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Spousal Bereavement in Later Life

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Spousal loss has been described as among the most stressful of all life events, especially for older adults (Holmes & Rahe, 1967). One of the most important research discoveries in recent decades, however, is the recognition that the death of a spouse is not universally distressing. Rather, older adults' psychological adjustment to widowhood varies widely based on characteristics of the marriage, the nature of the death, the co-occurrence of other stressful events and losses, and one's personal and social resources including social support, economic resources, personality, and prior mental health. Although an estimated 40–70% of bereaved spouses experience a period of 2 weeks or more marked by feelings of sadness immediately after the loss, a substantial proportion—anywhere from 30% to 60%—withstand spousal loss with relatively few distress symptoms (see Wolff & Wortman, 2006, for a comprehensive review). Given that clinical depression is the exception rather than the norm in the face of late-life spousal loss, practitioners and researchers are devoting their efforts to identifying risk and resilience factors among the recently bereaved, and developing targeted interventions that take into account the highly individualized nature of spousal bereavement.

In this chapter, we first summarize patterns of late-life spousal loss in the contemporary United States, and then discuss recent and cutting-edge research findings documenting four important influences on spousal grief: the nature of the death (including caregiving duties prior to loss), the quality of the marital relationship, social support and integration, and the co-occurrence of other chronic and acute stressors. We then provide a list of criteria that professionals may use to identify a bereaved client's distinct risk factors (and resources) that may heighten (or protect against) symptoms of depression and grief. We conclude by providing clinical applications, arranged within each of four "tasks of mourning" (Worden, 2009); these provide a helpful guide for practitioners and caregivers who are helping older bereaved spouses to cope with their loss.

LATE-LIFE SPOUSAL LOSS: PATTERNS AND TRENDS

Spousal loss can occur at any age, yet widowhood in the United States today is a transition overwhelmingly experienced by persons age 65 and older. Of the 900,000 persons who become widowed annually in the United States, nearly three quarters are age 65 or older (Federal Interagency Forum on Aging-Related Statistics, 2010). Women are much more likely than men to become widowed, because men have lower life expectancies than women. Life expectancy at birth today is 76 for men and 80 for women, so women are much more likely to outlive their spouse.

Among persons age 65 to 74, 26.3% of women but just 7.3% of men are widowed. These proportions jump to 58.2% of women and 20.5% of men age 75 and older. This stark gender gap also reflects the fact that widowers are far more likely than widows to remarry, and thus they may “exit” the widowed category. Widows are less likely than widowers to remarry because of the dearth of potential partners. Among persons ages 65 and older in the United States, the sex ratio is 1.5 women per every one man. 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 access to a similarly expanded pool of potential spouses.

Although widowhood historically has been characterized as an *event* that occurs upon the death of one’s spouse, contemporary late-life widowhood is best conceptualized as a *process*. Most deaths to older adults today occur due to chronic disease, or long-term illnesses for which there is no cure (Federal Interagency Forum on Aging-Related Statistics, 2010). The four leading causes of death to older adults today—heart disease, cancer, cerebrovascular disease, and chronic obstructive pulmonary disorder—account for nearly two thirds of all deaths to older adults; thus, most become widowed after at least one spell of caregiving for an ailing spouse. In the case of long-term chronic illness, spousal caregiving may have lasted for months or even years prior to the death. As we will discuss later in this chapter, the conditions leading up to and surrounding a spouse’s death shape bereavement experiences and are an important consideration when developing interventions to assist the newly bereaved.

ADJUSTING TO SPOUSAL LOSS: RISK AND PROTECTIVE FACTORS

As we noted earlier, older bereaved spouses vary widely in their psychological adjustment to loss. Some may have minor symptoms of depression and anxiety during the first 3 to 6 months following loss, 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, we focus here on four influences that recent studies have identified as particularly important and as potentially modifiable: the nature of the relationship, conditions surrounding the death, social support and integration, and other co-occurring losses and stressors.

