

Restoration after Bereavement

Dale Lund, Michael Caserta, Brian de Vries, and Scott Wright

The death of a spouse in later life, after many years of marriage is one of the most common of all major stressful life transitions. After age 65, 32% of the U.S. population is widowed (14% for men and 45% for women) with this increasing to 46% after age 75 and 66% after the age of 85 (U.S. Bureau of the Census, 2000).

The high intensity of stress for these newly widowed persons is attributed to the long-term and pervasive nature of the bereavement/widowhood adjustment process which potentially impacts every aspect of their lives (e.g., emotional, physical and mental health, identity, social interactions and relationships, sexuality, work productivity, decision-making, injuries, accidents and mortality). While our research-based knowledge has increased considerably over the past 30 years regarding the long term nature of the process, common difficulties and coping strategies and expected and unusual outcomes, there are two continuing gaps that have become more obvious. First, bereavement research is now only beginning to systematically test interventions other than traditional self-help strategies (Caserta, Lund, & Rice, 1999; Lund & Caserta, 1998; McKibbin, Guarnaccia, Hayslip, & Murdock, 1997). Second, theory needs to play a more prominent role in guiding the research (Kato & Mann, 1999; Stroebe, Hansson, Stroebe, & Schut, 2001). This paper is responsive to these gaps in that we 1) review some of the most relevant literature on bereavement interventions, 2) promote the use of theory in developing and testing bereavement interventions, 3) describe the essential features of the dual process model (DPM) (Stroebe & Schut, 1999) and 4) present a 14-week intervention plan to use and test the DPM model.

The Consequences of Spousal Loss

The consequences of spousal loss in later life have been well documented (Glick et al., 1974; Lund, 1989; Lund & Caserta, 2002; Stroebe & Stroebe, 1987; Stroebe, Stroebe, & Hansson, 1993). Although the long-term bereavement process is experienced with considerable variability, some common elements have included profound sadness, pining for the one who died, depressed mood, altered identity, negative health outcomes, loneliness and the withdrawal of support networks. There is also evidence of stress associated with role changes that accompany widowhood, particularly those related to disruptions in life patterns and daily routine, taking on new unfamiliar tasks, and changes in social relationships and connectedness (Anderson & Dimond, 1995; Moss, Moss, & Hansson, 2001).

The loss of a spouse can be disruptive to existing health care practices, as well as interfere with the adoption of new healthy behaviours (Powers & Wampold, 1994;

Rosenbloom & Whittington, 1993). Persons overwhelmed or preoccupied with their grief often neglect their own nutrition, fail to exercise regularly, discontinue physical and social activities that they previously did as a married couple, and become more accident prone because they pay less attention to their personal safety (Johnson, 2002; Powers & Wampold, 1994; Quandt et al., 2000; Rosenbloom & Whittington, 1993; Schone & Weinick, 1998; Shahar et al., 2001). Furthermore, bereavement can adversely impact the performance of tasks of daily living that are essential for health and independent functioning. For example, meal planning and preparation, household maintenance, managing finances, as well as other tasks often go unattended by the surviving spouse if these tasks were primarily the responsibility of his or her deceased partner. Those who fail to acquire new skills to accomplish these tasks are at increased risk for long-term mental and physical health problems (Carr et al., 2000; Lund, Caserta, & Dimond, 1993; Lund, Caserta, Dimond, & Shaffer, 1989; Olson & Hanover, 1985; Powers & Wampold, 1994; Rosenbloom & Whittington, 1993; Stroebe & Schut, 1999; Wells & Kendig, 1997). New research has estimated the annual economic costs of grief in the U.S. workplace to be approximately \$75.1 billion (James & Friedman, 2003). These costs are attributed to the loss of concentration, impaired decision-making, poor supervision, lowered productivity, accidents and injuries.

While the loss of a spouse is often associated with a variety of disruptive and negative outcomes, research and theory have also been focused on the processes related to successful adaptation, resiliency and personal growth (Wilcox et al., 2003). Several conceptual models have emerged to describe these processes as well as provide direction for ways to facilitate adaptation—most notably the "Grief Work Hypothesis" (Worden, 2002) and other more general stress and coping models (Lazarus & Folkman, 1984). Although these conceptual frameworks have made contributions to our understanding of bereavement adaptation and have informed the design of interventions, they are not without their shortcomings.

The grief work hypothesis emphasizes confronting the loss to avoid negative outcomes (Worden, 2002). This has been the driving feature of many psychoemotionally-focused grief interventions in which the bereaved are guided to work through grief-related "tasks" in order to achieve some degree of resolution. The grief work hypothesis emphasizes a focus on psychoemotional outcomes (e.g., loneliness, depression, unresolved grief), but pays little attention to other potentially positive consequences like opportunities for personal growth through learning, having new experiences and helping others (Lund, 1999). Furthermore, it does not consider those (secondary) stressors not directly linked to the loss itself, but follow from it due to the new roles and responsibilities faced by the bereaved.

