ABSTRACT

REYNOLDS, CAITLIN MARIE. A Ripple in Time: The Effect of End of Life within a Spousal Relationship. (Under the direction of Dr. Daniel Grühn).

Introductions. The death of a loved one is an impactful moment that expands and weaves through people's lives. Using a lifespan developmental approach, I define end of life – being a part of the lifespan – as a process that involves normative, developmental transitions and changes (Arantzamendi et al., 2020; Reynolds & Grühn, 2024; Vargens & Berterö, 2012). To unpack the developmental and interpersonal nature of end of life, I investigated spousal loss. Specifically, I focused on the deceased partner's dying context (e.g., where they died) and surviving partner's well-being after the death event.

Methods. I utilized a large dataset – Survey of Health, Ageing, and Retirement in Europe (SHARE: Börsch-Supan et al., 2013) that investigates physical, cognitive, and socioemotional functioning in a European sample (N = 209,606). I reduced the sample to 9,434 participants to specifically focus on couples where at least one of the partners died. I had three main research questions: 1) What are the aspects of dying well? 2) How might the partner's well-being depend on time since the loss? And 3) Does dying well predict the surviving partner's well-being after the loss? I utilized factor analyses, group comparisons, and structural equation modeling to address the main research question.

Results. For the deceased partner, *dying well* meant dying in the home, having autonomy and control, not taking pain medicine, and not receiving palliative care. For the surviving partner, *living well* after the death meant high satisfaction with life, high quality of life, good physical health, and having low negative affect. Surviving partners, in particular, were likely to show high negative affect immediately after the spousal loss (i.e., 0-1 years). My third hypothesis was not supported, that is, there was no direct effect of *dying well* on *living well*. After follow-up

analyses, I found that the deceased partner’s *dying well* may indirectly shape the surviving partner’s *living well*, depending on time since the loss and the deceased’s emotional state in their last month of life.

Discussions. My findings highlight the dynamic, interpersonal, and expansive aspects that occur during the end of life. I hope this project will bridge research around supporting the dying person’s unique, individual needs (e.g., Carr & Luth, 2019; Willig, 2015) and supporting the surviving loved ones after the loss (e.g., Bonanno et al., 2002; Boyraz et al., 2015; Neimeyer, 2019). I have outlined policy implications and future directions for further investigation.

A Ripple in Time: The Effect of End of Life within a Spousal Relationship

by
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DEDICATION

This work is dedicated to family and friends who have died before seeing this accomplishment. I am forever grateful to sit beside you, hold your hand, and listen to your stories. I hope by sharing your experience, your legacy lives on. In special remembrance to my Papa: the master of skipping rocks.

BIOGRAPHY

Caitlin Reynolds was born and raised in Chehalis, Washington, where she graduated from W.F. West High School in 2015. She moved to Stockton, California, where she was a student-athlete at the University of the Pacific. There, she earned her B.S. in Psychology with Magna Cum Laude in 2019. She then travelled across the country to pursue her PhD in Lifespan Developmental Psychology at North Carolina State University. She worked with Dr. Daniel Grühn from 2019 to 2024 in the Adult Cognition and Emotions lab. Her program of research focuses on end of life.

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Introduction

The death of a loved one is an impactful moment in a person's life. Yet, the impact is more than that single time event: it ripples in time and weaves through people's lives. These ripples are fluid across time and expand into relationships, meaning that the impact is shaped by what occurs before and continues to shape people after the death.

Using a lifespan developmental approach, the end of life – being a part of the lifespan – is a process that involves normative, developmental transitions and changes (Arantzamendi et al., 2020; Reynolds & Grühn, 2024; Vargens & Berterö, 2012). End of life is not a stagnant event, rather it is a *process* that involves change and transitions. Before the death, the dying person is developing and changing as they are adapting to what it means to be "living while dying" (Willig, 2015). For example, the dying person may be aware and reminded of challenges that arise with dying (e.g., navigating changes in physical, cognitive, or socioemotional functioning), while simultaneously being in the "land of the living" (Willig & Wirth, 2018, p. 233). Therefore, the dying process involves developmental change as the person approaches the end of their life. After the death, the surviving loved ones mourn, process, and adapt to the loss, which shapes their daily lived experience (Early et al., 2024; Stroebe & Schut, 2016) and continues to change as the bereaved learns how to navigate daily life (Stroebe & Schut, 2016).

The ripples are also interwoven into the lives of close loved ones. Spouses depend on each other daily, such as financially supporting each other, emotionally taking on the other's burdens, socially extending each other's social network, or physically helping the other with domestic tasks. Moreover, these close relationships can also converge over time; for example, partners tend to have similar health-related experiences based on their shared environment (Kiecolt-Glaser & Wilson, 2017). After spousal loss, daily life is disrupted (Naef et al., 2013). In particular, the surviving spouse may experience psychological distress (e.g., depression, anxiety, or grief) and financial strain, as well as a reduction in social and emotional support (Bourassa et al., 2016; Carr & Mooney, 2021; Spahni et al., 2015). These close, entwined relationships may be why spousal loss is so distressing (Bonanno et al., 2002; Bourassa et al., 2016; Naef et al., 2013).

To untangle the dyadic nature of spousal loss, my goals for this study are twofold. First, I aim to assess the quality of the dying person's context (e.g., location and pain management). Second, I aim to investigate the surviving loved ones' well-being after the death. My hope is that this project will bridge research around supporting the dying person's unique, individual needs (e.g., Carr & Luth, 2019; Willig, 2015) and supporting the surviving loved ones after the loss (e.g., Bonanno et al., 2002; Boyraz et al., 2015; Neimeyer, 2019). Throughout the manuscript, I will use the analogy of tossing rocks in a creek. Like the developmental lifespan, the creek is embedded in an ever-changing ecosystem. Like the death of a loved one, the impact of the rock changes the body of water. And like grieving, the ripples from the impact are expansive and dynamic on the environment over time.

The Creek

Throughout the lifespan, people develop and change as they adapt to new people, places, and things (Baltes et al., 2006). These developmental processes are embedded in socio-historical contexts, which act as boundaries that constrain or stretch the "fabric" of development (Nesselroade, 1991). End of life, being a part the lifespan (Reynolds & Grühn, 2024), also presents developmental transitions as people adapt to a new normal (Arantzamendi et al., 2020; Vargens & Berterö, 2012). For example, a dying person may be transported to live in a health care facility away from their family and friends, leading them to interact daily with their health care providers. In this situation, the dying person is adapting socially and learning how to navigate their physical needs in a new location. As they are navigating what their new normal is, they may experience “double awareness” (Colosimo et al., 2018, p. 1; Rodin & Zimmermann, 2008, p. 186), which refers to dying people engaging with the world while also being aware of their impeding death. Colosimo and colleagues (2018) described double awareness as the process of dying people shifting between their life narrative and their death narrative. Even more, double awareness may change over time as people are revisiting and adjusting to their new normal (Arantzamendi et al., 2020). The instability of living while dying may prompt social support (e.g., their spouse, family members, or healthcare providers) to ensure the dying person is adjusting or dying well.

Dying well, also known as a good or dignified death, refers to the preservation of one’s dignity, conscience, freedom, and responsibility during end of life (Järviö et al., 2023). A good death is specific and unique to each individual (Krikorian et al., 2020) and shifts based on historical (e.g., Cottrell & Dugglegy, 2016), cultural (e.g., Tong et al., 2003), and political contexts (e.g., Coombs & Long, 2008). Despite the variations in definitions, there appears to be a general consistency, across cultures and countries, that dying well means the person has reduced pain, has autonomy or a sense of control, is treated respectfully by healthcare staff, and is surrounded by loved ones (e.g., Bovero et al., 2020; Carr & Luth, 2019; Gold, 2011; Gonzalez Sepulveda et al., 2022; Järviö et al., 2023; van Wijngaarden & Sanders, 2022). As the dying process is often a shared, interpersonal experience, these preferences are not only common among the dying person, but also their family members and healthcare workers (Bovero et al., 2020; Gonzalez Sepulveda et al., 2022; Özyalçın Özcan & Çevik, 2023).

Unfortunately, some of these preferences, like being "pain-free" or having autonomy, may be unrealistic (Breitsameter, 2024; Carr, 2003). For example, people who die suddenly may not have the time to discuss their wishes or needs for end-of-life care; thus, their preferences are unlikely to be met. On the other hand, a person dying from terminal cancer may have the time to speak with their loved ones about their needs; thus, their preferences are likely to be met. However, having more time is not necessarily directly associated with dying well either (Cagle et al., 2015). That is, if the dying person is in prolonged pain, then more time would be unsatisfactory. Therefore, dying well should be captured through multiple aspects of a person's dying experience, such as managing pain (Bovero et al., 2020; Cagle et al., 2015; Gonzalez Sepulveda et al., 2022; Özyalçın Özcan & Çevik, 2023), maintaining autonomy (van Wijngaarden & Sanders, 2022), being respected (Bovero et al., 2020; Gonzalez Sepulveda et al., 2022; van Wijngaarden & Sanders, 2022), and dying at home (Carr & Luth, 2019; Gold, 2011; Higginson & Sen-Gupta, 2000). In doing so, I will be able to quantitatively understand the multidimensional construct of dying well. These aspects are not just unique to the individual person dying, but their loved ones. Overall, dying is a developmental process that is embedded in dynamic, layered cultural systems (Reynolds & Grühn, 2024), so when the person dies, others' lives are impacted.

The Impact of the Rock

The death of loved one is a distressing event. Similarly, the impact of tossing a rock in a creek changes the body of water. After the loss, a person needs to process and respond to the event, often by grieving. Grief is often viewed as a process of coping – strategies an individual uses after a stressful event (Stroebe & Schut, 2010). People who are grieving often show psychological distress, such as depression, loneliness, and anxiety (Bonanno et al., 2002; Fried et al., 2015; Gumá & Fernandez-Carro, 2021; Schwartz et al., 2018; Stroebe & Schut, 2016). Despite these potentially negative outcomes, Stroebe and Schut (2010, 2016) assumed that grieving is inherently a desirable or positive response after a loss; that is, the person is actively working through and processing the stressful event, which may eventually lead to relief or lower levels of distress (Lazarus & Folkman, 1987). As people grieve, they are oscillating between two aspects of coping (i.e., loss and restoration: Dual Processing Model: Stroebe & Schut, 2010, 2016). Moreover, as people are processing the loss, they are accumulating everyday stressors, which create this feeling of *overload* that makes grieving difficult to manage or cope with (Stroebe & Schut, 2016). Thus, although bereavement can be common experience, it is can also be severe or intense, leading to various responses and interindividual differences in how people respond to the death of a loved one.

Grieving can be different between people. Bonanno and colleagues (2002) suggested people may have different time-based patterns of bereavement before and after a loss: common grief, chronic grief, delayed grief, and resiliency. People who showed common grief patterns tended to have low depression before the loss, then had a grief reaction shortly after the loss, but then returned back to the same levels of depression as before. People who showed chronic grief patterns had low depression before the loss, then had a grief reaction shortly after the loss, which continued even after 18 months after the loss. People who showed delayed grief pattern tended to have low depression before the loss and only showed a grief reaction 18 months after the loss. And people who showed a resilient pattern had low depression before the loss, with no change after the loss. Overall, these different grief patterns proposed by Bonanno and colleagues (2002) suggest that grief can vary depending on time (i.e., when or if grief response occurs, as well as for how long the symptoms continue). These differences could be due to individual characteristics (e.g., personality, identity, and emotional capacity; Mancini & Bonanno, 2009), contextual factors (i.e., whether the deceased *died well*), or relational context (i.e., if the person was emotionally close to the deceased). After the death of a loved one, people may feel as if their identity is missing or they have lost a part of themselves (i.e., identity discontinuity), especially for those with strong relationships (Papa & Lancaster, 2016). Thus, it is important to consider the context of these close bonds, like spousal relationships.

The impact of spousal loss is particularly pronounced and momentous. Carstensen and colleagues (1999) proposed that people shift in their relational goals depending on how much time they perceive to have in the future (i.e., limited or unlimited time). Specifically, if they perceive their time as unlimited, their goal for relationships may be more knowledge-based; on the other hand, if they perceive time as limited, their goal for relationships may be relatively more emotion-based. Although the association between age and time perception is nuanced (Carstensen & Fredrickson, 1998; Chu et al., 2018; Giasson et al., 2019), older adults do consistently seek out emotionally meaningful relationships (Barrett & Montepare, 2015; Carr & Mooney, 2021; Strough et al., 2016). These close, quality relationships are associated with positive outcomes, such as a sense of belonging (Baumeister & Leary, 1995), better subjective and objective health (Kiecolt-Glaser & Wilson, 2017; Roberts et al., 2014), as well as improved well-being potentially buffering acute, daily stress (Carr & Utz, 2020). Unfortunately, when a spouse has died, the loss could lead to severe psychological distress and even “shatter” a person’s understanding of the world (Bonanno et al., 2002; Carr & Mooney, 2021; Carr & Utz, 2020; Coleman & Neimeyer, 2010). The severity of spousal grief may be from the interpersonal dependency between spouses (Bonanno et al., 2002). Spouses provide emotional, social, physical, and financial support on a daily level; all of which is disrupted after the spouse dies

(Naef et al., 2013). And the value of these close relationships persists even after the death event, that is, the ripples continue to change and move over time.

The Ripples Over Time

The impact of the death is not a stagnant event, people continue to grieve and integrate their loss in their everyday lives (Stroebe & Schut, 2016). Even after the death of a loved one, the relational and emotional connection is ongoing (Klass, 2006). Similarly, after a rock makes an impact on the water, the ripples continue to spread, disperse, and change its environment. Depending on the time since the loss, people process and interpret the loss differently (Boyraz et al., 2015; Feigelman et al., 2009; Reynolds & Grühn, 2023; Schwartz et al., 2018). Specifically, people who experienced a recent loss tend to show more grief symptoms compared to people who experienced a distant loss (Boyraz et al., 2015; Feigelman et al., 2009; Reynolds & Grühn, 2023; Schwartz et al., 2018). Furthermore, people who experience a recent loss understand death in general differently than people who experience a distant loss (Reynolds & Grühn, 2023), which suggests that over time how people perceive death changes. Although Bonanno and colleagues (2002) suggested recovery as early as 18 months after a loss, the average person may need longer time to recover. Particularly, there has been consistent evidence that people tend to experience intense grieving symptoms 1-2 years after the loss, then they plateau in symptoms after 5 years (Boyraz et al., 2015; Feigelman et al., 2009; Reynolds & Grühn, 2023). Therefore, as people are taking time to grieve their spouse, they are understanding the meaning of death (Neimeyer, 2019; Reynolds & Grühn, 2023) and integrating it in their daily life (Stroebe & Schut, 2016).

As spousal lives were once intertwined and converged (Kiecolt-Glaser & Wilson, 2017), the impact disperses into the *lived* experience of the surviving spouse. Meta-analyses (Moon et al., 2011; Singham et al., 2021; Wu-Chung et al., 2022) found that interpersonal loss shaped the surviving spouse's cognitive and health-related outcomes, specifically, a decline in cognitive functioning (Singham et al., 2021), increased risk of dementia (Wu-Chung et al., 2022), and increased mortality rate (Moon et al., 2011). Additionally, Adena and colleagues (2023) found the surviving partner's well-being continued to decline and slowly recover 5 years after the loss. Similarly, Bourassa and colleagues (2016) found the surviving spouses' quality of life was predicted by their deceased partner's quality of life, 4 years after the death. All of which suggests the death of a spouse persists and continues to expand into other aspects of living. And furthermore, these changes may be related to the deceased's previous experiences, that is, if they *died well*.

The Current Study

As a developmental period, end of life shapes the dying person's context which then ripples into the lives around them. The dying process has been widely explored, such as the individual's developmental trajectories (e.g., Cohen-Mansfield et al., 2018; Lunney et al., 2018) and the quality of end-of-life care (e.g., Quigley & McCleskey, 2021). Additionally, the grieving process has also been heavily studied regarding time-dependent grief (e.g., Bonanno et al., 2002; Feigelman et al., 2009; Reynolds & Grühn, 2023; Schwartz et al., 2018) and how to support grievers and educate their peers on ways to support them (e.g., Beaunoyer et al., 2020; Cacciatore et al., 2021). The purpose of the current study is to bridge these areas of research to investigate how the quality of the dying process may ripple into the well-being of the surviving spouse.

I had two main aims for the current study. My first goal was to understand the dying process and the dying person's lived experience. My second goal was to investigate the surviving loved ones' change in well-being after the death. I utilized a large secondary dataset that has paired couples, so that I can examine the individual and interpersonal components of end of life. The dataset – Survey of Health, Ageing, and Retirement in Europe (SHARE: Börsch-Supan et al., 2013) – is open accessed. Information on how to access the data can be found in the SHARE data documentation (https://www.share-datadocutool.org/study-units/view/1). SHARE is also a cross-national, longitudinal survey across European countries over the span of wave 8; therefore, I can measure both micro and macro level structures in which individuals are embedded in (Baltes et al., 2006; Bronfenbrenner, 1977), as well as examine developmental trajectories.

I had three main research questions: 1) What are the aspects of dying well? 2) How might the partner's well-being depend on time since the loss? And 3) Does dying well predict the surviving partner's well-being after the loss? To address these questions, I had three main hypotheses. First, I hypothesized dying well to be composed of high sense of autonomy, minimal pain, high sense of respect and care from others, and dies in a familiar place (i.e., home). These hypothesized domains are based on the cross-cultural evidence that they are unique and separate dimensions (e.g., Bovero et al., 2020; Carr & Luth, 2019; Gold, 2011; Gonzalez Sepulveda et al., 2022; Järviö et al., 2023; van Wijngaarden & Sanders, 2022); therefore, I have a theoretical basis for my model's assumptions. Second, I hypothesized well-being to decline immediately after the partner's loss, and then improve 4 years after the loss. I expect to replicate previous findings (Boyraz et al., 2015; Feigelman et al., 2009; Reynolds & Grühn, 2023) that immediately after a death of a loved one (1-2 years), individuals experience heightened grief symptoms, then plateaus after 4-5 years. The hypothesized timeframes are based on previous findings, the time in between each wave, and the number of participants who continued to participate in the study. Thirdly, I expected the surviving partners to recover sooner depending on if their deceased partner died well. Previous evidence has shown spousal loss impacting the surviving partner's well-being and quality of life years after the loss (Adena et al., 2023; Bourassa et al., 2016), which I expect to be dependent on how well the deceased died.

Methods

Participants

I utilized the large, open access dataset – Survey of Health, Ageing, and Retirement in Europe (SHARE: Börsch-Supan et al., 2013). Participants were initially recruited from 20 different European countries (including, but not limited to, Austria, Czech Repulic, France, Germany, Portugal, and Switzerland), which was expanded in later waves to 26 countries. Recruitment was conducted through telephone directory, civil register, and geographical databases. There are 8 waves total (2004 to 2020), and the time in-between each wave was 2-3 years. I will focus on waves 1, 2, 4, 5, 6, 7, and 8, excluding wave 3. Wave 3 did not include the measures of interest.

