Health and Well-Being of Spouse Caregivers and the Widowed

Yvonne D. Wells, PhD and Hal L. Kendig, PhD

Providing care for a spouse and widowhood are major experiences of later life. Many studies conclude that caregiving is stressful, particularly for spouses (e.g., Caserta, Lund, Wright, & Redburn, 1987; Gilhooly, 1984). There is a well-established literature on widowhood and its specific and global consequences (e.g., Avis, Brambilla, Vass, & McKinlay, 1991). Caregiving now dominates the gerontological literature, while there has been little recent interest in widowhood. Few studies have compared the two transitions or explored the effects of prior caregiving on the experience of widowhood.

This article contrasts the capacity of two models — the stress-coping model and the life transitions approach — to account for similarities and differences in caring for a spouse and being widowed. Both of these later life experiences were examined in a survey broadly representative of older people living in the community in an Australian city. The comprehensive study avoided a focus on negative outcomes and included specific health behaviors as well as global measures of health and well-being.

Literature Review

Variants of the stress-coping model have provided a useful basis for understanding the effects of undesirable life events. In the ABCX version of this model (see Biegel, Sales, & Schulz, 1991), an external stressor (A) interacts with the family’s ability to cope with the event (B) and with the family’s perception of the stressor (C). Health crises and mental health problems (X) may result. The Double ABCX model is similar to its predecessor but allows for a “piling up” of stressors over time (Rankin, Haut, & Keefover, 1992). The effects of stress may be time-lagged (Biegel et al., 1991, p. 9).

Stress-coping studies have viewed stress as unitary and cumulative, and have focused primarily on global outcomes, such as physical illness and depression. Relatively little attention has been paid to favorable life events, except as potential further sources of stress, or to positive outcomes such as life satisfaction. Further, specific behavioral outcomes, such as changes in physical and social activity, deserve attention and could well differ for different stressful events. For example, caring for a spouse restricts life styles (Aneshensel, Pearlin, & Schuler, 1993), whereas widowhood may represent a release from obligations (Aldersberg & Thorne, 1990).

Caregiving research has relied heavily on versions of the stress-coping model (Biegel et al., 1991). In contrast, although widowhood is rated the most stressful of all life events by Holmes and Rahe (1967), research on widowhood has relied more on concepts such as transition and adjustment. Transitions are permanent, sudden life changes that have major impact and initiate a period of dislocation and adjustment at both the individual and network level. Major transitions, such as retirement and widowhood, challenge important assumptions people hold about the world and their place in it (McCallum, 1986).

Global outcomes associated with caregiving include ill health, depression, and anxiety (see review by Schulz, O’Brien, Bookwala, & Fleissner, 1995). Caregiving research on specific outcomes has examined the impact on employment and social life (e.g., Schulz & Williamson, 1993). Little attention has been paid to other possible impacts, such as the capacity...
to engage in a healthy life style, even though health behaviors could mediate between caregiving stressors and global outcomes. Connell (1994) reported that caring for a person with dementia restricts preventive health behaviors, but other studies have found no such link (Schulz et al., 1995). Although alcohol overuse is implicated in elder abuse (Pillemer, 1986), few links have been established between caregiving and other health behaviors.

The conclusion that caregiving is universally stressful can be questioned for three main reasons. First, most studies are based on selective samples of caregivers who seek help from service providers or self-help groups (Barer & Johnson, 1990). Caregivers who seek help are likely to have the greatest need and to report negative consequences of caregiving disproportionately (MaloneBeach & Zarit, 1991; Matthews, 1988). Second, research on family care has focused heavily on caring for someone with dementia, which is more stressful than caring for someone with a physical disability (Birkel, 1987; Mohide, Torrance, Streiner, Pringle, & Gilbert, 1988) or an intellectual disability (Whittick, 1988). Third, most studies of caregiving cue participants to focus on the most negative aspects of their experiences. Some caregivers, however, report that the experience makes them feel closer to their dependent relative (Hinrichsen, Hernandez, & Pollack, 1992; Wilson, 1990). Caregivers may gain satisfaction and self-esteem from care provision (O'Bryant, Straw, & Meddagh, 1990; Wright, 1991).

