentally and physically. Among these six participants, a total of thirty-four meaning units were collected. From the thirty-four meaning units collected, six categories were identified which were then grouped into one theme (refer to table 1). Depression is the theme that was extracted from the transcribed data. While majority of these participants reported similar feelings and attitudes after bereavement, what is noteworthy is that their expectations and beliefs about social support differed. I will discuss these varying expectations and beliefs about social support in the latter portion of this section.

Depression

Feeling numb, traumatized, lonely, and mentally absent were common psychological states that were reported by middle-aged bereaved widows who have been bereaved for one year or less. Fearing the unknown and memory loss were also commonly reported among participants in this group. All thirty-four meaning units were grouped into 6 categories (numbness, trauma, impaired memory, loneliness, fear of unknown, and mentally absent) which was then grouped into the theme of depression. Widows in this group ranged between the ages of forty to fifty-two, were married for an average of eight to ten years, and all but one participant had children. Widows in this group did not divulge much about the quality of their marriages, but it appeared that they were each

satisfied with their marriages, and enjoyed being married. All participants in this group had received a Bachelor's degree, and were currently employed during the time of the interviews. The results described next will detail the feelings and attitudes of middle-aged widows who are all recently bereaved, have been married for a minimum of eight years, are employed, and have all received a Bachelor's degree.

Numbness, memory loss, and mentally absent

While the participants in this group are recently bereaved, they were *not* able to discuss in detail what their first few months of widowhood was like. I ignorantly made the presumption that because these widows are recently bereaved, they would be able to discuss the first few months or first few weeks of their event in exhaustive detail. To my surprise, not one of my participants in this group was able to recall in detail her experience and emotions that were surrounding the event of her husband's death. All participants reported feeling incredibly numb following the death of their husbands; while the death of their husbands did not come unexpectedly, each participant reported her inability to believe that her husband was truly deceased. Participants reported similar stories following the death of their husbands. Immediately following the death of their husbands, friends and family gathered around to mourn their loss; my participants reported their inability to recall in detail who was actually around to mourn the death of their husbands.

People were constantly walking in and out of my house to come visit me after my husband died- some of these people I have not seen in years. I barely remember their faces, let alone remember their names! There were tons of flowers and cards

in my home, and people started bringing me food as well. Did they not get it? I was not hungry- I could barely water the flowers or read the cards- I was numb!

Another participant recalled a similar incident. “Nearly one thousand people came to my house- people from all around the world. My phone was ringing off of the hooks. Everyone around me was either crying, screaming, or biting their fingernails. I was not in the mood to make small talk with these people- I had no idea where I was, or why I was there. I thought this was all just a really bad dream!” While my participants reported that there were people “all around them” following the death of their husbands, they were unable to tell me who these people were, or how they even found out about their husbands’ passing. One of my participants, Danielle, explained to me that when her husband died, she was constantly surrounded by a “sea of people.” Danielle told me repeatedly that she felt guilty because of her inability to remember who actually dropped by her house or attended her husband’s funeral. According to Danielle, “I have not even talked to most of these people for years. All of a sudden, because my husband dies, they decide to care.”

As I listened to my participants discuss their inability to recall much detail following the death of their husbands, I became incredibly curious as to *why* they were unable to remember details surrounding their husbands’ death. As I transcribed the data collected, I soon came to realize that participants were unable to recall much detail surrounding their husbands’ death because they were *numb*. My participants may have been *physically* present surrounding the time their husbands died, but they were in no way *mentally* present. As one of my participants said, “If someone had pinched me as hard as they could, I probably would not have even felt it. If someone had screamed loudly in my ear,

I probably did not hear it. If someone called me immediately following my husband's death and I answered the phone- I most likely do not remember who I was talking to. I lost all five senses when my husband died; I still cannot taste the food I eat."

Trauma, loneliness, and fear of the unknown

In addition to reporting an overwhelming feeling of numbness, participants reported feeling incredibly traumatized. "I could not sleep. I just stared at the ceiling for hours each night. I could barely remember what I did earlier that day- I could barely remember anything. Do you know how traumatizing it is to walk around feeling like a zombie?" Participants found it traumatizing that their short-term memory seemed to have vanished; they also reported feeling traumatized because they felt incredibly powerless and defeated. "I felt like I had a case of Alzheimers. If someone did not remind me to eat, I probably would have starved to death. I could not make any decisions because I was too numb and scared."

As table 1 indicates, for the "depression" theme, a fear of the unknown is a category that was commonly reported among participants. Participants described in detail their fear about the unknown because they could not imagine their life without their husbands. Without their husbands, they feared that they were unable to function. The fear of one's inability to function exacerbated one's overall fears about the future. As one participant said, "I can barely function right now. Am I still going to be this useless in 5 years or so? I feel like a waste of space." Furthermore, as table 1 indicates, for the "depression" theme, a feeling of loneliness is a category that was commonly reported among participants. Participants reported that feeling lonely or thinking they would be lonely for the rest of their lives was incredibly depressing.

Participants reported feeling lonely because of the realization that they were no longer a part of a “team” or a part of a unit. “For six years, everything was about ‘us.’ We made a rule that we were never allowed to say ‘me’ but we could only say ‘we.’” As the aforementioned quote demonstrates, going from “we” to “me” is a very depressing realization- participants feared a life alone, a life without their best friend. As I outlined themes regarding participants’ attitudes and feelings following bereavement, what I needed to learn was *who* or *what* could mitigate participants’ feelings of severe depression.

Type of social support needed

Participants in this group differed in their expectations regarding social support. While some did not have many or any expectations at all, others had higher expectations. As reported earlier, there are four types of social support: instrumental, informational, appraisal, and emotional. For these recently bereaved middle-aged widows, the type of social support that was expected or needed was only instrumental support. Instrumental support includes the provision of tangible assistance; examples may include assisting in household chores, helping with funeral or financial arrangements, and/or running errands. Because my participants reported feeling depressed, they were unable to make decisions and/or continue performing their daily tasks. Participants who were supported instrumentally reported feeling less overwhelmed and defeated.

My best friend Kathy flew into town and stayed with me for ten days. She cleaned my house, cooked for me, and took my kids to and from school. If it were not for her, my kids would probably have flunked out of school, and would be living in a

messy house with a mother who could not cook. Without her help, I probably would have ended my life.

Millie, a middle-aged widow with no children, reported what it would have been like *had* she had some instrumental assistance. “Sure, I do not have kids to take care of or anything, but that does not mean I am in the mood to take care of myself. It would have been great if someone would have taken care of the funeral arrangements. The last thing I want to do is select a coffin for my husband- I would rather not have dealt with that.” As mentioned earlier, instrumental support appears to be the only type of support that appears to mitigate the negative effects of bereavement for these participants. As one participant explained, “I do not want to talk about the events that led up to my husband’s death. I am trying to forget the horrifying details leading up to my husband’s death, and people *mistakenly* think it will help me to keep talking about it.” The aforementioned quote may indicate that during this stage of bereavement, emotional support (allowing one to talk about their ordeal) may exacerbate the pain and anguish participants are already experiencing.

Participants in this group reported that their social networks (friends, family, and co-workers) constantly encouraged them to speak openly about their ordeal. As one participant said, “They kept telling me that I would feel better if I *talked* about it, and that holding it in would be dangerous.” Another participant adds, “I am not much of a talker anyways, and my friends and family should know this about me. Now that my husband died, they keep trying to make me *talk*- it is like pulling out my damn teeth.” Mille, a widow with no children said, “I am the only woman in the office who does not have kids. Because of this, I swear, everyone gives me a pity look because now I do not have a

husband. Once I sit down in my chair to start some work, I am flooded with co-workers who think I want to talk about it. I *do not* want to talk; I want to distract myself with work!”

In addition to reporting that friends, family, and co-workers urged participants to talk about their ordeal, they were also encouraged to speak to a therapist. “Because we are given thirteen months of bereavement counseling from Hospice, my friends and family kept urging me to take advantage of the counseling offered.” Another participant adds, “My parents told me that they would take my children away from me unless I spoke to a bereavement counselor- they were afraid that I was unable to perform my role as a mother until I dealt with my husband’s death.” It appeared that not only did participants feel pressured to talk to their friends, family, and co-workers about their ordeal, but they were also encouraged to speak to a therapist. “It felt like I was given an ultimatum- either I talk to my family about my husband’s death, or I talk to a therapist. Either way, my family kept forcing the issue of openly communicating about my husband’s death.” Unbeknownst to friends, families, and co-workers, instead of talking about what happened, it appears that participants benefit when they are lent a helping hand.

I do not care if a complete stranger helps me- someone, anyone needs to just take out all of my husband’s clothing from our closet. I cannot sort through his stuff; when I smell his jacket, I can remember him putting on his favorite cologne. He had a shoe obsession- what husband has more shoes than a wife? When I lay eyes on a pair of his shoes, I instantly become nostalgic. While the memories are great, I do not want to reminisce about them if he is not around to make more memories with.

The aforementioned quote may suggest that during this stage of bereavement, participants are not too particular about *who* is offering them instrumental support. It appears that participants in this stage of bereavement will take any sort of tangible assistance when they can get it- regardless of who is providing it. A reason for this may be because participants feel numb and traumatized after bereavement, and they may be unable to process the situation in depth. As will be discussed later in this section, widows who have been bereaved for more than three years appear to be particular about the *type* of social support provided and *who* offers it. While participants in this group appear to benefit from one *type* of support (instrumental), they may not be too particular about *who* is providing the support because they may be too immersed in the ordeal because the ordeal is recent.

Other participants who did not have many or any expectations from others reported wanting to remain independent- or feared depending on someone only to be let down. As one participant said, “I have been taking care of my sick husband for four months. I have run the entire household on my own. I do not need someone taking care of me now- the only person who knows what to do is me.” Similarly, another participant reported not having any need for support because she desired to remain independent. “So what do I do? Lean on someone to get me through the day? I cannot do that- nothing is certain in this world, and I fear leaning on anyone because they may end up dying on me like my husband did- then what do I do?”

The next portion of this results section will detail the experiences of middle-aged widowers who have recently become bereaved. As we will see, feelings and attitudes

after the death of a spouse will not vary much from those reported by widows. Both widows and widowers reported feeling depressed; however, what is noteworthy is that while widows internally dealt with their pain, widowers externally dealt with their pain, and turned to outlets such as drinking, smoking, and gambling. What is also notable is that widowers did not benefit from receiving instrumental support like widows did; widowers reported benefiting from informational and emotional support. Also remarkable is that while some widows reported having no expectations for support due to their need to remain independent and/or due to their fears of depending on others, widowers reported the opposite- they *did* have expectations to receive support from their peers.

Middle-aged widowers- bereavement stage one year or less

Six middle-aged widowers who have been bereaved for one year or less provided me with information regarding their feelings and attitudes after bereavement- both mentally and physically. Among these six participants, a total of thirty-nine meaning units were collected. From the thirty-nine meaning units collected, four categories were identified which was then grouped into one theme (refer to table 2). The theme that was extracted from the transcribed data is depression-which is an identical theme that was found for widows in the same bereavement and life course stage. While widowers also reported their inability to recall specific details surrounding their wives' death, their inability to recall these details may have been due to their state of feeling lethargic. While widows reported losing their five senses or feeling like a "zombie," widowers reported feeling lethargic and useless.

Depression

As table 2 indicates, for the “depression” theme, feeling lethargic was a category that was commonly reported among participants. Joel, a recently widowed participant, reported feeling incredibly depressed due to his lethargic state of being:

My wife and I have three dogs. After my wife died, I could never get out of bed to feed the dogs- even though it was always the task that I performed while my wife was alive. Do not even ask me if I walked the dogs; I think the dogs adjusted to my state of being lethargic. They knew that ‘daddy’ would stay in bed a lot longer than normal in the mornings, and go to bed much earlier in the evenings.

Another participant recalls a similar incident of feeling lethargic. “I just mope around all day. It is what I do. I do not even have the energy to turn on the television- that is just pathetic.” Other categories for the depression theme, as shown in table 2, include the following: isolation, poor work performance, increase in risk-taking behaviors (higher levels of alcohol consumption, decrease in exercise, increase in the amount of cigarettes smoked), and feeling lethargic. As argued by many sociologists, men benefit more from marriage than women. A reason for this may be due to the fact that wives monitor their husbands’ health and hold their husbands accountable for their behaviors. As one participant said, “I started smoking immediately after my wife died. I stopped smoking when she was alive because she hated it; I am too depressed now, so smoking is the highlight of my day.”

Many participants in this group reported decreasing their productivity and/or attendance at work. “I thought that I would throw myself into work when my wife died- use work as a distraction to ease my pain. Because my wife died 7 months ago, I still feel

too depressed to even get ready for work. My wife always steamed my suits before work.” Another participant, Sam, reported that his ability to continue being a sales-representative was decreasing. “I use to be able to sell any of my products to anyone, at anytime. Now, I do not even know what the point of receiving my bonuses are- I do not have a wife to share it with.”

Loneliness

“I never once in my life considered suicide, but then when my wife died, I thought I would join her- I have no reason being alive without her.” The category loneliness includes the following meaning units: suicide ideation, yearning for deceased wife, and feeling useless without wife. “Without my wife, I have no reason to smile. She was my best friend- she was the only person I could talk to that would not judge me, and encouraged me to be vulnerable. I cannot do that with anyone else.” Majority of participants reported feeling unable to be “themselves” around other people. It was commonly reported among participants that the only person who truly knew them was their wives- not even their children or family.

She knew my deepest darkest secrets. Actually, she even knew what my biggest fears were. I know husbands are supposed to act brave and not appear defenseless, but my wife found my ‘weakness’ to be attractive. I cannot talk to any of my friends about stuff like that- they would think I am a coward. My wife did not think I was a coward; she thought I was brave, even though I had insecurities. No one will ever understand me like she did. I am on my own now.

Other participants reported yearning for their wives throughout the day since their wives’ death. “I am so lonely without my wife. In order to get over that, I often yearn for

her presence- sometimes I pretend she is there with me. I do not like being in that house without Joyce.” In addition to yearning for their wives, some participants also reported feeling lonely because they felt useless. “I am a provider. I like to provide. My wife and I did not have any children, but I always wanted to give her the best life I could. What is the point of doing that anymore? It is absolutely useless.” In sum, while middle-aged widows and widowers who have been bereaved for one year or less reported being depressed, their expectations and preferences for social support differed. The next section will describe the social support that was expected and desired by widowers.

Type of social support needed

While widows benefited from instrumental social support, widowers appear to benefit from emotional and informational support. As mentioned earlier, emotional support allows one to talk exhaustively about a particular incident, and/or increases one’s self-esteem. Informational support involves receiving information that can benefit or remedy a particular situation or ordeal. For this particular ordeal, some widowers reported that they benefited from receiving informational support. “My best friend Dave lost his wife 8 years ago. He told me what to expect in the future, and told me that it would get better with time. He even connected me with some friends who have also lost their wives to cancer. I am thankful he provided this information to me.”

Other types of informational support that appeared to mitigate the adverse effects of bereavement on these participants included information regarding the mourning process from others who had experienced a *similar* incident. “I do not want someone who has not lost his/her spouse trying to provide me with advice about this situation; I welcome any suggestions and opinions from other bereaved spouses.” As this

aforementioned quote may suggest, widowers in this group may be particular about *who* provides them with informational support. Widowers who received informational support about their situations from friends and family who had never experienced a similar ordeal reported feeling angry and resentful. “I grow angry when people tell me what they would do if they were in my situation. Well, the fact of the matter is that they are *not* in my situation- so the advice they are providing me is hypothetical, and not based off of personal experience.”

To my surprise, while widows reported not wanting to talk about their ordeal, widowers reported the opposite. “I do not know if my friends assume I do not want to talk about my wife’s passing because I am suppose to be some ‘macho’ and tough guy who can handle anything. I am not a robot- I have feelings.” Five out of six participants in this group expressed their desire to have someone to talk to regarding their ordeal. While these particular participants also desired to have someone to talk to, they also felt conflicted because they thought that they need to appear tough. “If I cry in front of my kids about their mom’s death- they will feel worse. Someone has to put on a brave face for the kids; they just lost their mom- they need to be able to count on dad.” A reason widowers may not receive emotional support (allowing one to speak, enhancing one’s self-esteem) may be due to gender and cultural norms in our society. While our society has become more tolerable and accepting of individuals deviating from gender roles, our society may also tend to exploit individuals who deviate from these norms. For example, a participant recalled this particular incident; “One of my co-workers saw me in my office and I was crying. He told me that I needed to be a ‘man’ and not cry over my wife. Instead of crying, he encouraged me to get back into playing golf.”

Influence of culture and gender norms

As the aforementioned quote may suggest, men may not feel too comfortable to show emotion regarding their loss. Majority of participants in this group reported feeling terrified to show any sort of emotion or pain. “I think bereaved husbands are allowed to show emotion for, like, a week following the loss of their wives. After a good 7-10 days, bereaved husbands are supposed to move on and focus on rebuilding their futures.” The aforementioned quote was expressed to me by one of my participants who had unwillingly received appraisal support (feedback about one’s behaviors or views) from one of his family members. He explained to me that individuals would often meddle in his life and provided him with feedback regarding the way he was handling his wife’s death. “I think my family thinks I am not handling my wife’s death properly because I have isolated myself and cry a bit. Who the hell are they to tell me how to mourn? If I want to sit at home and cry about it, I will. I did not ask them to assess how I am handling my wife’s death.”

As mentioned earlier, individuals who use Hospice services are provided with thirteen months of bereavement counseling following the death of a spouse. As widowers discussed their desire for emotional support, I started to wonder why widowers were not taking advantage of the bereavement counseling offered by Hospice. As I came to find out, widowers secretly desired seeking bereavement counseling; however, what stopped them from utilizing these services was their fear that they were not handling the situation the way their peers expected them to do so.

My brother Jim and I have a mutual group of friends. Jim lost his wife a few years back, and he recently remarried, and rebuilt his life. He never talked or cried

about the death of his wife; he always put on a brave face, and refused to allow anyone to pity him. Our group of friends admired him for that, and characterized Jim as a tough and logical ‘man.’ If they found out I was talking to a therapist, they would definitely think I am not as strong as Jim. I know it sounds childish, but I don’t want everyone thinking Jim is more in control than I am- especially because I am the older brother, and Jim is supposed to look up to me- not the other way around.