In the dataset, participants who died at some point after wave 1 (between 2004 and 2020), Börsch-Supan and colleagues (2013) reached out to their proxy to provide an end-of-life survey (i.e., information about the deceased and their dying context). Proxies were primarily the spouse/partner (63.0%) or another family member (28.3%). The dying process is often a shared experience (Bovero et al., 2020; Özyalçın Özcan & Çevik, 2023), meaning other people (e.g., the spouse or family members) are involved in the dying process, such as witnessing or potentially advocating for the deceased needs. Additionally, proxy data is typically a reliable source when the primary source is unavailable, such as deceased (Gerlach et al., 2017; Infurna et al., 2014). Specifically, retrospective proxy-reported data has shown to be largely congruent with self-reported satisfaction with life 1-2 years prior to death when the proxy was a spouse (Infurna et al., 2014) and retrospective proxy-reported data tends to show similar patterns of change to self-reported data (Gerlach et al., 2017; Gerstorf & Ram, 2013).

The sample pool consisted of 209,606 total participants who were primarily older adults (i.e., the eligibility requirement to participate was for people 50 years and older). I reduced the sample size, because I aimed to investigate spouses by selecting all participants who identified as coupled with another participant (N = 125,392). Of those 62,696 couples, there were 9,434 participants who they and/or their partner were reported to have died between wave 7 and 8. I specifically examined proxy-reports from waves 7 and 8 because those waves contained the measures that addressed my research questions. Of those participants, 5,107 participants were deceased and 4,327 surviving; for 780 participants, both partners died; even more, 200 participants died within the same year of their partner.

I then divided the sample size into two files: surviving (N= 4,327) and deceased (N= 5,107) partners. The surviving partners file included partners of the deceased who completed the main survey (n = 4,327). The deceased partners file included only participants who were reported to be deceased between waves 7 (n = 2,276) and 8 (n = 2,847) because the end-of-life survey questions of interest were included in waves 7 and 8. The deceased's data had the possibility of being reported at any consecutive wave, for example, participants who died in 2006, may not have been reported by their proxy until 2019. Thus, the final sample included participants who were reported to have died between 2006 and 2020, with the majority having died during 2016 (n = 1,105). Demographic information on the participants can be found in Table 1 (main survey) and Table 9 (end-of-life survey).

The final sample included participants from 26 countries, including but not limited to Estonia (10.2%), Spain (8.9%), Italy (6.4%), Czech Republic (6.3%), and Greece (6.1%). The surviving partners were primarily older adults (M_{wave1} = 66.7, SD_{wave1} = 9.7 to M_{wave8} = 76.7, SD_{wave8} = 8.6) and women (across all waves: 69.4%). The deceased partners were older adults (M_{wave1} = 69.5, SD_{wave1} = 8.3 to M_{wave7} = 78.4, SD_{wave7} = 9.6) and primarily men (across all waves: 66.4%). For specific information from each wave, see Tables 1. The final deceased sample was representative of global life expectancy and cause of death. Specifically, the age at moment of death (M_{wave7} = 78.0, SD_{wave7} = 9.6; M_{wave8} = 78.2, SD_{wave8} = 9.8) was similar to the European life expectancy (i.e., 78 years: World Health Organization, 2024). Also, participants who died between waves 7 and 8 primarily died from cancer (29.0%), cardiovascular-related illness (27.6%), or stroke (10.4%). And according to the World Health Organization (2020), the leading causes of death globally are heart disease, stroke, chronic obstructive pulmonary disease (COPD), respiratory infections, neonatal conditions, respiratory cancers, and dementia. Additionally, less than 3% of participants died from an accident, suggesting the majority of participants died from normative terminal illnesses.

In general, Börsch-Supan and colleagues (2013) collected a variety of health, economic, and social measurements to understand the aging process within Europeans. For more details on the measures, see the SHARE data documentation (https://share-eric.eu/data/data-documentation/release-guides). I focused specifically on the physical, cognitive, and socioemotional components from the main and end-of-life surveys.

Main Survey Measures

The main survey was provided to participants across all waves. Both surviving spouses and deceased spouses completed the main survey when they were living. I utilized the following measures from the main survey: physical functioning, cognition functioning, and socioemotional functioning.

Physical Functioning. Physical functioning was assessed using the self-reported general health: “Would you say your health is…” Participants rated their health on a 1 (*excellent*) to 5 (*poor*) scale. The surviving partners generally reported good health (i.e., M_{wave1}= 3.1, SD_{wave1}= 1.1 to M_{wave8}= 3.5, SD_{wave8}= 1.0). On the other hand, the deceased partners increasingly showed poorer health (i.e., M_{wave1}= 3.3, SD_{wave1}= 1.1 to M_{wave7}= 4.1, SD_{wave7}= 0.9). To assess this single item’s construct validity, I compared it to the participants’ difficulties in physical activities and daily tasks. The participants were given a list of 10 physical activities, such as getting up from a chair, pulling or pushing large objects, or stooping, kneeling, or crouching. These scores were summed to create a continuous variable, range 0-10. The surviving partners showed low difficulties in physical activity (i.e., M_{wave1}= 1.7, SD_{wave1}= 2.2 to M_{wave8}= 2.6, SD_{wave8}= 2.8), whereas the deceased partners showed increasingly more difficulties with physical activities (i.e., M_{wave1}= 1.8, SD_{wave1}= 2.2 to M_{wave7}= 4.0, SD_{wave7}= 3.3). The participants also selected up to 10 everyday tasks, such as dressing, eating, bathing, and walking, that were difficult to do. These scores were summed to create a continuous variable, range 0-10. The surviving partners showed low difficulties with everyday activities (i.e., M_{wave1}= 0.4, SD_{wave1}= 1.3 to M_{wave8}= 0.9, SD_{wave8}= 2.0). On the other hand, deceased partners show increasingly more difficulties in everyday activities (i.e., M_{wave1}= 0.5, SD_{wave1}= 1.4 to M_{wave7}= 2.2, SD_{wave7}= 3.2). See Table 2 for specific information from each wave on all these physical assessments. In general, the single-item health score showed good construct validity with both difficulties in physical activities and difficulties in activities in daily life. See Table 3 and 4 for the correlational matrices across waves and between health measures.

Cognitive Functioning. Cognitive functioning was assessed using the self-reported memory item: “How would you rate your memory at the present time?” on a scale from 1 (*excellent*) to 5 (*poor*). This measure was only reported in waves 4-8. In general, surviving partners reported good memory scores (i.e., M_{wave4}= 3.2, SD_{wave4}= 0.9 to M_{wave8}= 3.2, SD_{wave8}= 0.9), whereas the deceased partners reported some variation in memory (i.e., M_{wave4}= 3.3, SD_{wave4}= 1.0 to M_{wave7}= 3.7, SD_{wave7}= 0.9). To assess the memory item's construct validity, I compared it to two self-reported cognitive assessments: reading competency and writing skills. Reading competency was captured using the item "How would you rate your reading skills needed in your daily life?" on a scale from 1 (*excellent*) to 5 (*poor*). The surviving partners generally reported good reading competency (i.e., M_{wave1}= 2.5, SD_{wave1}= 1.2 to M_{wave8}= 2.7, SD_{wave8}= 1.1). Deceased partners also generally reported good reading competency (i.e., M_{wave1}= 2.6, SD_{wave1}= 1.2 to M_{wave7}= 3.0, SD_{wave7}= 1.3). Writing skills was captured using the item "How would you rate your writing skills needed in your daily life?" on a scale from 1 (*excellent*) to 5 (*poor*). The surviving partners reported good writing skills (i.e., M_{wave1}= 2.7, SD_{wave1}= 1.2 to M_{wave8}= 2.8, SD_{wave8}= 1.1). The deceased partners also reported good writing skills (i.e., M_{wave1}= 2.8, SD_{wave1}= 1.3 to M_{wave7}= 3.2, SD_{wave7}= 1.3). See Table 2 has specific information from each wave on all these cognitive assessments. Overall, self-reported memory showed good construct validity with reading and writing skills. See Table 5 and 6 for correlational matrix across waves and between cognitive measures.

Socioemotional Functioning. I utilized three measures to examine the participants' socioemotional functioning: satisfaction with life, negative affect, and quality of life. I have further evaluated each measure below.

Satisfaction with Life. Satisfaction of life was measured by using the single item: "How satisfied are you with your life?" Participants rated their life satisfaction on a scale from 0 (*dissatisfied*) to 10 (*satisfied*). This item was reported in waves 2-8. The surviving partners reported being satisfied with their life (i.e., M_{wave2}= 7.4, SD_{wave2}= 1.9 to M_{wave8}= 7.2, SD_{wave8}= 1.9). The deceased partners also reported a general satisfaction with life (i.e., M_{wave2}= 7.4, SD_{wave2}= 1.9 to M_{wave7}= 7.0, SD_{wave7}= 2.2). Table 1 has details on this measure for each wave.

Negative Affect. Negative affect was measured across waves by using 13 items from the EURO-D Scale (Prince et al., 1999), which assesses depressive symptoms (i.e., affective suffering and lack of motivation). There were 12 negative leaning items like "In the last month, have you been sad or depressed?"; "Have you had trouble sleeping recently?", or "In the last month, have you had too little energy to do the things you wanted to do?", and one positive leaning item: "What are your hopes for the future?" The positive leaning item was reverse coded. Participants selected yes (1) or no (0), so I summed all the items to create a continuous score (i.e., potential range: 0 to 13), where the higher the value, the more negative affect the participant is reporting. Surviving partners showed fairly low and increasing negative affect scores (i.e., M_{wave1}= 2.6, SD_{wave1}= 2.4 to M_{wave8}= 3.7, SD_{wave8}= 2.8). The deceased partners showed low then increasingly higher negative affect (i.e., M_{wave1}= 2.4, SD_{wave1}= 2.4 to M_{wave7}= 3.7, SD_{wave7}= 2.8). For each wave, this measure has shown adequate internal consistency; for surviving partners αs = .71-.76 and deceased partners αs = .73-.75. See Table 1 for details from each wave.

Quality of Life. I used 12 items from the Control, Autonomy, Self-realization, and Pleasure (CASP-19: Hyde et al., 2003) because these were the ones presented in the main survey. The CASP is a quality-of-life scale, which includes items like "I look forward to each day" or "How often do you feel that what happens to you is out of your control?" Participants rated each item on a 1 (*often*) to 4 (*never*) scale. With both positive and negative scores, I reverse coded the negative scores, then I averaged the sum of the 12 items. Thus, low scores represent good quality of life. The CASP scale was reported for waves 2-8. Surviving partners reported normal distribution in quality of life scores (i.e., M_{wave2}= 2.0, SD_{wave2}= 0.6 to M_{wave8}= 2.0, SD_{wave8}= 0.6). Deceased partners reported similar quality of life scores (i.e., M_{wave2}= 2.1, SD_{wave2}= 0.6 to M_{wave7}= 2.3, SD_{wave7}= 0.6). For each wave, this measure has shown good internal consistency; for surviving partners αs = .81-.83 and deceased partners αs = .80-.82. See Table 1 for details from each wave. To assess construct validity, I compared satisfaction with life with negative affect and quality of life. See Table 7 and 8 for correlational matrix across waves and between socioemotional measures.

End-of-Life Survey Measures. The quality of the dying person's context was assessed by using items from the end-of-life survey, which was completed by the deceased's proxy. Previous literature has supported the use of proxy data when the primary source is unavailable (Gerlach et al., 2017; Infurna et al., 2014); and because of the interpersonal nature of the dying process, other people, such as the spouse or family members, are involved and may provide insights that would otherwise be unavailable for researchers to explore. The majority of proxies were the deceased's partner (63.0%) or another family member (28.3%). From the end-of-life survey, I specifically used the items that focused on pain management, autonomy and control, place of death, and respect and care received. Additionally, these measures from the end-of-life survey are from waves 7 and 8 because previous waves did not collect the measures of interest. See Table 9 for demographic information of the deceased partners' dying context.

Demographic. The ages of participants who died were consistent with European life expectancies (WHO, 2024); that is, age at moment of death, M_{wave7}= 77.8, SD_{wave7}= 9.6; M_{wave8}= 78.2, SD_{wave8}= 9.7. Additionally, these participants died from potentially chronic diseases, such as cancer (29.3%), cardiovascular-related illness (27.3%), and stroke (10.4%). Specifically, 43.4% of participants were ill for one year or more before death and 25.0% of participants were in the hospital for one week to one month of time. Additionally, roughly half of the proxies (47.2%) reported the deceased feeling anxious or sad in the last month of their life.

Pain Management. Pain management was assessed using two items. First, proxies selected yes or no if the deceased received pain medicine; a follow-up question revealed that the participants who took pain medicine viewed the dosage as the right amount (47.9%). Second, the proxy selected yes or no if the deceased received palliative care in the last four weeks of life. Palliative care is a pain reduction treatment. Overall, more than half of the participants were taking medicine for their pain (59.3%) and 23.1% of participants received palliative care in the last four weeks of life.

Autonomy and Control. Autonomy and control was assessed using a difficulty completing daily tasks assessment. Proxies selected daily activities, from a 16-item list, that were difficult for the deceased to do in the last 12 months of life. Additionally, the difficulty was required to last for at least 3 months. These activities included everyday physical tasks, such as dressing, bathing, or walking, as well as independent-related tasks, such as making phone calls, managing money, doing personal laundry. I summed all difficulties into a continuous score, range 0-16, $M_{wave7} = 7.1$, $SD_{wave7} = 6.3$; $M_{wave8} = 7.3$, $SD_{wave8} = 6.4$. Additionally, 32.6% needed help for a full year before death and 17.7% needed around the clock support (i.e., 24 hours/day).

Place of Death. The place of death was assessed using a single item. The proxies reported the location of where the deceased died. Options included in their home (34.2%), at another person's home (0.6%), in a hospital (48.7%), in a nursing home (7.0%), in a residential home or sheltered housing (2.0%), in a hospice (2.9%), in transit to a medical facility (0.6%), or at some other place (1.4%). In the last year of life, participants were in the hospital, nursing home, or hospice for less than a week (11.6%), one week to one month of time (25.0%), one to three months (17.3%), three to six months (5.7%), six months to one year (2.4%), and a full year (3.3%). I created a binary variable to focus on people who died in their home (34.3%) and those who did not (65.7%) because the home is a familiar place, which aligns with the general publics' preferences for dying well (Carr & Luth, 2019; Gold, 2011; Higginson & Sen-Gupta, 2000).

Respect and Care Received. Respect and care received was assessed using two items. The proxies reported the deceased's quality of care and how the staff members treated the deceased. Specifically, they were asked "Overall, how would you rate the care the deceased received in [deceased] last month of life?" and "How often overall was the staff who took care of [decease] kind, caring, and respectful?". The respective anchors were 1 (*excellent*) to 5 (*poor*) and 1 (*always*) to 4 (*never*), meaning low scores represented quality care and respectful staff. In general, the deceased were reported to have very good care (M_{wave7} = 2.0, SD_{wave7} = 1.0, M_{wave8} = 2.1, SD_{wave8} = 1.0) and always or usually respectful staff (M_{wave7} = 1.4, SD_{wave7} = 0.8; M_{wave8} = 1.4, SD_{wave8} = 0.7).

Procedure

The open access, cross-national dataset – Survey of Health, Ageing, and Retirement in Europe (SHARE: Börsch-Supan et al., 2013) – is a longitudinal design that spans across 2004 and 2020 and includes 8 total waves. All participants completed the main survey, which included health, economic, and social measurements. Participants could have started at any wave to be a part of the study. For example, some participants completed the first wave and continued to complete all consecutive waves; whereas other participants started in wave 4 and then completed wave 7; or other participants completed only the final eighth wave. For participants who died after wave 1, Börsch-Supan and colleagues (2013) reached out to their proxy (e.g., spouse or family member) to provide an end-of-life survey (i.e., information about the deceased and their dying context).

Analytic Plan

All waves (i.e., 1-8 excluding waves 3) were included in the analyses. I utilized IBM SPSS and IBM SPSS Amos (Version 28.0.0) to organize the datasets and assess demographic information. I also used Amos and Mplus (Version 8.6) to address my main research questions. I conducted descriptive analyses, factor analyses, group comparisons, and structural equation models. To address my first research question – What are the aspects of dying well? – I conducted a confirmatory factor analysis on the components of a dying well. Factor analyses are appropriate when non-observable constructs are captured through observable measures (Thompson, 2000). This strategy also allowed me to assess the error variance in my model, determine model fit, and examine relational direction among constructs (Weston & Gore, 2006). To address my second research question – How might the partner's well-being depend on time since the loss – I conducted multiple separate general linear models. And to assess my third question – Does dying well predict the surviving partner's well-being after the loss – I conducted a factor analysis and structural equation model (SEM), as well as ran post-hoc multigroup SEM analyses.

Results

My main research questions were threefold: 1) What are the aspects of dying well? 2) How might the partner's well-being depend on time since the loss? And 3) Does dying well predict the surviving partner's well-being after the loss? To address these questions, I conducted descriptive analyses, factor analyses, group comparisons, structural equation models, and multi-group structural equation modeling.

Descriptive Analyses

I assessed change within individuals in their physical, cognitive, and socioemotional functioning, based on the main survey data. I conducted separated repeated-measures ANOVAs to examine physical, cognitive, and socioemotional change in surviving spouses across waves 6-8 and deceased spouses across waves 5-7.

Surviving Partner. Results showed linear change in surviving partners over three consecutive waves. That is, surviving partners showed poorer health, F (1, 1322) = 19.12, p < .001, significantly more negative affect, F (1, 352) = 28.43, p < .001, and increasingly dissatisfied with life F (1, 1235) = 21.16, p < .001. There was no within-subject change for quality of life, F (1, 1251) = 2.48, p = .116.

Deceased Partner. I then conducted separate repeated measures ANOVAs to examine physical, cognitive, and socioemotional functioning in deceased spouses across waves 5-7. The proxies reported linear change in the deceased partners over the consecutive waves. That is, the deceased partner showed poorer health, F (1, 1079) = 142.29, p < .001, significantly poorer quality of life, F (1, 887) = 84.64, p < .001, significantly more negative affect, F (1, 288) = 13.28, p < .001, and increasingly dissatisfied with life F (1, 867) = 4.28, p = .039.