Almost all research on widowhood in later life has focused on women (Bengtson, Rosenthal, & Burton, 1990). The death of a spouse may trigger changes in daily routines, such as those associated with food preparation and consumption (Rosenbloom & Whittington, 1993). Widowhood brings about changes in social participation (Lopata, 1979). Loneliness is the biggest problem reported by both widows and widowers (Lund, Caserta, & Dimond, 1986).

Widowed men and women report lower life satisfaction and poorer psychological well-being than their married counterparts and they are more likely to die (Arbuckle & de Vries, 1995; Bennett & Morgan, 1992; Parkes, 1986). However, widowhood can be a positive transition for some women (Aldersberg & Thorne, 1990). Widowed people often express greater self-efficacy than married adults (Arbuckle & de Vries, 1995), and most widows and widowers adjust successfully in time (McCallum, 1986).

Studies of entry into and exit from caregiving are limited almost entirely to adult children of older people (e.g., Dwyer, Henretta, Coward, & Barton, 1992; Walker & Pratt, 1991). Yet, older spouses are likely to have a different caregiving history. The most common conclusion of spouse caregiving is institutionalization of the care recipient (e.g., Pruchno, Michaels, & Potashnik, 1990), which has been likened to “quasi-widowhood” (Rosenthal & Dawson, 1991). Widowhood is the second major way by which spouse caregiving ends (Pruchno et al., 1990), but little attention has been given to the caregiver-to-widowhood transition, although Bass and Bowman (1990) found that a greater caregiving burden predicts a greater bereavement strain.

Conversely, few widowhood studies have taken prior caregiving experience into account. Sudden bereavement is a risk factor for more severe bereavement reactions (Hill, Thompson, & Gallagher, 1988; Smith, 1978). Widows who anticipate the death of their spouse may engage in anticipatory grieving that minimizes regrets and prevents “unfinished business” (Lopata, 1986); however, older people whose spouses suffer long illnesses can be vulnerable in widowhood (Gerber, Rusalem, Hannon, Batlin, & Arkin, 1975). Caring for a spouse, then, may either provide time to prepare for widowhood or serve as a cumulative stressor, depending on the duration of the caregiving experience.

The life transitions model provides a view that can take into account the relationship between caregiving and widowhood. Spouse caregiving can be viewed as a transition that may precede widowhood and influence the meaning of widowhood. Further, the life transitions model permits the interpretation of caregiving as being a source of satisfaction as well as stress, and of widowhood as a release as well as a loss.

In summary, the consequences of spouse caregiving in relation to widowhood are not well understood at present. The stress-coping model and the life transitions model provide alternative perspectives on these major late-life experiences.

Method
This study aimed to test the stress-coping and life transitions models as competing predictors of the consequences of spouse caregiving and widowhood. It examined specific as well as global consequences, including health behaviors, strain, and global well-being. Hypotheses were tested in the following three areas.

1. Consequences of spouse caregiving. The stress-coping model predicts that current and former spouse caregivers will report more negative outcomes (specific and global) than people who have not been spouse caregivers. In contrast, the life transitions model predicts that both positive and negative outcomes may be associated with caregiving experience.

2. Consequences of widowhood. The stress-coping model predicts that widows and widowers will report more negative outcomes (specific and global) than people who are married. In contrast, the life transitions model suggests that widowhood may entail both positive and negative consequences.

3. Comparison of widowhood and spouse caregiving experience.
   (a) More negative consequences will be associated with widowhood than with spouse caregiving, because widowhood is likely to require more adjustment than becoming a spouse caregiver.
   (b) The stress-coping model predicts that the consequences of the two experiences will be simi-
lar, while the life transitions approach permits them to entail different consequences.

(c) The stress-coping model predicts that the two stressors, widowhood and spouse caregiving, will operate cumulatively, whereas the life transitions approach permits them to operate interactively.

