BEREAVEMENT, MARITAL QUALITY, AND SOCIAL INTEGRATION: A
PROSPECTIVE STUDY OF WELL-BEING AND DEPRESSION

By

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Abstract

This project examines how social integration and marital quality affects older adult's psychological well-being and depression following spousal bereavement. Analyses were based on 250 persons from the Changing Lives of Older Couples study, a prospective study of elderly widowhood. Using multilevel growth modeling, we explored how trajectories of well-being and depression over time are altered by the predictors of interest: total social integration and marital quality. Well-being exhibited a trajectory of significant increase from baseline to 6-months post-bereavement and a leveling off from 6-months to 18-months post bereavement. Depression showed a trajectory of significant increase from baseline to 6-months post-bereavement, then significant decrease 6-months to 18-months post-bereavement. Those who reported the least amount of total social integration exhibited the fastest increases in well-being. Participants who reported high marital quality showed the highest levels of well-being at baseline, the lowest levels of depression at baseline, the slowest increase in well-being and fastest increase in depression following bereavement. These results suggest that, contrary to popular belief, urging widows to increase their social integration after bereavement might not be beneficial to their well-being. These results also indicate that those in stressful marriages will benefit most in terms of their well-being following bereavement.
Literature Review

Widowhood is considered one of the most distressing of all life events (Holmes & Rahe, 1967). Due to deteriorating health and death, the social networks of the elderly often diminish, resulting in an increased significance of one’s spousal relationship. After being involved in a marriage for many years, highly interdependent relationships are formed by many couples with a strong focus on commitments, interlocking roles and shared traditions (Moss, Moss & Hansson, 2001).

It is generally believed that following bereavement, widows experience a substantial amount of distress that decreases over time as they come to terms with the loss (Malkinson, 2001). However, there is a rising belief that there are distinct individual differences in how the bereaved will respond to conjugal loss (Lund, 1989; Bonanno, 2002), with some widows showing relatively little distress and others showing markedly substantial distress the first few months following their spouse’s death. A considerable amount of empirical evidence suggests that widows and widowers do not appear to experience overwhelming distress beyond the first initial weeks after the loss (Bonanno, Wortman & Nesse, 2004).

One understudied aspect of elderly bereavement is how social relationships impact adults’ adjustment. Spousal loss does not occur in a vacuum, and it is not a purely intrapersonal experience that must be coped-with in isolation. Upon spousal loss, the bereaved lose their status as married and must transition into the next stage of their life as one who is widowed. This transition may alter their social participation and networks. The loss of a spouse leads to deficits in the broad categories of instrumental, validational, emotional and social contact support (Stroebe & Stroebe, 1987). These deficits can be to
some extent compensated through the social support from family and friends. Utz and colleagues (2002) found that social participation levels increase after the loss because of increased support from family and friends. To date, this is one of the only studies that explore this phenomenon, making this area in need of greater consideration.

One subset of social relationships that plays a pertinent role in bereavement is the marital quality of the couple. Marriages marked as providing high levels of warmth and support may experience the most distress following bereavement. Bowlby (1980) theorized that the link between relationship closeness and grief is a central tenet of attachment theory. Attachment theory says that when a close, emotional bond is cut off—be it through death or separation—a grief process follows (Bowlby, 1980). Carr and colleagues (2000) founds evidence for this theory, demonstrating that bereaved adults yearn most for their partner when their relationship was highly close and interdependent.

One important issue in bereavement literature is that most research is conducted after the event of death, making it difficult to study accurately how preloss variables could contribute to the trajectory of adjustment following bereavement (Safer, Bonanno, Field, 2001). Typical trajectories that are reported might not be able to fully capture outcomes of interest, because of their inability to take into account preloss variables. For example, a person experiencing prolonged depressive symptoms during the bereavement period, might have been depressed prior to the loss, and thus experiencing chronic depression rather than chronic grief (Bonanno, et al., 2004). On the other hand, some individuals that are exhibiting absent grief may have had an extremely stressful marriage or had a spouse with a prolonged chronic illness that may have resulted in a significant decrease in depression after the spouse’s death (Bochner & Kiecolt-Glaser, 1994; Cohen
& Eis dorfer, 1988; Horowitz, 1985; Wheaton, 1990). To account for these possible discrepancies in the literature, and to provide greater information on the social context of a spousal loss experience, this project examined well-being and depression using prospective, longitudinal data from the Changing Lives of Older Couples (CLOC) study.