Factor Analyses

What are the indicators of the deceased partner's dying well? To address my first research question, I conducted a confirmatory factor analysis on the components of a dying well. I specifically used six variables: maintaining autonomy, receiving respect from staff, receiving quality care, receiving pain medicine, receiving palliative care, and dying at home. I first reverse scored the variables because I wanted high scores to represent good outcomes. That is, high scores represented less difficulties in daily activities (M = 8.8, SD = 6.3), being respected by staff

(*M* = 3.6, *SD* = 0.7), receiving excellent care (*M* = 3.9, *SD* = 1.0), not taking pain medicine (62.4%), and not receiving palliative care (72.8%). Additionally, dying at home (34.3%) equated to 1 and all other locations of death were 0. I then parceled the respect from staff and quality care items because these items were similar ($r = .48$, $p < .001$); that is, I added these two items (range: 1-9, *M*= 7.5, *SD*= 1.6). After parceling the respect and care variables, I now had five indicators for *dying well*. Lastly, I transformed the range of the variables – maintaining autonomy and receiving respect and care – because I wanted the variable to remain continuous and I wanted the scale to be consistent across all used variables (i.e., 0-1). To do so, for maintaining autonomy variable, I divided by 16 because the range was 0-16; the rescaled variable has a range of 0-1, *M*= .55, *SD*= .40. And for the receiving respect and care, I first subtracted 1 then divided by 8 because the range was 1-9; the rescaled variable has a range from 0-1, *M*= .81, *SD*= .21.

Model fit was assessed using goodness-of-fit indices: chi-square goodness-of-fit statistic, comparative fit index (CFI), Tucker-Lewis index (TLI), and root mean square error of approximation (RMSEA). Chi-square goodness-of-fit statistic examines how close the proposed model is to the null (perfectly fitted) model; meaning, the chi-square should be non-significant. The CFI and TLI range between 0 and 1; the closer these values are to 1 the better model fit. “Good” criteria for CFI and TLI values are suggested to be at least > .90 (Kline, 2016), with strict restrictions on “excellent” being > .95 (Weston & Gore, 2006). RMSEA is a parsimony-adjusted index, values closer to 0 represent a good fitting model. “Good” criteria for RMSEA values are suggested to be at least < .08 (Kline, 2016), with strict restrictions on “excellent” being < .06 (Weston & Gore, 2006).

In Model 1, the five variables – receiving respect and quality care, dying at home, maintaining autonomy, and receiving pain medicine and palliative care – were indicators for the *dying well* construct. The model fit was adequate, $\chi2$ (5) = 46.8, p < .001, *CFI*= .932, *TLI*= .865, *RMSEA* = .041 (.030-.051), $_{pRMSEA<.05}$ = .921. However, after screening the initial model, the results suggested some issues with the respect and care variable because it had the lowest regression weight (β = -.08, p = .003). I re-ran the model without the respect and care indicator. The modified model included dying at home, maintaining autonomy, and receiving pain medicine and palliative care – as the four indicators for dying well. Model 2 showed excellent fit: $\chi2$ (2) = 3.2, p = .204, *CFI*= .998, *TLI*= .994, *RMSEA* = .011 (.000-.032), $_{pRMSEA<.05}$ = 1.00. In the modified model, the standardized regression weights were all positively significant, specifically, dying at home β = .15, p < .001, maintaining autonomy β = .38, p < .001, taking pain medicine β = .52, p < .001, and receiving palliative care β = .46, p < .001. That is, dying well represented dying in a familiar place (i.e., home), not needing pain medicine, not receiving palliative care, and having low difficulties with daily physical activities.

To account for age-related effects during the end-of-life process, I then examined whether the deceased person's age at death was predictive of dying well. The dying experience could be different for oldest-old adults compared to young-old adults (Baltes & Smith, 2003). In model 3, dying well regressed on the deceased partner's age at death. This model showed poor fit to the data, $\chi2$ (5) = 345.0, p < .001, *CFI*= .628, *TLI*= -.116, *RMSEA* = .085 (.077-.093), $_{pRMSEA<.05}$ < .001. Age at death was related to their dying well, β = -.12, p < .001, however, because the model fit was poor, we cannot assume Model 3 represents the data well.

What are the indicators of the surviving partner's living well? To assess the surviving partner's living well, I conducted a confirmatory factor analysis on the components of living well. I assessed five variables: physical health, negative affect, quality of life, memory, and satisfaction with life. First, I reverse-coded the negative scored measures – physical health, negative affect, quality of life, and memory – so that high scores represented good outcomes (i.e., health: $M = 2.5$, $SD = 1.0$; negative affect: $M = 9.0$, $SD = 2.9$; quality of life: $M = 3.0$, $SD = 0.6$; memory: $M = 2.8$, $SD = 0.9$). Then, I rescaled the range of the variables – physical health, negative affect, quality of life, memory, and satisfaction with life – to be consistent and continuous across the variables and to avoid problems with unequal variances in the structural equation model. Variables were rescaled from zero (0) to one (1). To do so, for physical health, I subtracted by 1, then divided by 4 because the range was 1-5; the rescaled variable has a range of 0-1, $M= .37$, $SD= .24$. For negative affect, I divided by 13 because the range was 0-13; the rescaled variable has a range of 0-1, $M= .69$, $SD= .22$. For quality of life, I subtracted 1, then divided by 4 because the range was 1-5; the rescaled variable has a range of 0-1, $M= .65$, $SD= .19$. For memory, I subtracted 1, then divided by 4 because the range was 1-5; the rescaled variable has a range of 0-1, $M= .45$, $SD= .23$. And for satisfaction with life, I divided by 10 because the range was 0-10; the rescaled variable has a range of 0-1, $M= .72$, $SD= .19$.

In Model 4, the variables – physical health, negative affect, quality of life, memory, and satisfaction with life – were indicators for the *living well* construct. Model 4 showed good fit to the data, $\chi2\ (5) = 104.9$, $p < .001$, $CFI= .963$, $TLI= .926$, $RMSEA = .099$ (.083-.116), $_{\text{pRMSEA<.05}} < .001$. To improve model fit, I removed the self-perceived memory variable because this variable showed the lowest regression weight of all 5 variables; that is, $\beta = .45$, $p < .001$. Model 5 included physical health, negative affect, quality of life, and satisfaction with life as indicators. Model 5 showed better fit to the data, $\chi2\ (2) = 4.2$, $p = .124$, $CFI= .999$, $TLI= .997$, $RMSEA = .023$ (.000-.055), $_{\text{pRMSEA<.05}} = .910$. In Model 5, the standardized regression weights were all positively significant, that is, physical health $\beta = .58$, $p < .001$, quality of life $\beta = .87$, $p < .001$, negative affect $\beta = .70$, $p < .001$, and satisfaction with life $\beta = .64$, $p < .001$. That is, the surviving partner's living well represented good physical health, high quality of life, low negative affect, and high satisfaction with life.

I then examined the surviving partner's age at wave 8 because there has been substantial evidence for age-related changes in socioemotional domains (e.g., Kunzmann & Grühn, 2005; Kunzmann et al., 2022). Model 6 includes the latent construct living well regressed the surviving partner's age at wave 8. The model showed a poor fit to the data, $\chi2$ (5) = 108.6, $p < .001$, *CFI*= .956, *TLI*= .868, *RMSEA* = .047 (.039-.055), $_{\text{pRMSEA}<.05}$ = .734. Additionally, the results revealed a negative association with age and living well, $\beta = -.12$, $p < .001$, which suggests living well could be age-related; however, because the model fit was poor, we cannot assume Model 6 represents the data well.

Group Comparisons

How might the surviving partner's living well depend on time since the loss? To address my second research question, I conducted multiple separate general linear models. Specifically, I examined each indicator of the surviving partner's *living well* (i.e., satisfaction with life, physical health, quality of life, and negative affect) depending on how long since the spousal loss at wave 8. The time groups were 0-1 years (n = 880), 2-3 years (n = 992), and 4+ years (n = 550). These time groups are consistent with previous findings that recent losses may be different than distant losses (Boyraz et al., 2015; Feigelman et al., 2009; Reynolds & Grühn, 2023). The time since the loss was a between-subject factor. There were main effects in the surviving partner's satisfaction with life, R^2= .004, F (2, 1933) = 4.16, p = .016, partial η^2 = .004 and negative affect, R^2= .025, F (2, 1972) = 24.85, $p < .001$, partial η^2 = .025. There were no main effects in the surviving partner's quality of life, R^2= .001, F (2, 1949) = 0.86, p = .422, nor their physical health, R^2= .002, F (2, 2025) = 2.01, p = .135, partial η^2 = .002. Bonferroni post-hoc comparisons revealed that surviving partners reported significantly higher satisfaction with life at 4+ years, in comparison to 0-1 years; and their negative affect was significantly the highest immediately after the loss (i.e., 0-1 years), in comparison to 2-3 years and 4+ years after the loss.

I then re-tested those general linear models to include the surviving partner's age to account for age-related effects in socioemotional and physical change. Results showed that, even when accounting for age, surviving partner's satisfaction with life, $R^2 = .012$, F (2, 1933) = 3.10, $p = .045$, partial $\eta^2 = .003$, and negative affect, $R^2 = .025$, F (2, 1972) = 25.46, $p < .001$ partial $\eta^2 = .025$, differed depending on how long ago their partner died. Specifically, partners who lost their spouse 0-1 years ago reported lower satisfaction with life and more negative affect, in comparison to surviving partners who lost their partner 2-3 years or 4+ years ago. There were no main effects for physical health, $R^2 = .027$, F (2, 2025) = 2.31, $p = .100$, partial $\eta^2 = .002$, and quality of life, $R^2 = .012$, F (2, 1949) = 1.55, $p = .212$, partial $\eta^2 = .002$, when age was in the model. Additionally, there appeared to be main effects in age for physical health, $R^2 = .027$, F (2, 2025) = 51.66, $p < .001$, partial $\eta^2 = .025$, satisfaction with life, $R^2 = .012$, F (2, 1933) = 14.74, $p < .001$, partial $\eta^2 = .008$, and quality of life, $R^2 = .012$, F (2, 1949) = 21.17, $p < .001$, partial $\eta^2 = .011$. Bonferroni post-hoc analyses showed that negative affect was significantly higher for 0-1 years since the loss in comparison to 2-3 years and 4+ years. There were no significant differences in time since the loss for satisfaction with life after conducting Bonferroni post-hoc analyses, suggesting potential Type 1 error for the initial main effect. More details are in Table 11 and Figure 3.

Structural Equation Model

Does the deceased partner's dying well predict the surviving partner's living well? To assess my third question, I conducted a structural equation model. Specifically, in Model 7 the surviving partner's living well was regressed on the deceased's dying well. The model fit was good, $\chi 2$ (19) = 61.5, p < .001, *CFI*= .985, *TLI*= .978, *RMSEA* = .021 (.015-.027), $_{\text{pRMSEA<.05}}$ = 1.00; however, there was no significant path between the deceased partner's *dying well* and the surviving partner's *living well*, β = -.01, p = .892. Thus, contrary to my expectations, the deceased partner's *dying well* was not related to the surviving partner's *living well*. With a null hypothesis finding, I could not draw conclusions on the model (i.e., null findings cannot inform us why there is an absence of effect; Harms & Lakens, 2018; Mehler et al., 2019; Scheel et al., 2021). Therefore, I conducted post-hoc analyses to investigate alternative mechanisms.

Post Hoc Analyses

Emotional State. To explore alternative mechanisms, I explored the deceased's emotional experience. Based on Kiecolt-Glaser and Wilson (2017), spouses' health and well-being are *converged*; meaning because their daily context is similar (e.g., similar environment and social settings), they also tend to show similar health and well-being. Additionally, Klass (2006) proposed emotional and relational aspects continue, even after a person dies (i.e., Continuing Bond). Therefore, I expected that if the deceased partner was not dying well, their emotional state would reflect this, which may relate to how the surviving partner feels about the dying process, due to the converged health experiences between spouses (Kiecolt-Glaser & Wilson, 2017). The first step was to test if the deceased's perceived sadness was related to their dying well. I conducted a pathway model (i.e., Model 8) of deceased's perceived sadness regressed on their dying well. Model 8 represented the data well, $\chi 2$ (5) = 23.2, p < .001, *CFI*=

.981, *TLI*= .963, *RMSEA* = .027 (.016-.038), $_{\text{pRMSEA<.05}}$ = 1.00. I found a significant negative association, β = -.42, $p < .001$, suggesting that people who were dying well were less likely to be reported as sad or anxious in their last month of life. Next, I examined if the deceased's perceived sadness was related to the surviving partner's living well. I conducted multiple t-tests because the deceased's sadness was binary and the surviving partner's living well domains were continuous. I found that when deceased partners were reported to be sad in the last month, their surviving partner tended to show significantly higher negative affect (t = -4.60, $p < .001$), lower quality of life (t = -2.17, p = .030), and poor health (t = -2.81, p = .005). Additionally, I conducted a pathways model (i.e., Model 9) of the surviving partner's living well regressed on deceased's perceived sadness. Model 9 showed excellent fit, $\chi2$ (5) = 17.1, p = .004, *CFI*= .994, *TLI*= .989, *RMSEA* = .035 (.018-.054), $_{\text{pRMSEA<.05}}$ = .889, and all the parameters were significantly associated. Specifically, for deceased partners who were reported to be sad in the last month of life, their partner tended to show lower living well after the loss, β = -.08, p = .002. Based on these results, I added the deceased's perceived sadness to the structural equation model; that is, Model 10 consisted of the surviving partner's living well regressed on the deceased's perceived sadness, regressed on the deceased's dying well (see Figure 4). Model 10 fit was good, $\chi2$ (26) = 93.5, $p < .001$, *CFI*= .979, *TLI*= .971, *RMSEA* = .023 (.018-.028), $_{\text{pRMSEA<.05}}$ = 1.00. The standard regression weights were significant; that is, deceased's dying well negatively predicted if they were reported to be sad in the last month of life, β = -.42, $p <$ .001, which negatively predicted the surviving partner's living well, β = -.08, p = .001.

I then added both the surviving partner's age and the deceased partner's age to the model to account for potential age-related changes. Model 11 represented surviving partner's living well regressed on their age at wave 8 and the deceased's perceived sadness in the last month of life, also the deceased's perceived sadness and deceased partner's age both regressed on the deceased's dying well (see Figure 5). The fit indices were poor, $\chi 2$ (43) = 3264.5, $p < .001$, *CFI*= .499, *TLI*= .231, *RMSEA* = .089 (.087-.092), $_{\text{pRMSEA}<.05}$ < .001. The deceased's dying well negatively predicted if the deceased was reported to be sad in the last month of life, $\beta = -.42$, $p < .001$, which negatively predicted the surviving partner's living well, $\beta = -.08$, $p < .001$, accounting for the surviving partner's age at wave 8, $\beta = -.12$, $p < .001$ and deceased partner's age, $\beta = -.002$, $p = .918$.

I further explored potential mediations within the model (i.e., Model 12). That is, deceased partner's dying well was the predictor, the deceased's perceived sadness in the last month of life was the mediator, and the surviving partner's living well was the dependent variable. Model 12 fit indices were good, $\chi 2$ (25) = 91.8, $p < .001$, *CFI*= .980, *TLI*= .971, *RMSEA* = .023 (.018-.028), $_{\text{pRMSEA}<.05}$ = 1.00. Additionally, all parameters were significant, except for the deceased partner's dying well directly predicting the surviving partner's living well ($\beta = -.06$, $p = .197$). Therefore, we cannot assume any mediation effect; however, there may be an indirect effect on the surviving partner living well through the deceased's perceived emotional state and the deceased's dying well.

Time Since the Loss. Another alternative mechanism could be time since the loss. As evident from previous research (e.g., Boyraz et al., 2015; Feigelman et al., 2009; Reynolds & Grühn, 2023; Schwartz et al., 2018), depending on time since the loss, individuals may respond differently to the death of a loved one. Additionally, based on Dual Processing Model (Stroebe & Schut, 2010, 2016), how people process and understand the loss may change over time. Therefore, I further assessed the time since the loss by conducting a multigroup structural equation model. I first ran the unconstrained model (i.e., Model 13); that is, the surviving partner's living well regressed on the deceased's perceived sadness, which regressed on the deceased partner's dying well. Then, I created groups based on the time since the loss (i.e., 0-1 years, 2-3 years, and 4+ years). The fit indices showed a good fit to the data, $\chi 2$ (100) = 222.7, $p < .001$, *CFI*= .980, *TLI*= .963, *RMSEA* = .010 (.008-.012), $_{\text{pRMSEA<.05}}$ = 1.00. Interestingly, this multigroup structural equation model revealed differences in pathways depending on the time since the loss (see Figures 6-8). That is, for surviving partners who lost their spouse 0-1 years ago, the deceased partner's dying well does not predict the surviving partner's living well, β = -.10, p = .238, the deceased partner's dying well significantly predicted the deceased's perceived sadness, β = -.41, p = .036, and the deceased's perceived sadness predicted surviving partner's living well, β = -.11, p = .036. For losses 2-3 years ago, the deceased partner's dying well did not predict the surviving partner's living well, β = -.05, p = .461, the deceased partner's dying well predicted the deceased's perceived sadness, β = -.43, p = .005, and the deceased's perceived sadness predicted surviving partner's living well, β = -.11, p = .018. For losses 4+ years ago, all pathways were not significant; that is, the deceased partner's dying well did not predict the surviving partner's living well, β = .05, p = .649, the deceased's dying well did not predict the deceased's perceived sadness, β = -.49, p = .164, and the deceased's perceived sadness did not predict the surviving partner's living well, β = -.05, p = .511. Lastly, I tested model invariance to make sure the meaning of the latent variables – dying well and living well – were the same across all three time-groups. To do so, I used AMOS default function to examine different parameter constraints; that is, measurement weights, measurement intercepts, structural weights, structural intercepts, structural means, structural covariances, structural residuals, and measurement residuals. I then compared the models in a stepwise procedure. The unconstrained model and constrained measurement weights model were not significantly different, $\Delta\chi 2$ (21) =

15.0, p = .823. The constrained measurement weights model and the constrained measurement intercepts model were significantly different, $\Delta\chi2$ (27) = 86.1, $p < .001$. Thus, the unconstrained model was the final model. For information on all the constrained models, see Table 12.

Proxy-reported Data. Lastly, an alternative explanation for the lack of association between the deceased partner's dying well and the surviving partner's living well could be whether the proxy-reported data was from the spouse's perspective. Although previous literature has supported the use of proxy-reported data when the primary source is unavailable (Gerlach et al., 2017; Infurna et al., 2014), the majority of the proxy-reported data came from the spouse's perspective (63.0%). That means, the perspective of the deceased partner's dying well and the reported emotional state in the last month of the deceased's life could be biased from the surviving partner. To investigate potential differences in the proxy-reported data, I conducted a multigroup structural equation model. I first ran the unconstrained model; that is, the surviving partner's living well regressed on the deceased's perceived sadness, which regressed on the deceased partner's dying well. Then, I created groups based on the proxy's relationship to the deceased (i.e., spouse: n = 3,216 or non-spousal: n = 1,892). The fit indices showed a good fit to the data, $\chi2$ (75) = 205.4, $p < .001$, *CFI*= .980, *TLI*= .964, *RMSEA* = .011 (.009-.013), $_{\text{pRMSEA<.05}}$ = 1.00. This multigroup structural equation model revealed different pathways depending on the relationship of the proxy to the deceased (see Figures 9-10). That is, for spousal proxy-reported data, the deceased partner's dying well did not predict the surviving partner's living well, β = -.04, p = .395, the deceased partner's dying well predicted the deceased's perceived sadness, β = -.44, $p < .001$, and the deceased's perceived sadness predicted the surviving partner's living well, β = -.10, p = .003. Interestingly, for non-spousal proxy-reported data, all pathways were negatively significant. Specifically, the deceased's dying well predicted the surviving partner's living well, β = -.34, p = .048, the deceased partner's dying well predicted the deceased's perceived sadness, β = -.39, p < .001, and the deceased's perceived sadness predicted the surviving partner's living well, β = -.27, p = .020. Lastly, I tested model invariance to make sure the meaning of the latent variables – dying well and living well – were the same between the two different proxy-deceased relationship groups. Similar to the previous multigroup SEM, I used AMOS default function to examine different parameter constraints in a stepwise procedure. The unconstrained model and constrained measurement weights model were not significantly different, $\Delta\chi2$ (14) = 16.8, p = .267. The constrained measurement weights model and the constrained measurement intercepts model were significantly different, $\Delta\chi2$ (18) = 82.2, p < .001. Thus, the unconstrained model was the final model. For information on all the constrained models, see Table 13.