Another participant adds that while he considered seeking a bereavement counselor, he was afraid that talking to a bereavement counselor would be accepting defeat and weakness. “If I were to actually speak to the counselor, then that would mean that I could not handle things on my own. It would show a sign of weakness. While I am a sad and mourning man, I am *not* a weak and helpless man.”

Provider of social support

What is notable is that participants in this group not only benefited from emotional and informational support, but they were particular about *who* provided it to them. Widowers in this group were not appeased by receiving informational or appraisal support from individuals who had not experienced a similar incident. While these widowers knew that people had their best interest at heart, they did not realize that providing information and feedback about a particular situation that they did not personally experience exacerbated their painful ordeal. “My wife died two months ago, and I am living in hell. When other husbands who are not bereaved provide me with any sort of information, I just want to punch them in the face.” It is imperative to note that bereaved widowers may greatly benefit from receiving emotional support. Furthermore,

while most widowers in this group reported their desires to have someone to talk to, some widowers were indeed fortunate to have a shoulder to cry on. “My brother is a therapist. I am lucky. I get to talk to have someone to talk to whenever I want. I cannot bottle this stuff inside.”

While widowers in this group are particular about who offers informational and appraisal support, they are *not* too particular about who should offer them emotional support. Widowers may not be too particular about who provides them with emotional support because they may not be receiving much emotional support in the first place. As mentioned earlier, majority of widowers in this group desired having someone to talk to about their pain. Even if they were to express their pain, they have often been exploited for appearing “weak” and “cowardly.” As a result, because bereaved widowers may be at a disadvantage for receiving emotional support (due to cultural norms or gender norms), they may not be able to adapt to widowhood as smoothly as widows. As mentioned earlier, widows in the same bereavement stage were offered emotional support on a constant basis- even though they preferred not to receive it. On the contrary, widowers in the same bereavement stage would benefit from emotional support, but are not provided with any. It is imperative to take note of the lack of emotional support that is provided to widowers because it may indeed be the *lack* of emotional support that may be an additional source of pain and anguish. Receiving emotional support may mitigate the adverse effects of death on widowers’ overall mental/physical wellbeing.

Lack of emotional support

While widowers in this group reported a scarcity in emotional support from their social networks, they reported an increase in the encouragement of risk-taking behaviors

from their friends. As one participant said, “My friends thought that instead of talking or crying about my wife’s death, I should remember her by drinking in her honor. One beer led to two beers which ended up leading to ten beers.” As this aforementioned quote may suggest, widowers’ social networks mistakenly felt that their widowed friend would benefit by speaking less about the ordeal and would benefit by drinking and repressing the ordeal.

They would ask me- what the hell is sitting around and crying about Hailey going to accomplish? We are ‘men’ and we should handle things differently. We shouldn’t talk or cry about it. Instead of crying about Hailey over a cup of tea, we should go to a sports bar and play pool and drink. If a sports bar doesn’t help, then we should throw some steaks on the grill, and wash it down with some cold beer.

One participant, Ian, reported that after his wife’s death, his gambling problem resurfaced. “I rarely gambled when Jessica was alive, and if I did, I would hide it from her. Now that she is gone, gambling eases my pain, and my friends are always willing to join me.” As this aforementioned quote may suggest, Ian’s friends may enable his gambling problem because they *always* join him at the casinos. “I think they can’t say ‘no’ to me because Jessica died, and they are trying to be a good friend. I think that is why I always have someone to go to the casino with. Who is going to say ‘no’ to their sad and widowed friend?”

Other participants reported that their amount of exercise decreased significantly. “It sounds so bad, but going for a run is the last thing I want to do. I would rather just sit outside and smoke a cigar- it is easier than running.” As one participant said, “My guys and I would hike every Sunday morning. Since my wife died, I rarely want to go, and

they do not seem to insist that I come anyways. I do not think they want me bringing down the mood during a hike.” As widowers in this group reported, it appeared that not only did their social networks prefer to avoid talking about the ordeal, but they slowly began to shun their widowed friend in fears of being burdened by the ordeal. “When they went out for drinks, they always invited me, maybe because they knew I wouldn’t talk about Rachel at a bar. When they were going to the gym or somewhere more low-key, they weren’t adamant that I join them.”

Conclusion

For a bereavement stage that is one year or less, it appears that both widows and widowers that are middle-aged may not be benefiting from the social support they are receiving. The problem is, while these participants are receiving support, they are not receiving helpful support. Additionally, widowers reported feeling an increase of pain and anguish when they received support from individuals that did not experience a similar situation. While some participants have suggested that they are fortunate because they have been provided with helpful support, most participants are less fortunate. While widows and widowers prefer different types of social support, both widows and widowers expressed their frustrations with receiving unhelpful social support.

What is noteworthy is that all participants (widows and widowers) in this group have been working for an average of thirty-fifty hours a week. All participants are employed, and did not report any financial difficulties after their spouses died. While being employed may offer financial stability, it may also increase the opportunities of receiving unhelpful social support. Because employed individuals may come into contact with many peers within a work setting, they may also encounter the likelihood that they will

hear something from a co-worker who may perpetuate their negative psychological well-being. While most participants agree that their co-workers may have their best interests at heart when they provide support, they would prefer for co-workers and peers to stay out of their business if it is going to make them feel worse.

Participants in this group have been married for an average of eight-twelve years; additionally, while most participants did not disclose specifics about the quality of their marriages, it appeared that participants were happy in their marriages overall. Majority of participants in this group had children, and majority of participants had families and friends that lived close-by. In sum, widows and widowers in this group shared similar demographics- age, years married, bereavement stage, quality of marriage, financial stability, and close proximity of friends and family. With similar demographic characteristics, it is noteworthy that preferences for the type of social support differed by gender. The type of social support that was given to widows and widowers may have differed based upon gender norms. Regardless of the varying types of support desired by widows and widowers, it is imperative to note that neither widows nor widowers received helpful social support. As a result, both widows and widowers reported an elevated level of pain and anguish as a result of the unhelpful support given.

For example, widows reported constantly that they had multiple opportunities to exhaustively talk about their ordeal- mainly because friends and family made the assumption that they would benefit from talking about their ordeal. Widows received encouragement from their social network to not only speak openly about their ordeal, but were also encouraged to seek bereavement counseling that is provided by Hospice. "My friends and family would constantly tell me to see a therapist. They would tell me that the

therapist is a professional, and maybe he/she could help me move on.” Another widow added, “I think my co-workers began to realize that I didn’t want to talk to them about my husband’s death. Instead of urging me to talk to them about it, they begged me to speak to a therapist. It wasn’t anything personal- I just didn’t want to talk to *anyone*.”

Contrarily, widowers desired opportunities for emotional support, but may not have received it because their peers expected them to act “tough” and “masculine.” Unlike widows, widowers were discouraged by their social networks from speaking about their ordeal. “No one wanted to hear about my wife’s death. I think as a man, I am not expected to talk about it- not to anyone. I thought maybe I should talk to the bereavement counselor at Hospice, but I didn’t want anyone to find out.” Furthermore, not only did widowers not receive proper support, but they are more likely to engage in risk-taking behaviors compared to widows. Widowers reported an increase in alcohol consumption, cigarette smoking, gambling, and a decrease in physical activity and exercise. As pointed out, receiving unhelpful social support may exacerbate the negative and adverse effects of bereavement on participants’ mental and physical well-being. As reported by one widow, “I had the expectation that it would be my friends and family who would help me get through this ordeal. Ironically, they are the ones that often times make me feel worse.”

While most participants agree that their peers do not have malicious intentions, their words and/or support may further exacerbate their pain. As mentioned earlier, widowhood is a very distressing life event, and increases one’s risk of mortality. Additionally, social support has shown to positively influence one’s overall mental and physical well-being; however, social support may negatively influence one’s overall

mental and physical well-being if the social support provided is unhelpful. Therefore, it is important to note that bereaved spouses who are going through a significantly distressing life event may encounter social support that may exacerbate their negative state of well-being. It is important to discern between receiving social support and receiving *proper* and *helpful* social support. Making the assumption that one will adjust to widowhood smoothly because he/she is receiving social support is inaccurate; we must examine whether or not the type of social support given is proper and helpful. It is imperative to understand what can be done to inform individuals about the proper types of social support that can be offered to bereaved spouses. Unfortunately, it appears that middle-aged widows and widowers are receiving improper social support. These individuals may be at a higher risk of mortality, and may most likely not adjust to widowhood as smoothly as possible.

Table 1. Themes and categories of feelings and attitudes reported by middle-aged widows who have been bereaved for one year or less (n=6).

Themes	Categories	N (number of participants)
Depression	Numbness	6
	Trauma	6
	Impaired memory	5
	Loneliness	6
	Fear of unknown	6
	Mentally absent	5

Table 2. Themes and categories of feelings and attitudes reported by middle-aged widowers who have been bereaved for one year or less (n=6).

Themes	Categories	N (number of participants)
Depression	Lethargic	6
	Isolation	6
	Poor work performance	6
	Smoking	6
	Drinking	6
	Gambling	4
	Decrease in physical activity/exercise	5

** Smoking, drinking, gambling, and decrease in physical activity/exercise is grouped as one category (risk-taking behaviors) in the text **

Middle-aged bereaved spouses- bereavement stage three or more years

This next section will detail the experiences of middle-aged bereaved spouses who have been bereaved for three or more years. A total of twelve participants were interviewed for this section; six widows and six widowers. Participants in this group are all employed, have children, have a Bachelor's degree, and reported being happy in their marriages. Participants in this group have been married for an average of ten years, did not report any financial instability following the death of their spouse, and reported having overall decent mental/physical health before their spouse passed. Before discussing the type of social support that would benefit bereaved spouses in this group, I will be discussing the feelings and attitudes that were reported by these participants following the death of their spouses three or more years later.

Acceptance

Three or more years later, bereaved spouses in this group have come to terms with their loss. As reported by one of my participants, "I have finally adjusted to my new life; I found a 'new-normal.' I am not saying this 'new-normal' is particularly pleasant, but I am saying that I have accepted it. It is what it is." Both widows and widowers in this group have come to accept the death of their spouses. The theme that has been developed for these group of participants is acceptance; this theme was developed from a total of twenty meaning units, which was then grouped into one category (please refer to tables 3 and 4).

The theme, acceptance, was derived from the category, "new normal." The category "new normal" is characterized as the following: adjusting to a "new" and "different" lifestyle, renegotiating roles and household rules, and creating new traditions without

one's spouse. All twelve participants in this group, both widows and widowers, reported that while they have accepted the death of their spouses, the term 'acceptance' does not necessarily equate to happiness. My participant, Robert, continuously reminded me that just because he has come to accept his wife's death did not mean he was happy about it.

I have accepted my wife's death. It has been six years. I have not remarried, nor do I plan to remarry. I have two surviving, young children, and they do not need a new woman taking Elizabeth's place. I may change my mind about marriage later, but as of now, I do not want to remarry. I think people get confused when I say I have accepted Elizabeth's death; just because I have accepted it does not mean I am happy about it!

Ashley, a widow of four years adds, "I have started dating someone. It is semi-serious. While I am happy to have some romantic companionship, I still think about my husband every single day. Dating someone does not mean I am not sad anymore—it just means I am trying to accept what has happened to me." This aforementioned quote suggests that while participants have accepted the death of their spouse and are trying to move on, moving on and adjusting to a new normal is a constant challenge. Participants in this group reported being as proactive as possible regarding their adaptation trajectory; trying to adjust to a new normal as fast and positively as possible was their top priority—especially for their children.

I have four children. They are all under the ages of thirteen. When Larry passed away five years ago, I was so heartbroken that I thought that I would die, too. I was terrified that my children would become orphaned, and I could not allow that to happen—I mean, Larry would not want that for the kids! After the first

anniversary of Larry's death came and went, I slowly began to realize that I was not as depressed as I was when Larry first died. I had discovered abilities about myself that I didn't know I even had—I am a strong person. If you were to tell me five years ago that I would laugh again someday, I would have dismissed your comment. Now, I can say that while I still think of Larry and miss him tremendously, I can drive somewhere by myself without crying the entire time!

Brandon adds, "I can get through a few weeks or months nearly free of pain. Seven years ago, I lost the love of my life, my high-school sweetheart. When she died, I felt like my heart stopped beating. Now, I can listen to the music we both loved without crying."

As mentioned earlier, renegotiating roles and household rules was reported by participants. "Their mother has been deceased for three years. Since then, I am not only the father, but I am also the mother. I have two daughters—they need their mother." Julie adds, "I have always been a pushover. My children always knew to come to me because I will always say 'yes' and Tim would say 'no.' My kids are young, but I had to enforce a house rule since their father has passed—the kids must behave properly, and must behave in a manner in which their father would approve of." Some participants, both widows and widowers, admitted that when their spouses passed away, they were in charge of the household financials for the first time in years. "Adam always 'balanced the checkbook,' and made sure our bills were paid on time. When he died, I learned the hard way what happens when you forget to pay for your car insurance! I do everything Adam once did—just me, myself, and I."

What was also commonly reported by participants was that creating new traditions without their deceased spouse was a way of moving on and accepting the death. "Every

Friday night, the kids and I order a pizza and watch a movie. It is our new tradition. When their father was alive, we would go out to eat every Friday night; now, the four of us stay in and watch a movie. It is our 'new' family tradition." Michael adds, "I cook dinner every night for my kids. Their mother was a great cook, and always took requests for dinner. Now, my kids and I plan out in advance what we are going to have for dinner as a family, and we eat dinner every night at 6 pm sharp." For these middle-aged spouses who have been bereaved for three or more years, accepting the death of their spouse has been a priority, especially for the well-being of their children. Creating new household rules, developing new traditions, and readjusting to roles were commonly reported by participants. In addition to reporting similar attitudes and feelings following the death of their spouse, participants in this group also reported similar expectations for the social support that was given to them by their social networks.

Emotional support

As mentioned earlier, emotional support consists of allowing one to speak about a particular experience/ordeal and/or enhancing one's self-esteem. For participants in this category, receiving support that *enhanced* their self-esteem was commonly desired. "Since being widowed and becoming a single mother, I do need the occasional 'boost' of confidence. Reminding me that I am doing a good job and that I will survive has been particularly helpful." David adds, "When my kids tell me they love me, I feel like a million bucks, and I feel like my kids will live a prosperous life- even though their mother has died." While participants in this group highly desired emotional support that enhanced their self-esteem, they were *not* particularly selective about *who* provided them with emotional support.

When and if I make ‘small-talk’ with strangers or acquaintances, and they find out that my husband passed away years ago, they tell me that I seem to have ‘things together,’ and that I am a ‘strong,’ single mother. While they do not know me, or never met Jeffrey, it is really encouraging to hear every once in a while that I look like I am doing ‘alright.’ Even though I may be sad, everyday, since Jeffrey died, hearing that I appear ‘strong’ and ‘confident’ motivates me to continue appreciating the progress I have made, and somehow, makes me truly start to believe that life can go on.

In addition to enhancing one’s self-esteem, emotional support may also consist of allowing one to speak about a particular experience/ordeal. *All* participants in this group reported that they *did not* feel encouraged to continue speaking about the death of their spouse. “My wife died over four years ago. I feel like while I have just started to accept it and move on, people have moved on a long, long time ago. I do not even want to mention her name because sometimes people change the subject—intentionally!” Becky adds, “I do not feel too comfortable talking about Aaron’s death to anyone. I feel like when I talk about it, people think I am hanging onto the past, and criticize me for being overly sensitive and too sentimental.” As mentioned earlier, widowers who are middle-aged and have been bereaved for a year or less highly desired the ability to speak openly about their wives’ passing, but did not feel encouraged to do so. On the other hand, widows who are middle-aged and have been bereaved for a year or less were often encouraged to speak about their ordeal—even when they did not want to talk about it. These findings show that during a bereavement stage of three or more years, however, middle-aged

bereaved spouses are *not encouraged* to speak about the death of their spouse—regardless of their gender.

For this particular group of individuals, emotional support appears to be a beneficial source of support. While there are varying degrees of emotional support, individuals in this group appeared to benefit from emotional support that enhanced their self-esteem. What is noteworthy is that both widows and widowers in this group consistently spoke about their inability to speak about their ordeal. Regardless of their gender, individuals in this group believed that their social networks have grown tired of listening to their ordeal, and/or criticized their continuous mourning process.

While widows in this group were not encouraged to speak about their ordeal exhaustively compared to widows who have been bereaved for a year or less, *widows* in this group discussed their success with group counseling. “There is a ‘support-group’ for single-mothers who are widowed, like me. Most of the women in this group have been widowed for at least five years—it is nice to be able to talk to other women about this.” Sydney added, “While attending group counseling, I have not only been able to talk and cry as much as I wanted to about my sadness, but I also made new friends. These friends are unlike the ones I already had—they actually *understand* me.” Attending group counseling, through Hospice or other bereavement-specific services has been reported among 5 out of 6 widows in this group. The reason for this is mainly due to one factor— inability to receive emotional support that allows them to speak comfortably and exhaustively about their ordeal to their social networks.

I love my friends and family. They are my world. Ever since Harry died, I feel like I died, too. I do not want to hang out with my former friends as often because

they were friends with both Harry and me. Now, when I join them, I am the only widowed woman in the room—it is like instant pity. I hate it. Besides, while they may still feel sorry for me, I know they do not want to hear me talk about Harry—when I have cried about it, I was constantly reminded to ‘move on’ or ‘get over it.’ My friends in the group counseling sessions are literally my safety net. We have experienced a similar experience, and we can talk to one another in detail—there is no time limit or expiration date. I just cannot help but feel that my former friends have ‘clocked out.’ Too much time has passed to talk to them about Harry. It is old news, now.

As the aforementioned quote may demonstrate, widows in this group may have turned towards group counseling sessions as a source of social support. Receiving emotional support from former friends that enhances one’s self-esteem has been helpful, but exhaustively talking to them about their deceased husband is no longer an option. Again, widows in the previous group who have been bereaved for one year or less were constantly encouraged to speak about their ordeal. As time has passed, widows who have been bereaved for three or more years are no longer encouraged to speak about their ordeal; turning to group counseling has appeared to be the most beneficial source of social support.

