Routledge
Taylor & Francis Group

Aging & Mental Health

ISSN: 1360-7863 (Print) 1364-6915 (Online) Journal homepage: https://www.tandfonline.com/loi/camh20

Mental health of older widows and widowers: Which coping strategies are most protective?

Deborah Carr

To cite this article: Deborah Carr (2020) Mental health of older widows and widowers: Which coping strategies are most protective?, Aging & Mental Health, 24:2, 291-299, DOI: 10.1080/13607863.2018.1531381

To link to this article: https://doi.org/10.1080/13607863.2018.1531381

AGING & MENTAL HEALTH
2020, VOL. 24, NO. 2, 291–299
https://doi.org/10.1080/13607863.2018.1531381

Routledge
Taylor & Francis Group

Mental health of older widows and widowers: Which coping strategies are most protective?

Deborah Carr

Department of Sociology, Boston University, Boston, MA, USA

ABSTRACT

I examine: whether specific emotion-focused coping and help-seeking strategies adopted by older widow(er)s 6 months postloss affect depressive, anger, and yearning symptoms 1 year later; whether these effects are accounted for by psychosocial factors which guide the selection of coping strategies; and the extent to which patterns differ by gender. I estimate nested multivariate OLS regression models using data from the Changing Lives of Older Couples, a prospective multiwave survey of spousal bereavement ($N = 164$). Widows are more likely to use positive reframing, active distraction, help-seeking, and turning to God for strength, whereas widowers tend to use avoidant strategies, and are more likely to seek connection with their late spouse. Avoidant strategies like trying to forget and dulling the pain with alcohol increase depressive and anger symptoms; substance use is particularly consequential for men's anger symptoms. Positive reframing increases depressive symptoms yet mitigates against anger. Seeking comfort from God also protects against anger. Seeking help from a doctor increases anger and depressive symptoms in baseline models, although effects are accounted for by selection. Maladaptive coping strategies are linked with anger, whereas depression and yearning are relatively immune to coping strategies, reflecting the relatively short-lived time course of these two symptoms. The results carry implications for bereavement theories and mental health interventions targeting older widow(er)s. Older widowers who cope by turning to unhealthy behaviors are especially prone to anger, which has documented physical health effects and may alienate potential sources of social support.

ARTICLE HISTORY
Received 1 July 2018
Accepted 29 September 2018

KEYWORDS
Coping; depressive symptoms; gender; stress; widowhood

The death of a spouse is one of the most distressing of all life events, although it is an inevitable transition for nearly all partnered older adults (Holmes & Rahe, 1967). In the United States, 34% of women and 12% of men ages 65 and older are currently widowed, and these proportions increase to 73 and 34 among those ages 85 + (Federal Interagency Forum on Aging-Related Statistics, 2016). Emotional reactions vary widely; as many as 15% of widow(er)s experience prolonged or complicated grief (Shear et al., 2011), yet an estimated 50% of older bereaved spouses are resilient, exhibiting few or no prolonged symptoms of depression or grief (Bonanno, 2004). Extensive research documents the factors that render older widow(er)s vulnerable to grief and depression, focusing primarily on sociodemographic characteristics (Sasson & Umberson, 2013), the context of the death (Carr, 2004), and the coping resources one can access including social support (Bisconti, Bergeman, & Boker, 2006), financial resources (Van Grootheest et al., 1999), religious beliefs (Brown et al., 2004), and personality traits including conscientiousness (Pai & Carr, 2010).

However, less is known about the behavioral, emotional, and cognitive strategies used to cope with loss, and the efficacy of these strategies for mitigating against mental health symptoms in the longerterm (Young & Foy, 2013). Widow(er)s must cope with practical challenges such as living alone or managing the household tasks previously carried out by their spouse (restoration-oriented), and the emotional distress associated with the death (loss-oriented) (Stroebe, Schut, & Stroebe, 2005). Given the breadth and number of stressors surrounding widowhood, the coping strategies used may be highly consequential for late-life mental health.

Researchers have identified two broad strategies for coping with stress: problem-focused coping (PFC) seeks to alter or eliminate the stressful situation, whereas emotion-focus coping (EFC) is aimed at ameliorating one's emotional or cognitive response to the stressor. PFC may enhance mental health by improving the conditions that are a source of distress, and fostering a sense of personal control, efficacy, and accomplishment (Folkman & Moskowitz, 2004). However, in situations that cannot be altered, managing one's emotional reactions may be a more viable and protective strategy– no amount of PFC will bring back a deceased spouse. EFC encompasses avoidant strategies like denial and substance use, and approach strategies like seeking emotional support, cognitive reframing (i.e., thinking positive thoughts), or turning to a higher power (Nielsen & Knardhal, 2014). Avoidant EFC strategies like blocking out troubling thoughts are generally linked with poorer mental health, yet results are less conclusive regarding the use of approach-oriented strategies such as reminiscing about happier times, or help-seeking (Folkman & Moskowitz, 2004, Taylor & Stanton, 2007).

Mental health researchers have identified four main reasons for the inconsistent or equivocal findings regarding the efficacy of EFC (see Pearlin, 1999 for review). First, most studies use general measures of the coping strategies one

CONTACT Deborah Carr carrds@bu.edu

typically adopts during stressful times, rather than the specific strategies one actually used in the face of a particular stressor (e.g. Coping Orientations to Problems Experienced [COPE] scale, Carver, Scheier & Weintraub, 1989; Ways of Coping instrument; Folkman & Lazarus, 1988). As such, "knowing how an individual copes with stress in general may reveal very little about how he or she will cope with a specific stressful event" such as widowhood (Penley, Tomaka, & Wiebe, 2002: 552). Coping strategies have low stability over time, suggesting that the tactics one invokes are context-specific and vary based on the stressor's intensity, salience, novelty, or irreversibility (Carver & Connor-Smith, 2010; Nielsen & Knardhal, 2014).