Conversely, global stress and coping frameworks (Lazarus & Folkman, 1984) typically conceptualize coping

Dale Lund,
email:dale.lund@nurs.utah.edu,micahel.caserta@nurs.utah.edu
bdevries@scott.wright@nurs.utah.edu

strategies as being problem-focused (toward things that are generally changeable) or emotion-focused (directed at things that are not considered changeable). Within these frameworks, bereavement is considered a global stressor that in turn precipitates a series of secondary stressors. These models, however, do not adequately address how one deals with many of these bereavement-related stressors concurrently, some of which require emotion-focused strategies while others require problem-focused approaches (Doka & Martin, 2001; Stroebe & Schut, 1999).

Effectiveness of Bereavement Support Interventions

Although some individually-focused one-on-one programmes have existed (Silverman, 1986), the most common form of bereavement intervention has been the mutual-support group (also often referred to as self-help groups). Bereavement support groups, compared to other interventions are particularly appealing because of their relatively low cost and greater appeal (Levy, Derby, & Martinkowski, 1993). The group environment encourages sharing grief-related feelings, learning coping styles and skills from others, and recognizing the commonality of grief experiences among the participants. Support groups can also help strengthen informal support networks, address problems of loneliness and social isolation, and engender a sense of belonging among the participants (Gottlieb, 1988; Lieberman, 1993). Bereaved individuals have reported that the most valuable features attracting them to bereavement support groups were the chance to meet people and make new friends as well as to alleviate some of the loneliness they experience (Hopmeyer & Werk, 1994; Nash, 1992).

One of the most comprehensive reviews of the bereavement intervention literature to date appeared in Schut et al. (2001). It is difficult to compare the studies to each other because of differences in design, the make-up of the treatment conditions, what constituted the control groups, and length of follow-up. In general, however, they reported that the results have been "disappointing" (Schut et al., 2001, p. 705) pertaining to the interventions' minimal impact on outcomes.

In some of the studies, few or no differences were found between treatment and control conditions (Barrett, 1978; Levy et al., 1993; Sabatini, 1985; Tudiver, Hilditch, Permaul, & McKendree, 1992; Walls & Meyers, 1985), or if there were improvements they usually were modest at best (Lieberman & Videka-Sherman, 1986; Lieberman & Yalom, 1992) or were more noticeable among those who were experiencing greater initial difficulty (Caserta & Lund, 1993; Vachon et al., 1980). In half of the group intervention studies reviewed, participants self-selected into treatment conditions (Constantino, 1981; Levy et al., 1993; Lieberman & Videka-Sherman, 1986; Sabatini, 1985; Walls & Meyers, 1985) so any group effects that did appear may have been due to initial group differences or other potentially confounding selection factors.

Some of the reasons for the lack of substantial effects in many of these studies could be due to methodological limitations, most notably small samples and high dropout rates (Kato & Mann, 1999; Schut et al., 2001). On many occasions, there was no assessment of treatment reception on the part of those in the experimental groups nor an examination of what the controls had received that could be therapeutic and therefore attenuate group differences (Kato & Mann, 1999; Litterer Allumbaugh & Hoyt, 1999). Finally, the choice of measures in many of these studies may have been too narrowly focused and

therefore did not account for all potential outcomes or were not sufficiently sensitive to detect the potential effects of the intervention (Schut et al., 2001).

The Dual Process Model (DPM)

The dual process model (Stroebe & Schut, 1999) is a response to the limitations associated with these earlier models, considering two concurrent types of stressors and coping processes: loss-orientation and restoration (Figure 1). Loss orientation, which includes the grief-work concept as a component, involves the coping processes directly focused on the stress attributed to the loss itself. It is largely emotion-focused and encompasses many of the grief-related feelings and behaviours that tend to dominate early but can re-emerge throughout the course of bereavement.