Both widowers who have been bereaved for one year or less and three or more years were not encouraged to speak about their ordeals; the lack of encouragement to speak openly and freely may put widowers at a disadvantage—they are more susceptible to engaging in risk-taking behaviors. Widowers who have been bereaved for one year or less reported increases in nicotine and alcohol consumption, decreases in physical

activity, and a susceptibility to new addictions (gambling). What is important to note is that while widowers in this group may be more likely to engage in risk-taking behaviors compared to widows in this group, widowers who have been bereaved for three or more years *fare better* than widowers who have been bereaved for one year or less.

Within the first year of Julie's passing, I had turned into a complete alcoholic. I hit 'rock bottom' because I was not sober enough to maintain my finances. Four years has passed since Julie had died—I drink significantly less than I did when she first died, but drinking still helps ease the pain.

Jimmy adds, "When Harriet passed away, I was desperate to fill the void. I went out with hundreds of women; I slept around, drank, and acted like I was twenty-one years old. Six years later, I have decreased my alcohol consumption, but I still sleep around with women-- casually. I know it is not good, but I do not like being alone." While widows in this group have turned to group counseling, widowers in this group filled their void with risk-taking behaviors. While the levels of risk-taking behaviors have been reported to have decreased since the first year of their wives' death, widowers are less likely to seek out the opportunity to experience group counseling. Similarly to widowers in the former group, widowers who have been bereaved for three or more years are less likely to seek bereavement counseling. Widowers in this group report that they have been harshly criticized when they showed emotion in public. "My friends would tell me that I need to remain strong for my children, and crying in front of them would further shatter their hopes and dreams for the future." Doug adds, "I was never comfortable to show emotion about Hailey—especially in front of my friends. I feel like my friends would not respect

me as much if I appear ‘weak.’ I would rather just go hunting with them—that is their way of being there for me.”

Conclusion

Both widows and widowers who have been bereaved for three or more years were less likely to communicate to their social networks about their ordeal, due to the fear of criticism about their adaptation to widowhood and/or because their social networks have grown tired of hearing about the ordeal altogether. However, widows in this group were more likely to seek out group counseling compared to widowers in this group. Similarly to widowers in the former group, widowers who have been bereaved for three or more years did not feel it was acceptable to show emotion in public. Maintaining a “strong” and/or “calm” mentality was reported by widowers in this group—deviating from a “strong” or “calm” mentality was not an option. Because widowers are less likely to seek out group counseling or bereavement counseling, they may be at a higher risk of engaging in risk-taking behaviors compared to widows in this group. However, it is noteworthy that widowers who have been bereaved for three or more years have significantly decreased their levels of engaging in risk taking behaviors compared to widowers who have been bereaved for one year or less. While widowers who have been bereaved for three or more years are more likely to gamble, sleep around casually, and increase levels of alcohol compared to widows, widowers who have been bereaved for three or more years reported lower levels of engaging in these behaviors compared to widowers who have been bereaved for one year or less.

It appears that regardless of bereavement stage, widowers are not encouraged to openly speak about their ordeal to their social networks; showing any sort of emotion in

public has been harshly criticized, and widowers in this group avoided criticism altogether by remaining quiet. As an outlet, widowers externalized their pain and anguish rather than internalizing it. Externalizing, in this particular study, may be characterized as engaging in risk-taking behaviors. Excessive levels of alcohol and nicotine consumption, casually sleeping with women, and/or turning to gambling are a few examples of externalizing behavior. Because seeking bereavement specific support and/or group counseling has not been reported by widowers in both bereavement stages, it is important to note that widowers may have a higher linkage to negative health behaviors compared to widows. While widowers in both bereavement stages did not report the likelihood of seeking counseling, widowers who have been bereaved for three or more years fare better than widowers who have been bereaved for one year or less. Thus far, it appears that bereavement stage may influence the *type* and *amount* of social support that is given to bereaved spouses. As time elapses, bereaved spouses may have to seek support from individuals *outside* of their social networks; group counseling has appeared to be a source of social support for widows in this bereavement stage because they may need to interact with individuals who have experienced a similar ordeal.

Table 3. Themes and categories of feelings and attitudes reported by middle-aged widows who have been bereaved for three or more years less (n=6).

Themes	Categories	N (number of participants)
Acceptance	New lifestyle	6
	Renegotiating roles	6
	Creating new traditions	6

Table 4. Themes and categories of feelings and attitudes reported by middle-aged widowers who have been bereaved for three or more years less (n=6).

Themes	Categories	N (number of participants)
Acceptance	New lifestyle	6
	Renegotiating roles	6
	Creating new traditions	2
	Smoking	5
	Drinking	6
	Increase in casual sex	6
	Decrease in exercise	2

** Smoking, drinking, gambling, decrease in physical activity/exercise, and increase in casual sex is grouped as one category (risk-taking behaviors) in the text **

Retired bereaved spouses- bereavement stage one year or less

Earlier in this section, attitudes and feelings of middle-aged bereaved spouses who have been bereaved for one year or less have been detailed. Additionally, attitudes and feelings of middle-aged bereaved spouses who have been bereaved for three or more years have also been detailed. The next section of this dissertation will focus on a different life course stage—*retired* bereaved spouses. Specifically, for this section, I will be focusing on retired bereaved spouses who have been bereaved for one year or less.

Participants in this group range between the ages of sixty-five and ninety-three. All participants were married for a minimum of twenty years, had at least one surviving adult child with their deceased spouse, and are currently retired. Due to social security benefits, all participants reported no financial difficulty following the death of their spouse. All participants in this group, both widows and widowers, reported having physical health problems and symptoms *prior* to their spouse dying. Physical health problems and symptoms ranged from mild to serious. One participant had a stroke before her spouse died, two participants reported having sensory deficiencies, two participants reported having high blood pressure before their spouses died, two participants reported having a heart attack before their spouses died, and five participants reported having mobility deficiencies. As we will see, bereavement has amplified physical health problems and symptoms—especially because these participants are newly bereaved.

Similarly to middle-aged spouses who have been bereaved for one year or less, retired spouses who have been bereaved for one year or less also reported feeling incredibly depressed following the death of their spouse. For middle-aged spouses who have been bereaved for one year or less, thirty-four meaning units were grouped into 6 categories;

numbness, trauma, impaired memory, loneliness, fear of the unknown, and mentally absent are the categories that created the depression theme. For retired spouses who have been bereaved for one year or less, forty-four meaning units were grouped into 4 categories; loneliness, fear of the unknown, feelings of helplessness/hopelessness, and decreasing levels of physical health/energy. The four aforementioned categories created the depression theme for these participants. A major difference for participants in this group is that they reported declining levels of physical health *before* and *after* bereavement; participants in the same bereavement stage (one year or less) and different life-course stage (middle-aged) did not report declining levels of physical health. For this bereavement stage and life course stage, no differences were reported between widows and widowers. A significant and differing category for these participants is declining levels of physical health. Additionally, gender differences in terms of adapting to widowhood were not reported for this group of participants.

Prior declining physical health

“Before my wife died, I was already struggling with heart complications. After she died, my physical health went from bad to worse.” The aforementioned quote was mentioned to me by Samuel, a retired widower with three surviving adult children. He continued to say, “I know my kids probably resent me, because they have to physically assist me with everything. Getting to and from the bathroom takes me nearly an hour—when my kids help, it takes twenty minutes.” Other participants reported similar diminishing physical health. “My son, bless his heart, takes me to the doctor every week. Before my husband died, my husband would take me to the doctor. If it were not for my son, I would not be able to see a doctor consistently.”

While nearly identical feelings and attitudes were reported by both middle-aged and retired bereaved spouses during the first year of bereavement, the main difference is that retired spouses reported that their diminishing levels of physical health exacerbated their depressed state of well-being. As Leah explains, “I am seventy-five years old. I am not in the best physical health. Ben died two months ago, I do not think my body can handle this trauma.” The majority of retired bereaved spouses in this group reported that their diminishing levels of physical health further intensified their depressed state of mind. Examples of diminishing physical health are as follows: fatigue, weakening of bones, lower levels of energy, loss of appetite, lower levels of sensory details (eyesight, hearing, and smelling), and the inability to fall and stay asleep. Retired bereaved spouses (one year or less) may be at a disadvantage compared to middle-aged bereaved spouses (one year or less) because their lowering levels of physical health deepens their depressed state of well-being. On top of experiencing the loss of a spouse, retired bereaved spouses in this group further experienced a sense of depression because they reported that they were physically incapable of taking care of themselves.

Diminishing levels of physical health

As mentioned earlier, participants in this section ranged between the ages of sixty-five and ninety-three. While there are twelve participants in each group in this study, it is important to mention that their ages varied for these particular participants. The average age for participants in this group was eighty-four. The majority of participants (seven) in this group are older than the age of seventy-five, one participant is older than the age of ninety, and the remaining four participants are in between the ages of sixty-five and seventy. Seven out of twelve participants in this group reported community dwelling. For

the purposes of this study, community dwelling will be conceptualized as one living independently with his/her spouse, and/or not reporting the use of a retirement center during the time of the interview. The remaining five participants, on the other hand, utilized retirement centers. For the purposes of this study, a retirement center will be conceptualized as independent/assistant living; additionally, there were two retirement centers that were reported in this study –“*The Friendship Village*” and “*Homestead Hospice*.” Three out of five participants stayed at the “*Friendship Village*,” and two out of five participants lived at “*Homestead Hospice*.” The “*Friendship Village*” and “*Homestead Hospice*” are independent/assistant living facilities for elderly spouses. The “*Friendship Village*” and “*Homestead Hospice*” are available to anyone seeking a place for retirement. The “*Friendship Village*” and “*Homestead Hospice*” are Phoenix-style senior living centers; also the “*Friendship Village*” and “*Homestead Hospice*” are characterized as maintenance-free independent/assisted living, but do offer health care needs should a health problem arise.

The “*Friendship Village*” and “*Homestead Hospice*” have been reported to increase chances of socializing on-site with peers, increase transportation options, and provide structured activities such as a recreation center, clubhouse, and/or field trips. While participants in this group reported diminishing levels of physical health prior to their spouses’ death that ranged from mild (high blood pressure) to serious (stroke), participants in this group also varied in their preferences for assisted care. As mentioned earlier, seven out of twelve participants reported community dwelling at the time of the interview. Out of these seven participants, three participants reported hiring outside help, remodeling parts of their home, and having other family members lend assistance to them

because their physical health often posed a challenge to their lives. The remaining four participants who reported community dwelling, however, did not report the need to hire outside help or remodel parts of their home as a means of mitigating challenges of physical health on their daily activities. The remaining five participants who did not report community dwelling and lived in a retirement center reported that they did not need twenty-four hour assistance. While their retirement center provided assistance in activities of daily living, they differed from nursing homes in that they did *not* provide a high level of medical care. While a licensed physician may supervise each resident's care and a nurse or other medical professional is almost always on the premises of a nursing home, the retirement centers in this study do not center much on delivering high levels of medical care.

As mentioned earlier, seven out of twelve participants in this group reported community dwelling at the time of the interview. These seven participants (three males and four females) lived with their spouse prior to death, and did not have any of their adult children living with them. In fact, all seven participants reported that their adult children did not live in Arizona, and had started families of their own. While their adult children visited during Holidays and special occasions, these seven participants reported that their main source of social support came from their spouses. "I spent each and every day with Harold. We planned to spend our retirement days sitting around and doing nothing—as long as we were together. The kids came and visited us once or twice a year, but my life centered around Harold who was my best friend." Jack adds, "Lucy was my best friend—well, the only friend I really ever had. She hung out with our neighbor from

time to time, but ninety percent of her time was spent with me. I am so incredibly lonely without her, it scares me.”

While *all* participants reported having declining physical health prior to bereavement, only five participants had to relocate their residence. “Sammy and I moved into the retirement center because Sammy was dying, and I was just deteriorating physically. I could no longer walk unless I used my cane. It was like ‘the blind leading the blind’ – we were two people who could barely function.” Thai adds, “I was very unhappy about the fact that we moved into a retirement center three years ago—I did not want to leave my comfort zone, but we really had no choice. Now that she has died, I am thinking it was a good thing that we agreed to move out of our own place.” When I met with my participants who had to relocate due to their declining physical health, I made sure that I met them at their current location—which was at one of the retirement centers previously mentioned in this study. I noticed that while these participants had to relocate to a retirement center prior to their spouses’ death, these participants may be at an advantage compared to participants who reported community dwelling because they are constantly exposed to other elderly individuals and support systems.

“At the retirement center, I always play poker with my good friend Jeff. His wife died nearly around the same time my wife died. We both have kids, too, but our kids are living in the middle of the country. I spend a lot of time with Jeff, we are good friends.”

Another participant living at the retirement center also told me how helpful and calming the retirement center has been for him. “There is a huge entertainment room where we watch television and play cards; there are always people around. We may not all be in ‘tip-top’ shape, but we are surrounded by people. No one is ever in pain, and we have

access to all sorts of medical assistance and attention.” Participants who lived at the retirement center appeared to be a bit more positive than participants who reported community dwelling. Because these participants are retired, they do not come into contact with co-workers or individuals on a daily basis. However, living in a retirement center may serve as a buffer against the negative effects of retirement on loneliness because participants are always surrounded by people. Retirement centers may decrease the chances of being all alone, and appears to lower fears of the future without one’s spouse.

“I just turned seventy-seven, and I have pretty much lived my life. Now that I am widowed, I really am scared about spending the rest of my life alone. However, the retirement center shines a bright light in my life—there is always something going on—there are always voices, noises, and commotion.” Participants who are residing at a retirement center may be at an advantage compared to participants who are community dwelling because their chances of being all alone are significantly minimized; additionally, these participants report being less stressed about their physical symptoms impeding their daily living because access to transportation and on-site support is always available.

Community dwelling

The remaining seven participants who reported community dwelling during the time of the interview reported more negative feelings and attitudes following bereavement compared to participants who lived in a retirement center. While all participants reported negative feelings and attitudes following bereavement, the seven participants who reported community dwelling seemed to be at a disadvantage because they have been

exposed to a quiet life within the past year, and they have not adjusted to being alone in their home. For example, Daniel mentions, “I live in that home all alone, *all* alone. I cannot do it. Every inch of that house reminds me of Gracey. It is too quiet in there, and sometimes I try to hear her voice.” Ingrid adds, “I can no longer sleep in the same bed. I constantly wake up in the middle of the night, and no one is sleeping beside me. It makes me cry every-time, every night.” Other participants report that their home is still “under construction” because some of their projects and plans have fallen through. For example, Gloria mentions, “I started planting some flowers in our backyard. Since Frank died six months ago, I have yet to plant the remaining flowers.” Thomas adds, “We have a guest bedroom that I painted, and Rachel was suppose to knit a bed sheet that matched the color of the paint I used. I do not want to walk in that room—I guess it is just going to have to remain unfinished.”

Retirement center versus community dwelling

What is important to mention is that while there may be no differences reported between widows and widowers in this section, there is a difference reported between spouses who are community dwelling and spouses who live in a retirement center. Bereaved spouses who are community dwelling reported feeling incredibly lonely—both mentally and physically. “I am in that house all by myself. Noises and sounds come from me, and me only. It scares me at night, being there all alone.” Cindy, a widow at the retirement center happily reports that while she misses her husband terribly, she has had the opportunity to make friends at the retirement center. “The ‘*Friendship Village*’ literally focuses on the word, ‘friendship.’ That is exactly what it is—a place to meet and

make new friends. I constantly talk to people who are going through what I am going through. The *'Friendship Village'* tries to take us to a baseball game every summer."

Bill, a widower of four months mentions, "I need to interact with people more often. I try to, but I lack the *motivation* to do so. If people come to me, I am happy to see them, but I am not motivated enough to go out of my way to see them." The major difference between bereaved spouses who live in a retirement center and those who are community dwelling is that for the latter group, a lack of motivation is reported. For bereaved spouses who are community dwelling, a lack of motivation and/or a purpose for wanting to push through such a difficult time appears to be lacking. As mentioned earlier, middle-aged bereaved spouses who have been bereaved for three more years reported that they felt obligated and pressured to "move on" for the sake of their children. Middle-aged bereaved spouses who have been bereaved for three or more years used their children as a reason and motivator to work through their grief. Middle-aged bereaved spouses who have been bereaved for three or more years reported that the well-being of their surviving young children took precedence, and that their quick recovery would help and possibly mitigate the negative effects of bereavement on the family.

Because participants in this section are retired, they are not as motivated to work through their grief because their children are not young. As mentioned earlier, all participants in this section have a surviving adult child. The average age for the surviving adult child is roughly forty-five years old. The surviving adult child has a family of his/her own, and has also transitioned into the role of becoming a parent. Retired bereaved spouses in this group lack the motivation to want to "move on" for their child because their child has a life of his/her own, and no longer needs to rely on his/her

parent(s). While bereaved spouses in this section may not feel motivated to work through their grief for their children, bereaved spouses in this section did report the desire to “smile” and “laugh” again. “I do not know if it will ever be possible to ever laugh or smile again, but I want to. Does that make me sound bad? My husband has been deceased for nearly three months, but I really want to laugh again. Laughing always helps.”

Future goals

While retired spouses in this group may not feel the need to rapidly work through their grief as a means of protecting their child(ren), retired spouses nonetheless do want to “move on” and “live.” While participants may desire their ability to work through their grief and continue living their lives, they are not always certain about what their future holds. “Even if I do move on, and learn to adapt to life without Fynn, what is in store for me? I do not work, I have already had children. I have done it all. Is there anything left for me to do?” Julie adds, “I am not so sure about my future. It seems very ambiguous, and when I think about it, I am not too sure it will ever be good—I am no longer with my husband. I am, however, looking forward to becoming a grandmother. My daughter is pregnant—finally!”

