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The Depression of Widowhood*

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Freud (1917) was one of the first to call attention to the similarities and differences in mourning and melancholia. He wrote that although mourning involved a grave departure from the normal attitude of life it was not regarded as a pathological condition nor was it referred for medical treatment. He felt time overcame it and interference with it was useless or even harmful. He defined melancholia as 'a profoundly painful dejection, cessation of loss of interest in the outside world, loss of capacity to love, inhibition of all activity, and a lowering of self-regard sometimes to an extreme delusional degree.' Mourning involved the same symptoms except that disturbance of self-regard was absent. It should be noted that Freud made no comment about mourning being a precipitant or cause of melancholia.

Following Freud, numerous authors, Lindemann (1944); Marris (1958); Clayton *et al.* (1968); Maddison *et al.* (1968); Yamamoto *et al.* (1969, 1970); Kennell *et al.* (1970) to name a few, studying the bereaved prospectively and retrospectively, discussed the symptomatology of bereavement without an attempt to relate these to the symptoms of a clinical depression. In a previous paper (Clayton, in press) we discussed symptoms of the first month of bereavement in the 109 randomly selected widows and widowers who are the subjects of this paper. The cardinal symptoms were crying, depressed mood, and sleep disturbance. Most symptoms Freud might include as 'disturbances of self-regard' were infrequent. Guilt, however, was present in 21 per cent of the subjects, but this mainly referred to feelings of neglect or minor omissions chiefly occurring during the terminal illness. Feeling hopeless occurred in 11 per cent, wishing to be dead in 8 per cent, feeling worthless in 5 per cent, feeling a burden in 5 per cent, and thoughts of suicide in less than 1 per cent. Some of these feelings were based on accurate perceptions of the environment. Another rare symptom was 'the fear of losing your mind', occurring in less than 1 per cent of the subjects. Considering symptoms only, it is as Freud said, 'In mourning it is the world which has become poor and empty; in melancholia it is the ego itself.'

This paper is the second in a series dealing with conjugal bereavement. It will define a group of bereaved with a constellation of depressive symptoms and compare them on a number of demographic, physical and social variables to bereaved people without these symptoms. The second purpose of the paper will be to compare subjects with this constellation of depressive symptoms to depressed patients in hospital in an effort to distinguish various populations with depression. This can be done by using diagnostic criteria for depression described elsewhere (Feighner *et al.*, in press; Woodruff, 1971).

Methods and Subjects

In 1968 and 1969, 109 white widows and widowers were interviewed, using a systematic interview with questions dealing with the physical and mental health of the survivor as well as questions attempting to assess the marriage and the social network of the survivor.

The first 36 interviews were chosen from the obituaries of the local evening newspaper, using a random numbers table to select those for interview. It was recognized that the obituaries are paid death announcements and thus represent a sample with an unknown bias. Using the obituaries, only 49 per cent of those contacted consented to the interview, 60 per cent of the men contacted accepting compared to 45 per cent of the women.

Seventy-three subjects were chosen from death certificate records, a sample with no bias, again using

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a random numbers table to select those for interview. When the death certificates became available, it was possible to get the name of the clergyman who might be close to the surviving relative. The clergyman was contacted and the study was explained to him, and he was asked if he would arrange an interview for us. If there was no clergyman available or he did not know the family well the randomly selected subject was seen for the first time at the door. Using this method, 64 per cent of the people contacted accepted the interviews. The overall acceptance rate then was 58 per cent. The difference between the acceptances and refusals by these two methods was not statistically significant.

Every effort was made to gather more information on those who refused. At three months we personally tried to interview the refusers. After five refusals out of five attempts this method was given up. At one year a letter and a simple one-page health questionnaire was sent to all refusers and again the response was poor. One measure of poor health frequently recorded in widows and widowers is death within the first year of widowhood. In an effort to see if the refusers were different from the subjects, death certificates were searched. Within a year after the deaths of their spouses no deaths were recorded in the refusers. This does not seem different from the 4 of 109 subjects who died in one year or less.

In comparing the 36 subjects chosen from the obituaries with the 73 chosen from the death certificates a number of variables were examined, including sex, age, socio-economic index of the man of the family, religion, residence in St. Louis city or county, length of illness of the deceased, time since the death of the first interview, and the number of subjects at the first interview with a depressive symptom complex. The only significant differences were that those from the obituaries were younger ($p = < \cdot 005$) and were seen sooner ($p = < \cdot 0005$). The first difference could be because there are more younger than older deaths advertised in the obituaries. The second difference is explained by the fact that there is a time lag in getting the death certificates from the funeral homes to the Bureau of Vital Statistics. Hereafter, the two groups will be combined.

