Bereavement, Coping and Health Status of Older Widows

by

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TABLE OF CONTENTS

LIST OF TABLES

TABLE

LIST OF FIGURES

FIGURE

CHAPTER I

INTRODUCTION

Conjugal bereavement has became an important topic of concern among those who deliver health care to the elderly population. Spousal loss is to be expected among the married elderly, and it is more often the woman who is affected.

The loss of a spouse is a problem that mainly affects women because they have greater longevity, are usually younger than their husbands, and their marriage rate after bereavement is lower than that of widowers. In 1984, 67% of women age 75 or older were widowed, and had not remarried, while 67% of the men in this age group were married (Shick, 1986; U.S. Senate Special Committee on Aging, 1985-1986). Conjugal loss is a significant problem for women, especially for the elderly widow.

For these widows, the death of a spouse usually initiates a profound grieving process and disruptive role changes. In many instances these events are

sufficiently stressful to result in illness and health dysfunction of the elderly widow (Gass, 1987).

Although evidence exists that bereavement affects the health of the older widow, there is considerable variation in the extent to which these outcomes occur (Osterweis, Solomon, & Green, 1984). Various factors appear to protect some widows and leave others at increased risk for poor health outcomes.

The present investigator was prompted to study health outcomes of bereavement, when it was noted in her clinical practice that some bereaved spouses had more health problems than others. It was also noted that those widows who seemed to be in better health had used services that helped them to adapt to the bereavement process, such as preventive nursing interventions and bereavement counseling. In particular, a decrease in health dysfunction was shown in those persons who had intervention instituted prior to, or at least by the time of, bereavement.

This clinical impression of variation in adaptational outcomes is supported in various studies of elderly conjugal bereavement. These studies have shown that health outcomes can be impacted by

bereavement intervention programs (Osterweis, et al., 1984; Parkes, 1980; Rafael, 1977). Interventions which address adaptative ways to cope can facilitate the transition to widowhood.

Of particular interest to the present investigator was the bereavement study of Gass (1987) on the health of 100 older widows, bereaved one year or less. Gass studied the relationships between bereavement, coping, appraisal, resources, and health dysfunction of elderly widows, using the Stress-Coping Framework of Lazarus. Relationships between the ways of coping and appraisal of the bereavement were found to impact health status. Additional research which substantiates and extends the Gass study would be important, namely: testing a sample of elderly widows bereaved more than one year, measuring ways of coping with a newer revision of the instrument, and considering the effects of an intervention of bereavement counseling.

Studies were not found in the literature comparing groups of widows receiving or not receiving the intervention of bereavement counseling using the constructs of coping and appraisal on health outcomes. Further study into the relationship of the intervention

to bereavement health outcomes is indicated.

The implications for nursing are important. In an effort to intervene more effectively with the bereaved older widow, nurses need to be aware of the widow's perceived areas of loss, the appraisal of the stressful experience, the coping process, and the effect on health outcomes. Nurses can gain a greater awareness and knowledge of the coping strategies that have been shown to be beneficial to other bereaved spouses. Nurses can suggest meaningful interventions to support adaptative coping strategies and to make referrals to alternate support groups and resources as indicated from the nursing assessment of the bereaved spouse.

The aim of this present research was to examine the effects of a hospice bereavement counseling intervention on the coping and appraisal of the bereavement of the older widow during the second year of bereavement. The second year of bereavement was chosen, as increased health problems are prevalent in the second year of spousal loss (Zisook, DeVaul, & Click, 1982). The variables of interest in the study were: conjugal bereavement, bereavement counseling,

coping and appraisal and their effect on perceived health status among two groups of elderly widows.

Review of the Literature

This first section of the review of literature presents material relating to the major areas of interest in the present study: conjugal bereavement, bereavement counseling, coping and appraisal, and perceived health status of the bereaved elderly widow. In the second section, the Gass study on elderly bereavement, coping, appraisal, and health outcomes will be discussed with its implications for the present research study.

Conjugal Bereavement

In this section, the conceptual definition of bereavement will be presented. This will be followed by review of selective studies on elderly conjugal bereavement.

The definitions of bereavement are varied and multi-dimensional. Averill (1968) and Rando (1984) define bereavement similarly, as the total response or reaction pattern, psychological and physiological,

displayed by an individual following the loss of a significant object, usually a loved one. The loss of a loved one is the death of a spouse, child, parent, sibling, or friend, which can be profound for the bereaved individual. The focus of this present research is on conjugal bereavement, the death of an elderly spouse.

Averill states in his study on grief (1968) that bereavement has two components: (1) grief, the psychological and physiological reactions to the loss, and (2) mourning, the behavior determined by cultural norms and customs (Averill, 1968). The grief reaction to the loss is characterized by alterations in emotions and thought processes, behavioral changes, interpersonal and social changes and physical complaints (Osterweis, et al., 1984). This grief reaction can be a stressful event for the bereaved elderly widow suffering conjugal loss.

The work of Holmes and Rahe (1967) was among the early studies to identify the stressfulness of life event changes and to associate their importance as a risk factor for illness. They ranked conjugal bereavement as the highest on the continuum of life

stresses.

Also, bereavement has been characterized in terms of process in that it is a stressful, nonlinear process, with clusters of reactions or phases that change over time. The process of bereavement has been shown to not proceed in set stages with one clearly identifiable reaction to another in an orderly fashion. This carries the implication that there is substantial individual variation in terms of the manifestation of grief and in the rate bereaved persons move through the process (Osterweis, et al., 1984; Rafael, 1983; Zisook, et al., 1982). Thus, bereavement is a stressful, nonlinear process that does not proceed at a determined rate.

Various factors have been identified that are associated with placing the conjugally bereaved person at risk in terms of adaptational outcomes. A summary of the studies on bereavement can be seen in Table 1.

Table 1. ***Summary of Studies on Bereavement***

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Lindemann (1944)	Descriptive	Identification of symptomatology and management for acute grief.	N=101 bereaved individuals 1) Relatives of persons undergoing psychiatric treatment. 2) Relatives of expired patients. 3) Survivors and close relatives of disaster victims 4) Relatives of killed and MIA service men.	Recorded psychiatric interviews analyzed in terms of the symptoms reported and in observed changes in mental status.	Description of selected basic features of the grief phenomena: Symptomatology and course of normal grief, morbid grief reactions, prognostic evaluation, management and anticipating grief reaction.	Prophylactic interventions to prevent prolonged grief reactions.
Stern, Williams & Prado (1951)	Descriptive	Identification of grief reactions in later life.	25 subjects: mean age= 63 years Bereaved 5 months to 7 years	Interviews eliciting social history and psychiatric evaluation	Grief reactions manifested by replacement of emotional reactions with somatic complaints. Idealization of deceased. Self-isolation.	
Parkes (1964)	Descriptive	Effects of bereavement on physical and mental health	44 widows. Mean age = 60 years	Medical records of widows before and after bereavement.	Changes in mental health: ↑ in MD consults ↑ psychiatric symptoms: < 65 years - 3 x greater ↑ non-psychiatric: 5 x > 65 years - 50% greater. No data on physical health	Influence of grief on physical health in widows.
Maddison & Walker (1967)	Descriptive Predictive	Factors affecting the outcome of conjugal bereavement of widows.	132 bereaved widows, 13 months bereaved.	*Mailed questionnaires* Subjectives report of health	Significant inverse relation between illness score and age ($r = .33$, $p < .01$) in younger widows.	
		Differences between good and bad outcomes in perception of support	40 widows with good and bad outcomes for later interviews from original sample.	*Personal Interviews* 1) Perceptions of significant people in her environment 2) Specific interaction form (59 items) scored for degree of helplessness.	Bad outcome widows perceived environment as not meeting their needs. – Reported analysis of the group profiles for good-bad outcomes. – Multivariate discriminant function analysis predict good (-3.45) and bad (89.6) at $p<.01$ outcomes.	
Rees & Lutkins (1967)	Cohort	Mortality of conjugal bereavement	371 bereaved relatives. Mean age = 69.7; 878 comparison group	Vital statistics	Bereavement carries risk of ↑ mortality. ↑ rate for widowers in first year.	

Table 1. ***Summary of Studies on Bereavement (Con't)***

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Maddison & Viola (1968)	Descriptive Survey	Health deterioration of widows in the year following bereavement.	*Bereaved subjects*: Boston N = 132 Sidney N = 243 *Control subjects:* Boston N = 92 Sidney N = 101	Mailed health care questionnaire. Self-report of health.	Substantial deterioration of physical and mental health in Rx group: Boston = 21.2% Sidney = 32.1% The controls had much less deterioration: Boston = 7.2% Sidney = 2.0%	Prophylactic interventions to prevent prolonged grief reactions.
Parkes & Brown (1972)	Descriptive cross-sectional Part of the Harvard Bereavement Project.	Health after bereavement of young widows and widowers.	68 subjects: 49 - widows 19 - widowers Less than 45 years old with a matched control group.	Structured interviews at 14 months and second and fourth years.	Characteristics distinguished for first 14 months. Psychologic and somatic in relation to anxiety significantly different than non-bereaved with days sick in bed and increased admissions to the hospital. Psychological and somatic complaints were identified 2-4 years. Little different physical complaints between groups. Persisting disengagement.	Bereavement and ill health with young widowed.
Clayton (1974)	Descriptive prospective.	Psychological morbidity in older widowed during first year of bereavement.	Random Subjects N = 109 Mean age = 61 years	Structured interviews.	• No significant differences in mortality seen. • Increased psychological (10%) but no physical morbidity observed.	
Atchley (1975)	Descriptive secondary analysis of earlier study.	Direct comparisons of bereaved widows and widowers regarding adjustment to widowhood.	902 older persons aged 70-79 years. *Treatment:* 72 widowers and 233 widows. *Control:* 428 named men and 169 named women.	Mailed questionnaires.	Social psychological effects differentiated the groups. Economic circumstances influence the social situation of the widow, not the widower.	Longitudinal studies of the process of adjustment and economic impact of the older widow.
Clayton (1975)	Descriptive prospective.	Investigation of social isolation as a cause of bereavement symptoms of morbidity and mortality.	108 bereaved spouses: Mean = 61 years; 2 groups: Living alone vs living with others.	• Depression diagnosis of Feighner. • Systematic open-ended interviews at 1, 4 and 12 months.	• Bereavement at one month rather than the effects of living alone influence depressive symptoms and medical attention for symptoms. • Follow-up in one year with bereaved and married controls with same findings.	Replication to test if positive findings were real and not due to chance.
Zisook, Devaul, & Click (1982)	Descriptive methodological.	Expansion of TGI item pool and measurement of the frequency and time course of present grief-related behaviors and feelings.	211 bereaved (range 19-74 years)	TGI Mailed questionnaires.	Wide variations in symptoms, which can last indefinitely for some bereaved. Acute dysphoria peaked at 1 to 2 years.	Use of TGI to define and quantify grief and identify unresolved grief.

Table 1. ***Summary of Studies on Bereavement (Con't)***

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Lundin (1984)	Descriptive survey	Long-term outcome of bereavement of relatives who died unexpectedly.	78 bereaved close relatives 8 years after death.	Mailed questionnaire TGI interviews.	• Relatives of persons who died suddenly or unexpectedly had ↑ grief reactions than from expected death. • TGI good for assessing outcomes, but not risk.	
Zisook & Shuchter (1985).	Descriptive survey	Time course of spousal bereavement.	• 300 bereaved spouses (Mean Age=53 years) weeks to years bereaved. • Widow-to-widow groups. • 30 Cohort	• Mailed questionnaire • BDI • Holmes-Rahe Scale • HSCL	Time course for grief was prolonged for most subjects even after four years. Dysphoric feelings, symptoms, and behaviors.	Clarification of multi-dimensions of grief with a longintudinal prospective design.
Lund, Caserta & Dimond (1984)	Descriptive longitudinal of the University of Utah study.	Gender identification of differences through two years of elderly bereavement.	N=192; Range 50-93 years old	• Mailed questionnaires and interviews x 6 after death for two years. • Self-rating depresion scale • LS-Index A • Global scales.	No sex differences were seen among selected social and psychosocial bereavement outcomes.	Bereavement as a complex and multi-dimensional experience.
Mor, McHorney, & Sherwood (1986)	Secondary analysis of National Hospice study.	Secondary morbidity among recently bereaved caregivers related to morbidity and bereaved outcomes.	1,447 bereaved spouses and relatives, metastatic cancer patients.	Secondary interview data from the NHS for Hospice Care, NCHS for Convention Care to measure medical care utilization and morbidity.	Previous health problems and being widowed strongest predictors of morbidity and health care use.	Effects of social support, concurrent life stresses, depression and health of primary caregivers.
Gass (1987)	Correlational Ex post facto	Relationship between coping, appraisal and resources on the health of older widows.	N=100- widows 1-12 months bereaved Mean age = 71.3 years	Interview questionnaire Ways of Coping 1980 Appraisal of Bereavement Assessment of Resources SIP Perceived health status	• Good prior health and social support. • Increased resource strength → decreased physical and psychosocial health dysfunction. • Increased coping strategies → ↑ increased health dysfunction. • Appraisal groups differed in overall problem-focused coping. • No differences in emotional-focused coping.	Widow-to-Widow groups. Different bereavement periods to identify risk factors.
Remondet & Hansson (1987)	Methodological	Introducing the Grief Resolution Index (GRI), a reliable, short-term instrument to identify persons experiencing extended psychological distress associated with widowhood.	75 widowed unremarried women Median age=75.5 years	Grief Resolution Index *Short Term Adjustment* 1)Survival Expectations Index 2)Fear 3)Preparation 4)Desperation *Long-Term Adjustment* 1)BDI 2)Anxiety 3)Health Index 4)Widowhood Adjustment Coping Activities	Problems associated with widowhood more important than being widowed. GRI related to coping and adjustment. Valid measure.	Routine screening procedure with the GRI for prolonged grief reactions.