Discussion

Overall, my goal for this project was to highlight the relational and dynamic components of the dying process. The death of a loved one is an impactful moment in the lifespan yet cannot be captured as a single time-event because end of life is a developmental time-period (Reynolds & Grühn, 2024), which ripples into other people's lives. I utilized a cross-national, open-access dataset (i.e., SHARE: Börsch-Supan et al., 2013) to investigate spousal loss. For this European sample, I found four main results: 1) the deceased partner's *dying well* represented dying at home, maintaining autonomy, and experiencing low pain; 2) the surviving partners' negative affect was different depending on the time since the loss; 3) the deceased partner's *dying well* did not directly effect the surviving partner's *living well*; and 4) the deceased partner's *dying well* may indirectly effect the surviving partner's *living well* through the deceased's perceived emotional state and time since the loss. These findings highlight the complexity of end of life.

The Creek

Like the developmental lifespan, the creek is embedded in an ever-changing ecosystem. I defined end of life as a developmental process, meaning dying people are continuing to develop until their death. Using a lifespan developmental framework (Baltes et al., 2006), I examined the components of dying well. I hypothesized *dying well* included the dying person's pain management, their autonomy and control, where they died, and how well they were being cared for and respected, which was supported by previous cross-cultural evidence (e.g., Bovero et al., 2020; Gonzalez Sepulveda et al., 2022; Järviö et al., 2023; van Wijngaarden & Sanders, 2022). I assessed these domains of dying well by utilizing a confirmatory factor analysis. I found that in an European sample, *dying well* represented dying at home, not needing pain medicine, not receiving palliative care, and having low difficulties with daily physical activities. These results partially align with expectations; specifically, dying at home and maintaining high autonomy during end of life appear to be important for people as they are dying, which aligns with a variety of cultures and countries (e.g., Bovero et al., 2020; Carr & Luth, 2019; Gold, 2011; Gonzalez Sepulveda et al., 2022; Järviö et al., 2023; van Wijngaarden & Sanders, 2022), suggesting potential consistencies in end-of-life preferences within an European sample.

Interestingly, I found that these variables were being predicted by the dying well construct; meaning that the underlying mechanism of *dying well* may be shaping individual experiences during end of life. One potential explanation is the type of terminal illness. There are a variety of causes of death. According to the World Health Organization (2020), the leading causes of death globally are heart disease, stroke, chronic obstructive pulmonary disease (COPD), respiratory infections, neonatal conditions, respiratory cancers, and dementia. Additionally, in this study, the majority of participants died from cancer, cardiovascular-related illness, and stroke. Therefore, *dying well* could be due to what illness the person had. For example, dying from aggressive cancer may impair daily functioning and elicit more pain in the individual's daily life, requiring palliative care and pain medicine, as well as needing more intensive treatment within a healthcare facility. Although these aspects (e.g., their autonomy and pain level) could be outside of the individual's control, where the person is dying *could* be modified.

The location of dying depends on a variety of factors, such as privilege, preference, and time period. Dying at home is a privilege, such as in the person's racial identity, economic status, and the availability of their family. For example, despite people's preference to die at home, marginalized racial group's wishes may be ignored (Corpora, 2022). Also, in countries like the U.S. or Canada, where healthcare is expensive, people without economic resources may not have access to quality healthcare (Armstrong & Devlin, 2022). Additionally, dying at home may involve family members sacrificing their time to care for the dying person and their home. Dying at home also depends on the person's preference. Not everyone wants to die at home. The choice to select where a person dies appears to be important (Bovero et al., 2020; Gonzalez Sepulveda et al., 2022; van Wijngaarden & Sanders, 2022), yet the preference may depend on culture, disease progression, or attitudes toward appropriate care (Carr & Luth, 2019; Funk et al., 2023; Visser, 2017). Lastly, dying at home depends on the time period. Historically, where people are dying has shifted away from the home and into healthcare facilities (Gold, 2011).

Dying in the home means being surrounded by familiarity and cared for by people you trust. End of life can be a vulnerable time in a person's life and to share that experience with people you trust can be meaningfully intimate. On the other hand, dying in healthcare facilities could mean being surrounded by unfamiliar people and hooked up to potentially invasive and uncomfortable machines, all of which may feel like the person is being exposed. For example, in Türkiye, healthcare workers voiced their concerns with the lack of privacy for dying patients in hospital settings, like: "In some of the institutions, they breach privacy by putting 6–7 bed-tied people in one room and they change diapers. When there is an unpleasant odour, the other patients react in an offensive manner" (Duyan et al., 2016, p. 1950). Or the type of quality may be susceptible to systematic injustices; specifically, a Black individual explained that their family member was "in a lot of pain. I asked the nurse to give her something to ease her pain. [The nurse] said, she can't have any right now. We were begging her to give something" (Bullock et al., 2005, p. 10-11). I am not suggesting the advancements of medicine have not improved healthcare, nor am I suggesting that healthcare workers are inadequate in their role or not actively advocating for their patient's needs, rather I am critiquing the structure of healthcare. The hospital itself is designed to diagnosis, treat, and cure patients, so ideally, they can return to society; yet when a person is dying of a terminal illness, the goals within healthcare become suboptimal. Therefore, perhaps the best way to care for the dying is to bring care back into the homes and implement community care options (Abel, 2018; Staudt, 2013; Vernon et al., 2022).

My critique is an echo of long-standing work (e.g., Dame Cicely Saunders, Edith Balint, and Kübler-Ross). For decades, end-of-life care has emphasized the importance of reducing pain and optimizing comfortability (e.g., palliative and hospice care). Interestingly, in the current study, I found that *dying well* included not receiving palliative care. There are a few avenues for speculation on why *dying well* included not taking pain medicine nor receiving palliative care. First, a person who does not need pain medicine nor palliative care may be someone without pain, and in that sense aligns with consistent preferences to have limited pain while dying (Bovero et al., 2020; Gonzalez Sepulveda et al., 2022; Ozyalç Ozcan & Çevik, 2023). Second, a person who is not receiving pain medicine nor receiving palliative care may not have access to or does not want palliative care options. The latter interpretation is potentially the most difficult to unpack because the preferences of the participants were not collected, so that question is outside the scope of this project. Previous research has examined the preferences of dying people (e.g., Higginson & Sen-Gupta, 2000; Gonzalez Sepulveda et al., 2022; Stajduhar et al., 2008), as well as the socioeconomic factors that shape individual's access to their preferred place of death (Turner & Flemming, 2019). Turner and Flemming (2019) conducted a meta-synthesis on people with socioeconomic disadvantages (e.g., financially marginalized communities) from the UK. Interestingly, they found that although home was commonly preferred place of death, there was fluidity with how people discussed the home (e.g., equating the home with "belonging" or a place of "love"). Therefore, the perception of what home means may transform beyond a geographical location. In this study, proxies reported the place of dying from a variety of locations, that is, in the deceased's own home, another person's home, the hospital, in a nursing home, in a hospice, or at another place. Therefore, we could assume high face validity in that there was a preferred geographic location on where dying well ought to be, however, there is the possibility that dying at home was perceived as wherever the deceased was loved, such as in a familiar, intimate location during end of life. Therefore, future research should investigate the nuance of dying well and how to appropriately address individual needs during end of life.

Palliative care has consistently shown to benefit individuals psychologically and physiologically (e.g., Bakitas et al., 2009; Baumann et al., 2015; Fliedner et al., 2019; Li et al., 2012; Temel et al., 2010). For example, early palliative care use has been associated with improved mood, quality of life, symptom control, and for some, prolonged survivability (Baumann et al., 2015; Li et al., 2012; Temel, 2010). Despite the benefits, palliative care can be stigmatized, especially when there is a distrust with the healthcare system (Dillon & Basu, 2016; Fliedner et al., 2019; Yancu et al., 2010). Some people may perceive palliative care as synonymous with death or giving up (Dillon & Basu, 2016; Yancu et al., 2010); for example, "You'll hear people say that hospice is just a way to speed up someone's death…" or "You can't be giving up the fight…" (Dillon & Basu, 2016, p. 1390). Fliedner and colleagues (2019) highlighted the nuance of palliative care conversations. They found that some people perceived palliative care conversations as being "too early," especially if they were "paralyzed by the diagnosis." On the other hand, some perceived early palliative care conversations as "confrontational" yet "affirming." Therefore, it may not just be about *when* palliative care is implemented, but rather *how* palliative care is addressed. In this study, I found that one indicator of dying well was not receiving palliative care. Perhaps, for these participants, palliative care was lacking in aspects of trust, community, and familiarity that was explained more by dying at home.

End of life is an interpersonal experience, especially if people are dying within their homes. Their partners may be caring for them, advocating for their needs, and witnessing their dying process. The shared experience between spouses facilitates an intimate bond that is unique to the dying process. Thus, to understand the dying context, I also investigated the surviving partner's well-being, or *living well*, after the deceased partner's death. I first examined the components of what *living well* represented for this specific sample. Based on previous work (Moon et al., 2011; Singham et al., 2021; Wu-Chung et al., 2022), I had theoretical support for expecting *living well* to capture physical, cognitive, and socioemotional aspects. After conducting two confirmatory factor analyses, I found that *living well* represented good physical health, high quality of life, being satisfied with life, and having low negative affect. Interestingly, cognitive functioning was not represented in the final model, which contradicts evidence that suggests that the loss of a spouse could increase the likelihood of developing dementia or cognitive decline (Singham et al., 2021; Wu-Chung et al., 2022). One potential reason for cognitive functioning not being represented in this sample could be from the cognitive assessment used (i.e., self-reported memory ability). This item required the participant to have self-awareness of their own cognitive change, which could be a biased report. Additionally, the participants' cognitive functioning may be related to their own closeness to death or morality risk (Gerstorf & Ram, 2013; Kotter-Grühn et al., 2010).

In this study, I investigated both the deceased partner's *dying well* and the surviving partner's *living well* because of the close bond between spouses, which may even converge in developmental outcomes (Kiecolt-Glaser & Wilson, 2017). Thus, after one partner dies, the surviving partner may feel "shattered" (Bonanno et al., 2002; Carr & Utz, 2020) due to the impact of the death.

The Impact of the Rock

Like the death of a loved one, the impact of the rock changes the body of water. In this study, I replicated previous findings (e.g., Bonanno et al., 2002; Feigelman et al., 2009; Reynolds & Grühn, 2023; Schwartz et al., 2018) of time since the loss. I hypothesized the surviving spouses to have lower well-being immediately after the loss, in comparison to the 4+ years. I found that the surviving spouses showed high negative affect immediately after the loss. Specifically, partners who lost their spouse 0-1 years ago reported more negative affect, in comparison to surviving partners who lost their partner 2-3 years or 4+ years ago. Additionally, the time-based difference remained, even when accounting for age. These finding are consistent with Reynolds and Grühn (2023) who found that individuals who reported a recent loss (i.e., < 4 years) showed more grief symptoms, in comparison to individuals who reported distant loss (4+ years). The sample from Reynolds and Grühn (2023) had a wide age range (i.e., 21 to 72 years) and included a variety of relational loss (i.e., including, but not limited to spousal, parental, or familial). In comparison, this study specifically examined spousal loss. Spousal relationships are uniquely intertwined (Kiecolt-Glaser & Wilson, 2017), which shapes the surviving partner's socioemotional well-being, cognitive functioning, and even longevity (Moon et al., 2011; Singham et al., 2021; Wu-Chung et al., 2022). Bonanno and colleagues (2002) also examined spousal loss. They identified *chronic grievers* as spouses who showed immediate distress after the loss and continued to show distress 18 months after the loss, and *common grievers* who showed immediate distress after the loss, then returned to baseline at 18 months after the loss. These findings suggest the immediate gravity of a spousal loss; furthermore, their results imply if people continue to show high distress over an extended period of time, then that is potentially maladaptive.

Grieving is a time-dependent experience, that is, depending on the time since the loss, people may think, feel, and behave differently (e.g., Feigelman et al., 2009; Reynolds & Grühn, 2023; Schwartz et al., 2018). Based on the Dual Processing Model (Stroebe & Schut, 2010, 2016), people who are grieving oscillate between loss and restorative orientations. These oscillations, over time, become farther and farther apart, but do not disappear, rather they remain with the person. In other words, after a loss, people learn to live *with* the loss, rather than learn to live *without* the loss. Thus, over time, the impact of the spousal loss may disperse into aspects of *living well*, as people may need time to process the loss and navigate daily life.

The Ripples Over Time

Like grieving, the ripples from the impact are expansive and dynamic on the environment over time. Research on spousal loss has consistently shown long-term effects in mental and physical health, well-being, identity development, and everyday routine (Adena et al., 2023; Bonanno et al., 2002; Bourassa et al., 2016; Naef et al., 2013; Peña-Longobardo et al., 2021). Similarly, in this study, I examined the association between the deceased partner's *dying well* and the surviving partner's *living well*; contrary to expectations, I did not find a significant association. There are possibilities on why there was a null finding. For example, Klass (2006) proposed that relationships and emotional connections persists, even after the death of a loved one. Thus, potentially the perceived emotional state of the deceased is what shapes the surviving partner's living well. Another possibility is that based on Dual Processing Model (Stroebe & Schut, 2010, 2016), over time the oscillations between the loss and life orientations become farther apart, which could mean that over time, the surviving partner's living well becomes less associated with their deceased partner's dying well. To further investigate these speculations, I conducted post-hoc analyses.

After conducting post-hoc analyses, I found that the deceased's *dying well* may indirectly effect the surviving partner's *living well* through the deceased's emotional experience. After a follow-up multigroup structural equation model, I unpacked differences in pathways depending on the time since the loss. Specifically, for the 2-3 year time group, there was an indirect pathway from the deceased's *dying well* to the surviving partner's *living well* through the deceased's perceived sadness. The pathways were not all significant for the time groups: 0-1 years and 4+ years.

These results, in tandem with the previous work (e.g., Bonanno et al., 2002; Feigelman et al., 2009; Reynolds & Grühn, 2023; Schwartz et al., 2018) may reveal how surviving partners are processing the loss, when supports may be especially important, and potential underlying causes of the pattern. Firstly, in alignment with our group comparison findings, time-dependent research consistently suggests that recent loss can be distressing (Bonanno et al., 2002; Reynolds & Grühn, 2023), however, over time (i.e., 4-5 years) there is a plateau or slow recover in surviving partner's distress (Adena et al., 2023; Feigelman et al., 2009). However, results from this study showed that at 2-3 years after the loss, the surviving partner's *living well* depended on how well the deceased died and if the were reported to be sad in the last month of their life. Perhaps, 2-3 years may be particularly salient because the immediate impact of the loss has passed, and the surviving partner now has time to process and interpret what led up to their partner's death. Finding purpose or meaning in the death of a loved one is highlighted in clinical research as valuable for coping with the loss (Neimeyer, 2019). Therefore, the surviving partner may reflect on their deceased partner's *dying well* (i.e., experiencing minimal pain, maintaining autonomy, and dying in the home) and emotional state (i.e., did they show sadness in the last month of life), to establish meaning to their partner's death. Sharing the deceased's life can be valuable and affirming to people who are grieving, and difficulties in creating meaning may even foreshadow maladaptive grief (Neimeyer, 2019). Despite the importance of "telling the story", if a person experienced a traumatic or unfair death, then meaning making may become superficial, as the person may be pressured to maintain a "silent story" in which the mourner alone ruminations on the deceased's life story (Neimeyer, 2019). Thus, bereavement support services may need to consider time (i.e., time since the loss) and context (i.e., dying well) when offering support for surviving partners.

One approach to supporting surviving spouses is meaning-reconstruction through narrative telling. Neimeyer (2019) proposed “braiding together” the deceased’s story by integrating the *external narrative* (i.e., what happened to the deceased), *internal narrative* (i.e., how did that experience make the surviving person feel), and *reflexive narrative* (i.e., how does the surviving person make meaning to the end-of-life experience). The death of a loved one is not a finite experience, people often maintain narratives and relationships with the deceased (Klass, 2006; Neimeyer, 2019). For example, a spouse may reflect on their favorite meal together, share stories about the deceased with their friends, or keep photos of them in their house. These small reminders may continue the relationship and weave into the surviving partner’s life, even after the death event (Bourassa et al., 2016).

Limitations and Future Directions

Despite the importance of my findings, there are some limitations that I caution the reader to consider. Particularly, there are limitations in the sample pool, the theoretical assumptions of the dying process, and the proxy-reported data. I also have outlined below recommendations for future research and general policy implications.

The sample pool was from European countries. With the except of Estonia and Cyprus, participants resided in a country with universal healthcare. Although healthcare systems can vary across countries, the majority of the sample hypothetically had access to free or low-cost care. Thus, the context of healthcare is unique for this group of people. Additionally, my own biases of the healthcare system are based on my perspective in the U.S. For example, in the U.S., dying well is a privilege because of racial injustices in healthcare, both on a personal and structural level (Bullock et al., 2022; Carr & Luth, 2019; Corpora, 2022; Rhodes et al., 2017; Stajduhar et al., 2019; Townsend et al., 2017). Therefore, my interpretations of the participants’ experience could be biased. To combat this bias, I utilized evidence that represented multiple countries spanning across Europe, Asia, and the North Americas (e.g., Gonzalez Sepulveda et al., 2022; Järviö et al., 2023; Singham et al., 2021; Turner & Flemming, 2019). However, I caution the reader on this study's generalizability and encourage future research to replicate the findings in other countries, such as the U.S., to further explore the embedded layers of healthcare in relation to end of life.

In this study, I applied a developmental perspective to the dying process. In doing so, I defined end of life as a developmental process. Despite the need for this application (Reynolds & Grühn, 2024), this does not take into account the non-normative dying experiences (e.g., death by accidents, suicides, or homicides). These unfortunate experiences are possibilities, especially for some age and racial groups (WHO, 2020); however, investigating non-normative deaths are outside of the scope for this sample and study. Other researchers have focused on the impact of the surviving loved ones who experienced a traumatic loss (e.g., Early et al., 2024; Henderson et al., 2015); however, it is impossible to examine the individual's dying context, who is technically dying for seconds or minutes. With that being said, rather than studying short-term deaths, it may be more valuable to investigate how people with acute terminal diseases and chronic terminal diseases differ in their end-of-life experiences. Future research may need to explore how the type of terminal illness might predict dying well experiences, and how their dying experience may shape loved one's well-being after the loss.