Sample

Participants were drawn from the Health Status of Older People survey of 1,000 people aged 65 years and older living in the community (see Kendig et al., 1996). The survey was conducted in 1994 by the Lincoln Gerontology Centre in collaboration with the National Ageing Research Institute. An area probability sample was designed by the Australian Bureau of Statistics. The eligible population consisted of residents of private dwellings in the Melbourne Statistical Division, thus excluding older people living in hospitals, nursing homes, and hostels. Individuals were also ineligible if they did not speak basic English, were cognitively impaired, severely ill, or deaf. The response rate was 70% of the eligible population. In addition to personal interviews in the home, questionnaires were left for self-completion and return by mail. Eighty-five percent of survey participants returned a usable questionnaire, and the current study includes only this subsample. Comparisons with comparable community surveys indicate that the HSOP sample comprised slightly higher than expected proportions of healthy and married people (Kendig et al., 1996).

Four subgroups were identified for the purposes of the analyses. Group 1 comprised married people who had not been spouse caregivers (married non-caregivers), while Group 2 included married people who were currently providing spousal care (married current caregivers). Widows and widowers were included in the study if they had been widowed for four years or less. Group 3 comprised widowed people who had not been spouse caregivers (widowed never caregivers), while widowed people who formerly were spouse caregivers formed Group 4 (widowed former caregivers). People who were married but not living with their spouse were omitted. It was not possible to determine how many widowed people had formerly institutionalized their spouse.

The size, gender balance, and age distribution of each group are presented in Table 1. As expected, married current caregivers were older than married noncaregivers. Widowed people were older than married people and included a higher proportion of women. Men were more equally represented among the married current caregivers (Group 2) than is usual in studies of caregiving.

Measures

Married current and widowed former caregivers replied “yes” to the item, “Since the age of 60 have you had the main responsibility in caring for someone who has a long-term illness, disability, or other problem?” People who had been widowed were identified by an item on marital status, with a follow-up question on duration of widowhood.

Health, life style, and well-being variables were selected to provide a comprehensive assessment of the health status of older people (Teshuva, Stanislavsky, & Kendig, 1994). Following are the specific and global measures used in the analyses (see Kendig et al., 1996, for specification of the survey questions). Internal reliability for scales quoted below includes all survey participants and employs Cronbach’s alpha:

Specific Activity Measures. — Participants rated their current way of life on a 3-point scale from very healthy to not so healthy. Level of physical and social activity compared with others of the same age were both rated from 1 (more active) to 3 (less active).

Specific Health Practices. — Eating patterns were rated from 1 (very healthy) to 3 (not so healthy) and appetite during the past month was rated from 1 (very good) to 4 (poor). Smoking was designated yes or no, and alcohol consumption was rated from 1 (more than once a day) to 7 (never). Trouble falling asleep, waking at night, and feeling rested in the morning were all rated on 4-point scales from most of the time to never. Use of psychotropics was scored yes or no for each of four domains: analgesics, antidepressants, tranquilizers, and hypnotics.

Global Measures of Well-Being. — These were identified primarily from previous caregiving research. Participants rated their physical health from 1 (excellent) to 5 (poor). Feeling lonely and bored were each rated from 1 (never) to 5 (very frequently). Strain was measured using a single item, “How often do you feel that you are under so much strain that your health is likely to suffer?” rated from 1 (never) to 5 (very frequently).

<table>
<thead>
<tr>
<th>Group</th>
<th>Designation</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>65-74</td>
<td>75+</td>
<td>65-74</td>
</tr>
<tr>
<td>1</td>
<td>Married noncaregiver</td>
<td>46</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>2</td>
<td>Married current caregiver</td>
<td>33</td>
<td>16</td>
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<tr>
<td>3</td>
<td>Widowed never caregiver</td>
<td>8</td>
<td>17</td>
<td>50</td>
</tr>
<tr>
<td>4</td>
<td>Widowed former caregiver</td>
<td>21</td>
<td>6</td>
<td>52</td>
</tr>
</tbody>
</table>

Note: Row percentages may not sum to 100 due to rounding.
Lawton's Affect Balance Scale. — This was used to measure positive and negative affect (Lawton, Kleban, Dean, Rajagopal, & Parmelee, 1992). Each subscale includes five items, and internal reliability was .74 for both. Depression was measured using the Psychogeriatric Assessment Scales depression subscale (Jorm & Mckinnon, 1994). This subscale comprises 12 items; internal reliability was .67. Because scores on the depression scale were highly positively skewed, they were treated with a log transformation; participants were also categorized as likely (score of 5 or above) or not likely to be depressed.

