

WELLBEING IN BEREAVEMENT AND WIDOWHOOD

KATE MARY BENNETT

LAURA K. SOULSBY

University of Liverpool

ABSTRACT

This article will examine how bereavement and widowhood affect well-being drawing on psychological, gerontological, and sociological research. The article will begin with an outline of what is meant by bereavement and widowhood. It will then present an overview of the effects that bereavement and widowhood has on wellbeing. In the next section, a brief history of approaches to bereavement will be presented. Next, more recent approaches will be discussed including the Dual Process Model of Bereavement (Stroebe & Schut, 1999), and a discussion of the debate concerning continuing and relinquishing bonds. The focus will then turn to factors which influence wellbeing with a focus both on pre- and post-bereavement experiences, and on such factors as age and gender. Finally, there will be a discussion of factors which may enhance wellbeing, such as resilience, identity reconstruction, and coping strategies.

Key Words: bereavement, widowhood, wellbeing, older adults

Spousal bereavement in later life is a high probability event for women (Smith, Tomassini, Smallwood, & Hawkins, 2005) and while less common among older men the events are no less important. Age at widowhood has increased by almost 7 years since the 1970s, from a median age of around 65 to 72 (Hirst & Corden, 2010).

Thirty-one percent of women aged between 65-74 are widowed, rising to 80% of women aged 85 and over. Amongst men, 9% of those aged between 65-74 are widowed, and 47% of those aged 85 and over (Smith et al., 2005). The differences in these figures are accounted for by the earlier mortality of men. Two further reasons also account for these differences. First, women are more likely to marry men older than themselves, and second, widowed men are more likely to remarry than women (Stroebe, Stroebe, & Schut, 2001). Men do not expect to be widowers as much as women expect to be widows (Martin-Matthews, 1991). The loss of a spouse affects almost every domain of life, and as a consequence has a significant impact on wellbeing: psychological, social, physical, practical, and economic. This article will address the first three in some detail, and touch briefly on the latter two.

DIFFERENTIATING BEREAVEMENT AND WIDOWHOOD

Before any clear discussion of the effects of widowhood and bereavement is undertaken, it is important to be clear about what we mean by the terms. Often the terms spousal bereavement and widowhood are used interchangeably, not only by people in everyday conversation, but also by researchers and practitioners. Spousal bereavement is the state of having experienced the death of one's spouse. Its consequences are generally short-term (though not always) and have personal consequences and meanings. Widowhood, on the other hand, is a long-term and ongoing state which not only has personal consequences but carries with it social consequences and meanings. It is important to distinguish between them because the effects of one may well be different from the effects of another. For example, there may be short-term disruptions in sleeping and eating patterns as a consequence of bereavement, but these do not often continue into long-term widowed life (Mahrabani, Pienta, & Franks, 2006). In terms of the time-scale of effects for bereavement, 2 years is often seen as an appropriate cut-off for the effects of bereavement, and effects after this are often dismissed as not related to spousal loss. And yet, there are consequences which may have a longer-term effect and are concerned with the state of widowhood and its social and personal meanings. These include personal consequences such as continuing to miss the deceased, loneliness, and continuing restorative activities. There are also continuing changes to identity which demonstrate the interaction between the intra- and inter-personal (Bennett, 2010a). Finally, there are changes which continue at a social level such as changes in friendships, social support, and the changes in status within society which continue long after the husband or wife has died.