The Present Study

The current study examined the trajectories of well-being and depression from a pre-bereavement interview to 18 months postloss. This study aimed to see how the trajectories of well-being and depression would change when considering the preloss variable of marital quality and the ongoing effect of social integration. By analyzing the trajectories for well-being and depression, our goal is to be able to shed more light on the topic of how social relationships, both before and during the loss, cause change in these two dimensions.

The first aim of this study was to determine trajectories for well-being and depression and how they change from the preloss interview (baseline) to 18 months postloss. For well-being, we hypothesized that well-being would be highest at baseline, evidence a significant decrease 6-months post bereavement, and an increase at 18-months post bereavement. The general trajectory hypothesis for depression was that depression will have a significant increase 6-months after bereavement and will be slightly lower at 18-months post bereavement than at baseline.

The second aim of this study was to determine how social relationships affect the trajectories of well-being and depression, specifically focusing on social integration and marital quality. According to the literature, these two aspects of social relationships have
a profound effect on the grieving process, and the goal of this study is to explore how they change the course of adjustment. For social integration, we hypothesize that adults reporting greater social integration at any occasion will evidence the higher levels of well-being and lower levels of depression. For marital quality, we hypothesize that adults with a more positive view of their marriage at baseline will (a) report greater well-being and less depression at baseline, (b) show an increase in depression following bereavement, and (c) show a decrease in well-being following bereavement.

Method

Sample

The Changing Lives of Older Couples (CLOC) study is a prospective study of spousal bereavement. The data was collected from a two-stage area probability sample of 1,532 elderly married women and men from the Detroit Metropolitan Area. In order to be a participant, respondents had to be English speaking, married and live in a household where the husband was at least 65 years old. Participants could not be institutionalized and had to be able to take part in a 2 hour interview. Approximately 68% of contacted individuals participated in the initial interview, which is a consistent response rate to other studies conducted in the Detroit Metropolitan Area. Initial interviews were administered between June 1987 and April 1988 with follow up interviews for the bereaved spouses and controls occurring at 6, 18 and 48 months after the loss.

Spousal loss was monitored by research assistants reading the daily obituaries in the Detroit-area newspapers and using the monthly death record tapes provided by the State of Michigan. The National Death Index (NDI) was used to confirm and obtain the
cause of death as well as direct examination of death certificates. Of the 335 respondents known to have lost a spouse during the study period, 316 were contacted for follow up interviews. Of the 316 contacted, 263 individuals (83%) participated in at least one of three follow-up interviews. Follow up interviews were conducted at 6 months (Wave 1), 18 months (Wave 2) and 48 months (Wave 3) after the spouse’s death.

Each widowed participant was given a same-age, same-sex, same-race matched control from the sample taken at the baseline interview. Controls were interviewed at all waves (baseline (B), wave 1 (W1), wave 2 (W2) and wave 3 (W3)). Due to a cut in the initial funding, the number of controls at wave 1 is fewer than the amount of widows at wave 1.

For this study, we focused only on those who became widowed and participated in the 6 month and 18 month postloss interviews (n=250). Of these 250, 35 were men and 215 women. The average length of marriage for our sample was 46 years, 2 months (SD=12.6 years). On average, the time between the initial baseline interview and 6 month (W1) follow up was 42.99 months (SD= 18.997 months).

Measures

Outcome variables. For the analysis, we focused on two areas on mental health: depression and well-being. Depression (α = .76) was assessed by using 9 negative items from the 20-item Center for Epidemiologic Studies (CES-D) scale (Radloff, 1977). Instead of using the pre-determined CES-D scale, we created our own mean scale score of the nine items. The correlation between our own scale and the CLOC’s was .88. Participants were asked to signify how often they experienced each of the nine symptoms used the in the measure and rate on a scale of “hardly ever,” “some of the time,” or “most
of the time,” how much each symptom pertained to them. The nine symptoms were as follows: (a) “I felt depressed”; (b) “I felt that everything I did was an effort”; (c) My sleep was restless”; (d) “I felt lonely”; (e) “People were unfriendly”; (f) “I did not feel like eating. My appetite was poor”; (g) “I felt sad”; (h) “I felt that people disliked me”; and (i) “I could not get going.” All items were scored in the same direction of the index name, meaning that a higher value indicates a higher level of depression.