Life Satisfaction. — This was measured by summing ratings over eight domains (health, financial situation, friendship, marriage, family life, neighborhood, ability to handle problems, and life in general), each from 1 (extremely satisfied) to 5 (very dissatisfied). Items were selected from the domain life satisfaction measure (Campbell, Converse, & Rodgers, 1976) on the basis of their likely salience for older Australians. Internal reliability was .87. Interviewers also rated participants’ quality of life (5-point scale from highly meaningful to impoverished).

Self-efficacy. — This was measured using scales by Seeman, Rodin, and Albert (1993). The 3-item interpersonal efficacy subscale had an internal reliability of .79, while the 4-item instrumental efficacy subscale had an internal reliability of .84. Antonovsky's (1984) Sense of Coherence subscales measured respondents’ view of life’s Comprehensibility (5 items, alpha = .65), Manageability (4 items, alpha = .61), and Meaningfulness (4 items, alpha = .57).

Analysis

Analyses assessed relationships between key life experiences (widowhood and spouse caregiving) and outcomes (specific and global), employing a factorial design. Factor 1 differentiated those without spouse caregiving experience from both married current caregivers and widowed former caregivers. Therefore, variables associated with this factor indicated enduring consequences of spouse caregiving or selection effects in becoming a spouse caregiver. Factor 2 differentiated widowed from married people. Interactions between factors could indicate either that consequences associated with spouse caregiving ceased (or were exacerbated) on widowhood or that the consequences of being widowed differed according to prior caregiving experience.

The chi-square statistic was employed with categorical dependent variables. Categories on some items were combined to meet requirements for expected frequencies. To control for age group and gender, chi-square analyses were weighted so that all groups corresponded with the size and proportions in age and gender represented by the married current caregivers (Group 2). This group was chosen as the reference group for weighting because (a) men and women were almost equally represented; (b) the proportions in the young-old and old-old groups reflected proportions for the whole sample (65% young-old in Group 2; 64% young-old for the whole sample); and (c) the number of participants (43) was sufficient for the analyses without unduly inflating their power. Hence, for these analyses the number of widowed participants was increased (from 57 to 86), but the number of currently married people was substantially reduced (from 499 to 86).

Interaction effects (Factor 1 X Factor 2) were assessed using logit analysis, which is a method of testing relationships between three or more categorical variables. The logit model starts with all of the one-, two-, and three-way associations and then eliminates as many of them as possible while maintaining an adequate fit between expected and observed cell frequencies (Tabachnick & Fidell, 1989). Small numbers of outliers were deleted. Interaction effects (Factor 1 X Factor 2) were assessed using partial correlation, controlling for gender and age. (Regression analysis was chosen rather than analysis of variance because the research design was nonexperimental; Keppel & Zedeck, 1989.)

Results

Percentages and mean scores cited below are weighted for gender and age.

Outcomes Associated With Spouse Caregiving

In terms of specific outcomes, Table 2 shows that people with spouse caregiving experience were more likely to take tranquilizers (18% vs 7%). However, married current and widowed former caregivers were only one sixth as likely to smoke as the married noncaregivers and widowed never caregivers (3% vs 19%). Specific outcomes not associated with spouse caregiving included healthy life style, diet, sleep, and levels of both physical and social activity.

Associations between global outcomes and caregiving experience (see Table 3) were also mixed. Married current and widowed former caregivers rated their health as better than the noncaregiving groups (married noncaregivers and widowed never caregivers): 22% of the current and former caregivers reported being in excellent health, as opposed to only 12% of the noncaregiving groups. However, the married current and widowed former caregivers were more likely than the noncaregiving groups to report feeling so much strain that their health was likely to suffer — 45% vs 25%. Current and former caregivers had lower mean scores for all three Sense of Coherence subscales than the noncaregiving groups. Adjusted means were: on Comprehensibility, 25.88 (SD = 5.49) for current and former caregivers vs 27.35 (SD = 5.44) for noncaregiving groups; on Manageability, 20.89 (SD = 5.12) vs 22.01 (SD = 4.43), respectively; and on Meaningful-
Table 2. Correlates of Spouse Caregiving Experience: Specific Outcomes

