Coping Strategies of Rural Widows:

A Partial Replication

by

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Chapter I

Introduction

One of life's most stressful events for a married person is becoming widowed. Those widowed in the United States comprise 50.5% of all females over 65 and 13.7% of all males 65 and over (U.S. Bureau of the Census, 1988). The bereaved person is at risk for increased physical, social and emotional morbidity, and increased mortality (Glick, Weiss, & Parkes, 1974; Parkes, 1964; Rees & Lutkins, 1967).

Heyman and Gianturco (1973) found that most of the widows they studied adjusted well; however, 25% of the 41 widows were appreciably depressed 21 months after the death of their husbands. Other investigators have demonstrated that while many people handle losses without severe emotional distress, a substantial number develop pathological grief reactions requiring skilled professional assistance (Cummings & Henry, 1961; Stern, Williams, & Prados, 1951). The majority of bereaved people do recover with the aid of available supports in the community, but it is important to identify those individuals at risk early in their grief and offer appropriate assistance.

Many older individuals faced with the loss of a loved one live in rural settings. Being a widow and living in a rural area poses a double jeopardy to quality of life in the later years (Kivett, 1978), due in part to limited resources while dealing with the loss of a spouse. This aging population has also suffered the prejudices of ageism, the limitations of fixed income, and the stigma of our

society's customs and mores which do not sanction the role of widowhood (e.g., there is little recognition that widowhood is a part of adult living).

While rural values stress holism and general well-being, they also tend to emphasize conservatism, resistance to change, a tendency to distrust outsiders, a reliance on family and a strong feeling that one ought to handle one's own problems (Hassinger, 1976). A good deal of research indicates that these values make rural people less likely to seek care (Flax, Wagenfeld, Ivens, & Weiss, 1979).

Purpose

The purpose of this study was twofold: 1) to identify helpful and unhelpful coping patterns of older widows residing in a rural environment, and 2) to determine the relationship between ways of coping and health dysfunction following bereavement. This study was a partial replication of Dr. Kathleen Gass (1987a & 1987b) research study with the recently widowed. A rural sample of widows was used in this study.

One of the functions of nurses in general, and mental health nurses specifically, is to help individuals cope with stressors. Mental health nurses do not know whether coping strategies differ for people in the rural areas. Thus, knowledge of coping strategies of the rural widow may help mental health nurses facilitate the widow's transition to widowhood, spelling the difference between integrity and despair in adjustment (Roscow, 1967).

Review of the Literature

Research on bereavement and grief has been widely published in the nursing literature. Studies from the past 15 years were reviewed with a specific focus on the literature that addressed rural widows or widowers. What follows are brief overviews of widowhood and rurality. The overviews are followed by a description and critique of six research studies that focus specifically on the rural widowed. The review of literature concludes with a description of the research (Gass 1987a & 1987b) that was partially replicated.

Overview of Widowhood. The intense emotional distress following the death of a loved one often has features similar in nature and intensity to those of clinical depression. Most clinicians and theorists agree that although both grieving and depression share some of the same features they represent different conditions (Osterweis, Solomon, & Green, 1984). Parkes (1972) states that many people develop physical symptoms during the period of grieving and are seen by medical doctors who may or not be aware of the emotional origin of these symptoms. Brock and O'Sullivan (1985) contend that many widows are diagnosed as suffering from "illness" when in fact they are manifesting characteristics of poor psychological well-being. On the other hand, Blau (1975) considers grief an illness from which most people recover with scars and by which some people are severely disabled. It is important for nurses to be aware of the nature of bereavement that persons so affected will not be overlooked or misdiagnosed.

Lopata (1973) examined bereavement and grieving from a sociological perspective and concluded that being widowed is a transitional phenomenon. What the widow has to do is either cope with a series of events or fail to do so and realize substantial problems or crisis. However, 46% of the older widows studied by Lopata felt that they and their social life were unaffected by their husband's death. The literature is replete with data indicating that individuals who had highly ambivalent relationships with their spouses do worse than people whose relationships did not have these characteristics (Osterweis, Solomon, & Green, 1984).

Many studies of widowhood can be broadly classified into two closely related categories: 1) those investigating social support as a mediator (Abraham, 1972; Arling, 1976; Gubrium, 1974; Marrs, 1958; Richter, 1987); and 2) those dealing with pathological outcomes such as mortality, suicide and depression (Bock & Webber, 1972; Borstein et al., 1973; Feinson, 1986; Jones, 1987; Parkes, 1964, 1965, 1970; Parkes, Benjamin, & Fitzgerald, 1969; Rees & Lutkins, 1967; Townsend, 1957; Young, Benjamin, & Wallis, 1963). The importance of widowhood is evidenced in the ongoing research in this area. However, research with the rural widowed has been limited. Studies of widows and widowers from rural areas will be considered after a brief overview on rurality.

Overview of Rurality. The standard definition of rural according to the United States Census Bureau is a population of less than 2,500 people. This definition is deceptively simple. Rural, by this

definition, includes wide-open spaces sparsely sprinkled with people, relatively isolated pockets of people, and small town and suburban areas in or near larger metropolitan areas. Not all rural areas are the same. Rural does not necessarily mean remote. Within this definition of rural population, however, there are two subgroups identified: rural farm and rural nonfarm. Rural farm refers to those persons who live on farms. The census definition of farm is 10 acres or more from which sales of farm products amounted to $50 or more in the previous year, or less than 10 acres from which sale of farm products amounted to $250 or more (U. S. Bureau of Census 1971).

In 1978 the President's Commission on Mental Health concluded that rural communities tend to be characterized by limited opportunities for developing adequate coping mechanisms for facing stress and for problem solving. This conclusion was based on the Task Panel's literature review and empirical experience.

> Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression; by severe intergenerational conflicts; by an exodus of individuals who might serve as effective role models for coping; by an acceptance of conditions as being beyond individual control and by an acceptance of fatalistic attitudes and minimal subscription to the idea that change is possible (President's Commission on Mental Health, 1978, p. 1164).

The need to recognize not only illness patterns in the lives of

rural individuals but also the breakdown of coping mechanisms of rural citizens and the dysfunctions inherent in rural community support system has been noted (President's Commission on Mental Health, 1978). Reynolds, Banks, and Murphree (1976), in examining a rural county, suggested that normative features of rural areas include a rigid social structure that tended to minimize or retard the introduction of new ideas or to bring about change.

People are stigmatized for having psychological problems; this poses a particular problem in rural areas. Because of lack of anonymity and confidentiality, it is very difficult to hide anything in a small town. The stigma associated with mental illness is purported to be a major factor in the resistance of rural residents to mental health services. Rabkin (1974), in a review of the literature on attitudes toward mental illness, pointed out that very little data on rural populations existed.

In addition, few studies have been done comparing rural and urban widows in spite of the fact that over 50% of urban elderly and close to 40% of rural elderly are widowed (U.S. Bureau of the Census, 1973). A few studies have compared the characteristics of individuals who experience old age in rural versus urban settings. Lee and Lassey (1980), for example, indicate that rural elderly are not overall as healthy, and are not likely to receive professional help when they need it. They consider rural people as insecure and more lonely than their urban counterparts.

Most gerontologists have spent little time studying the rural

elderly because many believe that the developmental tasks of aging are similar in both rural and urban environments (Coward, 1980). However, Coward notes that there is common agreement among gerontologists that the delivery of services in small towns and rural communities differs from the delivery of such services in metropolitan areas. When alternative activities are insufficient because of physical isolation and limited opportunities, emotional support and companionship are also decreased considerably. The practitioner needs to take a critical look at what is known about the rural elderly widow in order to be better prepared to work with this population.

Research on the Rural Widowed. A preview of the literature from nursing, medicine and psychology revealed an overall paucity of research on the rural widowed. What is currently known about rural widowhood consists of primarily sociological information. Only six studies focused specifically on the rural widowed were found; each of these studies are reviewed below.

Roberto and Scott (1986) examined the involvement of two groups of elderly widowed individuals with children and friends. The two groups were rural elderly at different life stages: the young-old (ages 65-74) and the old-old (ages 75+). Only widowed persons with children were included in the study. The sample included 257 older widows and widowers residing in two Southwestern rural counties. The respondents were randomly selected using a compact cluster sampling technique and interviewed in their own homes by trained volunteers. The sample was drawn from a larger study (N=571) that dealt with the characteristics

and needs of older rural adults. The respondents had been widowed on the average for 12.4 years.

The widowed in Roberto and Scott's (1986) study were asked if they had received help from their children and/or a close friend in the past year with such chores as yardwork or shopping. They were also asked if they had participated with their children and/or close friends in any social activities in the past year (e.g., indoor/ outdoor recreation, vacations, birthday celebrations).

The measures used were questions which were answered with a yes (1) or no (0) and the scores were summed. The authors did not address reliability and validity of these measures with the exception of the three-item health index (Cronbach's alpha, .77). Using this health index, the respondents were asked to self-rate their overall health status and then compare it to five years ago. They were then to indicate the amount of happiness they were presently experiencing.

Analysis of covariances was performed to test for significant differences between the young-old and the old-old in help received and social activities. The number of years widowed and health served as covariates. Partial correlations were used to examine the relationship between involvement with social supports and the amount of happiness expressed by the young-old and the old-old widowed. The findings did not reveal significant differences in the use of informal supports by the young-old and the old-old.

One area that is not clear from Roberto and Scott's (1986) study is the information concerning involvement with friends. Only 51% of

the respondents answered the question pertaining to friends. Of those who responded, the young-old reported having 1 to 5 close friends as did the old-old. Ninety-two percent of the young-old who reported having close friends stated that they had monthly contact. In comparison, 97% of the old-old had monthly contact with their friends. One wonders about the 49% who did not respond to the item on friends. Roberto and Scott concluded that the self-selected rural sample may have contained more independent individuals who did not identify close friends.

A different methodological approach, using a time-activity diary as the tool, was utilized by Gibbs (1984). A structured 7-day time-activity diary was completed by 38 older widows residing in two contrasting non-metropolitan communities, a small town of about 34,000 people and a rural population of less than 1000. During a face-to-face interview, these women were asked to maintain a week long "wake-up until go-to-sleep-at-night" diary. Twenty women, widowed at least a year, from the rural community were asked to participate and two refused. After a week's time, a second interview was arranged in which the interviewer reviewed and clarified the items with the participants and probed for fuller explanations of the information in the diaries. Approximately 4,000 hours of the participants' waking time-use was recorded and analyzed through in-depth content analysis and statistical description.

Gibbs (1984) concluded from the information in the diaries that the inanimate surrogates of television and radio filled more time for

the widow than other activities, including interactions with other people. It was also evident that the social life of the older widow is spent mostly during daylight hours. Indeed, most of the widow's life, if spent in the presence of others, was in the company of other women usually of the same age and often widowed as well.

This study took an interesting approach to investigating people's use of time. The characteristics of the sample were fairly consistent. There was a slight difference, however, in the educational attainment of the two groups in that it was higher in the small town. There was also a considerable difference in current annual income; the rural women reported about half of the income of those of the small town group. The small town respondents were widowed from 1 to 42 years, while the rural widows were widowed from 3 to 30 years. With such a range one would speculate that responses might be dependent on the amount of grief work accomplished. If the women had been grouped according to years widowed, there might have been more differences. Although using a diary is a way to account for a person's time, this method is labor intensive for both the investigator and the respondent.

