

Black/White Differences in Psychological Adjustment to Spousal Loss Among Older Adults

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This study examines differences between Blacks and Whites in the effect of widowhood on depressive symptoms and anxiety; in grief symptoms six months after spousal loss; and the extent to which these differences are explained by marital quality, social support from children and friends, and religiosity. Analyses are based on the Changing Lives of Older Couples, a prospective study of 1,532 married individuals aged 65 and older. Widowhood is associated with elevated anxiety and depressive symptoms, yet these effects do not differ by race. Among widowed persons only, Blacks and Whites report similar levels of overall grief, yearning, intrusive thoughts, shock, depressive symptoms, and anxiety, whereas Blacks report significantly lower levels of anger and despair. The racial gap in anger is explained by Blacks' higher levels of religious participation and social support from children, whereas the difference in despair reflects Blacks' higher levels of preloss marital conflict.

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Widowhood is considered one of the most distressing life events (Holmes and Rahe 1967). The psychological consequences of late-life widowhood have been documented extensively (see Carr and

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Utz 2002 for review), yet explorations of racial differences are nearly absent from the literature. This omission reflects the fact that few sample surveys include adequate numbers of older Blacks, given their elevated risk of premature death (Gibson 1994; Kitson 2000). Studies of recently widowed older Blacks are even more difficult, given that Blacks are less likely than Whites to marry and to remain married over the life course (Lugaila 1998). Several small qualitative studies have described the experiences of Black and White widows (e.g., Lopata 1973), yet few studies have explored systematically racial differences in older adults' psychological adjustment to spousal loss. Understanding the distinctive sources of psychological distress and adjustment among Black elders will become increasingly important in the coming decades, as Blacks comprise an increasingly large proportion of the older population. Although Blacks currently account for 8% of the population over age 65, this proportion will increase to 12% by 2050 (U.S. Bureau of the Census 2002).

This study examines (1) whether spousal loss affects depressive symptoms and anxiety differently for Black and White older adults; (2) whether recently widowed Blacks and Whites experience different grief symptomatology; and (3) the extent to which Black-White differences in grief symptoms are explained by four theoretically informed pathways: marital quality, social support from children, social support from friends and distant relatives, and religiosity. Analyses are based on data from the Changing Lives of Older Couples (CLOC), a prospective study of widowhood among American men and women ages 65 and older.

Theoretical Background

Despite widespread belief that widowhood is among the most stressful life events (Holmes and Rahe 1967), most studies find that only 15% to 30% of older adults experience clinically significant depression in the year following their spouse's death (Jacobs et al. 1989; Lund et al. 1985-1986; Zisook and Shuchter 1991). Less severe psychological reactions are common, however. Depending on the sample and assessment procedures used, an estimated 40% to 70% of the recently bereaved experience a period of two or more weeks

marked by sadness shortly after the loss (Bruce et al. 1990; Zisook et al. 1997).

At first glance, these statistics suggest that depression and distress are typical reactions to loss, but upon further inspection, they reveal the remarkable psychological resilience of the widowed; at least 70% to 80% experience the widowhood transition without clinical depression, and roughly half survive spousal loss without a two-week period of sadness or despair. Given that clinical depression is the exception, rather than the norm, in the face of spousal bereavement, researchers face the challenges of identifying the specific psychological symptoms experienced by the newly bereaved as well as the personal and social resources that protect against decrements in psychological well-being among older bereaved spouses. Recent studies have documented that patterns of psychological adjustment to loss vary widely based on characteristics of the survivor (Matthews 1991; Stroebe and Stroebe 1983; Umberson, Wortman, and Kessler 1992), the deceased spouse (Parkes 1985), the marital relationship (Carr et al. 2000), and the widowed person's social relationships (Utz et al. 2002). However, few studies have explored whether Blacks and Whites evidence different psychological reactions to loss or the ways that racial differences in social and psychological resources may affect the bereavement process. Past research on racial differences in marital relationships, social support, and religious coping provides a theoretical foundation for understanding Black-White differences in psychological reactions to spousal loss.

MARITAL QUALITY AND ADJUSTMENT TO LOSS

How older adults experience widowhood is linked closely to how they experienced their late marriages. When a spouse dies, the survivor must adjust not only to the loss of an enduring emotional relationship but must also manage the daily decisions and household responsibilities that were once shared by both spouses (Umberson et al. 1992; Utz et al. 2004). A large literature shows that Blacks and Whites experience marriage differently and thus may adjust to spousal loss in different ways.

First, Black married couples are more likely than their White peers to both endorse and maintain an equitable division of labor within the

home. Studies consistently show that Black husbands perform more hours of housework than their White peers and that Black couples are less likely to adhere to a rigid gender-typed division of household labor (Beckett and Smith 1981; Dillaway and Broman 2001; Kane 1992; Orbuch and Custer 1995; Orbuch and Eyster 1997; Sutherland, Went, and Douvan 1990; Taylor et al. 1991).

The more egalitarian division of household labor among Black married couples has been attributed to long-standing patterns of economic inequality experienced by Black men. Due to discrimination in the labor market and educational system, Black men's educational attainment, earnings, and job stability lag behind White men's, and Black wives historically have worked for pay outside of the home to contribute to the family's economic well-being (Hacker 1995; Oliver and Shapiro 1995; Wilson and Neckerman 1986). The division of household labor tends to be more balanced when wives work outside the home for pay, although employed wives still consistently do more housework than their husbands (Shelton and John 1996).

Black men's economic marginality has further implications for negotiations about housework: Black wives may expect (and receive) assistance in housework because their husbands' economic contributions to the household may be unstable, whereas white husbands may "buy out" of housework with financial contributions to the household (Orbuch and Eyster 1997). Thus, it is possible that widowhood may be a less distressing event for Blacks than for Whites; Black spouses may be less dependent on one another for the exclusive performance of important gender-typed household tasks and thus are better prepared to manage both household maintenance and homemaking responsibilities following loss.

Emotional aspects of marriage also differ for Black and White spouses. Blacks consistently report lower levels of marital quality and satisfaction and higher levels of marital conflict than do Whites (e.g., Acitelli, Douvan, and Veroff 1997; Adelman, Chadwick, and Baerger 1996; Broman 1993; Goodwin 2003). This gap has been found to persist over the life course (e.g., Adelman et al. 1996; Glenn 1989) and net of economic resources and strain (e.g., Broman 1993; Oggins, Veroff, and Leber 1993). These patterns have been attributed to Blacks' disadvantage in terms of important resources that promote marital quality, such as good physical health (e.g., Booth and Johnson

1994), financial stability (White and Rogers 2000), and trust in a partner's fidelity (Cazenave and Smith 1990; Lopata 1973).