<table>
<thead>
<tr>
<th>Set of Outcomes</th>
<th>Measure</th>
<th>Statistic</th>
<th>Value</th>
<th>df</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity measures</td>
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<td>$\chi^2$</td>
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<td>Physical activity</td>
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<td>Social activity</td>
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<tr>
<td>Health practices</td>
<td>Appetite</td>
<td>$\chi^2$</td>
<td>3.53</td>
<td>2</td>
<td></td>
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<td></td>
<td>Healthy diet</td>
<td>$\chi^2$</td>
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<td></td>
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<tr>
<td></td>
<td>Drinks alcohol</td>
<td>$\chi^2$</td>
<td>3.01</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smokes</td>
<td>$\chi^2$</td>
<td>10.96</td>
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<td>Better</td>
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<tr>
<td></td>
<td>Falling asleep</td>
<td>$\chi^2$</td>
<td>2.86</td>
<td>3</td>
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<tr>
<td></td>
<td>Waking at night</td>
<td>$\chi^2$</td>
<td>1.30</td>
<td>3</td>
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<tr>
<td></td>
<td>Feels rested</td>
<td>$\chi^2$</td>
<td>0.32</td>
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<td>Medication use</td>
<td>Analgesics</td>
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<td></td>
<td>Antidepressants</td>
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<td></td>
<td>Tranquilizers</td>
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<tr>
<td></td>
<td>Hypnotics</td>
<td>$\chi^2$</td>
<td>3.16</td>
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*Chi-square analyses are weighted to take account of gender and age group (n = 172).
*p < .05; ***p < .001.

Table 3. Correlates of Spouse Caregiving Experience: Global Outcomes

<table>
<thead>
<tr>
<th>Set of Outcomes</th>
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<th>Value</th>
<th>df</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Social integration</td>
<td>Feels bored</td>
<td>$\chi^2$</td>
<td>3.06</td>
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<tr>
<td></td>
<td>Feels lonely</td>
<td>$\chi^2$</td>
<td>4.56</td>
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<tr>
<td>Physical health</td>
<td>Self-rated health</td>
<td>$\chi^2$</td>
<td>9.66</td>
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<td>Better</td>
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<tr>
<td>Mental health</td>
<td>Feels strain</td>
<td>$\chi^2$</td>
<td>7.16</td>
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<tr>
<td></td>
<td>Depression (scale)</td>
<td>r</td>
<td>.02</td>
<td>552</td>
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<td></td>
<td>Depression (category)</td>
<td>$\chi^2$</td>
<td>.31</td>
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<td></td>
<td>Positive affect</td>
<td>r</td>
<td>-.06</td>
<td>550</td>
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<tr>
<td></td>
<td>Negative affect</td>
<td>r</td>
<td>-.01</td>
<td>552</td>
<td></td>
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<tr>
<td>Quality of life</td>
<td>Life satisfaction</td>
<td>r</td>
<td>.04</td>
<td>531</td>
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<td></td>
<td>Observed quality</td>
<td>$\chi^2$</td>
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<tr>
<td>Self-efficacy</td>
<td>Interpersonal</td>
<td>r</td>
<td>.04</td>
<td>513</td>
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<tr>
<td></td>
<td>Instrumental</td>
<td>r</td>
<td>.02</td>
<td>515</td>
<td></td>
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<tr>
<td>Sense of coherence</td>
<td>Comprehensibility</td>
<td>r</td>
<td>-.11</td>
<td>520</td>
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</tr>
<tr>
<td></td>
<td>Manageability</td>
<td>r</td>
<td>-.10</td>
<td>526</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meaningfulness</td>
<td>r</td>
<td>-.09</td>
<td>528</td>
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</table>

*Chi-square analyses are weighted to take account of gender and age group (n = 172), while partial correlation coefficients (r) control for age and gender.
*p < .05.

ness, 21.77 (SD = 4.39) vs 23.02 (SD = 4.18), respectively. Global outcomes not associated with Factor 1 included social integration, self-efficacy, affect, and quality of life.

The first hypothesis generated by the stress-coping model, that spouse caregiving would entail negative outcomes, was partly supported. Positive outcomes associated with caregiving experience were more consistent with the life transitions model.