Well-being (α = .85) was assessed with a 7-item scale which asked participants to rate how much they identified with each statement in the week prior to the interview. As with the CES-D scale, we also created own mean scale score for well-being. The correlation of our scale and the CLOC’s was .97. Response categories were “hardly ever,” “some of the time,” or “most of the time.” The statements were (a) “I was happy”; (b) “I enjoyed life”; (c) “I was particularly excited or interested in something”; (d) “I was pleased about having accomplished something”; (e) “I felt things were going my way”; (f) “I felt proud because someone had complimented me on something I had done”; and (g) “I felt on top of the world.” All items were scored in the same direction of the index name, with higher values indicating higher well being.

Predictor variables. This project’s independent variables focused on marital quality and social integration. Martial quality (α = .88) was assessed at the prebereavement interview by using a 10-item scale which asked participants to rate how evaluated their marriage. We created our own mean scale score for marital quality and it has a correlation of .97 with the CLOC’s score. Items (a) “There are some serious difficulties in our marriage”; and (b) “My (husband/wife) doesn’t treat me as well as I deserve to be treated,” were answered using a scale ranging from “very true,” “somewhat
true,” “a little true,” to “not true at all.” Items (c) “How much does your (husband/wife) make you feel loved and cared for”; (d) “How much is (he/she) willing to listen when you need to talk about your worries or problems”; (e) “How much do you feel (he/she) makes too many demands on you”; and (f) “How much is (he/she) critical of what you do,” were answered using a scale ranging from “a great deal,” “quite a bit,” “some,” “a little,” to “not at all.” Items (g) “Thinking about your marriage as a whole, how often do you feel happy about it”; (h) “Taking all things together, how satisfied are you with your marriage”; and (i) “How often do you feel bothered or upset about your marriage,” were answered using a scale ranging from “almost always,” “often,” “sometimes,” “rarely,” to “never.” The last item (j) “How often would you say that you and your (husband/wife) typically have unpleasant disagreements or conflicts,” was rated using a scale ranging from “more than once a week,” “about once a week,” “1 to 3 times a month,” “less than once a month,” to “never.” Items c, d, h and i were reversed coded, while all other items were scored originally to indicate that higher scores indicate higher marital quality.

To measure social integration ($\alpha = .58$), we combined the scaled items the CLOC created for informal social integration (ISI) and formal social integration (FSI) to make a unique scale of total social integration (TSI). The TSI scale consisted of the following items: (a) “How often do you get together with your friends, neighbors or relatives and do things like go out together or visit in each other’s homes”; (b) “How often do you go out socially by yourself, or with people other than your (husband/wife)”; (c) “In a typical week, about how many times do you talk on the telephone with friends, neighbors or relatives”; (d) “How often do you attend meetings or programs of groups, clubs, or organizations that you belong to”; and (e) “How often do you usually attend religious
services?”. Each item was reversed scored to signify higher scores indicate a higher level of total social integration.

**Data Analysis**

To test the hypotheses, analyses were conducted using multilevel growth modeling (MGM). MGM is a way of examining change over time when data is nested across two levels. In the CLOC data, there are multiple occasions of measurement over time (level 1) nested under different people (level 2). The first approach was to identify an appropriate model that could best describe the rates of change in well-being and depression. We then added the predictors of interest to see how they would change the model. For this analysis, TSI is a level-1 moderator (because it is measured across all occasions) and marital quality is a level-2 moderator (because it was only measured at baseline). Chi-squared tests were used to examine whether model fit is significantly improved with the addition of predictors to the previous models. For all analyses, alpha levels of 0.05 (two-tailed) were used to evaluate associations based on a priori as well as unpredicted associations. To see how much the predictor variables accounted for the variance within each model, a *pseudo r-squared* statistic was computed according to the following equation:

\[
\frac{\text{Residual variance in unconditional means model} - \text{Residual variance in unconditional growth model}}{\text{Residual variance in unconditional means model}}
\]

For the outcome variables (marital quality and total social integration), we used group centering (centered on each participant’s own mean) instead of grand mean centering (using the mean of the entire sample). When using group-centering, the intercept is read as the within-person mean over time and the applicable coefficient is
interpreted as the mean within-person regression of the outcome variable on the covariate (Enders & Tofghi, 2007). We decided to use group centering for interpretability purposes.

