

Grief and Bereavement

Deborah Carr

Death is one of life's few certainties. All persons will die, and nearly all will survive the death of a loved one. Although death is universal, the timing, cause, and context of death vary widely over the life course (Carr, 2012). Consequently, the experience of bereavement, or losing a loved one through death, also varies widely over the life course and by gender. Grief is a typical reaction to the loss of a loved one, where survivors experience psychological and physical symptoms in the weeks and months that follow, and in some cases precede, the death (Rando, 1986; Weiss, 2008). The extent to which a bereaved person grieves, and the duration, nature and intensity of one's emotional distress is closely linked to the larger context of the death, one's relationship to the decedent, concurrent stressors, and one's coping resources (Bonanno et al., 2002; Carr, 2012). Survivors' reactions to loss vary widely, with some suffering from prolonged and even debilitating grief (Boelen & Prigerson, 2013), whereas others recover quickly, experiencing only short-lived symptoms of sadness (Bonanno et al., 2002).

In this chapter, I provide a brief overview of the nature of death and dying in the contemporary United States, which sets the stage for understanding the personal meaning and context of late-life bereavement. I then describe classic and contemporary work on grief and its subtypes. I then summarize research on distinctive types of family bereavement in late life, and show how and why the deaths of one's spouse, sibling(s), parent(s), and adult children affect the lives of older adults. Next, I focus in depth on the demographic, psychosocial, and contextual factors that shape grief in the face of one particular type of late-life bereavement: The loss of one's spouse/partner. This particular focus reflects the fact that the vast

majority of research on late-life bereavement focuses on the specific case of widow(er)hood. Finally, I highlight unanswered questions regarding loss and bereavement among older adults and suggest avenues for future research.

Death and Dying in the United States: A Brief Historical Overview

In order to understand late-life bereavement, a brief overview of mortality patterns is necessary. When, how, and of which causes older adults die carry important implications for their survivors' emotional, physical, and financial well-being. An epidemiologic transition occurred over the past two centuries, in which infant and child deaths were replaced by late-life deaths, and infectious diseases were replaced by lifestyle-related chronic diseases as the leading causes of death (Olshansky & Ault, 1986; Omran, 1971). In the 19th and early 20th centuries, deaths occurred primarily due to infectious diseases, such as diphtheria and pneumonia; death occurred relatively quickly after the initial onset of symptoms. Throughout the 20th century, improved sanitation and nutrition, immunization for communicable diseases, effective treatments for infections, and other medical advances dramatically reduced mortality among younger persons, and increased life expectancy (IOM, 2014). While median life expectancy in 1900 was just 46 years old, it approached 80 years old in 2009 (Arias, 2014).

Today, death is largely a late-life phenomenon. Roughly three-quarters of the 2.4 million deaths in the United States in 2010 were to persons aged 65 and older (Federal Interagency Forum on Aging-Related Statistics, 2012). The leading causes of death among older adults are chronic and progressive illnesses including heart disease, cancer, chronic lower respiratory diseases, stroke, Alzheimer's disease, and diabetes (Federal Interagency Forum on Aging-Related Statistics, 2012). Late-life deaths today typically occur months or even years after the initial onset of chronic illness, thus the prolonged "living-dying interval" (Pattison, 1977) between diagnosis and death is typically marked by compromised quality of life, comorbid conditions, functional impairment, mobility limitations, impaired cognitive functioning, physical discomfort, and the need for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). In 2009, more than 40 percent of persons aged 65 and older required assistance with ADLs or IADLs (Federal Interagency Forum on Aging-Related Statistics, 2012). The number of older Americans with serious cognitive impairment is also high and rising; the number of older adults suffering from Alzheimer's disease and related dementias is expected to grow from 5.5 million in 2010 to 8.7 million in 2030 (HHS/ASPE, 2013).

Because most late-life deaths occur following a period of chronic illness, the majority of older adults who experience the loss of a spouse, sibling, parent, or even an adult child typically have witnessed some suffering, have played a role as a caregiver, or have had the time to prepare practically and emotionally for the impending death. Caregivers to loved ones with dementia also must grapple with the loss of their loved one's ability to communicate and to be one's usual self prior to loss (Chan et al., 2013). In short, for most older bereaved persons, death is not an acute, sudden, and unexpected event, but is rather a slowly unfolding process. These dying trajectories carry implications for the nature and timing of grief.

Grief: Definitions and Subtypes

While bereavement refers to the objective situation of having lost a loved one through death, grief refers to the emotional or physical reactions of distress that one has in response to the loss. Grief has been described as “the cost we pay for being able to love in the way we do” (Archer, 1999, 5). Mourning, by contrast, refers to the public display or expression of grief, such as wearing black clothing or draping the coffins of deceased military personnel with American flags (Fontana & Keene, 2009). Rich anthropological research has documented cross-cultural differences in mourning practices, although the topic is beyond the scope of this chapter (see Robben, 2009).

As we shall see later in this chapter, the intensity and duration of one's grief symptoms vary widely based on who the decedent is, the cause of death, and a range of other personal and situational factors. Despite this heterogeneity, a core theme in grief research is distinguishing between normal grief and grief that is deemed complicated or prolonged (Prigerson et al., 2008; Shear et al., 2011). Although the boundaries demarcating these different types of grief are both fuzzy and controversial, a general assumption is that some sadness following the death of a loved one is normal and that grief symptoms are problematic only when they extend for prolonged periods of time, or inhibit one's daily functioning. For example, the types of grief viewed as most problematic and thus most in need of professional attention are chronic or prolonged grief (Shear et al., 2011), which is characterized by long-lasting symptoms associated with intense grief. Yet at the same time, individuals who show no symptoms of sadness historically were considered pathological. For example, delayed, inhibited, or absent grief were viewed as indications that an individual may not attach to significant others in a meaningful way, given that grief is a consequence of severed bonds to an important attachment object (e.g., Archer, 1999; Weiss, 2008).

One of the most hotly contested debates in grief research, theory, and practice over the past two decades has been the exclusion of bereavement in the *Diagnostic and Statistical Manual (DSM; American Psychiatric Association, 2013)*. The *DSM* provides mental health practitioners with a definition and treatment guidelines for mental health disorders. In the *DSM-4*, American Psychiatric Association (1994), persons who experienced two months or more of sadness were excluded from receiving a major depression diagnosis if those symptoms were a result of a recent bereavement. This exclusion suggested that sadness for a delimited time period is normal in the face of a major loss and as such was not a pathological condition in need of treatment. However, in the *DSM-5*, American Psychiatric Association (2013), the bereavement exclusion was removed, and thus enables practitioners to diagnose (and medicate) some bereaved persons as suffering from major depressive disorder. Impassioned debates continue among researchers and practitioners, and hinge on competing notions about whether sadness is a normal reaction to loss, and whether untreated symptoms will fade with the passage of time or require more serious interventions (e.g., Shear, 2011, Wakefield & First, 2012). Some of the most compelling empirical evidence to date suggests that for older adults, in particular, most bereaved spouses experience brief spells of depressive symptoms but then quickly return to their preloss functioning (Bonanno et al., 2002), although a small minority experiences persistent and debilitating symptoms that require treatment (Shear et al., 2011).