While retired spouses in this group may not be too sure what their future holds, they try to imagine a life with their future grandchildren, or great-grandchildren. While some retired spouses in this group may look forward to their role as a grandparent, others fear that certain things may be “bitter-sweet.” For example, Martha, a retired spouse suggests that while she is looking forward to becoming a great-grandparent, she is not too sure she will enjoy this role as much as she would have had her husband still been alive. “Frank and I were not sure if we would ever become great-grandparents! He will never

get to meet his great-grandchild, and that saddens me. While good things may come my way, they will also be difficult because I will not be able to share them with Frank.”

Type of social support needed

Instrumental/tangible support was highly desired by middle-aged spouses who have been bereaved for one year or less. Similarly, instrumental/tangible support was highly desired by retired spouses who have been bereaved for one year or less. Retired spouses desperately sought some type of tangible support—assistance with chores, taking one to and from the doctor’s office, arranging funeral arrangements, and assisting and maintaining one’s finances. An advantage that retired spouses reported was that the majority of them had children who were more than willing to assist with tangible support.

“My daughter flew into town when my husband died. She stayed with me for a week, and then had to fly back to Atlanta for work. I do not know how she was able to pull this off, but she ended up flying back and staying with me for nearly a month.” The aforementioned quote was mentioned by Selena, a retired bereaved spouse who has one surviving adult child. Selena mentions that had it not been for her daughter, she would have been unable to survive the death of her husband. What is important to mention is that retired spouses heavily relied on their children for tangible support. “Both of my parents died before I turned fifty years old; I have a lot of good friends, but they are not as readily available as my children are. Maybe they are just too old or have their own problems to deal with, but my children are the only reason why I may be able to push through this hard time.”

Because the majority of retired spouses in this group reported that their parents had died years ago, most retired spouses depended solely on their children and their siblings

for tangible/instrumental assistance. “My sister is my best friend. She never got married, but she has an adult child that is good friends with my daughter. When Smith died, she was the one who remained by my side the entire time. She made me see a movie the other day—even though I was not in the mood!” Trent adds, “I always wanted to have a brother, but I have two sisters. Neither of my sisters live in Arizona, but they might as well be living here—they call me every day on the hour every hour.” Taylor mentions that because of her siblings, she may be able to return to a life of normalcy. “My brother has remained by my side throughout each Holiday; while I have not yet experienced the first anniversary of my husband’s death, my brother made sure I was involved in every Holiday celebration. It felt like we were kids again—I did not feel alone.”

While siblings and children mitigated some of the negative effects of bereavement, at times, sometimes children and siblings were a source of stress. As Mary-Anne explained, “I thought I raised my children better than this. They moved out of Arizona years ago, but did not really do anything to make up for the geographical distance. Phone calls were not enough.” Due to geographical distance, some participants in this group reported that their children were unavailable because the proximity between them was too much. “I know my daughters would have done more if they could, but my daughters live across the country. I know they cannot just stop living their lives.”

While the majority of participants relied on their children for tangible support, other participants were not as lucky because their children live far away. While participants in this group know that relying on their adult children entirely is not feasible, most participants suggested that having their children in Arizona would make adjusting to widowhood a little less lonely. “I have two grandchildren. I know my son cannot just

leave his two kids to come take care of me, but I wish we could all be together. While he calls me everyday, I wish I could physically see him and my grandchildren.” The aforementioned quote was expressed to me by Samantha, a retired bereaved spouse who is ninety years old. Before her husband died, Samantha suffered a stroke that paralyzed the right side of her body. As a result, Samantha is confined to a wheelchair, and is unable to perform many daily tasks. She says, “I can feed myself and take care of myself, overall. However, when my husband died, I just feel worse. I am not in the mood to put much energy into anything—especially because I do not have much to start with, anyways.”

While Samantha acknowledges the fact that Sawyer has his ‘own’ family and is residing in Ohio, she was hoping that she would have become his first priority after her husband died. Timothy, a seventy-six year old bereaved widower adds, “I feel all alone. My wife died, and my kids are not near me. I was planning on spending the rest of my retirement days with my wife, and now, I am dreading each day.” Other participants have reported that while their surviving adult children would mitigate the negative effects of bereavement, depending upon them entirely is not a feasible option due to their children’s trajectories and responsibilities.

While the majority of retired bereaved spouses live far away from their adult children, some retired bereaved spouses did find some comfort in the *perceived availability* of support from their children. For example, Jonathon mentioned, “My kids live far, and always want to ‘Skype’ with me. I can barely figure out how to use the damn thing, so I prefer for them to just call me. While I do not want to ask them to come home and stay with me, I know if I did, they *would* come.” Joanna adds, “My son lives in Oregon. He is

currently going through a custody battle, and has a hectic life of his own. However, I know he would put me above anything if I were to ask him to.” In sum, some participants found peace and comfort in knowing that their children would be there for them should they ask—this perceived social support did mitigate some of the negative effects of bereavement.

One of my participants, Manuel, suggested that his children were there initially when his wife died. According to Manuel, “My kids actually paid for and set up the entire funeral arrangement. It was a beautiful funeral, I was so proud of them. After a week or so, I felt like my kids got back to their own lives.” The aforementioned quote provided by Manuel is a quote that best summarizes the overall response from participants in this group—their children were physically and tangibly available when their spouse died, but quickly got back to their own lives within a couple of weeks. Because participants in this group cannot heavily rely on their adult children for consistent support, most participants sought out the support from their siblings and in-laws. Martha mentions, “My sister-in-law is one of my biggest sources of support. When I married her brother, we became even closer. Since he has passed, I feel as though she has been a ‘real’ sister to me. She tries to drag me out of the house.” William adds, “When my wife died, I felt like I lost her forever. However, her nieces and nephews have had their own children, and they are very much a big part of my life. I see her every time I spend time with her family.”

Again, while siblings and in-laws may help mitigate some negative effects of bereavement, they may also be a source of stress, as well. “My sister-in-law actually criticized me the other day. She told me that she does not like the fact that I may consider moving to Oregon to be closer to my children and grandchildren. She suggested that her

brother would be disappointed if I abandoned the house he built for me.” Timothy adds, “My brothers are great, and I am very lucky to have them. However, they are still happily married, and sometimes do not understand why it is hard for me to be around them. I do not like feeling like the fifth-wheel. My wife died- I do not want to hang out with my brothers and their wives. It is a sad reminder I no longer have one.”

Retirement and minimal social support

Because participants in this group are retired, they face a bigger challenge than other participants in this study who are employed. The lack of communication and interaction with individuals took a toll on participants in this group after their spouse died. “We snuggled up and read books all day. We did not do much. Once she died, I tried to return to normal, but I cannot do it alone. It is too lonely, and I am scared.” Other participants suggested that if they were in better physical health, they would find a job—even if it were part-time. “Luckily, I do not need the money, but I cannot stay home alone all day. The days seem long, lonely, and dark. If I were to work at a bookstore or something, maybe I would come into contact with people. I would feel less alone.” Jeff adds, “I have been teaching all of my life. My wife and I finally retired, and now, I want nothing more than to go back to work. Without Angie, I have no purpose in life. I have to find work, but I probably will not get hired because I am too old.”

Also noteworthy is that some participants reported that their inability to operate a vehicle exacerbated their state of depression. “While I can drive, I am not instructed to do so by my doctor. Therefore, I feel trapped inside my own home because I cannot get myself anywhere unless I call someone—which I hate doing!” David adds, “My wife is the one that got us around. I have not driven in nearly three years, and now that she has

died, I definitely have no way of getting around. I know it stresses out my kids—they always have to come to me.” Other participants who were unable to drive due to their physical health worsening reported that the negative effects of bereavement amplified. “Even if I wanted to get together, informally, with some of my friends, I have no way of getting there. I cannot drive.” Margaret adds, “I really like going to church—being a part of a community really helps alleviate some of my feelings of loneliness. The problem is, if I do not have a ride to church, I will not be able to attend. It saddens me.”

Social support received

Due to the fact that participants in this group are recently bereaved, Hospice bereaved counselors appeared to be a big part of their recovery—for both widows and widowers. Sam mentioned, “It is probably because I am old and wrinkly, but the staff from Hospice call and check up on me—every other day, at least. They even arranged for a counselor to make trips to my house once a week for counseling.” Sam’s comment prompted me to do a bit more research at the Hospice program I was currently volunteering at—Homestead Hospice. After talking to many bereaved counselors and volunteers at Hospice, I learned that bereaved counselors took more of an initiative with older bereaved spouses because they feared for their physical health after their spouse died. Nicole, a bereavement counselor for Homestead Hospice mentioned, “When they are old, I am *so* scared and worried about them. They are not surrounded by many people when they utilize our services, so I feel as though it is my job to make more of an effort to keep in touch with the older folks.” Tanya, a volunteer at Homestead Hospice adds, “I knew that I would constantly run into bereaved families when I volunteered here. However, I am

particularly sensitive to older bereaved spouses because I fear that they will die soon after their spouse died. They need more attention than younger bereaved spouses.”

One interesting fact that I learned during my study while I was conducting interviews was the following-- Hospice staff and doctors appeared to take more of an initiative when they were dealing with older spouses. As a volunteer of Hospice for the last five years, I did not notice that older bereaved spouses were of particular concern to Hospice staff and volunteers compared to younger bereaved spouses. Once I was informed and enlightened about this piece of information, I made it a point to observe this relationship a bit more closely while I was volunteering. I noticed, while volunteering, that older spouses *did* indeed receive a bit more counseling support and encouragement from staff and doctors. For example, one of my participants that I interviewed and worked with during the time I volunteered mentioned that her husband’s oncologist even made a point to contact her after her spouse died. She added, “My husband’s oncologist was a very sweet man. He referred us to Hospice, and I never thought I would talk to or hear from him again. After John died, I received a card in the mail from his oncologist, and I even received a few phone calls from him—he was checking in on me!”

Social support received

As mentioned earlier, participants in this group highly valued and appreciated tangible/instrumental support from their surviving children and siblings. While majority did not receive support from their children due to their geographical distance, some did find comfort knowing that their children would be accessible and helpful should they ask for it. Additionally, while adult children and their support may be helpful, participants in this group reported that depending upon their adult children entirely would not be

feasible. “My kids have their own lives, and now they have their own kids. I know they love me and are here for me, but they have to live their own lives.” While relying on adult children may not be a feasible option, relying on siblings and in-laws appeared to be a big source of support. “Having my siblings around makes me feel like I still belong to a family. I am lucky, too. We all live in Arizona.” Maintaining and sustaining relationships with one’s in-laws also appeared to be a great source of support. “When I hang out with his family, I feel like he is around. Both of our parents have died, but we each have two sisters. They are still family.”

Bereaved counselors and other professional staff took more of an initiative to maintain and sustain contact with older bereaved spouses because they were greatly concerned about these spouses. As one staff member explained, “They are older, so they are more fragile. Their health is not that great, and it is only going to worsen. We have to reach out and make sure there is consistent support.” Living in a retirement center may have also mitigated the negative effects of bereavement because participants residing in these facilities never felt physically alone. The chances and opportunities of making and sustaining friendships is very possible when participants live in a retirement center because they are surrounded with other individuals who may be going through a similar situation. As reported by one participant, “I know that Tuesdays are a fun day at the retirement center because we watch comedies. It is a bit fun, actually. We try to laugh.”

Table 5. Themes and categories of feelings and attitudes reported by retired widows/widowers who have been bereaved for one year or less (n=12).

Themes	Categories	N (number of participants)
Depression	Loneliness	12
	Fear of unknown	12
	Unable to drive	5
	Unfinished projects	3
	Sensory deficiencies	2
	Mobility deficiencies	5
	Stroke	1
	Heart Attack	2
	High Blood Pressure	2

** Unable to drive and unfinished projects is grouped as one category (feeling helpless/hopeless) in the text. Sensory deficiencies, mobility deficiencies, stroke, heart attack, and high blood pressure is grouped as one category (declining physical health) in the text **

Retired bereaved spouses- bereavement stage three or more years

Thus far, attitudes and feelings of middle-aged bereaved spouses who have been bereaved for one year or less and three or more years have been detailed. The previous section concentrated on retired bereaved spouses who have been bereaved for one year or less. This final section will focus on the following: retired spouses who have been bereaved for three or more years.

Before I present information about these participants, I believe it is imperative to reexamine some previous findings and implications thus far. For middle-aged bereaved spouses in both bereavement stages (one year or less and three and more years), differing adaptation trajectories are reported among widows and widowers. Said differently, adaptation trajectories towards widowhood may vary between widows and widowers due to gender norms. With regards to similar demographic characteristics, it is noteworthy that preferences for the type of social support differed entirely by gender. Furthermore, the type of social support that was given to widows and widowers may have differed based upon gender norms, and the socialization of “appropriate” grieving trajectories for males and females. As was discussed earlier, middle-aged widowers in both bereavement stages had a higher likelihood of engaging in risk taking behaviors which may pose negative harm on their mental/physical well-being. Examples of these risk taking behaviors included the following: increase in alcohol and nicotine consumption, decrease in levels of physical activity, and an increase towards the likelihood of gambling and casual intercourse with multiple partners.

On the other hand, for *retired* spouses that have been bereaved for one year or less, preferences and types of social support that was provided did *not* vary by gender. In

fact, what was of interest was that participants who are retired for one year or less displayed varying adaptation trajectories as a result of one significant factor—whether or not the participant was community dwelling or living in a retirement center. Retired bereaved spouses who resided in a retirement center were more likely to report positive feelings and attitudes regarding their adaptation trajectory compared to retired bereaved spouses who were community dwelling. The constant interaction with other members in the retirement center may have significantly decreased feelings of loneliness and anxiety among retired bereaved spouses. Participants who resided in a retirement center reported that their consistent interactions created a “distraction” and produced “noise” which lowered the likelihood of obsessively dwelling over the death of their spouses. While decreasing feelings of loneliness and anxiety, retired bereaved spouses living in a retirement center were also less likely to report levels of diminishing self-worth, and higher levels of social inclusion and social integration.

On the other hand, community dwelling intensified negative effects of grief on participants’ well-being; a constant reminder of being widowed and adjusting to the home without one’s partner was a constant source of pain and anguish. As will be reported below, retired bereaved spouses who have been bereaved for three or more years and live in a retirement center also report higher levels of social integration and fare better than retired bereaved spouses who have been bereaved for one year or less and are community dwelling. “Next week, it will be four years that I have lived at the retirement center since my wife died. We never had any kids or anything, but I have a lot of friends and a family right here at the retirement center.” The aforementioned quote was given to me by Joseph, a widower of four years. While he just turned eighty, he enjoyed his birthday

because he was surrounded by his friends at the retirement center. While Joseph and his deceased wife were unable to have children of their own, Joseph enjoys acquainting himself with his friends' children and grandchildren. As he says, "I have a good friend, Dan, and his three granddaughters come and visit him bi-weekly at the retirement center. I see them every-time they visit. They call me 'grandpa,' too. It makes me feel like I am a part of a family."

While Joseph is one out of the eleven participants in this group, he is also one of the very few participants in this group who is coping fairly positively since his spouse died. Unfortunately, for participants in this group, many reported that the quality of their lives have decreased significantly since their spouse died, and feel incredibly apprehensive about the future. Participants in this section ranged between the ages of seventy-five and ninety-two. While there are twelve participants in each group in this study, it is important to mention that their ages varied for these particular participants. The average age for participants in this group was eighty. Majority of participants (ten) in this group are older than the age of seventy-five and two participants are older than the age of ninety. Eleven out of twelve participants in this section reported having at least one surviving adult child; the average age for the surviving adult child is forty-three. For participants in this group, seventy-six meaning units were grouped into 5 categories; loneliness, low mood, diminishing quality of life, poor self-image/concept, and desire to die. From the 5 categories created, the theme hopeless was derived (refer to table 6). The following paragraphs will detail each category that was used to develop the hopeless theme for participants in this section.

Loneliness

Participants in this group have been bereaved for a minimum of three years. While their negative attitudes and feelings about grief have lessened, and they have come to “accept” their lives, most participants report feeling incredibly lonely. “She is not coming back. I know that. I have accepted that, but it does not mean I am not incredibly lonely.” Similarly to middle-aged bereaved spouses who have been bereaved for three or more years, retired bereaved spouses report that while they have come to accept the death of their spouse, they are still incredibly lonely without them. As one participant said, “Accepting the death does not mean that I am not lonely—it just means I have accepted it. I am not in denial, but I am incredibly lonesome.”

As mentioned earlier, middle-aged spouses who have been bereaved for three or more years not only reported that they have come to accept the death of their spouses, but felt that it was in their children’s best interest if they adapted to widowhood as quickly and as positively as possible. Said differently, the aforementioned participants used their children’s well-being as a motivator to work through their spouses’ death. However, participants in this group, while also bereaved for three or more years, do not have the motivation or obligation to “move on” compared to their middle-aged counterparts. Participants in this section (eleven out of twelve) not only have adult children, but their adult children have responsibilities of their own—such as a career, children of their own, and a spouse. “My son is forty-two. I know he misses his mom, but I am not too concerned about him. He has a wife and three beautiful kids; he still has a lot on his plate. I have nothing left.” The aforementioned quote was presented to me by Leo-- an eighty-eight year old widower who has one surviving adult child—Alex. Leo believes that the

negative impact on his spouse's death is not nearly as detrimental on Alex as it is on him. Because Alex has a "life of his own" which includes many responsibilities, Alex, while saddened by his mother's death, can easily consume and distract himself with his own children and spouse. "He has a reason and obligation to 'work through' the grief. He has a wife and children to take care of. The only person I am responsible for is myself, and I am not too concerned about taking care of myself without my wife by my side."

Eleven out of twelve participants in this group reported having at least one surviving adult child; ten out of twelve participants in this group are grandparents. Most participants reported being in "good" health; for this group, "good" health can be conceptualized as not being in any pain, and being able to perform daily tasks. While most participants did report being in good health physically, some did struggle with cognitive deficiencies. Two participants reported having a difficult time going to and from the bathroom; three participants reported having poor eye sight, and one out of the three participants with poor eye sight also reported being deaf in his right ear. One participant complained of mild to moderate back pains which impeded her from attending field trips. "The back pains are not *that* bad, but I just feel like it affects my neck, and then I have a stiff neck for the remainder of the day. I often avoid participating in social activities with other residents because I would rather sit in my chair with a heating pad."