To measure time, we used two different time points to explore changes from baseline to W1 (0,1,1) and from W1 to W2 (0,0,1). By coding time in this manner, we were able to explore the specific changes between these three time points.

**Results**

First, descriptive analyses were conducted on all predictor and outcome variables of interest (see Table 1).

Table 1. Descriptive Statistics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Range</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Being</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B:</td>
<td>1.00</td>
<td>3.00</td>
<td>2.29</td>
<td>.48</td>
</tr>
<tr>
<td>W1:</td>
<td>1.57</td>
<td>4.33</td>
<td>2.90</td>
<td>.50</td>
</tr>
<tr>
<td>W2:</td>
<td>1.57</td>
<td>4.14</td>
<td>2.88</td>
<td>.50</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B:</td>
<td>1.00</td>
<td>9.00</td>
<td>1.40</td>
<td>.60</td>
</tr>
<tr>
<td>W1:</td>
<td>1.00</td>
<td>9.00</td>
<td>1.49</td>
<td>.60</td>
</tr>
<tr>
<td>W2:</td>
<td>1.00</td>
<td>3.22</td>
<td>1.40</td>
<td>.38</td>
</tr>
<tr>
<td>Marital Quality</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>B:</td>
<td>-2.85</td>
<td>.99</td>
<td>-0.01</td>
<td>.75</td>
</tr>
<tr>
<td>Total Social Integration</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>B:</td>
<td>-1.47</td>
<td>1.53</td>
<td>0.00</td>
<td>.42</td>
</tr>
<tr>
<td>W1:</td>
<td>-1.90</td>
<td>1.07</td>
<td>0.03</td>
<td>.37</td>
</tr>
<tr>
<td>W2:</td>
<td>-1.43</td>
<td>1.20</td>
<td>0.02</td>
<td>.40</td>
</tr>
</tbody>
</table>

*Multilevel Analyses*

The basic growth models demonstrated significant change for each of the two outcome variables. Well-being evidenced a significant increase from baseline to W1; there was no significant change from W1 to W2. The unstandardized parameter estimates are
displayed in Table 2. The effect for time on well-being was $b = .61, p < .001$. Depression evidenced two significant slopes: From baseline to W1 depression increased, $b = .09, p \leq .10$; from W1 to W2 (between 6-months and 18-months postloss) depression decreased significantly, $b = -.09, p \leq .05$.

Table 2. Regression coefficients for each model.

<table>
<thead>
<tr>
<th></th>
<th>$\beta_{0j}$</th>
<th>$\beta_{1j}$</th>
<th>$\beta_{2j}$</th>
<th>$\beta_{3j}$</th>
<th>$\beta_{4j}$</th>
<th>$\beta_{5j}$</th>
<th>Pseudo $r^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1a (wb)</td>
<td>2.29***</td>
<td>.61***</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>56%</td>
</tr>
<tr>
<td>H1b (dep)</td>
<td>1.40***</td>
<td>.09+</td>
<td>-.09*</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>26%</td>
</tr>
<tr>
<td>H2a (wb)</td>
<td>2.29***</td>
<td>.60***</td>
<td>.14*</td>
<td>-.26**</td>
<td>-----</td>
<td>-----</td>
<td>58%</td>
</tr>
<tr>
<td>H2a (dep)</td>
<td>1.40***</td>
<td>.089+</td>
<td>-.09+</td>
<td>.019+</td>
<td>-.02</td>
<td>-.08</td>
<td>-----</td>
</tr>
<tr>
<td>H2b (wb)</td>
<td>2.29***</td>
<td>.60***</td>
<td>.16***</td>
<td>-.12*</td>
<td>-----</td>
<td>-----</td>
<td>27%</td>
</tr>
<tr>
<td>H2b (dep)</td>
<td>1.40***</td>
<td>.09*</td>
<td>-.091+</td>
<td>-.13**</td>
<td>.11+</td>
<td>.01+</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