Fengler and Danigelis (1982) examined whether widows differ in objective characteristics (states of health, income, housing and transportation) and subjective characteristics (perceptions of health income and life satisfaction) depending on their place of residence. The purpose of this study was to determine the kind of life satisfaction which the widow experienced. The researchers divided the

sample into those who lived in urban and rural areas. The independent variable of residence was measured using the density and size of community. This resulted in communities having over 6000 population being considered urban while communities under 4000 were considered as rural.

The widowed sample (n=326) was part of a larger survey of 1400 elderly residing in a four county area in a New England state, 39% of whom were widowed. Two-thirds of the widowed subjects lived alone; a higher percentage of the widows lived in the city than in the country. Of those who did not live alone, 60% of them lived with their children. The other 40% lived with friends and other relatives, particularly siblings.

The instrument used in this research was a slightly modified version of the standardized Older American Status and Needs Assessment Survey. The survey included questions concerning health, income, transportation, housing, community participation, and life satisfaction. The measure of life satisfaction was derived from a factor analysis of a group of items, nine of which had been reproduced from the National Opinion Center Happiness Scale (Bradburn & Caplovitz, 1965). Three factors from Bradburn and Caplovitz's scale measured life satisfaction, happiness, isolation, and participation. The one question on happiness asked about feelings of boredom, depression or loneliness. The questions on isolation asked about frequency of visits with neighbors, number of friends who lived in the neighborhood, and whether respondent felt a part of community. For

participation, however, three questions were used to measure involvement in organizations, clubs, programs and religious services. Reliability or validity of the measures was not addressed.

The study showed rural widows as more content than urban widows and that the predictors of life satisfaction for rural and urban widows tended to be different. The rural sample's satisfaction depended primarily on actual health, perception of transportation and availability of someone to care for them. All of the rural widows and the urban widows living with children revealed higher life satisfaction than the urban widows who lived alone.

Scott and Kivett (1985) interviewed 257 widowed older adults to determine the effect of gender differences on their morale. The participants were selected by a compact cluster sampling technique from a larger (N=571) study. The subjects were 65 years and older and resided in a rural area. Twenty-one percent of the sample was male and 79% was female. The questionnaire included items covering nine major areas: demographic characteristics, housing, work and retirement, family and friends, health, nutrition, income, services and assistance, and psychological well-being. The measures used were as follows: 1) a five item self-rated health index which rated the overall health compared to five years ago (Cronbach's, alpha .74), 2) a three item index measuring the present financial status (Cronbach's, alpha .61), 3) a four item social interaction scale (Cronbach's alpha, .56), and 4) a revised version of the Philadelphia Geriatric Center Morale Scale (Lawton, 1975). There was no report of reliability or

validity for the morale measure.

Scott and Kivett (1985) found that the sex of the widowed person was not significantly associated with their morale. What was supported though was that the availability of resources, such as health, income, and education, influences the morale of older widows and widowers. The death of a spouse in later life would appear to be a crisis event requiring all of a person's resources to deal with the accompanying emotional and social stress. One factor that may have contributed to the lack of a relationship between the sex of the widowed person and morale could be the increased mortality rate for widowers. This may be a contributing factor to the lack of a relationship between the gender of the widowed person and morale.

Also, in this study, health status may have assumed added importance to both the widows and widowers because the rural area where the subjects were selected lacked adequate health care services. Scott and Kivett (1985) underscore the need for adequate health care for widowed older adults, especially as advancing years contribute to a decline in health.

Kivett (1978), in her study of rural widows, examined the importance of several variables to the level of loneliness. The sample (n=103), a subsample of a larger rural sample of 418 persons, was selected by including all those widows 65 and older who lived in a selected area. There was no information given concerning the length of time widowed or the financial situations of those widows. Reliability or validity of the measures was not addressed.

A questionnaire consisting of 99 items contained information relative to the physical, social and psychological characteristics of the individuals. The questionnaire was administered by a trained interviewer. Seventy percent of the subjects reported that their main work at age 50 was being a housewife. They also stated they had assisted in many farm responsibilities as well. Loneliness was measured with the question, "Do you find yourself feeling lonely quite often, sometimes, or almost never?" The 16 physical, social and psychological variables (such as physical mobility, education, a confidant, amount of free time) were each measured by specific questions. Life satisfaction and self-rated health were measured by the "Cantril ladder" technique (Cantril, 1965).

Results from this study showed that 3 out of 4 older rural widows surveyed experienced varying frequencies of loneliness, which could not be determined by any single cause. There was a difference between the group who reported "never lonely" and the group who reported "sometimes lonely" in terms of the quality of the relationships in their lives. The "frequently lonely" in contrast to the "never lonely", appeared to be characterized by poor perceived health, inadequate transportation, no confidant, and limitations in physical mobility as well as dissatisfaction with the frequency of contact with relatives and friends.

Kivett (1978) offers three major implications for action from this study: (a) the need for intervention processes that will provide more appropriate reference groups or role models for rural widows,

especially the physically and educationally disadvantaged; (b) the creation of intervention procedures that provide for preventive as well as corrective health measures; and (c) the development of accessible and flexible systems of transportation in rural areas.

Blackburn, Greenberg, and Boss (1987) examined the effect of loss on rural widows from one of the western mountain states. Of 58 names taken from courthouse records, 30 widows agreed to participate in the study. The participants responded to a questionnaire administered at 6 and 12 months after the death of the spouse. The questionnaire included items from the Psychological Father Presence Scale (Boss, 1983), the Family Coping Inventory (McCubbin, Boss, Wilson, & Dahl, 1979), three subscales from Derogates' SCL-90 R (Symptom Checklist) (Derogates, Lipman, & Covi, 1973), and the Rosenberg Self-Esteem Scale (Rosenberg, 1964). Each widow also completed a demographic and background information questionnaire at both times. The authors offered limited evidence of reliability and no evidence of validity for the above measures.

Cluster analysis was used with the Family Coping Inventory to determine what coping patterns were used most often and which coping patterns tended to change over time. Two cluster patterns were identified as helpful during the first six months. Cluster 1 (alpha =.91) contained five items which were identified as helpful by rural widows: doing things with my children, showing that I'm strong, becoming independent, trying to maintain family stability, and investing myself in my children. Thus, in the first six months,

investing in one's children and family while also becoming more independent appeared to be helpful to the widows in this sample. Cluster 2 (alpha=.93) contained five items which were identified as helpful by the rural widows: keeping myself in shape and well-groomed, engaging in relationships and friendships which are satisfying to me, involvement in social activities, building close relationships with people, and believing in God. These five items indicate that a second focus found helpful in the first six months of widowhood centered around social activities and religion.

Only one cluster of coping items were reported as helpful at 12 months. This cluster (alpha=.89) contained eight items that might have been perceived by the widows as being helpful: involvement in social activities, engaging in relationships with people, learning new skills, developing myself as a person, becoming more independent, planning my future, and making sure I take advantage of all the federal or state economic benefits I have coming to me. The findings indicate that there was a qualitative shift in the focus of coping behaviors over time.

This study demonstrates that it is possible for some widows to adjust to their new status and develop positive and satisfying lives as single women. However, several factors may have contributed to the normal grieving patterns of this sample. The participants were self-selected and those who were not adjusting as well could have chosen not to respond. Also, as Blackburn, Greenburg, and Boss (1987) suggest, the geographical location in which this study occurred

fosters rugged individualism which might be a key to successful coping of this particular group.

In summary, the six studies on the rural widowed indicate that successful coping depends on the resources available to the widowed. When widowhood occurs, persons in the support network may take on greater importance as sources of aid (Roberto & Scott, 1986). Five of the six studies obtained their subjects from a larger study; in two studies the subjects were randomly selected (Kivett, 1978; Roberto & Scott, 1986). There was a variety of existing measures used as well as newly created tools. All of the studies suggest that the feelings of greater dependency that arise from lack of resources can easily lead to a reduced sense of psychological well-being in the rural widow or widower.

The research of Dr. Kathleen Gass will be reviewed next. Gass's (1987a & 1987b) research was partially replicated for this research with a rural sample of widows.

Gass's Study. Gass (1987a & 1987b) obtained a convenience sample of 100 widows using burial records from Catholic parishes in a midwestern city. The purposes of her study were to identify helpful and unhelpful coping strategies which were used by older widows and to investigate the relationship between ways of coping and health dysfunction following bereavement. Criteria for inclusion in the study were that the husband had died between 1 and 12 months prior to the interview and the widow was aged 65 to 85 inclusive, not remarried, spoke English, and was not institutionalized. The widows

who met the criteria were mailed a letter of introduction and explanation of the study and within one week a phone call was made to ask their participation. Of the 153 widows who were contacted, 53 declined participation. This was a refusal rate of 34%. The respondents were white, Catholic, and bereaved from 74 days to 364 days. Forty percent of the sample had husbands who died a sudden death.

Coping was measured using Folkman and Lazarus (1980) Ways of Coping Checklist. This instrument describes a range of behavioral and cognitive coping strategies a person uses in a specific stressful situation. Items are classified into seven different ways of coping: problem-focused, wishful thinking, mixed (help-seeking/avoidance), growth, minimizes threat, seeks social support, and self-blame. Cronbach alphas for Gass's (1987b) widowed sample for the two overall coping scales and the seven subscales were: overall problem-focused (.69) and overall emotion-focused (.75); problem-focused (.62); wishful thinking (.66); mixed (.43); growth (.65); minimizes threat (.53); seeks social support (.48); and self-blame (.56). Reliabilities were lower than those for Lazarus' community sample who coped with the stressful events of daily living (Folkman & Lazarus, 1980) and may reflect differences in the samples studied (Lazarus & Folkman, 1984).

Health status was measured using the subscales of Gilson, Bergner, Bobbitt, and Carter's (1978) Sickness Impact Profile (SIP). The SIP is a behaviorally based measure which provides a reliable and valid

measure of health functioning. Items reflect the person's perception of his/her performance of certain activities. The subjects respond to only the items that describe them today. Each item has an assigned scale value indicative of the severity of the dysfunction. Test-retest coefficients (r=.97) for the overall instrument show a high level of reliability.

A variety of strategies were reported to be helpful by many of the widows. These were keeping busy, participation in social groups, learning new skills, review of the death, religion and prayers, talking with the deceased spouse, sensing the husband's presence, and recalling happy memories. Less helpful strategies were taking medications or alcohol, blaming oneself, bargaining or compromising, sleeping more, avoiding or getting mad at people, making promises to oneself, and using fantasy. Widows also reported receiving unhelpful or threatening information from friends or other widows which did not help them to cope with their bereavement. Another finding was that widows with high physical dysfunction also had high psychosocial dysfunction, while widows with low physical dysfunction had low psychosocial dysfunction.

Summary. In conclusion, the rural elderly widow and widower are vulnerable and at risk for illness. Many of these persons are overlooked by health professionals and often misdiagnosed as suffering from actual illnesses when indeed they are experiencing the phenomena of grieving. Others are treated for mental conditions when if assessed accurately the process of grieving would be understood.

