HEALTH, SOCIAL FUNCTIONING, AND MARITAL STATUS: STABILITY AND CHANGE AMONG ELDERLY RECENTLY WIDOWED WOMEN

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SUMMARY

Four-year changes in mental and physical health, morale and social functioning were assessed in a random sample of elderly women widowed during the course of a longitudinal study, together with never-married and still-married controls. All groups showed an age-related decline in mental and physical health, with the widows, the never-married, and the still-married displaying differing patterns of psychological change over time. However, while widows showed significantly greater changes in morale and personal disturbance, their levels of social functioning remained stable over the four-year period. The results confirm earlier findings of lifestyle stability after the loss of a spouse and indicate that, in addition to bereavement per se, single status and ageing itself may contribute substantially to the measured longitudinal effects of widowhood.

KEY WORDS—Longitudinal, widowhood, elderly women, mental health, physical health, social functioning.

For many elderly people widowhood is a high-probability life event. In Britain, for example, over 36% of all people aged 65 years or over are widowed (OPCS, 1990a). Further, the prospect of widowhood is greater for women than for men. In 1988, 50% of elderly British women were widowed, while 39% were married and the remainder were either never-married or divorced. With increasing age the number of widows rises steadily, such that, at age 75 or over, 65% of women are widowed (OPCS, 1990a). These findings reflect both women’s greater life expectancy (in 1985 at age 70 women had a life expectancy of 13.6 years and men 10.4 years; OPCS, 1990b) and women’s tendency to marry men older than themselves.

Widowhood can affect both mental and physical health. For example, Jacobs et al. (1989) found that 32% of bereaved spouses (especially women) suffered from depression six months after bereavement, while Ferraro (1989) has shown that widowhood contributes to lowered morale and short-term decline in physical health. Other studies have suggested that there is an increased risk of death following bereavement (see Jones and Goldblatt, 1986). However, from the available research literature it would appear that these effects on physical, psychological and emotional functioning are not matched by effects on social functioning.

In a study of long-term adaptation to bereavement, Heyman and Gianturco (1973), for example, suggested that levels of social functioning remained stable in elderly widows (women and men) 21 months after the loss of a spouse. More recently, relatively stable levels of participation in social activity, (including social support networks, church attendance, media consumption, etc) after widowhood have been reported by Dimond et al. (1987) and O’Bryant and Morgan (1990).

On theoretical grounds, levels of participation in the social milieu might be expected to change for a number of reasons following bereavement. The apparent stability of social functioning, therefore, draws attention not only to the global impact of widowhood, but also, and more generally, to the relationship between affective and social functioning in later life. Unfortunately, few studies have simultaneously assessed mental health and levels of social functioning in the same bereaved sample, so the strength of post-bereavement affect-activity relationship remains unclear. In addition, the mea-
measurement of such relationships introduces a number of practical and methodological issues concerned with the effects of widowhood.

Many of the physical and emotional changes assessed in relation to widowhood are known to occur as a result of ageing per se. Thus, physical health (eg Nowlin, 1974) and morale (eg Larson, 1978) both show age-related decreases. If assessed longitudinally, therefore, it is important to distinguish between the effects of widowhood and the confounding effects of ageing per se. Furthermore, widowhood itself comprises at least two distinct components, either of which might influence social functioning: (i) the emotional impact of grief and bereavement; and (ii) the transition from married to single status.

The present study, therefore, was designed to assess the impact of widowhood, and clarify relationships between mental health and social functioning, in women bereaved in the course of the Nottingham Longitudinal Study of Activity and Ageing. To control for the confounding effects of both ageing and changed marital status, this subsample was compared with further subsamples of still-married and never-married controls.

**METHOD**

The NLSAA was set up in 1983 to assess the role of lifestyle and Customary Physical Activity (CPA) in promoting and maintaining psychological well-being in later life. The first population survey was conducted between May and September 1985, during which time 1042 people randomly sampled from Family Practitioner Committee lists, and demographically representative of the British elderly population, were interviewed in their own homes. The interview questionnaire contained a total of 318 items and covered aspects of health, lifestyle, demographic and socioeconomic status (see Morgan et al., 1987; Dallosso et al., 1988).