+ $p \leq .10$; * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Hypothesis 1a

Well-Being$_{ij} = \beta_{0j} + \beta_{1j} \text{ (time)} + r_{ij}$

As described above, contrary to what we originally hypothesized, the trajectory of well-being exhibits a sharp increase from baseline to W1 post-bereavement and then a leveling off from W1 to W2. Therefore, all significant change in widows' well-being apparent in the CLOC occurs from baseline to W1. See Figure 1, below.
Figure 1. Trajectory of Well-Being Over Time (Time 0 = Baseline; Time 1 = W1; Time 2 = W2).

Hypothesis 1b (Depression)

Depression$_{ij} = \beta_{0j} + \beta_{1j} (\text{time}) + \beta_{2j} (\text{time1}) + r_{ij}$

As described above, the trajectory of depression exhibited a sharp increase from baseline to W1 and then a sharp decrease from W1 to W2. The increase from baseline to W1 and the decrease from W1 to W2 are both significant. See Figure 2, below.

Figure 2. Trajectory of Depression Over Time (Time 0 = Baseline; Time 1 = W1; Time 2 = W2).
Hypothesis 2a (Well-Being)

Well-Being\(_ij\) = \(\beta_{0i} + \beta_{1ij}\) (time) + \(\beta_{2i}\) (tsi\(_c\)) + \(\beta_{3i}\) (time * tsi\(_c\)) + \(r_{ij}\)

Total social integration significantly alters the trajectory of well-being. There is a main effect for total social integration at baseline (\(\beta_{2i} = .14\)), suggesting that those who report having high total social integration at baseline have higher levels of well-being at baseline. When interacting with time though, higher total social integration is associated with lower well-being (\(\beta_{3i} = -.26\)). See Figure 3, below.

Figure 3. Total Social Integration on Well-Being (Time 0=Baseline, Time 1=W1, Time 2=W2).

Hypothesis 2a (Depression)

Depression\(_ij\) = \(\beta_{0j} + \beta_{1ij}\) (time) + \(\beta_{2j}\) (time1) + \(\beta_{3j}\) (tsi\(_c\)) + \(\beta_{4j}\) (time * tsi\(_c\)) + \(\beta_{5j}\) (time1 * tsi\(_c\)) + \(r_{ij}\)

Total social integration has no significant effect on depression; however, the effect evidenced a trend toward significance (\(p < .10\)). See Figure 4, below.
Hypothesis 2b (Well-Being)

Well-Being_{ij} = \beta_{0j} + \beta_{1j} \text{ (time)} + \beta_{2j} \text{ (MQ_c)} + \beta_{3j} \text{ (time * MQ_c)} + r_{ij}

Higher marital quality at baseline was associated with (a) greater well-being at baseline, and (b) a less steep increase in well-being from baseline to W1 ($\beta_{2j} = .16$). Participants who started the study with lower marital quality exhibit the fastest increase in well-being from baseline to W1 ($\beta_{3j} = -.12$). See Figure 5, below.
Figure 5.

Marital Quality on Well-Being (Time 0=Baseline; Time 1=W1; Time 2=W2).

\[ \text{Hypothesis 2b (Depression)} \]

Depression_{ij} = \beta_{0i} + \beta_{1i} \text{ (time)} + \beta_{2i} \text{ (time1)} + \beta_{3i} \text{ (MQ_c)} + \beta_{4i} \text{ (time * MQ_c)} + \beta_{5i} \text{ (time1 * MQ_c)} + r_{ij} \]

Depression increases as a function of time, and participants reporting greater marital quality at baseline reported less depression at baseline (\(\beta_{3i} = -.13\)). The interaction of time (the time between baseline to W1) and marital quality evidences a trend toward significance, suggesting that those who report high marital quality at baseline demonstrated the fastest increase in depression between baseline and W1 (\(\beta_{4i} = .11\)). See Figure 6, below.
Discussion

Although depression following bereavement is actively studied (Fry, 2001; Lund, Caserta, Dimond, 1989; Nieboer, Lindenber & Ormel, 1998; Prokos & Keene, 2005, Bonanno, et al., 2002) few studies have investigated well-being as an independent outcome or the interpersonal factors that may alter the course of post-bereavement on either of these outcome variables. Of these studies that investigated well-being, even fewer investigated social relationships. Given these gaps in the literature, we looked at marital quality and social integration to explore their impact on well-being and depression.