Early initial symptomatic distress and prior health can be predictors for physical and psychological problems (Gass, 1987; Mor, McHorney, & Sherwood, 1986; Osterweis, et al., 1984; Parkes, 1985; Raphael, 1977, 1983; Zisook, et al., 1981). Prior coping skills affect adaptation to bereavement (Dimond, 1981; Gass, 1987; Raphael, 1977; Richter, 1985). Prior and concurrent losses can be overwhelming for the bereaved and adversely affect outcomes (Dimond, 1981; Garrett, 1987; Gass, 1987; Osterweis, et al., 1984). The younger the bereaved, the more health and adjustment problems will be seen, although the extent is not fully known (Maddison & Walker, 1967; Parkes, 1985).

Widowers have more adjustment problems, especially in the first year, than do widows (Osterweis, et al., 1984). Widowed persons with lower social class, income, and education appear to adjust more poorly to bereavement (Atchley, 1975; Gass, 1987; Osterweis, et al., 1984; Parkes, 1985). Length of illness and type of death influence adjustment to bereavement outcomes, although there are conflicting results regarding prolonged illness and sudden death as risk factors for unfavorable adjustment (Gerber, et al., 1975; Lundin,

1984; Maddison & Viola, 1968; Maddison & Walker, 1967; Parkes, 1975; Parkes & Brown, 1972). The nature of the marital relationship affects outcomes, especially if the marriage was unhappy or ambivalent (Osterweis, et al., 1984; Parkes, 1985; Raphael, 1983; Shanfield, 1983). Increased perceived social support is the one consistent predictor in adjustment (Cobb, 1974; Dimond, 1981; Gass, 1987; Maddison & Viola, 1968; Maddison & Walker, 1967; Parkes, 1985; Raphael, 1977; Windholz, 1985). These factors may alter the risks for poor health outcomes. The extent to which some of these factors operate in conjugal bereavement of the elderly widow warrants further study.

Although positive associations between risk factors for morbidity, mortality and other aversive bereavement outcomes have been documented in the literature, the explanation for this susceptibility is not fully known. It may be that the stress of bereavement may trigger multiple changes which might lead to disease in persons known to be at high risk and vulnerable with genetic predisposition, and with past or current illness (Osterweis, et al., 1984).

The first reported investigation of grief was done

by Stern, Williams, and Prado in 1951, and it is significant being the first reported investigation of grief reactions in older persons. Stern, et al., (1951) did pioneering work on elderly bereavement and somatic health, on a sample of 24 women and 1 man (mean age = 62.5 years), with personal interviews, at McGill University Old Age Counseling Service. The subjects had been bereaved from 5 months to 7 years. A major finding was that older persons showed a tendency to replace emotional reactions with somatic complaints (Stern, et al., 1951).

In the intervening years, researchers have reported in the literature that widowed persons have increased morbidity and mortality associated with bereavement (Clayton, 1974, 1979; Gass, 1987; Jacobs & Douglas, 1979; Jacobs & Ostfield, 1977; Lundin, 1984; Osterweis, et al., 1984; Rees & Ludkins, 1967; Richter, 1984; Zisook & Shucter, 1985). See Table 1. Other investigators have emphasized the tendency of bereaved persons to experience an increase in emotional problems associated with depression, (Brown & Stoudemire, 1983; Goldberg, Comstock, & Harlow, 1988; Greenblatt, 1978; Maddison & Walker, 1967; Mor, et al., 1986;

Osterweis, et al., 1984; Parkes, 1970; Raphael, 1977; Zisook, et al., 1982; Zisook, et al., 1985). These studies support the contention that bereavement affects both physical and psychological health of the bereaved spouse.

In summary, bereavement is a stressful experience and the total reaction to the death of a loved one. Outcomes of bereavement can be predicted by different known risk factors which have been discussed in this section. Bereavement for the older widow affects changes in emotions and thought process, behavior, social relations, and physical health. Factors related to its effects on health status need to be studied further. An important factor in the amelioration of bereavement is the assistance provided through bereavement counseling. This topic is discussed in the following section.

Bereavement Counseling

In this section, the conceptual definition of bereavement counseling will be presented. This will be followed by studies on bereavement counseling. The nature of the studies and their contribution to

knowledge will be discussed.

Bereavement counseling is defined as the informal or formal education and help, given by professionals, laypersons, or volunteers, to the grieving families following the death of loved one (Janson, 1986; Lattanzi, 1982; Osterweis, et al., 1984; Parkes, 1980; Raphael, 1977). The purpose of bereavement counseling is to provide the family members with information about the normal grief process; to reflect on the loss experience; to assess and monitor coping ability, stress levels, and available support; and to utilize existing or create new support networks (Lattanzi, 1982).

Four types of bereavement counseling and follow-up programs are referred to in the literature, which are : 1) professional services by trained doctors, nurses, social workers, and psychologists; 2) hospice; 3) voluntary services by selected and trained volunteers which are supported by professionals, and 4) self-help groups of previously bereaved persons who offer help to other bereaved people with or without the support of professionals. Each of these services may provide individual or group counseling (Osterweis, et

al., 1984; Parkes, 1980). Summaries of studies on bereavement counseling are found on Table 2.

Three studies of interest on professional bereavement counseling will be discussed in this section. The effectiveness of professional intervention was shown in Raphael's (1977) research study of 31 selected, high-risk widows, and 33 well-matched widowed controls (mean age = <60 years). Assessment of risk factors was done with a questionnaire developed by Maddison and Walker (1967), which measures the extent to which the bereaved see their family as unsupportive, their bereavement as traumatic, their marriage as ambivalent, and their life complicated by other crises than bereavement. Clients had a mean of four interviews, in which Raphael, a psychiatrist with much experience with bereaved persons, counseled the grieving spouse and family at three months post-bereavement. Thirteen months following bereavement, an index of health change showed statistically significant differences between supported and unsupported groups (Raphael, 1977). The supported group had significantly improved as measured by an index of health change and health care

Table 2. ***Summary of Studies on Bereavement Counseling***

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Gerber, Weiner, Battin & Arkin (1975)	Controlled prospective. Longitudinal study with interviews at 2, 5, 8 and 15 months.	One-to-one support of bereaved persons during first six months of bereavement to affect health outcomes and adjustment.	116 supported; 53 nonsupported aged bereaved.	Review of medical records; medical, social and psychological adjustment measures; telephone calls and one-to-one support.	• Fewer medical complaints and problems in support group. • Intervention more benefit for healthy subjects.	Prophylactic interventions to prevent prolonged grief reactions.
Parkes (1975)	Descriptive	Provision of support and practical advice to "high risk" survivors whose relative (mostly spouses) died at St. Christopher's Hospice.	181 bereaved survivors who were divided into three groups: • imperative need • high risk • low risk High risk were further divided into two groups: intervention and non-intervention.	• Interviews • Physical symptoms • Depression • Health status • Worry Index • General Health Index • Health habits	At 20 months: High risk bereaved changed to low risk with trained lay volunteer one-to one-support. Significant differences were seen between the two groups.	
Raphael (1977)	Experimental	Decrease of early post bereave-ment morbidity with preventive intervention during first three months post bereavement.	High risk widows: N = 31 Experimental N = 33 Control < 60 years old	• Preliminary interviews to identify subjects at risk for increased single outcome morbidity assessment at 13 months. • Health Change Index • Counseling (1-9x)	High risk individuals resemble low risk after treatment. Perceived support of network key predictor of ↑morbidity.	Replication for validity bereavement research into broad community preventive programs.
Vachon, Lyall, Rogers, Freedman-Letofsky, & Freeman (1980)	Descriptive longitudinal	Efficacy of a widow-to-widow program; a self help intervention study.	162 bereaved widows 22-69 years old Median age = 52 years N=68 treatment N=94 control	Personal questionnaire inter-views at 1, 3, 6, 12 and 24 months. Goldberg General Health Questionnaire. On-going contact with widow. Structured interviews for sensitive data regarding death.	Intervention group adapted faster than control group. Two years after bereavement disturbance differences were apparent between the groups.	
Lund, Dimond, & Juretich (1985)	Longitudinal Part of two-year study on elderly bereave-ment by University of Utah.	Identification of potential participant characteristics of widow support groups.	138 widowed persons N=61 support groups participation N=77 non-participation	Questions regarding participation in widow support groups.	Attendance at group meetings↑ coping abilities.	Social support network characteristics and desire for bereavement interventions.

Table 2. *Summary of Studies on Bereavement Counseling (Con't)*

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Essa (1986)	Case study	Psychotherapeutic intervention to accelerate grief work with elderly.	N=2: Female - 84 years Male - 69 years →	• Interview • Functions of Ego Aspects • Crisis Intervention • Model of Raphael 1) Affective 2) Defensive 3) Cognitive 4) Reality 5) Object relations	Rapidly facilitated grief work. Usefulness of psychotherapy with aged. Technique could be used by General Practitioner.	Use with elderly bereavement.
Kane, Klein, Bernstein & Rothenberg (1986)	Descriptive	Role of hospice in reducing impact of bereavement.	Random of hospice survivors: *Treatment Group:* N = 56 *Control Group:* N = 40 Mean Age = 57 years	• Demographics • Rand Anxiety Measure • CES-D • Interview Survey • Rand Health Perception Battery • Bereavement follow-up for two years with cards and phone calls with hospice	No significant differences between groups. Hospice did not provide protective effect during bereavement. Low risk participants in study.	Non-acute hospital based hospice may provide more care for bereaved.
Lieberman & Videka-Sherman (1986)	Descriptive correlational.	Impact of self-help groups in mental health through THEOS.	• Self selected 502 widowed persons • Mean months of bereavement = 43 months • 4 groups of members.	• Mailed questionnaires • HSCL-depression, anxiety & somatization subscales • Self-esteem scale • Mastery Scale • Well-being measure • LS	Significant positive changes for active participants in self-help groups for distress experiences.	Systematic research on bereaved self-help groups.

utilization. The counseling and support group decreased their health risk from high to low and decreased the number of symptoms and visits to the physician.

Another study of professional counseling is by Gerber, Weiner, Battin, and Arkin (1975) who studied 116 supported and unsupported aged bereaved subjects at 2, 5, 8 and 12 months following bereavement. Gerber and associates utilized both personal contact by phone and by interview for counseling. Fewer medical complaints and problems were noted in the group receiving support.

Likewise, Essa (1986) administered psychotherapeutic intervention (N = 2) to ascertain if it would accelerate grief work in the elderly, using Raphael's model of ego function aspects for crisis intervention. He found that intervention facilitated grief work for the elderly, and that it could be used by general practitioners trained in the technique.

Professional counseling is one mode of bereavement intervention, while hospice, a combination of both professional and volunteer services, provides bereavement counseling and follow-up to bereaved

spouses and families. Hospice is said to have a positive impact on both the terminally ill patient and their family, by reducing the impact of bereavement (Janson, 1982; Kane, Klein, Bernstein, & Rothenberg, 1986; Lattanzi, 1986; Osterweis, et al., 1984).

A study on the impact of hospice was done by Kane (1986). Survivors of patients, mostly widows, (N=56, mean age = 56 years) and controls (N=40, mean age = 58 years), in a randomized trial of a hospital based hospice, were followed for 18 months after the patient's death, by four personal interviews. (Kane, et al., 1984). There were no significant differences found between the groups, in health status, depression, social adjustment, or physician visits. The conclusion was that hospice care did not provide any protective effect for the bereavement period (Kane, et al., 1986).

With volunteer support services, Parkes' (1975) study yielded findings similar to Raphael (1977) with a high-risk group of bereaved survivors, mostly widows or widowers, whose relative had died at St. Christopher's Hospice in London. The high-risk group was divided into treatment and control groups, which were followed by trained lay volunteers. At the end of 20 months

post-bereavement, the groups were compared on a number of measures; physical symptoms, depression, habit changes, an index of worry, and a general health index on changes in health. Significant differences were found between the intervention group and control group on two of the three measures; the control group had increased autonomic symptoms and increased consumption of drugs, alcohol, and tobacco. The supported group had changed from high-risk to low-risk, as seen by changes in their health status (Parkes, 1975).

Not only do professional, hospice, and volunteer services provide support, but in recent years, self-help groups of bereaved helping other bereaved are available for needed support. Three studies will be described on self-help groups.

A systematic comparative study of bereavement self-help was done by Vachon and associates (1980) on 162 widows randomly assigned to two groups. The intervention group (N = 68) received one-to-one support and group support from widows, who had resolved their bereavement reactions and were trained by Vachon and her colleague to reach out with help. The control group (N = 94) received only the initial data gathering

interview. The intervention group adapted faster and had decreased overall distress at the end of two years (Vachon, Lyall, Rogers, Freedman-Letofsy, & Freeman, 1980).

Silverman did pioneering work with the successful Widow-to-Widow groups at the Harvard Medical School. The purpose of the intervention program was to prevent emotional breakdown in a vulnerable population. The program assisted the widows to accept their changed marital status, to learn how to manage their own lives, and to demonstrate to themselves and others that they could be independent (Silverman, 1970).