Racial differences in marital quality may have important implications for how Blacks and Whites adjust to spousal loss. Early psychoanalytic theories of grief proposed that the loss of a conflicted or ambivalent marital relationship would be associated with prolonged or "pathological" grief (Abraham [1924] 1927; Freud [1917] 1959). Survivors who had strained relationships with their spouses are believed to have both anger toward and a strong attachment to the deceased. These conflicting feelings make it difficult for survivors to let go of their loved ones, yet they are also angry at the deceased for abandoning them (Freud [1917] 1959). Recent empirical evaluations provide support for an alternative pattern, however; persons with conflicted relationships report the fewest grief symptoms after their spouse's death, whereas those who had the closest marriages experience the most profound grief upon loss (Carr et al. 2000). These findings suggest that Blacks may experience fewer grief symptoms than Whites following spousal loss. Given their higher levels of marital conflict and lower levels of marital satisfaction than Whites, the loss of a partner may require less profound psychological adjustments.

SOCIAL AND RELIGIOUS SUPPORT

Psychological adjustment to spousal loss also may be affected by the broader network of social ties maintained by older adults; support from extended family, friends, and participation in formal religious activities may be particularly important for older Black bereaved spouses. Some scholars have argued that because Black marriages were not recognized as legal unions in the United States until after emancipation, Blacks historically have found social support beyond the boundaries of the nuclear family or marital dyad and have turned to extended kinship networks and the church (Genovese 1974; Taylor, Jackson, and Chatters 1997). Recent studies document that Blacks are less likely to depend on and interact with members of the nuclear family only and instead maintain a more diffuse social network that may include friends, distant relatives, neighbors, and members of their church congregation (Ajrouch, Antonucci and Janevic 2001; Chatters, Taylor, and Neighbors 1989; Stack and Burton 1993; Taylor

and Chatters 1986). Blacks also have more frequent contact with members of their social networks (Ajrouch et al. 2001) and more frequent face-to-face contact with both relatives (Cantor, Brennan, and Sainz 1994) and nonrelatives, including church members (Kim and McKenry 1998). Given that social support is one of the most important resources for coping with stressful life events (Thoits 1995), Blacks' more frequent social contacts and more diverse social networks may provide an important source of instrumental and expressive support as they adjust to spousal loss. In this analysis, I examine whether race differences in psychological adjustment to loss are explained, in part, by patterns of reliance on two important sources of nonmarital social support: (1) support from children and (2) support from friends and distant family.

Blacks also are more likely than Whites to participate in formal religious activities and to rely on their religious beliefs as a strategy for coping with stressful events (Levin, Taylor, and Chatters 1994; Mattis and Jagers 2001). The beneficial effects of religion—particularly for older adults—have been widely documented (Koenig 1998; Levin, Chatters, and Taylor 1995; Taylor and Chatters 1986, 1991). One study of racial differences in religiosity among older adults found that Blacks had higher scores than Whites on 19 of 21 possible indicators of religiosity (Levin et al. 1994). The importance of religion in the Black community has been attributed to a history of discrimination and prejudice in the United States; the church historically has provided Blacks with a social and spiritual haven that was built, funded, and controlled by their community (Nelsen and Nelsen 1975).

Religion is a multifaceted construct and encompasses religious behavior (such as attendance at services), beliefs (including the use of faith and reliance on God), and social integration (including emotional and spiritual support) (Krause 2002). Each of these dimensions may provide distinctive benefits to older adults as they cope with spousal loss. First, church attendance may be associated with the receipt of instrumental, socioemotional, and spiritual support. Persons who frequently attend religious services may receive more instrumental support than those who do not; frequent interpersonal contact may make congregants more aware of the needs of older church members (Krause 2002). Second, persons who frequently attend services are more likely to engage in social and religious rituals

that enhance solidarity and closeness among congregants, perhaps by increasing commitment to the ideals, goals, and values of the church (Stark and Finke 2000). Third, persons who regularly attend services may receive spiritual support or assistance that is aimed toward increasing their religious commitment, beliefs, and behavior. For instance, parishioners may share their own religious experiences with recently widowed older adults or may show them how to apply their religious beliefs as they manage their loss (Krause et al. 2001)

Religion also provides a framework for thinking about the world and for coping with difficult stressors. Religious teachings and beliefs may provide a sense of certainty (Peterson 2000) and may instill hope during times of despair (Levin 2001:138). Persons who have a close relationship with God may develop a deep sense of trust in God and may believe that God is in control of their lives, God knows what is best for them, and God will provide what they need to manage life's challenges (Koenig 1994). Drawing on past research and theory on the protective effects of religion, I focus on two aspects of religiosity in this study: attendance at religious services and religious coping, or the extent to which one's religious beliefs affect adjustment to, and understanding of, difficult life stressors. These two aspects of religion may offer distinctive types of support to older Blacks and Whites as they adapt to spousal loss.

*OTHER INFLUENCES ON
ADJUSTMENT TO SPOUSAL LOSS*

This analysis includes indicators of three other potential influences on psychological adjustment to loss. First, I control psychological well-being prior to loss to help distinguish one's affective state before the death and change in affective state that occurred following the death (Jacobs 1993; Zisook and Shuchter 1991). Second, I control both spouse's and respondent's physical health at baseline because physical health may affect one's likelihood of being widowed, as well as psychological adjustment at the six-month follow-up (Booth and Johnson 1994; Wickrama, Lorenz, and Conger 1997).

Third, I control socioeconomic status prior to loss (including income, education, and home ownership) in order to address the possibility that the relationship between spousal loss and psychological

adjustment is spurious. Low socioeconomic status increases one's likelihood of becoming widowed (Preston and Taubman 1994) and of experiencing psychological distress (Miech and Shanahan 2000). It is particularly important to control socioeconomic status in analyses of Black-White differences in psychological adjustment because of long-standing racial disparities in education and earnings in the United States. Blacks are disadvantaged relative to Whites in terms of education, income, and assets (Oliver and Shapiro 1995). Richer socioeconomic resources, particularly education, enable effective coping by providing both the financial and psychological resources (such as high levels of perceived control) to manage adversity (Shaw and Krause 2001). Studies that fail to control for socioeconomic resources may inaccurately characterize the relationship between race and psychological adjustment.