Rural individuals have strengths which help them pursue their life-styles. They also have definite ideas which may make them less likely to seek help.

The literature indicates that of those widows who have children, their children are important to them especially in the first few months after the death of their spouse. Some of these rural elderly widows, however, do not seek help and are not sought out by others. Research has shown that widows use radio and television as replacements for socialization (Gibbs, 1984).

Neugarten (1968) believes that women go through a rehearsal for widowhood as they grow older and watch their friends going through the real thing; this lessens the effects of the death of their own husband. Perhaps this rehearsal works in conjunction with the rugged individualism of country living for the rural widow. Knowledge of what widows perceive as helpful is important for nurses so that they may be facilitators in the process of grieving. Mental health nursing specialists are well suited to provide bereavement care to the rural elderly because of their training and expertise in counseling and community action (American Nurses Association, 1982).

Conceptual Framework

Lazarus' Stress and Coping framework guided this study (Lazarus & Folkman, 1984). According to Lazarus, appraisal, coping, and the presence of psychological, social, and material resources are interrelated and associated with health following stressful experiences. In their research Folkman and Lazarus (1980) have

attempted to operationalize two basic forms of appraisal: primary appraisal (what is at stake for a person) and secondary appraisal (the person's evaluation of coping options). In primary appraisal, the degree of stress a person experiences depends on how much of a stake he/she has in the outcome of an encounter. The fundamental feature of secondary appraisal is the extent to which the person senses that something can or cannot be done to alter the troubled person-environment relationship. Lazarus and Folkman show that primary and secondary appraisal variables help explain coping and the emotional response.

It is important to identify the multiple demands in a stressful situation and assess coping with respect to those demands and how those demands shift over time. The way a demand is appraised influences the ways of coping employed to deal with the demand. Also, appraisal and coping are influenced by factors located within the individual and in the individual's environment. The processes of appraisal and coping are interrelated and factors influencing each may be common to both processes (Folkman & Lazarus, 1980, 1985).

Coping refers to strategies for dealing with threats. Bereavement is a demand which may produce threat. The degree of threat produced depends on how the bereavement is appraised and whether the bereaved can utilize coping strategies to deal with grief. Threat in the absence of adequate coping and counterharm (psychological, social and material) resources is associated with stress reactions which manifest themselves in negative health changes. An individual appraises a

situation in order to evaluate demands, options, and constraints. Appraisal is based on past experience, learning, and the availability of personal (problem-solving skills) and environmental resources, such as social and financial supports (Wrubel, Benner, & Lazarus, 1981). In addition, acquired attitudes and expectations exert a strong influence on the individual's perception of an event. Bereavement may be appraised as a harm or loss, as a loss with additional anticipated harms or losses, or as a challenge. If an event is perceived as undesirable or threatening, the individual is confronted with demands from the internal and external environment to change and adapt. The way a demand is appraised influences the ways of coping employed to deal with the demand. Factors which can influence coping include but are not limited to: degree of threat, the possibility of alternative coping actions, motive strength and ego resources and, general beliefs about the environment and one's resources (Lazarus, 1966).

Research Questions

The following research questions were addressed: 1) What are the helpful and unhelpful coping patterns of older widows and, 2) What is the relationship between coping and health dysfunction following bereavement in the older rural widow? These questions were taken directly from the Gass study, the only change being the addition of the word rural to the second research question.

Chapter II

Methods

Design

This study was a descriptive survey with a correlational design. The study was a partial replication of Gass' (1987a & 1987b) research with the recently widowed.

Subjects

A convenience sample of 15 widows was obtained from rural areas of a Pacific Northwest state. With one addition, the criteria for inclusion in the study were identical to Gass' (1987a & 1987b). Gass's criteria included: 1) the widow's spouse died between 1 and 12 months prior to the time of the interview; 2) the widow was between the ages of 65 and 85, inclusive; 3) the widow had not remarried; 4) the widow was able to understand and speak English; and 5) the widow was not institutionalized. The additional criteria for inclusion in the study was that the potential subjects be from rural areas.

For purposes of this study rural was defined as sparsely settled areas which lack substantial cities and many of the services of a metropolitan area. The widows all lived within a 50 mile radius of the investigator. Potential subjects were identified through the bereavement program at a regional university medical center, a funeral home that serves a rural population, and a home-based hospice program.

Selected demographic characteristics of the respondents are provided in Table 1. The 15 participants were aged 65 to 85 (M=73.8

Table 1

Description of Sample

	N	%
Quality of Marriage		
Very satisfied	8	53.3
Satisfied	7	46.7
Current Health		
Same	9	60.0
Better	5	33.3
Worse	1	6.7
Religion		
Roman Catholic	3	20.0
Protestant	8	53.0
Other	1	6.7
No preference	3	20.0
How religious		
Not at all	2	13.3
Somewhat	8	53.3
Very	5	33.3
Last year completed in school		
6	1	6.7
8	3	20.0
9	1	6.7
10	1	6.7
12	3	20.0
13	1	6.7
15	2	13.3
16	2	13.3
18	1	13.3
Highest academic degree		
None	4	26.7
Grade school diploma	2	13.3
High school diploma	4	26.7
Special diploma*-**	3	20.0
College degree	2	13.3

* 1 teacher certification
** 2 registered nurses

years) and they were married from 27 to 62 years (M=49.5 years). All of the widows were either satisfied or very satisfied with their marriages and all of the widows cared for their spouses at home anywhere from 1 to 48 months (M=24.3) before their husband's death. None of the deaths were considered sudden deaths although some widows didn't expect the death to occur as soon as it did. Sixty percent (n=9) of their spouses died at home and often the death occurred in the presence of the respondent and other family members. Thirty-three percent (n=5) of the widows claimed their health had improved since the death and was better than before their husband's death.

The majority of widows (n=9, 60%) had a high school diploma or greater as shown in Table 1. Two (13.3%) were also registered nurses. Forty percent (n=9) of the widows never worked in a paid position during their married life; the remainder worked in a variety of occupations (i.e., farm hand, nurse, welder, clerk, personnel manager, and teacher). Forty percent (n=6) did not drive a car, however, only 2 of these widows considered transportation a problem. The distance travelled to obtain groceries ranged from 2 to 30 miles (M=8.5 miles).

Eighty percent (n=12) claimed a religious affiliation; 97% (n=13) stated they were somewhat or very religious. Those who claimed they were very religious (n=5) stated that didn't mean "fanatic".

Measures

The measures administered are described below. They included: Appraisal of Bereavement, Ways of Coping Revised, Assessment of

Counterharm Resources, Sickness Impact Profile, and the Self Rating of Health (see Appendix A for a copy of the interview schedules). A Data Form was used to gather the descriptive data as well as responses to three open ended questions included in the form at the end of the personal interview. The three open-ended questions on the data form were analyzed using qualitative methods. Major themes and recurring concepts were identified.

Appraisal of Bereavement. A question developed by Gass (1987a & 1987b) measured the meaning of bereavement (see Appendix A). Three statements reflect stressful meanings and inquire of the widow whether the loss of her spouse was a harmful loss without other losses, fears, and problems; a harmful loss which has many other losses, fears, and problems to anticipate; or a challenge, that is, a stressful experience which the widow will overcome or master. Those widows who considered their bereavement a challenge also viewed their widowhood as an opportunity for growth.

Ways of Coping Revised. Ways of coping with bereavement was measured using Folkman and Lazarus' (1985) Ways of Coping Revised (WCR) (see Appendix A). The WCR is a 67 item measure describing a broad range of behavioral and cognitive coping strategies that a person might use in a specific stressful situation. The WCR differs from the original Ways of Coping Checklist (Folkman & Lazarus, 1980) in several ways. The response format in the original version was yes/no; on the revised version the subject responds on a 4-point Likert scale (0 = does not apply and/or not used; 3 = used a great

deal). Redundant and unclear items were deleted or reworded from the original checklist and several items, such as prayer, were added.

Reliability figures for the Ways of Coping Revised were based on the data from 48 men and 52 women aged 45 to 64 who coped with the stressful events of daily living during a one year period (Aldwin, Folkman, Schaefer, Coyne, & Lazarus, 1980; Folkman & Lazarus, 1980). Internal consistency reliability figures for WCR were .80 for the overall problem focused scale and .81 for the emotion focused scale (Folkman & Lazarus, 1980). In addition, Kirschling (1984) used the WCR with a sample of 72 widows and widowers from an urban area in the midwest.

To obtain reliability figures on a widowed sample, thirty-six of the widows from the Kirschling study (1984) were matched agewise and combined with the 15 widows from this present study. The developers of the WCR have proposed three different scale configurations based on their research with a student sample ($\underline{N}$=108), community sample ($\underline{N}$=74) and older sample ($\underline{N}$=161). Reliability figures were obtained for each of these scale configurations with the combined widowed sample ($\underline{n}$=41). The reliability data is presented in Table 2.

Based on the results for the combined widowed sample four subscales were selected for inclusion in the analysis of the data from the 15 rural widows. These subscales include: wishful thinking from the student sample, self-controlling and planful problem solving from the community sample, and distancing from the older sample. The alpha coefficients were compared across all of the subscales and the four

selected contained mutually exclusive items (that is no item appeared in more than one scale). A description of the coping subscales and the item numbers for the four subscales are presented in Table 3.

Health. Health status was operationalized in three ways by Gass (1987a & 1987b): physical health, psychosocial health and overall health. Two subscales of Gilson and colleagues' (1978) Sickness Impact Profile (SIP) (see Appendix A) were used to measure physical and psychosocial health status. The complete SIP consists of 136 items that address activities involved in carrying on one's life and reflects the person's perception of his or her performance of these activities.

The SIP was administered by the researcher. Subjects were asked to respond to only those items that describe them and are related to their health. Each SIP item has an assigned scale value indicative of severity of dysfunction. The dimension scores are calculated by adding the scale values for each item checked within the category dimensions, dividing by the maximum possible dysfunction scores for these categories, and then multiplying by 100. For both the physical and psychosocial dimensions, the larger the percent score, the greater the impairment of health functioning.