Furthermore, unlike participants in the previous group, *all* participants in this group are currently living at the retirement center. The retirement center is where I was able to come in contact with participants in this group. What is important to mention is that the majority of participants in this group lived at the retirement center *before* their spouses died. As one participant mentioned, "We moved to the retirement center because

Catharine was transitioning into hospice; I was physically unable to take care of her needs while she was getting ready to die.” Patrick, another widower in this group who moved into the retirement center before his wife died adds, “I think my kids thought it would be a good idea for us to relocate here. Marlene was dying, and I think we were just trying to make it as peacefully as positive—for *both* of us.” While the majority of participants lived at the retirement center before their spouses died, some moved into the retirement center as a consequence of their spouses dying. “I could not live in the house alone. I was alone—all day long. There is only so much television you can watch before you go insane. Moving here after Charlie’s death has not been so lonely.” The aforementioned quote was provided to me by Gloria-- a retired spouse who has been bereaved for four and a half years. Gloria insists that the reason she relocated to the retirement center was due to her own personal desire to be surrounded by people. “My children live in Washington, and I prefer warmer temperatures. Moving into the retirement center seemed like a good idea to me because I do not want to be lonely. I decided to surround myself with other people my age. It is up to me to make this transition as smooth as possible.”

However, unlike Gloria, other residents reported that moving to the retirement center after their spouses died was not their idea. “After my wife died, I just wanted to live in the house we built together, and try to slowly piece my life back together. Our children encouraged me to move to a retirement center because they kept insisting that it would be ‘good for me,’ and living all alone would ‘kill’ me.” Shannon adds, “I moved into the retirement center because my sister thought it would be a good idea for me to socialize with other people who may be going through the same thing I am going through. She

kept reminding me that I am a ‘social’ person, and that I thrive on meeting new people.” Other participants relocated to the retirement center after their spouses died because they felt like they had no other choice. For example, David reports that he moved to the retirement center because his wife was the one who monitored his health and without his wife by his side, he would be scared to live alone. “I do not have the best vision, but I can still get through the day. Marlene was the one who constantly guided me through everything, and when she died, I just felt like I needed a ‘replacement.’ I got comfortable with her taking care of me, and when she died, I felt like I lost my heartbeat.”

Retired bereaved spouses who have been bereaved for one year or less and lived at the retirement center reported that their current housing situation was full of friendship and integration; however, retired spouses who have been bereaved for three or more years and are currently living at the retirement center reported feeling lonely and isolated. With similar demographic characteristics (age, number of children, housing location, and physical health), the factor that may be influencing the varying trajectories among retired spouses in this study is the bereavement stage. While it is obvious that recently bereaved retired spouses may report higher levels of fear, abandonment, and anxiety following their spouses’ death, what is less obvious is that they may be reaping the advantages of a retirement center at a greater level compared to retired bereaved spouses who have been bereaved for three or more years. “While I am not in shock anymore, and it has been six years since my wife has died, I think I have just grown angrier and mean. When she first died, it was distracting and somewhat helpful to be around residents at the retirement center. Now, I am just bitter and grow irritated with the other residents here—I do not even know why!” Victor, a retired spouse who has been bereaved for one year or less

suggests, “I think when we first become widowed, we are surrounded by people whether we want them to be there or not. Whether these people are our kids, family, nurses, or other residents living at the retirement center, you do not have much time to process what has just happened because it is so crowded and loud. I think that while my sadness will lessen with time, it may just hit me like a ‘ton of bricks’ down the road—then what?”

Low mood

What may make participants in this section lonely, and what may exacerbate their sense of loneliness is not feeling as though they have a sense of purpose. As a result, feeling lonely and having no purpose may render participants in this section to report being in a low or bad mood. What is concerning is that being in a low or bad mood may perpetuate the cycle of feeling lonely. For example, one participant told me that because she always feels irritated, she avoids interacting with people at the retirement center because she does not want to bring down their mood. Additionally, another participant adds that his low mood may intensify as a result of being around other residents at the retirement center. “I sound like such a cranky and evil person, but I do not like being around people who are so ‘happy’ and ‘sunny.’ It makes me feel worse about myself, and makes me feel as though I am the only sad person in the world. I would rather avoid people if I am going to feel that way.”

Participants in this section felt as though they had no purpose in their lives because there is nothing else they can do or “live for.” As one participant mentioned, “I do not work. My physical body and strength weakens by the minute. My children moved out a long time ago, and my grandchildren barely know enough about me. What is left for me to do?” Another participant adds, “When I retired, my wife and I planned to reinvent

ourselves, and do as much traveling as we could. Since she has died, I do not desire to go anywhere, and I just do not know if there is anything to look forward to. It can only get worse.” By not having anything to look forward to, retired bereaved spouses who have been bereaved for three or more years feel as though their lives have no purpose, and their presence is useless. “I am just a physical body. I do not contribute to this world. If anything, I need nurses just to help me with basic tasks. I am useless—there is no point to life. There has got to be more in life, but I am convinced there is nothing left for me.”

Diminishing quality of life

A proliferation of stress and feeling lonely may definitely influence one’s mood. Furthermore, feeling as though one’s quality of life is diminishing may also fuel one’s low or bad mood. For example, one participant suggested that having a “lack of milestones” to accomplish diminishes the quality of her life and positive mood. “There is nothing else to look forward to. Unless I could start my life all over, there is nothing I am driven to accomplish. I went to college, got married, had babies, and now here I am. It is done.” Jeffrey adds, “I do not think there is anything left to see. I should be grateful for the life I have had, but there is no life to be lived in the future. I have no motivation or fuel; nothing gets me out of bed.”

As participants explained that they felt as though the quality of their lives were diminishing, they did not really suggest that anything could mitigate this feeling. “I saw my grandchild the other day, and while it was amazing to see him, I just felt that I am not going to be around much longer to watch him grow up. I am getting old, and I will not be around for much longer.” What is important to mention is that participants in this group also commented on their overall attitudes and opinions about aging in general. Said

differently, feeling as though one is growing older and weaker influenced one's outlook on his/her life. "You know you are getting old when your back hurts from simply sitting on the couch. I have two strands of hair on my head, and I am no longer the athletic guy I use to be. I am just getting old—it is not so fun." Martha adds, "I think as I age, I feel as though I have less to accomplish. Even if I wanted to get back to work or something, I am getting older, and I am probably not capable of running my own business anymore. A while back, I was a very successful business owner. I guess you just grow out of it."

As mentioned earlier, one's attitudes about aging may negatively exacerbate one's widowhood trajectory. "I am getting old, and now I am widowed. I mean, I guess it is something to expect—it is not a total shock." Harry adds, "I hoped that when I married Grace, I was going to grow old with her. I thought that I could handle growing older because Grace was by my side, and we would grow old and die together. She has passed away five years ago, and I am growing old all alone." Harry is a widower of five years who is eighty-six years old. While he is grateful that he has lived a long life with his wife, he feels as though he has been "cheated" and is now going to have to transition and live life all alone as a widower.

What also appeared to contribute to a diminishing quality of life was one's overall perspective about aging. While some participants did not refer to their age as often, majority of participants referred to themselves as an "old person." Participants who characterized themselves as an "old person" commonly reported that their joy in life has slowly diminished, and growing older did not exactly reverse this negative feeling. If anything, participants did not look forward to their upcoming birthdays, and felt that with every upcoming birthday, their thoughts felt justified and validated. For example, a

participant mentioned to me that old age equated to depression; becoming widowed definitely did not make this transition any easier. “With every birthday that comes and goes, I feel as though it is only a matter of time before I leave this world. At least when Smith was alive I had a constant companion—now, it is just scary because I am old and alone.” Samantha adds, “I do not know if anyone actually thinks getting older is a good thing. Think about it, do people grow stronger and wiser with age? Some may say ‘yes,’ but I do not think so.”

Poor self-image/concept

Feeling lonely, being in a bad mood, and feeling as though one’s quality of life is diminishing may influence one’s self-image. Unfortunately, for every participant in this group, their current mental and physical health influenced the way they viewed themselves. “I fear the future. I actually dread it. I feel like when tomorrow comes, I will not be able to handle it.” The aforementioned quote was presented to me by Vyran, a seventy-six year old widower who is currently living at the retirement center. Vyran claims that while there are always staff and people around, he feels that without them, he cannot get through the day. “It does not feel very good when you have to rely on everyone to help you with everything. My wife took care of me, and I got accustomed to it. It made me feel safe when Hannah was taking care of me; nurses and other staff members, while nice, are not as comforting as Hannah. They do not have that ‘special touch.’”

Because Vyran needs help with basic daily tasks (such as remembering to take certain medications) he reports having much anxiety about the future. The anxiety he holds for the future negatively impacts his self-image. Vyran explains that when he looks in the

mirror, his reflection indicates his weakness and fears. “I see a scared and weak person looking back at me. I never felt this way when Hannah was alive. I try to avoid mirrors at all costs—your reflection does not lie. My reflection shows a sad person.” Margaret adds, “On a scale of 1-10, I would give myself a 2. If 10 indicated the highest score of confidence, I would give myself a 2 because I do not feel complete without my husband. My husband validated me, and made me the person I am. Without him, I am not as confident.”

Participants in this group had anxiety regarding their futures because they did not report a high level of confidence or self-image. As a result of their spouses’ death, bereaved spouses in this group lost their confidence and sense of security. “We were a team. It was me and my husband all day, everyday. When you lose your confidant, you lose yourself and your worth.” Javier adds, “I have no sense of security without my wife. Selfishly, I relied on her to take care of me. She was my ‘look-out,’ the one who held me accountable for everything. Without her, I fear I am going to go off the deep end.”

Without their spouses, participants in this group felt that they could never be the same person again. Furthermore, participants in this group felt that their spouses validated their self-worth, and gave them a sense of purpose and comfort in their lives. Without their spouses, participants felt incredibly lonely and scared, which negatively influenced their self-concept. “I am never going to be the same ‘Carrie’ ever again. My kids tell me that since dad died, I have not been the same. It scares me, but I know—or I just feel that I will never be as happy as I was before my husband died.” Rafael adds, “The way my wife viewed me was the way I viewed myself. She was my ‘life-line,’ my ‘safety net.’ Without her, I do not know who I am anymore; I most certainly cannot return to my former self.”

Death

While participants in this group had no intention of committing suicide, every participant reported that at least once a day, he/she has imagined what life would be like once he/she died. “I think about the idea of being with Hannah again. I would not be alone, I would not be so scared, and I would become that ‘strong’ person I know I can be. Since she is not coming back, I wish I could just leave this world and join her.” In addition to imagining what it would be like to die, participants in this section also reported higher levels of yearning for their spouse. “It has been six years since she has died, but while I have accepted the death, I cannot seem to stop yearning for her. I talk to her all of the time, I think about her all of the time, and I want to join her.”

Participants in this group reported that their spouses completed them. Their spouses were their source of support, their confidant, their best friend, and the person they planned to retire with. Without their spouses, and three or more years since their spouses’ death, participants reported often fantasizing about their “after-life” with their spouse. “Sometimes I just envision Tory walking up to me, grabbing my hand, and taking me to her house in heaven. It looks just like our old house; she has a pot of stew brewing in anticipation of my arrival.” Nicole adds, “I have children, and it sounds selfish, but I want to be reunited with my husband. My kids are my pride and joy, but they are adults now and do not need me like they use to. I like feeling needed—I want to be with Frank in the skies, and watch our children from up top together.”

Because the theme that was created for this group of participants is “hopeless,” it is important to highlight why the category “death” was derived from the meaning units collected. Participants in this group constantly reported how their low mood, loneliness,

poor self-concept, and uselessness exacerbated their negative state of mind. As a source of comfort, participants often fantasized about being re-united with their spouses. Furthermore, yearning for their spouses and imaging their afterlives with their spouses was a way of coping with the death of their spouses. As a way of coping, participants reported visualizing their afterlives; furthermore, participants reported that they were ready to join their deceased spouses, and did not see the point in living and being retired all alone.

Social support needed

In terms of receiving social support, participants reported that having someone to vent to, and/or having someone to talk to about their afterlives minimized a lot of anxiety. “My friend at the retirement center allows me to ramble on and on about Ted. I tell her how I imagine dying, and not being afraid to die because Ted will be waiting for me at the gates of heaven. My kids do not like me talking about dying; my friend just listens, and does not say anything.” Mark adds, “My friends, siblings, or children do not like me talking or yearning about my wife. They think my ‘obsession’ over her and my yearning for her is what is preventing me from moving forward. What I do not think they understand is that dying may be the only way I can move forward—I can be back with my wife again.”

Participants reported that having emotional support (the ability to have one to talk to) was an effective way of minimizing anxiety and loneliness. “When someone allows me to talk about my husband, and all of our great memories, I feel like I am keeping him alive.” While desiring emotional support, participants in this group were not particular about who provided this support to them. The ability to be able to talk unconditionally to

a staff-member at the retirement center, sibling, friend, stranger, child, and/or acquaintance about their spouses' memory was a positive way of mitigating the negative effects of bereavement on their mental/physical health. However, when a person interrupted their story-telling and/or prevented them from fantasizing about reuniting with their spouses, participants were not too thrilled. "I have spoken about Charles' memory a lot. I talk about his favorite things, and how peacefully he died. When someone seems disinterested in my stories, or is trying to change the subject, I feel even lonelier. Consequently, I avoid talking about my husband because people are tired of it, and when I am interrupted, it hurts even more—it is isolating."

Unfortunately, it appears that participants in this group may be trapped in a negative cycle. As a result of loneliness, participants report being in a low mood and having lower levels of self-esteem; on the other hand, being in a low mood and having lower levels of self-esteem may also contribute to loneliness. Because participants in this group reported desiring a person to talk to about their spouse, and/or about their desires to reunite with their spouse, not receiving emotional support appeared to increase levels of loneliness and isolation. "When my kids ask me about my day, and allow me to talk about reuniting with their dad again-- I feel a slight boost of positivity. Oddly enough, thinking about dying may be the only thing I look forward to. I know earlier in this interview I said that I felt like I had no purpose, but often times, I think my purpose may be to die and be with my husband."

Relocation – before and after spouse dies

Majority of participants reported living at the retirement center before their spouses died. Participants who resided at the retirement center before their spouses died

reported that a contributing factor to their relocation was their inability to take care of their sick spouses. “I am not too sure how to be a caregiver. I often feared that I was making his situation worse, and that I am not informed enough about how to reduce levels of pain and anxiety.” Another participant adds, “Our children suggested that we move to the retirement center before their father died because they did not want me to be burdened with his illness. They were looking out for me.”

The remaining participants who relocated to the retirement center as a result of their spouses’ death reported doing so because it was encouraged by their families and friends, and/or they decided that it would be in their own best interest to surround themselves with other individuals at a retirement center. While some participants were advised to relocate to the retirement center by their families-- *regardless* of their own personal preferences, other participants reported feeling enthusiastic about the relocation. “I thought that it would be a good idea. My family does not live near me, and I do not want to be lonely—who would want that? The best option was to relocate to a place that would allow me to still maintain some independence, yet have a plethora of opportunities to meet people and develop relationships.” Lucy adds, “I can still accomplish daily tasks on my own; however, it is a bit relieving to not have to worry about maintaining my former home—the backyard, garden, kitchen. I do not have to worry about that here.”

What is noteworthy is that differences were reported among participants who relocated to the retirement center *before* their spouses died, and participants who relocated to the retirement center *after* their spouses died. Participants who relocated before their spouses died appeared to be faring a bit more positively compared to participants who relocated after their spouses died. It appears that relocating to the retirement center before a

spouse's death may lessen the negative effects of bereavement on one's trajectory. Again, while the majority of participants in this group reported overall levels of hopelessness three or more years after their spouses died, participants who relocated prior to their spouses' death did not report feelings of guilt and defeat compared to participants who moved after their spouses' death. "Before he died, we moved to the retirement center. This relocation was triggered by my lack of knowledge as a caretaker. I could not handle the responsibility, and I would blame myself when he was in pain. I know for a fact that when he did die, he was in peace. No pain. No tears. He left this world as beautifully as possible." Another participant adds, "I could not stop her from dying, but at least I know she was not in anymore pain when we moved to the retirement center and utilized Hospice services. Before we moved, when we were at home, she was in a lot of pain. It was scary. Her death was peaceful."

Participants who relocated as a consequence of their spouses' death often reported feelings of guilt and defeat. "I feel like I failed her. I could not live in the house that we built together anymore. After she died, I just did not want to be there all alone. I am afraid she thinks I abandoned her." Another participant adds, "It may sound illogical, but I feel guilty I moved out of our former home. We had always promised one another that we would take care of our home, no matter what happens, because that home is a symbol of our love and union. While my kids practically begged me to relocate, I often feel like I broke a promise, and compromised his trust." Timothy suggests that he feels defeated because he moved to the retirement center after his wife died. "If I were stronger, I would not be living here right now. The truth is—I need some help to get me through the day. It is not major, but I know I cannot live by myself. I feel defeated. First my wife dies, and

then years later, I feel like I died because my life ended when I had to move out of our home.”

Conclusion

Retired bereaved spouses who have been bereaved for three or more years reported that while they were living in a retirement center, they still reported feeling lonely. As mentioned earlier, retired bereaved spouses who have been bereaved for one year or less and lived in a retirement center were less likely to report levels of loneliness, and higher levels of social inclusion. While it is important to mention that some participants in this group (retired for three or more years) did find the retirement center to be helpful and less isolating, most participants in this group (retired for three or more years) considered their lives to be lonely and useless. As we can see, coping trajectories among retired spouses in this study vary by bereavement stage. Additionally, coping trajectories among retired spouses may vary due to the timing of relocating to the retirement center. Participants who moved to the retirement center before their spouses died were less likely to report feelings of guilt and defeat. Because the aforementioned participants relocated prior to their spouses' death, they may have also been less likely to report feelings of guilt and defeat because they did not doubt that their spouses died peacefully and painlessly. “I often wonder if there is anything I could have done to prevent his death. I know it sounds silly, but if he would have died in our home, I would feel incredibly guilty. Dying outside of our home and relocating before his death wipes out any doubt that he was in pain. He was in good hands. I do not feel responsible—I feel like I did the best I could.” Margaret adds, “I am grateful that he did not die in my arms in our former home. While he died in my arms at the Hospice of the Valley, I was not worried that he was afraid to die. He was

ready to go. Relocating before his death prepared the both of us, I think. Relocating decreased his fears of mortality while increasing my belief that he would die painlessly.”

