

Why Did He Die? The Attributions of Cause of Death among Women Widowed in Later Life

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Abstract

The study aimed to examine the causal attributions of death made spontaneously by older widowed women to explain the deaths of their husbands. The data presented are from two qualitative interview studies using the same methodology. There were 65 widows aged between 55 and 93 years old who had been widowed between 0.25 and 60 years. Data were analysed using a grounded theory method and content analysis. Nearly half of the women gave causal explanations for why their husbands died. These explanations can be best understood in terms of lay illness attributions. These results indicate that a broad analysis of cause of death attributions is important in understanding the bereavement experience. The function of attributions in post-bereavement experiences is also examined.

Keywords

attribution, cause of death, health, widowhood

Introduction

FOR WOMEN in later life the death of a spouse is a probable life event (Morris, 1997). Most studies have examined coping and 'recovery' (see, for example, Byrne & Raphael, 1994; Parkes & Weiss, 1983; Thuen, Reime, & Skrautvoll, 1997). However, few have asked widows what it is like to be widowed and more specifically what explanations do the widows have for their husbands' deaths (see Bennett & Bennett, 2001).

The need of people to seek causal explanations was first articulated by Heider (1944). He argued that people were 'naïve psychologists' attempting to make sense of events or actions. It follows, therefore, that people will try to make sense of the deaths of their spouses and yet this has been little studied. The literature that does exist focuses on two areas of attribution, both in the context of adaptation: infant loss (Downey, Silver, & Wortman, 1990; Dunn, Goldbach, Lasker, & Toedter, 1991); and blame (Field & Bonanno, 2001; Field, Bonanno, Williams, & Horowitz, 2000; Weinberg, 1994, 1995). Dunn et al. (1991) found that parents who suffered a pregnancy loss wanted to know why it had happened and that their attributions fell into four categories: blaming the mother; physical problems; fate; and no explanation. On the other hand, Downey et al. (1990), found that almost half of the parents who experienced Sudden Infant Death syndrome were not concerned with attributional issues three weeks after the loss. They also found no evidence to support the assumption that adjustment is affected by attributions. The issue of adaptation and attribution is most clearly explored in studies of blame in bereavement. For example, Weinberg (1994, 1995) suggests that self-blame hinders recovery although when self-blame was followed by making amends she found recovery was associated with a more favourable outcome. Field and colleagues, using an empty chair monologue task examined attributions of self-blame and partner-blame in conjugal bereavement. They found that self-blame was associated with poorer long-term recovery and grief-specific symptoms (Field & Bonanno, 2001; Field, Bonanno, Williams, & Horowitz, 2000). However, these approaches to attributions in bereavement are limited by focusing first on

adaptation and second on blame. It is proposed that causal attributions of death may be broader and more widespread than this literature suggests.

In understanding attributions in bereavement there is value in considering two other approaches. The first approach utilizes lay representations of illness, since spousal death is most often associated with prior (recognized or unrecognized) illness in people in later life. The second examines illness attribution, for the same reasons but also because the literature is richer than that which focuses solely on attributions of blame in the bereaved.

In recent years, there has been increasing interest in lay representations of illness and the cognitive framework in which they lie (Lau & Hartman, 1983; Leventhal, Meyer, & Nerenz, 1980). Lay representations of illness can be said to be common-sense beliefs of illness. Leventhal et al. (1980) proposed a schema that comprised identity, perceived cause, time line, consequences and curability and controllability. In the context of understanding cause of death these all may have relevance. However, some may be more salient, for example, what does a person believe the cause of death to be, how long did it take for a person to die, could the death have been prevented? More recently, Furze, Lewin, Roebuck, Thompson and Bull (2001) examined whether the beliefs held about angina by sufferers had implications for their quality of life. The majority of their participants held lay beliefs about their illness and misconceived avoidance strategies were identified by most. However, as with the attribution of death literature, the focus has been on adaptation and outcome, rather than on their purpose and frequency.