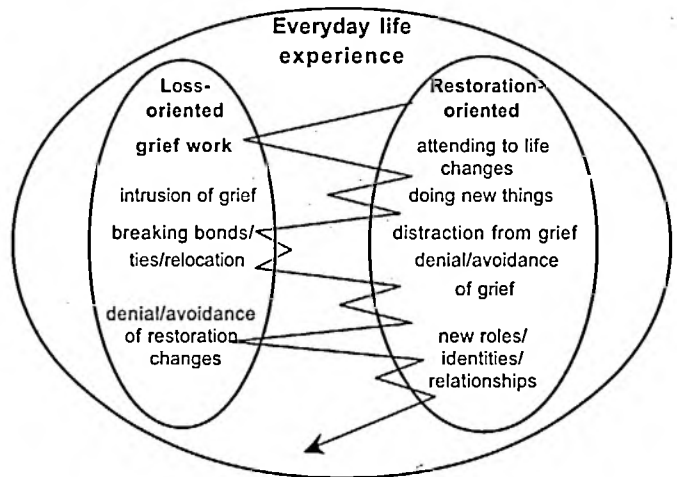


Figure 1. A Dual Process Model of Coping With Bereavement (Stroebe & Schut, 1999)

Restoration refers to those processes the bereaved use to cope with the secondary stressors that accompany new roles, identities, and challenges related to the new status as a widow and widower. These often include the need to master new tasks, make important decisions, meet new role expectations, and take greater self-care initiative, which may be especially difficult for bereaved widows(ers) because of insufficient skills and neglect. If restoration progresses effectively, self-efficacy beliefs emerge and help facilitate greater confidence, independence, and autonomy needed to manage their daily lives (Arbuckle & de Vries, 1995; Caserta, 2003; Fry, 2001; Lund & Caserta, 2002; Lund, Caserta, Dimond, & Shaffer, 1989). Another desired outcome is a sense of personal growth which often takes longer to emerge (Lieberman, 1996; Schaefer & Moos, 2001). Many bereaved persons report that as they learn to become more independent and have some success in developing new skills they benefit from gaining a sense of personal growth.

Also unique to this model, and what distinguishes it from the more global stress and coping frameworks, is the recognition that the bereaved will oscillate between these two processes throughout the course of bereavement. The widowed will alternate between the two as demands arise in their daily lives, even on a moment to moment basis (Richardson & Balaswamy, 2001; Stroebe & Schut, 1999). Furthermore, a key feature of restoration is the need to take brief periods of respite from grieving itself, whether to address these new tasks or demands or to keep busy with

other diversionary meaningful activity to restore a sense of balance and well-being. There has been a growing body of literature suggesting that engaging in physical activity, hobbies and other leisure activities, as well as socializing and being involved with others can provide sources of restoration and respite for the bereaved (Anderson & Dimond, 1995; Fitzpatrick *et al.*, 2001; Lee & Bakk, 2001; Lund *et al.*, 1993; Richardson & Balaswamy, 2001; Utz, Carr, Nesse, & Wortman, 2002).

Many aspects of the restoration coping process are amenable to intervention by focusing on self-efficacy, skills for addressing new unfamiliar tasks of daily living, self-care, and opportunities to engage in activities that provide brief periods of respite from grief and the emotional disruption associated with the loss. Nevertheless, most of the bereavement interventions that exist have focused primarily on the emotional impact of the loss itself and have rarely addressed the often concurrent restoration issues that the bereaved confront in their daily lives.

The past emphasis on the psychoemotional features of bereavement adjustment has resulted in a lack of sufficient attention on restoration-focused (i.e., self-efficacy, competencies, personal growth) adaptation (Schut *et al.*, 2001). Older bereaved spouses have new or unfamiliar daily demands that must be met to function effectively. This gap in abilities suggests a need for intervention strategies which focus on improving those skills needed to master tasks of daily living, engage in self-care behaviours, and function socially as a widow or widower in society (Gallagher-Thompson *et al.*, 1993; Levy, Martinkowski, & Derby, 1994; Lund & Caserta, 1998; Trunnell, Caserta, & White, 1992). One of the major findings in our previous research was the strong association between competencies in tasks of daily living and more favourable adjustments in the psychoemotional aspects of grief (Lund, Caserta, Dimond & Shaffer, 1989).

The features of restoration are often interrelated. First, older widows and widowers can be expected to live for several years beyond the death of their spouse and would have a higher quality of life if they did so with greater independence (Hansson, Remondet, & Galusha, 1993). Many new tasks of daily living now confronting them could have been the primary responsibility of the deceased spouse. If these skills are not acquired the health, functioning, autonomy and overall quality of life of the bereaved could be adversely affected. Furthermore, the inability to cope with attending to these tasks interferes with the emotion-focused energy the bereaved need to direct toward the loss itself (Lund, Caserta, Dimond, & Shaffer, 1989). This also illustrates the inextricable interaction between both loss orientation and restoration processes described in the dual process model (Stroebe & Schut, 1999). Effectively coping with the secondary stress associated with these new challenges reduces the emotional disruption of bereavement. As new skills are mastered the bereaved feel more confident to meet future challenges in their daily lives, whether emotionally or in a practical sense, and in some cases could experience personal growth as they venture into "previously uncharted territory" (Arbuckle & de Vries, 1995; Lund & Caserta, 2002; Lund, Caserta, Dimond, & Shaffer, 1989; Schaeffer & Moos, 2001).