Second, when study participants are asked to describe their coping strategies in the face of a specific stressor (typically assessed as "the most stressful event" one has experienced "in the past week or month"), the events selected vary on the basis of recency, severity, and emotional salience (Folkman & Moskowitz, 2004; Penley et al., 2002). The emotional consequences of stressful life events tend to be fairly short-lived, so studies that combine recent and distal stressors may offer misleading findings regarding the impact of particular coping practices on mental health. Additionally, one respondent may reference something as severe as a death in the family, and another may mention something more mundane such as a minor traffic accident. As such, studies cannot easily disentangle whether a particular coping strategy is protective against mental health symptoms, or whether these purported effects are confounded with characteristics of the stressor (Aldwin & Revenson, 1987; Nielsen & Knardhal, 2014).

Third, most studies focus on the single outcome of depressive symptoms, which may conceal the distinctive ways that widows and widowers adapt to loss (Nielsen & Knardhal, 2014). In the face of major stressors, women tend to express internalizing symptoms such as sadness, whereas men may exhibit externalizing symptoms such as anger (Rosenfield & Mouzon, 2013). Moreover, grief encompasses complex symptoms beyond sadness; the loss of close emotional bond may trigger feelings of sorrow, anxiety, anger, and yearning for the deceased (Parkes, 1985). Each symptom may respond differently to the coping strategies used. For instance, yearning refers to a preoccupation with and pining for the deceased (Bowlby, 1980). Continuing bonds with the deceased through strategies like reminiscing about the marriage, speaking with the deceased, or visiting their grave may help mitigate against yearning as one copes with the pain of separation (Klass, Silverman, & Nickman, 2014). Anger, by contrast, may result from feelings of frustration following the loss (Parkes, 1970). Anger is a particularly maladaptive reaction because it can threaten personal relationships, and push away the very people who could be providing support (Keltner, Ellsworth, & Edwards, 1993).

Fourth, studies evaluating the effects of coping strategies on mental health do not consistently address whether one's immediate emotional response to stress motivates the selection of a coping strategy (Aldwin & Revenson, 1987). Depressed persons are less likely to use PFC and more likely to use EFC, although few studies have examined whether mental health shapes the selection of specific EFC strategies (Carver & Connor-Smith, 2010). Depressed widow(er)s may turn to alcohol to self-medicate, whereas those experiencing anger may avoid seeking social support, and those who yearn for their late spouse may seek comfort through positive reminiscence about the marriage. Studies that fail to control for baseline mental health may overstate the mental health consequences of particular coping strategies.

Finally, inconclusive findings regarding the efficacy of coping strategies for older widow(er)s' mental health may reflect that fact that studies do not typically stratify by gender. If the mental health effects of a particular strategy differ substantially for men versus women, then these distinctive effects may be cancelled out or muted in a study using a pooled sample only. Men and women tend to rely on coping tactics consistent with gender-typed socialization regarding emotional display, especially among older cohorts who were raised to comply with such expectations (Brody & Hall, 2010). Men are more likely to use PFC, and to control their emotions, avoid thinking about the situation, and show emotional inhibition or a "bottling up" of emotions (Matud, 2004). Women, by contrast, tend to seek social support, and use EFC tactics such as distracting themselves, releasing their feelings, or praying (Matud, 2004; Thoits, 1995).

To address these concerns and prospectively examine the efficacy of particular coping strategies on older adults' mental health, this study: (1) focuses on the specific stressor of late-life widowhood; (2) examines whether specific EFC strategies adopted six months post-loss affect three conceptually and statistically distinct mental health symptoms (depression, anger, and yearning) 12 months later; and (3) explores the distinctive mental health consequences of these strategies for widows versus widowers. The multivariate analyses incorporate demographic, health, and psychosocial factors that may confound the association between coping strategies and mental health symptoms 18 months postloss.

Methods

Data

Changing Lives of Older Couples (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 in which the husband was age 65 or older. All sample members were non-institutionalized and capable of participating in a two-hour interview. Approximately 65% of those contacted for an interview participated, consistent with response rates from other Detroit area studies. Baseline face-to-face interviews were conducted in 1987 and 1988 (Carr, Nesse, & Wortman, 2005).

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 date and cause 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 which were conducted 6, 18, and 48 months after the spouse's death. I focus on the 164 persons (44 men and 120 women) who participated at the 6 and 18 month follow-ups; this allows

a prospective exploration of how coping strategies employed in the early aftermath of loss affect mental health symptoms 1 year later. I do not extend the analyses through the four-year follow-up, because attrition and mortality render this sample size insufficient for this study ($n = 83$). Attrition analyses reveal that age and baseline anxiety increase the likelihood of nonresponse in subsequent waves, whereas home ownership decreases it. Thus, caution should be taken in generalizing findings to the older widowed population at large, because older, more anxious, and residentially mobile persons may be underrepresented.

Measures

Dependent variables

Depressive symptoms ($\alpha = 0.81$, W1, .83, W2) are assessed with a subset of nine negative items from the 20-item Center for Epidemiologic Studies depression (CES-D) scale (Radloff, 1977). Respondents indicate how often they experienced each symptom in the last week: 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. *Anger* ($\alpha = 0.68$, W1, 0.63, W2) is assessed with three items: in the past month, have you felt (1) resentful or bitter about the death; (2) the death was unfair; and (3) anger toward God. *Yearning* ($\alpha = 0.75$, W1, 0.73, W2) is assessed with four questions: In the last month have you (1) found yourself longing to have your spouse with you; (2) had painful waves of missing your spouse; (3) experienced feelings of intense pain or grief over the loss of your spouse; and (4) experienced feelings of grief, loneliness, or missing your spouse? Response categories are no, never; yes, but rarely; yes, sometimes; and yes, often. Items were drawn from widely used grief scales including the Bereavement Index (Jacobs, Kasl, & Ostfeld, 1986), and Texas Revised Inventory of Grief (Zisook, DeVaul, & Click, 1982).

