

## Spousal/Intimate Partner Loss and Bereavement

### Key Concepts

- ◆ *Spousal loss can occur at any age, yet, in the United States and most advanced nations today, it is a transition overwhelmingly experienced by persons aged 65 and older. Widowhood/widowerhood is the loss of one's husband, wife, or romantic partner through death.*
- ◆ *Bereavement is the objective condition of having lost someone meaningful through death.*
- ◆ *Complicated grief is a period of at least 6 months immediately following the death of a loved one, marked by prolonged acute grief symptoms and an unsuccessful struggle to rebuild one's life without the decedent. It affects roughly 10% of bereaved persons.*
- ◆ *Death context affects the grieving process and includes characteristics of the dying process and death, including location, cause of death, symptoms, duration of illness, pain, and intensity of caregiving.*
- ◆ *Caregiving is the process of providing direct physical, emotional, or instrumental care to a person with a physical or mental health condition and may involve basic care or complex personal and nursing care tasks.*
- ◆ *Widow(er)s' psychological adjustment varies based on the nature of the relationship lost.*
- ◆ *Tailored interventions that take into account heterogeneity in the widow(er)'s experience are more effective than a "one size fits all" approach.*

Spousal bereavement, or the death of one's husband, wife, or long-term romantic partner, is considered one of life's most stressful events (Carr & Jeffreys, 2011). Today, death in the United States and other wealthy nations typically occurs in later life following a long period of chronic illness, such as cancer. Consequently, widowhood is a stressor that overwhelmingly befalls older adults and, given that men have higher mortality rates than women and typically die before their spouse, creates a context where widowhood is largely an older women's problem (Miniño & Murphy, 2012).

Following the death of their spouse, most older adults experience a period of at least 2 weeks marked by sadness, depressive symptoms, and anxiety; a much smaller proportion experience more persistent or serious symptoms including complicated grief, major depression, physical health declines, or death (e.g., Utz, Caserta, & Lund, 2012). Given this wide variation in bereaved spouses' response to loss, researchers have focused on identifying specific characteristics of the late marriage, the survivor, and the death context that contribute to widow(er)'s adjustment.

This chapter (1) summarizes data on the demography of spousal bereavement in the United States today; (2) describes aspects of the late marriage (e.g., marital quality), death context (e.g., cause of death, caregiving, prolongation, quality of care), and co-occurring stressors (e.g., financial strains) that contribute to bereaved spouse well-being; and (3) suggests practices for social work professionals who work with newly and longer-bereaved spouses. Tailored interventions that take into account heterogeneity in the widow(er)'s experience are more effective than a one-size-fits-all approach.



### Background: What We Have Learned So Far

#### The Demography of Spousal Bereavement

Spousal loss can occur at any age, yet, in the United States and most wealthy nations today, it is a transition overwhelmingly experienced by persons aged 65 and older. Of the roughly 900,000 persons widowed annually in the United States, nearly three quarters fall into this age category (FIFARS, 2012). And because life expectancy is roughly 79 years for men and 84 years for women, women are much more likely than men to become widowed (Miniño & Murphy, 2012).

Among persons aged 65 to 74, 26.3% of women but just 7.3% of men are widowed; at ages 75 and older, these percentages jump to 58.2% of women and 20.5% of men (Figure 75.1). This stark gender gap also reflects that widowers are far more likely than widows to remarry and thus may “exit” the widowed category. Widows are less likely than widowers to remarry because of a dearth of potential partners, because for persons aged 65 and older in the United States, the sex ratio is 1.5 women per every one man, and by age 85, this ratio is more than three women per every man. As a result, few widows have the opportunity to remarry even if they would like to do so. Additionally, cultural norms encourage men to marry women younger than themselves, so widowed men may opt to remarry a younger woman, whereas older widows do not typically have that option (FIFARS, 2012). Qualitative interviews also show that women who were caregivers to dying husbands, especially those dying from prolonged, distressing, and treatment-intensive illness such as cancer, are reluctant to remarry again and possibly relive the stressful role of caregiver (Bennett, Hughes, & Smith, 2003).