One field of study which does consider the frequency and purpose of causal explanations which may be more useful in understanding the broader context of beliefs about why a spouse has died is the study of ill-health attributions. Mercado-Martinez and Ramos-Herrera (2002) examined lay theories of causality with respect to diabetes. They found that the primary attribution was to socio-emotional circumstance and not to biomedical reasons. Men believed their disease was caused by work and social life outside the home, while women believed it to be caused by their familial and domestic circumstances. Furnham and Baguma (1999), in a

cross-cultural study, identified eight factors associated with attributions of illness including emotional well-being, lifestyle, constitution, and in the Ugandan sample, more supernatural causes. One of the most interesting articles, from the point of view of this current study, is work by Arefjord, Hallaråker, Havik and Mæland (2002). They examined the causal attributions made by the wives of myocardial infarction patients. Although they examined them in the context of later adjustment what is most relevant are the types of attributions the women made. The attributions fell into four categories: medical causes; lifestyle; stress; and 'magical explanations'. This last category is especially interesting since it is concerned with 'irrational causes' not associated with medical explanations. These consisted of psychological, physical and religious explanations. For example, they classified the explanation 'he got a cold after a long walk' as 'magical' (Arefjord et al., 2002, p. 104). The conceptualizations used in their article are useful for the current study for at least two reasons. First it is concerned with the wives of the ill (or in the case of the current study dead) person (in attribution terms the 'observer'), and second it includes a category (magical explanations) into which lay understandings of health (and indeed dying) may fit.

Using the classification proposed by Arefjord et al. (2002) this article aims to examine the causal attributions of death made by older women following the death of their husbands. It will also examine what role attribution plays in the understanding of spousal bereavement.

Method

Participants

The respondents were recruited during the course of two studies of older widowed women, the first conducted in the East Midlands of England (denoted Mrs) and the second in the north-west of England (denoted W). Recruitment was through a variety of organizations concerned with older people, including widows' clubs, trade unions, Age Concern, social service departments. Most respondents were living in their own homes although a few were living in sheltered accommodation. The data consist of tape-recorded interviews with 65 widows aged between 55 and 93 years old who had been

widowed between one-quarter and 60 years. Seven women had been married twice.

The interview

The interviews were tape-recorded and undertaken in the respondents' own homes; they were semi-structured and lasted between three-quarters of an hour and an hour-and-a-half. Before beginning the interview, the respondent was given an information sheet to read and asked to sign a consent form; confidentiality and anonymity were assured. The interview was not prescriptive; the aim was to learn from the widows what was important to them. The approach was 'We are the novices and you have the experience'.

The interview schedule consisted of five parts: first factual questions concerning age, length of marriage, widowhood and family relations; then four sections inquiring about the widow's life at various times.

The first of the middle sections asked about what the marriage had been like. Questions included what hobbies they had pursued together, what the division of labour had been, what had they done separately, whether they had argued, and so on. The second section asked about the time around the death of their husbands. For example, they were asked to describe what a typical day had been like after the death, whether they went out, what support they had had from family and friends, how they had felt and what emotions they had experienced. The next section asked them what they did and how they felt one year on. They were asked how their lives had changed by then, what a typical day was like at that stage, whether they were now doing anything new, whether anything had changed with regards to work around the home. They were asked had their feelings changed, whether they were lonely or whether they enjoyed being able to spend time alone. The last section asked about what their lives were like at the present time. What did they do with their time, how did they feel about their widowhood, how had their lives changed, what their emotions were and how they felt now about being alone.

Analysis

The interviews were coded using grounded theory and content analysis methods by three

members of the team, see Bennett and Bennett (2001) for a detailed description. One of the domains that emerged which is fundamental to the experience of bereavement was that of death and that is where the content analysis begins. Within this domain one code arose spontaneously in nearly half of the interviews (27/65): attributions of death. This code was used when the widows discussed the cause of death of their husbands and gave their reasons why he had died. These do not represent the official cause of death. These sections of interviews were then extracted and further recoded in the manner described earlier. A refined content analysis was carried out on these specific codes within the passages about attribution. The main themes of this content analysis, with respect to the 27 interviews, are discussed below.

Results and discussion

Formal causes of death

Before examining the attributions of cause of death it is interesting to look at the causes of death reported to the interviewer by the widows. It is possible that there could be mismatches between the widow-reported cause and the death certificate. However, access to the death certificates was not possible and in any case it is the widows' accounts that are of interest in this context.

Several causes of death were reported. The two most common causes of death, out of the 65, are cancer ($n = 18$) and heart disease and stroke ($n = 16$), these are in line with the most common causes of mortality in the UK (Department of Health, 1998). In addition, other causes of death included motor neurone disease, dementia, pneumonia. Finally, three widows do not say what their husbands died of.

