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ABSTRACT

The loss of one's spouse is a disorganizing life event. This study explores the mental health of older women who have lost a spouse. The specific aims of this study were: (1) to identify the incidence of depression or other psychiatric morbidity among widows during the first two years of bereavement; and (2) to evaluate a model which incorporates: suddenness of the death event, other concurrent life events, supportive and unsupportive social ties, and coping behavior as predictors of widows' mental health. The subjects were 364 widows between the ages of 50 and 86. The study employed a longitudinal panel design with data collection intervals at 6 weeks, and 6, 12, 18, and 24 months following the death of the spouse. Data was collected through semi-structured home interviews which incorporated a number of standardized rating scales and questionnaires. Findings suggest that the depressive symptomatology and negative mood states experienced by the majority of widows reflect normal grieving rather than psychiatric morbidity. For those women who do experience psychiatric morbidity, interventions directed toward assisting high risk widows to learn more active ways of coping with their stressors are suggested to help reduce the severity of their grieving. (SR)

A PREDICTIVE MODEL OF OLDER WIDOWS' MENTAL HEALTH

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A PREDICTIVE MODEL OF OLDER WIDOWS' MENTAL HEALTH

That the loss of one's spouse is a generally disorganizing life event and entails severe stress has been well documented. While numerous studies have described the depressive symptomatology and mood states associated with bereavement, the extent to which such symptoms are sufficient to meet the criteria for clinical depression is largely unknown. Careful and controlled prospective studies of the short- and long-term frequency of psychiatric morbidity following bereavement are few in number. Among those studies that have examined psychiatric morbidity, the incidence of severe depression has been noted to range from 12-35% depending on time of measurement following the loss event (1-4). Variations in age and sex of subjects studied, however, confound the validity of the reported statistics (5-7). The differential impact that the relative suddenness of the death event, other concurrent life events, social environments, and coping behavior have upon psychological distress and psychiatric morbidity among the bereaved also have not been adequately addressed (8-10).

Purpose and Theoretical Framework

The specific aims of this study were: (a) identify the incidence of depression or other psychiatric morbidity among widows during the first two years of bereavement, and (b) evaluate a model which incorporates suddenness of the death event, other concurrent life events, supportive and unsupportive social ties, and coping behavior as predictors of widows' mental health. The proposed theoretical model is depicted in Figure 1. As illustrated, the suddenness of the death event in conjunction with other undesirable life events is viewed as