Another study of self-help groups was done by Lieberman and Videka-Sherman (1986). The researchers studied the impact of a self-help group, They Help Each Other Spiritually (THEOS), on the mental health of 502 widowed persons. These findings revealed that those who actively participated had greater ability to handle formerly distressful experiences associated with bereavement.

In summary, the studies generally show the positive impact of professional, hospice, volunteer, and mutual support bereavement interventions. Hospice

bereavement programs have much in common with mutual support groups, as they are targeted for the vast majority of bereaved people who can be expected to work through their grief without needing professional help. Bereavement programs emphasize education and support. Most of the interventions had positive outcomes, and only the hospice study by Kane, et al., (1986) showed no significant change in health status. Other studies on hospice programs and counseling were shown to be effective for bereaved persons (Lattanzi, 1986; Osterweis, et al., 1984; Parkes, 1980, 1981; and Roy & Sumpter, 1983). Further research is needed to explicate the relationship between bereavement counseling and effective ways of coping to provide healthy adaptation to conjugal loss among elderly widows.

Coping and Appraisal

The following section will discuss the conceptual definition of coping and appraisal. Studies on coping and elderly adjustment to bereavement will be presented.

There are many definitions of coping. Coping may

be defined in terms of ego processes or defenses, as a personality trait or style, or in terms of transactions between the person and the environment. In the present study the transactional definition, as defined by Lazarus & Folkman (1984), is used.

Transactional coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Coping is an individual's attempt to handle a stressful situation, and it can be adaptive or maladaptive.

Two processes mediate this transactional relationship: appraisal and coping. Appraisal is the cognitive process through which an event is perceived as stressful by a given individual. The way a demand is cognitively appraised influences the ways of coping used to deal with the demand or threat. Appraisal and coping are influenced by factors within the individual and the environment. Threat in the absence of adequate coping and resources is associated with stress reactions which is manifested in negative health changes (Gass, 1987).

Thus, coping is process-oriented, as it focuses on what the person actually thinks and does in a specific stressful encounter, and how this changes as the encounter unfolds. Also, coping is contextual, as it is influenced by the person's appraisal of the actual demands in the encounter and resources for managing them. Primary and secondary appraisals converge to determine if the person-environment transaction is significant for well-being, and if it is primarily threatening or challenging. The emphasis on context means that the particular person and situational variables together shape coping efforts. No assumptions can be made about good or bad coping, as coping is a person's efforts to manage demands, whether or not the efforts are successful (Folkman & Lazarus, 1986).

Few coping studies related to the process model of elderly widow bereavement were found in the literature. Most studies were concerned with the buffering effect of social support. Summaries of the studies on coping and appraisal are found in Table 3.

Table 3. ***Summary of Studies on Coping***

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Heyman & Gianturco (1973)	Longitudinal Descriptive. Duke University Center for the Study of Aging.	Adaptation to bereavement in a group of older persons before and after bereavement.	27 women: mean age = 73 years. 14 men: mean age = 75 years. Married at time of initial EV. Mean lapse time between bereavement and follow-up 21 months.	• Initial Interview • Havighorst Scale • Cavan Adjustment Scale • Psychiatric Evaluation • Physical Function Rating	Elderly adapt with emotional stability, stable social network, few life changes and only time-related health deterioration. Elderly women tolerate bereavement loss well.	Use with elderly bereavement.
Brock (1984)	Correlational Survey	Determination of factors necessary for a widow to have a healthy adjustment to the life pattern of a single person.	273 widows (28-80 years) metropolitan and rural women.	• Self report questionnaire • Holmes-Rahe Stress Test • Graney's Scale • Affect Balance Scale • Guttman Health Scale	Most demographic factors not considered in the analysis. Minimal support of the validity of life style, life changes, social participation, education, marriage as predictors of psychological well-being.	Large scale studies in adaptation to single status in widows.
Lund, Dimond, Caserta, Johnson, Poulton & Connelly (1985).	Longitudinal Descriptive	Elderly coping difficulties two years post-bereavement	138 bereaved spouses > 50 years of age.	• Questionnaires x 6 • LSI-A • Self-Depression Scale • Self reports of health, coping and stress	↑ Self-esteem → ↑ coping skills. ↓ Self esteem → ↑ coping difficulties. 18% had coping difficulties Self esteem not significantly affected by bereavement.	
Folkman, Lazarus, Dunkel-Schetter, DeLongisk & Gruen (1986)	Methodological	Measurement of cognitive appraisal, copying and encounter outcomes. Interrelationship between primary and secondary with intra-individual analysis.	Random middle-aged community sample. 85 couples Mean age of women = 39.6 years Mean age of men = 41.4 years	Interviews x 5 Primary appraisal Secondary appraisal Revised Ways of Coping (1984)	Coping strongly related to cognitive appraisal. Forms of coping used depended primary and secondary appraisal.	
Dimond, Lund, & Caserta (1987)	Longitudinal Descriptive	The role of structural and qualitative components of social support, depression, coping, health and life satisfaction.	192 elderly bereaved.	• Questionnaires x 6 • LSI-A • Self-Depression Scale • Self reports of health, coping and stress	Social support significant but modest bereavement outcomes - size of network related to depression, coping and L.S.	Extent of social networks.
Gass (1987)	Correlational Ex post facto	Coping strategies of older widows	100 Widows 1-12 Months bereaved	•Ways of Coping (1980) •SIP	Helpful and non-helpful coping strategies. Widows with ↑ health, use ↓ coping techniques than widows with ↑ health dysfunction.	Longitudinal study on beneficial strategies during phases of grieving process.

Table 3. ***Summary of Studies on Coping (Con't)***

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Norris & Murrell (1987)	Descriptive Longitudinal	Older adult family stress and adaptation before and after bereavement.	63 bereaved older adults; 387 non-bereaved older adults.	• Interviews pre and post bereavement • Hollingshead 2 Factor Index of Social Class • Belloc Physical Health Scale • CES - D Scale and • Louisville Older Persons Event Scale	Bereavement did not affect health. Psychological distress ↑ post-bereavement. Interventions post-bereavement are mistimed. Inventions should be instituted pre-bereavement.	
Blanchard-Field & Irion (1987)	Descriptive	The relationship between locus of control and coping as moderated by age and context.	96 subjects 14 - 60+ years (4 groups of 24 subjects)	• Questionnaire • Ways of Coping 1984 • Defensive Coping Scale • Levenson's Internality Powerfulness of Others and Chance Scale.	• Age moderated the relation between locus of control and coping. • Dimension of control varies with age. • Distancing and self-controlling positive relationship for older adults > 60. • Challenging situations more controllable.	Other moderators of controllability and coping; i.e. personality in longitudinal study.

Lopata (1973) proposes two tasks faced by the elderly widow to enhance successful coping and adaptation. These are the ability to live independently and to interact in society as a single person.

A longitudinal study by Heyman and Gainturco (1973) researched long-term adaptation to bereavement of 14 elderly males (mean = 74.8 years) and 27 females (mean = 73.1 years). They were followed prior to spousal loss and interviewed within 21 months following bereavement. Four measurements were used to assess attitudes, activities, psychological and physical evaluation. The data confirmed that elderly adaptation to the death of a spouse is characterized by emotional stability, stable social network of family and friends, and few life changes made after the death. No signs of health changes were seen between pre-bereavement and post-bereavement. The sample was able to cope and adapt to the conjugal loss (Heyman, et al., 1973).

Conversely, Lund, Dimond, Caserta, Johnson, Poulton, and Connelly (1985) studied 138 bereaved elderly and found that 18% were having difficulties coping with spousal loss after two years. Low esteem,

even prior to bereavement, is likely to be predictive of coping difficulties two years following the death of a spouse (Lund, et al., 1985).

Research by Folkman and Lazarus (1986), and Blanchard-Fields and Irion (1987) showed that older adults can cope with challenge and threatening situations. Coping was measured by the revised Ways of Coping Questionnaire (1984), using eight scales, on a middle-aged community sample and subjects of various ages. Appraisal influences coping, coping may influence the person's reappraisal. Positive reappraisal may be influenced by the outcome of the encounter. Both distancing and positive reappraisal were emotion-focused coping seen in good and bad outcomes.

In summary, research supports that a relationship exists between bereavement, as a stressor, and coping, and health dysfunction among bereaved widows. The association was studied by Gass (1987). Further work is needed to understand how bereavement counseling or other therapeutic interventions facilitate coping in the elderly bereaved.

Perceived Health Status

The conceptual definition of perceived health status will be discussed. This will be followed by brief citations of studies on the relation of perceived health status and bereavement.

Perceived health is defined as an individual's assessment, reaction and feeling of one's own health status. Self-assessed health ratings reflect a person's perception of health in relation to one's biologic, psychologic, and social characteristics.

Elderly adults' self-ratings of health are positively correlated with physicians' ratings of health status (LaRue, Bank, Jarvik, & Hetland, 1979). Self-report instruments are used almost exclusively to obtain indices of physical health status in virtually all bereavement studies (Thompson, Breckenbridge, Gallagher, & Peterson, 1984).

Two studies on the self-rating of health and subjective health with the elderly will be briefly described. A summary of studies of perceived health is seen in Table 4.

Table 4. *Summary of Studies on Perceived Health*

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
Heyman & Jeffers (1963)	Longitudinal Part of Duke University Interdisciplinary Geriatric Research Program.	Effects of time lapse on consistency of self-health and medical evaluations of elderly persons on two examinations--initial interview and three years.	Non random sample: 182 subjects Mean age = 70 years	• Physical Function Rating (PFR) • Self-Health Rating • Health Attitude Scale	First and second exams were consistent on self-health estimate, health attitude scores with medical evaluation. Interrelationships among variables on second exam with PFR significantly related to three variables of health.	Use of self-health appraisal as beneficial tool for older persons. Realistic self-appraisals are given by older persons.
Palmore & Luikart (1972)	Longitudinal	Health and social factors related to life satisfaction, health, activity, psychosocial, and socio-economic.	502 persons (aged 45-69)	• Life Satisfaction by Cantril Ladder • Self-rated health status measure • Activity measure • Jessor Scale of internal-external control of reinforcement. • Career-Anchorage Scale • Wechsler Adult Intelligence Scale.	Self-rated health predominant variable related to life satisfaction. Self-perceived health more important than MD rating. Involvement contributes to life satisfaction.	Health improvement, ↑ organizational activity and life satisfaction in middle aged groups.
Tissue (1972)	Longitudinal	Identification of variables underlying general ratings of health: 1) objective conditions of physical health 2) subjective feelings of physical state 3) recent medical care or hospitalization 4) response to aging.	256 older persons: 111 men and 145 women. Median age = 68 years.	• Interviews • Physical or Objective Health with Functional Health Index Number of Health Problems. • Subjective Health • History of Medical Care • Response to Aging Index Self-Perception • Affect Balance • Kutner Morale Scale	Self-ratings derived from a core of items that relate to health. Self-rating is a summary of perceived health. First-year ratings are high degree of association between second year relating to overall health.	Selectivity in self-ratings do not always suffice for every purpose.
Ware (1976)	Methodological Field Testing.	Evaluation of Health Perception Scales	2,000 adult subjects	• Health Perception Questionnaire II (HPQII)	Scales are reliable, valid and stable over time for general health measures. Health perception negatively correlated with age.	Research to understand clinical significance of scale scores; development and validation of shorter forms, ones for children; validity of scales in prospective study.

Table 4. ***Summary of Studies on Perceived Health (Con't)***

Author	Type of Study	Research Problem	Sample	Instruments	Results	Future Study
LaRue, Bank, Jarvik & Hetland (1979)	Longitudinal (from medical records)	Relationship between self-reports of health and physician ratings in an elderly sample.	69 subjects (mean age = 84.25 years)	• Medical records of surviving twins	Self ratings of health significantly correlated with MD records. Valid measure for health assessment.	Use of ratings in psychosocial older adult research.
Gallagher, Breckenbridge, Thompson & Peterson (1983)	Longitudinal (on-going)	Psychological distress at two months post-bereavement in an elderly bereaved sample.	*Treatment Group:* N=199 *Control Group:* *N=79* Mean age = 68 years	• Structured interview • Self-report measures • BDI • Symptom Inventory Severity Index • TGI • MHSR	Differences in health status among bereaved having ↑psychological distress at two months with grief and ↑ depression.	Follow-up for two years post bereavement to detect mental distress-a major risk MH factor for bereaved.
Thompson, Breckenbridge, Gallagher & Peterson (1984)	Longitudinal (on-going)	Bereavement effects on self perceptions of physical health in elderly bereaved at two months.	212 bereaved elderly. Mean age = 67 years 162 controls Mean age = 69 years	• Structured Interviews • Self-perceived health status • Health problem list	Poorer perceived health among women. Significantly more health complaints and poorer health ratings with bereaved sample.	On-going longitudinal investigation of impact of bereavement on elderly over 30 months.
Horgan (1987)	Descriptive Correlation	Relationship between subjective health status and health practices among the elderly.	Convenience: N = 79 Mean age = 73 years.	• Interviews • Health-related behaviors • Self-rating of health	Positive correlation between frequency of physical activity and perceived health status.	Relationship between self perceived health and health related behaviors using broader scores for perceived health and physiological measure of well-being.

Tissue (1972) conducted a longintudinal study on self-rated health among the 256 elderly and found that self-rating is a reliable and valid summary of perceived health with the older population. General health perception does not distinguish between the different components of health, physical, mental and social (Tissue, 1972).