Independent variables

Coping strategies. Strategies for coping with widow(er)hood are assessed with questions designed expressly for the CLOC. Items were adapted from general coping inventories such as the Ways of Coping (Lazarus & Folkman, 1984) and Coping Orientation to Problems Experienced (COPE; Carver, Scheier, & Weintraub, 1989). Six months postloss, CLOC participants are asked: "I am going to read you a list of things people sometimes do to handle feelings of grief, loneliness or missing their (husband/wife). Please tell me how much you have done this to help you cope with your feelings, at any time since your (husband/wife) died. Have you done this a lot, a little, or not at all? (a) gotten out of the house – gone somewhere, or taken a walk or drive; (b) kept busy or tried to get involved in some activity; (c) turned to God for strength or comfort; (d) tried to dull the pain by turning to alcohol, food, or drugs, or sleeping more; (e) think about the good things about your life; (f) told yourself that things will get better with time, that you have gone through the worst of it; (g) tried to remember the good times that you and your spouse had together; (h) done things that helped you feel close to your spouse, such as going to the cemetery; and (i) tried to forget about what happened?" A dichotomous measure indicates whether each strategy was used "a lot" versus "a little/not at all." Only 2.5% of respondents indicated that they tried to dull the pain by turning to alcohol, food, or drugs, or sleeping "a lot," so I combined the response categories of "a lot" and "a little" (12.2%) for adequately powered analyses.

Factor analyses based on the three-category indicators of each item yielded four subscales, albeit with low to modest scale reliability. The subscales are broadly consistent with more general coping scales, and include *active distraction* ($\alpha = 0.52$; got out of the house, and kept busy); *affiliation-seeking* ($\alpha = 0.27$; turned to God for strength, and did things to feel close to spouse); *avoidance/denial* ($\alpha = 0.31$; used food or substances to dull pain, and tried to forget); and *positive reframing* ($\alpha = 0.53$; think about good things, focus on how things will get better, and remember good times when married). These low scale alphas are consistent with the modest zero-order correlations among the dichotomous indicators of the nine items; correlations are less than 0.40, with most less than 0.20 (see Appendix A). In the multivariate analyses, I evaluate the effects of the dichotomous indicators of each coping strategy and two subscales with alphas greater than 0.50 (active distraction, and positive reframing).

Formal help-seeking is assessed with two items: "To help handle feelings of grief, loneliness, or missing your spouse, have you: (a) seen a minister, priest, or other clergy for help; and (b) talked to your family doctor about your feelings of grief, loneliness, or missing your spouse. Responses are yes or no (reference category). Respondents also indicated whether they had seen a mental health professional or attended a support group. Very few respondents sought these two options ($n = 5$ and 16, respectively), which would not enable sufficiently powered analyses. These patterns are consistent with national trends on help-seeking among older adults, who turn to primary care providers rather than mental health specialists (Jeste et al., 1999).

Three sets of potential correlates of coping and mental health are controlled. First, sociodemographic characteristics include gender (1 = female), race (1 = black), age (in years), education (in years), and home ownership (1 = yes). Both own and late spouse's health (at the baseline preloss interview) are assessed with a standard self-rated health measure: how would you rate your/your spouse's health at the present time. Responses are dichotomized as "fair/poor" versus "good" or better health. Second, I control for a measure of each dependent variable at the six-month interview, to address the concern that the coping strategies employed reflect one's concurrent emotional state.

Third, both coping strategy and adjustment to loss may be a function of emotional dependence on one's late spouse, and social ties beyond one's spouse. Emotional dependence on spouse prior to loss ($\alpha = .80$) is assessed with four items: the idea of losing my (husband/wife) is terrifying to me; no one could ever take the place of my (husband/wife); if my (husband/wife) died, it would be the worst thing that could happen to me; and I would feel completely lost if I didn't have my (husband/wife). One's other social ties ($\alpha = 0.52$) are assessed with two items at baseline: "how often do you go out socially by yourself, or

Table 1. Means (and Standard Deviations) or Proportions, All Variables Used in Analysis.

Dependent variables	Men	Women	Significance
Depressive symptoms (CESD), 18 months	−.056 (.78)	.231 (1.07)	†
Anger, 18 months	.049 (.79)	−.024 (1.06)	
Yearning, 18 months	.051 (.81)	−.107 (1.02)	
Independent Variables			
Coping strategies, 6 months (1 = a lot/very true)			
Gotten out of house	.58	.55	
Kept busy or tried activity	.41	.67	***
Turned to God for strength and comfort	.49	.77	***
Done things to feel close to spouse	.55	.36	*
Dull pain through food or substances[a]	.20	.13	
Tried to forget what happened	.26	.18	
Think about good things in life	.72	.82	*
Told yourself things will get better.	.42	.60	*
Tried to remember good times when married	.90	.85	
Active distraction scale (α = 0.518)	2.30 (.715)	2.48 (.616)	†
Positive reframing scale (α = 0.529)	2.51 (.53)	2.69 (.42)	*
Help-seeking			
Talked to clergy (1 = yes)	.093	.26	*
Talked to doctor about grief (1 = yes)	.27	.36	
Demographics			
Age (in years)	72.92 (5.43)	69.15 (7.21)	***
Race (1 = black)	.16	.16	
Education (in years)	10.69 (3.43)	11.65 (2.42)	*
Owns home (1 = yes)	.96	.91	
Health and Well-being			
Own self-rated health, baseline (1 = fair/poor)	.41	.28	
Depressive symptoms, 6 months	.031 (1.02)	.435 (1.16)	*
Anger, 6 months	.073 (.92)	−.042 (.99)	
Yearning, 6 months	−.036 (.97)	−.059 (1.01)	
Spouse, self-rated health (1 = fair/poor)	.53	.63	
Baseline (Preloss) Support and Strain			
Dependency on spouse scale	.061 (1.06)	−.263 (1.17)	†
Social engagement scale	−.235 (1.08)	.067 (.968)	†
N	44	120	

Men and Women of the Changing Lives of Older Couples (CLOC) Study ($N = 164$).

Notes: Chi-square (categorical measures) and *t*-tests (continuous measures) were conducted to evaluate statistically significant gender differences where $^{\dagger}p < .10$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

[a]Percentage who did this "a lot" or "a little" ($n = 26$) versus never ($n = 138$), reflecting the small number of cases ($n = 4$) in the "a lot" category only.

with people other than your spouse?" and "Although my marriage is important to me, I have a lot of outside interests and friends."