A self-rating of overall health was obtained by using the Cantril ladder (Cantril, 1965; Palmore & Luikart, 1972). On an equal interval 10 point scale ranging from 0 (representing lack of health) to 9 (representing perfect health), subjects were asked to rate their own health. Three of the four questions asked about the subject's health

Table 2

Reliability Data of WCR Scales

Scale name	Chronbach's Alpha	Widowed [d]	Interitem Correlations		Average Interitem Correlation
Student Sample [a]					
Problem-focused	.88	.76	-.13	.50	.22
Wishful thinking	.86	.78 [e]	.24	.64	.42
Detachment	.74	.38	-.17	.34	.09
Seeking social support	.82	.16	-.38	.30	.02
Focusing on positive	.70	.40	-.02	.24	.16
Self-blame	.76	.14	-.04	.16	.09
Tension reduction	.59	.37	.10	.24	.16
Keep to self	.65	.38	.11	.38	.22
Community Sample [b]					
Confronting coping	.70	.16	-.20	.25	.04
Distancing	.61	.47	-.25	.52	.12
Self-controlling	.80	.67 [e]	-.00	.48	.23
Seeking social support	.76	.42	-.10	.30	.11
Accept responsibility	.66	.25	-.15	.25	.08
Escape-avoidance	.72	.53	-.11	.54	.13
Planful problem solving	.68	.69 [e]	-.03	.52	.28
Positive reappraisal	.79	.44	-.21	.49	.10
Older Sample [c]					
Confrontive coping	.69	.17	-.07	.25	.06
Distancing	.60	.67 [e]	.13	.51	.33
Self-controlling	.56	.37	.04	.22	.13
Seek social support	.76	.41	-.04	.30	.12
Accept responsibility	.53	.23	-.04	.25	.11
Escape-avoidance	.59	.62	.11	.54	.31
Planful problem solving	.66	.65	.05	.52	.32
Positive reappraisal	.67	.39	-.21	.49	.16

a Folkman & Lazarus (1985)
b Folkman, Lazarus, Dunkel-Schetter, Delongis, & Gruen (1986)
c Folkman, Lazarus, Pimley, & Novacek (1987)
d Combined sample (Kirschling & Harris)
e Selected for analyses of data with 15 rural widows

Table 3

Description of the Four Coping Subscales Scales selected for Inclusion in this Study

Subscales	Item #'s*	Description
Distancing	13 21 41 44	Describes cognitive efforts to detach oneself to minimize the significance of the situation.
Wishful Thinking	11 55 57 58 59	Describes wishful thinking and behavioral efforts to escape or avoid the problem. Items on this scale contrast with those on the distancing scale, which suggest detachment.
Planful problem-solving	1 26 39 48 49 52	Describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem.
Self-Controlling	10 14 35 43 54 62 63	Describes efforts to regulate one's feelings and actions.

* See Appendix A Ways of Coping for actual items

right now, her health prior to the death of her spouse, and her health at three months following her spouse's death. The fourth question asked of the health of a married friend the same age of the widow. In terms of scoring the Cantril ladder, the higher the score, the better the health. No reliability coefficients are available for the Cantril ladder.

Counterharm. The Assessment of Counterharm Resources (ACR) was developed by Gass (1987a & 1987b) to measure counterharm resources reported in the literature which influence health outcome to bereavement. The ARC consists of 16 items (9 ordinal and 7 dichotomous) and assess counterharm resources. The scale is based on the extent to which each resource is present. The overall counterharm resource strength score was the sum of the scores on items 1 through 12 plus the sum of the scores on items 13 through 16 divided by 4. The higher the score the better the counterharm resources. Content validity was established through the literature review on factors influencing health following bereavement.

Procedures

This research was approved by the Human Subjects Committee of the Oregon Health Sciences University. A list of potential subjects was initially obtained from the bereavement program of a regional university medical center. This program had been in existence for four years and had served 458 families in 1988. From a list of 500 names only seven widows who fit the sampling criteria of living in a rural area and having had a spouse die within the last 12 months were

identified. The seven widows were mailed a "Letter of Explanation and Permission" which explained the study and invited her to participate. Enclosed with the letter was a stamped, addressed postcard to be returned if the widow wished not to participate (see Appendix B for the letter and postcard). Within a week after receiving the letter and postcard, the researcher contacted the widow by telephone to answer any questions, seek her participation in the study, confirm the criteria, and set up a time for an interview (see Sampling Form Appendix C). Only two widows from the bereavement program met all of the criteria and both agreed to participate.

The researcher then met with a person from a local funeral home and obtained an additional 18 names of widows whose husbands had died within the year and who resided in a rural area. Of the 18 who were mailed letters, two returned their postcards indicating they could not participate in the study. Four others could not be reached by telephone and of the remaining 12 telephoned, 7 met the criteria and agreed to participate. The procedure for securing subjects and for data collection were consistent with Gass's (1987a & 1987b) research.

The third set of potential subjects were called on the telephone by the social worker from the home-based hospice program to determine if they would want to participate in this study. Of the six widows who were called, all agreed to be contacted by the researcher. The researcher did not send a letter but instead called for an appointment to eliminate waiting for the letter to arrive. The researcher brought the letter and reviewed it with the subject prior to the start of the

interview. All of the widows were called before the day of the interview to confirm the interview day and time.

Data Collection

Data collection involved a one time face to face interview. At the start of the interview the subject was given an informed consent form to review and sign (Appendix D). The researcher read out aloud to the widow the entire form while the widow read along. After signing the consent form, the subject was given large typed copies of the questionnaires (see Appendix E) to be read concurrently while the researcher asked each question. Not everyone wished to read along due to either poor eyesight or the inability to think about the question while reading. The measures were administered in random order to control for possible order effects.

The subjects were reminded as to the length of the interview and the researcher frequently had to refocus the widow to continue with the interview schedules. At the conclusion of the interview time was allowed to discuss the areas that went beyond the focus of the interview. The average time spent with the widow was two hours.

Chapter III

Analyses and Results

In this chapter the results are addressed, including the findings for the measures of appraisal of bereavement, assessment of counterharm resources, coping and health. The research questions are addressed and the questions at the conclusion of the interview are presented.

Appraisal of Bereavement and Assessment of Counterharm Resources

Sixty percent of the sample (n=9) appraised their bereavement as a challenge which could be mastered. Those widows who appraised their bereavement as a challenge tended to score higher on the Assessment of Counterharm Resources (ARC) than those widows who appraised their bereavement as a harmful loss. Out of a possible 39 on the ARC, 80% had a score of 20 or greater.

Coping

The Ways of Coping Revised (WCR) was scored in terms of the degree of use of the coping strategy. If the respondent answered 0 = not used/does not apply or 1 = used somewhat these were considered unhelpful strategies. On the other hand, if the response was 2 = quite a bit or 3 = a great deal, these scores were considered as helpful strategies.

Many of the widows commented on selected items on the WCR. On item 8 (talked to someone to find out more) and item 42 (asked a relative for advice) two widows insisted they made their own decisions. For item 13 (went on as though nothing happened) one

respondent stated, "sometimes you just have to" and another "I don't want to make it tough on others". Item 21 (tried to forget the whole thing) received such responses as "how could you", "I loved my husband dearly but I can't just sit here and do nothing" and "that's impossible".

Four coping subscales were selected for analyses after internal consistency reliability figures were obtained (see Table 2 pg. 29). The four subscales are: Distancing, Wishful thinking, Problem-solving, and Self-control. Pearson Product-Moment Correlation Coefficients between the four subscales are provided in Table 4. Wishful thinking was moderate to strongly correlated with Problem-solving and Self-control. Self-control and Problem-solving were also moderately correlated.

Health

The data analysis indicated the sample was a relatively healthy group of widows. Ninety-three percent (n=14) of the widows considered themselves in good health for their age. The question on the Data Form asking if the widow's health was better, worse or the same since their husband's death was answered by 33% (n=5) responding "better". The two subscales of the SIP looked at physical health and psychosocial health. The maximum possible scores on the SIP were 100% physical and 100% psychosocial dysfunction. The higher the score, the greater the dysfunction. The mean physical and psychosocial dysfunction scores for the total sample were 9.13% (sd=7.8) and 14.13% (sd=9.5), respectively. All 15 of the widows scored lower than 44% on

Table 4

Pearson Product-Moment Correlation Coefficients: Ways of Coping Revised

Scale	1.	2.	3.	4.
1. Distancing		0.41	0.39	0.26
2. Wishful thinking			0.62*	0.76**
3. Problem-solving				0.68**
4. Self-control				

* p <.01, ** p <.001, two-tailed.

the SIP items concerned with body movement, mobility and ambulation. The total sample (N=15)also scored lower than 34% on the communication and social interaction dimension. The alertness behavior and the emotional behavior dimensions received the highest dysfunction scores, the scores of all 15 widows were 59%. The Sickness Impact Profile physical and psychosocial dysfunction scores were moderately correlated ($r=.54$, $p<.05$).

On a scale of 0-9 on the Cantril Ladder, 47% (n=7) rated themselves 7 or higher. The intercorrelations of the Cantril Ladder are presented in Table 5. The items on the Cantril Ladder were also correlated with the physical and psychosocial dimensions of the SIP as shown in Table 6.

Research Questions

Research question 1. What are the helpful and unhelpful coping patterns of older widows? Tables 7 and 8 include the helpful and unhelpful coping strategies. Eighty-seven percent (n=13) of the widows accepted their husbands' deaths as they agreed with the statement that nothing could be done about the situation. In addition, 80% (n=12) tried to look on the bright side of things. Most of the widows (73%) relied on prayer and 67% would often remind themselves how much worse things could have been.

All of the 15 widows (100%) found the behaviors of "expressing anger to the person causing the problem" and "taking it out on others" not helpful. Eighty-seven percent didn't sleep any more than usual, get professional help, or take chances or do something risky.

Table 5

Pearson Product-Moment Correlation Coefficients: Cantril Ladder

Item	1.	2.	3.	4.
1. Health right now		0.73	0.62**	0.92*
2. Health of friend[a]			0.60	0.81
3. Health prior to death				0.70**
4. Health three months[b]				

** p <.001, * p <.01, two-tailed.

a (n=6)

b (n=14)

Table 6

Pearson Product-Moment Correlation Coefficients: Cantril with SIP

Cantril Ladder	Dysfunction Measures: Physical Dysfunction	Dysfunction Measures: Psychosocial Dysfunction
Health right now	-0.56*	-0.18
Health of married friend[a]	-0.62	-0.57
Health prior to death	-0.57*	-0.62*
Health three months after death[b]	-0.55*	-0.28

* $p < .05$, two-tailed.

a (n=6)

b (n=14)

Table 7

Helpful Coping Strategies

#	Item	M	sd	% [a]
14.	I try to keep my feelings to myself	2.0	1.00	67
15.	Look for the silver lining, so to speak; try to look on the bright side of things.	2.1	.70	80
28.	I let my feelings out somehow.	1.5	.83	53
37.	Maintain my pride and keep a stiff upper lip.	1.7	1.10	67
53.	Accept it since nothing can be done.	2.3	.90	87
54.	I try to keep my feelings from interfering with other things too much.	1.9	1.10	47
60.	I pray	2.1	.95	73
65.	I remind myself how much worse things could be	1.7	.90	67

[a] % of sample using these strategies

Table 8

Unhelpful Coping Strategies

#	Item	M	sd	a %
5.	Bargained or compromised to get something positive from the situation.	.33	.62	73
7.	Tried to get the person responsible to change his mind.	.20	.78	93
11.	Hoped a miracle would occur.	.40	.91	80
16.	Slept more than usual.	.27	.70	87
17.	Expressed anger to person who caused the problem.	.00	.00	100
22.	Got professional help.	.20	.57	87
23.	Changed or grew as a person.	.47	.64	60
24.	Waited to see what would happen.	.27	.59	80
25.	Apologized or did something to make up.	.13	.52	93
29.	Realized I brought the problem on myself.	.13	.35	87
33.	Tried to make myself feel better by eating, drinking, smoking etc.	.50	.65	57
34.	Took a big chance or did something risky.	.27	.70	87

table continued

Table 8 (continued)

#	Item Name	M	sd	% [a]
40.	Avoided being with people in general.	.27	.70	87
47.	Took it out on others.	.00	.00	100
48.	Drew on past experiences.	.33	.90	87
50.	Refused to believe it happened.	.13	.52	93
51.	Made a promise things would be different next time.	.13	.51	93
52.	Came up with a couple of different solutions to the problem.	.13	.35	87
56.	Changed something about myself.	.27	.46	73
58.	Wished that the situation would go away or somehow be over with.	.40	.83	73
59.	Had fantasies or wishes about how things might turn out.	.47	.99	80

[a] percent of sample who did not use these strategies

Research question 2. What is the relationship between coping and health dysfunction following bereavement in the older rural widow? The WCR was correlated with the physical and psychosocial dysfunction measures and the Cantril ladder measure. Pearson Product-Moment Correlation Coefficients of the above measures are presented in Table 9. The more wishful thinking and self-controlling behaviors were used, the higher the widow's psychosocial dysfunction. In addition, higher use of wishful thinking coping was related to higher physical dysfunction, although this finding was not statistically significant. Higher wishful thinking was also negatively correlated to the health of the widow prior to her spouse' death. The more planful problem-solving coping was related to all four items on the Cantril ladder but the findings were not significant.