Horgan (1987) examined the relationship between subjective health status and common health practices among a sample of 80 elders (mean age = 72.9 years), using Orem's self-care framework. Horgan analyzed self-perceived health status and seven health-related behaviors. The results showed that 63.7% of the sample considered themselves to be in good or excellent health, while only 7.5% in poor health. The frequency of physical activity was seen as the leading behavior positively related to perceived health status (Horgan, 1987).

Measurement of the self-rating of health and subjective health has been predominantly done with self-report questionnaires (Ware, 1976), and self-anchor scales (Cantril, 1965). The advantages of the latter technique is that it provides a continuous and

equal-interval scale to measure the subject's own health perception. It has been extensively used to measure health perception in different populations: post-surgical cardiac patients (Brown & Rawlinson, 1975); elderly widows (Gass, 1987); middle-aged adults (Palmore & Luikart, 1972), and elderly bereaved spouses (Thompson, et al., 1984).

Only a few studies were found on perceived health status of elder bereaved widows and widowers, and one will be discussed. Thompson and associates (1984) studied the effects of bereavement on self-perceptions of physical and psychological health in elderly widows and widowers two months following the death of the spouse. The sample included 212 bereaved adults (113 women and 99 men) and 162 comparison control participants (78 women and 84 men) between the ages of 55 and 83. Structured interviews and perceived rating of current health status and comparision of their health with others the same age were done on a 7-point self-anchor scale. The results were that conjugal bereavement is a significant stressor that may adversely affect the health status of survivors. The bereaved rated their overall health, and health

compared with others their own age, more poorly than the comparison group. The researchers reported an association between bereavement and perceived health status (Thompson, et al., 1984).

In summary, studies indicate that the health status of the widow can be adversely affected by bereavement. Perceived health is used almost exclusively in bereavement studies. It has been shown to be a valid data tool to ascertain perceived health status.

Gass Study

The study by Gass (1987) will be described in detail in this section, as it served as the basis for the present study exploring bereavement of older widows, coping, appraisal and health status.

Gass (1987) studied the relationships between bereavement, coping, appraisal, resources, and health dysfunction in 100 older women (mean age = 71.3 years) widowed 1 to 12 months prior to interview. The purpose of the Gass study was to examine the meaning of bereavement, coping patterns, resources, and the effects on health functioning of aged widows within the

context of Lazarus' Stress-Coping Framework.

Gass used the following instruments in the study: 1) Appraisal of Bereavement, a one question instrument to assess the meaning of bereavement; 2) Ways of Coping Questionnaire, a 68 item instrument, developed by Lazarus and Folkman (1980), to measure bereavement coping. It consisted of two overall classifications of problem-focused and emotion-focused coping and seven scales, measuring domains of coping, namely: overall problem-focused; overall emotion-focused; problem-focused; wishful thinking; mixed; growth; minimizes threat; seeks social support, and self-blame. Alpha reliabilities from the Gass study were lower than the alpha reliabilities of Folkman & Lazarus (1980), as seen in Table 5; 3) Assessment of Resources, developed by Gass, to assess psychological, social, and material factors which may influence bereavement; 4) Sickness Illness Profile, to measure health, and 5) Cantril Ladder, developed by Cantril (1965), to measure perceived health status.

Gass tested five hypotheses of which the first three were used in the present study. The three hypotheses and results from Gass were: 1) There are

Table 5

Internal Consistency Comparisons Between the Original (1980) and Revised (1984) Ways of Coping on 4 Samples[a,b,c,d]

Ways of Coping Scales	Alpha		Difference
Original (1980)	Folkman	Gass	
Overall problem-focused	.80	.69	.11
Overall emotion-focused	.81	.75	.06
Problem-focused	.89	.62	.17
Wishful thinking	.91	.66	.25
Help-seeking/avoidance	.83	.43	.40
Growth	.90	.65	.25
Minimizes threat	.83	.53	.30
Seeks social support	.79	.48	.31
Blames self	.77	.56	.21
Revised (1984)	Folkman	Hawley	
Confrontive coping	.70	.43	.27
Distancing	.61	.56	.05
Self-controlling	.70	.52	.18
Seeking social support	.76	.46	.30
Accepting responsibility	.66	.57	.09
Escape-avoidance	.72	.55	.17
Planful problem-solving	.68	.45	.23
Positive reappraisal	.79	.75	.04

Note. a = Folkman, et al., (1980). b = Gass (1987). c = Folkman, et al., (1986). d = present study of Hawley.

differences in coping by widows who appraised their bereavement differently, which was partially supported; 2) There is a relationship between ways of coping and health dysfunction, which was partially supported; 3) There is a relationship between individual resources and health dysfunction, which was partially supported.

Gass found that appraisal groups differed significantly in overall problem-focused coping, wishful thinking, help seeking/avoidance, self-blame, and growth-oriented coping. No differences were found among the appraisal groups in the use of emotion-focused coping, ways to minimize threat and seeking social support. Social support, strong religious beliefs, belief in control over bereavement, and good prior mental health were related to decreased health dysfunction. Appraisal of bereavement as a higher threat was associated with less adaptive ways of coping, such as self-blame or wishful thinking. Further research is needed in identifying helpful and non-helpful coping strategies utilized by elder widows.

The present study builds upon the first three of Gass' hypotheses. The Gass study needs to be replicated on widows bereaved over one year, as

the anniversary date of the death of the spouse will be past, and widows tend to have more problems in the second year of bereavement with health dysfunction (Osterweis, et al., 1984; DeVaul, et al., 1982).

The present study expanded the Gass study by testing the effects of bereavement counseling using two groups of widows in the second year of bereavement. The treatment group received the intervention of post-bereavement counseling, and the control group had not received a bereavement counseling intervention. The theoretical Stress-Coping framework of Lazarus and Folkman, revised Ways of Coping Questionnaire (1984), Appraisal of Bereavement questionnaire, and a perceived health measure were used to test the generalizability of the Gass results among two groups of widows in their second year of bereavement. A more current version of the Ways of Coping instrument (1984) was used, which is a refinement of the scale after intensive factor analytic studies. The number of scales was extended to eight and the response options to each item was changed from a yes\no to 4 alternatives. The resource of bereavement counseling intervention was compared to a no treatment group for

its affect on coping, appraisal and perceived health status.

Summary

Bereavement is a disruptive life-stress event that impacts the elderly survivor, physiologically, psychologically, and socially. Widows are at risk for increased morbidity and mortality. Bereavement is perceived as stressful, and it is a life change associated with general predisposition to morbidity. Stress reactions can affect perceived health status and are reflections or consequences of coping processes.

Bereavement counseling has been shown to be beneficial in most instances to enhance coping and adaptation to spousal loss. Improved perceived health status is associated with post-bereavement intervention. The ways the widows appraise and cope with their bereavement impacts their perceived health status, as seen in the Gass study and other studies. The present research study examined these variables.

Conceptual Framework

The conceptual framework of the present study consists of four parts: the antecedent, the intervention, the intervening variable of appraisal, and the outcome. The antecedent is a stressful event, which is bereavement. All of the subjects had experienced the loss of a spouse within the last two years.

The intervention part of the conceptualization contains two aspects. The bereavement process brings into play the manner in which the widows cope with their conjugal loss. The ways in which the widows cope are seen two ways: 1) hospice bereavement intervention, and 2) informal, or no bereavement intervention. Group I had bereavement intervention of hospice post-bereavement counseling for 13 months. Group II had no formal bereavement intervention, although they may have had some kind of informal family, widow-to-widow, group or individual counseling to assist them in the bereavement process. This conceptualization links the extent to which the eight ways of coping were used to the type of bereavement intervention. The rationale

is that persons who had experienced the more formalized hospice bereavement counseling would be better equipped to utilize constructive ways of coping than persons who had no formal intervention.

The next step in the conceptualization is the intervening variable of appraisal. The assumption is that coping will influence appraisal of the stressful event and the degree of stressfulness. Appraisal will reflect how the widow has used the different resources of coping. The model purports that Group I with post-bereavement counseling will appraise their bereavement as more of a challenge, while Group II with no post-bereavement counseling will appraise their bereavement as more of a harmful loss.

The final component of the model is outcome, which is specified as the widow's perception of her health. Maintained or improved health status, as evidenced by decreased health dysfunction, is expected in the intervention group subjects. Reduced health status, as evidenced by increased health dysfunction, is expected in the non-intervention group subjects.

ANTECEDENT	INTERVENTION	INTERVENING VARIABLE	OUTCOME
	<u>Group I</u>		
Stressful Event of Spousal Loss	Bereavement Intervention The use of more effective Ways of Coping	Stressful Appraisal as a challenge or harmful loss without other losses	Maintained or Improved Health Status
	<u>Group II</u>		
Stressful Event of Spousal Loss	No Bereavement Intervention The use of less effective Ways of Coping	Stressful Appraisal as a harmful loss with anticipated threats and losses	Reduced Health Status

Figure 1. Conceptual Framework

Purpose of the Study

The purpose of this study was to explore the relationship between coping and appraisal on the health outcomes of older bereaved widows. Its aim was to determine if statistically significant differences in health outcomes occur between widows who receive bereavement counseling and widows who do not receive any bereavement counseling as an intervention. It was expected that bereaved widows who receive counseling would use more adaptive ways of coping and would appraise their bereavement as more of a challenge and less of a loss than those who do not receive counseling. As a result, widows who receive counseling would score higher on the perceived health status instrument scores than those who did not receive counseling.

The study also explored the differences between the two groups of subjects in relation to appraisal and ways of coping. In addition, relationships were examined among selected variables of the study, using the entire sample.

Hypotheses

The following hypotheses were tested:

1. There will be significant differences between the bereaved widows who receive counseling and those who do not receive counseling in coping, appraisal, and perceived health status.
    a. Bereaved widows who receive counseling will have higher scores on the eight ways of coping scales than those who do not receive counseling.
    b. Bereaved widows who receive counseling will appraise their bereavement as more of a challenge and less of a loss than those who do not receive counseling.
    c. Bereaved widows who receive counseling will score higher on the perceived health status scale than those who do not receive counseling.

2. There will be statistically significant differences among the subjects on each of the eight ways of coping scales in relation to the three levels of bereavement appraisal.
3. There will be statistically significant correlation among all subjects between the ways of coping and perceived health status; and the appraisal of bereavement and perceived health status.

CHAPTER II

METHODS

Subjects and Setting

The subjects were 10 bereaved widows who had post-bereavement counseling for a period of 13 months following the death of their spouse, and 10 bereaved widows who did not have any post bereavement counseling or follow-up by the agencies involved since the death of their spouse. It was a convenience sample of spouses of married men who had died within the previous 25 months obtained from the patient records of two agencies. The agencies provided the names of potential subjects to the researcher.

The criteria for inclusion in this study were a widow: 1) whose spouse died between 13 and 25 months prior to the time of interview; 2) who was 60 years of age or older; 3) who had not remarried; 4) who was able to understand, read and write English, and 5) who was able to fulfill the demands of completing the paper and

pencil tests.

Group I, the treatment group, had hospice bereavement intervention, consisting of 13 months of counseling and follow-up to assist them in the grieving process through the selected hospice agency. Two of the subjects were referrals from the home health agency (HHA).

Group II, the control group, did not have any formal bereavement intervention by any agency personnel. Some of the subjects did have informal intervention by family, friends, church, widow-to-widow groups, or other counseling, which was noted on the subject characteristics form. This latter group was composed of widows from the selected HHA. All subjects from both groups were seen in their own homes by the researcher for the one-time interviews.

The hospice agency used in this study is a county community-based service organization located in a rural area, which provides holistic care and support for terminally ill persons and their families. Emphasis is placed on providing physical, spiritual, emotional, social support, home care, and assistance to the family during the bereavement period. Care is given to all

persons based on need rather than ability to pay. Approximately 35 patients are served by the hospice every year. From this pool of hospice patients, the agency identified deceased male spouses who were 60 years or older and who had died within the previous 13 to 25 months. Eighteen eligible older widows of these patients were identified as potential subjects.

The hospice provides bereavement services which are available to the surviving significant other or others for a period of 13 months following a patient's death. A bereavement committee consisting of the bereavement coordinator, bereavement team members, a representative of the Board of Directors, and the hospice coordinator as an ex-officio member plans, implements, and evaluates the bereavement program.

A range of services has been developed by the hospice to assist families through the process of loss and grief of a family member. Services include, individual and family visitations, group discussions for support and education, consultation with community agencies and groups, pamphlets and resource materials, and public informational sessions on loss and grief. Follow-up on the well-being of those suffering from the

stress of grief is done for a period of 13 months of all survivors admitted to the program.

The home health agency is a home care agency based at a small community hospital. The agency was established in 1966, as an offical HHA under the County Health Department. In April of 1983, the County Home Health Care Association, a subsidiary of the community hospital, was established as a non-profit HHA. The agency is certified under Medicare and licensed by the State of Oregon. It serves all county residents, as well as persons living in neighboring counties.

The agency offers a complete range of professional health services provided on an intermittent basis in the home, under the direction of a physician. It permits the patient to remain in the home for health treatment as an alternative to hospital or nursing home care.

A team of health care professionals, under the direction of the attending physician, provides many services. Services offered by the agency include, 1) skilled nursing, 2) home health aides, 3) physical therapy, 4) speech pathology, 5) occupational therapy, 6) medical social service, 7) nutritional guidance, 8)

medical supplies and equipment assistance, and 9) terminal care. The HHA contracts with the hospice to provide specialized services to patients and their families in need of terminal care and bereavement counseling.