Preamble

The categorization used for this analysis is based on the system employed by Arefjord et al. (2002) consisting of medical causes, lifestyle causes, stress and 'magical' causes. In order to remain consistent with Arefjord et al. this analysis classifies all work-related causes (whether associated with stress or not) under the category stress, although a category name of 'work' would be equally appropriate.

Before any analysis of categories of attributions is made it is important to mention that attributions made by an individual participant could fall into more than one category. For example, Mrs D makes a number of attributions concerning the death of her husband that fall into at least two categories. It is also the case that a single attribution might fall into one or more categories. For example, in more than one instance smoking could be considered both a medical cause, in the case of emphysema, and a lifestyle cause, as in work-related smoking. Readers should not attempt, therefore, to total up the numbers between categories.

It is also useful to bear in mind that the central focus of this article is that widowed people do make attributions spontaneously. These attributions were unasked for and the attributional responses would almost certainly have been higher had respondents been asked to give explanations. It is the spontaneity of these responses rather than their implications for adjustment that is of interest to this discussion.

Health-related and medical attributions

In nine of the interviews there were attributions associated with health and with medical interventions. These covered both pre-existing health conditions and medical care and intervention.

Four of the women mentioned heart problems or stroke as the attribution of death. Two examples are given here. First:

But he said [the doctor], 'I think he ought to go into hospital', he said, 'I'm not quite sure', but he said, 'I think he's had a heart attack.' So I said, 'Oh, I thought he'd had a stroke with him not being able to talk to me.' (Mrs Q)

Second:

Because we thought it was all to do with the heart, and they got it right before so they'd get it right again.

[Interviewer. Yeah.]

But when he'd had all the tests done we found he'd got cancer. (Mrs N)

The procedures and operations that the husbands underwent were also given as attributions. For example:

The arthritis went back to about his first operation in 1976, he had a hip operation.

[Interviewer. Right.]

And that was very good. It lasted for nearly 10 years, and then he had to have it replaced and then his troubles started. (Mrs J)

However, some of the most distressing attributions concerned medical errors and negligence. Four of the widows believed that the medical profession was in some way responsible for the death of their husbands. These could be seen as a need for someone to blame (a recurrent theme). However, the interviews do leave one feeling that these accounts are also accurate. This is one of the clearest and most poignant:

I'll always feel that they could have done more,

[Interviewer. Right.]

And could have acted differently. But if it was lymphoma, that's treatable.

[Interviewer. Yeah.]

I mean, he was ill in plenty of time for them to have, if they'd found it straight away.

[Interviewer. Yeah.]

He could have had treatment, I mean, I know two people who've had treatment and they're clear of it. (Mrs D)

Interestingly, Mrs D does not blame the consultant in charge of her husband's case:

But Dr X, Jim thought the world of him, and he was very nice and I feel certain he did do his best.

[Interviewer. Yeah.]

I think the mistakes were made by other people under him.

[Interviewer. Yeah.]

You know, so I wouldn't have wanted to make any complaint that involved Dr X.

As an aside, it shows the awe in which senior medical practitioners are frequently held.

Lifestyle attributions

In nine of the interviews women made lifestyle attributions. Six of the women identified smoking as one (or the) reason for their husband's death. While smoking does cause death, the links between the attribution of smoking and the eventual cause of death are not, in these examples, straightforward. For example, in case of Mrs K, the relationship between smoking and cause of death is not clear. She expected that her husband would die of coronary heart disease as a result of smoking and is surprised when he dies of cancer. She did not make the connection between smoking and cancer:

And he used to smoke and I used to say to him, you are naughty to smoke. And he did try to give it up but he didn't really.

[Interviewer. Mmm.]

Anyway, all my fears were not, didn't materialize because when he did die it was through cancer. (Mrs K)

In contrast this widow believes that smoking contributed to his death and cannot understand why nobody asked her about it: 'But never once did they ask me if he smoked' (Mrs Q). In this case both the attribution and the cause of death are clear: '... emphysema—through smoking—smoking related' (W24).

One woman, reflecting current health concerns, blames her husband's death on the fact that he was overweight and would not stop eating (he also smoked): 'He was overweight and we tried desperately to put him on diets but we used to catch him with bars of chocolates and he smoked which of course he shouldn't have done' (W36).

The recognition by these widows that lifestyle factors may contribute to their husband's death reflects the current societal interest in the role that lifestyle has to play in health and illness. But it is also important to remember that for most of the deceased smoking, for example, was not acknowledged as a risk factor for disease and mortality until their smoking habits had been well established.