Already existing health problems, particularly chronic conditions, tend to be more prevalent as individuals age. This underscores an increasing need for all older adults to engage in self-care activities to manage their chronic conditions more effectively (Ory & Cox, 1994; Stoller, 1998). As discussed earlier, self-care behaviours are often

partnered activities among married couples and the death of one partner frequently disrupts these behavioural patterns or interferes with the ability to engage in new ones (Johnson, 2002; Powers & Wampold, 1994; Rosenbloom & Whittington, 1993; Shahar, Schultz, Shahar, & Wing, 2001). The importance for widows and widowers to take care of themselves while still addressing the need to grieve represents another set of secondary stressors requiring restoration coping strategies. Furthermore, those who engage more effectively in self-care could conceivably be in a better position to address the negative emotional effects of the loss.

An important feature of the restoration process is the adaptation to new roles and identities and establishing new relationships as well as maintaining one's level of social connectedness (Richardson & Balaswamy, 2001; Stroebe & Schut, 1999). Older bereaved spouses prefer to maintain the most meaningful relationships and activities they have had throughout their life course. Therefore, from an intervention perspective, it makes more sense to provide information that facilitates those needs as opposed to merely introducing new activities that by themselves may not be as meaningful to older widows and widowers (Utz *et al.*, 2002). Older bereaved spouses often want to learn ways to access services and programmes more effectively and how to maximize opportunities to meet and socialize with others (Lund, Caserta, Dimond, & Shaffer, 1989). These can include inexpensive entertainment and leisure options, safe places to go to socialize with others, and even volunteering opportunities to help others (Lund, 1999) also allow the bereaved to remain socially connected and function more effectively and comfortably as a single person. These activities provide them with potential linkages to the service network and other community resources and could represent opportunities for time away from grief itself (Caserta *et al.*, 1999).

To summarize, the bereavement interventions that have traditionally focused on grief work and psychoemotional outcomes have only been moderately effective largely due to having a limited focus on primarily emotional coping. Alternatively, an intervention that also addresses the restoration process in addition to loss orientation as proposed by the dual process model (Stroebe & Schut, 1999) could provide a more promising approach (possibly the beginning of a paradigm shift) by also helping the bereaved develop skills specific to practical daily challenges as well as the emotional disruption and upset that permeate bereavement. The key to an intervention guided by this oscillatory model is that the relationship between loss orientation and restoration is synergistic, not merely additive. Efforts in one area can theoretically influence adaptation in another.

Content for the DPM-Based Intervention

The 14-session intervention we describe now is based on the DPM approach and also a previous demonstration project that we completed from 1997-2000 that we called "Pathfinders" (Caserta *et al.*, 1999; 2001a; 2001b). The "Pathfinders" approach was primarily a self-care, skill-building and health education programme for older widows and widowers without a loss orientation component. Each of the 14 weekly sessions that we suggest will have a primary emphasis on either loss orientation (L) or restoration (R) content (as indicated in the left column of Table 1) with loss issues receiving the greatest attention in the early sessions and restoration issues emphasized later. However, in order to maximize the oscillation feature in the

DPM approach, each session will not be exclusively (L) or (R) but will have some content that encourages oscillation as a complementary aspect of bereavement adaptation. The first week consists of an introductory session (I) featuring an overview of the purpose of the groups and the group process and material on understanding grief. This meeting essentially is the first loss orientation session. The remaining L sessions will focus on grief work issues, the nature of the bonds with the deceased, the commonality of experiences, and mutual support. The participants will be asked to keep a journal of their feelings and experiences each week pertaining to what was discussed in the sessions. The restoration content will emphasize ways to assume new responsibilities and tasks of daily living, self-

care education, role transition issues, identifying and utilizing sources of help, mastery and personal growth as well as the importance of taking appropriate time away from grief itself. The participants will be introduced to ways to set goals for themselves to help them take small doable steps toward assuming new responsibilities, tasks, and roles, as well as to engage in ways to meet their own health-related needs. A final wrap-up session (Week 14) will include equal elements of both loss orientation and restoration. This session will emphasize personal growth as well as coping with future challenges, having realistic expectations about their bereavement experience, and where the bereaved can find additional resources in the community.