I also caution the reader regarding my reliance on proxy-reported data. In this study, I utilized the end-of-life survey to capture the deceased's dying context because the deceased was unavailable to complete the end-of-life survey. Previous literature has supported the use of proxy-reported data to provide information on the dying context, when the primary source is unavailable (Gerlach et al., 2017; Infurna et al., 2014). In this study, the majority of proxies were the deceased's partner (63.0%), meaning in some cases there was mono-reported data. Specifically, the perceived dying context and emotional state of the deceased could have been reported by the same surviving partner who reported their own living well. I further investigated group differences in the spousal and non-spousal proxy-reported data and found differences in the models depending on the proxy-reported data. Future research may need to investigate these differences further. Additionally, I encourage the use of retrospective approaches that investigate physical, cognitive, and socioemotional predictors before the death event (see Gerstorf & Ram, 2013; Kotter-Grühn et al., 2010), as well as examine dyadic perspectives that assess both the terminally ill spouse and their partner (see Braun et al., 2009; Daley et al., 2017; Horning et al., 2019).

Lastly, I will call to action the need for practical implications that could benefit the dying person and support surviving partners' living well. My findings highlight the importance of having minimal pain, maintaining autonomy, and dying at home. Of course, these values could differ depending on the individual and their context, however, I will emphasize the need for structural supports that adequately address the individual's preferences during end of life. For example, person-centered care (Balint, 1969) and community-care (e.g., Abel, 2018; Staudt, 2013; Vernon et al., 2022) are both valuable healthcare approaches. Person-centered end-of-life care is a holistic, interdisciplinary approach that recognizes the dying person as a human being (Kmetec et al., 2022). Although there are structural barriers with implementing person-centered care (Moore et al., 2015), person-centered care can effectively support better quality of life for both the patient and their partner, reduce unnecessary hospitalization, and encourage discussions around end-of-life care and preferences (Kmetec et al., 2022). When communities do not trust the healthcare system, community care can be an alternative solution that targets quality care that is both accessible and appropriate (e.g., Abel, 2018; Staudt, 2013; Vernon et al., 2022). Community care can range in a variety of settings. For example, community care programs can target a specific healthcare facility by training community members to be liaisons between the patient and medical professionals (Sedhom et al., 2021). Community care programs can also target structural barriers of care, such as implementing *Compassionate Cities* that foster mutual services among clinicians and the community (Kellehear, 2005; Librada-Flores et al., 2020). At the core, community care initiatives recognize that end-of-life care is a public health issue and values the strength of a collective approach (Abel, 2018; Kellehear, 2005; Librada-Flores et al., 2020; Pfaff et al., 2020). All in all, to support individuals who are dying, we may need pull back the frame and support the lives embedded in the dying context. End of life incorporates people, not subjects, not participants, nor contributions to science. Therefore, healthcare may need to frame the dying process as a community, shared experience to support the person dying and their loved ones.

Conclusion

In the analogy of tossing a rock in a creek, over time, the ripples expand and change the environment. Similarly, the death of a loved one is an impactful moment, that depends on the dying context before the death, which continue to disperse and shape the surviving loved one's well-being. My project focused on spousal loss to emphasize the interpersonal and relational components of dying. Although the deceased partner's dying well did not directly predict the surviving partner's living well, there may be indirect effects depending on time since the loss and the deceased's perceived emotional state in their last month of life. I encourage future research to investigate appropriate end-of-life care from a developmental and community approach.

REFERENCES

Abel, J. (2018). Compassionate communities and end-of-life care. *Clinical Medicine, 18*(1), 6-8. https://doi.org/10.7861/clinmedicine.18-1-6

Adena, M., Hamermesh, D., Myck, M., & Oczkowska, M. (2023). Home alone: Widows' well-being and time. *Journal of Happiness Studies, 24*(2), 813-838. https://doi.org/10.1007/s10902-023-00622-w

Arantzamendi, M., García-Rueda, N., Carvajal, A., & Robinson, C. A. (2020). People with advanced cancer: the process of living well with awareness of dying. *Qualitative Health Research, 30*(8), 1143-1155. https://doi.org/10.1177/1049732318816298

Armstrong, C.D., & Devlin, R.A. (2022). Dying at home: A privilege for those with time and money. *Canadian Public Policy 48*(6), 81-98. https://muse.jhu.edu/article/874207.

Balint, E. (1969). The possibilities of patient-centered medicine. *The Journal of the Royal College of General Practitioners, 17*(82), 269. https://bjgp.org/content/bjgp/17/82/269.full.pdf

Bakitas, M., Lyons, K.D., Hegel, M.T., Balan, S., Brokaw, F.C., Seville, J., Hull, J.G., Li, Z., Tosteson, T.D., Byock, I.R., & Ahles, T.A. (2009). Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. *Journal of American Medical Association, 302*(7), 741–749.5. doi:10.1001/jama.2009.1198

Baltes, P. B., Lindenberger, U., & Staudinger, U. M. (2006). Life span theory in developmental psychology. In R. M. Lerner & W. Damon (Eds.), *Handbook of child psychology: Theoretical models of human development.*, Vol. 1, 6th ed. (pp. 569–664). John Wiley & Sons Inc.

Baltes, P. B., & Smith, J. (2003). New frontiers in the future of aging: From successful aging of the young old to the dilemmas of the fourth age. *Gerontology, 49*(2), 123-135. https://doi.org/10.1159/000067946

Barrett, A. E., & Montepare, J. M. (2015). " It's About Time". *Annual Review of Gerontology & Geriatrics, 35*(1). https://doi.org/10.1891/0198-8794.35.55

Baumann, A. J., Wheeler, D. S., James, M., Turner, R., Siegel, A., & Navarro, V. J. (2015). Benefit of early palliative care intervention in end-stage liver disease patients awaiting liver transplantation. *Journal of Pain and Symptom Management, 50*(6), 882–886. https://doi.org/10.1016/j.jpainsymman.2015.07.014

Beaunoyer, E., Hiracheta Torres, L., Maessen, L., & Guitton, M. J. (2020). Grieving in the digital era: Mapping online support for grief and bereavement. *Patient Education and Counseling, 103*(12), 2515–2524. https://doi-org.prox.lib.ncsu.edu/10.1016/j.pec.2020.06.013

Börsch-Supan, A., M. Brandt, C. Hunkler, T. Kneip, J. Korbmacher, F. Malter, B. Schaan, S. Stuck, S. Zuber (2013). *Data Resource Profile: The Survey of Health, Ageing and Retirement in Europe (SHARE)*. International Journal of Epidemiology. DOI: 10.1093/ije/dyt088.

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., Carr, D., & Nesse, R. M. (2002). Resilience to loss and chronic grief: a prospective study from preloss to 18-months postloss. *Journal of personality and social psychology, 83*(5), 1150-1164. https://psycnet.apa.org/doi/10.1037/0022-3514.83.5.1150

Bourassa, K. J., Knowles, L. M., Sbarra, D. A., & O'Connor, M.-F. (2016). Absent but not gone: Interdependence in couples' quality of life persists after a partner's death. *Psychological Science, 27*(2), 270–281. https://doi-org.prox.lib.ncsu.edu/10.1177/0956797615618968

Bovero, A., Gottardo, F., Botto, R., Tosi, C., Selvatico, M., & Torta, R. (2020). Definition of a good death, attitudes toward death, and feelings of interconnectedness among people taking care of terminally ill patients with cancer: An exploratory study. *American Journal of Hospice & Palliative Medicine, 37*(5), 343–349. https://doi-org.prox.lib.ncsu.edu/10.1177/1049909119883835

Boyraz, G., Horne, S. G., & Waits, J. B. (2015). Accepting death as part of life: Meaning in life as a means for dealing with loss among bereaved individuals. *Death Studies, 39*(1), 1–11. https://doi.org/10.1080/07481187.2013.878767

Braun, M., Scholz, U., Bailey, B., Perren, S., Hornung, R., & Martin, M. (2009). Dementia caregiving in spousal relationships: a dyadic perspective. *Aging and mental health, 13*(3), 426-436. https://doi.org/10.1080/13607860902879441

Breitsameter, C. (2024). When dying does not go well: a qualitative study. *BMC Palliative Care, 23*(1), 69. https://doi.org/10.1186/s12904-024-01379-6

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist, 32*(7), 513. https://psycnet.apa.org/doi/10.1037/0003-066X.32.7.513

Bullock, K., Gray, T. F., Tucker, R., & Quest, T. E. (2022). Race roundtable series: Structural racism in palliative care. *Journal of Pain and Symptom Management, 63*(5), e455-e459. https://doi.org/10.1016/j.jpainsymman.2022.01.015

Bullock, K., McGraw, S. A., Blank, K., & Bradley, E. H. (2005). What matters to older African Americans facing end-of-life decisions? A focus group study. *Journal of Social Work in End-Of-Life & Palliative Care, 1*(3), 3–19. https://doi.org/10.1300/J457v01n03_02

Cacciatore, J., Thieleman, K., Fretts, R., & Jackson, L. B. (2021). What is good grief support? Exploring the actors and actions in social support after traumatic grief. *PLoS ONE, 16*(5). https://doi-org.prox.lib.ncsu.edu/10.1371/journal.pone.0252324

Cagle, J. G., Pek, J., Clifford, M., Guralnik, J., & Zimmerman, S. (2015). Correlates of a good death and the impact of hospice involvement: findings from the national survey of households affected by cancer. *Supportive Care in Cancer, 23*, 809-818.

Carr, D. (2003). A" good death" for whom? Quality of spouse's death and psychological distress among older widowed persons. *Journal of Health and Social Behavior*, 215-232.

Carr, D., & Luth, E. A. (2019). Well-being at the end of life. *Annual Review of Sociology, 45*, 515-534. https://doi.org/10.1146/annurev-soc-073018-022524

Carr, D., & Mooney, H. (2021). Bereavement in later life. In *Handbook of aging and the social sciences* (pp. 239-254). Academic Press. https://doi.org/10.1016/B978-0-12-815970-5.00015-2

Carr, D., & Utz, R. L. (2020). Families in later life: A decade in review. *Journal of Marriage and Family, 82*(1), 346-363. https://doi.org/10.1111/jomf.12609

Carstensen, L. L., & Fredrickson, B. L. (1998). Influence of HIV status and age on cognitive representations of others. *Health Psychology, 17*(6), 494–503. https://doi.org/10.1037/0278-6133.17.6.494

Carstensen, L. L., Isaacowitz, D. M., & Charles, S. T. (1999). Taking time seriously: A theory of socioemotional selectivity. *American Psychologist, 54*(3), 165–181. https://doi.org/10.1037/0003-066X.54.3.165

Chu, Q., Grühn, D., & Holland, A. M. (2018). Before I die: The impact of time horizon and age on bucket-list goals. *GeroPsych: The Journal of Gerontopsychology and Geriatric Psychiatry, 31*(3), 151. https://psycnet.apa.org/doi/10.1024/1662-9647/a000190

Cohen-Mansfield, J., Cohen, R., Skornick-Bouchbinder, M., & Brill, S. (2018). What is the end of life period? Trajectories and characterization based on primary caregiver reports. *The Journals of Gerontology: Series A: Biological Sciences and Medical Sciences, 73*(5), 695–701. https://doi-org.prox.lib.ncsu.edu/10.1093/gerona/glx195

Colosimo, K., Nissim, R., Pos, A. E., Hales, S., Zimmermann, C., & Rodin, G. (2018). "Double awareness" in psychotherapy for patients living with advanced cancer. *Journal of Psychotherapy Integration, 28*(2), 125. https://psycnet.apa.org/doi/10.1037/int0000078

Coombs, M., & Long, T. (2008). Managing a good death in critical care: can health policy help?. *Nursing in critical care, 13*(4), 208-214. https://doi.org/10.1111/j.1478-5153.2008.00280.x

Corpora, M. (2022). The privilege of a good death: An intersectional perspective on dying a good death in America. *The Gerontologist, 62*(5), 773–779. https://doi-org.prox.lib.ncsu.edu/10.1093/geront/gnab130

Cottrell, L., & Duggleby, W. (2016). The "good death": An integrative literature review. *Palliative & supportive care, 14*(6), 686-712. https://doi.org/10.1017/S1478951515001285

Daley, R. T., O'Connor, M. K., Shirk, S. D., & Beard, R. L. (2017). 'In this together' or 'going it alone': Spousal dyad approaches to Alzheimer's. *Journal of Aging Studies*, *40*, 57–63. https://doi-org.prox.lib.ncsu.edu/10.1016/j.jaging.2017.01.003

Dillon, P. J., & Basu, A. (2016). African Americans and hospice care: A culture-centered exploration of enrollment disparities. *Health Communication, 31*(11), 1385-1394. https://doi.org/10.1080/10410236.2015.1072886

Duyan, V., Serpen, A. S., Duyan, G., & Yavuz, S. (2016). Opinions of social workers in Turkey about the principles on die with dignity. *Journal of Religion and Health, 55*(6), 1938–1953. https://doi-org.prox.lib.ncsu.edu/10.1007/s10943-015-0090-x

Early, A. S., Reynolds, C. M., & Neupert, S. D. (2024). Traumatic losses permeate daily emotional experiences: Roles of daily uplifts and subjective age. *Applied Psychology: Health and Well-Being*. http://doi.org/10.1111/aphw.12530

Feigelman, W., Jordan, J. R., & Gorman, B. S. (2009). How they died, time since loss, and bereavement outcomes. *Omega: Journal of Death and Dying, 58*(4), 251–273. https://doi.org/10.2190/OM.58.4.a

Fliedner, M., Zambrano, S., Schols, J. M. G. A., Bakitas, M., Lohrmann, C., Halfens, R. J. G., & Eychmüller, S. (2019). An early palliative care intervention can be confronting but reassuring: A qualitative study on the experiences of patients with advanced cancer. *Palliative Medicine, 33*(7), 783–792. https://doi.org/10.1177/0269216319847884

Fried, E. I., Bockting, C., Arjadi, R., Borsboom, D., Amshoff, M., Cramer, A. O. J., Epskamp, S., Tuerlinckx, F., Carr, D., & Stroebe, M. (2015). From loss to loneliness: The relationship between bereavement and depressive symptoms. *Journal of Abnormal Psychology, 124*(2), 256–265. https://doi-org.prox.lib.ncsu.edu/10.1037/abn0000028

Funk, L., Krawczyk, M., Cherba, M., Cohen, S. R., Dujela, C., Nichols, C., & Stajduhar, K. (2023). 'The beauty and the less beautiful': exploring the meanings of dying at 'home' among community and practitioner representatives and advocates across Canada. *Palliative Care and Social Practice, 17*. https://journals.sagepub.com/doi/pdf/10.1177/26323524231156944

Gerlach, K., Ram, N., Infurna, F. J., Vogel, N., Wagner, G. G., & Gerstorf, D. (2017). The role of morbidity for proxy-reported well-being in the last year of life. *Developmental Psychology, 53*(9), 1795–1809. https://doi.org/10.1037/dev0000368

Gerstorf, D., & Ram, N. (2013). Inquiry into terminal decline: Five objectives for future study. *The Gerontologist, 53*(5), 727–737. https://doi-org.prox.lib.ncsu.edu/10.1093/geront/gnt046

Giasson, H. L., Liao, H. W., & Carstensen, L. L. (2019). Counting down while time flies: Implications of age-related time acceleration for goal pursuit across adulthood. *Current opinion in psychology, 26*, 85-89. https://doi.org/10.1016/j.copsyc.2018.07.001

Gold, D. T. (2011). Late-life death and dying in 21st-century America. In *Handbook of aging and the social sciences* (pp. 235-247). Academic Press. https://doi.org/10.1016/B978-0-12-380880-6.00017-4

Gonzalez Sepulveda, J. M, Baid, D., Johnson, F. R., & Finkelstein, E. A. (2022). What is a good death? A choice experiment on care indicators for patients at end of life. *Journal of Pain and Symptom Management, 63*(4), 457–467. https://doi-org.prox.lib.ncsu.edu/10.1016/j.jpainsymman.2021.11.005

Harms, C., & Lakens, D. (2018). Making'null effects' informative: statistical techniques and inferential frameworks. *Journal of clinical and translational research*, *3*(Suppl 2), 382. https://pmc.ncbi.nlm.nih.gov/articles/PMC6412612/

Henderson, D. X., Bond, G. D., Alderson, C. J., & Walker, W. R. (2015). This too shall pass: Evidence of coping and fading emotion in African Americans' memories of violent and nonviolent death. *Omega: Journal of Death and Dying, 71*(4), 291–311. https://doi-org.prox.lib.ncsu.edu/10.1177/0030222815572601

Higginson, I. J., & Sen-Gupta, G. J. A. (2000). Place of care in advanced cancer: a qualitative systematic literature review of patient preferences. *Journal of palliative medicine, 3*(3), 287-300. https://doi.org/10.1089/jpm.2000.3.287

Horning, M. A., Shin, J. Y., DiFusco, L. A., Norton, M., & Habermann, B. (2019). Symptom progression in advanced Parkinson's disease: Dyadic perspectives. *Applied nursing research, 50*, 151193. https://doi.org/10.1016/j.apnr.2019.151193

Hyde, M., Wiggins, R. D., Higgs, P., & Blane, D. B. (2003). A measure of quality of life in early old age: The theory, development and properties of a needs satisfaction model (CASP-19). *Aging & Mental Health, 7*, 186–194. doi:10.1080/1360786031000101157

Infurna, F. J., Gerstorf, D., Ram, N., Schupp, J., Sprangers, M. A. G., & Wagner, G. G. (2014). Linking concurrent self-reports and retrospective proxy reports about the last year of life: A prevailing picture of life satisfaction decline. *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences, 69*(5), 695–709. https://doi-org.prox.lib.ncsu.edu/10.1093/geronb/gbt055

Järviö, T., Nosraty, L., & Aho, A. L. (2023). Older individuals' perceptions of a good death: A systematic literature review. *Death Studies, 47*(4), 476–489. https://doi-org.prox.lib.ncsu.edu/10.1080/07481187.2022.2092787

Kellehear, A. (2005). *Compassionate Cities: Public Health and End of Life Care*. Routledge, New York.

Kiecolt-Glaser, J. K., & Wilson, S. J. (2017). Lovesick: How couples' relationships influence health. *Annual review of clinical psychology, 13*(1), 421-443. https://doi.org/10.1146/annurev-clinpsy-032816-045111

Klass, D. (2006). Continuing conversation about continuing bonds. *Death Studies, 30*(9), 843-858. https://doi-org.prox.lib.ncsu.edu/10.1080/07481180600886959

Kline, R. B. (2016). *Principles and practice of structural equation modeling*, *4th edition*. Guilford publications.