In summary, this study will contribute to research on racial differences in late-life spousal bereavement in four ways. First, I examine whether psychological adjustment of Black and White widowed persons differs from still married matched controls. By comparing the recently bereaved with a matched control, I can differentiate the psychological effects of widowhood from psychological changes due to aging or the passage of time. Second, I examine whether Black and White widowed persons differ in their specific psychological reactions to loss by considering a broad array of grief symptoms. Specific grief symptoms may respond in very different ways to the widowhood transition, and these (potentially) competing effects may cancel out one another if only an aggregated scale, such as overall grief, is used as an outcome variable. Third, I examine the extent to which Black-White differences in adjustment to loss can be explained by racial differences in how the late marriages were experienced and in other sources of emotional and social support, including religiosity and support from both children and friends. These resources are measured prior to loss and thus are not subject to retrospective recall bias—such as the tendency to retrospectively “sanctify” the memory of one's late spouse and marriage (Lopata 1973). Finally, all analyses control socioeconomic status and psychological and physical health prior to the loss in order to address possible confounds in the relationships among race, widowhood, and psychological adjustment.

Method

DATA

The CLOC is a prospective study of a two-stage area probability sample of 1,532 married individuals from the Detroit standardized metropolitan statistical area (SMSA). To be eligible for the study, respondents had to be English-speaking members of a married couple where the husband was age 65 or older. All sample members were noninstitutionalized and were capable of participating in a two-hour-long interview. Approximately 65% of those contacted for an interview participated, which is consistent with response rates from other Detroit-area studies. Baseline face-to-face interviews were conducted in 1987 and 1988.

Spousal loss was monitored by reading the daily obituaries in three Detroit-area newspapers and by using monthly death record tapes provided by the state of Michigan. The National Death Index (NDI) was used to confirm deaths and obtain causes of death. Of the 319 respondents who lost a spouse during the study period, 86% ($n = 276$) participated in at least one of the three follow-up interviews that were conducted six months (Wave 1), 18 months (Wave 2), and 48 months (Wave 3) after the spouse's death. Controls from the original baseline sample were selected to match the widowed persons along the dimensions of age, race, and sex. The matched controls were reinterviewed at the three follow-up interviews at roughly the same time as the corresponding widowed persons.

I use two analytic samples in this study. The first includes all 297 persons who participated in the six-month follow-up interview. The 297 comprise 210 widowed persons (177 White and 33 Black) and 87 matched controls (75 White and 12 Black); this sample is used to evaluate whether the event of widowhood affects psychological adjustment differently for Blacks and Whites. The CLOC includes fewer controls than widowed respondents at the Wave 1 interview because funding for data collection was cut from the proposed budget and not reinstated until halfway through the data collection period for Wave 1, thus providing more control respondents for the Wave 2 and 3 interviews (see Carr and Utz 2002 for further detail on the CLOC study). The second analytic sample includes widowed persons only and allows an exploration of racial differences in how older adults adjust

to spousal loss. The widowed sample includes 210 persons (177 White and 33 Black) interviewed at the six-month follow-up.

The issue of selective attrition deserves brief mention. If persons who failed to participate in the six-month follow-up interview are significantly different from those who did participate (in terms of baseline characteristics), then caution should be taken in generalizing my findings to the larger population of elderly widowed persons. I estimated logistic regression models to identify the correlates of nonparticipation in the Wave 1 interview. The following variables were evaluated as possible predictors of attrition: baseline (preloss) demographic and socioeconomic characteristics, marital quality, social support, physical and mental health, and spouse's health. I also separately evaluated interaction terms of each potential predictor variable by race in order to ascertain whether Blacks and Whites have significantly different sources of sample attrition. Overall, only three variables were significant predictors of attrition, and these effects did not differ significantly by race (i.e., race interaction terms were not statistically significant at the $p \leq .05$ level. However, this may reflect the small sample of Black controls). Age and baseline anxiety increase the likelihood of nonparticipation, and home ownership decreases the likelihood of nonparticipation. Caution should be taken in generalizing findings to the population at large because older, more anxious and residentially mobile persons may be underrepresented.

MEASURES

Dependent Variables

Two general (i.e., depressive symptoms and anxiety) and six loss-related (i.e., overall grief, yearning, despair, anger, intrusive thoughts, and shock) dimensions of psychological adjustment at the six-month follow-up are considered. I focus on the six-month follow-up because grief symptoms tend to be most acute during the first six months following loss and then decline over time (Zisook and Shuchter 1991). *Depressive symptoms* ($\alpha = .83$) are assessed with a subset of nine negative items from the 20-item Center for Epidemiologic Studies–Depression Scale (CES-D; Radloff 1977). Respondents indicate how often they experienced each of nine symptoms in the week prior to interview. Symptoms are the following: I felt

depressed; I felt that everything I did was an effort; My sleep was restless; I felt lonely; People were unfriendly; I did not feel like eating. My appetite was poor; I felt sad; I felt that people disliked me; and I could not get going.

Anxiety ($\alpha = .86$) is measured with the Symptom Checklist 90–Revised (Derogatis and Cleary 1977). Respondents indicate how often they experienced each of 10 symptoms in the week prior to interview. Response categories were *not at all*, *a little bit*, *moderately*, *quite a bit*, and *extremely*. Symptoms were nervousness or shakiness, trembling, feeling suddenly scared for no reason, feeling fearful, heart pounding or racing, feeling tense and keyed up, spells of terror and panic, feeling so restless you couldn't sit still, feeling that something bad is going to happen to you, and thoughts and images of a frightening nature.

Five specific dimensions of grief also are considered. *Yearning* ($\alpha = .75$) was assessed with four questions: In the last month, (1) have you found yourself longing to have your spouse with you; (2) have you had painful waves of missing your spouse; (3) have you experienced feelings of intense pain or grief over the loss of your spouse; and (4) have you experienced feelings of grief, loneliness, or missing your spouse? *Despair* ($\alpha = .64$) reflects three symptoms felt during the past month: (1) life seemed empty, (2) I felt empty inside, and (3) I felt life had lost its meaning. *Anger* ($\alpha = .68$) is based on three questions: In the past month, have you (1) felt resentful or bitter about the death, (2) felt the death was unfair, and (3) felt anger toward God? *Intrusive thoughts* ($\alpha = .66$) are based on three symptoms experienced in the past month: (1) difficulty falling asleep because thoughts about your spouse kept coming into your mind, (2) tried to block out memories or thoughts of your spouse, and (3) unable to get thoughts about your spouse out of your mind. *Shock* ($\alpha = .77$) reflects three symptoms experienced during the last month: (1) felt in a state of shock, (2) couldn't believe what was happening, and (3) felt emotionally numb. *Overall grief* ($\alpha = .86$) is the average of the five subscale scores. Items were drawn from widely used grief scales including the Bereavement Index (Jacobs, Kasl, and Ostfeld 1986), Present Feelings About Loss (Singh and Raphael 1981), and Texas Revised Inventory of Grief (Zisook, Devaul, and Click 1982). Dependent variables are standardized for ease of interpretation and comparison across indicators. Each scale

has a mean of 0 and standard deviation of 1, where higher scores reflect more frequent grief symptoms.