Table 1. Intervention Content by Session

Session	Content	Link to Model
1. Introductory (L-1)	<ul style="list-style-type: none"> - Introductions - Overview of purpose of groups and dual processes - Circumstances surrounding spouse's death - <u>Overview of grief</u>: What it is, typical reactions, how the groups will help - Identify specific concerns participants wish to talk about - Encouraging journaling and other forms of written thoughts 	Grief work
2-3. L-2/3	<ul style="list-style-type: none"> - Physical sensations, cognitions, and behaviours - How grief affects daily functioning - Dealing with ways to express grief-related feelings 	Grief work Intrusion of grief
4. L-4	<ul style="list-style-type: none"> - Continuation of previous weeks issues as appropriate - Assuming new responsibilities: Each one's unique situation as well as commonly experienced challenges - Feelings about taking on new roles: Anger, frustration, feeling overwhelmed, etc. - Feelings of pressure to take on new responsibilities - <u>Homework Assignment</u>: Identify one new responsibility that one wants to learn how to do better 	Grief work Intrusion of grief Denial/avoidance of restoration changes
5. R-1	<ul style="list-style-type: none"> - Share responses from homework assignment - How to begin to take more control of the situation - Orientation and importance of setting goals to learn new skills and behaviours - Sharing ideas for success - Tending to one's own needs while still addressing the need to grieve: Importance of rest, proper nutrition, physical activity, and "taking a break" from grieving - <u>First Goal</u>: "Do something nice for yourself" 	Attending to life changes Doing new things Distraction from grief
6. L-5	<ul style="list-style-type: none"> - Discuss goals from previous week - Discussion of ways participants have not put their own needs first - Dealing with loneliness - <u>Critical time periods</u> (birthdays, holidays, anniversaries) 	Intrusion of grief Denial/avoidance of restoration changes
7. R-2	<ul style="list-style-type: none"> - Continuing material on meeting one's own health needs: To what extent was spouse a "partner" in meeting health-related needs? - Utilizing the health care system and service network effectively : Immunizations and screenings, medication management, communicating with one's health care provider, services and programs available in the community 	Attending to life changes
8. L-6	<ul style="list-style-type: none"> - What participants miss and do not miss about their spouse - Unfinished business - Other issues raised by participants 	Grief work Reframing ties/bonds with deceased spouse

... continued

9. R-3	<u>Finances, Forms, and Legal Issues</u> - Wills and trusts - Filing important forms - Understanding statements - Developing and managing a household budget - Making decisions about property issues - Recognizing and avoiding scams	New roles and identities Doing new things Attending to life changes
10. L-7	- Putting self first: Dealing with requests from others - Things that have interfered with need to grieve - Things that have interfered with the ability to be independent	Intrusion of grief Avoidance/denial of restoration changes
11. R-4	<u>Household and Motor Car Responsibilities</u> - Breaking Household duties into small, manageable steps - Regular maintenance schedules for home and car - Identifying and remedying household hazards - Who to contact for help and how to avoid being defrauded	Attending to life changes Doing new things Distraction from grief
12. R-5	<u>Nutrition for One</u> - Tips for shopping for one and understanding food labels - Simple one or two step meals - Preparing and freezing portions for later use - Recipe sharing - Sources of nutritional assistance in the community	Attending to life changes Doing new things Distraction from grief
13. R-6	<u>Remaining Socially Connected</u> - Social participation – functioning “comfortably” as a single person - Identifying prior sources of satisfying and meaningful activities and strategies for continuing them - Inexpensive and accessible entertainment/leisure options - Non-threatening socialization opportunities - Volunteering opportunities - Community resources	Attending to life changes New roles, identities, and relationships Distraction from grief
14. Final Session (L & R)	- Rediscovering sources of joy, fulfillment, and growth: renewing old interests and exploring new ones - “A time to mourn, a time to dance”: Giving one’s self permission to grieve as well as time away from grieving - Having realistic expectations - Where to learn more	Most elements

L = Loss Orientation R = Restoration

Conclusions

We hope that professional clinicians, service providers and research investigators will begin to use and test theoretical models more systematically to assist bereaved persons, especially those who are older and recently widowed. The authors now have the opportunity to begin a test of the DPM model using the intervention content described in this paper with a new 5-year grant funded by the National Institute on Aging beginning in September 2004. The proposed intervention builds on and extends the previous work of others by combining the best features of traditional grief support groups with restoration features along with the oscillatory nature of bereavement adjustment playing a critical role in the dual process model (Stroebe & Schut, 1999). If the DPM approach is found to be as effective as we anticipate, future bereavement interventions for older adults may experience the beginning of a paradigm shift away from the long-standing and pervasive approach of using an almost exclusive emphasis on psychoemotional

aspects surrounding loss orientation issues. The proposed intervention takes advantage of these properties by emphasizing the role of emotional support early in the process with a gradual movement toward restoration over time as well as the importance of appropriate periods of respite from the grief process altogether. The fact that keeping busy was a predictor of more positive outcomes suggests that “time out from grieving” does occur and it is restorative. Interventions are especially appealing for those whose own support networks are perceived as inadequate (Lehman *et al.*, 1999; Lund *et al.*, 1993; Stylianos & Vachon, 1993; Tedeschi & Calhoun, 1993). While interventions focusing on loss orientation can be especially effective in facilitating positive bereavement outcomes for those experiencing greater difficulty, our previous work also found that those in the self-help groups who were not experiencing as much difficulty as others still improved their ability to cope with the stress of bereavement over time.