Anticipatory Grief

Most writings on grief focus on a bereaved person's psychological and physiological responses after the death occurs. However, in the case of older adults, as noted earlier, the majority of deaths tend to occur after a prolonged illness. As such, one's feelings of loss, sadness, and loneliness may begin far earlier than the actual death, and may begin to unfold as one is caring for an ailing loved one, or watching the personhood of their loved one slip away as dementia symptoms take over (Chan et al., 2013; Rando, 1986). While these individuals may experience sadness during the dying process, they may ultimately be better prepared for the death when it arrives.

For example, researchers have administered grief surveys to caregivers when they were still providing care for their loved ones and found that predeath grief symptoms were highly correlated with feelings of distress (e.g., Meuser & Marwit, 2001). Several recent studies also show that those experiencing grief symptoms prior to the loss have reduced symptoms postloss, with some bereaved persons even reporting relief. For example,

one study of older widows in Sweden found that 40 percent described the preloss period as more stressful than the postloss period. For these widows of men who died of cancer, preparatory grief involved emotional stress, intense preoccupation with the dying, longing for his/her former personality, loneliness, tearfulness, cognitive dysfunction, irritability, anger and social withdrawal, and a need to talk (Johansson & Grimby, 2012). However, they also reported resilience and effective coping after the loss, in part because the “living-dying interval” (Pattison, 1977) provided a time and space to prepare for the impending death.

Family Bereavement in Late Life

The primary types of family bereavement experienced by older adults are the deaths of spouses or romantic partners, siblings, parents, and adult children.

Spouse and Partner Loss

Spousal loss can occur at any age, yet in the United States and most wealthy nations today, it is a transition overwhelmingly experienced by persons aged 65 and older. Of the roughly 900,000 persons widowed annually in the United States, nearly three-quarters fall into this age category (Federal Interagency Forum on Aging-Related Statistics, 2012). Because life expectancy is roughly 79 for men and 84 for women, women are much more likely than men to become widowed (Miniño & Murphy, 2012). Among persons aged 65 to 74, 26 percent of women but just 7 percent of men are widowed; at ages 75 and more, these percentages jump to 58 percent of women and 21 percent of men. This stark gender gap also reflects the fact that widowers are far more likely than widows to remarry and thus may exit the widowed category. Widows are less likely than widowers to remarry because of a dearth of potential partners. Among persons aged 65 and older in the United States, the sex ratio is 1.5 women per every one man and by age 85, this ratio is more than 3 women per every man. As a result, few widows have the opportunity to remarry even if they would like to do so. Additionally, cultural norms encourage men to marry women younger than themselves, so widowed men may opt to remarry a younger woman, whereas older widows do not typically have that option (Federal Interagency Forum on Aging-Related Statistics, 2012). Qualitative interviews also show that older women who were caregivers to dying husbands, especially those dying from prolonged or treatment-intensive illness such as cancer are reluctant to remarry again and possibly resume the stressful role of caregiver (Bennett, Hughes, & Smith, 2003).

Far less is known about the number of bereaved persons following a long-term same-sex relationship. According to data from the 2010 U.S. Census, there are currently 605,000 same-sex households in the United States, 27 percent of whom identify as married. The average age of the partners in same-sex households is 48; roughly 13 percent are 65 or older, whereas 17 percent are between 55 and 64 (Lofquist, 2011). Thus a sizeable number of older gays and lesbians are at risk of losing a partner. As I discuss later in this chapter, gay and lesbian couples face both distinctive challenges yet possess protective resources as they cope with the loss of their partner.

Sibling Loss

Studies of sibling bereavement in late life are rare; most studies of the death of a brother or sister are focused on childhood and adolescence (e.g., Devita-Raeburn, 2004). This omission is troubling, given that most older adults have at least one living sibling, and most have emotionally close and mutually supportive relationships (White, 2001). Theoretical writings propose that the death of a sibling may have profound effects on older adults because “it marks an end to what is expected to be one of the longest and most intimate relationships of a lifetime” (Mahon, 1997).

One of the few empirical studies of adjustment to sibling loss in late life reveals that sibling death is linked with heightened depressive symptoms, and that this association is partly explained by the fear of death and sense of personal vulnerability that is triggered by a sibling’s demise (Cicirelli, 2009). Because most siblings are close in age and spent their formative years together, the death of one sibling may render the other acutely aware of his or her own mortality. Relationships among surviving siblings typically grow closer following sibling death (Moss & Moss, 1989), and siblings with strained relationships may work to make amends, especially as they cope with the challenges of aging including illness, cognitive decline, and caregiving for parents (Hays, Gold, & Pieper, 1997).

Parental Loss

With rising life expectancy in recent decades, many older adults have at least one living parent, and the proportion of persons aged 65+ with a living parent is expected to increase further among future cohorts. Most older adults with a living parent will eventually face the death of that parent. However, very little is known about bereavement experiences of older adult children who survive the loss of very aged parents. Moss and Moss (1983–1984) attribute this research gap to the facts that late-life mortality is normative, and adult children have limited daily contact with their

aging parent(s). As such, many presume that the daily lives of older adult children may not be disrupted by parental death, given a norm of residential independence in the United States and many other wealthy nations. However, adult children play an active role in end-of-life decision making (Carr & Khodyakov, 2007) and are the most common source of informal care to aging parents (Wolff & Kasper, 2006). Given adult children's high levels of engagement with their parents' health and health care, parental death remains "an unexpected crisis for most healthy, well-functioning adults" (p. 7) and also "represents a rite of passage into a new adult identity" (Umberson, 2003, p. 8).

A handful of studies have explored psychological reactions to late-life parental death and find wide variation based on the gender of parent and child, and nature of the late relationship. An estimated 45 percent of adult children experience somatic reactions to the death of a parent and roughly 10–15 percent report declines in overall health (Scharlach & Fredriksen, 1993). Symptoms of anxiety and depression often occur immediately after the death yet rarely persist in the longer term (Scharlach & Fredriksen, 1993). After six months, there is generally a significant decline in these emotional reactions to death (Pratt, Walker, & Wood, 1992). Umberson and Chen (1994) also found that adults who had recently lost a parent had significantly more frequent alcohol use and more depressive symptoms than their peers without a parental loss, and effects were largest for those who had positive relationships with their late parent. Grief symptoms also are linked to the nature of the death; some studies suggest that sudden deaths or deaths that the adult child feels partly responsible for are particularly likely to trigger symptoms of distress (Horowitz et al., 1984).