Independent Variables

The central independent variable is *race*, a dichotomous variable set equal to 1 for Blacks. The reference category includes non-Hispanic Whites. Four sets of mediating variables are evaluated as pathways that may account for racial differences in psychological adjustment to widowhood: marital quality, social support from children, social support from extended family/friends, and religiosity.

Marital quality. Three characteristics of marriage (evaluated prior to spousal loss) are considered: duration, conflict, and instrumental dependence. *Marital duration* is the number of years one had been married to one's late spouse. *Marital conflict* ($\alpha = .64$) is a two-item scale based on the following items: "How often would you say you and your spouse typically have unpleasant disagreements and conflicts?" and "In some marriages, there are times when you feel very close, but other times when you can get more upset with that person than with anyone else. How much does this sound like the relationship you have with your spouse?" *Instrumental dependence* is measured with the following questions: "Husbands and wives often depend on one another to handle different responsibilities. At the present time, how much do you depend on your spouse to (1) handle or help with home maintenance and minor repairs; (2) keep up with checking and savings accounts and pay bills; (3) make major financial and legal decisions; and (4) prepare meals, general housework, and laundry?" Factor analyses yielded one three-item subscale ($\alpha = .54$) that taps *home maintenance and financial management tasks* that are usually performed by husbands (Items 1 through 3) and a single-item tapping *homemaking tasks*, which are typically performed by wives (Item 4). Items evaluating marital conflict and dependence are drawn from the Dyadic Adjustment Scale (Spanier 1976).

Religiosity. Two aspects of religiosity are considered: attendance at religious services and religious coping. *Attendance at religious services* is assessed with the question: "How often do you usually attend religious services? More than once a week, about once a week, one to

three times a month, less than once a month, or never?" Responses are recoded into two dichotomous variables: never and at least once a week. The reference category includes persons who attend services fewer than three times per month. *Religious coping* ($\alpha = .76$) is a two-item scale based on the following questions: "When you have problems or difficulties in your family, work, or personal life, how often do you seek spiritual comfort and support?" and "When you have decisions to make in your everyday life, how often do you ask yourself what God would want you to do?" Response categories are *almost always*, *often*, *sometimes*, *rarely*, or *never*. The scale is standardized and has a mean of 0 and standard deviation of 1. Higher scores represent higher levels of religious coping.

Social support. Two sources of social support are considered: (1) children and (2) other family members and friends. *Dependence on children* ($\alpha = .60$) is based on three items: "How much do you depend on your children for emotional support, for help or advice with financial and legal matters, and for help with errands or other chores?" Persons who have no living children are assigned the sample mean and are also indicated by a dichotomous variable (1 = has no living children). *Social support from friends and relatives* ($\alpha = .71$) is based on the following two items: "On the whole, how much do your friends and relatives make you feel loved and cared for?" and "How much are your friends and relatives willing to listen when you need to talk about your worries or problems?" Response categories are *a lot*, *some*, *a little*, or *not at all*. Both scales are standardized, and higher values represent greater levels of support.

Well-being at baseline. Preloss indicators of psychological and physical well-being are controlled to address the possibility that the relationship between widowhood and psychological adjustment is spurious. The characteristics that elevate one's risk of widowhood, such as poor health, also may be associated with poorer psychological adjustment following loss. *Depressive symptoms* ($\alpha = .83$) and *anxiety* ($\alpha = .86$) are evaluated at baseline with scales identical to those used at the Wave 1 follow-up (Derogatis and Cleary 1977; Radloff 1977). Respondent's *physical health* is assessed with the question: "How would you rate your health at the present time? Would you say it is excellent, very good, good, fair or poor?" *Spouse's physical health* (at

baseline) is evaluated with a similar question: "How would you rate your spouse's health at the present time?" Both respondent's and spouse's health are recoded into dichotomous variables where responses of "fair" and "poor" are coded 1 and those with "good" or better health are coded 0.

Socioeconomic resources. Socioeconomic resources are controlled to address the possibility that the relationship between widowhood and psychological adjustment is spurious. Three indicators of socioeconomic resources (at baseline) are considered: *education* (a continuous measure ranging from 3 to 17 years of completed schooling), *home ownership* (1 = owns home), and *total household income* (natural log of income). Respondents indicate which of 10 income categories most accurately describes their economic status. I derived a continuous measure of income by taking the midpoint of each of the 10 income categories, with Pareto estimation of the mean for the top income category. The natural log of income is used because the distribution is skewed, with most respondents in the lower income categories.

Demographic variables. The analyses include controls for *gender* (1 = female), *age*, and the duration (in months) between the baseline and Wave 1 interviews. All Wave 1 interviews were conducted six months after spousal death, but the duration between the baseline and Wave 1 interviews ranges from 9 to 76 months due to variation in the timing of spouse's death. Baseline assessments are more temporally distant for those who lost their spouses at later dates.

ANALYTIC PLAN

The analysis has four parts. First, I present descriptive statistics (means for continuous variables and proportions for dichotomous variables) and the results of two-tailed *t* tests comparing values on all variables for Blacks and Whites in the CLOC sample (Table 1). Second, I present unadjusted means for Black and White widowed persons on each of the grief symptom scales and indicate statistically significant race differences (Table 2). Third, I use ordinary least squares (OLS) regression models to examine whether the event of widowhood affects depressive symptom and anxiety levels among older adults. I

also evaluate race-by-widowhood interaction terms to assess whether widowhood affects Blacks and Whites differently (Table 3). Finally, I use OLS regression models to examine whether Black and White widowed persons differ in their grief symptoms. I evaluate the extent to which observed race differences are mediated by marital quality, social support from children and friends, and religiosity (Tables 4 and 5).

Results

SAMPLE CHARACTERISTICS

Descriptive statistics and *t* tests comparing means for Blacks and Whites are presented in Table 1. Asterisks denote significant Black-White differences within the total (column 1), control (column 2), and widowed samples (column 3). Overall, Blacks have significantly lower levels of income and education than Whites. Blacks and Whites also differ in terms of marital conflict, religiosity, and dependence on their children. No racial differences are found for preloss health and well-being, instrumental dependence on one's spouse, and support from friends and other family members.