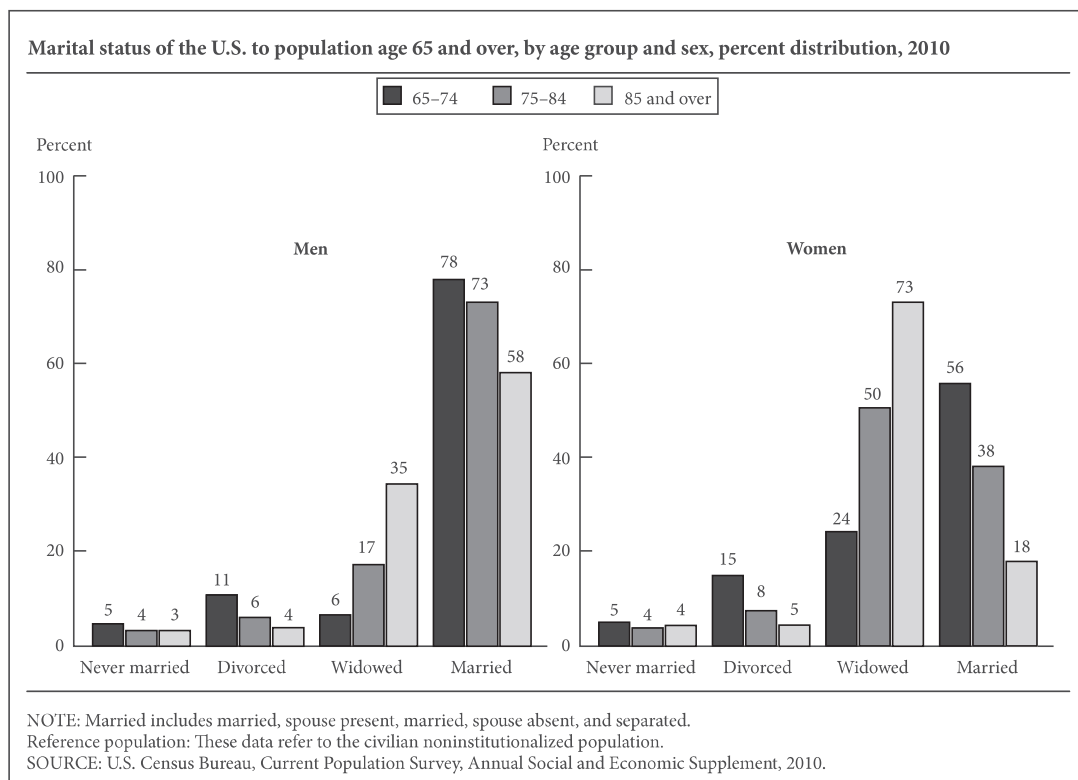
Far less is known about the number of bereaved persons following a long-term same-sex relationship. According to data from the 2010 U.S. census, there are currently 605,000 same-sex households in the United States, 27% of whom identify as married. The average age of the partners in same-sex households is 48 years old; roughly 13% are 65 or older, and 17% are between 55 and 64 years (Lofquist, 2011). Thus, many older gay and lesbian persons are at risk of losing a partner. As we discuss later in this chapter, gay and

lesbian couples both face distinctive obstacles and have access to different resources than do straight couples as they cope with the loss of these relationships.

Historically, spousal or partner loss has been characterized as an *event* that occurs upon the death of one’s spouse; however, contemporary late-life widowhood is best conceptualized as a *process*. Most older adults die as a result of chronic diseases that can persist for months and even years, requiring care from a personal caregiver (FIFARS, 2012). The four leading causes of death among older adults in the United States today—heart disease, cancer, cerebrovascular disease, and chronic obstructive pulmonary disorder—account for nearly two thirds of all deaths in this age group. Cancer accounts for 22% of these deaths and one third of all deaths among those aged 55 to 64; thus, most older adults become widowed after at least one spell of caregiving for an ailing spouse. In the case of chronic illness, such as most cancers, spousal caregiving may last for months or even years before death (Kim, 2013). The conditions leading up to and surrounding a spouse’s death shape bereavement experiences and are an important consideration when developing interventions.