The first complete follow-up of survivors, using identical methods and materials, was conducted between May and September 1989. All respondents who had participated in 1985, and who were still living in Nottingham, were invited to participate in the follow-up study. Information on respondents who had died, moved or migrated since 1985 was provided by the NHS central register, general practitioners’ records, and hospital case-notes. Six hundred and ninety follow-up interviews were conducted, representing a follow-up response rate of 88.3%. The principal causes of attrition are: (i) death (N = 261); (ii) refusal (N = 63); (iii) untraceable (N = 25); and (iv) emigration (N = 3).

The subsample of widows comprised all those women who had been married in 1985, at the first interview, but who had been bereaved by 1989, at the second interview (N = 39). For the control groups each widow was then randomly age-matched (± 3 years) with a woman who had been married both in 1985 and 1989 (N = 39) and had never been widowed. Care was taken to avoid over-matching. The second comparison group comprised all those women who had never been married (N = 29). This group was not age-matched. However, the mean ages for the three groups did not differ significantly (never-married women’s mean age = 74.7 (SD = 6.1); widowed women’s mean age = 73.4 (SD = 4.6); still-married women’s mean age = 73.5 (SD = 5.0); F = 0.54, df = 2, 105, p < 0.58). The six social classes (OPCS, 1980) were collapsed into three categories comprising classes I and II (professional and managerial), classes IIIM and IIIN (skilled manual and skilled non-manual), and classes IV and V (semi- and un-skilled manual). There were no significant class differences between the three groups (χ² = 6.1, df = 4, p < 0.2). The sample of bereaved women will be referred to as the widows, the sample of married women will be referred to as the still-married, and the sample of single women as the never-married.

Analyses in the present report focus on four aspects of well-being: affective status, morale, social functioning and health. Personal disturbance and affective status was assessed using the Symptoms of Anxiety and Depression (SAD) Scale (Bedford et al., 1976). This 14-item instrument deals with recent symptomatology and comprises two seven-item subscales relating to anxiety and depression. In non-clinical samples the scale is not active across its full range and lower scores tend to predominate.

Morale was measured by Wood et al.’s (1966) 13-item version of Neugarten et al.’s (1961) Life Satisfaction Index (the LSIZ) modified for use with a British sample (see Morgan et al., 1987). Items, rated agree, disagree, or don’t know, include: ‘This is the dearest time of my life’; ‘As I look back on my life, I am fairly well satisfied’; and ‘I’ve got pretty much what I expected out of life’, etc.

Social functioning was assessed using the Brief Assessment of Social Engagement (BASE) scale developed specifically for this project and fully described elsewhere (Morgan et al., 1987). This dично-
tomously rated 20-item scale assesses both active (eg ‘Have you been away on holiday in the last year or so?’) and symbolic (eg ‘Do you read a national or local newspaper, or a weekly or monthly magazine?’) participation in the social milieu, and perceived quality of social networks (eg ‘Do you have at least one friend living in or near this district?’).

Physical health was assessed using a 14-item information and symptom checklist covering the presence or absence of: heart, stomach, eyesight or feet problems; giddiness, headaches, urinary incontinence, arthritis, insomnia and falls; long-term disabilities; and current usage of drugs, walking aids, or medical services (Bassey et al., 1989). Items were dichotomously rated 1 (yes) or 0 (no) and were included in the scale: (a) if positive responses were obtained from more than 2% of respondents; and (b) if the item total correlation was >0.2. The resulting 14-item scale showed reliability coefficient of 0.7 (Cronbach, 1951).

The data were analysed using a repeated measures analysis of variance model. The between-subjects factor was marital status with three levels (widows; still-married; and never-married) and the within-subject factor was the time of interviews, with two levels, 1985 and 1989. Means were compared using the uncorrelated t-test.

RESULTS

Mean levels (and standard error) of personal disturbance, morale, social functioning and health in 1985 and 1989 are shown in Table 1. Results of the analysis of variance are shown in Table 2. Analysis of variance of SAD scores revealed no significant main effect for marital status ($F = 1.89, df = 2, 95, p < 0.16$), but did reveal a significant marital status by time of interview interaction ($F = 8.17, df = 2, 95, p < 0.001$). Widows showed higher levels of personal disturbance in 1989 than the still-married ($t = 3.02, df = 47, p < 0.004$), but not the never-married women.

Analysis of variance of LSIZ scores showed a significant main effect for marital status ($F = 4.68, df = 2, 95, p < 0.01$), the widows displaying lower levels of morale than either the still-married or never-married women. Once again, this main effect was not independent of time of interview (interaction effect: $F = 4.93, df = 2, 95, p < 0.009$). Paired comparisons showed significant differences in 1989 between both the still-married and the widowed women ($t = -4.11, df = 55, p < 0.001$) and the never-married and widowed women ($t = 2.09, df = 55, p < 0.04$), where the widows reported lower levels of morale.