Outcomes Associated With Widowhood

Relative to married people, people who had been widowed within the previous four years showed poorer appetite (32% vs 10% with fair-to-poor appetite), more smoking (17% vs 5%), and higher use of hypnotics (18% vs 7%) (Table 4). Specific outcomes not associated with widowhood included activity levels, alcohol use, and sleep patterns.

With respect to global outcomes (see Table 5), widows and widowers relative to married people showed more loneliness (33% vs 2% frequently or very frequently lonely), more boredom (19% vs 8% frequently or very frequently bored), and poorer health (37% vs 58% excellent or very good health). Widowed people also reported more symptoms of depression than married people (Ms 1.77 and 1.20, respectively; SDs 1.92 and 1.68, respectively) and less positive affect (Ms 19.37 and 20.55; SDs 2.91 and 2.65). However, widows and widowers reported less strain than married people (72% vs 56% never felt strain). Quality of life, self-efficacy, and sense of coherence were not associated with widowhood. The second hypothesis generated by the stress-coping model, that negative outcomes would be associated with widowhood, was supported overall.

Comparison of Widowhood and Spouse Caregiving Experience

Spouse caregiving experience and widowhood were not independent. On the one hand, current spouse caregivers were relatively rare, comprising only 4% of the HSOP sample and 9% of those who...
were married. On the other hand, 58% of the widowed people were former spouse caregivers.

(a) Hypothesis: More negative consequences will be associated with widowhood than with spouse caregiving.

This hypothesis was supported. A simple count of significant positive and negative associations revealed that widowhood appeared to have somewhat worse consequences for people than spouse caregiving. Negative consequences of widowhood were comprehensive and included health behaviors, social integration, physical health, and mental health. Negative consequences of spouse caregiving were confined to strain and sense of coherence.

(b) Similarity of spouse caregiving and widowhood.

The consequences of widowhood and spouse caregiving were not similar. Only three variables were associated with both of these factors, and for these variables the relationships between stressors and outcomes were in opposite directions: Current and former spouse caregivers reported lower rates of smoking and better health despite more strain than noncaregivers, whereas widowed people reported higher rates of smoking and worse health but less strain than married people. These results are more consistent with the life transitions model than with the stress-coping model.

(c) Spouse caregiving and widowhood as cumulative or interactive.

Interaction effects between Factor 1 and Factor 2 were examined for two reasons: to detect further differences between groups and to examine nonadditivity of factors. Such nonadditivity would provide support for the life transitions model rather than the stress-coping model. Interaction effects were detected only for “trouble falling asleep,” the categorical depression variable, and the probability of taking tranquilizers. Widowed former caregivers

Table 4. Correlates of Widowhood: Specific Outcomes

<table>
<thead>
<tr>
<th>Set</th>
<th>Measure</th>
<th>Statistic</th>
<th>Value</th>
<th>df</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity measures</td>
<td>Healthy life style</td>
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<td>0.21</td>
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<td>Health practices</td>
<td>Appetite</td>
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<td>Worse</td>
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<td>Healthy diet</td>
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<td>0.91</td>
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<td></td>
<td>Drinks alcohol</td>
<td>$\chi^2$</td>
<td>2.38</td>
<td>3</td>
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</tr>
<tr>
<td></td>
<td>Smokes</td>
<td>$\chi^2$</td>
<td>6.37**</td>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>Falling asleep</td>
<td>$\chi^2$</td>
<td>5.17</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waking at night</td>
<td>$\chi^2$</td>
<td>4.95</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feels rested</td>
<td>$\chi^2$</td>
<td>1.51</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medication use</td>
<td>Analgesics</td>
<td>$\chi^2$</td>
<td>2.74</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Antidepressants</td>
<td>$\chi^2$</td>
<td>1.43</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tranquilizers</td>
<td>$\chi^2$</td>
<td>0.53</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypnotics</td>
<td>$\chi^2$</td>
<td>5.35*</td>
<td>1</td>
<td>Worse</td>
</tr>
</tbody>
</table>

*Chi-square analyses are weighted to take account of gender and age group (n = 172).
*p < .05; ***p < .001.