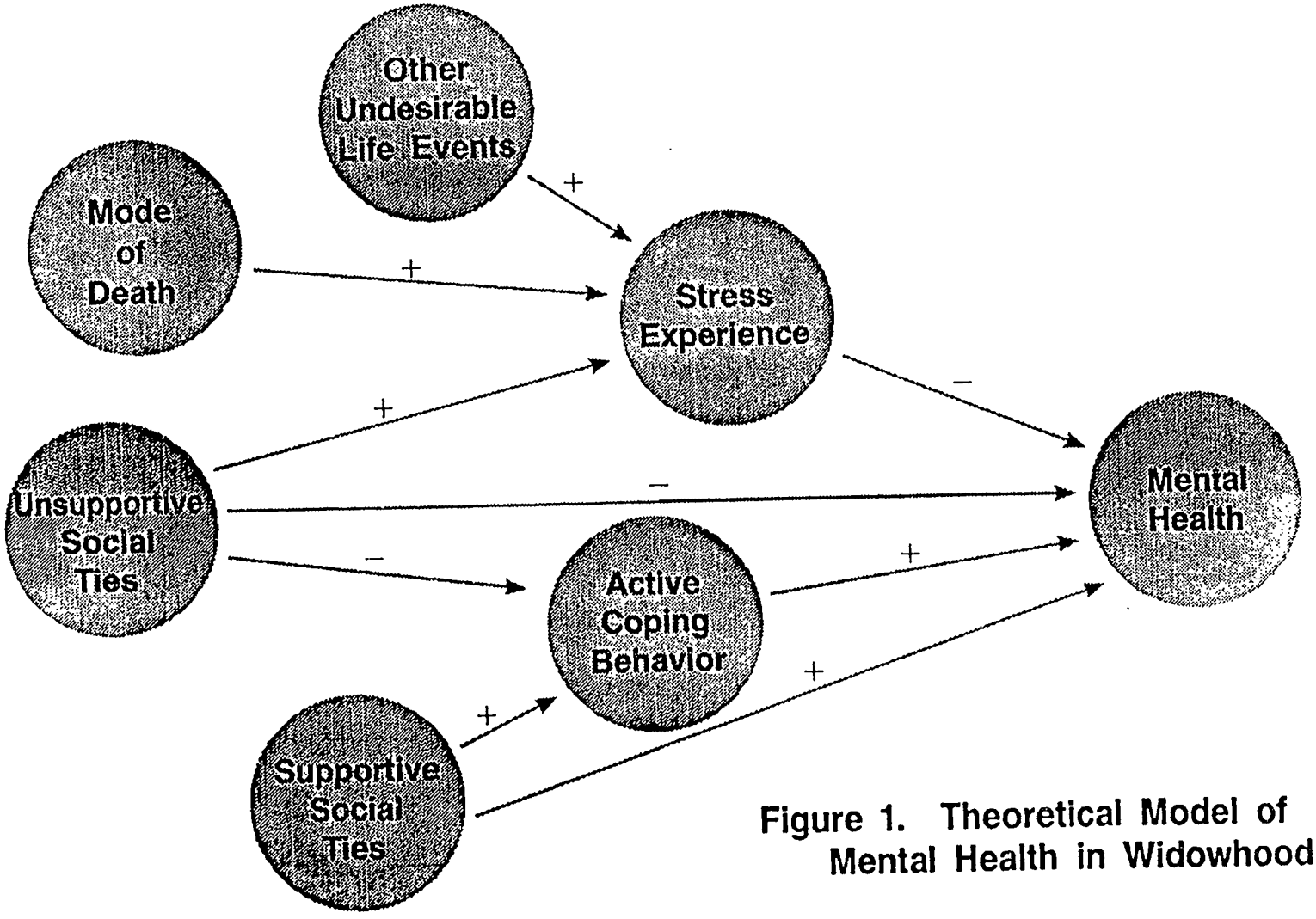

Figure 1. Theoretical Model of Mental Health in Widowhood

increasing the stress experience which, in turn, negatively effects widows' mental health. The latter is consistent with the conceptualization of Pearlin and colleagues (11) that life events exert their effects through a wider context of ongoing strains. Unsupportive social ties are theorized to have a direct negative effect as well as an indirect effect on widows' mental health through the diminishment of active coping behavior. Whereas, supportive social ties are conceptualized as having both a direct positive effect and an indirect effect on widows' mental health through the enhancement of active coping behavior. The incorporation of supportive and unsupportive social ties into the proposed model reflects the observation in current literature that positve and negative social ties represent relatively independent domains of experience (9). Finally, active coping behavior is viewed as having a direct positive effect on widows' mental health.

Sample

Potential subjects for the study were identified through death certificates. The sample was restricted to new widows who were 50 years of age or older, resided in the general community, and were living with their spouse at the time of death. The decision to restrict the sample to widows was an attempt to avoid the confounding influence of sex on study findings. The practical reality that the proportion of widows to widowers in the general population is approximately 3:1 precluded the possibility of obtaining an adequate sample of both widows and widowers on which to evaluate the proposed model. Widows meeting study criteria were invited to participate in the study via a letter from the investigator and follow-up telephone call. A summary of the characteristics of the sample appear in Table 1.