Last year, 945 patients, with various diagnoses, including terminally ill patients, were treated by all disciplines. From this pool of HHA patients, the agency identified deceased male spouses who were 60 years or older and who had died within the previous 13 to 25 months. Thirty-one eligible older widows of these patients were identified as potential subjects.

Data Collection Instruments

Data were collected by means of one personal interview per subject to obtain information pertaining to selected subject characteristics, as well as information relevant to coping, appraisal and health. In the following section, four instruments which were used to collect the data are described.

Instruments that were used in the data collection are; 1) Selected Subjects Characteristics Form; 2) 1984 Revised Ways of Coping Questionnaire,

developed by Lazarus and Folkman; 3) Appraisal of Bereavement, developed by Gass (1984), and 4) Cantril's Ladder, a self-perceived health status instrument to measure health.

Selected Subject Characteristics Form

The subject characteristics form consisted of 19 items. These items included questions regarding the spouse's illness and death; and demographic data pertaining to the subject, such as date of birth, educational level, current or prior occupation, religion, ethnic background, and income. Additional comments were also solicited. (Appendix A).

Revised Ways of Coping Questionnaire, 1984

The Ways of Coping (revised) is a 66 item questionnaire containing a wide range of thoughts and acts that people use to deal with the internal and/or external demands of specific stressful encounters. The measure is not designed to assess coping styles or traits. It is designed as a process measure to assess transactional coping. It is also designed to be used to assess the coping processes in a particular

stressful encounter.

Fifty of the original 66 items were retained by the author as a result of factor analytic studies on a community sample of married couples. Sixteen of the items were eliminated; 9 contained marginal factor loading or lacked conceptual coherence with their scale, and 7 items did not consistently load on any factor. A final principal factor analysis of the 50 item scale yielded 8 factors. These factors are represented by the 8 scales. The factor analysis conducted by Folkman and Lazarus (1986) provides support for the validity of the instrument. Further research is being done on the reliability and validity of the revised Ways of Coping Questionnaire.

Scale 1 is confrontive coping. It contains six items and describes aggressive efforts to alter the situation. Scale 2 is distancing with six items and describes efforts to detach oneself. Scale 3 is self-controlling, consisting of seven items and describes efforts to regulate one's feelings. Scale 4 is seeking social support, consisting of six items and describes efforts to seek informational support. Scale 5 is accepting responsibility with four items and

acknowledges one's role in the problem. Scale 6 is escape-avoidance with eight items and describes wishful thinking. Scale 7 is planful problem-solving with six items and describes deliberate problem-focused efforts to alter the situation. Lastly, scale 8 is positive reappraisal with seven items and describes efforts to create positive meaning by focusing on personal growth. All of the alpha coefficients represent acceptable levels of reliability for research purposes with the possible exception of scales 2, 5, and 7 (Folkman, et al., 1986). See Table 5.

The revised Ways of Coping format required that the subject respond to each item on a 4-point Likert scale, with 0, indicating that the item does not apply and/or was not used; 1, used somewhat; 2, used quite a bit; and 3, used a great deal. The potential range of the 8 scales scores are as follows: scales 1, 2, 4, and 7 from 0-15; scale 3 and 8 from 0-21; scale 5 from 0-12; and scale 6 from 0-24.

Gass used the original Ways of Coping Questionnaire but suggested (per personal correspondence, December 2, 1987) using the revised version, although the scales will differ from those in

her study. The original Ways of Coping response format is yes/no, while the revised version response is on a four point Likert scale, as previously mentioned. (Appendix B).

The Cronbach alpha reliabilities in the present study for the eight scales are shown in Table 5 on page 45. Reliabilities were lower than those in the community sample (Folkman, et al., 1986) and may have reflected differences in the samples studied. The present sample was a homogeneous group, which showed little variability in the responses to coping strategies, with a small range of answers. Only a few subjects offered variability in the responses, so the variability could have been affected.

Appraisal of Bereavement

The instrument to assess appraisal of bereavement consisted of a question on the meaning of bereavement to the individual widow, which was devised by Gass (1987). In the present study, three statements with stressful meanings were used: a harmful loss in and of itself; a harmful loss with additional anticipated threats; and a challenge. Nonstressful appraisal

bereavement statements were not considered in the present study, as advised per personal correspondence with Gass, based on her research findings.

Widows with other anticipated threats appraised their bereavement as a loss with other losses, fears, and problems to anticipate and worried that they would not be able to manage them. Widows who appraised their bereavement as a loss without other losses appraised their spouse's death as a great personal loss, but felt there were no other bereavement-related losses, fears, or problems they could not manage. Challenged widows appraised their bereavement as something to overcome or master and viewed widowhood as an opportunity for personal growth (Gass, 1987).

The instrument was pilot tested by Gass on six widows prior to conducting her research in 1987, and it was found to be reliable in self-appraisal of the individual's bereavement. No other information is available on the instrument. (Appendix C).

Cantril Ladder of Perceived Health

A self-rating of overall health was administered using the Cantril ladder (Cantril, 1965; Palmore &

Luikart, 1972). The health scale is a self-anchored, one time measure of perception of health. On an equal interval ten-point scale ranging from 0 (representing worst possible health) to 9 (representing best possible health) subjects were asked to rate their own health at various times and the health of a married friend of the same age. Widows were asked to indicate on the ladder the steps best representing 1) her health right now; 2) the present health of a married friend of the same age; 3) her health prior to death of her spouse, and 4) her health three months after the death of her spouse.

Heyman and Jeffers (1963) found to a statistically significant degree that a greater proportion of elderly subjects remained unchanged in their self-ratings of health on retesting at two and three years (76.3% agreement). Also, self ratings of health were significantly related to the physician's estimate of the subject's capacity to function effectively in daily living. Heyman and Jeffers' findings provided support for convergent validity of self ratings of health. It is a useful measure of the perceived health status of the older person (Gass, 1987). (Appendix D).

Procedures

This study was quasi-experimental in design, in which subjects were drawn from two populations; one group had the intervention of post-bereavement counseling, and the other group had no formal post-bereavement counseling.

Potential subject names were provided by two agencies from records of older male patients who had died within the previous 25 months (Appendix E). Letters were first sent out by the agencies to inform the potential sample, Group 1 (N = 18) and Group 2 (N = 31), of the study (Appendix F). This was followed by a letter from the researcher to explain the study with a return postcard (Appendix G). These persons were encouraged to return the postcard to indicate their decision either to voluntarily participate or to not participate. All subjects who agreed to participate were contacted by phone. Verbal consent was obtained, and subjects were offered an interview in their own home, or at a mutually agreed upon location. All subjects requested to be interviewed in their own home. A mutually agreed upon time was determined and

verified. Prior to commencement of the interview in the subject's home, a consent form was signed by the subject (Appendix H).

Data collection was completed in three weeks, during July of 1988. The administration of the research instruments were completed for each subject in one hour or less.

Data Analysis

Descriptive statistics were used to present demographic data and selective characteristics of the subjects. The data were presented in terms of measures of central tendency and variability for the two groups to see how comparable the two groups were in descriptive characteristics.

In Hypothesis 1, data were analyzed regarding differences in the individual ways of coping and appraisal of their bereavement and perceived health status between the two groups of subjects. The differences between the means of the two groups were tested by use of the t-test.

Hypothesis 2 was tested by one-way analysis of variance (ANOVA) among the subjects for differences

between the means on each of the eight ways of coping scales in relation to the three levels of bereavement appraisal and the ratio of the variances. Hypothesis 3 was tested by Pearson's r correlational technique.

CHAPTER III

RESULTS

In this section, the findings of the study are presented in the following order. First, the sample of the two groups of bereaved widows are described in relation to participation rate, selected demographic characteristics, and various factors pertaining to spousal bereavement. Second, the results of the hypotheses testing are presented.

Description of Subjects

Participation

The sample consisted of 20 older bereaved widows, whose husbands had been cared for by either a home health agency or a hospice service prior to death. Of the 20 subjects interviewed, 10 agreed to participate from the hospice, which comprised the treatment group (Group 1), while 10 subjects agreed to participate from the HHA, which served as the control group (Group 2). The treatment group had received 13 months of

bereavement counseling as an intervention from the hospice. The control group had not received any bereavement counseling from the agency involved.

The potential sample consisted of 18 bereaved widows, referred by the hospice, and 31 widows, referred by the HHA. Twenty-six of the total possible sample of 49 responded to the letter, which included 7 from the treatment group and 19 from the control group. Ten persons from the control group and six from the treatment group consented to participate in the study. Telephone calls were made to non-responders in the latter group to insure that they had received the letter and to confirm their addresses in an effort to achieve a sample of 10. From these contacts, four additional persons were recruited to arrive at the final number of 10 subjects in the treatment group.

Reasons given for non-participation were varied. Of the 6 who declined to participate in Group 1, the treatment group, one was going on an extended trip, one had died, one had remarried, two were too ill, and one did not want to participate. Of the 9 who declined in Group 2, the control group, 8 did not want to be a part of the study, and one refused for physical reasons

having had a recent CVA. No answer or replies were received by 14 potential subjects; two in Group 1 and 12 in Group 2.

Demographic Characteristics

The two groups were very similar in all of the selected characteristics, with the possible exception of the subjects in the control group who had been married longer periods of time. See Table 6. Thus, the entire sample may be characterized as primarily elderly caucasian Protestant women who had been widowed from 1-2 years.

The mean educational level of the subjects was equivalent to a high school education (12.3 years). However, there was considerable variability with 40% having completed grades 8-11; 20% having graduated from high school, and 40% having completed 2 or more years of college, nursing school, or business college. Nationally, the education figures for women over 65 were quite similar, with 28% completing grades 8-11, 38% graduating from high school, and 34% going on for higher education (Shick, 1986).

Table 6

Comparison of the Treatment and Control Groups[a] on Selected Demographic Characteristics

Characteristic	Treatment Group 1	Control Group 2
Age (in years)		
Mean	69.9	71.6
S.D.	7.0	6.3
Range	59-78	62-79
Education (in years)		
Mean	12.4	12.2
S.D.	2.7	1.5
Religion		
Protestant	9	8
Catholic	0	1
Jewish	1	0
Other	1	0
Race		
Caucasian	10	10
Other	0	0
Annual Gross Income (in $ for 1988)		
0- 4,999	1	0
5,000-14,999	5	6
15,000-24,999	2	3
25,000-34,999	1	1
35,000 or over	1	0
Years Married (in years)		
Mean	28.7	41.8
S.D.	15.7	9.5
Range	4-49	18-52
Children (number)		
Mean	3.1	2.5
S.D.	1.7	1.6
Range	1-6	0-5
Living Arrangements		
Lives alone	9	8
Lives with family	1	2
Activity Participation with Others		
Participation	9	10
No participation	1	0

[a]

Note. n = 10 for each group.

Socio-economic status data revealed that 11 of the subjects anticipated an annual gross income for 1988 of $5,000 to $14,999. Only one widow had an income under $5,000, while 5 of the sample had income from $15,000 to $24,999, and 3 anticipated an income from $25,000 or over. In the county 48% of the single women over the age of 62 years old had an average income of less than $10,788 per year for 1987. Twenty-one percent had incomes ranging from $10,800 to $17,268 per year, while 31% of the women had incomes greater than $17,700 in the county for 1987 (Personal communication, Bill Bellish, figures from the County Community Development Plan, 1987). Income for the present sample was comparable to the median for the single women in the county, but it was much higher than the national 1982 median income of $5,620 for single women over age 65 (Shick, 1986).

Four in the treatment group and three in the control group had been widowed previously more than once, which accounted for the differences in the years married. One widow in the treatment group had been married to her second husband only 4 years. Researchers have found that prior losses does affect

and impact coping skills and bereavement adjustment (Dimond, 1981; Gass, 1987; Osterweis, et al., 1984).

In respect to the number of children, the mean number for the entire sample was about 3 children. Only two of the total sample had no children. Most of the subjects lived alone, and three lived with others. The findings are comparable to national statistics in 1982, in which only 11% of the older single women lived with children or others (Shick, 1986).

Factors Pertaining to Spousal Bereavement

In comparing the two groups on factors pertaining to the spousal bereavement, they appear to be similar on most aspects. The factors upon which these comparisons were made included the following: type and place of death, length of spousal care in months, support, and causes of spousal death. (See Table 7).

The types of death of the spouse were classified as 1) acute, with the death occurring within or less than two months following diagnosis of the condition; and 2) chronic, with the death occurring more than two months after diagnosis. All but one of the deaths were classified as chronic; the one acute death was in the

treatment group.

Three-quarters of the spousal deaths occurred at home among the total sample. As anticipated, there were differences between the two groups because of the nature of the agencies administering the spousal care. Most of the subjects in the treatment group died at home, with only one dying in the hospital. The place of death varied to a larger extent among the control group spouses, as 6 died at home, while 3 died in the hospital, and 1 in a nursing home.

The length of time in months that the subjects cared for their husbands also varied between the two groups. One wife provided care for 96 months, and another wife provided care for 156 months. With those two outliers removed, the two groups appear to be quite similar, for Group 1 the means and S.D. were 16.1 and 20.4 months respectively, and for Group 2 the means and S.D. were 15.3 and 14.8 months respectively. Two husbands did not receive any care, as they were ambulatory and able to provide for their own needs until the time of death. All received supportive nursing and other services from the two agencies involved.