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 6 months post loss (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 held 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 where maintaining emotional ties to one's late spouse may be helpful. For instance, Rando (1993) observed that bereaved persons, when faced with a difficult decision, may think about what their late spouse might do. 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 spousal loss is affected by the timing and nature of the late spouse's death. In general, 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, House, Wortman, Nesse, & Kessler, 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, 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, & Hebert, 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, the 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. Providers should remember the strains faced by caregivers before the death as well as post loss.

Quality of end-of-life care 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 post loss 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 bereavement outcomes (Christakis & Iwashyna, 2003). 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, the vast majority of Americans (roughly 70%) currently die in institutions (Federal Interagency Forum on Aging-Related Statistics, 2010); this carries implications for survivors’ well-being.

Social Support and Integration

Women’s emotionally intimate social relationships over the life course are an important resource as they adjust to spousal loss. 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. 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. 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. As such, practitioners should be aware of community resources which can enable older bereaved persons to be with others in recreational, mealtime, education, spiritual, and support group activities.

Other Losses and 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 walking or driving), health declines, a 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 (Carr, 2008). 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, Folkman, Hansson, & Schut, 2006).

The well-documented effects of widowhood on mortality risk, disability and functional limitations, and depressive symptoms are consistently larger for men than women (e.g., Lee & DeMaris, 2007). Although popular myth suggests that emotionally devastated widowers may "die of a broken heart" shortly after their wives die, research shows that it is the loss of a helpmate and caretaker that is really the culprit. Wives monitor their husbands' diets, remind them to take their daily medications, and urge them to give up vices like smoking and drinking (Umberson, Wortman, & Kessler, 1992). Widowers are more likely than married men to die of accidents, alcohol-related deaths, lung cancer, and chronic ischemic heart disease during the first 6 months after their loss, but not from causes that are less closely linked to health behaviors (Martikainen & Valkonen, 1996).

Widows, by contrast, often experience declines in their economic well-being, which may trigger anxiety and distress (Umberson et al., 1992). Within 3 years of the death of her husband, a widow's income drops by 44% on average (Holden & Kuo, 1996). More than half of elderly widows in poverty were not poor prior to the death of their husbands. Costs associated with the 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. Older widows who try to reenter the labor force also may lack the experience to secure a good job, or may face age discrimination. Each of these strains may compound the emotional pain and cognitive disruption triggered by spousal loss.

AU: Also, they're less likely to have paid substantially into Social Security or to have pensions; comment briefly on this as well?

DIAGNOSING AND TREATING BEREAVED OLDER SPOUSES

Many of the factors discussed above combine to affect grief and distress symptoms in bereaved older spouses. To effectively treat patients, the clinician will be initially concerned with taking a comprehensive history of the bereaved survivor (Jeffreys, 2011). The information obtained should include the following:

- Nature of spouse's death (e.g., prolonged illness or sudden death)
- Location of spouse at time of death
- Duration and nature of surviving spouse's caregiving
- Nature of marital relationship
- Medical, mood, and mental status of surviving spouse
- Hospitalizations
- Functional status and limitations
- History of other losses and stressors
- Occupational history
- Level of social, emotional, and practical support from family, friends, and professionals
- Cultural and religious information
- Contextual and economic realities: location of residence, neighborhood, residential facility, social memberships, financial status, education, and instrumental skills
- Goals: short term and long term

Developing a Course of Treatment

After completing a clinical portrait, the provider should ascertain whether treatment is necessary. Recent research suggests that clinical treatment may not be necessary or desirable for all older bereaved persons, particularly those suffering "normal" and relatively short-lived sadness over their loss (e.g., Bonanno & Lilienfeld, 2008). However, when the clinical picture of the grief response includes diagnosable psychiatric disorders such as major depression (including suicidal ideation), anxiety, thought disorder, cognitive functioning disturbance (e.g., confusion), chronic physical symptoms, social phobia, or withdrawal, then the clinician will develop a treatment plan which is in the best interest of the bereaved spouse.