Additional Findings

The qualitative data derived from the open-ended questions is summarized below. A central theme emerging from the question "What would you say is the most important problem of widowhood?" was loneliness. Many women added the statement "especially at night" which was in addition, a concern for their security. Before their husbands' deaths the widows hadn't locked their doors or worried about intruders. Now, many were more alert to possible dangers. Several offered solutions to their problems, from letting the dog in the bedroom at night, having a neighbor telephone at a specified time if an unknown guest (e.g., this researcher) was visiting, or having a cyclone fence installed around their home.

Table 9

Pearson Product-Moment Correlation Coefficients: Ways of Coping Revised with SIP Measures and Cantril Ladder

	SIP Measures			Cantril Ladder		
				[a]		[b]
	Physical	Psychosocial	Health	Health	Health	Health
Ways of Coping Revised	Dysfunction	Dysfunction	Now	Friend	Prior	3 months
Distancing	.18	.19	-.10	-.16	-.30	-.08
Wishful Thinking	.29	.78**	-.24	-.43	-.77	-.38
Planful Problem-solving	.06	.26	-.39	-.33	-.46	-.39
Self-controlling	.11	.65*	-.09	-.18	-.34	-.20

a (n=6)

b (n=14)

* $p < .01$

** $p < .001$, two-tailed.

A secondary theme centered around their inability to get "odd jobs" done. Most of the women relied on their husbands' to mow the lawn, cut the wood, make repairs, fix the plumbing etc.. When their husbands were alive, family and friends offered to help out. After her husbands' death the widow found that she had to ask all the time and/or pay someone to do the jobs. This had been a burden to many both psychologically and financially. The comments received were "I get tired asking all the time", and "now I have to use my savings to pay for the necessities".

A second question asked "What is the most important piece of advice you could offer a recently widowed women?". The central theme that emerged was "Take care of yourself". Suggestions ranged from "force yourself to do things, at first", "when others invite you out, go", and "keep busy at things you enjoy". A second theme addressed independence. Their advice included "take care of business matters", "ask for assistance to learn the best way to accomplish something", and "have faith in the Lord".

Chapter IV

Discussion and Summary

The purpose of this study was to explore coping and health dysfunction in older rural widows. This chapter will begin with an examination of the limitations of the study. Following the limitations, the major findings will be discussed. This section will include the discussion of the helpful and unhelpful coping strategies, the relationship between coping and health and the recurring themes from the comments on the questionnaires. Additional information from the Data Form will also be presented along with ideas for further research. Lastly, the significance of this research to nursing will be reviewed.

Limitations

The limitations of this study were the small sample (N=15), the sample itself and the reliability of some of the measures. The size of the sample reflects the difficulty in obtaining meaningful numbers of rural widows to interview. By design, the study was limited to a radius of fifty miles. To obtain a larger sample one would need to expand the geographical parameters. This would result in a significant increase in the amount of time and money needed to conduct similar research.

The sample was limited in that none of the widows experienced the sudden death of their spouse. Sudden death may contribute to more physical and mental distress and more intense grief (Ball, 1976; Lundin, 1984). The sample also may not have been totally descriptive

of the overall rural population. This sample was comprised of widows who were non-farm women who lived within 50 miles of a fairly large metropolitan area in the pacific northwest. The majority had relatively easy access to large suburban sized shopping malls and urban cultural activities were also available within the fifty miles. There are many other widowed persons who reside in farm, logging, and mining communities, many of whom live greater distances from a large city and who do not have access to the urban amenities as did this sample. It is unknown how this would affect adaptation to widowhood. It is also unknown if women who lived in rural areas without access to urban amenities would respond in similar ways. Therefore, the characteristics of this particular sample limit the generalizability of the findings to women in rural areas within 50 miles of a metropolitan area.

The moderate reliabilities on the coping measure also limit generalizability of the findings. Internal consistency estimates of coping measures generally fall at the low end of the traditionally acceptable range (Folkman & Lazarus, 1988). However, the alpha coefficients of the Ways of Coping Revised are higher than the alphas reported for most other measures of coping processes. For purposes of this study, the alpha coefficients used were taken from a combined sample of widowed persons aged 65 and older and were fairly close to those of Lazarus and Folkman (refer to Table 2). Many investigators develop their own subscales from the original instrument and therefore, the psychometrics of coping often differs from study to

study.

In this study, the subjects were asked "what are you doing to cope at this time of your bereavement". Although the Ways of Coping Revised was designed as a tool to measure the coping process, the use in this study and Gass's (1987a & 1987b) could be considered more a trait measure than a process measure. This line of reasoning is consistent with Folkman and Lazarus' recently published manual for the Ways of Coping Questionnaire (WCQ). Folkman & Lazarus, (1988) state that although the WCQ is designed to identify the thoughts and actions an individual has used to cope with a specific stressful encounter, it is also possible to assess coping styles by expressing the items in trait terms. However, the psychometric properties of the revised instrument would have to be established anew. Instructions "to focus on one specific encounter such as an argument that morning rather than a generalized condition of their life style such as a difficult marriage" are given in the manual for administering the WCQ measure Folkman and Lazarus (1988, p.10). Therefore, using the scales which have been developed as coping responses to specific stressful encounters may not be appropriate for bereavement. A new measure of coping designed for the conjugally bereaved may need to be developed.

Research Questions

Bereavement is associated with many stressful problems that require different types and amounts of coping. The number of bereavement related problems confronting the widowed at one time may affect the number of coping strategies used. The use of more coping

strategies could be the result of more problems. However, it could also be that the coping strategies being used were not working and resulted in the development and utilization of additional coping strategies. Conversely, the use of less coping strategies may be the result of fewer problems or it could be the result of the success of the present or initial coping strategies. The widows in this study used limited coping strategies overall.

Research question 1. What are the helpful and unhelpful coping patterns of older widows? The strategies listed in the WCR questionaire which the fifteen rural widows found helpful were: I try to keep my feelings to myself, look for the silver lining, so to speak; try to look on the bright side of things; I let my feelings out somehow; maintain my pride and keep a stiff upper lip; accept it since nothing can be done; I try to keep my feelings from interfering with other things too much; I pray; and, I remind myself how much worse things could be.

Other helpful coping behaviors identified by the widows were showing family and friends "how strong I am", "doing things which are satisfying to me", and "keeping myself in good shape". These coping strategies support the findings of Blackburn, Greenburg, and Boss (1987). Also identified as helpful were keeping busy, participating in social activities, praying, and learning new skills which were similar to Gass's (1987a & 1987b) findings.

In reviewing the unhelpful coping strategies from the WCR questionnaire there were several items which the respondents

considered not applicable and/or never used. A few of these unhelpful coping strategies were: Tried to get the person responsible to change his mind; expressed anger to the person who caused the problem; Got professional help; realized I brought the problem on myself; took it out on others; refused to believe it happened; made a promise things would be different the next time; and came up with a couple of different solutions to the problem. Those unhelpful coping behaviors of avoiding people, becoming angry at the person responsible for the problem, taking it out on others, making promises to oneself, and wishing that the situation would go away agree with Gass's (1987a & 1987b) findings.

The findings from this present study, however, are much different from the findings of rural widows by Gibbs (1984). In the Gibbs study, rural widows reported watching television and listening to the radio as significant activities to occupy their days. In the present study, one widow reported listening to music to "boost her spirits" and another, an avid 80 year old basketball fan, listened to as many games on the radio as she could. None reported watching television as a significant activity. Therefore, media activity in this study was not considered as helpful or unhelpful.

Research question 2. What is the relationship between coping and health dysfunction following bereavement in the older rural widow? The widows in this study were relatively healthy as indicated by low mean physical and psychosocial dysfunction scores of the Sickness Impact Profile and the high score of overall health measured by the

Cantril ladder. When subjects were asked about their health status, they generally responded positively to the questions addressing physical health. However, there was more reticence with the emotional and psychosocial items. This may be a characteristic peculiar to this cohort of older rural women.

Both health instruments (SIP and Cantril ladder) measured the individual's present and past health. The majority of widows considered themselves in good health for their age. Many volunteered information about health problems which they considered a part of the aging process yet excluded them from the overall health appraisal. In terms of the individual's health right now, health prior to death, and health three months after death, all were significantly negatively correlated to physical dysfunction. This indicated that the person's perception of their physical condition was reflected and coincided with the subscales of the SIP.

Health prior to death was significantly related to psychosocial health dysfunction. Many of the respondents indicated their health was poor prior to the death of their spouse. The widows all were caring for their spouses at home anywhere from a few months to four years. As the time increased, with the physical care becoming more intensive, the widows' health (both physical and psychosocial) was also deteriorating. Several of the widows were supported by family and/or a hospice program but their health did not improve until after the death of their spouse. Those widows who used a greater amount of wishful thinking had poorer health prior to their husband's death. In

contrast, those who considered themselves healthier prior to the death of their spouse were actually healthier and therefore they scored lower in the physical and psychosocial scales.

The item asking about the health of a married friend who was the same age and who was still married posed a problem to most of the widows as they were unable to think of a person who met that criterion. Most responded by saying that all their friends their age were widows, and they just couldn't think of anyone.

Widows who used greater distancing and planful problem-solving coping strategies experienced lower physical and psychosocial health scores. This may indicate that these adaptive behaviors had a positive impact on the individual's health. There was, on the other hand, a significant relationship for those who used more wishful thinking and self-controlling strategies in that they experienced higher physical and psychosocial scores. This is in agreement with Gass' (1988) findings and could indicate that these behaviors may be more maladaptive.

Believing to have control over bereavement and the expectation of the spouse's death were associated with better physical and psychosocial health. Sixty-seven percent of the respondents remarked that they had grieved before their husband's death as well as after his death. Those widows who were helped by the hospice team expressed how important it was to have assistance when the situation became unmanageable. All six widows referred by the Hospice program volunteered information as to the importance of needing both aid for

the physical tasks and just as important, the caring support and encouragement from the nursing staff.

Additional Findings

An unanticipated outcome of this study was the unsolicited information that the respondents offered when asked questions from the structured interview schedule. The widows in this study were honest in their responses and several related that they hadn't had the opportunity to talk in such depth about their situation previously. All of the widows appreciated the opportunity to have an active listener, not necessarily a family member or friend. One of the themes to emerge from the comments during the interview was being grateful for the occurrence of their husband's deaths. These women often referred to the poor quality of life their spouses were experiencing. One widow, however, responded to her husband's request to help him end his life by simply stating, "you know I can't." He died the following day and she shared that a large burden had been lifted.