Analysis plan

The analysis has four steps. First, I provide descriptive information on the coping strategies used by older bereaved spouses six months postloss, and indicate significant gender differences. Second, I use OLS regression to evaluate whether each coping strategy affects depressive symptoms, anger, and yearning 1 year later, and the extent to which these associations are accounted for by potential confounds. Finally, I conduct moderation analyses to evaluate gender differences in the effects of coping on mental health, in fully adjusted models.

Results

Bivariate analysis: Gender differences in coping with loss

Older women and men differ significantly regarding the strategies they use "a lot" to cope with spousal loss, as the results show in Table 1. Of the two indicators of active distraction, women and men do not differ with respect to getting out of the house (0.58 vs. 0.55), although a significantly higher proportion of women try to keep busy through involvement in activities (0.67 vs. 0.41, $p < .000$). Widows and widowers differ with respect to their efforts to seek affiliation; 77 percent of women yet just 49 percent of men ($p < .000$) turned to God for strength, although more men than women did things to feel close to their spouse, such as going to the cemetery (0.55 vs. 0.36, $p < .05$).

Avoidant strategies are the least frequently endorsed. Widowers are more likely than widows to say they tried to forget about the death (0.26 vs. 0.18), and that they turned to alcohol, food, or drugs to lessen their pain (0.20 vs. 0.13), although these differences are not statistically significant. By contrast, positive reframing is the most widely used strategy, with nearly all sample members using at least one of the three approaches "a lot." Men and women do not differ with respect to remembering good times when they were married (0.85 and 0.90, n.s.), although a significantly higher proportion of women try to think about the good things in life (0.82 vs. 0.72, $p < .05$), and tell themselves that things will get better in the future (0.60 vs. 0.42, $p < .05$).

Widows are more likely than widowers to seek formal help; a higher proportion of women than men talked to clergy (0.26 vs. 0.093, $p < .05$) or a doctor (0.36 vs. 0.27, n.s.). Widows also report significantly more depressive symptoms than widowers both six (0.44 vs. 0.31, $p < .05$) and 18 (0.23 vs. −.06, $p < .10$) months postloss, although they do not differ significantly with respect to yearning and anger symptoms at either time point. Other gender differences are consistent with prior studies of older adults, where women report lower levels of emotional reliance on their spouse yet higher levels of social integration preloss.

Table 2. Summary of OLS Regressions Predicting Depressive Symptoms (CESD) 18 Months Postloss, Based on Coping Strategies Adopted Six Months Postloss.

	Model 1	Model 2	Model 3	Model 4
Tell yourself things will get better with time	.385* (.155) [.031]	.356* (.159) [.081]	.254† (.133) [.363]	.242† (.133) [.368]
Try to forget what happened	.379* (.145) [.017]	.415* (.204) [.076]	.186 (.173) [.353]	.192 (.175) [.359]
Positive reframing scale (Range: 1 to 3)	.303† (.173) [.013]	.287 (.181) [.072]	.286† (.150) [.359]	.237 (.154) [.361]
Talked to doctor about grief	.438** (.163) [.037]	.405* (.161) [.089]	.162 (.139) [.353]	.087 (.147) [.356]

Note: Values presented are regression coefficient, (standard error), and [adjusted R^2].
Each coping indicator entered into separate model. Model 1 includes coping indicator only. Model 2 adjusts for age, sex, education, home ownership, race, own health, and spouse health; Model 3 further controls for depressive symptoms (CESD) 6 months postloss; and Model 4 incorporates controls for emotional dependence on spouse and social integration preloss. Statistically significant coefficients indicated where $^{\dagger}p < .10$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Table 3. Summary of OLS Regressions Predicting Anger 18 Months Postloss, Based on Coping Strategies Adopted Six Months Postloss.

	Model 1	Model 2	Model 3	Model 4
Turned to God for strength and comfort	−.349* (.166) [.021]	−.332† (.175) [.029]	−.318* (.156) [.222]	−.308* (.157) [.223]
Tell yourself things will get better with time	.229 (.155) [.007]	.307† (.161) [.029]	.302* (.144) [.223]	−.303* (.144) [.226]
Tried to forget what happened	.362† (.192) [.015]	.484* (.205) [.041]	.443* (.184) [.230]	.400* (.188) [.226]

Note: Values presented are regression coefficient, (standard error), and [adjusted R^2].
Each coping indicator entered into separate model. Model 1 includes coping indicator only. Model 2 adjusts for age, sex, education, home ownership, race, own health, and spouse health; Model 3 further controls for anger symptoms 6 months postloss; and Model 4 incorporates controls for emotional dependence on spouse and social integration preloss. Statistically significant coefficients indicated where $^{\dagger}p < .10$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Table 4. Summary of OLS Regressions Predicting Yearning 18 Months Postloss, Based on Coping Strategies Adopted Six Months Postloss.

	Model 1	Model 2	Model 3	Model 4
Tried to remember the good times that you and your spouse had together.	.519* (.219) [.028]	.510* (.230) [.026]	.154 (.190) [.366]	.120 (.193) [.374]
Talked to doctor about grief	.503** (.157) [.054]	.503** (.158) [.057]	.079 (.138) [.365]	.019 (.143) [.372]

Notes: Values presented are regression coefficient, (standard error), and [adjusted R^2].
Each coping indicator entered into separate model. Model 1 includes coping indicator only. Model 2 adjusts for age, sex, education, home ownership, race, own health, and spouse health; Model 3 further controls for yearning symptoms six months postloss; and Model 4 incorporates controls for emotional dependence on spouse and social integration preloss. Statistically significant coefficients indicated where $^{\dagger}p < .10$; $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Multivariate analysis

The primary aim is to examine prospectively the mental health effects of loss-related coping strategies, and to evaluate the extent to which these effects are accounted for by potential confounds. Separate models are estimated for each coping strategy; only statistically significant coping indicators are presented. Coefficients from nested models are presented in Tables 2–4; Model 1 shows unadjusted effects of coping indicators only, Model 2 incorporates sociodemographics and health, Model 3 adds in mental health at the six-month follow-up, and Model 4 further adjusts for relationship characteristics at baseline (Model 4).