Table 1

DEMOGRAPHIC CHARACTERISTICS OF SUBJECTS (N=364)

Variables	Frequency	Percent
Age ($\bar{x}$ = 65.8 years)		
50 - 55 years	51	14.0
56 - 65 years	128	35.2
66 - 75 years	132	36.2
76 - 85 years	50	13.8
86+ years	3	0.8
Employment Status		
unemployed/retired	278	78.3
part-time employed	37	10.2
full-time employed	42	11.5
Education		
11th grade or less	101	27.7
high school graduate	117	32.1
partial college	74	20.3
college graduate	72	19.8
Income		
less than $10,000	88	24.2
$10,000 - $19,999	161	44.2
$20,000 - $29,999	70	19.2
$30 000 - $39,999	25	6.9
$40,000 or more	20	5.5
Religion		
Catholic	163	44.8
Protestant	161	44.2
Jewish	21	5.8
Other	19	5.2
Current Living Arrangement		
live alone	266	73.1
live with relative	96	26.4
live with non-relative	2	0.5
Cause of Spouse's Death		
heart disease	148	40.7
cancer	123	33.8
stroke/arteriosclerosis	28	7.7
influenza/pneumonia	12	3.3
general infection/sepsis	14	3.8
accident	2	0.5
suicide	1	0.3
other	36	9.9
Mode of Death		
sudden/unexpected	83	22.8
short-term illness	88	24.2
long-term illness	193	53.0

Overall, the predominantly white sample (97%) included 364 widows between the ages of 50 and 86 years, with a mean of 65.8 years. The mean years of marriage for the sample as a whole was 37.7 years, suggesting that the loss of the spouse resulted in the disruption of a significant long-term relationship for most subjects. Seventy-three percent reported they now lived alone, 26% lived with children, and less than 1% lived with nonrelatives. Slightly less than one-fourth (22%) were employed either full- or part-time. The largest proportion of subjects (52%) had completed high school or 1-2 years of college and reported annual incomes between $10,000 - $20,000 (42%).

Measurement of Constructs

The study employed a longitudinal panel design with data collection intervals at 6 weeks, 6, 12, 18 and 24 months following the death of the spouse. Data was collected through semi-structured home interviews which incorporated a number of standardized rating scales and questionnaires. To determine mode of death, information regarding the length of spouse's death, subject's anticipation of spouse's death, and extent of subject's involvement in caring for ill spouse was elicited at the first data collection period. Based on the data obtained, the death event was coded according to the degree of suddenness: (a) sudden, unexpected death of the husband, (b) expected death of the husband following a short- term illness of six months or less, and (c) expected death of the husband following a prolonged illness of greater than six months duration.

Data was collected about other concurrent life events experienced by subjects in the six months immediately preceding the death of the spouse and for the subsequent six month intervals prior to each interview using the Louisville Older Persons Event Scale (12). For

each event that was experienced, subjects rated the desirability and undesirability of the event. Only the sum of undesirable life events experienced was used in the analysis.

Widows' stress experience was assessed by two indicators. As noted earlier, stress was conceptualized as ongoing strains related to life events. The Impact of Event Scale (IES), developed by Horowitz et al. (13), was used to tap the extent of conscious intrusion of the spouse's death in the subject's current life. The second indicator of stress was the degree to which the respondent remained preoccupied with other undesirable life events as measured by the Louisville Older Persons Event Scale.

Characteristics of the widow's social network and the perceived supportiveness or unsupportiveness of such ties were assessed through a semistructured interview utilizing an adaptation of Hirsch's Support System Scale (14). Computed variables included: (a) total number of supportive ties; (b) overall mean supportiveness of network relative to socialization, tangible assistance, cognitive guidance, social reinforcement, and emotional support; (c) total number of unsupportive ties; and (d) overall mean unsupportiveness of network relative to socialization, tangible assistance, cognitive guidance, social reinforcement, and emotional support.

The Ways of Coping, developed by Lazurus and associates (15), was used to elicit information about the strategies widows used to deal with the loss of the spouse. Scores on factor scales for "planful problem-solving," "positive reappraisal," and "confrontive coping" were viewed as active modes of coping in this study. Whereas, "distancing," and "escape-avoidance" strategies were considered passive modes of coping.