Kmetec, S., Fekonja, Z., Kolarič, J. Č., Reljić, N. M., McCormack, B., Sigurðardóttir, Á. K., & Lorber, M. (2022). Components for providing person-centred palliative healthcare: An umbrella review. *International Journal of Nursing Studies, 125*. https://doi-org.prox.lib.ncsu.edu/10.1016/j.ijnurstu.2021.104111

Kotter-Grühn, D., Grühn, D., & Smith, J. (2010). Predicting one's own death: the relationship between subjective and objective nearness to death in very old age. *European Journal of Ageing, 7*(4), 293-300. https://doi.org/10.1007/s10433-010-0165-1

Krikorian, A., Maldonado, C., & Pastrana, T. (2020). Patient's perspectives on the notion of a good death: A systematic review of the literature. *Journal of pain and symptom management, 59*(1), 152-164. https://doi.org/10.1016/j.jpainsymman.2019.07.033

Kunzmann, U., & Grühn, D. (2005). Age differences in emotional reactivity: The sample case of sadness. *Psychology and Aging, 20*, 47-59. https://psycnet.apa.org/doi/10.1037/0882-7974.20.1.47

Kunzmann, U., Katzorreck, M., Wieck, C., Schilling, O., Lücke, A. J., & Gerstorf, D. (2022). Emotion regulation in old and very old age. *Emotion, 22*(7), 1473–1486. https://doi.org/10.1037/emo0001075

Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of personality, 1*(3), 141-169.

Li, Z., Tosteson, T. D., & Bakitas, M. A. (2013). Joint modeling quality of life and survival using a terminal decline model in palliative care studies. *Statistics in medicine, 32*(8), 1394-1406. https://doi.org/10.1002/sim.5635

Librada-Flores, S., Nabal-Vicuña, M., Forero-Vega, D., Muñoz-Mayorga, I., & Guerra-Martín, M. D. (2020). Implementation Models of Compassionate Communities and Compassionate Cities at the End of Life: A Systematic Review. *International Journal of Environmental Research and Public Health, 17*(17), 6271. https://doi.org/10.3390/ijerph17176271 https://doi.org/10.1002/per.2410010304

Lunney, J. R., Albert, S. M., Boudreau, R., Ives, D., Satterfield, S., Newman, A. B., Harris, T., & Health Aging and Body Composition Study. (2018). Mobility trajectories at the end of life: comparing clinical condition and latent class approaches. *Journal of the American Geriatrics Society, 66*(3), 503-508. https://doi.org/10.1111/jgs.15224

Mancini, A. D., & Bonanno, G. A. (2009). Predictors and parameters of resilience to loss: Toward an individual differences model. *Journal of personality, 77*(6), 1805-1832. https://doi.org/10.1111/j.1467-6494.2009.00601.x

Mehler, D. M., Edelsbrunner, P. A., & Matić, K. (2019). Appreciating the significance of non-significant findings in psychology. *Journal of European Psychology Students, 10*(4), 1-7. https://doi.org/10.5334/e2019a

Moon, J. R., Kondo, N., Glymour, M. M., & Subramanian, S. V. (2011). Widowhood and mortality: a meta-analysis. *PloS one, 6*(8), e23465. https://doi.org/10.1371/journal.pone.0023465

Moore, J. E., Titler, M. G., Kane Low, L., Dalton, V. K., & Sampselle, C. M. (2015). Transforming patient-centered care: Development of the Evidence Informed Decision Making through Engagement Model. *Women's Health Issues, 25*(3), 276–282. https://doi-org.prox.lib.ncsu.edu/10.1016/j.whi.2015.02.002

Naef, R., Ward, R., Mahrer-Imhof, R., & Grande, G. (2013). Characteristics of the bereavement experience of older persons after spousal loss: An integrative review. *International Journal of Nursing Studies, 50*(8), 1108–1121. https://doi-org.prox.lib.ncsu.edu/10.1016/j.ijnurstu.2012.11.026

Neimeyer, R. A. (2019). Meaning reconstruction in bereavement: Development of a research program. *Death Studies, 43*(2), 79–91. https://doi-org.prox.lib.ncsu.edu/10.1080/07481187.2018.1456620

Nesselroade, J. R. (1991). The warp and the woof of the developmental fabric. In R. M. Downs, L. S. Liben, & D. S. Palermo (Eds.), *Visions of aesthetics, the environment & development: The legacy of Joachim F. Wohlwill*. (pp. 213–240). Lawrence Erlbaum Associates, Inc.

Özyalçın Özcan, D., & Çevik, B. (2023). Opinions of cancer patients, their relatives, and nurses on good death. *OMEGA-Journal of Death and Dying, 86*(4), 1473-1492. https://doi.org/10.1177/00302228211053473

Papa, A., & Lancaster, N. (2016). Identity continuity and loss after death, divorce, and job loss. *Self and Identity, 15*(1), 47-61. https://doi.org/10.1080/15298868.2015.1079551

Peña-Longobardo, L. M., Rodríguez-Sanchez, B., & Oliva-Moreno, J. (2021). The impact of widowhood on wellbeing, health, and care use: A longitudinal analysis across Europe. *Economics & Human Biology, 43*, 101049. https://doi.org/10.1016/j.ehb.2021.101049

Pfaff, K. A., Dolovich, L., Howard, M., Sattler, D., Zwarenstein, M., & Marshall, D. (2020). Unpacking 'the cloud': A framework for implementing public health approaches to palliative care. *Health Promotion International, 35*(1), 160–170. https://doi-org.prox.lib.ncsu.edu/10.1093/heapro/day123

Quigley, D. D., & McCleskey, S. G. (2021). Improving care experiences for patients and caregivers at end of life: A systematic review. *American Journal of Hospice & Palliative Medicine, 38*(1), 84–93. https://doi-org.prox.lib.ncsu.edu/10.1177/1049909120931468

Reynolds, C. M., & Grühn, D. (2023). Does time heal all wounds? An investigation of time, grief, and attitudes toward death. *Death Studies.* https://doi.org/10.1080/07481187.2023.2297065

Reynolds, C. M., & Grühn, D. (2024). *The end-of-life phase as part of the lifespan: The Self, Health, Future-Time model*. [Manuscript in preparation]. Department of Psychology, North Carolina State University.

Rhodes, R. L., Elwood, B., Lee, S. C., Tiro, J. A., Halm, E. A., & Skinner, C. S. (2017). The desires of their hearts: the multidisciplinary perspectives of African Americans on end-of-life care in the African American community. *American Journal of Hospice and Palliative Medicine®, 34*(6), 510-517. https://doi.org/10.1177/1049909116631776

Rodin, G., & Zimmermann, C. (2008). Psychoanalytic reflections on mortality: a reconsideration. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 36*(1), 181-196. https://doi.org/10.1521/jaap.2008.36.1.181

Scheel, A. M., Tiokhin, L., Isager, P. M., & Lakens, D. (2021). Why hypothesis testers should spend less time testing hypotheses. *Perspectives on Psychological Science*, *16*(4), 744-755. https://doi.org/10.1177/1745691620966795

Schwartz, L. E., Howell, K. H., & Jamison, L. E. (2018). Effect of time since loss on grief, resilience, and depression among bereaved emerging adults. *Death Studies, 42*(9), 537–547. https://doi.org/10.1080/07481187.2018.1430082

Sedhom, R., Nudotor, R., Freund, K. M., Smith, T. J., Cooper, L. A., Owczarzak, J. T., & Johnston, F. M. (2021). Can community health workers increase palliative care use for African American patients? A pilot study. *JCO Oncology Practice, 17*(2), e158-e167.

Singham, T., Bell, G., Saunders, R., & Stott, J. (2021). Widowhood and cognitive decline in adults aged 50 and over: A systematic review and meta-analysis. *Ageing Research Reviews, 71*, 101461. https://doi.org/10.1016/j.arr.2021.101461

Spahni, S., Morselli, D., Perrig-Chiello, P., & Bennett, K. M. (2015). Patterns of psychological adaptation to spousal bereavement in old age. *Gerontology, 61*(5), 456–468. https://doi-org.prox.lib.ncsu.edu/10.1159/000371444

Staudt, C. (2013). Whole-person, whole-community care at the end of life. *Virtual Mentor, 13*(12):1069-1080. doi: 10.1001/virtualmentor.2013.15.12.msoc1-1312

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: A decade on. *OMEGA-journal of Death and Dying, 61*(4), 273-289. https://doi.org/10.2190/OM.61.4.b

Stroebe, M., & Schut, H. (2016). Overload: A missing link in the dual process model? *Omega: Journal of Death and Dying, 74*(1), 96–109. https://doi-org.prox.lib.ncsu.edu/10.1177/0030222816666540

Strough, J., Bruine de Bruin, W., Parker, A. M., Lemaster, P., Pichayayothin, N., & Delaney, R. (2016). Hour glass half full or half empty? Future time perspective and preoccupation with negative events across the life span. *Psychology and aging, 31*(6), 558. https://psycnet.apa.org/doi/10.1037/pag0000097

Temel, J. S., Greer, J. A., Muzikansky, A., Gallagher, E. R., Admane, S., Jackson, V. A., Dahlin, C. M., Blinderman, C. D., Jacobsen, J., Pirl, W. F., Billings, J. A., & Lynch, T. J. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 363(8), 733–742. doi: 10.1056/NEJMoa1000678

Thompson, B. (2000). Ten commandments of structural equation modeling. In L. G. Grimm & P. R. Yarnold (Eds.), *Reading and understanding MORE multivariate statistics*. (pp. 261–283). American Psychological Association.

Tong, E., Mcgraw, S. A., Dobihal, E., Baggish, R., Cherlin, E., & Bradley, E. H. (2003). What is a good death? Minority and non-minority perspectives. *Journal of Palliative Care, 19*(3), 168-175. https://doi.org/10.1177/082585970301900304

Townsend, A., March, A. L., & Kimball, J. (2017). Can faith and hospice coexist: Is the African American church the key to increased hospice utilization for African Americans? *Journal* *of Transcultural Nursing, 28*(1), 32–39. https://doi-org.prox.lib.ncsu.edu/10.1177/1043659615600764

Turner, V., & Flemming, K. (2019). Socioeconomic factors affecting access to preferred place of death: A qualitative evidence synthesis. *Palliative Medicine, 33*(6), 607–617. https://doi-org.prox.lib.ncsu.edu/10.1177/0269216319835146

Vargens, O. M. D. C., & Berterö, C. (2012). The phantom of death improving quality of life: you live until you die. *American Journal of Hospice and Palliative Medicine®, 29*(7), 555-562. https://doi.org/10.1177/1049909111432450

van Wijngaarden, E., & Sanders, J. (2022). 'I want to die on my own terms': Dominant interpretative repertoires of 'a good death' in old age in Dutch newspapers. *Social Science & Medicine*, *311*, 115361. https://doi.org/10.1016/j.socscimed.2022.115361

Vernon, E., Hughes, M. C., & Kowalczyk, M. (2022). Measuring effectiveness in community-based palliative care programs: A systematic review. *Social Science & Medicine*, *296*. https://doi-org.prox.lib.ncsu.edu/10.1016/j.socscimed.2022.114731

Visser, R. C. (2017). "Doing death": Reflecting on the researcher's subjectivity and emotions. *Death Studies, 41*(1), 6–13. https://doi-org.prox.lib.ncsu.edu/10.1080/07481187.2016.1257877

Weston, R., & Gore, P. A., Jr. (2006). A Brief Guide to Structural Equation Modeling. *The Counseling Psychologist, 34*(5), 719–751. https://doi-org.prox.lib.ncsu.edu/10.1177/0011000006286345

Willig, C. (2015). "My bus is here": A phenomenological exploration of "living-with-dying." *Health Psychology, 34*(4), 417–425. https://doi-org.prox.lib.ncsu.edu/10.1037/hea0000176

Willig, C., & Wirth, L. (2018). A meta-synthesis of studies of patients' experience of living with terminal cancer. *Health Psychology, 37*(3), 228–237. https://doi-org.prox.lib.ncsu.edu/10.1037/hea0000581

World Health Organization. (2020). *The top 10 causes of death*. https://www.who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death

World Health Organization. (2024). *Life expectancy at birth (years)*. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/life-expectancy-at-birth-(years)

Wu-Chung, E. L., Leal, S. L., Denny, B. T., Cheng, S. L., & Fagundes, C. P. (2022). Spousal caregiving, widowhood, and cognition: a systematic review and a biopsychosocial framework for understanding the relationship between interpersonal losses and dementia risk in older adulthood. *Neuroscience & Biobehavioral Reviews, 134*, 104487. https://doi.org/10.1016/j.neubiorev.2021.12.010

Yancu, C. N., Farmer, D. F., & Leahman, D. (2010). Barriers to hospice use and palliative care services use by African American adults. *American Journal of Hospice and Palliative Medicine®,* 27(4), 248-253. https://doi.org/10.1177/1049909109349942

Table 1. *Demographic and socioemotional measures from the main survey.*

		Age	Women	SWL	Negative Affect	Quality of Life
Wave 1	Surviving (*n*= 888)	66.7 (9.7)	65.2%		2.6 (2.4), α = .731	
	Deceased (*n*= 1096)	69.5 (8.3)	37.0%		2.4 (2.4), α = .726	
Wave 2	Surviving (*n*= 1184)	68.7 (9.6)	64.3%	7.4 (1.9)	2.8 (2.5), α = .740	2.0 (0.6), α = .825
	Deceased (*n*= 1530)	71.2 (8.6)	37.7%	7.4 (1.9)	2.7 (2.5), α = .740	2.1 (0.6), α = .821
Wave 4	Surviving (*n*= 2234)	69.9 (9.3)	70.3%	7.5 (1.9)	3.0 (2.5), α = .714	2.0 (0.5), α = .805
	Deceased (*n*= 2921)	72.9 (9.2)	33.9%	7.4 (2.0)	3.1 (2.6), α = .729	2.1 (0.6), α = .804
Wave 5	Surviving (*n*= 2341)	72.2 (9.5)	69.0%	7.4 (1.9)	2.8 (2.4), α = .733	2.0 (0.5), α = .815
	Deceased (*n*= 3084)	75.2 (9.2)	34.7%	7.2 (2.1)	3.2 (2.6), α = .754	2.1 (0.6), α = .817
Wave 6	Surviving (*n*= 2473)	73.4 (9.7)	71.7%	7.5 (1.9)	3.0 (2.5), α = .724	2.0 (0.5), α = .826
	Deceased (*n*= 3476)	77.0 (9.3)	33.8%	7.2 (2.1)	3.5 (2.7), α = .747	2.2 (0.6), α = .823
Wave 7	Surviving (*n*= 2902)	73.9 (9.1)	75.0%	7.1 (2.0)	3.8 (2.8), α = .748	2.1 (0.6), α = .827
	Deceased (*n*= 2114)	78.4 (9.6)	33.2%	7.0 (2.2)	3.7 (2.8), α = .753	2.3 (0.6), α = .822
Wave 8	Surviving (*n*= 2030)	76.7 (8.6)	74.4%	7.2 (1.9)	3.7 (2.8), α = .760	2.0 (0.6), α = .826

Note. SWL: Satisfaction with Life on a 1 (*completely dissatisfied*) to 10 (*completely satisfied*) scale. Negative Affect list of 13 items from the EURO-D scale. Quality of Life: on a 1 (*often*) to 4 (*never*) scale, 12 items from the CASP measure.

Table 2. *Physical and cognitive functioning measures from the main survey.*

		Health	Physical Activities	ADLs	Memory	Reading	Writing
Wave 1	Surviving (*n*= 888)	3.1 (1.1)	1.7 (2.2)	0.4 (1.3)		2.5 (1.2)	2.7 (1.2)
	Deceased (*n*= 1096)	3.3 (1.1)	1.8 (2.2)	0.5 (1.4)		2.6 (1.2)	2.8 (1.3)
Wave 2	Surviving (*n*= 1184)	3.3 (1.1)	2.0 (2.5)	0.6 (1.7)		2.6 (1.3)	2.7 (1.3)
	Deceased (*n*= 1530)	3.5 (1.1)	2.2 (2.6)	0.7 (1.7)		2.7 (1.2)	2.8 (1.3)
Wave 4	Surviving (*n*= 2234)	3.5 (1.0)	2.2 (2.5)	0.6 (1.6)	3.2 (0.9)	2.6 (1.1)	2.7 (1.1)
	Deceased (*n*= 2921)	3.8 (1.0)	2.8 (2.8)	1.0 (2.1)	3.3 (1.0)	2.8 (1.2)	3.0 (1.2)
Wave 5	Surviving (*n*= 2341)	3.4 (1.1)	2.1 (2.5)	0.6 (1.7)	3.2 (0.9)	2.5 (1.2)	2.7 (1.2)
	Deceased (*n*= 3084)	3.8 (1.0)	3.1 (3.0)	1.4 (2.5)	3.5 (1.0)	2.8 (1.3)	3.0 (1.3)
Wave 6	Surviving (*n*= 2473)	3.5 (1.0)	2.1 (2.5)	0.5 (1.4)	2.9 (1.0)	2.4 (1.1)	2.6 (1.1)
	Deceased (*n*= 3476)	4.0 (1.0)	3.7 (3.2)	2.0 (3.1)	3.2 (1.1)	2.8 (1.2)	3.0 (1.2)
Wave 7	Surviving (*n*= 2902)	3.5 (1.0)	2.3 (2.6)	0.6 (1.6)	3.0 (1.1)	2.5 (1.2)	2.7 (1.2)
	Deceased (*n*= 2114)	4.1 (0.9)	4.0 (3.3)	2.2 (3.2)	3.7 (0.9)	3.0 (1.3)	3.2 (1.3)
Wave 8	Surviving (*n*= 2030)	3.5 (1.0)	2.6 (2.8)	0.9 (2.0)	3.2 (0.9)	2.7 (1.1)	2.8 (1.1)

Note. Health: self-reported on a 1 (*excellent*) to 5 (*poor*) scale. Physical Activities: list of 10 physical activities. ADLs: Activities in Daily Living list of 10 everyday tasks. Memory: self-reported on a 1 (*excellent*) to 5 (*poor*) scale. Reading: self-reported on a 1 (*excellent*) to 5 (*poor*) scale. Writing: self-reported on a 1 (*excellent*) to 5 (*poor*) scale.