Table 5. Correlates of Widowhood: Global Outcomes

<table>
<thead>
<tr>
<th>Set</th>
<th>Measure</th>
<th>Statistic</th>
<th>Value</th>
<th>df</th>
<th>Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social integration</td>
<td>Feels bored</td>
<td>$\chi^2$</td>
<td>6.98*</td>
<td>2</td>
<td>Worse</td>
</tr>
<tr>
<td></td>
<td>Feels lonely</td>
<td>$\chi^2$</td>
<td>57.81***</td>
<td>4</td>
<td>Worse</td>
</tr>
<tr>
<td>Physical health</td>
<td>Self-rated health</td>
<td>$\chi^2$</td>
<td>7.85*</td>
<td>3</td>
<td>Worse</td>
</tr>
<tr>
<td>Mental health</td>
<td>Feels strain</td>
<td>$\chi^2$</td>
<td>6.04*</td>
<td>2</td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td>Depression (scale)</td>
<td>$r$</td>
<td>.11**</td>
<td>552</td>
<td>Worse</td>
</tr>
<tr>
<td></td>
<td>Depression (category)</td>
<td>$\chi^2$</td>
<td>.82</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive affect</td>
<td>$r$</td>
<td>-.14***</td>
<td>550</td>
<td>Worse</td>
</tr>
<tr>
<td></td>
<td>Negative affect</td>
<td>$r$</td>
<td>-.01</td>
<td>551</td>
<td></td>
</tr>
<tr>
<td>Quality of life</td>
<td>Life satisfaction</td>
<td>$r$</td>
<td>.08</td>
<td>531</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observed quality</td>
<td>$\chi^2$</td>
<td>3.68</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>Interpersonal</td>
<td>$r$</td>
<td>-.03</td>
<td>515</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Instrumental</td>
<td>$r$</td>
<td>-.01</td>
<td>511</td>
<td></td>
</tr>
<tr>
<td>Sense of coherence</td>
<td>Comprehensibility</td>
<td>$r$</td>
<td>-.06</td>
<td>520</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manageability</td>
<td>$r$</td>
<td>.03</td>
<td>526</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meaningfulness</td>
<td>$r$</td>
<td>-.04</td>
<td>528</td>
<td></td>
</tr>
</tbody>
</table>

*Chi-square analyses are weighted to take account of gender and age group (n = 172), while partial correlation coefficients ($r$) control for age and gender.
*p < .05; **p < .01; ***p < .001.
had the most trouble falling asleep of any group: 39% had trouble falling asleep most of the time, compared with 14% to 18% for the other three groups. The widowed former caregivers were also most likely to be taking tranquilizers (21%, compared with 0% to 8% for the other groups). High use of tranquilizers in widowed former caregivers accounted for the bivariate relationship between spouse caregiving experience and tranquilizer use: Married current caregivers were no more likely than any other group to use these drugs.

Widowed people with no caregiving experience were more likely than any other group to be classified as depressed: 18%, compared with 12% for married current caregivers, 7% for widowed former caregivers, and 5% for married noncaregivers. Hence, widowed people were about twice as likely to be classified as depressed if they had no spouse caregiving experience. This supports a buffering effect of spouse caregiving experience, as predicted by the life transitions model.

Discussion

This study compared the stress-coping and life transitions models in predicting the consequences of two life events — widowhood and spouse caregiving. The results show that it is useful to examine spouse caregiving and widowhood together. Spouse caregiving is a transition that is closely linked with widowhood: More than half of the widowed people were former spouse caregivers, and both life experiences had enduring consequences.

The general stress model does not apply equally to spouse caregiving and widowhood because the outcomes of these life events were different and sometimes contrary. Some outcomes showed interactive rather than additive effects. In regard to depression, former spouse caregivers appeared to be provided with a measure of protection against the stress of widowhood. That result supports the notion that people who are forewarned of their spouse’s death may adjust better to widowhood (e.g., Lundin, 1984). Conversely, in regard to sleeping problems and the use of tranquilizers, apparent difficulties of widowed people were exacerbated by prior caregiving experience.

The outcomes associated with widowhood were strongly negative and pervasive across aspects of health and well-being. These results closely parallel those of other widowhood studies (e.g., Breckenridge, Gallagher, Thompson, & Peterson, 1986) and conform well to the general stress model. They are also consistent with the life transitions model, because adjustment is likely to continue up to four years after widowhood (Lund, Caserta, & Dimond, 1986; McCallum, 1986). For life events whose consequences are largely negative, the stress-coping and life transitions models are not mutually exclusive.