Coping Strategies and Mental Health. The two active distraction strategies, getting out of the house and keeping busy with activities, are not significant predictors of mental health, in either the baseline or adjusted models. The seven other EFC strategies are linked prospectively with mental health, although effects vary based on the outcome considered. In general, efforts to improve one's mood through avoidance or positive reframing are ineffective approaches to enhancing mental health in the longer term. Trying to forget about the loss predicts elevated depressive and anger symptoms one year later. Table 2 shows that those who try to forget about the death subsequently report depressive symptoms roughly .4 standard deviations higher than those who don't use this strategy, in the unadjusted model and after sociodemographics are controlled (b = 0.379 and 0.415 respectively, $p < .05$). However, after six-month depressive symptoms are controlled in Model 3, the coefficient for "try to forget" declines substantially and is no longer statistically significant. By contrast, efforts to forget are linked with elevated symptoms of anger one year later, even in the fully controlled model (b = 0.400, $9#$p < .05$).

One positive reframing strategy, telling oneself that things will get better over time, affects bereaved spouses' mental health, albeit in different ways for depressive versus anger symptoms. Depressive symptoms are significantly elevated at the 18-month follow-up for bereaved persons who tried to convince themselves that their grief would get better over time. As with efforts to forget, these effects decline substantially after depressive symptoms at six months are controlled; however, effects remain marginally significant (b = 0.24, $p < .10$). In sharp contrast, adopting a positive outlook is linked with significantly lower levels of anger, with effects persisting net of all controls (b = −.303, $p < .05$).

Turning to God for strength and comfort is a powerful predictor of just one of the three outcomes: anger. Across all four models in Table 3, those who turn to God evidence anger levels roughly one-third standard deviation lower than those who don't ($p < .05$). Similarly, trying to remember good times with one's spouse is linked with only one outcome: yearning. Table 4 shows that those who reminisce about happy times with their spouse have yearning scores roughly one-half standard deviation higher than those who don't, in both the baseline model and after sociodemographics are adjusted. However, this association is no longer significant after yearning symptoms at 6 months are controlled, suggesting that those who yearn most for their spouse in the early stages of loss are especially motivated toward positive reminiscence. In the longer-term, however, this strategy is not consequential for yearning symptoms.

Formal Help-Seeking. Seeking help from clergy is not a significant predictor of any of the three mental health symptoms at the 18 month follow-up. Likewise, turning to clergy is not a function of one's concurrent mental health symptoms; none of three mental health symptoms at the 6

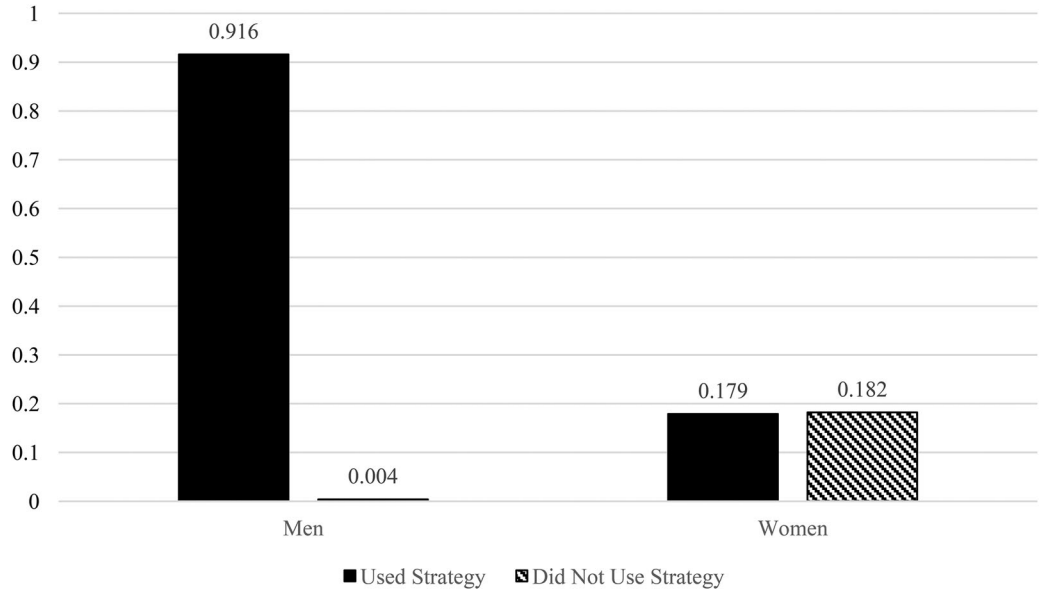

Figure 1. Anger Symptoms (Standardized) 18 Months Postloss by Gender, Based on Use of Substances or Food to Dull Pain 6 Months Postloss.
Note: Plotted values based on fully adjusted model

month interview are significantly correlated with turning to clergy, and all zero-order correlations are less than 0.03 (see Appendix A). In sharp contrast, turning to one's doctor is a powerful predictor of subsequent mental health, although these effects are fully due to social selection. Widow(er)s who spoke with a family doctor to help them cope with loss reported significantly higher unadjusted levels of depressive symptoms (b = .438, $p < .01$) and yearning (b = .503, $p < .01$) 1 year later (see Model 1, Tables 2 and 4). However, these sizeable effects are due to selection, where those who were most depressed or yearned most for their spouses in the first 6 months postloss were more likely to seek out help from their doctors. As Model 3 in Tables 2 and 4 show, once mental health symptoms at the six month interview are controlled, the previous effects decline substantially in magnitude and are no longer statistically significant. The zero-order correlations between seeking a doctor's help and both depressive symptoms and yearning at the six-month follow-up are substantial ($r = 0.22$ and 0.34 respectively; $p < .05$).