Other studies suggest that the toll of parental death is more severe when the second parent dies (Marshall, 2004). Some research also suggests that sibling relationships may grow closer upon the death of a second parent, as the surviving children must develop new rituals and practices to make up for those previously upheld by their parents, such as family holiday meals (Russo, 2010). In sum, while little is known about older adults' adjustment to elderly parents' deaths, the literature generally concludes that effects are short-lived, although the early weeks and months are marked by profound sadness and identity shifts, which are particularly acute when a second parent dies and the surviving child(ren) must assume the identity as the most senior member of their family line (Rosenblatt, 2000).

Child Loss

The death of a child is generally considered the most distressing event a parent can withstand, as it betrays that assumption of a natural order

in which children outlive their parents (Hazzard et al., 1992). Extensive research explores the effects of parents' psychological and physical well-being, marital stability, and economic well-being following a child's death, with studies uniformly showing devastating effects that often linger for years (Klass, 1988). The bulk of this research is focused on the deaths of children under the age of 18 and shows that parental distress is particularly acute when the child's death was sudden due to causes such as SIDS, suicide, murder, or accidents (Institute of Medicine, 2003).

Far less research is focused on older adults' adjustment to the death of an adult child, although the general patterns that emerge are similar to those found earlier in the life course (Moss et al., 1986). However, the specific symptoms evidenced among surviving parents differ based on the expectedness and cause of their child's death, with sudden deaths such as murders and suicide eliciting symptoms of anger and shock, similar to PTSD. By contrast, deaths that occur following long chronic illnesses such as cancer are more often accompanied by anticipatory grief symptoms prior to the death (e.g., Shanfield, Benjamin, & Swain, 1984; Van Humbeeck et al., 2013). One way for older parents to adapt to the untimely death of an adult child is to maintain strong ties with their grandchild(ren) who were offspring of their now-deceased son or daughter and in doing so maintain their identity as a parent (Blank, 1998).

Surviving Spousal Bereavement: Risk and Protective Factors

Widowhood, or the loss of a spouse/romantic partner, is the most well-researched area of late-life family bereavement, reflecting the primacy of marriage in the lives of most older adults (Carr & Moorman, 2011). Older bereaved spouses vary widely in their social, emotional, and behavioral adjustment to loss. Some may have minor symptoms of depression and anxiety during the first six months following loss (Bonanno et al., 2002), whereas others may experience severe, debilitating, and persistent symptoms, including complicated and prolonged grief (Prigerson, Vanderwerker, & Maciejewski, 2008). Although myriad influences, including biological, psychological, social, and economic factors affect one's adjustment, I focus here on five sets of influences that recent studies have identified as particularly important: sociodemographic factors (age, cohort, gender, sexual orientation, and race) and four potentially modifiable factors: the nature of the late marital relationship, conditions surrounding the death, social support and integration, and other co-occurring losses and stressors.

Sociodemographic Influences on Partner Bereavement

The meaning, context, and personal consequences of spouse and partner bereavement vary based on one's social location, including one's age, birth cohort, gender, sexual orientation, and race/ethnicity. Although researchers have investigated extensively the ways that age and gender shape spousal bereavement, comparisons across other subgroups of older adults are rare. One reason for the limited research on race and sexual orientation differences in bereavement experiences reflect data availability. Most research on adjustment to late-life spousal loss focuses on mental and physical health symptoms during the first 12 to 18 months postloss, as symptoms typically fade after that time (e.g., Bonanno et al., 2002). However, given the relatively small number of recently bereaved persons in any cross-sectional study of bereavement, and the relatively low proportion of older adults identified as a sexual or racial minority, most data sets used to study spousal bereavement would not have adequate sample sizes to explore these particular points of intersectionality. For example, in 2010, only 9 and 7 percent of persons aged 65 or older identified as black or Latino, respectively (Federal Interagency Forum on Aging-Related Statistics, 2012), while only 2 percent identified as gay, lesbian, or bisexual (Gates & Newport, 2012).

Studying cohort differences also is challenging, as such studies would require not only multiple interviews with bereaved persons to track their adjustment over time but comparable interviews would need to be done at different points in historical time to capture the distinctive experiences of different birth cohorts. Taken together, research on subgroup differences in bereavement and grief underscore that spousal loss is not a monolithic experience and sheds light on the ways that social factors shape the quality of one's marriages and one's access to psychosocial, economic, and instrumental resources that may ease adjustment to loss.

Age. Spouse or partner bereavement has profoundly different meanings and consequences for older versus younger persons. Older adults have risk factors that render them particularly vulnerable to the emotional and physical health consequences of spousal loss, yet they also possess skills, experiences, social resources, and even cognitive capacities that enable them to adapt to loss. Older adults are more likely than younger persons to have experienced the deaths of significant other prior to spousal loss, and they may be better equipped to make sense of and cope with their most recent loss (Thompson et al., 1991). With older age, spousal loss may be at least somewhat expected. More than half of all women over age 65 in the United States are widowed (Federal Interagency Forum on Aging-Related Statistics, 2012); thus, older women may anticipate and

prepare for the deaths of their husbands as they observe their peers experiencing spousal loss (Silverman, 2004). They also may turn to their widowed peers for emotional support and advice after their loss. By contrast, deaths to younger adults are more likely to occur suddenly and under very distressing circumstances, such as murders or accidents. Given that predictable, anticipated life transitions are less stressful than unexpected ones (George, 1993), older bereaved spouses may experience a less difficult readjustment than their younger counterparts.

Research also suggests developmental reasons why older adults tend to have less acute symptoms of depression in the face of loss, relative to their younger counterparts. Compared with younger adults, older adults have reduced emotional reactivity, or a greater capacity to manage or regulate their emotional states (Carstensen & Turk-Charles, 1994). As a result, their grief reactions also are shorter lived and less intense, compared with younger bereaved persons (Nolen-Hoeksema & Ahrens, 2002). Emotional reactivity declines in late life due to a variety of factors: biological decreases in autonomic arousal, the greater habituation of older adults to emotional life events, adherence to cultural expectations that the elderly should not be too emotional, and shifts in the relative salience of emotion versus cognition in late life (Carstensen & Turk-Charles, 1994). Older adults also are believed to possess wisdom, which may help minimize loss-related distress; they may respond to adverse life events with equanimity and acceptance (Baltes, Smith, & Staudinger, 1992).

In late life, bereaved heterosexual adults also may be better prepared to manage the practical tasks that were once managed by their late spouse. The boundaries demarcating traditional men's roles and women's roles in marriage become blurred as husbands and wives age. Although older married couples abide by a gender-typed division of household labor, just as younger couples do, this division may change as older adults face health declines and limitations to daily functioning (Szinovacz, 2000). The onset of physical health problems may render older adults less able to perform the specialized homemaking or home maintenance tasks they performed earlier in the life course. For instance, if a wife's physical limitations prevent her from preparing meals or cleaning, her husband may take over those duties. Likewise, cognitive decline in a husband may result in a wife's increased involvement in estate planning and other financial decisions that previously were managed by the husband. Older adults may gradually take on their spouses' tasks even prior to widowhood, and thus they may be better prepared on the death of a spouse (Carr, 2004).