A 78 year old was planning ahead for her future and stated that she may have problems driving at 80 years of age so she is considering a move to be closer to public transportation. Others who didn't drive and found this a problem also considered moving for the same reason.

A trend which may have implications for further research was that of widows expressing their fears of feeling vulnerable to outsiders. Several women shared their fears of being robbed or raped, and just terrified of the unknown. Many found solutions such as installing a

chain-link fence, obtaining a guard dog, locking everything up, and adding extra security measures.

In summary, the findings in this study suggest that health of the widowed is influenced by their appraisal of bereavement, coping behaviors utilized and resources available. The women in this study offered "an understanding of the meaning the widowed give to death and the implications this meaning has for their lives" Gass (1988 p. 209). Gass also suggests that nurses need to learn to identify appropriate times to introduce helpful strategies that facilitate a more positive reappraisal of bereavement. Through follow-up visits and bereavement counseling, nurses can help the widowed understand their grief, provide opportunities to talk about feelings, and provide information about community resources.

The women in this study who were familiar with the community hospice program praised the nurses for their helpful counseling. The two widows referred from the university bereavement program also volunteered how important it was for the nurse to telephone them and inquire about them personally and their situation. Those widows unfamiliar with bereavement counseling did not know where to access help.

Significance to Nursing

The group of widows in this study were for the most part resilient women. They had positive attitudes concerning life and death in general. Many of the women were realistic in their approach to coping with the death of a spouse by using planful problem-solving coping

patterns. It is important for nurses serving a rural community to be aware of the combination of rurality and widowhood. In many communities a widow without close family support has very few resources left. The exceptions are those widows who are members of a church group or local organizations.

Findings from this study have practical implications for nurses caring for the older rural widow. Although the majority of the widows in this study appraised their bereavement as a challenge which can be mastered, Gass (1987a & 1987b) indicated some widows reported their bereavement as a harmful loss with other anticipated threats. This "anticipatory threat" group is at greatest risk for health dysfunction. As nurses serving rural populations learn how widows view their bereavement, the opportunity for referral and intervention becomes available. Often when distressed, the rural widow will seek out her local physician. Office nurses are likely to be in a position for referral of these widows if there are available services.

These findings could also have implications for the delivery of mental health nursing services to the older bereaved in rural areas where such services exist. Kivett's (1978) suggestion for focused programs to help the widowed identify and use resources is essential. A community mental health nurse could provide either direct service or consultation to community health nurses. The appropriateness of having a nurse as the person of choice is encouraged since the findings of this present study suggest the widows experience greater ease when talking about their physical health rather than addressing

any mental health issues initially.

In rural areas with comprehensive mental health services, an outreach program could be established in communities to serve the older bereaved. Given notice of the death of an aged person either from a minister, funeral director or friend/neighbor, an initial home visit to the bereaved could be made. A nurse would be able to assess normal grieving, appraisal of bereavement, coping skills, resources, and the need for follow-up. If counseling were appropriate and desired, the nurse could assist the widowed by identifiying and encouraging healthy coping mechanisms. Some widows may not be using very helpful coping patterns and may need assistance in trying new options. As was true of some of the widows in this study, rural widows may not be able to access resources without the assistance of someone they could trust. Mental health nurses, either through direct service or consultation are in key positions to provide services to this population as well as develop and expand programs for older bereaved persons.

Conclusion

Few researchers have studied widows' appraisal and coping of their bereavement and their influence on health (Clark, Siviski, & Weiner, 1986). Fewer researchers have studied the rural bereaved and their coping strategies. This study was a partial replication of Gass's (1987a, 1987b) work using a rural sample. The small, convenience sample provided a glimpse of the helpful and unhelpful coping strategies utilized by older rural widows. The study explored the

relationship between coping and health. The theoretical framework of stress and coping developed by Lazarus and Folkman (1984) was used to guide this study. This framework considers the relationship between stress, appraisal, coping, resources and health adaptation.

The findings indicated that the widows in this study used a limited number of coping strategies with consistency among those selected. This may have resulted because a majority of these women viewed their bereavement as a challenge which they could master. Of the helpful strategies which were found to be significant, there was a strong correlation between those behaviors and the health of the widowed. In other words, the more a helpful strategy was used the more healthy the individual scored. The more an unhelpful strategy was used the greater the health dysfunction.

Future research is needed to better identify both adaptive and maladaptive coping strategies particularly with other rural populations. In addition, reliable and valid measures need to be developed specifically for the bereaved population.

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APPENDICES

APPENDIX A

INTERVIEW SCHEDULE

Measures

1). Appraisal of Bereavement

2). Ways of Coping Revised

3). Sickness Impact Profile

4). Self Rating of Health (Cantril Ladder)

5). Assessment of Counterharm Resources

6). Descriptive Data

ID#_____

APPRAISAL OF BEREAVEMENT

People look at the loss of their spouse differently. Please circle the statement (1., 2., or 3.) which best describes the meaning of the loss of your spouse to you at this time.

1). A harmful loss which has many other losses, fears and problems to anticipate. (You view your bereavement as stressful in and of itself, but you also fear the problems to come later (for example, finding substitute relationships, finding new roles)).

2). A harmful loss without others losses, fears and problems. (You view your bereavement as stressful in and of itself, but you know you can deal with the problems to come i the future (for example, finding substitute relationships, finding new roles)).

3). A challenge, that is a stressful experience which will be overcome or mastered. (You view your bereavement as stressful, but you are determined that you will overcome or master this experience despite what is to come in the future)).

ID #_____

WAYS OF COPING REVISED

Below is a list of ways people cope with a wide variety of stressful events. Please indicate by circling the appropriate number the strategies you are using in dealing with the death of your spouse.

	Does not apply and/or not used	Used somewhat	Used quite a bit	Used a great deal	Coding
1. Just concentrate on what I have to do next week -- the next step.	0	1	2	3	_____
COMMENTS:					
2. I try to analyze the problem in order to understand it better.	0	1	2	3	_____
COMMENTS:					
3. Turn to work or substitute activity to take my mind off things.	0	1	2	3	_____
COMMENTS:					
4. I feel that time will make a difference -- the only thing to do is to wait.	0	1	2	3	_____
COMMENTS:					
5. Bargain or compromise to get something positive from the situation.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
6. I'm doing something which I don't think will work, but at least I'm doing something.	0	1	2	3	_____
COMMENTS:					
7. Try to get the person responsible to change his or her mind.	0	1	2	3	_____
COMMENTS:					
8. Talk to someone to find out more about the situation.	0	1	2	3	_____
COMMENTS:					
9. Criticize or lecture myself.	0	1	2	3	_____
COMMENTS:					
10. Try not to burn my bridges but leave things open somewhat.	0	1	2	3	_____
COMMENTS:					
11. Hope a miracle will happen.	0	1	2	3	_____
COMMENTS:					
12. Go along with fate; sometimes I just have bad luck.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
13. Go on as if nothing is happening.	0	1	2	3	_____
COMMENTS:					
14. I try to keep my feelings to myself.	0	1	2	3	_____
COMMENTS:					
15. Look for the silver lining, so to speak; try to look on the bright side of things.	0	1	2	3	_____
COMMENTS:					
16. Sleep more than usual.	0	1	2	3	_____
COMMENTS:					
17. I express anger to the person(s) who caused the problem.	0	1	2	3	_____
COMMENTS:					
18. Accept sympathy and understanding from someone.	0	1	2	3	_____
COMMENTS:					
19. I tell myself things that help me feel better.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
20. I am inspired to do something creative.	0	1	2	3	_____
COMMENTS:					
21. Try to forget the whole thing.	0	1	2	3	_____
COMMENTS:					
22. I'm getting professional help.	0	1	2	3	_____
COMMENTS:					
23. I'm changing or growing as a person in a good way.	0	1	2	3	_____
COMMENTS:					
24. I'm waiting to see what will happen before doing anything.	0	1	2	3	_____
COMMENTS:					
25. Apologize or do something to make up.	0	1	2	3	_____
COMMENTS:					
26. I'm making a plan of action and following it.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
34. Take a big chance or do something risky.	0	1	2	3	_____
COMMENTS:					
35. I try not to act too hastily or follow my first hunch.	0	1	2	3	_____
COMMENTS:					
36. Find new faith.	0	1	2	3	_____
COMMENTS:					
37. Maintain my pride and keep a stiff upper lip.	0	1	2	3	_____
COMMENTS:					
38. Rediscover what is important in life.	0	1	2	3	_____
COMMENTS:					
39. Change something so things will turn out all right.	0	1	2	3	_____
COMMENTS:					
40. Avoid being with people in general.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
41. Don't let it get to me; refuse to think too much about it.	0	1	2	3	_____
COMMENTS:					
42. Ask a relative or friend I respect for advice.	0	1	2	3	_____
COMMENTS:					
43. Keep others from knowing how bad things are.	0	1	2	3	_____
COMMENTS:					
44. Make light of the situation; refuse to get too serious about it.	0	1	2	3	_____
COMMENTS:					
45. Talk to someone about how I am feeling.	0	1	2	3	_____
COMMENTS:					
46. Stand my ground and fight for what I want.	0	1	2	3	_____
COMMENTS:					
47. Take it out on other people.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
48. Draw on my past experiences; I was in a similar situation before.	0	1	2	3	_____
COMMENTS:					
49. I know what has to be done, so I am doubling my efforts to make things work.	0	1	2	3	_____
COMMENTS:					
50. Refuse to believe it will happen.	0	1	2	3	_____
COMMENTS:					
51. Make a promise to myself that things will be different next time.	0	1	2	3	_____
COMMENTS:					
52. Come up with a couple of different solutions to the problem.	0	1	2	3	_____
COMMENTS:					
53. Accept it, since nothing can be done.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
54. I try to keep my feelings from interfering with other things too much.	0	1	2	3	_____
COMMENTS:					
55. Wish that I can change what is happening or how I feel.	0	1	2	3	_____
COMMENTS:					
56. Change something about myself.	0	1	2	3	_____
COMMENTS:					
57. I daydream or imagine a better time or place than the one I am in.	0	1	2	3	_____
COMMENTS:					
58. Wish that the situation would go away or somehow be over with.	0	1	2	3	_____
COMMENTS:					
59. Have fantasies or wishes about how things might turn out.	0	1	2	3	_____
COMMENTS:					
60. I pray.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
61. I prepare myself for the worst.	0	1	2	3	_____
COMMENTS:					
62. I go over in my mind what I will say or do.	0	1	2	3	_____
COMMENTS:					
63. I think about how a person I admire would handle this situation and use that as a model.	0	1	2	3	_____
COMMENTS:					
64. I try to see things from the other person's point of view.	0	1	2	3	_____
COMMENTS:					
65. I remind myself how much worse things could be.	0	1	2	3	_____
COMMENTS:					
66. I jog or exercise.	0	1	2	3	_____
COMMENTS:					

ID #_____

	Does not apply and/or not used	Used some-what	Used quite a bit	Used a great deal	Coding
67. I try something entirely different from any of the above. (Please describe.) _____ _____ _____	0	1	2	3	_____

COMMENTS:

ID #_____

SICKNESS IMPACT PROFILE

THE FOLLOWING INSTRUCTIONS ARE FOR THE INTERVIEWER-ADMINISTERED QUESTIONNAIRE.