Standard of care treatment for older bereaved spouses can include assessment for level of depression, including suicidal thoughts; the nature and degree of anxiety; and individual psychotherapy, group psychotherapy, referral to physician for medication evaluation, and, depending on safety concerns, hospitalization. When the clinical picture of the grief response falls into the category of complicated or prolonged grief, the bereaved spouse should be evaluated for the existence of *emotional* (e.g., deep feelings of guilt, or inability to express feeling), *cognitive* (e.g., intrusive thoughts, or feeling dazed), *behavioral* (e.g., self-destructive or compulsive behaviors), and *physical* (e.g., chronic complaints, or disrupted sleep) "danger signals" (see chapter 12 in this book and Jeffreys [2011] for specific criteria for diagnosing complicated grief).

The practitioner should take particular care to gather information on these potential danger signals when taking a history, whether by clinical observation or from reports of family, friends, and/or other care providers. Every loss situation contains a distinctive set of influences on grief symptoms and behaviors, and these factors must be taken into consideration when assessing and drawing up a treatment plan for each case.

CLINICAL APPLICATIONS FOR OLDER BEREAVED SPOUSES

We have highlighted the sources of distress (and resilience) for older bereaved spouses, and have provided general guidelines for assessing grief symptoms among the bereaved. We now set forth a specific plan of action for structuring interventions that may help the bereaved older adult to heal. Several of these steps require no special training, whereas others should be engaged in by professional providers only. We encourage care providers to consult with a licensed mental health practitioner if they have doubts about their capacity to deliver each such action. Care providers should adapt the suggestions given here to their own level of training, as well as to the individualized needs of the bereaved. We have adapted Worden's (2009) "Four Tasks of Mourning" (see chapter 6 in this book for further explanation and clinical examples) and added clinical interventions (Jeffreys, 2011) expressly for effective use among older widows and widowers.

Task 1: Accept the Reality of the Loss

Many bereaved spouses go through periods of denial or difficulty in accepting the death. Providers must be particularly sensitive to the widow(er)'s need to strike some balance between confronting and avoiding the loss. Some bereaved persons may experience a *head–heart split*: They may recall loss events with few or no physical or emotional reactions because the "head" knows the terrible truth but the "heart" has not yet registered it. Thus, the grieving spouse may act as though the loss had not occurred. The following activities may help the grieving spouse come to terms with the reality and finality of the loss.

Listen: The First Provider Action *The care provider* will listen first and provide ample opportunity for the grieving person to tell the story of the loss. This is the first step in the long road to acceptance. If the bereaved spouse doesn't want to talk, suggest that he or she write down thoughts in a journal, speak them into a recording device, or write a new eulogy and bring it to the next appointment to share with the care provider. The client should set the pace and timing of these activities.

Revisiting the Time of Death To help a grieving client come to terms with the loss, it is important to ask questions such as "Were you there when (he or she) died?" "How did you find out about the death?" "Where were you when you found out?" "Who made the funeral arrangements?" "Was there a viewing?" "Can you describe what happened?" And "What was that like for you?"

Recall Rituals Asking questions about the death-associated rituals can also help to reintroduce the reality of loss. Consider questions like “What was the funeral like?” “Where was it held?” “What can you remember about the eulogies?” “Who gave them?” “Did you say anything at the service? At the graveside?” “Were you satisfied with the service?” And “What did you like or dislike?”

Identify Changes in Life To help a grieving spouse gain a sense of what has changed since the loss, ask questions like “What is different in your daily life now?” “What do you miss the most?” “When is the worst time for you?” And “What are some next steps for you now?”

Task 2: Experience the Feelings of Grief

If you are seeing a grieving person for a counseling session, make sure that the meeting room is private, quiet, and soundproof. Have one or two boxes of tissues within easy reach. Allow ample time for the session so that you are not tempted to look at the clock or your watch.

The goal of the care provider is to accept whatever emotions the grieving person is capable of expressing. To facilitate the expression of grief, care providers can make these suggestions.

Look at Photos Photos are a good source of background information. Old photos may provide opportunities for grieving people to talk about earlier losses and the childhood messages they received about the acceptability of expressing such feelings as sadness, anger, and fear.

Write a History Some people can better grasp the reality of their loss after they put it in historical perspective. Writing the “life history” of a relationship that has ended or some other significant loss can help individuals express feelings they are unable to verbalize.

Write Stories The grieving person may write a fictional account of his or her loss if this will help elicit feelings and expressions related to the loss.