Yet older adults also have important vulnerabilities. They are more likely than younger persons to experience co-occurring stressors that may overwhelm their ability to cope, including cognitive and physical declines;

financial strains; the deaths of friends and loved ones; and the loss of other important social roles, such as employment (Norris & Murrell, 1990). As noted earlier, because late-life deaths typically occur after a long illness, bereaved spouses often experienced a stressful period of caregiving and may see their loved one suffer for long periods prior to the death (Carr et al., 2001). As a result, older adults may be overwhelmed not only by their spouse's death but also by the acute and chronic stressors that accompany the death.

Cohort. Very little is known about generational or cohort differences in older widow(er)s' experiences. However, the nature of death and dying has changed dramatically over the past two centuries and these shifts, accompanied by other sweeping social changes in gender roles and family relations, have created a context in which loss is experienced very differently today than in the past.

No studies in the United States have directly compared cohorts of widow(er)s and their adjustment to loss. However, one recent study compared the psychological and social adjustment of two cohorts of widowed older women in Switzerland, one born in the early 1900s and widowed during the 1970s or earlier, the other born in the 1930s–1940s and widowed in the 2000s (Perrig-Chiello et al., 2015). These two cohorts of women faced very different opportunities for education and employment and also varied widely in the gender relations maintained in their households. The cohorts also differed with respect to the public benefits they received, reflecting the expansion of Switzerland's public pension system and expanded survivor and old-age benefits over the 20th century. The study showed that the two cohorts of women did not differ with respect to their emotional reactions to loss; the sadness and loneliness they experienced was comparable for the two cohorts. However, when other aspects of adaptation were considered including perceived financial strain and availability of social support, the more recent cohort fared considerably better, suggesting that while sadness may be a near universal consequence of spousal loss, other financial and social costs can be ameliorated through social programs or expansion in the social roles afforded to women.

Gender. The well-documented effects of spouse or partner loss on mental health (including depressive symptoms, loneliness, and anxiety) and on physical health outcomes (including mortality risk, disability, and functional limitations) are consistently larger for men than women (Lee & DeMaris, 2007), although one recent study suggests that with the passage of time, long-term widowed men and women do not differ significantly with respect to depressive symptoms (Sasson & Umberson, 2013). While romantic lore suggests that emotionally devastated widowers may die of a broken heart shortly after their wives die, research shows the loss of a

helpmate and caretaker is a more plausible explanation for men's health declines following spousal loss. Wives monitor their husbands' diets, remind them to take daily medications, and urge them to give up vices like smoking and drinking (August & Sorkin, 2010). Widowers are more likely than married men to die of accidents, alcohol-related deaths, lung cancer, and chronic ischemic heart disease during the first six months after their loss, but not from causes less closely linked to health behaviors (Moon et al., 2011; Shor et al., 2012).

Widows, by contrast, often experience declines in their economic well-being, which may trigger anxiety and distress (Stroebe et al., 2006). Widows experience substantial declines in income from all sources, ranging from earned income to pensions to Social Security (Gillen & Kim, 2009). Within three years of the death of her husband, a widow's income drops by 44 percent on average (Holden & Kuo, 1996). More than half of older widows in poverty were not poor prior to the death of their husbands. Costs associated with burial, funeral, long-term and medical care, or estate-related legal proceedings can devastate the fixed income of older adults. Because current cohorts of older women typically tended to child-rearing and family responsibilities during their younger years, they have had fewer years of paid work experience and lower earnings than their male peers, on average. Older widows who try to reenter the labor force also may face age discrimination (Holden & Kuo, 1996), which in turn may compromise their emotional and financial well-being.

Sexual orientation. Relatively little is known about whether older gay men and lesbians adjust differently than heterosexual men and women to the loss of their long-term partners. However, mounting research suggests that older gay men and lesbians may face both distinctive challenges and advantages as they cope with loss. The stressors associated with loss may be particularly acute for gays and lesbians, who may also experience institutional and interpersonal discrimination due to their sexual orientation (Meyer, 2003). They may encounter conflict with their deceased partner's family, particularly with respect to the dispersion of personal possessions following death. Legal rights extended to heterosexual married couples have not typically been available for same-sex couples, including the opportunity to make health care and end-of-life decisions for ill partners. Bereaved same-sex partners may not receive sufficient emotional support upon loss because the end of their relationship is not recognized or acknowledged in the wider community (Green & Grant, 2008). The increasing legalization of marriage for same-sex individuals may gradually alleviate some of these stresses.

However, gay men and lesbians also have resources that may enable successful adjustment to partner loss. They have often created their own

support networks of friends and selected family members. They also may be more likely than their heterosexual peers to enact flexible gender roles throughout the life course. Because they are not bound to traditional gender-typed family roles, they may be better prepared to manage the daily challenges and responsibilities faced by the newly bereaved (Almack, Seymour, & Bellamy, 2010).

Race. Research on racial differences in late-life spousal bereavement is sparse. This omission reflects the fact that few sample surveys include adequate numbers of older blacks, given their elevated risk of premature death (Federal Interagency Forum on Aging-Related Statistics, 2012). Studies of recently widowed older blacks are even more difficult, given that blacks are less likely than whites to marry, to remain married over the life course, or to remarry following an early-life marital dissolution (Federal Interagency Forum on Aging-Related Statistics, 2012). As such, we know very little about similarities and differences in how blacks and whites adjust to widow(er)hood. One prospective study of late-life spousal loss found that blacks and whites did not differ significantly with respect to depressive symptoms or yearning for their late spouse, although blacks had significantly fewer symptoms of anger and despair (Carr, 2004a). Blacks' lower levels of anger were largely explained by two important coping resources: their higher levels of religiosity and their greater reliance on their children for social and instrumental support relative to whites. By contrast, blacks' lower levels of despair were explained, in part, by the fact that they reported higher levels of preloss marital conflict than did whites. These findings are consistent with emerging evidence that bereavement experiences are most painful when the relationship lost was marked by closeness and warmth, rather than strain and conflict.

Nature of the Marriage or Romantic Relationship

Older adults' psychological adjustment to partner death varies based on the nature of the relationship lost. Early writings, based on the psychoanalytic tradition, proposed that bereaved persons with the most troubled marriages would suffer heightened and pathological grief (Parkes & Weiss, 1983). This perspective held that persons who had conflicted marriages would find it hard to let go of their spouses, yet also feel angry at the deceased for abandoning them. However, longitudinal studies that track married persons over time through the widowhood transition find that older persons whose marriages were marked by high levels of warmth and dependence and low levels of conflict experience elevated grief symptoms within the first six months postloss (Carr et al., 2000).