INSTRUCTIONS TO THE RESPONDENT

Before beginning the questionnaire, I am going to read you the instructions.

You have certain activities that you do in carrying on your life. Sometimes you do all of these activities. Other times, because of your state of health, you don't do these activities in the usual way: you may cut some out; you may do some for shorter lengths of time; you may do some in different ways. These changes in your activities might be recent or longstanding. We are interested in learning about any changes that describe you today and are related to your state of health.

I will be reading statements that people have told us to describe them when they are not completely well. Whether or not you consider yourself sick, there may be some statements that will stand out because they describe you today and are related to your state of health. As I read the questionnaire, think of yourself today. I will pause briefly after each statement. When you hear one that does describe you and is related to health please tell me and I will check it.

Let me give you an example. I might read the statement, "I am not driving my car." If this statement is related to your health and describes you today, you should tell me. Also, if you have not been driving for some time because of your health, and are still not driving today, you should respond to this statement.

On the other hand, if you never drive or are not driving today because your car is being repaired, the statement, "I am not driving my car" is not related to your health and you should not respond to it. If you simply are driving less, or are driving shorter distances, and feel that the statement only partially describes you, please do not respond to it.

ID #_____

	Yes	No	Coding
1. I make difficult moves with help, for example getting into or out of cars, bathtubs.	_____	_____	_____
2. I do not move into or out of bed or chair by myself but am moved by a person or mechanical aid.	_____	_____	_____
3. I stand only for short periods of time.	_____	_____	_____
4. I do not maintain balance.	_____	_____	_____
5. I move my hands or fingers with some limitation or difficulty.	_____	_____	_____
6. I stand up only with someone's help.	_____	_____	_____
7. I kneel, stoop, or bend down only by holding on to something.	_____	_____	_____
8. I am in a restricted position all the time.	_____	_____	_____
9. I am very clumsy in body movements.	_____	_____	_____
10. I get in and out of bed or chairs by grasping something for support or using a cane or walker.	_____	_____	_____
11. I stay lying down most of the time.	_____	_____	_____
12. I change position frequently.	_____	_____	_____
13. I hold on to something to move myself around in bed.	_____	_____	_____
14. I do not bathe myself completely, for example, require assistance with bathing.	_____	_____	_____
15. I do not bathe myself at all, but am bathed by someone else.	_____	_____	_____
16. I use bedpan with assistance.	_____	_____	_____
17. I have trouble getting shoes, socks, or stockings on.	_____	_____	_____
18. I do not have control of my bladder.	_____	_____	_____

ID #_____

	Yes	No	Coding
19. I do not fasten my clothing, for example, require assistance with buttons, zippers, shoelaces.	_____	_____	_____
20. I spend most of the time partly undressed or in pajamas.	_____	_____	_____
21. I do not have control of my bowels.	_____	_____	_____
22. I dress myself, but do so very slowly.	_____	_____	_____
23. I get dressed only with someone's help.	_____	_____	_____
24. I am getting around only within one building.	_____	_____	_____
25. I stay within one room.	_____	_____	_____
26. I am staying in bed more.	_____	_____	_____
27. I am staying in bed most of the time.	_____	_____	_____
28. I am not now using public transportation.	_____	_____	_____
29. I stay home most of the time.	_____	_____	_____
30. I am only going to places with restrooms nearby.	_____	_____	_____
31. I am not going into town.	_____	_____	_____
32. I stay away from home only for brief periods of time.	_____	_____	_____
33. I do not get around in the dark or in unlit places without someone's help.	_____	_____	_____
34. I am going out less to visit people.	_____	_____	_____
35. I am not going out to visit people at all.	_____	_____	_____
36. I show less interest in other people's problems, for example, don't listen when they tell me about their problems, don't offer to help.	_____	_____	_____

ID #_____

37. I often act irritable toward those around me, for example, snap at people, give sharp answers, criticize easily.	_____	_____	_____
38. I show less affection.	_____	_____	_____
39. I am doing fewer social activities with groups of people.	_____	_____	_____
40. I am cutting down the length of visits with friends.	_____	_____	_____
41. I am avoiding social visits from others.	_____	_____	_____
42. My sexual activity is decreased.	_____	_____	_____
43. I often express concern over what might be happening to my health.	_____	_____	_____
44. I talk less with those around me.	_____	_____	_____
45. I make many demands, for example, insist that people do things for me, tell them how to do things.	_____	_____	_____
46. I stay alone much of the time.	_____	_____	_____
47. I act disagreeable to family members, for example, I act spiteful, I am stubborn.	_____	_____	_____
48. I have frequent outbursts of anger at family members, for example, strike at them, scream, throw things at them.	_____	_____	_____
49. I isolate myself as much as I can from the rest of my family.	_____	_____	_____
50. I am paying less attention to the children.	_____	_____	_____
51. I refuse contact with family members, for example, turn away from them.	_____	_____	_____
52. I am not doing the things I usually do to take care of my children or family.	_____	_____	_____
53. I am not joking with family members as I usually do.	_____	_____	_____
54. I walk shorter distances or stop to rest often.	_____	_____	_____

ID #_____

55. I do not walk up or down hills.	_____	_____	_____
56. I use stairs only with mechanical support, for example, handrail, cane, crutches.	_____	_____	_____
57. I walk up or down stairs only with assistance from someone else.	_____	_____	_____
58. I get around in a wheelchair.	_____	_____	_____
59. I do not walk at all.	_____	_____	_____
60. I walk by myself but with some difficulty, for example, limp, wobble, stumble, have stiff leg.	_____	_____	_____
61. I walk only with help from someone.	_____	_____	_____
62. I go up and down stairs more slowly, for example, one step at a time, stop often.	_____	_____	_____
63. I do not use stairs at all.	_____	_____	_____
64. I get around only by using a walker, crutches, cane, walls, or furniture.	_____	_____	_____
65. I walk more slowly.	_____	_____	_____
66. I say how bad or useless I am, for example, that I am a burden on others.	_____	_____	_____
67. I laugh or cry suddenly.	_____	_____	_____
68. I often moan and groan in pain or discomfort.	_____	_____	_____
69. I have attempted suicide.	_____	_____	_____
70. I act nervous or restless.	_____	_____	_____
71. I keep rubbing or holding areas of my body that hurt or are uncomfortable.	_____	_____	_____
72. I act irritable and impatient with myself, for example, talk badly about myself, swear at myself, blame myself for things that happen.	_____	_____	_____

ID #_____

73. I talk about the future in a hopeless way.	_____	_____	_____
74. I get sudden frights.	_____	_____	_____
75. I am confused and start several actions at a time.	_____	_____	_____
76. I have more minor accidents, for example, drop things, trip and fall, bump into things.	_____	_____	_____
77. I react slowly to things that are said or done.	_____	_____	_____
78. I do not finish things I start.	_____	_____	_____
79. I have difficulty reasoning and solving problems, for example, making plans, making decisions, learning new things.	_____	_____	_____
80. I sometimes behave as if I were confused or disoriented in place or time, for example, where I am, who is around, directions, what day it is.	_____	_____	_____
81. I forget a lot, for example, things that happened recently, where I put things, appointments.	_____	_____	_____
82. I do not keep my attention on any activity for long.	_____	_____	_____
83. I make more mistakes than usual.	_____	_____	_____
84. I have difficulty doing activities involving concentration and thinking.	_____	_____	_____
85. I am having trouble with writing or typing.	_____	_____	_____
86. I communicate mostly by gestures, for example, moving head, pointing, sign language.	_____	_____	_____
87. My speech is understood only by a few people who know me well.	_____	_____	_____

ID #_____

88. I often lose control of my voice when I talk, for example, my voice gets louder or softer, trembles, changes unexpectedly.	_____	_____	_____
89. I don't write except to sign my name.	_____	_____	_____
90. I carry on a conversation only when very close to the other person or looking at him.	_____	_____	_____
91. I have difficulty speaking, for example, get stuck, stutter, stammer, slur my words.	_____	_____	_____
92. I am understood with difficulty.	_____	_____	_____
93. I do not speak clearly when I am under stress.	_____	_____	_____

ID#_____

CANTRIL'S LADDER

9	Best Possible Health
8	
7	
6	
5	
4	
3	
2	
1	
0	Worst Possible Health

Above is a picture of a ladder. Suppose we say that the top of the ladder represents the best possible health, and the bottom represents the most serious illness or worst possible health.

1. On which step would you say your health is right now? _____(please write down the number of the step)

2. On which step would you say the health of a friend of yours is who is the same age and married?_____

3. On which step would you say your health was prior to death of your spouse?_____

4. On which step would you say your health was three months after the death of your spouse?_____

Please try to answer these questions, even if they are "educated guesses".

ID #_____

ASSESSMENT OF COUNTERHARM RESOURCES

Below are questions about factors which have been found to influence bereavement. Please circle the answer (0, 1, 2, or 3) that best states your view. Feel free to comment on your answer.

Coding

1. How helpful or supportive have your family and/or friends been to you during your bereavement? _____

   0 - not helpful or supportive at all
   1 - minimally (rarely) helpful or supportive
   2 - moderately (usually) helpful or supportive
   3 - always helpful or supportive

COMMENTS:

2. When your spouse died, did you follow practices specified by your cultural background or religion, such as burial customs or other death and mourning rituals? _____

   0 - none of them
   1 - a few of them
   2 - most of them
   3 - all of them

COMMENTS:

3. Have your religious beliefs helped you in your understanding and/or accepting the loss of your spouse? _____

   0 - not at all
   1 - some of the time
   2 - most of the time
   3 - yes, very much so

COMMENTS:

ID #_____

Coding

4. Prior to the death of your spouse, did you receive information on grieving and/or widowhood from friends or others? _____

   0 - no
   3 - yes

   If yes, did this information help you to know what to expect when you lost your spouse?

   Yes _____ No _____

COMMENTS:

5. Prior to the death of your spouse, did you have previous experiences with losses through the death of a parent, sister, brother, child, prior spouse or close friend? _____

   0 - no
   3 - yes

COMMENTS:

6. Did you expect your spouse would die? _____

   Yes _____ No _____

   Did you grieve over your spouse's death before he actually died?