Although emotional support was identified as a primary need among the participants in our studies, there appears to be a need for other educational and skill building content within bereavement interventions, which the proposed project will incorporate. As mentioned previously, the restoration-focused feature of the intervention will address the difficulties associated with the need to complete tasks of daily living, many of which are important to self-care (Caserta et al., 1999, 2001a, 2001b; Lund, Caserta,

Dimond, & Shaffer 1989). Although the bereaved can be quite resourceful in learning how to accomplish new tasks, many are clearly frustrated by their deficiencies in these skills and the frustration contributes to having greater difficulty in the adjustment process. Early interventions clearly need to focus on helping the bereaved learn new skills or otherwise help them identify and utilize community-based resources where they can obtain further assistance.

References

- Anderson, K. L., & Dimond, M. F. (1995). The experience of bereavement in older adults. *Journal of Advanced Nursing*, 22, 308-315.
- Arbuckle, N. W., & de Vries, B. (1995). The long-term effects of later life spousal and parental bereavement on personal functioning. *The Gerontologist*, 35, 637-647.
- Barrett, C. J. (1978). Effectiveness of widows' groups in facilitating change. *Journal of Consulting and Clinical Psychology*, 46, 20-31.
- Carr, D., House, J. S., Kessler, R. C., Nesse, R. M., Sonnega, J., & Wortman, C. (2000). Marital quality and psychological adjustment to widowhood among older adults: A longitudinal analysis. *Journal of Gerontology: Social Sciences*, 55B, S197-S207.
- Caserta, M. S. (2003). Widowers. In R. Kastenbaum (Ed.), *Macmillan encyclopedia of death and dying* (vols. 1 & 2). New York: Macmillan Reference USA.
- Caserta, M. S., & Lund, D. A. (1993). Intrapersonal resources and the effectiveness of self-help groups for bereaved older adults. *The Gerontologist*, 33, 619-629.
- Caserta, M. S., Lund, D. A., & Rice, S. J. (1999). Pathfinders: A self-care and health education program for older widows and widowers. *The Gerontologist*, 39, 615-620.
- Caserta, M. S., Lund, D. A., & Rice, S. J. (2001a). *Changes in self-care abilities among older widows and widowers: Evidence from the Pathfinders Project*. Paper presented at the Gerontology Society of America, Chicago, IL.
- Caserta, M. S., Lund, D. A., & Rice, S. J. (2001b). Participants' attendance at a health promotion program for older widows and widowers. *American Journal of Health Education*, 32(4), 229-236.
- Constantino, R. E. (1981). Bereavement crisis intervention for widows in grief and mourning. *Nursing Research*, 30, 351-353.
- Doka, K. A., & Martin, T. (2001). Take it like a man: Masculine response to loss. In Lund, D. A. (Ed.), *Men coping with grief* (pp. 37-48). Amityville, NY: Baywood.
- Fitzpatrick, T. R., Spiro, A., Kressin, N. R., Greene, E., & Bosse, R. (2001). Leisure activities, stress, and health among bereaved and non-bereaved elderly men: The normative aging study. *Omega*, 43, 217-245.
- Fry, P. S. (2001). Predictors of health-related quality of life perspectives, self-esteem, and life satisfactions of older adults following spousal loss: An 18-month follow-up study. *The Gerontologist*, 41, 787-798.