While Hospice of the Valley provides twenty-four hours a day assistance at one’s home, participants that experienced the death of their spouse in their home were more likely to doubt that their spouses died painlessly. “While he died in our house, on our bed, I still wonder if he would have died a bit more peacefully if we had relocated to the Hospice of the Valley and the retirement center before he died. I just wonder if I could have done more. Is it possible he may have been in more peace and in less pain if he died outside of the home?” As reported earlier in the literature, individuals that utilize Hospice services may be less likely to feel conflicted between their roles as a spouse and a caregiver. Utilizing Hospice services may provide a “good death” which is characterized as a painless death. Moreover, participants in this group that utilized Hospice services outside of their homes were less likely to report feeling guilty and defeated compared to participants that utilized Hospice services within their homes. As a result, relocating to the retirement center before one’s spouse dies and utilizing Hospice service outside of the home may decrease feelings of guilt and defeat.

Additionally, what is noteworthy is that in the literature presented earlier in this study, researchers have found that the first year of bereavement may incorporate the highest levels of loneliness, depression, anger, and anxiety. As time elapses, the negative effects of death may lessen, and may lower levels of loneliness, depression, anger, and anxiety. However, I find it interesting that retired bereaved spouses who have been bereaved for one year or less and lived in a retirement center reported higher levels of positivity compared to retired bereaved spouses who have been bereaved for three or more years

and lived in a retirement center. I am intrigued by these findings; I hypothesized earlier that retired bereaved spouses who have been bereaved for one year or less may be more likely to negatively adjust to widowhood compared to retired spouses who have been bereaved for three or more years. As we can see, living in a retirement center may benefit and positively influence retired spouses' adaptation to widowhood. However, living in a retirement center may not be as helpful for retired bereaved spouses who have been bereaved for three or more years. I suggest that the reason for this is because after three or more years of bereavement, retired bereaved spouses are no longer in shock and denial, and are confronted with their loss on a daily basis. While living in a retirement center may lower levels of isolation, retired bereaved spouses who have been bereaved for three or more years are no longer in shock and denial, and are more likely to experience the magnitude of their loss.

“Yes, I am not in denial, and I am no longer walking around like a zombie. It has been six years since my husband has passed, but the truth is, it hurts more everyday. Once the ‘shock’ disappears, you feel the impact of your loss.” The aforementioned quote was given to me by Debbie, a widow who has been bereaved for nearly six years. Debbie explains that while levels of anxiety, shock, and anger have lessened, other feelings and attitudes about death have become elevated. For example, Debbie explains that with time and age, one realizes that there is nothing left to accomplish and look forward to—especially when one loses a spouse. Joel adds, “I was not really processing what was happening at the moment because her death was so recent, and I was immersed in sadness. Now that it has been four years, the ‘adrenaline’ has vanished, and you come to terms with your loss. What makes it hard is that there is nothing left to look forward to,

so all you do is consume yourself with feelings of loneliness and uselessness.” As a result, I argue that while levels of shock and numbness may lessen with time, other feelings and attitudes about death may increase—for example, feeling hopeless and useless.

As feelings of hopelessness and uselessness become elevated with time, participants in this group may increase their desire to die and reunite with their spouses. Because participants feel as though they have nothing else to look forward to, participants reported that perhaps death may be the next and final stage in their lives. “Like I said, I have done it all-- marriage, babies, grand-babies. Now, I am widowed. The only thing left for me to do is die. I am seventy-seven, what else is there to look forward to? At least if I die, I will be with Harold again.” It is also important to mention that participants in this section also reported that their current feelings and attitudes about widowhood may also be influenced by their overall feelings and attitudes about aging. “Nobody likes getting older. With every year, a part of my body starts to fall apart. The only part of aging was growing old with my wife. Now, I feel like I am in hell—times two. I am getting older, and I am widowed.”

All participants in this group were able to perform daily tasks; however some participants reported having cognitive deficiencies. Two participants reported that they needed assistance when using the restroom—mainly due to the inability to sit up and down as easily. “I am fine. I am good, really. Once I sit down, it takes a lot of work to get up. I cannot go to the bathroom alone—I guess they fear that I will be stuck in there all day without assistance.” Additionally, one participant reported that he needed to be reminded to take his medications at a certain time, and reported that he often forgot about

taking his medication until he was reminded about it. While participants in this group did report being in “good” physical health, it is imperative to mention that they were not optimistic that they would remain in “good” physical health for much longer. “It is only a matter of time. I mean, before you know it, I will become bed-ridden or something. Old people do not get better with age—they get worse!” As mentioned earlier, opinions about aging in general may influence participants’ overall feelings and attitudes about death and social support. Because participants are aging, and are not enthusiastic about it, they are less likely to report feeling confident about their future physical health. “I want to think that I will be OK, and remain strong. I could think that when I was thirty—now, I just know it is going downhill from here.”

In conclusion, while participants in this group reported being in “good” physical health, their overall feelings and attitudes about death were negative. Participants may have also confounded their feelings and attitudes about death with their attitudes about aging in general. Participants reported that they were hopeless and had nothing to look forward to in their lives as a result of aging; furthermore participants also reported fantasizing about their deaths, and enjoyed the ability to talk about their death exhaustively. As a result, participants in this group reported benefiting from the availability of emotional support. Participants were not concerned with who provided them with emotional support—as long as they were able to speak about their spouses’ memory and their desire to reunite with them, participants reported feeling less anxious and depressed. Unfortunately, participants reported that the availability of emotional support was limited. Participants suggested that perhaps their social networks felt that it was not in their best interest to long and yearn for their deceased spouses. “My kids hate

when I talk about their mom all of the time. They think that I am ‘stuck’ in this time-zone. It has been four years since she has died, but I like talking about her. Not wanting me to talk makes me feel worse.” As a result, it is important to recognize that because retired bereaved spouses in this group may not be receiving helpful social support, their negative state of mental health may become exacerbated. Unfortunately, examples of exacerbated levels of negative mental health may include the following: higher levels of loneliness, higher levels of feeling useless, lower levels of self-esteem, low/bad moods, and diminishing quality of life. As we can see, retired participants in this group may not be adjusting positively to widowhood, and it is important to recognize what can be done to mitigate these problems.

Table 6. Themes and categories of feelings and attitudes reported by retired widows/widowers who have been bereaved for three or more years (n=12).

Themes	Categories	N (number of participants)
Hopeless	Loneliness	12
	Low mood	10
	Lack of milestones	10
	No purpose in life	10
	Fearing the future	8
	Unable to handle the future	8
	Dreading the future	8
	Suicide Ideation	5
	Longing to join deceased partner	5

Lack of milestones and no purpose in life is grouped as one category (diminishing quality of life) in the text. Fearing the future, unable to handle the future, and dreading the future is grouped as one category (poor self image/concept) in the text. Suicide ideation and longing to join deceased partner is grouped as one category (death) in the text

Chapter 5

CONCLUSION

Life course stage and bereavement stage

This study has examined four different groups of bereaved spouses. Additionally, this study has discerned between one's life course stage and bereavement stage. The two life course stages in this study centered on middle-aged spouses and retired spouses. The two bereavement stages in this study focused on spouses who have been bereaved for one year or less, and spouses who have been bereaved for three or more years. As hypothesized earlier, discerning between life course stages and bereavement stages is important because the aforementioned stages may influence one's adaptation to widowhood.

Middle-aged bereaved spouses

An important finding that was discovered in this study is that participants who are middle-aged reported having different adaptation trajectories towards widowhood due to gender differences. Male and female middle-aged spouses in this study differed in their coping strategies in both bereavement stages. Regardless of bereavement stage, widows and widowers differed in their expectations and preferences for social support. Additionally, widowers were more likely to engage in risk-taking behaviors compared to widows—in both bereavement stages.

Middle-aged widowers who have been bereaved for one year or less reported being more susceptible to risk-taking behaviors compared to middle-aged widows who have been bereaved for one year or less. Examples of risk-taking behaviors are as follows: increase in nicotine and alcohol consumption, increase in the likelihood of engaging in

casual sexual intercourse, susceptibility to gambling, lower work performance, and/or decrease in physical activity. Additionally, middle-aged widowers who have been bereaved for three or more years also reported being more susceptible to risk-taking behaviors compared to middle-aged widows who have been bereaved for three or more years.

While the levels of engaging in risk-taking behaviors appears to be more prevalent among widowers than widows in this study, it is important to note that widowers reported lower levels of engaging in risk-taking behaviors as time elapsed. While widowers who have been bereaved for three or more years were more likely to be susceptible to risk-taking behaviors compared to widows who have been bereaved for three or more years, widowers who have been bereaved for one year or less reported the highest levels of susceptibility towards engaging in risk-taking behaviors. As time elapsed, and/or one's bereavement stage increased, the chances of engaging in risk-taking behaviors lessened. Again, middle-aged widowers were more likely to report engaging in these risk-taking behaviors compared to middle-aged widows; as widowers' bereavement stage increased, their susceptibility to engage in risk-taking behaviors lessened.

As reported by middle-aged widowers in this study, their likelihood of engaging in risk-taking behaviors was due in part to their inability to express their grief to their social networks. Middle-aged widowers in both bereavement stages reported that their social networks inadvertently discouraged them from crying and/or appearing "weak." By showing emotion in public, middle-aged widowers reported that they feared that their social networks would characterize them as "weak" men. Middle-aged widowers in both bereavement stages reported that the appropriate way to grieve was to engage in risk-

taking behaviors and suppress negative emotions. Furthermore, middle-aged widowers in both bereavement stages also reported that when they did not suppress their negative emotions and/or opted to cry, they were often scolded for not grieving appropriately. Appearing “strong” and grieving appropriately was important to the middle-aged widowers in this study. Deviating from an “acceptable” widowhood trajectory was not an option; as a result, middle-aged widowers in this study reported that they externalized their negative emotions by engaging in risk-taking behaviors. Middle-aged widowers in this study reported that majority of the time, their social networks would actually encourage these risk-taking behaviors because that was their way of providing support.

Unlike middle-aged widowers in this study, middle-aged widows were less likely to engage in risk-taking behavior. What may contribute to these varying gender differences in regards to adapting to widowhood may be due to social and cultural norms that are governed by our society. For example, because widowers felt discouraged to openly speak about their negative emotions and depressed state of mind, they were less likely to have a “shoulder to cry on” and to have someone to talk to indefinitely. On the contrary, because widows are encouraged to speak about their ordeals and express negative emotions, they are more likely to receive emotional support compared to widowers. As mentioned earlier, emotional support refers to an increase in one’s self-esteem, and/or being encouraged to speak openly about a subject without being judged.

While middle-aged widowers were less likely to receive emotional support compared to middle-aged widows, middle-aged widows reported feeling overwhelmed by their social networks because they were encouraged to speak about their ordeal at all times. Regardless of bereavement stage, middle-aged widows were encouraged to show

emotion and cry; not showing enough emotion and/or not engaging in crying spells often led their social networks to believe that they were not grieving properly. As one widow mentioned, “I do not like to cry or talk about my feelings—I never have. Because I am a woman, I am expected to look ‘heart-broken,’ and should cry at the ‘drop of a hat.’ Just because I do not do that does not mean I am not still sad.” On the contrary, a middle-aged widower who has been bereaved for less than one year suggests that he cannot show negative emotions because it would signify a “weakness.” He suggests, “I just think it is the curse of being a man. You have to act tough, be tough, and never shed a tear. The minute you do that, you lose respect from others.”

Regardless of bereavement stage, middle-aged bereaved spouses reported that their adaptations towards widowhood were governed and shaped by the expectations of their social networks. Additionally, middle-aged bereaved spouses also reported that their adaptation towards widowhood was important for the well-being of their surviving children; middle-aged bereaved spouses felt that if they did not adjust properly to widowhood, then concerns about the well-being of their surviving children would be questioned by their social networks. Widows and widowers both reported that it was in their best interest to rapidly and efficiently work through their grief in order to protect the well-being of their surviving children. Not protecting the well-being of their surviving children was not only a concern reported by middle-aged respondents in this study, but it was also a source of stress because they did not want their social networks to intervene and take their surviving children away from them. As one middle-aged widow reports, “I know my parents thought that my kids were going to be harmed because I was emotionally unable to take care of their needs when Tim died. If my parents or friends

feared the well-being of my children, they would let me know. Trust me—the last thing you want someone to tell you is that your children are going to grow up doomed because their father died, and their mother was unable to take care of them.”

A middle-aged widower reports, “I have to appear like a ‘strong’ man because not only is everyone around me going to think I am falling apart, but they are going to think my kids are going to be raised by a negligent father. I have to hold it together—I cannot let anyone think that I cannot take care of my kids because their mother died.” Out of the twenty-four middle-aged respondents interviewed, only two respondents reported not having any surviving children. The average age of surviving children in this study ranged between four to twelve years old. Middle-aged bereaved spouses, both widows and widowers, reported that it was their responsibility to work through their grief as a means of protecting their surviving children. While middle-aged bereaved widows were more likely to be encouraged to speak openly about their ordeal compared to middle-aged bereaved widowers, *both* middle-aged widowers and widows in this study reported feeling motivated to work through their grief as positively as possible for the well-being of their children.

In addition to having surviving children, middle-aged respondents in this group also reported being employed during the time of the interview. The average number of hours worked per week was thirty-five; both middle-aged widows and widowers in this study reported being employed. While two out of the twenty-four middle-aged participants did not have surviving children, all middle-aged participants reported being employed. Overall, it appears that middle-aged respondents in this study may report higher levels of motivation regarding their adaptation towards widowhood because of

their employment status. Middle-aged respondents reported that having a job/career was a great motivator to work through their pain and grief because it gave them a sense of purpose and responsibility. Being employed lowered the likelihood of obsessively dwelling about their deceased spouses; being employed may have mitigated the adverse effects of bereavement because it may serve as a distraction for middle-aged respondents in this study.

While being employed may have advantages, it may also come with disadvantages as well. Middle-aged respondents reported that being employed not only maintained a sense of purpose and responsibility, but it also increased the likelihood of coming into contact with other co-workers; being employed may increase the chances of developing a social network. However, while employed middle-aged respondents may have reported higher levels of social networking due to their employment, they also reported that their social networks often exacerbated their pain and anguish. Coming into contact with co-workers on a daily basis may increase the likelihood of receiving harmful social support. Middle-aged respondents in this group reported that the majority of the time, their co-workers would evaluate their grieving process, and would make remarks that were unwarranted or unnecessary. "I just feel like they think I am not handling my wife's death properly. They think I should use my grief wisely, and use it as a way of making more sales for the company. I just wish they would back the hell off!"

As reported earlier, appraisal support refers to the evaluation of one's behaviors and opinions. Receiving opinions about one's coping trajectory often fueled resentment and anger among middle-aged respondents in this study. The majority of the time, middle-aged respondents reported receiving feedback about their coping trajectories from their

social networks—the feedback received was not always helpful. “They think I am dragging this on, and I need to get over it by now. I know they are tired of me being sad. They keep telling me to ‘move on,’ and after awhile, that just becomes annoying. It adds fuel to the fire.” A middle-aged widower adds, “If I appear sad, then everyone will think my life is crumbling, and my kids will grow up troubled. Believe me, my friends and co-workers tell me that I need to manage my emotions as soon as possible before it takes a toll on my children. You know they are just trying to help, but sometimes, they piss you off even more.”

In conclusion, middle-aged participants in this study varied in their coping trajectories and expectations regarding social support due to the cultural and social norms that are governed by our society. While widows report feeling encouraged to speak about their ordeal, widowers report the opposite. According to the respondents, it is unacceptable for a widower to show negative emotion and cry; however, should a widow not show enough emotion and cry, then she is criticized for not grieving properly. As an outlet, middle-aged widowers reported higher levels of drinking, gambling, casual sex, and lower levels of physical activity. While it is important to recognize that middle-aged widowers in both bereavement stages reported the increase in risk-taking behaviors, widowers who have been bereaved for one year or less were more at risk compared to the widowers who have been bereaved for three or more years.

It appears that as time elapses, both middle-aged bereaved widows and widowers report needing to take care of their surviving children, and must continue keeping the household intact—financially, emotionally, socially, and psychologically. As mentioned earlier, should middle-aged widows’ and widowers’ social support groups suspect that

the surviving children may be in danger because their bereaved parents are negligent and unable to provide for the kids, then they may intervene. “My mom literally told me that if I did not stop drinking or gambling then she would take my children away from me.” Sally adds, “I never really wanted to talk or cry about Ted’s death—especially in front of my kids. My friends actually thought that my kids will grow up to lack emotion and sensitivity because their mother did not express emotion in regards to a traumatic event. They feared my kids would grow up to be alcoholics or something because their mother never demonstrated a proper way to grieve.”

For middle-aged participants in this study, it appears that appraisal support may negatively influence their adaptation to widowhood. Appraisal support refers to an individual receiving feedback about his/her behaviors and/or opinions. Middle-aged participants expressed frustration when their social networks would “intervene” and provide opinions about their grieving process—especially when their social networks did not experience a similar ordeal. “His parent are still alive, his wife is still alive. He has actually never lost anyone he loves, and he has the audacity to tell me how to bereave? Who the hell does he think he is? He literally does not know what I am going through; therefore, shut your mouth!” Emotional support, which refers to one’s ability to openly speak about an ordeal and/or provides a boost of self-confidence was highly desired by middle-aged widowers in this study, however, they were not offered any. Tangible support on the other hand, which refers to the provision of instrumental assistance, was reported to be a popular type of social support by middle-aged widowers. Middle-aged widowers reported that their friends never objected to drinking, gambling, and other risk-taking behaviors. In fact, middle-aged respondents suggest that their friends intentionally

provide tangible support and engage in risk-taking behaviors as a way of helping them cope with their loss. “They always want to have a BBQ and drink beers. In the background, they have the football game going on. It is not really an environment that is conducive to self-disclosing. You just drink your beer, and bite your tongue.”