Mental health was conceptualized as the adaptive capacity of the individual to function effectively under changing environmental circumstances. The General Health Questionnaire (GHQ) was used to assess the potential seriousness of psychological distress experienced by widows adjusting to the loss of their spouse (16). A score of 5 or more on the GHQ is considered an index of 'caseness' warranting further psychiatric assessment. Subjects with a score or 5 or more on the GHQ received a diagnostic interview in order to assess the presence or absence of psychiatric morbidity. The Structured Clinical Interview for DSM-III (SCID) developed by Spitzer and Williams (17) was the protocol used in conducting the diagnostic assessments.

Findings

A total of 75 or 21% of the widows met DSM-III criteria, establishing some form of psychiatric morbidity during the two years following the loss of the spouse. The majority of diagnostic episodes had their onset during the first year of bereavement with most apparent as early as six weeks following the loss of the spouse. Only a small percentage of these women, less than 4%, had a previous history of psychiatric illness. Major depression, followed by Dysthymia and Generalized Anxiety, were the predominant diagnostic categories. Those widows diagnosed as Dysthymic generally experienced the onset of depressive symptoms during a spouse's terminal illness phase with symptoms persisting through the first year following the spouse's death. Among those widows who met DSM-III criteria, slightly less than one-half (43%) met diagnostic criteria at two or more data points suggesting that when psychiatric morbidity occurs following the loss of the spouse, it is not a transient phenomena.

Evaluation of the proposed theoretical model employed a linear

structural equation approach using the statistical program LISREL VII. Data employed in the analysis of the model was limited to subjects who completed all five data collection intervals (N=229) in order to permit examination of both cross-sectional and time-lagged effects among the theoretical constructs. Age, education, and income were entered into the analysis as exogenous variables.

The proposed model could not be estimated with an adequate fit as iterations based on initial parameter estimates did not reach convergence. Based on the technical output, modifications of the model were attempted. The number of observed measures for each construct were limited to one or two variables and parameters whose estimates were nonsignificant were eliminated. A markedly simplified model was estimated with an adequate fit for T1 - T5. As illustrated in Figure 2, other concurrent undesirable life events had direct positive effects on network unsupportiveness and psychiatric morbidity. Whereas, network unsupportiveness had both a direct positive effect and an indirect effect on psychiatric morbidity through an increase in passive coping. Passive coping, in turn, had a direct positive effect on psychiatric morbidity. Moreover, there appeared to be a reciprocal relationship between unsupportiveness and passive coping. Finally, education manifested a significant negative effect on passive coping. The coefficients shown in Figure 2 are for T1 (six weeks after the loss of the spouse); coefficients of similar magnitude were obtained for T2 - T5.

The preceding analysis utilized cross sectional data collected at similar time intervals. Since psychiatric morbidity at subsequent time intervals may, in part, reflect prior levels of illness, an attempt was made to estimate a model for T2 - T5 controlling for prior psychiatric