Although those with high-quality marriages may suffer a greater sense of sadness within the earlier months of loss, their strong emotional ties to

the late spouse may prove protective in the longer term. Recent research suggests that those in high-quality marriages may be able to draw strength from continuing bonds with the decedent. Early work on grief suggested that bereaved persons needed to dissolve or relinquish their emotional ties to the deceased and get on with their lives (e.g., Freud 1917/1957), yet current research suggests that maintaining a psychological tie to the deceased is an integral part of adaptation (Field, 2008). Although some aspects of continuing bonds may be problematic for adjustment, researchers point to particular scenarios for which maintaining emotional ties to one's late spouse may be helpful. For instance, Rando (1993) observed that bereaved persons may think about what their late spouse might do, when faced with a difficult decision. Others may keep alive their spouse's legacy by recognizing the continuing positive influence the deceased has on one's current life. In this way, the warmth and closeness of the relationship may continue to be protective and affirming to the bereaved spouse.

Nature of the Death

Researchers have documented that adjustment to spouse or partner loss is affected by the timing and nature of the late spouse's death. As noted earlier, anticipated deaths tend to be less distressing than unanticipated ones. The knowledge that one's partner is going to die in the imminent future provides the couple with the time to address unresolved emotional, financial, and practical issues before the actual death. This preparation for death is believed to enable a smoother transition to widowhood. However, for older persons, anticipated deaths often are accompanied by long-term illness, painful images of a loved one's suffering, intensive caregiving, and neglect of one's own health concerns, thus taking a toll on one's health and emotional well-being (Carr et al., 2001).

Contrary to popular lore, there is no clear-cut evidence that caregivers show greater symptoms of distress than those who did not provide direct care to their late spouse. Emerging research shows that caregivers may even experience improved psychological health following the loss of their spouse, either because they are relieved of their stressful caregiving duties, they are no longer witnessing their loved one suffer, or they experience a sense of satisfaction, meaning, and accomplishment from caring for their loved one in his or her final days (Schulz, Boerner, & Herbert, 2008). However, family caregivers—who currently number more than 50 million in the United States alone—may require assistance prior to the death of their spouse (Caregiver Alliance, 2010). The threat of impending death, strain of caregiving work, and the loss of personal time and activities may be distressing in the days and weeks leading up to the death.

The quality of end-of-life care received by the decedent and place of death also affect the bereavement experience. Older adults who believe that their loved one was in pain or received problematic medical care at the end of life report greater anxiety and anger postloss than persons whose loved one had a good death (Carr, 2003). Use of hospice or palliative care services at the end of life is associated with better spousal bereavement outcomes (Christakis & Iwashyna, 1993), including fewer symptoms of depression (Ornstein et al., 2015). Site of care also matters. Teno and colleagues (2004) found that family members of recent decedents who received at-home hospice services were more likely than those who died at hospitals or nursing homes to say that their loved one received high-quality care, that they were treated with respect and dignity at the end of life, and that they and the patient received adequate emotional support. Ironically, however, more than three-quarters of Americans currently die in institutions (Federal Interagency Forum on Aging-Related Statistics, 2012); this carries implications for survivors' well-being.

Social Support and Integration

Emotionally intimate social relationships over the life course are an important resource as older adults adjust to spousal loss. One widely cited explanation for women's lower levels of distress following spousal loss relative to men's is that women maintain closer relationships over the life course than their male counterparts (Carr & Moorman, 2011). Older widows typically receive more practical and emotional support from their children than do widowers, given mothers' closer relationships with their children throughout the life course. Women also are more likely to have larger and more varied friendship networks than men, and these friendships are an important source of support as women cope with their loss (Ha, 2008). Men, by contrast, often seek social support in new romantic relationships, whether dating or remarriage (Carr, 2004b). Many researchers concur that one reason why women typically adjust better psychologically to loss than men is because they have closer social ties with their children, friends, and siblings.

For both widows and widowers, however, social isolation and limited contact can impede adjustment to loss. Social isolation often is due to structural factors. Older adults living independently may lack transportation, they may have physical limitations that impair their mobility, and they may be cut off physically from loved ones following a relocation to a new home or an assisted living facility. Even those who live close to their family may feel lonely because of family conflict, or because their family does not offer support of the type or amount that the widow(er) would like (Cacioppo & Cacioppo, 2014). The deaths of siblings and friends also

may leave older bereaved spouses feeling isolated, as they have no one with whom to reminisce or share their private thoughts and feelings.

Other Stressors

Stress researchers agree that the psychological consequences of any one stressor may be amplified when experienced in conjunction with other losses or strains. For older bereaved persons, the death of a spouse is almost always accompanied by other strains and losses which may compromise their well-being, including financial strain, the loss of work and community roles including retirement and relocation, compromised mobility whether by walking or driving, health declines, decline or loss of sensory functions including vision and hearing, and even the loss of daily routines that gave one's life order and meaning. Widowhood often sets off a chain of secondary stressors, or stressors that result from the loss of a spouse; these secondary stressors in turn may compromise one's emotional and physical well-being. For widowers, the loss of a confidante, helpmate, and caregiver may be particularly harmful, whereas for widows, financial difficulties often are a source of distress (Stroebe et al., 2006).

Discussion and Future Research

This chapter has summarized the context of family bereavement in the contemporary United States, the general patterns of grief that emerge in the face of loss, and the distinctive challenges associated with spouse/partner, sibling, parent, and child loss in late life. However, our knowledge about family bereavement in late life is still in the nascent stages, especially with respect to sibling, parent, and child death, and with respect to race and sexual orientation differences in adjustment to spouse/partner loss. Moreover, much of what we know about bereaved spouses is based on current cohorts of older adults, who were born mainly in the early 20th century, married at midcentury, and experienced old age in the late 20th and early 21st centuries (e.g., Carr, Wortman, & Nesse, 2006). As such, extant research may not necessarily characterize the experiences of future cohorts of bereaved adults, especially the 75 million baby boomers born between 1946 and 1964 (Pruchno, 2012). The baby boomers are much more ethnically and racially diverse than prior cohorts, are more likely to have identified as gay or lesbian in early adulthood, and are more likely to have abided by egalitarian gender roles in the home than their predecessors. As such, in the future, researchers will be charged with exploring more fully the ways that race, ethnicity, and sexual orientation shape the experiences of older bereaved persons.