The next section will detail findings between retired bereaved spouses who have been bereaved for one year or less and retired bereaved spouses who have been bereaved for three or more years. As we will see, coping trajectories and preferences for a specific type of social support did not vary by gender among retired bereaved spouses. In fact, what influenced varying trajectories and different preferences for social support was where the respondent was living. The next section will detail how community dwelling versus independent/assistant living may influence different trajectories towards widowhood.

Retired bereaved spouses

An important finding that was discovered in this study is that participants who are retired reported having different adaptation trajectories towards widowhood due to housing locations. For retired bereaved spouses in this study, differences in one’s trajectory may have been influenced by one’s living situation. Regardless of bereavement stage, one’s living situation influenced his/her expectations and preferences for social support. Again, it is important to highlight that no differences were reported among retired bereaved widows and retired bereaved widowers. Differences in one’s trajectory was influenced by one’s *housing location*.

Out of the twenty four retired bereaved respondents, less than ten of them (seven) were community-dwelling. The majority of retired bereaved spouses (seventeen) reported

living in a retirement center. This study finds differences between community-dwelling participants versus participants who are living in a retirement center. It appears that the seventeen participants who are living in a retirement center reported lower levels of loneliness and depression compared to the remaining seven community-dwelling participants. Out of the seventeen retired bereaved spouses who are living in a retirement center, five participants reported relocating to the retirement center as a consequence of their spouses' death. Three out of the five participants who were "forced" to relocate to a retirement center reported being a bit apprehensive and nervous about relocating. "I did not want to leave the beautiful home my husband and I built together. I felt like I was breaking a promise, and/or betraying the love I shared for my husband by moving out of the house." Another participant adds, "I am doing this because my kids are making me do it. They do not want me to be all alone in the house, and would feel at ease if I were surrounded by people. I did it for them, and only for them."

While some retired bereaved participants dreaded the unknown, or the ambiguity centering around relocating, others found it to be a blessing. "I can still maintain an independent lifestyle without carrying around the burden of maintaining and sustaining my former home. I was not dreading the move to the retirement center because I figured it would give me a chance to make friends." While five participants reported being "forced" to relocate to a retirement center, they did so as a result of others encouraging them to do so. The five participants who were encouraged to relocate did so as a way of combating their depression/loneliness; relocating to a retirement center was not a result of lower levels of physical health. Because there were no participants who reported needing twenty-four hour care and supervision, and/or needing to utilize nursing homes—it is

important to recognize that these participants relocated based upon the fact that their social networks urged them to do so, not because they were incapable of taking care of their own physical needs. While some retired bereaved spouses did report needing a staff member to occasionally assist with daily tasks, not one participant in this study reported needing an assistant every hour of every day.

The remaining seven participants who are community-dwelling reported that while they preferred to live within the community, they did make some modifications to assist them within their home. For example, one out of the seven participants reported that he had a ramp installed in his home so it would make it a bit easier for him to walk to the kitchen. Another participant reported that a few days out of the month, she would call for some in-house service and care. Examples of the in-house service or care includes assisting with chores, cleaning, and general maintenance of the home.

This study finds that retired bereaved spouses who are community-dwelling fare worse than retired bereaved spouses who are living in a retirement center. Living in a retirement center appears to lower levels of isolation, while allowing one to maintain an independent lifestyle. However, contrary to previous findings, it appears that retired bereaved spouses who have been bereaved for three or more years and are living in a retirement center fare worse than retired bereaved spouses who have been bereaved for one year or less and live in a retirement center. It has been argued that the first year of bereavement or less may incorporate the highest levels of anxiety, fear, and isolation; as a result, one would think that retired bereaved spouses who are living in a retirement center and are recently bereaved would report lower levels of overall well-being compared to retired bereaved spouses who have been bereaved for three or more years and are living

in a retirement center. The reason that may explain this finding may be that as time elapses, retired bereaved spouses who have been bereaved for three or more years are no longer numb and in shock about their spouses' death. In fact, retired bereaved respondents who have been bereaved for three or more years suggest that the pain has settled in since time has passed since their spouse died. "While you were expecting your wife to die, when she does, it still shocks and numbs you. It has been four years since she has died, and I feel lonelier than ever. Within the first year, I was just sad and quiet. Now, I am angry and lonely. It is worse with time, I think." Another participant adds, "You really are like a zombie when your spouse first dies. You are just trapped in a world with your own thoughts. As time goes by, the dust settles in. It hits you. When it hits you- it hits you hard!"

Another factor that may explain why bereaved spouses who have been bereaved for three or more years and are living in a retirement center may fare worse than recently bereaved retired spouses living in a retirement center may be due to higher levels of hopelessness and helplessness. As time elapses, retired bereaved spouses who have been bereaved for three or more years not only feel the impact of their loss, but are also more likely to not envision any future goals. "You realize your husband is gone, and everything you planned to do together during retirement is no longer an option. You just feel hopeless. Feeling numb was much easier than feeling hopeless—how is that possible?" Again, because the literature does suggest that recently bereaved individuals are at higher level of experiencing negative mental/physical health outcomes than bereaved individuals who have been bereaved for three or more years, it is a bit astounding to find the opposite effect in this study.

In this study, retired bereaved spouses who were bereaved for one year or less reported higher levels of numbness and shock. Being numb and in shock may be conceptualized as not being able to process the magnitude or impact of a traumatic event. However, as time elapses, levels of numbness and shock lessen while feelings of hopelessness and helplessness increase. As reported in this study, feeling hopeless and helpless lowered the likelihood of a participant viewing him/herself positively and/or increased the amount of time envisioning their after-lives with their spouses. As a result, it is important to recognize that while the literature has indicated that bereavement effects may be higher during the first year or less, the effects of bereavement should not be undermined as time elapses—especially among the elderly. Compared to middle-aged bereaved spouses, retired bereaved spouses did not feel motivated and did not report having any responsibilities. Because middle-aged bereaved spouses in this study reported being employed and having young surviving children, they may be more likely to want to rebuild their futures and protect their children. On the other hand, retired bereaved spouses reported that their surviving adult children are not dependent upon them anymore because they are all grown. “He can feed, dress, and take care of himself. My son is thirty-six years old. He does not need his momma to hold his hand. Now, if he were six years old, that would be a completely different story!”

Being employed may also lower levels of hopelessness and helplessness. Because middle-aged bereaved spouses reported being employed during the time of their interview, they were more likely to report higher levels of self-purpose and responsibility. On the other hand, not being employed and experiencing retirement without one’s spouse may decrease levels of self-worth and confidence. “You plan your life around your

retirement, and you and your spouse imagine what retirement will be like. It was supposed to just be the two of us, and now it is just me. It is scary, and I do not think I can do this alone.” On the other hand, an employed middle-aged widow explains, “I have a job to go to, and I have two little girls to raise. When I work, I make money, and I can take care of my kids. I have responsibilities.” As we can see, retired bereaved spouses may have lower levels of physical and mental well-being because they are less likely to be employed and thus do not have the advantages of having an additional set of contacts at work that provide some social support. The retired people in this study are more likely to have surviving adult children who are no longer dependent upon them. Adult children may not provide the same type of motivation to improve one’s attitudes toward life as having to care for younger children does. As one respondent suggests, “I have done it all, and now I have no one to take care of or be responsible for. My kids are grown and have moved away. Now my husband has died—I do not know how to cope with not being needed. I like being needed.”

What may buffer against higher levels of hopelessness and helplessness may be one’s housing situation. Retired bereaved spouses who lived in a retirement center reported higher levels of social integration and communication compared to retired bereaved spouses who are community-dwelling. Living in a retirement center may definitely buffer against the negative impact of bereavement because it is a place that centers on friendship-making and social outings. “Every Wednesday, we go to a movie. It is a tradition. We leave the retirement center, get on the bus, and go to a movie. It is a fun field-trip.” Additionally, living at a retirement center also increases one’s chances of having access to transportation. “There is a shuttle there. It comes on the hour every hour.

So even if you do not want to drive or cannot drive, you can still leave the retirement center, go outside and explore. You are not stuck there.”

However, retired bereaved spouses who are community-dwelling are less likely to have access to consistent transportation. Having lower levels of energy and/or not being able to operate a vehicle may further isolate community-dwelling retired bereaved spouses. Additionally, community-dwelling retired bereaved spouses reported that the majority of their interactions with others was contingent upon others making the effort or the trip to come visit them in their homes. “If they come to me, I am satisfied. If they do not make the effort to come see me, I may not interact with people for a while. Driving my car is stressful. I would rather avoid driving. Therefore, my interaction with others is solely dependent upon their willingness to make the commute to see me.” Unlike community-dwelling retired bereaved spouses, retired bereaved spouses living in a retirement center were less likely to report feeling isolated because their opportunities for commuting were greater and more accessible. As one participant living in a retirement center said, “I have not driven in like six years—I am legally blind in my right eye. However, I can still go to and from church and group meetings because I can just hop on a shuttle. I am never stuck. If I miss the shuttle, I can just catch another one.”

Summary

The findings in this study suggest that retired bereaved spouses may fare worse than middle-aged bereaved spouses. Middle-aged bereaved spouses reported differences among their preferences for social support and adaptation towards widowhood due to gender norms. While middle-aged bereaved widows were more likely to internalize their pain and anguish, middle-aged bereaved widowers were more likely to externalize their

pain and anguish. For the purposes of this study, externalizing pain and anguish is translated to engaging in risk-taking behaviors. Because middle-aged widowers reported their inability to openly express themselves and show emotion, they were more likely to report repressing these feelings by engaging in risk-taking behaviors.

What is noteworthy is that middle-aged widowers who have been bereaved for one year or less fare worse than middle-aged widowers who have been bereaved for three or more years. As time elapsed, middle-aged widowers were less likely to engage in risk-taking behaviors. While middle-aged widowers who were bereaved for three or more years were less susceptible to engaging in risk-taking behaviors compared to middle-aged widowers who were bereaved for one year or less—middle-aged widows were least likely to engage in risk-taking behaviors. Furthermore, middle-aged widows who have been bereaved for three or more years were the least likely to report engaging in risk-taking behaviors. Middle-aged bereaved widowers who have been bereaved for one year or less may report lower levels of overall physical and mental well-being, and have a higher probability of engaging in risk-taking behaviors.

Unlike middle-aged bereaved spouses, retired bereaved spouses did not report any differences in their preferences for social support and adjustment to widowhood in regards to gender. However, what influenced the trajectory of retired bereaved spouses was their housing location. Retired bereaved spouses who reported living in a retirement center were less likely to report lower levels of overall mental and physical health compared to retired bereaved spouses who are community-dwelling.

However, differences were reported among retired bereaved spouses *living in a retirement center* as a result of *bereavement stage*. Contrary to previous findings, this

study argues that retired bereaved spouses who have been bereaved for three or more years and are living in a retirement center may fare worse than retired bereaved spouses who have been bereaved for one year or less and are living in a retirement center. The literature suggests that a bereaved spouse who has been bereaved for one year or less may report higher levels of anxiety, fear, and pain; these higher levels of negative feelings and attitudes may negatively increase one's overall mental and physical health. However, despite previous findings, bereavement stage may also play an important factor in influencing one's adaptation to widowhood.

Earlier in this study, I hypothesized that retired bereaved spouses who have been bereaved for one year or less may be more likely to report negative effects of bereavement on their overall mental and physical well-being. While this hypothesis has been supported, what is noteworthy is that the opposite effect was reported among retired bereaved spouses who have been bereaved for one year or less *and* lived in a retirement center compared to retired bereaved spouses who have been bereaved for three or more years *and* lived in a retirement center. This study argues that bereavement stage may play an important role in influencing the trajectories of retired spouses living in a *retirement center*. Retired bereaved spouses who are community-dwelling and have been bereaved for one year or less reported lower levels of overall physical and mental health compared to retired bereaved spouses who are community-dwelling and have been bereaved for three or more years. However, the opposite effect is found among retired spouses who are living in a retirement center. It appears that the longer one has been bereaved and is living in a retirement center, the more likely he/she will be to report higher levels of hopelessness and helplessness.

What may contribute to these findings is that as time elapses, retired bereaved spouses are more likely to recognize that the unchanging aspects of having lost their spouses may not get any better. In addition to feeling as though their lives may not get any better, retired bereaved spouses may also report declining levels of mental and physical health as a result of aging. Retired bereaved spouses who are living in a retirement center have reported that as one's bereavement stage increases, his/her overall levels of confidence and well-being decreases. Retired bereaved participants reported that during the first year of bereavement, higher levels of numbness and shock were reported. With time, levels of numbness and shock lessened while levels of hopelessness and helplessness increased. For example, one retired bereaved spouse argues that there is a non-linear relationship between bereavement stage and levels of confidence. "When Harold died, originally, I was too shocked to actually process what was happening to me. I was paralyzed with fear and sadness. As time went on, I began to realize that he really *was* gone, and this took a toll on my self-confidence." Retired bereaved spouses who have been bereaved for one year or less and lived in a retirement center reported that a lot of "noise" and distraction from the retirement center may have *delayed* their actual processing of the death of their spouse. "When my wife died 8 months ago, I was never really able to hear myself think because the retirement center was so busy and 'loud.' As time passed, I was able to 'tune out' the noise, but I realized that I was truly widowed." Another participant adds, "The retirement center may serve as a good distraction when you are first widowed. However, time catches up to you, and you cannot run. There you are—confronted with your loss."

Limitations and future research

This next section will detail some limitations that may have influenced the findings reported in this study. All data reported in each interview were transcribed *immediately* following the interview as a means of reducing bias and subjectivity. Regardless of the qualitative researcher's ability to avoid bias and subjectivity, there are other factors which may influence the findings of a study. In order to reduce bias and increase validity and reliability, the following limitations will be discussed as a means of successfully reducing levels of bias.

Hospice use

Participants in this study were recruited through the Hospice of the Valley and Homestead Hospice. What may have influenced the findings in this study may be that certain individuals may be “selected” into utilizing specific Hospice services. For example, a reoccurring theme that was reported among participants in this study was that they were referred to one of the two aforementioned Hospice services because of the *recommendations* and *referrals* given to them by their deceased spouses' doctor and/or oncologist. As one participant mentioned, “His oncologist just got us in touch with Hospice-- the phone number, list of staff—everything. It was just handed to us on a brochure. We did not even need to do any research— we just went with what the doctor suggested.” Another participant adds, “The Hospice services we ended up using was a result of the recommendation given to us by the oncologist. He mentioned that the Hospice was located literally a mile away from our home, and he recommended that we use that location.” Additionally, some participants mentioned that they utilized a specific Hospice service simply because they trusted their doctor and/or oncologist. “He said he

has had good experience with that Hospice—he said he never had any patients complain about it. He said the service was exceptional.” Another participant adds, “Our oncologist has known us for five years, and we just went with what he suggested. We just trusted him. He seemed to be very involved in our battle with cancer, and we figured we would have him help us towards the final stages of my husband’s life. It was a family decision.”

Using Hospice services may be contingent upon a selection effect, and may also explain why some participants utilize Hospice services and others do not. Even differences for utilizing Hospice within the home and outside of the home may have also influenced the data reported in this study. For example, some participants had their spouses die in the home, and some participants had their spouses die outside of the home. Either way—participants in this study utilized Hospice services, but some opted to have their spouse die in their homes and some preferred the opposite. Differences were found between spouses who had their spouses die in their home and between spouses who had their spouses die outside of their home. Participants in this group that utilized Hospice services outside of their homes were less likely to report feeling guilty and defeated compared to participants that utilized Hospice services within their homes. As one participant said, “If I had him die at our house, even though the Hospice staff would assist us, I would somehow wonder if he would have had a peaceful death if he died outside of our home. I am so glad he died outside of the home—I do not doubt that his death was not peaceful.” Timothy, whose spouse died in their home reports, “I sometimes worry that I could have prevented her death. She died in our bed—could I have stopped that? Having her die at our house makes me feel like I failed her.”

It is important to perceive the selection effect of Hospice users versus non-Hospice users. Because all participants in this study utilized Hospice services, it is very possible that their adaptation towards widowhood may differ from bereaved spouses who do not utilize Hospice services at all. Additionally, a spouse dying in one's home may increase levels of guilt and defeat compared to a spouse dying outside of one's home. Recognizing the selection effect that may influence these varying adaptation processes is important in order to reduce bias and increase levels of validity and reliability.

Care-taking effect

A benefit of using Hospice services is that bereaved spouses are less likely to experience the “care-taking” effect on their overall mental/physical well-being compared to bereaved spouses who do not utilize Hospice services. “By using Hospice services, I did not find myself conflicted between two different roles—a nurse and a wife. I just focused on being a wife because Hospice took care of everything else.” Another participant adds, “If it were not for Hospice, I would have no idea how to have helped Bill relax and lower his levels of pain. I would have probably made things worse because I did not go to medical school, and I do not think I am qualified to take care of someone who is terminally-ill.”

Utilizing Hospice may lower overall levels of negativity and stress on one's mental/physical health because it provides much information about the process of death and dying. “The staff was very helpful—they explained to me what was most likely going to happen, and told me not to panic. Having them around made me feel like I could handle this—without them, I would have probably had a meltdown.” Another participant adds, “They warned me that before my husband died, he would vocalize his ability to see

his bereaved loved ones. That is exactly what he did four hours before he died—he said he could see his bereaved mother. Because the staff prepared me for this, I was not so surprised and scared when he did see his bereaved mother.” Lowering the ambiguity surrounding the process of death and assisting families prepare for the death of a loved one may put Hospice users at an advantage compared to non-Hospice users. It may be of importance to examine the trajectories of bereaved spouses who did not utilize Hospice services in order to examine whether or not there may be discrepancies reported among their adaptation trajectories. Controlling for the “care-taking” effect may lower levels of bias for future studies. It is important to recognize that the utilization of Hospice services may have put participants in this study at an advantage because it lowered levels of anxiety and ambiguity surrounding the process of death.

Surviving young children

Middle-aged respondents in this group reported that a factor that influenced their adaptation towards widowhood was the presence of their surviving young children. Twenty-two out of twenty-four middle-aged participants reported having at least one surviving young child. Middle-aged participants with surviving young children reported an obligation and urgency to “move on” as quickly and positively as possible for the well-being of their children. It is important to recognize that the influence of having surviving young children may influence the trajectories of middle-aged participants in this study.