Of the 109 subjects, 76 were female and 33 were male. The age range varied from 20 to 90 with a mean of 61·5. All but 6 were interviewed within 30 days of the death of the spouse. Other details of the group are described elsewhere by Clayton *et al.* (in press).

For a diagnosis of depression in this study, the subject had to admit to low mood characterized by feeling depressed, sad, despondent, discouraged, blue, low mood not further differentiated, or any other terms such as lost or numb, plus 5 of the following 8 symptoms for a definite depression and 4 of the 8 symptoms for probable depression: (1) loss of appetite or weight loss; (2) sleep difficulties including hypersomnia; (3) fatigue; (4) feeling restless; (5) loss of interest, (6) difficulty concentrating; (7) feelings of guilt; (8) wishing to be dead or thoughts of suicide. This cluster had to be present since the death of the spouse.

The statistical method used was the chi-square test, with the use of the Yates' correction. Differences were defined as significant when there was one chance in 20 or less that they occurred by chance ($p \leq 0 \cdot 05$).

Results

Using the criteria for depression described above, 22 subjects were diagnosed as definite depression and 16 as probable depression. Thus 38 of 109 subjects (35 per cent) received a diagnosis of depression. These two groups, definite and probable, were then combined and compared with the non-depressed group on a number of variables.

Table I shows the results of comparisons

Table I

Demographic data

	Depressed N = 38 %	Not depressed N = 71 %
Female[a]	71[b]	69
Age < 50	18	14
Otis Dudley Duncan socio-economic index < 40 ..	53	53[c]
Religion: Catholic ..	29	48
Protestant ..	61	47
Other	11	6
Religion: Very active ..	13	9

[a] There were 109 women considered in this study, 33 deceased and 76 surviving widows. Of these 109 women, 81 per cent of the deceased women were housewives and 47 per cent of the surviving women were housewives. This difference is highly significant ($p < \cdot 005$). The women who died were not significantly older than those who survived, nor were they unemployed because of illness, as they were coded as employed if they had worked within the last 5 years.

[b] Taking the total sample, 36 per cent of the women and 33 per cent of the men were depressed.

[c] Percentages figured on 'N' of 106, 107, or 108 as all subjects did not answer questions.

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of the two groups on demographic data. No significant differences were found. The finding, if replicated, that working women are less likely to die than housewives is noteworthy.

Findings which might be expected to show differences between the depressed and non-depressed groups but did not do so are: (1) The depressed group did not contain more women. Rather, equal percentages of men and women were depressed in the first month of bereavement. (2) Age did not differentiate one group from another. (3) Subjects were given tentative psychiatric diagnoses based on their lifelong psychiatric history. Examples of such diagnoses were anxiety neurosis, hysteria, alcoholism, previous depression, etc. Whether a subject received such a diagnosis or not did not differentiate the depressed from the non-depressed. Also treatment for a previous depression did not predict outcome. (4) Family history of psychiatric illness, primary affective disorder or alcoholism did not predict outcome. (5) A very brief (5 days or less) terminal illness compared to a longer terminal illness, or the place of death (home vs. hospital) did not differentiate the two groups. (6) Whether married for 10 years or less or for longer or whether or not there were problems in the marriage did not differentiate the depressed from the not depressed group. Data for these conclusions are based on a minimum of 106 patients, as not all subjects answered every question.

Table II shows the subjects' symptoms and medical actions after the deaths. Many subjects with depression reported a time of day when they felt worse, especially in the evening. Other symptoms not used in making the diagnosis of depression but associated with it were more common in the depressed group. These include feeling hopeless and feeling a burden. These findings lend direct credence to the diagnosis of depression in the group. Indirect evidence of depression was that the depressed group had a large number (45 per cent) of subjects who would have done things differently, chiefly surrounding the terminal illness or the death, and more who felt angry about the death. Although one group was depressed and the other not there were no differences in the number of somatic symptoms elicited nor in the number who took drugs or saw a physician in the first month of bereavement.

TABLE II

Subjects' symptoms and medical actions after death

	Depressed N = 38 %	Not depressed N = 71 %
Symptoms not used in diagnosis of depression		
> 3 somatic symptoms[a]	24	18
Diurnal variation ..	61	18[b]***
Worse in a.m. ..	24	13[b]
Worse in p.m. ..	37	6[b]***
Feels hopeless	24	4**
Feels worthless and no good	11	1
Feels a burden	13	0**
Would have done things differently[c]	45	17[b]**
Feel anyone to blame ..	14[b]	13
Feel angry about death[d]	14[b]	1*
Subject felt deceased had a full life	73[b]	77[b]
Subject felt deceased was better off dead	62[b]	65[b]
Subject took sleep medicines since death	29	27[b]
Subject took tranquillizer since death	42	36[b]
Subject saw or called M.D. since death	42	36
Subject saw or called physician for symptoms related to grieving ..	18	13

[a] Somatic symptoms: headaches, blurred vision, dyspnea, abdominal pain, constipation, urinary frequency, dysmenorrhea, other body pains.