### Adjusting to Spousal Loss: Risk and Protective Factors

Older adults vary widely in their psychological adjustment to the loss of a spouse or partner. Most have some symptoms of depression and anxiety during the first 3 to 6 months



**Figure 75.1.** Proportion of Older Adults Who Are Widowed, Married, Divorced, or Never Married in the United States (2010)

following loss, although a sizeable minority may experience severe and persistent symptoms, including complicated grief. Complicated grief is diagnosed when an individual's ability to resume normal activities and responsibilities is continually disrupted beyond 6 months of bereavement (Prigerson, Vanderwerker, & Maciejewski, 2008). Myriad biological, psychological, social, and economic factors affect one's adjustment. I focus here on three influences that studies identify as both particularly important and potentially modifiable: the nature of the marital relationship, the death context, and co-occurring losses and stressors.

#### *Nature of the Marriage or Romantic Relationship*

Widow(er)s' psychological adjustment varies based on the nature of the relationship lost. Early writings, based on the psychoanalytic tradition, proposed that bereaved persons with troubled marriages find it hard to let go of their deceased spouses, yet also feel angry at the deceased for abandoning them and as a result are most likely to suffer heightened and pathological grief (Parkes & Weiss, 1983). However, contemporary longitudinal studies reveal different findings; 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 after loss because they yearned most strongly for their spouses (Carr, House, Wortman, Nesse, & Kessler, 2001).

Persons with marriages marked by high levels of warmth and low levels of conflict may suffer a greater sense of sadness within the earlier months of loss, yet their strong emotional ties to the late spouse may prove protective in the longer term. They may be able to draw strength from continuing bonds with the decedent. Early theories about grief held that bereaved persons needed to "relinquish" their emotional ties to the deceased and "get on" with their lives; current research, however, suggests that maintaining a psychological tie to the deceased is an integral part of adaptation (Field, 2008). For instance, bereaved persons may think about what their late spouse might have done when faced with a difficult decision. Others may keep alive their spouse's legacy by recognizing the continuing positive influence the deceased has on their lives. In this way, the warmth and closeness of the relationship may continue to be protective and affirming to the bereaved spouse (Root & Exline, 2013).

Given the complex ways in which cancer shapes marital relations, understanding the ways marital quality affects adjustment to the death of one's partner is particularly important for oncology social workers. Although research is equivocal, most studies find that a cancer diagnosis does not have either uniformly positive or negative implications for marital quality (Hagedoorn, Sanderman, Bolks, Tuinstra, & Coyne, 2008). Rather, the impact of cancer on marital relations is closely tied to the nature of one's marital relationship before the ill partner received a cancer diagnosis (Manne & Badr, 2008). A strong relationship may be a source of solace and support during times of distressing treatments and

symptoms; for example, nearly half of women with breast cancer report that the cancer brought them closer to their spouse (Dorval et al., 2005). Conversely, a strained marriage marked by low levels of commitment may not survive the threats and changes imposed by a cancer diagnosis (Glantz et al., 2009). Thus, practitioners working with bereaved spouses of deceased cancer patients need to consider the history and nature of the marital relationship before loss when developing interventions and therapies.

#### *Nature of the Death*

Adjustment to spousal loss also is affected by the timing and nature of the death. In general, anticipated deaths tend to be less distressing than unanticipated ones (Carr et al., 2001). The knowledge that one's partner is going to die in the imminent future provides the couple with time to address unresolved emotional, financial, and practical issues. This preparation is believed to enable a smoother transition to widowhood (Carr, 2012). However, for older persons, "anticipated" spousal death often is accompanied by long-term illness, suffering, intensive caregiving, and neglect of one's own health concerns, thus taking a toll on the survivor's well-being (Carr et al., 2001).

Family caregivers—who currently number more than 50 million in the United States alone—experience a range of financial, psychological, and spiritual needs associated with the demands of their caregiving role and often require assistance before the death of their spouse (Family Caregiver Alliance, 2005). Caregivers may benefit from a range of services, including assistance with administering physical care, meal preparation, transporting the patient to treatment, and picking up prescriptions; spiritual support to make sense of the illness and death; and counseling to manage feelings of distress associated with caregiving burden and impending death (National Cancer Institute, 2013).