The CLOC data reveal pronounced racial differences in how marriage is experienced. In the total sample (column 1), Blacks report levels of marital conflict at baseline that are roughly one-half standard deviation higher than that of Whites (.33 versus $-.21$, $p < .001$) and significantly shorter marriages (37 versus 42 years, $p < .05$). However, Blacks are advantaged in terms of two other psychosocial resources: religiosity and support from children. In the total sample, Blacks have significantly higher levels of religious coping (.66 versus $-.12$, $p < .001$), are more likely to attend religious services at least weekly (70% vs. 51%, $p < .05$), and are less likely to report that they "never" attend services (2% versus 19%, $p < .01$). They also report greater reliance on their children for instrumental and emotional support (.59 versus .06, $p < .001$).

Blacks and Whites do not differ in terms of depressive symptoms or anxiety at either the baseline interview or six-month follow-up. Although the gap in depressive symptoms between the nonwidowed and widowed is almost twice as large among Whites compared to

TABLE 1
Means and Standard Deviations for Blacks and Whites, Changing Lives of Older Couples (N = 297)

	Total Sample (N = 297)				Control Sample (n = 87)				Bereaved Sample (n = 210)			
	Blacks		Whites		Blacks		Whites		Blacks		Whites	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
<i>Dependent variables</i>												
Depressive symptoms (CES-D) ^a	0.165	1.27	0.269	1.16	-0.063	1.07	1.64	0.978	0.249	1.34	0.446	1.19
Anxiety (SCL-90) ^a	-0.189	0.575	0.034	1.06	-0.361	0.399	-0.077	1.03	-0.125	0.622	0.079	1.07
<i>SES and demographic characteristics</i>												
Education	10.68	3.02	11.51	2.84	11.86	3.25	1.64	2.73	10.24	2.86	11.46*	2.89
Income, baseline	15,507	11,134	22,804**	17,138	17,652	10,182	24,219	17,652	14,711	11,515	22,210*	16,933
Income (natural log)	1.12	0.490	1.39**	0.501	1.29	0.373	1.45	0.475	1.06	0.517	1.36**	0.511
Owens home	0.886	0.322	0.939	0.238	0.916	0.290	0.976	0.156	0.87	0.34	0.92	0.26
Sex (1 = female)	0.772	0.424	0.723	0.449	0.916	0.290	0.728	0.448	0.72	0.46	0.72	0.45
Age	69.48	7.55	70.23	6.58	66.99	6.93	69.38	5.91	70.4	7.66	70.6	6.82
<i>Preloss health and well-being</i>												
Depressive symptoms (CES-D) at baseline ^a	0.059	0.978	0.039	1.02	-0.065	0.758	-0.009	1.15	0.104	1.06	0.06	0.963
Anxiety at baseline ^a	0.089	0.917	-0.056	0.717	0.061	0.802	-0.159	0.717	0.099	0.967	-0.013	0.714
Fair/poor physical health at baseline	0.306	0.466	0.307	0.462	0.301	0.479	0.244	0.433	0.308	0.469	0.334	0.473
Spouse in fair/poor health at baseline	0.544	0.504	0.502	0.501	0.395	0.510	0.269	0.447	0.599	0.498	0.601	0.491

<i>Marital quality</i>												
Marital duration in years (baseline)	37.38	13.97	42.10*	13.29	34.82	12.01	38.53	15.13	38.33	14.69	43.61*	12.18
Marital conflict at baseline ^a	0.333	1.17	-0.210***	0.961	0.585	1.33	0.777	-0.256***	0.239	1.12	-0.073*	0.914
Dependence, homemaking tasks ^a	0.088	0.958	-0.016	1.01	-0.383	0.723	-0.221	1.02	0.262	0.985	0.071	0.995
Dependence, home maintenance and financial tasks ^a	0.171	0.656	-0.020	0.806	0.561	0.517	0.331	0.647	0.027 ^a	0.649	-0.167	0.822
<i>Religiosity</i>												
Never attends religious services	0.02	0.149	0.193***	0.395	0.042	0.209	0.162	0.371	0.015	0.123	0.206**	0.405
Attends religious services at least once per week	0.702	0.463	0.508***	0.501	0.666	0.492	0.535	0.502	0.715	0.459	0.496*	0.501
Religious coping scale ^a	0.658	0.702	-0.116***	1.00	0.81	0.75	-0.069**	1.03	0.602	0.687	-0.136***	0.991
<i>Social support</i>												
Dependence on children at baseline ^a	0.593	1.19	0.065***	0.908	0.819	1.29	-0.036**	0.900	0.509	1.16	0.107	0.910
Has no living children	0.126	0.335	0.076	0.266	0	0.000	0.103	0.306	0.172	0.384	0.065*	0.247
Overall support from friends/relatives at baseline ^a	0.227	0.932	0.044	1.03	0.568	0.632	0.059	1.04	0.101	1.00	0.037	1.03
Months between baseline and Wave 1 interview	41.49	18.59	43.36	19.37	60.9	10.48	59.16	7.96	34.29	15.54	36.72	18.90
<i>N</i>		45	252			12	75		33		177	

NOTE: Weighted data are reported in the table. Two-tailed *t* tests were used to assess significant differences between means. Asterisks denote significant Black-White differences in the total (column 1), control (column 2), and widowed samples (column 3). CES-D = Center for Epidemiologic Studies-Depression Scale; SCL-90 = Symptom Checklist 90-Revised; SES = socioeconomic status.

a. These variables are standardized.
p* < .05. *p* < .01. ****p* < .001.

TABLE 2
Means and Standard Deviations for Grief, Anxiety,
and Depressive Symptoms, Among Black and White Bereaved
Spouses, Six Months Following Spousal Loss ($N = 210$)

	<i>Unadjusted Means</i>			
	<i>Blacks</i> ($n = 33$)		<i>Whites</i> ($n = 177$)	
	M	SD	M	SD
Overall grief	-0.30	0.99	0.06	0.99
Yearning	-0.30	1.05	0.06	0.98
Despair	-0.52	0.71	0.095***	1.02
Anger	-0.41	0.74	0.076*	1.02
Intrusive thoughts	0.10	1.03	-0.02	0.99
Shock	-0.05	0.93	0.01	1.01
Depressive symptoms (CES-D)	0.25	1.34	0.45	1.2
Anxiety (SCL-90)	-0.13	0.62	0.08	1.07

NOTE: Weighted data are reported in the table. All subscales are standardized, where $M = 0$ and $SD = 1$. Two-tailed t tests were used to compare unadjusted mean scores for Black and White bereaved older spouses. CES-D = Center for Epidemiologic Studies–Depression Scale; SCL-90 = Symptom Checklist 90–Revised.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Blacks, the difference is not statistically significant. Blacks and Whites also report similar levels of most grief symptoms. Table 2 presents Blacks' and Whites' (unadjusted) mean levels of grief symptoms, depressive symptoms, and anxiety, among the 210 widowed persons interviewed six months following spousal loss; standardized scores are shown. Whites have significantly higher levels of despair (.095 versus -.52) and anger (.076 versus -.41) than do Blacks. White and Black widowed elders do not differ in terms of overall grief, yearning, intrusive thoughts, shock, depression, or anxiety.