A HISTORICAL PERSPECTIVE

Most of the work in both bereavement and widowhood has been conducted during the last few decades of the 20th century and has continued into the 21st. However, in his seminal paper *Mourning and Melancholia* in 1917, Sigmund

Freud (1953/1974) identified the differences between grief and melancholia. He realized that the death of somebody one loved sometimes caused depression. He also believed that it was necessary for people to undertake tasks to relieve their grief, what we now know as *grief work*. The next major work on bereavement was undertaken by Lindemann in 1944 following the Coconut Grove Fire. Nearly 500 people were killed in this nightclub fire in Boston. He characterized two types of grief, normal and morbid grief. Normal grief typifies what most people experience during the course of their everyday experiences of losing someone dear to them. On the other hand, morbid grief is characterized by a longer-lasting and more complex reaction, a grief which might be seen as pathological. Much of the later work on bereavement has come to reflect his distinction. Peter Marris, in 1958, studied bereavement among women who had lost their husbands in the normal course of events. He found that there were lower rates of morbid grief than had been found when the loss had been more traumatic. But at the same time he also found that regardless of the type of death, there were shared similarities, and in particular the sense of presence of the deceased. Later, Colin Murray Parkes (1964, 1972) began to examine the effects of bereavement in widowed people during the first year after their loss. He identified the features of grief and the factors that contributed to the nature of the grief. His focus was on people widowed at younger ages. The work was important because it drew attention both to the similarities and the differences in bereavement at different ages. The first researcher to focus research on widowhood, rather than on bereavement alone, and on women, was Helena Lopata who carried out an extensive study in Chicago (1973, 1996). She made important contributions to understanding the losses that widowed women suffered as a consequence of the deaths of their husband: loss of financial stability, loss of social status, loss of social relationships. Sometime later Dale Lund and Mike Caserta examined the effects of spousal bereavement on older men (Lund & Caserta, 2001). They examined, longitudinally, the situation of men who, in general, do not expect their wives to die before them. They found that men in their 70s had the greatest difficulty in coming to terms with their loss than did men at other ages. They also found that men in their 50s were seen to be best at coping and resolving issues around grief, compared with older widowers.

THEORETICAL APPROACHES

Almost all of the theoretical approaches which examine bereavement and widowhood have focused on bereavement. On the whole, these approaches have considered why people, in general, come to terms with and adapt to their bereaved state. These approaches have focused on bereavement in general and not on spousal loss in particular. Many of the older approaches have resembled stage theories, akin to those developed by Kübler-Ross in relationship to end of life (1969). These stage theories suggest that people must experience the stages sequentially or else risk a problematic recovery and are situated within the

medical model. Practitioners and researchers argued that people needed to experience emotional states such as anger, depression, numbness, disorganization, and reorganization (Weiss, 1993). Weiss (1993) suggested that "Phases of grieving have been reported to occur with some reliability in all grieving that eventually moves to recovery" (p. 279). In this conceptualization, grief has not only recognizable emotional characteristics, but also behavioral and psychological characteristics. As Bennett and Bennett (2000-2001, p. 238), in their critique of such approaches point out, those who hold these stage views believe that "[bereaved people] will, and must, learn to slacken the bonds of love, to readjust to an environment in which the dead person is missing, and to form new relationships" and that "the signs of a "pathological" grief reaction is that the mourner gets stuck in one of the early destructive phases and fails to move on at the appropriate time to the later reconstructive phases." As suggested by Bennett and Bennett (2000-2001), these approaches have been considered problematic for a number of reasons. First, their apparent prescriptive nature may be at least unhelpful, and at worst harmful since they imply that people must have these experiences and they must be in a particular order (Lopata, 1996). Footman (1998), arguing from personal experience, suggests that models should be inclusive and not exclusive, and that for him stage models, and the downward adjustment of loss, are unhelpful. Another, in some ways inter-related theoretically, is grief work. Grief work is the idea that one needs to confront the experience of grief in order to come to terms with the loss. Many of the early researchers and practitioners believed that grief work was necessary (Bowlby, 1980; Freud, 1953/1974). Grief work involves the active, cognitive process of focusing on the deceased and working towards detachment from the deceased. However, as with stage models, the focus on grief work has excluded bereaved people who adapt to their loss without these efforts, and thus runs the risk of pathologizing their experiences.