Caregiver distress levels vary based on the perceived difficulty of the care; those who reported high levels of physical, emotional, or financial strain due specifically to their caregiving responsibilities often show elevated physical and mental health symptoms after the loss (Kim & Schulz, 2008). Caregiving strains may be especially distressing in the days and weeks leading up to the death. In particular, those who provide complex illness-related tasks at home in addition to personal care (e.g., feeding, bathing, and toileting) may experience a crisis in caregiving that requires assistance or relocation of the patient outside the home (Waldrop & Meeker, 2011). Managing ventilators and feeding tubes, tending to pressure sores, and administering medications are also linked to elevated symptoms of distress among family caregivers (Moorman & Macdonald, 2013).

Emerging research also suggests that caregivers may experience improved psychological well-being following the death of a spouse, perhaps because they are relieved of stressful caregiving duties, are no longer witnessing their loved one suffer, or feel a sense of satisfaction, meaning, and



accomplishment from caring for their loved one in his or her final days (Schulz, Boerner, & Hebert, 2008). Practitioners should assess for strains and rewards of caregiving.

Quality of care and place of death also affect the bereavement experience. Older adults who believe their loved one was in pain or received problematic medical care at the end of life report greater postloss anxiety and anger than those 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 et al. (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 their loved one received high-quality care and was treated with respect and dignity at the end of life, and that they and the patient received adequate emotional support. However, most Americans currently die in institutions (FIFARS, 2010). The past decade has documented increases in the number of cancer patients who use hospice services, including in-home hospice. Still, fully one third of cancer patients spend their final days in hospitals and intensive-care units, and just over one half use hospice during their final month (Goodman et al., 2010). These patterns carry implications for survivors' well-being.

#### *Other Losses and Stressors*

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 stressors, including financial strain; retirement and relocation; compromised health and mobility; 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 & Jeffreys, 2011). In general, partner loss often sets off a chain of "secondary stressors," or stressors that result from the loss of a partner, that in turn may compromise one's emotional and physical well-being. For widowers from older, more traditionally gendered generations, the loss of a confidante, helpmate, and caregiver may be particularly harmful, whereas for widows, financial difficulties often are a source of distress.

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 lore suggests that emotionally devastated widowers may "die of a broken heart" shortly after their wives die, research shows the loss of a helpmate and caretaker is really the culprit. Wives monitor their husbands' diets, remind them to take daily medications, and urge them to give up vices like smoking and drinking (August & Sorkin, 2010). Widowers are more likely than married men to die of accidents, alcohol-related deaths, lung cancer, and chronic ischemic heart disease during the first 6 months after their loss, but not from causes less closely linked to health behaviors (Moon, Kondo, Glymour, & Subramanian, 2011; Shor et al., 2012).

Widows, by contrast, often experience declines in their economic well-being, which may trigger anxiety and distress (Stroebe, Folkman, Hansson, & Schut, 2006). Widows experience serious declines in income from all sources, ranging from earned income to pensions to Social Security (Gillen & Kim, 2009). Costs associated with burial, funeral, long-term and medical care, or estate-related legal proceedings can devastate the fixed income of older adults. Because current cohorts of older women typically tended to childrearing and family responsibilities during their younger years, they have had fewer years of paid work experience and lower earnings than their male peers, on average. Older widows who try to re-enter the labor force also may face age discrimination. Younger widows, especially those charged with intensive caregiving, may have exited the labor market during a spouse's illness. Each of these strains may compound the emotional pain and cognitive disruption triggered by spousal loss.

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

However, gay men and lesbians also have resources that may enable successful adjustment to partner loss. They have often created their own support networks of friends and selected family members. They also may be more likely than their heterosexual peers to enact flexible gender roles throughout the life course. Because they are not bound to traditional gender-typed family roles, they may be better prepared to manage the daily challenges and responsibilities faced by the newly bereaved (Almack, Seymour, & Bellamy, 2010).