MULTIVARIATE ANALYSES

Black-White Differences in Effect of Widowhood

The first objective of the multivariate analysis is to investigate whether widowhood has significantly different effects on the depressive symptoms and anxiety levels of Blacks and Whites. Table 3 displays OLS regression models evaluating the main effects of widow-

TABLE 3
 Ordinary Least Squares Regression of Depressive
 Symptoms and Anxiety (at six-month follow-up)
 on Widowhood Status, Race, and Mediating Variables,
 Changing Lives of Older Couples Study ($N = 297$)

	<i>Depressive Symptoms</i>		<i>Anxiety</i>	
	<i>Model 1</i>	<i>Model 2</i>	<i>Model 1</i>	<i>Model 2</i>
<i>Demographic characteristics</i>				
Widowhood (1 = widow)	.78*** (.17)	.82*** (.18)	.32* (.14)	.30* (.15)
Race (1 = Black)	-.10 (.18)	.11 (.34)	-.22 (.15)	-.31 (.29)
Widowhood \times Black		-.30 (.40)		.14 (.34)
Age	.01 (.01)	.01 (.01)	-.01 (.01)	-.01 (.01)
Sex (1 = female)	.11 (.15)	.11 (.15)	-.01 (.13)	-.01 (.13)
<i>Socioeconomic resources</i>				
Years of education	.01 (.02)	.01 (.02)	.02 (.02)	.03 (.02)
Own home, baseline	.29 (.25)	.29 (.25)	.26 (.22)	.27 (.22)
Income (natural log), baseline	-.07 (.14)	-.07 (.14)	-.04 (.11)	-.04 (.11)
<i>Baseline well-being</i>				
Depressive symptoms (CES-D) at baseline	.36*** (.07)	.36*** (.07)	.28*** (.06)	.28*** (.06)
Anxiety, baseline	-.01 (.10)	-.01 (.10)	.1 (.08)	.1 (.08)
Self-rated health fair or poor at baseline	.25 (.15)	.25 (.15)	.42*** (.12)	.42*** (.12)
Spouse's health fair or poor at baseline	.15 (.14)	-.15 (.14)	-.25* (.15)	-.25* (.15)
Adjusted R^2	.15	.15	.16	.16
Constant	-1.94 (.92)	-1.95 (.92)	-.04 (.77)	-.04 (.77)

NOTE: Standardized regression coefficients and standard deviations (in parentheses) are shown. Dependent variables are standardized, with mean of 0 and standard deviation of 1. All models control for number of months between baseline and follow-up interview. CES-D = Center for Epidemiologic Studies–Depression Scale.

* $p < .05$. ** $p < .01$. *** $p < .001$.

hood and race on the two outcomes (Model 1) as well as a two-way interaction term between widowhood and race (Model 2). A statistically significant interaction term indicates that widowhood affects Blacks and Whites differently. The analyses show that race is not a significant predictor of either depressive symptoms or anxiety. Widowhood is a significant predictor of both depressive symptoms ($b = .8, p < .001$) and anxiety ($b = -.3, p < .05$) at the six-month follow-up, yet these relationships do not differ significantly by race.

The lack of statistical significance in the interaction term analyses could reflect low statistical power, given that the widowed-control sample includes only 12 Black control respondents at the 6-month follow-up. To further investigate the possibility that small sample size (rather than the actual absence of significant race differences) accounts for these findings, I reestimated the models shown in Table 3, using the widowed-control sample at the 18-month follow-up. This sample includes 168 widowed persons (144 Whites and 24 Blacks) and 202 controls (170 Whites and 32 Blacks). The CLOC data collection team obtained more interviews among controls than widowed persons at Wave 2, so that the total number of widowed persons and controls combined across all interview waves would be roughly equal. The replicated analysis on the larger Wave 2 sample also revealed that widowhood is associated with a significant increase in depressive symptoms but has no significant effect on anxiety (net of baseline health, demographic, and socioeconomic characteristics). These effects do not differ significantly by race, nor is race a significant predictor of either depressive symptoms or anxiety. (Tables are available from the author.)

Race Differences in Grief Symptomatology

The next two objectives of the multivariate analysis are to (1) examine racial differences in grief symptoms six months following spousal death and (2) evaluate the extent to which these differences are attributable to differences in Blacks' and Whites' marital quality and social support resources. To investigate the first objective, I estimated OLS regression models predicting each of the five grief symptoms and the overall grief scale. A series of stepwise models was estimated; the baseline models included race and demographic characteristics only,

whereas subsequent models incorporated socioeconomic status indicators, preloss well-being characteristics, and each of the four potential mediator variables. Neither the gross nor net effects of race were statistically significant for four of six outcomes: overall grief, yearning, intrusive thoughts, and shock (results not shown, but are available from author). The remaining two symptoms, anger and despair, are significantly lower among Blacks than Whites (results shown in Tables 4 and 5, respectively).

Race Differences in Anger Six Months After Loss

Table 4 presents OLS regression models evaluating the predictors of anger six months after spousal loss. Black bereaved spouses report significantly lower levels of anger six months following their spouse's death, and this racial gap declines by roughly 20% when religious participation and coping are controlled. In Model 1, where only demographic, socioeconomic status, and baseline health factors are controlled, Blacks evidence levels of anger that are one-half standard deviation lower than that of Whites. The effect of race on anger declines by roughly 10% (i.e., from $-.50$ to $-.44$) when religious participation is controlled (Model 2) and declines by 20% (i.e., from $-.50$ to $-.39$) when religious coping is controlled (Model 3). However, when both forms of religiosity are controlled in Model 4, frequent church attendance only remains a significant predictor of anger ($b = -.47$), and the racial gap in anger equals roughly .4 standard deviations. Reliance on children for social support (Model 5) is associated with reduced levels of anger ($b = -.15$), and the racial gap in anger is no longer statistically significant when both support from children and religiosity are controlled.

Marital characteristics (i.e., duration, conflict, and dependence) are neither significant predictors of widowed persons' anger nor mediators of the relationship between race and anger. Neither socioeconomic resources nor preloss well-being are significant correlates of anger. Age is related inversely to anger; each additional year of age is associated with a .03 standard deviation decrease in anger symptoms. Gender is associated with anger in Model 1; women report anger symptoms that are .35 standard deviations lower than men.