Rubin (1981) proposed a two-track model of bereavement which addressed both the process and outcome of child-loss. Track 1 focuses on the biopsychosocial reactions to the bereavement, and is, therefore, the outcome track. It considers psychological, somatic, and social outcomes. The second track focuses on the relationship with the deceased, and the ways in which that relationships changes, or can be changed. It considers positive and negative feelings toward the deceased, imagery, and emotional distance. It is an important precursor to more recent models because it identifies two, rather than one, important components in relationship to adaptation to bereavement.

In parallel with models of grief, models were being developed which examined how people coped with stress, and without doubt bereavement is one of the most stressful life-events people experience. One stress theory in particular has much to contribute to potentially understanding the stresses of bereavement and how people cope with them. Cognitive stress theory (Lazarus & Folkman, 1984) focuses on the interaction between the external demand, in this case the bereavement, the appraisal of the situation, and the resources available to meet the

demand. Situations may be appraised as challenging, harmful, or threatening. Resources can refer, for example, to personal resources (e.g., personality, life view), social support (emotional or practical), or to finance. However, it is only in the last decade or so that attempts have been made to bring together theoretical approaches to stress and to bereavement. The most widely influential of these attempts is the Dual Process Model of bereavement (Stroebe & Schut, 1999). This model will now be discussed in some detail.

The Dual Process Model of bereavement (DPM) was developed to address criticisms both of stage theories of bereavement, and with the emphasis on grief work. It was also developed with widowhood in mind, although it is potentially applicable to other forms of bereavement. The model identifies two types of coping experiences, loss-oriented and restoration-oriented. Loss-oriented coping focus on those experiences and behaviors which are associated with a focus on the deceased. Stroebe and Schut (1999) identified four types of experiences: grief work, intrusion of grief, denial/avoidance of restoration changes, and breaking bonds/ties/relocation. Continuing to lay the table for two instead of for one is an example of denial/avoidance of restoration changes, while seeing someone who resembles her dead husband might cause a widow to cry, would be an example of intrusion of grief. Restoration-oriented coping includes attending to life changes, doing new things, denial/avoidance of grief, new roles/identities/ relationships, and distraction from grief. Reorganizing finances might be an example of attending to life changes, while people may keep very busy just to distract themselves from their grief. The key feature of the DPM is oscillation. This is the idea that people move back and forth between loss-oriented to restoration-oriented coping (and with neutral spaces in between). Thus, the emphasis is not only on loss-related coping but on the coping necessary to forge a different new life.

Richardson and Balaswamy (2001) found that both loss- and restoration-oriented coping were relevant in the second year of bereavement, but that the former were more salient earlier, and the latter more salient later. Loss-oriented stressors were likely to influence negative affect and restoration-oriented more likely to influence positive affect. In 2007, Richardson confirmed that both types of coping were important during bereavement. She argued that it was important to help widowed people distinguish between constructive and destructive grief work and that widowed people needed to balance out LO and RO activities. In recent years, three groups of researchers have been working on testing the DPM, including both Richardson and Bennett and their work came together in a special issue of *Omega: Journal of Death and Dying* in 2010. Richardson examined data from the same large sample of widowed men that she had used in 2001. She wanted to examine the influence of both caregiving, and participation in restorative coping on positive and negative affect. She found that one of the most important influences on negative affect was time since death and participation in social activities. On the other hand, length of caregiving, number of friends, and having a confidant influenced positive affect. Bennett, Gibbons, and