Demographic shifts over the past half-century have had profound effects on family structure, roles, and relationships, each of which may shape the experiences of spouse, child, sibling, or parent loss in late life (Manning & Brown, 2011). For example, declining fertility rates and increases in geographic mobility mean that future cohorts of older persons will have fewer children on whom they can rely for social support, and these children will be less likely than past generations to live close to their parents. For parents with only one child, the loss of that child may be particularly devastating emotionally, as it deprives one wholly of one's identity as parent (Klass, 1988) and may deprive parents of the one child who was a source of late-life emotional, instrumental, or financial support. Parental death may also be particularly difficult for adult children with no siblings, as they lack an important source of support and assistance.

Divorce and remarriage also may reshape the nature of family bereavement (Manning & Brown, 2011). Current and future cohorts of married couples are more likely than past generations to dissolve dissatisfying marriages through divorce; consequently, persons who remain married until late life may have higher levels of marital closeness and may suffer elevated grief following the loss of these close relationships (Carr et al., 2001). Likewise, older adults who have divorced and then remarry in late life may find spousal death to be particularly distressing, as they are being robbed of relatively new marriages and the promise of a future with their spouse. Emerging research shows, for example, that older women in second marriages report higher levels of marital happiness than their counterparts in long-term first marriages (Freedman, Cornman, & Carr, 2015). Remarriage also may be accompanied by the formation of reconfigured families which include step-children. Although stepchildren may be a source of support as older adults manage the loss of their spouses, emerging evidence suggests that stepchildren and parents often have conflicted interactions at the end of life, especially regarding caregiving responsibilities and the dispersion of the decedent's assets (Sherman, 2012; Sherman & Bauer, 2008).

Shifting gender roles also may reshape the bereavement experience of older heterosexual spouses. Current generations of young adult women have higher levels of education, more years of work experience, and more egalitarian divisions of labor in their families than do past cohorts. Thus, they may be less dependent on their husbands for income, home repair, and financial management tasks, whereas husbands may be less dependent on their wives for homemaking chores and emotional support (Spain & Bianchi, 1996). Under this scenario, future cohorts of widowed persons may experience much lower levels of anxiety than previous cohorts, as they have a greater comfort level in performing a range of household tasks.

Cultural contexts also may continue to powerfully shape experiences of loss and grief. The research described in this chapter has focused primarily on the United States or other Western, individualistic nations similar to the United States. Researchers should further explore how adjustment to familial loss may reflect a broader array of cultural contexts. Cultural factors, including patterns of household structure and filial piety, and attitudes toward life and death, may condition the experiences of older bereaved spouses, siblings, parents, and children. As practitioners develop policies and interventions for older bereaved persons, they must take into consideration the larger cultural, social, historical, and demographic backdrop against which family loss occurs.

Future research also should explore more fully the medical and technological contexts in which late-life death occurs. In particular, technological and medical advancements that extend the lifespan may create the need for more intensive family caregiving, a task that typically falls to wives, daughters, and mothers. Those who perform complex illness-related tasks at home in addition to personal care such as feeding, bathing, and toileting, may experience a crisis in caregiving that requires assistance or relocation of the patient outside the home (Waldrop & Meeker, 2011). Managing ventilators and feeding tubes, tending to pressure sores, and administering medications are also linked to elevated symptoms of distress among family caregivers (Moorman & Macdonald, 2013). If women continue to bear the burden for personal care of ailing family members, then cohorts of women entering old age in the future may find their own emotional and physical well-being compromised. Further exploration of the way that social, cultural, and technological forces shape the bereavement experience will provide knowledge of theoretical and practical importance for future generations of bereaved older adults.

References

- Almack, K., Seymour, J., & Bellamy, G. (2010). Exploring the impact of sexual orientation on experiences and concerns about end of life care and on bereavement for lesbian, gay, and bisexual older people. *Sociology*, 44(5), 908–924.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders, (DSM-IV)*. Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, (DSM-5)*. Washington, DC: American Psychiatric Association.
- Archer, J. (1999). *The nature of grief: The evolution and psychology of reactions to loss*. London: Routledge.
- Arias E. (2014). *United States life tables, 2009. National vital statistics reports, 62(7)*. Hyattsville, MD: National Center for Health Statistics.

- August, K.J., & Sorkin, D.H. (2010). Marital status and gender differences in managing a chronic illness: The function of health-related social control. *Social Science and Medicine*, 71(10), 1831–1838.
- Baltes, P., Smith, J., & Staudinger, U. (1992). Wisdom and successful aging. In T. Sonderegger (Ed.), *Nebraska Symposium on Motivation* (Vol. 39, Psychology and aging, pp. 103–121). Lincoln: University of Nebraska Press.
- Bennett, K. M., Hughes, G. M., & Smith, P. T. (2003). “I think a woman can take it”: Widowed men’s views and experiences of gender differences in bereavement. *Ageing International*, 28(4), 408–424.
- Blank, J. W. (1998). *The death of an adult child: A book for and about bereaved parents*. New York: Baywood Publishing.
- Boelen, P.A., & Prigerson, H. G. (2013). Prolonged grief disorder as a new diagnostic category in DSM-5. In M. Stroebe, H. Schut, and J. van den Bout (Eds.), *Complicated grief: Scientific foundations for health care professionals*. New York: Routledge.
- Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., Carr, D., & Nesse, R. M. (2002). Resilience to loss and chronic grief: A prospective study from preloss to 18-months postloss. *Journal of Personality and Social Psychology*, 83, 1150–1164.
- Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. *Social and personality psychology compass*, 8(2), 58–72.
- Caregiver Alliance. (2010). *Fact Sheet on Statistics*. Retrieved May 26, 2015 from <http://www.caregiver.org/caregiver/jsp/content>.
- Carr, D. (2003). A good death for whom? Quality of spouse’s death and psychological distress among older widowed persons. *Journal of Health & Social Behavior*, 44, 215–232.
- Carr, D. (2004a). Black/White differences in psychological adjustment to spousal loss among older adults. *Research on Aging*, 26(6), 591–622.
- Carr, D. (2004b). The desire to date and remarry among older widows and widowers. *Journal of Marriage and Family*, 66(4), 1051–1068.
- Carr, D. (2004c). Gender, pre-loss marital dependence and older adults’ adjustment to widowhood. *Journal of Marriage and Family*, 66, 220–235.
- Carr, D. (2012). Death and dying in the contemporary United States: What are the psychological implications of anticipated death? *Social and Personality Psychology Compass*, 6(2), 184–195.
- Carr, D., House, J. S., Kessler, R. C., Nesse, R., Sonnega, J., & Wortman, C. B. (2000). Marital quality and psychological adjustment to widowhood among older adults: A longitudinal analysis. *The Journals of Gerontology, Series B: Social Sciences*, 55, S197–S207.
- Carr, D., House, J. S., Wortman, C. B., Nesse, R., & Kessler, R. C. (2001). Psychological adjustment to sudden and anticipated spousal death among the older widowed. *The Journals of Gerontology, Series B: Social Sciences*, 56B, S237–S248.
- Carr, D., & Khodyakov, D. (2007). Health care proxies in late life: Whom do we choose and why? *Journal of Health and Social Behavior*, 48, 180–194.