In contrast, outcomes associated with spouse caregiving experience were fewer than expected from the caregiving literature and not invariably negative. For example, current and former spouse caregivers were more likely to report good health and less likely to smoke than people without spouse caregiving experience. Negative outcomes associated with spouse caregiving were largely limited to sense of coherence, and caregiving appeared to have no negative consequences for health behaviors, health, affect, or quality of life.

These findings suggest that spouse caregiving is not best conceptualized simply as a stressor for most people. Rather, spouse caregiving may provide a complex challenge, giving a sense of competence and satisfaction that may compensate for the losses experienced (O’Bryant et al., 1990; Wright, 1991). Our results support Matthews’ (1988) criticism that too pessimistic a picture of caregiving has been perpetuated. It is overly simplistic to stereotype older caregivers as necessarily hidden victims of their spouse’s illness.

This cross-sectional study does not, of course, suggest that caregiving improves health or helps people give up smoking (although the responsibility of looking after a spouse may motivate people to maintain health habits). It is more plausible that healthy people are more likely to take on spouse caregiving in the first place. Alternatively, a person who provides care may not view him- or herself as a caregiver if he also has poor health and each partner relies on support from the other.

Despite a generally encouraging picture, there were signs that spouse caregivers endured more difficulties than their counterparts without caregiving experience. They reported higher levels of strain and were more likely to use sedatives. Further, both current and former spouse caregivers experienced life as less meaningful, manageable, and comprehensible than people who had never been caregivers. The sense of coherence (Antonovsky, 1984) experienced by spousal caregivers appears to be diminished. This loss of faith in the order and purpose of life persists after the death of the dependent spouse.

We might speculate as to why providing care for a spouse has persistent effects on existential beliefs, while widowhood impacts on affective state. Although widowhood is a potentially traumatic transition, it is an expected event for people over the age of 65 (Lopata, 1986; McCallum, 1986). Conversely, becoming a spouse caregiver, although a less traumatic transition, may not be anticipated by most people. There is some evidence that middle-aged men are less likely to anticipate spouse caregiving than women, and are more idealistic in their expectations (Wells, 1993). In contrast to having a spouse die, the realities of spousal caregiving may profoundly violate the expectations people have of their retirement years. More research on the meaning of spouse caregiving is required to extend the few studies now available (Motenko, 1988; Vinick, 1984). Preparation and counseling for spousal caregiving should include a focus on the meaning and purpose of life.

Findings on medication use are of some concern. Widows, especially those who had not provided
care for their spouse before their bereavement, reported a high level of depressive symptoms, but they were no more likely than still-married people to be receiving antidepressant medication. Widows were, however, relatively likely to be taking hypnotics; widows with spouse caregiving experience were the group most likely to be taking tranquilizers. These apparent contradictions between depressive symptoms and prescription of medication merit further study. Health promotion for older people needs to consider the heightened risk of inappropriate medication use among widows.

The cross-sectional design of the study has limitations in distinguishing consequences from selection effects. This is not a major issue for the widowhood findings because low well-being is unlikely to increase the risk of widowhood. Some findings associated with spouse caregiving, however, may be interpreted as selection effects because people with fewer disabilities are more likely to take on these responsibilities. Further, even in a study of 1,000 people, there were too few present or past spouse caregivers to examine potentially important gender differences in the consequences of caregiving (see meta-analyses by Miller & Cafasso, 1992) or widowhood. For example, women usually expect to outlive their husbands.

One might question why these findings are so similar to those in the widowhood literature but starkly different from those in the caregiving literature. The explanation may lie mainly in the predominance of caregiving studies that focus on the difficulties of people who seek help. That emphasis brings recognition to a genuine social problem and guides the provision of support. However, there is a paucity of population-based studies that also examine positive aspects of caregiving and include representative samples of people at different points in their caregiving history.

This study has shown the importance of carefully considering the appropriateness of the stress-coping and life transition models in terms of specific life experiences and specific consequences. Caregiving and widowhood are usual experiences that have different but interrelated consequences in old age. While both experiences can require difficult adjustments, it is important to emphasize that a satisfactory level of well-being is achieved eventually by most older people.

References


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