Table 7

Comparison of the Treatment and Control Groups[a] on Factors Pertaining to Spousal Bereavement

Factors	Treatment Group 1	Control Group 2
Type of Death		
Acute (< 2 months)	1	0
Chronic (> 2 months)	9	10
Place of Death		
Home	9	6
Hospital	1	3
Nursing Home	0	1
Length of Care (in months)		
Mean	24.1	29.4
S.D.	31.7	46.6
Range	0-96	0-156
Perceived Current Health		
Better	5	4
Same	5	5
Worse	0	1
Support Before and After Death from Others		
Family	5	7
Friends	2	2
Nurses	3	0
Physician	0	1

Note. [a] n = 10 for each group.

There were no differences between groups in their rating of current health that was included in the subject's characteristics form with all of the subjects stating that their current health was the same or improved. It is of interest to note that the responses to this question were significantly correlated ($r=.58$, $p<.001$) with the same question on the perceived health status measurement for "perceived health now".

Family and friends provided the most meaningful support before and after the death for both groups. Differences between the groups were shown in the case of three subjects in the treatment group who indicated that nurses were the most meaningful support system for them; while a physician was mentioned as the support for one widow in the control group. Support systems are an important variable and asset in the coping process of spousal loss, as shown in studies by Cobb, 1974; Dimond, 1981; Gass, 1987; Heyman, et al., 1973; Osterweis, et al., 1984; Rafael, 1977; Stroebe & Stroebe, 1987; and Vachon, et al., 1980.

The various causes of spousal death are given in Table 8. The most frequent cause of death was cancer. Twelve of the total deaths were from cancer, with lung

Table 8

Causes of Spousal Death Between the Treatment and Control Groups[a] and Total Sample[b]

Causes of Death	Group 1	Group 2	Total
Cancer			
Lung	4	5	9
Stomach	1	0	1
Pancreas	1	0	1
Brain	1	0	1
Cardiovascular			
CVA	2	3	5
MI	1	1	2
Endocrine			
Diabetes	0	1	1

Note. [a] n = 10 for each group. [b] n = 20 for total sample.

cancer accounting for 9 deaths, and stomach, brain and pancreatic cancer accounting for three deaths. Other causes were cardiovascular and diabetic complications. Seven of the treatment group and five of the control group died of cancer.

In summary, the two groups were alike in the demographic characteristics of age, race, religion, education, income, number of children, and activity participation. The groups differed in number of years married. Spousal bereavement factors were likewise similar in type and place of death, support systems, perceived current health, and causes of death. Most widows cared for their husbands at home. Hospice played a role in the treatment group in facilitating the process of the spouse dying at home, as documented in the hospice literature (Kane, et al., 1986; Lattanzi, 1986; Parkes, 1980). The length of time the widow took care of her spouse was varied, with two widows providing care for 8 and 13 years respectively.

Report of the Hypothesis Testing

This section presents the results of the testing for statistical significance in relation to the three

hypotheses of the study.

The hypotheses were as follows:

Hypothesis 1: There will be significant differences between the bereaved widows who receive counseling and those who do not receive counseling in coping, appraisal, and perceived health status. This hypothesis has three parts.

A. Bereaved widows who receive counseling will have higher scores on the eight ways of coping scales than those who do not receive counseling.

Tests of differences between the two groups were conducted by means of t-tests. Scores on the eight ways of coping scales of confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, planful problem solving, and positive reappraisal did not significantly differ between the two groups. (See Table 9). Therefore, this aspect of Hypothesis 1 was rejected. In neither group did the subjects appear to engage in counterproductive coping mechanisms, such as accepting responsibility of the spousal death or unrealistic modes as in the use of escape-avoidance as a coping mechanism. But they did endorse the positive

Table 9

Comparison Between the Treatment and Control Groups[a] on the Ways of Coping Scales

Ways of Coping	Group 1		Group 2	
	Mean	S.D.	Mean	S.D.
Confrontive coping	.87	.54	1.05	.56
Distancing	1.30	.67	1.05	.65
Self-controlling	1.46	.62	1.49	.70
Seeking social support	1.23	.66	1.25	.57
Accepting responsibility	.57	.86	.55	.61
Escape-avoidance	.29	.35	.44	.50
Planful problem solving	1.79	.54	1.62	.68
Positive reappraisal	1.34	.86	1.60	.61

Note. The mean for the sample is divided by the total of items in each subscale.

[a] $n = 10$ for each group.

kinds of coping such as positive reappraisal (efforts to create positive meaning by focusing on personal growth) and planful problem-solving (deliberate problem-focused efforts to alter the situation).

B. Bereaved widows who receive counseling will perceive their bereavement as more of a challenge and less of a loss than those who do not receive counseling.

Comparison of bereavement appraisal between the two groups was analyzed by t-test. As may be noted on Table 10, the differences were not statistically significant. Therefore, the hypothesis was rejected.

Overall, the two groups appraised their bereavement similarly, and only a small percentage selected the most stressful appraisal category on the scale. Two of the treatment group and three of the control group appraised their bereavement as a harmful loss with other anticipated losses or threats. Appraisal of bereavement as a harmful loss without other losses or as a challenge were almost equally divided. Four widows in each group appraised their bereavement as a harmful loss without other losses. Four widows in the treatment group and three in the

Table 10

Comparison Between the Treatment and Control Groups[a] on Appraisal of Bereavement

Bereavement Appraisal	Group Treatment	Control	t
1-Harmful with other losses	2(20%)	3(30%)	
2-Harmful without other losses	4(40%)	4(40%)	
3-Challenge	4(40%)	3(30%)	
Total	10(100%)	10(100%)	-.56
Mean	2.20	2.00	
S.D.	.79	.89	NS

Note. [a] n = 10 for each group.

control group appraised their bereavement as a challenge and time for growth. Apparently, bereavement counseling did not influence their appraisal.

C. Bereaved widows who receive counseling will score higher on the perceived health status scale than those who do not receive counseling.

The four measures of health status were tested for significant differences between the two groups by means of the t-test. (See Table 11). "Health now" of the widow was the item of most interest here to test the hypothesis. The differences were not significantly different, therefore the hypothesis was rejected.

In conclusion, the intervention of bereavement counseling did not make a significant difference in the ways the subjects coped, appraised their bereavement, or perceived their state of health.

Hypothesis 2: Among the subjects, there will be statistically significant differences between each of the ways of coping subscales and the three levels of bereavement appraisal. Eight one-way-analysis of variance (ANOVA's) were conducted for significant differences among the three levels of bereavement appraisal. (See Table 12). None of the eight ANOVA's

Table 11

Comparison of the Treatment and Control Groups[a] on Perceived Health Measurement

Perceived Health	Group 1	Group 2
CL1 Perceived health now		
Mean	7.50	6.80
S.D.	1.58	2.30
Range	5-9	2-9
CL2 Perceived health of friend		
Mean	7.50	7.30
S.D.	.85	1.57
Range	6-9	4-9
CL3 Perceived health before bereavement		
Mean	6.00	5.70
S.D.	2.67	2.60
Range	0-9	2-9
CL4 Perceived health 3 months after bereavement		
Mean	5.30	5.40
S.D.	2.70	2.50
Range	2-9	2-9

Note. Perceived health measurement scale ranges from 0-9, with 9 indicating the best possible health. [a] n = 10 for each group.

Table 12

Means, Standard Deviation and One-Way-Analysis of Variance on the Ways of Coping with the Appraisal of Bereavement

Ways of Coping	Appraisal of Bereavement				
	[a] #1	[b] #2	[c] #3	F	p*
Confrontive coping					
Means	.87	.94	1.05	.16	.85
S.D.	.62	.68	.36		
Distancing					
Means	1.20	1.29	1.02	.30	.75
S.D.	.59	.85	.47		
Self-controlling					
Means	1.37	1.41	1.61	.24	.79
S.D.	.76	.78	.43		
Seeking social support					
Means	1.20	1.25	1.26	.02	.98
S.D.	.57	.75	.52		
Accepting responsibility					
Means	1.00	.47	.36	1.30	.30
S.D.	1.08	.67	.39		
Escape-avoidance					
Means	.67	.30	.21	2.01	.16
S.D.	.62	.38	.21		
Planful problem solving					
Means	1.50	1.79	1.73	.36	.71
S.D.	.76	.74	.25		
Positive reappraisal					
Means	.91	1.66	1.67	1.50	.24
S.D.	1.04	.79	.73		

Note. See Table 10 for levels of bereavement appraisal. [a] $n = 5$ of the total group of 20. [b] $n = 8$ of the total group of 20. [c] $n = 7$ of the total group of 20. *p = <.05.

achieved statistical significance for differences. Therefore, Hypothesis 2 was rejected.

Hypothesis 3: There will be statistically significant correlations among all subjects between the ways of coping and perceived health status; and the appraisal of bereavement and perceived health status.

The strength of the relationships was analyzed by Pearson's r correlational techniques. As may be seen in Table 13, only one coping scale, positive reappraisal, was significantly correlated with perceived current health ($r=.48$, $p<.03$). In the second part of the hypothesis, there were no significant correlations between appraisal of bereavement and perceived health status. This hypothesis was weakly supported, except for the relationship between positive reappraisal and perceived current health.

Table 14 shows a correlation matrix between the perceived health status measures for the entire sample. A significant correlation ($r=.56$, $p<.01$) was achieved between perceived current health (CL1) and perceived health of a married friend (CL2). Thus, the bereaved widow perceived that her present health was similar to that of a married friend. In viewing their

Table 13

Correlation of Appraisal of Bereavement, Ways of Coping Scales, and Perceived Health Status Among the Sample

Perceived Health	Now CL1	Friend CL2	Prior CL3	3 months CL4
	a			
Appraisal of Bereavement	.16	-.15	.11	.14
Confrontive coping	.01	.30	-.26	-.34
Distancing	.04	.20	-.32	-.08
Self-controlling	.11	.38	-.28	-.16
Seeking social support	.17	.41	-.05	-.08
Accepting responsibility	-.04	.12	.23	-.18
Escape-avoidance	-.16	.16	.19	.21
Planful problem solving	.34	.28	-.10	-.30
Positive reappraisal	.48*	.28	.04	-.08

Note. a = correlation coefficient (r). *p = .03.

Table 14

Correlation of Perceived Health Status Among the Sample

	CL1	CL2	CL3	CL4
	a			
CL1-Perceived Health Now	----	.56*	.32	.48*
	b			
	----	.01	.17	.03
CL2-Perceived Health of Friend		----	-.15	.04
		----	.54	.88
CL3-Perceived Health Prior to Bereavement			----	.74*
			----	.001
CL4-Perceived Health 3 Months After Bereavement				----

Note. a = denotes correlation coefficient. b = denotes p value.
* = significant correlation (r).

health similar to a married friend (a reference group) might indicate that the bereaved widows feel that their health was in accord with others their own age.

Another positive correlation ($r=.48$, $p<.03$) was achieved between perceived health now (CL1) and perceived health three months after bereavement (CL4). This may also indicate that their health did not deteriorate in the months following the death of their spouse. The strongest relationship ($r=.74$, $p<.001$) was obtained between the perceived health prior to bereavement (CL3) and perceived health three months after bereavement (CL4).

Summary of Results

Few statistical differences were achieved between the two groups of subjects in demographic characteristics and in the hypotheses analysis testing. Only Hypothesis 3 was weakly supported.

Bereaved widows who received counseling and those who did not receive counseling were no different in respect to the ways they coped, their appraisal of bereavement, and their health perception. Taking the sample as a whole, it was also found that there was no

relationship between the ways they coped and their bereavement appraisal. Except for the coping scale of positive reappraisal, coping was not related to health perception, and appraisal was not related to health.

CHAPTER IV

DISCUSSION

Sample

The two groups of the study were similar in most demographic characteristics and factors pertaining to spousal bereavement, except length of marriage. The sample appeared to be a homogeneous group. Thus, the study was successful in controlling for variables that are reported in the literature to affect widow's course of adaptation to bereavement, such as her previous losses, age, social support network, and prior health; and her spouse's length of illness and type of death.

Hypothesis 1

Hypothesis 1 was rejected, as there were no significant differences between widows who received counseling and those who did not receive counseling in coping, appraisal, and perceived health status.

This finding is in agreement with Kane, et al., (1986) and Greer, et al., (1986) who found that

bereavement care provided by hospice was not superior to conventional care in protecting survivors from developing health-related problems. However, the weight of evidence from other studies (Lattanzi, 1984; Osterweis, et al., 1984; Parkes, 1975, 1980) favors the view that hospice does provide health protection function to survivors. At the present time, the elements of the hospice bereavement programs that are reported in the literature are not well documented. Specifically, various facets of the program are not sufficiently described. Because of this situation it is impossible to know the critical factors that make some hospice programs effective (Lattanzi, 1984; Osterweis, et al., 1984; Parkes, 1980) and another ineffective (Kane, et al., 1986; Greer, et al., 1986) to assist the bereaved spouse.

There are many factors that may have mitigated the effect of the hospice program. In the present study, a problem exists in knowing exactly how hospice bereavement care was delivered to the bereaved widows and what conventional care was given to the control group. There is the possibility that widows did not avail themselves of the hospice service in the 13

months period following the death of their husbands. Or it may be that the hospice bereavement program for some reason did not meet the widow's particular needs.