[b] Percentages figured on 'N' of 106, 107, or 108 as all subjects did not answer questions.

[c] This is due to large number of subjects who would have done something different concerning the terminal illness or death of the spouse.

[d] Either bitter that the death occurred or angry at things surrounding the death.

* Significant < ·05.

** Significant < ·01.

*** Significant < ·001.

Table III reviews the problems these bereaved subjects experienced subsequent to the death. Not surprisingly, more of the non-depressed group than the depressed group felt they had had no or few problems after the death. Specific problems expressed more commonly by the

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TABLE III

Problems subsequent to death

	Depressed N = 38 %	Not depressed N = 71 %
No problems since the death (see problems below) ..	3	24*
Zero or one problem since the death	16	62**
Problems inquired about:		
Loneliness	87	49**
Care of children ..	11	4
Money worries	13	11
Concern with the suddenness of death	34	25
Concern with the suffering of the deceased ..	42	17*
Conduct of physician or hospital	27	17
Other problems not listed	37	20
No other deaths preceding 6 months	87	83[a]

[a] Percentages figured on 'N' of 106, 107, or 108 as all subjects did not answer questions.
* Significant < ·01.
** Significant < ·001.

TABLE IV

First degree relatives of survivor

	Depressed N = 38 %	Not depressed N = 71 %
No children by this marriage	37	39
No adult (> 18) children in area considered close ..	61	41*
No living sibs	21	16
No living sibs in area considered close	68	55
Parents deceased	65[a]	77[a]
No living parents in area considered close	8[a]	7[a]

[a] Percentages figured on 'N' of 106, 107 or 108 as all subjects did not answer questions.
* Significant < ·05.

depressed group were loneliness and concern with the suffering of the deceased (despite the fact that the length of illness was very similar in the two groups).

It can be said from the differences noted in Tables II and III that the mood of the depressed group was more often one of dissatisfaction and discontent.

Table IV shows the survivors' available support from first-degree relatives. The only significant difference was that more of the depressed had no children that they considered close in the St. Louis area. Because of the average age of 61·5 it would seem that children would be capable of providing the best support to these widows and widowers.

There are a few additional findings not included in the Tables. Subjects were asked to list the things which might be considered helpful during the bereavement period, such as family, friends, religion, financial security, things they had talked about with the deceased before his death, and anything else they considered important. There were no differences in the two groups in the number of helps they recorded nor in the specific types of helps listed. They were also asked to rate their children, parents, siblings, close friends, neighbours, the physician, minister, undertaker, lawyer, other in-laws, and others as helpful, not helpful, disappointing, or no contact (meaning either they could not get involved because of age, location, situation, etc., or help was offered but refused as not needed). There were no significant differences in the replies or the patterns of reply in these two groups although there was a trend toward the not depressed group reporting fewer not helpful or disappointing responses and the depressed group reporting more not helpful or disappointing responses.

DISCUSSION

Some comment should be made about the acceptance rate of 58 per cent. Yamamoto *et al.* (1969, 1970), in two prospective studies of widows got acceptance rates of those contacted of 44 per cent and 43 per cent. In our group, using death occurring in one year as a measure of poor health, there were no deaths in the refusers and four in our study group. It could be that those who refused were no more ill than those who accepted. Maddison *et al.* (1967) has some evidence concerning refusers. He gathered information on the survivors of all

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male deaths registered in the city of Boston over a 6 month period, when a male had died between the ages of 45 and 60 years of age. Thirteen months after their bereavement he sent questionnaires to all these women. He gathered adequate data, finally, on 132 women or 48 per cent of the total. The questionnaire, beside basic social and demographic information about each subject, centred on the widow's health during the year preceding and was so structured that only those items which were either new or substantially more troublesome during this period were scored as positive. On the basis of the questionnaire he divided widows into 'good outcome widows', those with low illness scores, and 'bad outcome widows', those with high illness scores. In attempting then to interview 20 'good outcome widows' and 20 'bad outcome widows' he had to approach 49 subjects to get 40 to consent. Of the 9 who refused, 3 were women whom he had labelled as 'bad outcome widows' and 6 were women he had labelled as 'good outcome widows'. Loewenstein *et al.* (1962) studied 'hardest to obtain interviews', and found interviews with families of only one or two persons were harder to obtain than interviews with larger families and interviews with people over 45 were harder to obtain than with younger people. Both are present in our subjects. She found that answers to questions on anger, guilt, and fear were not significantly different in easy or hard to obtain interviews, nor did being a psychiatric patient differentiate the subjects of easy and hard to obtain interviews.