Mackenzie-Smith (2010) presented two analyses. First they identified that both loss- and restoration-oriented coping was associated with poor psychological adjustment (poor coping in their paper). Those people who engaged in Denial/Avoidance of Restoration or who engaged in Distraction from Loss were more likely to be coping poorly. On the other hand, those who experienced intrusion, renamed continuing bonds by Bennett et al., or who had New identities/Roles/Relationships were more likely to be coping well (again one each of loss- and restoration-oriented coping). In their second analysis, they focused on the qualitative experiences of restoration-oriented coping. They found that not all participants experienced all aspects of restoration. It was especially interesting to note the diverse views of the participants as to the efficacy of distraction as a coping strategy, with some participants strongly of the view that it was unhelpful, while others considered it to be very helpful. There were two other empirical papers in this issue. These focused on intervention. Lund, Caserta, Utz, and de Vries (2010) examined the effectiveness of an intervention which targeted restoration activities, in addition to the loss-focused activities of traditional interventions. They observed only modest support for the restoration intervention. What was also evident was that participants in the loss-oriented only intervention were, in any case, engaging in some restoration-oriented activities. They also suggest that restoration activities might need to be focused on the needs of the individuals. Some of the restoration activities were unnecessary for some participants; for example, a session on nutrition, for one, might have been unnecessary for women who had been planning meals for a lifetime. Or different activities might have been of more use, such as on low cost medical insurance. Finally, Shear (2010) focuses on one component of the DPM, avoidance, in bereavement. She argues that avoidance can be an important strategy for bereaved people and focuses on the private experiences rather than external ones. She argues that this strategy can be adaptive but that it can also become an encumbrance and lead to complicated grief when it is over-used. In these cases people need assistance in decreasing both behavioral and cognitive avoidance.

Even more recently, in 2006, Stroebe and Folkman integrated further the DPM with Cognitive Stress Theory into an integrative risk factor framework (Stroebe, Folkman, Hansson, & Schut, 2006). This framework allows an exploration of the ways that individual differences influence adaptation to bereavement. The aim, therefore, is to identify those individuals who will deal with bereavement and widowhood normally, as well as those who would benefit from some form of intervention. However, as yet there have not been any empirical studies evaluating its potential.

Focusing on the problems found with the traditional view that ties should be severed with the deceased, Klass, Silverman, and Nickman (1996) proposed that maintaining bonds with the deceased was normal and indeed healthy. In their book *Continuing Bonds: New Understandings of Grief*, they showed how common it was to maintain a bond with the deceased. In this volume, Moss and

Moss discussed the triadic relationship that was often maintained between the widow, new partner, and deceased spouse. Lopata also discussed the sanctification of the deceased husband. More recently, Bennett and Bennett (2000) found that widowed people often felt the presence of the deceased and took comfort from the experience. Bennett, Hughes, and Smith (2005a) found that better coping was more common among those who continued to talk with the dead spouse than among those who did not. Further, in Bennett et al.'s analysis of the DPM, what Stroebe and Schut had termed intrusion of grief, Bennett et al. had relabeled continuing bonds, and as has been shown above, this was associated with better coping. The debate has continued as to whether it is useful to maintain or to relinquish bonds with the deceased. Stroebe and Schut (2005) suggest that either one or the other is beneficial, rather it may depend on the individual differences: for some it may be helpful to maintain the bonds, while for others it may be important to relinquish them. Stroebe and Schut suggest that the key may be to distinguish between continuing bonds and grief intensity.

THE EFFECTS OF BEREAVEMENT ON WELLBEING

When looking at the consequences of bereavement, much of the work in the past has focused on the unusual and problematic outcomes. However, as we have seen, for the majority of older widowed people widowhood is a common experience with common and familiar effects. Research has demonstrated that the widowed experience lower levels of psychological wellbeing (Hughes & Waite, 2009; Umberson, Wortman, & Kessler, 1992). Bennett's work suggests that widowed men and women report higher levels of depressive symptoms, lower morale, and decreases in social engagement, in studies looking at spousal loss between 4 and 8 years before (Bennett, 1997, 1998; Bennett & Morgan, 1992). However, other research suggests that the effects are of shorter duration (Zisook, Schuchter, Sledge, Paulus, & Judd, 1994). Dugan and Kivett (1994) found elevated levels of loneliness in widowed people. Carr et al. (2000) found that level of dependency on the spouse during the marriage is positively associated with reported anxiety in widowhood. There is evidence to suggest that the negative impact of becoming widowed on psychological health may recover over time (Lopata, 1996; Stroebe, Stroebe, & Hansson, 1993; Wilcox, Evenson, Aragaki, Wassertheil-Smoller, Mouton, & Loevinger, 2003). The effects on physical health are less straightforward. For example, in Bennett's work, above, there were no decreases in health problems as a consequence of bereavement, only changes which occurred as a result of increased age. However, in other work, she suggests that there are differences in the patterns of health variables as a consequence of widowhood when compared with newly divorced and stable marital status groups. For example, she found that there was a disassociation for health and welfare service use between baseline and the year following bereavement, while the effect