Of course, it is entirely possible that the hospice intervention was effective but that no differences were found due to conditions in the control group. That is, perhaps the control group had access to resources in the community such as support from other informal groups which served the same function in giving assistance in handling their bereavement as that provided by hospice. Such support can come from family, friends, and clergy in an informal way; by other widows in similar circumstances, and by a community support group, such as a Widow-to-Widow organization or self-help group for bereaved persons, which has been shown in many studies to be effective (Lieberman, et al., 1982; Osterweis, 1984; Parkes, 1980; Silverman, 1980; Vachon, 1980).

Finally, it should be noted that failure to confirm Hypothesis 1 could also be attributed to other factors such as the ex post facto nature of the study, small sample size, or weaknesses in measurement of the dependent variables. These factors will be discussed

in the following section.

Hypothesis 2

Hypothesis 2 was rejected as there was no statistically significant differences between the eight ways of coping scales and the three levels of bereavement appraisal. This finding does not support the work of Gass (1987) who found significant differences among the appraisal groups for all ways of coping, except for minimizes threat, seeking social support, and overall emotion-focused coping. The findings of Gass (1987) support that higher threat appraisal contributes to less adequate ways of coping strategies.

One explanation for the failure to achieve a relationship between coping and appraisal in the present study may reside in the measures themselves. The Revised Ways of Coping Questionnaire was used to measure coping and yielded very low alphas on seven of the eight scales. (See Table 5). The reliabilities were probably affected by the type of sample (elderly bereaved widows), the homogeneity of the sample, and the small sample size. The alphas were lower than

those reported by Folkman, et al., (1986) for the revised questionnaire. The drop in coefficient alpha in the present sample (.04 to .30) in comparison to Folkman & Lazarus middle-aged sample is similar to the findings of Gass who reported lower alphas (.06 to .40) than those obtained by the originators of the questionnaire from the middle-aged sample (1980).

Gass used the Original Ways of Coping with an elderly widow sample that was very similar to that of the present investigator. As Folkman, et al., (1986) used a middle-age community sample (N = 150) in the reliability studies, the most likely reason for the differences in reliabilities is the sample tested. The middle-age community sample was more diverse as it included both sexes and covered a wider age span. It is recognized that the reliabilities of the present study are lower than those reported by Gass using a similar population. However, this result may be due partly to the fact that the originators of the scales obtained lower reliabilities on the revised questionnaire in comparison to the original scale.

In sum, it appears that the Revised Ways of Coping Questionnaire is not sensitive enough to provide

sufficient discrimination in the responses of elderly bereaved widows. Further work on the scales is indicated.

The Appraisal of Bereavement instrument needed to have more specific discriminations between the three responses on appraisal, as an overlap in the appraisal choices existed (advised, per personal correspondence, Gass, 1987). Subjects in this present research had difficulty in determining which response category to choose. Further work on the instrument is necessary to discriminate levels of bereavement appraisal.

Hypothesis 3

Hypothesis 3 was weakly supported. There were no statistically significant correlations between the ways of coping and perceived health status, except for positive reappraisal; and no significant correlations between the appraisal of bereavement and perceived health status. The composition and size of the sample and factors related to the measurement of coping and appraisal that could have operated to result in largely nonsignificant findings.

It is possible that the significant association

between positive reappraisal and perceived current health being only one result among the many associations that were tested may have occurred by chance. However, the association may also be meaningful as the items on this positive appraisal scale appear to have face validity for the present sample. For instance, the seven items on the positive reappraisal scale contain coping statements that were relevant to persons experiencing spousal bereavement. These statements were: "Changed or grew as a person in a good way"; "Came out of the experience better than when I went in"; "Found new faith"; "Rediscovered what is important in life"; "Changed something about myself"; "Prayed", and "Inspired to do something creative". In addition, the positive reappraisal scale in this present study achieved an acceptable alpha reliability of .75. This scale appeared to provide diversity of responses and to discriminate responses among the sample. The positive reappraisal scale shows promise for the elderly bereaved population, as the items appear to be relevant to bereavement, and it has shown acceptable degree of reliability. The other seven scales particularly need additional work to test

their relevancy for the older population.

The significant association between positive reappraisal and "perceived health now" is similar to adaptation factors that Heyman and Gianturco (1973) found with widows following a lengthy illness of the deceased spouse. These adaptational factors for a widow were: 1) they had survived a long, dreaded event of conjugal loss; 2) they did everything possible for the husband; 3) they had a sense of peace that their spouse's suffering had ended, and 4) they had a lessening of the sheer physical exhaustion and burden of the nursing care, and 5) they can now go on with own lives (Heyman, et al., 1973).

Discussion of Other Findings

This study supports previous findings of Dimond, 1981; Gass, 1987; and Lazarus, et al., 1984, that individuals use a variety of coping strategies, adaptive and nonadaptive, to manage stressful life events, such as bereavement.

Previous studies of bereavement have suggested a peaking of adverse health consequences between the first and second years. Adverse health consequences

reported by Lindemann, 1944; Osterweis, et al., 1984; Thompson, et al., 1986, and Zisook, et al., 1981 were not evident in the present sample. The bereaved spouses may not have been at risk for poor bereavement outcomes, being a comparatively healthy sample by their own admission.

Limitations

Lazarus and Folkman's revised Ways of Coping Questionnaire is currently being tested on various populations and in regard to a variety of contexts. It has had limited testing with the elderly and/or the bereaved. But in two studies of elderly subjects there were concern about the use of the instruments which were similar to the present investigation (Gass, 1987; Irion, et al., 1987). The instrument was not totally sensitive to the feelings and thoughts of bereaved persons. The 66 statements were often ambigious and hard for many of the subjects to understand in relation to spousal death and age. Selecting an appropriate response was difficult for most subjects, with the response being mostly not used at all or used a great deal, with little variability seen in the answers among

the whole sample. Specific statements should be deleted or revised to make it sensitive for bereavement subjects. The sample size was small and may not have been representative. A larger sample from the agencies was not available as originally contemplated. Partly, it was due to the limitation of having widows who had been bereaved within the last 13 to 25 months.

Further, all data were collected by self-report. Although the measures of the study had acceptable degree of reliability and validity, it is a definite limitation not to have the responses validated through other data collection methods, such as validation from friends or medical records.

Data from Home Health Agencies and Hospice would be of interest to ascertain if families are utilizing the full measure of offered bereavement services. Bereavement outcomes for the elderly availing themselves of the programs would be benefical for nurses, in knowing referral sources for bereaved widows and family members.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This study addressed the problem of health outcomes in elderly bereaved widows. Of primary interest was the concept of bereavement counseling as an effective intervention to alter bereavement outcomes.

The following hypotheses were tested:

1. There would be significant differences between the bereaved widows who received counseling and widows who had not received counseling in coping, appraisal, and perceived health status.

2. There would be statistically significant differences in all subjects between the scores of eight ways of coping scales and the three definitions of appraisal of bereavement.

3. There would be statistically significant correlations in all subjects between the ways of coping and perceived health status; and appraisal of

bereavement and perceived health status.

The present study was based on Gass' (1987) research of the relationships among coping, appraisal, resources, and health dysfunction among older widows. A quasi-experimental design was used to examine the effects of bereavement counseling between a treatment and control group.

The convenience sample consisted of 20 elderly bereaved widows. The criteria for participation were a widow: 1) widowed 13 to 25 months prior to the time of interview; 2) 60 years or older; 3) unmarried; 4) able to understand, read, and write English, and 5) able to fulfill the demands of completing the paper and pencil tests. Ten of subjects had received bereavement counseling as an intervention, while ten subjects had not received counseling. The sample was obtained from a nearby hospice and home health agency.

Data collection instruments included a Selected Subjects Characteristics Form, revised Ways of Coping (1984) Questionnaire, Appraisal of Bereavement Questionnaire, and a self-anchoring Perceived Health Status Scale. Hypothesis 1 and 2 were rejected, while hypothesis 3 was weakly supported. A statistically

significant correlation ($r=.48$, $p<.03$) between the positive reappraisal coping scale and perceived current health was found.

Questions were raised in respect to the applicability of eight ways of coping scales to an elderly bereaved population. Further work on the Appraisal of Bereavement questionnaire is indicated.

Conclusion

Gass' findings were not supported in the present study. And further, the hospice bereavement intervention was not associated with more favorable outcomes to the widows than conventional home health care. It does suggest that further testing the stress-coping model of Lazarus with an elderly population will require revisions of the measures of appraisal and coping. However, the coping strategy of "positive reappraisal" appears to have promise for use in future studies with elderly bereaved persons.

Recommendations

Further study on elderly conjugal bereavement and the effect of bereavement counseling as an

intervention, with the variables of coping and appraisal could be achieved by:

1. Using a more representative sample of elderly bereaved widows.

2. Doing a longitudinal study with timely assessments of the elderly over a two year period to evaluate bereavement intervention outcomes.

3. Interviewing the subjects at different time periods during the bereavement process.

4. Using physical and psychological assessments of widows to add validation to the measures of health status, in addition to self-report data.

5. Using instruments more specific to measuring grief, coping and appraisal in the elderly.

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APPENDIX A

Selected Subject Characteristics Form

ID#_____

BEREAVEMENTMENT QUESTIONNAIRE
Selected Subject Characteristics

A. Illness and Death of Spouse

BQ1 Was your spouse's death
1). an acute illness death? (The death occurred without warning and prior knowledge of the condition within two months).
2). a chronic illness death? (The death occurred more than two months after diagnosis).

BQ2 Did your spouse's death occur
1). at home?
2). in the hospital?
3). in a nursing home?
4). in another place? _____

BQ3 How long did you care for your spouse while he was ill before death? _____months

BQ4 How do you perceive your current state of health now as compared to your health before your spouse's death?
1). better
2). same
3). worse

B. Subject Characteristics

BQ5 What is your age and date of birth? AGE_____
DATE OF BIRTH_____/_____/_____
month day year

BQ6 What is the highest educational level you have completed?
1 2 3 4 5 6 7 8 9 10 11 12*
COLLEGE: 13 14 15 16*
POST GRADUATE: 17* Highest degree attained_____
*If 10-12 are circled, note if high school graduate.
13-16 are circled, note any type of degree awarded (such as A.A. or Baccalaurate).

BQ7 What is your current or prior occupation?_____

ID#_____

BQ8 What is your religion?
1). Protestant
2). Catholic
3). Jewish
4). Other_____

BQ9 What is your ethnic background (race)?
1). Asian
2). Black
3). Caucasian
4). Mexican-American
5). Native American
6). Other_____

BQ10 How long were you and your spouse married?_____

BQ11 Do you have any children?_____ BQ12 How many?_____

Where is your place of residence?_____

BQ12 How many people live with you in your household?_____

BQ13 How many of your close relatives live within fifty miles of you?_____

BQ14 Do you get out to participate in activities by yourself or with other people?
1). yes
2). no

BQ15 What is the approximate income from all sources you anticipate this year (1988)?
1). 0- $ 4,999
2). $5,000- $14,999
3). $15,000- $24,999
4). $25,000- $34,999
5). $35,000 or more

C. Coping and Support

BQ16 Who helped you the most to cope with the death of your spouse?
1). family
2). friends
3). nurses
4). physician
5). other_____

What was the most important help you received during your bereavement?_____

BQ17 Prior to the death of your spouse, did you receive information on grieving and/or widowhood from friends or others?
1). yes
2). no

BQ18 If yes, did this information help you to know what to expect when you lost your spouse?
1). yes
2). no
3). not applicable

4. Comments

Additional comments you want to share_____

_____

_____

_____

_____

THANK YOU FOR YOUR PARTICIPATION

APPENDIX B

1984 Revised Ways of Coping Questionnaire

ID #_____

WAYS OF COPING (Revised)

Please read each item below and indicate, by circling the appropriate category, to what extent you used it in the situation you have just described.