Draw Pictures Grieving people who are more comfortable with images than words can be encouraged to draw images relating to the loss and their life now. If the care provider has no training in the interpretation of drawings, then he or she could ask the bereaved to explain the drawing.

Task 3: Adjust to a Changed Life: Creating New Meanings in the Postloss World

Acknowledge the Changes Moving from a couple to widowhood status requires a reconfigured self-concept and a new way to be seen by others. The provider can assist the grieving spouse with this transition. Grieving spouses will

typically experience pain as they adjust to their new circumstances. To help grievers understand, make sense of, and adjust to their new world, practitioners can suggest the following tasks:

Compile a loss book that will describe the postloss world. Ask the bereaved to answer questions such as the following:

1. “What’s different now?”
2. “Who am I now? ... that I am no longer part of a couple, nor able to walk or breathe without life support...” The list can go on and on.
3. “What do I need to learn or get help with in order to make my life work now?” This list may help to identify new skills required for life in the postloss world.
4. “How are others doing it?” Support groups of people with similar losses may offer comfort, acceptance, and an opportunity to learn from others how to handle many of the concerns that are part of their new identity. The bereaved may feel a sense of normalcy when surrounded by people coping with similar challenges.

Act as Coach in the Postloss World Care providers need to help grieving people to function effectively in the postloss world, or to find resources to help with this challenge. “Lessons” might entail the following:

1. Explaining the nature and varieties of grief to surviving spouses.
2. Acknowledging and normalizing feelings and behaviors that arise in difficult situations. Widows, for instance, often report that they don’t feel welcome when they are with married friends.
3. Providing decision-making support for the newly bereaved, such as advising a widow on home repairs, making financial decisions, or learning how to identify resources via the Internet.
4. Encouraging the bereaved to socialize. For example, coach a widowed man who wants to ask a woman for a date, or provide contacts for recreational activity groups.

Reenter the Social World Grieving spouses may need the care provider’s assistance as they develop a new picture of themselves in the postloss world. Developing a new way of being with other people is an important part of healing. The care provider can help the newly bereaved by setting up “length-of-stay time limits” and a “back door” arrangement for easy departure if needed. For example, the care provider can suggest that a widow sit at the back of a religious service near an exit, or that she go to a party for only an hour, or take her own car so that she can leave when she wants to. Remember to respect people’s own timing when they begin to reenter social life. Grieving people are creating a new narrative for living—and this takes time. For many, a gradual reentry to outer society beyond the safety and comfort of their inner social support circle is the least threatening approach.

Task 4: Reconfigure the Bond With the Lost Person

The bereaved must learn how to maintain a bond with his or her late spouse while reclaiming life in the postloss world. This often means holding onto the past while also living in the present. A grieving person may benefit from thinking, “The image of my loved one is always with me, and although I hold onto the legacy of values we shared, I don’t expect him or her to be physically present as a living bond-mate.”

Many bereaved spouses have benefitted by creating a new kind of bond with their deceased loved one—a *spiritual bond*. This new bond may define the loved one as gone but still available to the grieving person in his or her thoughts. In this way, the griever can feel a continued connection to the loved one. Care providers can facilitate this transition by helping to establish *personal rituals* in which the loved one is included: lighting candles, setting out fresh flowers, cooking his or her favorite foods, visiting the grave or ashes location, working with the loved one’s social cause or charity, having a heart-to-heart “talk” with the loved one, and identifying and integrating the loved one’s values into the bereaved spouse’s own life. Prayer and meditation can be interwoven into the daily rituals if appropriate.

CONCLUSION

Spousal loss will befall nearly all married older adults, many of whom may experience symptoms of grief, distress, loneliness, and anxiety. However, such symptoms vary widely in intensity and duration, and reflect individual-level differences in the nature of the marriage, the context of the death, one’s social and emotional support systems, and other stressors and resources that one faces. No two individuals grieve in precisely the same way. We hope that the general roadmap we have set out provides a useful framework as clinicians seek to understand, diagnose, and ultimately adapt appropriate clinical applications for helping the bereaved older spouses whom they encounter in their practices.

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