Stress

In the interviews presented here all of the stress attributions relate to work. This might be the

stress of the job, a change in job, redundancy or retirement. Eight widows gave this as the attribution. In this first example, the widow believes over-work contributed to her husband's death:

Yeah, he was a workaholic, and he set up his own business with a partner.

[Interviewer. Right.]

So they worked long hours to get it going. I think he had it for 10 years, but that's when he became ill. (Mrs I)

In this case the widow believed that his death was caused by the work he had done years before. It could be argued that this is not a stress attribution, and could be considered under the medical explanations, but it is discussed here since it is concerned with work: 'Mind you he had been working on asbestos down the docks' (W17). While, in the next of these examples (the first of which also has a lifestyle attribution), it is a change of job which was given as the attribution:

Anyway, he got a job at the gas board and unfortunately he was sitting at an office desk all the time.

[Interviewer. Mmm.]

Passing cigarettes round . . .

And then he came home in the car and went out in the car, you see, so. (Mrs M)

So we moved up to X to still be—he didn't want to be in any other [] force on (. . .) so that is why we moved to X and that is when he started to be ill. (W43)

Here is a final example:

He'd been made redundant twice in a year.

[Interviewer. Oh.]

So, obviously that was a lot of stress and worry. (Mrs P)

The attribution of stress is in these examples more specifically related to work. Elsewhere there are attributions, such as anxiety, which could have been included here but these fit more effectively into other categories such as the 'magical'.

Magical explanations

One of the richest categories in this analysis concerns the magical explanations. In many respects this category reflects true lay representations of illness. By that it is meant that these are the explanations made by people without recourse to accurate medical knowledge or influenced by health promotion messages. Nine women used magical attributions to explain their husband's death. Three sub-categories emerge to account for most of these attributions: quasi-medical explanations; accidents; and people explanations. Turning first to quasi-medical explanations women identify viruses, medical procedures and anxiety as possible causes. In this first example the widow associates a bout of flu with her husband's cancer:

And it was total bone cancer. But it was one of those rapid ones.

[Interviewer. Yeah.]

It had just gone. It was, er, the flu, obviously, he'd obviously got it in the back, but we didn't know anything about it because he was so well. (Mrs A).

Mrs D, who makes many attributions, also attributes her husband's death to his annual flu vaccination. In this next example, the woman attributes her husband's anxiety about his health to his eventual death: 'Oh—well he worried an awful lot about himself' (W31). Finally in this sub-category, quasi-medical procedures also come under scrutiny. In this last example, it is an old-fashioned medical procedure that is given as the attribution:

So he went to the doctor and he said it was a ganglion or something.

[Interviewer. Right.]

And he should hit it with a family Bible, you know how they used to. (Mrs H)

A number of the women suggest that an accident (the second sub-category), in some cases much earlier, caused their husband's death. In this first passage is both an attribution of accident and work, again from Mrs D:

And he had a heart attack. And, a couple of days before that, he'd been in his workshop and, er, as I say he was a French polisher and

there was some very big panels in the workshop and he was alone [words lost] and he decided to move one. And, I mean, I'm not quite sure what happened because he tried to hide it from me but, apparently he tried to move them and he fell backwards with them all on top of him.

In this second example, the widow believes a car accident was responsible for her husband's eventual death:

But that's what caused my husband's illness.

[Interviewer. Right.]

Was that chap smashing into him. (Mrs E)

Family circumstances and personal characteristics (termed 'people' explanations) are also another type of quasi-medical attribution mentioned by the widows. The first is an example that is of self-blame: 'But, I realize it's silly to feel like that, because, you know, it wasn't me that gave him the cancer' (Mrs B). While this is a classic example of dying of a broken heart:

No. He had his first heart attack 12 month after June died.

[Interviewer. June was your daughter?]

Yeah. He never let his grief come out. (Mrs C)

The above example is also an attribution that could be described as emotional or stress-related.

Other women also mention, often in passing, family troubles that contributed to their husband's death. For example W31, quoted earlier, implies that her husband's death was caused by long-standing anxiety that was an aspect of his personality.