Table 3. *Correlation matrix of surviving partners self-reported health with difficulty in physical activities and activities in daily life (ADLs).*

		General Health						
		Wave 1	Wave 2	Wave 4	Wave 5	Wave 6	Wave 7	Wave 8
Wave 1	Physical Activity	.46***	.41***	.38***	.39***	.26***	.30***	.18***
	ADLs	.31***	.30***	.23***	.27***	.10*	.15***	.03
Wave 2	Physical Activity	.39***	.56***	.42***	.41***	.33***	.36***	.33***
	ADLs	.24***	.40***	.27***	.30***	.22***	.26***	.26***
Wave 4	Physical Activity	.39***	.47***	.54***	.47***	.41***	.38***	.35***
	ADLs	.14*	.28***	.33***	.28***	.22***	.21***	.17***
Wave 5	Physical Activity	.43***	.47***	.48***	.55***	.43***	.41***	.35***
	ADLs	.33***	.33***	.32***	.36***	.26***	.26***	.21***
Wave 6	Physical Activity	.36***	.38***	.44***	.44***	.52***	.45***	.37***
	ADLs	.24***	.26***	.25***	.24***	.32***	.28***	.23***
Wave 7	Physical Activity	.41***	.44***	.40***	.45***	.45***	.52***	.41***
	ADLs	.33***	.28***	.26***	.28***	.28***	.35***	.27***
Wave 8	Physical Activity	.40***	.43***	.43***	.44***	.43***	.42***	.53***
	ADLs	.27***	.28***	.25***	.27***	.25***	.26***	.40***

Note. *** $p < .001$. ** $p < .01$. * $p < .05$.

Table 4. *Correlation matrix of deceased partners self-reported health with difficulty in physical activities and activities in daily life (ADLs).*

		General Health					
		Wave 1	Wave 2	Wave 4	Wave 5	Wave 6	Wave 7
Wave 1	Physical Activity	.52	.41	.35	.35	.28	.23
	ADLs	.38	.27	.27	.20	.20	.18
Wave 2	Physical Activity	.46	.56	.39	.42	.34	.30
	ADLs	.36	.38	.25	.27	.24	.19
Wave 4	Physical Activity	.42	.44	.50	.43	.36	.34
	ADLs	.30	.31	.35	.29	.26	.25
Wave 5	Physical Activity	.38	.45	.45	.56	.42	.33
	ADLs	.32	.35	.30	.42	.32	.28
Wave 6	Physical Activity	.32	.40	.41	.47	.56	.41
	ADLs	.29	.29	.28	.34	.43	.33
Wave 7	Physical Activity	.34	.31	.33	.40	.45	.53
	ADLs	.30	.22	.22	.32	.35	.43

Note. All correlations are significant (i.e., $p < .001$).

Table 5. *Correlation matrix of surviving partners self-reported memory with self-reported reading and writing skills.*

		Memory				
		Wave 4	Wave 5	Wave 6	Wave 7	Wave 8
Wave 4	Reading	.45***	.27***	.09	--	.21***
	Writing	.46***	.30***	-.34	--	.24***
Wave 5	Reading	-.73	.50***	--	--	.22***
	Writing	-.40	.49***	--	--	.22***
Wave 6	Reading	.81**	.52	.46***	--	.29***
	Writing	.77*	.53	.50***	--	.33***
Wave 7	Reading	.28***	.26***	.92**	.59***	.37***
	Writing	.29***	.26***	.84*	.52**	.39***
Wave 8	Reading	--	--	--	--	.48***
	Writing	--	--	--	--	.58***

Note. *** $p < .001$. ** $p < .01$. * $p < .05$. Empty spaces represent missing data too large for analysis to compute.

Table 6. *Correlation matrix of deceased partners self-reported memory with self-reported reading and writing skills.*

		Memory			
		Wave 4	Wave 5	Wave 6	Wave 7
Wave 4	Reading	.43***	.28***	.59	--
	Writing	.46***	.32***	.62	--
Wave 5	Reading	-.05	.47***	.06	--
	Writing	-.14	.47***	-.09	--
Wave 6	Reading	.83**	.02	.44***	--
	Writing	.72*	.01	.49***	--
Wave 7	Reading	.27***	.33***	--	.48
	Writing	.29***	.30***	--	.53

Note. *** $p < .001$. ** $p < .01$. * $p < .05$. Empty spaces represent missing data too large for analysis to compute.

Table 7. *Correlation matrix of surviving partners satisfaction with life with quality of life and negative affect.*

		Satisfaction with Life					
		Wave 2	Wave 4	Wave 5	Wave 6	Wave 7	Wave 8
Wave 2	Quality of Life	-.59	-.44	-.49	-.37	-.38	-.39
	Negative Affect	-.46	-.36	-.31	-.25	-.16	-.20
Wave 4	Quality of Life	-.42	-.55	-.37	-.39	-.32	-.29
	Negative Affect	-.31	-.41	-.31	-.27	-.17	-.17
Wave 5	Quality of Life	-.41	-.40	-.55	-.44	-.41	-.37
	Negative Affect	-.30	-.33	-.40	-.28	-.20	-.23
Wave 6	Quality of Life	-.37	-.38	-.45	-.57	-.42	-.40
	Negative Affect	-.24	-.27	-.30	-.39	-.26	-.22
Wave 7	Quality of Life	-.30	-.32	-.38	-.40	-.57	-.37
	Negative Affect	-.20	-.26	-.24	-.29	-.44	-.24
Wave 8	Quality of Life	-.35	-.36	-.33	-.35	-.44	-.56
	Negative Affect	-.23	-.28	-.23	-.23	-.32	-.42

Note. All correlations are significant ($p < .001$).

Table 8. *Correlation matrix of deceased partners satisfaction with life with quality of life and negative affect.*

		Satisfaction with Life				
		Wave 2	Wave 4	Wave 5	Wave 6	Wave 7
Wave 2	Quality of Life	-.60	-.42	-.36	-.39	-.41
	Negative Affect	-.45	-.30	-.28	-.23	-.26
Wave 4	Quality of Life	-.36	-.55	-.38	-.35	-.27
	Negative Affect	-.28	-.44	-.28	-.23	-.22
Wave 5	Quality of Life	-.39	-.41	-.57	-.43	-.40
	Negative Affect	-.33	-.30	-.42	-.27	-.26
Wave 6	Quality of Life	-.39	-.38	-.42	-.60	-.42
	Negative Affect	-.26	-.31	-.34	-.46	-.30
Wave 7	Quality of Life	-.29	-.28	-.34	-.38	-.57
	Negative Affect	-.17	-.22	-.25	-.30	-.43

Note. All correlations are significant ($p < .001$).

Table 9. *Dying person's context from the end-of-life interview.*

	Wave 7 (*n*= 2270)	Wave 8 (*n*= 2837)
Age of Decease	78.0 (9.6)	78.2 (9.8)
Cause of Death	29.3% (Cancer) 27.9% (Cardiovascular) 10.7% (Stroke)	28.8% (Cancer) 27.3% (Cardiovascular) 10.2% (Stroke)
Place of Death	52.1% (Hospital) 31.1% (Home) 14.1% (some other place)	46.0% (Hospital) 36.6% (Home) 14.7% (some other place)
Hospice or Palliative Care	24.2% (Yes)	22.2% (Yes)
Medicine for Pain	59.6% (Yes)	59.2% (Yes)
Medicine Amount	48.1% (Right amount)	47.8% (Right amount)
Autonomy and Control	7.1 (6.3)	7.3 (6.4)
Respect from staff	1.4 (0.8)	1.4 (0.7)
Rate of care	2.0 (1.0)	2.1 (1.0)
Feelings of sadness	47.1% (Yes)	47.3% (Yes)

Note. Autonomy and Control: 16-item list of difficulties in physical and independent-related tasks. Respect from staff: proxy-reported on a 1 (*always*) to 4 (*never*) scale. Rate of care: proxy-reported on a 1 (*excellent*) to 4 (*poor*) scale.

Table 10. *Confirmatory factor analysis of model fit indices.*

Model	$\chi 2$	df	*CFI*	*TLI*	*RMSEA*	pRMSEA<.05
1	46.8	5	.932	.865	.041 (.030-.051)	.921
2	**3.2**	**2**	**.998**	**.994**	**.011 (.000-.032)**	**1.000**
3	345.0	5	.628	-.116	.085 (.077-.093)	< .001
4	104.9	5	.963	.926	.099 (.083-.116)	< .001
5	**4.2**	**2**	**.999**	**.997**	**.023 (.000-.055)**	**.910**
6	108.6	5	.956	.868	.047 (.039-.055)	.734
7	61.5	19	.985	.978	.021 (.015-.027)	1.000
8	23.2	5	.981	.963	.027 (.016-.038)	1.000
9	17.1	5	.994	.989	.035 (.018-.054)	.889
10	**93.5**	**26**	**.979**	**.971**	**.023 (.018-.028)**	**1.000**
11	3264.5	43	.499	.231	.089 (.087-.092)	< .001
12	91.8	25	.980	.971	.023 (.018-.028)	1.000
13	**222.7**	**100**	**.980**	**.963**	**.010 (.008-.012)**	**1.000**

Note. **Bolded** models represent the models used for main analyses and discussion.

Table 11. *Surviving partner's living well differences depending on time since the loss, accounting for age.*

	Time since the Loss				
	0-1 years	2-3 years	4+ years		
Main Effects Models	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*F*	Effect size
Physical Health	3.5 (1.0)[a]	3.6 (1.0)[a]	3.5 (1.0)[a]	2.01	.002
Satisfaction with Life	7.0 (2.0)[a]	7.3 (1.9)[ab]	7.3 (1.9)[b]	**4.16**	**.004**
Quality of Life	2.1 (0.5)[a]	2.0 (0.6)[a]	2.0 (0.6)[a]	0.86	.001
Negative Affect	4.3 (2.7)[a]	3.5 (2.7)[bc]	3.2 (2.8)[bc]	**24.85**	**.025**
Main Models with the Covariate Age					
Physical Health	3.5 (1.0)[a]	3.6 (1.0)[a]	3.5 (1.0)[a]	2.31	.002
Satisfaction with Life	7.0 (2.0)[a]	7.3 (1.9)[a]	7.3 (1.9)[a]	**3.10**	**.003**
Quality of Life	2.1 (0.5)[a]	2.0 (0.6)[a]	2.0 (0.6)[a]	1.55	.002
Negative Affect	4.3 (2.7)[a]	3.5 (2.7)[b]	3.2 (2.8)[b]	**25.46**	**.025**

Note. The time since the loss groups were 0-1 years (n = 880), 2-3 years (n = 992), and 4+ years (n = 550). Physical health: 5-likert scale, 1 (*excellent*) to 5 (*poor*). Satisfaction with Life: 10-likert scale, 1 (*completely dissatisfied*) to 5 (*complete satisfied*). Quality of Life: on a 1 (*often*) to 4 (*never*) scale, averaged 12 items from the CASP measure. Negative Affect list of 13 items from the EURO-D scale; high score represents more negative affect. Bronferroni post-hoc analyses were conducted between the different time groups; values with different superscripts are significantly different. Effect sizes for these models were partial eta^2. **Bolded** models represent significant effects ($p < .05$).

Table 12. *Testing for model invariance in multi-group structural equation models based on time since the loss.*

	$\chi2$	df	CFI	TLI	RMSEA	$\Delta\chi2$	Δdf	*p*
Unconstrained	222.7	100	.980	.963	.010			
Measurement weights	237.7	121	.981	.971	.009	15.0	21	.823
Measurement intercepts	323.8	148	.971	.964	.010	86.1	27	< .001
Structural weights	331.6	154	.970	.965	.010	7.8	6	.253
Structural residuals	339.1	160	.970	.966	.010	7.5	6	.277
Measurement residuals	363.6	187	.971	.972	.009	24.5	27	.602

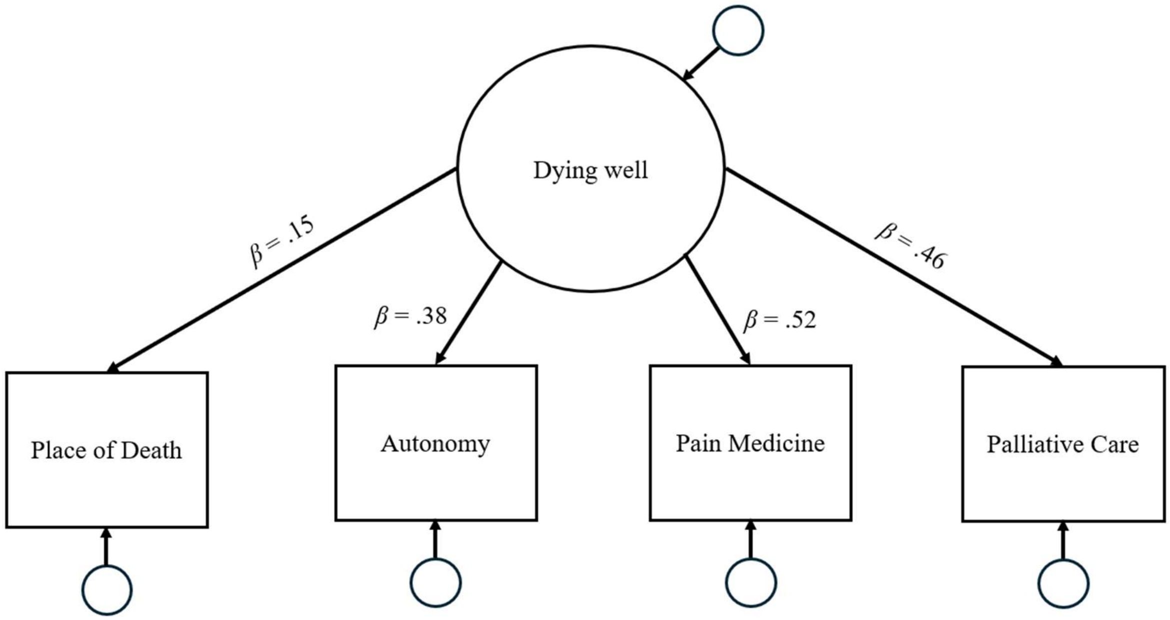
Note. The constraints are based on Model 13. The groups were based on time since the loss (i.e., 0-1 years, 2-3 years, and 4+ years).

Table 13. *Testing for model invariance across multi-group structural equation models based on proxy-relationship to the deceased.*

	$\chi2$	df	CFI	TLI	RMSEA	$\Delta\chi2$	Δdf	*p*
Unconstrained	205.4	75	.980	.964	.011			
Measurement weights	222.2	89	.979	.969	.010	16.8	14	.267
Measurement intercepts	304.4	107	.970	.962	.011	82.2	18	< .001
Structural weights	353.2	111	.963	.955	.012	48.8	4	< .001
Structural residuals	382.3	115	.959	.952	.013	29.1	4	< .001
Measurement residuals	408.4	133	.958	.957	.012	26.1	18	.097

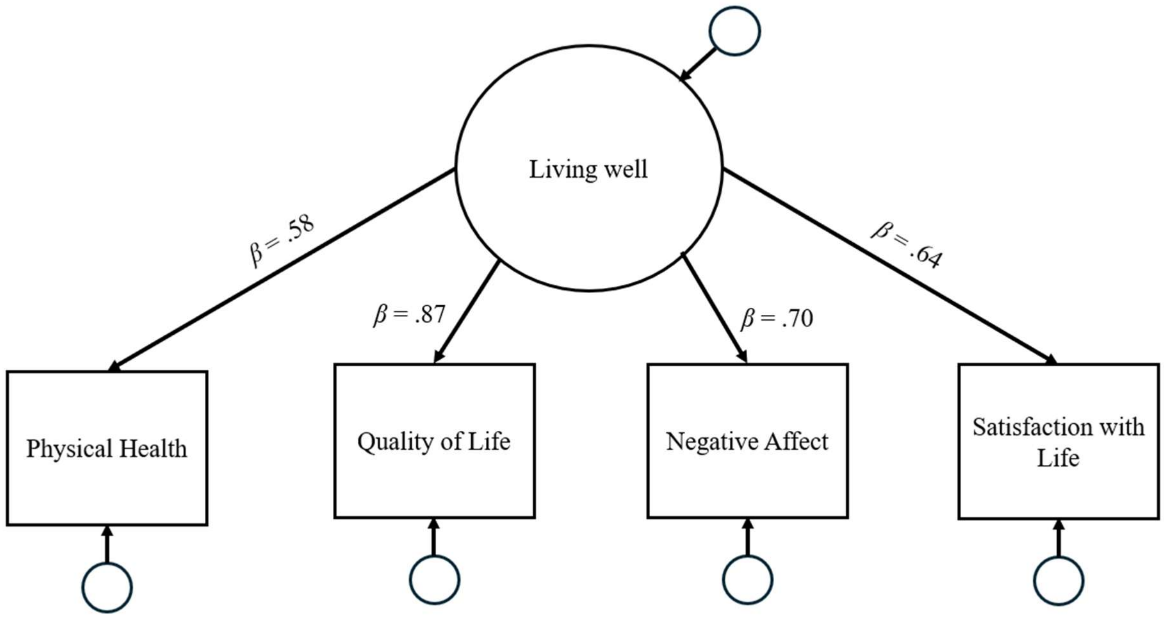
Note. The constraints are based on Model 13. The groups were based on proxy relationships to the deceased (i.e., spousal relationship or non-spousal relationship).

Figure 1. *Confirmatory factor analysis of dying well.*



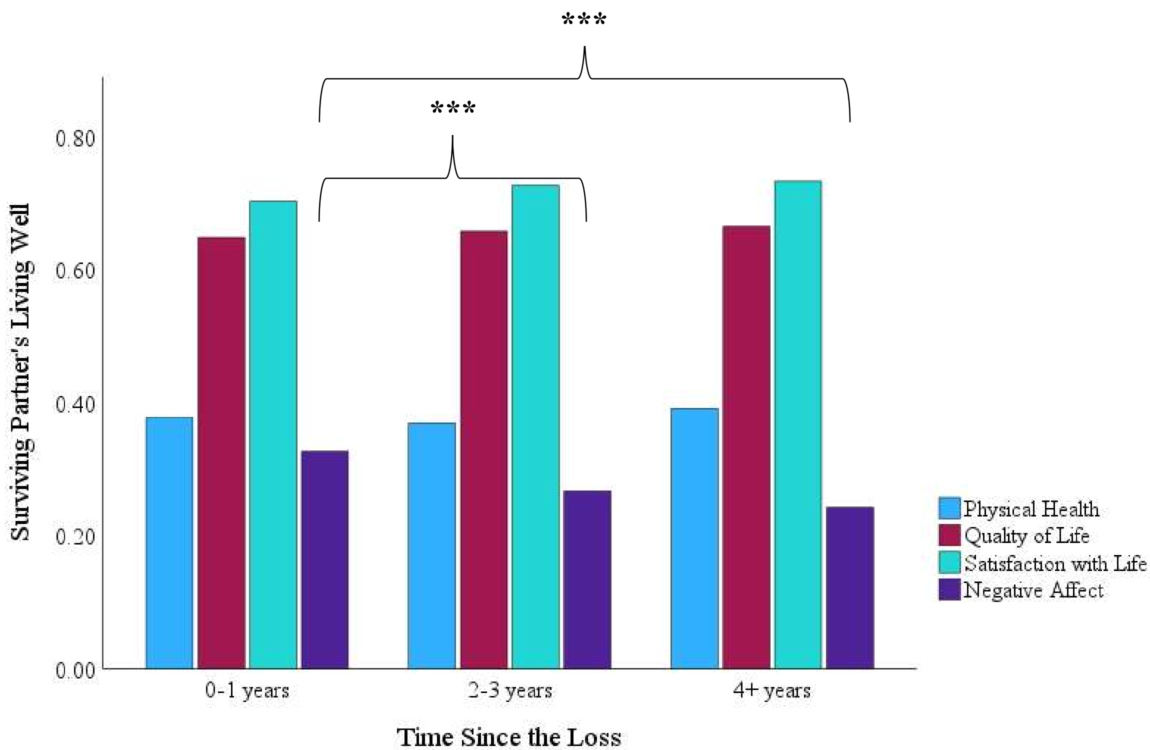
Note. All parameters are significant (p < .001), and the regression weights are standardized. Model 2 fit indices, $\chi 2$ (2) = 3.2, p = .204, *CFI*= .998, *TLI*= .994, *RMSEA* = .011 (.000-.032), $_{\text{pRMSEA<.05}}$ = 1.00.