- Carr, D., & Moorman, S. M. (2011). Social relations and aging. In R. A. Settersten Jr., & J. L. Angel (Eds.), *Handbook of sociology of aging* (pp. 145–160). New York: Springer.
- Carr, D., Nesse, R. M., & Wortman, C. B. (Eds.). (2006). *Spousal bereavement in late life*. New York: Springer Publishing Company.
- Carstensen, L., & Turk-Charles, S. (1994). The salience of emotion across the adult life span. *Psychology and Aging, 9*, 259–264.
- Chan, D., Livingston, G., Jones, L., & Sampson, E. L. (2013). Grief reactions in dementia carers: A systematic review. *International Journal of Geriatric Psychiatry, 28*(1), 1–17.
- Christakis, N. A., & Iwashyna, T. J. (2003). The health impact on families of health care: A matched cohort study of hospice use by decedents and mortality outcomes in surviving, widowed spouses. *Social Science and Medicine, 57*, 465–475.
- Cicirelli, V. G. (2009). Sibling death and death fear in relation to depressive symptomatology in older adults. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 64*(1), 24–32.
- DeVita-Raeburn, E. (2004). *The empty room: Surviving the loss of a brother or sister at any age*. New York: Simon and Schuster.
- Federal Interagency Forum on Aging-Related Statistics. (2013). *Older Americans 2012: Key indicators of well-being*. Washington, DC: Department of Health and Human Services.
- Field, N. P. (2008). Whether to relinquish or maintain a bond with the deceased. In M. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: 21st century perspectives* (pp. 133–162). Washington, DC: American Psychological Association (APA) Press.
- Fontana, A., & Keene, J. R. (2009). *Death and dying in America*. Malden, MA: Polity.
- Freedman, V., Cornman, J. C., & Carr, D. (2015). *Second time around: Second marriages, wellbeing and time use in late life*. Unpublished manuscript.
- Freud, S. (1917/1957). Mourning and melancholia. In J. Strachey (Ed. and Trans.), *The standardized edition of the complete psychological works of Sigmund Freud* (pp. 152–170). London: Hogarth Press (Original work published 1917).
- Gates, G. J., & Newport, F. (2012). *Special report: 3.4% of U.S. adults identify as LGBT*. Princeton, NJ: Gallup Poll. Retrieved May 30, 2015 from <http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx>.
- George, L. K. (1993). Sociological perspectives on life transitions. *Annual Review of Sociology, 19*, 353–373.
- Gillen, M., & Kim, H. (2009). Older women and poverty transition: Consequences of income source changes from widowhood. *Journal of Applied Gerontology, 28*(3), 320–341.
- Green, L., & Grant, V. (2008). “Gagged grief and beleaguered bereavements?” An analysis of multidisciplinary theory and research relating to same sex partnership bereavement. *Sexualities, 11*(3), 275–300.
- Ha, J. (2008). Changes in support from confidantes, children, and friends following widowhood. *Journal of Marriage and Family, 70*, 306–318.

- Hays, J. C., Gold, D. T., & Pieper, C. F. (1997). Sibling bereavement in late life. *OMEGA: Journal of Death and Dying*, 35(1), 25–42.
- Hazzard, A., Weston, J., & Gutierrez, C. (1992). After a child's death: Factors related to parental bereavement. *Journal of Developmental & Behavioral Pediatrics*, 13(1), 24–30.
- HHS/ASPE (Department of Health and Human Services, Assistant Secretary for Planning and Evaluation). (2013). *National plan to address Alzheimer's disease—2013 update*. Retrieved May 30, 2015 from <http://aspe.hhs.gov/daltcp/napa/NatlPlan2013.shtml#intro>.
- Holden, K. C., & Kuo, H. H. D. (1996). Complex marital histories and economic well-being: The continuing legacy of divorce and widowhood as the HRS cohort approaches retirement. *Gerontologist*, 36(3), 383–390.
- Horowitz, M. J., Weiss, D. S., Kaltreider, N., Krupnick, J., Marmar, C., Wilner, N., & DeWitt, K. (1984). Reactions to the death of a parent: Results from patients and field subjects. *Journal of Nervous and Mental Disease*, 172, 383–392.
- Institute of Medicine (IOM). (2003). *When children die: Improving palliative and end-of-life care for children and their families*. Washington, DC: National Academies Press.
- Institute of Medicine (IOM). (2014). *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies.
- Johansson, Å. K., & Grimby, A. (2012). Anticipatory grief among close relatives of patients at hospice and palliative wards. *American Journal of Hospice and Palliative Medicine*, 29, 134–138.
- Klass, D. (1988). *Parental grief: Solace and resolution*. New York: Springer.
- Lee, G. R., & DeMaris, A. (2007). Widowhood, gender, and depression: A longitudinal analysis. *Research on Aging*, 29, 56–72.
- Lofquist, D. (2011). *Same sex couple households: American Community Survey briefs*. Washington, DC: U.S. Census Bureau. Retrieved June 10, 2013, from <http://www.census.gov/prod/2011pubs/acsbr10-03.pdf>
- Mahon, M. M. (1997). Sibling bereavement: A concept analysis. *Death Studies*, 21(5), 477–499.
- Manning, W. D., & Brown, S. L. (2011). The demography of unions among older Americans, 1980–present: A family change approach. In R. A. Settersten Jr. & J. L. Angel (Eds.), *Handbook of sociology of aging* (pp. 193–210). New York: Springer.
- Marshall, H. (2004). Midlife loss of parents: The transition from adult child to orphan. *Ageing International*, 29(4), 351–367.
- Meuser, T. M., & Marwit, S. J. (2001). A comprehensive, stage-sensitive model of grief in dementia caregiving. *The Gerontologist*, 41(5), 658–670.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697.
- Miniño, A. M., & Murphy, S. L. *Death in the United States, 2010*. NCHS data brief, no. 99. Hyattsville, MD: National Center for Health Statistics. 2012.