		Not used	Used somewhat	Used quite a bit	Used a great deal
1.	Just concentrated on what I had to do next -- the next step.	0	1	2	3
2.	I tried to analyze the problem in order to understand it better.	0	1	2	3
3.	Turned to work or substitute activity to take my mind off things.	0	1	2	3
4.	I felt that time would make a difference -- the only thing to do was to wait.	0	1	2	3
5.	Bargained or compromised to get something positive from the situation.	0	1	2	3
6.	I did something which I didn't think would work, but at least I was doing something.	0	1	2	3
7.	Tried to get the person responsible to change his or her mind.	0	1	2	3
8.	Talked to someone to find out more about the situation.	0	1	2	3
9.	Criticized or lectured myself.	0	1	2	3
10.	Tried not to burn my bridges, but leave things open somewhat.	0	1	2	3
11.	Hoped a miracle would happen.	0	1	2	3
12.	Went along with fate; sometimes I just have bad luck.	0	1	2	3
13.	Went on as if nothing had happened.	0	1	2	3
14.	I tried to keep my feelings to myself.	0	1	2	3
15.	Looked for the silver lining, so to speak; tried to look on the bright side of things.	0	1	2	3
16.	Slept more than usual.	0	1	2	3
17.	I expressed anger to the person(s) who caused the problem.	0	1	2	3
18.	Accepted sympathy and understanding from someone.	0	1	2	3
19.	I told myself things that helped me to feel better.	0	1	2	3
20.	I was inspired to do something creative.	0	1	2	3
21.	Tried to forget the whole thing.	0	1	2	3
22.	I got professional help.	0	1	2	3

	Not used	Used some-what	Used quite a bit	Used a great deal
23. Changed or grew as a person in a good way.	0	1	2	3
24. I waited to see what would happen before doing anything.	0	1	2	3
25. I apologized or did something to make up.	0	1	2	3
26. I made a plan of action and followed it.	0	1	2	3
27. I accepted the next best thing to what I wanted.	0	1	2	3
28. I let my feelings out somehow.	0	1	2	3
29. Realized I brought the problem on myself.	0	1	2	3
30. I came out of the experience better than when I went in.	0	1	2	3
31. Talked to someone who could do something concrete about the problem.	0	1	2	3
32. Got away from it for a while; tried to rest or take a vacation.	0	1	2	3
33. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.	0	1	2	3
34. Took a big chance or did something very risky.	0	1	2	3
35. I tried not to act too hastily or follow my first hunch.	0	1	2	3
36. Found new faith.	0	1	2	3
37. Maintained my pride and kept a stiff upper lip.	0	1	2	3
38. Rediscovered what is important in life.	0	1	2	3
39. Changed something so things would turn out all right.	0	1	2	3
40. Avoided being with people in general.	0	1	2	3
41. Didn't let it get to me; refused to think too much about it.	0	1	2	3
42. I asked a relative or friend I respected for advice.	0	1	2	3
43. Kept others from knowing how bad things were.	0	1	2	3
44. Made light of the situation; refused to get too serious about it.	0	1	2	3
45. Talked to someone about how I was feeling.	0	1	2	3
46. Stood my ground and fought for what I wanted.	0	1	2	3
47. Took it out on other people.	0	1	2	3

		Not used	Used some-what	Used quite a bit	Used a great deal
48.	Drew on my past experiences; I was in a similar situation before.	0	1	2	3
49.	I knew what had to be done, so I doubled my efforts to make things work.	0	1	2	3
50.	Refused to believe that it had happened.	0	1	2	3
51.	I made a promise to myself that things would be different next time.	0	1	2	3
52.	Came up with a couple of different solutions to the problem.	0	1	2	3
53.	Accepted it, since nothing could be done.	0	1	2	3
54.	I tried to keep my feelings from interfering with others things too much.	0	1	2	3
55.	Wished that I could change what had happened or how I felt.	0	1	2	3
56.	I changed something about myself.	0	1	2	3
57.	I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3
58.	Wished that the situation would go away or somehow be over with.	0	1	2	3
59.	Had fantasies or wishes about how things might turn out.	0	1	2	3
60.	I prayed.	0	1	2	3
61.	I prepared myself for the worst.	0	1	2	3
62.	I went over in my mind what I would say or do.	0	1	2	3
63.	I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
64.	I tried to see things from the other person's point of view.	0	1	2	3
65.	I reminded myself how much worse things could be.	0	1	2	3
66.	I jogged or exercised.	0	1	2	3

APPENDIX C

Appraisal of Bereavement

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 other 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 in the future (for example, finding substitute relationships, finding new roles)).

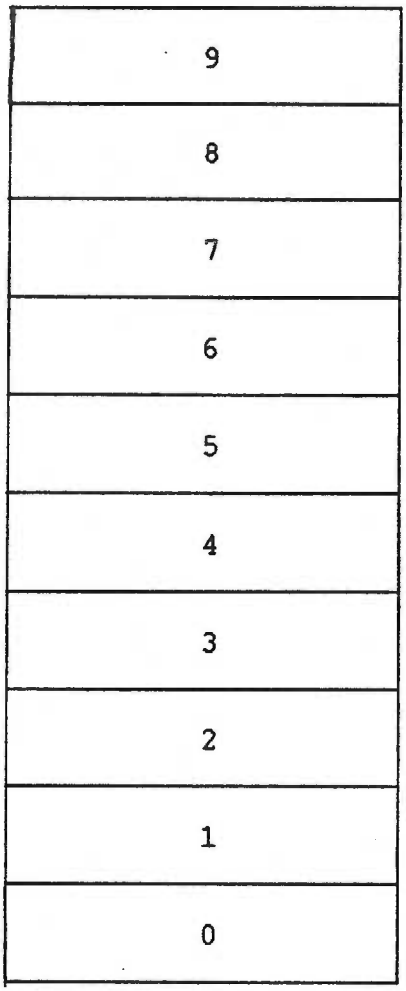
3). A challenge, that is, a stressful experience which will be overcome or mastered. (You view your bereavement as stressful, but you are determined that you will overcome or master this experience despite what is to come in the future).

APPENDIX D

Cantril Ladder of Perceived Health

ID #____

CANTRIL'S LADDER



Best Possible Health

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 <u>right</u> now? _____ (Please write down the number of the step)
2. On which step would you say the health of a friend of yours who is the same age and married? _____
3. On which step would you say your health was <u>prior</u> to death of your spouse? _____
4. On which step would you say your health was <u>three months after</u> the death of your spouse? _____

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

APPENDIX E

Consent to Provide Subject's Names

CONSENT TO PROVIDE SUBJECT'S NAMES

Hospice agrees to provide Mary Anne Hawley, BSN, a graduate student at the Oregon Health Sciences University with names and addresses of spouses of deceased patients. The purpose is to assist her with obtaining subjects for the data collection of her Master's Research Project on Bereavement, Coping, and Health of Older Widows.

Mary Anne Hawley will not have access to any other information on the chart, except the data provided her by the agency. In return for assisting in the project, she will share with the Hospice the results of her findings.

_____	_____
Date	Hospice
_____	_____
Date	Mary Anne Hawley, BSN

CONSENT TO PROVIDE SUBJECT'S NAMES

The Home Health Agency agrees to provide Mary Anne Hawley, BSN, a graduate student at the Oregon Health Sciences University with names and addresses of spouses of deceased patients. The purpose is to assist her with obtaining subjects for the data collection of her Master's Research Project on Bereavement, Coping, and Health of Older Widows.

Mary Anne Hawley will not have access to any other information on the chart, except the data provided her by the agency. In return for assisting in the project, she will share with the Home Health Agency the results of her findings.

_____	_____
Date	Home Health Agency
_____	_____
Date	Mary Anne Hawley, BSN

APPENDIX F

Agency Letter to Potential Sample

June 13, 1988

Dear

Home Health has been approached about participating in a research project by Mary Anne Hawley, RN, a graduate student at the Oregon Health Sciences University. As part of the requirements for her Masters Degree, she is studying how widows cope with the loss of their spouses through bereavement and how this process affects the health of the widows. Home Health has agreed to provide Ms. Hawley with a list of previous patients that qualify as potential candidates for her research project.

Some time in the near future, you may be contacted by Ms. Hawley soliciting your interest in participating in her study. I would like you to understand that your participation in this research project is voluntary. Your relationship with Home Health will continue as it has in the past, whether you decide to accept or decline Ms. Hawley's invitation. Home Health supports Ms. Hawley's efforts, thus providing her with the list of names. However, we recognize that participation in a study such as this will need to be voluntary based on each individual's needs at the particular time.

If you have any questions regarding the information received from Ms. Hawley in the future, please feel free to contact me at your convenience.

Sincerely,

Director

APPENDIX G

Letter of Explanation of the Study

Letter of Explanation

Oregon Health Sciences University

Dear Mrs.

This letter is about a research study on how older widows manage the loss of their spouse. I am a registered nurse and a graduate student at the Oregon Health Sciences University. As part of my requirements for my Master's Degree, I am doing this research project. I am studying how widows appraise and cope with the loss of their husbands, factors that affected their bereavement, and the health of widows.

Your name and address were obtained from the Home Health Agency or from the Hospice, which provided health care services for your husband. The agencies are assisting me with this research study.

I would sincerely appreciate your help with this project. This assistance involves about one to one and one-half hours of your time to answer questions regarding your bereavement in the loss of your husband. At a time which is convenient for you I will come to your home, or to another place if you wish, to ask you these questions.

All information you share with me will be treated in a confidential manner. Anonymity will be assured, as your name will not be used on any of the questionnaires or in the final report of my study. Your participation will not involve any known risks. Your refusal to participate in this study will not affect your relationship with either of the referring agencies.

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. It will also assist nurses in providing appropriate help to older widows.

I will call you, following the return of the enclosed postcard to me, and answer any questions you may have about participating in my study. At that time, we will set up a time for the interview.

I will look forward to hearing from you and meeting you. Thank you very much.

Sincerely yours,

Mary Anne Hawley, R.N.

APPENDIX H

Letter of Informed Consent

LETTER OF INFORMED CONSENT

Oregon Health Sciences University

I,_____, herewith agree to serve as subject in the research study "Bereavement, Coping, and Health Status of Older Widows", conducted by Mary Anne Hawley, BSN, under the supervision of May Rawlinson, R.N., Ph.D., at the Oregon Health Sciences University, School of Nursing. The research aims to discover how coping and appraisal affects health status of the bereaved widow. I understand that my participation will involve:

1. Accepting a home visit, or at a place I choose, from Mary Anne Hawley to receive three (3) questionnaires and a personal interview. This visit will last no longer than one and one-half hours. The questionnaires deal with the loss of my husband, how I reacted and coped with it and how I perceive my health.

2. All information that I give will be handled confidentially. My anonymity will be maintained on all documents, which will be identified by code numbers.

3. I will not benefit directly, but my participation in this research study will help nurses in understanding the bereavement process and experience of older widows.

4. My participation does not involve any known risks.

5. I understand that I am free to participate or withdraw from participation in this study at any time, and it will in no way affect my relationship with the Home Health Agency or the Hospice.

6. Mary Anne Hawley has offered to answer any questions I might have about the study and what is required of me.

I have read the explanation and agree to participate as a subject in the study described.

Date_____ Signed_____

Witness_____

APPENDIX I

Committee on Human Research

THE OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, L106, Portland, Oregon 97201 (503) 279-7784/7887
Research Services

Date: May 19, 1988

To: Mary A. Hawley, MSN

From: Donna Buker, Administrative Assistant
Committee on Human Research

Subject: Bereavement, Coping and Health Status of Older Widows

The above entitled study falls under category #_3___ and is considered to be exempt from review by the Committee on Human Research. Therefore, I have put your study into our exempt files and you will receive no further communication from the committee concerning this study.

If the involvement of human subjects in this study changes you should contact the Committee on Human Research to find out whether or not these changes should be reviewed.

If you have any questions regarding the status of this study, please contact Donna Buker at X7887.

APPENDIX J

Gass Correspondence

p1

Center for Health Sciences
University of Wisconsin-Madison
School of Nursing

600 Highland Avenue
Madison, Wisconsin 53792

December 2, 1987

Dear Ms. Hawley,

Greetings! Thank you for your interest in my research. Yes, you may replicate any part of my study you like. You mentioned in your letter that you will study widows bereaved 11 to 24 months. Recall that I focused on widows bereaved less than one year. I am very interested in receiving a copy (summary) of your findings for sharing my materials. You sound like you have an exciting project! It would be interesting to know if widows who attend a support group differ in appraisal and

(continued)

Center for Health Sciences
University of Wisconsin-Madison
School of Nursing

600 Highland Avenue
Madison, Wisconsin 53792

coping and health from those who do not attend a support group.

I have enclosed photocopies of my instruments and other materials from my dissertation which may be helpful to you. I suggest you do use the "revised ways of coping" (based on the community and not the student sample). However, your informants will differ from those in my study. (I used the original yes-no version of the ways of coping).

I am returning your check for 1.00 since I found photocopying.

I look forward to hearing about what you have learned.

(continued)

Center for Health Sciences
University of Wisconsin-Madison
School of Nursing

600 Highland Avenue
Madison, Wisconsin 53792

If I can be of further assistance, please let me know. Best wishes.

Sincerely,

[redacted] MSN, RN
Assistant Professor

AN ABSTRACT OF THE MASTER'S RESEARCH PROJECT OF
MARY ANNE HAWLEY

For the MASTER OF SCIENCE
Date of Receiving this Degree: December 5, 1988
Title: Bereavement, Coping and Health Status of Older Widows

APPROVED: [redacted]
May Rawlinson, Ph.D., Professor, Master's Research Project Advisor

This study addressed the problem of health outcomes in elderly bereaved widows which was based on Gass' (1987) research of the relationships among coping, appraisal, resources, and health dysfunction among older widows. The study by Gass was partially replicated and extended to investigate the effects of bereavement counseling as an intervention to alter bereavement outcomes.

The convenience sample, obtained from a hospice and a home health agency, consisted of 20 elderly bereaved widows. The criteria for participation were a widow: 1) widowed 13 to 25 months prior to the time of interview; 2) 60 years or older; 3) unmarried; 4) able to understand, read, and write English, and 5) able to fulfill the demands of completing the paper and pencil tests.

In this quasi-experimental study, 10 of the subjects had received hospice bereavement counseling as an intervention for 13 months post-bereavement, while 10 subjects had not received counseling. Data collection instruments were a Selected Subjects Characteristics Form, revised Ways of Coping (1984) Questionnaire, Appraisal of Bereavement Questionnaire, and a self-anchoring Perceived Health Status Scale.

No differences were found between the two groups in the ways of coping, appraisal of bereavement, and perceived health status. Considering the sample as a whole, there were no differences between the eight ways of coping, appraisal of bereavement, and perceived health. Only the coping scale of positive reappraisal was statistically significantly related to health perception.

Questions were raised in respect to the applicability of eight Ways of Coping scales to an elderly bereaved population. Further work on the Appraisal of Bereavement questionnaire is indicated. Conclusions were drawn and recommendations for future study were offered.