The main, novel findings of this study were as follows: (1) Total social integration and marital quality significantly affect the trajectories of well-being and depression over time, (2) higher levels of total social integration indicate lower levels of well-being, and
(3) those who report having low marital quality evidence the fastest increase in well-being after bereavement.

Contrary to our original hypothesis of well-being decreasing after bereavement and then increasing by 18 months postloss, well-being had evidenced significant increases from the baseline measure to W1, remaining stable between W1 and W2. The trajectory of depression was consistent with our hypothesis that it would significantly increase between baseline and wave 1 and then significantly decrease from wave 1 to wave 2.

The findings suggest that both depression and well-being increased from baseline to the 6-month assessment. This seems rather odd and could perhaps be explained by the amount of time that elapsed from bereavement to wave 1. The W1 assessment occurred six months after bereavement, which might be too long to fully capture the changes in well-being and depression following widowhood. Due to the stressful nature of spousal bereavement, depression is going to be more elevated during the months following bereavement. It even might be the case that those who lost their spouse report more felt depression because they are trying to play the part of the “good” grieving widow. Well-being on the other hand is more consistent over time and the reported increases in well-being might be explained by the fact that when participants are asked how their well-being is, they may look back at how they felt and decide that they are feeling better than they were, thus reporting higher levels of well-being. If we were to look at a smaller window closer to the actual bereavement, for example within the first two months, we predict that the trajectory for well-being would be more consistent with our original hypothesis.
A substantial amount of literature discusses increases in depression after bereavement, which is due to the stress and hardship that comes with becoming bereaved. Depression decreases significantly from W1 to W2, suggesting that over time, the transition to widowhood becomes easier and reduces the initial depression following the loss. Although both the transition from baseline to W1 and W1 to W2 for depression are statistically significant, the magnitude change (approximately 0.1) does not seem large. With that being said, the subjective experience of this depression may not be noticeable or even distinguishable from normative bereavement to individuals and this effect is extinguished at wave 2 when widows report levels of depression nearly identical to their preloss measures. Those who do not evidence this trajectory are usually categorized at chronically depressed rather than chronically grieving (Bonanno et al., 2002).

Using the CLOC data, Utz et al. (2002) reported that social participation increases after spousal death, however, their investigation did not assess correlates of psychological adjustment, and their analysis presumes more social integration is better. The present study-- finding that higher social participation after loss is associated with lower well-being-- extends this work to suggest that high levels of social integration may not always be beneficial, perhaps due to the fact that social involvement reminds participants that their spouse is not present (at least within the first 6-months post-loss). The analysis did reveal a positive correlation of total social integration and well-being at baseline, suggesting that social integration may operate differently before and after becoming a widow.

Marital quality also significantly altered the trajectories of well-being and depression, suggesting that those who have a strong marriage will experience less steep
increases in well-being and higher levels of depression after the loss. Nevertheless, by 18 months postloss, even widows who reported having strong marriages appear to adjusting well to the loss. Although well-being increases for the entire sample, it increases the fastest for those who reported having poorer marital quality, suggesting that the loss of their spouse, and thus the end of a stressful marriage, actually improved their own well-being.

Taken together, contrary to the original hypotheses, our results represent a stark contrast to commonly held beliefs about how individuals should cope with the loss of a significant other. Though many believe one should push themselves to integrate in their social communities and not become isolated following their spouse’s death, our results indicate that these individuals evidence a poorer adjustment in widowhood. Additionally, those who report having low marital quality evidence the steepest increases in well-being suggesting that bereavement might not be as stressful on the individual. Although those who report having high marital quality evidence the fastest increases in depression, by W2 they are nearly at baseline depression, which goes to show that having a good marriage will not significantly prolong the grieving process. Future research should continue on the track of investigating how total social integration affects well-being after bereavement although it does not follow conventional wisdom. Also, by taking multiple measures during the first two months following bereavement, we might be able to understand how well-being and depression function more on a level closer to the actual event of bereavement.
References