Thirty-five per cent of widows and widowers have a number and pattern of symptoms in the first month of bereavement similar to those symptoms common to patients with primary affective disorder. The proportion of subjects with a collection of depressive symptoms is similar to the per cent of patients with a diagnosis of primary affective disorder found in studies of hospitalized psychiatric patients—40 per cent—(Winokur and Clayton, 1967), patients coming to a psychiatric emergency room—22 per cent—(Munoz *et al.*, in press), and a psychiatric clinic population—32 per cent—(Woodruff, in press). It is, indeed, high for a nonpsychiatric population, but may not be high considering the circumstances of bereavement.

When this group of depressed bereaved is compared to a non-depressed group of bereaved on 53 variables very few differences appear. Most of the differences seem to involve feelings directly associated with the diagnosis of depression or the more general mood of discontent. These include in the depressed group diurnal variation of mood, especially feeling worse in the evening, feeling a burden, feeling hopeless, feeling angry about the death and wishing to have done things surrounding the terminal illness or the death differently. The non-depressed group reported fewer problems after the death, and the depressed group reported that loneliness and the suffering of the deceased bothered them more than the non-depressed group. The only environmental difference found in the present study was that fewer of those with depression had children living in the St. Louis area whom they considered close. One means of support, emotional, physical or financial, was not available to them. Except for this last finding it would be difficult, even after reviewing the case records, to conclude that any of the differences noted were the cause, rather than the result, of the depressive symptom complex.

Kendell *et al.* (1970) recently published data showing that neurotic and psychotic depression are difficult to distinguish on clinical data alone and conclude that these should be thought of as occurring on a continuum. This work extends such conclusions. It appears that clinical symptoms alone cannot be used to make a diagnosis of depression. The circumstances need be considered. In this study the circumstance was widowhood. In the context of widowhood, 35 per cent of the bereaved victims must be considered depressed. This study does not give answers to the general descriptive differences involved in reactive versus endogenous depression, as both deal with psychiatric populations.

Important negatives in the 'normal depression of widowhood' as compared to that expected in primary affective disorder are: (1) it is not more common in women than men, (2) it is not more often associated with a positive family history of psychiatric illness or of affective

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disorder in first degree relatives, and (3) it is not more common in those previously treated for a depression. This last finding indicates that a serious precipitating event like the death of a spouse may or may not be associated with a depressive symptom complex in those already shown to have the depressive diathesis. The number of subjects (7 per cent) given a previous diagnosis of depression is similar to that (6·8 per cent) reported by Helgason (1961) in the Iceland study.

Additional factors about the depression are worth noting. Age does not predict outcome. It is not seen by the psychiatrist and does not lead to psychiatric hospitalization. In fact it is so accepted by the subjects as a natural response to stress that no more receive tranquillizers or sleeping medicines, or consult physicians about it than those with fewer and less severe symptoms.

In conclusion, it seems clear that people respond to bereavement with unhappiness and other depressive symptoms. This affective syndrome shares common symptoms with clinically observed depressions. There are some points of difference. The relationship between the two still remains questionable. Using depressed bereaved persons in comparison with non-depressed bereaved or depressed psychiatric patients in future pathophysiological studies might provide additional information about these relationships.

Finally, it must be emphasized that from the group of durable marriages 65 per cent of the conjugally bereaved emerged in the first month of bereavement with minimal depressive symptoms.

Summary

A group of 109 randomly selected widows and widowers, average age 61, were evaluated one month after the deaths of their spouses. Thirty-five per cent of them had a collection of depressive symptoms similar to those common in psychiatric depressed patients.

The group of bereaved with the reactive depression was compared to bereaved with fewer depressive symptoms on 53 demographic, social and physical variables. Few differences were found, and most were related to the diagnosis of depression in the one group and not in the other. One social variable that showed a significant difference was that fewer of those with reactive depression had children in the area they considered close. Thus one means of support, emotional, physical or financial, was not available to them. As opposed to other differences, this difference of support might be thought of as a causative factor in the development of the depression.

Age, sex, previous treatment for a depression, family history of depression or alcoholism were not different in the two groups and therefore could not predict outcome. One incidental finding is noteworthy. Of the 109 women in the study, 81 per cent of the deceased and 47 per cent of the surviving women were housewives ($p < \cdot 005$). The women who died were not significantly older or unemployed because of illness.

Finally, from a group of durable marriages, 65 per cent of the conjugally bereaved experienced minimal depressive symptoms.

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