Because the majority of middle-aged participants reported having at least one surviving young child, their trajectories towards adaptation may vary compared to their middle-aged bereaved counterparts who do not have surviving young children.

Additionally, *all* middle-aged participants in this study reported being employed full-time; it may be important to recognize that there may be an employment effect on middle-aged participants in this study. It is very possible that bereaved middle-aged participants who are not employed may report varying trajectories towards widowhood compared to their bereaved middle-aged counterparts who are employed.

Presence of children

A limitation in this study is that the majority of middle-aged participants in this study did report having at least one surviving young child, so I was not able to compare the recovery from bereavement among middle-aged people without children. It is important to keep in mind that the influence of having a surviving young child may influence one's widowhood trajectory. Not having any surviving young children and/or not living with any surviving young children may also influence one's widowhood trajectory. This lack of motivation may be a key predictor in influencing one's widowhood trajectory—either in a positive or negative way.

Housing location

For a bereavement stage of one year or less, retired bereaved spouses in this study reported living in a retirement center and/or community dwelling. However, for a bereavement stage of three or more years, *all* retired bereaved spouses reported living in a retirement center. A limitation in this study is that I did not interview any people three or more years after bereavement that were community dwelling. Because all retired bereaved respondents in a bereavement stage of three or more years reported living in a retirement center, I could not examine how bereavement experiences felt for those post three years and living in the community. It is important to note that because of the lack of

community dwellers in the latter bereavement stage, widowhood trajectories for these individuals may vary because they are living in a retirement center. Not having a comparison group (community dwellers) in the latter bereavement stage for retired bereaved spouses may pose as a threat to the validity of the findings in the fourth group (retired bereaved spouses who are bereaved for three or more years).

What may have also influenced the results found in this study is that not a single retired participant reported living in a nursing home—regardless of bereavement stage. Additionally, all participants in this study reported that they were able to manage their own care. Should a health problem arise, participants who needed care reported only needing minor assistance. Because all retired participants were either living at a retirement center or community dwelling, it is important to recognize that their trajectories may vary compared to retired spouses who are living or are planning to live in a nursing home. A majority of participants reported being in good physical and mental health during the time of the interview; not a single participant in this study needed around-the-clock care and assistance. Most participants in this study were able to take care of themselves physically and perform daily tasks; some participants needed assistance with performing daily tasks, but no one in the study reported life-threatening symptoms or health problems.

Differences in this study were reported between retired participants who are living in a retirement center versus participants who are community dwelling. It may be important to recognize that one's housing location may influence his/her adaptation towards widowhood. The availability of greater social support was reported among retired participants who lived in a retirement center versus those who are community dwelling.

Additionally, participants who lived in a retirement center also had access to transportation which enabled them to come and go as they pleased. Participants who reported community dwelling reported that their ability to drive was limited, and thus the majority of time, their social interactions occurred depending upon the willingness of others to come to them. All of these varying factors may influence the adaptation trajectories that were reported among retired bereaved spouses in the study. Controlling for housing location, physical health, and access to social support must be thoroughly examined as a means of lowering bias and increasing levels of validity and reliability.

Role of social support

This study has found that the role of social support may be both helpful and harmful. All four types of social support were reported by participants in this study—emotional, instrumental, appraisal, and informational. The type of social support received by participants differed between bereavement stages and life course stages; the type of social support that participants may have expected may have also differed due to the aforementioned stages. The availability of emotional support was highly desired by middle-aged widowers in this study. While emotional support was highly desired by middle-aged widowers, a lack of emotional support was actually reported. Middle-aged widowers in this study may not have received emotional support as a result of the social construction and reinforcement of gender norms.

On the other hand, middle-aged widows reported receiving a plethora of emotional support. What middle-aged widows desired, on the other hand, was instrumental support. Assistance with chores, funeral arrangements, and maintenance of the children's well-being were examples of the instrumental support middle-aged widows preferred to

receive. Being encouraged to constantly speak about their ordeal (emotional support) was not desired by widows; constantly speaking about their ordeal was a source of stress, and widows reported preferring to avoid the constant discussion about the death of their husbands.

Bereavement stage may have also influenced the type of social support middle-aged participants received and expected. Middle-aged bereaved widowers reported the desire to receive emotional support, in both bereavement stages. Middle-aged bereaved widows reported desiring instrumental support during the first year or less of bereavement, and desired emotional support once they were bereaved for three or more years. However, middle-aged bereaved widows who have been bereaved for three or more years did not receive emotional support because they felt as though their social networks were tired of hearing about their problems. “They change the subject. They want me to get over it already. I think after a certain amount of time, people just do not want to talk about your husband’s death anymore. If I keep holding onto the pain, then I get scolded for not letting it go and not moving on!”

As we can see, middle-aged participants in this study did receive social support. However, what needs to be noted is that the *type* of social support is what may be determined as helpful or harmful. One must recognize the difference between providing helpful social support versus providing harmful social support. Additionally, social support may be perceived as helpful or harmful depending upon the person who is providing the support. Middle-aged widows who were bereaved for one year or less desired instrumental support; most middle-aged widows were not too particular about who provided instrumental support. What was important was that instrumental support

was provided, and it would be helpful regardless of *who* provided the support. Middle-aged widowers were very particular about who provided informational or appraisal support. The aforementioned widowers reported feeling frustrated if they received informational or appraisal support from an individual who has not experienced a similar ordeal. Middle-aged widowers welcomed and appreciated appraisal and informational support from other widowers; receiving appraisal and informational support from men who have not experienced a similar situation amplified their stress and pain.

Retired bereaved spouses may or may not have received an ample amount of social support depending upon their housing situation. Living in a retirement center increased the likelihood of receiving and perceiving the availability of social support. A retirement center increased the likelihood of interacting with other residents at the retirement center, increased the availability of transportation, and encouraged group activities and field-trips. Retired bereaved spouses who lived in a retirement center and have been bereaved for one year or less were more likely to report feeling a great deal of social support compared to bereaved spouses who lived in a retirement center and have been bereaved for three or more years. Living in a retirement center and being bereaved for one year or less increased the likelihood of feeling socially integrated. As some respondents suggested, living in a retirement center during the first year or less of bereavement may serve as a distracting and buffering source of support.

Retired bereaved spouses who have been bereaved for three or more years were less likely to report high levels of social support. A bereavement stage of three or more years may have negatively influenced the perception and availability of social support. Because retired spouses who live in a retirement center and are bereaved for three or more years

are more likely to report higher levels of hopelessness and helplessness, they are also more likely to isolate themselves from other residents in the retirement center.

Consequently, a vicious cycle of loneliness is reinforced as one's bereavement stage increases. One respondent suggested that a non-linear relationship may exist between bereavement stage and one's well-being. "The longer you are bereaved, the more likely you are to feel crummy. You just do not feel good. You do not want to talk with people—everyone and everything annoys you." A retired bereaved spouse who has been bereaved for one year or less and lives in a retirement suggests that she could not have imagined her life after her husband died if it were not for her friends at the retirement center.

"When he died, everyone was by my side. No one left my side. They encouraged me to participate in group activities and tried to keep me distracted." Contrarily, a retired bereaved spouse who has been bereaved for three or more years and lives in a retirement center suggests that the depth of your loss is truly experienced as time elapses. "I was in shock and numb during the first six months. It has been four years since she has died, and I feel the lack of her presence by my side with every passing day. It becomes more and more real—you just cannot hide from it."

Retired bereaved spouses who did not live in a retirement center and were community dwelling were less likely to report receiving social support. Retired bereaved spouses who were community dwelling suggested that if it were not for their friends and family making the trip to see them, then they would most likely spend each day alone. "I love when my kids come and see me. My sister drops by and visits me, too. If they do not come to me, I usually do not go to them. My interaction with others is solely dependent upon them—*not* me." In a retirement center on the other hand, retired bereaved spouses

are constantly coming into contact with other residents. While the likelihood of interacting and socializing may be more likely when one lives in a retirement center, it is important to remember that the perception of social support may vary by bereavement stage.

In sum, retired bereaved spouses may or may not be able to recognize the availability of social support depending upon their housing location. More specifically, bereavement stage may also influence one's ability to recognize the availability of social support. As a result, this study finds that the role of social support does remain inconclusive and may go one of two ways—social support may be harmful or helpful. The *type* of social support and the *provider* of social support may also influence one's perception of the availability of social support. What this study finds is that social support may be helpful as long as the right type of social support is received. Because Hospice services provide bereavement counseling for thirteen months following the death of a spouse, perhaps Hospice services should consider educating and informing social networks (social support providers) about providing the proper *type* of social support to bereaved individuals. Hospice services may want to consider acquainting social networks (social support providers) with the four types of social support. If the social network of bereaved spouses thoroughly understood which type of social support may be helpful, then the likelihood of providing harmful social support to bereaved spouses may decrease.

Future research regarding social support may want to further delve into ways that may help acquaint individuals with the various types of social support. Receiving proper social support may buffer against the impact of stress in addition to lowering the adverse effects of bereavement on one's trajectory. The data collected in this study may lend

support to the notion that the role of social support is inconclusive, and may need to be further examined. The findings in this study also suggest that receiving social support is one thing, but receiving *helpful* social support is another thing. Discerning between the two is very important, and may be the key predictor in examining whether or not the role of social support on adjustment to widowhood is positive or negative.

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APPENDIX A
SURVEY

Basic Information

- 1) How old are you? How old was your spouse?
- 2) How long have you and your spouse been married?
- 3) How many children do you and your spouse have? How old are they?
- 4) How would you characterize the quality of your marriage?
- 5) How long was your spouse sick for before he/she passed away?
- 6) How many years of schooling did you and your spouse receive?
- 7) How would you characterize your financial situation?
- 8) Were you and your spouse both working before he/she passed? If not, were you and your spouse retired or planning to retire?
- 9) Did you and your spouse socialize with other married couples? If not, who did you and your spouse socialize with?
- 10) How did you and your spouse spend your leisure time? Did you spend much time with one another?

Composition and quantity of participants' social support groups

- 1) How many individuals would you estimate is in your social support group?
- 2) Out of all these individuals in your social support group, how many of them are comprised of family members? Friends? Co-workers? Bereavement counselors? Acquaintances? Etc?
- 3) Do you talk to the individuals in your social support group on a weekly basis? On a scale of 1-10 (one being the lowest and ten being the highest), how many times a week, on average, do you keep in contact with your support group?

- 4) Who do you keep in touch with the most throughout the week (family members, co-workers, friends, counselors, etc?) Why do you keep in touch with these aforementioned individuals the most? How do the aforementioned individuals offer you support (phone, email, face to face, etc?) Who do you keep in contact with the least throughout the week (family members, co-workers, friends, counselors, etc)? Do you keep in touch with these aforementioned individuals the least because of your geographical location? Do you keep in touch with these aforementioned individuals the least because the quality of your relationship is not characterized as high quality? If not, why do you keep in touch with these aforementioned individuals the least?
- 5) Does your social support group consist of individuals who live in the same state as you? If so, how many of these individuals in your social support group live within 50 miles of you? What relation do these local individuals have to you (are they your family, friends, co-workers, etc)? If not, how many of these individuals in your social support group live far away from you? Which individuals consist of the ones who live further away from you?
- 6) For the most part, how does your social support group provide you support? Over the phone, through face to face interactions, through email, through Skype, through letters, etc?
- 7) Are there individuals in your social support group who live near you, but provide you more with phone or email support compared to face to face interactions? If so, what is your relation to these individuals? Conversely, are there individuals in

- your social support group who live far away from you, but strive to keep an open line of communication with you? If so, what is your relation to these individuals?
- 8) Overall, out of all the individuals in your social support group, who would you report being the most reliable and helpful? Why? What is your relation to these individuals? Out of all the individuals in your social support group, who would you report being the least reliable and helpful? Why? What is your relation to these individuals?
 - 9) What is your preferred way of receiving support? Do you prefer it to be via the phone, emails, through face to face interactions, etc? Why?
 - 10) On a score of 1-10 (one being the lowest and ten being the highest), how would you rank/report the quality of your social support group? Why? If you ranked a low score, what factors would increase the quality of your relationships?
 - 11) On a score of 1-10 (one being the lowest and ten being the highest), how would you rank/report how reliable and accessible your social support group is?
 - 12) Overall, how helpful was your social support group in helping you cope with the loss of your spouse?

Types and effectiveness of social support groups

- 1) Is your social support group able to sympathize and/or empathize with your loss?
- 2) Are they emotionally supportive (do they give you a shoulder to cry on, allow you to vent indefinitely, hold your hand, etc)?
- 3) Does your social support group provide instrumental support (assist financially, assist with chores that the deceased spouse used to accomplish, offer to drive you around, etc)?

- 4) If it were not for your social support group, could you adapt to the loss of your spouse on your own?
- 5) Does your social support group inadvertently exacerbate some of your pain and anguish; for example, does your social support group make insensitive comments regarding your adaptation trajectory ('get over your loss already, life goes on, move on, let it go')?
- 6) Does your social support group make you feel as though you are burdening them with your pain? Would you rather keep your emotions bottled up inside rather than communicating with your social support group out of fear that you are frustrating them?
- 7) Do you ever feel as though your social support group is not trying hard enough to understand exactly what you are going through?
- 8) Was the support you received from your social support group consistent? Did the support you received from your support group slowly lessen or increase as time elapsed since the death of your spouse?"
- 9) On a scale of 1-10 (one being the lowest and ten being the highest), how would you rank/report the effectiveness of your social support group? On a scale of 1-10 (one being the lowest and ten being the highest), how would you rank your dependency upon your social support group?

Physical/Mental Health

- 1) On a score of 1-10 (one being the lowest and ten being the highest), how would you rank your overall physical and mental health *before* your spouse passed

- away? How would you rank your overall physical and mental health *after* your spouse passed away?
- 2) On average, how many times a week did you feel as though you did not want to get out of bed before your spouse passed? After your spouse passed? On average, how many times a week did you suffer from insomnia before your spouse passed? After your spouse passed?
 - 3) On average, how many times a week do you exercise? Did your amount of exercise increase or decrease following the loss of your spouse?
 - 4) On a score of 1-10 (one being the lowest and ten being the highest), how would you rank your overall levels of depression before and after your spouse passed? How would you rank your overall levels of anger before and after your spouse passed? How would you rank your overall levels of fear and loneliness before and after your spouse passed?
 - 5) Throughout the week, how often do you feel as though you want to stay in and avoid the “outside world?” Did this number increase or decrease after your spouse passed? On average, how often do you feel lethargic (both mentally and physically) before and after your spouse passed?
 - 6) On a weekly basis, how often do you socialize with your social support group? If you socialize with your social support group on a weekly basis, how would you rank your overall feelings of self- worth and happiness after socializing with your social support group on a scale of 1-10 (one being the lowest and ten being the highest)? Do you or do you not feel happier socializing with your social support group since your spouse passed?

- 7) On a scale of 1-10 (one being the lowest and ten being the highest), how would you rank your overall levels of self-esteem and self-worth before and after your spouse passed?
- 8) On a scale of 1-10 (one being the lowest and ten being the highest), how would you rank your overall levels of motivation before and after your spouse passed?
- 9) On a scale of 1-10 (one being the lowest and ten being the highest), how would you rank your desire to live before and after your spouse passed?
- 10) Has your desire to socialize with your social support group increased or decreased since your spouse died? Have you become more introverted or extroverted following the death of your spouse? Why?
- 11) On a scale of 1-10 (one being the lowest and ten being the highest), how often did you clean your home on a weekly basis before and after your spouse died? Have you increased or decreased the amount of time you spend on your housework chores since your spouse passed?
- 12) Since your spouse passed, have your levels of procrastination increased or decreased?

APPENDIX B
INFORMATION LETTER

Study: Examining the Role of Social Support on Adjustment to Widowhood.

2/20/2012

Dear participants,

I am a graduate student under the direction of Professor Kronenfeld in the School of Social and Family Dynamics at Arizona State University. We are conducting a research study to examine the effects of bereavement on bereaved spouses. Additionally, we are examining the role of social support on adjustment to widowhood; does it hurt or help?

I am inviting your participation, which will involve your willingness to openly discuss the effects of bereavement, experiences of Hospice services, and how social support may or may not have positively influenced your coping trajectories. Each interview will be conducted privately, and will last roughly between 60-90 minutes. You have the right not to answer any question, and to stop the interview at any time.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. While there may be no possible benefits for participants in this study, there may be potential benefits for future bereaved spouses. This study hopes to shed light on ways to positively influence one's adaptation to widowhood. There are no foreseeable risks or discomforts to your participation.

Your participation in this study is greatly appreciated, and we will make sure your anonymity is maintained. Each participant will receive fictitious names, and no real names will be disclosed in this study. The results of this study may be used in presentations, publications, and/or a dissertation. However, your name will never be known/used in this study.

In this study, we are planning to audiotape each interview. In order to thoroughly capture the effects of bereavement on each participant, I would like to audiotape each interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be taped; you can also change your mind after the interview starts, just please let me know. Tapes will be kept in a secure locker at the office of the School of Social and Family Dynamics. Only the researchers will have access to this locker. Tapes will be kept for roughly a week, as we plan on transcribing each interview immediately following completion. Each tape will be completely destroyed; we will make sure each tape is completely inaccessible.

If you have any questions concerning the research study, please contact the research team at: Jennie.kronenfeld@asu.edu and nrafiee@asu.edu. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.

APPENDIX C
RECRUITMENT SLIP

To whomever this may concern,

I am a graduate student under the direction of Professor Kronenfeld in the Department of School of Social and Family Dynamics at Arizona State University. We are conducting a research study in order to examine the effects of bereavement on bereaved spouses.

Additionally, we hope to further examine the role of social support on adjustment to widowhood; does it help or hurt?

I am recruiting bereaved spouses to openly discuss their experiences with Hospice services, effects of grief, and how social support has influenced their coping trajectories.

Each interview will roughly last 60-90 minutes. Your participation in this study is voluntary. If you have any questions concerning the research study, please call me at (480) 612-3265. Thank you for your time.