for health problems occurred later (Bennett, 2006). These results support those of others who suggest that it is health behaviors and health maintenance behaviors which are challenged by bereavement. For example, there may be disruptions in eating and sleeping patterns. People may attend more, or less, at GP surgeries. These changes may depend on who was the health gatekeeper—traditionally the wife—and whether s/he is the one that has died (Williams & Umberson, 2004). Among men, in particular, there is evidence of increased mortality across all causes of death, but especially in accidental deaths. The popular view of people dying from a broken heart is borne out to some extent by data from death certificates (Parkes, Benjamin, & Fitzgerald, 1969).

For younger widowed people, bereavement is a non-normative event and, therefore, its effects are less familiar. At younger ages widowhood is associated with a greater decline in physical and psychological health (Prigerson, Maciejewski, & Rosenheck, 1999; Stroebe & Stroebe, 1987; Wilcox et al., 2003).

Widowed men and women often discuss the effects that widowhood has on their social and familial relationships. Widowed women, in particular, talk about changes in their friendships, and the ways in which they are dropped by their married friends, and make new friends with other widowed women. Widowed women also note how little social support (formal and informal) they receive compared with their widower friends (Bennett, Hughes, & Smith, 2003). Bennett (2009) found that this was born out by her data. However, it is not clear whether this is because widowed women need less social support, need it but are not offered it, or are offered it and refuse it. Men's social lives also change. Often men's social lives revolved around work, or around social activities arranged by their wives. When their wives die men are faced with a reduced social network, which either they must adapt to, or they must go out and make new friendships. One solution to this problem is to remarry. Widowers are more likely both to desire remarriage and to remarry than widowed women (Bennett et al., 2003). On the other hand, for many widowed women there is no desire to remarry. Bennett et al., found that for many women of the inter-war generation there was no desire to remarry and to take on again the traditional gender roles of their earlier marriage.

FACTORS INFLUENCING WELLBEING

Age

Adopting a life course perspective, spousal bereavement in later life may be expected, or on-time and consequently the negative impact of a transition out of marriage through widowhood may be reduced, regardless of whether the loss was sudden (Arbuckle & deVries, 1995; Lopata, 1996; **Stroebe & Schut, 1993**). **QA: Need ref. in ref. section** Off-time widowhood is seen to be the most disruptive since younger adults are generally less prepared emotionally and practically than older adults to cope with the loss of a spouse (Scannell-Desch, 2003; Stroebe & Stroebe, 1987). Parkes

and Weiss (1983) and Lopata (1979) found that people who are widowed young have been found to present more psychological problems and have fewer friendships than people who are widowed in later life. Baler and Golde (1964) found a higher risk of mental illness, physical illness, and mortality in younger compared to older widows and widowers, and Parkes (1964) reported higher consultation rates for psychiatric symptoms from widows under 65. Ball (1977) compared the experiences of widows over three age groups, and found that young widows were found to be more symptomatic and, moreover, the symptom severity was more pronounced for those widows who had lost their husband suddenly. In contrast, physical health symptoms are more strongly associated with spousal bereavement for older compared to younger adults (Ensel & Lin, 2000; Williams & Umberson, 2004). A longitudinal study by Sanders (1980-81) found that although initially younger adults had poorer psychological health, after 2 years the levels significantly improved. For those widowed older, the opposite pattern was found. Considering social relationships, Lund, Caserta, van Pelt, and Gass (1990) found that younger (50-75) widows and widowers have a more stable social network compared to older (over 75), and that those over the age of 75 experienced a reduced sense of closeness to members of their social network. Spousal bereavement at a young age may involve substantial restricting of the social life, and may result in single-parenthood (Lopata, 1979).