TABLE 4
 Ordinary Least Squares Regression of Anger
 (at six-month follow-up) on Race and Mediating Variables,
 Changing Lives of Older Couples Study ($N = 210$)

	<i>Model 1</i>	<i>Model 2</i>	<i>Model 3</i>	<i>Model 4</i>	<i>Model 5</i>
<i>Demographic characteristics</i>					
Race (1 = Black)	-.50** (.19)	-.44* (.19)	-.39* (.19)	-.39* (.19)	-.36 (.19)
Age	-.031** (.010)	-.029** (.010)	-.029** (.010)	-.028** (.010)	-.029** (.010)
Sex (1 = female)	-.353* (.157)	-.272 (.155)	-.284 (.159)	-.226 (.159)	-.255 (.159)
<i>Socioeconomic resources</i>					
Years of education	.025 (.025)	.026 (.024)	.019 (.025)	.021 (.025)	.02 (.024)
Own home, baseline	.142 (.247)	.233 (.243)	.159 (.245)	.241 (.243)	.214 (.241)
Income (natural log), baseline	-.065 (.144)	-.099 (.141)	-.059 (.142)	-.098 (.141)	-.110 (.139)
<i>Baseline well-being</i>					
Depressive symptoms (CES-D), baseline	.137 (.080)	.119 (.079)	.105 (.081)	.102 (.079)	.105 (.079)
Anxiety, baseline	.072 (.078)	.087 (.077)	.115 (.079)	.109 (.078)	.117 (.078)
Self-rated health fair or poor at baseline	-.107 (.152)	-.149 (.149)	-.103 (.151)	-.138 (.149)	-.148 (.148)
Spouse's health fair or poor at baseline	-.141 (.142)	-.180 (.139)	-.165 (.142)	-.192 (.139)	-.186 (.139)
<i>Religiosity</i>					
Never attends religious services		-.262 (.201)		-.351 (.211)	-.336 (.211)
Attends religious services at least one per week		-.527*** (.154)		-.469** (.159)	-.437** (.159)
Religious coping scale (standardized)			-.156* (.074)	-.113 (.085)	-.107 (.209)
<i>Filial support</i>					
Dependence on children for support and assistance					-.146* (.068)
Has no living children					.113 (.242)
Adjusted R^2	.085	.129	.101	.132	.145
Constant	2.34 (.910)	2.4 (.889)	2.17 (.905)	2.31 (.891)	2.45 (.889)

NOTE: Standardized regression coefficients and standard deviations (in parentheses) are shown. Dependent variables are standardized, with mean of 0 and standard deviation of 1. All models control for number of months between baseline and follow-up interview. CES-D = Center for Epidemiologic Studies-Depression Scale.

* $p < .05$. ** $p < .01$. *** $p < .001$.

TABLE 5
 Ordinary Least Squares Regression of Despair
 (at six-month follow-up) on Race and Mediating Variables,
 Changing Lives of Older Couples Study ($N = 210$)

	<i>Model 1</i>	<i>Model 2</i>	<i>Model 3</i>	<i>Model 4</i>
<i>Demographic characteristics</i>				
Race (1 = Black)	-.543** (.191)	-.468* (.194)	-.544** (.189)	-.459* (.192)
Age	-.001 (.010)	-.015 (.013)	0.003 (.010)	-.013 (.013)
Sex (1 = female)	-.011 (.159)	-.056 (.161)	.036 (.183)	-.019 (.184)
<i>Socioeconomic resources</i>				
Years of education	.039 (.025)	.032 (.025)	.044 (.025)	.037 (.025)
Own home, baseline	.207 (.249)	.228 (.249)	.141 (.248)	.159 (.246)
Income (natural log), baseline	.025 (.145)	.024 (.144)	.059 (.144)	.063 (.142)
<i>Baseline well-being</i>				
Depressive symptoms (CES-D) at baseline	.104 (.081)	.095 (.081)	.162* (.083)	.158* (.082)
Anxiety, baseline	.091 (.105)	.153 (.108)	.051 (.104)	.119 (.107)
Self-rated health fair or poor at baseline	.165 (.154)	.155 (.153)	.157 (.154)	.146 (.152)
Spouse's health fair or poor at baseline	.116 (.144)	.098 (.143)	.238 (.149)	.231 (.147)
<i>Marital relationship</i>				
Years married		.006 (.007)		.007 (.007)
Marital conflict		-.134* (.071)		-.157* (.070)
Dependence, home maintenance and financial tasks			.169* (.088)	.193* (.087)
Dependence, homemaking tasks			-.134 (.075)	-.145* (.074)
Adjusted R^2	.065	.08	.09	.112
Constant	-.858 (.919)	-.088 (.976)	-1.09 (.912)	-.221 (.959)

NOTE: Standardized regression coefficients and standard deviations (in parentheses) are shown. Dependent variables are standardized, with mean of 0 and standard deviation of 1. All models control for number of months between baseline and follow-up interview. CES-D = Center for Epidemiologic Studies–Depression Scale.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Black-White Differences in Despair Six Months After Loss

Table 5 presents OLS regression models evaluating the predictors of despair six months after spousal loss. Blacks have levels of despair that are one-half standard deviation lower than Whites ($b = -.54$), when demographic, socioeconomic, and baseline health characteristics are controlled (Model 1). Not one of the socioeconomic status or health variables is significantly linked to despair, and only 7% of the variance in despair is explained by the baseline variables. Each of the mediator variables was evaluated, and only the marital quality characteristics were significant predictors of despair.

Model 2 adjusts for marital conflict and marital duration; the inclusion of these variables results in a 10% decline in the racial difference in despair. Moreover, higher levels of marital conflict at baseline are linked to lower levels of despair, or one's sense of emotional emptiness following spousal loss. Model 3 incorporates indicators of instrumental dependence in the marriage; although these variables do not mediate the effect of race, one indicator of instrumental dependence is significantly linked to despair. Persons who were dependent on their spouse for home repair and financial matters have higher levels of despair ($b = .17, p < .05$), whereas those who were dependent for homemaking tasks have lower levels of despair ($b = -.13, p < .10$). Even after marital dependence, duration, and conflict are controlled, however, the race gap in despair persists ($b = -.46, p < .05$). This finding highlights the need for further research on the ways that Blacks and Whites adapt emotionally to the death of their spouses.