   0 - no
   3 - yes

COMMENTS:

7. Prior to the death of your spouse, did you have any depressive reactions to other problems and/or hospitalizations for mental-emotional problems? _____

   0 - yes
   3 - no

COMMENTS:

ID #_____

Circle all that apply: Coding

8. Around the time of your spouse's death were you experiencing of the following? _____

   a. an illness or injury yourself
   b. retirement
   c. change in residence or loss of a home
   d. a major change in health or behavior of other relatives
   e. death of a friend or other close relatives
   f. financial losses
   g. other changes (describe)

   0 - yes (circle 0 if any of the above were experienced)
   3 - no (circle 3 if none of the above were experienced)

COMMENTS:

9. Was your spouse's death preventable, that is, were there factors leading to your spouse's death which could have been controlled? _____

   0 - yes
   3 - no

COMMENTS:

10. Did you let out emotions by talking freely to others about your spouse's death and/or crying while in the presence of others? _____

   0 - never
   1 - rarely
   2 - usually
   3 - always

COMMENTS:

ID #_____

Coding

15. How would you describe the amount of disagreements/conflicts with your spouse? _____

    0 - daily disagreements/conflicts
    1 - frequent disagreements/conflicts
    2 - occasional disagreements/conflicts
    3 - seldom had disagreements/conflicts

COMMENTS:

16. How would you describe the amount of ambivalent (opposite) feelings such as like-dislike feelings toward your spouse? _____

    0 - I have strong opposite feelings
    1 - I frequently have opposite feelings
    2 - I occasionally have opposite feelings
    3 - I rarely have opposite feelings

COMMENTS:

ID#_____

DESCRIPTIVE DATA

I have a few more questions that I need to ask you. The questions ask about your husband's death and you.

1. Was you spouses death — CODE
   1. a sudden death?
   2. a chronic illness death? ____

   a. Did you provide care for you spouse while he was ill before death? ____
      If yes for how long? ____

   b. Where did you spouse die?
      1. in the hospital?
      2. at home?
      3. in a nursing home?
      4. in another place? ____

   c. What type of funeral service did you have for your spouse?
      1. burial
      2. cremation
      3. other ____

2. To whom did you turn for help & support at the time of your husband's death?_____

3. In thinking over all of your experiences since you have become widowed, what do you think are the most important problems of widowhood?_____

4. Each woman has her own way of adjusting to widowhood. You may have some additional thoughts about the way you have coped with your widowhood. Please tell me about additional thoughts or behaviors you have found helpful?_____

5. What is the most important piece of advice you could offer a recently widowed woman?_____

ID#_____

6. If you were to rate the quality of your marriage on a scale of 1 to 4 with one being very satisfied: 2 being satisfied; 3 being unsatisfied and 4 being very unsatisfied, what number would best describe the quality of your marriage?

very satisfied	satisfied	unsatisfied	very unsatisfied
1	2	3	4

7. How do you perceive your current state of health now as compared to your health before your spouse's death?
   1. same
   2. better
   3. worse

   ____

8. What is your age? ____

9. How many years were you married? ____

   a. Was this your first marriage? 1. Yes 2. No ____

10. What was the last year of school you completed? ____
    a. What is the highest degree that you received?
       1. none
       2. Grade school diploma
       3. High school diploma
       4. Special diploma
       5. College diploma
       6. Master's degree
       7. Ph.D or other professional degree

       ____

11. Do you currently work outside the home? 1. Yes 2. No ____
    If yes what is (was) your present (last) occupation or job title?_____

12. Did you work outside the home prior to your husbands death?
    1. Yes 2. No

    ____

    If yes, what kind of work did you do?

    ____

13. Do you drive a car? 1. Yes 2. No ____
    a. If no, how do you usually get around?
       1. public transportation
       2. people drive
       3. taxi
       4. other (specify)_____

       ____

ID#_____

b. How far do you travel to go grocery shopping?_____

c. Do you consider transportation a problem for you?
1. Yes 2. No ____

14. What is your religious preference?
1. Roman Catholic
2. Protestant
3. Jewish
4. Other (specify)_____
5. No preference ____

15. How religious would you say you are?
1. Not at all religious
2. Somewhat religious
3. Very religious ____

16. Since being widowed, what is your approximate monthly income from all sources?_____
a. What as it before you were widowed?
1. less
2. more
3. same ____

That is all the questions I have to ask you, do you have any other thoughts that you want to share? Thank you.

APPENDIX B

LETTER OF EXPLANATION AND PERMISSION

POSTCARD SAMPLE

Dear Mrs.

This letter is about a research study on how widows manage the loss of their husband. I am a graduate student at The Oregon Health Sciences University. and a registered nurse. As part of the requirements for my Masters degree I am doing a research study. I received your name from the Bereavement Program at The Oregon Health Sciences University.

I would appreciate your help with my study. This involves about one hour of your time for an interview. When it is convenient for you I will come to your home, or another place if you wish, to ask you questions.

All the information you share with me will be treated in a confidential manner and your name will not be used on any of the questionaires or in the report of my study. The information which you provide for this study will be helpful to nurses and others because it will enable them to better understand the bereavement experience of women who have recently experienced the death of their husband. It may also assist nurses in providing appropriate help to widows.

The enclosed postcard is for you to return to me if you are unable to participate at this time. Otherwise, I will call you during the next week to answer any questions you may have and to ask if you are able to participate in my study.

If you have any questions about this study please feel free to contact my faculty advisor, Dr. Jane Kirschling, at (503) 279-8382.

Sincerely,

Helen E. Harris, RN., BSN.

POSTCARD SAMPLE

HELEN HARRIS, RN, BSN.

OHSU SCHOOL OF NURSING

3181 SW SAM JACKSON PARK ROAD

PORTLAND, OREGON 97201

I AM NOT ABLE TO

PARTICIPATE IN YOUR

STUDY AT THIS TIME.

_____

Signature

APPENDIX C

SAMPLING CRITERIA FORM

SAMPLING CRITERIA

(to be completed during the screening telephone call)

Name_____

Telephone #_____

Date_____

Spouse's death _____

Age _____

Living situation _____

Rural _____

Speak/read English _____

Are you remarried? _____

Appointment made: _____

Address: _____

Directions to Home:_____

_____

_____

_____

_____

INFORMED CONSENT
CONSENT TO ACT AS A SUBJECT FOR RESEARCH AND INVESTIGATION

I,----------agree to participate in the study with the recently widowed under the direction of Helen Harris, RN, a graduate nursing student at the Oregon Health Sciences University. The purpose of the study is to find out more about the experience of coping with widowhood.

I understand that participation in this study involves being interviewed one time in a convenient location. This interview may take one (1) hour. The investigator is not aware of any known risks or discomforts that may result from this research. I understand that there may be no benefit to me except for the chance to talk about my experience.

It is not the policy of the United States Department of Health and Human Services or any agency funding the research project in which I am participating to compensate or provide medical treatment for human subjects in the event the research results in physical injury. The Oregon Health Sciences University, as an agency of the state, is covered by the State Liability Fund. If you suffer any injury from the research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. If you have further questions, please call Dr. Michael Baird at (503) 279-8014

Helen Harris, RN, BSN (503) 279-7827, has offered to answer any questions which I might have regarding the study. I understand that I may refuse to participate or I may end my participation in the study at any time without affecting my relationship with or treatment at The Oregon Health Sciences University.

I further understand that my responses to the interviews will be strictly confidential. I understand that I do not have to answer all questions. Information will not become part of my medical record and the answers I give will be seen only by the researcher. My name will not appear on any written or recorded data; data will be identifiable by code number only.

I have read the above and agree to participate in this study.

Witness---------- Signed----------

Date---------- Date----------

APPENDIX E

SAMPLE OF LARGE-TYPED QUESTIONNAIRE

7. Prior to the death of your spouse, did you have any depressive reactions to other problems and/or hospitalizations for mental-emotional problems?

   0 - yes
   3 - no

8. Around the time of your spouse's death were you experiencing of the following? Circle all that apply:
   a. an illness or injury yourself
   b. retirement
   c. change in residence or loss of a home
   d. a major change in health or behavior of other relatives
   e. death of a friend or other close relatives
   f. financial losses
   g. other changes (describe)

   0 - yes (circle 0 if any of the above were experienced)
   3 - no (circle 3 if none of the above were experienced)

9. Was your spouse's death preventable, that is, were there factors leading to your spouse's death which could have been controlled?

   0 - yes
   3 - no

10. Did you let out emotions by talking freely to others about your spouse's death and/or crying while in the presence of others?

    0 - never
    1 - rarely
    2 - usually
    3 - always

11. Do you believe you are in control of your bereavement, that is the main thing which affects your future outcome to the loss of your spouse is what you do yourself?

    0 - no, not at all
    1 - occasionally
    2 - usually
    3 - yes, very much so

12. Are your present sources of financial support adequate?

    0 - no
    3 - yes

The following questions relate to your relationship with your spouse. I realize this is a personal area but the information you provide will be helpful.

13. How would you describe your degree of closeness to your spouse?

    0 - overly close - I would find it impossible to replace the relationship
    1 - very close
    2 - moderately (usually) close
    3 - minimally (rarely) close

14. How would you describe your degree of dependency on your spouse?

    0 - overly dependent - dependent on my spouse for everything
    1 - very dependent
    2 - moderately dependent
    3 - minimally (rarely) dependent

15. How would you describe the amount of disagreements/conflicts with your spouse?

    0 - daily disagreements/conflicts
    1 - frequent disagreements/conflicts
    2 - occasional disagreements/conflicts
    3 - seldom had disagreements/conflicts

16. How would you describe the amount of ambivalent (opposite) feelings such as like-dislike feelings toward your spouse.

0 - I have strong opposite feelings
1 - I frequently have opposite feelings
2 - I occasionally have opposite feelings
3 - I rarely have opposite feelings

ABSTRACT:

Title: COPING STRATEGIES OF RURAL WIDOWS: A PARTIAL REPLICATION

Author: Helen E. Harris RN, BSN

Approved: [redacted]

Jane Marie Kirschling, RN, DNSc, Associate Professor, Family Nursing, School of Nursing; Advisor

The rural elderly widow is vulnerable and at risk for illness. Many of these persons are overlooked by health professionals and often misdiagnosed as suffering from actual illnesses when indeed they are experiencing the phenomena of grieving. The purpose of this study was to explore coping and health dysfunction in rural widows. The following research questions were addressed: 1) What are the helpful and unhelpful coping patterns of older widows and, 2) What is the relationship between coping and health dysfunction following bereavement in the older rural widow?

This study involved a one time face to face interview with a convenience sample of 15 rural widows. This study was a descriptive survey with a correlational design. The study was a partial replication of the Gass (1987a & 1987b) research with the recently widowed. The convenience sample was obtained from rural areas of a Pacific Northwest state. Potential subjects were identified through the bereavement program at a regional university medical center, a local funeral home serving a rural population, and a home based hospice program.

The sample were widows whose spouses died between one and twelve months prior to the time of the interview. The widow was between the ages of 65 and 85, inclusive and not remarried, was able to understand and speak English; and was not institutionalized.

The measures administered were: Appraisal of Bereavement, Ways of Coping Revised, Assessment of Counterharm Resources, Sickness Impact Profile, and the Cantril ladder. A Data Form was used to gather the descriptive data as well as responses to three open ended questions included in the form at the end of the personal interview.

Findings suggest that health of the widowed is influenced by the appraisal of bereavement, coping behaviors utilized and resources available. The findings indicated that the widows in this study were quite healthy and used a limited number of coping strategies with consistency among those selected. This may have been a result of a majority of these women viewing their bereavement as a challenge which they could master. Of the strategies found to have statistical significance, there was a strong correlation between those behaviors and the health of the widowed. The more a helpful strategy was used the more healthy the individual scored. The more an unhelpful strategy was used, the greater the health dysfunction.

The significance to nursing comes from the greater understanding of the rural widow as a result of this study. Community nurses and/or community mental health nurses could use this knowledge to facilitate a more healthy adaptation to widowhood in rural areas.