- Moon, J. R., Kondo, N., Glymour, M. M., & Subramanian, S. V. (2011). Widowhood and mortality: A meta-analysis. *PLoS ONE* 6(8), e23465. doi:10.1371/journal.pone.0023465
- Moorman, S. M., & Macdonald, C. (2013). Medically complex home care and caregiver strain. *The Gerontologist*, 53(3), 407–417.
- Moss, M. S., Leshner, E. L., & Moss, S. Z. (1986). Impact of the death of an adult child on elderly parents: Some observations. *OMEGA: Journal of Death and Dying*, 17(3), 209–218.
- Moss, M. S., & Moss, S. Z. (1983–1984). The impact of parental death on middle aged children. *OMEGA: Journal of Death and Dying*, 14(1), 65–75.
- Moss, S. Z., & Moss, M. S. (1989). The impact of the death of an elderly sibling: Some considerations of a normative loss. *American Behavioral Scientist*, 33(1), 94–106.
- Nolen-Hoeksema, S., & Ahrens, C. (2002). Age differences and similarities in the correlates of depressive symptoms. *Psychology and Aging*, 17, 116–124.
- Norris, F. H., & Murrell, S. A. (1990). Social support, life events, and stress as modifiers to bereavement by older adults. *Psychology of Aging*, 5, 429–436.
- Olshansky, S. J., & Ault, A. B. (1986). The fourth stage of the epidemiologic transition: The age of delayed degenerative diseases. *Milbank Quarterly*, 64, 355–391.
- Omran, A. (1971). The epidemiologic transition: A theory of the epidemiology of population change. *Milbank Quarterly*, 29, 509–538.
- Ornstein, K. A., Aldridge, M. D., Garrido, M. M., Gorges, R., Meier, D. E., & Kelley, A. S. (2015). Association between hospice use and depressive symptoms in surviving spouses. *JAMA Internal Medicine*. Online First.
- Parkes, C. M., & Weiss, R. S. (1983). *Recovery from bereavement*. New York, NY: Basic.
- Pattison, E. M. (1977). The living–dying process. In C. A. Garfield (Ed.), *Psychosocial care of the dying patient* (pp. 133–168). New York, NY: McGraw-Hill.
- Perrig-Chiello, P., Spahni, S., Höpflinger, F., & Carr, D. (2015). Cohort and gender differences in psychosocial adjustment to late-life widowhood. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, gbv004. Online First.
- Pratt, C. C., Walker, A. J., & Wood, B. L. (1992). Bereavement among former caregivers to elderly mothers. *Family Relations*, 41, 278–283.
- Prigerson, H. G., Vanderwerker, L. C., & Maciejewski, P. K. (2008). A case for inclusion of prolonged grief disorder in DSM-V. In M. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: 21st century perspectives* (pp. 165–186). Washington, DC: American Psychological Association (APA) Press.
- Pruchno, R. (2012). Not your mother's old age: Baby Boomers at age 65. *The Gerontologist*, 52(2), 149–152.
- Rando, T. A. (1986). *Loss and anticipatory grief*. New York: Lexington Books.
- Rando, T. A. (1993). *Treatment of complicated mourning*. Champaign, IL: Research Press.
- Robben, A. C. (Ed.). (2009). *Death, mourning, and burial: A cross-cultural reader*. New York: John Wiley & Sons.

- Rosenblatt, P.C. (2000). *Parent grief: Narratives of loss and relationship*. Philadelphia, PA: Taylor & Francis.
- Russo, F. (2010). *They're your parents, too!: How siblings can survive their parents' aging without driving each other crazy*. New York: Bantam.
- Sasson, I., & Umberson, D.J. (2014). Widowhood and depression: New light on gender differences, selection, and psychological adjustment. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 69(1), 135–145.
- Scharlach, A.E., & Fredriksen, K.I. (1993). Reactions to the death of a parent during midlife. *OMEGA*, 27, 307–319.
- Schulz, R., Boerner, K., & Hebert, R.S. (2008). Caregiving and bereavement. In M. Stroebe, R.O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: 21st century perspectives* (pp. 265–286). Washington, DC: American Psychological Association (APA) Press.
- Shanfield, S.B., Benjamin, A.H., & Swain, B.J. (1984). Parents' reactions to the death of an adult child from cancer. *The American Journal of Psychiatry*, 141(9), 1092–1094.
- Shear, M.K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., . . . & Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, 28(2), 103–117.
- Sherman, C.W. (2012). Remarriage as context for dementia caregiving: Implications of positive support and negative interactions for caregiver well-being. *Research in Human Development*, 9(2), 165–182.
- Sherman, C.W., & Bauer, J.W. (2008). Financial conflicts facing late-life remarried Alzheimer's disease caregivers. *Family Relations*, 57(4), 492–503.
- Shor, E., Roelfs, D.J., Curreli, M., Clemow, L., Burg, M.M., & Schwartz, J. (2012). Widowhood and mortality: A meta-analysis and meta-regression. *Demography*, 49, 575–606.
- Silverman, P.R. (2004). *Widow to widow: How the bereaved help one another*. New York: Routledge.
- Spain, D., & Bianchi, S.M. (1996). *Balancing act: Motherhood, marriage and employment among American women*. New York: Russell Sage Foundation.
- Stroebe, M.S., Folkman, S., Hansson, R.O., & Schut, H. (2006). The prediction of bereavement outcome: Development of an integrative risk factor framework. *Social Science and Medicine*, 63(9), 2440–2451.
- Szinovacz, M.E. (2000). Changes in housework after retirement: A panel study. *Journal of Marriage and Family*, 62, 78–92.
- Teno, J.M., Clarridge, B.R., Casey, V., Welch, L.C., Wetle, T., Shield, R., & Mor, V. (2004). Family perspectives on end-of-life care at the last place of care. *Journal of the American Medical Association*, 291, 88–93.
- Thompson, L.W., Gallagher-Thompson, D., Futterman, A., Gilewski, M.J., & Peterson, J. (1991). The effects of late life spousal bereavement over a 30-month interval. *Psychology and Aging*, 3, 434–441.
- Umberson, D. (2003). *Death of a parent: Transition to a new adult identity*. New York: Cambridge University Press.
- Umberson, D., & Chen, M.D. (1994). Effects of a parent's death on adult children: Relationship salience and reaction to loss. *American Sociological Review*, 59, 152–168.

- Van Humbeeck, L., Piers, R. D., Van Camp, S., Dillen, L., Verhaeghe, S. T., & Van Den Noortgate, N. J. (2013). Aged parents' experiences during a critical illness trajectory and after the death of an adult child: A review of the literature. *Palliative Medicine*, 26, 583–595.
- Wakefield, J. C., & First, M. B. (2012). Validity of the bereavement exclusion to major depression: Does the empirical evidence support the proposal to eliminate the exclusion in DSM-5? *World Psychiatry*, 11(1), 3–10.
- Waldrop, D., & Meeker, M. (2011). Crisis in caregiving: When home-based end-of-life care is no longer possible. *Journal of Palliative Care*, 27(2), 117–125.
- Weiss, R. S. (2008). The nature and causes of grief. In M. S., Stroebe, R. O. Hansson, H. E. Schut, W. E. Stroebe, & E. I. Van den Blin (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 29–44). Washington, DC: American Psychological Association.
- White, L. (2001). Sibling relationships over the life course: A panel analysis. *Journal of Marriage and Family*, 63(2), 555–568.
- Wolff, J. L., & Kasper, J. D. (2006). Caregivers of frail elders: Updating a national profile. *The Gerontologist*, 46(3), 344–356.