Figure 2. *Confirmatory factor analysis of living well***.**



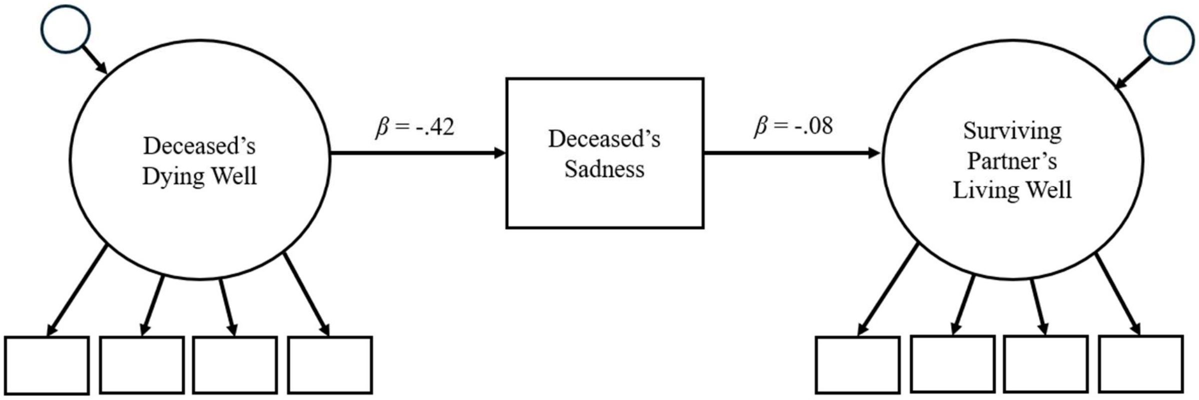
Note. All parameters are significant (p < .001), and the regression weights are standardized. Model 5 fit indices, $\chi 2$ (2) = 4.2, p = .124, *CFI*= .999, *TLI*= .997, *RMSEA* = .023 (.000-.055), $_{\text{pRMSEA<.05}}$ = .910.

Figure 3. *Surviving partner's living well dependent on time since the loss.*



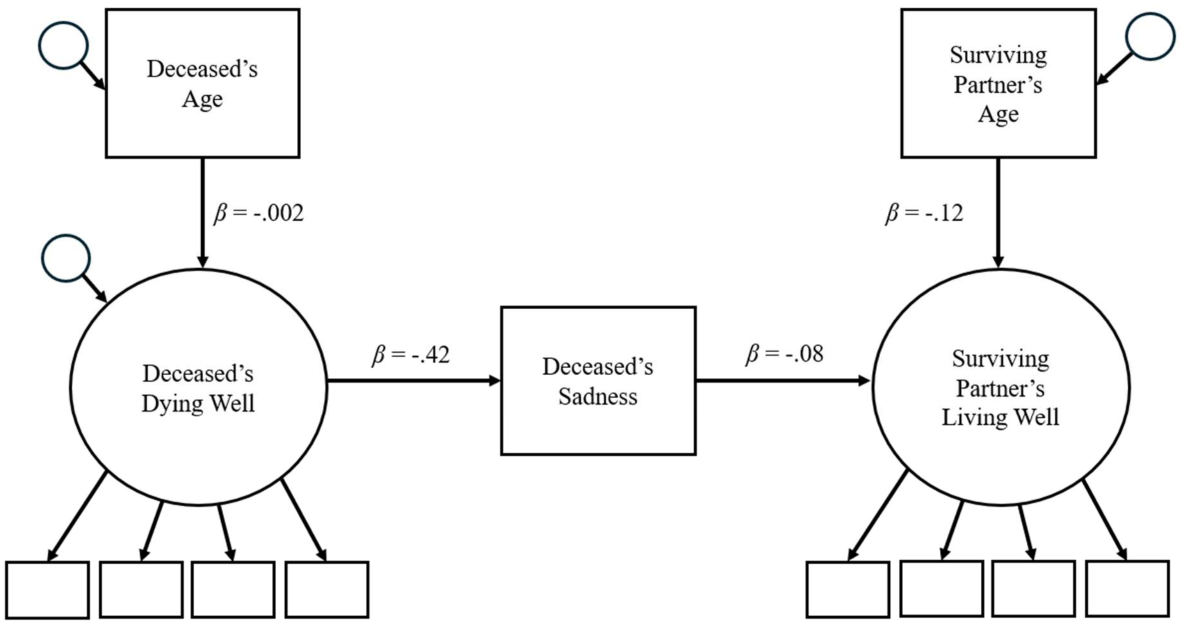
Note. All living well components are rescaled to be on a 0-1 continuous scale. Physical health and quality of life were reverse coded, so that higher score represented better health and quality of life. High scores in satisfaction of life represent being satisfied with life. High scores in negative affect represent more negative affect. Brackets represent Bronferroni post-hoc analyses. * $p < .05$. ** $p < .01$. *** $p < .001$.

Figure 4. *Surviving partner's living well predicted by the deceased partner's sadness and their dying context.*



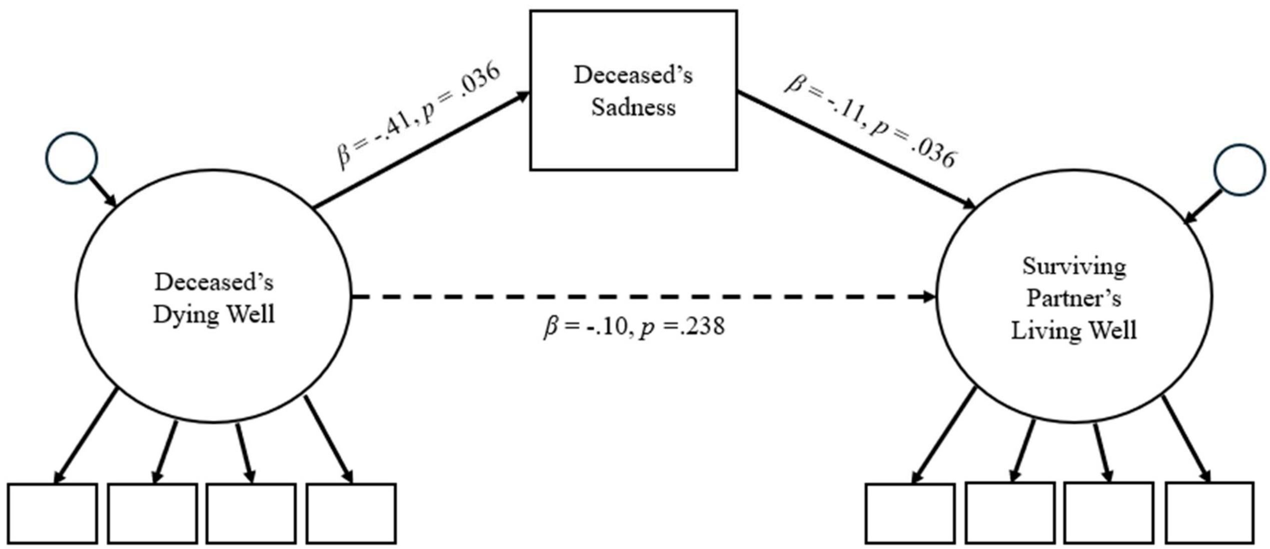
Note. Model 10 fit indices, $\chi 2$ (26) = 93.5, $p < .001$, *CFI*= .979, *TLI*= .971, *RMSEA* = .023 (.018-.028), $_{pRMSEA<.05}$ = 1.00. All parameters are significant ($p < .001$).

Figure 5. *Surviving partner's living well predicted by the deceased partner's sadness and their dying context, accounting for age.*



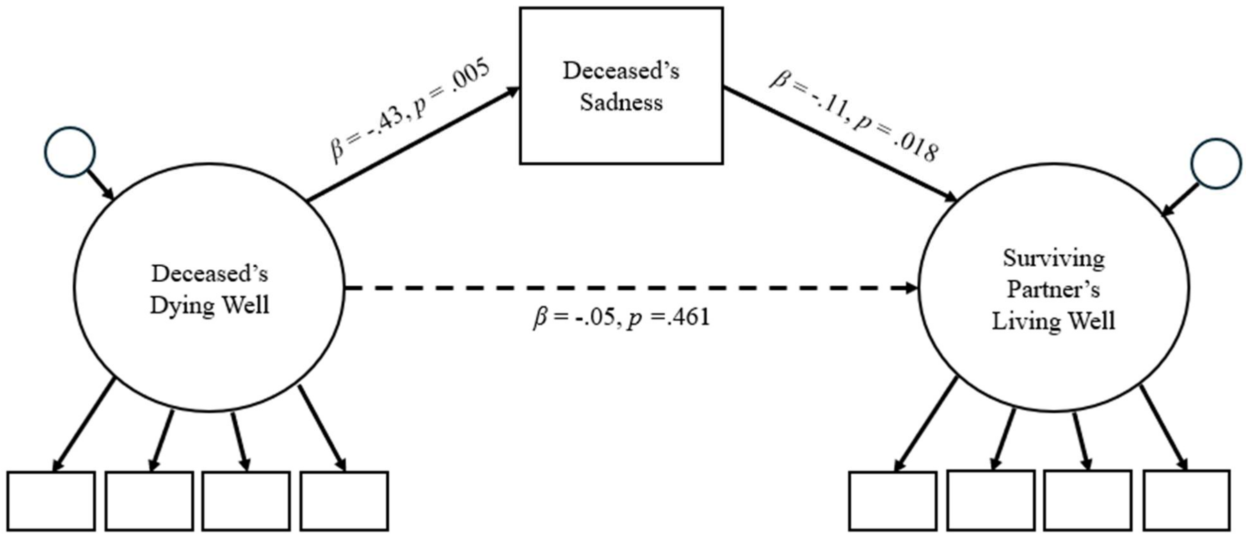
Note. Model 11 fit indices: $\chi2$ (43) = 3264.5, $p < .001$, *CFI*= .499, *TLI*= .231, *RMSEA* = .089 (.087-.092), $_{\text{pRMSEA<.05}}$ < .001. All parameters are significant, except deceased's dying well regressed on deceased's age (β = -.002, p = .918).

Figure 6. *For spousal losses 0-1 years ago, surviving partner's living well predicted by the deceased partner's sadness and their dying context.*



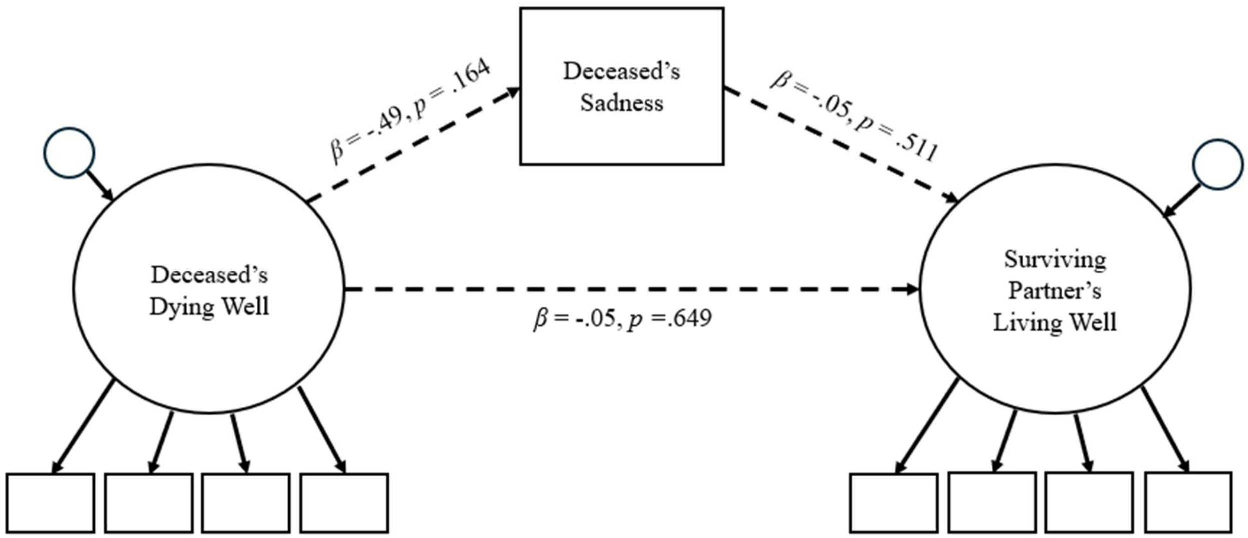
Note. 0-1 years since the loss. Model 13 fit indices: $\chi 2$ (100) = 222.7, $p < .001$, *CFI*= .980, *TLI*= .963, *RMSEA* = .010 (.008-.012), $_{\text{pRMSEA<.05}}$ = 1.00.

Figure 7. *For spousal loss 2-3 years ago, surviving partner's living well predicted by the deceased partner's sadness and their dying context.*



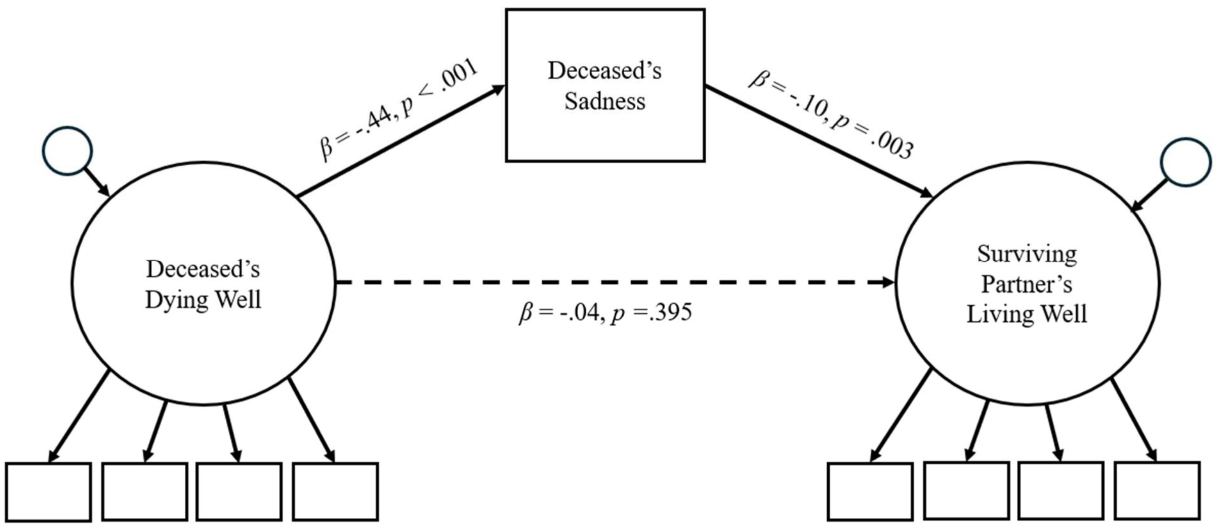
Note. 2-3 years since the loss. Model 13 fit indices: $\chi 2$ (100) = 222.7, $p < .001$, *CFI*= .980, *TLI*= .963, *RMSEA* = .010 (.008-.012), $_{pRMSEA<.05}$ = 1.00.

Figure 8. *For spousal loss 4+ years ago, surviving partner's living well predicted by the deceased partner's sadness and their dying context.*



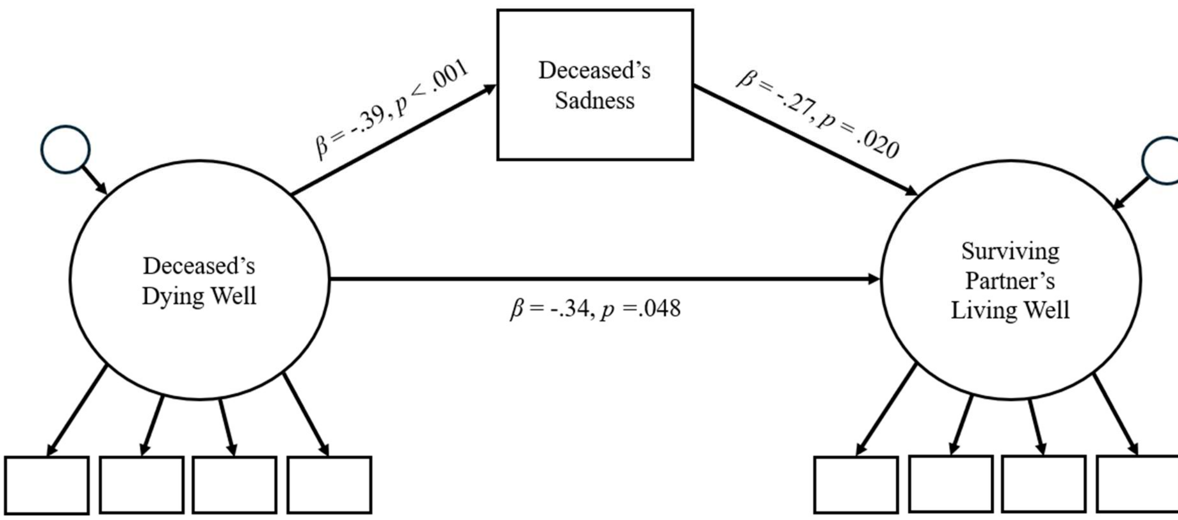
Note. 4+ years since the loss. Model 13 fit indices: $\chi 2$ (100) = 222.7, p < .001, *CFI*= .980, *TLI*= .963, *RMSEA* = .010 (.008-.012), $_{pRMSEA<.05}$ = 1.00.

Figure 9. *For spousal proxy-report data, surviving partner's living well predicted by the deceased partner's sadness and their dying context.*



Note. Mode fit indices: $\chi2$ (75) = 205.4, p < .001, *CFI*= .980, *TLI*= .964, *RMSEA* = .011 (.009-.013), $_{\text{pRMSEA<.05}}$ = 1.00.

Figure 10. *For non-spousal proxy-reported data, surviving partner's living well predicted by the deceased partner's sadness and their dying context.*



Note. Mode fit indices: $\chi 2$ (75) = 205.4, $p < .001$, *CFI*= .980, *TLI*= .964, *RMSEA* = .011 (.009-.013), $_{\text{pRMSEA}<.05}$ = 1.00