The 'magical' category of attributions contains some of the most interesting causal attributions representing explanations taken from medical folklore (using a Bible to treat a ganglion) and from lay experience (dying from a broken heart). The term 'magical' provides a useful short-hand for these attributions. However, Arefjord et al.'s definition as 'irrational causes not supported by empirically validated medical understanding' (2002, p. 104) is more judgmental than the current authors wish it to be. The attributions presented here

sound plausible, the widows might take some medical knowledge and stretch it further than it might realistically go, but these explanations should not be dismissed out of hand as irrational. The concern here is not whether the attributions are accurate or not, it is that attributions are made and appear to be a common aspect of bereavement.

What do the attributions represent?

The previous passages show that many of the women interviewed in this study make attributions concerning the deaths of their husbands. It is also clear that these attributions fall into different categories for which Arefjord et al.'s (2002) classification is useful: medical; lifestyle; stress; and 'magical'. At the outset of this article three theoretical approaches were addressed: attributions of death; lay representations of illness; and illness attributions.

The literature of attributions of death focused primarily on blame and on the role of attribution in adaptation. The blame literature focuses on guilt when discussing self-blame and anger when focusing on other-blame (Field & Bonanno, 2001). While the widows often did blame an event or a person for the death, on the whole they did not appear to be associated with a particular outcome (nor is outcome the focus of this article). The tone of the interviews suggested, in fact, that finding someone or something to blame was only one aspect of a bigger picture. Explanations of the death formed a part of the narrative of death, that is the personal story of the widows' loss (Bennett & Vidal-Hall, 2000). Bennett and Vidal-Hall, analysing the same interviews, suggested that one of the purposes of narrative was to make sense of the events, and the attributions discussed here form an important aspect of that search for meaning.

The bereavement literature does not focus on lay representations of health and yet this is a rich and relevant area of study with regard to attributions of death. The interviews show the widows do have lay representations of health and use them to make sense of the deaths. For example, one husband died of a broken heart, another man was advised to hit his ganglion with the family Bible, and yet another man's wife was convinced that the cause of her husband's death

was a hit and run accident which occurred two years previously.

Last, the attributions made by the widowed women can be understood in terms of Arefjord et al.'s classification of illness attributions (2002). In many cases, however, the explanations do not fit neatly into just one category, for example, there were both medical and stress attributions. Indeed the least satisfactory of these categories was the stress category. For convenience all the work-related attributions were placed in the stress category, but it would have been as useful to categorize them as 'work' attributions. Nevertheless the Arefjord et al.'s system provided the most useful of all systems in which to understand the attributions of cause of death.

Why do widows make attributions?

Why did the widows make attributions as to cause? Twenty-seven out of the 65 widows gave an explanation as to why their husbands died. Attribution theorists argue that people need to explain events around them. Since the loss of a partner is a significant and profound life-event, it is not surprising that widows try to understand why. There are several reasons why attributions may be made in these circumstances.

First, in some cases people are looking for someone to blame: themselves; doctors; car drivers; their husbands. Almost all of the widows elsewhere in the interview expressed the unfairness and injustice of their husband's death. The need to blame someone or something for unfairness is common and in these circumstances not unexpected. There were also some examples of self-blame, for example one woman 'half-believes' that she gave her husband cancer (see Field & Bonanno, 2001; Weinberg, 1995).

Second, in other cases the widows are trying to determine whether if they had done something differently their husbands might still be alive. So, for example, one widow believes that had she been more assertive with doctors her husband might have lived, and other women wish they had stopped their husbands from smoking.

The third reason that women make attributions is the need to find meaning for, or to make sense of, their husband's death. For example, the women are just trying to understand the

connections between events and their husband's death: for example, linking flu and cancer. While others go over past events searching for meaning, and if not meaning for some kind of understanding.

A review of the literature suggests that attribution, where the focus is on blame, is associated with poor outcome (Field & Bonanno, 2001; Weinberg, 1994). However, this study suggests otherwise. The results discussed here comprise two smaller studies using the same methodology. In the course of the second study, reported elsewhere, widows were classified as copers and non-copers. Using these data it is possible to assess whether attributions are made more often by one group or the other. The results of this brief analysis suggest no significant difference between the two groups with respect to the reporting of attributional statements ($\chi^2 = 0.15, p > 0.05, d.f. = 1$). In the case of the first study, a close reading of the interviews would support this position. As a consequence it is possible to argue that making attributions is a normal process associated with bereavement, and not necessarily the negative one suggested by much of the literature. The widows interviewed for this study were a normal, well-adjusted group of women, who miss their husbands greatly, but whose lives are full and relatively happy. In conclusion, it is suggested that making attributions is a normal aspect of bereavement and does not necessarily predict later misery.

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