- Gallagher-Thompson, D., Futterman, A., Farberow, N., Thompson, L., & Peterson, J. (1993). The impact of spousal bereavement on older widows and widowers. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 227-239). New York, NY: Cambridge University Press.
- Glick, I. O., Weiss, R. S., & Parkes, C. M. (1974). *The first year of bereavement*. New York: Wiley & Sons.
- Gottlieb, B. H. (1988). *Marshaling social support: Formats, processes and effects*. Newbury Park, CA: Sage.
- Hansson, R. O., Remondet, J. H., & Galusha, A. (1993). Old age and widowhood: Issues of personal control and independence. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (pp. 227-239). London: Cambridge University Press.
- Hopmeyer, E., & Werk, A. (1994). A comparative study of family bereavement groups. *Death Studies*, 18, 243-256.
- James, J. W., & Friedman, R. (2003). *The grief index: The 'hidden' annual costs of grief in America's workplace* (pp 1-33). Sherman Oaks, CA: The Grief Recovery Institute Education Foundation.
- Johnson, C. S. (2002). Nutritional considerations for bereavement and coping with grief. *Journal of Nutrition, Health and Aging*, 6, 171-176.
- Kato, P. M., & Mann, T. (1999). A synthesis of psychological interventions for the bereaved. *Clinical Psychology Review*, 19, 275-296.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.
- Lee, C. D., & Bakk, L. (2001). Later-life transitions into widowhood. *Journal of Gerontological Social Work*, 35, 51-63.
- Lehman, D., Wortman, C., Haring, M., Tweed, R., de Vries, B., DeLongis, A., Hemphill, K., & Ellard, J. (1999). Recovery from the perspective of the bereaved: Personal assessments and sources of distress and support. In B. de Vries (Ed.), *End of life issues: Interdisciplinary and multidimensional perspectives* (pp. 119-144). New York: Springer.
- Levy, L. H., Derby, J. F., & Martinkowski, K. S. (1993). Effects of membership in bereavement support groups on adaptation to conjugal bereavement. *American Journal of Community Psychology*, 21, 361-381.
- Levy, L. H., Martinkowski, K. S., & Derby, J. F. (1994). Differences in patterns of adaptation in conjugal bereavement. *Omega*, 29, 71-87.
- Lieberman, M. A. (1993). Bereavement self-help groups: A review of conceptual and methodological issues. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 411-426). New York: Cambridge University Press.
- Lieberman, M. A. (1996). *Doors close, doors open: Widows grieving and growing*. New York, NY: G. P. Putnam's Sons.
- Lieberman, M. A., & Videka-Sherman, L. (1986). The impact of self-help groups on the mental health of widows and widowers. *American Journal of Orthopsychiatry*, 56, 435-449.
- Lieberman, M. A., & Yalom, I. (1992). Brief group psychotherapy for the spousally bereaved: A controlled study. *International Journal of Group Psychotherapy*, 42, 117-132.
- Litterer Allumbaugh, D., & Hoyt, W. T. (1999). Effectiveness of grief psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 46, 370-380.
- Lund, D. A. (Ed.). (1989). *Older bereaved spouses: Research with practical applications*. Washington, DC: Taylor-Francis/Hemisphere Press.
- Lund, D. A. (1999). Giving and receiving help during later life spousal bereavement (203-212). In Davidson, J. D. & Doka, K. J. (Eds.) *Living with grief at work, at school, at worship*, Levittown, PA: Brunner/Mazel.
- Lund, D. A., & Caserta, M. S. (1998). Future directions in adult bereavement research. *Omega*, 36, 287-303.