Analysis of variance of BASE levels also revealed a significant main effect for marital status ($F = 3.52, df = 2, 83, p < 0.03$). Levels of BASE were significantly higher for the still-married women when compared with widowed and never-married women ($t = -3.06, df = 147, p < 0.0001; t = 2.62, df = 130, p < 0.001$, respectively). There was no significant marital status by time of interview interaction effect ($F = 0.58, df = 2, 83, p < 0.51$).

Analysis of variance of Health Index scores revealed no significant main effect for marital status ($F = 0.96, df = 2, 101, p < 0.39$) and no marital status by time of interview interaction effect ($F = 0.94, df = 2, 101, p < 0.39$).

Analyses of SAD, LSIZ and Health Index showed significant main effects for time of interview, with personal disturbance ($F = 4.74, df = 2, 95, p < 0.03$) showing a significant increase, and morale ($F = 8.46, df = 1, 95, p < 0.005$) and health ($F = 7.16, df = 1, 101, p < 0.0001$) showing a significant decrease over the four-year period. Only for health, however, were these main effects independent of marital status. Increases in personal disturbance were most marked among the never-married and widowed, while decreases in morale were greatest among the widows. No significant main effect for time of interview was shown for social functioning ($F = 0.68, df = 2, 83, p < 0.51$).

DISCUSSION

The results confirm earlier, but separately reported, findings that while morale declines significantly
Table 2. Repeated measures analysis of variance of psychological and physical health and social functioning

<table>
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<th>Marital status</th>
<th>Main effects</th>
<th>Time of interview</th>
<th>Interaction effect Marital status × Time of interview</th>
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<td></td>
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<td>df</td>
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<td>4.74</td>
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<tr>
<td>BASE</td>
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<td>2, 83</td>
<td>0.03</td>
<td>0.68</td>
</tr>
<tr>
<td>Health Index</td>
<td>0.96</td>
<td>2, 101</td>
<td>0.39</td>
<td>71.06</td>
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after widowhood (Heyman and Gianturco, 1973; Ferraro, 1989; Jacobs et al., 1989), social functioning shows remarkable stability (Dimond et al., 1987; O'Bryant and Morgan, 1990). While the BASE provides an admittedly crude measure of social functioning, previous experience has shown that, in a large random sample, the instrument is active across its range, with scores correlating significantly with variations in morale (Morgan et al., 1987). It is unlikely, therefore, that the observed stability in the present analysis is due simply to instrument insensitivity. Rather, the present results may be interpreted in at least two ways. First, irrespective of marital status, social functioning appears to be a particularly robust aspect of lifestyle in elderly women. And second, relative to the quite marked reduction in morale among widows, the stability of their social functioning suggests a weakening of cognitive-behavioural links after bereavement. Interestingly, a similar 'uncoupling' was found in earlier reported analyses focusing on the relationship between physical activities and mental health (Morgan et al., 1991). In these latter analyses, levels of physical activity tended to predict levels of morale in men, but not in women. Whether or not the present findings provide evidence for a gender-influenced stoicism, it is clearly the case that the medium-term impact of bereavement is most evident in what elderly women feel, rather than what they do.

The results clearly show the effect of ageing on both mental and physical health. This is particularly evident in the physical health index, where all the groups report an increase in the number of symptoms between 1985 and 1989. The results also show some influence of marital status on overall levels of social functioning. The still-married women had significantly higher levels of social functioning than either the widows or the never-married women at both times of measurement. It is possible that there were different influences affecting the widows at the first and at the second interview: (i) the widows had low levels of social functioning at the time of the first interview because of their situation (eg caring for a sick spouse); and (ii) low social functioning at the second time of interview because of their changed marital status.

Finally, it should be noted that while these analyses have assumed stability in social functioning between the two (1985–1989) points of measurement, it is also possible that there was a decline in social functioning immediately after bereavement and that this was followed by a recovery which returned the mean to baseline levels. Nevertheless, the literature reviewed earlier, together with the pattern of results reported here, strongly suggests that BASE levels in the present study reflect stability rather than strength of recovery.

ACKNOWLEDGEMENTS

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REFERENCES


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