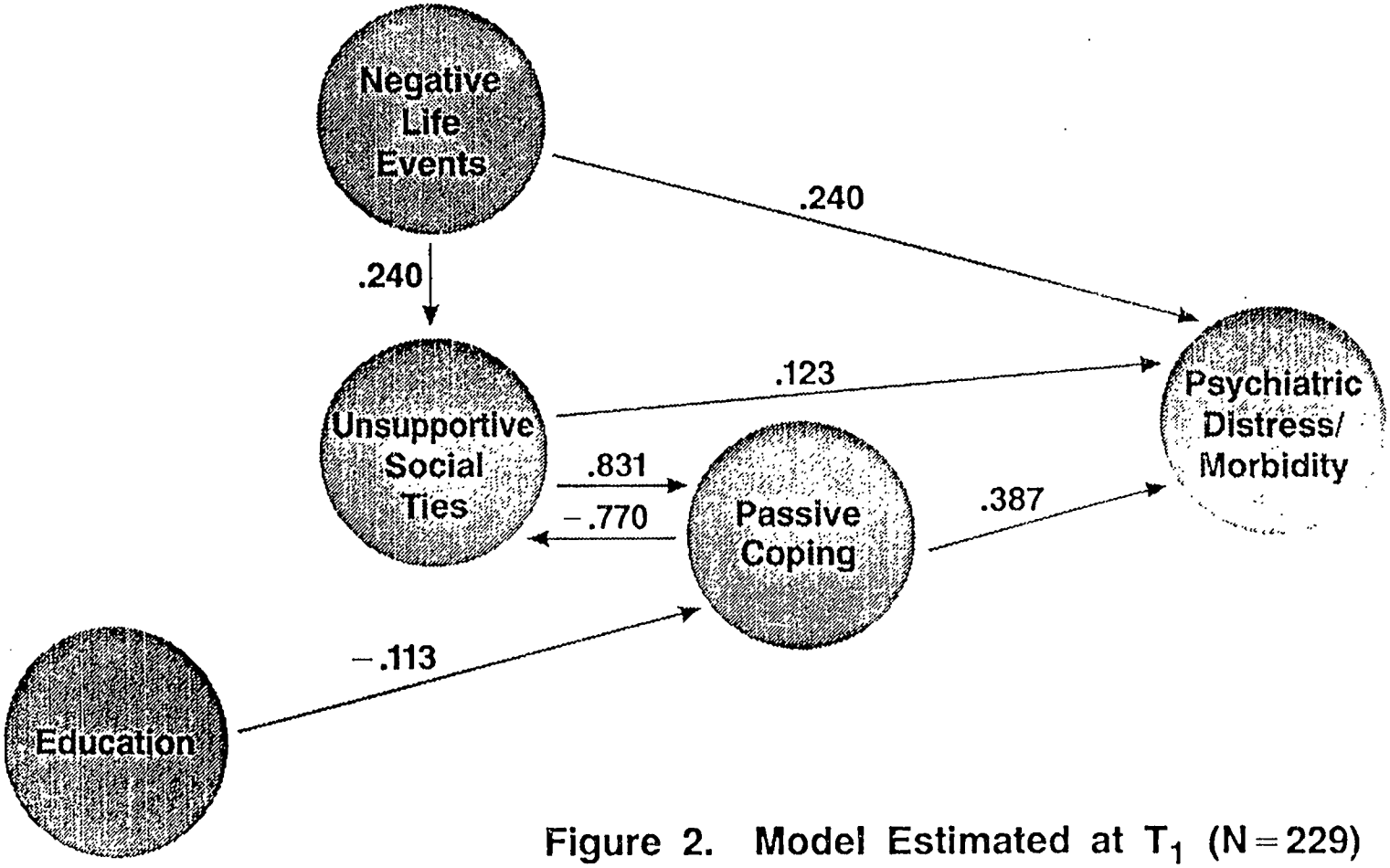

Figure 2. Model Estimated at T_1 (N = 229)

morbidity. A model with adequate fit was estimated for T2 - T4, but not for T5. As illustrated in Figure 3, prior psychiatric morbidity had a direct positive effect on subsequent psychiatric morbidity as well as on subsequent negative life events, unsupportiveness of social ties, and passive coping. However, the direct effect of unsupportiveness on psychiatric morbidity was negligible, suggesting that with prior psychiatric morbidity controlled, unsupportiveness of social ties exerted its effect only through the enhancement of passive coping strategies.

Models incorporating time-lagged effects among the constructs also were examined using data from the five panel waves. Overall, psychiatric morbidity at T2, T3, T4 and T5 could be adequately predicted by negative life events, unsupportiveness of social ties, and passive coping at T1. An illustrative example of the results of these time-lagged analyses is shown in Figure 4.

Summary

The characterization of widowhood as both a stressful life event and a continuing stressful situation was supported in this study. As previously noted in the literature, the loss of the spouse is often accompanied by other concurrent undesirable life events. In the models evaluated, other undesirable life events evidenced a direct effect on widows' mental health as well as an indirect effect through increased unsupportiveness of social ties and passive coping. Contrary to expectation, the constructs related to suddenness of the spouse's death and supportiveness of social ties had negligible effects resulting in the elimination of these parameters in the final models. The construct, stress experience, also was dropped from the model as it