- Lund, D. A., & Caserta, M. S. (2002). Facing life alone: The loss of a significant other in later life. In K. Doka (Ed.), *Living with grief: Loss in later life*. Levittown, PA: Brunner/Mazel
- Lund, D. A., Caserta, M. S., & Dimond, M. F. (1989). Impact of spousal bereavement on the subjective well-being of older adults. In D. A. Lund (Ed.), *Older bereaved spouses: Research with practical applications* (pp. 3-15). Washington, DC: Taylor-Francis/Hemisphere Press.
- Lund, D. A., Caserta, M. S., & Dimond, M. F. (1993). The course of spousal bereavement in later life. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (pp. 240-254). London: Cambridge University Press.
- Lund, D. A., Caserta, M. S., Dimond, M. F., & Shaffer, S. K. (1989). Competencies: Tasks of daily living and adjustments to spousal bereavement in later life. In D. A. Lund (Ed.), *Older bereaved spouses: Research with practical applications* (pp. 135-156). Washington, DC: Taylor-Francis/Hemisphere Press.
- McKibbin, C. L., Guarnaccia, C. A., Hayslip, B., & Murdock, M. E. (1997). Locus of control perceptions among bereaved older adults: A pilot study. *International Journal of Aging and Human Development*, 44, 37-45.
- Moss, M. S., Moss, S. Z., & Hansson, R. O. (2001). Bereavement and old age. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 241-260). Washington, DC: American Psychological Association.
- Nash, P. (1992). New horizons for widowed persons: A caring program. *Psychology: A Journal of Human Behavior*, 29, 44-47.
- Olson, T. & Hanover, J. (1985). Preparing women to be widows. *Health Values*, 9, 8-11.
- Ory, M. G., & Cox, D. M. (1994). Forging ahead: Linking health and behavior to improve quality of life in older people. *Social Indicators Research*, 33, 89-120.
- Powers, L. E., & Wampold, B. E. (1994). Cognitive-behavioral factors in adjustment to adult bereavement. *Death Studies*, 18, 1-24.
- Quandt, S. A., McDonald, J., Arcury, T. A., Bell, R. A., & Vitolins, M. Z. (2000). Nutritional self-management of elderly widows in rural communities. *Gerontologist*, 40, 86-96.
- Richardson, V. E., & Balaswamy, S. (2001). Coping with bereavement among elderly widowers. *Omega*, 43, 129-144.
- Rosenbloom, C. A. & Whittington, F. J. (1993). The effects of bereavement on eating behaviors and nutrient intakes in elderly widowed persons. *Journal of Gerontology: Social Sciences*, 48, S223-S229.
- Sabatini, L. (1985). The First Step Program: A bereavement service for widowed people. *Crisis Intervention*, 14, 72-83.
- Schaefer, J. A., & Moos, R. H. (2001). Bereavement experiences and personal growth. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 145-167). Washington, DC: American Psychological Association.
- Schone, B. S., & Weinick, R. M. (1998). Health-related behaviors and the benefits of marriage for elderly persons. *Gerontologist*, 38, 618-627.
- Schut, H., Stroebe, M. S., Van Den Bout, J., & Terheggen, M. (2001). The efficacy of bereavement interventions: Determining who benefits. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 705-737). Washington, DC: American Psychological Association.
- Shahar, D. R., Schultz, R., Shahar, A., & Wing, R. (2001). The effect of widowhood on weight change, dietary intake, and eating behavior in the elderly population. *Journal of Aging and Health*, 13, 186-199.
- Silverman, P. R. (1986). *Widow to widow*. New York, NY: Springer.
- Stoller, E. P. (1998). Dynamics and processes of self-care in old age. In M.G. Ory & G. H. DeFries (Eds.), *Self-care in later life: Research, program, and policy issues* (pp. 24-61). New York, NY: Springer.
- Stroebe, M. S., Stroebe, W., & Hansson, R. O. (1993). *Handbook of bereavement: Theory, research, and intervention*. New York: Cambridge University Press.
- Stroebe, M. S., Hansson, R. O., Stroebe, W., & Schut, H. (2001). Future directions for bereavement research. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 741-766). Washington, DC: American Psychological Association.
- Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, 23, 197-224.
- Stroebe, W., & Stroebe, M. S. (1987). *Bereavement and health: The psychological and physical consequences of partner loss*. New York: Cambridge University Press.
- Stylianou, S. K., & Vachon, M. L. S. (1993). The role of social support in bereavement. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research and intervention* (pp. 397-410). London: Cambridge University Press.
- Tedeschi, R. G., & Calhoun, L. G. (1993). Using the support group to respond to the isolation of bereavement. *Journal of Mental Health Counseling*, 15, 47-54.
- Trunell, E. P., Caserta, M. S., & White, G. L. (1992). Bereavement: Current issues in intervention and prevention. *Journal of Health Education*, 23, 275-280.
- Tudiver, R., Hilditch, J., Permaul, J. A., & McKendree, D. J., (1992). Does mutual help facilitate newly bereaved widowers? Report of a randomized controlled trial. *Evaluation & Health Professions*, 15, 147-162.
- U.S. Bureau of the Census. (2000, March). Current population survey, special populations branch, marital status of the population 55 years and over by age and sex. Washington DC: U.S Government Printing Office.
- Utz, R. L., Carr, D., Nesse, R., & Wortman, C. B. (2002). The effect of widowhood on older adults' social participation: An evaluation of activity, disengagement, and continuity theories. *The Gerontologist*, 42, 522-533.
- Vachon, M. L. S., Lyall, W. A. L., Rogers, J., Freedman-Letofsky, K., & Freeman, S. J. J. (1980). A controlled study of self-help interventions for widows. *American Journal of Psychiatry*, 137, 1380-1384.
- Walls, N., & Meyers, A. W. (1985). Outcome in group treatments for bereaved: Experimental results and recommendations for clinical practice. *International Journal of Mental Health*, 13, 126-147.
- Wells, Y. D., & Kendig, H. L., (1997). Health and well-being of spouse caregivers and the widowed. *Gerontologist*, 37, 666-674.
- Wilcox, S., Evenson, K. R., Aragaki, A., Wasscrtheil-Smoller, S., Mouton, C. P., & Loevinger, B. L. (2003). The effects of widowhood on physical and mental health, health behaviors, and health outcomes: The Women's Health Initiative. *Health Psychology*, 22(5), 1-10.
- Worden, J. W. (2002). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (3rd ed.). New York: Springer.