#### **Pearls**

- Most widows and widowers are able to begin rebuilding their lives with reduced or less frequent intense grief symptoms about 6 months after the death of a spouse.



- Those whose strong grief symptoms continue and who are unable to begin rebuilding their lives are likely to benefit from more intense psychosocial counseling.
- Sources of stress are quite varied and can include anger about the context of the death, worry over the patient's care, financial challenges, and physical problems, including caregiver exhaustion and the need for relocation.
- Bereaved individuals may need interventions to help them rebuild their support networks, implement their stated goals for themselves, and regain a sense of agency about moving forward (Martell, Dimidjian, & Herman-Dunn, 2010).



### Pitfalls

- Not intervening with, assessing, or referring bereaved individuals expressing intense depression and other psychological symptoms.
- Not making bereavement services accessible to bereaved individuals either in the hospital or community.

Contemporary research on spousal bereavement demonstrates that the extent to which widow(er)s mourn following their loss varies widely based on the nature of their marriage, the death context (including caregiving demands), and the postloss financial and lifestyle strains that may arise. Practitioners working with bereaved survivors of cancer patients need to consider this heterogeneity when developing interventions and therapies. The research reviewed in this chapter suggests three key messages for practitioners.

First, a one-size-fits-all model will not be effective in working with the bereaved. Most bereaved spouses experience short-term symptoms of sadness and loneliness and return to normal levels of psychological functioning within 6 months, even in the absence of psychological intervention. More-intensive interventions may be prioritized for those with the most serious symptoms (Bonanno & Lilienfeld, 2008).

Second, those who faced the greatest adversities either preceding or following the loss may be at highest risk of poor adjustment. For example, those with historically strained family relations or who have suffered economic disadvantage throughout their lives may have fewer resources to cope with the death of a spouse. As such, general interventions (bereavement groups or brief counseling) may be helpful but are insufficient for the most distressed individuals. Randomized controlled trials of therapeutic interventions with cancer patients' families both during the dying process and after the loss have been far more effective with functional rather than dysfunctional families; the latter require long-term and more intensive services (Kissane & Hooghe, 2011).

Third, perceptions of the death's context are linked to survivor adjustment. In particular, widow(er)s who view the death

as unfair tend to report more symptoms of anger and intrusive thoughts than other bereaved persons (Carr, 2009). These symptoms are particularly distressing; intrusive thoughts may disrupt sleep and regular daily activities, whereas anger often places a barrier between the bereaved and those who would like to provide support. In cases where the surviving spouse viewed others as partly responsible for the death—whether health care professionals providing poor quality care or family members not providing appropriate home-based care—anger symptoms tend to be most severe (Carr, 2009). In such cases, therapists working with bereaved spouses may need to move beyond concrete facts regarding the death and instead focus on the widow(er)'s perceptions of conflicts and inequities during the dying and caregiving process (Kissane & Hooghe, 2011). Helping the bereaved make sense of and accept the death context may facilitate adjustment.

Although research delineates ways the death context shapes spousal bereavement, important questions remain unanswered. I know of no studies that explore the distinctive ways particular cancer deaths are grieved. For example, pancreatic cancer deaths typically occur much more suddenly and rapidly than lung cancer deaths, although the latter may entail more physically difficult and emotionally depleting caregiving demands. Furthermore, little is known about the ways specific combinations of illness and symptoms, such as cancer and dementia, affect the marital relation during the couples' final days, and consequently the survivor's adjustment to loss. Answers to these questions may help practitioners develop more effective and targeted interventions to protect family caregivers and ultimately widow(er)s.

### ADDITIONAL RESOURCES

- American Association of Retired Persons: Modern Hospice Care: <http://www.aarp.org/relationships/caregiving/info-09-2011/modern-hospice-care.html>
- American Cancer Society: Coping with the Loss of a Loved One: <http://www.cancer.org/treatment/treatmentsandsideeffects/emotionalsideeffects/griefandloss/coping-with-the-loss-of-a-loved-one-toc>
- Stanford Cancer Center: The Experience of Grief: <http://cancer.stanford.edu/information/coping/grief.html>

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