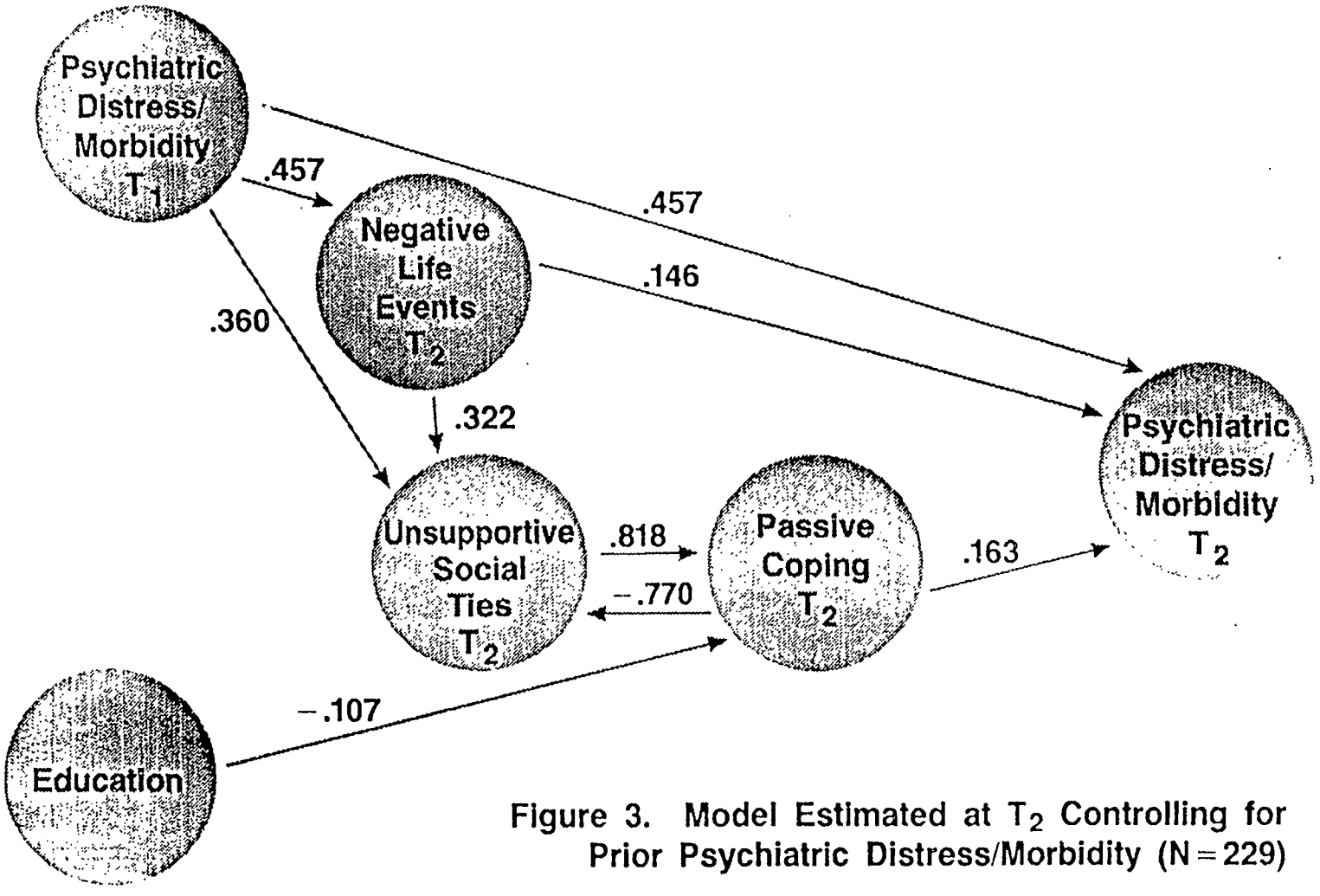

Figure 3. Model Estimated at T_2 Controlling for Prior Psychiatric Distress/Morbidity (N = 229)