Discussion

The analyses revealed few Black-White differences in the ways that older adults adjust psychologically to the death of a spouse. Compared with married matched controls, the widowed evidenced significantly higher levels of anxiety and depressive symptoms, but these patterns do not differ by race. When widowed persons only were considered, Blacks and Whites did not differ in terms of four grief symptoms: overall grief, yearning, shock, and intrusive thoughts. Blacks had significantly lower levels of two grief symptoms: despair and anger.

Blacks' lower levels of anger are attributable partly to their higher levels of religious participation and coping and also are explained partially by Blacks' greater reliance on their children for social support. These findings are consistent with the argument that anger is symptomatic of the most socially isolated widowed (Parkes and Weiss 1983). Blacks' lower levels of anger are due in part to their social integration with the religious community and their children, underscoring the importance of having a broad and varied base of social support. Widowhood is believed to be particularly distressing in individualistic societies where the nuclear family is socially and economically autonomous and where spouses may have few alternative sources of social, emotional, or instrumental support (Lopata 1973; Volkart and Michael 1957). African Americans, perhaps due to their lower rates of marriage and greater likelihood of divorce, have developed a stronger and more varied web of social relationships, including extended family and the church; it is precisely these resources that may buffer against symptoms such as anger in the face of spousal loss.

Blacks' lower levels of despair are explained, in part, by the fact that they report higher levels of marital conflict than do Whites. Although early psychoanalytic perspectives on grief proposed that the loss of a conflicted relationship is associated with prolonged or "pathological" grief and longing (Abraham [1924] 1927; Freud [1917] 1959), more recent empirical analyses reveal that widowed persons confronting the loss of conflicted or ambiguous relationships tend to grieve less for their deceased partners, whereas those in close loving relations yearned most for the deceased (Carr et al. 2000). Thus, Blacks may experience less despair and emotional emptiness because they are losing a less emotionally rewarding relationship. Future research should explore whether the linkage between marital conflict and adjustment to loss differs for Blacks and Whites. Recent research suggests that Black and White couples have different expectations and criteria for evaluating their marriages (Acitelli et al. 1997; Chadiha, Veroff, and Leber 1998); if Blacks are more likely than Whites to both anticipate and acknowledge marital conflict, then perhaps the inverse relationship between marital conflict and grief may be weaker for Blacks than for Whites.

Although I expected that Blacks would evidence lower levels of dependence on their spouses for homemaking and home maintenance tasks and consequently, lower levels of despair, the CLOC data did not

support this hypothesis. There are several possible reasons why the CLOC data did not confirm the widely documented observation that Black and White spouses adhere to more egalitarian gender roles in the family (e.g., Dillaway and Broman 2001; Orbuch and Eyster 1997). First, long-standing patterns of allocating household responsibilities may change in later life; declines in physical health may mean that older adults give up tasks that they can no longer perform, thus leaving their spouses to take on new responsibilities even before widowhood (Szinovacz 2000; Szinovacz and Harpster 1994). Second, the small sample size prevented sex- and race-specific analyses; it is possible that dependence on one's spouse for "male-typed" tasks is associated with women's distress only and vice versa. Future studies should evaluate the extent to which a sex-typed or egalitarian division of household labor among married couples affects overall adjustment to spousal loss and racial differences in adjustment to spousal loss.

Overall, the study findings have potentially important implications for understanding psychological adjustment among older bereaved spouses. First, psychological reactions to spousal death appear to be closely tied to social patterns established earlier in the life course, such as marital relationships, religious participation, and interactions with one's children. For instance, the racial gap in anger symptoms attenuated when preloss levels of religiosity and parent-child dependence were controlled, suggesting that enduring patterns of roles and relationships may be important resources for coping with loss. However, I did not explore the extent to which these social roles and relationships change in the face of loss. Future research should explore whether Blacks and Whites alter their religious beliefs or behavior following loss and the extent to which reliance on other family members changes following the loss of spouse.

Second, these results underscore the importance of considering multiple psychological outcomes when studying psychological adjustment to loss. The data revealed racial differences in levels of anger and despair, but not in more global mental health outcomes such as depressive symptoms, anxiety, or overall grief. If only global indicators—rather than precise grief symptoms—had been considered, then the Black-White differences in anger and despair would have gone undetected. Moreover, the consideration of a diverse array of grief symptoms allows researchers to move away from the question "who suffers worse" in the face of loss and to instead identify the spe-

cific psychological reactions experienced by distinctive social groups and demographic categories (e.g., Stroebe and Stroebe 1983).

LIMITATIONS AND FUTURE DIRECTIONS

This study has several important limitations. First, by design, the CLOC sample includes the most physically and economically advantaged, given that all sample members were married and were age 65 or older at the time of the baseline interview. Blacks tend to have higher levels of mortality (Gibson 1994) and lower rates of both marrying and staying married than Whites (Lugaila 1998), therefore the Black sample may be more selective (and less representative) than their White peers. This potential positive selection bias also may contribute to the slightly better psychological adjustment evidenced by Blacks in the CLOC sample.

Second, the small sample size prevented the analysis of more fine-grained racial differences, such as within-race gender or socioeconomic status differences in adjustment to spousal loss. Examining only broad Black-White differences implies that between-race differences are larger or substantively more important than within-race sources of variation in psychological adjustment to loss. Identifying the latter is an important pursuit for developing both racially sensitive and individually targeted programs and interventions to help older adults adjust to spousal loss (Alvidrez, Azocar, and Miranda 1996; Phinney 1996). Moreover, because of the small sample size and low statistical power, few relationships were statistically significant. Additional research, based on larger samples, must be conducted before strong conclusions can be drawn about racial differences in adjustment to late life spousal loss.

Third, all spousal deaths were treated similarly in the analysis; the assumption was that the effects of widowhood are invariant regardless of the cause, timing, or context of the death. However, the psychological consequences of widowhood have been found to vary based on the duration of the late spouse's illness and the amount of forewarning one had (Carr et al. 2001). The context and cause of death also matter; deaths that are due to medical negligence or where the dying patient was in severe pain are much more distressing to survivors (Carr 2003). Given well-documented racial differences in the cause and timing of death (National Center for Health Statistics 2000) and evidence that

Blacks receive poorer quality health care than do Whites (Livingston 1994; Williams and Collins 1995), it is important also to explore how the late spouse's dying process affects the psychological adjustment of Black and White older adults.

Despite these weaknesses, the analyses document the different grief symptoms experienced by Black and White widowed older adults and suggest ways that race differences in marital relations and social support, broadly defined, account for Black-White differences in adjustment to loss. This study should be regarded as an important preliminary look and springboard for future research, rather than as a definitive statement about Black and White widowed older adults.

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