Moderation Analyses: Do Effects of Coping Strategies on Mental Health Differ by Gender? The final aim is to assess whether particular coping strategies affect mental health differently for widows versus widowers. Only one two-way interaction term of the 33 tested (11 per each of three outcomes) is statistically significant, after applying a Bonferroni correction for multiple comparisons per each outcome. Fully adjusted results are plotted in Figure 1 (complete models available from author). Dulling one's pain through use of alcohol, drugs, sleep, or food has significantly different effects on men's and women's anger symptoms, such that widowers who used this strategy have anger scores .912 standard deviations higher than those who did not ($p < .001$), and .183 standard deviations higher than widows who relied on this strategy ($p < .004$). By contrast, anger symptoms among women do not differ significantly based on use of this strategy (b = 0.183 vs. 0.178, n.s.). Dulling pain through substances was not a significant predictor of anger in the main effects model, and the addition of the two-way interaction improved model fit (adjusted R^2 increased from .205 to .245). The non-significant effect in the main effects model likely reflects the disproportionately large share of women in the sample.

Discussion

This study explored how widow(er)s' EFC strategies and formal help-seeking in the early stages of loss affect three dimensions mental health one year later, and the extent to which these patterns differ by gender. Six main findings emerged. First, widows and widowers differ in how they cope with bereavement-related stress, and these patterns are generally consistent with those detected in studies using dispositional coping styles measures (Kelly et al., 2008). Men are more likely to use avoidant strategies such as trying to forget, or dulling their pain through food or drink. Women are more likely to turn to God and keep busy with activities, consistent with research emphasizing the salience of social and religious ties to women (Levin, Chatters, & Taylor, 1994). However, widowers are more likely to rely on the two strategies linked explicitly to their marital relationship: positive reminiscence about the marriage and "continuing bonds" with their late spouse. Widows may rely more heavily on long-standing and new social ties to cope with loss, whereas widowers may be drawn to comforting memories of their late spouse, consistent with research documenting the centrality of marriage to older men's emotional well-being (Carr, Freedman, Cornman & Schwarz, 2014).

Second, turning to God for strength and comfort protects against anger symptoms, net of all confounds. Theoretical work suggests that religious beliefs create systems of meaning, order, and sense-making that help one to cope with loss (Neimeyer, 2005). Faith or belief in God also may provide a sense of equanimity and acceptance that mitigates against feelings of anger and injustice, and may help older adults to regulate their negative emotions (Davis, Wortman, Lehman, & Silver, 2000).

Third, cognitive attempts at positive reframing have distinctive effects for depression versus anger. In baseline models, bereaved spouses trying to adopt a positive outlook evidenced heightened depressive symptoms 1 year

later, although these effects were accounted for by earlier mental health. In contrast, positive reframing significantly reduced anger symptoms, net of controls. These findings are intriguing and require further exploration. Emerging research challenges the "power of positive thinking." Overly positive thoughts may engender complacency and weaken one's motivation to improve their situation, or may require intensive cognitive and emotional work that yields few tangible results, especially in the face of an irrevocable stressor like bereavement (Oettingen, 2014). However, if positive reframing enables a re-interpretation of death as just or inevitable (rather than unjust and preventable), then these cognitions may minimize feelings of anger.

Fourth, yearning was the only outcome linked to coping strategies intended to sustain ties with the deceased, although this association was no longer statistically significant in the fully controlled models. Theoretical writings on "continuing bonds" argue that it is helpful for widow(er)s to talk with and find comfort in the felt presence of their late spouse (Klass et al., 2014). However, some empirical assessments suggest that neither relinquishing nor continuing bonds with the decedent is uniformly adaptive; rather, the impact may be conditional on other factors such as the quality of the late marriage (Stroebe et al., 2005). Future studies based on larger samples should explore whether strategies like revisiting memories of one's marriage or maintaining connections through visits to the cemetery are more or less protective based on levels of closeness and conflict in the late marriage.

Fifth, seeking help from one's family doctor or clergy did not affect mental health in the longer term, once mental health-related selection was controlled. These results underscore the importance of considering the ways that one's mental health symptoms immediately postloss guide the selection of a particular coping strategy. Failure to control for baseline mental health would have yielded the potentially erroneous conclusion that treatment worsens bereaved spouses' mental health. These findings are consistent with research showing that few interventions or treatments are successful in reducing symptoms of sadness and loss among bereaved spouses, except in cases where the bereaved had a history of depression unrelated to the loss (Bonanno, 2004).

Finally, only one strategy had significantly different mental health consequences for men and women. Turning to alcohol, food, or sleep to dull one's pain was a powerful predictor of widowers' anger, although comparable effects were not evidenced among widows. Future work should explore more fully what this strategy entails. Men may turn to heavy drinking, whereas women may use less extreme types of self-soothing, such as sleeping or eating comfort foods. The large (nearly 1 standard deviation) effect documented for widowers' anger symptoms suggests a critical point for intervention. The outward expression of anger can undermine widowers' personal relationships and push away potential sources of social support, rendering one vulnerable to the stress-drinking cycle (Keltner, Ellsworth, & Edwards, 1993; Schieman, 2006). Unexpressed or suppressed anger, by contrast, increases one's risk of health problems including cardiovascular disease (Suls & Bunde, 2005). Thus, practitioners should be particularly attentive to anger symptoms among older widowers, and should facilitate the use of coping practices that do not further intensify these symptoms.

This study identified specific coping strategies that protect against (or intensify) anger symptoms among older widows and widowers. The results reveal surprisingly weak associations between coping and subsequent depressive and yearning symptoms, consistent with recent cross-sectional and longitudinal studies detecting only modest associations between general coping tendencies and mental health (Nielsen & Knardhal, 2014; Penley et al., 2002). These weak effects may reflect the time course of depressive and yearning symptoms, especially among older adults. Bonanno et al. (2002) examined trajectories of depressive and grief symptoms (excluding anger) in the CLOC and found that by the 18-month follow-up, three-quarters of study participants had returned to preloss symptom levels. My results confirm that while bereaved older adults may experience "transient perturbations in normal functioning" (Bonanno, 2004: 21), symptoms of yearning and depression are relatively immune to the influence of coping strategies in the longer term. Coping strategies appear to have "a relatively small influence on adjustment and recovery compared to factors such as timing and nature of the death, history, and personality" (Folkman, 2001, p. 564).