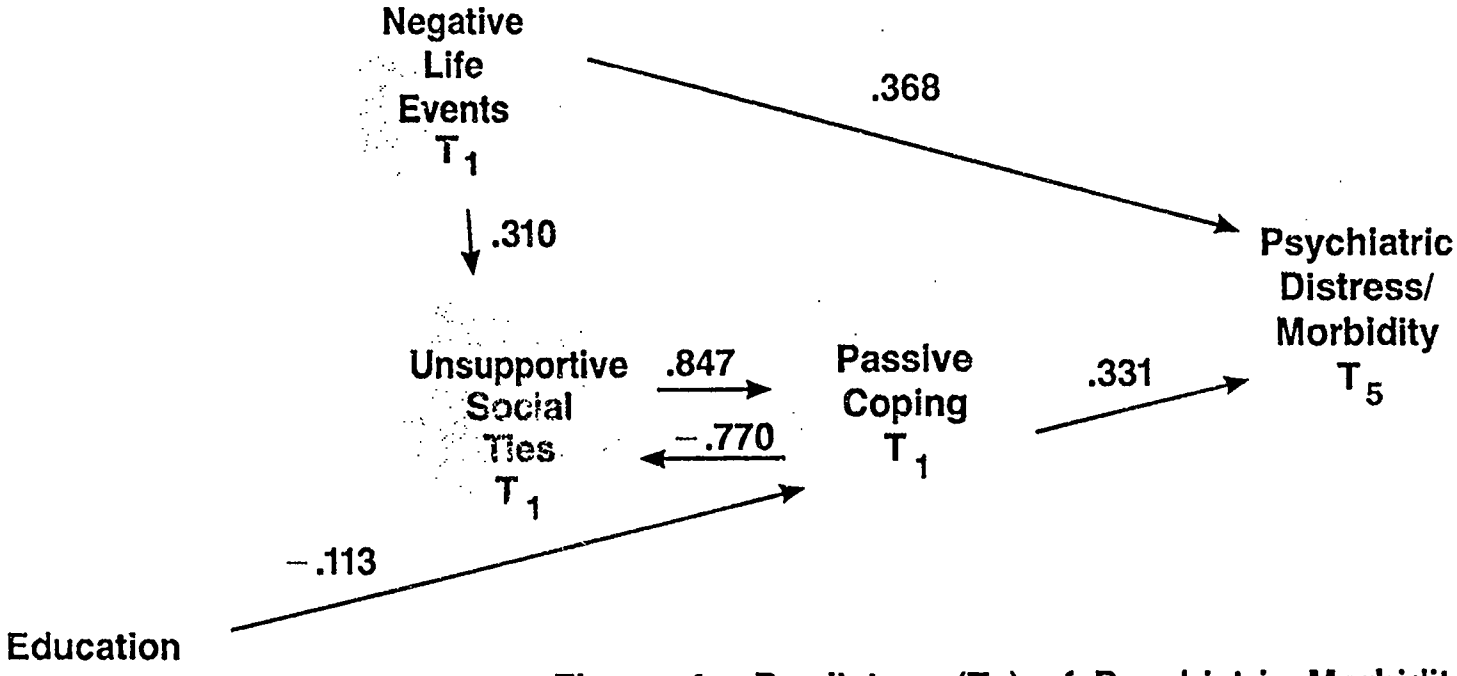

Figure 4. Predictors (T_1) of Psychiatric Morbidity At T_5 (N = 229)

could not be discriminated from psychological distress. While the latter may be a measurement issue, evaluation of an alternative model in which a new construct reflecting the interaction of stress and support is incorporated may be beneficial since findings from previous research suggest that social support may buffer the negative impact of stress.

Overall, the findings from this study suggest that the depressive symptomatology and negative mood states experienced by the majority of widows reflect normal grieving rather than psychiatric morbidity. The percentage of women in this study experiencing psychiatric morbidity post-bereavement, namely 21%, was consistent with previous estimates wich reported ranges from 12 - 35% For those women who do experience psychiatric morbidity, risk factors appear to be the occurrence of other undesirable life events and unsupportive social ties, which, in turn, enhance passive coping strategies. Thus, interventions directed toward assisting such high risk widows to learn more active ways of coping with their stressors, including how to deal with unsupportive social ties, may help to reduce the severity of their grieving.

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