Gender

Throughout the literature, and among lay people, there is a general belief that women fare better than men in adapting to widowhood (Bennett et al., 2003). Widowed men and women believe this is for three main reasons: women have better domestic skills; women are socially more capable; and men in the West “bottle-up” their feelings. There is also some marginal evidence that this may be the case at least with respect to emotional responses. Stroebe, Stroebe, and Schut (2001) in a comprehensive literature review suggested that men were more emotionally vulnerable than women, although these differences may be small. Bennett, Hughes, and Smith (2005b) also suggest that it is important to consider the methods used in assessing distress: self-report questionnaires might be effective for women, but interviews were more effective when identifying depressive feelings in men. Bennett (2007) also suggested that men experienced emotions but were more likely to express them in terms of masculine characteristic such as control and self-sufficiency.

Circumstances of Death

The circumstances of death are important. Situational variables surrounding the death can impact adaptation following bereavement (Carr, House, Wortman, Nesse, & Kessler, 2001). For example, when the likelihood of widowhood is very small, as is usually the case for young widows, forewarning of spousal death

is important (Balkwell, 1981). Longer terminal illnesses may allow the surviving spouse to prepare for the death and anticipatory grieving may take place (Donnelly, Field, & Horowitz, 2001). Wells and Kendig (1997) found that people who provided care for their spouse may experience lower levels of depression following widowhood compared to those who were not caregivers. In sudden death situations, on the other hand, there is usually no opportunity to discuss impending death with the spouse and is, therefore, often associated with more severe grief reactions (Burton, Haley, & Small, 2006).

In Parkes' seminal work he examines some of the determinants of grief, including the circumstances of the death (1996). He found that unexpected deaths, violent deaths, and deaths as a result of human agency (e.g., suicides) were more often associated with psychological distress than other types of circumstances, especially those which occurred in natural circumstances. Lopata (1996) also discussed the effects of sudden or violent deaths on the psychological wellbeing of the bereaved. She too found that these circumstances had a greater impact than those where the death was anticipated. Schaefer and Moos (2001) suggested that being forewarned of a death gave the bereaved an opportunity to prepare for the death and to enhance personal growth. Work reviewed by Stroebe and Schut (2001) suggests that the evidence is more mixed than our review has so far suggested. For example, they refer to work by Breckenridge, Gallagher, Thompson, and Peterson (1986) who found that responses to a depression measure did not differ between those whose loss was unexpected and those whose loss was not. More equivocally, Stroebe, Stroebe, and Domittner (1988) found that expectedness was marginally significant only at first point of measurement, and only then in those people with external locus of control beliefs. These equivocal findings suggest that more investigation is needed.

Researchers have also examined other circumstances concerned with the circumstances of death such as the interpersonal relationships surrounding the deceased and the bereaved. For example, as Stroebe and Schut (2001) point out lack of social support is widely recognized as a risk factor for poor outcomes following bereavement. Parkes and Weiss (1983) found that those widowed people who had an ambivalent relationship with the deceased were more likely to experience poorer outcomes than those who had enjoyed a rewarding relationship.

Bennett (2004) interviewed 92 older widowed people about their experiences of bereavement and widowhood. Each widow was assessed as whether or not they were coping with their widowhood. A variety of circumstances prior to the death were examined including expectations of death, interpersonal relationships, and the facts of the death. Surprisingly, only the circumstances of the death itself predicted coping. Those who coped less well were more likely to have had a spouse who was unwell before their death but whose death was nevertheless unexpected. Those widowed people for whom their spouse's death was either expected or indeed unexpected coped better.