Limitations

This study has several limitations. First, formal help-seeking measures are coarse, and do not specify what happened in the clinical or pastoral encounter, the duration or quality of care received, whether the widow(er) adhered to recommended treatments, and whether one sought help voluntarily, was referred by a social worker, or was brought in by a concerned family member (Pescosolido & Boyer, 1999). It would be premature to conclude that help-seeking is ineffective in reducing older widow(er)s' mental health symptoms without delving more fully in precisely what the formal support entailed. Second, the small analytic sample prevented the examination of more fine-grained patterns; the mental health effects of coping strategies may be moderated by personality, the quality of the late marriage, the context of the death, and other coping strategies employed simultaneously or sequentially.

Despite these limitations, the study has documented the mental health consequences of EFC strategies used by older widows and widowers, and reveals that coping strategies undertaken with the goal of ameliorating one's emotional health in the short-term, like trying to block out one's grief, may carry longer-term harmful consequences. Further, no single strategy is uniformly protective (or detrimental) for the three mental health outcomes considered. As such, psychological, medical, or social service interventions should be tailored to meet the distinctive vulnerabilities and symptoms of older bereaved spouses.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

National Institutes of Aging.

ORCID

Deborah Carr http://orcid.org/0000-0002-8175-5303

References

Aldwin, C. M., & Revenson, T. A. (1987). Does coping help? A re-examination of the relation between coping and mental health. *Journal of Personality and Social Psychology*, *53*, 337–348.

Bisconti, T. L., Bergeman, C. S., & Boker, S. M. (2006). Social support as a predictor of variability: an examination of the adjustment trajectories of recent widows. *Psychology and Aging*, *21*, 590–599.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, *59*, 20–28.

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Sonnega, J., Carr, D., & Nesse, R. M. (2002). Resilience to loss and chronic grief: a prospective study from pre-loss to 18 months post-loss. *Journal of Personality and Social Psychology*, *83*, 1150–1164.

Bowlby, J. (1980). *Attachment and loss*. New York: Basic Books.

Brody, L. R., & Hall, J. A. (2010). Gender, emotion, and socialization. In J. C. Chrisler & D. R. McCreary (Eds.), *Handbook of gender research in psychology* (pp. 429–454). New York: Elsevier.

Brown, S. L., Nesse, R. M., House, J. S., & Utz, R. L. (2004). Religion and emotional compensation: Results from a prospective study of widowhood. *Personality and Social Psychology Bulletin*, *30*, 1165–1174.

Carr, D. (2004). Gender, pre-loss marital dependence and older adults' adjustment to widowhood. *Journal of Marriage and Family*, *66*, 220–235.

Carr, D., Freedman, V. A., Cornman, J. C., & Schwarz, N. (2014). Happy marriage, happy life? Marital quality and subjective well-being in later life. *Journal of Marriage and Family*, *76*, 930–948.

Carr, D., Nesse, R., & Wortman, C. B. (Eds.). (2005). *Spousal bereavement in late life*. New York: Springer Publishing.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, *56*, 267–286.

Carver, C. S., & Connor-Smith, J. (2010). Personality and coping. *Annual Review of Psychology*, *61*, 679–704.

Davis, C. G., Wortman, C. B., Lehman, D. R., & Silver, R. C. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death Studies*, *24*, 497–540.

Federal Interagency Forum on Aging-Related Statistics. (2016). *Older Americans 2016: Key indicators of well-being*. Washington, DC: U.S. Government Printing Office.

Folkman, S., & Lazarus, R. S. (1988). *Ways of coping questionnaire*. Sunnyvale, CA: Consulting Psychologists Press.

Folkman, S. (2001). Revised coping theory and the process of bereavement. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.). *Handbook of bereavement research: Consequences, coping, and care* (pp. 563–584), Washington, DC: American Psychological Association.

Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annual Review of Psychology*, *55*, 745–774.

Jacobs, S., Kasl, S. V., & Ostfeld, A. (1986). The measurement of grief: bereaved versus non-bereaved. *The Hospice Journal*, *2*, 21–36.

Jeste, D. V., Alexopoulos, G. S., Bartels, S. J., Cummings, J. L., Gallo, J. J., Gottlieb, G. L., … & Lebowitz, B. D. (1999). Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. *Archives of General Psychiatry*, *56*, 848–853.

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment scale. *Journal of Psychosomatic Research*, *11*, 213–228.

Kelly, M. M., Tyrka, A. R., Price, L. H., & Carpenter, L. L. (2008). Sex differences in the use of coping strategies: Predictors of anxiety and depressive symptoms. *Depression and Anxiety*, *25*, 839–846.

Keltner, D., Ellsworth, P. C., & Edwards, K. (1993). Beyond simple pessimism: Effects of sadness and anger on social perception. *Journal of Personality and Social Psychology*, *64*, 740–752.

Klass, D., Silverman, P. R., & Nickman, S. (2014). *Continuing bonds: New Understandings of Grief*. New York: Taylor & Francis.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Levin, J. S., Taylor, R. J., & Chatters, L. W. (1994). Race and gender differences in religiosity among older adult: Findings from four national surveys. *Journals of Gerontology: Social Sciences*, *49*, 137–145.

Matud, M. P. (2004). Gender differences in stress and coping styles. *Personality and Individual Differences*, *37*, 1401–1415.

Neimeyer, R. A. (2005). Widowhood, grief and the quest for meaning. In D. Carr, R. M. Nesse, & C. B. Wortman (Eds.) *Spousal bereavement in late life* (pp. 227–252). New York: Springer.

Nielsen, M. B., & Knardhal, S. (2014). Coping strategies: a prospective study of patterns, stability, and relationships with psychological distress. *Scandinavian Journal of Psychology*, *55*, 142–150.

Oettingen, G. (2014). *Rethinking positive thinking: inside the new science of motivation*. New York: Current.

Pai, M., & Carr, D. (2010). Do personality traits moderate the effects of spousal loss on psychological adjustment? *Journal of Health and Social Behavior*, *51*, 183–199.

Parkes, C. M. (1970). The first year of bereavement: A longitudinal study of the reaction of London widows to the death of their husbands. *Psychiatry*, *33*(4), 444–467.

Parkes, C. M. (1985). Bereavement. *The British Journal of Psychiatry*, *146*, 11–17.

Pearlin, L. I. (1999). The stress process revisited: reflections on concepts and their interrelationships. In C. S. Aneshensel & J. C. Phelan (Eds.), *Handbook of sociology of mental health* (pp. 395–415). New York: Kluwer Academic/Plenum Publishers.

Penley, J. A., Tomaka, J., & Wiebe, J. S. (2002). The association of coping to physical and psychological health outcomes: A meta-analytic review. *Journal of Behavioral Medicine*, *25*, 551–592.

Pescosolido, B. & Boyer, C. A. (1999). How do people come to use mental health services? Current knowledge and changing perspectives. In A. V. Horwitz & T. A. Scheid (Eds.), *A handbook for the study of mental health* (pp. 392–411). New York: Cambridge University Press.

Radloff, L. S. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement*, *1*, 385–401.

Rosenfield, S., & Mouzon, D. (2013). Gender and mental health. In C. S. Aneshensel, J. C. Phelan, & A. Bierman (Eds.), *Handbook of the sociology of mental health* (pp. 277–296). New York: Springer.

Sasson, I., & Umberson, D. J. (2013). Widowhood and depression: New light on gender differences, selection, and psychological adjustment. *Journals of Gerontology: Social Sciences*, *69*, 135–145.

Schieman, S. (2006). Anger. In J. E. Stets & J. H. Turner (Eds.), *Handbook of the sociology of emotions* (pp. 493–515). New York: Springer.

Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., & Gorscak, B. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, *28*, 103–117.

Stroebe, M., Schut, H., & Stroebe, W. (2005). Attachment in coping with bereavement: A theoretical integration. *Review of General Psychology*, *9*, 48–66.

Suls, J., & Bunde, J. (2005). Anger, anxiety, and depression as risk factors for cardiovascular disease: The problems and implications of overlapping affective dispositions. *Psychological Bulletin*, *131*, 260–300.

Taylor, S. E., & Stanton, A. L. (2007). Coping resources, coping processes, and mental health. *Annual Review of Clinical Psychology*, *3*, 377–401.

Thoits, P. A. (1995). Stress, coping, and social support processes: where are we? What next? *Journal of Health and Social Behavior*, *19*, 53–79.

Van Grootheest, D. S., Beekman, A. T. F., Broese van Groenou, M. I., & Deeg, D. J. (1999). Sex differences in depression after widowhood: Do men suffer more? *Social Psychiatry and Psychiatric Epidemiology*, *34*, 391–98.

Young, W. B., & Foy, S. L. 2013. The influence of meaning-making after spousal loss on trajectories of psychological distress. *Society and Mental Health*, *3*, 187–202.

Zisook, S., Devaul, R. A., & Click, M. A. (1982). Measuring symptoms of grief and bereavement. *The American Journal of Psychiatry*, 139, 1590–1593.

Appendix A. Zero-order correlations among coping strategies, mental health at six and 18 months postloss, and sociodemographic controls.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)
(1) Got out of house																				
(2) Kept busy	**.36**																			
(3) Turned to God	.02	.09																		
(4) Close to spouse	**.22**	.15	**.16**																	
(5) Dull pain	**.26**	.12	−.06	.05																
(6) Try to forget	−.02	.032	**−.15**	−.01	**.22**															
(7) Think good	−.12	.10	**.22**	.13	−.13	.12														
(8) Things better	.14	**.17**	.01	.03	.02	**.26**	**.33**													
(9) Remember married	.17	−.01	.14	.15	.013	.06	**.37**	**.19**												
(10) Active distraction	**.77**	**.71**	−.03	**.21**	**.22**	.08	−.04	**.20**	.11											
(11) Positive reframing	.07	.12	.10	.12	−.05	**.22**	**.68**	**.70**	**.62**	**.19**										
(12) Clergy	.09	.12	**.20**	.06	.01	.01	**.76**	**.22**	.05	.13	**.22**									
(13) Doctor	**.26**	.05	.14	.11	**.23**	**.15**	.13	**.28**	**.20**	**.18**	**.28**	**.18**								
(14) CESD, 6 mos.	.04	.10	.09	.07	**.25**	.09	−.01	.08	−.01	.11	−.01	.13	**.22**							
(15) Anger, 6 mos.	**.22**	.12	−.07	.01	**.17**	.04	**−.16**	−.01	.04	**.19**	−.05	.01	.09	**.31**						
(16) Yearning, 6 mos.	**.21**	.14	**.24**	**.26**	**.18**	−.03	.08	−.06	**.17**	**.18**	−.02	.03	**.34**	**.47**	**.28**					
(17) Depend spouse	.13	−.14	.01	.13	.05	.14	.15	.02	**.25**	−.01	.11	.03	**.29**	.11	−.07	**.31**				
(18) Social life	−.01	.06	.09	−.18	−.14	−.10	.11	.08	.03	.12	**.18**	.01	.09	**−.19**	.01	**−.19**	**−.18**			
(19) CESD, 18 mos.	−.02	.06	.02	−.05	−.01	**.15**	−.14	**.19**	.07	.09	.14	.10	**.21**	**.55**	**.21**	**.34**	.14	.01		
(20) Anger, 18 mos.	−.02	.03	**−.16**	.07	.13	**.15**	−.03	.11	−.01	−.02	**.03**	.00	.11	**.25**	**.47**	**.26**	.04	−.12	.12	
(21) Yearning, 18 mos.	.12	−.03	.12	.08	.06	.03	.12	.01	**.18**	.06	**.09**	.05	.25	**.27**	.18	**.58**	**.25**	**.03**	**.50**	**.28**

Note: Bold face denotes a statistically significant correlation at the $p < .05$ level.