FACTORS FACILITATING WELLBEING: RESILIENCE

Recently attention has been turned to research which focus not only on the factors that support widowed people in coping or adjusting to their bereavement but on factors which allow widowed people to, for want of a better word, excel at being widowed. Thus, researchers have focused on resilience in bereavement and widowhood. Traditionally, resilience has been considered in the psychological literature in terms of childhood development (Bowlby, 1980; Luthar, Doernberger, & Zigler 1993; Rutter, 1999), and either as a factor protecting children from adverse events or as a pathological reaction to trauma. However, within the field of later life bereavement three strands of evidence have suggested that resilience is more common, and indeed more normative, than has been previously thought (Bennett, 2010b; Bonanno, 2004; Moore & Stratton, 2003). Bonanno's work has focused on the effects of bereavement, and in particular the ways in which some bereaved spouses (and partners) do not experience grief or decreased mood following their bereavement, but do not experience pathological grief (as traditional grief researchers would expect). Using data from the Changing Lives of Older Couples study, he found that 46% of the sample experienced a resilient response, that is there were no *significant* changes in depression between pre-loss and 6 and 18 months post-loss (Bonanno, Wortman, Lehman, Tweed, Haring, Sonnega, et al., 2002). Bonanno (2004, p. 20), argued that resilience is the "ability to maintain a stable [psychological] equilibrium" following the loss, without long-term consequences. Moore and Stratton (2003) focused more on widowhood, rather than bereavement specifically, in their study of older men. They identified four models of behavior: reorganization (Rubinstein, 1986); adaptation (Moore & Stratton, 2003); finding positive benefit (Janoff-Bulman, 1992; McMillen 1999); and compensation (Ferraro, Mutran, & Barresi 1984). They identified many of their widowers as resilient and they were characterized by: initial painful awareness of loss; the sense of a continuing "hole in their lives" despite being engaged in meaningful activities; an integrated belief and value system; an optimistic and positive personality; and an ability to get social support. They suggested that resilient widowers adjusted in one of three ways: they changed themselves in some way; they changed their environment; and/or they found a companion. They also emphasized, in line with much resilience literature, and it is not out of tune with Bonanno, that resilient widowers were able to bounce back from the stressor, bereavement. Both the work of Bonanno and that of Moore and Stratton agree that a resilient widowed person is someone well-adjusted to life following the loss. Further, their views can be reconciled by considering the time-frame—Bonanno uses a short time frame, while Moore and Stratton use a longer time frame. Bennett (2010b) drew together these two approaches, and suggested that Bonanno focuses on bereavement, and Moore and Stratton on widowhood. Bennett, using data from two studies of

widowhood, identified men who were resilient as described by Bonanno in their bereavement and men who were resilient as widowers. She went further and argued that for some widowers the achievement of resilience might be gradual, but that for some men it might be following some major or minor turning point. She also began to consider the nature of agency in achieving resilience. She has some evidence that resilience might be achieved passively, either by the active intervention of another person, as in the case of social support, but that it could also be achieved by an unidentified or unnoticed, external agent. In other cases the widower was the agent of change, either through personal characteristics—personality or life view—or through engaging in social activity or the marshalling of social or instrumental resources.

CONCLUSION

This article has focused attention on the ways in which bereavement and widowhood influence psychological wellbeing. It is important to distinguish between the effects of bereavement and those of widowhood in understanding the lives of widowed people. Both bereavement and widowhood can affect psychological and physical health and can have substantial influences on older people's interactions with the social world. The circumstances that precede the bereavement can influence how well people can adapt to being widowed and cope with their bereavement. Factors such as age and gender influence the ways in which people adapt. It is also clear that there are different ways in which people confront their lives as widowed people and these can influence how people live their lives as widowed people. However, it is important to remember that for older people bereavement and spousal loss are common and that the majority of older adults take these events in their stride. They miss their spouses but life goes on.

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Direct reprint requests to:

Dr. Kate M Bennett
School of Psychology
University of Liverpool
Eleanor Rathbone Building
Bedford Street South
Liverpool L69 7ZA
UK
e-mail: kmb@liv.ac.uk